

2006 Report on the global AIDS epidemic

A UNAIDS 10th anniversary special edition

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UNAIDS brings together in the AIDS response the efforts and resources of ten UN system organizations.



The **OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)** is mandated to lead and coordinate international action to protect refugees and other persons of concern. UNHCR strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another State. In 50 years, the agency has helped an estimated 50 million people restart their lives. UNHCR is at the forefront of combating HIV and AIDS among conflict-affected and displaced populations. Refugees, asylum seekers and internally displaced persons are at risk of infection as conflict and displacement expose them to poverty, family disintegration, social disruption and increased sexual violence. HIV and AIDS prevention, care and treatment, including access to antiretroviral treatment, are central to the overall protection of refugees and other persons of concern to UNHCR.



For 60 years, the **UNITED NATIONS CHILDREN'S FUND (UNICEF)** has been working with partners around the world to promote the recognition and fulfilment of children's human rights. This mandate was established in the Convention on the Rights of the Child, and is achieved through partnerships with governments, nongovernmental organizations and individuals in 162 countries, areas and territories. UNICEF brings to UNAIDS this extensive network and its ability for effective communication and advocacy. UNICEF's priorities in addressing the AIDS epidemic include prevention among young people, reducing mother-to-child transmission and caring for and protecting orphans, vulnerable children, young people and parents living with HIV or AIDS.



The **WORLD FOOD PROGRAMME (WFP)** is the world's largest humanitarian agency. It helps poor households affected by hunger and AIDS by using food aid and other resources to address prevention, care and support. WFP's food assistance helps keep parents alive longer, enables orphans and vulnerable children to stay in school, permits out-of-school youth to secure viable livelihoods and enables tuberculosis patients to complete their treatment. WFP works in partnership with governments, other United Nations agencies, non-governmental organizations and communities and helps people—regardless of their HIV status—who lack adequate food to secure nutrition and food security.



The **UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)** is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. Working on the ground in 166 countries, the organization supports national partners in finding their own solutions to development challenges. Responding to HIV and AIDS is one of UNDP's core priorities, and as a cosponsor of UNAIDS, focus areas include addressing the human development and governance dimensions of AIDS, protecting the rights of people living with HIV, and promoting gender equality. UNDP helps countries to place responses to AIDS at the centre of national development plans and processes, and builds national capacity for coordinated action across sectors.



United Nations Population Fund

UNFPA, the **UNITED NATIONS POPULATION FUND**, builds on over three decades of experience in reproductive health and population issues by focusing its response to the epidemic—in over 140 countries—on HIV prevention among young people and pregnant women, comprehensive male and female condom programming and strengthening the integration of reproductive health and AIDS. UNFPA further contributes through meeting the reproductive health rights and needs of HIV-positive women and adolescents, promoting voluntary counselling and testing as well as services which prevent mother-to-child HIV transmission, improving access to HIV and AIDS information and education and to preventive commodities, including those needed in emergency settings. It also provides demographic and socio-cultural studies to guide programme and policy development.



Within UNAIDS, the **UNITED NATIONS OFFICE ON DRUGS AND CRIME (UNODC)** is the lead agency for HIV and AIDS and injecting drug use and in prisons. Across the UN family, UNODC is also responsible for facilitating the development of a UN response to HIV and AIDS associated with human trafficking. These marginalized populations are often subjected to discrimination and neglect. Only few have access to HIV prevention and care services. UNODC assists countries to provide injecting drug users, prisoners and potential and actual victims of human trafficking with comprehensive HIV prevention and care services equivalent to those available in the community through support in developing effective legislation and policies and capacity-building to ensure high coverage with HIV services.



The **INTERNATIONAL LABOUR ORGANIZATION (ILO)** promotes decent work and productive employment for all, based on principles of social justice and non-discrimination. The ILO's contribution to UNAIDS includes: its tripartite membership, encouraging governments, employers and workers to mobilize against AIDS; direct access to the workplace; long experience in framing international standards to protect the rights of workers; and a global technical cooperation programme. The ILO has produced a Code of Practice on HIV/AIDS and the world of work—an international guideline for developing national and workplace policies and programmes.



Within the UN system, the **UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO)** has a special responsibility for education. Since ignorance is a major factor in the AIDS epidemic, prevention education is at the top of UNESCO's agenda. Education is needed to make people aware that they are at risk or vulnerable, as well as to generate skills and motivation necessary for adopting behaviour to reduce risk and vulnerability and to protect human rights. UNESCO works with governments and civil society organizations to implement policies and programmes for prevention education, and to mitigate the impact of AIDS on education systems.



The objective of the **WORLD HEALTH ORGANIZATION (WHO)** is the attainment by all peoples of the highest possible level of health. Its work in HIV and AIDS is focused on the rapid scale up of treatment and care while accelerating prevention and strengthening health systems so that the health sector response to the epidemic is more effective and comprehensive. WHO defines and develops effective technical norms and guidelines, promotes partnership and provides strategic and technical support to Member States. The Organization also contributes to the global AIDS knowledge base by supporting surveillance, monitoring and evaluation, reviewing the evidence for interventions and promoting the integration of research into health service delivery.



The **WORLD BANK's** mission is to fight poverty with passion and professionalism. To combat AIDS, which is threatening to reverse the gains of development, the Bank has committed more than US\$ 2 billion for HIV and AIDS projects worldwide. Most of the resources have been provided on highly concessional terms, including grants for the poorest countries. To address the devastating consequences of AIDS on development, the Bank is strengthening its response in partnership with UNAIDS, donor agencies and governments. The Bank's response is comprehensive, encompassing prevention, care, treatment and impact mitigation.

PREFACE



This year marks a quarter century since the first cases of AIDS were reported. In that time, AIDS has fundamentally changed our world—killing more than 25 million men and women, orphaning millions of children, exacerbating poverty and hunger, and, in some countries, even reversing human development altogether. Nearly 40 million people are living with HIV today—half of them women. What was first reported as a few cases of a mystery illness is now a pandemic that poses among the greatest threats to global progress in the 21st century.

After a tragically late and slow start, the world's response has gathered strength—as we saw at the United Nations General Assembly Special Session on HIV/AIDS five years ago. Since then, there has been remarkable progress in rallying political leadership, mobilizing financial and technical resources, bringing lifesaving antiretroviral treatment to people the world over, and even reversing the spread in some of the world's poorest nations.

It is my hope that the General Assembly 2006 High Level Meeting on AIDS—a key follow-up to the Special Session—will help move the response to AIDS to yet another level: effectively containing and reversing the pandemic. That means doing much more than simply redoubling our current efforts. We need a far greater commitment of political will, courage and resources: we need united action on a new scale.

The only acceptable goal for the world is to stop and, ultimately, put an end to AIDS. Only then will we achieve the Millennium Development Goals and succeed in our efforts to build a humane, healthy and equitable world.

A handwritten signature in black ink, which appears to read "K. Annan". The signature is fluid and stylized, with the first letters of the first and last names being capitalized and prominent.

Kofi A. Annan
Secretary-General of the United Nations

FOREWORD



The 2006 Report on the global AIDS epidemic shows that the world is at a defining moment in its response to the AIDS crisis. Even though the pandemic and its toll are outstripping the worst predictions, for the first time ever we have the will, means and knowledge needed to make real headway.

Since the world's leaders committed themselves, at the 2001 UN General Assembly Special Session on HIV/AIDS, to mount an urgent response to AIDS, there has been real progress on key fronts. Goals that appeared impossible to achieve just five years ago have now been realized. There is robust political commitment today. In nearly 40 developing countries, the national AIDS response is now personally led by heads of government or their deputies. Total financing for the response in developing countries rose fivefold between 2001 and 2005, reaching US\$ 8.3 billion in the last year. About 1.3 million people in developing countries are on life-preserving antiretrovirals medicines, which saved about 300 000 lives last year alone. And in more and more countries, on every continent, AIDS epidemics are declining—the most concrete proof that AIDS is a problem with a solution.

Thus, today the foundations exist for the world to mount a response commensurate with the challenge of stopping and reversing the pandemic.

In the immediate term, we must work at an emergency pace to keep the pledge, made by governments at the World Summit in September 2005, of rapidly scaling up towards universal access the entire range of essential HIV programmes, spanning HIV prevention, treatment, care and impact mitigation. Only access on this population-wide scale can affect the pandemic's trajectory.

But that is just the beginning. Because this pandemic and its toll cannot be reversed in the short term, we need to sustain a full-scale response for the next decades. Each intervention, plan and programme established today must become the building block for longer-term, sustainable strategies to free the world of AIDS. We must make this conceptual leap in our planning and actions—and move from the reactive to the active and strategic.

To get us to the point where future generations are free from AIDS will require that every aspect of the response be sustained over the longer term—leadership commitment, activism, financial resources, innovation in developing new medicines and preventive technologies, and, not least, real action to tackle the fundamental drivers of this pandemic, particularly gender inequality, poverty and discrimination.

In this 25th year of AIDS, success is in sight—but securing it will require an unprecedented response from the world for the next decades. We cannot afford to rest until then.

A handwritten signature in black ink, appearing to read 'P. Piot'.

Peter Piot
Executive Director
Joint United Nations Programme on HIV/AIDS

Chapter 01



INTRODUCTION

"In June of 1981 we saw a young gay man with the most devastating immune deficiency we had ever seen. We said, 'We don't know what this is, but we hope we don't ever see another case like it again'." (WHO, 1994)

The words of Dr. Samuel Broder, then of the National Cancer Institute in the United States of America, remind us how much the world has changed in 25 years, since physicians saw the earliest cases of AIDS in hospitals in the United States, in the Democratic Republic of the Congo and on the shores of Lake Victoria, East Africa. The world was slow to recognize the gravity of this new health crisis, and in the years in which AIDS remained off the political agenda, the infection took a foothold that it has not yet relinquished. Indeed, affected communities galvanized and drove much of the initial response to the rapidly developing epidemic.

By 1985, with cases reported in every region of the world, a group of scientists and health professionals came together under the auspices of the World Health Organization (WHO) to recommend a global strategy for AIDS prevention and control that was then endorsed by the World Health Assembly and the United Nations General Assembly. With the establishment of the Global Programme

on AIDS in 1987 and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996, the United Nations moved to address AIDS not as an isolated health problem but as a human development issue as significant as any facing the world today.

At the 2001 Special Session of the UN General Assembly on AIDS, 189 nations agreed that AIDS was a national and international development issue of the highest priority, signing an historic Declaration of Commitment on HIV/AIDS that promised innovative responses, coordinated efforts and accountability for progress against the epidemic. The Declaration set a comprehensive list of time-bound targets to support the Millennium Development Goal of halting and beginning to reverse the epidemic by 2015. Importantly, the Declaration also called for an assessment of national, regional and global progress against AIDS at the end of 2003, 2005 and 2010, using a series of core indicators developed by UNAIDS and diverse partners.

Building on that commitment, this report summarizes and analyses data from reports from 126 countries collected by UNAIDS between December 2005 and March 2006, along with additional reporting on key HIV prevention, treatment, care and support interventions prepared by UNAIDS and civil society groups. This is the first systematic reporting by countries on services for populations most at risk, and these reports provide one of the most comprehensive reviews of progress made and obstacles to be overcome in the response to AIDS.

The story told in this report is complex and at times disheartening. New systems, including greatly improved surveillance, tell us with increasing accuracy where and how the epidemic is moving. Nearly twenty-five years of experience with HIV prevention and ten years of experience with effective antiretroviral therapy have produced mountains of evidence about how to prevent and treat this disease. Yet, these advances in the social and biomedical sciences, while vitally important to mounting an effective response, do nothing to mitigate the shortages of leadership and human compassion that frequently hinder progress towards our shared goals.

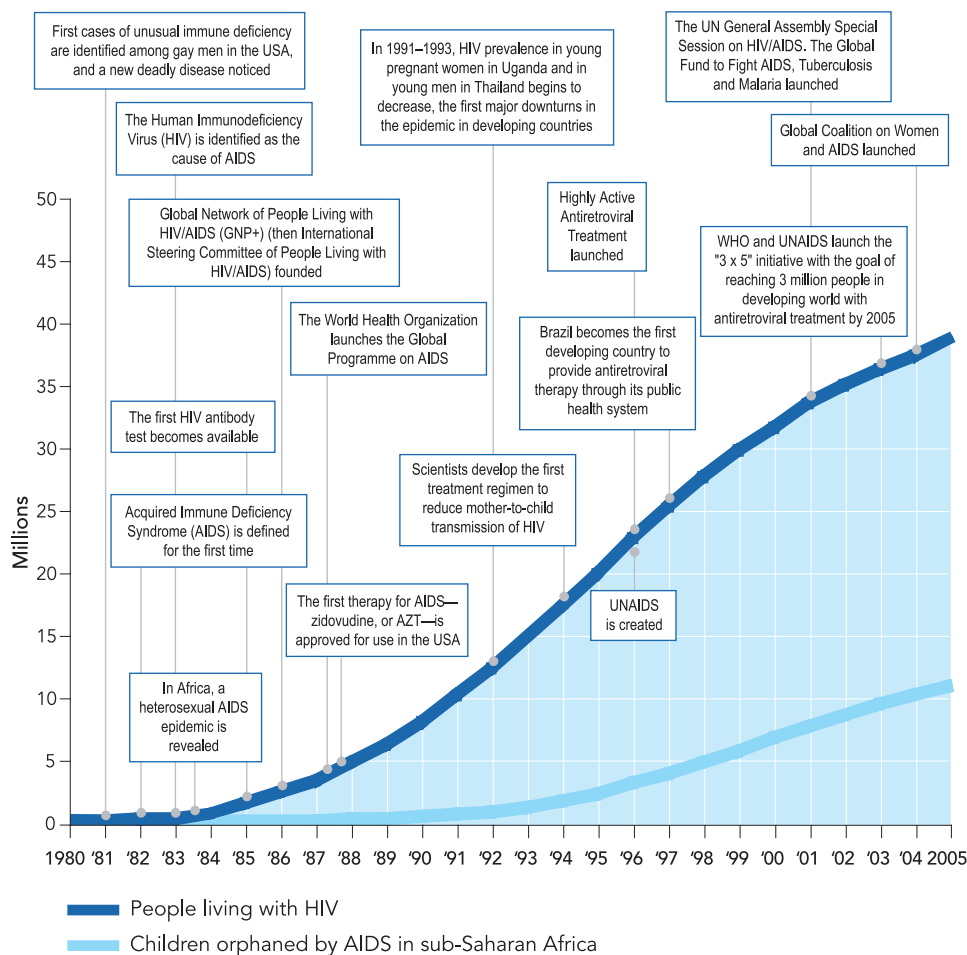
This report provides one of the most comprehensive pictures ever developed of how the epidemic is affecting women and girls, men, young people, sex workers, injecting drug users, men who have sex with men, prisoners and babies born with HIV. It provides a regional picture, from sub-Saharan Africa where a mature epidemic continues to expand beyond limits that many experts believed impossible, to relatively new but rapidly growing epidemics in regions such as eastern Europe and South-East Asia that may come to rival that of sub-Saharan Africa in scope. In doing so, it also illustrates some enormous and often frightening divides . . . between the number of people in need and the number being helped; between what we could be doing to stop AIDS, and what is actually being done today.

Many successes are also documented here, in terms of behavioural change, national responses and increasing access to prevention, care and treatment. This report includes stories of brave and effective action that have demonstrated time and again that HIV can be stopped with concerted effort and the use of evidence-



Nearly twenty-five years of experience with HIV prevention and ten years of experience with effective antiretroviral therapy have produced mountains of evidence about how to prevent and treat HIV.

FIGURE 1.1 25 years of AIDS



based strategies. Overall, however, despite some notable achievements, the response to the AIDS epidemic to date has been nowhere near adequate. In just 25 years, HIV has spread relentlessly from a few widely scattered “hot spots” to virtually every country in the world, infecting 65 million people and killing 25 million.

As noted in The Declaration of Commitment on HIV/AIDS Five Years Later, Report of the Secretary-General, “A quarter century into the epidemic, the global AIDS response stands at a crossroads. For the first time ever the world

possesses the means to begin to reverse the epidemic. But success will require unprecedented willingness on the part of all actors in the global response to fulfill their potential, to embrace new ways of working with each other, and to . . . sustain the response over the long term.”

Barriers to providing widespread HIV prevention and treatment, such as lack of infrastructure, poor transportation or shortages of trained workers are substantial and can only be overcome through our greatest collective efforts. As we mobilize to address these, however, we



We must fortify the responses of those nations struggling to meet their goals and we must continue to demand greater action from those that have not yet responded to the best of their abilities.

must not forget that stigma, discrimination and denial about issues such as sexuality and drug use may be as great as any other barrier to an effective response to AIDS. It has been estimated that as many as two-thirds of the new HIV infections expected to occur in this decade could be averted by the implementation of a comprehensive range of evidence-based prevention measures (UNAIDS, 2005). Yet access to HIV prevention, care and treatment is continually limited by unwillingness to address issues long considered taboo, such as sex, sexuality and drug use. This must change.

This report shows wide differences between countries in implementing the response pledged in the Declaration of Commitment on HIV/AIDS. While some have reached key targets and milestones, many have fallen short of the pledges made in 2001. We must fortify the responses of those nations struggling to meet their goals and demand greater action from those that have not yet responded to the best of their abilities.

Failure to meet the goals to which all member nations have pledged is a serious



Failure to meet the goals to which all member nations have pledged is a serious matter with global consequences.

matter with global consequences. If we do not urgently strengthen the AIDS response, neither the 2010 targets nor the Millennium Development Goal of halting the spread of AIDS and rolling back HIV infections by 2015 will be met. Failure to meet this Goal will also seriously endanger progress towards the Millennium Development Goals to reduce poverty, hunger and childhood mortality, as each of these is inextricably tied to our response—or lack of response—to AIDS.

National economies and international security are at risk.

One of the greatest paradoxes is that, although it causes 11 000 new infections and (nearly) 8000 deaths daily, in many ways the epidemic remains hidden. It is hoped that this report will help take this epidemic one step further out of the shadows and into the centre of the global agenda. In the 21st century, we are all living with HIV, and we must all be part of the response.

Chapter 02



OVERVIEW OF THE GLOBAL AIDS EPIDEMIC

An estimated 38.6 million [33.4 million–46.0 million] people worldwide were living with HIV in 2005. An estimated 4.1 million [3.4 million–6.2 million] became newly infected with HIV and an estimated 2.8 million [2.4 million–3.3 million] lost their lives to AIDS.

Introduction

Overall globally, the HIV incidence rate (the annual number of new HIV infections as a proportion of previously uninfected persons) is believed to have peaked in the late 1990s and to have stabilized subsequently, notwithstanding increasing incidence in a number countries. In several countries, favourable trends in incidence are related to changes in behaviour and prevention programmes. Changes in incidence along with rising AIDS mortality have caused global HIV *prevalence* (the proportion of people living with HIV) to level off (see Figure 2.1). However, the *numbers* of people living with HIV have continued to rise, due to population growth and, more recently, the life-prolonging effects of antiretroviral therapy. In sub-Saharan Africa, the region with the largest burden of the AIDS

epidemic, data also indicate that the HIV incidence rate has peaked in most countries. However, the epidemics in this region are highly diverse and especially severe in southern Africa, where some of the epidemics are still expanding.

New survey data underscore the disproportionate impact of the AIDS epidemic on women, especially in sub-Saharan Africa where, on average, three women are HIV-infected for every two men. Among young people (15–24 years), that ratio widens considerably, to three young women for every young man.

Among the notable new trends are the recent declines in national HIV prevalence¹ in two sub-Saharan African countries (**Kenya** and **Zimbabwe**), urban areas of **Burkina Faso** and

¹Other countries have reported declines in HIV prevalence among young pregnant women (15–24) in capital cities but these declines have not yet affected overall national adult prevalence (refer to country specific text in this chapter and 'Progress in countries' chapter).

similarly in **Haiti**, alongside indications of significant behavioural change—including increased condom use, fewer partners and delayed sexual debut. In the rest of sub-Saharan Africa, the majority of epidemics appear to be levelling off—but at exceptionally high levels in most of southern Africa.

HIV prevalence has also been declining in four states in **India**, including Tamil Nadu, where prevention efforts were scaled up in the late 1990s. In **Cambodia** and **Thailand**, steady ongoing declines in HIV prevalence are continuing. However, HIV prevalence is increasing in some countries, notably **China**, **Indonesia**, **Papua New Guinea**, and **Viet Nam**, and there are signs of HIV outbreaks in **Bangladesh** and **Pakistan**.

The majority of people living with HIV in eastern and central Asia are in two countries: the **Ukraine**, where the annual number of new HIV diagnoses keeps rising, and the **Russian Federation**,

which has the biggest AIDS epidemic in all of Europe.

Meanwhile, evidence continues to emerge of resurgent epidemics in the **United States of America** and in some countries in Europe among men who have sex with men, and of largely hidden epidemics among their counterparts in Latin America and Asia.

More than 1.3 million people were receiving antiretroviral therapy in low- and middle-income countries by December 2005, up from approximately 400 000 people two years earlier. In sub-Saharan Africa, the number of people receiving treatment increased more than eight-fold (from 100 000 to 810 000) between 2003 and 2005, and more than doubled in 2005 alone. Most of that trend is due to increased treatment access in a few countries (notably **Botswana**, **Kenya**, **South Africa**, **Uganda** and **Zambia**). The number of people receiving antiretroviral therapy in Asia increased almost three-fold, to 180 000 in 2005.

UNDERSTANDING THE LATEST HIV AND AIDS ESTIMATES

The latest UNAIDS and WHO estimates are lower than those published in the *AIDS epidemic update—December 2005*, even though the new estimates of the number of adults living with HIV (and of adults with new infections and of AIDS mortality) featured in this report are no longer restricted to those in the 15–49-year age group. Historically, UNAIDS and WHO restricted the estimates to this age group to ensure comparability across countries, especially for HIV prevalence. However, it is now evident that a substantial proportion of people living with HIV are 50 years and older, as shown in age distributions of HIV and AIDS case reports, community studies and population-based surveys. Accordingly, UNAIDS and WHO now present estimates of adults living with HIV, new infections and AIDS deaths among adults for all adults ‘15 years and older’. In addition, we continue to provide estimates of HIV prevalence for ‘adults 15–49 years’, to continue to allow for comparisons across countries. Analysis of the difference between all adults and adults aged 15–49 shows that around 2.8 million adults aged 50 years and older were living with HIV in 2005. UNAIDS and WHO also estimate trends among children ‘less than 15 years of age’.

ESTIMATING HIV AND AIDS TRENDS

Why are the global HIV and AIDS estimates for 2005 in this report lower than previously published estimates?

UNAIDS and WHO estimates of the HIV epidemic show a downward revision in the current report as compared to estimates published in the *AIDS epidemic update—December 2005*. The lower estimates are partly due to genuine declines in HIV prevalence in several countries, as discussed elsewhere in this report. However, most of the differences between the estimates published in the *AIDS epidemic update—December 2005* and those published in this report are due to revisions based on new data that have become available.

Different sources of data are used to calculate estimates of HIV prevalence for *generalized* (where adult HIV prevalence exceeds 1% in the general population and transmission is mostly heterosexual) and *concentrated* (low-level—where HIV is concentrated in groups with behaviours that expose them to a high risk of HIV infection) epidemics. In countries with *generalized* epidemics, estimates of HIV prevalence are primarily based on surveillance among pregnant women attending antenatal clinics (ANC). In the absence of population-based surveys that include testing for HIV antibodies, HIV prevalence among pregnant women attending antenatal clinics generally provides a good proxy for HIV prevalence in the general population. For countries with low-level or *concentrated* epidemics, HIV estimates are based on studies among key populations who are at higher risk of HIV exposure—such as injecting drug users, sex workers and their clients, or men who have sex with men.

The growing number of population-based HIV prevalence surveys in sub-Saharan Africa, new and improved HIV surveillance data globally and improved analyses in countries indicate that HIV prevalence in several countries is lower than had previously been estimated. National population-based surveys have been conducted in 20 countries since 2000. Nineteen of these are in sub-Saharan Africa, and they include some of the region's most populous countries (such as **Ethiopia** and **South Africa**). In countries that have conducted such surveys, the survey results have been incorporated into our analysis to generate the updated estimates in this report.

For countries with a recent national survey, Table 1 (below) shows HIV prevalence among pregnant women attending antenatal clinics, HIV prevalence in the national household survey, as well as the estimates published in the *Report on the global AIDS epidemic 2004* and in the current publication, the *Report on the global AIDS epidemic 2006*. It shows clearly that, except for **Uganda**, these new national surveys have consistently indicated lower HIV prevalence compared to HIV estimates derived from antenatal clinic data. Information and insights gleaned from these surveys, notably that HIV prevalence in urban areas is on average 1.7 times higher than in rural areas, have also informed new estimates for several other populous countries (such as the **Central African Republic**, the **Democratic Republic of the Congo**, **Nigeria**). The methods used to derive the current estimates are described in greater detail in a series of papers in *Sexually Transmitted Infections 2006* (in press).

In addition to the new data from national population-based surveys, the quality and coverage of sentinel surveillance in many countries have improved over time. In several countries, recent surveillance has expanded into rural areas where prevalence is known to be lower. That has resulted in lower estimates of overall HIV prevalence in some countries (such as **Burkina Faso, Ethiopia, Lesotho and Nigeria**).

HIV estimates have also been revised in some countries outside of sub-Saharan Africa. Of particular note is **China**, where a process conducted over several months in 2005 in each of the country's provinces enabled an improved analysis of the epidemic, and resulted in a more reliable, albeit lower, estimate of the number of people living with HIV.

Between March 2005 and April 2006, UNAIDS and WHO conducted 12 regional workshops, training staff from over 150 countries responsible for HIV estimates in the specific tools and methodologies used to produce the estimates in this report. In addition UNAIDS and WHO participated in 10 country-specific consensus meetings on HIV estimates.

FIGURE 2.1		Adult (aged 15–49 years) HIV prevalence (%) in countries in sub-Saharan Africa which have conducted population-based HIV surveys in recent years				
Country	Median HIV prevalence (%) among women attending antenatal clinics 2003–2004*	Population-based survey prevalence (%) (year)	2003 HIV prevalence (%) reported in 2004 Report on the global AIDS epidemic	Adjusted 2003 HIV prevalence (%) in current report	2005 HIV prevalence (%) in current report	Trend in prevalence
Botswana	38.5	25.2 (2004)	38.0	24.0	24.1	Stable
Burkina Faso	2.5	1.8 (2003)	4.2	2.1	2.0	Decline in urban areas
Burundi	4.8	3.6 (2002)	6.0	3.3	3.3	Decline in capital city
Cameroon	7.3†	5.5 (2004)	7.0	5.5	5.4	Stable
Ethiopia	8.5	1.6 (2005)	4.4	(1.0–3.5)	(0.9–3.5)	Decline in urban areas
Ghana	3.1	2.2 (2003)	3.1	2.3	2.3	Stable
Guinea	4.2	1.5 (2005)	2.8	1.6	1.5	Stable
Lesotho	28.4	23.5 (2004)	29.3	23.7	23.2	Stable
Rwanda	4.6	3.0 (2005)	5.1	3.8	3.1	Decline in urban areas
Senegal	1.9	0.7 (2005)	0.8	0.9	0.9	Stable
Sierra Leone	3.0	1.5 (2005)	–	1.6	1.6	Stable
South Africa	29.5	16.2 (2005)	20.9	18.6	18.8	Increasing
United Republic of Tanzania	7.0	7.0 (2004)	9.0	6.6	6.5	Stable
Uganda	6.2‡	7.1 (2004–5)	4.1	6.8	6.7	Stable

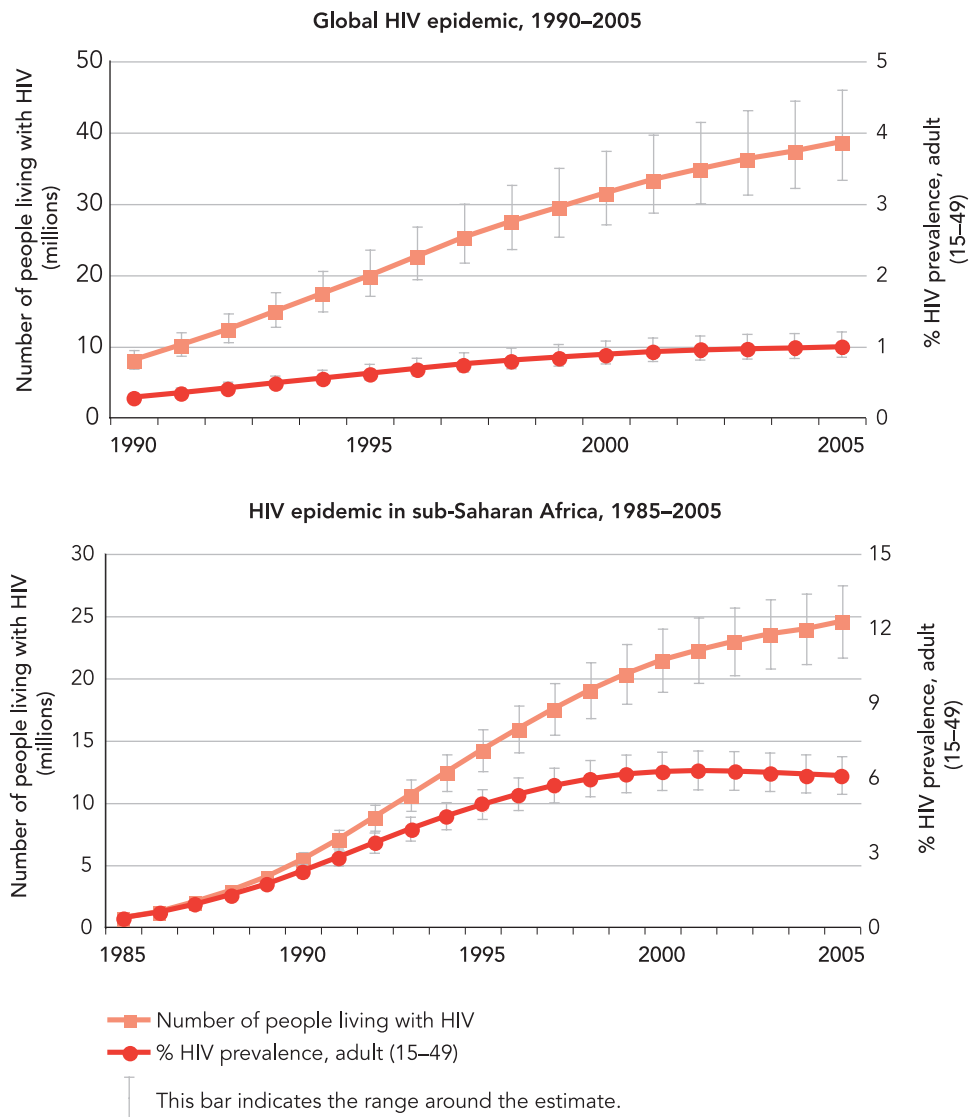
*WHO Africa (2005). HIV/AIDS epidemiological surveillance report for the WHO African region, 2005 Update. Harare.

†Estimate based on country report for 2002 (2003). Ministry of Public Health Cameroon. National HIV sentinel surveillance report 2002.

‡Estimate based on country report 2002 (2003). Ministry of Health Uganda. STD/HIV/AIDS surveillance report. STD/AIDS control programme. Kampala.

FIGURE 2.2

Estimation du nombre de personnes vivant avec le VIH et de la prévalence de l'infection (%) parmi la population adulte dans le monde et en Afrique subsaharienne, 1985–2005²



²Even though HIV prevalence rates have stabilized in sub-Saharan Africa, the actual number of people infected continues to grow because of population growth. Applying the same prevalence rate to a growing population will result in increasing numbers of people living with HIV.

FIGURE 2.3 Regional HIV and AIDS statistics and features, 2003 and 2005				
Country	Adults (15+) and children living with HIV	Adults (15+) and children newly infected with HIV	Adult (15–49) prevalence (%)	Adult (15+) and child deaths due to AIDS
Sub-Saharan Africa				
2005	24.5 million [21.6–27.4 million]	2.7 million [2.3–3.1 million]	6.1 [5.4–6.8]	2.0 million [1.7–2.3 million]
2003	23.5 million [20.8–26.3 million]	2.6 million [2.3–3.0 million]	6.2 [5.5–7.0]	1.9 million [1.7–2.3 million]
North Africa and Middle East				
2005	440 000 [250 000–720 000]	64 000 [38 000–210 000]	0.2 [0.1–0.4]	37 000 [20 000–62 000]
2003	380 000 [220 000–620 000]	54 000 [31 000–150 000]	0.2 [0.1–0.3]	34 000 [18 000–57 000]
Asia				
2005	8.3 million [5.7–12.5 million]	930 000 [620 000–2.4 million]	0.4 [0.3–0.6]	600 000 [400 000–850 000]
2003	7.6 million [5.2–11.3 million]	860 000 [560 000–2.3 million]	0.4 [0.2–0.6]	500 000 [340 000–710 000]
Oceania				
2005	78 000 [48 000–170 000]	7200 [3500–55 000]	0.3 [0.2–0.8]	3400 [1900–5500]
2003	66 000 [41 000–140 000]	9000 [4300–69 000]	0.3 [0.2–0.7]	2300 [1300–3600]
Latin America				
2005	1.6 million [1.2–2.4 million]	140 000 [100 000–420 000]	0.5 [0.4–1.2]	59 000 [47 000–76 000]
2003	1.4 million [1.1–2.0 million]	130 000 [95 000–310 000]	0.5 [0.4–0.7]	51 000 [40 000–67 000]
Caribbean				
2005	330 000 [240 000–420 000]	37 000 [26 000–54 000]	1.6 [1.1–2.2]	27 000 [19 000–36 000]
2003	310 000 [230 000–400 000]	34 000 [24 000–47 000]	1.5 [1.1–2.0]	28 000 [19 000–38 000]
Eastern Europe and Central Asia				
2005	1.5 million [1.0–2.3 million]	220 000 [150 000–650 000]	0.8 [0.6–1.4]	53 000 [36 000–75 000]
2003	1.1 million [790 000–1.7 million]	160 000 [110 000–440 000]	0.6 [0.4–1.0]	28 000 [19 000–39 000]
North America, Western and Central Europe				
2005	2.0 million [1.4–2.9 million]	65 000 [52 000–98 000]	0.5 [0.4–0.7]	30 000 [24 000–45 000]
2003	1.8 million [1.3–2.7 million]	65 000 [52 000–98 000]	0.5 [0.3–0.6]	30 000 [24 000–45 000]
TOTAL				
2005	38.6 million [33.4–46.0 million]	4.1 million [3.4–6.2 million]	1.0 [0.9–1.2]	2.8 million [2.4–3.3 million]
2003	36.2 million [31.4–42.9 million]	3.9 million [3.3–5.8 million]	1.0 [0.8–1.2]	2.6 million [2.2–3.1 million]

FIGURE 2.4

A global view of HIV infection

38.6 million people [33.4–46.0 million] living with HIV, 2005

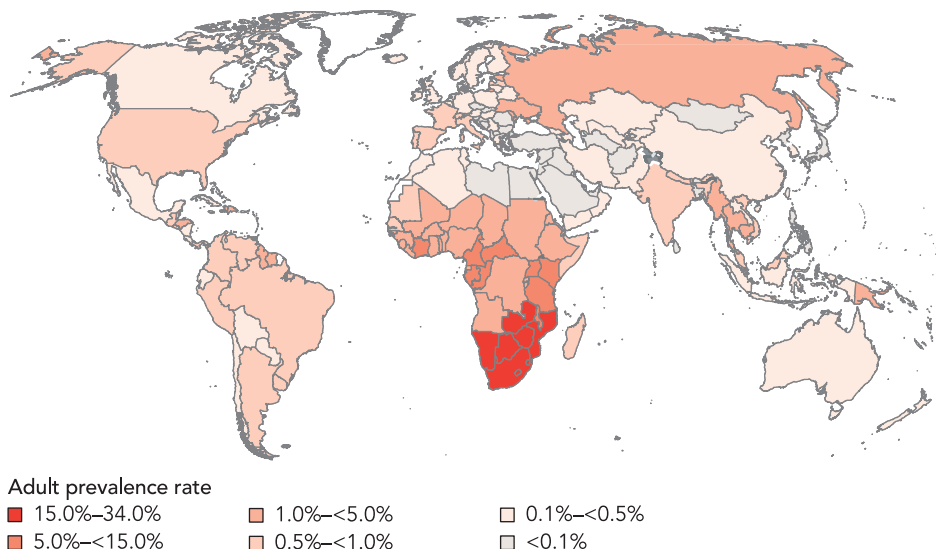
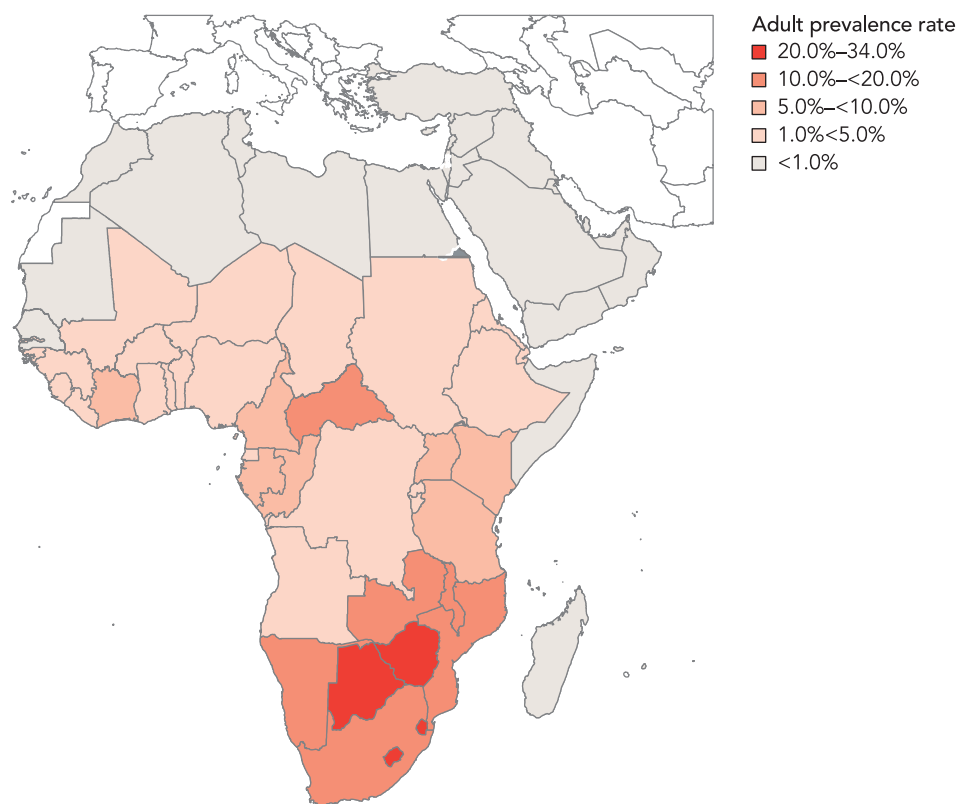


FIGURE 2.5

HIV prevalence (%) in adults in Africa, 2005



Sub-Saharan Africa

Sub-Saharan Africa remains the worst-affected region in the world. Across the region, rates of new HIV infections peaked in the late 1990s, and a few of its epidemics show recent declines, notably in **Kenya**, **Zimbabwe** and in urban areas of **Burkina Faso**.³ Overall, HIV prevalence in this region appears to be levelling off, albeit at exceptionally high levels in southern Africa. Such apparent ‘stabilization’ of the epidemic reflects situations where the numbers of people being newly infected with HIV roughly match the numbers of people dying of AIDS-related illnesses.

A little more than one-tenth of the world’s population live in sub-Saharan Africa which is home to almost 64% of all people living with HIV—24.5 million [21.6 million–27.4 million]. Two million [1.5 million–3.0 million] of them are children younger than 15 years of age. Indeed, almost nine in ten children (younger than 15 years) living with HIV are in sub-Saharan Africa. An estimated 2.7 million [2.3 million–3.1 million] people in the region became newly infected, while 2.0 million [1.7 million–2.3 million] adults and children died of AIDS. There were some 12.0 million [10.6 million–13.6 million] orphans living in sub-Saharan Africa in 2005.

Three-quarters of all women (15 years and older) living with HIV are in sub-Saharan Africa. In most of the region, women are disproportionately affected by AIDS, compared with men—expressions of the often highly unequal social and socio-economic status of women and men. Women comprise an estimated 13.2 million [11.4

million–15.1 million]—or 59%—of adults living with HIV in Africa south of the Sahara.

An estimated 930 000 [790 000–1.1 million] adults and children died of AIDS in southern Africa in 2005—one-third of all AIDS deaths globally. Access to antiretroviral therapy has increased more than eight-fold since the end of 2003, with about 810 000 people on treatment in December 2005. About one in six (17%) of the 4.7 million people in need of antiretroviral therapy in this region now receive it. Progress is uneven, however, with coverage reaching or exceeding 50% in only three countries (**Botswana**, **Namibia** and **Uganda**) but remaining below 20% in most others. **South Africa** accounts for one-quarter of all people receiving antiretroviral therapy in sub-Saharan Africa (WHO/UNAIDS, 2006).

It bears reminding that there is no single, ‘African’ epidemic, and that HIV prevalence varies significantly between and within subregions and countries. Such general trends in HIV prevalence therefore should not obscure the highly varied nature of the AIDS epidemics underway throughout this region.

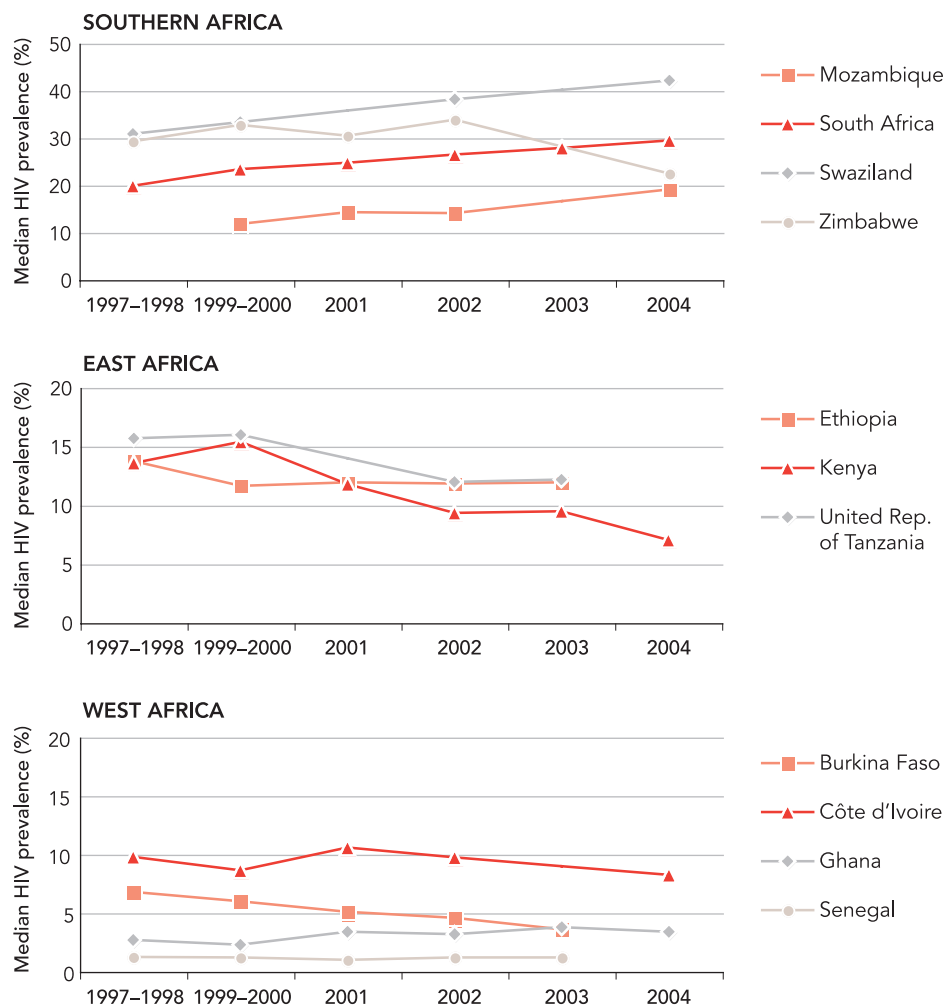
Southern Africa remains the global epicentre of the epidemic. Almost one in three people infected with HIV globally live in this subregion. About 43% (860 000 [560 000–1.4 million]) of all children (under 15 years) living with HIV are in southern Africa, as are approximately 52% (6.8 million [5.9 million–7.7 million]) of all women (15 years and older) living with HIV.

Except in **Angola**, national HIV infection levels are exceptionally high and show no

³Other countries have reported declines in HIV prevalence among young pregnant women (15–24) in capital cities but these declines have not yet affected overall national adult prevalence (refer to country specific text in Chapter 2 and Chapter 3).

FIGURE 2.6

HIV prevalence (%) among pregnant women attending antenatal clinics in sub-Saharan Africa, 1997/98–2004



Note: Analysis restricted to consistent surveillance sites for all countries except South Africa (by province) and Swaziland (by region).

Sources: Ministry of Health (Mozambique); Department of Health (South Africa); Ministry of Health and Social Welfare (Swaziland); Ministry of Health and Child Welfare (Zimbabwe); Adapted from Asamoah-Odei, et al. HIV prevalence and trends in sub-Saharan Africa: no decline and large subregional differences. *Lancet*, 2004 (Ethiopia); Ministry of Health—National AIDS/STD Control Programme (Kenya); Ministry of Health (United Republic of Tanzania); Conseil national de lutte contre le sida et les IST (Burkina Faso); Centers for Disease Control and Prevention (CDC)—GAP—Côte d'Ivoire (Côte d'Ivoire); Ghana Health Service (Ghana); Conseil National de Lutte Contre le SIDA (Senegal).

signs of abating. (In Angola's case, isolation and inaccessibility of the population during the country's prolonged conflict may have served to restrict the spread of HIV.)

However, in **Zimbabwe**, data from national sentinel surveillance, and national and local community-based surveys show a declining trend in HIV prevalence.

National adult HIV prevalence is estimated

at 20.1% [13.3%–27.6%], down from 22.1% [14.6%–30.4%] in 2003. HIV prevalence among pregnant women attending antenatal clinics fell from 32% in 2000 to (a still-very-high) 24% in 2004, while in Harare it declined from 35% in 1999 to 21% in 2004 (Mahomva et al., 2006; Hargrove et al., 2005; Mugurungi et al., 2005). In the eastern province of

Manicaland, HIV prevalence in young women (15–24 years) in the general population fell by half—from 16% in 1998 to 8% in 2003 (Gregson et al., 2006). The same study showed more women and men were delaying their sexual debut and were avoiding casual sex liaisons. Nationally, there appears to have been a substantial increase in condom use since the early 1990s. Such behavioural change is likely associated with a combination of AIDS awareness, relatively extensive health infrastructure and a growing fear of AIDS mortality. However, a significant part of the decline in HIV prevalence is attributable to high mortality rates. With 1.7 million [1.1 million–2.2 million] people living with HIV, Zimbabwe needs to sustain the declining trend in HIV prevalence and dramatically improve the provision of antiretroviral treatment if it is to gradually bring its epidemic under control. An estimated 320 000 people needed antiretroviral treatment in 2005, yet about 23 000 were receiving antiretroviral drugs (WHO/UNAIDS, 2006).

South Africa's AIDS epidemic—one of the worst in the world—shows no evidence of a decline. Based on its extensive antenatal clinic surveillance system, as well as national surveys with HIV testing and mortality data from its civil registration system, an estimated 5.5 million [4.9 million–6.1 million] people were living with HIV in 2005. An estimated 18.8% [16.8%–20.7%] of adults (15–49 years) were living with HIV in 2005⁴. Almost one in three pregnant women attending public antenatal clinics were living with HIV in 2004 and trends over time show a gradual increase in HIV prevalence (Department of Health South Africa,

2005). While household surveys with HIV testing in 2003 and 2005 show lower HIV prevalence, they are plagued by high non-response rates (over 40%). The 2005 national household HIV survey found high levels of HIV infection levels among young people (aged 15–24 years), which were about the same as those found in a national young people survey in 2003, a sign that the epidemic has not lost momentum (Shisana et al., 2005; Reproductive Health Research Unit and Medical Research Council, 2004). The 2005 survey also revealed high HIV infection levels among men aged 50 years and older: 14% among those 50–54 years of age, and 8% for those 55–59 years of age. On the positive side, almost one-third of the respondents aged 15 years and older said they had been tested for HIV, and levels of stigma appear to be diminishing (although almost one in three said they would prefer to hide the HIV status of an HIV-positive family member) (Shisana et al., 2005).

While **South Africa's** HIV prevention efforts have not made notable inroads against the epidemic, there has been significant progress on the treatment front. With approximately 190 000 people receiving antiretroviral treatment by the end of 2005, South Africa accounts for a large share of the treatment scale-up in sub-Saharan Africa overall this decade (WHO/UNAIDS, 2006). However, this still means that less than 20% of the almost one million South Africans in need of antiretroviral treatment were receiving it in 2005 (WHO/UNAIDS, 2005).

There are no clear signs of declining HIV prevalence elsewhere in southern Africa—including in **Botswana**,

⁴UNAIDS' HIV prevalence estimates describe the percentage of adult men and women (15–49 years) living with HIV nationally. These estimates incorporate a variety of HIV data, including those gathered in household HIV surveys and at antenatal clinics. Antenatal clinic HIV data, meanwhile, reflect only HIV prevalence in pregnant women who use public antenatal facilities. Comparisons between these two sources of data have shown that antenatal clinic-based HIV estimates tend to be higher than those based on household HIV surveys.

Namibia and **Swaziland**, where exceptionally high infection levels continue. In **Swaziland**, national adult HIV prevalence is estimated at 33.4% [21.2%–45.3%]. HIV prevalence among pregnant women attending antenatal clinics rose from 4% in 1992 to 43% in 2004 (Ministry of Health and Social Welfare Swaziland, 2005). Although many young women report delaying their sexual debut, once women do have unprotected sex, the odds of acquiring HIV are dauntingly high. Sexual aggression appears to be widespread: in a study among high school students, almost one in five (18%) of the sexually active female students said their first sexual experience had been coerced (Buseh, 2004).

Botswana's epidemic is equally serious, with national adult HIV prevalence estimated at 24.1% [23.0%–32.0%] in 2005. Among pregnant women attending antenatal clinics, prevalence in 2004 was 34% overall, and close to 50% among women 30–34 years of age. Prevalence among pregnant women generally has remained at 34%–37% since 2001 (National AIDS Coordinating Agency Botswana, 2003 and 2005). According to a recent national household survey, HIV knowledge still lags: only about one in ten survey participants knew three ways of preventing sexual transmission of HIV (National AIDS Coordinating Agency, 2005).

Lesotho's epidemic seems to be relatively stable at very high levels, with an estimated national adult HIV prevalence of 23.2% [21.9%–24.7%]. High infection levels of 27% were observed among antenatal clinic attendees in 2004, when over one-third (36%–38%) of pregnant women 25–34 years of age tested HIV-positive. In urban areas, HIV prevalence among pregnant women remains on the increase (Ministry of Health and Social Welfare Lesotho, 2005a). Worryingly, knowledge about the

epidemic still lags among young people: only 26% of women and 18% of men aged 15–24 years demonstrated comprehensive knowledge of AIDS when surveyed in 2004 (Ministry of Health and Social Welfare, 2005).

In parts of sparsely populated **Namibia**, the epidemic is as intense as in some of its neighbours, with HIV prevalence estimated at 19.6% [8.6%–31.7%] among adults nationally. In antenatal clinic attendees, HIV prevalence is surpassing 42% in Katima Mulilo (in the Caprivi Strip flanked by Angola, Botswana and Zambia) and ranging between 22% and 28% in the port cities of Luderitz, Swakopmund and Walvis Bay (Ministry of Health and Social Services Namibia, 2004). To the north, **Angola** remains an anomaly, with HIV prevalence much lower than in any other country in this subregion. An estimated 3.7% [2.3%–5.3%] of adults were HIV-positive in 2005. Although the country's HIV surveillance system has improved dramatically in recent years, it remains difficult to discern clear trends in the epidemic (Ministerio da Saude do Angola, 2004). Where comparable data do exist—in the capital, Luanda, for example—prevalence rose from 0.3% in 1986 to 4.4% in 2004.

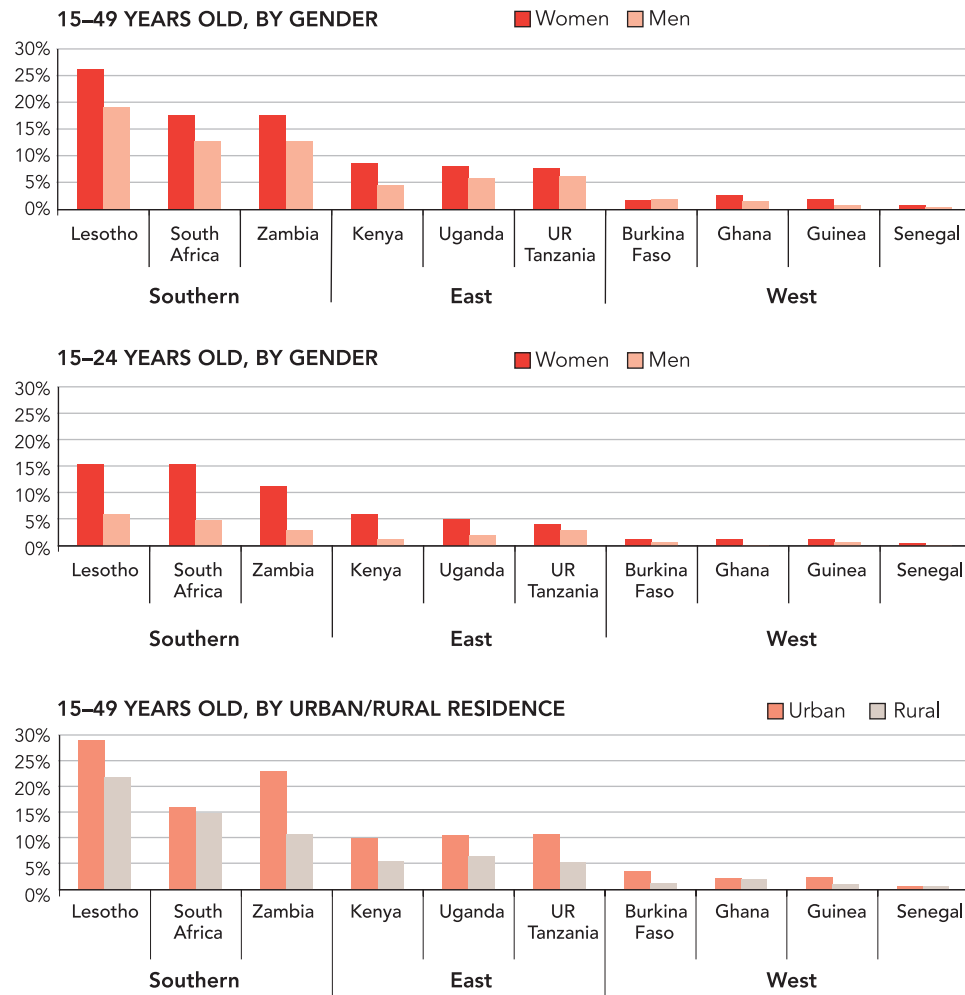
On the eastern coastline, a dynamic epidemic is underway in **Mozambique**, where the estimated national adult HIV prevalence is 16.1% [12.5%–20.0%]. HIV is spreading fastest in provinces linked by major transport routes to **Malawi**, **South Africa** and **Zimbabwe**. High infection levels are being found in Gaza (from where large numbers of migrants working in South Africa originate) and Sofala provinces (which is traversed by Zimbabwe's main export route) (Ministry of Health Mozambique, 2005). In neighbouring

Malawi, national adult HIV prevalence is estimated at 14.1% [6.9%–21.4%]. HIV prevalence among antenatal clinic attendees provides insight into the long-term trends and has stayed relatively stable at around 20%. Most HIV infections are concentrated in the country's southern tip, where HIV prevalence as high as 33% has been found among pregnant women at some sites (Ministry of Health and Population Malawi, 2003). **Zambia's** epidemic appears not to be relenting either, with

adult HIV prevalence estimated at 17.0% [15.9%–18.1%]. There is wide geographic variation, though, with HIV infection levels among pregnant women ranging from under 10% in some places (e.g. Kasaba, Macha and Mukinge) to as high as 30% in others (e.g. Matero and Livingstone). Cities and towns with the highest HIV prevalence tend to be clustered along major transport routes—including Kabwe, Livingstone and Ndola (National HIV/AIDS Council Zambia, 2005).

FIGURE 2.7

HIV prevalence (%) by gender and urban/rural residence, selected sub-Saharan African countries, 2001–2005



Sources: Demographic and Health Survey reports (Burkina Faso, Ghana, Guinea, Kenya, Lesotho, Zambia, Kenya, Senegal) (2001–2005). Nelson Mandela Foundation (South Africa) (2005). Ministry of Health (Uganda), 2005. Tanzania Commission for AIDS (United Republic of Tanzania) (2005).

The picture is starkly different in the island nations of southern Africa. National adult HIV prevalence in **Madagascar** stood at an estimated 0.5% [0.2%–1.2%] in 2005, but low levels of HIV knowledge and significant risk behaviour mean this could change. Fewer than one in five Malagasy could name two methods for preventing the sexual transmission of HIV when surveyed in 2003–2004, and only about one in 10 young men and one in 20 young women (aged 15–24 years) said that they had used a condom the last time they had sex with a casual partner (Ministère de l'Economie, des Finances et du Budget, 2005). Meanwhile, high levels of transmission of HIV among injecting drug users (with estimated HIV prevalence of 10%–20%) and significant infection levels (3%–7%) among female sex workers in **Mauritius** indicate that larger HIV outbreaks are possible there.

In the countries of East Africa, HIV prevalence has either decreased or remained stable in the past several years. Here, too, women face considerably higher risk of HIV infection than men, especially at younger ages. The epidemics are varied, with HIV prevalence among pregnant women ranging from approximately 2% in **Eritrea** to 7% and higher in **Kenya**, **Uganda** and **United Republic of Tanzania** (Ministry of Health Eritrea, 2006; Ministry of Health Uganda, 2005; National AIDS Commission Tanzania, 2005; Ministry of Health Kenya et al., 2003).

While **Burundi** and **Uganda**'s epidemics appear to have stabilized, HIV prevalence among pregnant women in **Kenya** has been declining, especially in urban areas (Cheluget et al., 2006; WHO, 2005a; Baltazar, 2005). As a result, national adult HIV prevalence is estimated to have fallen from 10% in the late 1990s to about 7% in 2003

(Ministry of Health Kenya, 2005). Various behavioural surveys show the proportion of adults with more than one sexual partner is shrinking, more women are delaying their sexual debut, and condom use is rising. Increased mortality and the saturation of infection among people most at risk also appear to be the factors associated with the decline in HIV prevalence (Cheluget et al., 2006). But there are troubling trends, too. Very high HIV prevalence has been found in women attending some antenatal clinics (including in Busia and Chulaimbo, in the west, and Suba, on the coast), where prevalence ranged from 14% to 30% (Baltazar, 2005). In addition, injecting drug use is a factor in the epidemics in some cities and large towns—including Nairobi, where 53% of injecting drug users (mostly heroin users) have tested HIV-positive (Beckerleg et al., 2005).

In **Uganda**, which saw a steep decline in HIV prevalence during the mid- and late-1990s, adult HIV prevalence was an estimated 6.7% [5.7%–7.6%] in 2005. New HIV surveillance data indicate that HIV prevalence continues to decline among pregnant women in the capital, Kampala, and has remained stable elsewhere, including in most rural areas since 2001. However, a 2004–2005 national household survey found condom use was erratic (only about half the men and women surveyed reported using a condom the last time they had sex with a casual partner), and almost one in three men said they had had more than one sexual partner in the previous year (Ministry of Health Uganda, 2005).

Overall, **Rwanda**'s epidemic has been stable in recent years, with 190 000 people [180 000–210 000] (3.1% of adults [2.9%–3.2%]) estimated to live with HIV in 2005. Observed national



In Burundi, HIV infection levels have declined from 13% in 2000 to 9% in 2004 among 15-24-year-old pregnant women in Bujumbura and in urban areas generally.

HIV prevalence has declined since the late 1990s, but improved HIV surveillance methodology probably accounts for an important part of that trend.

However, there are signs of declining HIV prevalence in pregnant women in some urban areas, including Kigali, where prevalence nevertheless was 13% in 2003 (Kayirangwa et al., 2006). HIV trends in neighbouring **Burundi**, where adult HIV prevalence is estimated at 3.3% [2.7%–3.8%], are also ambiguous. HIV infection levels have declined among 15–24-year-old pregnant women (from 13% in 2000 to 9% in 2004) in Bujumbura and in urban areas generally.

However, HIV prevalence has been rising in rural and periurban areas, and varies strikingly from place to place (from below 1% to almost 13%) (Ministère de la santé publique Burundi, 2005).

On the mainland of the **United Republic of Tanzania**, an estimated 1.4 million people [1.3 million–1.6 million] (6.5% of adults [5.8%–7.2%]) were living with HIV in 2005, highlighting the challenges of improving prevention efforts and substantially expanding access to treatment and care. HIV infection trends suggest a relatively stable epidemic, but

prevalence has increased markedly in older age groups, reaching 13% among women aged 30–34 years (Tanzania Commission for AIDS, 2005). Injecting drug use is increasing here, too—not only in Dar es Salaam, but also on the island of Pemba (Beckerleg et al., 2005).

In **Ethiopia's** urban areas, HIV prevalence among women seeking antenatal care has remained stable at high levels since the late 1990s (almost 15% in Addis Ababa and 12% in other urban areas in 2003), the exception being among 15–24-year-old pregnant women where prevalence fell from 15.0% in 2000 to 11.5% in 2003. (Hladik et al., 2006; Federal Ministry of Health Ethiopia, 2004). Meanwhile, the epidemic appears to have intensified in some rural areas in recent years, with rising HIV infection levels in women attending antenatal clinics (2.6% in 2003, up from 1.9% in 2000) (Hladik et al., 2006; Federal Ministry of Health Ethiopia, 2004). A recent household survey and new data from a larger number of rural surveillance sites has helped to re-assess HIV prevalence levels in this predominantly rural country where fewer than half of pregnant women attend antenatal clinics (and where previous HIV estimates based on antenatal clinic

data therefore provided an incomplete picture of the epidemic). Meanwhile, neighbouring **Eritrea**'s epidemic appears to be stable, with adult HIV prevalence having remained at 2.4% [1.3%–3.9%]. However, infection levels are considerably higher in the south of the country and in 2005 exceeded 7% in Assab town (Ministry of Health Eritrea, 2006).

Less is known about HIV trends in **Djibouti** and **Somalia**. The former has a serious epidemic, with national adult HIV prevalence estimated at 3.1% [0.8%–6.9%] in 2005. An earlier population-based HIV survey found HIV infection levels of 4%–6% among 20–34-year-olds in the capital, Djibouti (Ministère de la santé Djibouti, 2002). In **Somalia**, a 2004 survey indicated that the virus was present in most of the country, but HIV prevalence among pregnant women nationally was still low, at 0.6% (WHO, 2005b). However, the higher HIV infection levels (4% and over) found among people seeking treatment for sexually transmitted infections are not surprising, given that knowledge of HIV transmission is very poor, and condom use uncommon (17 out of 20 men and 19 out of 20 women aged 15–24 years had never used a condom, according to one survey) (WHO, 2005b).

West Africa is less severely affected than other parts of sub-Saharan Africa, with national adult HIV prevalence estimates lower than 2% in several countries. The highest adult prevalence in the region is in **Côte d'Ivoire** at 7.1% [4.3%–9.7%]. Significant declines in HIV prevalence among pregnant women have been observed in urban areas of **Burkina Faso**, and in Abidjan, **Côte d'Ivoire**, and Lomé, **Togo**, (WHO, 2005). However, in Dakar, **Senegal**, and Accra,

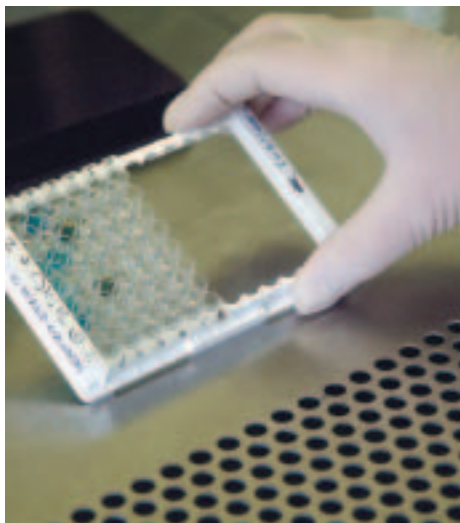
Ghana, infection levels have been rising among antenatal clinic attendees (WHO, 2005). **Nigeria** has the third-largest number of people living with HIV—2.9 million [1.7 million–4.2 million]—in the world. The median HIV prevalence among antenatal clinics has levelled off at around 4%, but infection levels vary radically across this large country (from 2.6% in the South West to 6.1% in the North Central zones) (Federal Ministry of Health Nigeria, 2006). **Côte d'Ivoire**'s epidemic also appears to have stayed relatively stable for almost a decade. However civil conflict has been preventing the gathering of new, national HIV-related data. In **Guinea**, adult HIV prevalence was estimated at 1.5% [1.2%–1.8%] in 2005. A national survey with HIV testing in 2005 found HIV prevalence was about twice as high in women than men (1.9% and 0.9%, respectively).

Senegal's epidemic, meanwhile, still pivots mainly on the sex trade, and there is an ongoing danger of HIV spreading more widely from sex workers and their clients to lower-risk sections of the population. HIV prevalence among female sex workers has remained high (at around 20% in Dakar and 30% in Ziguinchor) for almost a decade (Gomes et al., 2005; WHO, 2005a). National HIV prevalence was estimated at 0.9% [0.4%–1.5%] in 2005, although one survey has found adult HIV prevalence of around 3% in the south of the country (Centre de recherche pour le développement humain et MEASURE DHS+, 2005). Sex work is also a driving factor in **Ghana**'s epidemic, where adult HIV prevalence is estimated at 2.3% [1.9%–2.6%]. HIV prevalence in women attending antenatal clinics has risen to just under 4% (3.6%) since the turn of the century. **Togo** has very limited HIV surveillance data to

ascertain levels and trends, but appears to have an epidemic similar in size to that in neighbouring Ghana (WHO, 2005a; Ministère de la santé Togo, 2004). Adult HIV prevalence in Togo is estimated at 3.2% [1.9%–4.7%].

A different trend is visible towards the north of those two countries, in **Burkina Faso**, where HIV prevalence among young pregnant women (15–24 years) attending antenatal clinics in urban areas has dropped from almost 4% in 2001 to just under 2% in 2003 (Présidence du Faso, 2005; Ministère de l'économie et du développement, 2004). This could reflect the effects of increasing HIV prevention efforts over the past decade; sex with non-regular partners has decreased and condom use in such liaison has increased, especially among young people. Adult HIV prevalence is estimated at 2.0% [1.5%–2.5%]. In **Sierra Leone**, with an estimated 1.6% [0.9%–2.4%] adult prevalence, a recent population-based survey showed that HIV prevalence did not differ much between men and women (Ministry of Health and Sanitation Sierra Leone, 2005).

More serious epidemics appear to be underway in some central African countries, notably **Cameroon**, where adult HIV prevalence is estimated at 5.4% [4.9%–5.9%] in 2005. A national household survey in 2004 found female HIV prevalence to be considerably higher than male prevalence (6.8% and 4.1% respectively) (Ministère de la santé publique Cameroon, 2004). The estimated adult HIV prevalence in the **Central African Republic** is 10.7% [4.5%–17.2%], although HIV data there are limited. As many as 120 000 people [75 000–160 000] are living with HIV in the **Congo** (estimated adult HIV prevalence of 5.3% [3.3%–7.5%]) (Ministère de la Santé République du Congo, 2004). In the



Democratic Republic of the Congo, an estimated 1.0 million people [560 000–1.5 million] were living with HIV in 2005 (adult HIV prevalence of 3.2% [1.8%–4.9%]). HIV surveillance among pregnant women indicates that approximately 4% of women attending antenatal clinics nationally were HIV-positive in 2004, but HIV prevalence as high as 7% was found among pregnant women in Lubumbashi (Ministère de la Santé République Démocratique du Congo, 2004). However, HIV surveillance data are unavailable for many parts of this large country.

In southern and east Africa, as well as in parts of central Africa, AIDS epidemics will continue to have serious consequences for at least another generation. Prevention and treatment strategies—and the support provided by the rest of the world—need to take that into consideration, as well as the massive hindrances of frail health systems and weakened public sector capacities.

Asia

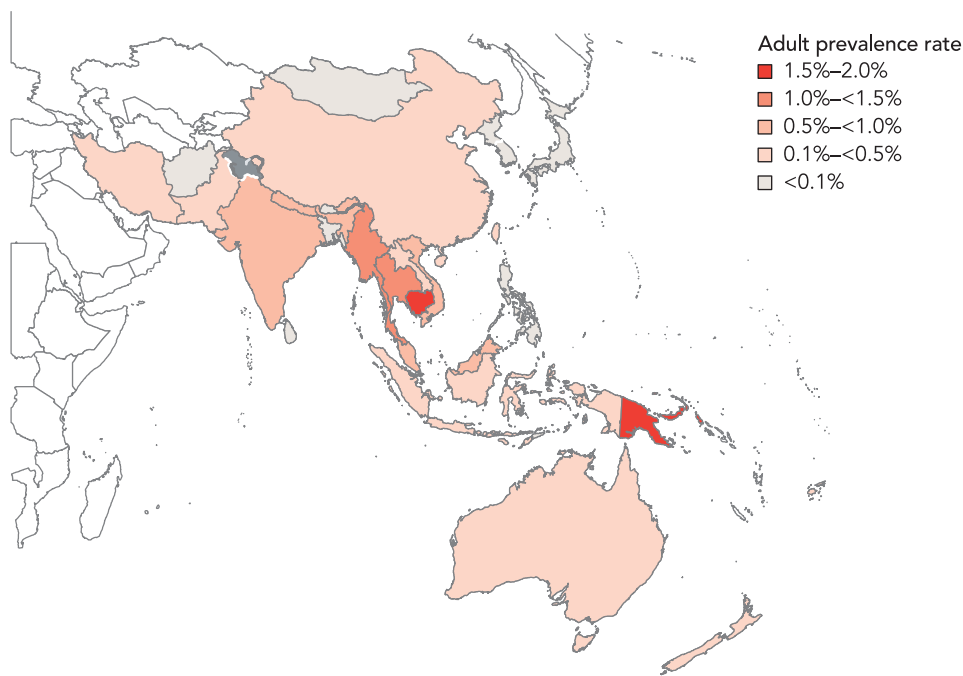
Latest estimates show some 8.3 million [5.7 million–12.5 million] people (2.4

million among adult women [1.5 million–3.8 million]) were living with HIV in Asia at the end of 2005—more than two-thirds of them in one country, **India**. In Asia, an estimated 180 000 [75 000–390 000] children were living with HIV. Approximately 930 000 [620 000–2.4 million] people were newly infected with HIV in 2005, while AIDS claimed approximately 600 000 [400 000–850 000] lives.

The number of people receiving antiretroviral therapy rose from 70 000 in 2003 to 180 000 at the end of 2005. About one in six people (16%) in need of antiretroviral treatment in Asia are now receiving it. While progress has been strongest in **Thailand**, coverage still remains well below 10% in **India** (which has more than 70% of the region's total treatment needs).

Expanded HIV surveillance and improved estimation methods are enabling a clearer picture to be assembled of the AIDS epidemic in **China**. Approximately 650 000 [390 000–1.1 million] people in China were living with HIV in 2005 (Ministry of Health China, 2006). Injecting drug users (of whom there are at least one million registered in the country) account for almost half (44%) of the people living with HIV (Ministry of Health China, 2006; Ruan et al., 2005). Almost one-half of China's injecting drug users share needles and syringes, and one in ten also engage in high-risk sexual behaviour (Ministry of Health China, 2006). In some areas of Xinjiang, Yunnan and Sichuan provinces, HIV prevalence among injecting drug users exceeds 50% (MAP, 2005a). China has established 128 methadone clinics and 91 needle and syringe exchange pilot sites. Coverage

FIGURE 2.8 HIV prevalence (%) in adults in Asia and Oceania, 2005



however will need to be expanded considerably to make a significant impact.

On current evidence, the overlap between paid sex and injecting drug use could spark more serious HIV outbreaks. Available research indicates that a large proportion of injecting drug users buy sex, and that at least half of female drug users have at some stage also sold sex (Liu H et al, 2006; Yang et al., 2005). In some provinces (such as Sichuan) a small but significant percentage of sex workers also inject drugs (MAP, 2005a). Sex workers who also inject drugs face very high risks of HIV infection: they tend to have a high number of clients, low levels of condom use and high rates of sharing needles (MAP, 2005a; MAP, 2005b). As HIV spreads from drug users, sex workers and their clients to the general population, the proportion of sexually transmitted HIV infections is growing, and with it the proportion of HIV infections in women. In 2004, women constituted 39% of reported HIV cases (compared with 25% just two years earlier). In parts of Yunnan, Henan and Xinjiang provinces, HIV prevalence already exceeds 1% among pregnant women and those receiving premarital and clinical HIV testing (Ministry of Health China, 2006).

Although stepped up in recent years, basic elements in China's AIDS response still need to be improved. AIDS awareness is unacceptably low and mass media education has been of limited scope and effectiveness. Priorities include strengthening training for prevention, treatment and care; increasing the provision of antiretroviral drugs to patients in rural areas and low-income patients in urban areas; expanding testing and education of high-risk groups; and further improving the

country's monitoring system (Ministry of Health China, 2006; Yang et al., 2005).

In the world's second-most populous country, **India**, an estimated 5.2 million people in the 15–49-year-age range were living with HIV in 2005, as estimated by the National AIDS Control Organization (NACO). National adult HIV prevalence was 0.9% [0.5%–1.5%]. HIV prevalence tends to be higher in the industrialized peninsular states (with the exception of Kerala), with infection levels of over 1% found in pregnant women in Andhra Pradesh, Karnataka and Maharashtra in 2004 (NACO, 2004a). Especially affected is the Mumbai-Karnataka corridor, the Nagpur area of Maharashtra, the Nammakkal district of Tamil Nadu, eastern districts of Andhra Pradesh, and parts of Manipur and Nagaland (in the north-east of India) (Kumar et al., 2005). However, HIV is spreading into rural areas: in Karnataka and Nagaland; upward of 1% of pregnant women in rural areas tested HIV-positive in 2004.

On a positive note, HIV prevalence for 15–24-year-old pregnant women in Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu, combined, declined from 1.7% in 2000 to 1.1% in 2004 (Kumar et al., 2006). The latter two states were among the earliest in India to respond to the AIDS epidemic, and the current trends reflect their sustained HIV prevention efforts over the past several years.

Overall, most HIV infections (more than 80% of reported AIDS cases) (NACO, 2005) are due to unprotected heterosexual intercourse, and a significant proportion of them are in women. Injecting drug use is the main driver of the HIV epidemics in the north-east

(especially in the states of Manipur, Mizoram and Nagaland, where prevalence among pregnant women is also over 1%), and increasingly elsewhere, including in the major cities Chennai, Mumbai and New Delhi (Solomon et al., 2004; NACO, 2004a; MAP, 2005a, NACO, 2005). There is a substantial overlap between injecting drug use and paid sex in those parts of the country—so much so that in Tamil Nadu, for example, HIV prevalence of 50% has been found among some sex workers (Solomon et al., 2004; NACO, 2004b). Meanwhile, little is known about the role of sex between men in India's epidemic, although available information indicates that sex between men is not uncommon. In Chennai (Tamil Nadu), for example, 6% of men living in slum neighbourhoods said they had had sexual intercourse with another man (Go et al., 2004). The future size of India's HIV epidemic will depend particularly on the effectiveness of programmes for sex workers and their clients, men who have sex with men (and their other sexual partners), and injecting drug users (and their sexual partners) (Kang et al., 2005).

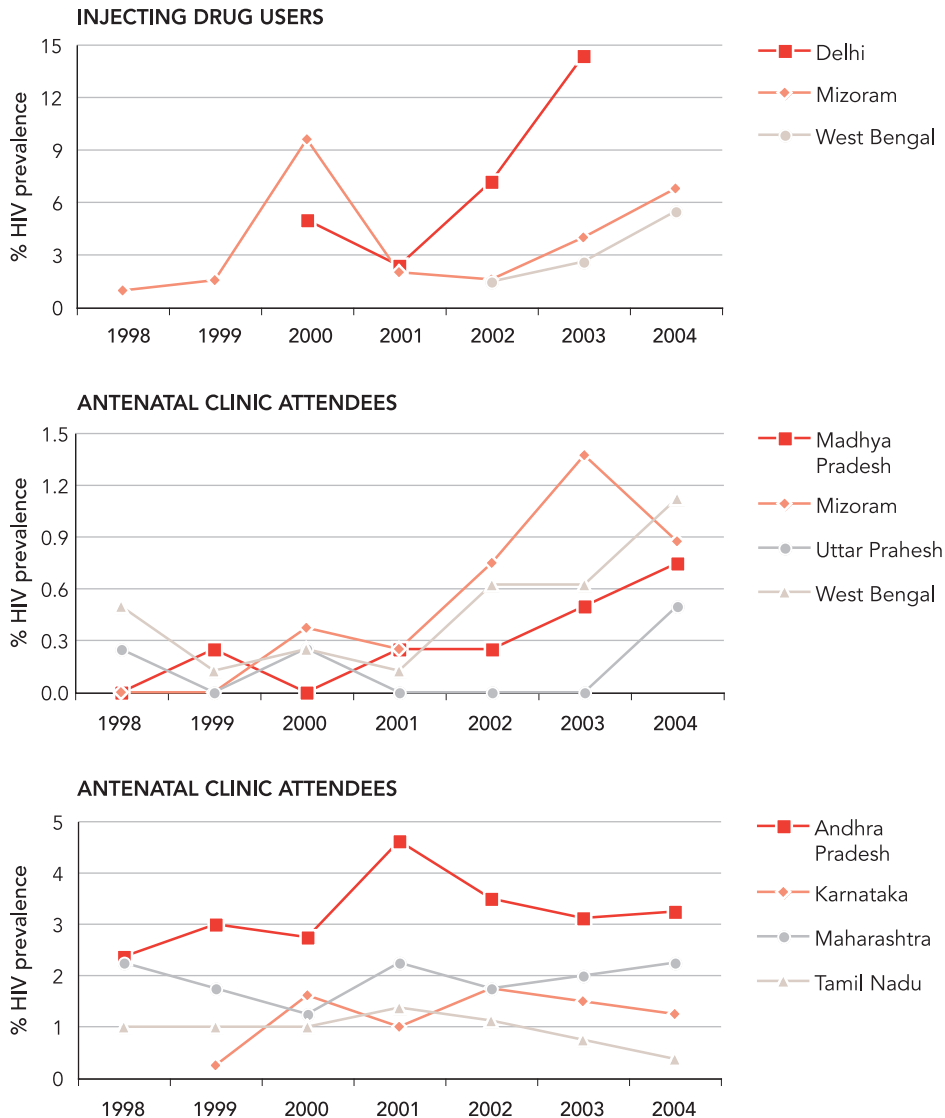
The overlapping risks of injecting drug use and unprotected sex feature in several other epidemics in Asia (MAP, 2005a). An example is **Viet Nam**, where HIV has spread to all 59 provinces and all cities. Approximately 260 000 [150 000–430 000] people were living with HIV in 2005, more than double the number in 2000. National adult HIV prevalence was an estimated 0.5% [0.3%–0.9%] in 2005. Official estimates are that almost 40 000 people are being infected with HIV each year (Ministry of Health Viet Nam, 2005). Injecting drug users and sex work are the main factors driving the epidemic, phenomena that

have grown as a consequence of the opening of the country's markets and borders (Grayman et al., 2005). With needle-sharing commonplace, HIV prevalence among injecting drug users increased from 9% in 1996 to 29% in 2002 and 32% in 2003, and HIV infection levels as high as 40% have been found in some cities (Ministry of Health Viet Nam, 2005; Hien et al., 2004). Among the many injecting drug users who also buy sex, condom use is erratic: less than half of them consistently use condoms with sex workers (USAID et al., 2001). Large proportions of sex workers also inject drugs (20% of street-based sex workers in Ho Chi Minh City and 43% in Hanoi), and they are least likely to use condoms when having sex (Tran et al., 2005; Hien et al., 2004b; MAP, 2004). In a Hanoi study, HIV infection levels were 1.6% among non-injecting sex workers, compared with 33% among those who injected drugs—highlighting the need to make sex workers who also inject drugs a major focus of HIV prevention efforts (Tran et al., 2005). There is an urgent need for strategies that reduce needle-sharing and sexual risk-taking quickly and on a wide scale. Unfortunately, the stigmatization and outlaw status of sex workers and injecting drug users pose an enormous challenge, particularly to ensuring universal access to HIV prevention, treatment and care options (Tran et al., 2005).

The epidemics in **Cambodia** and **Thailand** have evolved largely around the sex trade. Both countries have seen their prevention efforts rewarded with diminishing epidemics over the past decade, as fewer men bought sex and condom use rates rose (MAP, 2005b). At 1.6% [0.9%–2.6%], adult national HIV prevalence in **Cambodia** was one-third lower

FIGURE 2.9

HIV prevalence (%) trends in India among injecting drug users and pregnant women, selected areas, India, 1998–2004*



*Data from consistent surveillance sites only.

Source: National AIDS Control Organization (NACO) (2005).

in 2005 than in the late 1990s—due mainly to a combination of rising mortality rates and HIV prevention efforts that helped reduce unprotected paid sex (National Center for HIV/AIDS, Dermatology and STIs, 2004). Nonetheless, the country remains burdened with one of the worst AIDS epidemics in Asia (Mills

et al., 2005). The fact that women constitute a growing share of people living with HIV (an estimated 47% in 2003, compared with 37% in 1998) suggests that significant numbers of women are being infected by husbands and boyfriends who probably acquired the virus during paid sex (National

Center for HIV/AIDS, Dermatology and STIs, 2004). In addition, there are signs that more men are again buying sex, along with evidence of increasing injecting drug use, including among sex workers, in the capital, Phnom Penh. There are also indications of increasing HIV infections among street youth who use amphetamine-type stimulants (National Centre for HIV/AIDS, Dermatology and STIs, 2005; Burrows, 2003). A 2005 survey found that 28% of such street youth were HIV-positive, more than double the 12% reported a year earlier in a similar survey (Mills et al., 2005).

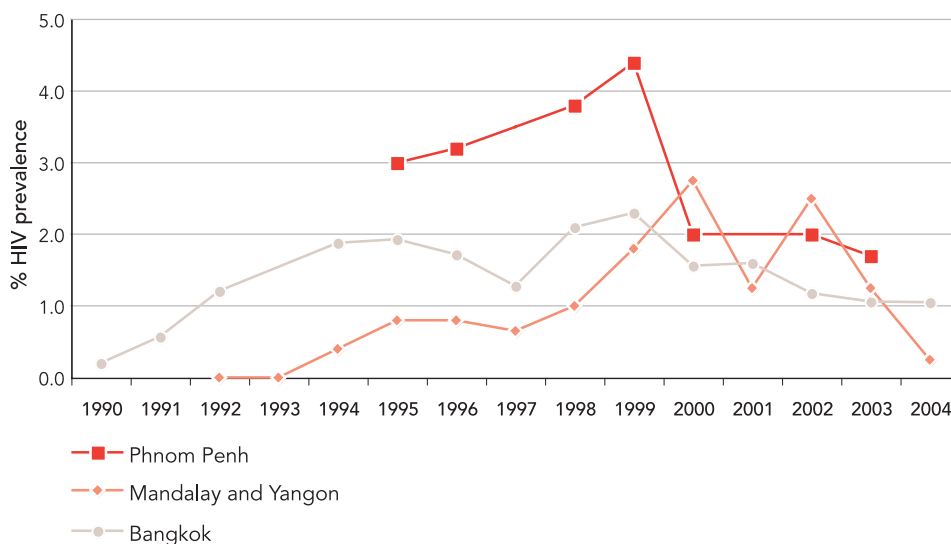
In neighbouring **Thailand**, national adult HIV prevalence was estimated at 1.4% [0.7%–2.1%] in 2005. Declining levels of HIV and other sexually transmitted infections have been recorded in **Thailand** since the late 1990s. However, Thailand's prevention efforts appear not to be matching recent changes in its epidemic. According to the Ministry of Health, more than one-third of HIV infections in 2005 were among women who had been infected by their long-term partners, and about one-fifth were among men who have sex with men. Premarital sex has become more commonplace among young Thais, including women, with condom use typically rare (only 20% to 30% of sexually active young people are using condoms consistently) (Punpanich et al., 2004; UNDP, 2004). Meanwhile, condom use during paid sex is on the wane. A study among female sex workers (in Bangkok, Chiang Mai and Mae Hong Son) found that condoms were used in only 51% of commercial sex encounters. That finding agrees with an earlier household survey in which less than one-third of young men in northern Thailand said they consistently used condoms with sex workers (Bucking-

ham et al., 2005; UNDP, 2004). HIV infection levels in sex workers, injecting drug users and men who have sex with men have remained high—over 10% of brothel-based female sex workers were living with HIV in 2003, as were 45% of injecting drug users who attended treatment clinics (Punpanich et al., 2004). Among men who have sex with men in Bangkok, HIV prevalence rose from 17% in 2003 to 28% in 2005—and among those younger than 21 years of age, HIV prevalence tripled in the same period (Van Griensven et al., 2006). Not only are safer sex campaigns in clear need of an overhaul, but sex between men, like injecting drug use, is still largely neglected in Thailand's HIV prevention programme. Meanwhile, heartening progress has been made on the treatment front. Official figures indicate that an estimated 80 000 HIV-positive Thais had received antiretroviral treatment by end-2005. The roll-out of antiretroviral treatment in recent years has coincided with a drastic drop in the number of officially reported AIDS-related deaths—from 5020 in 2004 to 1640 in 2005.

In 2005, an estimated 360 000 [200 000–570 000] adults and children were living with HIV in **Myanmar**, and national adult HIV prevalence stood at 1.3% [0.7%–2.0%]. **Myanmar's** initial, limited response to its AIDS epidemic allowed HIV to spread relatively freely for more than a decade, leaving the country with one of the most serious epidemics in Asia. More recently, that response has been augmented—on current evidence, to encouraging effect (Thwe, 2004). National HIV prevalence in pregnant women declined from 2.2% in 2000 to 1.8% in 2004, while infection levels among both men and women seeking treatment for other sexually

FIGURE 2.10

HIV prevalence (%) trends among pregnant women in major cities in Cambodia, Myanmar and Thailand, 1990–2004



Source: National AIDS Control Sources: Cambodia National Center for HIV/AIDS, Dermatology and STDs (Phnom Penh); Myanmar Ministry of Health (Mandalay and Yangon); Thailand Ministry of Public Health (Bangkok), 2005.

transmitted infections dropped significantly in the same period (from 7% to 3% for men, and 12% to 6% for women) (Wiwat et al., 2005). On the other hand, large proportions of people who engage in high-risk behaviour have been infected: it is estimated that one in four female sex workers and one in three injecting drug users were HIV-infected in 2004. Given that HIV transmission in population groups such as those remains a major factor in Myanmar's epidemic, harm reduction programmes along with social programmes that mitigate high-risk behaviour can help reduce HIV spread. More and improved HIV-related data (especially regarding infection patterns among men who have sex with men) are needed to gain a more comprehensive understanding of Myanmar's epidemic.

In **Pakistan**, approximately 85 000 [46 000–210 000] adults and children were

living with HIV in 2005. The country will need to improve its prevention efforts if it is to avoid more serious HIV outbreaks. Almost one in four injecting drug users tested in Karachi was HIV-positive in 2004; less than a year earlier the same community yielded only one HIV-positive case (Altaf et al., 2004). Many of these injecting drug users move from city to city, and large proportions of them share injecting equipment (48% in Karachi and 82% in Lahore had shared in the previous week). There is significant overlap between injecting drug use and sex work—against a backdrop of dismal AIDS knowledge among persons at high risk of infection. In Karachi, one in four injecting drug users had never heard of AIDS, while one in five sex workers could not recognize a condom, and one in three had never heard of AIDS. A mere 2% of female sex workers said they had used condoms with all their clients in

the previous week (Ministry of Health Pakistan, DfID, Family Health International, 2005; MAP, 2005b).

An estimated 170 000 [100 000–290 000] adults and children were living with HIV in **Indonesia** in 2005. Although national adult HIV prevalence there remains very low at 0.1% [0.1%–0.2%], the country faces the prospect of a rapidly expanding AIDS epidemic in some areas. An especially troubling situation has emerged in the westernmost province of Papua, which borders on **Papua New Guinea**, where a serious HIV epidemic is underway. In Papua, HIV has spread beyond sex workers and their clients, and almost 1% of adults in five villages have tested HIV-positive in a serosurvey (MAP, 2004). Meanwhile, HIV prevalence as high as 48% has been found in injecting drug users at rehabilitation centres in Jakarta and even higher infection levels have been reported in Pontianak (on the island of Borneo) (Riono and Jazant, 2004; MAP, 2005a). Here, too, the overlap between injecting drug use and paid sex is strong. Of the one in five injecting drug users in Jakarta who bought sex, three-quarters did not use condoms when doing so, according to one study (Center for Health Research and Ministry of Health, 2002). Generally, too, condom use during paid sex is not the norm. In Jakarta, three-quarters of sex workers operating out of massage parlours and clubs in 2004, and 85% of their counterparts in brothels, said they had not used condoms with any of their clients in the previous week (MAP, 2005b).

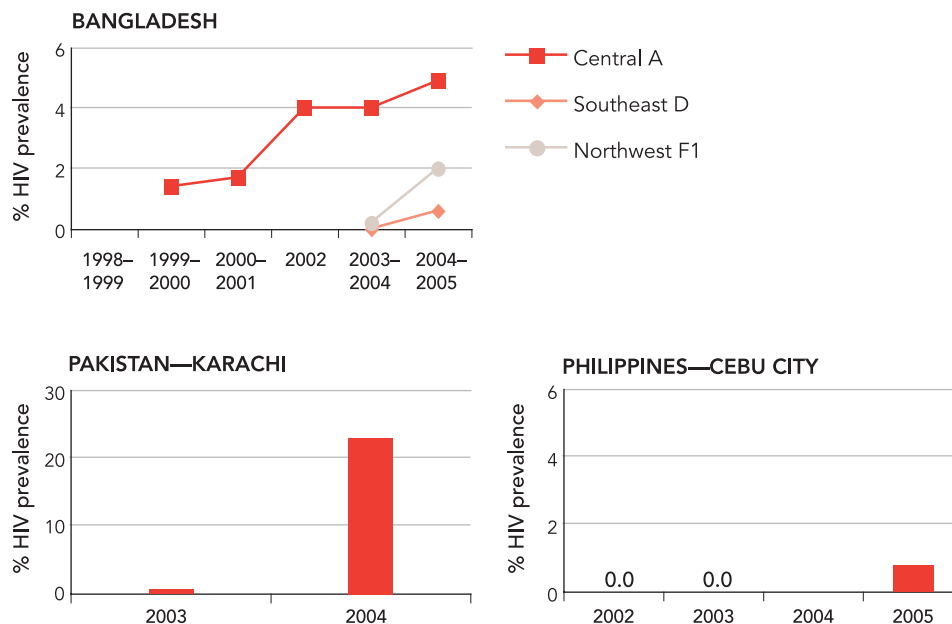
National adult HIV prevalence in **Malaysia** stood at an estimated 0.5% [0.2%–1.5%], and approximately 69 000 [33 000–220 000] adults and children were living with HIV in 2005. Injecting drug

use is the main driving force in Malaysia's epidemic, although sexual transmission accounts for a growing share of HIV infections: 17% in 2002, compared with 7% in 1995 (Ministry of Health Malaysia and WHO, 2004; Huang and Hussein, 2004). HIV prevalence of 41% and 31% has been found among injecting drug users in Keleantan and Terengganu, respectively, while in parts of Kuala Lumpur up to 10% of female sex workers have tested HIV-positive in studies (Ministry of Health Malaysia and WHO, 2004).

In **Bangladesh**, national adult HIV prevalence is still extremely low at under 0.1% [$<0.2\%$] partly due to focused prevention efforts, which have probably helped keep HIV prevalence below 1% among men who have sex with men and among female sex workers. About 11 000 [6400–18 000] adults and children were living with HIV in 2005. However, unsafe injecting drug practices have caused HIV infection levels in injecting drug users to increase from 1.7% to 4.9% between 2000–2001 and 2004–2005 in a central surveillance site. HIV infection was also detected among injecting drug users in two out of 15 other sites. Given that at least one-half of injecting drug users in three regions said they used non-sterile equipment the last time they injected drugs, those HIV trends could persist. A large proportion of injecting drug users (as many as one in five in some regions) report buying sex and among them, fewer than one in ten consistently used a condom during commercial sex in the previous year (Ministry of Health and Family Welfare Bangladesh, 2005). The quality and coverage of prevention initiatives aimed at reducing transmission through injecting drug use and commercial sex require strengthening.

FIGURE 2.11

HIV prevalence (%) trends among injecting drug users in Bangladesh, Pakistan and the Philippines, 1998–2005*



*Other sites in Bangladesh and Pakistan continue to show very low HIV prevalence in their latest surveillance surveys (0% in 13 sites in Bangladesh, and 0.5% in Lahore, Pakistan).

Sources: 2005 Integrated HIV Behavioral and Serologic Surveillance Findings, Summary Report. National Epidemiology Center, Department of Health (Philippines); National HIV Serological Surveillance, 2004–2005, 6th Round Technical Report. National AIDS/STD Programme, Ministry of Health and Family Welfare (Bangladesh); National Study of Reproductive Tract and Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, 2005. National AIDS Control Program, Ministry of Health (Pakistan).

The **Philippines**, too, is experiencing a very limited epidemic, with national adult HIV prevalence of under 0.1% [$<0.2\%$] and an estimated 12 000 [7300–20 000] adults and children living with HIV in 2005. Routine screening of sex workers for sexually transmitted infections, along with the provision of other HIV prevention services, has probably helped to keep HIV prevalence at very low levels (MAP, 2005b; Mateo et al., 2004). However, this could change, given infrequent use of condoms during paid sex (especially among indirect sex workers), high levels of sexually transmitted infections in several population groups, and very high rates of needle-sharing among drug injectors in some areas (77% in Cebu City, for example) (Mateo et al., 2004; Wi et al., 2002; Department of Health Philippines,

2003). While HIV prevalence among female sex workers has remained very low (0.1%, 0.02% and 0.16% in 2002, 2003 and 2005, respectively), surveillance among injecting drug users in Cebu city in 2005 for the first time detected the presence of HIV in this group, although only at 1% prevalence (Department of Health Philippines, 2005).

A similar situation exists in **Lao People's Democratic Republic**. At 0.1% [0.1%–0.4%], national adult HIV prevalence is still very low overall, but young men are becoming more sexually active. In Vientiane, the capital, almost two in three young men said they had had several female partners in the previous six months, and one in three reported paying for sex (Toole et al., 2005). Prevalence of

gonorrhoea is high (13%–14%) among ‘service women’ (who work in venues that also offer paid sex) (Phimphachanh and Sayabounthavong, 2004). This indicates a clear need for a comprehensive AIDS programme that includes a 100% condom use programme and improved treatment services for sexually transmitted infections.

Oceania

Papua New Guinea’s relatively young but already-serious epidemic accounts for more than 90% of all HIV infections reported in Oceania to date (excluding Australia and New Zealand) (Secretariat of the Pacific Community, 2005). Overall, an estimated 78 000 people [48 000–170 000] in Oceania were living with HIV at the end of 2005, including the 7200 [3500–55 000] people who acquired HIV in that year. Regional adult HIV prevalence was approximately 0.3% [0.2%–0.8%], mainly due to the epidemic in Papua New Guinea. Fewer than 3400 [1900–5500] people are believed to have died of AIDS in the region in 2005—which mainly reflects widespread treatment access in the countries with mature epidemics.

The epidemic in **Papua New Guinea** is growing at a dismaying pace: HIV diagnoses have been increasing by about 30% annually since 1997. An estimated 60 000 [32 000–140 000] Papua New Guineans were living with HIV in 2005, with HIV prevalence estimated at 1.8% nationally [0.9%–4.4%]. Several factors are associated with the growing epidemic. Sociocultural norms discriminate heavily against women and high levels of sexual violence against women have been reported. Both paid and casual sex liaisons feature prominently, and condom use is

generally erratic (National AIDS Council Papua New Guinea, 2004). Seroprevalence surveys have found HIV prevalence of 2.5% and 2% among women seeking antenatal care in Lae and Goroka, respectively. Among people seeking treatment for sexually transmitted infections in the capital, Port Moresby, 20% tested HIV-positive in 2004, as did 6% in Mount Hagen (National AIDS Council and National Department of Health Papua New Guinea, 2004; Secretariat of the Pacific Community, 2005). Recent efforts to improve access to HIV prevention knowledge notwithstanding, most young people still lack access to prevention education and counselling (National AIDS Council and National Department of Health Papua New Guinea, 2004). Papua New Guinea’s AIDS response needs to improve radically if it is to restrain its epidemic.

Meanwhile, **Australia’s** much older AIDS epidemic is not dissipating either. There, an estimated 16 000 [9700–27 000] adults and children were living with HIV in 2005. After declining in the late 1990s, annual new HIV diagnoses are approaching earlier levels again, and numbered some 820 in 2004. Newly acquired HIV infections (largely attributable to unprotected sex, mostly between men) are also increasing, which plausibly reflects a revival of sexual risk behaviour (National Centre in HIV Epidemiology and Clinical Research, 2005). Thus, a study among gay men in Sydney found a ten-fold rise in syphilis cases from 1999 to 2003 (Fairley et al., 2005). Although national HIV infection trends appear to be generally similar among Indigenous and non-Indigenous people, a recent study revealed marked discrepancies in western Australia. While HIV notifications among non-Indigenous Australians



In Vanuatu, more than 40% of pregnant women have been found to have at least one sexually transmitted infection, as did 43% of pregnant women in Samoa's capital, Apia.

decreased in 1985–2002, those among Indigenous men and women increased. Indigenous women were found to be 18 times more likely to be HIV-infected than non-Indigenous women, and three times more likely than non-Indigenous men (Wright et al., 2005). Unsafe injecting drug use accounts for one in every five HIV diagnoses in Indigenous Australians (compared with about 2% for non-Indigenous people) (National Centre in HIV Epidemiology and Clinical Research, 2005). These trends underline the need to revamp prevention, diagnosis and treatment efforts so that they reach all at-risk and affected sections of the population.

Annual, new HIV diagnoses in **New Zealand** have more than doubled since 1999—from fewer than 80 to 183 in 2005—but national adult HIV prevalence remains very low at under 0.2% (Ministry of Health New Zealand, 2006). Much of the recent trend is attributable to an increase in HIV diagnoses among men who have sex with men. Unlike HIV infections acquired during sex between men, most of the heterosexual HIV infections diagnosed in recent years were

acquired abroad (Ministry of Health New Zealand, 2006).

HIV-infection levels are very low in the rest of Oceania, but this could change. In many places, behaviour that favours the spread of sexually transmitted infections is common enough to spark HIV outbreaks if the virus establishes a presence. On **Vanuatu**, for example, more than 40% of pregnant women have been found to have at least one sexually transmitted infection, as did 43% of pregnant women in **Samoa's** capital, Apia (Sullivan et al., 2003; Sullivan et al., 2004). In Dili, **Timor-Leste**, 60% of sex workers have tested positive for HSV2, as have almost 30% (29%) of taxi drivers and men who have sex with men (Pisani and Dili STI survey team, 2004).

Eastern Europe and Central Asia

The epidemics in eastern Europe and central Asia continue to expand. Some 220 000 [150 000–650 000] people were newly infected with HIV in 2005, bringing to about 1.5 million [1.0 million–2.3 million] the number of

people living with HIV—a twenty-fold increase in less than a decade. Between 2003 and 2005, the number of adults and children living with HIV in this region increased by more than one-third.

The epidemic's death toll is rising sharply, too. AIDS killed an estimated 53 000 [36 000–75 000] adults and children in 2005—almost twice as many as in 2003. Increasingly large numbers of women are being infected with HIV. In 2005, an estimated 420 000 [270 000–680 000] women aged 15 years and older were living with HIV—one-third more than the 310 000 [200 000–490 000] in 2003.

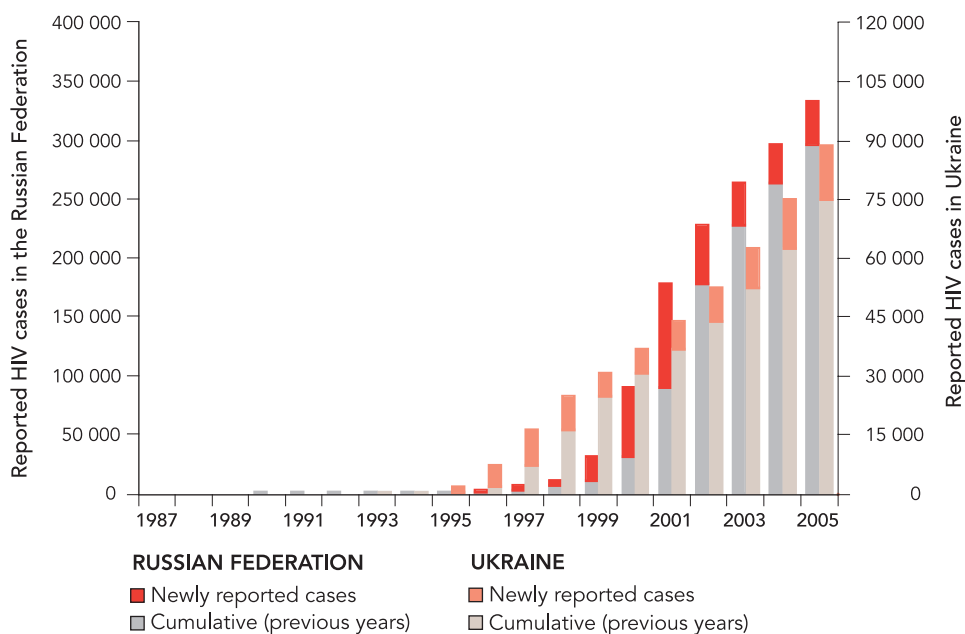
National responses need to be boosted to meet the combined challenges of HIV, injecting drug use and sexual risk behaviour—especially among young people—if they are to have a significant impact on

the epidemics in this region. Antiretroviral therapy coverage remains inadequate in this region, with only 21 000 of the estimated 160 000 people in need of antiretroviral treatment receiving it at the end of 2005. Injecting drug users account for more than 70% of HIV cases in this region, but represent only about 24% of the people receiving antiretroviral therapy (WHO/UNAIDS, 2006).

The majority of people living with HIV in this region are in two countries:

Ukraine, where the annual number of new HIV diagnoses keeps rising, and the **Russian Federation**, which has the biggest AIDS epidemic in all of Europe. After reaching their highest level to date in 2001, new annual HIV diagnoses in the Russian Federation have remained relatively steady in recent years. More recent epidemics are underway in **Kazakhstan**, **Tajikistan** and **Uzbekistan**,

FIGURE 2.12 Increase in reported HIV cases in the Russian Federation and Ukraine 1987–2005



Sources: Russian Federal AIDS Centre; Ukrainian AIDS Centre and Ministry of Health of Ukraine.

where the annual number of new HIV diagnoses has been rising steeply.

By the end of 2005, some 350 000 HIV cases had been officially registered in the **Russian Federation** since its epidemic began (Ladnaya, 2005). The actual number of infections is much higher: an estimated 940 000 people [560 000–1.6 million] were living with HIV in the country at the end of 2005. National adult HIV prevalence was an estimated 1.1% [0.7%–1.8%]. As the Russian Federation's epidemic matures, AIDS mortality rates are likely to contribute to the country's ongoing demographic decline.

The **Russian Federation's** AIDS epidemic is associated with factors rooted in the socioeconomic and socio-political upheavals of the 1990s, when economic and social dislocation created a climate in which drug markets, drug use and related HIV risk thrived (Rhodes and Simic, 2005). Large numbers of people inject drugs, many of them young and unemployed. At least three in every four new HIV infections so far this decade have been in people younger than 30 years, with unsafe drug injecting practices the main cause of infection (Pokrovskiy, 2005; EuroHIV, 2005). In St Petersburg, for example, HIV infection levels of 30% were found among injecting drug users recently, and prevalence of 12%–15% has been found in provincial cities such as Cherepovets and Velikiy Novgorod (Verevchkin et al., 2005; Smolskaya et al., 2005). Harm reduction programmes can cut the odds of unsafe injecting practice and HIV transmission among injecting drug users (Rhodes et al., 2004; Des Jarlais et al., 2002; Gibson et al., 2001). In the cities of Pskov and Tomsk, for example, injecting drug users *not* participating in local harm reduction projects

were found to be at least three times more likely to share injecting equipment compared with those who did take part (Eroshina et al., 2005). A rapid assessment of harm reduction programmes in 15 cities of the Russian Federation has made similar findings (Open Health Institute, 2004). More syringe exchange projects are being introduced, but they are still too few in number to curb the epidemic's growth. At the same time, vast geographic disparities in HIV prevalence among injecting drug users have been observed, suggesting substantial variations in risk behaviour.

Disenfranchised people living on the margins of society appear to be especially at risk of HIV infection. A study among juvenile detainees, homeless persons and women at a temporary detention centre in Moscow has found HIV prevalence 30–120 times higher than in the general population (Shakarishvili et al, 2005). The Russian Federation's prison system is disproportionately affected by the epidemic, with HIV prevalence estimated to be at least four times that found in the wider population.

Increasingly, HIV is spreading from (mostly male) injecting drug users to their sexual partners and beyond, with more women becoming infected. At 210 000 [110 000–370 000], the estimated number of adult women (aged 15 years and over) living with HIV in 2005 was almost one-third bigger than two years earlier. About 38% of total registered HIV cases were in women in 2004—a larger share than ever before. The trend is marked among young women, especially those in their late teens (15–20 years), who accounted for a larger share of newly reported HIV cases in 2004 than did men in that age group. Some of

those women were infected through injecting drug use (indeed female injecting drug users have become more numerous in the past decade); but many acquired HIV during unprotected sex with infected men (Federal Service of the Russian Federation in Consumer Rights Protection and Human Welfare, 2005). Effective prevention efforts will need to be expanded—particularly among injecting drug users and their sexual partners, as well as among sex workers and their clients.

As the epidemic in the Russian Federation matures, the need for antiretroviral treatment access grows. In 2005, a mere 5000 of the estimated 100 000 people in need of antiretroviral therapy were receiving it (WHO/UNAIDS, 2006). High costs of antiretroviral drugs are a major hurdle. So, too, is the shortage of technical capacity, which is thwarting not only treatment access but the entire AIDS response.

Ukraine's epidemic continues to grow. Annual HIV diagnoses have almost doubled since 2000, reaching 12 400 in 2004, a figure that substantially understates the actual scale of the epidemic since it only reflects infections among people who have been in direct contact with official testing facilities (Ukrainian AIDS Centre, 2005a; EuroHIV, 2005). National adult HIV prevalence was estimated at 1.4% in 2005 [0.8%–4.3%]—or 410 000 [250 000–680 000] people.

A combination of unsafe injecting drug use and unprotected sex is fuelling Ukraine's epidemic. In cities such as Odessa and Simferopol, for example, 58%–59% of injecting drug users have tested HIV-positive (Ukrainian AIDS Centre, 2005b). In Odessa, 67% of sex workers who also injected drugs were

HIV-positive, as were 35%–50% in Donetsk, Lutsk, Poltava and Simferopol (Ukrainian AIDS Centre, 2005b). Partly as a result of such patterns, sexual transmission of HIV has become more common, and accounted for one in three new HIV diagnoses in 2004 (compared with 14% during 1999–2003) (Ukrainian AIDS Centre, 2005a). Some of those new infections were acquired from sexual partners who probably had been infected when injecting drugs. An increasing number of new, sexually transmitted HIV cases involve people who do not have a history of injecting drug use (Grund et al., 2005), indicating that HIV has spread into the population at-large. More women are being infected: in 2004, 42% of new HIV diagnoses were among women (Ukrainian AIDS Centre, 2005a).

As in the Russian Federation, HIV is also prevalent in Ukraine's prison system, where inmates' knowledge of HIV tends to be poor. In one recent survey, only 39% of prisoners knew how to prevent the sexual transmission of HIV (Ukraine UNGASS Report, 2005). Also hidden from the public gaze is the role of sex between men in the epidemic. Although scant, the available research data are troubling. Just more than half (55%) of the men surveyed in seven Ukrainian cities said they had used a condom the last time they had sex with another man (Ukraine AIDS Centre, 2005b). In Odessa, 28% of men who have sex with men tested HIV-positive in a recent study (Ukrainian AIDS Centre, 2005b). Prevention activities overall, and particularly among prisoners and men who have sex with men, need to be intensified and scaled up. Some pilot projects (including harm reduction projects) are making headway, but they are too few in number and too limited in scope to slow the growth rate of the epidemic.



A total of 330 000 [240 000–420 000] people are living with HIV in the Caribbean, 22 000 [9 800–43 000] children younger than 14 years old.

02

Ukraine's epidemic has reached the stage where AIDS deaths have begun to increase. In the first seven months of 2005, 1138 people died of AIDS-related illnesses, almost one-fifth of the total number of reported AIDS-related deaths to date (Ukrainian AIDS Centre, 2005a). In the last two years, Ukraine has begun to scale up HIV treatment and the number of people on antiretroviral therapy has risen from less than 200 in July 2004 to more than 3000 in December 2005. These efforts will need to continue expanding to keep pace with the growing number of people who need treatment. As in many other countries, scale-up requires measures to ensure that people who inject drugs benefit from antiretroviral therapy (WHO, 2005; WHO/UNAIDS, 2006).

In **Belarus**, where an estimated 20 000 [11 000–47 000] adults and children were living with HIV in 2005, the spread of HIV appears not to be slowing. National adult HIV prevalence stood at 0.3% [0.2%–0.8%]. Sexual transmission now accounts for the largest share of new HIV diagnoses (55% in 2004) (Ministry of Health Belarus, 2005). In **Uzbekistan** the number of new HIV diagnoses rose from 28 in 1999 to 2016 in 2004. Inject-

ing drug use (and, to a lesser extent, paid sex) fuels this epidemic, which is concentrated in and around the capital Tashkent (EuroHIV, 2005; Todd et al., 2005). A similar combination of risk behaviours underpins the epidemic in **Kazakhstan**, where an estimated 12 000 people [11 000–77 000] were living with HIV in 2005. National adult HIV prevalence was 0.1% [0.1%–3.2%]. Very high HIV prevalence has been found among injecting drug users: 56% in a recent study in Kashgar City, for example (Ni et al. 2006).

Tajikistan's smaller epidemic is also rapidly evolving. The annual number of reported HIV diagnoses had been less than 50 before 2004, but rose to 198 in 2004. An estimated 4900 [2400–16 000] people were living with HIV in 2005, and national adult HIV prevalence was approximately 0.1% [0.1%–1.7%]. A study among injecting drug users in the capital, Dushanbe, showed HIV prevalence of 12%, while 77% of women in this study reported having traded sex for drugs or money (Beyer et al., 2006). The epidemics in the Caucasus appear to be growing less rapidly than many of those elsewhere in the former Soviet Union (EuroHIV, 2005). However, conditions in **Armenia, Azerbaijan and Georgia**

favour a possible surge in HIV. In Armenia, injecting drug use has emerged as a major route of HIV transmission, while significant HIV prevalence is being found in injecting drug users and sex workers in Baku, Azerbaijan's capital (EuroHIV, 2005). South-eastern Europe's epidemics are even more low-key, but there, too, injecting drug use and sexual risk behaviour in several countries could start HIV outbreaks. Worst-affected in that subregion is **Romania**, where a cumulative total of 6200 HIV infections were diagnosed by the end of 2004, and where most new infections are attributed to unprotected sex (EuroHIV, 2005).

Caribbean

A total of 330 000 [240 000–420 000] people are living with HIV in the Caribbean, 22 000 [9800–43 000] of them children younger than 15 years. An estimated 37 000 [26 000–54 000] people became infected with HIV in 2005. Women comprise 51% of adults living with HIV. The Caribbean's epidemics—and countries' AIDS responses—vary considerably in extent and intensity. HIV infection levels have

decreased in urban parts of **Haiti**, and have remained stable in neighbouring **Dominican Republic**. As well, expanded access to antiretroviral treatment in the **Bahamas** and **Barbados** appears to be reducing AIDS deaths. However, such progress has not been enough to undo the Caribbean's status as the second-most affected region in the world. AIDS is the leading cause of death among adults (15–44 years) and claimed an estimated 27 000 [19 000–36 000] lives in 2005. Overall, less than one in four (23%) persons in need of antiretroviral therapy was receiving it in 2005 (WHO/UNAIDS, 2006).

National adult HIV prevalence exceeds 2% in **Trinidad and Tobago**, and 3% in the **Bahamas** and **Haiti**, while in **Cuba** it is 0.1% [<0.2]. Unfortunately, inadequate HIV surveillance still blurs the picture of recent epidemiological trends in many Caribbean countries (and especially in rural areas).

As in many other parts of the world, the region's epidemics occur in a context of deep impoverishment and gender inequalities. Unprotected heterosexual intercourse is the main mode of HIV transmission,

Young Haitians are becoming sexually active at earlier ages. The average age at first sex for men and women declined by approximately one year between 1994 and 2000. Condom use among 15–24-years-olds has become less frequent.



and women (particularly young women) are increasingly prone to HIV infection. In **Trinidad and Tobago**, for example, females in their late teens (15–19-years-old) were six times, and in Jamaica two-and-a-half times, more likely to be HIV-infected, compared with males of the same age (Inciardi et al., 2005; MAP, 2003). These patterns are caused mainly by a combination of girls' and young women's physiological susceptibility, and the relatively common practice of younger women establishing relationships with older men (who, by virtue of their age, are more likely to have acquired HIV). Generally overlooked, though, is the fact that more than one in ten (12%) reported HIV infections in this region is attributable to unprotected sex between men. Homophobia and strong sociocultural taboos that stigmatize same sex relations mean that the actual proportion could be somewhat larger (Inciardi et al., 2005). Except for **Bermuda** and **Puerto Rico**, injecting drug use plays a minor role in the Caribbean's epidemics.

Cuba, with adult HIV prevalence of 0.1% [$<0.2\%$] and about 4800 [2300–15 000] people living with HIV, remains an anomaly in the region. The country's HIV prevention of mother-to-child transmission programme is among the most effective in the world, and has kept the total number of HIV-infected babies to date below 100, while universal, free access to antiretroviral therapy has limited both AIDS cases and deaths (Susman, 2003; Caribbean Technical Expert Group, 2004). Still, AIDS epidemics can change, and Cuba will need to be sensitive to emerging social changes that could spur wider HIV spread (Inciardi et al., 2005).

Overall, with a few exceptions, the Caribbean's epidemics have stayed relatively

stable in recent years. **Haiti** is home to more people living with HIV than any other country in the region: 190 000 [120 000–270 000]. National adult HIV prevalence in 2005 was estimated at 3.8% [2.2%–5.4%]. However, the percentage of pregnant women found to be HIV-infected declined by half from 1993 to 2003–2004. The decline has been most marked in urban areas, where prevalence fell from 9.4% in 1993 to 3.7% a decade later. HIV prevalence declines in semi-urban and rural areas have been slight, by comparison (Gaillard et al., 2006). Haitians are generally well-informed about AIDS and there is evidence of increasing condom use, abstinence and fidelity, as well as a reduction in the number of occasional partners, especially in urban areas. However, HIV incidence began declining before those behaviour changes became evident (Gaillard et al., 2006). Thus a recent analysis has attributed Haiti's trend of diminishing HIV prevalence also to AIDS-related mortality and to improvements made in blood safety during the early stages of the epidemic (Gaillard et al., 2006). Moreover, there are warning signs that trends could reverse again. Young Haitians are becoming sexually active at earlier ages—median age at first sex has declined by approximately one year for women and men in 1994–2000—and condom use among 15–24-year-olds has become more infrequent (Gaillard et al., 2004).

In the **Dominican Republic**, which shares Hispaniola Island with Haiti, HIV prevalence in pregnant women began decreasing in the mid-1990s—especially in the capital, Santo Domingo—but has been relatively stable overall in recent years (Secretaria de Estado de Salud Pública y Asistencia Social de Republica Dominicana, 2005). Adult national HIV

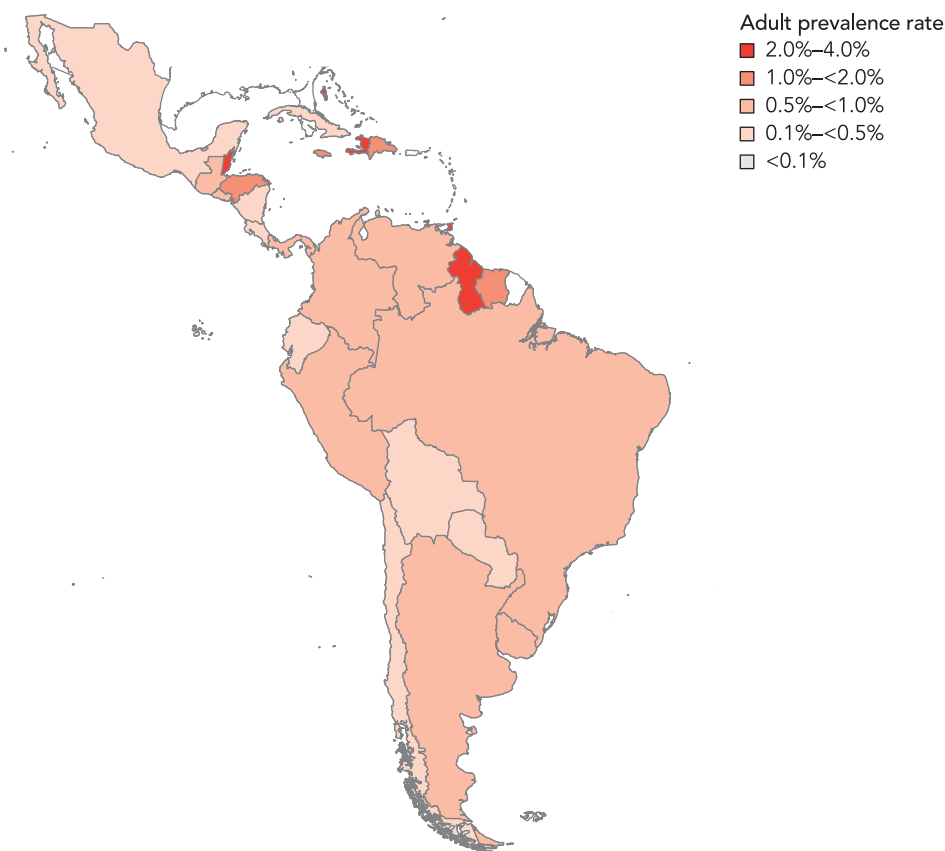
prevalence was estimated at 1.1% [0.9%–1.3%] in 2005. The trend seen in Santo Domingo is possibly linked to sustained efforts to promote consistent condom use and safer behaviour among sex workers and their clients. Higher HIV infection levels have been found among pregnant women in other parts of the country (over 2% in San Juan and La Romana, for example, in 2004) and in some *bateyes* (the impoverished communities of mainly Haitian sugar plantation workers) (Secretaria de Estado de Salud Pública y Asistencia Social de Republica Dominicana, 2005). HIV infection levels of 11% have been found in three cities among men who have sex with men (Toro-Alfsono, Varas-Díaz, 2005).

In **the Bahamas**, where an estimated 6800 [3300–22 000] adults and children were living with HIV in 2005, national adult HIV prevalence was 3.3% [1.3%–4.5%], among the highest in the region. HIV prevalence among pregnant women has declined from 4% in the mid-1990s to less than 3% in 2005. Improved management and treatment of AIDS appears to have reduced the number of annual deaths attributable to AIDS (Department of Public Health The Bahamas, 2004). The latter trend has also been seen in **Barbados**, where annual AIDS deaths were halved in 1998–2003 (Caribbean Epidemiology Centre, PAHO, WHO, 2004; Caribbean Epidemiology Centre, PAHO, WHO, 2003). New HIV diagnoses among pregnant women decreased by half between 1999 and 2003 (Kumar and Singh, 2004). Expanded counselling and testing services, along with the provision of anti-retroviral regimens have reduced mother-to-child transmission of HIV in both these countries (Department of Public Health The Bahamas, 2004; St John et al., 2003).

Evidence of similar progress is not yet visible in **Trinidad and Tobago** (where national adult HIV prevalence is estimated at 2.6% [1.4%–4.2%]), nor in **Guyana** and **Suriname**, where serious epidemics have been observed in urban areas (Duke et al., 2004). AIDS has become the number one cause of death in Guyana among people aged 25–44 years, and national HIV prevalence stood at an estimated 2.4% [1.0%–4.9%] in 2005 (UNAIDS/WHO, 2004). High HIV infection levels among men and women seeking treatment for other sexually transmitted diseases (12%–15%) and the rising trend in officially reported HIV infections underscore the need to improve Guyana's AIDS response (Caribbean Technical Expert Group, 2004). Similar urgency is required in **Suriname**, where an estimated 1.9% [1.1%–3.1%] of adults were living with HIV in 2005.

Meanwhile, national HIV infection levels in **Jamaica** appear to have stabilized, although there are signs that HIV prevalence is receding slightly in some places (such as the parishes of St. Ann and St. James), amid indications that more Jamaicans are protecting themselves against HIV infection (Ministry of Health Jamaica, 2004; Caribbean Technical Expert Group, 2004). In 2005, national adult HIV prevalence was 1.5% [0.8%–2.4%], and an estimated 25 000 [14 000–39 000] adults and children were living with the virus. Signs of progress in some countries' responses are shadowed by several unmet challenges. The incomplete and inconsistent nature of HIV and behavioural surveillance in many countries presents a major obstacle to prevention efforts. Especially lacking is accurate information about behaviour patterns and trends among at-risk sections of the population (such as sex workers and men who have sex with men). With

FIGURE 2.13 HIV prevalence (%) in adults in Latin America and the Caribbean, 2005



the exception of **Cuba** and, to a lesser degree, the **Bahamas** and **Barbados**, antiretroviral treatment access is highly uneven, particularly in some of the worst-affected countries in the Caribbean. In **Haiti** and the **Dominican Republic**, for example, fewer than 20% of people needing antiretroviral treatment were receiving it in 2005 (WHO/UNAIDS, 2006).

Latin America

In Latin America, some 140 000 [100 000–420 000] people were newly

infected with HIV in 2005, bringing to 1.6 million [1.2 million–2.4 million] the number of people living with the virus. There are about 32 000 [19 000–59 000] children younger than 15 years living with HIV. In 2005, AIDS claimed some 59 000 [47 000–76 000] lives. Approximately 294 000 people were receiving antiretroviral therapy in this region at the end of 2005—73% of the estimated 404 000 people in need of treatment (WHO/UNAIDS, 2006).

However, in contrast to **Argentina**, **Brazil**, **Chile**, **Costa Rica**, **Mexico**, **Panama**, **Uruguay** and **Venezuela** (where notable gains have been made)

the poorest countries of Central America and those in the Andean region of South America are struggling to expand treatment access in the face of affordability barriers (PAHO, 2005).

The region's biggest epidemics are in the countries with the largest populations, notably **Brazil** which is home to more than one-third of the people living with HIV in Latin America. The most intense epidemics, however, are underway in the smaller countries of **Belize** and **Honduras**, in each of which 1.5% or more of adults were living with HIV in 2005.

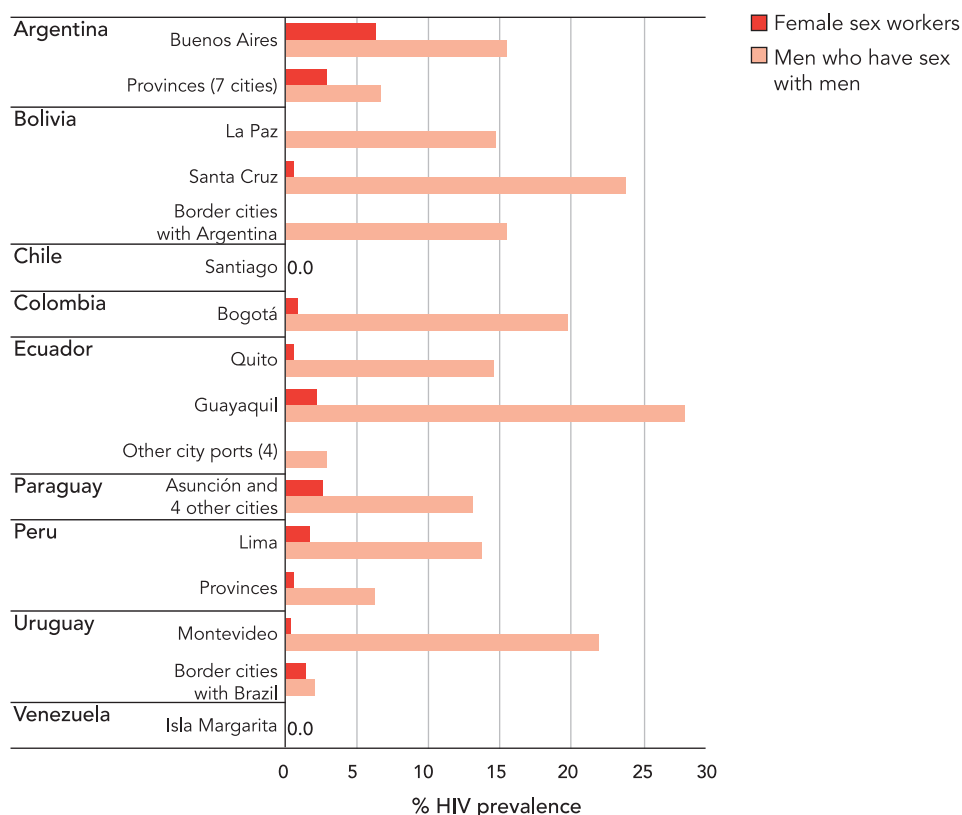
In several Latin American countries, high levels of HIV infection (between 2% and 28%, depending on the place) are being found in men who have sex with men—a pattern that is generally not reflected in their HIV prevention strategies. In most countries, HIV transmission between female sex workers and their clients is another significant, though less prominent factor in the spread of HIV. As the epidemics mature, increasing numbers of women are being infected, with those living in impoverished conditions appearing to be especially at risk. More effective programming that takes the epidemic's pattern into account, especially among men who have sex with men, could significantly curb the continued growth of the epidemics in this region (Montano et al., 2005).

Brazil's AIDS response continues to be commendable. The national adult HIV prevalence was 0.5% [0.3%–1.6%] in 2005, HIV infections related to unsafe injecting drug use are on the decline in several cities, and treatment access is widespread. About 170 000 of the 209 000 Brazilians needing antiretroviral therapy were receiving it in 2005, including 30 000 injecting drug users (WHO/

UNAIDS, 2006). However, the highest HIV infection levels are still being found in injecting drug users. The country also seems to exemplify a trend seen elsewhere in the region: women are increasingly affected, and this increase has taken place in recent years. Other recent developments warrant concern. Survey data from 2004 indicate, for example, that more young people are having sex at earlier ages and with more partners. At least one in three (36%) Brazilians aged 15–24 said they were sexually active before their 15th birthday, and one in five said they had had sex with more than ten partners so far in their lives (Ministerio da Saude do Brasil, 2005). These trends underline the need to sustain and fine-tune HIV prevention efforts.

In **Argentina**, national adult HIV prevalence stood at 0.6% [0.3%–1.9%] in 2005, and there were an estimated 130 000 [80 000–220 000] adults and children living with HIV. Prisoners in major urban jails are among the worst-affected population groups: in 2004, between 17% and 28% of prisoners surveyed in Buenos Aires province were found to be HIV-infected. That trend possibly reflects the fact that injecting drug use and unprotected sex between men remain important drivers of the country's epidemic. For example, almost one in two (44%) injecting drug users tested in Buenos Aires have been found to be HIV-positive (Weissenbacher et al., 2003). HIV infection levels of 7%–15% have been recorded in recent years among men who have sex with men (Segura et al., 2005; Bautista et al., 2004; Pando de los et al., 2003).

Largely centred on unprotected sex between men, **Chile's** epidemic is becoming more varied as increasing numbers of

FIGURE 2.14 HIV prevalence (%) among female sex workers and men who have sex with men in Latin America, 1999–2002

Source: Montano SM et al., JAIDS (2005).

HIV-infected men transmit the virus to their female partners (National AIDS Commission Chile, 2003). Some of those characteristics are shared by other Andean countries, including **Bolivia**, where HIV prevalence as high as 24% has been found among men who have sex with men in Santa Cruz. In **Peru**, too, HIV prevalence as high as 23% has been recorded among men who have sex with men in Lima, and prevalence between 6% and 12% has been found in several other cities (Montano et al., 2005; Ministerio de salud de Peru, 2005). Paid sex is another factor that might lead to an expanding epidemic in Peru. Levels of HIV infection in female sex workers have been low, but almost half (44%) of

surveyed young (18–29-year-old) urban men acknowledged paying for sex, and condom use among them was uncommon (Ministerio de Salud, 2004). Sex between men is a salient factor also in **Ecuador's** small but growing epidemic. HIV prevalence of 17% and 23% has been found in Quito Pichincha and Guayaquil Guayas, respectively, among men who have sex with men (Ministerio de Salud de Ecuador, 2005). National adult HIV prevalence in all these countries was estimated to be well under 1% in 2005.

Partly due to social taboos, many men who have sex with men also maintain sexual relationships with women (who

might be unaware of the entirety of their partners' sexual lives). In **Ecuador**, for example, where HIV infection levels among female sex workers are low (under 2%), a significant number of women with HIV appear to have been infected by husbands or regular partners who acquired the virus during unprotected sex with another man (Montano et al., 2005). **Colombia** exhibits similar trends. Much higher HIV infection levels have been found in groups of men who have sex with men (as high as 20% in Bogotá) than among female sex workers (less than 1% in Bogotá) (Montano et al., 2005; Khalsa et al., 2003; Mejía et al., 2002). Yet, increasing numbers of women are becoming infected, especially along the Caribbean coast and in the north-east of the country. It would appear that many of the women acquired the virus from male partners who also have sex with other men (Prieto, 2003). Among women testing HIV-positive at projects aimed at preventing mother-to-child transmission of HIV, 72% were in stable relationships (García et al., 2005).

There is an urgent need to improve HIV surveillance in **Central America**, where available data indicate that the epidemics

are mainly associated with unprotected sex. One of the worst-affected is **Honduras**, with about one-sixth of the 380 000 [270 000–680 000] people living with HIV in Central America, and where the epidemic seems to typify those in the subregion. An estimated 1.5% of Hondurans [0.8%–2.4%], or 63 000 people [35 000–99 000], were living with HIV in 2005, and AIDS is the leading cause of death for Honduran women (UNAIDS/WHO, 2004). Although HIV is circulating relatively freely in the wider population, paid sex and sex between men are the epidemic's driving factors. One in 12 female sex workers have tested HIV-positive in the capital, Tegucigalpa, and prevalence of 8% and 16% has been found there and in San Pedro Sula, respectively, among men who have sex with men (Proyecto Acción SIDA de Centroamérica, 2003).

With an estimated 61 000 people living with HIV [37 000–100 000], **Guatemala**'s epidemic is similar to that of **Honduras**. National adult HIV prevalence was 0.9% [0.5%–2.7%] in 2005. Available information on HIV, though incomplete, indicates that HIV transmission mainly occurs in urban areas,

In the United States, more people than ever were living with HIV in 2005: 1.2 million [720 000–2.0 million] people. Meanwhile, more women are being infected—and not only during unprotected sex.



especially those straddling major transport routes (Ministerio de Salud Pública y Asistencia Social de Guatemala, 2003). Other factors associated with HIV include unprotected paid sex (HIV prevalence of up to 15% has been found among street-based female sex workers) and sex between men (HIV infection levels of almost 12% have been found in Guatemala City among men who have sex with men) (Ministerio de Salud Pública y Asistencia Social de Guatemala, 2003; Proyecto Acción SIDA de Centroamérica, 2003). Sex between men is also a hidden but powerful factor in the epidemics of **Belize, El Salvador, Nicaragua** and **Panama**, and a clear driving factor in that of **Costa Rica** (UNAIDS/WHO, 2004; various Ministries of Health, 2003). Adult HIV prevalence in **Mexico** is low, 0.3% [0.2%–0.7%] but its large population means that approximately 180 000 [99 000–440 000] people were living with HIV in 2005—as many as two-thirds of them men who are believed to have been infected during unprotected sex with other men (Magis-Rodríguez et al., 2002). There are signs that heterosexual transmission of HIV is on the increase, as more women are infected during intercourse with male partners who also have sex with men. (Magis-Rodríguez et al., 2004).

North America, Western and Central Europe

Overall in these regions, approximately 65 000 [52 000–98 000] people were newly infected with HIV in 2005, bringing to 2.0 million [1.4 million–2.9 million] the number of people living with HIV. AIDS deaths in 2005 were comparatively few, about 30 000 [24 000–45 000]—a consequence of widespread

access to antiretroviral therapy. However, AIDS responses are not matching shifts in the epidemics of many countries in North America, western and central Europe. In particular, there is an urgent need for improved prevention, diagnosis and treatment services for immigrants and migrants, ethnic minority groups and men who have sex with men.

In the **United States**, more people than ever were living with HIV in 2005: 1.2 million [720 000–2.0 million] people. Nationally, adult HIV prevalence was an estimated 0.6% [0.4%–1.0%]. The increase reflects mixed results in the USA's efforts to combat its epidemic. On the one hand, more people with HIV are living longer due to antiretroviral treatment (which averted or delayed deaths for between 33 000 and 42 000 people in 1995–2002) (Holtgrave, 2006). On the other hand, the early gains made on the prevention front have not been sustained. The number of new, recorded HIV cases in the 33 states with confidential, name-based reporting has varied only slightly since the late 1990s. Half of all HIV infections (in men, women and children) diagnosed during 2004 were in men who have sex with men, and several studies have reported evidence of resurgent risk behaviour in this population group (US Centers for Disease Control and Prevention, 2006 and 2004a). In the city of Baltimore, for example, HIV *incidence* of 8% has been found in men who have sex with men. Almost two in three (62%) of the men testing HIV-positive in that city were unaware that they had been infected (US Centers for Disease Control, 2005b).

Meanwhile, more women are being infected with HIV—and not only during unprotected sex. About one in four

*As in the rest of Europe, unprotected sex between men remains an important factor in the **United Kingdom**, contributing about one-third of new HIV diagnoses (2214 in 2004).*



American women newly diagnosed with HIV in 2003 had been infected while injecting drugs (overall about 20% of new HIV infections are attributable to injecting drug use) (US Centers for Disease Control, 2004a). However, for many of the women who acquired HIV during sex, the main risk factor appears to have been the risk behaviour of their male partners (such as injecting drug use, commercial sex or sex with other men) (McMahon et al., 2004; Valleroy et al., 2004; Montgomery et al., 2003). For example, in a Centers for Disease Control survey, 65% of men who have ever had sex with men also had sex with women (Valleroy et al., 2004). In addition, as in Latin America, women living in impoverished and marginal circumstances appear to be at disproportionate risk of HIV infection. One recent study in North Carolina, for example, found that HIV-positive women were considerably more likely to be unemployed, requiring public assistance and exchanging sex for money and gifts (Leone et al., 2005).

Also of importance is the concentration of HIV infections among African Americans and Hispanic Americans. African Americans make up just over 12% of the

USA population (according to the 2000 census), but account for 50% of new HIV diagnoses in the 35 areas with long-term, confidential name-based HIV reporting. Hispanics, who comprise 14% of the population in the USA and Puerto Rico, account for about 18% of new HIV diagnoses (US Centers for Disease Control and Prevention, 2005a). Among African-Americans and Hispanics, most men with HIV were exposed to the virus during sex with other men (49% and 59%, respectively), while most women with HIV became infected during heterosexual intercourse (78% and 73%, respectively) (US Centers for Disease Control and Prevention, 2005c). African American women are up to a dozen times more likely to be infected with HIV than their white counterparts. AIDS is the leading cause of death among African American women aged 25–34 years and ranks in the top three causes of death for African American men aged 25–54 years (US Centers for Disease Control and Prevention, 2004b). Moreover, African Americans are about half as likely to be receiving antiretroviral treatment, compared with other population groups (Walensky et al., 2005). In 2003, almost twice as many African Americans died of

AIDS, than did whites (US Centers for Disease Control, 2004a). In the USA, the challenge of slowing the rate of new HIV infections overlaps with a need to provide diagnosis, treatment and care services more equitably (US Centers for Disease Control and Prevention, 2005b).

Canada's much smaller epidemic is also in flux. Although reported new annual HIV infections have remained at about 2500 since 2002 (having risen in the preceding years), the relative composition of HIV diagnoses keeps changing. Unprotected sex between men remains the single-most prominent mode of HIV transmission (43% of new diagnoses in the first six months of 2005), and more women are also being infected. In 2004, women accounted for more than one-quarter (27%) of new HIV diagnoses (compared to just over one-tenth in 1995). Driving that trend is unprotected sex (accounting for about two-thirds of positive HIV test reports) and unsafe injecting drug use (Public Health Agency of Canada, 2005). Also significant is the epidemic's disproportionate impact on Aboriginal persons—who represent just over 3% of Canada's population, but comprise 5%–8% of people living with HIV and 6%–12% of new HIV infections. Almost half the HIV diagnoses among Aboriginal persons are in women (Public Health Agency of Canada, 2004).

Across the Atlantic, an estimated 720 000 [550 000–950 000] were living with HIV in 2005 in western and central Europe, where heterosexual intercourse has become the main mode of transmission of new HIV infections in several countries. Accordingly, a growing proportion of new HIV diagnoses are in women—roughly one-third in those countries with new data for 2004 or later.

A considerable share of those diagnoses are among people originating from countries with serious epidemics, chiefly in sub-Saharan Africa (Hamers and Downs, 2004; EuroHIV, 2005). A case in point is the **United Kingdom**, where annual, new HIV diagnoses have doubled since 2000, exceeding 7200 in 2004 and possibly reaching 7700 in 2005 (Health Protection Agency United Kingdom, 2005). Most of that increase was attributable to a steep rise in the number of heterosexually acquired HIV infections, which totalled more than 4300 in 2004 (60% of all new diagnoses). More than three-quarters (77%) of newly diagnosed HIV infections in 2004 were contracted in high-prevalence countries (Health Protection Agency United Kingdom et al., 2006; Dougan et al., 2005). Similar trends are being observed in **Belgium, Denmark, France, Germany** and **Sweden**, where at least one-third of HIV infections attributable to heterosexual contact were probably acquired abroad, mostly in sub-Saharan Africa. Many immigrants and migrants living with HIV are unaware of their serostatus, and many of them are women, indicating a need for increased HIV prevention outreach as well as diagnosis, treatment and care services.

As in the rest of Europe, unsafe sex between men remains an important factor in the **UK**, contributing about one-third of new HIV diagnoses (2214 in 2004) (Health Protection Agency et al., 2006). Studies have shown that high-risk sexual behaviour among men who have sex with men in the UK has not decreased, emphasizing the need to overhaul prevention efforts in this population group (Elford et al., 2005). A similar challenge confronts **Germany**, where the recent rise in newly diagnosed HIV infections

has been largely restricted to men who have sex with men (Marcus et al., 2005). One in every two (49%) new HIV diagnoses in Germany is attributable to unsafe sex between men, compared with just over one in three (37%) in 2001 (Robert Koch Institut, 2005; EuroHIV, 2005). Sex between men remains a prominent factor in the epidemics of most other western European countries, including the **Netherlands** and **Spain**, where the evidence points to a revival of unprotected intercourse in recent years (Van de Laar and Op de Coul, 2004; Vall Mayans et al., 2004; EuroHIV, 2005).

Meanwhile, harm reduction programmes have helped to reduce the spread of HIV among injecting drug users. Following the introduction of methadone treatment and needle-exchange projects in **Spain** in the 1990s, HIV diagnoses among injecting drug users decreased markedly. The 2400 new diagnoses in 2004 among injecting drug users in **Portugal** were less than half the number in 2000. Along with sustaining such gains, countries where injecting drug users features strongly in their epidemics also need to act to curb HIV transmission from infected injecting drug users to their sexual partners (EuroHIV, 2005).

The epidemics in central Europe remain small. Most new HIV diagnoses are in **Poland**, which exhibits the only noteworthy new HIV trends. Annual HIV diagnoses there have been increasing steadily since 2001, reaching 656 in 2004 (EuroHIV, 2005). Unprotected sex—heterosexual and between men—is the main cause of this increase (National AIDS Centre, 2005).

Among the Baltic states, **Estonia** is the worst-affected, with national adult HIV

prevalence of 1.3% [0.6%–4.3%]. There, the cumulative number of reported HIV cases exceeded 5000 by end-2005 (Health Protection Inspectorate Estonia, 2006). The cumulative number of HIV diagnoses in **Latvia** keeps rising, too, and reached 3311 in 2005—although the rate of new infections has slowed, as it has also in **Lithuania**'s smaller epidemic (AIDS Prevention Centre, 2006; Lithuanian AIDS Centre, 2006).

Middle East and North Africa

Except for **Sudan**, national adult HIV prevalence in the countries of the Middle East and North Africa is very low, and does not exceed 0.1%. However, available data suggest that the epidemics are growing in several countries—including in **Algeria**, **Islamic Republic of Iran**, **Libyan Arab Jamahiriya** and **Morocco**. Across the region, an estimated 64 000 [38 000–210 000] people were newly infected with HIV in 2005, bringing the total number of people living with the virus to some 440 000 [250 000–720 000]. **Sudan** accounts for fully 350 000 [170 000–580 000] of those people. Against a backdrop of uneven access to antiretroviral treatment in this region, AIDS killed an estimated 37 000 [20 000–62 000] adults and children in 2005. Just 5% of the estimated 75 000 people needing antiretroviral therapy were receiving it at the end of 2005 (WHO/UNAIDS, 2006).

In **Sudan**, national adult HIV prevalence was an estimated 1.6% [0.8%–2.7%] in 2005. The epidemic is most severe in the country's southern areas (which are flanked by countries with comparatively high HIV prevalence). HIV prevalence of 2.2% was found at antenatal clinics in



*Unprotected sex (including during paid sex and sex between men) is one of the major drivers in the Middle East epidemics—especially in countries such as **Egypt, Morocco and Saudi Arabia.***

White Nile state in 2005, for example (Ministry of Health Sudan, 2006). Recent surveys among adults in the community and among pregnant women found HIV prevalence levels of 4.4% and 3%, respectively, in the town of Yei (which lies close to the Ugandan border) and 0.4% and 0.8% in Rumbek (which is further inland) (Kaiser et al., 2006). There are recent signs of significant HIV spread in Khartoum, in the north (Ministry of Health Sudan, 2005). Among displaced pregnant women seeking antenatal care in Khartoum in 2004, for example, HIV prevalence of 1.6% was found, compared to under 0.3% for other pregnant women (Ministry of Health Sudan, 2005).

The main mode of HIV transmission in this region is unprotected sexual contact—although injecting drug use is an increasingly important factor, especially in the epidemics in the **Islamic Republic of Iran** and **Libyan Arab Jamahiriya**. With risk behaviour widespread among Iran's large population of injecting drug users, high HIV infection levels are being found: when tested, 15% of male injecting drug users attending Tehran drug treatment centres were HIV-positive. Most of the injecting drug

users were sexually active, and exchanging money for sex was common; yet, only about half had *ever* used a condom (Zamani et al., 2005; Ministry of Health and Medical Education Iran, 2004). In Marvdasht, two in three injecting drug users seeking treatment reported sharing needles, and one in five said they had done so in prison (Day et al., 2005). Indeed, an important risk factor for HIV infection among injecting drug users appears to be incarceration (Rahbar et al., 2004). Given that a large proportion (almost half, by some estimates) of the total prison population in Iran comprises persons detained for drug-related offences, there is an urgent need to expand HIV prevention (including methadone maintenance therapy) programmes, especially in correctional settings (Zamani et al., 2005).

A similar challenge confronts the **Libyan Arab Jamahiriya**, where HIV prevalence of 18% has been found among prisoners (Sammud, 2005). This is not surprising, given the ten-fold increase in HIV infections in young men in Libya since the turn of the century; unsafe drug injecting practices were responsible for about 90% of those infections. Risk behaviour

associated with injecting drug use boosts the likelihood of HIV outbreaks among injecting drug users in several other countries, as well. According to various studies, in **Algeria** some 41% of injecting drug users shared injecting equipment, as did 55% in **Egypt** and 65% in **Lebanon** (Mimouni and Remaoun, 2005; Elshimi et al., 2004; Khoury and Aaraj, 2005).

Unprotected sex (including during paid sex and sex between men) is the other major factor in the region's epidemics—in countries such as **Egypt**, **Morocco** and **Saudi Arabia**, for example. About half the HIV infections detected during a study in the **Saudi Arabian** capital, Riyadh, occurred during heterosexual intercourse. There, the majority of women with HIV were married and probably acquired the virus from their husbands, who were most likely infected during paid sex (Abdulrahman et al., 2004). Sex work is a significant risk factor in several countries: 9% of female sex workers tested in Tamanrasset, **Algeria**, in 2004 were HIV-positive, while in **Morocco**, studies have found HIV prevalence of

1.9% (in 2004), and in **Sudan**, 4.4% (in 2002) among female sex workers (Fares et al, 2004; Ministère de la santé Maroc, 2005; Federal Ministry of Health, Sudan, 2002). Algeria's epidemic has expanded into the wider population, with HIV among women in antenatal care in parts of the south exceeding 1% (Institut de Formation Paramédicale de Parnet, 2004).

Very little is known about the spread of HIV in other countries in the region, due to the limited information about the patterns of HIV transmission and behaviour (especially the roles of sex work and of sex between men in the epidemics). It is possible that hidden, localized epidemics could be occurring undetected in some places. HIV-related prevention information and services are in short supply across the region. Knowledge of AIDS tends to be poor, and preventive practices rare, even among populations most at risk of becoming infected. HIV prevention strategies and services need to be strengthened to curb the mostly nascent epidemics in this region, and major efforts are needed to tackle stigma and discrimination, which hamper current efforts.

Chapter 03



PROGRESS IN COUNTRIES

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.

Reaching targets

Five years after the 2001 Special Session, available evidence underscores the extraor-

dinary diversity between countries and regions in implementing the response envisioned in the Declaration of Commitment on HIV/AIDS. While some countries have reached key targets and milestones for 2005, many countries have failed to fulfil the pledges specified in the Declaration. Some countries have made great strides in expanding access to treatment but have made little progress in bringing HIV prevention programmes to scale, while other countries that are now experiencing a reduction in national HIV prevalence are making only slow progress in their efforts to ensure that treatment is available to those who need it. Overall progress towards the agreed global targets for 2005 is presented in Figure 3.1 below. The wide range on almost every indicator reflects the diversity of performance across countries.

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

FIGURE 3.1 2005 Country progress towards 2001 Declaration of Commitment on HIV/AIDS global targets (low- and middle-income countries)	
GLOBAL RESULTS 2005	GLOBAL TARGETS 2005
Total annual expenditure*	
US\$ 8 297 000 000 Estimated range: US\$ 7.5 billion–US\$ 8.5 billion	US\$ 7.0–US\$ 10.0 billion ■ <i>Global target achieved</i>
Percentage of youth aged 15–24 who correctly identify ways of preventing HIV transmission and who reject major misconceptions about HIV transmission**	
MALE: 33% (Country range: 7%–50% coverage), (n = 16) FEMALE: 20% (Country range: 8%–44% coverage), (n = 17)	90% coverage ■ <i>No country achieved this</i>
Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis***	
9% (Country range: 1%–59% coverage), (n = 41)	80% coverage ■ <i>No country achieved this</i>
Percentage of people with advanced HIV infection receiving antiretroviral therapy****	
20% (Country range: 1%–100% coverage), (n = 116) 1 300 000 people on treatment	50% coverage ■ <i>21 countries achieved this</i> 3 million people on treatment ■ <i>Global target not achieved</i>
Percentage of young males and females, aged 15–24, who are HIV infected *****	
MALES: 1.4% (Measure of uncertainty: 1.1%–1.8%), (n = 54) FEMALES: 3.8% (Measure of uncertainty: 3.0%–4.7%), (n = 54) <i>No comparable global data on this age cohort is available from 2001. Progress towards target can only be measured in individual countries.</i>	25% reduction in most affected countries ■ <i>6 of the most affected countries achieved this</i>
Estimated percentage of infants born to HIV-infected mothers who are infected in 2005*****	
26% of infants born to HIV-infected mothers were also infected (n = 33 most affected countries). <i>In 2001, approximately 30% of infants were infected. There has been an estimated 10% reduction in HIV transmission between 2001 and 2005.</i>	20% reduction ■ <i>11 of the most affected countries achieved this</i>

Footnotes:

*See 'Financing' chapter

**Demographic and Health Survey/AIDS Indicator Survey, 2001–2005 (MEASURE DHS, 2006)

***Stover et al. (2006)

****3 by 5" Report (WHO/UNAIDS, 2006)

*****UNAIDS/WHO 2005 Estimates for countries with generalized epidemics, see Annex 2

*****UNAIDS/WHO 2005 Estimates, see Annex 2

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 anti-retroviral 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-habiting 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.

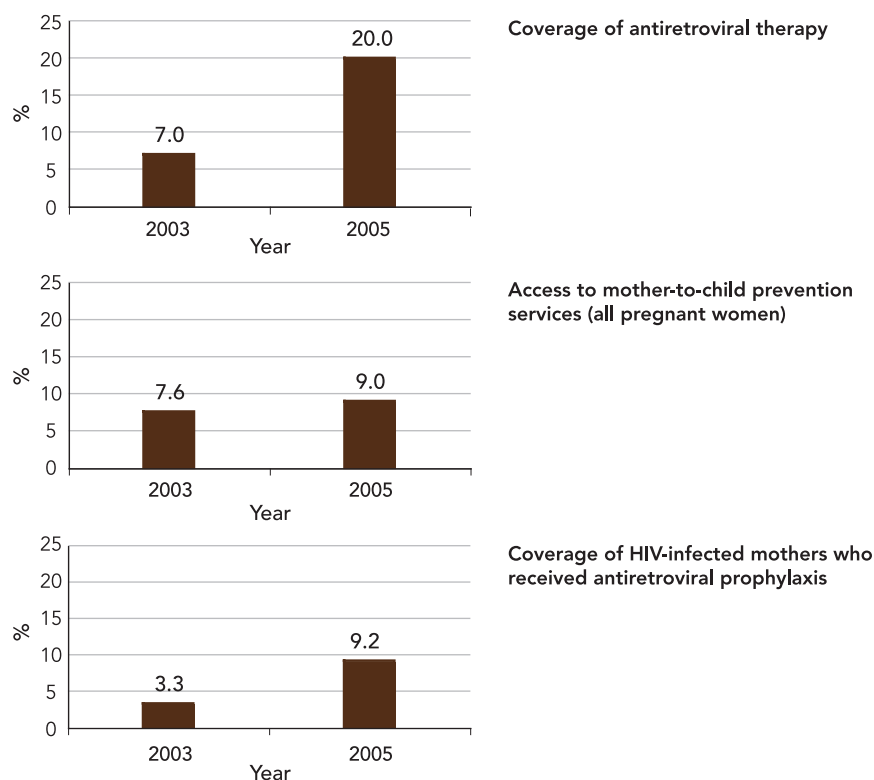
Several civil society groups cited the need to improve coordination between national AIDS efforts and civil society activities. The civil society report on Nicaragua, for example, said that nongovernmental organizations, academic researchers, health workers and government agencies often work in isolation 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 coinfection 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.

FIGURE 3.2

Comparison of 2003 and 2005 data on the coverage of antiretroviral therapy, access to mother-to-child prevention services and coverage of HIV-infected mothers who received antiretroviral prophylaxis to prevent mother-to-child transmission



Sources: WHO/UNAIDS (2006). Progress on global access to HIV antiretroviral therapy: a report on "3 by 5" and beyond; USAID et al. (2006). Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003 and 2005.

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 antenatal 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.

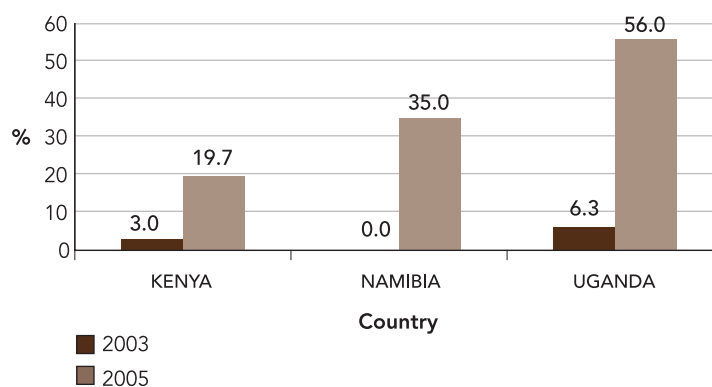
INCREASING KNOWLEDGE AND AWARENESS

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

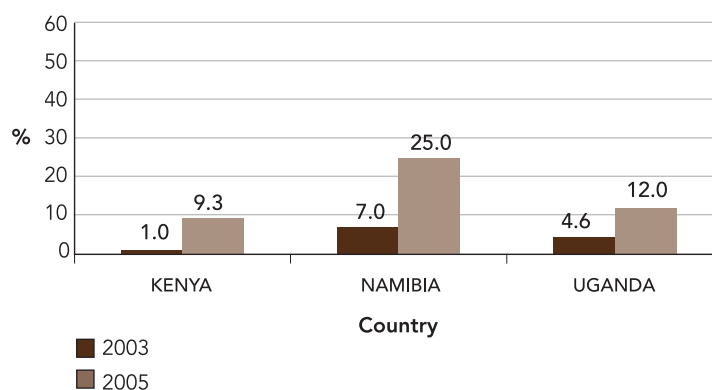
FIGURE 3.3

Comparison of 2003 and 2005 data on the expansion of antiretroviral therapy and coverage of HIV-infected mothers who received antiretroviral prophylaxis in three sub-Saharan African countries

Coverage of antiretroviral therapy



Coverage of HIV-infected mothers who received antiretroviral prophylaxis



Source: Individual country reports (2005).

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 indi-

cate 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, underscoring 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).

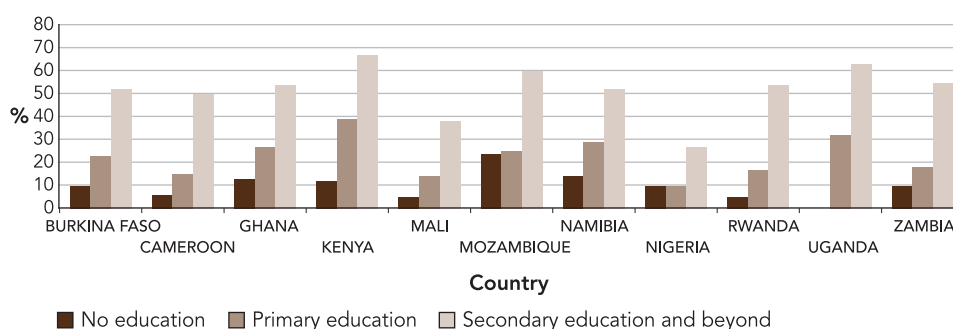
Surveys of sexual behaviour pose many challenges, especially with respect to young people, who may give in to social pressure to respond in ways that may result in under- or over-reporting of actual sexual activity. Even accounting for reporting bias, such surveys reveal enlightening aggregate trends. 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

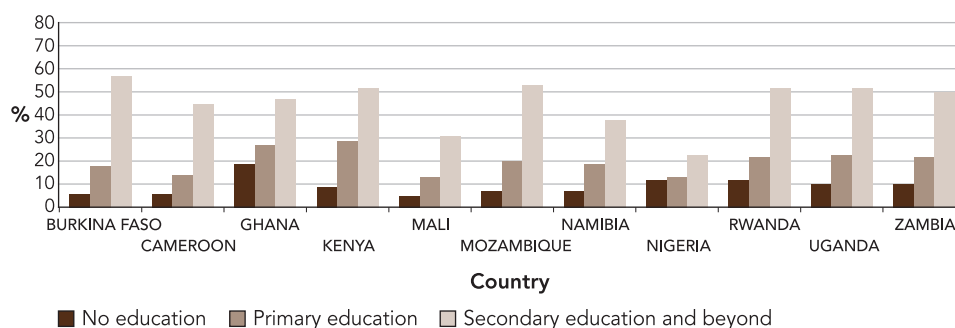
Comprehensive knowledge about HIV and AIDS among young males aged 15–24, by level of education, in 11 sub-Saharan African countries, 2000–2004



Sources: Demographic and Health Surveys; HIV/AIDS Indicator Surveys (2000–2004).

FIGURE 3.5

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



Sources: Demographic and Health Surveys; HIV/AIDS Indicator Surveys (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% (Madagas-

car) 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

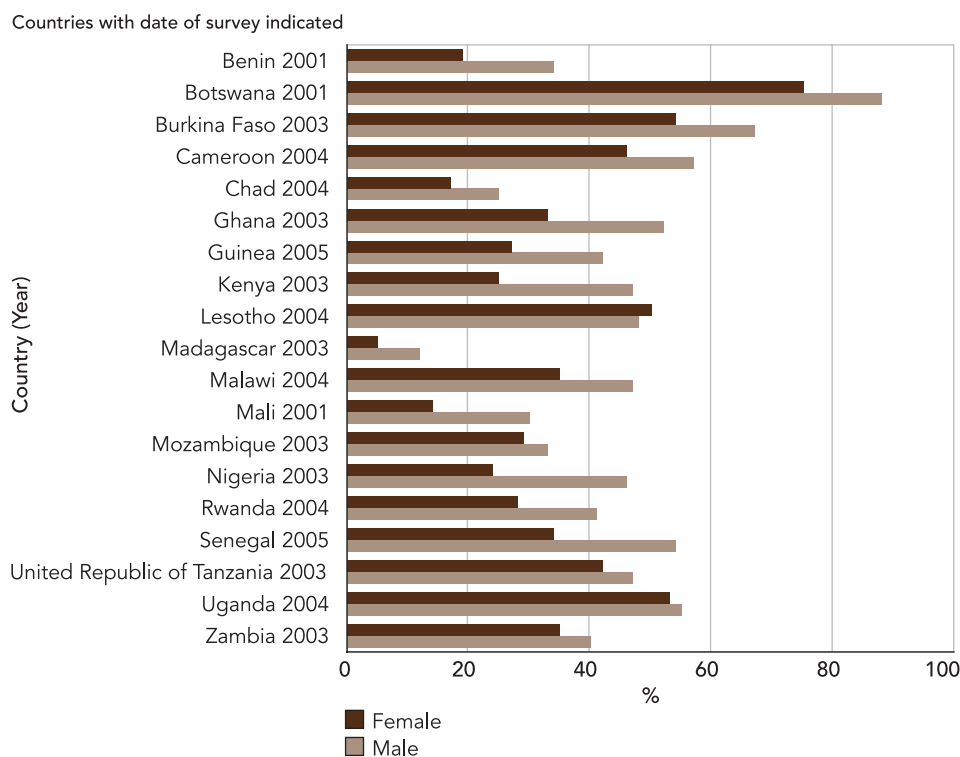
condom use with a non-regular partner (Measure DHS, 2006). Among 20 sub-Saharan countries for which survey data are available, the percentage of young people who use a condom with non-regular partners ranges from 5% of females and 12% of males in Madagascar, to 75% of females and 88% of males in Botswana (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



Sources: Demographic Health Surveys; HIV/AIDS Indicator Surveys (2001–2005).

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. It 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. Seventy-nine percent of all countries

report having involved “vulnerable groups” in the design of AIDS policies and programmes, but uncertainty over the definition of this term makes it difficult to ascertain the degree to which the most-at-risk populations are actively engaged in the development, implementation and monitoring of national AIDS efforts.

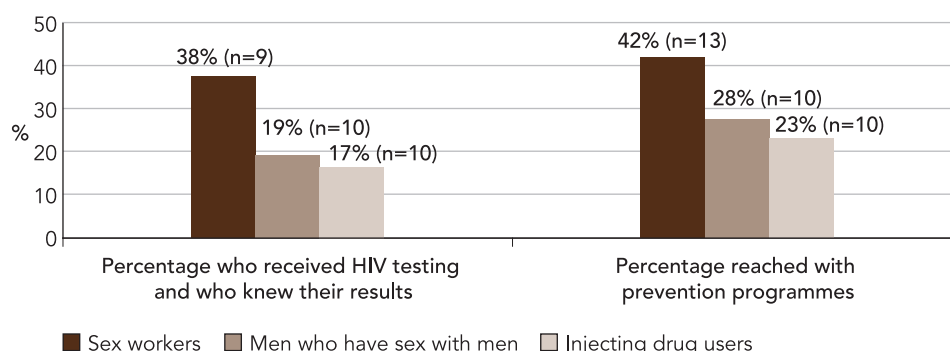
The greater majority (82%) of countries have national strategies to ensure equal access by women and men to prevention and care. The major challenge in many countries with respect to reducing vulnerability and ensuring equitable access for women appears to concern effective implementation and enforcement 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.

FIGURE 3.7

Median percentage of most-at-risk populations reached with prevention programmes and those who received HIV testing in the last 12 months and who knew their results



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).

antiretroviral drugs in 2005 (WHO/UNAIDS, 2006).

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.

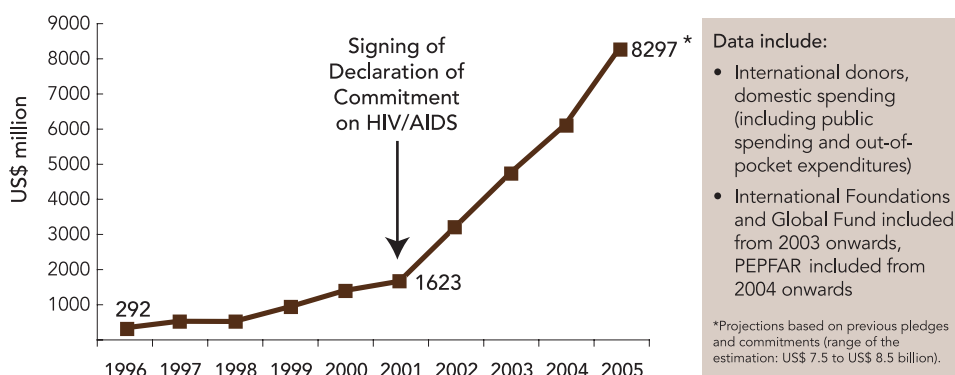
Overall resource mobilization is one of the few hard targets for 2005 from the Declaration of Commitment on HIV/AIDS that the global community clearly achieved. On the basis of current trends in pledges and funding commitments, UNAIDS projected that HIV spending, from national and international sources,

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



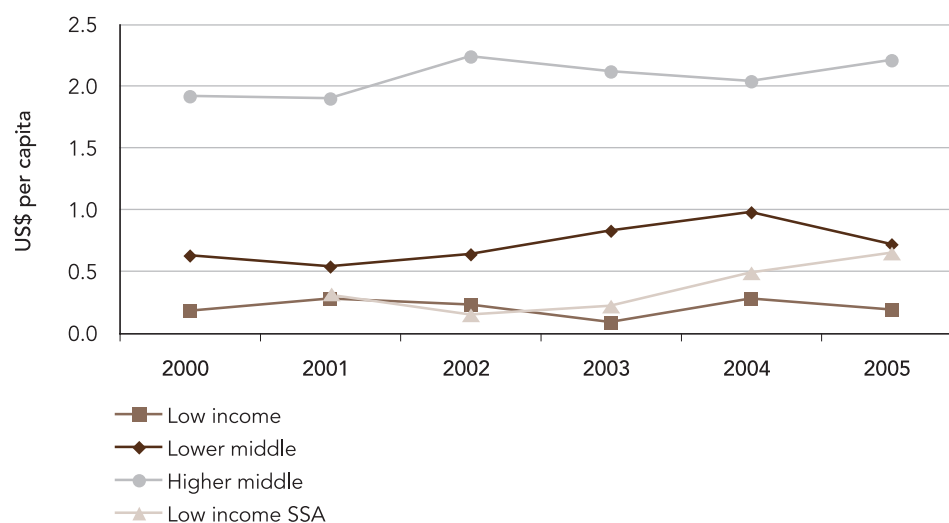
Based on reports to the Organisation for Economic Co-operation and Development from donor countries, between 2001 and 2004, the level of bilateral financing for HIV activities increased by 61%, while spending from multilateral sources (e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria, organizations 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

FIGURE 3.9 Per capita HIV and AIDS expenditures by country income level*

*Trends based on a sample of 25 countries from sub-Saharan Africa and 57 countries from other regions.

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.

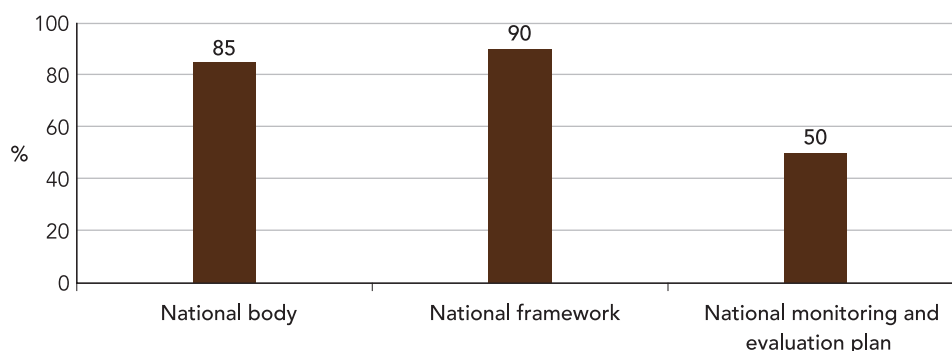
About half (49%) of countries indicate there is a moderate to high level of sharing with the national government of monitoring and evaluation results by UN agencies, bilateral agencies and other institutions. Although this represents improvement, substantial further strides are needed with respect to 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

FIGURE 3.10

Progress towards achieving the "Three Ones": Percentage of countries with one national coordinating body, one national HIV/AIDS strategy or framework and one national monitoring and evaluation plan



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capacity, as well as guideposts for future efforts to increase national capacity in this field. While indicators pertaining to anti-retroviral 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.

Chapter 04



THE IMPACT OF AIDS ON PEOPLE AND SOCIETIES

In the approximately 25 years since AIDS emerged as a major health emergency, the epidemic has had a serious, and in many places devastating, effect on human development. In some countries, AIDS is undermining progress towards the Millennium Development Goals, particularly those related to poverty reduction, achieving universal primary education, promoting gender equality, reducing child mortality and improving the health of mothers (IAVI, 2005; UNFPA, 2003).

The scale of the epidemic's impact, highly varied from place to place, has been documented with increasing precision over the years as surveillance and analytical tools have improved. As a result, the interrelationship of AIDS with other problems of human development has become clearer. The late Jonathan Mann's insight from the early 1990s—that AIDS shines a spotlight on human rights and societal issues—has been borne out in many ways, particularly in the epidemic's interactions with poverty, gender inequality and social exclusion (Mann et al., 1994). Research over the past few years has shown how it exacerbates other major challenges to development, from the deterioration of public services and governance to humanitarian emergencies such as food insecurity and conflict. As a recent study of the relationship between AIDS and famine in

southern Africa states, "HIV/AIDS accentuates existing difficulties, compelling us to confront many simultaneous problems, all of which need resolution" (de Waal and Whiteside, 2003).

The impact of AIDS is still not fully understood, particularly when the long term is considered. The epidemic comes in successive waves, with the first wave being HIV infection, followed several years later by a wave of opportunistic diseases, and later still by a wave of AIDS illness and then death (Barnett and Whiteside, 2002). The final wave affects societies and economies at various levels, from the family and community to the national and international levels. None of the highly affected countries have yet hit the peak of the third wave nor advanced very far into the fourth, and as one study put it (Bell et al., 2003):

We don't know how severe the impacts of the third and fourth waves will be—little about this pandemic is linear and AIDS is a unique threat . . . What for example is the likely long-term damage—social, economic, psychological—wrought by the orphaning of millions of children? What we do know is that impacts will continue to be felt for years to come and the situation will get significantly worse before it gets better.

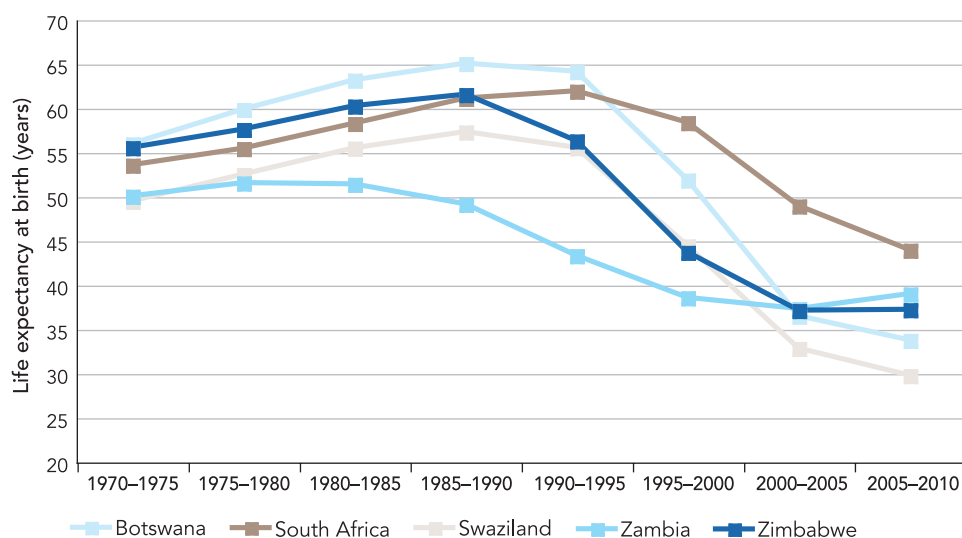
Determined responses in prevention, care, support and treatment can do much to reduce the epidemic's impact, and welcome surprises may be in store as antiretroviral treatment is rolled out around the world. Yet one thing is sure: No matter how the AIDS epidemic takes shape in any given country, its social and economic effects—and particularly its erosion of human capital—will continue to grow for many years after prevalence begins to fall. This has important implications, discussed in later chapters, for efforts to mitigate the epidemic's impact.

Population and population structure

The overall impact of AIDS on the global population has not yet reached its peak, and its demographic effects will likely be felt well into the second half of the 21st century. Current projections suggest that by 2015, in the 60 countries most affected by AIDS, the total population will be 115 million less than it would be in the absence of AIDS. Africa will account for nearly three-quarters of this difference in 2050, and although life expectancy for the entire continent will have risen to 65.4 years from the current 49.1 years, it will still be almost 12 to 17 years less than life expectancy in other regions of the world (UN Population Division, 2005b). The modelled impact on life expectancy in some of the hardest-hit countries can be seen in Figure 4.1.

In the most severely affected countries of sub-Saharan Africa, AIDS continues to slow or reverse improvements in life

FIGURE 4.1 Impact of AIDS on life expectancy in five African countries, 1970–2010



Source: United Nations Population Division (2004). World Population Prospects: The 2004 Revision, database.

ADDRESSING THE HUMAN DEVELOPMENT IMPACT OF THE AIDS EPIDEMIC

Responding to AIDS is one of the core priorities of the United Nations Development Programme (UNDP). The organization's Human Development Reports are an important source of information and analysis on the epidemic's socioeconomic impact and serve as policy and advocacy tools for promoting strategies to reverse its spread.

While many methods exist for measuring the impact of AIDS, the human development approach focuses on people rather than medical or economic indicators. UNDP's Human Development Index captures three basic dimensions of human development: a long and healthy life—measured by life expectancy at birth; knowledge—measured by adult literacy and school enrolment; and standard of living—measured by per capita gross domestic product (UNDP, 2005).

The 2005 Human Development Report identified AIDS as the factor inflicting the single greatest reversal in human development history (UNDP, 2005). Between 1990 and 2003, many of the countries most severely affected by AIDS dropped sharply in the global ranking of countries on the Human Development Index. South Africa fell by 35 places, Zimbabwe by 23, Botswana by 21, Swaziland by 20, Kenya by 18, Zambia by 16 and Lesotho by 15. (The report ranked 135 countries across regions, using data from both 1990 and 2003.)

In addition to the annual global report, national and regional Human Development Reports on HIV and AIDS have been produced by several countries (Botswana, Burkina Faso, Burundi, Cambodia, Ghana, Namibia, Nigeria, South Africa, Uganda, Zimbabwe) and regions (including eastern Europe, southern Africa and south Asia).

The reports promote a better understanding of the epidemic's impact at household, community and national levels and propose actions tailored to specific conditions. For example, the Zimbabwe report draws attention to the increasing number of students, particularly girls, who drop out of school to look after family members affected by AIDS, and highlights priorities for increasing gender equality (UNDP, 2003b). The eastern Europe report calls for a rebalancing of social policies, so that injecting drug use and sex work are addressed through a human rights and public health lens (UNDP, 2004).

More information and access to the reports are available at the Human Development Report website, <http://hdr.undp.org>.

expectancy and distort the age-sex structures of entire populations. Although the majority of highly affected countries in the region have seen declining life expectancy due to the epidemic—and other factors such as armed conflict, economic stagnation, and the resurgence

of tuberculosis, malaria and other diseases—overall populations will grow in most of these countries because of high fertility rates.

Part of the impact of AIDS on life expectancy in sub-Saharan Africa is due to

child mortality, either directly or indirectly related to AIDS. The steady progress towards improved life expectancy that was being made until the advent of the epidemic has eroded. In Botswana, under-five mortality had been reduced to 62 deaths per thousand live births between 1990 and 1995; today, under-five mortality is approximately 106 deaths per thousand live births. However, the biggest increase in mortality has been among adults aged 20–49, reversing the previous distribution of deaths according to age. Whereas this age group had accounted for only 20% of all deaths between 1985 and 1990, today they account for almost 60%. This is illustrated in Figure 4.2, which compares the current distribution of deaths by age in southern Africa with the distribution before the AIDS epidemic struck with full force. This phenomenon reverses the usual pattern of disease-related mortality, normally concentrated among the very young and very old. Instead, AIDS strikes down adults in their most economically productive years and removes the very people who could respond to a crisis.

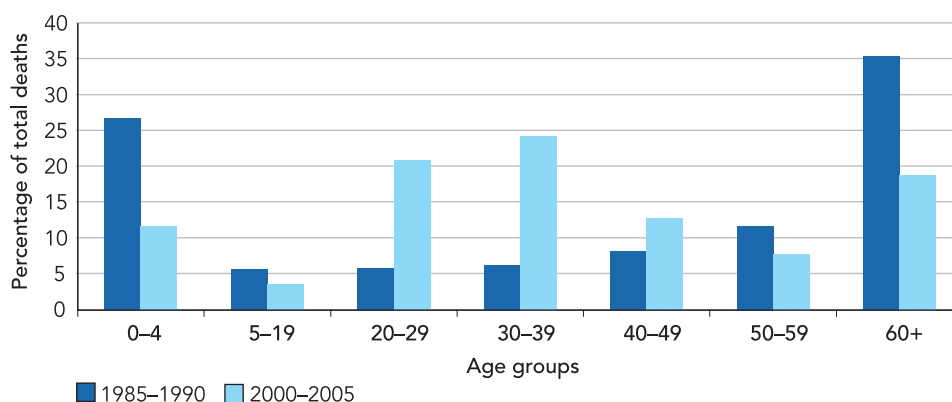
Outside of sub-Saharan Africa, in regions with lower HIV prevalence, AIDS has slowed rather than reversed gains in life expectancy. It is estimated that life expectancy in Cambodia is currently four years lower than it would have been without AIDS.

In the Americas, Caribbean countries have the highest HIV infection levels. AIDS has become the leading cause of death in Haiti among adults between the ages of 15 and 44. Life expectancy in the Dominican Republic is estimated to be three years lower than it would have been in the absence of AIDS. In Trinidad and Tobago, a country which is already losing population to out-migration, AIDS mortality is expected to reduce the overall population by 2010 (Stanecki, 2004; World Bank, 2005a).

Current projections of the long-term demographic impact of AIDS are somewhat less severe than in previous reports. This is partly due to revised HIV prevalence and AIDS mortality estimates for some countries and partly because

FIGURE 4.2

Percentage of distribution of deaths by age in southern Africa, 1985–1990 and 2000–2005



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2005). World Population Prospects: The 2004 Revision. Highlights. New York: United Nations.

projections now assume that antiretroviral therapy will reach increasing numbers of people in hard-hit regions. However, this assumption carries a big “if”: it will only be realized if sustained progress is made towards universal access to—and wide-spread uptake of—a comprehensive range of prevention, treatment and impact-mitigation measures.

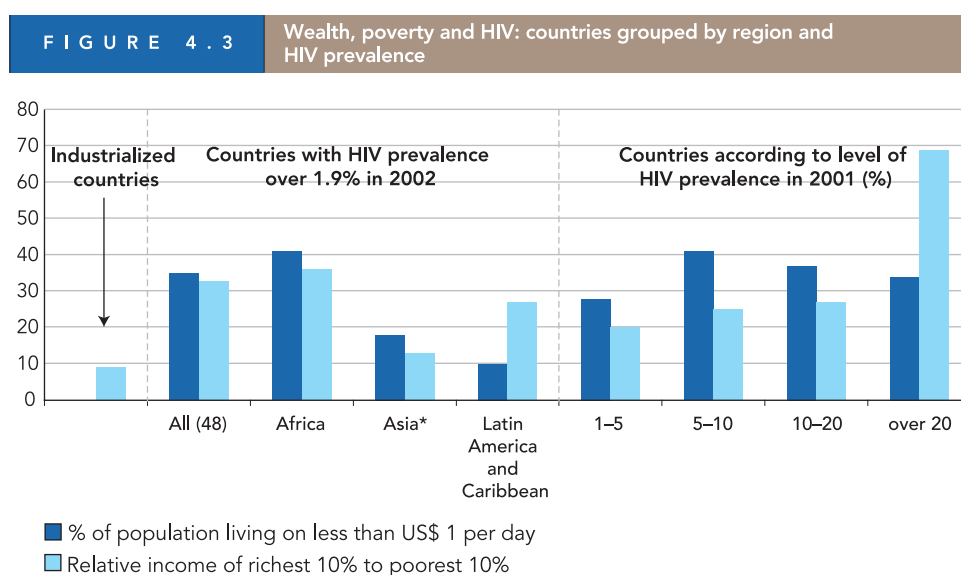
Poverty and inequality

The relationship between AIDS and poverty is a powerful but nuanced one. Living standards of poor people in some of the hardest-hit countries were being eroded before the impact of AIDS was felt, and the worst-hit countries today are not necessarily the poorest. Southern Africa, with the world’s highest HIV prevalence, includes the most economically developed countries in sub-Saharan Africa. Generally, these countries have higher levels of education, gross domestic product and access to water and sanita-

tion than other parts of the continent. However, they also tend to have greater economic inequality and large numbers of people living in poverty, both of which have been clearly associated with HIV transmission.

This is illustrated in Figure 4.3. In the most-affected countries (prevalence over 20%—all in southern Africa), the richest 10% of the population have revenues that are almost 70 times those of the poorest 10% of the population. This compares with much lower disparities or ratios of between 20 and 27 in countries with lower prevalence. On average, one-third of the population in the most-affected countries with high income disparity lives on less than US\$ 1 per day—a large proportion, given their relatively high gross domestic product (UN Population Division, 2005a).

AIDS tends to affect the poor more heavily than other population groups. In Botswana, it is estimated that, on average,



*Except Japan

Source: United Nations Population Division (2005a). Most figures relate to 2002, or earlier.

every income earner is likely to acquire one additional dependent over the next 10 years due to the epidemic. But families in the poorest quartile will acquire an additional eight people who will become dependent on their income as a result of AIDS. Moreover, a “dramatic” increase in destitute households—those with no income earners—is predicted (Greener, 2004). Similar findings apply to India, where a review of economic research on AIDS concluded that households belonging to the poor and less educated or unskilled groups, as well as female members of households, face a proportionately greater economic burden due to AIDS (Mahal and Rao, 2005).

Governments are increasingly recognizing the importance of tackling poverty as a response to AIDS and tackling AIDS as a means of reducing poverty, but they have been slow in translating this into programmes. A 2004 review of the Poverty Reduction Strategy Papers and National Strategic Plans on AIDS of 19 African countries showed that most governments remain focused on health-sector responses. Only 16% of the papers reviewed included a clear discussion of the link between AIDS and poverty, and 42% did not analyse the issue at all (Bonnell et al., 2004).

HOUSEHOLD IMPACTS

Implications of having ‘AIDS in the family’ have been documented in many parts of the world. They range from increased medical costs and expenditures on funerals to withdrawal of family members from work or school to look after those who are ill. Research in New Delhi, India, found that average monthly expenditures exceeded income among families of people living with HIV, partly because of a doubling in purchases of

medicines. While these families spent less on entertainment and on children’s education to cope with rising care, support and treatment costs due to HIV, most were also forced to sell assets and borrow from friends and relatives (ILO, 2003).

Coping strategies also vary from place to place. For example, Rwandan households that have experienced an adult death are more likely to replace the lost labour by adding new family members (e.g. through marriage or bringing in young relatives) than those in Kenya and Mozambique (Gillespie and Kadiyala, 2005). Whatever the country, much depends on the age, gender and position of the family member who becomes ill or dies.

A recent study in northern Zambia explores the dynamics of the impact of HIV-related illness on families and communities, comparing five household categories: female-headed households with orphans; male-headed households with orphans; female-headed households taking care of people with HIV-related illness; male-headed households taking care of people with HIV-related illness; and non-affected households. Among other conclusions, the study found that female-headed households taking care of people living with HIV supported an average of 3.6 orphans each, far more than male-headed households. They were also ‘food-insufficient’—that is, they had less food than they needed—for an average 3.4 months per year. Few households taking care of HIV-positive people were able to participate in cooperatives—the main source of loans for agriculture—because of financial constraints or lack of time. Female-headed households taking care of HIV-positive people were less able than others to participate in community-based organizations and had

"COPING" IN QUESTION

Statistics cannot convey the countless examples of domestic heroism by AIDS-affected families. Research in countries such as Kenya, Malawi, Rwanda and Zambia suggests that family structures in sub-Saharan Africa are more resilient than many in the international development field had expected. Instead of disintegrating in the face of AIDS, many families are finding ways to make a living, feed and educate their children, and care for the ill—although frequently at great cost, stress and sacrifice.

But coping strategies should be examined critically. As one commentator puts it (Marais, 2005):

[T]o describe as "coping" the activities of households sunk in impoverishment is to unmoor the discussion from ethics. By any humane definition of the word, such households are not "coping"; a "successful coping strategy" becomes an oxymoron. Regaining a precarious and chronically insecure form of household "viability" cannot reasonably be declared a success.

Societies can only be pushed so far, and other threats—armed conflict, famine, market disruption—can easily combine with AIDS to drag large numbers of families deeper into poverty, break them up and deprive their members of the care and support they desperately need.

fewer assets such as axes, radios and bicycles—often because of distress sales and property grabbing by other community members (FAO, 2004). These findings concurred with studies from other countries showing that the heaviest impact of AIDS tends to fall on widows and their family members (Aliber et al., 2004).

The weight of stigma and discrimination

Stigma and discrimination are not only obstacles to HIV prevention, care and treatment for people living with HIV, but are among the epidemic's worst consequences. HIV-related stigma consists of negative attitudes towards those infected or suspected of being infected with HIV and those affected by AIDS by association, such as orphans or the children and families of people living with

HIV. Discrimination, as defined by UNAIDS Protocol for Identification of Discrimination against People Living with HIV, refers to any form of arbitrary distinction, exclusion or restriction affecting people because of their confirmed or suspected HIV-positive status. Both place a burden on human development by denying hundreds of thousands of people the chance of reaching their full potential.

HIV-related stigma and discrimination are found in all parts of the world, but their manifestation varies from place to place. Half the participants in a study in an eastern Chinese coastal city believed that punishment was an appropriate response towards those living with HIV, over half (56%) were unwilling to be friends with HIV-positive people and 73% thought that those living with HIV should be isolated. Stigmatizing attitudes tended to

be associated with being male, older, married, less educated and unwilling to be tested for HIV (Lee et al., 2005). Such attitudes have serious implications.

Research in other parts of the country shows that to avoid stigma and discrimination, some HIV-positive people refuse to get information about HIV and sexually transmitted diseases, staying away from health-care professionals and shunning those suspected of risk behaviour in an effort to blend in with community norms (Lieber et al., 2005).

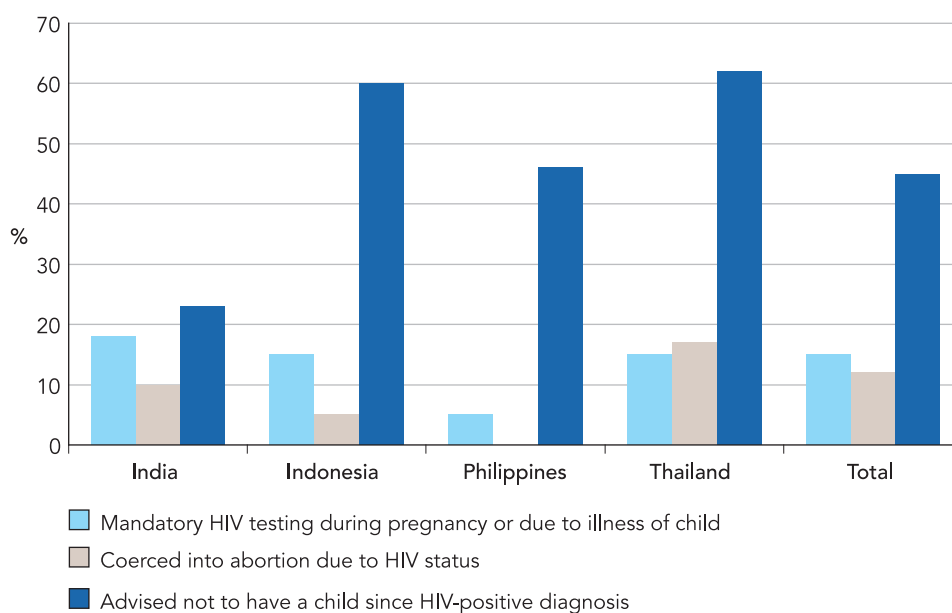
HIV-related stigma is frequently conflated with negative attitudes towards marginalized groups and may be reinforced by legislation and legal systems that attack basic human rights (see 'At risk' chapter). A recent review of World Bank HIV programming in the Caribbean said (World Bank, 2005a):

The legal framework of the English-speaking Caribbean actually perpetuates stigma and discrimination against some high risk groups, particularly MSMs [men who have sex with men] and CSWs [sex workers]. Homosexual behaviour is illegal in every country visited as is prostitution. Nevertheless, there are growing signs of recognition of the consequences of such legislation. The Bahamas recently decriminalized homosexual behaviour and a more inclusive attitude toward PLWHAs [people living with HIV] was described in most—but by no means all—countries.

In 2005, the Asia Pacific Network of People Living with HIV/AIDS (APN+) reported on a study it carried out in India, Indonesia, the Philippines and Thailand. Over half of the 762 HIV-positive people in the survey reported experiencing some form of discrimination from health-care systems, including violations of women's reproductive rights (see

FIGURE 4.4

Violations of reproductive rights—women surveyed in four Asian countries



Source: Paxton S et al. (2005). AIDS-related discrimination in Asia.

As reflected in Millennium Development Goal 3, one of the main tasks in human development is to reduce and eventually eliminate inequality between men and women by empowering women.



Figure 4.4). People who reported coerced testing were significantly more likely than other respondents to face subsequent HIV-related discrimination, and many were refused treatment after being diagnosed with HIV. Within the family and the community, women were significantly more likely to experience discrimination than men, including ridicule and harassment, physical assault and being forced out of their homes (Paxton et al., 2005).

Stigma can persist even when treatment becomes readily accessible. In Brazil, where antiretroviral therapy is universally available, many HIV-positive children and youth still face significant stigma (Abadia-Barrero and Castro, 2005). In Botswana, where free antiretroviral therapy, infant formula and safe drinking water are widely available, stigma was given as the reason why over half of the pregnant women in a study did not feed their babies with formula—an important means of preventing mother-to-child transmission of HIV but one that in many settings clearly announces a mother's HIV status (Shapiro et al., 2003).

Impact on women

As reflected in Millennium Development Goal 3, one of the main tasks in human development is to reduce and eventually eliminate inequality between men and women by empowering women. Effectively responding to AIDS can play a key role in achieving this task.

Women in sub-Saharan Africa are infected more often and earlier in their lives than men. Young women aged 15–24 are between two and six times as likely to be HIV-positive than men of a similar age. This evens out in older age groups, but it highlights the vulnerability of young women and girls and unequal power relations in many societies.

A similar pattern is found in parts of the Caribbean. In the Dominican Republic, young women aged 20–24 are almost twice as likely to be HIV-positive as young men (Measure DHS and ORC Macro International, 2002). However, in Latin America, eastern Europe and central Asia, young men are most likely to be infected—although this is changing as HIV increasingly affects the general population.

REFUGEES, DISPLACED PERSONS AND THEIR HOST COUNTRIES

In 2005, the global number of refugees and displaced people stood at 19.2 million. Many of them reside in countries where health services are heavily burdened by HIV and AIDS. Approximately four million live in sub-Saharan Africa, where drought and conflict continue to force people from their homes in massive numbers.

A variety of stigmatizing myths surround the issue of AIDS and displaced populations. For example, host-country citizens commonly assume that these people 'bring AIDS with them'. In fact, the reality is more complex. Many refugees and other displaced persons flee countries with lower HIV prevalence to more stable countries with higher prevalence. For example, sentinel surveillance among pregnant women in refugee camps in Kenya, Rwanda and United Republic of Tanzania found that the refugees had lower (though still significant) levels of HIV infection than the surrounding populations (Spiegel, 2004; Griekspoor et al., 2004).

As a recent review of humanitarian aid projects points out, it is urgent that the HIV-related needs of refugees and displaced populations be met for the good of both the newcomers and the host population (UNAIDS/UNHCR, 2005).

Many countries are already overburdened by the impact of AIDS, and are often unable or unwilling to provide these populations with the HIV-related services they require. This places many refugees in a unique situation. They are no longer guaranteed the protection of their country of origin, they often do not have the assistance of the country of asylum and they go without the HIV-related services which they need and to which they are entitled under international human rights instruments. This failure to provide HIV prevention and care to refugees not only undermines effective HIV prevention and care efforts, it also hinders effective HIV prevention and care for host country populations. Since refugee populations now remain on average in their host country for 17 years, the implications for both refugee and host populations are very serious. Addressing HIV-related needs in the context of refugee situations requires a change in the thinking of the authorities in many countries of asylum. It is impossible to determine the actual length of time that refugees will remain in the host country. However, it is critical that during this time both refugees and surrounding host populations receive all necessary HIV-related services, including those that require long-term funding and planning.

GENDER, MORTALITY AND FERTILITY

Although in most parts of the world women live longer than men, AIDS has driven female life expectancy below that of men in four countries: Kenya, Malawi, Zambia and Zimbabwe (UN Population Division, 2005b). Empirical evidence supports the existence of gender differ-

ences in mortality. For example, a recent three-year study in Zambia, which involved almost 19 000 people between the ages of 15 and 59, found that 61% of all deaths (i.e. for any cause) occurred among women, and that women on average died at younger ages than did men (Chapoto and Jayne, 2005).

HIV affects women's fertility, reducing it as much as 25–40%. This may be for a variety of reasons, from coinfection with other sexually transmitted infections to increased rates of spontaneous abortion (UN Population Division, 2005a). Fertility rates may also be affected in the future as more and more HIV-positive women gain access to HIV testing and counseling and, knowing their serostatus, will be able to make informed decisions about child-bearing. For the moment, however, the majority of HIV-positive women do not know their status, and even if they did, many could not change the behaviour of their partners or take steps themselves to protect their partners or prevent pregnancy.

The gender inequality that is imbedded in many cultural traditions means that the domestic burden of AIDS care falls especially heavily on women because of their traditional roles as carers and homemakers, deeply engrained social attitudes and insufficient social services. Caring for family members affected by AIDS is a compassionate undertaking, but it is also a burden that can limit educational and

economic opportunities for women and girls.

STIGMATIZING ATTITUDES

Stigma attaches itself strongly to women because of negative assumptions made about sexual risk behaviour—even when a woman has not engaged in any—and its association with HIV. A recent four-city study in India found that while almost 90% of the HIV-positive women were infected by their husbands, they faced more stigma and discrimination than men and were often blamed for their husbands' illnesses. Women living with their husband's family frequently faced expulsion if the husband died, and many had trouble finding anyone to care for them when they themselves became ill (ILO, 2003). This is common in other regions as well.

The impact on women from marginalized groups can be especially harsh. In the Russian Federation, HIV prevalence is relatively high among female injecting drug users, yet these women are the least likely to access health services, both because of stigma by health-care

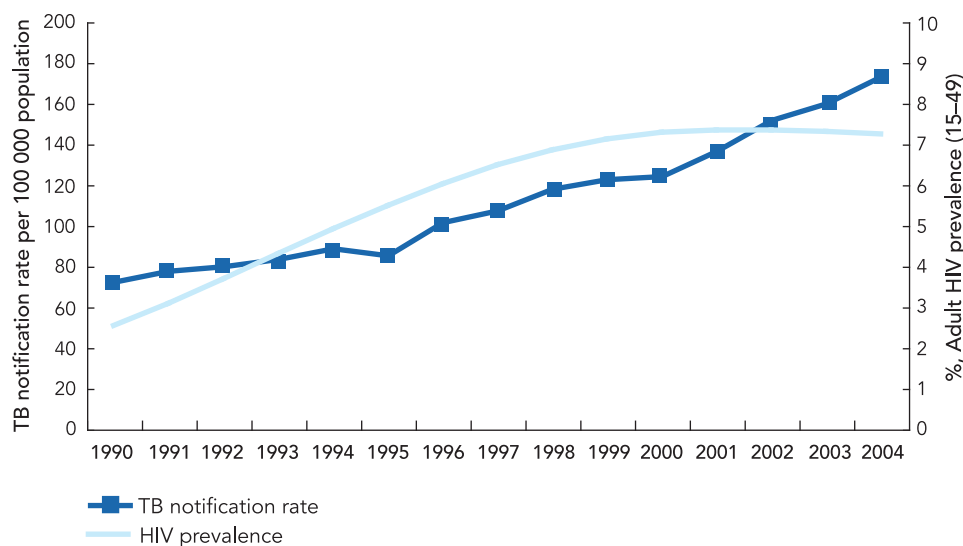
MAKING POOR HEALTH EVEN WORSE

AIDS has had a powerful impact on other epidemics. For example, AIDS is the primary force behind the global resurgence of tuberculosis. After falling for the previous two decades, new tuberculosis cases have climbed drastically since 1990 throughout sub-Saharan Africa, fuelled by the simultaneous rise in HIV infection (see Figure 4.5). In the Caribbean, tuberculosis is now the number one killer of people living with HIV (CAREC/PAHO/WHO, 2004).

Less well known is the fact that HIV infection impairs antimalarial immunity (Mount et al., 2004). In areas where malaria is endemic, HIV infection increases the risk that an individual over five years of age will become infected with malaria and experience malaria-related diseases. In five southern African countries, the WHO estimates that high HIV prevalence in rural areas increased malaria incidence by 28% and more than doubled the malaria death toll (Korenromp, 2005).

FIGURE 4.5

TB notification rate in 20 African countries* versus HIV prevalence in sub-Saharan Africa, 1990–2004



*Consistently reporting each year: Algeria, Angola, Botswana, Cameroon, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Kenya, Malawi, Mauritius, Mozambique, Nigeria, Senegal, South Africa, Uganda, United Republic of Tanzania, Zimbabwe

Sources: World Health Organization (2006); Global TB database; UNAIDS (2006).

providers and because of the chaotic lifestyles that made them vulnerable in the first place. Reluctant to attend antenatal services when pregnant, these women frequently learn their serostatus only when they go to hospitals to give birth and are much more likely to abandon their newborn children on learning their status—often in the hope that the child will have a better life without them (Intigrinova and Hauslohner, 2004).

Impact on children

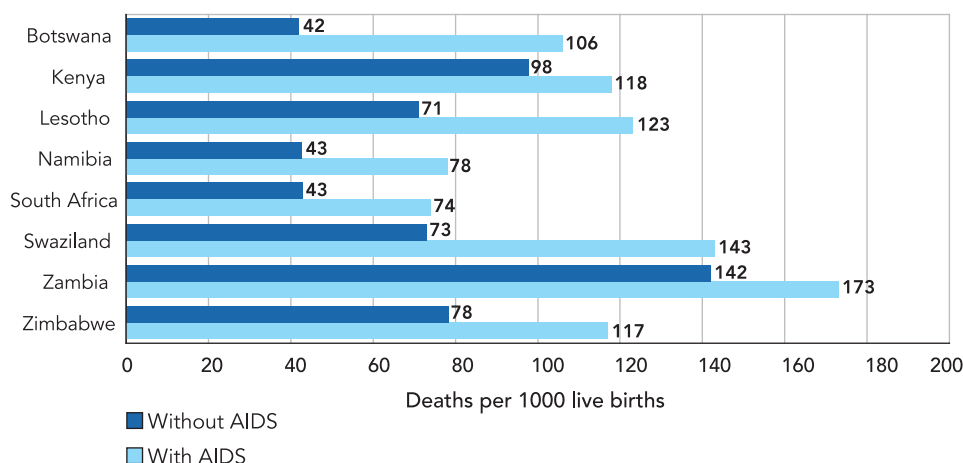
The impact of AIDS on children continues to mount in various parts of the world. Currently, children under 15 account for one in six AIDS-related deaths worldwide and one in seven new HIV infections—the vast majority through mother-to-child transmission of

the virus (UNICEF, 2005). Figure 4.6 illustrates the extent to which AIDS has increased the proportion of deaths per 1000 live births in eight of Africa's hardest-hit countries.

After illness and death itself, the harshest impact on children is the loss of their parents' affection, support and protection. The likelihood of a parent becoming infected if the other parent unknowingly has HIV rises over time. The emotional shock of losing one parent may be inexorably followed by the death of the other. Separation from siblings is frequent as orphans from large families are often sent to live in different households. In addition to the psychological trauma suffered by these children, poverty and social dislocation, as well as stigma and discrimination, may also be added to their woes and in turn increase their

FIGURE 4.6

Estimated impact of AIDS on under-five mortality rates 2002–2005, selected countries in sub-Saharan Africa



Source: UNICEF (2005). United Nations Population Division, World Population Prospects: The 2004 Revision, database.

vulnerability to HIV. Furthermore, countless children coping with the impact of HIV-related illness on their families become responsible for the care of their siblings and other family members when parents are debilitated by poor health.

In sub-Saharan Africa, approximately 9% of children under the age of 15 have lost at least one parent to AIDS, and one in six households with children is caring for at least one orphan. (A maternal or paternal orphan is a child who has lost one parent—mother or father, respectively—while a double orphan has no living parent.) To date, prevailing families are considered to have coped remarkably well with this, with 90% of double orphans being taken in by their extended family (Monasch and Boerma, 2004). But this statistic does not account for the huge variation in living conditions experienced by these children, and it still leaves millions of children being cared for by strangers—or by no one.

A recent analysis of household surveys from 40 sub-Saharan African countries

found that, on average, orphans are more vulnerable than other children, according to several indicators (Monasch and Boerma, 2004). Patterns differ between countries and regions, but in general, orphans are more likely to live in households that are female-headed, larger and have more people dependent on fewer income-earners (that is, less favourable dependency ratios). As seen in Figure 4.7, education is significantly affected, with orphans being about 13% less likely to attend school than non-orphans (34 countries).

Some of this may be because of the additional financial burden or workload taken on by caregiver households. However, a study of 10 sub-Saharan African countries found that orphans are less likely to attend school than non-orphans living in the same household, indicating that much depends on the closeness of the ties between the orphan and the head of the household (Case et al., 2004).

Overall, paternal orphans are more likely to live with their mothers than maternal

FIGURE 4.7 Impact of orphanhood on school attendance among 10–14-year-olds (%)					
Percentage in school	WEST (9 countries)	CENTRAL (6 countries)	EASTERN (9 countries)	SOUTHERN (10 countries)	ALL (34 countries)
Non-orphans	67	75	70	88	74
Orphans	58	69	54	84	69
Double orphans	57	58	49	80	64
Ratios					
Double vs. non-orphans	0.86	0.94	0.72	0.90	0.87
Boys	0.96	0.96	0.82	0.93	0.94
Girls	0.91	0.94	0.88	0.96	0.93

Source: Monasch R and Boerma JT (2004). Orphanhood and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries, *AIDS* 2004, 18 (Suppl 2): S55-S65.

orphans are to live with their fathers. An orphan's attendance in school can depend on which parent has died. In Zimbabwe, a study found markedly low primary school completion rates among children who had lost their mothers. This is partly because of a lack of support from fathers (many of whom are absent for employment reasons) and stepmothers' reluctance to care for their stepchildren. School completion was higher among paternal orphans and double orphans, particularly girls (Nyamukapa and Gregson, 2005). A similar study involving 20 000 Kenyan children found that school participation rates fell by an average of 5% after a parent's death, but the decrease following a maternal death was more than twice that of a paternal death (Evans and Miguel, 2005).

Although the number of orphans and vulnerable children is proportionately smaller outside of Africa so far, the impact on individuals is harsh. As mentioned earlier, children born to HIV-positive mothers in the Russian Federation (and in other countries of the Commonwealth of Independent States such as Ukraine) are frequently abandoned by their mothers. Of the 13 000 children born to HIV-positive women by the end of 2003, about one in twenty was left in state care or simply aban-

doned. Unlike their counterparts in Africa, these children are rarely adopted or placed in family care. Most grow up in state institutions and children's homes, while some spend the first years of their lives in hospitals—often being physically, emotionally and intellectually stunted as a result (Intigrinova and Hauslohnner, 2004). Fortunately the proportion of HIV-positive mothers who abandon their infants is falling. This is partly a reflection of increasing HIV incidence among women in the general population who are likely to have more support in their lives than injecting drug users; as well, this is also due to the fact that HIV-positive women in general are becoming better informed about mother-to-child transmission of HIV (Voronin et al., 2005).

Governments and governance

In countries with high levels of HIV prevalence, the epidemic is having a serious impact on public-service sectors. At the same time as productivity and tax bases are being constrained by the deaths of adults in their productive prime, AIDS is placing increasing demands on public-sector services, such as health and education, and on public administration (Grant et al., 2004).

ELDERLY CAREGIVERS

The burden of care for HIV-positive adults and for children orphaned by AIDS frequently falls on elderly people—many of whom are poor and do not benefit from social protection measures such as state pensions. In Thailand's Chiang Mai province, a recent study of children who have lost one or both parents to HIV-related illnesses found a large proportion of children being cared for by grandparents and other extended family members. Many of these carer families suffered significant financial hardship, highlighting concerns about the children's long-term well-being, stability and educational opportunities (Safman, 2004). Similarly, in rural United Republic of Tanzania, Uganda and Zambia, grandparents are the primary caregivers for over one-third of orphans (Deininger et al., 2003). As well as providing care, they may also find themselves responsible for other costs such as debts incurred during HIV-related illness or paying funeral bills. This results in financial and physical hardship, compounded by grief for the deceased and worry about the future of the living (Schatz and Ogunmefun, 2005).

Concerns are growing about the long-term effects on the continuity and quality of public services and governance, with the significant destruction of 'institutional memory'. For example, a government ministry can likely accommodate the one-time loss of 2–3% of staff (that is, staff lost during a single year, above normal losses due to retirement, non-AIDS deaths, etc.) by increasing recruitment or reassigning staff internally. If, however, 25% of staff beyond normal turnover is lost cumulatively to AIDS over 10 years, the change in age composition and the loss of staff experience and expertise may seriously impair that institution's effectiveness and efficiency. For example, a reduction in the number of candidates for senior management positions may result in less experienced or less qualified individuals being appointed, with a likely erosion of the quality of decision-making (Haacker, 2004).

AIDS can have a negative effect on political participation and other aspects of democratic government, although research on this is scarce (de Waal, 2005).

Possible effects include declining involvement in voluntary organizations and local politics (due to death, illness or demoralization), absenteeism and death of elected representatives, and a shift from debating long-term issues of democracy and human rights to focusing on more narrow and immediate issues of service provision (Manning, 2002; Marais, 2005; Strand et al., 2004).

SECURITY AND ORDER

Rights-based security and order are important parts of creating an environment in which human development can flourish, and the epidemic's impact on police forces and the military is of considerable concern in some countries. Mozambique has trouble recruiting and training enough police officers to replace those dying of AIDS-related illnesses, while in Ethiopia a 2004 study of police officers' wives found that about one-third were living with HIV (Garrett, 2005).

A recent global review of AIDS and national security found that high-ranking officials around the world are concerned

about levels of prevalence within the uniformed services and among new recruits. In Africa, Zimbabwe's armed forces suffered a serious blow in 2004 when one-third of army officers sent to China for advanced training were expelled after being diagnosed as HIV-positive (Garrett, 2005). Across the Commonwealth of Independent States, notably in the Russian Federation and Ukraine, armed forces are having some difficulty finding enough healthy recruits to maintain their ranks. This situation may become even worse: declining birth rates in the late 1980s and early 1990s and high rejection rates among recruits due to poor military fitness threaten the Russian Federation's goal of maintaining a million-man army (Frolov, 2004).

Health services

A strong health system is a vital component in any country's response to AIDS and a key stepping stone in development. Yet, in the hardest-hit countries, the epidemic is undermining health services in a variety of ways. These range from the deaths of already scarce health-care workers to the additional numbers of people needing beds

in already understaffed and underfinanced hospitals and clinics.

For example, Botswana lost approximately 17% of its health-care workforce due to AIDS between 1999 and 2005. In Zambia, an estimated 40% of midwives in Lusaka are believed to be HIV-positive (ILO, 2004), while 16% of a sample of public and private health-sector workers in four South African provinces were living with HIV in 2002. Among younger health workers (aged 18–35), the estimated prevalence was even higher at 20% (Shisana et al., 2004).

The epidemic is placing unprecedented burdens on the scarce health-care resources that currently exist. People with HIV-related diseases occupy more than half of all hospital beds in sub-Saharan Africa. Excessive workloads, compounded in many cases by fear of infection due to the absence of standard infection-control practices in many health-care workplaces, are causing many to leave the health profession altogether.

Increased access to antiretroviral therapy will give back years of good-quality life to millions of people living with HIV



The epidemic is placing unprecedented burdens on the scarce health-care resources that currently exist.

Currently, only 64% of children in Africa and 83% of children in south and west Asia are enrolled in primary school.



who would otherwise die, yet this will also put additional pressure on health services already under great strain. In the United Republic of Tanzania, for instance, the health-sector workforce has been significantly reduced by structural adjustment policies since the 1990s and has itself been struck heavily by AIDS. Yet the need to expand the sector is urgent. A WHO mission to the country has calculated that delivering antiretroviral therapy to everyone needing it would take the full-time services of almost half the existing health workforce (ILO/GTZ, 2004).

The implications for the hardest-hit countries are obvious, but the threat also applies to countries with much lower prevalence. In Viet Nam, a recent assessment suggests that by 2007, HIV and AIDS may absorb nearly 5% of all public health spending, if spending meets the level required to provide a comprehensive response to the epidemic. Although donor assistance can offset some of this spending, “financing the necessary prevention, care and treatment services will test the commitment, capacity, and will of the Vietnamese economy” (UNDP, 2003a).

In India, the epidemic could have a severe impact on the poorest citizens’ access to health care. Health insurance, both public and private, currently covers only 15% of the population, and the public health facilities available to the poor are underfunded and understaffed. As India increases the availability of anti-retroviral therapy, the additional workload and increase in costs will fall most heavily on public facilities, as increasing numbers of poor people living with HIV begin to seek treatment (Mahal and Rao, 2005).

Impact on education

Education is one of the pillars of development, and providing universal access to primary education by 2015 is a target of both the Millennium Development Goals and the Education For All (EFA) Initiative (UNESCO, 2000). The latest UNESCO report on progress towards the EFA goals set at the World Education Forum in Dakar in 2000 indicates that, despite steady improvement, current rates of progress in school enrolments need to quadruple in sub-Saharan Africa and double in south Asia to reach the 2015

goal. Currently, only 64% of children in Africa and 83% of children in south and west Asia are enrolled in primary school (UNESCO, 2006).

Over half the countries considered unlikely to meet the 2015 goal are among the most AIDS-affected. UNESCO states unequivocally that, along with armed conflict and high fertility rates, “HIV/AIDS is a major global constraint on the provision of good-quality education” (UNESCO, 2005).

Although prevalence and death rates vary greatly, in some countries the impact of AIDS on teaching staff is critical. The United Republic of Tanzania needs around 45 000 additional teachers to make up for those who have died or left the system because of AIDS. The greatest proportion of these, according to the Tanzania Teachers’ Union, constituted highly experienced staff in the 41–50 year age group (ILO/GTZ, 2004).

South Africa’s education system is struggling with a variety of problems. Although the number of school-age children (6–18-year-olds) has been increasing, enrolment has been falling.

This is attributed to a variety of factors, including an increase in the proportion of vulnerable children (notably orphans and girls) whose access to school is restricted. At the same time, the total number of public school teachers is declining; between 1998 and 2003, the net reduction was over 5%. Along with retirement, resignation and emigration of teachers, death while in service was one of the main factors in this decline. AIDS accounts for much of this. HIV prevalence among South African teachers is 21% among those aged 25–34 and 13% among those aged 35–44. At the same time, the number of people graduating from teacher training is declining (Peltzer et al., 2005).

The world of work

Because it most frequently strikes adults in the prime of their working years, HIV poses a threat to the economic growth and development of millions of people employed in the informal sector (also known as the ‘informal economy’). The impact is widespread and complex: consumption is reduced, profits are foregone, tax revenue and investments are

IMPACT ON EDUCATION QUALITY

One of the main concerns of the Education For All initiative is that the quality of education offered to children should be of a high standard. Here, too, HIV is having a serious impact as illness progressively affects the ability of teachers to teach, learners to learn and managers to manage the school system effectively and efficiently. In the Zambian school system, the illness of teachers or their responsibilities of caring for family members (including attending family funerals) accounts for over 60% of teacher absences. Strikingly, a survey carried out among teachers of year 5 mathematics and English found that a 5% increase in a teacher’s rate of absence reduced students’ average gains in learning by 4–8% per year. This results not only from the teacher’s absence but also from the indirect impact of less lesson preparation and lower teaching quality when teachers actually do work (Das et al., 2005).

COUNTING THE COST—AND TAKING ACTION

Singareni Collieries is a major employer in Andhra Pradesh, one of India's states with the highest HIV prevalence. The colliery, which supplies about 10% of the country's coal and employs over 93 000 people, sought to understand the current and potential impact of the epidemic on its staff and operations. Having estimated that approximately 2% of the workforce were currently HIV-positive (slightly higher than in the local population as a whole), the study calculated a variety of costs that will accrue over the following years such as loss of production, medical expenses, insurance costs and expenditure on employee replacement in cases of illness or death. Among other findings, the study found that if workers were untreated, the cost of compensating them as their illnesses progressed over 10 years would reach US\$ 21 million, if workers were not treated. In contrast, provision of antiretroviral therapy over the same period—thereby prolonging the working life of the employees and permitting them to sustain their families—would amount to only US\$ 1.24 million. In response to these and other findings, the company has implemented a variety of HIV and sexually transmitted infection prevention measures, and it is currently exploring with the government, unions and local nongovernmental organizations a variety of options for providing care and treatment to HIV-positive workers (ILO, 2005).

lost and essential services not delivered. Adults living with HIV, who would otherwise be generating income, supporting families and contributing to local and national economies, find themselves losing wages, jobs, savings and, eventually, their lives.

WORRIES IN THE BUSINESS COMMUNITY

Business, labour and government bodies have accumulated a growing body of research in recent years on the impact of AIDS on the world of work. It strongly supports the 'business case' for prevention, care and treatment.

The impact in the hardest-hit countries of southern Africa is already serious but is forecast to deepen over the coming decades. The South African Business Coalition on HIV and AIDS recently surveyed 1006 companies in the manufacturing, retail, wholesale, motor trade, and building and construction sectors and found that 9% had suffered a significant negative impact due

to AIDS. About one-third reported higher labour turnover rates, and one-quarter had incurred additional recruitment and training costs due to the epidemic. Regional impacts followed HIV prevalence levels closely, with just under 40% of companies operating in hard-hit KwaZulu-Natal and Gauteng reporting a negative impact on profits. While most of the larger companies surveyed have implemented AIDS policies and begun a variety of prevention and care interventions, only 13% of companies with fewer than 100 employees had a company policy in place (SABCOHA, 2004).

Balanced and sustainable economic growth over the long term will depend on many factors. For example, developing countries will need more foreign investment to grow their economies. However, the extent of the AIDS epidemic is one of the factors investors take into account when deciding whether to invest in a given country, and this works against the hardest-hit countries.



Given the size and complexity of the informal sector in so many countries, AIDS can have far reaching consequences on these workers, but the impact is difficult to track, prevent or mitigate.

04

THE INFORMAL SECTOR

Most developing countries have thriving informal sectors. They account for between 25% and 40% of gross domestic product in developing countries in Asia and Africa and can account for as much as 80% of non-agricultural employment in many countries (World Bank, 2005b). For example, informal employment is estimated to be 40% of total employment in Egypt, 69% in El Salvador, 14% in Russia and 23% in South Africa (Avirgan et al., 2005). In India, about 60% of informal workers are women (Treacy, 2003).

Given the size and complexity of the informal sector in so many countries, AIDS can have far-reaching consequences on these workers, but the impact is difficult to track, prevent or mitigate. ILO research in Ghana, South Africa, United Republic of Tanzania and Uganda in 2003 provides a great deal of information on the vulnerability of informal sector workers to HIV infection. For example, brewing and selling beer is an informal sector activity most often carried out by women and one to which women from HIV- and AIDS-affected households



There is considerable evidence of a relationship between AIDS, orphanhood and increased levels of child labour, most of which occurs in the informal sector.

often turn. The United Republic of Tanzania research showed a number of vulnerability factors associated with this activity, beginning with the fact that the majority of beer sellers were women and their main customers were men. The women were at increased risk of offering or being coerced into sex with customers in order to sell their beer (Mackay, 2003). The research highlighted the need for HIV prevention initiatives among informal sector workers in the four countries.

AIDS also affects existing antipoverty initiatives within the informal sector. Microcredit programmes, which frequently target people working in the informal sector, can be affected in a variety of ways by HIV-related illness. These range from reduced cash flow and higher transaction costs, as clients miss more and more payments, to illness among microfinance institution staff themselves (Murray, 2005). Mitigation efforts for the

informal sector are thus an important part of any national response to AIDS (see 'Reducing the impact' chapter).

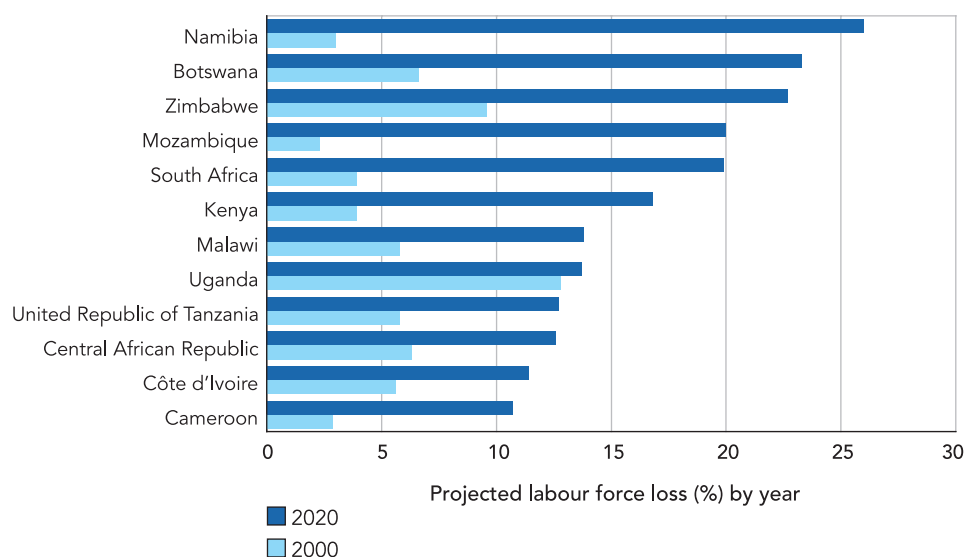
There is considerable evidence of a relationship between AIDS, orphanhood and increased levels of child labour, most of which occurs in the informal sector. Much of this evidence comes from sub-Saharan Africa (ILO/IPEC 2003), but the relationship has also been established in other parts of the world. Research among AIDS-affected families in New Delhi found that not only were many children withdrawn from schools as a way to cope with decreasing incomes and increasing expenditures on medicines, but 17% of them had to take up remunerated jobs to contribute to their families' financial stability (ILO, 2003).

AGRICULTURE AND RURAL DEVELOPMENT

Agriculture is essential to most developing countries to feed the majority of

FIGURE 4.8

Projected reduction in African agricultural labour force due to HIV and AIDS by 2020



Source: ILO (2004). HIV/AIDS and work: global estimates, impact and responses.



As is generally the case, the worst impact tends to be on the poorest members of the population.

04

their citizens but also provides much of their export earnings. It is often the largest single source of employment.

By 2000, the agricultural workforces in 12 high-prevalence African countries were between 3% and 10% smaller than they would have been in the absence of AIDS, according to FAO estimates. (In Uganda, struck early by the epidemic, the figure was 13%.) As Figure 4.8 shows, by 2020 the loss could be over 10% in these countries and over 20% in Botswana, Mozambique, Namibia and Zimbabwe.

Agricultural workers feel the impact over years as the virus takes its course, reducing their attendance (not only because of illness but also due to caring duties and mourning periods for others who die), productivity and earning power. A recent study of workers in Kenya's tea industry illustrated this. Comparing tea pluckers who eventually stopped working because of HIV-related causes with other workers, the study quantified sick days, casual leave days and those spent doing less strenuous tasks. The impact on workers' wages was marked, as HIV-positive tea pluckers earned 16% less in their second-

last year of work and 18% less in their last year. It is possible that the impact was actually worse, since it was found that the affected workers often brought unre-corded 'helpers' to aid in the job (Fox et al., 2004).

As is generally the case, the worst impact tends to be on the poorest members of the population. A survey in Kenya found that relatively poor households in rural areas do not recover quickly when the head of a family dies; over the three-year life of the survey, reduced crop production and non-farm incomes did not return to pre-death levels. As in other countries, the sex of the deceased seriously affects the value of crops a family produces, since the death of an adult male reduces production of 'cash crops' (typically coffee, tea and sugar) while the death of an adult female more often results in reduced production of grain and other subsistence crops (Yamano and Jayne, 2004).

DEVELOPING ECONOMIES

While the impact of HIV and AIDS on individuals, families and communities can

AIDS AND THE ENVIRONMENT

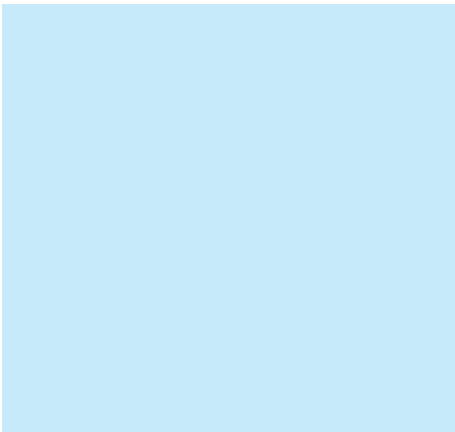
At first glance, Millennium Development Goal 7—ensuring environmental sustainability—has little to do with HIV and AIDS. Yet even here, the epidemic is having an impact. For example, a study of four fishing communities in Uganda found that not only were fishing families hit hard by illness, but fish stocks were being depleted as unskilled youth who were replacing sick fishermen did not know or ignored the traditions that have protected these communities' livelihoods for generations (Tanzarn and Bishop-Sambrook, 2003).

Current research (FAO, 2004) shows the impact that HIV and AIDS is having on the Miombo woodlands, a vast ecoregion stretching through some of the African countries with the highest prevalence of HIV, including Angola, Malawi, Mozambique, United Republic of Tanzania, Zambia and Zimbabwe. Carried out in six communities in Malawi and Mozambique, the research found that the forest was an important source of medicinal plants used by people to deal with HIV-related symptoms (most often for diarrhoea, mouth and throat sores, rashes and fevers) and of food and fuel for HIV- and AIDS-affected families. Families that had suffered the death of one of their members (and thereby less able to afford fuel sources such as propane) were five times more likely than those unaffected to have increased their collection of firewood, denuding areas close to their settlements. A number of other threats were also emerging. For example, medicinal plant species were threatened by destructive harvesting methods and commercial harvesting of these plants by people outside the community. The findings point out the urgency of assessing impact on forests and response to minimize destruction (Barany et al., 2005; Siteo et al., 2004).

be huge, research on national economies has found relatively modest effects using measures such as annual gross domestic product. Studies focusing on sub-Saharan Africa place the net impact on gross domestic product to be around 1% yearly

(Bell et al., 2003), and figures are considerably lower for countries with lower HIV prevalence. Recent work has aimed at understanding longer-term impact and investigating the factors that will influence these impacts.

At risk and neglected: four key populations 05



Chapter 05



AT RISK AND NEGLECTED: FOUR KEY POPULATIONS

This chapter focuses on four populations: sex workers; men who have sex with men; injecting drug users; and prisoners. In most countries, these populations tend to have a higher prevalence of HIV infection than that of the general population because (i) they engage in behaviours that put them at higher risk of becoming infected and (ii) they are among the most marginalized and discriminated against populations in society. At the same time, the resources devoted to HIV prevention, treatment and care for these populations are not proportional to the HIV prevalence—a serious mismanagement of resources and a failure to respect fundamental human rights.

In countries with low-level and concentrated epidemics, well-designed and adequately funded HIV prevention programmes among these populations have proven decisive in slowing or even stopping the epidemic in its tracks. For example, in the late 1980s, Thailand moved decisively to implement its brothel-based “100% condom use” programme, which provided concentrated HIV prevention services to sex workers and their clients. Had it not done so, adult HIV prevalence today would be an estimated 15%—10 times the current level of about 1.5% (MAP, 2005). Countries with generalized epidemics that place a high priority on HIV programming for these populations, guided by epidemiological surveillance,

will ensure the most effective use of resources.

Sex workers, men who have sex with men, injecting drug users and prisoners are largely under-represented and voiceless in the decision-making processes that affect their lives, including those related to HIV. Yet where they have been engaged in responses to the epidemic, they have often been among the most effective actors in those responses. Civil society’s involvement in responding to AIDS began with associations of men who have sex with men in industrialized countries, followed by organized groups of sex workers and injecting drug users in various parts of the world (see ‘Civil society’ chapter).

HIV RISK AND VULNERABILITY

HIV risk can be defined as the probability of an individual becoming infected by HIV either through his or her own actions, knowingly or not, or via another person's actions. For example, injecting drugs using contaminated needles or having unprotected sex with multiple partners increases a person's risk of HIV infection. Vulnerability to HIV reflects an individual's or community's inability to control their risk of HIV infection. Poverty, gender inequality and displacement as a result of conflict or natural disasters are all examples of social and economic factors that can enhance people's vulnerability to HIV infection. Both risk and vulnerability need to be addressed in planning comprehensive responses to the epidemic (UNAIDS, 1998).

Many other populations are also vulnerable to HIV (e.g. women and girls, young people, people living in poverty, migrant labourers, people in conflict and post-conflict situations, refugees and internally displaced people) and their HIV prevention needs should also be addressed.

Sex workers

While it is not possible to accurately count the number of people selling sex, it is estimated that sex workers may number in the tens of millions worldwide—and their clients in the hundreds of millions.

While sex workers can be of all ages, most are young and the great majority are female; their clients (for both male and female sex workers) are mostly male. In many countries, a high percentage of sex workers are migrants.

Although countries may criminalize sex work and thereby subject the act of buying or selling sex for money to criminal sanction, sex workers have the same human rights as everyone else, particularly rights to education, information, the highest attainable standard of health and freedom from discrimination and violence, including sexual violence.



Poverty, gender inequality and displacement as a result of conflict or natural disasters are all examples of social and economic factors that can enhance people's vulnerability to HIV infection.

Although many countries may criminalize sex work and thereby subject the act of buying or selling sex for money to criminal sanction, sex workers have the same human rights as everyone else.



Governments have a responsibility to protect these rights and, in the context of the HIV epidemic, to reach sex workers and their clients with the full panoply of HIV information, commodities and services. Furthermore, ways must be found to empower sex workers to use these HIV services and to actively participate in the design and provision of the health services they need.

HIGH RATES OF HIV INFECTION

In Asia, a high proportion of new HIV infections are contracted during paid sex, and a relatively high HIV prevalence has been found among sex workers in many countries. In Viet Nam, HIV prevalence among female sex workers increased rapidly throughout the 1990s, from 0.06% in 1994 to 6% in 2002. In Indonesia, the rate of HIV infection among female sex workers is 3.1% nationally but varies significantly from region to region. In Jakarta, it reached 6.4% in 2003 (MAP, 2005). In China, it is estimated that sex workers and their clients account for just less than 20% of the total number of people living with HIV (Ministry of Health, People's Republic of China/UNAIDS, 2005a).

High HIV prevalence is also found in the Caribbean and Latin America (Pan Caribbean Partnership on HIV/AIDS, 2002). In Suriname, HIV prevalence among female sex workers was found to be 21% in a 2005 study, while in Guyana, levels of almost 27% were recorded in 2004. Jamaica reported an HIV prevalence of 20% among female sex workers in 2002 (Ministry of Health of Jamaica 2002), while in El Salvador, 16% of street-based sex workers in San Salvador and Puerto de Acajutla tested HIV-positive in the same year (Ministerio de Salud Pública y Asistencia Social de El Salvador, 2003).

While little is known about sex work in the Middle East and North African countries, one exception is Tamanrasset, where HIV prevalence rose from 1.7% in 2000 to 9% in 2004 among sex workers (World Bank, 2005). More is known about Eastern Europe and Central Asia. For example, a study in St Petersburg, Russian Federation, found that 33% of sex workers under 19 years of age tested HIV-positive (Central and Eastern European Harm Reduction Network/OSI, 2005).

In major urban areas of sub-Saharan Africa, various studies over the past eight years have recorded HIV infection among female sex workers at levels as high as 73% in Ethiopia, 68% in Zambia, 50% in Ghana and South Africa, 40% in Benin, 31% in Côte d'Ivoire, 27% in Djibouti and Kenya, and 23% in Mali (UNAIDS, 2003). These data underscore the need for HIV prevention efforts to be scaled up among sex workers, even in countries with generalized epidemics.

SEX WORK AND DRUG USE

In many parts of the world, sex work and injecting drug use are intricately linked: drug users resort to sex work to fund their habit, while sex workers turn to injecting drugs to escape the pressures of their work. Sex workers who also inject drugs are at further risk, not least because the combination of their work and drug taking puts them beyond the protection of the law and so opens them to exploitation and abuse, including sexual violence and harm, and incapacity to negotiate condom use.

High rates of HIV and sexually transmitted infections have been found among sex workers in countries with large popu-

lations of injecting drug users. In China, Indonesia, Kazakhstan, Ukraine, Uzbekistan and Viet Nam, the large overlap between injecting drug use and sex work is linked to growing HIV epidemics (UNAIDS, 2005a). In Manipur, India, which has a well-established HIV epidemic driven by injecting drug use, 20% of female sex workers said they injected drugs, according to behavioural surveillance (MAP, 2005). In Ho Chi Minh City, in 2002, 49% of sex workers who reported injecting drugs were found to be HIV-positive, compared to 19% of sex workers who used drugs without injecting them and 8% of those who did not use drugs at all. Research also showed that drug-using sex workers in Viet Nam were about half as likely to use condoms compared with those who did not use drugs (Tran et al., 2004).

YOUNG AND ILL-INFORMED

Most women and men enter sex work in their teens or early 20s. It is estimated that 80% of sex workers in eastern European and central Asian regions are under 25 years of age, and that sex workers who inject drugs may be even younger than those who do not.

MALE AND TRANSGENDER SEX WORKERS

While not as numerous as female sex workers, male and transgender sex workers also sell sex, predominantly to men. Among these populations, HIV prevalence is frequently high. A recent study in Spain found HIV infection rates of over 12% in male sex workers who visited HIV testing clinics in 19 Spanish cities (Belza, 2005). In Indonesia, a study found HIV prevalence of 22% among transgender sex workers and 3.6% among male sex workers. Approximately 60% of the transgender sex workers and 65% of the male sex workers reported recent unprotected anal intercourse with clients. Almost 55% of the male sex workers reported having had sex with female partners in the preceding year (Pisani et al., 2004). A recent survey by municipal health authorities found that 5% of male sex workers in Shenzhen, a city in southern China, were HIV-positive (South China Morning Post, 2005).

The majority of HIV interventions that address sex work are aimed at the sex workers themselves, with insufficient attention paid to their clients or the contexts in which they work.



Many sex workers lack information about HIV and about services that might help protect them. A 2003 study carried out along major transport routes in Africa found that the average age of sex workers was 22.8 years and the average education level was grade six (upper primary school). Only 33% knew that they were at risk if they had unprotected sex. None reported seeking HIV counselling and testing services (Omondi et al., 2003). Sex workers are frequently less likely than the general population to access public health services, and may not know about or be able to afford treatment for sexually transmitted infections, which can increase physiological vulnerability to HIV. In Dili, one-quarter of sex workers surveyed in 2003 were diagnosed with gonorrhoea or chlamydial infections, and 60% were infected with herpes simplex virus 2 (Pisani and Dili STI survey team, 2004). Among incarcerated sex workers in a juvenile detention facility in the Russian Federation, 58% had at least one bacterial sexually transmitted infection and 4% were HIV-positive (Shakarishvili et al., 2005).

IMPACT OF THE SEX WORK ENVIRONMENT

Sex workers operate in a variety of different environments, ranging from highly

organized brothels and massage parlours to the street, markets and vehicles or cinemas, bars, hotels and homes. Each location carries with it its own degree of risk and vulnerability in terms of stigma, discrimination or the potential for violence, as well as the obvious danger of HIV infection. Moreover, the sex trade is not fixed but is evolving in reaction to social and economic conditions. This means HIV prevention programmes must adapt to address these changes. In Thailand, for example, there has been a large increase in the number of non-brothel-based sex service establishments, such as massage parlours. The sex workers in these establishments are largely unaffected by “100% condom use” programming, which concentrates on brothel-based sex work, and must therefore be reached in other ways. Similarly, many cities in India have reported an increase in non-brothel-based sex workers (UNAIDS, 2005a).

CLIENTS OF SEX WORKERS

The majority of HIV interventions that address sex work are aimed at the sex workers themselves, with insufficient attention paid to their clients or the contexts in which they work. In many countries, the fact that there is consistent

SEX WORK, HUMAN TRAFFICKING AND HIV

Every year, an estimated 600 000 to 800 000 people are trafficked across international borders (US Department of State, 2004). When those trafficked within their own countries are added, the annual toll of people trafficked may come to 4 million, including 1.2 million children under 18 years (ILO, 2002). All regions of the world are affected, although there are some well-established routes along which large numbers of people are trafficked. Within the South Asia region, for example, India and Pakistan are the main destinations for trafficked girls aged under 16 years, especially from Bangladesh and Nepal (UNAIDS, 2005b).

There are few data on HIV prevalence among trafficked women and girls. However, even in countries where HIV rates are low, trafficked women and girls are highly vulnerable to infection because they are often placed in situations where they cannot negotiate condom use, are forced to endure multiple sex partners and are subjected to violent sex (Burkhalter, 2003).

Trafficked women and girls come mostly from sectors of society and settings where there is poverty, indebtedness, high unemployment and gender discrimination (ILO, 2004). Efforts to overcome these factors with the objective of preventing human trafficking should be supported. However, until such efforts can show decisive success, interventions which address immediate needs—including HIV prevention and care services for potential and actual victims of human trafficking—are required.

demand for sex work is often ignored by government policies, which focus solely on repressing or regulating supply. The prevalence of purchasing sex varies greatly. For example, a general population study in 24 Peruvian cities found that 44% of men aged 18–29 years said they paid for sex in 2002. Of these, 45% said they did not consistently use condoms with sex workers (Guanira et al., 2004). In some Asian countries, levels as high as 15% of men in the general population and 44% of men in mobile, high-risk populations (e.g. long-distance truckers and men who work in mines or forests far from home) reported buying sex during 2004 (MAP, 2005).

HIV PROGRAMMING

There is substantial evidence that HIV prevention programmes for sex workers

are effective and that sex workers can be strong participants in HIV prevention programmes. The Thai “100% condom use” policy has been replicated with success in countries from South-East Asia to the Caribbean, while the lessons learnt from organized sex workers in India (Kolkata), have been a touchstone for sex worker projects around the world (UNAIDS, 2000).

In Santo Domingo, low HIV infection levels of 3–4% among sex workers are thought to partly reflect consistent condom use and other safer behaviours promoted in the city’s “100% condom use” programme. A recent survey found that 87% of sex workers reported using a condom the last time they had sold sex and 76% said they always used a condom during paid sex (Secretaria de Estado de

Salud Pública y Asistencia Social de Republica Dominicana, 2005).

Many projects seek to provide sex workers with alternative ways of earning income. In Ethiopia, for example, the Sister Self-Help Association was formed by a small group of sex workers to try to provide themselves with a regular income and better health provision. The income-generating activities include a restaurant, a convenience store (a shop with extended opening hours, stocking a limited range of household goods and groceries) and a catering service for local hotels.

Successful HIV programmes use a mix of strategies, taking into account factors such as whether sex workers are brothel-based, if they work in one area or are mobile and the legal status of sex work. Effective strategies include (UNAIDS, 2002):

- promotion of safer sexual behaviour among sex workers, their partners and clients (e.g. promotion of condom use and negotiation skills) and of sex worker solidarity and local organization (in particular, so that clients cannot search for sex workers who are willing to have sex without a condom);
- provision of sexually transmitted infection prevention and care services, and access to commodities such as male and female condoms and lubricants;
- peer education and outreach work, including health, social and legal services;
- care for sex workers living with HIV; and
- policy and law reform, along with efforts to ensure that those in authority, such as police and public health staff, respect and protect sex workers' human rights.

These strategies should be accompanied by programmes to prevent entry into sex work, assistance to help women get out of it and anti-trafficking measures, including protection and assistance to women and girls who have been trafficked into the sex trade. Overall, programming works best if it has the active involvement of sex workers themselves in all phases of projects, from development to evaluation, and aims to decrease their vulnerability by addressing the conditions and context (e.g. economic and gender issues) surrounding sex work.

Men who have sex with men

The term “men who have sex with men” describes a social and behavioural phenomenon rather than a specific group of people. It includes not only self-identified gay and bisexual men, but also men who engage in male–male sex and self-identify as heterosexual or who do not self-identify at all, as well as transgendered males. Men who have sex with men are found in all countries, yet are largely invisible in many places.

Current indicators suggest that globally fewer than one in twenty men who have sex with men have access to the HIV prevention and care services they need (see ‘Overview’ chapter). Many factors contribute to this situation including denial by society and communities, stigma and discrimination, and human rights abuse.

Complex gender issues, social and legal marginalization and lack of access to HIV information affect how many of these men perceive, or do not perceive, their HIV-related risks. Traditional gender norms of masculinity and femininity

contribute strongly to homophobia and the related stigma and discrimination against men who have sex with men, transgendered and ‘third-gender’ people. (An example of the latter is the *hijaras* who live in various regions of South Asia and who may define themselves as neither men nor women, but as a third gender.) Homophobia has been identified as one of the primary obstacles to effective HIV responses in the move towards universal access to treatment.

NOT ENOUGH DATA?

In some regions of the world, epidemiological information about male-to-male HIV transmission is relatively scarce. This is partly because of the fact that many of the men involved are married to women and are thus regarded as part of the general population, rather than a distinct subpopulation. Crucially, in many parts of the world, men who have sex with men have no separate social identity (unlike self-identified “gay” men) and sex between men is not commonly talked about or acknowledged, even by the men concerned.

Nevertheless, much useful research has been carried out over the years in many

low- and middle-income countries, and the burden of HIV infection in men who have sex with men is becoming increasingly clear. Sex between men is central to the HIV epidemic in nearly all Latin American countries (UNAIDS, 2006). In Bogotá, for example, an HIV prevalence of 20% has been registered among men who have sex with men (Montano et al., 2005). But sex between men also has important implications in many other regions. In Bangkok, and Mumbai, for example, HIV infection levels of 17% have been found in men who have sex with men (UNAIDS, 2005a). Unfortunately, even in the many countries where data indicate that men who have sex with men are severely affected by HIV, their prevention needs have been largely ignored or underfunded (see ‘National responses’ chapter).

LACK OF HIV INFORMATION AND AWARENESS OF RISK

Many men who have sex with men do not regard themselves as homosexual and therefore rule themselves out of being exposed to HIV. Even among men who readily identify themselves as gay, bisexual or transgender, there is still considerable lack of awareness of HIV



In some regions of the world, epidemiological information about male-to-male HIV transmission is relatively scarce.

Faced with legal or social sanctions, men having sex with men are either excluded from, or exclude themselves from, sexual health and welfare agencies because they fear being identified as homosexual.



and what constitutes sexual risk behaviour. A peer-to-peer study among men who have sex with men in south-eastern Europe discovered misconceptions about modes of HIV transmission, with some men reporting sexual risk behaviours (Longfield et al., 2004). In Beijing, only 15% of a sample of 482 men who have sex with men understood that they were at risk of HIV infection, and many had misconceptions about HIV transmission routes and limited knowledge about condoms. Some 49% of the participants reported unprotected anal intercourse with men during the previous six months. Less than one-quarter obtained free condoms and condom lubricants in the previous two years (Gibson et al., 2004).

SEX WITH BOTH MEN AND WOMEN

Many men who have sex with men also have sex with women. In the study in Beijing just described, 28% of the men surveyed reported having sex with both men and women during the previous six months and 11% had unprotected intercourse with both men and women (Gibson et al., 2004). A large study, conducted in Andhra Pradesh, found that 42% of men in the sample who have sex

with men are married, that 50% had had sexual relations with a woman within the past three months and that just under half had not used a condom (Dandona et al., 2005).

CRIMINALIZED AND MARGINALIZED

Vulnerability to HIV infection is dramatically increased where sex between men is criminalized. In Jamaica, men having sex with men can be convicted of a crime and sentenced to jail. Same-sex relations between men in Malawi attract a 14-year penal sentence (Goyer, 2003). Criminalization and homophobia severely limit the ability of many men who have sex with men to access HIV prevention information, commodities and treatment and care (USAID, 2004). Faced with legal or social sanctions, men having sex with men are either excluded from, or exclude themselves from, sexual health and welfare agencies because they fear being identified as homosexual.

PREVENTION EFFORTS LOSING GROUND?

In some countries, self-identified homosexual men have taken their places within mainstream society through a process of activism, legal reform and changes in social attitudes. They have been at the

forefront of HIV prevention since the early years of the epidemic, and continue to be so. A five-city survey of men who have sex with men in India recently found that use of peers to distribute and promote condoms resulted in significant increases in condom use, especially in Mumbai, where peer educators distributed more than two-thirds of the condoms used by the survey population (MAP, 2005).

Yet some of the success against HIV achieved by men who have sex with men is apparently being eroded. For example, sexual risk-taking among men who have sex with men is increasing in many countries, some of it closely linked with alcohol or drug use. For example, the United States has witnessed a rapid growth in recent years in the use of the stimulant crystal methamphetamine. Research indicates that in Los Angeles, men who use this drug and have sex with men have an HIV infection rate more than three times higher than non-methamphetamine-using men who have sex with men (Peck et al., 2005). In San Francisco, approximately one in five men who have sex with men have recently reported that they use the drug, while in New York City, the figure was one in seven, and in Chicago and Los Angeles it was one in ten (Chicago Department of Public Health, 2005; de Herrera et al., 2005).

The resurgence of sexual risk behaviours has a number of possible explanations. One may be the erroneous belief that with widespread access to antiretroviral therapy, AIDS is more or less curable and protected sex is therefore optional. At the same time, public health authorities in most countries are devoting fewer resources to men who have sex with men

than epidemiological evidence suggests is necessary. Rising HIV prevalence among this population in many countries confirms this is a short-sighted and irresponsible public policy.

A RANGE OF RESPONSES

A range of responses aimed at reducing the risk behaviours and vulnerability to HIV of men who have sex with men has proved successful in a variety of settings (UNAIDS, 2000b). These include:

- general and targeted promotion of high-quality condoms and water-based lubricants, and ensuring their continuing availability;
- safer-sex campaigns and skills training, focusing mainly on reducing the number of partners, increasing condom use and alternatives to penetrative sex;
- peer education among men who have sex with men, along with outreach programmes by volunteers or professional social or health workers;
- provision of education and outreach to female partners of men who have sex with men; and
- programmes tailored to particular subpopulations such as the police and military personnel, prisoners and male sex workers.

In addition to these prevention measures, a number of activities must be encouraged among managers of health systems and governments. First, it is important to support organizations of self-identified gay men, enabling them to promote HIV prevention and care programmes. Alliances should be built between epidemiologists, social scientists, politicians, human rights groups, lawyers, clinicians, journalists, organized groups of men who have sex with men and other civil society organizations. Laws that

SEXUAL PARTNERS (MALE AND FEMALE) OF MEN WHO HAVE SEX WITH MEN

Ignoring the risks of unprotected anal sex not only makes men who have sex with men vulnerable to HIV infection, but also puts their female sexual partners at risk. In high-income countries, a relatively high incidence of HIV continues among men who have sex with men. Recent research indicates that many either do not disclose their HIV serostatus to their sexual partners or may be becoming complacent about sexual risk behaviour. HIV-positive men who have sex with men surveyed recently in Los Angeles and Seattle in the United States were found to be unlikely to disclose their HIV serostatus to sexual partners because they consider it “nobody’s business” or because they are in denial, have a low viral load or fear rejection (Gorbach et al., 2004).

criminalize same-sex acts between consenting adults in private need to be reviewed, and antidiscrimination or protective laws enacted to reduce human rights violations based on sexual orientation. Finally, but crucially, public commitment is needed from governments, national AIDS commissions, community organizations and donors to include men who have sex with men in their HIV programming and funding priorities. National AIDS action frameworks should have specific prevention, treatment and care plans for men who have sex with men.

Injecting drug users

Injecting drug use is estimated to account for just less than one-third of new infections outside sub-Saharan Africa. Once HIV enters a community of injecting drug users, progress of the infection into the rest of the population can be very rapid if appropriate measures are not taken early. Yet in spite of the importance of injecting drug users in the response to HIV, coverage of HIV prevention for this population is at best 5% across the globe (USAID et al., 2004).

There are approximately 13 million injecting drug users worldwide, of whom 8.8 million live in eastern Europe and Central, South and South-East Asia. There are around 1.4 million injecting drug users in North America and 1 million in Latin America (UNODC, 2004). Use of contaminated injection equipment during drug use is the major route of HIV transmission in eastern Europe and Central Asia, where it accounts for more than 80% of all HIV cases. It is also the entry point for HIV epidemics in a wide range of countries in the Middle East, North Africa, South and South-East Asia and Latin America. Alarming, new epidemics of injecting drug use are being witnessed in countries of sub-Saharan Africa (UNAIDS, 2005c).

RISK AND VULNERABILITY

Certain drug-use practices contribute significantly to HIV infection among drug users, with the biggest risk being use of contaminated needles and syringes; sexual risk practices also contribute, but to a lesser extent. For instance, sex workers in Ho Chi Minh City who inject drugs were about half as likely to use condoms as those who did not use drugs (MAP, 2004). A high prevalence of sexually transmitted infections among

drug users reflects their unsafe sexual practices.

Beyond the physical risks associated with drug injection, drug users are vulnerable to HIV because of their social and legal status. Ironically, in many countries this means that HIV interventions are not available to drug users, or that drug users are unable or unwilling to access them for fear of recrimination. For example, about 80% of Russians living with HIV became infected through using contaminated needles and syringes, and it is estimated that between 1.5% and 8% of all Russian men younger than 30 years have injected drugs at some time in their lives (Molotilov et al., 2003). Despite the proven efficacy of HIV prevention measures for injecting drug users such as needle and syringe exchanges and drug substitution treatment, the Russian Federation has been slow to take advantage of such measures. A recent survey found that funding for needle and syringe exchange programmes had actually fallen by 29% between 2002 and 2004. Although some regional legislators have contributed funds to needle and syringe exchange projects and to AIDS centres offering HIV treatment, this support was

neither universal nor sufficiently widespread to approach the levels of coverage needed to contain HIV epidemics driven by injecting drug use. However, new funding may help to begin to redress the balance. The first grant to the Russian Federation from the Global Fund to Fight AIDS, Tuberculosis and Malaria supported 23 exchange projects in 10 regions, and its funding of treatment for people living with HIV explicitly included injecting drug users among those targeted (Wolfe, 2005).

HARM REDUCTION: A HIGH PRIORITY

Some 20 years of research and experience confirm that HIV epidemics among injecting drug users can be prevented, stabilized and even reversed using a comprehensive package of HIV prevention and care activities. This package was recently summarized in a UNAIDS position paper on HIV prevention as “a comprehensive, integrated and effective system of measures that consists of the full range of treatment options, (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confi-



Some 20 years of research and experience confirm that HIV epidemics among injecting drug users can be prevented, stabilized and even reversed using a comprehensive package of HIV prevention and care activities.

Numerous studies in diverse epidemiological settings have demonstrated that harm reduction strategies are cost effective in preventing the spread of HIV.



dential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary health care and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users” (UNAIDS, 2005d).

Numerous studies in diverse epidemiological settings have demonstrated that harm reduction strategies are cost effective in preventing the spread of HIV (Sullivan et al., 2005). Since the 1990s, maintenance programmes using methadone have reported success in helping to contain HIV epidemics in areas as diverse as Australia, China, Hong Kong Special Administrative Region, Sweden, Thailand and the United States (Mattick et al., 2003). Such maintenance programmes provide an opportunity for stabilizing the health and social situations of drug users and enhancing antiretroviral treatment compliance. Despite the evidence, however, certain aspects of harm reduction remain controversial in some parts of the world (Beckley Foundation, 2005). For example, counterproductive laws and

policies in some countries prohibit substitution therapy using methadone or buprenorphine.

WHO added methadone and buprenorphine to the *WHO Model List of Essential Medicines* in 2005, and has been advocating for their introduction into drug programmes in countries where use of opioids (e.g. opium and heroin) is prevalent, as an essential component of both HIV prevention and treatment. This has included supporting the development of national guidelines for methadone substitution therapy and the scaling up of harm reduction programmes in countries such as China, Myanmar and Ukraine.

The lessons of comprehensive HIV prevention are being applied in an increasing number of countries. Despite a strong commitment to compulsory treatment for drug dependence and abstinence-based programmes, Malaysia has recently decided to introduce harm reduction programmes. In 2004, the country had an estimated 117 000 to 240 000 injecting drug users, and approximately 52 000 people who were living with HIV, the vast majority of them young men aged 20–29 years (Ministry of Health Malaysia

EVIDENCE FOR HARM REDUCTION

HIV transmission and HIV/AIDS impact associated with injecting drug use can best be contained by implementing a core package of interventions ... There is strong and consistent evidence that this package of harm reduction interventions significantly reduces injecting drug use and associated risk behaviours and hence prevents, halts and reverses HIV epidemics associated with injecting drug use. Conversely, there is no convincing evidence of major negative consequences of such interventions, such as initiation of injecting drug use among people who have previously not injected or an increase in the duration or frequency of illicit drug use or drug injection (UNAIDS, 2005c).

and WHO, 2004; Huang and Hussein, 2004). After sustained advocacy by nongovernmental organizations and the health community, pilot methadone maintenance programmes have been established, and pilot needle and syringe exchange programmes are planned to start in 2006. In addition, antiretroviral therapy is now being provided to injecting drug users resident in drug-dependence treatment facilities. In 2005, a judicial order in the Islamic Republic of Iran stipulated that individuals who use illegal drugs would no longer be targets of criminal repression but would instead be treated as patients by the public health system (Asian Harm Reduction Network, 2005).

In Central Asia, the Kyrgyz Government supports needle and syringe exchange programmes in three cities and in prisons in the country, and was the first member of the Commonwealth of Independent States to offer methadone maintenance therapy. Although such programmes have yet to be implemented on a wide scale, early evidence suggests that the country has benefited from its active search for technical assistance and its strong engagement of nongovernmental organizations in formulating and implementing national HIV prevention efforts (Wolfe, 2005).

China has also embraced comprehensive HIV prevention among injecting drug users, having established 91 needle and syringe exchange programmes in various parts of the country (Ministry of Health, People's Republic of China/UNAIDS, 2005). It is currently in the process of establishing 1500 methadone maintenance programmes to cover 300 000 opioid users over a period of three years, and linking these services to sites delivering antiretroviral drugs.

HIV TREATMENT FOR INJECTING DRUG USERS

The International Treatment Preparedness Coalition recommends that global and national treatment goals specify targets for key at-risk populations. This is in response to evidence that in many countries injecting drug users, prisoners, men who have sex with men, sex workers and certain mobile populations face acute barriers to proper HIV care and treatment (International Treatment Preparedness Coalition, 2005).

This is especially true in the case of injecting drug users. The reasons for this are complex. Because of the illegality of drug use and the stigma associated with it, injecting drug users are often estranged from the health-care system and perceive little reason to seek medical services. In

The tension between law enforcement objectives and public health concerns may never be fully resolved with regard to injecting drug use.



the Russian Federation, for example, a drug user will be officially registered with government authorities if he or she seeks treatment for addiction or otherwise accesses various health or social services.

While injecting drug users on antiretroviral drugs can achieve clinical outcomes comparable to those of patients on antiretroviral therapy who do not inject drugs, they require experienced clinicians with the ability to address the many serious and potentially life-threatening conditions that must be managed in tandem with HIV infection. Injecting drug users who are infected with HIV are especially prone to severe bacterial infections, such as infective endocarditis and pulmonary tuberculosis (Gordon and Lowy, 2005).

In hospital settings, providing care and treatment to injecting drug users frequently presents special challenges. Those who have had chaotic lifestyles frequently try to continue injecting drugs when in hospital, find it difficult to adjust to hospital rules and sometimes feel stigmatized by hospital staff. Some innovative approaches have been developed to deal with these challenges. Clinicians in

Vancouver have long been concerned with the fact that injecting drug-using patients frequently leave hospital before treatment for bacterial infections has been completed, leading to long-term health problems and repeated hospital stays. In response, the public health authority has recently piloted a transitional care unit designed to accommodate the complex needs of drug-using patients. The apartment-style unit provides care 24 hours a day, not only for immediate medical problems—including the AIDS-related illnesses frequently found in this population—but also access to drug treatment programmes and social services such as housing when they leave. Since the project began in early 2005, monitoring has found improved health outcomes among patients, higher levels of satisfaction in both patients and staff, and significantly lower costs in comparison with hospital care (Vancouver Coastal Health Authority, 2005).

ACCOMMODATING DRUG CONTROL OBJECTIVES AND PUBLIC HEALTH POLICY

The tension between law enforcement objectives and public health concerns may never be fully resolved with regard to injecting drug use. However, as a

matter of both basic ethical principle and proven public health practice, drug control policies should reduce, not increase, the HIV risk faced by injecting drug users (for example, they should not deprive them of access to medical care or reduce their access to sterile injection equipment). At the same time, HIV prevention activities should not inadvertently promote illegal drug use. In practice, there needs to be clear government policies and legislation that authorize the implementation of all elements of the comprehensive package of HIV prevention and care activities, as well as sufficient funding so they can be carried out on a sufficiently large scale. As with all HIV programmes aimed at vulnerable populations, policies and programmes that deal with injecting drug users and their families should also conform to international human rights standards.

Prisoners

"It was Dostoevsky, of course, who said that the degree of civilization in society can be judged by entering its prisons. He was a wise man.... We cannot allow discrimination and stigma to stand between us and a solution. Injecting drug users in prison must have access to the same care offered to people on the outside."

Speech by Antonio Maria Costa, Executive Director, UNODC, 1 April 2005

It is estimated that at any given time there are over nine million people in prisons, with an annual turnover of 30 million moving from prison to the community and back again (Walmsley, 2005). Conditions reigning in most pris-

ons make them extremely high-risk environments for HIV transmission, leading them to be called 'incubators' of HIV infection, as well as of hepatitis C and tuberculosis (OSI, 2004). Prisons are sites for illicit drug use, unsafe injecting practices, tattooing with contaminated equipment, violence, rape and unprotected sex. They are often overcrowded and offer poor nutrition, limited access to health care and high rates of airborne and bloodborne diseases.

Although data from low- and middle-income countries are relatively scarce, the evidence available confirms that the prevalence of HIV infection in prisons is almost invariably higher than that in the general population. In South Africa, estimates put the figure as high as 41% in the general prison system and higher yet in individual prisons. In Cameroon, HIV prevalence at the New Bell prison in the city of Douala was 12.1% in 2005. A recent report from Zambia's prison headquarters stated that, in 2004 alone, some 449 inmates had died of AIDS-related illnesses (Simoooya and Sanjobo, 2006). HIV prevalence in prisons in the Russian Federation has been estimated to be at



If countries are reluctant to introduce harm reduction programmes to the general population, or to recognize and condone sex between men, they are even more unlikely to do so in their prisons.



least four times higher than that in the wider population (Russian Ministry of Justice, 2004). Nor is HIV confined to male prisoners: in the United States it is estimated that women prisoners are 15 times more likely to be HIV-positive than women in the general population (De Groot, 2005).

The risk factors explaining these prevalence levels are clear. To begin with, both male and female prisoners often come from marginalized populations, such as injecting drug users or sex workers, who are already at an elevated risk of HIV infection. Use of contaminated or non-sterile injecting equipment is almost invariably higher inside prisons than among injecting drug users outside of prison, while the prevalence of male–male sexual activity is often higher in prison than in the general population (WHO, 2005; Dolan et al., 2004). Tattooing represents another risk factor for the transmission of bloodborne viruses as contaminated instruments are often used. There is generally no access to sterile injecting equipment and condoms—the basic tools against HIV transmission.

HIV PREVENTION AND CARE

If countries are reluctant to introduce harm reduction programmes to the general population, or to recognize and condone sex between men, they are even more unlikely to do so in their prisons. There is considerable anecdotal evidence that some public officials feel that prisoners who inject drugs or participate in male–male sex “get what they deserve.” More pragmatically, many worry that harm reduction measures and condom provision in prison might lead to an increase in sex between men or injecting drug use.

In fact, there is no empirical evidence for these fears. In European prison systems there has been no increase in sexual risk behaviours as a result of harm reduction programmes for inmates (WHO, 2005). Rather, provision of HIV prevention services in prisons has been a considerable success story in many countries (Stöver and Nelles, 2003). Following successful pilot programmes beginning in the late 1990s, Spain has expanded its provision of needle and syringe exchanges to more than 30 prisons. Other countries are only beginning to see the benefits

of such programmes. In Ukraine, a 2005 study found that most prisoners' knowledge of HIV was generally poor, with only 39% having basic knowledge of how to prevent the sexual transmission of HIV. However, among prisoners who had been reached by prevention programmes in prison, two-thirds knew how to protect themselves against HIV (Ministry of Health of Ukraine, 2005). Following implementation of a peer-based health education programme in a prison setting in the Siberia region of the Russian Federation, HIV-related knowledge and condom use among prisoners increased, while the prevalence of tattooing declined (Dolan et al., 2004).

Prisons are not closed off from the world. Prisoners are eventually released and infection acquired inside prison can be readily transmitted outside it. HIV prevention and treatment for prisoners is also therefore a strategy with high potential benefits for the rest of society. To be truly effective, national AIDS programmes must significantly expand their provision of comprehensive HIV prevention, treatment, care and support services in prison.

In October 2004, WHO convened an international meeting on prisons and health in De Leeuwenhorst. The resulting *Status Paper on Prisons, Drugs and Harm Reduction* recommended that all prison systems adopt an approach based on public health and human rights "even if this means acknowledging the limitations in depending on an official enforcement of total abstinence [from drug use and sex]" (WHO, 2005). Recommended HIV-related measures for prisons include:

- providing what is required so that prison staff can ensure that all prisoners

are given basic information relating to HIV and other bloodborne diseases and how they spread;

- providing clinical management of drug-dependent prisoners at a standard equivalent to that in the local community;
- ensuring that adequate information and guidance are provided before prisoners are released; and
- providing follow-up care with links to community services, which is important for all prisoners with health problems, but is essential for those dependent on drugs.

All prison systems are urged to move as quickly as resources allow to introduce important additional harm reduction action:

- developing a planned and comprehensive clinical treatment programme for drug-dependent prisoners, including the use of opiate substitution maintenance therapy;
- developing a needle and syringe exchange programme equivalent to that available in the community, especially if the local prevalence of HIV or hepatitis C is high or if injecting drug use is known to occur in the prison; and
- providing an effective method for disinfecting needles and syringes and tattooing instruments along with appropriate information and training should needle and syringe exchange programmes be considered not necessary or feasible.

A MATTER OF HUMAN RIGHTS

HIV prevention and treatment efforts in prisons should be important components of national AIDS strategies not only because of the undoubted benefits in

HIV PREVENTION: AS NECESSARY OUTSIDE OF PRISON AS INSIDE

The United Nations Office on Drugs and Crime (UNODC) emphasizes that the presence of drugs and HIV in prisons presents two distinct dilemmas. First, drugs in prison represent a failure of security and a breach in the rule of law. Second, injecting drug use among prison populations results in high rates of HIV transmission between prisoners and to uninfected sexual partners once the prisoner is released. Two population streams—new inmates who may be uninfected and inmates who are already HIV-positive—flow in and out of prisons on a regular basis.

Experience in various countries has shown that evidence-based HIV prevention programming is effective in prisons. But UNODC, along with WHO and other UNAIDS Cosponsors, emphasize that prison authorities alone cannot fix the problem. Coordinated efforts with other government entities, particularly health and justice agencies, are necessary to break the chain of HIV transmission that accompanies incarceration and release, and to care for prisoners living with HIV—whether they are in prison or have served their sentence and are outside.

public health terms but also as a matter of fundamental human rights. People retain the majority of their human rights when they enter prison, losing only those that are necessarily and explicitly limited because of their imprisonment. They retain such rights as freedom from cruel and inhuman punishment, and the right to the highest attainable standard of health and security of the person. Courts in many parts of the world have ruled that governments actually have greater obligations to prisoners than to the general public because governments are the sole source of essential services provided to prisoners, including health care.

In a presentation to the United Nations Commission on Human Rights in April 1996, UNAIDS stated (UNAIDS 1996):

“[By] entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected.”

Some 10 years later, this position has not changed.

Chapter 06



COMPREHENSIVE HIV PREVENTION

The steady growth of the AIDS epidemic stems not from the deficiencies of available prevention strategies but rather from the world's failure to use the highly effective tools at its disposal to slow the spread of HIV. Some 25 years after the epidemic was first recognized, most people at high risk of HIV infection have yet to be reached by HIV prevention, as many policy-makers refrain from implementing approaches that have been shown to work.

Whereas the previous chapter focused on key populations particularly within concentrated epidemics, this one discusses the programmatic interventions and policy actions that are essential to all strong national HIV prevention programmes. It specifically addresses the urgent prevention needs of women and young people, as well as the complex prevention opportunities and challenges presented by expanding access to treatment. Most importantly, it emphasizes the urgent need for comprehensive, robust national HIV prevention programmes to be scaled up, to cover sufficient numbers of people and target resources where they can be most effective.

Intensifying HIV prevention

If anything has been learnt from the past 25 years of the epidemic, it is that HIV

prevention works. The early successes of Brazil, Thailand and Uganda in reversing their national AIDS epidemics through courageous political leadership and starting strong prevention efforts early have been well documented. More recent evidence suggests that prevention efforts are now also contributing to reductions in HIV prevalence in Cambodia and Zimbabwe, and in parts of Burkina Faso, Haiti, Kenya and the United Republic of Tanzania (UNAIDS, 2005a).

HIV prevention, like treatment, is for life. Instead of short-term or isolated prevention initiatives, effective national programmes need to sustain essential programmatic and policy actions at a sufficient scale over the long term, adapting them as the epidemic evolves, responding to changes in infection patterns and social environments. In recognition of the inherent long-term nature of the HIV prevention enterprise, implementation

and scaling up of available prevention strategies should be coupled with longer-term efforts to address human resource challenges and to develop new prevention technologies, including the ultimate prevention tool, a preventive vaccine.

Although much progress has been made, the global prevention response falls far short of the urgent, scaled-up effort needed to curb the epidemic's expansion. While funding for HIV programmes has increased in recent years, many countries are failing to direct financial resources towards activities that address the prevention needs of the populations at highest risk, opting instead to prioritize more general prevention efforts that are less cost effective and less likely to have an impact on the epidemic (see 'Financing' chapter).

There are also disturbing signs that support for HIV prevention in some regions may be diminishing. In recent years, Thailand, for example, has reduced its HIV prevention budget by two thirds, even though injecting drug use is contributing to substantial new HIV infections. (UNDP/UNAIDS, 2004).

Decisive action can—and must—make the difference

The world's failure to make proven prevention methods available to those who need them represents a remarkable missed opportunity. Scaling up available prevention strategies in 125 low- and middle-income countries would avert an estimated 28 million new HIV infections between 2005 and 2015—more than half of those that are projected to occur during this period—and would save US\$ 24 billion in associated treatment costs (Stover et al., 2006).

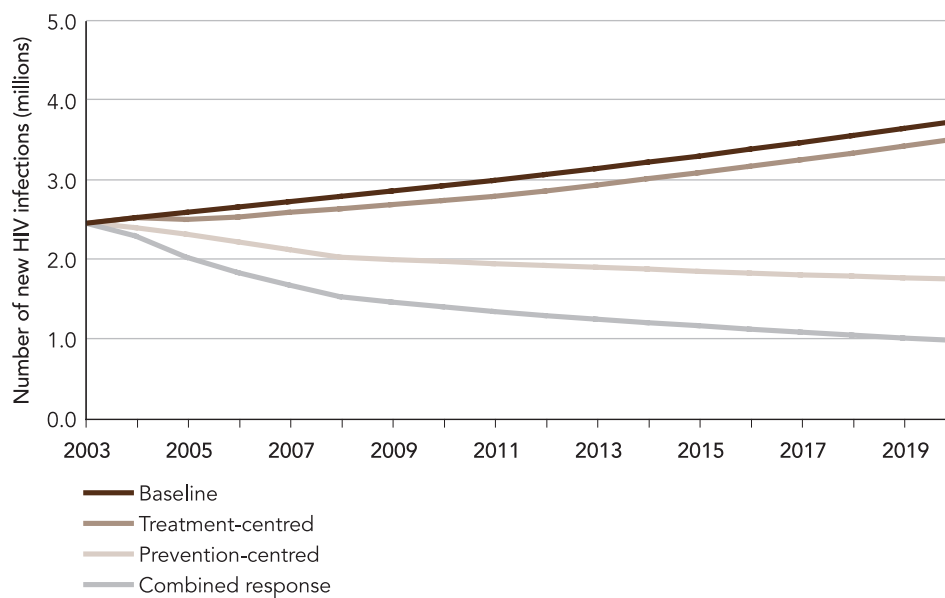
Countries also need to ensure that both prevention and treatment are scaled up in a balanced way, in order to capitalize fully on synergies between the two. Globally, it is estimated that a response focusing solely on treatment would result in only 9 million averted new HIV infections. In contrast, simultaneous scaling up of both prevention and treatment would avert 29 million new HIV infections by the end of 2020 (Salomon et al., 2005). Figures 6.1 and 6.2 illustrate the benefits of scaling up prevention and treatment together (the combined response



Countries also need to ensure that both prevention and treatment are scaled up in a balanced way, in order to capitalize fully on synergies between the two.

FIGURE 6.1

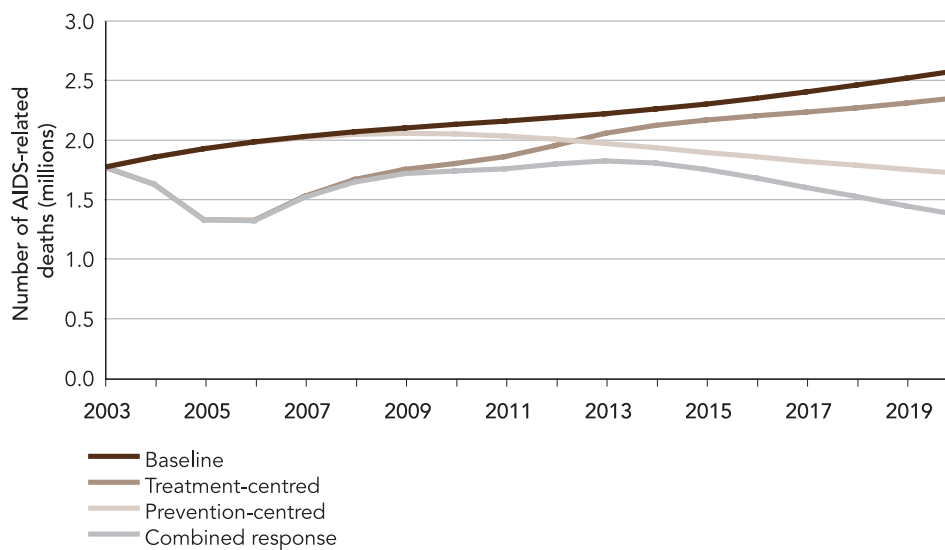
Impact of three scenarios on HIV infection in sub-Saharan Africa, 2003–2020



Source: Salomon JA et al. (2005). Integrating HIV prevention and treatment: from slogans to impact.

FIGURE 6.2

Impact of three scenarios on AIDS-related deaths in sub-Saharan Africa, 2003–2020



Source: Salomon JA et al. (2005). Integrating HIV prevention and treatment: from slogans to impact.

scenario), compared with concentrating on either prevention or treatment alone or with doing nothing (the baseline).

Preventing sexual transmission of HIV

Unprotected vaginal intercourse accounts for the vast majority of HIV infections globally. Effective prevention of sexual transmission of HIV requires a combination of programmatic interventions and policy actions that promote safer behaviours, reduce biological and social vulnerability to transmission, encourage use of key prevention technologies, and promote social norms that favour risk reduction, as stated in the UNAIDS' policy position paper *Intensifying HIV Prevention* (see end of this chapter).

SAFER BEHAVIOURS AND SEXUAL NORMS

Analysis of prevention interventions to change behaviour has consistently found that such programmes reduce the frequency of sexual risk behaviours (Crepaz et al., 2005; Elwy et al., 2002; Merson et al., 2000). Behavioural change programmes typically include basic information about the virus, personal risk assessment, counselling, building skills, such as negotiating condom use with sex partners, and access to condoms and other prevention technologies.

As discussed in the previous chapter, behavioural change programmes targeting populations at especially high risk are among the most cost-effective prevention interventions available and represent a core component of any national HIV prevention programme. Although these are indispensable in all national responses, broader-based programmes are also essential in generalized epidemics or in settings

where the epidemic is likely to spread from discrete high-prevalence groups into the broader population. Public education and awareness programmes that reach the general population are essential to any sound HIV response.

Behavioural aims for HIV prevention include: abstinence and delayed sexual debut for young people; monogamy within relationships; reduction in the number of partners; and correct and consistent condom use. Especially in settings with high HIV prevalence, effective HIV prevention often requires changes to deep-seated traditions and social norms regarding human sexuality. Given the important role of concurrent unprotected sexual partnerships in the spread of HIV in sub-Saharan Africa (Halperin and Epstein, 2004), persuading sexually active individuals to accept partner reduction and monogamy as valued norms may be critical to the long-term success of HIV prevention efforts. Countries that have lowered HIV incidence have benefited from the emergence of new sexual behaviour patterns—fewer commercial sex transactions in Cambodia and Thailand, delayed sexual debut in Zimbabwe, increasing emphasis on monogamy in Uganda, and an increase in condom use.

CONDOMS STILL VITAL

For sexually active people, the condom remains a vital prevention technology (UNFPA et al., 2004). Correct and consistent use of the male condom reduces the risk of sexual transmission of HIV by 80–90%—an efficacy rate that exceeds those reported for many of the world's standard vaccines (Halperin et al., 2004; Cohen and Farley, 2004). Observational studies, laboratory experiments and mathematical modelling indicate that female

condoms also offer strong protection against HIV infection (Hoffman et al., 2004).

In addition to promoting condom access for especially vulnerable populations, prevention efforts should prioritize encouraging condom use for all sexually active adults, especially in countries with generalized epidemics. According to one global estimate, condoms supplied by the public sector were used in only 21% of unprotected sex acts involving non-regular partners in 2003 (USAID et al., 2004).

Many men harbour negative attitudes towards condoms, feeling that condom use reduces sexual pleasure or impedes sexual intimacy with regular partners. However, strong and sustained promotion of condoms helps overcome such resistance, significantly increasing condom use. For example, with the goal of normalizing condom use, this year the Brazilian Ministry of Health distributed 25 million condoms at parades, dances, parties and on the street during the annual carnival—just one component of the government’s plan to distribute 1.5 billion condoms in 2006. In Singapore,

following implementation in 1995 of energetic condom promotion for sex workers and their clients, consistent condom use increased from 45% before the intervention to more than 95% in 2002, and sex workers experienced significant declines in gonorrhoea incidence (Wong, Chan and Koh, 2004). In addition to condom social marketing, condoms should be also made available free of charge, as even extremely low prices for over-the-counter condoms can serve as a deterrent to use (Cohen and Farley, 2004).

URGENT ACTION: INCREASING KNOWLEDGE OF HIV SEROSTATUS

Once diagnosed with HIV, and particularly if they receive proper counselling, most individuals take steps to avoid exposing others to the virus. Unfortunately, however, most people living with HIV are unaware of their serostatus.

Worldwide, only 12% of people who want to be tested are currently able to do so (UNAIDS et al., 2005c). In 2003, it was estimated that only 0.2% of adults in low- and middle-income countries

THE PERSISTENT GAP IN CONDOM SUPPLY

UNFPA, the largest public-sector purchaser of male condoms, estimates the global supply of public-sector condoms is less than 50% of that needed to ensure adequate condom coverage. The agency estimates that the gap between supply and actual need totals 8.3 billion condoms. While donor support for condom programmes increased by 16% between 2003 and 2004, to US\$ 72 million, such funding was nearly US\$ 20 million below amounts spent in 2001. To ensure a sufficient condom supply to halt the AIDS epidemic by 2015, the level of funding for condom procurement and distribution must increase threefold. In 2005, UNFPA launched the Global Programme to Enhance Reproductive Health Commodity Security. The five-year initiative seeks to catalyse national efforts to define, own and drive strategies to ensure access to all sexual and reproductive health technologies, including male and female condoms.

received voluntary HIV counselling and testing services (USAID et al., 2004).

There are many reasons why people at risk of HIV infection fail to be tested: fear of discrimination, fear that the test result will be positive, lack of access to treatment or lack of access to testing services. According to ILO, fear of losing employment often discourages individuals from making use of available testing services. Workplaces with 'Know your status' campaigns administered jointly by managers and workers' representatives report improved uptake of testing, treatment and prevention services. For example, trade unions in Rwanda that maintain solidarity funds to care for workers who test positive report that nearly all their members have been tested for HIV (UNAIDS/ILO/ICFTU, 2006).

Recognizing the urgency of increasing knowledge of HIV serostatus, in June 2004, UNAIDS and WHO recommended that traditional voluntary testing and counselling programmes be supplemented by enhanced diagnostic HIV testing and by the routine offer of HIV testing in clinics for sexually transmitted infections, in programme sites for the

prevention of mother-to-child HIV transmission, and in clinical and community-based health-service settings in areas with high levels of HIV and access to antiretroviral drugs (UNAIDS and WHO, 2004).

In recommending a scaled-up approach to HIV testing, UNAIDS and WHO built on lessons learnt in Botswana, where the national government decreed in early 2004 that public and private health-care sites must offer HIV testing as a routine part of medical check-ups—a policy change that has led to more rapid uptake of testing (WHO, 2005a). For example, since up to half of all people living with HIV develop tuberculosis, clinics for tuberculosis represent an ideal venue for the promotion of HIV testing and linkage of HIV-positive individuals to HIV services. However, as this trend is taken up by health systems, care must be taken to ensure that the routine offer of testing does not lead to the imposition of a test.

In addition to a lack of testing locations, other obstacles need to be addressed including cost and convenience. A number of approaches have proven



Workplaces with 'Know your status' campaigns administered jointly by managers and workers' representatives report improved uptake of testing, treatment and prevention services.

More than 340 million people contract a curable sexually transmitted infection each year, with women having greater vulnerability to infection than men.



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effective. Experience in the United Republic of Tanzania has shown that eliminating out-of-pocket costs associated with HIV testing services can significantly increase use of the services and their cost-effectiveness (Thielman et al., 2006). Another approach is to reduce the time that testing takes. According to a survey of adults in Malawi, 90% who wished to know their HIV serostatus preferred to learn their results the same day of the test (Degraft-Johnson et al., 2005). Such a desire can be met by rapid HIV tests, which provide results in about 20 minutes and eliminate the need for individuals to return days later for their results. While rapid HIV testing technologies are not unduly complex, they nevertheless require training of laboratory personnel. WHO and the United States' Centers for Disease Control and Prevention have developed a comprehensive five-day training module for rapid testing that is being rolled out in 2006.

PREVENTING SEXUALLY TRANSMITTED INFECTIONS

More than 340 million people contract a curable sexually transmitted infection each year, with women having greater vulnerability to infection than men

(WHO, 2005b). As untreated sexually transmitted infections increase the risk of HIV transmission by several orders of magnitude (Fleming and Wasserheit, 1999), efforts to ensure the prompt diagnosis and treatment of sexually transmitted infections represent an essential programmatic component of a strong and comprehensive response to HIV (Dallabetta and Neilson, 2004). Increased cooperation between HIV prevention efforts and programmes to diagnose and treat other sexually transmitted infections has been identified as an important means of increasing the effectiveness of both.

While available treatments for sexually transmitted infections are among the most potent HIV prevention tools, more effective technologies are still needed. Hepatitis B is the only sexually transmitted infection for which a preventive vaccine is licensed, although emerging evidence suggests that a vaccine to prevent human papilloma virus infection may be imminent. Syphilis control continues to depend on therapies that have barely changed in 60 years, as newer antibiotics have not systematically been studied to assess their potential in treating syphilis and other sexually transmitted

CIRCUMCISION: HOW EFFECTIVE IN HIV PREVENTION?

Although it has long been documented that circumcised males have lower infection rates than uncircumcised males, until recently no prospective study had specifically tested the efficacy of adult male circumcision in preventing the acquisition of HIV (Siegfried et al., 2005; Weiss et al., 2000). In 2005, researchers announced the results of a randomized controlled trial recruiting 3274 men aged 18 to 24 years in Orange Farm, South Africa, in an area where almost one in three adults are HIV-positive. The trial found that adult male circumcision reduced the men's risk of contracting HIV during sexual intercourse by over 60% during the 18-month study period. (Auvert et al., 2005.) Research suggests that among other possibilities, male circumcision may help to protect against HIV infection by removing cells in the inner foreskin that serve as entry points for the virus (Reynolds et al., 2004).

In July 2005, UNFPA, UNICEF, WHO and the UNAIDS Secretariat advised that the South Africa trial results should be confirmed before male circumcision is broadly promoted as a standard measure within comprehensive HIV prevention programmes (UNFPA et al., 2005). Two efficacy trials for adult male circumcision are underway in Kenya and Uganda, with results anticipated in 2007. The Kenyan trial of 2776 men uses the same circumcision method as the one tested in South Africa while the Uganda trial of 5000 men uses a different circumcision method. Both trials are designed to follow participants over a longer period to assess the duration of any observed benefit and to determine whether the intervention has an effect on overall levels of sexual risk behaviour. A third trial in Uganda is assessing the degree of protection that male circumcision may offer to female partners of HIV-positive men.

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infections (Hook and Peeling, 2004). Two large-scale trials are currently under way to assess the HIV prevention efficacy of mass administration of acyclovir. If successful, this will provide a relatively inexpensive treatment for herpes simplex virus type 2 infection, a condition which increases the risk of HIV acquisition three-fold (Freeman et al., 2005).

HIV PREVENTION IN EMERGENCY SITUATIONS

Displacement as a result of conflict can sometimes increase the affected population's HIV risk by reducing their access to HIV prevention services, disrupting social support networks, increasing exposure to sexual violence, encouraging sex in return for food, shelter or other necessities, or simply moving to a higher HIV prevalence location (UNAIDS and

UNHCR, 2005). In Nepal, where a continuing violent conflict has displaced between 200 000 and 400 000 people, widespread population displacement may be accelerating the country's HIV epidemic. In particular, the conflict is severely curtailing the ability of nongovernmental organizations to provide HIV prevention services in such chaotic and dangerous circumstances (Singh et al., 2005).

UNAIDS and UNHCR recommend that refugee programming should include culturally and linguistically relevant community-based prevention interventions (UNHCR, 2005). In Uganda, where more than 220 000 refugees share health services with 135 000 people from surrounding communities, UNHCR

HIV PREVENTION IN THE TRANSPORT SECTOR

HIV prevention efforts designed for specific occupational groups, often targeting the purchase of sex while on the road, have met with considerable success. For example, there is ample evidence that HIV prevention programmes aimed at truck drivers can reduce their frequency of unprotected sex. In Tamil Nadu, for example, research carried out after an HIV prevention programme for truck drivers found the percentage of drivers reporting that they had had commercial sex declined from 14% in 1996 to 2% in 2003. Moreover, the percentage of drivers whose last instance of commercial sex was unprotected fell from 45% to 9% in the same period (MAP, 2005).

Although long-haul truck drivers are more likely to engage in casual sex due to extended periods of time away from home, short-haul drivers have more access to communities and have been known to withhold goods and food in exchange for sex. This is particularly likely to happen when the goods being delivered are urgently needed, for instance in emergency situations. Opportunities for sexual exploitation and abuse and unprotected sex may increase in such situations and need to be addressed (WFP, 2006).

Programmes targeting truck drivers are most effective if carried out with the agreement of both employers and employees. In South Africa, an agreement between representatives of workers and employers has led to the establishment of a network of roadside clinics that provide general health services and HIV prevention interventions (ILO, 2005). In Malawi, the World Food Programme is in partnership with private companies, nongovernmental organizations and the government to provide HIV prevention information, condoms, treatment of sexually transmitted infections, voluntary HIV counselling and testing and referrals for HIV treatment to truck drivers and sex workers in two locations in the country.

works with the government to provide refugees with access to voluntary HIV testing and counselling, screening and treatment for sexually transmitted infections, and services to prevent mother-to-child HIV transmission. Recent evidence has documented an increase in condom use among refugees at the Kyaka II refugee settlement in Uganda.

Humanitarian relief efforts now routinely integrate HIV prevention into their work. UN agencies and nongovernmental organizations, for example, prioritized HIV prevention from the outset of the international response to the 2004 Asian tsunami.

Preventing mother-to-child transmission of HIV

Each day, 1800 children worldwide become infected with HIV—the vast majority of them newborns. More than 85% of children infected with HIV live in sub-Saharan Africa, although incidence of mother-to-child transmission of HIV is rapidly rising in Eastern Europe and Central Asia (UNICEF, 2005).

Effective prevention of mother-to-child HIV transmission involves a combination of strategies. These include primary HIV prevention for women (including integration of HIV prevention into reproductive

and sexual health services), prevention of unintended pregnancies in HIV-positive women, access to comprehensive antenatal care, promotion of voluntary HIV testing and counselling for pregnant women and their partners in antenatal and community-based settings, antiretroviral therapy for mother and newborn and counselling on strategies to reduce the risk of HIV transmission via breastfeeding.

Although pilot projects are currently delivering HIV prevention services in antenatal settings, few countries have effectively scaled up such services. Globally, just less than 8% of pregnant women are currently offered services to prevent mother-to-child transmission of HIV (see 'Progress' chapter). In sub-Saharan Africa, fewer than 6% of pregnant women in 2005 were offered services for the prevention of mother-to-child HIV transmission.

Timely administration of antiretroviral drugs to the HIV-diagnosed pregnant woman and her newborn significantly reduces the risk of mother-to-child HIV transmission. Combination regimens appear to be most effective but were until

recently regarded as too costly for widespread use in low- and middle-income countries. In recent years, projects to prevent mother-to-child transmission in resource-limited settings have primarily focused on the provision of single-dose intrapartum and neonatal nevirapine, which cuts the risk of HIV transmission by more than 40% (Jackson et al., 2003). However, studies indicate that women who receive single-dose nevirapine to prevent transmission to their newborn may develop resistance to the drug, potentially compromising the effectiveness of future antiretroviral regimens (Johnson et al., 2005; Flys et al., 2005; Jourdain et al., 2004). While the benefits of single-dose nevirapine outweigh the risk of resistance in resource-limited settings, development of affordable regimens with superior resistance profiles represents an urgent global priority.

Prolonged breastfeeding by HIV-infected mothers significantly increases the risk of HIV transmission to the infant. Breastfeeding is preferable to artificial feeding in the first six months of life, regardless of the mother's HIV status, as replacement feeding poses a greater risk of death to the infant than breastfeeding from an



Timely administration of antiretroviral drugs to the HIV-diagnosed pregnant woman and her newborn significantly reduces the risk of mother-to-child transmission.



HIV-infected mother in the first months (Ross and Labbok, 2004). HIV-infected mothers are advised to wean their infants early to avoid prolonged exposure of the infant and to avoid combining breastfeeding with replacement feeding, which appears to heighten the risk of transmission. The complex relationship between breastfeeding and HIV transmission risk to the newborn underscores the importance of extensive, culturally appropriate counselling on breastfeeding to new mothers who are living with HIV. Current research is focused on the potential of an extended course of nevirapine therapy to reduce the risk of HIV transmission through breastfeeding.

Because the women and households served by prevention of mother-to-child transmission services have multiple, often overwhelming needs, efforts to scale up such services require extensive investments in programmes that extend well beyond the delivery of counselling and short-course antiretroviral drugs in antenatal settings. Founded in 2002, the MTCT-Plus initiative administered by Columbia University's Mailman School of Public Health in the United States

seeks to accelerate uptake of HIV prevention services by ensuring long-term access to antiretroviral drugs by women reached by prevention of mother-to-child transmission programmes. As of early 2006, the initiative was supporting 13 sites in 9 countries in Africa and Asia and providing HIV care and treatment to more than 8000 individuals.

In 2004, WFP issued formal guidance to the field on the integration of food and nutrition support into programmes for the prevention of mother-to-child transmission. In Rwanda, WFP provides food assistance from the 7th month of pregnancy until the baby is 12 months old. Such assistance not only contributes to the health of HIV-infected mothers and their newborns, but also helps reduce economic burdens associated with childbirth and HIV infection. (WFP, 2004.)

The Family Planning Association of Kenya provides an example of such integration in action. Working closely with the International Planned Parenthood Federation, the Family Planning Association of Kenya developed a model of services that offers comprehensive sexual and reproductive health care together with a wide range of services related to HIV including antiretroviral therapy for people living with HIV. The association's pioneering programme offers antiretroviral therapy in a sexual and reproductive health setting. All nine clinics of the association provide voluntary HIV counselling and testing; several offer prevention of mother-to-child HIV transmission as part of their maternal health services, and four of the nine are geared up to provide antiretroviral therapy. The provision of antiretroviral therapy is part of the BACKUP Initiative (Building Alliances – Creating Knowledge – Updating

LINKING HIV RESPONSES WITH REPRODUCTIVE AND SEXUAL HEALTH SERVICES

There is an inherent association between HIV and sexual and reproductive health as many more than 75% of HIV infections are acquired through sexual transmission or through transmission during pregnancy, labour and delivery, or during breastfeeding. The presence of sexually transmitted infections other than HIV increases the risk of HIV transmission. Apart from these obvious direct associations, many of the same root causes affecting sexual and reproductive health status are also linked with the epidemic, such as gender inequality, poverty, stigma and discrimination, and marginalization of populations vulnerable to HIV (UNFPA, 2005).

Experience teaches that strengthening links between sexual and reproductive health and HIV programming can lead to important public health benefits. The commitment of the international community to intensify links between sexual and reproductive health and HIV at the policy and programme level is expressed in the June 2005 UNAIDS policy position paper *Intensifying HIV Prevention*. This reflects and builds upon two internationally agreed-upon policy statements: (i) the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health (UNFPA, 2004a); and (ii) The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (UNFPA, 2004b).

The New York Call to Commitment was issued in June 2004 by UNAIDS, UNFPA and Family Care International, at a high-level consultation that stressed the critical need to link HIV and sexual and reproductive health services. Noting that failure to link these systems has diminished the effectiveness of global efforts, the Glion Call to Action called for necessary resources to promote links between HIV and sexual and reproductive health, integration of links in national development plans and budgets, and a coordinated and coherent HIV response built on the principles of the “Three Ones” (see ‘National responses’ chapter).

Partners in the fight against HIV/AIDS, tuberculosis and malaria) of the German development agency, Deutsche Gesellschaft für Technische Zusammenarbeit. Thus, the Family Planning Association of Kenya has demonstrated that the provision of antiretroviral therapy within sexual and reproductive health settings is both possible and practical. The strong network of community health volunteers attached to the clinics provides an excellent infrastructure for delivery of antiretroviral therapy and has good prospects of reaching the poor and marginalized with this life-saving therapy.

HIV prevention for women and girls: a global priority

Extensive evidence demonstrates that HIV prevention initiatives that are specifically tailored to women’s needs can reduce women’s risk of HIV infection. Nevertheless, there are still far too few evidence-based prevention programmes that are designed for the particular needs of women and girls. These are sorely needed. For the most part, HIV prevention strategies have yet to grapple effectively with the gender dimensions of HIV prevention, treatment and impact mitigation. As well as being more

UNAIDS estimates that people under 25 years account for half of all new HIV infections.



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physiologically vulnerable to sexual HIV transmission than men, women face a host of social, economic and legal disadvantages that severely limit their ability to protect themselves against HIV infection. In many countries, married women have little means of insisting on abstinence or that their husbands use a condom during sexual intercourse, even if they suspect he is having unprotected sex outside their marriage.

Effective HIV prevention for women has many components. These include easy access to HIV prevention services and commodities, intensified research efforts to develop new prevention methods that women can control, policy reforms to reduce women's vulnerability to HIV infection, and longer-term efforts to develop new gender norms and influence the behaviour and attitudes of men and boys. Sustained advocacy will be necessary for these to be realized, and with this in mind, the Global Coalition on Women and AIDS was launched by UNAIDS in 2004. The coalition aims to increase global awareness of the epidemic's growing burden on women and girls and to catalyze effective action to address

the many sources of women's vulnerability to HIV infection. The coalition unites a broad array of stakeholders—including civil society groups, networks of women living with HIV, governments and UN agencies—to advocate for policies that address fundamental gender inequities and that promote women's empowerment.

EMPOWERMENT OF WOMEN AND GENDER EQUALITY

Provision of clinical services and HIV prevention commodities are far from sufficient, however, to contain the epidemic among women and girls. In the long run, effective HIV prevention for women will require policy reforms that empower women and promote gender equality. Central to an effective prevention response for women is a strong commitment to universal education (see 'Reducing the impact' chapter). Higher education levels for girls are associated with a higher age of marriage, reduced fertility, improved health-seeking behaviour, lower vulnerability to genital mutilation, and reduced risk of HIV and other sexually transmitted infections (Grown et al., 2005).

CHANGING THE ATTITUDES OF MEN AND BOYS

Forging new gender norms requires changing the attitudes and practices of men and boys. The International Planned Parenthood Federation currently has a number of projects around the world that aim to engage men in efforts to build healthier norms. For example, as a component of an initiative to build sexual and reproductive health capacity in Haiti, support from the foundation enabled the PROFAMIL (Association pour la Promotion de la Famille Haïtienne) project to help women and men negotiate sexual decision-making and to recognize that both partners should together decide whether to use a condom (IPPF, 2003a). With the aim of changing men's gender attitudes and to promote communication between men and women regarding condom use, the foundation sponsored a project in Kenya that included male-only clinics, motivational exercises to encourage male use of condoms, and various male-targeted information, education and communications approaches (IPPF, 2003b). In Brazil, it supports men's discussion groups that encourage men to reformulate certain beliefs about sexuality and the role of men in sexual and reproductive health.

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Other policy actions that support HIV prevention for women and girls include legal reform to secure women's property and inheritance rights, implementation and enforcement of strong legal measures tackling violence against women, enhanced global and regional collaboration to fight human trafficking, and mainstreaming of gender issues into programmes and policies. Leaders in government, religion, business and the media should vocally lead efforts to promote equality and empowerment for women, and education sectors should prioritize initiatives to inculcate healthier gender norms among boys.

Protecting young people

UNAIDS estimates that people aged under 25 years account for half of all new HIV infections. Young people's risk of HIV infection is closely correlated with age of sexual debut (Pettifor et al., 2004). Accordingly, abstinence from sexual intercourse and delayed initiation of sexual behaviour are among the central aims of

HIV prevention efforts for young people (Santelli et al., 2006). For the many young people who are sexually active, access to comprehensive prevention services, including prevention education and provision of condoms, represents an urgent global health necessity and a fundamental human right.

Young people who need HIV prevention services include both males and females, school students and young people who do not attend school, sexually inexperienced young people and those who are sexually active, and a substantial percentage (especially among girls) who are already married. No single prevention approach will meet the diverse needs of all young people who are vulnerable to HIV infection.

To be effective, HIV prevention services for young people should be widely accessible, evidence-based, grounded in human rights, age-specific and gender-responsive, and should help build life skills to enable young people to reduce their vulnerability. Such services should

Contrary to common fears or stereotypes, extensive research has detected little evidence that sex education leads to an increase in sexual activity.



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also involve young people living with HIV, and support balanced and comprehensive prevention strategies that promote abstinence, faithfulness, women's equality and empowerment, reduction in the number of partners, and consistent condom use (UNICEF, 2005). Young people themselves are often especially effective deliverers of HIV prevention interventions to their peers and thus have an important role to play in the development, implementation and evaluation of youth-oriented HIV prevention programmes.

Open discussion of sex is necessary to the provision of effective HIV prevention for young people. In some cultures, many young people, especially girls seeking to preserve their virginity, may engage in anal or oral sex in the belief that such behaviours do not constitute sex. Veiled or euphemistic discussion of sexuality may inadvertently permit such misconceptions to persist, potentially placing young people at risk of HIV infection.

SCHOOL-BASED HIV PREVENTION PROGRAMMES

Ensuring young people's access to school or other educational opportunities plays a

critical role in HIV prevention efforts. Not only are higher levels of education associated with safer sexual behaviours and delayed sexual debut (UNICEF, 2005; Prata, Vahidnia and Fraser, 2005), but school attendance enables students to benefit from school-based sexuality education and HIV prevention programming. In a review of studies of school-based HIV prevention programmes in Africa, 10 of 11 studies found they were associated with significant improvements in young people's HIV-related knowledge, and all studies that assessed students' attitudes detected positive behavioural changes. The review found evidence that school-based programmes can contribute to delayed sexual initiation, a reduction in the number of sexual partners, and increases in condom use, although producing sustained behavioural change appears more difficult than increasing knowledge (Gallant and Maticka-Tyndale, 2004).

Contrary to common fears or stereotypes, extensive research has detected little evidence that sex education leads to an increase in sexual activity (Kirby et al., 2005; Cowan, 2002). In recent years, programmes that promote abstinence as the sole HIV prevention strategy for

young people have attracted considerable attention from researchers, programme implementers, policy-makers, advocates and commentators. On the basis of extensive experience in low- and middle-income countries as well as in high-income countries, experts in adolescent health broadly agree that comprehensive HIV prevention programmes—which simultaneously promote condom use and delayed initiation of sex for those who are sexually active—represent the most effective approach to HIV prevention for young people. A formal position statement of the Society for Adolescent Medicine, released in January 2006, supports a “comprehensive approach to sexual risk reduction, including abstinence, as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active” (Santelli et al., 2006).

However school-based HIV prevention programmes cannot reach young people who are not sent to school. Provision of in-school meals helps to bring vulnerable children to school and provides them with access to education including HIV education. WFP is working with governments, nongovernmental organizations and UN agencies to integrate HIV prevention education into its school feed-

ing programmes, thereby serving a dual purpose of protecting young people.

Given the links between HIV infection and injecting drug use (see ‘At Risk’ chapter), HIV prevention programmes for young people should integrate strong, evidence-based drug prevention messages. Youth-oriented HIV prevention initiatives should also address the many other factors that increase the risk of HIV transmission, such as violence or sexual abuse. Moreover, programmes are needed to meet the HIV prevention needs of the millions of school-age children who do not attend school (see ‘Reducing the Impact’ chapter).

In 2005, in response to the urgent need for HIV prevention with and for young people, UNAIDS and UNICEF, with the support of UNFPA and UNESCO, initiated the *Unite for Children, Unite against AIDS* campaign, which seeks, among other things, to ensure achievement of the 2001 Declaration of Commitment’s target of a 25% reduction in HIV prevalence among young people by 2010.

HIV EDUCATION THROUGH THE MASS MEDIA

The mass media has an important role to play in promoting greater awareness and understanding of HIV and thus its

USING THEATRE TO PROMOTE HIV PREVENTION FOR YOUNG PEOPLE

In Burkina Faso, the International Building Workers Union supports a drama group that uses music, drama and poetry to educate communities about HIV. Called Yamwekre, which means ‘prick your conscience’, the group has reached more than 10 000 people. Discussion sessions follow each performance. The group has particularly focused on reaching young people and their parents. Since good practice emphasizes the participation of children in designing the programmes that affect them, children from 30 schools have been asked to take part in a competition to choose the themes the theatre group should incorporate in its work.

prevention. A study of a youth-oriented media campaign in Zambia called the Helping Each Other Act Responsibly Together (HEART) campaign found that young people who saw the campaign were 60% more likely than those who had not to report being abstinent and more than twice as likely to have ever used a condom (Underwood et al., 2006). Similarly, a youth-oriented mass media and interpersonal communication campaign in Cameroon increased condom use during the last episode of sex with a regular partner by 32% (Meekers, Agha and Klein, 2005). To achieve successful results, reporters and editors must themselves be properly educated about HIV. Not doing so can have serious consequences, as was shown in three case studies in Guinea, Sudan and Uganda. In each case, inaccurate, misleading and stigmatizing media reports on HIV and refugees risked inflaming the local population and exposing refugees to discrimination (Lowicki-Zucca, Spiegel and Ciantia, 2005).

Since the UN Secretary-General Kofi Annan convened a special meeting of media leaders in January 2004 to establish the Global Media AIDS Initiative, the media's engagement in the response has significantly increased at a global level. Meetings of regional- and national-level

media leaders have been held in Moscow and New Delhi and in November 2004, 100 creative individuals from 35 media companies attended the first ever meeting to encourage greater integration of HIV prevention messages in entertainment programming. Transatlantic Partners Against AIDS and the Heroes Project have launched public education campaigns in the Russian Federation and India, respectively. At a meeting in Johannesburg, in October 2005, African broadcast media leaders adopted the Old Fort Declaration on HIV/AIDS, which called for a redoubling of regional media efforts including incorporating HIV and AIDS as an integral part of the strategic business plans of media companies.

Linking treatment access to HIV prevention

Today's global efforts towards universal treatment access for people living with HIV (see 'Treatment and care' chapter) provide critical opportunities to strengthen and accelerate HIV prevention efforts. Strong evidence demonstrates that increased treatment access enhances awareness, reduces stigma, increases use of HIV testing services and promotes the mobilization

TELEVISION FOR CHILDREN TEACHES TOLERANCE

In South Africa, Takalani Sesame Street teaches children about HIV and AIDS. Started by the Public Broadcasting System in the United States in 1969, Sesame Street was introduced in South Africa in 1996, and in 2000 the country's own version was launched with the support of the United States Agency for International Development and South African Department of Education. In September 2002, Kami, a five-year-old girl puppet became part of the show. She is an orphan whose mother died of AIDS-related illness and her role is to humanize and destigmatize people living with HIV and encourage open discussion about issues such as coping with illness and loss.

of communities affected by HIV (Global HIV Prevention Working Group, 2004). Many people believe that antiretroviral drugs may reduce the per-contact likelihood that an HIV-infected individual will transmit the virus, although this hypothesis is not substantiated by data.

A complicated dynamic exists between HIV prevention and treatment. As treatment access expands in resource-limited countries, the health, longevity and quality of life for people with HIV will improve, potentially increasing opportunities for sexual transmission. At the same time, optimism about the treatment or misperceptions about the effects of antiretroviral drugs may also cause some people to increase their risk behaviour. Concern about this potential effect is not without foundation. In a study of 1168 HIV-positive women in the United States, initiation of antiretroviral therapy was associated with an increased likelihood of engaging in unprotected sex (Wilson et al., 2004). Among men who have sex with men in Sao Paulo, men who were optimistic about HIV treatment prospects were

significantly more likely to engage in unprotected sex (da Silva et al., 2005).

HIV PREVENTION SERVICES FOR HIV-POSITIVE PEOPLE

One strategy for maximizing the prevention benefits of greater treatment access is to increase prevention services for people living with HIV. While most people who test HIV-positive take careful steps to avoid exposing others to the virus, studies indicate that a minority of people with diagnosed HIV infection often have difficulty implementing and sustaining safer sexual practices (Denning and Campsmith, 2005). Relatively few studies have been undertaken to measure the effectiveness of behavioural interventions for people living with HIV, but emerging evidence indicates that such programmes are effective in reducing the likelihood that people with HIV will engage in sexual activity that might expose others to the virus (Crepaz et al., 2005). Integration of HIV prevention counselling in a home-based antiretroviral therapy programme in Uganda, combined with voluntary HIV counselling and testing for the partners of persons on antiretroviral therapy, resulted in a 70% drop in



Effective HIV prevention measures exist for the major sources of bloodborne transmission—injecting drug use, injections in health-care settings and blood transfusion—although many countries are making inadequate use of these highly effective tools.

unprotected sex, including an 85% reduction in unprotected sex among married couples (Bunnell, 2006).

As a result of expanded treatment access, millions of people living with HIV are periodically visiting health-care delivery sites to monitor their treatment progress. This provides important opportunities for the delivery and reinforcement of HIV prevention for people living with HIV (Global HIV Prevention Working Group, 2004; CDC, 2003). A study of six HIV clinics in California, found that the delivery of brief HIV prevention counselling by medical providers reduced reported episodes of unprotected sex by 38% among HIV-infected patients seen at the clinic (Richardson et al., 2004).

Safe injections and health-care precautions

Although bloodborne exposure results in substantially fewer new HIV infections each year than does sexual intercourse, direct exposure of blood to HIV is the most efficient means of transmission. Effective HIV prevention measures exist for the major sources of bloodborne transmission—injecting drug use (see ‘At risk’ chapter), injections in health-care settings and blood transfusion—although many countries are making inadequate use of these highly effective tools.

Unsafe injections in health-care settings account for an estimated 5% of new HIV infections worldwide, including 2.5% of new infections in sub-Saharan Africa (Hauri, Armstrong and Hutin, 2004). Although unsafe injections account for substantially fewer new HIV infections than does sexual intercourse (Schmid et al., 2004), an estimated 250 000 people

contracted HIV through medical injections in 2003, underscoring the need for all national HIV prevention programmes to promote adherence to sound infection control practices in health-care settings, including prohibitions on the reuse of injection equipment. Relatively inexpensive auto-disable syringes help prevent HIV transmission in health-care settings by making reuse impossible and by eliminating the risk of inadvertent needle-stick injuries. International guidelines recommend use of auto-disable syringes as the equipment of choice for immunization initiatives (WHO et al., 1999).

While use of auto-disable syringes for routine immunization has significantly increased in recent years, 38% of low- and middle-income countries did not use such syringes in their national vaccine programmes in 2004 (WHO, 2005c). The Global Alliance for Vaccines and Immunization has significantly contributed to the implementation of safer injection practices worldwide, financing the purchase and delivery of nearly 1 billion auto-disable syringes between 2000 and 2005.

Preventing unsafe injections is only one component of a broader effort to ensure sound infection control practices in health and emergency settings, where workers may be exposed to blood or other body fluids. This risk can be significantly lowered through workers’ adherence to universal precautions, which involve the routine use of gloves and other protective equipment to prevent occupational exposures, safe disposal of sharps, and timely administration of a four-week prophylactic course of antiretroviral drugs (CDC, 2001). Where workers have the potential to encounter blood or other body fluids in the course of their work, employers

have an obligation to train these workers in infection control and to ensure ready access to protective equipment and post-exposure prophylaxis.

BLOOD SAFETY

While blood transfusions were an important source of HIV transmission in the epidemic's early stages, the incidence of blood-related HIV infection has declined over time as countries have implemented recommended strategies to improve the safety of the blood supply. Despite recent progress, ensuring the safety of the blood supply remains a particular challenge in times of emergency, when wars, civil strife, disasters or epidemics damage health infrastructure.

One important measure for public health systems to carry out is to reduce and eventually stop paying for blood and increase the use of voluntary donors, who are the least likely to transmit infectious agents such as HIV and hepatitis viruses. Only 40 countries in the world have achieved 100% voluntary blood donation.

However, some countries have made substantial progress in this direction. In China, for example, the percentage of blood units obtained from voluntary

donors increased from 22% to 94.5% between 1998 and 2005 (Ministry of Health China, 2006).

Prevention technologies

Although available prevention strategies are highly effective, they have important limitations. Existing tools for the prevention of sexual HIV transmission are not 100% efficacious, do not confer lifelong protection and typically depend on the individual's correct and consistent use during each instance of sex, as well as the individual's ability to negotiate condom use with his or her partner. The current array of prevention options is notably insufficient for women, who lack access to unobtrusive prevention methods under their control.

However, recent years have witnessed an acceleration of efforts to develop new prevention approaches. By early 2006, large-scale human trials had been initiated to assess the HIV prevention efficacy of microbicides, the female diaphragm and adult male circumcision, and research continues on vaccine development.



Ultimately, the world's best hope for reversing the AIDS epidemic is a preventive vaccine.

KEEPING UP MOMENTUM ON MICROBICIDES

In light of the critical need for unobtrusive prevention technologies that women can control, increased global energy has been focused on research to develop topical microbicides that protect against HIV transmission during vaginal intercourse (Weber et al., 2005; Moore, 2005). Microbicides are gels, creams or other substances that can be inserted in the vagina to reduce the risk of HIV transmission. It is believed that microbicides might also potentially offer a measure of protection against transmission of HIV and other sexually transmitted microorganisms during rectal intercourse, although research and development for such a product is much less advanced than for vaginal microbicides. More than 60 candidate vaginal microbicides are under development, including 5 that are now being tested in large Phase III human trials in 10 countries.

Spending by the public and philanthropic sectors on microbicide research and development has more than doubled since 2000 (see 'Financing' chapter). On World AIDS Day in 2005, the governments of Denmark, Ireland, Sweden and the United Kingdom announced nearly US\$ 30 million in new funding for the International Partnership for Microbicides, the result of sustained advocacy by the international partnership and other partners such as the Global Campaign for Microbicides and the Alliance for Microbicide Development.

SUPPORTING RESEARCH

Although progress on HIV vaccine research has been slow, the search for a vaccine remains one of the world's most urgent scientific priorities. A Phase III trial is under way in Thailand to assess the efficacy of a vaccine based on a canary-pox vector containing genetic components of HIV. Numerous other candidates are also in earlier stages of development, with clinical trials currently under way in Africa, Asia, Australia, Europe, South America and North America.

However, a host of complex scientific challenges has slowed progress on development of a vaccine. No perfect animal model exists for HIV, the correlates of immunity are unknown, the virus can be transmitted in multiple ways, and there is substantial viral variability around the world.

In an effort to overcome obstacles to accelerated vaccine development, diverse partners in 2003 launched the Global HIV/AIDS Vaccine Enterprise. This is a multi-stakeholder alliance of independent research organizations dedicated to greater strategic collaboration on HIV vaccine research. Following extensive deliberations by working groups focused on the key scientific and logistic barriers to swifter vaccine development, the enterprise published a strategic scientific plan in 2005 that is intended to guide the collaboration and resource allocations of key actors in the field (Global HIV/AIDS Vaccine Enterprise, 2005).

A founding member of the Global HIV/AIDS Vaccine Enterprise, the International AIDS Vaccine Initiative—which celebrates its tenth anniversary this year—has assembled research consortia to improve understanding of the mecha-

nisms of action of live-attenuated vaccines and of the requirements for broadly neutralizing HIV antibodies. Since its creation, this initiative has advanced five vaccine candidates into human trials, and mobilized roughly US\$ 300 million in new funding for HIV vaccine research.

Political support for HIV vaccine development has increased, as has available funding (see 'Financing' chapter). In October 2005, 2000 African leaders, international scientists and vaccine stakeholders gathered in Yaoundé, Cameroon, to devise strategies concerning legislation and other policy responses to ensure regional preparedness for future vaccine trials. The Group of Eight leading industrialized countries reaffirmed their commitment to a robust vaccine research effort at their annual summit meeting in Gleneagles, in 2005.

OBSTACLES TO RESEARCH AND DEVELOPMENT

The quickened pace of research on new HIV prevention approaches is merely one outcome of a new approach to global health, catalysed by strong and sustained

activism and new sources of funding. However, HIV prevention clinical trials are often complex and expensive, requiring the enrolment and retention over several years of thousands of uninfected volunteers. Between 2004 and 2010, it is estimated that capacity for at least 96 000 volunteers in clinical trials will be needed to prevent delays in the development of potentially promising new HIV prevention tools.

Prevention research can often be highly controversial. For example, activist criticism regarding the fairness of planned multi-country research led to termination in 2005 of trials in Cambodia and Cameroon that were to test the use of the antiretroviral drug tenofovir in pre-exposure prevention. The experience with tenofovir highlights the need for researchers to engage a broad range of national and community stakeholders in the planning and conduct of prevention trials (UNAIDS, 2006; International AIDS Society, 2005). UNAIDS initiated a global consultation process in 2005 designed to inform the development of guidelines for durable partnerships between HIV prevention researchers and key stakeholders.



A sound policy environment

Implementing a strong national HIV prevention programme involves more than the selection of an appropriate mix of programmatic actions. It also requires a strong national policy framework that encourages safer behaviours, reduces vulnerability, maximizes the accessibility and effectiveness of HIV prevention services, promotes gender equality and women's empowerment, and reduces stigma and discrimination (see 'National responses' chapter).

To mount a comprehensive, sustained HIV prevention effort with the appropriate coverage and intensity, financing for such efforts must significantly increase. UNAIDS and its research partners estimate that US\$ 11.4 billion in financing for HIV prevention activities will be needed by 2008 to ensure that the world is on track to achieve the Millennium Development Goal of halting and beginning to reverse the global AIDS epidemic by 2015. Were the world to mount such a comprehensive, evidence-based response in all regions, HIV prevention would account for 52% of all HIV and AIDS spending worldwide in 2008 (UNAIDS, 2005c).

In 2005, with the aim of promoting universal access to HIV prevention, UNAIDS published a policy position paper, *Intensifying HIV Prevention*, which articulates basic principles and strategies that form the basis of strong national HIV prevention plans (UNAIDS, 2005a). For all countries, HIV prevention requires specific policy actions and programmatic actions, implemented with sufficient coverage, scale and intensity. These actions are detailed below. While national prevention programmes in all settings should incorporate each essential programmatic and policy action, the relative emphasis of specific HIV prevention measures may differ, based on the nature and severity of national and subnational HIV epidemics.

ESSENTIAL POLICY ACTIONS FOR HIV PREVENTION

- Ensure that human rights are promoted, protected and respected and that measures are taken to eliminate stigma and discrimination.
- Build and maintain leadership from all sections of society, including governments, affected communities, nongovernmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions.
- Involve people living with HIV in the design, implementation and evaluation of prevention strategies, addressing their distinct prevention needs.
- Address cultural norms and beliefs, recognizing both the key role they play in supporting prevention efforts and the potential they have to fuel HIV transmission.
- Promote gender equality and address gender norms and relations to reduce the vulnerability of women and girls to HIV infection, involving men and boys in this effort.
- Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted.
- Promote the links between HIV prevention and sexual and reproductive health.
- Support the mobilization of community-based responses throughout the continuum of prevention, care and treatment.
- Promote programmes targeted at HIV prevention needs of key affected groups and populations.
- Mobilize and strengthen financial, human and institutional capacity across all sectors, particularly in health and education.
- Review and reform legal frameworks to remove barriers to effective, evidence-based HIV prevention, eliminate stigma and discrimination, and protect the rights of people living with HIV or vulnerable to or at risk of HIV infection.
- Ensure that sufficient investments are made in the research and development of, and advocacy for, new prevention technologies.



While national prevention programmes in all settings should incorporate each essential programmatic and policy action, the relative emphasis of specific HIV prevention measures may differ, based on the nature and severity of national and subnational HIV epidemics.

06

ESSENTIAL PROGRAMMATIC ACTIONS FOR HIV PREVENTION

- Prevent the sexual transmission of HIV.
- Prevent mother-to-child transmission of HIV.
- Prevent the transmission of HIV through injecting drug use including harm reduction measures.
- Ensure the safety of the blood supply.
- Prevent HIV transmission in health-care settings.
- Promote greater access to voluntary HIV counselling and testing while promoting principles of confidentiality and consent.
- Integrate HIV prevention into AIDS treatment centres.
- Focus on HIV prevention among young people.
- Provide HIV-related information and education to enable individuals to protect themselves from infection.
- Confront and mitigate HIV-related stigma and discrimination.
- Prepare for access to and use of vaccines and microbicides.

Chapter 07



TREATMENT AND CARE

In the past decade, AIDS has helped drive a global revolution in thinking about the delivery of complex and expensive lifelong therapy in resource-limited settings.

When thousands of delegates gathered at the XI International Conference on AIDS in 1996, results of studies in high-income countries confirmed the effectiveness of combination antiretroviral regimens in preventing AIDS-related illness and death. Most delegates left the conference with the fear that the new therapies would remain beyond the reach of people living with HIV in low- and middle-income countries. True to these fears, while the number of AIDS-related deaths plummeted in the world's richest countries in the years immediately following the conference, the human toll from the epidemic soared in low- and middle-income countries, erasing decades of public health gains in sub-Saharan Africa.

By 2000, however, a growing chorus of voices rejected the inevitability of uncontrolled death and despair in the world's poorest countries. In their demands that the world recognize the universal human right to access treatment, people living with HIV were soon joined by leaders in government, religion, industry and civil society. The Declaration of Commitment

on HIV/AIDS, unanimously endorsed by the UN General Assembly in 2001, embraced equitable access to care and treatment as a fundamental component of a comprehensive and effective global HIV response. In 2003, WHO called the treatment gap a global public health emergency and on World AIDS Day launched the "3 by 5" initiative, which committed all components of the UNAIDS family and a broad array of partners to a highly ambitious target. At the same time, levels of funding for treatment increased greatly as a result of initiatives such as the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria (see 'Financing' chapter).

Although the world fell short of the "3 by 5" target, the initiative galvanized unprecedented global action to expand access to treatment and forever altered approaches to treatment and care. The "3 by 5" initiative, the President's Emergency Plan for AIDS Relief and the Global Fund definitively demonstrated the feasibility of delivering HIV treatment

in even the most resource-limited settings and confirmed that the extraordinary declines in AIDS-related illness and death seen in high-income countries can be achieved in low- and middle-income countries as well. Experience has identified the key elements of success, shed light on the obstacles to rapid scaling up of treatment access and aided in the identification of best practices to overcome these obstacles. Treatment access has helped mobilize communities in the response to HIV, preserved the health and viability of households vulnerable to HIV, and strengthened HIV prevention efforts in many parts of the world. For the first time, a comprehensive AIDS response now encompasses HIV prevention, care and treatment.

Building on momentum generated by the “3 by 5” initiative, the Global Fund and the President’s Emergency Plan for AIDS Relief, the Group of Eight leading industrialized countries, meeting in Scotland in the summer of 2005, called on the world to move as close as possible towards universal access to antiretroviral drugs by 2010. This goal was subsequently endorsed by all UN Member States at the High

Level Plenary Meeting of the 60th Session of the UN General Assembly in September 2005 (see ‘Financing’ chapter).

Expanding access to antiretroviral drugs

To expand delivery of antiretroviral drugs in resource-limited settings, WHO has outlined a public health approach to therapy, simplifying and standardizing treatment regimens. A key to this approach is national consensus on one or more WHO-recommended first-line treatment regimens, along with second-line therapy for those whose first-line treatment fails (WHO, 2004). In a recent survey, 36 out of 49 of the “3 by 5” focus countries had developed national antiretroviral therapy guidelines with at least one WHO-recommended first-line treatment regimen (Beck et al., 2006).

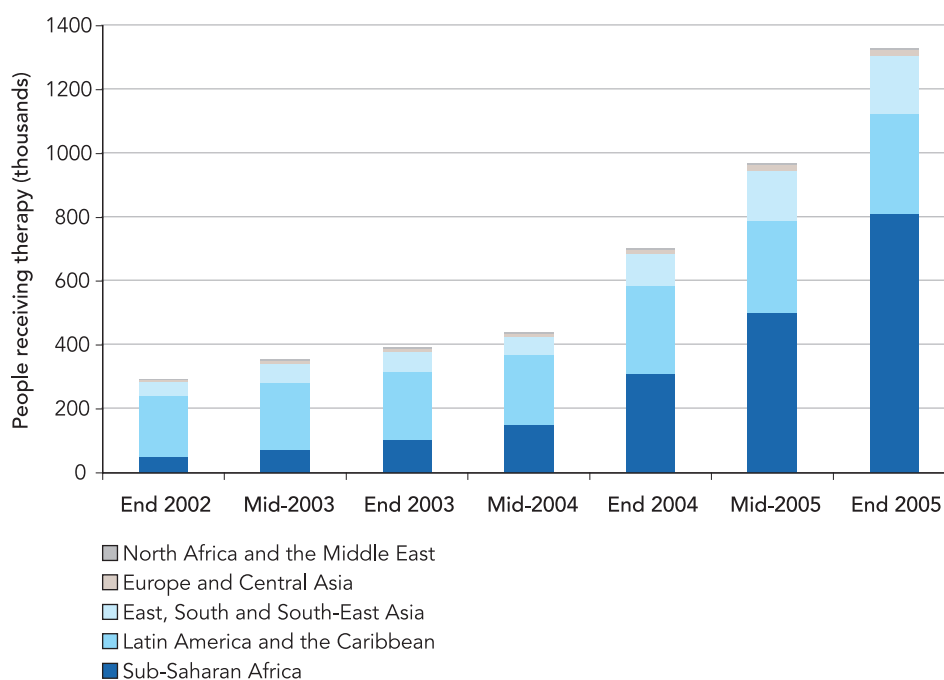
Between 2001 and 2005, the number of people on antiretroviral therapy in low- and middle-income countries increased more than fivefold—from 240 000 to approximately 1.3 million (Figure 7.1). As of June 2005, 21 countries were providing antiretrovirals to at least 50% of those in clinical need (WHO and UNAIDS, 2005).

In Africa, the number of people on antiretroviral therapy more than doubled in 2005 alone, with roughly one in six people who needed treatment receiving antiretrovirals by December 2005. Nearly 200 sites in Kenya were providing antiretrovirals by December 2005. In South Africa—the country with the largest population of people living with HIV—the number of people receiving antiretrovirals grew from fewer than 5000 at the beginning of 2004 to roughly



FIGURE 7.1

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



Source: WHO/UNAIDS (2005). Progress on global access to HIV antiretroviral therapy: An update on "3 by 5."

190 000 by the end of 2005 (WHO/UNAIDS, 2006). Figure 7.2 shows the rapid rise in coverage in sub-Saharan Africa during the past two years, while also indicating that there have been significant differences in progress between countries. Coverage levels of 50% or greater have been achieved in countries such as Botswana and Uganda, while in others levels remained at less than 10%.

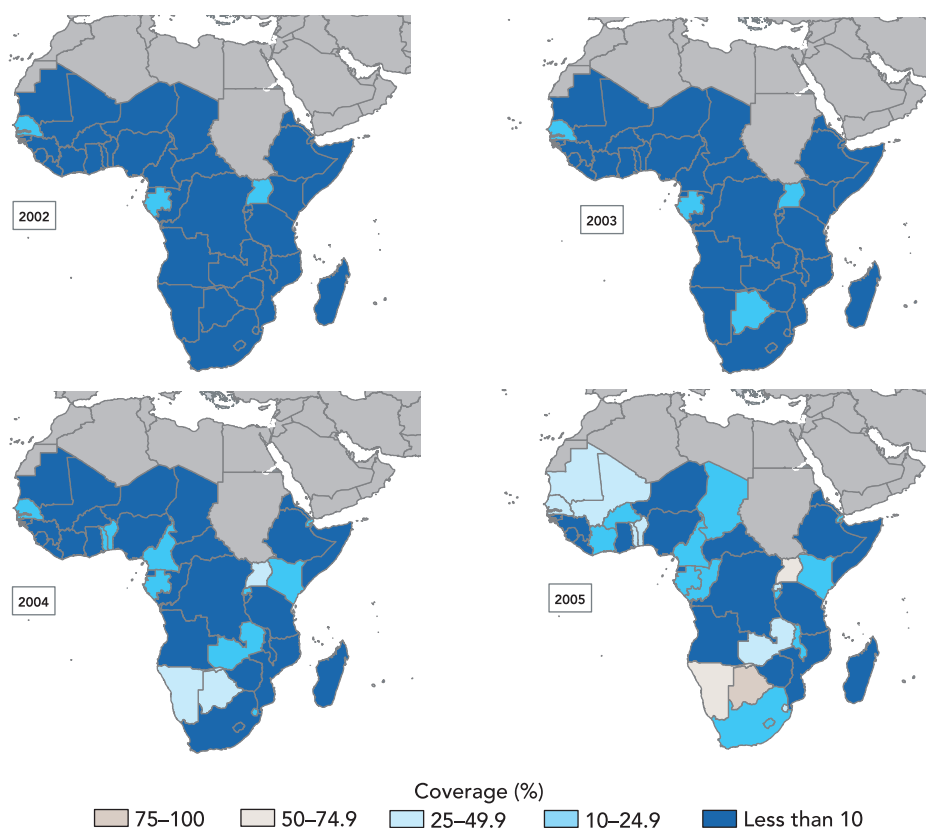
Progress was also made in other regions. With strong support from the national government to increase access to treatment, Cambodia was delivering antiretrovirals to more than 12 000 people by the end of 2005. In early 2006, more than 20 000 individuals were receiving antiretrovirals in 28 provinces in China (Ministry of Health, People's Republic of China, 2006). The Latin

America and Caribbean region currently has the highest coverage for antiretroviral therapies (68%), with the number of people on treatment increasing from 275 000 at the end of 2004 to 315 000 at the end of 2005.

Major strides in expanding access to treatment are being achieved in countries that are struggling against extraordinary challenges. Still recovering from the genocide that claimed hundreds of thousands of lives in the 1990s, Rwanda was delivering antiretroviral drugs to more than 18 000 individuals by the end of 2005, with substantial further expansion in treatment access anticipated. It had also established 76 antiretroviral therapy sites by September 2005, compared with 16 sites at the end of 2003. However, humanitarian agencies report that only a very limited

FIGURE 7.2

People in sub-Saharan Africa on antiretroviral treatment as percentage of those in need, 2002–2005



Source: WHO/UNAIDS (2005). Progress on global access to HIV antiretroviral therapy: An update on "3 by 5."

number of refugees in 26 countries in Africa and Asia are currently receiving antiretroviral therapy (UNHCR, 2006).

Worldwide, it is estimated that between 250 000 and 350 000 deaths were averted in 2005 as a result of increased treatment access (WHO/UNAIDS, 2005).

Although a variety of technical and logistic issues have slowed the roll-out of paediatric HIV treatment and care, progress has been made in some countries. As of July 2005 in Malawi, 19 out of 61 sites providing antiretroviral therapy to adults were treating children as well.

FINANCING AND DELIVERING EXPANSION OF TREATMENT ACCESS

Expanding access to treatment is truly a global endeavour, as a broad range of international donors and multilateral agencies have joined together to work with governments to purchase and deliver antiretrovirals. More than 50 countries and numerous foundations and corporations have contributed financially to the Global Fund, which as of December 2005 was supporting programmes providing antiretrovirals to 384 000 people. The number of people receiving antiretrovirals through Global Fund-supported projects nearly tripled between December 2004 and December 2005. Through the

SAVING LIVES, EXPLODING MYTHS

Expanding treatment access is exploding the once-widespread belief that antiretroviral therapy programmes could not succeed in resource-limited settings or among high-risk populations. Available evidence reveals that adherence to antiretroviral regimens in low- and middle-income countries is at least equal to, and often greater than, rates of adherence reported in high-income countries (Nemes et al., 2004). In Haiti, 87% of adults and 98% of children were alive one year after initiating antiretroviral therapy, with the typical adult experiencing an increase of 163 in the CD4+ T-cell count (Severe et al., 2005). Likewise, programmes in Argentina, Brazil, China, Hong Kong Special Administrative Region and elsewhere are effectively delivering antiretrovirals to HIV-infected injecting drug users, achieving high rates of treatment adherence and dispelling the notion that such individuals cannot reliably participate in, and benefit from, AIDS treatment initiatives (Open Society Institute, 2004).

President's Emergency Plan for AIDS Relief, the United States' Government is providing intensive assistance to 15 countries in Africa, Asia and the Caribbean, and support to 100 additional countries. The President's Emergency Plan aims to deliver antiretrovirals to two million people by 2007. As of October 2005, the President's Emergency Plan was supporting antiretroviral therapy for about 471 000 people living with HIV, approximately 60% of whom are women and 7% are children. For its part, the World Bank launched a US\$ 60 million Treatment Acceleration Project, with initial grants for scaling up treatment access provided to Burkina Faso, Ghana and Mozambique in 2004 and 2005.

Bolstered by such increases in funding, a wide variety of civil society organizations are leading efforts to expand access to antiretroviral drugs and to promote "treatment literacy" (see 'Civil society' chapter). In Burundi, for example, the 125 member organizations of the nationwide Alliance Burundaise contre le SIDA are deeply involved in delivering 14 of the 16 component programmes of the National Action Plan, including antiret-

roviral therapy, treatment of opportunistic infections and psychosocial support. The national association representing HIV-positive people, the Association Nationale des Séropositifs et Sidéens du Burundi, now provides care to over 3000 people, of whom 1357 are receiving antiretroviral therapy. The Kenya Coalition on Access to Essential Medicines—which includes networks of people living with HIV, the Kenya Medical Association, international nongovernmental organizations and a broad range of civil society groups—promotes coordinated action to enhance scaling up treatment access. Civil society advocacy remains an important factor in expanding access. For example, the Indian Network of People Living with HIV/AIDS played an important role in influencing the decision by the Government of India to provide free antiretroviral drugs in six heavily affected states.

At the same time, growing numbers of employers are providing antiretrovirals and other medical services to their workers living with HIV (UNAIDS, 2005a). By mid-2005, the private sector in South Africa was providing antiretroviral drugs to between 70 000 and 80 000 people,

while in several other African countries, public sector employers such as ministries of education and health are beginning to offer antiretroviral drugs as part of their employee health activities (see 'Reducing the impact' chapter).

DAUNTING OBSTACLES

Despite these many achievements, as of December 2005 at least 80% of those in clinical need of antiretroviral drugs were not receiving them. In India alone, where an estimated 770 000 individuals needed antiretroviral drugs in 2005, only about 40 000 were believed to be receiving the drugs in August 2005, with the public sector accounting for fewer than one-third of those on therapy (ITPC, 2005).

Although dramatic price declines for leading antiretroviral drugs have helped make expansion of treatment access possible in low- and middle-income countries, not all countries have taken full advantage of optimal pricing options. In the Russian Federation, for example, generic antiretroviral drugs have yet to be registered nor have clear steps been taken by the country's considerable pharmaceutical industry towards local manufacture of antiretrovirals (International Treatment Preparedness

Coalition, 2005). As many second-line antiretroviral drugs remain too costly for widespread use in many countries, further price declines are likely to be needed to sustain and expand treatment access initiatives.

Even with the growing provision of drugs by public health systems, treatment often involves considerable out-of-pocket costs, including fees charged to patients for the use of public services. In Nigeria, out-of-pocket costs for individuals who receive antiretroviral therapies at public clinics reportedly average US\$ 300 annually (International Treatment Preparedness Coalition, 2005), a significant sum for the 91% of households in the country that live on less than US\$ 2 a day (UNDP, 2005). The nongovernmental organization Médecins Sans Frontières reported in December 2005 that 44% of Nigerian patients on antiretroviral therapy surveyed experienced one or more treatment interruptions or took insufficient doses because of inability to cover fees required by public antiretroviral therapy clinics (Deutsche Presse-Agentur, 2005). Zambia—a country in which one in six adults are HIV-positive—aims to avoid the deterrent effect of out-of-pocket costs



Even with the growing provision of drugs by public health systems, treatment often involves considerable out-of-pocket costs, including fees charged to patients for the use of public services.

GUIDANCE AND TECHNICAL SUPPORT FOR EXPANSION OF TREATMENT ACCESS

WHO provides a wide range of technical support to help countries scale up treatment access based on a public health approach. It recommends that national plans for scaling up treatment use a chronic care model with standardized first- and second-line antiretroviral regimens, integrated service delivery, training of new cadres of health-care workers based on WHO's Integrated Management of Adolescent and Adult Illness (see below), strengthened procurement and supply management of medicines, diagnostics and commodities, and other actions to enable the widest possible access to life-preserving medications (WHO, 2004).

WHO prequalifies antiretroviral drugs as suitable for inclusion in national programmes. Prequalified drugs can include biogeneric compounds that are determined by WHO to be bioequivalent to patented products produced by the major pharmaceutical companies. WHO's prequalification programme not only provides guidance to national policy-makers but also helps ensure that drugs used to treat AIDS are of acceptable quality. The WHO-convened AIDS Medicines and Diagnostic Service provides countries with crucial information on pricing and availability of prequalified AIDS medicines. It includes over 20 partner agencies, including UN organizations (such as UNDP, UNICEF and the World Bank), procurement agencies (such as Crown Agents and the International Development Association), donors (such as the United States Agency for International Development, The Global Fund and the Clinton Foundation), and technical support agencies (such as the Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau).

WHO also works with other UNAIDS Cosponsors on a variety of treatment projects, and has provided technical assistance to scores of countries in developing successful Global Fund proposals.

by providing antiretroviral drugs free of charge in public clinics. In 2005, the number of people on antiretroviral drugs was increasing by 1000 each month, with approximately 30 000 people on treatment by June 2005 (WHO/UNAIDS, 2005). In some cases, countries that have reduced or eliminated out-of-pocket fees for antiretroviral drugs have not extended such policies to treatment for opportunistic infections.

Although funding has increased rapidly, a variety of obstacles remain to scaling up treatment access at the same rate. Large numbers of HIV-positive people live in rural areas, yet treatment is largely

confined to urban areas, requiring rural residents either to go without treatment or to travel long distances to obtain essential care. Thus, treatment often entails an overnight stay, which may be too expensive or made impossible by childcare and other household responsibilities. It can sometimes be difficult for patients who start antiretroviral therapy in the private sector, where a wide range of antiretrovirals may be available, to receive the same regimens under the standardized approach recommended for the public sector.

Efforts to expand access to treatment have also inadequately addressed the needs of certain populations especially

vulnerable to HIV. These include sex workers, men who have sex with men, injecting drug users and prisoners (see 'At risk' chapter), as well as refugees, internally displaced people and a range of mobile populations who cross borders for work or other reasons. As countries scale up treatment access, these populations must not be excluded. International financing mechanisms, such as the Global Fund, rely on proposals from the countries. However, many countries of asylum and countries with internally displaced people do not give priority to refugees or internally displaced people, populations who are commonly discriminated against.

National treatment guidelines provide an important vehicle to accelerate scaling up access to treatment, promote equity and demonstrate national ownership of the treatment agenda. Many countries have developed their own rules for managing national roll-out of antiretroviral therapy, typically using the framework of WHO's treatment guidelines. First produced as recommendations in 2001, the revised 2003 guidelines have now evolved at countries' request into separate guidelines for infants and children (WHO, 2006a) and adults, and are fully harmonized with

revised guidelines for prevention of mother-to-child transmission of HIV (both due for publication in mid-2006 by WHO).

In forging national guidelines, countries must inevitably deal with the tensions between the public health approach of mass therapy and the high variability of individual patient needs. WHO advocates that countries arrange for the provision of specialty care in tertiary referral centres, which can mentor and supervise treatment sites in nearby areas. In Senegal, this approach has enabled a relatively small number of centres to support district hospitals and treatment centres throughout the country. Physician-mentors are on call to answer urgent inquiries from nurses in the field, an innovation that helped Senegal meet its "3 by 5" target of placing 4200 people on anti-retrovirals by the end of 2005.

Building towards universal access to treatment

Building on the strong momentum from the "3 by 5" initiative, the world has embarked on an unprecedented quest to



Building on the strong momentum from the "3 by 5" initiative, the world has embarked on an unprecedented quest to move towards universal access to HIV care and treatment,

move towards universal access to HIV care and treatment. To reach this goal, workable strategies will be needed to overcome a host of obstacles that have thus far slowed the pace of scaling up access to treatment. Fortunately, as the number of countries with experience in introducing antiretrovirals increases, successful strategies for overcoming impediments to implementation are beginning to emerge.

INCREASING KNOWLEDGE OF HIV SEROSTATUS

HIV cannot be effectively treated unless it is diagnosed. In numerous countries, expansion of treatment access has been accompanied by a sharp increase in use of voluntary HIV counselling and testing services (Global HIV Prevention Working Group, 2004). For example, Cambodia increased the number of voluntary counselling and testing sites by nearly 20% in early 2005, with further expansion planned. On an international level, UNHCR and its partners now offer voluntary HIV counselling and testing in over 30 refugee camps in 11 countries.

Overall, however, use of testing services remains far too low to support the worldwide scaling up of access to antiretroviral drugs. Even in the United States, where antiretrovirals have been widely available for a decade, an estimated one in four people living with HIV are unaware that they are infected.

A variety of efforts are being made to increase use of testing services. For example, a 2005 study in the United Republic of Tanzania indicates that waiving fees for testing increases both the number of people tested and the cost-effectiveness of the intervention (Thielman et al., 2006). Making the process simpler and more

convenient also helps, as is being done in Lesotho, which in 2005 began offering rapid testing free of charge to all citizens, using health workers to make door-to-door visits to villagers. The country has embarked upon an ambitious 'Know your status' programme, in which all citizens are encouraged to be HIV tested. HIV testing procedures in hospitals and clinics also need to evolve, particularly when life-saving treatment can be initiated for a sick person. This has been recognized by Botswana, which recently launched a new policy to routinely offer an HIV test in all health-care settings. The move towards a routine offer of HIV testing (sometimes called provider-initiated testing) has great potential if adopted in tuberculosis clinics, antenatal services, re-feeding wards, clinics for sexually transmitted infections and for all hospitalized adults and children in countries with high HIV prevalence.

REDUCING STIGMA-BASED OBSTACLES TO SCALING UP TREATMENT

Known to be a frequent obstacle to HIV prevention programming, stigma associated with HIV (see 'The impact' chapter) also hinders scaling up treatment access. Informants surveyed in Kenya cited stigma and discrimination as the most significant impediments to expansion of treatment access (International Treatment Preparedness Coalition, 2005). Similarly, companies in South Africa that provide antiretrovirals through employment-based medical coverage schemes believe that stigma may be contributing to workers' underuse of AIDS treatment services (UNAIDS, 2005a).

Efforts to reduce stigma and discrimination among health providers as well as among the general public (see 'Reducing the impact' chapter) will be important in

scaling up both access to and use of anti-retroviral therapy in many countries. At the same time, it is expected that increased access to care will serve to reduce stigma and discrimination, as AIDS loses its association with death and becomes redefined as a treatable chronic disease that—most importantly—can also be prevented.

BUILDING HUMAN CAPACITY TO SUSTAIN HIV TREATMENT

Efforts to scale up access to treatment programmes must overcome the human resource crisis in low- and middle-income countries, which is especially pronounced in the health sector (see Chapter 8). For this reason, many international donors and nongovernmental organizations are building training components into their treatment programmes. In India, for example, the Clinton Foundation is working with the national government to train medical providers in the administration of antiretrovirals and to upgrade needed laboratories. In Botswana, more than 1300 health-care providers have received in-service training from senior HIV experts from international medical institutions who spend between six and 24 months serving

in the Clinical Preceptorship Programme of the African Comprehensive HIV/AIDS Partnerships, a public–private initiative of the national government, the Bill & Melinda Gates Foundation and the Merck Company Foundation/Merck & Co., Inc. Developed in 2005, WHO's training tools for the Integrated Management of Adolescent and Adult Illness and the Integrated Management of Childhood Illness have enabled more than 15 000 providers of AIDS-related services to be trained in an integrated approach to anti-retroviral therapy, care and prevention (WHO, 2006a, 2006b). In the same year, the first of a series of UNAIDS-supported regional technical facilities around the world became operational in southern Africa.

Traditional training initiatives, although critically important to scaling up treatment access, are not enough to remedy the acute global shortage and maldistribution of health-care workers (Narasimhan et al., 2004). In addition to providing training programmes, it is important for governments, donors and other partners to explore innovative solutions (UNDP, 2005). For example, at the Third International AIDS Society Conference on HIV



Traditional training initiatives, although critically important to scaling up treatment access, are not enough to remedy the acute global shortage and maldistribution of health-care workers.

Pathogenesis and Treatment in Rio de Janeiro, Brazil, in July 2005, experts studied examples of private companies that have successfully extended AIDS treatment beyond the workplace to surrounding communities in several countries (Beckmann et al., 2005).

In the absence of sufficient numbers of trained health-care providers, countries should maximize use of existing community health workers, medical assistants and other community-based resources to facilitate scaling up treatment access. Cooperation between low- and middle-income countries—such as in the form of medical brigades to support and train mid-level workers—can help stretch health-care resources further, especially when combined with careful examination of optimal roles and responsibilities of physicians, nurses and other staff (UNDP, 2005). Such task shifting is promoted by WHO in the Integrated Management of Adolescent and Adult Illness approach (WHO, 2006b).

IMPROVING SUPPLY MANAGEMENT

Once a person begins antiretroviral therapy, the drugs must be taken regularly for the rest of her or his life. Yet in many places, delays in procurement and disbursement of antiretroviral drugs frequently lead to interruptions of therapy and waiting lists for HIV treatment. National AIDS programmes and individual treatment centres need the capacity to gauge future demand for antiretroviral drugs and to implement reliable procurement, delivery and supply systems to avert stock shortages.

The Dominican Republic, for example, has occasionally experienced acute shortages of first-line medications, reportedly prompting some physicians to smuggle

antiretrovirals into the country to avoid potentially serious treatment interruptions. Treatment centres in Nigeria in 2005 similarly reported antiretrovirals being out of stock for up to two months. Slow disbursement of funds was one of the factors cited by the Global Fund in its finding of non-performance on the country's Round 1 grant for expanding treatment access.

The need to increase countries' ability to manage supplies of medications and effective health service delivery is an important focus of the "Three Ones" principles (see 'Building national capacity' chapter) and one that is supported increasingly by donors, multilateral agencies and international nongovernmental organizations. Many different approaches are being tried, responding to the specific conditions in each country. Following an assessment of the country's procurement supply management system by WHO and UNICEF, Cambodia is in the process of replacing its fragmented process for purchasing and managing treatment supplies with a unified national system that includes a national drug inventory database. Burkina Faso is attempting to overcome bureaucratic delays by setting up a stand-alone, not-for-profit agency to ensure a steady supply of affordable drugs and diagnostics as it scales up treatment access. At an international level, the World Bank's Implementation Acceleration Team works with governments to improve activities such as planning, financial management and expenditure tracking (World Bank, 2005).

PROMOTING TREATMENT ADHERENCE

Sustaining effectiveness of antiretroviral therapies over time requires minimizing the risk of the virus becoming resistant to the drugs used to treat the infection.

Resistant strains of HIV can be transmitted to others, potentially foreclosing or impeding the effectiveness of future treatment options for individuals who are newly infected. Efforts to control tuberculosis, malaria and respiratory infections have each been impeded by the growth over time of resistance to first-line therapies, underscoring the potential long-term danger of drug resistance to the global HIV response (Norrby et al., 2005; Okere et al., 2005; Bates et al., 2004).

To prevent or significantly delay the emergence of drug resistance, it is critical that patients follow antiretroviral regimens exactly as prescribed. Adherence of 90% or greater is required to suppress viral activity and minimize drug resistance over time (Paterson et al., 2000). Discontinuation or interruption of therapy is even more dangerous than periodic non-adherence (Lucas, 2005).

Although rates of adherence to antiretroviral therapy recorded to date are at least as high in resource-limited settings as in high-income countries, studies nevertheless indicate that rates of adherence may be insufficient to prevent the emergence of drug resistance. Among patients

surveyed over 12 months in a public clinic in Belo Horizonte, Brazil, nearly 40% were non-adherent (Bonolo et al., 2005). One factor affecting adherence is the complexity of the medication regimen: patients are less likely to take their medications consistently when the medication regimen is complicated, e.g. with a large number of pills to be taken at different times of the day (Osterberg and Balsche, 2005). WHO has always promoted fixed-dose combinations and urged manufacturers to produce such products. Several fixed dose-combinations of antiretrovirals based on WHO's simple five-drug, first-line formulary are available, either from the research and development or generics industry, and either have regulatory approval or have been prequalified by WHO.

As a component of the "3 by 5" initiative, WHO and a large number of partners have created a network called HIVResNet dedicated to standardized global surveillance and monitoring of HIV drug resistance, and is assembling a global network of laboratories to perform surveillance using a standardized protocol. A country-specific package to monitor HIV drug resistance in patients will be



To prevent or significantly delay the emergence of drug resistance, it is critical that patients follow antiretroviral regimens exactly as prescribed.

"IT'S TIME FOR YOUR MEDICATION..."

Experience all over the world shows that family members and social or work peers are often the most effective in supporting adherence. In ground-breaking antiretroviral therapy projects in Haiti and South Africa, the use of peer support has been cited as an important factor in the strong rates of patient adherence and treatment success. With more and more workplace-based treatment programmes emerging, HIV-positive peer educators are becoming ever more important as positive role models and examples of successful treatment. To promote treatment adherence in its company-sponsored antiretroviral programme in South Africa, the mining company Anglo American recruits treatment supporters from among its workers who are HIV-positive, supporting their fellow workers who are taking antiretrovirals (UNAIDS, 2005a).

used to adjust treatment guidelines and programming.

INTEGRATING HIV CARE WITH OTHER HEALTH SERVICES

By integrating HIV care with systems designed to address other health problems, countries can increase uptake of antiretroviral therapy and deliver more comprehensive, higher-quality care. In many countries, for example, HIV and tuberculosis are managed by two separate vertical care systems that interact little with each other. Moreover, HIV clinicians often have little experience or expertise in treating tuberculosis, and vice versa. Without close care coordination for both HIV and tuberculosis, clinicians may fail to intervene to avert or address potential drug interactions, side-effects of medications, and infections sometimes associated with reconstitution of the immune system (Karim et al., 2004).

As an example of what can be done, Malawi has worked with national, bilateral, international and nongovernmental organization partners to link its HIV and tuberculosis care systems in the country's National Antiretroviral Treatment Scale-up Plan. The Global Fund represents an

ideal vehicle to promote integration of HIV and tuberculosis care and treatment.

Programmes to prevent mother-to-child transmission of HIV and reproductive and sexual health services also provide opportunities for integration or improved coordination. In Latin America and the Caribbean, for example, the International Planned Parenthood Federation supports HIV testing and referral services in reproductive health settings in Barbados, Brazil, Colombia, El Salvador, Guatemala and Nicaragua. The International HIV/AIDS Alliance and other organizations are supporting country-level programmes to enhance the integration of HIV programming in sexual and reproductive health services, and the Global Coalition on Women and AIDS is advocating for such integration to be a core component of national AIDS programmes.

PATIENT MONITORING

Over the next few years, most patients in low- and medium-income countries will continue to be monitored clinically because of limited access to immunological (CD4+ T-cell count) monitoring and laboratory facilities. To support health

TREATMENT IN CONFLICT SETTINGS

Conflict often results in broad-based population displacement, disrupting health-care services and exposing individuals to severe health risks. However, each situation is context specific and must be examined individually (Spiegel and Qassim, 2003; Spiegel and Haroff-Tavel, 2005). Although special challenges arise to ensure proper adherence to therapy in such conditions, more and more evidence shows that people affected by conflict are able to receive and adhere to antiretroviral therapy (Ellman et al., 2005).

The Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings—a broad-based alliance of UN agencies, nongovernmental agencies and other stakeholders committed to swift, effective and coordinated action to address the needs of people affected by conflicts and other emergencies—has developed *Guidelines for HIV/AIDS Interventions in Emergency Settings* (IASC 2004). These guidelines, which are now used by various partners in different emergency contexts, provide a common practical reference framework for use in emergency situations (UNHCR, 2006). Timely provision of care and treatment is a core priority of the guidelines—an emphasis that is also reflected in UNHCR's HIV/AIDS strategy for 2005–2007, which calls for efforts to ensure the access of refugees and other displaced individuals to antiretrovirals when such therapies are available in the surrounding population (UNHCR, 2005).

systems in this regard, WHO has recently revised its clinical and immunological staging guidelines for adults and for children (WHO, 2006a). The new adult and paediatric treatment guidelines, and the revised guidelines for preventing mother-to-child transmission of HIV, both promote much

wider roll-out and availability of technologies for testing CD4+ T-cell counts. However, they also recognize that clinical decisions can still be made without access to CD4+ T-cell counts regarding when to start treatment, when to substitute antiretroviral drugs as a result of toxicity and



Programmatic interventions designed to meet the treatment needs of children and women should be specifically examined and incorporated into national responses, along with those of vulnerable populations such as refugees, displaced people and populations at highest risk.

As the AIDS epidemic's burden on women and girls increases, there is a growing need to ensure that women benefit from equitable access to antiretroviral drugs and other HIV-related treatments.



07

when to switch regimens because of treatment failure.

Many donors and international agencies are now prioritizing initiatives to expand access to critical laboratory services and equipment. In 2004, the Clinton Foundation brokered an agreement with five companies to sharply lower prices for tests for CD4+ T-cell counts and viral load in low- and middle-income countries. In the Caribbean region, the World Bank is providing financial assistance to the Pan Caribbean Partnership Against HIV/AIDS to enhance regional laboratory capacity to support scaling up treatment access. A US\$59 million World Bank loan to Nigeria is supporting development of national diagnostic capacity. However, obtaining servicing and spare parts for diagnostic equipment remains a problem in many resource-limited settings, which will require considerable effort to overcome.

Ensuring equity as access to treatment expands

In most countries, the most vulnerable and least well-off populations (frequently one and the same) have less access to HIV-

related treatment than those that are wealthier or live in wealthier communities. To ensure equitable access to treatment as scaling up proceeds, WHO and the UNAIDS Secretariat recommend that countries take action in several areas. These include establishing a broadly representative ethics advisory body (in line with the structures set up under the “Three Ones” principles), carry out a public dialogue on equitable access to HIV treatment and care, and develop and enforce policies and evaluation systems specifically designed to promote equity (WHO/UNAIDS, 2004). In addition, programmatic interventions designed to meet the treatment needs of children and women should be specifically examined and incorporated into national responses, along with those of vulnerable populations such as refugees, displaced people and populations at highest risk (see ‘At risk’ chapter).

THE TREATMENT NEEDS OF CHILDREN

With over 600 000 children contracting HIV infection each year, mostly through mother-to-child transmission, access to affordable HIV diagnostics and treatment represents an urgent global health priority. In 2005, UNAIDS and UNICEF issued a global call to action

UNCERTAINTY OVER INTELLECTUAL PROPERTY

The cost of medications has always been an issue in the response to HIV. Many of the drugs used in antiretroviral therapy are covered by patents and intellectual property laws that can limit their use or maintain their price at levels too high for widespread use in low-income countries. The development of generic antiretroviral drugs, as well as the willingness of the international pharmaceutical industry to reduce prices in low-income countries, have been key advances in increasing access to treatment.

Over the past two years, the global community has taken new steps to increase access to affordable antiretroviral therapies. In December 2005, the WTO amended its intellectual property rules to make permanent a temporary waiver permitting countries that lack a strong pharmaceutical industry to import generic medications for HIV and other high-priority communicable diseases. In 2004–2005, UNDP and other partners assisted 36 African countries to make best use of the flexibilities and safeguards available for accessing essential medications under the WTO's agreement on Trade-Related Aspects of Intellectual Property Rights.

Uncertainty about the continued viability of existing sources of generic medications nevertheless clouds future prospects for sustainable access to needed antiretrovirals. In particular, it is unclear whether countries will have secure access to affordable second-line therapies, in line with WHO recommendations for long-term treatment efficacy. Treatment options after second-line therapy are not yet identified and it remains uncertain how many countries will seek to provide such therapy through the public health systems.

In 2005, India revised its patent laws to comply with WTO's rules, potentially preventing the country's generic pharmaceutical industry from manufacturing generic equivalents for drugs patented after 1996. Historically, India has served as a pivotal source of generic antiretrovirals, which have contributed to the price reductions that have made treatment access feasible in resource-limited settings. While national treatment programmes may continue to have access to affordably priced zidovudine and other first-generation antiretrovirals—in part because the patents for such medications will soon begin to expire—the revised laws may prevent countries from looking to India for affordable generic equivalents of second-line antiretrovirals (Havlir and Hammer, 2005).

that challenges the world to ensure that antiretroviral therapy and prophylaxis with the antibiotic cotrimoxazole (see below) reach 80% of children in need by 2010 (UNICEF and UNAIDS, 2005).

Accurate diagnosis of HIV infection in children can be difficult in resource-

limited settings. Because of the persistence of maternal antibodies up to 18 months after birth, highly sensitive tests such as polymerase chain reaction or viral load testing are typically needed to render a definitive diagnosis in infants. While such tests have long been regarded as not feasible in low-resource settings because of their high cost and the difficulty of

collecting blood from newborn infants, more recent technical developments using dried blood spots show promise, enabling earlier diagnosis and avoiding the need to take blood from a vein.

Formulations of antiretrovirals suitable for use in children remain rare and tend to be more expensive than adult regimens. Most paediatric antiretroviral formulations are syrups that taste unpleasant to many children, potentially complicating adherence. Some must be diluted with drinking water or refrigerated, which may be impractical in certain settings. In many places, dosages of adult medications are simply reduced for children, risking undertreatment (which can lead to drug resistance) or overtreatment (which can produce side-effects because of the drugs' toxicity). Recently, some manufacturers have piloted the production of mini-pills, which are particularly suitable for young children. However, all new products need to be properly tested, prequalified and licensed for use, and this takes time.

Access to cotrimoxazole is critical, especially in settings where antiretrovirals are not yet accessible. The antibiotic, which provides protection against life-threatening opportunistic infections and can delay the need to initiate antiretroviral therapy, has been shown to reduce the risk of death in children living with HIV by more than 40% (Chintu et al., 2004). However, even though cotrimoxazole costs as little as US\$ 0.03 a day, an estimated four million children who need the drug are currently unable to obtain it (WHO and UNAIDS, 2005).

Side-effects associated with antiretroviral therapy can sometimes be more severe in children than in adults (McComsey and Leonard, 2004). It can also be difficult to

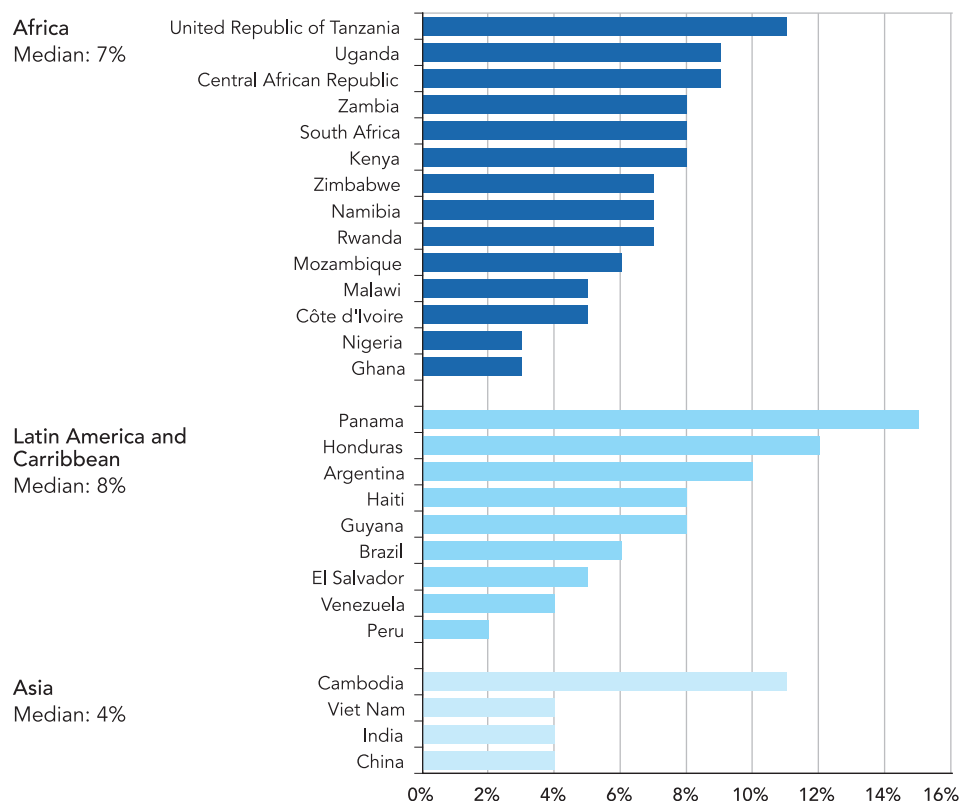
distinguish in children between the complications of HIV disease itself and toxicities or side-effects associated with the drugs used to manage HIV. Many HIV-infected children also suffer from tuberculosis or malnutrition, further complicating medical management (WHO, 2006a).

Because HIV-positive children are vulnerable to severe infections, timely and proper immunization is especially important. Routine vaccines are generally safe to administer to HIV-infected children, but additional research is needed to find ways to ensure the effectiveness of routine immunization in children living with HIV and to enable clinicians to make more informed treatment decisions (Obaro et al., 2004).

Figure 7.3 provides data from three regions of the world, showing children as a percentage of the total number of people receiving antiretroviral therapy. In sub-Saharan Africa about 7% of all people being treated are children. In Latin America and the Caribbean, the median value of nine countries is 8%, while in Asia it is about 4%.

MONITORING WOMEN'S ACCESS TO TREATMENT

As the AIDS epidemic's burden on women and girls increases (see 'Overview' chapter), there is a growing need to ensure that women benefit from equitable access to antiretroviral drugs and other HIV-related treatments. To that end, treatment programmes should be designed to address the many obstacles that women and girls face in accessing health care, and include efforts to reduce violence against women, lower the costs of treatment, shorten waiting times, provide appropriate

FIGURE 7.3 Percentage of people on treatment who are children, by country, 2005

Source: WHO/UNAIDS (2005). Progress on global access to HIV antiretroviral therapy: An update on "3 by 5."

appointment schedules and sufficient female health workers, address stigma and discrimination, and guarantee privacy and confidentiality.

Inequalities are well documented in some areas of AIDS care. In Kenya, for example, HIV-positive men in 2002–2004 were twice as likely to be admitted to hospital as women living with HIV, and women paid 65% more per visit than men (UNAIDS Global Resource Tracking Consortium, 2004).

Fortunately, as access to antiretroviral therapies has expanded in recent years, it appears that the world has thus far

avoided significant gender inequities in the use of antiretroviral drugs. In June 2005, UNAIDS and WHO reported that data from low- and middle-income countries on the use of antiretroviral drugs failed to detect notable gender inequities (WHO and UNAIDS, 2005). Moreover, the continued expansion of programmes to prevent mother-to-child transmission of HIV—particularly the Prevention of Mother-to-Child Transmission-Plus approach, which includes comprehensive care for the mother—has provided another avenue for an increasing number of women to be tested and start receiving (or be referred for) antiretroviral therapy. However, entry points for non-pregnant

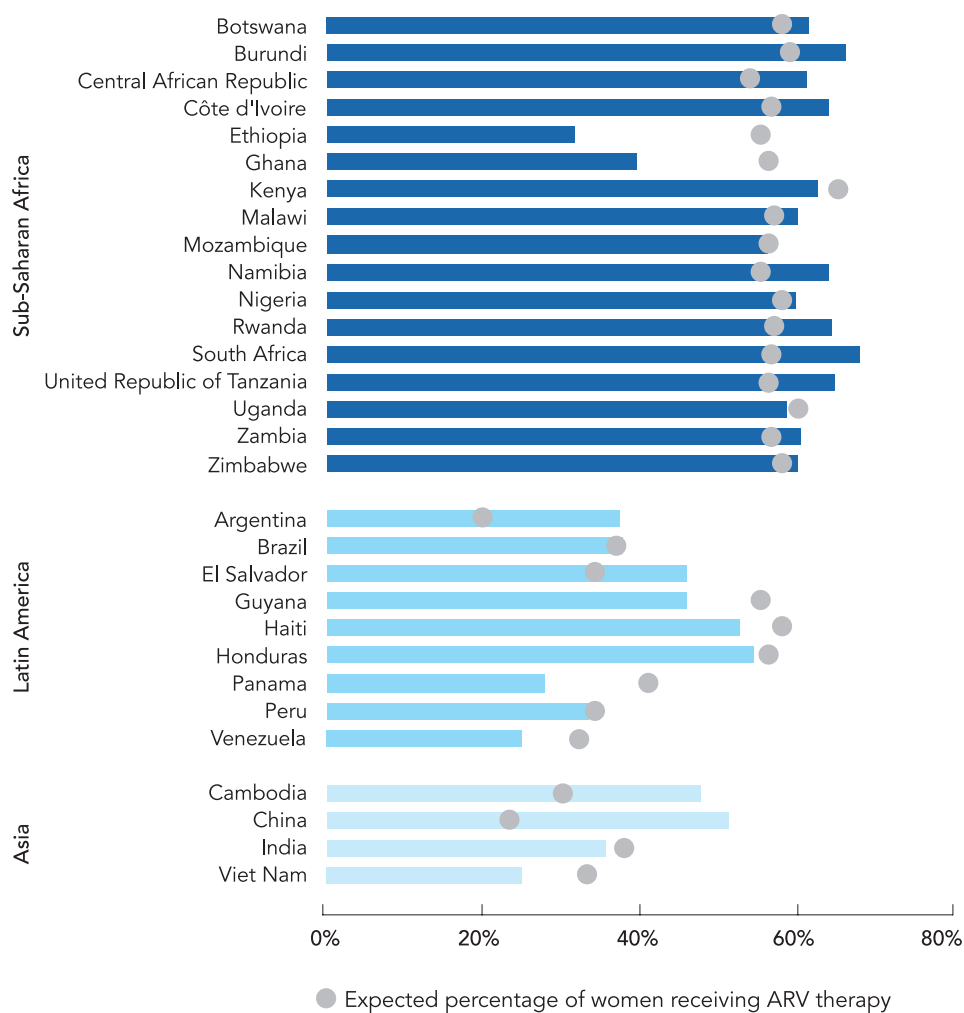
women and girls to HIV testing, counseling and treatment need to be more readily accessible.

Figure 7.4 provides data from 30 countries, showing women as the percentage of adults receiving antiretroviral therapy, compared with their expected percentage. The expected percentage varies according to the type of epidemic: more women would be expected to

receive treatment in a generalized epidemic than in one concentrated among injecting drug users (who are more likely to be male). Data from Ethiopia and Ghana, which both have generalized epidemics, show a possible male bias, with the percentage of women on antiretroviral therapy being far less than 50%. In Burundi, Cambodia, China, Panama and South Africa, the reverse is seen, with women

FIGURE 7.4

Women as a percentage of all adults receiving antiretroviral therapy in 30 countries: actual versus expected percentages, 2005^a



^aThe expected percentage of women receiving ARV therapy is based on the percentage of people living with HIV/AIDS who are women.

Source: WHO/UNAIDS (2006). Progress on global access to HIV antiretroviral therapy. A report on "3 by 5" and beyond.

figuring as a higher than expected proportion of adults on treatment. There are currently few data available to explain exactly why such differences between countries occur.

Using expanded treatment access to strengthen HIV prevention

Expanded access to treatment will inevitably have an important impact on HIV prevention efforts. Most notably, providing antiretroviral drugs to pregnant women for their own health needs substantially reduces the risk of transmission during birth or as a result of breastfeeding. Because the risk of sexual transmission is closely associated with viral load (Quinn et al., 2000), reducing a person's viral load through antiretroviral therapy could reduce the likelihood that he or she will transmit the virus to someone else. A recent study in Uganda calculated that the risk of sexual HIV transmission in HIV serodiscordant couples fell by 98% when the HIV-infected partner was receiving antiretroviral therapy (Bunnell et al., 2006).

It is widely hoped that enhanced treatment access will buttress HIV prevention efforts by increasing incentives for voluntary testing, reducing HIV-related stigma,

and providing clinicians with new opportunities for service delivery and reinforcing prevention messages in clinical settings (Global HIV Prevention Working Group, 2004). However, there are also concerns that broader access to treatment could potentially complicate prevention efforts by lengthening the period of infectiousness, contributing to drug resistance and increasing risk behaviours by making HIV infection appear less threatening (Over et al., 2004). Surveys of HIV-infected men who have sex with men in Sao Paulo, Brazil, found that those who were most optimistic about HIV treatments were more likely to have had unprotected anal intercourse with regular or casual partners in the previous six months (da Silva et al., 2005). This apparent dynamic tension between sexual risk behaviour and increased treatment access may require new prevention strategies to be devised (Gayle and Lange, 2004).

To capitalize on treatment's beneficial effects on HIV prevention and to avert an increase in sexual risk behaviour, the Global HIV Prevention Working Group urges a simultaneous scaling up of treatment access and prevention programmes. Efforts to model the future course of the AIDS epidemic consistently demonstrate that a response that combines expanding

IMPROVING THE COLLECTION OF GENDER-DISAGGREGATED DATA

To ensure that women have equal access to antiretroviral therapy, accurate data must be collected on the sex of individuals receiving antiretroviral therapy. The International Community of Women Living with HIV and other members of the Global Coalition on Women and AIDS have actively advocated for incorporation of gender equity mandates in AIDS funding mechanisms. The President's Emergency Plan for AIDS Relief is the first major treatment initiative to collect gender data as part of its performance indicators.

Adequate nutrition is also necessary to ensure optimal benefits from the use of antiretroviral therapy, which is essential to prolong the lives of HIV-infected people and prevent transmission of HIV from mother to child.



prevention and treatment access will have a far greater impact on the epidemic than a response that prioritizes one over the other (Salomon et al., 2005; Over et al., 2004).

Making care and treatment comprehensive

With the understandable excitement about the benefits of antiretroviral therapy, it is sometimes forgotten that antiretroviral therapy is only one component of comprehensive treatment and care for people living with HIV. Even when on antiretrovirals, people have a host of other needs, such as proper food and nutrition, prevention and treatment of opportunistic infections, and psychosocial support. For this reason, efforts to scale up care and treatment access must aim to be comprehensive. If properly planned and funded, for example, provision of comprehensive care and treatment will also reinforce efforts to diagnose and treat other conditions relevant to AIDS, such as tuberculosis and malaria. This will not only improve patient outcomes but

accelerate progress against a broad range of public health threats.

FOOD AND NUTRITION

Adequate nutrition cannot cure HIV infection but is essential to maintain a person's immune system, to sustain healthy levels of physical activity and for optimal quality of life (WHO, 2005). Adequate nutrition is also necessary to ensure optimal benefits from the use of antiretroviral therapy, which is essential to prolong the lives of HIV-infected people and prevent transmission of HIV from mother to child. The WFP provides food as part of a comprehensive antiretroviral therapy package in 17 countries in Africa.

WHO's resolution on Nutrition and HIV/AIDS, which was adopted at the 117th session of the Executive Board in January 2006, urges Member States to make nutrition an integral part of their response to HIV by identifying nutrition interventions for immediate integration into HIV and AIDS programming. This includes strengthening political commitment to nutrition and HIV as part of countries' health agenda and reinforcing

nutrition components in HIV and AIDS policies and programmes, and incorporating HIV and AIDS issues in national nutrition policies and programmes.

To date, however, nutrition interventions have not been widely integrated into national treatment plans. At the Harriet Shezi Clinic of Chris Hani Baragwanath

Hospital in South Africa, for example, only 6% of children on antiretroviral drugs have access to nutritional support, such as fortified maize meal and milk formula, and there are insufficient staff to advise patients on nutritional issues. UNAIDS Cosponsors such as UNICEF, WFP and WHO work closely to ensure the integration of food and nutrition in expansion of treatment

FOOD AND TREATMENT FOR THE VERY POOR

The WFP has been a strong advocate for greater attention to the role of food and nutrition in HIV treatment and care, working closely with WHO in the "3 by 5" initiative. In 2005, WFP provided food and nutrition through a variety of programmes to nine million HIV-positive individuals and others affected by HIV and AIDS in Africa, Asia and Latin America.

With growing recognition of the importance of food and nutritional support as part of comprehensive care for people living with HIV, the WFP now provides food support alongside antiretroviral therapy in 17 African countries. In many cases, activities are still in the pilot stages, and have typically been implemented for less than two years. It is hoped that testing different approaches to the provision of food and nutritional support to those in treatment, along with rigorous evaluation, will lead to the development of a model that can be scaled up. To date, WFP's pilot programmes have led to some innovative approaches.

In Malawi, WFP works with the international nongovernmental organization Action Against Hunger to provide severely malnourished patients with a daily ration of a high-protein, high-energy peanut paste, developed in France in the late 1990s. The ready-to-use paste is highly effective for rehabilitation of severely malnourished children. For patients with less severe forms of malnutrition, an individual food basket of corn soya blend and vegetable oil is provided. Body mass index and HIV staging are used to determine eligibility for food assistance. Outcomes such as weight gain and recovery time are closely monitored in order to document results.

While the approach being piloted in Malawi is focused on individualized care, many countries have found that a significant proportion of those seeking antiretroviral therapy are affected by food insecurity at the household level, often the result of prolonged sickness of the household's main wage earner. Such vulnerability presents a real challenge for service providers. Lack of both income and food security makes it difficult for families to prioritize seeking care over seeking food, which means that food provided for the sick individual is likely to be shared with family members, diluting the intended benefits. To help address this problem, many countries provide a protection ration in addition to an individual ration, to minimize dilution at the household level. Health workers in Mozambique and Zambia have also developed food security checklists, which are used by health-care providers or community household workers to help identify households that are most likely to benefit from food assistance.

HIV-related immune suppression increases vulnerability to a host of potentially life-threatening opportunistic illnesses, including respiratory ailments, certain bacterial and fungal infections and neurological disorders.



access, both as a treatment intervention and as a means of mitigating AIDS effects on individuals and communities (see ‘Reducing the impact’ chapter). Organizations providing services to refugees and displaced people have found that food and nutrition programmes can also be vehicles for providing HIV prevention education. UNHCR and WFP have together developed 20 programme strategies which integrate HIV-related activities with food and nutrition support in refugee settings. These have been implemented in refugee camps in Uganda and Zambia (UNHCR/WFP, 2004).

TUBERCULOSIS

As tuberculosis is a leading cause of AIDS-related death, accurate diagnosis, prevention and treatment of tuberculosis are of overriding importance (see ‘The impact of AIDS’ chapter). There are a number of barriers to timely diagnosis and treatment of tuberculosis that must be overcome. For example, since rapid diagnostic tests routinely used in high-income countries are often unavailable in low- and middle-income countries, a substantial percentage of people with tuberculosis have to wait for several weeks before being diagnosed with the

disease, threatening their own health and those living around them.

Patients who are HIV-positive and diagnosed with latent tuberculosis infection need preventive therapy to prevent development of potentially life-threatening active tuberculosis. It is important, however, to exclude active tuberculosis when isoniazid is to be used to prevent tuberculosis and this presents significant operational challenges. Preventive therapy coverage is very poor, with only 1% of HIV-infected adults covered worldwide, with virtually no coverage in sub-Saharan Africa (USAID et al., 2003).

There is also an urgent need for simpler, better drug regimens for the treatment of tuberculosis. Growing resistance to available tuberculosis drugs increases the cost and complexity of tuberculosis control and underscores the need for new drugs. In Botswana, the prevalence of resistance to at least one tuberculosis drug among individuals undergoing anonymous HIV testing increased from 3.7% in 1995 to 10.4% in 2002 (Nelson et al., 2005). Simpler, shorter regimens of tuberculosis drugs would increase treatment completion rates and reduce the emergence of

resistance. Leading global efforts to generate new drugs to treat tuberculosis, the Global Alliance for TB Drug Development is a public–private alliance that has built the most comprehensive pipeline of investigational tuberculosis drugs since the 1960s, with the aim of ensuring development of at least one new drug in the next decade.

OPPORTUNISTIC INFECTIONS

HIV-related immune suppression increases vulnerability to a host of potentially life-threatening opportunistic illnesses, including respiratory ailments, certain bacterial and fungal infections and neurological disorders (Felkin et al., 2004). HIV infection can also raise the risk of certain cancers, especially among individuals who are coinfecting with human papilloma virus (Sobhani et al., 2004). Up to half of people living with HIV experience oral disease, often early in the course of the HIV infection (Petersen et al., 2005). Antiretroviral therapy significantly reduces the incidence of disabling and potentially life-threatening opportunistic infections.

In the era of antiretroviral drugs, preventing and treating HIV-related opportunistic infections remains a cornerstone of the global response to AIDS. Even in high-income countries where antiretroviral therapy is universally available, opportunistic infections remain a major cause of death in people living with HIV (Bonnett et al., 2005). A substantial portion of patients fail on antiretroviral therapy, typically because they are not fully adherent to prescribed regimens or had pre-existing resistance to one or more antiretroviral medications. For such individuals—and for the majority of the world’s HIV-positive people who currently lack access to antiretroviral

therapy—medications for opportunistic infections can mean the difference between life and death.

Because many opportunistic infections such as tuberculosis, malaria, bacterial pneumonia, bacterial enteritis or diarrhoea are caused by infectious agents that have long been common in the community, treatments for such conditions should be readily available. Others, such as the protozoal disease *Pneumocystis carinii* pneumonia, can be prevented and treated with widely available antibiotics, such as cotrimoxazole. However, some opportunistic diseases—such as cryptococcal infections, disseminated herpes simplex infections and infections caused by cytomegalovirus and hepatitis C virus, toxoplasmosis and Kaposi sarcoma—require complex and expensive medications that are not available or affordable in many settings.

In fact, only a small fraction of people living with HIV have reliable access to proven prophylaxis or treatments for opportunistic infections. Globally, only 4% of HIV-infected adults and 1% of children living with HIV were able to obtain cotrimoxazole, an inexpensive medication that prevents *Pneumocystis carinii* pneumonia and other bacterial infections. Several studies have shown the benefits of this antibiotic in different settings and situations, but unfortunately very few centres or programmes globally are promoting this simple pre-antiretroviral therapy intervention with much enthusiasm. The low level of coverage is especially worrying for infants who are born to HIV-positive mothers and identified as HIV-exposed by programmes for the prevention of mother-to-child HIV transmission. Newly revised WHO guidelines emphasize the need to implement this simple

HIV COINFECTION WITH HEPATITIS B AND C

Because unscreened blood transfusions and injecting drug use are principal modes of transmission for both HIV and hepatitis B or C virus, many HIV-positive people are coinfecting with hepatitis B and hepatitis C viruses. In the United States and Europe, an estimated 30% of HIV-infected individuals are also infected with hepatitis C virus (Kontorinis, Agarwal and Dieterich, 2005), including as many as 90% of people who contracted HIV as a result of injecting drug use (CDC, 2003). Even in Kenya, where injecting drug use is much less prevalent than in some other parts of the world, nearly one in 25 patients surveyed at a major AIDS clinic were coinfecting with hepatitis C (Karuru et al., 2005). HIV infection may accelerate the progression of hepatitis C, increasing the risk of life-threatening liver disease (Bonacini et al., 2004).

Two antiretrovirals effective against HIV are also effective against hepatitis B virus, and antiretroviral therapy may provide indirect benefits for patients with chronic hepatitis B infection. Although effective treatments exist for both newly acquired and chronic hepatitis C infection, the regimen is costly (an average of US\$ 25 000 for a 48-week regimen) and often unavailable in low- and middle-income countries. The timing of therapy for hepatitis C infection may also be affected by the presence of HIV infection, as clinicians advise that immune restoration following antiretroviral therapy for HIV should precede initiation of antiviral treatment for hepatitis C infection (Cooper, 2005). To ensure that injecting drug users fully benefit from antiretroviral therapies, national guidelines should provide clear guidance on antiretrovirals for individuals who are coinfecting with HIV and hepatitis B or C virus.

intervention much more widely, and also consider at what stage to discontinue cotrimoxazole administration for children or adults who have started antiretroviral therapy (WHO, 2006b).

Some of the leading treatments for opportunistic infections are currently unaffordable for many national public health systems. In the Dominican Republic, for example, some of more expensive medications used to treat common opportunistic infections—such as fluconazole, amphotericin B, aciclovir and ganciclovir—are available only for direct purchase through private pharmacies, an option that is economically untenable for most people living with HIV (International Treatment Preparedness Coalition, 2005). However, progress has been made

on a number of fronts. For example, Pfizer has made fluconazole available free of charge or highly discounted through its corporate donation programme, while in South Africa, lobbying by activists persuaded Bristol-Myers Squibb, maker of amphotericin B, to sharply reduce the drug's price in 2005 (Bicanic et al., 2005).

MITIGATING AND MANAGING SIDE-EFFECTS

While antiretroviral drugs are highly effective in slowing HIV disease progression, they can cause important side-effects in some individuals, some of which can be life-threatening. Side-effects include severe skin reactions, hepatitis, anaemia and cardiovascular disease. Some chronic side-effects can be debilitating (e.g. chronic gastrointestinal intolerance) or

cause long-term changes in body appearance (e.g. lipodystrophy and lipoatrophy). The range and severity of side-effects may vary according to the nutritional status or other characteristics of different patient populations. Medical management of patients on antiretrovirals must also take account of potential drug–drug interactions—most notably between tuberculosis medications (especially rifampicin) and several classes of antiretrovirals, and also with long-term hepatitis C therapy. As access to treatment continues to expand, experience gained is shedding light on patient safety issues in resource-limited settings, providing information useful to WHO’s regular review of treatment guidelines and recommendations for optimal first- and second-line treatment regimens.

PSYCHOSOCIAL SUPPORT

Most countries allocate less than 1% of national health budgets to mental health, and there are proportionally very few mental health professionals in low- and middle-income countries, compared with industrialized countries. This is an obstacle to comprehensive care and treatment, as HIV infection can result in mental and neurological impairment, and a substantial

number of people living with HIV have underlying cognitive and substance abuse disorders (McArthur et al., 2005). Untreated mental illness not only reduces the quality of life for HIV-affected individuals and households, but poor mental health is strongly associated with non-adherence to treatment regimens (Singh et al., 1999; Gordillo et al., 1999). To date, planning for HIV care and treatment has often failed to take into account the need to integrate strong mental health and psychosocial support interventions (Baingana et al., 2004).

Antiretroviral therapy is probably the single most effective intervention for HIV-related mental disorders, reducing the incidence of dementia and improving cognitive and behavioural functions. However, it may not address underlying depression and other mental health problems that are not associated with HIV infection itself (Siegel et al., 2004). Initiatives to expand antiretroviral access should be accompanied by enhanced capacity to recognize mental illness, integration of psychosocial services in treatment programmes and increased access to psychotropic medications (Baingana et al., 2004).



Typically, the intensive and diverse needs of individuals living with HIV outstrip the capacity of community-based support resources, and the stigma associated with HIV and AIDS discourages affected households from accessing palliative services that might be available.

PALLIATIVE CARE

Even with the best of treatments for HIV, palliative care for symptom management, control of pain and end-of-life care remain an important component of a comprehensive care package for people living with HIV. WHO has produced Integrated Management of Adolescent and Adult Illness guidelines for palliative care (WHO, 2006b), but there are few other manuals, protocols and systems for controlling pain and managing terminal care in resource-limited settings.

Recently, an analytical review of 26 palliative-care service organizations in sub-Saharan Africa found that hospital-based palliative care is virtually non-existent in the region because of its high costs and the low priority it is accorded in health systems. Although home care has long been proven to be an excellent source of palliative support for people living with HIV, access to such care is low, especially in rural areas. Typically, the intensive and diverse needs of individuals living with HIV outstrip the capacity of community-based support resources, and the stigma associated with HIV and AIDS discourages affected households from accessing palliative services that might be available. Greater commitment is urgently needed to integrate palliative care into comprehensive patient management and to develop simplified protocols for delivery of palliative care by clinical and lay staff (Harding and Higginson, 2005).

Research is vital

A key pillar of the “3 by 5” initiative was the identification and rapid application of new knowledge. The initiative placed particular emphasis on learning by doing,

according high priority to continuing evaluation and analysis of programme performance and focused operational research.

Working with the UNAIDS Secretariat and other partners, WHO has developed patient monitoring guidelines for HIV care and antiretroviral therapy to assist primary health-care facilities to collect follow-up data on adults and children. Patient records and facility registers generate data that can be useful for evaluation efforts. WHO has supported four countries in the development of operational research agendas linked with scaling up access to treatment and bilateral donors are also investing significant resources in targeted programme evaluations.

There is currently notable variation in guidelines regarding initiation of antiretroviral therapy, with no randomized trial having been undertaken to date to clarify the optimal timing for such therapy (Wood et al., 2005). Unanswered questions include the long-term clinical benefit, if any, of antiretroviral therapy during primary infection. Additional research is needed to provide clinicians and patients with a stronger basis on which to make important treatment decisions.

Further research is also needed on the prevention and treatment of opportunistic infections. For example, while antiretroviral therapy moderates the incidence and severity of HIV-related dementia, the prevalence of neurological disease among people living with HIV in areas with long-standing access to antiretrovirals has actually increased. This underscores the need for new therapeutic strategies that act directly on the central nervous system (Perry et al., 2005).

Chapter 08



REDUCING THE IMPACT OF AIDS

Mitigation activities aim to repair or reduce the damage done by the AIDS epidemic to individuals, their families and communities, institutions, and in some cases to economies and social systems.

Like the wider response to AIDS, efforts to mitigate its impact must reinforce other health and development initiatives, notably the Millennium Development Goals of eradicating extreme poverty, reducing the burden of disease, achieving universal primary education, ensuring gender equality, protecting the environment, and developing a global partnership for development. The links between ill-health and poverty are well known and provide a powerful argument for placing responses to AIDS at the centre of the international development agenda (WHO, 2001).

The growing focus on AIDS by development agencies and national governments represents an opportunity to reinforce or build health, educational and social services systems in places where these are neglected or under-resourced. Improvements in these areas—for example, better coverage by basic reproductive health services, water and sanitation projects or poverty reduction measures—will in turn help to reduce the impact of AIDS, even

though that is not their primary objective. In countries that are beset by a variety of challenges in addition to AIDS, such indirect approaches are a necessary complement to the direct provision of HIV-focused prevention, care and treatment programmes (Sengwana and Quinlan, 2004). An important component of mitigation in countries with generalized epidemics is the protection and strengthening of human capacity, as illness removes skilled personnel from the workforce, and deprives both the state and private sector of their knowledge and experience (UNDP, 2005).

Like prevention and care initiatives, AIDS mitigation programming should be ‘mainstreamed’ into development processes at a variety of levels (see ‘National responses’ chapter). This includes international and national development instruments, such as the United Nations Development Assistance Framework and Poverty Reduction Strategy Papers, but also the civil society work of nongovernmental organizations and

community or faith-based groups at field level.

Since the social and economic impacts of adult deaths from AIDS-related illnesses fall most heavily on poorer households, many of which are headed by women, development programming should include a strong pro-poor and gender-sensitive component (Mather et al., 2004). Civil society has a key role to play in this respect, not least in helping to ensure, through advocacy and political pressure, that efforts are sustainable in the long term and are not disrupted by political cycles.

It is important to stress that AIDS mitigation cannot be seen as an alternative to HIV prevention: it is a vital part of a comprehensive global response to AIDS. In cost-benefit terms, any success in preventing infection today represents huge savings in money and effort in the future.

It is essential that all such efforts be based on human rights. As well as achieving the desired outcomes—stable income and food security, support for orphans and other children made vulnerable by AIDS,

gender equality, etc.—AIDS mitigation programming needs to be built on rights-based processes. That means programming must be participatory, transparent and inclusive of the people affected by the epidemic.

Support for HIV-positive people and their families

The people most directly affected by AIDS are, of course, those living with HIV and their families. Therefore, the first priority in mitigation is to enable the HIV-positive person to stay healthy as long as possible through interventions such as antiretroviral therapy, nutritional assistance and treatment for opportunistic infections. In most low- and middle-income countries, this requires the expansion of health services to increase access to counselling and HIV testing facilities (since most of the world's HIV-positive people are unaware of their status) and to increase access to care and treatment. It should also be remembered that the health of large numbers of HIV-positive people in low- or middle-income countries is undermined by tuberculosis, malaria, sexually transmitted infections



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Countries such as Botswana, Namibia, Malawi, Rwanda and Zimbabwe have created comprehensive national policies for orphans and other children made vulnerable by AIDS while others such as Cambodia, Haiti and Kenya deal with them specifically within their national AIDS strategies.



and a variety of parasitic conditions such as schistosomiasis (also known as bilharziasis). The impact of AIDS can thus be reduced by dealing with these diseases through relatively inexpensive public health interventions such as tuberculosis and malaria control programmes, diagnosis and treatment of sexually transmitted infections and deworming (Stillwaggon, 2005).

Antiretroviral therapy can have a rapid impact not only on the health of someone living with AIDS, but on their social and economic life. A recent study attempted to estimate the economic impact of this treatment in sub-Saharan Africa, focusing on the labour participation of AIDS patients (i.e. people receiving medical care) and of the children and adults living in the patients' homes. The study found that within six months of beginning treatment, the likelihood of the patient participating in the labour force increased by 20% and weekly hours worked increased by 35%. The researchers commented, "Since patient health would continue to decline without treatment, these labour supply responses are underestimates of the

impact of treatment on the treated" (Thirumurthy et al., 2005).

Access to antiretroviral therapy can also provide substantial economic and social benefits for those caring for people living with HIV and their families. Older carers in particular benefit as the health of the person they are caring for improves. Physical care demands may be reduced or eliminated altogether, the carer's emotional stress reduced and their economic well-being improved (HelpAge International, 2005).

Comprehensive programming that includes psychosocial and financial support as well as medical attention is likely to provide the best results in mitigating the impact of AIDS on individuals. In China, a national policy termed the "Four Frees and One Care" takes this into account, offering the following to people living with HIV:

- free antiretroviral drugs to AIDS patients who are rural residents or people with financial difficulties living in urban areas;
- free voluntary counselling and testing;

SECURING LIVELIHOODS FOR ORPHANS AND VULNERABLE CHILDREN

WFP and FAO have initiated an innovative approach to securing the future livelihoods and long-term food security of orphans and children affected by AIDS. Using a combination of traditional and modern agricultural techniques, the Junior Farmer Field and Life Schools (JFFLS) train children from 12–17 years of age (equal numbers of boys and girls) for 12 months, focusing primarily on agricultural practices such as field preparation, harvesting, storage, nutrition and marketing skills. HIV prevention education is woven into the curriculum. Children attend the field schools three times a week and are provided with two meals each day (FAO, 2006). This model has shown such potential that the Ministry of Agriculture in Mozambique has incorporated the approach into their national agriculture plan.

- free drugs to HIV-infected pregnant women to prevent mother-to-child transmission, and free HIV testing of newborn babies;
- free schooling for children orphaned by AIDS; and
- care and economic assistance to the households of people living with HIV and AIDS.

The policy is particularly appropriate in the high-prevalence prefectures of China, where approximately one-third of AIDS patients have late-stage illness and tend to seek treatment only when the symptoms of opportunistic infections become life-threatening. The “Four Frees and One Care” ensure that many can return to a normal life, without the heavy financial burden that HIV-positive people bear in many parts of the world (UNAIDS, 2006).

Protecting income and living standards

Many AIDS-affected families face an urgent need to preserve or recover a means of livelihood, particularly in areas where social ‘safety nets’ are few and widespread poverty prevents extended

families or neighbours from providing sufficient support.

SOCIAL PROTECTION APPROACHES

Expanding social protection and welfare systems has received increasing priority among policy options for mitigating AIDS’ impact, particularly in sub-Saharan Africa (Wilton Park and UNICEF, 2005). Social protection options include a wide range of measures including welfare programmes, child and orphan support, public works to provide employment, state pension systems, destitution allowances and microfinancing. Since people most affected by AIDS are those who are least able to pay for services, specifically pro-poor payment strategies such as payment exemptions and vouchers for people below a certain income threshold may need to be instituted in places where medical services involve user fees (Onwujekwe and Uzochukwu, 2005). Although it is likely that donor resources will be necessary for years to come in the hardest-hit countries, tax-supported or insurance-based financing systems will eventually need to be implemented or expanded in order to make social protection sustainable (Russell, 2004).

Recently, UNICEF commissioned a massive study of social protection interventions aimed at reaching orphans and other children made vulnerable by AIDS in 15 countries of eastern and southern Africa (UNICEF, 2005a). Grouping interventions under the three categories of education, public works and cash transfer systems, the study showed that there are many approaches at work across the region ranging from food subsidy programming in Mozambique to Zambia's cash transfer pilot programme for the poorest 10% of households (the Kalomo District Pilot Social Cash Transfer Scheme). However, their scale is limited and many interventions could be more effective if planned or coordinated with each other.

For example, cash transfer schemes (e.g. foster-care grants, food subsidies and non-contributory pensions) are becoming more widespread as a response to chronic poverty, food insecurity and AIDS in high HIV-prevalence countries of eastern and southern Africa. A variety of schemes have been implemented or piloted, often but not always with support from international donors and nongovernmental organizations. The study found that although relatively few were specifically child-oriented, children did benefit from the spending, both directly and indirectly. Cash transfers were found to bolster other social protection measures relevant to AIDS-affected children including access to health and education, legal protection and psychosocial support (Save the Children, HelpAge International and Institute of Development Studies, 2005).

Similarly, pensions for older people are useful because so many orphans and other children made vulnerable by AIDS are cared for by their grandparents (see

'Impact' chapter). A recent study by the International Labour Organization on the cost of social protection in low-income countries in Africa estimates that a universal, non-contributory pension paid at US\$ 15 per month to individuals over 65 years of age or who have a disability would cost less than 1% of gross domestic product in all seven countries studied (Pal et al., 2005).

MICROFINANCING

Microfinancing arrangements are being used to help protect the income and assets of AIDS-affected households. Many are donor-driven, though some have emerged from local initiatives such as cooperatives. Products and services offered to AIDS-affected households in various countries include specialized financial advice, concessionary or emergency loans, incentives to accumulate savings, burial insurance and education trusts for children (Mathison, 2005; CGAP, 2003).

Microfinance is generally most useful to households before the impact of AIDS becomes severe, while people are still well enough to save money and to use loans for productive activities. They are also useful later on for supporting productive activities by family members who remain healthy (Murray, 2005). In Thailand, since 2002, an innovative approach called the Positive Partner Project, which receives funding and technical support from the country's Community Development Association, has successfully paired HIV-positive and HIV-negative people in income-producing partnerships. The partnerships can obtain loans of up to US\$ 600, which have been used to provide income and employment in activities such as livestock raising, laundry services and other low-cost, rapid-return enterprises (PDA, 2005).



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In Mozambique, the Provincial Union of Small Farmers and the nongovernmental organization HelpAge International have been helping older people caring for HIV-positive family members establish *Conselhos dos Idosos* (older people's committees), with the twin aim of reducing the cost of care and increasing income. The need is clear: while an older person's average monthly income in rural Mozambique is US\$ 12, the monthly cost of looking after an orphan is about US\$ 21, while caring for someone living with AIDS costs US\$ 30. Using profits from small businesses financed by a community credit arrangement (itself a way of increasing earning opportunities), a social fund run by the committees pays for transport to HIV testing centres and clinics where antiretroviral therapy is available. There are currently 44 older people's committees in four rural districts (HelpAge International, 2005).

Orphans and other children made vulnerable by AIDS

Millions of children have been orphaned by AIDS or heavily affected by the multiple impacts of AIDS on their families and

communities (see 'Impact' chapter). As the epidemic continues to result in rising mortality and a heavy burden of illness among adults, the challenge for governments and communities is to provide safe and healthy childhoods for these young people, and to do so for increasing numbers over (at least) the next decade.

Gathering together the experience of international agencies, governments, nongovernmental organizations and child protection experts, UNICEF and UNAIDS published the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children in a World with HIV and AIDS* (UNICEF/UNAIDS, 2004). By the end of 2005, the framework had been endorsed by nearly 30 diverse organizations, signalling wide acceptance of its strategies to shape effective responses to the growing problem. Recognizing that no single model is appropriate in all communities or countries, the framework sets out five key strategies that can be applied from local to national level:

- strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing

- economic, psychosocial and other support;
- mobilize and support community-based responses;
 - ensure access for orphans and vulnerable children to essential services, including education, health care, birth registration and others;
 - ensure that governments protect the most vulnerable children through improved policy and legislation and by channelling resources to families and communities; and
 - raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV.

The importance of national governments coming to grips with the problem in a comprehensive way was recognized by the 2001 United Nations General Assembly Special Session in its Declaration of Commitment on HIV/AIDS. Governments agreed that they would “by 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/

AIDS.” Encouragingly, many governments have made progress in this respect since the Declaration. For example, countries such as Botswana, Namibia, Malawi, Rwanda and Zimbabwe have all created comprehensive national policies for orphans and other children made vulnerable by AIDS while others such as Cambodia, Haiti and Kenya deal with them specifically within their national AIDS strategies (FHI, 2005).

CARING ENVIRONMENTS

Whenever possible, community-based care is preferable to long-term placement of children in institutions such as orphanages (although these may be necessary as short-term solutions for children in immediate need of care). Community-based care arrangements include supporting the child’s AIDS-affected family, adoption or placement with extended or foster families, and direct assistance to children made vulnerable by AIDS. Such care is not always easy to implement or manage and the quality of care can vary widely, but research suggests that it is considerably more cost effective than institutional care and involves a more equitable use of scarce resources. For example, a World Bank study of recent projects for orphans

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ADVOCACY FOR CHILDREN AT THE LOCAL LEVEL

Governments may provide direction and policy guidelines, but local-level organizations are doing much of the work that needs to be done for children affected by AIDS. For example, community-based organizations all over sub-Saharan Africa are providing support such as meals and school uniforms for AIDS-affected children. However, these organizations also have an important advocacy role. For example, they strongly defend the right to education of orphans and other children made vulnerable by AIDS, a constant task because of the school systems' limited capacity to assist children in greatest need. A recent report by Human Rights Watch cites a number of examples. In Soweto, a local organization caring for children orphaned by AIDS negotiated with school officials to waive school fees for these children—in fact, a right the children already have legally but which many schools refuse to grant. In Uganda, a number of local nongovernmental organizations subsidize the school expenses of AIDS-affected children and conduct workshops in schools to counter AIDS-related stigma (Human Rights Watch, 2005).

and other children made vulnerable by AIDS found that while the cost of creating a group home for orphans in Eritrea averaged about US\$ 1900, the corresponding one-time cost of placing an orphan with a family was about US\$ 100 (Prywes et al., 2004).

Even more fundamentally, as is clear in the UNICEF/UNAIDS 2004 framework, singling out children orphaned by AIDS for special help is stigmatizing and in many settings impractical. In terms of social security options, this means that rather than providing grants to particular categories of children (such as orphans), the aim of government programming should be to draw more impoverished children—irrespective of their parental circumstances—into the social security 'safety net' (Meintjes et al., 2003).

ACCESS TO EDUCATION

Helping children stay in school and ensuring that girls are not disadvantaged in their access to education are among the most important activities in the field of human development. This is recognized

in the Education For All Initiative and in Millennium Development Goal 2 (universal primary education by 2015) and Goal 3 (eliminating gender disparity in primary and secondary education by 2015 as part of promoting gender equality and empowering women). Progress has been made towards both goals (UNESCO, 2005a): for example, while only 82% of the world's school-age children were enrolled in primary school in 2001, by 2005 this had risen to an estimated 85% (UNICEF, 2005b). Nonetheless, an estimated 113 million school-age children are currently not in school and of these, 54% are girls (UN Population Division, 2005). These children are most likely to be engaged in some sort of child labour, which, in some instances, can increase their vulnerability to HIV infection.

The costs involved are one of the main obstacles to many children attending school. This has been amply proven by the rapid increases in enrolment that followed the abolition of fees in Kenya, Malawi, Uganda and the United Republic of Tanzania. For example, when

Kenya eliminated primary school tuition fees in 2003, it took only a few months for enrolment to rise from about 6 million to 7.2 million. Yet, even where tuition fees have been abolished, children's access to school may still be blocked by levies of parent-teacher associations, compulsory uniforms, books and materials, and other costs. Thus, abolishing fees is only part of comprehensive commitment to universal primary education. It must be accompanied by other measures, particularly in education systems hard-hit by AIDS (see below under Strengthening the education sector). The World Bank and UNICEF are currently working on strategies for countries to not only abolish school fees, but also to manage the policy, financial and management issues that must accompany such initiatives (Global Partners Forum, 2006).

"Abolition of fees opens the doors to marginalized and excluded children. Given the importance of schooling for every child in a world with HIV and AIDS, the abolition of school fees is clearly of the highest priority for all children affected by the pandemic."

Global Partners Forum on Children Affected by HIV and AIDS, February 2006.

AIDS AND CHILD LABOUR

The International Labour Organization's International Programme for the Elimination of Child Labour has carried out rapid assessments in several sub-Saharan countries (South Africa, United Republic of Tanzania, Zambia and Zimbabwe) to investigate the links between AIDS, orphanhood and child labour. In the United Republic of Tanzania, for example, orphans accounted for about 70% of surveyed children involved in the self-employed sector, 60% of those in domes-

tic work and 55% of those in the sex trade—the majority of their parents having died of AIDS-related illness. Most of the children had either dropped out of or never attended school. AIDS particularly curtails educational and employment opportunities for girls since they are more likely to be withdrawn from school to reduce household costs and help at home (ILO/IPEC, 2003).

Mitigation efforts need to address the root causes of child labour, including poverty, illiteracy and food shortages. An example is the Together Ensuring Children's Security project in Malawi. The project, which is largely funded by the tobacco industry, aims to reduce child labour in the agricultural sector, particularly the tobacco sector where much child labour occurs. By improving local families' food security and income levels as well as farm productivity, the project helps ensure that children are not forced into paid labour to help support their families. The project has an educational component aimed at encouraging children to attend primary school by raising community awareness of the importance of education and by constructing school facilities (Sibale and Kachale, 2004).

Service delivery and administration

Public services are affected so severely in some countries that old methods of administration are no longer sustainable and they need to be reconstructed—i.e. adopting new ways of working and managing human resources—to account for AIDS' impacts on their own staff. Special efforts will be needed if they are to maintain their organizational integrity, protect and add to existing knowledge and expertise, and meet the rising



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demands on service delivery (Sengwana and Quinlan, 2004).

In 2005, a report entitled *Hoping and Coping: A Call for Action—The Capacity Challenge of HIV/AIDS in Least Developed Countries* was jointly published by UNDP and the Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (UNDP, 2005). In assessing the capacity challenges facing countries hard-hit by the epidemic, the report provides a number of recommendations aimed at mitigating AIDS' direct impact on the effectiveness of government institutions. The most urgent is, of course, workplace-based treatment and care to prolong the productive life of HIV-positive staff. But the report also offers more innovative suggestions such as requiring all service-providing institutions to dedicate a percentage of overall budgets to building supplementary capacity. Other measures include examining how existing state structures impede or facilitate service delivery in order to use human resources most efficiently and improving human resource planning and development.

Another approach is to improve public administration practices, assuming that this can increase efficiency and improve services even in the absence of new resources. Yet by themselves, these are unlikely to meet the extraordinary challenges facing public authorities at all levels, particularly in key sectors such as health and education, and those responsible for expanding vital infrastructure. Sadly, resource allocation decisions do not always take this into account and are often restricted by macroeconomic realities and agreements with international lending institutions. For example, Zambia recently became eligible for the Highly Indebted Country Initiative after agreeing to maintain its public-sector wage bill at a maximum of 8% of gross domestic product (UNDP, 2005). While the measure is aimed at reducing deficits and controlling inflation, which also hurt entire populations, it severely limits the country's ability to hire more public-sector workers.

Such constraints on national budgets and policy options are faced by many countries with precarious economies and donor dependence. They make it

REGIONAL COOPERATION IN AFRICA'S GREAT LAKES REGION

In the Great Lakes region of Africa, it is estimated that more than six million people are currently living with HIV. In 1999, ministers of health from six countries (Burundi, Democratic Republic of Congo, Kenya, Rwanda, Uganda and the United Republic of Tanzania) acknowledged that they could not adequately respond to HIV without addressing the role that migration and displacement play in its spread. They agreed to cooperate in the Great Lakes Initiative on AIDS with funding from the World Bank's Multi-Country HIV/AIDS Programme. The initiative requires national governments to learn new ways of working, addressing the needs of populations who normally receive little attention and few services.

A large part of the initiative's work is focused on HIV-related prevention and care for refugees, surrounding communities, internally displaced people and returnees. Under a recent agreement, responsibilities for different population groups have been assigned as follows. Programming for individuals in refugee-affected areas is the responsibility of the participating countries and should be provided for under the terms of their national HIV and AIDS frameworks. UNHCR retains its mandated responsibility for all refugees, while responsibility for internally displaced individuals is decided on a case-by-case basis. Finally, programmes for returnees are the shared responsibility of UNHCR and each country's National AIDS Commission.

In March 2005, the World Bank approved a US\$ 20 million grant to finance the initiative over the next four years. Joint HIV programme planning has been undertaken and plans of action completed for the first year of implementation in all six countries. To provide a solid basis for evaluating the initiative, behavioural and antenatal sentinel surveillance among the refugee and surrounding host communities are planned in all six countries during the first and fourth years of the project (UNAIDS/UNHCR, 2005).

extremely difficult for public health and education services to expand, at a time when the ability of millions to pay for services is so low that the private sector cannot be expected to bridge the gap. It is also a time when efforts to improve labour productivity in Africa—also an urgent requirement for development—need to address public-sector priorities such as recruitment of teachers and health workers, and reorienting health-delivery systems “so that they focus less on curative facilities in relatively well off areas and more on rural, preventative facilities staffed by community nurses and other auxiliary health

workers” (Centre for Development Policy Research, 2005).

Preserving health-sector capacity

A well-functioning health sector is an essential element of any national response to AIDS and is crucial to meeting three of the eight Millennium Development Goals. However, in many countries the health sector is threatened not only by AIDS but by many other major forces, notably accelerating labour migration (the so-called “brain drain” of doctors and nurses to industrialized countries) and

chronic underinvestment in human resources. In addition to shortages of skilled professionals—sub-Saharan Africa has less than one-tenth of the health professionals per capita that Europe has—skills are often badly distributed, with too great a dependency on city-based medical specialists and too few public-health staff in rural areas (Joint Learning Initiative, 2004).

Low- and middle-income countries in general, and those with high- and medium-prevalence epidemics in particular, need to train many more doctors, nurses and administrators to fill the shortages and remedy the imbalance in the current distribution of services. This is a massive task. WHO has estimated that scaling up to meet Millennium Development Goals 4 and 5 (reducing child mortality and improving maternal health) will require the equivalent of 100 000 more full-time health professionals in the 75 countries where the bulk of child mortality occurs (WHO, 2005a). Yet the massive training effort required will be largely wasted if countries cannot retain these precious professionals. One of the most important ways to do this is to ensure that salary levels are fair, sufficient

and live up to the expectations of health professionals.

Many nurses and doctors in low-income countries are attracted to industrialized countries not only by higher wages but by facilities that enable them to use their training and skills to better advantage. In addition to those ‘pull’ factors, ‘push’ factors include the increased pressure of work as the epidemic grows, fear of infection and the fact that the stigmatization of people living with HIV often extends to those caring for them. The effects are plain and growing. In 1999, Ghana certified 320 new nursing graduates and lost 320 nurses through emigration. The following year, it lost twice as many. Today, more than half of its nursing positions are unfilled, a pattern that prevails throughout much of sub-Saharan Africa. The pull factors are equally clear. In 2001, the National Health Service in the United Kingdom promised to stop the direct recruitment of nurses in countries suffering from their own nursing shortages but, since then, large private-sector institutions in the United Kingdom have lured more than 7000 nurses from Africa. In the United States, Congress approved an Emergency Supplemental



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Appropriations bill in 2005 which made 50 000 new visas available for nurses and their families. This measure was designed to address a shortage of 126 000 nurses, a shortage exacerbated daily. The country's own nursing schools are not keeping up with demand, while its population is growing and ageing and in need of ever more nurses (Chaguturu and Vallabhaneni, 2005).

A variety of approaches to the problem have been suggested, including increased exchange programmes and the creation of a global educational reinvestment fund to help improve and expand training opportunities in low- and middle-income countries (Joint Learning Initiative, 2004). In addition to actions at the national and international level, innovative approaches that reach out to the many private-sector health providers in low- and middle-income countries may also be helpful. An example of this can be seen in Uganda, where a microfinance programme was piloted to provide private-sector midwives with business-skills training, improve the quality of service offered (client-provider interaction, hygiene and sanitation, confidentiality, etc.) and provide revolving loans that could be used for purposes such as improving their working environment or buying medical supplies. Funding was provided by the Summa Foundation and administered through the Uganda Micro-Finance Union. Piloted in 15 district and urban clinics (with an additional 5 as controls) over 13 months, the results indicate the programme has good potential: the midwives themselves were enthusiastic about the project and had a high loan-repayment rate, while patients reported that the quality of care improved at the participating clinics. These findings suggest that such small-

scale interventions could strengthen the private sector in its vital role in health care. (Agha, Balal and Ogojo-Okello, 2004).

Strengthening the education sector

AIDS is having a serious impact on education systems in many of the hardest-hit countries (see 'Impact' chapter), limiting their ability to meet the Education For All goals agreed in 2000 (UNESCO, 2005a). Evidence from Uganda shows that a child who drops out of school is three times more likely to be HIV positive in his or her twenties than a child who completes basic education. Community analyses show consistently higher HIV prevalence in children who do not attend school versus those that complete an education. A recent World Bank analysis of Demographic and Health Survey data from five countries in Africa shows that education is a strong predictor of some important preventive behaviours, and there is considerable agreement in educational research that effective girls' education is associated with protective behaviours (World Bank, 2006).

Mitigating AIDS' impact on the education sector entails a number of priority actions. These include ensuring HIV is addressed across the whole education sector and that capacity is built to achieve the Education For All goals (IATT, 2003). A number of responses have been created by the international community, such as the Education for All-Fast Track Initiative launched in 2002—a global partnership created to accelerate progress towards quality primary education for all children by 2015. This initiative can facilitate financial support to all low-income

countries facing funding gaps as they pursue the goal of universal primary school completion. In 2004, external aid for the 12 countries participating in the initiative increased from about US\$ 300 million to US\$ 350 million, closing the financing gap between funds needed and funds available in five of the countries. Two other countries will close their gap through additional financing from bilateral donors in 2005–2006. The initiative has disbursed US\$ 45 million to date through its own Catalytic Fund, one of two trust funds that can provide short-term financing to close funding gaps and help develop sound educational strategies.

The UNAIDS Inter Agency Task Team on Education, with its secretariat at UNESCO, was established to enhance coordination and harmonization among UN agencies, multilateral and bilateral donors, and civil society organizations. In 2002, a working group was established to support the education sector in countries across Africa under its 'Accelerate the Education Sector Response to HIV/AIDS in Africa' effort. Among other activities, this effort has provided subregional and national workshops that bring together education, health and AIDS

teams to share good practices and develop strategies to ensure that they are implemented within schools. Since 2002, 33 countries in sub-Saharan Africa have participated in this effort and 19 of these are currently engaged in accelerated national programmes. Leadership is increasingly based within subregional entities: the Economic Community of West African States' network of 15 countries, an eastern Africa network of 9 countries, a lusophone (Portuguese-speaking) network of 5 countries, as well as Central African and Southern African Customs Union networks in the process of being developed. UNAIDS Cosponsors are now supporting the development of this approach outside Africa, with the Caribbean Community and Common Market leading a regional effort involving 15 countries, the development of a Greater Mekong subregional programme with 6 countries in East Asia, a Central Asia effort with 5 countries and an emerging programme in South Asia involving 5 countries.

Another multi-country initiative called EDUCAIDS (the Global Initiative on Education and HIV/AIDS) was launched in 2004 under the leadership of



Employers have a significant stake in successful AIDS mitigation measures, as do workers and their representatives and ministries of labour.

Cooperation between education systems and social protection initiatives provides opportunities for improving the effectiveness of both.



UNESCO. This initiative has so far begun work in a number of countries, including Cambodia, Jamaica, Lesotho, Namibia, Swaziland and Zimbabwe, with the objective of strengthening education systems. It is one of three core Education For All initiatives, complementing those focused on literacy and on teacher education (UNESCO, 2005a). For its part, the global union Education International, with a membership of over 29 million teachers and education workers, has an HIV training programme with WHO and other partners. To date, this has reached 133 000 teachers in almost 25 000 schools in 17 countries (ILO et al., 2006).

The task of strengthening school systems to meet the pressures posed by AIDS and other problems needs to be based on sound evidence of the actual conditions in the educational sector, in order to know how best to apply scarce resources. Recently, a study was undertaken of how ready the education sectors in various parts of the world were to respond to the impact of AIDS (Boler and Jellema, 2005). The study used two approaches. The first used a self-assessment questionnaire sent by post to ministries of education in 117

countries, from which 71 replies were received. The second sought input from civil society organizations (see ‘Civil society’ chapter) through workshops that brought together representatives from nongovernmental education networks, teachers’ unions and ministries of education in 18 countries heavily burdened by AIDS. A summary report unifying the two approaches revealed mixed results (IATT, 2006). For example, three quarters of the responding countries—and all of the high-prevalence countries—reported having established dedicated management structures to coordinate the response of ministries of education to the epidemic. Less promisingly, only 59% of these structures in all countries and 70% in high-prevalence countries had a dedicated budget, calling into question the actual powers and effectiveness of these structures.

Cooperation between education systems and social protection initiatives provides opportunities for improving the effectiveness of both. An example can be seen in the relationship between two projects in Namibia—one to enhance the involvement of school board members in

improving schools and the other aimed at creating “circles of support” for orphans and other children made vulnerable by AIDS. The above-mentioned study of social protection measures found that in working together, the two initiatives avoided working at cross purposes and helped participating schools assist children made vulnerable by AIDS to stay in school ((UNICEF, 2005a). Emphasizing the intersecting interest of education-sector policy, AIDS responses and programming for orphans and other children made vulnerable by AIDS, the study concluded with a message for governments:

“Finally, given that the scale of the EMC [educationally marginalised children] and OVC [orphans and other children made vulnerable by AIDS] crisis in Africa is only

beginning to emerge .. governments and partners are faced with a stark choice: embrace and mainstream social protection as an integral function of education’s mandate, or abandon any real prospect of achieving those national and international goals to which the sector is committed.”

World of work

Employers have a significant stake in successful AIDS mitigation measures, as do workers and their representatives and ministries of labour. The underlying and most important factor is that the provision of care and treatment in the workplace saves lives, maintains enterprise production and complements public-health services. The guiding document for workplace responses is *The ILO Code*

PRESERVING AN EDUCATION SYSTEM UNDER STRESS

In South Africa, AIDS-related deaths are contributing to an overall reduction in the number of teachers, along with other factors such as emigration and insufficient supply of new staff graduating from teacher training. In 2004 alone, an estimated 8% of HIV-positive teachers died. Mitigating this situation will require a variety of actions. Following a detailed situation assessment, the Human Sciences Research Council of South Africa made a number of recommendations for the country’s ministry of education, universities and education trade unions. In addition to HIV prevention programmes, the Council recommended urgent implementation of a targeted programme of antiretroviral therapy and treatment of opportunistic infections for teachers, estimating that about 3% of them (approximately 10 000 individuals) currently need antiretroviral therapy.

At the same time, recognizing that medical approaches to preserving capacity will not be enough to meet the rising demand for education in South Africa’s young population, the Council also recommends measures such as improving pay and career paths for teachers in order to attract (or retain) more of them into the profession. To cope with losing teachers to Commonwealth and other countries, the Council suggests that some form of community service be required of newly qualified teachers, as is the practice with other scarce professions in the country. Other measures are recommended to encourage teachers to work in rural areas, such as loans for student teachers and supported field experience for urban teachers (Peltzer et al., 2005).

Although not sufficient on its own to change social attitudes, progressive legislation is an important avenue for tackling acts of discrimination against people living with HIV or affected by AIDS.



of Practice on HIV/AIDS and the World of Work, published in 2001 (ILO, 2001). It provides guidelines that can be used to develop policies and interventions at enterprise, community and national levels, based on consensus between employers, employees and government.

Employers clearly have a significant stake in successful mitigation measures when AIDS threatens their staff. In a recent study of the impact of AIDS on the financial performance of companies, the international bank UBS and the investment management firm FandC Asset Management concluded that there was a strong business case for companies to take their own action against AIDS (UBS and FandC Asset Management, 2005). The study modelled the calculations a major firm might make about setting up a business venture in a high-prevalence setting. Factoring in the cost of the epidemic to the venture and the costs and benefits of a treatment programme for employees (the cost of treatment amounting to 17% of wages), the net present value of the venture after 5 years was more than 5% higher with treatment than without it. The study also discussed practical considerations for businesses undertaking

treatment programmes, including whether to extend treatment to dependents as well as employees and whether to provide treatment in-house or in collaboration with local medical services.

In the area of public investment, some international donors are supporting the efforts of local and national governments to mainstream AIDS mitigation efforts into infrastructure projects such as those aimed at improving urban transport or water systems. In this context, mainstreaming does not mean turning such projects into HIV-specific projects. Rather, it aims to integrate particular activities that can mitigate AIDS' short- and long-term impacts on project workers and administrators, as well as the surrounding communities.

For example, the World Bank's Urban Unit reviewed mainstreaming project experiences in 13 countries in sub-Saharan Africa, including Burundi and the Congo. In the latter, a massive project for Emergency Reconstruction, Rehabilitation and Living Conditions Improvement benefited, from the early stages of the project, from close cooperation between the Ministry of Health and

the project management. In addition to awareness efforts and condom distribution at work sites, funding is given to local nongovernmental organizations to provide services such as voluntary counseling and HIV testing, treatment of sexually transmitted infections for construction workers and sex workers in the area, and care and support. The project is considering extending some activities to benefit local government authorities in the project cities. In Senegal, a major initiative that is improving public transportation in Dakar and other cities has included HIV-related programming since the design stages of the initiative (Schuler et al., 2005).

AGRICULTURE

Agriculture is the economic mainstay of many low- and middle-income countries, both in its subsistence role and its contribution to the formal economy. Many AIDS mitigation programmes aim to directly or indirectly support AIDS-affected rural households whose main source of livelihood is growing crops or raising livestock. Experience suggests that indirect programmes—e.g. agricultural

training, credit and access to seeds or machinery—open to all rural families in a given area need careful planning if they are to help AIDS-affected families, since such families are often less able to take advantage of the services offered (Jayne et al., 2004).

In Zambia, where the agricultural sector accounts for 67% of the workforce and generates between 18% and 20% of gross domestic product, the Ministry of Agriculture and Cooperatives has been exploring a variety of AIDS mitigation activities with various international partners. A particular focus is on improving access of HIV and AIDS-affected families to existing training and credit programmes, since their participation in such schemes is low, particularly in the case of families headed by women. Efforts to increase the income of such families may include promoting income-generating activities that are low-input, low in labour intensity, close to the family home and have a quick financial turnover: these include bee-keeping, mushroom cultivation, seed gardens (growing seeds during the dry season for planting during the rainy season), market

BUSINESS REACHES OUT

In conjunction with Kenya's Ministry of Health, the Federation of Kenya Employers issued its first guidelines on HIV in the workplace in 1988 and now promotes compliance with *The ILO Code of Practice on HIV/AIDS and the World of Work*. In 2000, the National AIDS Council designated the federation as a focal point in the response to AIDS. Since then, the federation has established a broadly representative HIV/AIDS Advisory Committee which oversees the integration of HIV prevention and management components into its broader training programmes for business managers and also trains specialized animators and peer educators to promote and support workplace programmes. In addition, the federation encourages corporate social responsibility whereby businesses reach out to their communities by donating resources to the AIDS response, social marketing of condoms and working with the government and others in attending to the health, education and general welfare of children orphaned by AIDS (GBC, 2006).

Confronting stigma and discrimination and mitigating their impacts are important elements of any response to AIDS, and many HIV prevention and care projects include efforts to reduce stigma.



gardening and raising poultry (FAO and Government of Zambia, 2004).

A great deal of attention has been paid to reducing the demands of agricultural activity on AIDS-affected farming households by helping them change from labour-intensive crops such as sugar cane or tea to crops such as sweet potato that require less strength or fewer people to tend and harvest. However, some of the most effective labour-saving solutions for these households are closer to home, namely those which reduce the time women spend on three tasks: fetching water, collecting firewood and preparing food. Research into time-use in Zambia indicates that labour-saving technologies for such domestic tasks (e.g. food-processing technologies for household staple foods, such as maize and cassava) are likely to save considerably more hours for the family than labour-saving technologies used for agricultural activities (Mather et al., 2004).

The agricultural sectors in many countries and regions are currently undergoing rapid change because of factors such as climate change and rural-to-urban migration of young people, in addition to

AIDS. As a result, farming is becoming less sustainable and less of a food 'safety-net' for many rural peoples. Some commentators suggest that a policy debate is due on questions such as "whether it is feasible to revitalise African agriculture or whether to allow the transformation of this sector through market forces with the inevitable danger of benefit to a minority of commercial entrepreneurs and widespread food insecurity in the absence of formal sector employment opportunities" (Sengwana and Quinlan, 2004). This debate has profound implications for AIDS mitigation activities in the agricultural sector.

Action against stigma and discrimination

Confronting stigma and discrimination and mitigating their impacts are important elements of any response to AIDS, and many HIV prevention and care projects include efforts to reduce stigma (UNAIDS, 2005). However, little is known to date about the relative effectiveness of specific interventions. A recent review by the International Center for Research on Women found that very few

interventions specifically against stigma have yet been evaluated in any systematic way, and that, as previous reviews have shown (Brown et al., 2001), most have been implemented in industrialized rather than low- or middle-income countries.

LEGAL AND HUMAN RIGHTS PROTECTION

Although not sufficient on its own to change social attitudes, progressive legislation is an important avenue for tackling acts of discrimination against people living with HIV or affected by AIDS. However, legislation tends to change only as a result of advocacy.

This lesson is being put into practice in Central America and the Caribbean, where trade unions have launched a major project to deal with workplace discrimination against people with HIV. The partners are ORIT (the regional organization of the International Confederation of Free Trade Unions) and the Latin American and Caribbean Council of AIDS Services Organizations, an umbrella nongovernmental organization representing AIDS service organizations. The project has begun with a comprehensive survey of legislation and practices in

eight countries, the first stage towards legislative reform (ILO et al., 2006).

Legal action can be an important avenue in counteracting discriminatory practices. This has been particularly true in protecting the property of AIDS-affected families, particularly those headed by women. Such families are more likely to lose land (in rural areas) and other assets than unaffected families. Women's groups are generally the most important advocates for turning this situation around and a variety of such groups have done excellent work in various parts of the world. However, other parts of society must play their part, particularly police forces and justice systems.

An example of cooperation between women's groups and the police can be seen in Zambia, where the Justice for Widows and Orphans Project is contending with the problem of two legal codes existing side by side in the country. Both customary law and statutory law are set in the framework of a constitution that recognizes personal law and the right to discriminate in matters such as succession and inheritance. At the same time, the



One of the most keenly felt forms of stigma and discrimination experienced by people living with HIV is that from health-care workers.

FINANCING LEGAL SERVICES FOR THE POOR

In Zimbabwe, where asset protection and guardianship of children have become major issues resulting from the high rates of AIDS mortality, an innovative programme piloted by the United States Agency for International Development provides vouchers for legal services to poor, AIDS-affected households. The vouchers are issued by local nongovernmental organizations and service organizations already involved in AIDS-related activities and can be used to purchase services from law firms participating in the project. As of 2004, over 80% of the vouchers have been distributed to women, many of whom care for children orphaned by AIDS as well as their own children. Staff noticed that lawyers in the project areas now see AIDS-affected households as desirable clients and compete to provide their services. An important lesson learnt in the project is that partnerships with organizations already working in the community provide more effective coverage than static walk-in centres (Foan and Irwin, 2004).

government has ratified international conventions that outlaw such discrimination. The project brings together government bodies and international and national civil society organizations to help widows and orphans negotiate their way through this legal tangle. (Death of a husband from AIDS-related illness is the most common cause of widowhood in Zambia.)

As part of the project, the Zambian chapter of the Women and Law in Southern Africa Trust and the National Legal Aid Clinic for Women participate in Police Victim Support Units to intervene in situations where women and children orphaned by AIDS are being denied rights protected by international conventions. They also hold legal aid clinics (some of them mobile) and produce simple pamphlets and run programmes in schools informing women and children about their rights. In addition, they train women and orphans in paralegal and personal counselling, preparing them to establish community support groups and participate in radio broad-

casts (Russell, 2005). The Police Victim Support Unit now provides counselling, including explanation of people's rights. The police have also begun to respond vigorously to property-grabbing against widows and orphans, which is often perpetrated by the deceased spouse's family (WHO, 2002, 2005b). This has resulted in greatly increased conviction rates in such cases, which rose from 6% (of 909 reported cases) in 2001 to 31% (of 734 reported cases) in 2003. However, the police are conscious that many cases are not reported for a variety of reasons, from ignorance of the law to widows' reluctance to speak out against their relatives (FAO, 2004).

CHANGING HEALTH-CARE WORKER ATTITUDES

One of the most keenly felt forms of stigma and discrimination experienced by people living with HIV is that from health-care workers (e.g. open disrespect, ignoring confidentiality of HIV test results and serostatus and refusing services). Discrimination can have a variety of causes, but surveys conducted by Public Services International, the global union representing health-care workers,

found that discrimination by health-care workers towards patients stemmed in particular from lack of information and training, and from poor working conditions including health and safety concerns (ILO/WHO, 2005).

Efforts to change health-care workers' attitudes and practices have been proven to be effective and can make a big difference to HIV-positive people's lives. In India, the National AIDS Control Organisation, three New Delhi hospitals, the nongovernmental organization SHARAN and the Population Council's Horizons project designed a training and awareness programme to reduce hospital-based stigma and discrimination (Mahendra and Gilborn, 2006). A number of challenges had to be overcome, including hospital managers' initial hesitation to acknowledge stigma and discrimination, fear of being overwhelmed by a large number of HIV-positive people and losing HIV-negative patients, distrust between the health-care staff and the nongovernmental organization, and the very size and bureaucratic complexity of the hospitals. In the end, however, progress was made, with health workers expressing greater respect for the rights of patients and

people living with HIV, and practising improved procedures. For example, physicians were more likely to state that informed consent must be received before HIV tests (37% at baseline versus 67% at follow-up), were more likely to arrange pretest counselling (56% versus 80%) and were less likely to inform ward staff of the status of HIV-positive patients admitted to the hospital (51% versus 29%).

Sometimes the benefit of training can be multiplied beyond the immediate target group, as was found by a study in China. In Fuyang Prefecture, Anhui Province, a training programme to improve attitudes among health providers not only reduced stigmatizing attitudes by providers, but also improved the attitudes of other community members who received AIDS information from the trained health providers (Wu et al., 2002).

CHANGING ATTITUDES OF THE GENERAL PUBLIC

To date, the number of interventions aimed at health-care providers is not matched by those aimed at the general public, and the review carried out by the



In the end, efforts to improve access to antiretroviral therapy and other HIV-related treatment may prove to be one of the most powerful anti-stigma interventions.

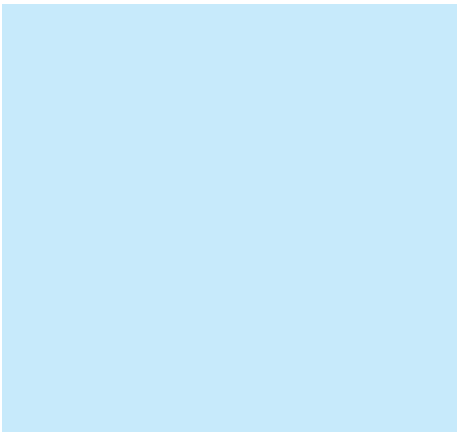
International Center for Research on Women found little quantifiable evidence of success among the few that exist. While understanding of HIV stigma itself has grown substantially in recent years (see ‘At risk’ chapter), large gaps remain in understanding how best to reduce stigma, what tools are most useful and the best way for these to be scaled up to the national level. Efforts to create robust stigma indicators by projects such as the Tanzania Stigma-Indicators Field Test Group should partly address the lack of evaluated programmes, but clearly more interventions are needed (USAID et al., 2005).

Nevertheless, some hopeful signs are visible, including those in some regions with low HIV prevalence. In 2005, Algeria’s Ministry of Religious Affairs announced a programme of training for the imams of the country’s 150 000 mosques. The programme will take advantage of the imams’ moral authority to encourage not just support but also solidarity with HIV-positive people. The announcement was made at a regional conference on HIV care and support in 15 countries of the

Middle East and northern Africa, which recognized the serious problem posed by stigma and discrimination against people living with HIV in these regions (Kourta, 2005).

In the end, efforts to improve access to antiretroviral therapy and other HIV-related treatment may prove to be one of the most powerful anti-stigma interventions. A study of stigma and the experiences of a group of HIV-positive children in Sao Paulo concluded that universal access to antiretroviral therapy in Brazil can indeed have an effect on stigma and discrimination in the wider community. The study found that treatment had this effect because it “transforms AIDS from a debilitating and fatal disease to a chronic and manageable one, belongs to a broader effort to assure citizens’ rights, and reduces social inequalities in access to health care” (Abadia-Barrero and Castro, 2005). Such findings provide yet further impetus to regard the rolling out of universal access to treatment as an urgent priority.

The essential role of civil society 09



Chapter 09



THE ESSENTIAL ROLE OF CIVIL SOCIETY

Almost universally, the first response to the AIDS epidemic came from HIV-positive individuals, their families and communities, by organizing themselves to care for those in need.

In most countries, these early civil society initiatives are the foundations on which the national response has been built, and it is civil society which remains at the forefront of prevention, care and support programmes, particularly among the most vulnerable and hard-to-reach populations. Over the years, civil society has also helped to guide scientific research and has played a key role in challenging drug patents and bringing down the cost of AIDS medication.

What is civil society?

Essentially “civil society” is made up of ordinary citizens who organize themselves outside of government and the public service to deal with specific issues and concerns that normal governmental process cannot address by itself. Societies function more effectively when the State and its citizens engage openly on how policies are formulated and implemented.

In the context of AIDS, many different individuals and organizations participate

actively in the epidemic response outside of government structures. At one end of the spectrum they include the woman at village level planting a vegetable garden to feed a family of orphaned children; the nurse who hands out information leaflets on AIDS and tuberculosis to fellow churchgoers on Sundays; and the young people in anti-AIDS clubs who distribute condoms to the bars and barber shops in their neighbourhoods.

At the other end of the spectrum, civil society includes development nongovernmental organizations, faith-based organizations, women’s groups, farmers’ groups and other special-interest associations, business enterprises and labour unions, private foundations and the media. The most active members of civil society are often those with personal experience of the epidemic, either as people living with HIV or members of marginalized and vulnerable populations, such as sex workers, men who have sex with men and injecting drug users. They are present at every level of the response, in associations and networks of HIV-positive

people, specialist community organizations or as regular members of other AIDS-related organizations.

A look back at history

Civil society groups have engaged in advocacy to press for a range of policy objectives, including better access to health care and more cheaply priced drugs. For example, in 1987 the AIDS Coalition to Unleash Power was launched by gay and lesbian activists in New York. Through public protests the members drew attention to their claim that excessive profits earned by pharmaceutical companies on AIDS medications limited access to treatment and slowed the process of drug approval, thus placing lives unnecessarily at risk. The Coalition also campaigned for public education on the epidemic and an end to AIDS-related discrimination. This early activism helped create the foundation for more affordable treatment initiatives.

Also in 1987, the AIDS Support Organisation was founded in Uganda by 16 volunteers who had been personally affected by AIDS. Most were HIV-posi-

tive themselves and all had lost family members to the epidemic and experienced first hand the stigma of AIDS. They were the forerunners of the principle of “living positively with AIDS” and have since grown into one of the most extensive grass-roots organizations in the world. Today, their programme of comprehensive community-based care and support is a model for AIDS service organizations worldwide.

In the early years of the epidemic, gay communities in the United States, Latin America and Europe were among the hardest hit by the new disease. They mobilized to demand action from their governments and from the scientific and public health authorities. Acting courageously in the face of discrimination and human rights violations which saw many HIV-positive people summarily dismissed by their employers, turned away from schools, or refused treatment by health-care workers, these organizations were the first to give a voice and a face to the epidemic. The San Francisco AIDS Foundation, the AIDS Project Los Angeles, the Gay Men’s Health Crisis in New York and the London-based Terrence Higgins Trust—all launched in



Civil society groups have engaged in advocacy to press for a range of policy objectives, including better access to health care and more cheaply priced drugs.

"WE CONDEMN ATTEMPTS TO LABEL US AS 'VICTIMS'... "

From very early on in the epidemic, AIDS activists have demanded recognition as equal partners in the response to the epidemic. In 1984, a United States-based group called the National Association of People with AIDS—the first network of its kind in the world—issued a statement known as the “Denver Principles” in which it claimed the right for HIV-positive people “to be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge.” The statement also said: “We condemn attempts to label us as ‘victims’, a term which implies defeat, and we are only occasionally ‘patients’, a term which implies passivity, helplessness, and dependence upon the care of others. We are ‘People With AIDS’.* Thus the people at the heart of the epidemic set the basic terms of debate in a way which has had a profound effect on perceptions and attitudes ever since.

*Note, the term ‘people with AIDS’ has been the subject of much debate and change. Currently, UNAIDS uses the term ‘people living with HIV’, which includes the range of HIV-positive people from those with no symptoms to those with advanced HIV infection and AIDS.

1982—combined provision of care and support for HIV-infected people with HIV prevention strategies such as activities aimed at educating and advising on safer sex. In Brazil, gay activists successfully advocated the adoption of the first government AIDS programme in 1983 in Sao Paulo State (Berkman et al., 2005).

Civil society groups have been particularly effective in drawing attention to populations and communities that are often left out of policy debates and deliberations. For example, in 1988 a professor of medicine at the University of Casablanca in Morocco recognized that it was difficult for a government AIDS programme to work with people whose behaviour was condemned by legal and social systems, such as sex workers and drug users. To meet their needs, she founded the Association marocaine de lutte contre le SIDA, the first nongovernmental AIDS organization in the Maghreb. In 1989 in Slovenia, a group of

drug users started Stigma, a self-help organization, to attend to the needs of drug users and keep them informed about AIDS. The Ljubljana branch of Stigma set up a needle-exchange programme, a measure that has proven effective at reducing HIV transmission in drug-using populations. That same year, the Pakistan AIDS Prevention Society was formed by a group of people, including teachers and trade unionists, who saw the need for broad-based community action. In addition, organizations like the Treatment Action Campaign in South Africa have provided a voice to people in need of treatment worldwide as well as within national borders.

In the 1990s, when the epidemic emerged in countries with little tradition of civil society, such as the former Soviet countries of Central Asia, international agency support for HIV prevention emphasized working through nongovernmental organizations, based on the success

of this approach in other parts of the world. As well as creating new nongovernmental organizations where none had previously existed, this helped to change official attitudes towards vulnerable populations and to spread both the concept and practice of democratic governance and grass-roots political participation (Atlani-Duault, 2005).

THE POWER OF NETWORKS

In 1990, the Fourth International Conference for People Living with HIV/AIDS was held in Madrid, Spain, attended by 500 people from 43 countries. This marked the first truly international conference to unite a broad range of HIV-positive people from different countries and provided an occasion for raising awareness and sharing experiences. It also prepared the ground for action beyond national boundaries. In 1992, the Global Network of People Living with HIV/AIDS was officially launched, the same year that the International Community of Women with HIV/AIDS was set up.

In addition to the emergence of global networks, similar trends have also had a huge impact at national level. In 1997, the Indian Network for People living

with HIV was formed by 12 people from various states. Today it has more than 20 000 members, making it one of the largest networks of HIV-positive people in the world.

The Egyptian nongovernmental organization Network against AIDS was established in December 2003 with a membership of 19 nongovernmental organizations, many of which had never worked on HIV but were committed to learning more. This network conducts training for member nongovernmental organizations and provides a space for people living with HIV in the absence of an established independent association for them in Egypt. Although still faced with many challenges, in the short years since its inception the network has created a voice for nongovernmental organizations in the AIDS response and now participates fully in the national HIV coordinating forum.

Thanks to the combined efforts of organizations and networks, the basic principle of ensuring meaningful involvement of civil society, and particularly of people living with HIV, is now being written into the policies and strategies of many



Thanks to the combined efforts of organizations and networks, the basic principle of ensuring meaningful involvement of civil society—particularly of people living with HIV—is now being written into the policies and strategies of many organizations, institutions and AIDS programmes.

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**UNITED NATIONS GENERAL ASSEMBLY
SPECIAL SESSION ON HIV/AIDS 2001: A
TRIUMPH AND AN OPPORTUNITY**

The UN General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001 was a momentous event and a tribute to the zeal and advocacy of civil society campaigns which have helped keep AIDS high on the political agenda. The Declaration of Commitment signed by 189 heads of state at the close of proceedings prescribed a key role for civil society, in partnership with government, in meeting a set of time-bound goals in response to the epidemic, and in monitoring governments' compliance with these obligations. The 2001 Session not only demonstrated the tensions that often exist between governments and civil society groups but also generated some heated debate about appropriate representation and the need to ensure that the provisions for civil society in general, particularly in its role as a voice for people living with HIV, were not just acts of tokenism. Articulating these tensions helped set the stage for a genuine commitment to working in partnership towards shared goals.

The Declaration set deadline targets to be assessed in 2003, 2005 and 2010. The UN General Assembly's review of progress for the year 2005 therefore constitutes an important milestone and one which has focused the attention and energies of many members of civil society.

One example is the development of a civil society consortium of nongovernmental organizations organized in 2005

to support civil society-led monitoring, advocacy and reporting around the implementation of the UNGASS Declaration of Commitment. The consortium includes the nongovernmental organizations Fundar, Gestos and Panos (based in Mexico, Brazil and the United Kingdom respectively), the Public Health Watch/Open Society Institute, the International Council for AIDS Service Organizations, the World AIDS Campaign, and the Latin American and Caribbean Council of AIDS Service Organizations. The consortium built on earlier work by the International Council for AIDS Service Organizations which was the first organization to support this kind of civil society-led monitoring and advocacy.

In 2004, they published a report presenting the findings and recommendations from community-based research in Kenya, the Philippines, Ukraine and Venezuela, representing four pilot regions affected by the HIV epidemic (ICASO, 2004a). The research focused on five areas of commitment under the Declaration: access to treatment, women's empowerment, human rights of people living with HIV, allocation of resources, and the involvement of civil society. A major finding was that government adoption of the Declaration of Commitment has had no evident impact on the vulnerability of girls and women to HIV, and that this remains one of the most neglected areas in the global response. Reports from the International Council and the consortium of nongovernmental organizations indicate that collaboration between government and civil society is often more akin to tokenism than to real commitment, which translates into a lack of meaningful civil society involvement in policy-making.



Scaling up and sustaining the response

To tackle the long-term challenges of AIDS, countries need to think beyond short-term planning and election cycles and envisage a sustained and wide-reaching response. Civil society is uniquely placed to help ensure a longer term perspective.

In December 2004, nongovernmental organizations from around the world came together to agree on a code of practice to help guide their response to the epidemic. They created the nongovernmental organization HIV/AIDS Code of Practice. Aspirational in nature, it provides a set of principles of good practice for advocacy and AIDS programming, to which nongovernmental organizations can commit themselves and be held accountable. The code advocates a human rights-based approach to AIDS work which promotes the meaningful involvement of people living with HIV and seeks to address the causes of vulnerability through programmes based on evidence.

More than 160 nongovernmental organizations have signed up to this code so far.

Protecting existing human resources across all sectors involved in the AIDS response is a high priority and includes safeguarding the health of people living with HIV. These people are often the backbone of the national response. Access to treatment and care, including antiretroviral therapy and treatment for concomitant tuberculosis, is essential, as are measures to minimize stress and exhaustion. In Brazil, universal provision of treatment and prevention services has played a major role in averting sickness and death among nongovernmental organization staff and volunteers and maintaining their effectiveness in responding to the epidemic (Halmshaw and Hawkins, 2004).

In South Africa, the Health Economics and HIV/AIDS Research Division of the University of Natal have developed tools for helping nongovernmental organizations and community-based organizations to plan for and respond to AIDS in the workplace. This was spurred on by a research project carried out in the worst affected province, KwaZulu-Natal, and which underlined the urgency of mitigating the impact of AIDS on civil society organizations (Manning, 2002).

The International AIDS Alliance produced a toolkit to help nongovernmental organizations evaluate and build their capacity to respond to the epidemic (International AIDS Alliance, 2004). Field-tested by more than 50 nongovernmental and community-based organizations in Ecuador, Cambodia and India, the toolkit focuses on five areas of capacity: organizational strength, technical understanding of HIV, participation of

NGONGOVERNMENTAL ORGANIZATION HIV/AIDS CODE OF PRACTICE: PROGRAMMING PRINCIPLES***Cross-cutting issues**

- Our HIV/AIDS programmes are integrated to reach and meet the diverse needs of people living with HIV and affected communities.
- Our HIV/AIDS programmes raise awareness and build the capacity of communities to respond to HIV/AIDS.
- We advocate for an enabling environment that protects and promotes the rights of people living with HIV and affected communities and supports effective HIV/AIDS programmes.

Voluntary Counselling and Testing (VCT)

- We provide and/or advocate for voluntary counselling and testing services that are accessible and confidential.

HIV prevention

- We provide and/or advocate for comprehensive HIV prevention programmes to meet the variety of needs of individuals and communities.
- Our HIV prevention programmes enable individuals to develop the skills to protect themselves and/or others from HIV infection.
- Our HIV prevention programmes ensure that individuals have access to and information about the use of commodities to prevent HIV infection.
- We provide and/or advocate for comprehensive harm reduction programmes for people who inject drugs.

Treatment, care and support

- We provide and/or advocate for comprehensive treatment, care and support programmes.
- We enable people living with HIV and affected communities to meet their treatment, care and support needs.

Addressing stigma and discrimination

- We enable people living with HIV and affected communities to understand their rights and respond to discrimination and its consequences.
- We monitor and respond to systemic discrimination.
- We enable communities to understand and address HIV/AIDS-related stigma.
- We foster partnerships with human rights institutions, legal services and unions to promote and protect the human rights of people living with HIV and affected communities.

Source: Nongovernmental organization HIV/AIDS Code of Practice Project, 2004.

*The Code was developed jointly by ActionAid International, CARE USA, the Global Health Council, the Global Network of People Living with HIV/AIDS (GNP+), Grupo Pela Vidda, the Hong Kong AIDS Foundation, the International Council of AIDS Service Organizations (ICASO), the International Federation of Red Cross and Red Crescent Societies, the International Harm Reduction Association, the International HIV/AIDS Alliance and the World Council of Churches.

people living with HIV and other affected groups, partnerships, and coordination and effective advocacy. By early 2006, the toolkit had been used by 165 of the Alliance's partner organizations in more than eight countries.

AT THE FOREFRONT OF HEALTH-CARE PROVISION

Early in the epidemic, as public hospitals became overwhelmed by the burden of HIV, civil society organizations also took on responsibility for health care. They were the pioneers of counselling, both for and by infected and affected people, and of home-based care for the sick. And as medicines—including, eventually, antiretroviral drugs—were developed to treat HIV, civil society organizations were at the forefront of efforts to bring down the cost of treatment, to demonstrate that antiretroviral therapy is feasible in resource-poor settings and to urge national governments to commit themselves to providing treatment. Furthermore, in many countries where a combined epidemic of HIV and tuberculosis is present, it is often civil society that drives efforts to ensure integrated programmes address the crisis created by the two diseases.

A joint survey, conducted in 2004 by the Paris-based treatment rights group, Sidaction, and UNAIDS and WHO, found that nongovernmental organizations are still the main providers of health care in many African countries, where the burden of HIV is heaviest. The survey covered 274 community-based organizations working with HIV-positive people in 45 countries, with a total of 210 400 clients between them. Antiretroviral therapy was carried out by 182 organizations, of which 68 were prescribing drugs themselves, while 133 were giving medical follow-up and 156 psychosocial follow-up for people on therapy. A total of 159 organizations were providing education and information on antiretroviral therapy and on the symptoms and management of side-effects. In addition, 141 organizations reported that they were providing direct treatment for opportunistic infections, including tuberculosis (Sidaction et al., 2005).

Community-based organizations in Burkina Faso preceded the government and international donors in importing generic antiretroviral drugs; and community groups serve as the primary source for HIV treatment in Burundi. In



Early in the epidemic, as public hospitals became overwhelmed by the burden of HIV, civil society organizations also took on responsibility for health care.

Civil society groups play a central role in advocating for greater treatment access and they also promote greater accountability by monitoring treatment-related activities of governments, donors and nongovernmental organizations.



Uganda, the AIDS Support Organisation used its experience providing antiretroviral drugs to its own employees to develop its community-based treatment programme, which began in 2004 with 3000 clients and currently serves over 7000. In Haiti, Partners in Health and The Haitian Study Group on Kaposi's Sarcoma and Opportunistic Infections were the first organizations in the country to offer antiretroviral therapy, and nongovernmental organizations still care for the majority of people on antiretroviral drugs. In Cambodia, 70% of nongovernmental organizations engaged in the response to HIV focus on health care and treatment.

Civil society groups play a central role in advocating for greater treatment access and they also promote greater accountability by monitoring treatment-related activities of governments, donors and nongovernmental organizations. Extensive networks have been forged in many countries to support easier access to antiretroviral drugs. For example, the Kenya Coalition on Access to Essential Medicines—whose network includes people living with HIV, the Kenya Medical Association, international nongovernmental

organizations and a broad range of civil society groups—promotes coordinated action to scale up treatment.

Besides threatening the lives and well-being of people living with HIV and violating their human rights, stigma and discrimination inhibit every aspect of the response to AIDS. They adversely affect people's willingness to heed prevention messages, come forward for HIV testing, or seek treatment for HIV-related health problems, and are root causes of denial and slowness to act by governments (Ogden and Nyblade, 2005). These issues are discussed extensively elsewhere in this report. However, it should be remembered that civil society has always played a leading role in combating stigma and discrimination, and its efforts continue today in most parts of the world. In addition to heading the fight to tackle these issues, civil society has provided much needed support for the rights of marginalized groups to access AIDS-related services and information.

In the south of Kazakhstan, the nongovernmental organization "Senim" which means "trust" in Kazakh, gives support to commercial sex workers in distributing

condoms, organizing referrals to sexual health services, as well as setting up a syringe exchange system for drug users. Senim speaks for the rights of the sex workers and advocates against the violence they are often subjected to. Over the last four years the incidence of sexually transmitted infections among this community decreased from 64% to 40% and HIV prevalence has remained stable at 1.6%, with 60% of sex workers reporting condom use with clients.

In Ethiopia, the Integrated Service for AIDS Prevention and Support Organization has helped minimize the risk of HIV infection among commercial sex workers. Sex workers in Ethiopia are a neglected and marginalized group and have been difficult to reach through HIV interventions that have tended to target the population in general. The

Organization has worked to raise awareness and change behaviour and living conditions through creating opportunities and choices for various populations. More than 1000 women have been reached through these activities and more than 200 of them have left sex work to run small businesses.

Old partners, new partnerships

Enhancing and sustaining the involvement of civil society groups in multisectoral national responses is essential if countries are to get ahead of their epidemics. Strength in unity is ever more widely recognized and organizations of all kinds are seeking opportunities to set up new partnerships and alliances, and to revitalize existing ones.

PREPARING THE GROUND FOR ANTIRETROVIRAL THERAPY

Successful antiretroviral therapy requires much more than simply making services available. Those who could benefit need to know they are HIV-positive, which means being prepared and able to go for testing. People need to understand what antiretroviral treatment is, how the drugs work and what lifelong medication means to themselves and to their family members, who may well be required to make sacrifices to accommodate the demands of treatment. In addition, the general public needs to be aware of and knowledgeable about the issues and to create a supportive environment for treatment.

Such activities—widely known as treatment “preparedness” or “literacy”—have been undertaken almost exclusively by nongovernmental groups. Besides campaigning for HIV treatment services and stimulating public debate, they have developed and implemented treatment literacy programmes in all regions and provided ongoing psychosocial support to individuals and communities through a myriad of grassroots mechanisms. Since November 2004 their efforts have been given additional support by the Collaborative Fund, a partnership between the International Treatment Preparedness Coalition, a global coalition of community-based treatment advocates and educators, and the Tides Foundation, a United States-based charity with long experience in administering small grants to community-based organizations. The leadership positions in the Fund are held by people living with HIV who, through their associations and networks, set the funding priorities.

A DIFFERENT PERSPECTIVE: TAPPING CIVIL SOCIETY EXPERTISE

As well as its work in AIDS-related service provision and advocacy, civil society constitutes a vast reservoir of information and independent expertise. This was illustrated vividly in 2004 when the UNAIDS Inter-Agency Task Team under the leadership of UNESCO commissioned the first ever Education Sector Global HIV/AIDS Readiness Report (IATT, 2006). This involved a self-assessment questionnaire mailed to ministries of education in 117 countries and answered by 71 (the summary findings are discussed in 'Reducing the impact' chapter). A parallel study, conducted by the nongovernmental organization Global Campaign for Education, was based on workshops bringing together civil society education networks, teachers' unions and representatives from ministries of education in 18 countries heavily burdened by AIDS (Boler and Jellema, 2005).

The two studies provided very different assessments of how well ministries of education and schools are responding to AIDS. The report by the Global Campaign for Education entitled "Deadly Inertia," is considerably more critical of the situation than is the Inter-Agency Task Team's report. For instance, it points out that coherent AIDS strategies are actually being implemented in only two of the 18 countries and that little action has been taken to address the educational needs of orphans and vulnerable children. Both these informative studies draw attention to the AIDS-related challenges facing the education sector (see 'Impact' chapter).

In addition to adding qualitative data to the Global Readiness Report, the Global Campaign for Education project aimed to stimulate dialogue between civil society and governments and encourage civil society participation in shaping national AIDS and education policies.

The research for these studies generated important spin-offs. In Bolivia, for example, the agencies taking part in the Campaign's workshops decided to act immediately and submitted a proposal to government for the immediate inclusion of AIDS education in the national curriculum.

ORGANIZATIONS OF PEOPLE LIVING WITH HIV: TIME FOR CHANGE?

As a general rule, organizations of people living with HIV are initially created to provide mutual support and care, and evolve gradually to play wider and more varied roles in the epidemic response as their capacity and collective voice strengthen. Today, in addition to the thousands of people living with HIV who continue to provide support and care services at the grass-roots level, there are

networks of HIV-positive people working at national, regional and global levels.

The primary purpose of networking is to represent the interests of HIV-positive people in the wider arena and give them a voice wherever policies and decisions are being made that affect their lives. But today these networks are at a crossroads. Although the principle of involving HIV-positive individuals in all aspects of the response is widely accepted and they have

won seats at many tables, the question now facing them is how to make effective use of the opportunities they have won. To look for answers, a group of people living with HIV from around the world have been discussing future strategies. A series of brainstorm ‘think tank’ meetings in 2005 were supported by UNAIDS and partners in Johannesburg and Nairobi (UNAIDS, 2005c, 2005d).

After a process of self-examination, the participants agreed that there was a pressing need to professionalize informal structures to enable them to function effectively and participate independently in high-powered organizations and forums. Discussions also revealed a tendency for networks to lose touch with the grass roots as they engage with the wider world and the need for clear mandates, accountability and proper lines of communication. Participants in the discussions also emphasized the need for mechanisms to help new people and new ideas to advance within their organizations and networks so that they remain relevant to younger generations of HIV-positive people. A more recent development is the diminishing commitment to action on AIDS-related issues—especially

among people on antiretroviral treatment, for whom sheer survival is no longer such a preoccupation and wider opportunities have opened up (Rawstorne and Prestage, 2005).

One of the many important issues identified by the think tanks was the tendency to allow donor priorities to influence the agenda set up for people living with HIV. Another matter of concern was the lack of real commitment to the principle of Greater Involvement of People Living with HIV/AIDS (GIPA) by donors and other organizations working on AIDS, including nongovernmental organizations, governments and the UN. Thus, the response to the epidemic continues to grow at national, regional and global levels but often without the meaningful participation of people living with HIV.

Women’s groups

Of the 40 million people living with the virus in the world today, more than 17 million are women and the gender gap continues to narrow. In 2004, The Global Coalition on Women and AIDS was launched under the auspices of



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BREAKING NEW GROUND

The All-Ukrainian Network of People Living with HIV is a unique example of the effective mobilization and self-organization of people living with HIV in the Commonwealth of Independent States of the former Soviet Union. Over the last six years the Network has reached and united people living with HIV in 34 Ukrainian cities. It has established itself firmly as both an ardent advocate for the rights of people living with HIV and as a strategic service provider for its constituency. The Network is an excellent example of how civil society organizations can address issues of sustainability at different levels. For instance, the Network invests consistently into its own organizational development, by identifying, recruiting, training and retaining leaders from the community. As a result, the Network can boast a large nucleus of managers who lead the organization on a number of fronts.

In 2005 the All-Ukrainian Network founded the Union of People Living with HIV in eastern and central Europe involving organizations of HIV-positive people from 10 countries of the former Soviet Union. This Union serves as a valuable reference for the 24 countries in the eastern European and central Asian regions which have experienced serious difficulty in obtaining funds to create and maintain their own organizations. They now have at least one functional organization of people living with HIV. These groups are mainly small and located in major cities with weak outreach to HIV-positive people further afield. However, they constitute a hopeful development in a region unfamiliar with the practices of civil society.

In September 2005, the Russian Orthodox Church launched an HIV prevention and care programme in the Russian Federation. The programme seeks to train clergy and church volunteers in counselling and nursing care of HIV-positive people, establish telephone helplines, and develop prevention programmes for young people that address the issues of drug use and HIV. It has the potential to bring together church communities across the countries of the former Soviet Union and benefit from their considerable network of social centres, Sunday schools and youth clubs.

UNAIDS to highlight the effects of the epidemic on women and girls and to stimulate practical and efficient action to address their needs. The Coalition constitutes an informal global alliance of a wide range of partners from civil society groups, networks of people living with HIV, governments and UN agencies. It has three interrelated spheres of action: evidence and policy development, high level advocacy and country-level action.

By providing 'catalytic' funds of up to US\$ 50 000 to UN Theme Groups in

countries affected by HIV, the Coalition strengthens the gender component in national AIDS strategies and fosters the inclusion of women's groups in civil society forums. In 2004–2005, seven countries in Asia and Africa and two regions, Mekong and the Middle East, received support (UNAIDS, 2006). In Kenya, for instance, the funds were used to map women's organizations as a resource for the National AIDS Coordinating Committee. In Viet Nam, UNAIDS partnered with the Women's Union, which has 13 million members

countrywide, to develop an HIV strategy. In the Middle East, a regional meeting in Jordan in June 2005 focused on promoting women's human rights, capacity-building for women's organizations and raising awareness of gender, risk and vulnerability to HIV.

Research shows that ensuring women are adequately represented in policy and planning forums is a difficult strategy to implement. For example, the International Center for Research on Women found that women's organizations had not involved themselves in a systematic way in the discussions leading to the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and that there remains a lack of expertise on gender issues among the civil society representatives on the Fund's board (Cornman and Duvvury, 2005). Furthermore, case studies from countries show that gender concerns are rarely reflected in the programmes that receive funding. Programmes that do address women's needs tend to focus primarily on mother-to-child transmission. The general picture is one of limited participation of women's groups in national AIDS planning forums. A recent UNAIDS assessment carried out

in 79 countries showed that 90% of the national AIDS frameworks received little or no input from women's organizations, although participation was improving in 50% of the countries reviewed (see 'National responses' chapter).

FAITH-BASED ORGANIZATIONS

Churches and other faith-based organizations, especially in developing countries, were among the first to deliver treatment, care and support to people living with HIV and dying of AIDS, and to address the needs of orphaned children. They remain at the forefront of service delivery in many places. The Christian Health Associations in Africa, for example, working in collaboration with ministries of health, provide around 40% of national health care in Lesotho, 45% in Zimbabwe, 48% in Tanzania, 47% in Liberia, 40% in Kenya and 30% in Zambia (Dimmock, 2006). Worldwide, WHO estimates that one in five organizations engaged in AIDS programming is faith-based (WHO, 2004). However, there is undoubtedly still untapped potential within faith-based communities to contribute to the AIDS response—not least in working with their extensive membership structures to challenge



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Businesses are ideally placed to contribute to the epidemic response. They have the capacity to reach millions of workers through workplace AIDS programmes.



stigma and discrimination, and expand coverage of education, care and support services. UNAIDS helps to identify gaps in the response for subsequent action by faith-based groups. It also seeks to broker partnerships with other AIDS-focused organizations and collaborates with the larger, international faith-based development organizations, such as World Vision, Christian Aid, and Norwegian and Danish Church Aid. UNAIDS has signed a formal memorandum of understanding with Caritas Internationalis to work jointly to stimulate HIV activities in 180 countries through its worldwide network of member organizations. UNAIDS also collaborates with Positive Muslims based in Cape Town and has a special relationship with the African Network of Religious Leaders Infected or Affected by HIV (see box).

Since the epidemic poses moral and ethical dilemmas that can be divisive and confusing, it is important to encourage open debate within and between religious communities about responding to AIDS. In December 2004, for example, a colloquium for religious leaders from Africa was organized in Cairo by UNDP in partnership with Family Health International.

Held under the auspices of the League of Arab States, it brought together Muslim and Christian leaders from 19 countries who drafted and signed the Cairo Declaration committing themselves to urgent action in response to the epidemic. The Declaration, which has since been signed by a further 300 religious leaders, emphasizes the need “to abolish all forms of discrimination ... and stigmatization of people living with HIV....”

PRIVATE ENTERPRISE AND WORKERS’ ORGANIZATIONS

Businesses are ideally placed to contribute to the epidemic response. They have the capacity to reach millions of workers through workplace AIDS programmes, and also the communities from which they draw their employees and customers. The 2006 report on business and AIDS from the World Economic Forum says that an increasing number of companies have AIDS policies in place or plans to introduce them, although the potential remains for a greater contribution to the epidemic response (Bloom et al., 2006).

Many smaller companies, however, lack the resources to measure the potential impact of HIV on their business, let alone

respond. For this reason they are the focus of the ILO Workplace AIDS Education Programme with the United States Department of Labor, now operational in 289 enterprises in 22 countries. Focal points are identified and peer educators are trained in enterprises as diverse as small mines in India and Russia, garages in Ghana and hotels in Cambodia. Strategies for HIV prevention and health care are developed with the assistance of the local trade unions and employers' organizations. Surveys of workers are carried out and a monitoring plan agreed upon. Both public sector workplaces and the informal sector are covered, ranging from the docks authorities in Indonesia to hairdressers in Jamaica (ILO, unpublished reports).

Organizations of employers have a particular role in helping motivate and support smaller, nationally owned, and less well-resourced companies. These organizations—which are supported by a global

body, the International Organization of Employers, with a membership of 142 national organizations in 137 countries—provide guidance and training, encourage the pooling of resources and partnerships between larger and smaller companies. The Barbados Employers' Confederation, for example, disseminates examples of good practice among members, provides materials and training, and has collaborated with the Ministry of Labour to draft a national code for the workplace.

Trade unions have also played an important part in the response to HIV. Many unions deal with issues such as pre-employment screening, continuity of employment for people with HIV, provision of sickness benefits and death benefits for dependents. Efforts have also focused on prevention, with the training of union officials and activists as AIDS focal points, peer educators and trainers. In this way, trade unions are helping

RELIGIOUS LEADERS LIVING OPENLY WITH HIV

In November 2002, a group of church men and women in the Ugandan town of Mukono decided to set up the African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS. To Canon Gideon Byamugisha this was the fulfilment of a dream. The first Anglican priest to disclose his HIV status publicly, Canon Gideon had been living openly with the virus for 10 years and knew there were many other HIV-positive religious leaders living in silence and fear of discrimination who were in need of care and support. He and his colleagues at the Mukono meeting—convened partly to celebrate the tenth anniversary of his disclosure—believed that, as leaders in their various faith communities, they were uniquely well-placed to break the silence surrounding AIDS and challenge stigma and discrimination. Their Network was launched officially at the 11th International Conference for people living with HIV held in Kampala in October 2003 with the theme "The Dawn of New Positive Leadership." With funding from World Vision International, Christian Aid, SIDA and USAID, the Network started with a series of training workshops in several countries and today has more than 1000 members in most African nations and from all faith-based communities represented on the sub-continent. All members are HIV-positive themselves or caring for close relatives living with HIV.

extend access to treatment. In Uganda, the federation for agricultural, food and hotel workers has partnered with local women's groups to set up clinics on plantations where workers can receive HIV testing and family planning (UNAIDS/ILO/ICFTU, 2006). At the global level, the International Confederation of Free Trade Unions, with 236 affiliated organizations in 154 countries, has partnered with the 10 global union federations to run a Global Unions Programme on HIV/AIDS.

The Global Business Coalition on HIV/AIDS is a leading and expanding alliance of more than 200 international companies which are dedicated to responding to the AIDS epidemic. Its aim is to harness the individual and collective power of the world's top corporations to tackle AIDS at the local, national and international levels. Working to raise awareness and stimulate the business response to AIDS, it created the first international measurement system, the Best Practice AIDS Standard, a quantitative self-assessment tool that measures a company's involvement and guides business strategies for addressing the AIDS pandemic.

National private sectors are also increasing their response to AIDS. A group of leading professional entertainers in Barbados including musicians, performance poets, disc jockeys, songwriters and events planners, formed a network to promote HIV prevention within the national music industry. These champions are developing a strategic approach to the promotion of positive and safer sexual lifestyles, in a context where risk behaviour is often aggressively exploited by the entertainment business. The mobilization and transformation of an organized core

group of music industry professionals and performers creates a powerful medium, given the immense popular appeal of the music industry among the majority of youth in Barbados, and in the Caribbean region as a whole.

Considering how difficult it is to reach sexually active youth through more traditional channels, this innovative approach holds much promise. Early successes include a four-fold increase in the acceptance of voluntary counselling and testing provided by mobile services at music festivals.

Spending money where it most helps

"Community initiatives must be a priority for our support, because they are the foundation for a sustainable response owned by the people who have the most to lose, the most to gain."

Peter Piot, 27th June 2005

In 2005, the amount of money spent on AIDS in low- and middle-income countries was around six times more than was spent in 2001 (see 'Financing' chapter). The dramatic increase is due in part to the tireless advocacy and activism of civil society organizations at all levels. It still falls short of what is required to get ahead of the epidemic, and a number of civil society organizations continue to work across sectors to focus on mobilizing resources and sustaining the commitment of the international community. Raising the level of funding is as important as ensuring the money is used effectively to improve people's lives and slow the course of the epidemic.

CIVIL SOCIETY AND THE GLOBAL FUND

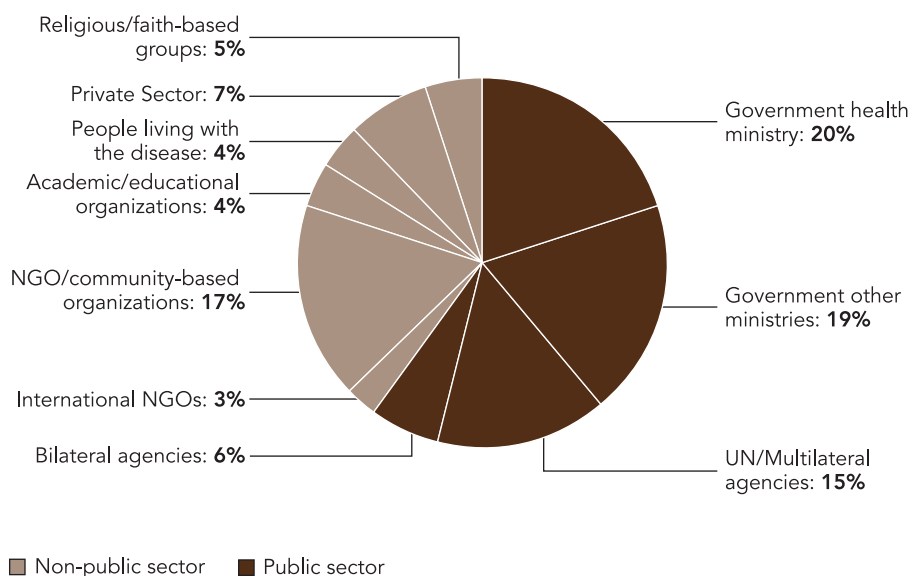
Building on the experiences of other organizations working on AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria set out to offer HIV-positive people and civil society organizations the opportunity to participate in policy and decision-making processes. Nongovernmental organizations and people living with or affected by HIV, tuberculosis or malaria constitute around 25% of the Fund's membership and have full voting rights. The Fund's Country Coordinating Mechanisms—responsible for developing and submitting grant proposals to the Global Fund and overseeing implementation—are required to include representatives from all sectors and interest groups (see Figure 9.1). The Global Fund Partnership Forum, which meets every two years, enables a broad range of stakeholders to provide feedback and

to recommend changes in policies and procedures.

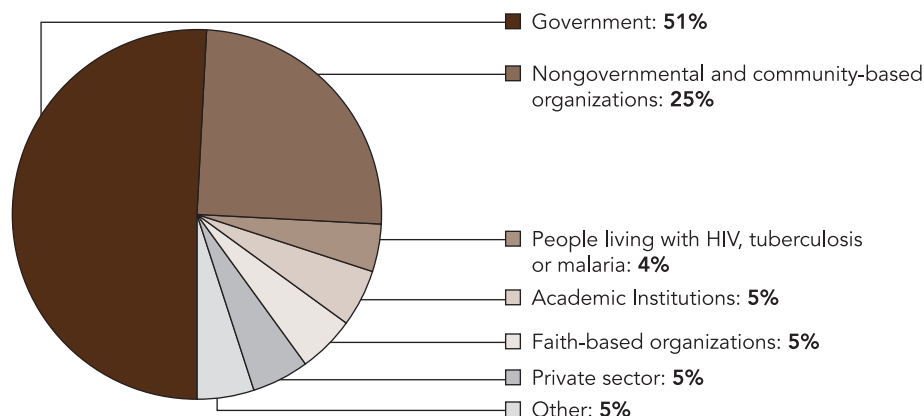
By late 2005, the Fund had committed US\$ 4.4 billion to 350 grants in 128 countries. Nearly one-third of the grants were made to nongovernmental and community-based organizations (see Figure 9.2), many working with difficult-to-reach populations who are at most risk of HIV exposure. In Kazakhstan, for example, the Global Fund is helping the national programme to build partnerships with nongovernmental organizations to provide services for injecting drug users, and sex workers and their clients, among whom the epidemic is spreading fast. In Madagascar, the Fund is directly financing the nongovernmental organization Population Services International to provide information and condom supplies with the aim of reducing sexually transmitted infections, and to increase access to

FIGURE 9.1

Country Coordinating Mechanisms (CCMs):
Entities participating in preparation of Round Four proposals
100% = all representatives of all 78 surveyed CCMs



Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

FIGURE 9.2 Sector of recipients

Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria (2005). Rounds 2–4 only. Information not available for Round 1.

youth-friendly sexual health services (Global Fund, 2006).

IMPROVING EFFECTIVENESS

Evaluation of the Global Fund by a number of organizations, including the Fund itself, shows that, despite the organizational commitment to civil society involvement, performance has been uneven and challenges remain (ICASO, 2004b). For example:

- commitment to multisectoral partnership among the leadership of the Global Fund is often not reflected at country level—many governments lack experience and willingness to work with civil society organizations;
- on many Country Coordinating Mechanisms there is inadequate representation of nongovernmental organizations and vulnerable populations, including people living with HIV, injecting drug users, sex workers, men who have sex with men, and women;
- civil society representatives often do not have a mandate from their constituencies—they may be appointed by government rather than selected

through a democratic and transparent process; and

- civil society representatives often lack the education, skills, confidence and/or financial resources to participate effectively in Country Coordinating Mechanisms or other forums, or to challenge the imbalances of power.

A variety of efforts are being made to respond to these problems. As the Country Coordinating Mechanisms are the gateways to grants and a critical structure for building a truly multisectoral response, it is essential that they function properly. In Arusha in late 2004, the Global Fund's board agreed to guidelines explaining their purpose, structure and composition, with explicit instructions to ensure that civil society constituencies select their representatives, that people living with or affected by the disease be represented, and that the full range of stakeholders participate in developing proposals and overseeing grants (Global Fund, 2005a, 2005b). The Global Fund's Technical Evaluation Reference Group has developed a Country Coordinating Mechanism Performance Checklist available on the

Global Fund website. A handbook to facilitate the involvement of HIV-positive people has been produced by the Global Network of People Living with HIV/AIDS with support from USAID's POLICY Project and Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation). Recently the Global Network and the International Council of AIDS Service Organizations secured a grant from the Open Society Institute to support the developing country delegation to the Global Fund's Board.

Towards greater harmonization of national action

The “Three Ones” principles (one national AIDS action framework, one national AIDS coordinating authority, and one agreed country-level monitoring and evaluation system—see ‘National responses’ chapter) are the foundations of a supportive environment for civil society activities, and simplify the administrative processes involved in the AIDS response. In particular, the national AIDS coordinating authority provides the opportunity to advocate for and move towards a truly meaningful role for civil society in all aspects of the national response, from policy-making and planning to implementation.

The success of the “Three Ones” is threatened, however, by the dramatic imbalance of power which exists between civil society, state and donors. Unless measures are taken to correct it, a new bureaucracy may emerge within which civil society has only token involvement. The outcome will be a response that reflects the agendas of the most powerful stakeholders such as

government ministries or international donors. Building the capacity of civil society groups is a key strategy for redressing this power imbalance. The International HIV/AIDS Alliance and the 2005 discussion paper “Civil Society and the ‘Three Ones’” put forward a two-way process wherein the role and contribution of civil society are explained to governments and donors and advice given on how to respond to its needs. Suggested measures include raising awareness of the function of civil society and improving skills in collaborative planning and jargon-free communication (ICASO, 2005).

Perhaps the most significant outcome of the wide-ranging discussions prompted by the “Three Ones” and other worldwide initiatives has been the recognition that civil society organizations, with their unrivalled understanding of the epidemic and people's needs, are essential components of the national response. If countries are to progress towards meeting the commitments made by their governments at the UN General Assembly Special Session on HIV/AIDS in 2001, every effort must be made to support and strengthen civil society and give it a voice that is heard.

Aware of the multiple challenges faced by civil society organizations—especially the thousands of smaller groups working in isolation at community level—the Institute for Democracy in South Africa offers training in budget analysis and resource tracking to nongovernmental organizations, academics, AIDS activists and others in their region. More recently, the training sessions have expanded to include government officials. Participants from government and civil society prepare budget analyses and draft reports together, actions which help foster understanding and cooperation between them, thus

ADVANCING CIVIL SOCIETY THROUGH THE “THREE ONES”

Experience in two very different countries shows how the “Three Ones” can be used to advance civil society involvement in national AIDS responses.

Indonesia is the fourth most populous country in the world, with 212 million people spread across a vast geographical area and thousands of islands. It has a national AIDS strategy and a national AIDS coordinating authority but is currently going through a process of decentralization. Strategies are therefore needed to ensure that directives from its coordinating authority are not simply imposed on provincial authorities. In the spring of 2005, two civil society consultations were held in Jakarta to explore the concept of the “Three Ones” and facilitate the involvement of civil society. Their recommendations cited the need to make documentation about the “Three Ones” more comprehensible to ordinary Indonesians and communicate the principles widely among stakeholders, including community-based groups which are distanced from global dialogue.

In Nigeria, the Civil Society Network on HIV/AIDS organized a consultation on the “Three Ones” in 2005 to define the roles of different civil society players within the national AIDS framework. The consultation culminated in a civil society Declaration of Commitment on the “Three Ones.” Nigeria’s network of people living with HIV, NEPWHAN, already has two seats on the national AIDS committee, two seats on the antiretroviral therapy committee and is expected to secure two seats on AIDS committees at state level.

promoting the key theme of coordination and greater cooperation that underpins the “Three Ones” Principles.

In Indonesia, civil society organizations in Bali, East Java, Jakarta and Papua are involved in drafting provincial regulations that will determine budgeting for the AIDS response as well as presenting as experts in the parliamentary hearings. In addition to assisting in the planning of AIDS work, civil society is also active in service provision and monitoring. Spiritia, a national support network in Indonesia formed in 1995, assists 65 groups of people living with HIV throughout the country by providing treatment education, basic fact sheets and training in advocacy. Members of the Spiritia team regularly visit most of

Indonesia’s 35 provinces, documenting treatment, care and support and encouraging local government to improve services.

The role played by civil society is often underestimated, largely because it is not systematically measured. Yet it is clear that without the nongovernmental sector’s participation—including the work of vast numbers of volunteers at community level—many of the strategies and targets set by countries and the international community for responding to HIV would be unattainable. The experience and knowledge of these front-line providers is of utmost importance to national policy-making and to the development of stronger public health sectors.

Chapter 10



FINANCING THE RESPONSE TO AIDS

From UNAIDS' launch in 1996 until 2005, available annual funding for the response to AIDS in low- and middle-income countries increased 28-fold, from US\$ 300 million to US\$ 8.3 billion. Existing pledges, commitments and trends suggest the rate of increase may be declining and that available funds will be US\$ 8.9 billion in 2006 and US\$ 10 billion in 2007.

Those amounts will be far short of meeting the estimated requirements of US\$ 14.9 billion in 2006, US\$ 18.1 billion in 2007 and US\$ 22.1 billion in 2008. Looking beyond 2007, an effective response will depend on sustained growth in annual funding until the epidemic is stopped and reversed (UNAIDS, 2005).

Global and national advocacy to boost and sustain political leadership and public support remain essential. Also essential is making far better use of funding flows that are available. That means streamlining the flow of financial resources to the front lines of the epidemic, putting it to optimal use and providing HIV-related prevention, treatment, care and support as quickly as possible to everyone in need.

Current funding in perspective

The annual increases in funding have been impressive but, given the rapid

spread of the epidemic, the resulting amounts are disappointing. In 2005, the 148 countries classified as low- and middle-income by the World Bank (World Bank, 2005) were home to 5.5 billion people, or 85% of the world's population (United Nations, 2005). The estimated annual funding of US\$ 8.3 billion for the AIDS response that year included out-of-pocket spending by HIV-positive people and their households. In millions of cases, they were spending far beyond their capacity and being driven even deeper into poverty and debt but still not receiving antiretroviral therapy and other basic services.

The funding estimates also included everything spent within each country by the government, civil society organizations and private businesses, and everything donated by bilateral and multilateral donors and international civil society organizations, including philanthropic foundations. That same year, the 22 high-income countries that are the main

donors to development aid (and members of the Organisation for Economic Cooperation and Development's Development Assistance Committee) were home to 879 million people, or 13.6% of the world's population. The money spent from all sources on providing those 879 million people with the full range of health services came to more than US\$ 3 trillion (OECD, 2005). That was so even though these 22 countries carry nothing approaching the burden of HIV infection, tuberculosis, malaria, gastrointestinal infection and other poverty-related diseases carried by the 148 low- and middle-income countries.

In the United States, home to 298 million people (4.6% of the world's population), around 55% of annual health-care spending is private, while the remaining 45% is split between the federal and state governments. At the start of 2005, the federal government alone committed to spending US\$ 17.3 billion on the domestic response to AIDS that year (Henry J. Kaiser Family Foundation, 2005).

Comparatively speaking, US\$ 8.3 billion available for spending in low- and middle-income countries in 2005 was not sufficient. More importantly, it did not come close to meeting the actual requirements for that year and that was not just because of the obvious shortfall in the total amount available. It was also because

there was a mismatch between where the money was most needed and where it was actually spent.

Estimated requirements

UNAIDS began estimating financial resource needs in 2001. In early 2005, three expert groups—the Global Resource Tracking Consortium, the UNAIDS Reference Group on Economics, and the UNAIDS Reference Group on Estimates, Modelling and Projections—began developing the current estimates of funding requirements. To help develop the estimates further, the High Level Meeting on the Global Response to AIDS, held in London in March 2005, established a Resource Needs Steering Committee representing donors, national governments, civil society, the private sector and technical partners (UNAIDS, 2005). Figure 10.1 summarizes the resulting estimates of the funding requirements from 2006 through 2008.

PREVENTION

The severity of the epidemic, the current coverage and necessary target coverage of people in need of HIV prevention, and the costs of providing HIV prevention services were all taken into consideration, country by country, to estimate the total

FIGURE 10.1	AIDS funding requirements for low- and middle-income countries			
US\$ billion	2006	2007	2008	2006–2008
Prevention	8.4	10.0	11.4	29.8
Care and treatment	3.0	4.0	5.3	12.3
Support for orphans & vulnerable children	1.6	2.1	2.7	6.4
Programme costs	1.5	1.4	1.8	4.6
Human resources	0.4	0.6	0.9	1.9
Total	14.9	18.1	22.1	55.1

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

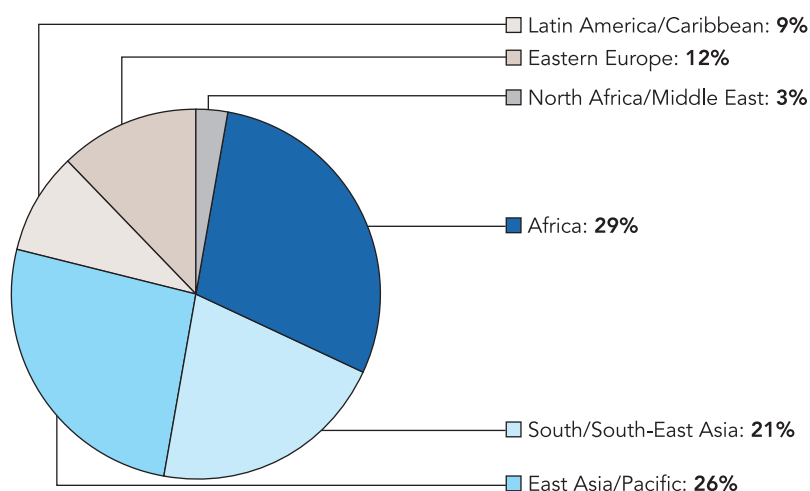
funding requirements. Also taken into consideration were needs for HIV-specific health services, broader interventions in the health-care system (e.g. to ensure blood safety) and activities in non-health sectors (e.g. education). Figure 10.2 shows the resulting estimates of funding required for prevention activities in all low- and middle-income countries, while Figure 10.3 presents these estimated needs by region.

It is estimated that more than half the total required for the AIDS response each year

should go to prevention, due to the many elements that make up comprehensive prevention programmes and the large populations they must reach. Effective prevention activities create environments where people are knowledgeable about HIV, do not stigmatize or discriminate against HIV-positive people or those at greater risk of HIV exposure, and feel safe and comfortable when they take action to establish HIV-related services or seek access to services for themselves or others. In such environments, counselling, testing, treatment and care services will be more

FIGURE 10.2	Funding required for prevention			
Prevention activities (US\$ million)	2006	2007	2008	2006–2008
Mass media	91	100	109	299
Community mobilization	449	608	772	1830
Voluntary counselling and testing	451	569	690	1710
Youth in school	101	104	108	313
Youth out of school	768	945	1126	2838
Programmes focused on sex workers and their clients	429	552	682	1663
Programmes focused on men who have sex with men	312	407	499	1218
Harm reduction programmes for injecting drug users	114	149	180	443
Workplace	421	523	628	1573
Prevention programmes for people living with HIV	22	33	48	103
Special populations	151	252	252	654
Condom social marketing	159	175	190	525
Public and commercial sector condom provision	1381	1501	1625	4506
Improving management of sexually transmitted infections	672	718	764	2154
Prevention of mother-to-child transmission	206	264	324	794
Blood safety	226	228	231	685
Post-exposure prophylaxis (health-care setting, rape)	1	2	2	5
Safe medical injections	897	897	897	2690
Universal precautions	1590	1944	2303	5838
Total	8441	9969	11 430	29 840

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

FIGURE 10.3 Distribution by region of the funding required for prevention

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

effective as people become better informed, less fearful and more likely to take fuller advantage of them. Good prevention is a prerequisite and an essential companion to good treatment and care.

TREATMENT AND CARE

The WHO/UNAIDS “3 by 5” initiative set a target of reaching three million people in need of treatment in low- and middle-income countries with antiretroviral therapy by the end of 2005. Although 1.3 million people were actually reached, this was by no means a failure. When the initiative was launched on World AIDS Day (December 1) 2003, there were only 400 000 people receiving

therapy; an additional 900 000 people started antiretroviral therapy during 2004 or 2005. Besides that significant achievement, the experience of trying to hit the “3 by 5” target taught WHO, UNAIDS and their many partners a great deal about where basic health-care infrastructure and human resources are lacking and where more money needs to be invested to accelerate access to treatment.

Figures 10.4 shows an estimate of the money required over the next three years to accelerate access to treatment at a rate that can achieve levels as close as possible to the most common definition of universal access for treatment by 2010. Figure

FIGURE 10.4 Funding required for treatment and care, including antiretroviral therapy (ART), in order to achieve the coverage targets shown			
Year	People on ART (million)	ART coverage of urgent cases	Total funding (US\$ million)
2006	3.0	55%	2986
2007	4.8	67%	4029
2008	6.6	75%	5250
2009	8.3	79%	-
2010	9.8	80%	-

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

FIGURE 10.5	Distribution by activity of the funding required for treatment and care			
Treatment and care activities (US\$ million)	2006	2007	2008	2006–2008
Palliative care	308	302	295	905
Provider-initiated testing	66	79	109	254
Opportunistic infections treatment	686	703	707	2096
Opportunistic infections prophylaxis	287	403	510	1200
Antiretroviral therapy, including nutritional support	1642	2482	3624	7748
Laboratory testing	54	79	104	237
Total	3043	4048	5349	12 440

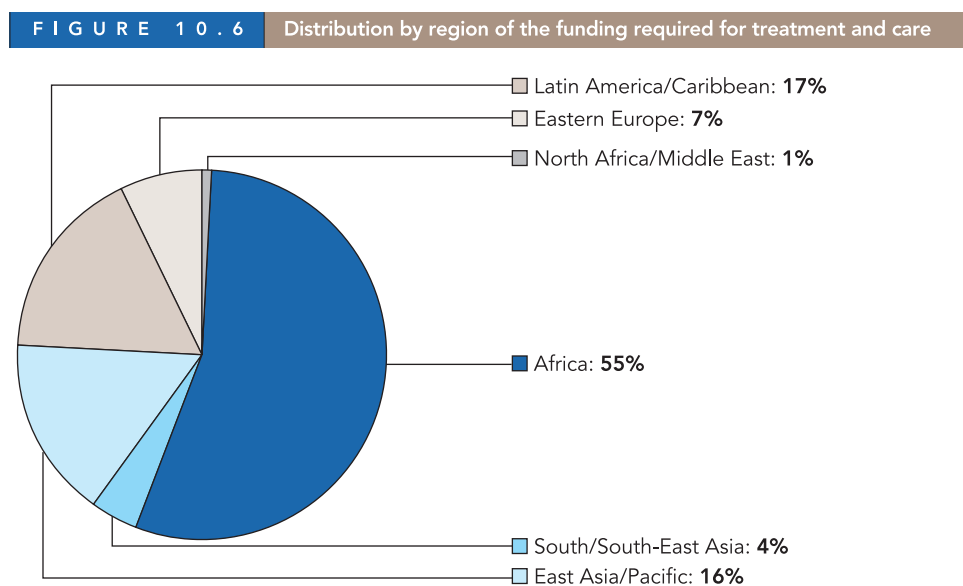
Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

10.5 shows the distribution of funding requirements by activity, while Figure 10.6 shows the distribution by region. It should be noted that research and discussions to specify what “universal access” means in different countries are ongoing. Meanwhile, the working definition used for estimating resource needs is that “universal access” occurs when 80% of all people in urgent need of treatment are receiving it. This is based on the experi-

ence in high-income and some middle-income countries with well-developed health-care systems, where treatment coverage seldom exceeds 80% for a variety of reasons, including adverse reactions to drugs and personal choice.

SUPPORT FOR ORPHANS AND VULNERABLE CHILDREN

Estimates of the funding required for activities supporting orphans and vulnerable



Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

children take into account children living below national poverty lines who are double orphans (having lost both parents), single orphans (having lost one parent) and near orphans (likely to lose a parent within one year) due to their parents' HIV-related illness or death from AIDS. There was multi-agency agreement that, for the purpose of these estimates, UNICEF's estimates for all double, single and near orphans living below the poverty line in sub-Saharan Africa would be used, whatever the cause of their parents' death or illness. This was to reflect the high burden of HIV in the region (Stover et al., 2005). Figure 10.7 shows the funding required by activity. Of the total required from 2006–2008, 95% is required in sub-Saharan Africa.

PROGRAMME SUPPORT AND INFRASTRUCTURE

To deliver the services described above will require improvements to programme support and infrastructure. Estimates include the costs of developing and administering HIV policies, plans and programmes; undertaking monitoring and evaluation, as well as local and international technical assistance; and acquiring equipment, as well as constructing and upgrading health centres, hospitals and laboratories. They include only the costs of building on existing programmes and infrastructure, by increments, and do not include the direct costs incurred in the delivery of services by health and other

workers to the public. As shown in Figure 10.8, they fluctuate from year to year to account for the different stages, from planning to completion, of constructing 2700 new health centres by 2010 and upgrading 19 000 existing health centres and 800 hospitals.

HUMAN RESOURCES

Estimated costs for human resources (as outlined in Figure 9) include only the costs of training, retaining and attracting sufficient numbers of qualified nurses and physicians to support the AIDS response in low-income countries and two middle-income countries, Botswana and South Africa. They do not include the costs of training, retaining and attracting counsellors, clinical officers, adherence supporters, laboratory technicians, palliative care and community workers, or community coordinators. Those are part of the per-patient-visit costs taken into account in the estimates above for prevention, treatment and care, support for orphans and vulnerable children, and programme support. For example, training and honoraria for more than 316 000 community workers are covered under estimates for programme support. Assessing the need for a comprehensive package of human resources to support the scale-up of the AIDS response in each country will require further analysis but the estimates given here are based on the best information currently available.

F I G U R E 1 0 . 7		Funding required for activities supporting orphans and vulnerable children			
Orphan support activities (US\$ million)	2006	2007	2008	2006–2008	
Education	193	287	443	923	
Health-care support	145	174	200	519	
Family/home support	971	1255	1604	3830	
Community support	14	18	25	57	
Organization costs	246	322	422	990	
Total	1569	2055	2694	6319	

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

FIGURE 10.8 Funding required for programme support and infrastructure				
Programme activities (US\$ million)	2006	2007	2008	2006–2008
Management	485	376	390	1251
Advocacy and communications	118	111	111	340
Monitoring and evaluation	148	138	146	432
Operations research	11	7	7	25
Training	72	136	231	439
Logistics and supply, including transportation	305	259	304	868
Supervision of personnel and patient tracking	97	68	92	257
Drug resistance surveillance	69	68	68	205
Construction of new health centres	60	23	167	250
Laboratory and other infrastructure upgrading	121	185	236	542
Programme and infrastructure costs	1486	1371	1753	4610

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

Included in the estimates are the costs of training an additional 5700 student nurses and 3070 student doctors every year between 2006 and 2008, so the first additional student nurses will graduate in 2009 and the additional first student doctors in 2012. (These numbers may seem low but reflect the estimated capacity of existing medical schools in the region.) Also included are the costs of wage supplements in low-income countries, where average annual wages are now US\$ 3200 for nurses and US\$ 5300 for doctors. The supplements will put

their wages midway between what they are now and what they might expect to earn if they accepted jobs in the United Kingdom. These supplements are urgently needed to retain the current drastically depleted supply of nurses and doctors and to add to the supply by retaining new graduates and attracting nurses and doctors from elsewhere.

LIMITATIONS OF THE ESTIMATES

The preceding numbers are estimates of the overall requirements for all low- and middle-income countries. Decisions

FIGURE 10.9 Funding required for building human resource capacity				
US\$ million	2006	2007	2008	2006–2008
Education	50	89	123	262
Nurses' wage supplements	153	261	370	784
Doctors' wage supplements	152	258	366	776
Total	355	608	859	1822

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

about resource allocations in any particular country should be based on assessments of that country's unique circumstances and needs. For example, though the overall requirements suggest that 12% of all money should go towards supporting orphans and vulnerable children, over nine-tenths of that 12% is for sub-Saharan Africa. For countries outside of sub-Saharan Africa, the percentage of all HIV-related requirements assigned to supporting orphans and vulnerable children is likely to be considerably less than 12%. Spending decisions should be based on reliable evidence about the nature of each country's particular epidemic, that is, concentrated among particular groups in urban areas or mainly in certain districts—or generalized and spreading into rural areas. Current efforts should also be reviewed in terms of their resources and programmes, their cost-effectiveness, where more effort might be focused, and whether or not stigma and discrimination are denying equal access to services for everyone in need.

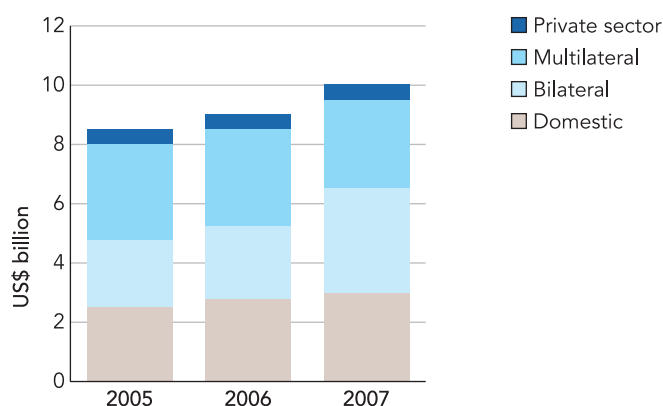
It is also crucial to recognize that any estimate has its limitations, due to limited availability of data and inherent uncertainty about the future. However, given the considerable efforts made to solicit the latest available data, UNAIDS is confident that the preceding resource estimates constitute the best available estimates of overall requirements for low- and middle-income countries for the years 2006 through 2008. In concert with UNAIDS, many international and country-level partners are constantly at work improving and updating the data and analysis that go into making the most reliable estimates possible.

The money available—estimates and trends

Based on UNAIDS projections done in mid-2004, in 2005 there was an estimated US\$ 8.3 billion available for the AIDS response in low- and middle-income countries. If recent trends

FIGURE 10.10

Sources of the estimated and projected funding for the AIDS response from 2005 to 2007*



*Assuming there are no new commitments

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

GLOBAL RESOURCE TRACKING CONSORTIUM AND NATIONAL AIDS SPENDING ESTIMATES

The UNAIDS Global Resource Tracking Consortium provides the baseline data needed for estimating funding availability for future years, including data on existing sources and allocations of funding in all countries. It also assesses absorptive capacity (e.g. human resources and infrastructure to deliver treatment) and identifies bottlenecks (e.g. national drug licensing policies that slow importation of medicines) in countries.

Although the Consortium's members include a growing number of international and regional organizations, it depends on countries' resource tracking practitioners to provide the most comprehensive, reliable and up-to-date information possible. A problem with data from countries is that they usually come in the form of budgets, which are often higher than actual expenditures but also lack sufficient detail. For example, a budget may not count an expenditure on treatment and care of opportunistic infections as HIV-related and may not show that part of the expenditure is recovered from fees (i.e. out-of-pocket spending by patients and their families.) Also, the budgetary data provided by countries usually pertain only to the health sector, not to education or to other sectors.

In 2005, UNAIDS launched an initiative promoting National AIDS Spending Assessments (NASAs) and the establishment of country-wide systems for continually gathering, analysing and reporting data on HIV-related expenditures in all sectors, not just the health sector.

continue and donors honour their prior pledges and commitments, there will be US\$ 8.9 billion available in 2006 and US\$ 10 billion in 2007 (UNAIDS, 2005). Figure 10.10 shows the sources of that funding (note that 'Private sector' in these projections includes not only businesses but also charitable foundations and nongovernmental organizations).

Domestic spending—by people and their governments

UNAIDS projects that funding from domestic sources within low- and middle-income countries will increase from US\$ 2.6 billion in 2005 to US\$ 2.8 billion in 2006 and then to US\$ 3 billion in 2007. Many governments have yet to make HIV a priority in their budget allo-

cations but, if governments and external donors do not spend more, affected individuals and families will have to spend more out of their own pockets.

HOW MUCH AFFECTED INDIVIDUALS AND FAMILIES SPEND

The best available data on domestic spending come from Latin America and the Caribbean, thanks to pioneering work done by the Regional AIDS Initiative for Latin America and the Caribbean (SIDA-LAC and FUNSALUD, 2004). On average, out-of-pocket spending by households accounts for around 25% of all spending on HIV but the percentage varies widely from country to country. In some upper-middle-income countries, governments cover from 80% to 95% of HIV-related costs through their public health and social security programmes. In



While domestic spending now accounts for around 30% of all spending on HIV in low- and middle-income countries, most of that 30% is accounted for by middle-income countries.

some low- and lower-middle-income countries, governments and external donors together cover from 25% to 50% of costs. The balance is covered by out-of-pocket spending.

Where out-of-pocket spending accounts for a high percentage of all HIV spending it is because hospitals and other health-care providers are underfunded. Patients and their families often pay for their own medicines (e.g. antibiotics for the treatment of opportunistic infections) and also pay user fees to cover all or part of the costs of other essentials, such as bedding, meals and disposables.

A 2002 analysis of out-of-pocket spending in 13 Latin American countries found that out-of-pocket expenditure on HIV came to US\$ 73.9 million (around 25% of all HIV expenditure in those countries). Of this, people paid US\$ 18.9 million for clinical services, with half going to antiretroviral therapy. The remainder, US\$ 55 million, paid for condoms (UNAIDS Resource Tracking Consortium, unpublished).

Outside of Latin America and the Caribbean, only a handful of countries have

systematically collected information on out-of-pocket spending but, in sub-Saharan Africa, a series of studies have found that out-of-pocket spending accounts for a substantial share of total spending on HIV. For example, out-of-pocket spending in 2002 accounted for 45% of all HIV expenditure in Kenya, 9.4% in Ghana, and 30% in the Republic of Zambia, and in 2003 for 14% in Burkina Faso (Kates, 2005).

HOW MUCH GOVERNMENTS SPEND

While domestic spending now accounts for around 30% of all spending on HIV in low- and middle-income countries, most of that 30% is accounted for by middle-income countries. UNAIDS estimates that, over the next three years, the largest proportion of spending from all sources will be in sub-Saharan Africa but the largest proportion of domestic spending (around 57% of all domestic spending in low- and middle-income countries) will be in Latin America and the Caribbean (UNAIDS, 2004).

There are two reasons for the asymmetry. First, all but a few of the sub-Saharan African countries are low-income and heavily dependent on external funding

for their response to AIDS, whereas all but a few of the Latin American and Caribbean countries are middle-income and have well-developed health-care systems funded largely by domestic spending. Second, many governments in Asia, Central Europe and elsewhere should be spending more on HIV and could afford to do so but have yet to recognize HIV as an urgent problem requiring more attention. In fact, government spending in the majority of low- and middle-income countries in all regions has not kept pace with the need for expanded and comprehensive prevention, treatment, care and support services. This has been one of the chief constraints on countries' capacity to implement their national AIDS plans.

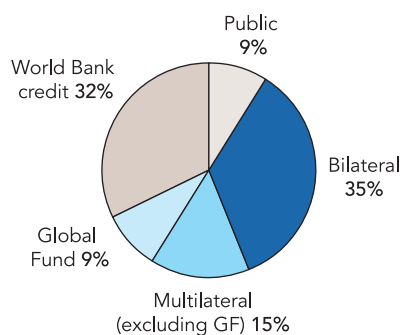
Spending patterns differ considerably from country to country. For example, Burkina Faso is one of the world's poorest countries. In 2003, the country's sources for total expenditure on HIV was external funding (78%); out-of-pocket spending (14.3%) and from government (7.7%). The World Bank, alone, accounted for 25.6% of its total expenditure and for 77% of all resources managed by public organizations. Around 74% of the country's spending went towards HIV prevention, including information, education and communication programmes and condom distribution. Only 26% went towards treatment and care, due largely to the fact that only 1200 people were being provided with antiretroviral therapy, even though many more were in urgent need. That year, the Global Fund to Fight AIDS, Tuberculosis and Malaria approved a grant which would expand treatment coverage to an additional 3500 people.

Until recently, HIV spending estimates for countries have covered only spending

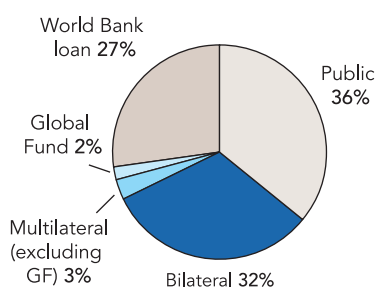
in the health sector. In 2005, UNAIDS began advocating and supporting National AIDS Spending Assessments to help all international and national partners monitor financial flows from all sources into all sectors. Figure 10.11 shows early results, with 2004 HIV spending estimates from three countries broken down by source. The wealth of the three countries differed significantly: with Gross Domestic Product (GDP) per capita of US\$ 1174 in Burkina Faso, US\$ 2982 in India, and US\$ 9230 in the Russian Federation. Per capita spending on HIV also differed significantly, from US\$ 0.28 in the Russian Federation to US\$ 1.28 in Burkina Faso.

Figure 10.12 also shows early results from the new National AIDS Spending Assessments, with 2004 HIV spending estimates from four countries broken down by programmatic area of spending.

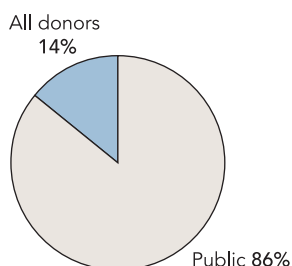
The spending estimates shown in Figure 10.11 and Figure 10.12 show no obvious relationship between countries' per capita spending on HIV and their per capita GDP or the nature of their HIV epidemics—whether their epidemics are low level, concentrated or high level and whether emerging or advanced. Clearly, to meet needs for an expanded and comprehensive response to AIDS, countries will have to increase their total spending on HIV and they will also have to do better jobs of targeting their spending, based on solid evidence of where interventions are most required. In particular, middle-income countries should give higher priority to spending on HIV from their own sources. All countries and donors need to give higher priority to reducing the burden placed on low-income households when they are obliged to pay for their own HIV-related services because no one else will pay.

FIGURE 10.11 Sources of HIV spending in three countries, 2004**BURKINA FASO**

HIV and AIDS spending per capita: US\$ 1.87

**INDIA**

HIV and AIDS spending per capita: US\$ 0.59

**RUSSIAN FEDERATION**

HIV and AIDS spending per capita: US\$ 0.28

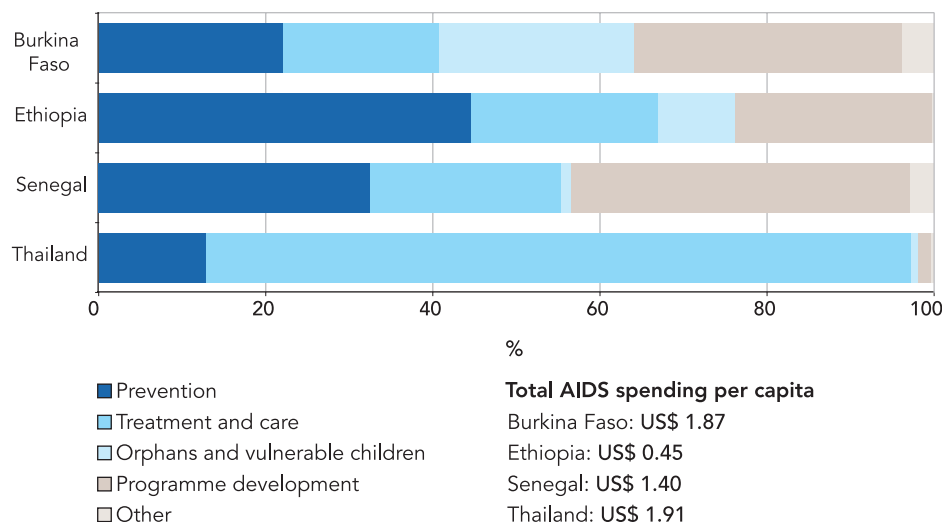
Source: UNAIDS, based on National AIDS Spending Assessments.

Commitments of Official Development Assistance

Donor country governments provide the bulk of the development aid that flows from higher income countries to lower income countries. The main donor countries are the 22 member countries of the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) and they include the G7. Official Development

Assistance (widely known by its acronym, ODA) is the term for development aid from DAC members.

Thirty-seven years ago at the UN General Assembly, Development Assistance Committee members promised to spend 0.7% of their Gross National Income on official development assistance but, to date, only five have achieved this target. In 2005 Development Assistance Committee members renewed the promise

FIGURE 10.12 HIV spending by programmatic area in four countries, 2004

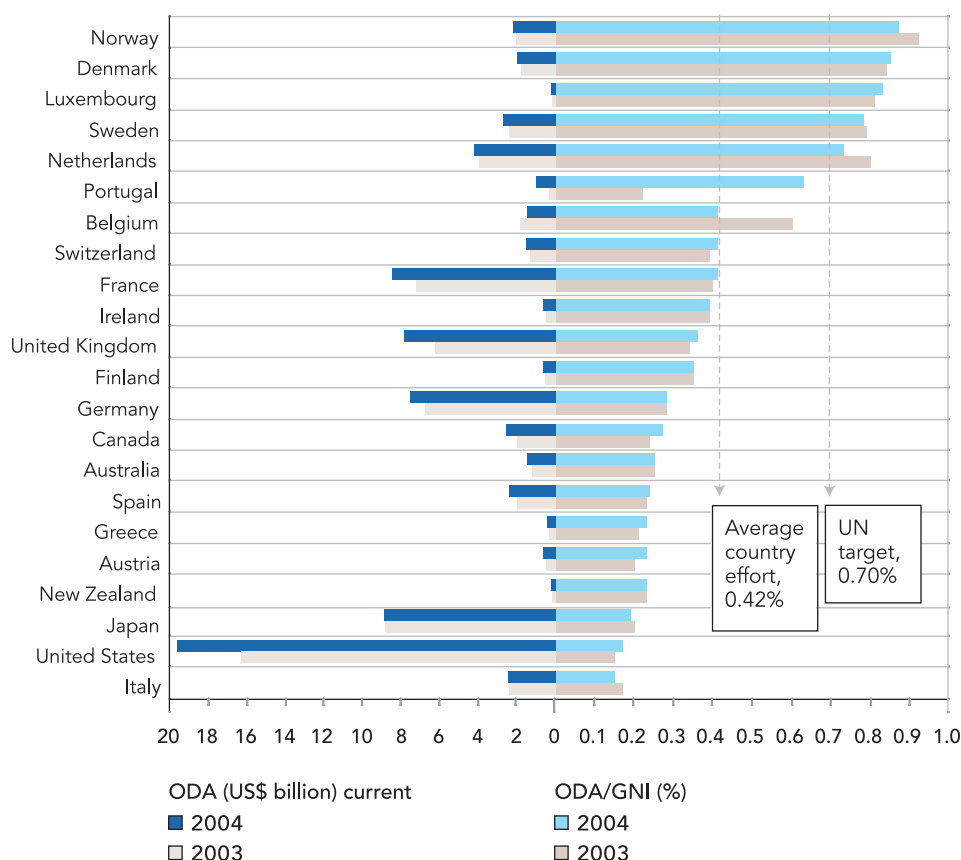
Source: UNAIDS, National AIDS Spending Assessments.

THE MISMATCH BETWEEN GOVERNMENT SPENDING AND COUNTRIES' REAL NEEDS

Over the last few years, many countries have developed national AIDS plans to guide their responses but, in many cases, the plans have not been sufficiently strategic, evidence-based and targeted. Several reviews by the World Bank and others have found that many do not serve as genuine tools for guiding interventions, most are too general, few are followed by annual action plans, and few are informed by recent epidemiological information (Mullen, 2005). It is not surprising, then, that there is a substantial disconnection between what should be financed and what is actually financed at country level.

To illustrate, in one Asian country HIV infection levels in the general population remain low, as indicated by an HIV prevalence of less than 0.3% among pregnant women. By contrast, HIV prevalence among injecting drug users approaches 60% in the largest city and among sex workers it is 30% in selected areas. Data analyses from surveillance indicate that injecting drug use accounts for up to 75% of HIV transmission and that, together, injecting drug use and sex work account for more than 90% of all cases. Yet, despite these data, most of the country's interventions are not directed towards these two groups. This example is not isolated. There are similar situations in many other countries.

Clearly, countries benefit from technical assistance that supports development of national AIDS plans and annual action plans that are strategic, prioritized and responsive to the epidemiological picture in the country. But such assistance has to avoid the all too common pattern of different donors and international aid agencies doing overlapping and uncoordinated studies.

FIGURE 10.13 DAC members' Official Development Assistance in 2003 and 2004

Source: Organisation for Economic Co-operation and Development (2005).

at the G8 Summit at Gleneagles and elsewhere (G8, 2005). Greece is now committed to reaching the 0.7% target in 2007, France in 2012 and the United Kingdom in 2013. If all the 2005 commitments are met, including one to double aid to Africa, the amount will reach nearly US\$ 130 billion in 2010 (OECD, 2006).

Official Development Assistance increased by 5.9% from 2003 to 2004, to reach US\$ 79.5 billion. Their commitment to long-term programmes increased by 13.3%, which shows increasing support to sustained development. Figure 10.13

shows the contributions made by each Development Assistance Committee member country, in absolute terms and as a percentage of Gross National Income.

BILATERAL AND MULTILATERAL FLOWS TO THE AIDS RESPONSE

Official Development Assistance is spent in one of two ways, through bilateral or multilateral aid. Bilateral aid is direct assistance from one country (the bilateral donor) to another, in the form of financial, technical and other assistance to support development, including development of the AIDS response. Multilateral aid is indirect assistance, mostly originating

COMMITMENTS VERSUS DISBURSEMENTS

In any discussion of aid flows, it is important to notice the difference between commitments and disbursements. Donors often commit money one year that may not be spent until the following year or that may be spent over a number of years. In the current environment, where funding for the AIDS response is increasing, the commitments tend to be more than disbursements each year. Depending on the source of information, available figures are often only for commitments or for disbursements but not for both.

with donor countries but some with philanthropic foundations. It goes, first, to multilateral organizations (World Bank, regional development banks, UN agencies and others, including the Global Fund to Fight AIDS, Tuberculosis and Malaria) and they, in turn, give it to recipient countries.

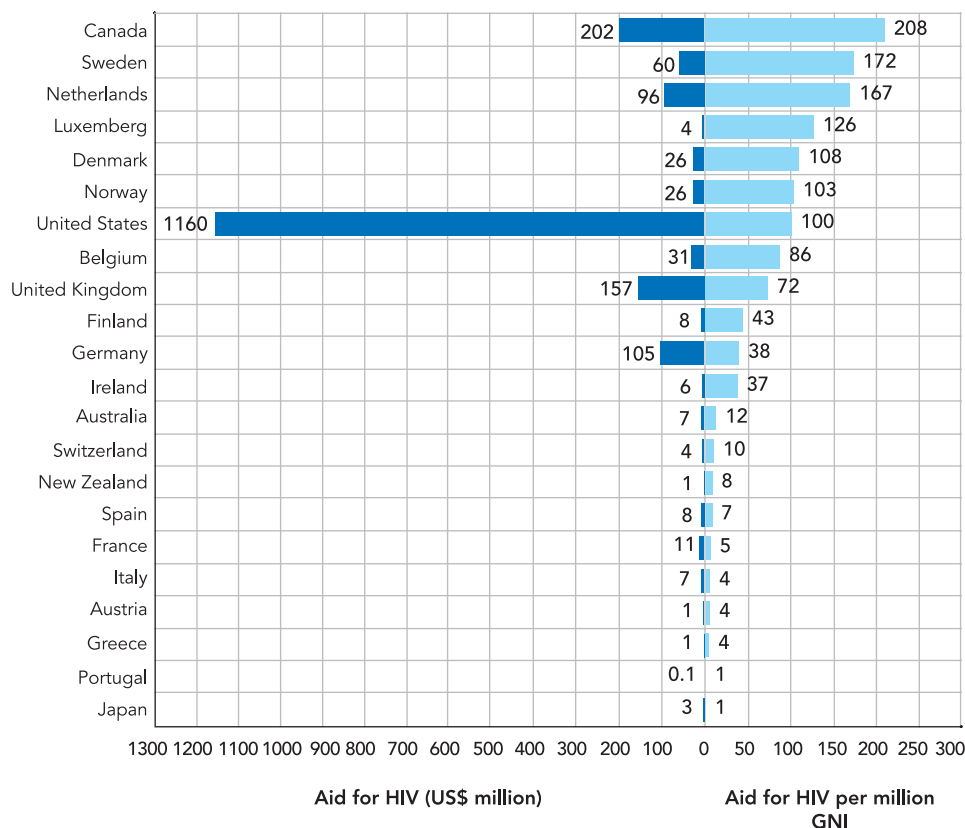
UNAIDS estimates that bilateral and multilateral flows accounted for US\$ 5.7 billion, or 68.8% of the US\$ 8.3 billion available for the AIDS response in 2005. Based on the original pledges, commitments and trends at the time estimates were made, bilateral and multilateral flows will account for US\$ 6.2 billion (70%) of the US\$ 8.9 billion available in 2006 and for US\$ 7.0 billion (70.0%) of the US\$ 10 billion in 2007 (UNAIDS, 2005).

Bilateral flows to the AIDS response

UNAIDS estimates that bilateral support of the AIDS response will grow faster than support from any other source, rising to US\$ 3.7 billion in 2007 (UNAIDS, 2005). The sharp rise will be due mainly to increases in support from the United States President's Emergency Plan for AIDS Relief (PEPFAR), which could be providing about 75% of all bilateral support in 2007. A 2004 study of

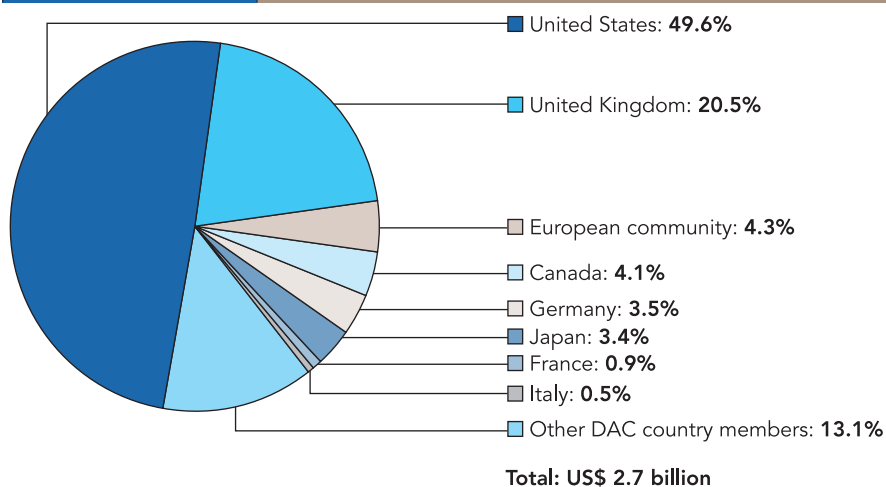
bilateral support from 2000 to 2002 found that large donors tend to focus on treatment programmes, which require substantial funding and long-term commitments. Smaller donors tend to focus on HIV prevention but also support home-based care and some mitigation activities. Figure 10.14 shows how much Development Assistance the member countries committed to the response to HIV, in absolute terms and as a percentage of Gross National Income, for 2004.

The amounts shown in Figure 10.14 are derived from an analysis of Official Development Assistance figures reported to the Organisation for Economic Co-operation and Development, where reports break down commitments by category. For a variety of reasons, a significant amount of spending on HIV is hidden in the official reports (for example, because it is an unidentified part of a larger category of spending on health, education, etc.) An earlier analysis, based on interviews with high ranking officers from Development Assistance Committee member countries, suggests that their actual commitments to HIV spending came to a total of just over US\$ 2.7 billion in 2004 and their disbursement totalled just over US\$ 1.9 billion. Figure 10.15 shows the percentages of the total committed by particular members (Kates, 2005).

FIGURE 10.14 DAC members' Official Development Assistance committed to HIV in 2004

Source: UNAIDS, based on data from DAC members' reports to OECD.

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FIGURE 10.15 DAC members' bilateral commitments to HIV-related programmes in 2004

Source: UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.

THE UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

In January 2003, the United States President announced a commitment of US\$ 15 billion over five years for the global response to AIDS, to be channelled through the United States President's Emergency Plan for AIDS Relief (PEPFAR). Most is channelled bilaterally rather than through multilateral mechanisms and, of that, two thirds is going to 15 focus countries—12 in Africa, 2 in the Caribbean and 1 in Asia—heavily burdened by HIV. The first PEPFAR annual report shows that PEPFAR disbursed US\$ 570.2 million to the AIDS response in those 15 countries in 2004 and was committed to an additional US\$ 915.6 million in 2005 (Office of the United States Global AIDS Coordinator, 2005).

PEPFAR's policy to distribute bilateral funding across HIV-related programmes is as follows:

- 55% for treatment of people with HIV, with 75% of that to be spent on the purchase and distribution of antiretroviral drugs in 2006 and 2007;
- 15% for palliative care of people experiencing HIV-related end-stage illness;
- 20% for HIV prevention, with at least 33% of that to be spent on abstinence-based programmes; and
- 10% for support services for orphans and vulnerable children.

Recognizing that tuberculosis is the leading cause of death among people with HIV, PEPFAR committed US\$ 20 million to HIV-Tuberculosis programmes in 2005 and promised a significant increase in funding for such programmes in 2006.

Multilateral flows to the AIDS response

UNAIDS estimates that multilateral aid accounted for US\$ 3.0 billion, or 36% of the US\$ 8.3 billion available for the AIDS response in 2005. It is likely to remain constant at around US\$ 3.0 billion and account for only 30% of the US\$ 10 billion available in 2007 (UNAIDS, 2005). The Global Fund to Fight AIDS, Tuberculosis and Malaria is the largest source of multilateral financial aid to countries, followed by the World Bank Group, which includes a number of regional development banks. The UNAIDS Secretariat and the other nine UN agency Cosponsors of UNAIDS (besides the World Bank) are sources of multilateral aid but, while some of it comes in the form of funding or co-funding of

country-level programmes, most of it comes in the form of advocacy, information, facilitation, mediation and technical assistance.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The Declaration of Commitment on HIV/AIDS called for “a global HIV/AIDS and health fund” and “a worldwide fund-raising campaign aimed at the general public as well as the private sector” to contribute to the fund. Six months later, in January 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established. Since its launch, the Global Fund has been guided by the “additionality” principle, meaning that its grants should in no way have negative impacts on national



The UNAIDS Secretariat and Cosponsors as well as the World Bank are sources of multi-lateral aid. While some of it comes in the form of funding or co-funding of country level programmes, most of it comes in the form of advocacy, information, facilitation, mediation and technical assistance.

governments' or other partners' commitments to support programmes to address the three diseases.

By the end of December 2005, the Global Fund had received US\$ 4.7 billion in contributions and also pledges that would bring the cumulative total to US\$ 8.6 billion by the end of 2008. It had approved five rounds of grants—in April 2002, January 2003, October 2003, June 2004, and September 2005—for a total of 350 grants to governments and other recipients in 128 countries. Proposals considered by the Fund are divided into two phases, phase 1 covering the first two years and phase 2 usually covering three but sometimes only one or two additional years. The total of all phase 1 and 2 grants approved by the end of 2005 was US\$ 4.8 billion. The total of all proposals approved by the end of 2005 will be US\$ 9.6 billion, assuming all phase 2 grants are approved.

The Global Fund monitors and evaluates implementation of all programmes it funds and disburses funds when programmes are ready to receive them (see 'National responses' chapter). It began making

disbursements in 2003 and total disbursements had come to US\$ 1.9 billion by the end of December 2005, with US\$ 1.1 billion disbursed in 2005 alone. Based on an analysis of actual funding from both phases of all proposals approved in the first five rounds, annual disbursements are distributed as shown in the box below.

Tuberculosis is the leading cause of death among people with HIV infection. Besides supporting tuberculosis-specific programmes, the Global Fund supports programmes that have both HIV and tuberculosis components. As of the end of December 2005, programmes supported by the Global Fund had:

- provided 2.5 million people with counselling and HIV testing;
- put 384 000 people on antiretroviral therapy for HIV and were expected to reach a total of 1.8 million people by the end of their five-year grants;
- reached 600 000 people with treatment for tuberculosis, many of them co-infected with HIV, and were expected to reach a total of 3.5 million people;
- provided 397 000 orphans and vulnerable children with social, medical and educational support; and

DISTRIBUTION OF ALL GLOBAL FUND COMMITMENTS TO THE END OF 2005

- 56% to HIV, 26% to malaria, 17% to tuberculosis, and 1% to health-system strengthening;
- 67% to low-income countries, 25% to lower-middle income and 8% to upper-middle income countries;
- 60% to sub-Saharan Africa; 12% to East Asia and Pacific; 10% to Latin America and Caribbean; 9% to Eastern Europe and Central Asia; 8% to South Asia, Middle East and North Africa;
- 47% to drugs and commodities; 20% to human resources and training; 12% to physical infrastructure; 8% to administration; 6% to monitoring and evaluation; 7% to other; and
- 61% to government, 16% to multilateral organizations, 15% to nongovernmental and community-based organizations, 4% to faith-based organizations, 3% to private sector, 1% to other (based on rounds 2–5 only).

(Note that this breakdown only shows disbursements to Principal Recipients, not to the many civil society organizations that are registered as Sub-Recipients.)

- trained 304 000 additional people to work on HIV, tuberculosis or malaria (Global Fund, 2005).

Set up as a charitable foundation under the laws of Switzerland, the Global Fund is required to be financially prudent. It

only approves a phase 1 or 2 grant if it has sufficient assets to cover all years of that phase. To date, donors have all followed through on the pledges they have made, so the Global Fund is confident it will be able to provide phase 2 grants in a timely manner to all proposals

THE GLOBAL FUND'S VOLUNTARY REPLENISHMENT MECHANISM

Until 2004, the Global Fund to Fight AIDS, Tuberculosis and Malaria depended on ad hoc contributions from more than 45 countries, and also from philanthropic foundations, corporations and individuals. To make its resources more sustainable and predictable, it established the Voluntary Replenishment Mechanism with UN Secretary General Kofi Anan as Chair and regular replenishment meetings attended by representatives of all stakeholder groups. These meetings give them opportunities to review results achieved, comment on the Fund's operations and effectiveness and make pledges based on mutually agreed targets and contributions.

In 2005, there were three replenishment meetings. At the last of these, held in London in September, 29 international donors pledged a total of US\$ 3.7 billion for 2006 and 2007, which was more than half of the Fund's estimated need of US\$ 7 billion for the two-year period. The next meeting, scheduled for July 2006, will seek additional pledges to meet the total need.



International nongovernmental organizations make substantial contributions to the AIDS response in low- and middle-income countries.

approved. Efforts to secure future pledges include a mid-year replenishment conference in 2006, a strategic plan to increase contributions from the private sector and the mobilization of new donors.

WORLD BANK

The World Bank is one of UNAIDS' ten Cosponsors and has the largest HIV-related budget of any UN agency, making it the second largest multilateral donor to the AIDS response in low- and middle-income countries, after the Global Fund to Fight AIDS, Tuberculosis and Malaria. The World Bank has been providing grants, interest-free credits and low-interest loans to support HIV projects in low- and middle-income countries since 1988. It began sharply increasing support in 2000.

By the end of December 2005, the World Bank had committed a cumulative total of more than US\$ 2.5 billion to HIV projects, including HIV components of broader projects. As of December 2005, 79 active projects, approved since 2001, had disbursed US\$ 893 million and were expected to disburse more than one billion more. These commitments, projects and disbursements were as follows.

- Through the World Bank's Multi-Country HIV/AIDS Programme for Africa, US\$ 1.15 billion was committed to 3 subregional projects and 33 projects in 33 different countries in sub-Saharan Africa; US\$ 545 million has been disbursed.
- Through the World Bank's Multi-Country HIV/AIDS Programme for the Caribbean, US\$ 118 million was committed to one regional project and nine projects in nine different countries; US\$ 25 million has been disbursed.
- Through other development programmes, US\$ 706 million was committed to 2 regional projects and 31 country-based projects in 26 different countries (10 in sub-Saharan Africa); US\$ 322 million has been disbursed.

As a major provider of development aid, the World Bank has always been the object of close scrutiny and sharp criticism. It admits to past mistakes and is stepping up efforts to monitor and evaluate its own performance as well as the performance of all projects it funds. In 2005, it published *The World Bank's Global HIV/AIDS Program of Action*, showing

WORLD BANK'S EVOLVING HIV PROGRAMMING

Launched in 2000, the World Bank's Multi-Country HIV/AIDS Programme (MAP) has introduced a number of innovations to donor practices, including funding the operating and recurring costs of multisectoral programmes; instituting simplified procedures for approval and disbursement of funds; and directly funding civil society programming at the national, district and community levels. MAP was designed to meet the challenge of responding to AIDS in Africa. Lessons learnt while trying to meet that challenge have led to redesign so that it now accommodates a far wider scope and complexity of activity than traditional World Bank funding was able to accommodate. It was anticipated, at the outset, that this would be the case and recognized that programme implementation would require intense supervision and technical assistance and, also, constant learning and alteration of the design. Such was the success of the programme in Africa that one for the Caribbean was established.

Aside from MAP, the World Bank has developed new ways of supporting cross-country interventions that cannot be supported through individual country programmes. These include subregional AIDS programmes in the Caribbean, Central America, Central Asia and Africa. The World Bank has also integrated HIV programming into development projects (e.g. construction of transportation corridors or pipelines) by requiring safeguards against HIV infection where there is risk of HIV transmission.

how it intends to proceed over the next few years (World Bank, 2005).

OTHER UNAIDS COSPONSORS AND THE UNAIDS SECRETARIAT

All agencies in the United Nations system are responsible for mainstreaming HIV strategies and activities into their policies and programmes, and that includes providing HIV-related services to their own employees and their families. The main agencies contributing to the global response to AIDS, however, are the UNAIDS Secretariat and their 10 Cosponsors.

Every two years, the UNAIDS Programme Coordinating Board approves a UNAIDS Unified Budget and Workplan (UBW) allocating funds for specific activities and identifying which agency or agencies will be responsible for each activity. Under this budget, activities of the

UNAIDS Secretariat and the Cosponsors are guided by the UNAIDS' Strategic Framework for Action (UNAIDS, 2003). It sets five main objectives and one cross-cutting objective: to build human resource capacity for responding to AIDS in countries. The five main objectives are:

1. To empower leadership for the country response to AIDS.
2. To mobilize and empower public, private and civil society partnerships.
3. To promote and strengthen management of strategic information.
4. To build capacities to plan, track, monitor and evaluate country responses.
5. To facilitate access to technical and financial resources.

In addition, each of the Cosponsors engages in HIV-related activities that are

consistent with its general mandate. In 2005, for example, the Office of the United Nations High Commissioner for Refugees (UNHCR) carried out activities aimed at ensuring that HIV-related prevention, treatment, care and support were provided to the approximately 20 million refugees, asylum seekers, returnees and other persons of concern for which it has a mandated responsibility.

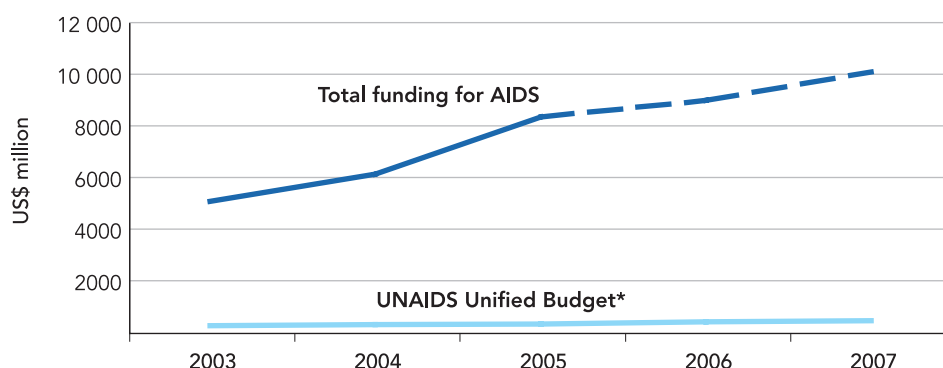
The Unified Budget for 2004 and 2005 was US\$ 522 million, an average of US\$ 261 million per year. The Cosponsors' HIV-related country-level budgets brought the total to US\$ 1.34 billion, an average of US\$ 667 million per year (UNAIDS, 2003). The UNAIDS Unified Budget for 2006 and 2007 is US\$ 797 million, an average of US\$ 398.5 million per year, up by 52.7% from the 2004–2005 average. The Cosponsors' country-level budgets for HIV-related activities bring the total to US\$ 2.56 billion, an average of US\$ 1.28 billion per year, up by 91.0% from the 2004–2005 yearly average (UNAIDS, 2005). Figure 10.16 compares increases in the Unified Budget to increases to the total amount available for the response to

AIDS in low- and middle-income countries.

Flows from business, foundations and nongovernmental organizations

The UNAIDS projections of HIV-spending conducted in mid-2004 and illustrated in Figure 10.10 used the term “private sector” very broadly, to include private businesses, foundations and nongovernmental organizations and particularly those with an international reach, rather than ones based in countries. (The projections do not include in-kind contributions made by private businesses through their AIDS-in-the-workplace programmes or through extending those programmes out into surrounding communities.) The 2001 Declaration of Commitment called for a worldwide fund-raising campaign aimed at this sector but, so far, the results have been disappointing. Given the trends, UNAIDS projects that contributions from these sources will remain constant at around US\$ 400 million for 2006, 2007 and 2008 and three-quarters of that amount

FIGURE 10.16 UNAIDS Unified Budget compared to resources available for HIV in low- and middle-income countries

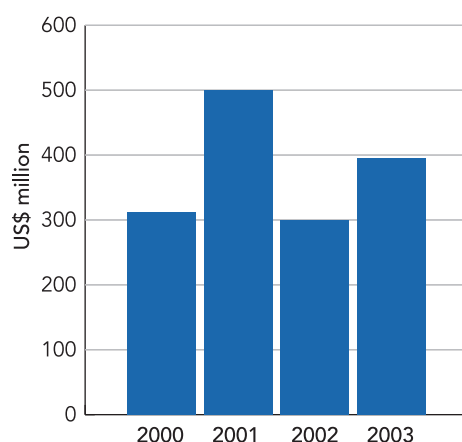


*UNAIDS Unified Budget includes core, supplemental and agency own resources. It does not include estimates of country-level spending by Cosponsors.

Source: UNAIDS (2005). UNAIDS Unified Budget and Workplan 2006–2007.

FIGURE 10.17

Commitments by foundations based in the United States to domestic and global HIV projects, 2000–2003



Source: Funders Concerned About AIDS (2005).

will come from foundations based in the United States (UNAIDS, 2005).

FOUNDATIONS

Independent bodies in both the United States and Europe have attempted to quantify the contribution of charitable foundations to HIV funding in recent years. As shown in Figure 10.17, a study by Funders Concerned about AIDS found that 2003 was the fourth consecutive year in which US-based foundations (including the charitable arms of corporations) committed more than US\$ 300 million to the domestic and global AIDS response (Funders Concerned about AIDS, 2005). Of the US\$ 394.5 million committed in 2003, US\$ 308.2 million was for projects that would benefit low- and middle-income countries and, of that, two thirds was committed by the Bill and Melinda Gates Foundation. The amount for projects benefiting low- and middle-income countries was distributed as follows:

- 75% to organizations based in North America or Western Europe which would use it for global projects or re-

granting to projects in low- and middle-income countries;

- 14% to Africa and Middle East;
- 8% to Asia and Pacific;
- 2% to Eastern Europe and Central Asia; and
- 1% to Latin America and Caribbean.

In Europe, a 2005 study by the European HIV/AIDS Funders Group found that, in 2003, foundations based in Europe disbursed the equivalent of US\$ 33.6 million to HIV-related projects that would benefit low- and middle-income countries (European HIV/AIDS Funders, 2005). The study noted that traditions and laws in the United States support a level of private philanthropic activity found in few other countries. It also noted the advantages that private grant-makers have over public ones, including the ability to innovate and take risks.

INTERNATIONAL NONGOVERNMENTAL ORGANIZATIONS

International nongovernmental organizations make substantial contributions to the AIDS response in low- and middle-income countries. It is sometimes

assumed that they derive all of their revenue from members of the public who respond to their fund-raising campaigns but, in fact, they usually derive most of their revenue from bilateral and multilateral donors and foundations. There are hundreds of international nongovernmental organizations, large and small, engaged in international development work and putting at least some of their effort into the response to AIDS. Currently, however, there are insufficient data on which to base even approximate estimates of the financial value of their collective contributions to the AIDS response and to avoid double-counting of contributions made by others.

Funding for HIV vaccine and microbicide research

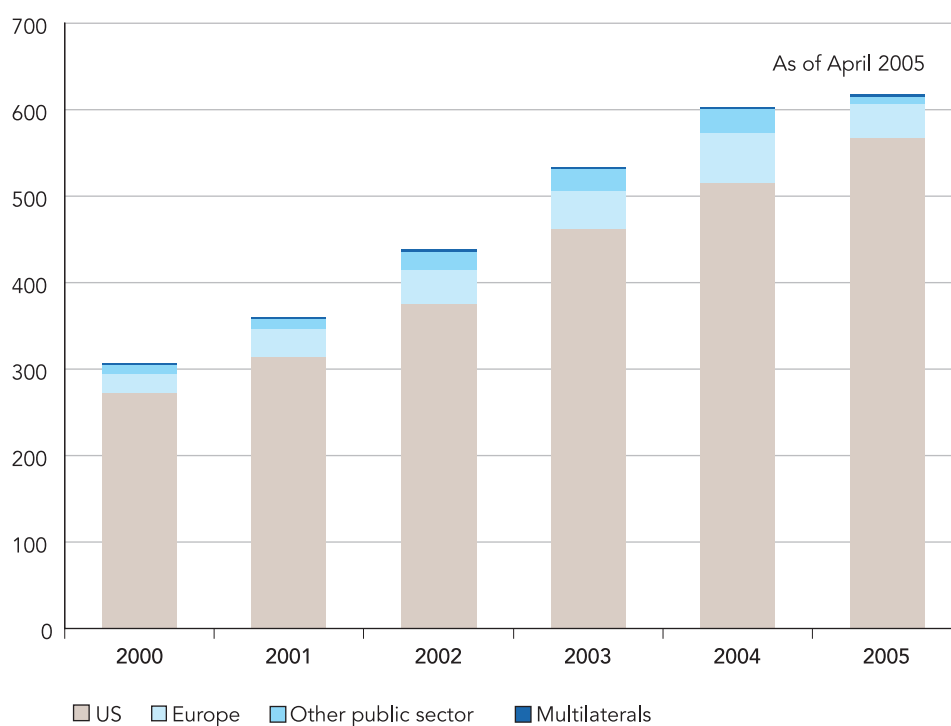
HIV vaccines and microbicides will benefit people in all countries, from the richest to the poorest. For that reason, expenditures and requirements for research and development of these products are not factored into any of the estimates provided elsewhere in this chapter. Though there is increasing scientific confidence that it will be possible to develop safe and effective preventive HIV vaccines and microbicides, there are many challenges that will require the investment of significantly more resources than have been available so far.

The Coordinating Committee of the Global HIV Vaccine Enterprise estimates that disbursements of US\$ 1.2 billion per year are required to accelerate the search for a safe and effective HIV vaccine. There was approximately US\$ 682 million available in 2004, of which 88% was from the public sector

(governments and universities), 10% from industry and 2% from private philanthropy. Since 2000, there has been a slight decline in funding from industry. Though pharmaceutical and biotechnology companies invest heavily in developing many other health-care products, they have invested little in developing an HIV vaccine. By contrast, public-sector financing has increased considerably, as shown in Figure 10.18. (For 2005, actual disbursements and firm commitments made as of April 2005 are taken into account (HIV Vaccines and Microbicides Resource Tracking Working Group, 2005).)

The International Partnership for Microbicides and the Alliance for Microbicide Development estimate that over the next five years, US\$ 280 million per year will be required to accelerate the search for safe and effective microbicides. Figure 10.19 shows that total non-commercial investment increased from US\$ 65.1 million in 2000 to US\$ 163.4 million in 2005, still far short of the amount required. As in the case of the search for an HIV vaccine, pharmaceutical and biotechnology companies have shown little interest in this work. They have developed a number of microbicide candidates for testing but, in 2004, their own investments were estimated to be less than US\$ 6 million (HIV Vaccines and Microbicides Resource Tracking Working Group, 2005).

Funding is only one component of the significant contribution the public sector makes to HIV vaccine and microbicide research. The public sector in low- and middle-income countries provides essential in-kind support. In countries where trials of candidate vaccines and microbicides

FIGURE 10.18 Annual public-sector investment in preventive HIV vaccine research and development between 2000 and 2005 by region

Source: HIV Vaccines and Microbicides Resource Tracking Working Group (2005).

are tested, hospitals and clinics and their regular salaried staff play crucial roles in conducting and supporting the trials. National regulatory authorities and ethics committees work to ensure that candidate products are safe and trials are conducted

in an acceptable manner. In sub-Saharan Africa, for example, the African AIDS Vaccine Programme supports countries to develop national HIV vaccine plans and works with local partners to devise methods to recruit and retain volunteers for

FIGURE 10.19

Annual public- and philanthropic-sector investment in microbicide research and development between 2000 and 2005 (US\$ million)

	2000	2001	2002	2003	2004	2005
PUBLIC SECTOR						
United States	34.6	61.3	75.3	78.8	92.0	99.3
Europe	0.7	0.4	5.1	10.6	29.9	37.8
Other	0.3	<0.1	0.2	0.9	2.0	5.0
Multilaterals	<0.1	0.3	0.4	<0.1	0.2	0.2
Total public	35.7	62.0	81.0	90.2	124.2	142.3
PHILANTHROPIC SECTOR						
Total philanthropic	29.4	3.4	24.8	16.9	18.1	21.1
NON-COMMERCIAL (Public & Philanthropic)						
Total non-commercial	65.1	65.4	105.8	107.1	142.3	163.4

Source: HIV Vaccines and Microbicides Resource Tracking Working Group (2005).

THE MISMATCH BETWEEN DONORS' AID AND COUNTRIES' REAL NEEDS

The summary of estimated funding requirements is based on estimates of the amount of money needed for specific HIV prevention, treatment and other activities in all low- and middle-income countries. Few countries have produced comparable estimates, based on sound evidence of where spending is needed, and few have mechanisms through which all stakeholders agree on estimates and priorities and allocate resources accordingly. In addition, donor countries have their own priorities and these often do not coincide with recipient countries' priorities. As a result, there is a significant mismatch between spending and actual needs.

In recent years, donors have increased their aid in response to the need to build countries' capacity to respond to the HIV epidemic. A question now being asked is, "Why does capacity building seem to be lagging so far behind the increase in aid?" The answer is complex but two factors stand out. First, donors' policies often limit the scope for using their aid. If it comes in the form of money it is frequently tied to conditions that require currency exchange and purchase of imported goods (e.g. drugs, equipment and supplies). If it comes in another form, it usually consists of foreign technical assistance or foreign-managed construction of health facilities. Second, countries' needs are mostly for core budget expenditures that are mainly local (e.g. wages for nurses, doctors and other personnel) and are recurring.

There is general consensus that current methods of managing aid are inefficient and ineffective (see 'National responses' chapter). The long-term nature of the epidemic means that countries need sustained and predictable funding that increases over time. Given the predominantly local and recurring nature of countries' real financial needs, donor aid should be in the form of ongoing support for general budgets or specific parts of budgets. In countries that meet public expenditure management standards, aid flows through government budgets can improve harmonization and help strengthen governance, minimizing the need for disbursement through parallel systems outside of government.

the trials and ensure that they are properly informed and protected.

Measuring the gap: available versus required funding

According to the estimates described above (see Figure 10.1), funding needed for the AIDS response in low- and middle-income countries will be US\$ 14.9 billion in 2006 and US\$ 18.1 billion in 2007 but only US\$ 8.9 billion and US\$ 10 billion will be available. It is

tempting to do the arithmetic and conclude that there is urgent need for additional commitments of US\$ 6 billion and US\$ 8.1 billion. However, measuring the gap between what may be available and what will be required is not so simple.

Closing the gap

To meet the funding requirements, there must be action on two fronts. First, more money must be raised. There is

Rising levels of funding and ongoing efforts to improve the management of financial resources provide grounds for cautious optimism about support for national responses to AIDS.



considerable potential for several of the current sources of funding, including governments of middle-income countries, to commit more to the AIDS response. There is also potential for the main donor countries to raise money in new ways by, for example, adding an AIDS tax to air fares or income tax and by issuing bonds. It is clear, however, that enough funding to meet the requirements can be achieved only if the main donor countries fulfil the promises they made, first, at the G8 Summit at Gleneagles, Scotland, in July 2005 (G8, 2005) and then at the 2005 World Summit in New York in September. At the latter, a UN General Assembly resolution reaffirmed Member States' commitments to the Millennium Declaration (2000) and Declaration of Commitment on HIV/AIDS (2001) and stated a new commitment to "developing and implementing a package for HIV-prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it" (United Nations, 2005).

Second, the national and international partners in the response to AIDS must stay on course and accelerate efforts to

build countries' capacity to respond to AIDS and make better use of whatever money may be available. The following chapter discusses the challenges faced in scaling up national responses and how the partners are meeting them, guided by the "Three Ones" principles. However, two issues regarding funding should be emphasized here: absorptive capacity and the importance of resource tracking.

ABSORPTIVE CAPACITY

As well as being the most heavily burdened by HIV, the countries of sub-Saharan Africa also have weak health-care systems. This has raised concerns that implementing agencies in those countries may not be able to translate rapidly increasing financial support into programme spending in a timely manner.

Evidence from South Africa shows that, after initial delays while establishing new programmes or enhancing existing ones, the country's government agencies were able to rapidly increase their spending on HIV-related programmes. The South African Government launched the National Integrated Plan for HIV/AIDS in 2000, and it involved conditional grants from

three ministries to their nine provincial counterparts in health, education and social development. During the first year (fiscal year 2000–2001) the provincial authorities were able to spend only 36.5% of the funds made available to them that year. During the second year, they were able to spend 74.5% of the funds and, by the third year, they had reached a spending rate of 85%. A 2003 study concluded:

The massive improvement in spending over the next two years suggests that the problem initially was not the CG [conditional grant] mechanism, itself, but the mammoth administration and financial management challenges to be expected in the first year of a national programme. Getting the NIP [National Integrated Plan for HIV/AIDS] programmes up and running required setting up management structures and employing co-ordinators in the provinces, developing financial transfer and monitoring systems and establishing programme standards, plans and materials (Hickey et al., 2003).

A 2005 study found, however, that South Africa is still hampered by its weak health-care system and insufficient government capacity to absorb funds. It concluded:

“Increased government and donor allocations for HIV and AIDS, without improved capacity to spend, challenge the overall strength of the health system. . . . Absorptive capacity is increasingly becoming the issue for HIV and AIDS spending in South Africa, rather than availability of resources. For this reason the donor community should . . . invest in capacity building in the government system to ensure that the resources they inject into the government are utilised effectively and efficiently” (Ndlovu, 2005).

Another study found that the design of a country’s own funding mechanisms can

improve absorption of nationally sourced funds but that bilateral donors’ funds are more problematic. This is due, in large part, to conditions bilateral donors attach to their funds. Evidence from South Africa and Mozambique indicates that, while “ring-fenced” funding (i.e. funding that restricts spending to certain activities) can help ensure that new and critical projects are supported, such funding may clash with national priorities. This decreases flexibility for programme managers as they try to manage the flow of funds so that they serve countries’ own priorities (NACC, 2004).

Accurate analysis of expenditures of bilateral funding for HIV is rendered largely unfeasible because of the tendency of bilateral donors to report only on the amounts they have committed, rather than on amounts actually disbursed. However, government officials in Africa estimate that actual disbursement rates from bilateral donors may be below 50% (Ndlovu, 2005).

RESOURCE TRACKING

One of the most serious obstacles to proper use of funds comes in the form of “bottlenecks”—bureaucratic procedures or regulations that stop or slow down the flow of financial resources from the original source (e.g. a national government or donor) to final destination (e.g. a service provider on the front lines of the epidemic). Because typically there are several intermediaries between source and destination, it is important to map all of these elements (sources, intermediaries and destinations) and track the flow of money so problems can be identified. The greater the number of intermediaries, the more likely fund transfers will be delayed and some of the original amounts lost or stopped along the way.

AIDS budget analyses conducted in Kenya, Mozambique, Namibia and South Africa show the value of resource tracking monitoring whether disbursed funding is actually being spent. For example, in Kenya from April 2002 to May 2003, only 60% of the money approved by the National AIDS Coordinating Council for community-based organizations was actually disbursed to the organizations. Of the 60% that reached them, only 42% was actually spent. This meant that only 25% of the funding approved for community-based organizations over that period was actually spent during that period (NACC, 2004).

Ensuring that prevention, treatment and care are properly funded

Rising levels of funding and ongoing efforts to improve the management of financial resources provide grounds for cautious optimism about support for national responses to AIDS. There are three significant *ifs*, however. *If* the funding requirements for 2006–2008 (shown in Figure 10.1) can be met, *if* adequate funding can be sustained beyond 2008 and *if* the national and international partners can meet the challenges outlined

above, the following could be achieved by 2010:

- Comprehensive HIV prevention, based on the characteristics of the epidemic in each country, including programmes to reduce risk behaviours by those at greatest risk of exposure to HIV, as well as all adults and youth; to prevent mother-to-child transmission; and to ensure safe blood supplies and injections.
- Treatment and care for 9.8 million people, including 80% of those in urgent need.
- Adequate support for all orphans and vulnerable children, including home support, schooling, health care and community support.
- Sufficient programme capacity (planning, administration, staff, etc.) and infrastructure (hospitals, health centres, laboratories, etc.) to support the interventions shown.
- Sufficient numbers of appropriately trained nurses, doctors and other personnel to support the above (UNAIDS, 2005).

Those achievements would constitute the “package for HIV-prevention, treatment and care” by 2010 called for by the UN General Assembly at the 2005 World Summit (United Nations, 2005).

Chapter 11



GETTING THE BEST OUT OF NATIONAL RESPONSES

Until recently, AIDS advocacy focused largely on fostering leadership and commitment and mobilizing the financial resources required to mount an effective response to AIDS, globally and within countries. Since 2001, such advocacy has attracted substantial year-after-year increases in funding, making it ever more realistic to hope the AIDS epidemic will be halted and reversed by 2015, the goal set out in the Millennium Declaration (United Nations, 2000). More leadership and more money are still urgently needed, and thus these two areas of focus remain essential, but now there is widespread recognition that a third focus is also vital: making the money work more effectively.

Why is this necessary? As more money has become available, more government, international, civil society and other organizations have been responding to AIDS in many of the low- and middle-income countries most heavily burdened by the epidemic. Often, there have been no mutually agreed-upon strategies or mechanisms guiding, coordinating, monitoring and evaluating their efforts. The result has been duplication, waste and serious gaps in the national AIDS response in many countries. Often, for example, there has been insufficient surveillance to identify the people whose behaviour places them most at risk of infection and consequent failure to reach these people with

prevention, treatment, care and support services.

Globally and within countries, as the main players have become increasingly aware of this issue, a central question has arisen in their minds: how can they, individually and collectively, make better use of whatever money may be available to reduce the number of new cases of HIV infection and to reduce the harm done by infection when it occurs and do both these things as quickly as possible? The short answer is that countries must lead and bilateral and multilateral organizations must follow, becoming partners with national governments and other country-level stakeholders.

The framework for international cooperation on country-led development

In 2002, the United Nations Conference on Financing Development in Monterrey, Mexico, concluded that the best way of making optimal use of the available money was through country-led processes through which bilateral and multilateral donors work in partnership with national governments and other country-level stakeholders in mobilizing all the resources available to each country, whether from internal or external sources. Known as the Monterrey Consensus, this end-of-meeting agreement expanded on that conclusion and now provides the framework for international cooperation on development in low- and middle-income countries (United Nations, 2002).

Subsequent meetings have built on the Monterrey Consensus. In February 2003, the High Level Forum on Harmonization issued the Rome Declaration committing donor countries, host countries and bilateral and multilateral institutions to

harmonize their policies and procedures (World Bank, 2003). In March 2005, the High Level Forum on Joint Progress toward Aid Effectiveness reviewed results of action to implement the Rome Declaration and issued the Paris Declaration (see box) committing international and national partners to a specific set of harmonization measures.

Guiding principles for country-led action

At the 13th International Conference on AIDS and Sexually Transmitted Infections in Africa, held in Nairobi, Kenya, in September 2003, a working group of country and international representatives developed a set of guiding principles for improving the AIDS response in countries. These principles became known as the “Three Ones” and were endorsed by donor countries, host countries, bilateral and multilateral institutions and international nongovernmental organizations at the Consultation on Harmonization of International AIDS Funding in Washington, DC, United States, in April 2004



Often, for example, there has been insufficient surveillance to identify the people whose behaviour places them most at risk of infection and consequent failure to reach these people with prevention, treatment, care and support services.

PARIS DECLARATION ON AID EFFECTIVENESS

In March 2005, senior ministers from donor countries and host countries and the heads of bilateral and multilateral institutions met at the High Level Forum on Joint Progress toward Aid Effectiveness hosted by the Development Assistance Committee of the Organisation for Economic Co-operation and Development. Their end-of-meeting agreement (the Paris Declaration) states their resolve to “scale up for more effective aid” by:

- strengthening host countries’ capacity to develop and deliver results-driven national development strategies;
- defining performance standards and measures for host countries’ financial management systems and other systems;
- reforming and simplifying donors’ policies and procedures to make them as cost effective as possible, to reduce unnecessary duplication and bureaucratic burden on countries and to achieve progressive alignment with host countries’ policies and procedures;
- providing more predictable, multi-year aid flows consistent with the sustainable development needs of host countries;
- doing a better job of integrating global initiatives—in areas such as HIV and AIDS—into host countries’ broader development agendas; and
- enhancing both donor countries’ and host countries’ accountability to their citizens and parliaments by making their policies, procedures and activities more transparent.

(UNAIDS, 2004). The “Three Ones” are:

- One agreed AIDS action framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority, with a broad-based multisectoral mandate; and
- One agreed country-level monitoring and evaluation system.

The Washington meeting called on UNAIDS to act as facilitator and mediator for all the partners in country-led efforts to apply the “Three Ones” and to support integration of monitoring and evaluation into national policies, programmes and reports. It also called on each bilateral and multilateral donor, international aid agency and international nongovernmental organization to play its

part. Instead of entering into its own unique relations with its country-level partners, each would harmonize its policies and procedures with country-led ones and coordinate its activities through country-based mechanisms recognized by all the partners. In other words, international cooperation on national action against AIDS would be consistent with the Monterrey Consensus, the Rome Declaration and, more recently, the Paris Declaration.

In March 2005, donor countries, host countries, bilateral and multilateral institutions and international nongovernmental organizations met again, in London at the High Level Forum on the Global Response to AIDS. The meeting—entitled “Making the money work: the ‘Three Ones’ in action”—concluded with a decision to



In order for all those concerned to work towards common objectives according to common priorities, the Global Task Team recommended that countries 'mainstream' AIDS into their national development plans and public expenditure frameworks.

establish a Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. Its mandate was to develop recommendations for action by bilateral and multilateral institutions to strengthen their support for the country-led response to AIDS (UNAIDS, 2005a).

Global Task Team: building support for the principles

"The 'Three Ones' represents our promise to developing nations that we will work with their national plan, under their coordinating authority, using their monitoring and evaluation systems. We certainly want to help them develop these things where assistance is needed, but they must own them."

Ambassador Randall L. Tobias, United States Global AIDS Coordinator

The Global Task Team's recommendations, presented in June 2005, were aimed mainly at multilateral institutions (UN agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria)

but were also considered applicable to bilateral institutions (UNAIDS, 2005b). In response to the recommendations, the multilateral institutions agreed on:

- a division of labour (UNAIDS, 2005c);
- a Consolidated UN Technical Support Plan (UNAIDS, 2005d); and
- a Global Joint Problem-Solving and Implementation Support Team.

The First "One": an agreed AIDS action framework

In order for all those concerned to work towards common objectives according to common priorities, the Global Task Team recommended that:

- countries engage all key stakeholders in the development of annual priority AIDS action plans that are evidence-based, multisectoral, prioritized, fully budgeted and permit clear and simple monitoring and evaluation. These plans should clearly delineate the roles and responsibilities of all stakeholders, stating who does what, when and where. They should detail, prioritize and

budget for any needs for technical support and for building capacity of human resources and infrastructure;

- countries 'mainstream' AIDS into their national development plans and public expenditure frameworks;
- donors comply with the Paris Declaration on Aid Effectiveness and shift their support from short-term projects to sustained programmes;
- multilateral institutions, including UN agencies, work with countries to develop internationally recognized standards for annual priority AIDS action plans plus a simple self-assessment tool. They should also assist with the simple and rapid development of plans through processes that do not interfere with continuing implementation.

As outlined below, countries generally face five main challenges in applying the first "One": (i) facing the facts and countering stigma and discrimination; (ii) engaging all key stakeholders; (iii) gathering and analysing strategic information; (iv) translating AIDS action frameworks into annual priority action plans with budgets; and (v) mainstreaming AIDS strategies into national development plans and expenditure frameworks.

FACING THE FACTS AND COUNTERING STIGMA AND DISCRIMINATION

A recent analysis of the experience of Asian countries found that the most successful programmes to prevent the spread of AIDS have three features in common. First, they face the facts about how HIV is mainly transmitted in their region, i.e. by anal or vaginal penetration without condoms or by injecting drugs with contaminated needles and syringes. Second, they provide ready access to information, services and supplies on a scale large enough to have an impact on

the rate of transmission among people who participate in these activities by reaching most men who have sex with men, injecting drug users, sex workers and men who live and work in isolated settings such as prisons, mines and military camps. Third, they provide secure and supportive social and political environments where people most at risk feel safe taking advantage of the information, services and supplies on offer (Monitoring the AIDS Pandemic, 2004).

When the AIDS epidemic emerges in a country, it tends to appear first among people whose behaviours are the objects of traditional taboos, social prejudices and general embarrassment and may even be illegal, or it may simply appear among the young, who often defy behavioural norms. One result is that people in these key populations do their best to remain invisible to disapproving eyes. If countries do not face the facts and respond appropriately at this early stage, they may soon find themselves with concentrated epidemics, where there is a high prevalence of HIV among these populations. Since these populations are not isolated but overlap and interact sexually with others in society, countries may eventually find themselves with generalized epidemics, with a high prevalence of HIV among the whole population.

Country-specific information (including data from good surveillance of HIV disease and behaviours associated with the disease) and education that counters ignorance, stigma and discrimination are essential elements of any effort to mobilize the public and their leaders—not only to start a realistic response to AIDS but also to keep accelerating, adjusting and sustaining the response until the epidemic is halted and reversed.

ENGAGING ALL KEY STAKEHOLDERS

If key stakeholders are left out of processes for developing, reviewing and updating the national AIDS plan, it is unlikely that the plan will be comprehensive and well balanced, taking all stakeholders' legitimate concerns into account and giving them fair weight. It is also unlikely that all key stakeholders will be committed to participating in implementing the plan or accepting it as an instrument that should guide their efforts. The key stakeholders include:

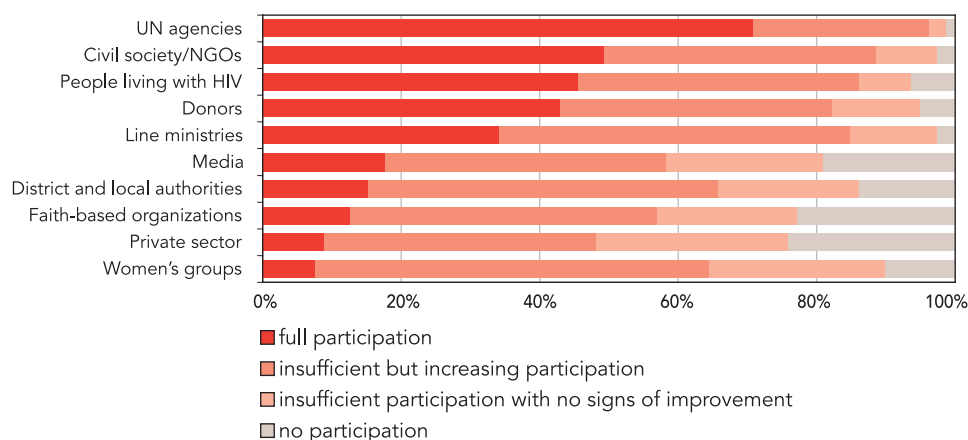
- national government ministries responsible for key sectors of socioeconomic development, including not only ministries of health but also other ministries, such as those responsible for finance, national planning, district and local affairs, education, employment and labour, social services, justice, defence and agriculture;
- provincial, district and local government authorities;
- civil society organizations (including faith-based organizations) at the international, national and subnational levels,

including those involved in delivering AIDS-related services;

- individuals and networks of people living with HIV and people at high risk of infection, including youth, women, men who have sex with men, injecting drug users, sex workers, people with sexually transmitted infections, men who live and work in isolated settings, mobile populations (migrant workers, refugees and displaced people, asylum seekers and people who have been trafficked);
- the private sector, from the largest international corporation to the smallest local business and from large labour unions to small workers' associations; and
- bilateral and multilateral donors, international institutions and philanthropic foundations.

In its 2004 UNAIDS Annual Country Report survey, UNAIDS Country Coordinators assessed the degree of participation of many of the main categories of stakeholder in the review and update of national AIDS plans. Figure 11.1 shows the results, indicating that the

FIGURE 11.1 Stakeholder participation in development of national AIDS plans in 79 countries, 2004



Source: UNAIDS (2006). From advocacy to action: a progress report on UNAIDS at country-level. UNAIDS.

highest degrees of participation were by UN agencies, followed by associations of people living with HIV and donors. The lowest degrees of participation were by faith-based organizations, the private sector and women's groups.

GATHERING AND ANALYSING STRATEGIC INFORMATION

Any effective plan against AIDS is based on reliable information about: (i) the people infected and affected by HIV; (ii) the conditions and behaviours that put those people at risk; (iii) the resources available for the response; (iv) current efforts to intervene with prevention, treatment, care and support; (v) the results of those efforts; and (vi) what other coun-

tries are doing that may be worth adapting.

How countries are meeting the challenge of gathering the evidence on which to base their plans is discussed at greater length in the Third "One" section later in this chapter.

TRANSLATING AIDS ACTION FRAMEWORKS INTO ANNUAL ACTION PLANS

While an overall philosophy and broad set of aims can be a useful beginning, a national AIDS plan may amount to little more than a statement of good intentions unless it also outlines firm commitments to specific objectives and milestones for achievement. For the plan to be effective,

IN LATIN AMERICA, UNRELIABLE DATA HAVE LED TO NEGLECT OF MEN WHO HAVE SEX WITH MEN

Annual spending estimates provided by the Regional AIDS Initiative for Latin America and the Caribbean confirm that many Latin American countries make little effort to provide AIDS-related services that address the needs of men who have sex with men (SIDALAC, 2005). In fact, many Latin American countries have done little sentinel surveillance to provide reliable evidence on which to base their HIV estimates on prevalence. Instead, they have relied on passive surveillance, using reports from hospitals and clinics of people who have presented with symptoms and have been subsequently tested. Since people often have no symptoms until years after they are infected, such records do not provide up-to-date data. Neither do they provide reliable evidence of the mode of transmission in countries where men having sex with men is strictly taboo. Often, health professionals are too embarrassed to ask the right questions and, even if asked, men are afraid to provide the right answers (PAHO et al., 2005).

Recently reported findings of a study that carried out surveillance between 1999 and 2002 in a number of cities in the Andean countries found that HIV prevalence among men who have sex with men was as high as 23.7% in a Bolivian city, 19.7% in a Columbian city, 27.9% in an Ecuadorian city and 13.7% in a Peruvian city and averaged 12.0% in all cities covered by the study (Montano et al., 2005). Surveillance in the capital cities and seaports of Central America between 2000 and 2002 found HIV prevalence among men who have sex with men averaging 17.7% in El Salvador, 11.5% in Guatemala, 13.0% in Honduras, 9.3% in Nicaragua and 10.6% in Panama (PASCA et al., 2003).



While an overall philosophy and broad set of aims can be a useful beginning, a national AIDS plan may amount to little more than a statement of good intentions unless it also outlines firm commitments to specific objectives and milestones for achievement.

these objectives and milestones must be translated into annual AIDS action plans with budgets, assigning responsibilities and tasks and allocating resources to all partners that are called on to act.

In 2004, Indonesia had a population of more than 220 million people and more than 100 000 were infected with HIV. It was in the early stages of mobilizing its comprehensive response to an emerging and rapidly spreading AIDS epidemic largely concentrated among injecting drug users, except in Papua province, where the epidemic was generalized. Since the 1990s, Australia and the United States had been providing support for capacity-building in national and provincial AIDS commissions and in the ministry of health and also supporting the work of many nongovernmental organizations, with emphasis on outreach to populations at greatest risk of infection. However, the national government had allocated an annual budget of only US\$ 10.6 million for implementation of the country's National AIDS Strategy. Despite public commitments by six ministers and six governors of the most affected provinces, the small budget meant the National AIDS Commission

was unable to take full advantage of this political support by mobilizing the ministries and provinces for comprehensive action.

A breakthrough came in June 2004 when the Global Fund approved a grant of US\$ 65 million. In late 2004, the Country Coordinating Mechanism was revitalized by an internal task force. This process saw the establishment of a Country Coordinating Mechanism Secretariat that now shares office space and other resources with the National AIDS Commission Secretariat. A further grant of £25 million (US\$ 43.9 million), from the United Kingdom's Department for International Development, established the Indonesian Partnership Fund for HIV/AIDS to support capacity-building of the National AIDS Commission Secretariat and implementation of the National AIDS Strategy. Now, for the first time, Indonesia's National AIDS Commission and its Secretariat are able to translate the National AIDS Strategy into action plans with supporting budgets for key partners. In early 2006, four regional meetings launched a minimum response package for 100 priority districts and cities across the country.

MAINSTREAMING AIDS STRATEGIES INTO NATIONAL DEVELOPMENT PLANS AND EXPENDITURE FRAMEWORKS

A UNAIDS survey of 68 low- and middle-income countries with Poverty Reduction Strategy Papers showed that 48 had included AIDS strategies in their papers. These papers are prerequisite to grants, interest-free credits and low-interest loans from the World Bank and are among the main development instruments of most low- and middle-income countries heavily burdened by AIDS. Other instruments include National Development Plans, Medium Term Expenditures Frameworks and the annual plans and budgets of national government ministries and their district and local counterparts. Failure to include AIDS strategies in Poverty Reduction Strategy Papers is a strong indication of failure to mainstream the national response to AIDS into the regular work of all sectors of government at the national, district and local levels. (It also indicates failure to mainstream the national response in public-sector workplaces, since providing AIDS-related services to employees and their families is a major contribution all employers can make to the national response.)

The World Bank, UNDP and UNAIDS Secretariat are currently engaged in a joint project to build the capacity of countries to mainstream their response to AIDS into their Poverty Reduction Strategy Papers. Assessments in Ethiopia, Ghana, Mali, Rwanda, Senegal, the United Republic of Tanzania and Zambia have collected views from key stakeholders and produced 'issue' papers outlining progress and identifying challenges for each country. A joint regional workshop for the seven countries used these issue papers as the basis for action plans to mainstream their AIDS response into their Poverty Reduction Strategy Papers through 2006 and 2007. During 2006 and 2007, additional rounds of assessment, issue paper production and action plan development will build mainstreaming capacity in other countries with Poverty Reduction Strategy Papers in Africa, the Asia-Pacific region, Latin America and the Caribbean, eastern Europe and the Commonwealth of Independent States.

In December 1997, after taking part in a symposium at the Xth International Conference on STD/AIDS in Africa, held in Abidjan, Côte d'Ivoire, mayors and municipal leaders from 10 countries

WHAT DOES IT MEAN TO 'MAINSTREAM' AIDS?

Mainstreaming AIDS has been broadly defined as "a process that enables all development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace" (UNAIDS, 2005d). For example, in August 2004, representatives of the four major faith-based groups (Roman Catholic, Evangelical, Islamic and Orthodox) in Ethiopia committed themselves to mainstreaming AIDS into their spiritual and development endeavours. Governments have a particular responsibility, however, to lead the way in all sectors (such as health, education and justice) and at all levels (national, district and local).

in sub-Saharan Africa issued the Abidjan Declaration stating their commitment to address AIDS in their communities and to work in solidarity with each other and in partnership with national, international and public and private stakeholders. At the Africities Summit in 1998, also in Abidjan, they launched the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa, which now has 'chapters' in 13 countries. Before Swaziland's chapter of this alliance was established in 2001, there was no organized local government response to AIDS in the country. Now the governments of all 12 major municipalities, with around 25% of the country's population, collaborate with the National Emergency Response Council on HIV and AIDS and are in partnership with more than 25 national and international organizations on building capacity and scaling up prevention, treatment and care for municipal residents (AMICAALL, 2006).

A comprehensive national HIV and AIDS response must also include marginalized populations such as refugees and internally displaced people. Integrating these populations into existing HIV programmes for surrounding host popula-

tions is complementary to the national effort and makes public health sense as these populations often mix and interact closely. Uganda and Zambia have integrated host and refugee HIV programmes, leading to improved infrastructure of district hospitals (UNAIDS/ UNHCR, 2005).

The Second "One": a national AIDS coordinating authority

The Global Task Team recommends that:

- national AIDS coordinating authorities take the lead and bilateral and multilateral institutions harmonize their policies and activities with those of the national AIDS coordinating authorities;
- when requested by countries, the Joint UN Team on AIDS support national AIDS coordinating authorities in building their capacity to develop AIDS action plans, to coordinate multi-stakeholder implementation and to monitor and evaluate results;
- when requested by countries, multilateral and bilateral partners assist other stakeholders to convene under the umbrella of the national AIDS



The World Bank, United Nations Development Programme and UNAIDS Secretariat are currently engaged in a joint project to build the capacity of countries to mainstream their response to AIDS into their Poverty Reduction Strategy Papers.

Fostering leadership has been a major focus of AIDS advocacy since the epidemic emerged 25 years ago, when people living with HIV or at high risk of infection became leaders themselves and began demanding leadership and specific commitment from politicians and other stakeholders.



coordinating authority in teams for problem-solving and action on human-resource capacity development and other matters;

- when requested by countries, the Global Fund, World Bank and UNAIDS Secretariat support efforts to address problems and clarify relations between national AIDS coordinating authorities and Country Coordinating Mechanisms and disseminate examples of good practice.

Typically, a national AIDS coordinating authority includes both a governing council and a secretariat or some other entity acting under the council's oversight and direction. It derives its authority from three sources: (i) from government, which requires political leadership, commitment and delegation of authority through laws, policies and procedures; (ii) from its own competence, which requires adequate budgets, qualified staff and access to advice, training and technical support; and (iii) from stakeholders who recognize its mandate from government and its competence.

Stakeholders will only have confidence in a national AIDS coordinating authority if

they feel they are adequately consulted and otherwise involved in mutually beneficial relationships with the authority. To build such relationships with all key stakeholders, the national AIDS coordinating authority needs to build or encourage the building of structures (e.g. committees or partnership forums) as vehicles for communication of information and ideas and for coordination of efforts. It may also require specialized staff, skilled in attracting, sustaining and coordinating the involvement of hundreds of stakeholders. In addition, it requires stakeholder leadership, commitment and capacity to be meaningfully involved.

The nature and quality of the existing authorities vary vastly, however, and there is room for improvement even in the best of them. Countries face four main challenges in applying the second "One": (i) fostering leadership and commitment; (ii) establishing the legal and policy framework; (iii) developing structures for engagement of stakeholders; and (iv) building partnerships with international development agencies. Learning from other countries' experiences and actively collaborating with them are

among the ways of meeting these challenges.

FOSTERING LEADERSHIP AND COMMITMENT

The degree of stakeholder involvement, as discussed earlier in this chapter, is a fair measure of the degree of leadership, not only at the highest levels of government but also within line ministries, district and local authorities and other stakeholder groups. Fostering leadership has been a major focus of AIDS advocacy since the epidemic emerged 25 years ago, when people living with HIV or at high risk of infection became leaders themselves and began demanding leadership and specific commitment from politicians and other stakeholders.

An example can be seen in the Asia Pacific Leadership Forum on HIV/AIDS and Development. Launched in 2002, it has proved effective in supporting and strengthening political and civil society leadership within 33 countries and at subregional and regional levels. The forum is guided by a Steering Committee of prominent leaders—for example, the former prime ministers of India and Thailand, the former First Lady of Papua New Guinea and the Chief of China's Institute of Viral Disease Control and Prevention. It has developed a number of advocacy tools, including a book featuring statements from prominent political and civil leaders in the region which has been translated into many of the region's languages. It also hosts advocacy events for leaders in different fields, including the media and faith-based organizations (APLF et al., 2005). Over the past three years, the Asia Pacific Leadership Forum has worked with the Pacific Islands Forum to develop the Pacific Regional Strategy on HIV/AIDS (2004–2008) and the Pacific Regional Strategy Implementation Plan,

which was approved in October 2005. Regional cooperation on fostering leadership and commitment and developing a common strategy has proved to be a cost-effective way for the 22 small island nations of the Pacific region to respond to AIDS (Secretariat of the Pacific Community, 2005).

ESTABLISHING THE LEGAL AND POLICY FRAMEWORK

In general, a national AIDS coordinating authority will be strengthened if its mandate to lead and coordinate the national AIDS response is specified in law and if the law also specifies its relationships with the country's most senior authorities (e.g. prime minister, cabinet committee and parliament) and with ministries. Without such a specific mandate, a national AIDS coordinating authority may find itself overridden or undermined by, for example, senior ministries with their own AIDS agendas.

A national AIDS coordinating authority will also be strengthened by a national AIDS policy laying out the government's broad aims (e.g. protecting public health and reducing harm associated with HIV) and specifying its attitudes towards such matters as respecting human rights, protecting confidentiality and assisting with harm reduction even in the case of behaviours that may be illegal (e.g. injecting drug use and sex work). Related legislation should be reviewed and reformed to ensure that it is in accordance with the national policy. The International Labour Organization, for example, advises governments on the review and, if necessary, redrafting of labour legislation to include HIV and AIDS, with particular attention to preventing discrimination in employment.

The legislation must be carefully crafted, however, to ensure that the national

Civil society organizations have understood that ensuring their engagement will require leadership on their part and they have been asserting this leadership to ensure that their interests are taken into full consideration.



AIDS coordinating authority is an active, well-functioning body. In Mozambique, a May 2000 Ministerial Decree established what promised to be a powerful National AIDS Council, with the Prime Minister as chair, the Minister of Health as vice-chair, representatives from the ministries of finance, planning and development, education, women and social action and youth and sports, plus representatives from parliament, civil society organizations, universities and the media. When a multi-agency advocacy mission

visited Mozambique in March 2005, however, it found that the National AIDS Council had not met for more than a year. As a result of the visit, the council met twice in April 2005, reviewed the composition of its board and agreed to involve provincial leaders and decentralize the national response to provinces and communities. In November 2005, a “Three Ones” assessment mission found that there had been further action to revitalize the council. In response to complaints that the civil society

PRIME MINISTER OF VIET NAM LEADS A MULTI-MINISTRY RESPONSE

In March 2004, Viet Nam’s Prime Minister approved the National Strategy on HIV/AIDS Prevention and Control, which extends to 2010 and also establishes a vision to 2020. It was developed by the Ministry of Health, one of three ministries that serve as secretariats to the National Committee for AIDS, Drugs and Prostitution Prevention and Control, a committee chaired by the Prime Minister. The Strategy calls for coordination by the Ministry of Health and action by five other ministries. In December 2004, the Prime Minister declared that 2005 would be “the year for AIDS programme implementation” and called for all ministries to develop AIDS plans for their sectors. Also in 2004, the Prime Minister initiated development of the 2006–2010 Socioeconomic Development Plan, identifying AIDS as a major issue to be addressed in the plan. In addition, he asked the Communist Party to become active in AIDS through the Fatherland Front (a coalition which mobilizes society), the Viet Nam Women’s Union and the Viet Nam Youth Union (UNAIDS, 2005e).

representatives were appointed by government, a process has been established whereby civil society umbrella groups appoint their own representatives. The umbrella groups include a national network of civil society organizations, a national network of people living with HIV, the Mozambican Christian Council, ECOSIDA (an organization representing businesses against AIDS) and the Organization of Mozambican Workers. With its new, more committed membership, the National AIDS Council has been meeting every 45 days and has become much more active (Barcellos, 2005).

A “Three Ones” assessment mission to Zambia in early 2005 found that the 2002 act of parliament establishing the National AIDS Council had created an organizational structure strong at its base, with Provincial and District AIDS Task Forces that facilitated involvement of a broad range of government agencies, civil society organizations and private businesses. However, it had weaknesses at the top, including a largely inactive National AIDS Council, whose authority was undermined by the fact that the Director-General of the National AIDS Council Secretariat could bypass the council and report directly to the Cabinet Committee of Ministers on HIV/AIDS. The mission also noted that there was a draft National HIV/AIDS Policy outlining a broad vision for the national response but it was insufficiently specific to provide useful guidance to the review in progress and for updating the national AIDS plans (Roseberry et al., 2005). The draft was subsequently amended and the policy adopted by Zambia’s parliament in June 2005 was more specific in identifying measures for realization of the vision. It also clarified the legal and institutional framework.

DEVELOPING STRUCTURES FOR ENGAGEMENT OF STAKEHOLDERS

Since September 2003, when the 13th International Conference on AIDS and Sexually Transmitted Infections in Africa formulated the “Three Ones” principles, countries have been taking steps to improve stakeholder engagement. Much of the drive for this movement has come from civil society organizations. In the past, they have been insufficiently involved in the mechanisms for developing and implementing national AIDS plans and in monitoring and evaluating results. They now see that the “Three Ones” principles, with their emphasis on a multisectoral response, present strong arguments for greater involvement.

Civil society organizations have understood that ensuring their engagement will require leadership on their part and they have been asserting this leadership to ensure that their interests are taken into full consideration. For example, in early 2005, the International HIV/AIDS Alliance and International Council of AIDS Service Organizations collaborated on a discussion paper outlining the opportunities and challenges presented by the “Three Ones.” At a joint UNAIDS and civil society planning meeting in Recife, Brazil, in September 2005, it was agreed that civil society organizations would play a role in monitoring progress on the 2001 UN General Assembly’s Declaration of Commitment on HIV/AIDS and would prepare their own reports on progress in selected countries, to be considered alongside the reports submitted by countries (UNAIDS, 2005f).

Civil society organizations and other key stakeholders are often not sufficiently engaged in developing national AIDS plans and other processes, though there are signs

BRAZIL PROVIDES FOR BROAD STAKEHOLDER ENGAGEMENT

Brazil is often cited as a model of good practice when it comes to responding to AIDS. One key to Brazil's success is that the country's national AIDS response is guided by three forums and a number of advisory committees involving a broad range of stakeholders, including more than 1800 civil society organizations.

Meeting four times a year, the National AIDS Commission has representatives from universities, research institutions, faith-based organizations, private enterprise, labour organizations, civil society, national government ministries and agencies from the federal district and state and local government. The Articulating Commission for Social Movements, which also meets four times a year, is a forum for people living with HIV and populations at risk, including indigenous people, other racial minorities, women, young people, self-identified gay men, transvestites and injecting drug users. The third forum coordinates activities at the state and local level. In addition, there are advisory committees on specialized areas such as prevention, support, vaccine research and the media.

The three forums and advisory committees are all involved in regular reviews and updates of the national AIDS plan and their involvement means that they are strongly committed to seeing that it is implemented. Although the structure of the plan is strong, the National AIDS Commission recognizes that the plan needs to be extended to rural states and communities where recent surveillance gives reason for concern. In Brazil, as everywhere else, building, sustaining and improving the structure for engagement will always be a continuing process.

of improvement in terms of stakeholder engagement in many countries. They have been doing this through such measures as making their national AIDS councils more broadly representative and adding or strengthening committees and partnership forums through which networks of stakeholders are engaged in developing, reviewing and updating national AIDS plans and coordinating their efforts to implement the plans and monitor and evaluate the results.

Each country has to discover the mechanisms that suit its own circumstances best but, at the same time, each country can learn from what other countries are doing.

BUILDING PARTNERSHIPS WITH INTERNATIONAL DEVELOPMENT AGENCIES

In March 2005, before establishing the Global Task Team, the High Level Forum on the Global Response to AIDS considered a report describing problems countries often experience in their relations with donors. They include: (i) limited donor participation in the development of national AIDS plans; (ii) limited harmonization of policies and procedures among donors and between donors and national AIDS coordinating authorities; (iii) lack of transparency, with the result that donors' policies, procedures and decisions are not always apparent; (iv) donors' tendency to follow their own

agendas rather than agendas set by countries; (v) donor preference for supporting projects rather than continuing programmes; (vi) donor preference for using their own financial mechanisms rather than government mechanisms; and (vii) high transaction costs resulting from donors' policies and procedures (UNAIDS, 2005g).

Many countries have been finding their own unique solutions. In 2005, for example, the Government of the United Republic of Tanzania combined the Country Coordinating Mechanisms with other financial coordinating mechanisms to form the Tanzania National Coordinating Mechanism. The Secretariat of the Tanzania Commission for AIDS doubles as the Secretariat for the Tanzania National Coordinating Mechanism, which is chaired by the Permanent Secretary of the Prime Minister's Office. Represented on the Coordinating Mechanism are the ministries of health and finance, Office of the President, civil society organizations including faith-based organizations, people living with HIV, academia, the Trade Union Congress, the AIDS Business Coalition and the Media Council

of Tanzania. Also represented are the Development Partners Group (an umbrella group representing a number of bilateral donors), the United States President's Emergency Plan for AIDS Relief and UN agencies (Global Fund, 2005).

After the Global Task Team produced its recommendations in June 2005, the Global Fund commissioned an independent assessment of its proposal development and review process (European Health Group, 2006) and, with the World Bank, a study comparing the strengths of the two institutions and how they might complement each other better in their joint support for country programmes (Shakow, 2006). The two resulting reports contained several pages of recommendations: the principal recommendations can be broadly summarized as follows.

- Both organizations should make stronger efforts to support the "Three Ones" by working together on preparing, budgeting and implementing country-specific action plans. A specific area of duplication they should examine is the existence of Country Coordinating



The Global Task Team's recommendations invite countries to take the lead on such matters by requesting, for example, reviews of the relationship between their national AIDS coordinating authorities, Country Coordinating Mechanisms and the main financial mechanisms used by their national governments and their various ministries.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA EVALUATES AND IMPROVES COUNTRY COORDINATING MECHANISMS

In 2005, the Global Fund commissioned an independent assessment of the composition and performance of Country Coordinating Mechanisms, using an agreed set of tools and measures and requiring evidence in the form of verified documentation (see 'Civil society' chapter). The results covered 82 Country Coordinating Mechanisms (77% of 106 surveyed) and found that their members were broadly representative of the groups engaged in countries' responses to the three diseases within the remit of the Global Fund. On average, 50% of members were drawn from outside of government and 71% of Country Coordinating Mechanisms had members representing people living with the diseases. The assessment also revealed some weaknesses, including the following:

- only one in five members had been selected through a transparent, well-documented process;
- only about half of Country Coordinating Mechanisms had made calls for proposals publicly available; and
- less than half had published their decisions and information on the proposals approved.

In May 2005, immediately after the assessment, the Global Fund released revised guidelines and many Country Coordinating Mechanisms introduced reforms to address their weaknesses and comply with the guidelines. The Global Fund is now incorporating Country Coordinating Mechanism self-assessment into routine grant management with a view to identifying weaknesses, taking steps to correct them and reporting on progress.

Mechanisms separate from national AIDS coordinating authorities and their financial mechanisms.

- The Global Fund should clarify what it will and will not do. Its focus should be on direct financing of prevention and treatment, rather than on direct technical support and far-ranging and diverse systematic and multisectoral support, which is provided by the World Bank, other UNAIDS Cosponsors and bilateral institutions.
- The World Bank, in conjunction with UN agencies, should focus on the systematic health-sector capacity-building that is fundamental to progress against AIDS and other diseases. The World Bank should link health-sector capacity-building to broader macroeco-

nomic and budgetary aims. It should also help governments be more strategic and selective in setting priorities for AIDS and other health-related activities, to take best advantage of their limited capacities.

The Global Task Team's recommendations invite countries to take the lead on such matters by requesting, for example, reviews of the relationship between their national AIDS coordinating authorities, Country Coordinating Mechanisms and the main financial mechanisms used by their national governments and their various ministries. Meanwhile, multilateral donors are continuing to review their policies and procedures with a view to serving countries better.

The Third “One”: an agreed country-level monitoring and evaluation system

The Global Task Team recommends that:

- multilateral and other international institutions assist national AIDS coordinating authorities in the strengthening of country-wide monitoring and evaluation systems and other systems that facilitate oversight and problem-solving;
- national AIDS coordinating authorities, multilateral and other international institutions increase the role of civil society and academic institutions in monitoring and evaluation, including the gathering of data from marginalized communities and the critical analysis of all data;
- participatory reviews of national AIDS plans and programmes include reviews of the performance of all stakeholders, including country-based stakeholders and multilateral and other international institutions.

National AIDS coordinating authorities and all stakeholders need reliable informa-

tion to ascertain which programmes and services are required to provide HIV prevention, treatment, care and support. Once these programmes and services are in place, they need reliable information to monitor their outputs (e.g. the number of people provided with preventive education) and outcomes (e.g. changes in the number of people using condoms) and longer-term impacts (e.g. changes in HIV prevalence). The third “One,” an agreed country-level monitoring and evaluation system, points to the most efficient and effective way of gathering, analysing and reporting this information.

Effective monitoring and evaluation requires gathering and analysing data from a variety of sources. Data need to include information on the policy environment and on financial resource flows, as well as on the nature and quality of services, who provides the services, who uses them, frequency of use, costs and outcomes. Programme monitoring requires the establishment of indicators for measuring progress and then regular reviews to determine progress on implementation and outcomes. Programme evaluation involves a more detailed



Effective monitoring and evaluation requires gathering and analysing data from a variety of sources.

analysis to determine the merit of programmes and provide explanations of why particular outcomes have or have not occurred. Programme monitoring and evaluation can be performed at all levels, from a particular facility in a community to a programme covering a whole community, district or country. Programme evaluation, or lack thereof, is the weakest component of most monitoring and evaluation systems.

Surveillance is another essential component of effective monitoring and evaluation. It provides data on HIV and AIDS prevalence in the general population and among particular populations and on associated infections, behaviours and knowledge. It also monitors trends over time. These data help both to identify needs for programmes and services and to identify the outcomes and impacts of those services.

All the various data produced by an effective monitoring and evaluation system are referred to as strategic information. Reliable and comprehensive strategic information provides the basis for effective planning and implementation and also for increasingly effective monitoring and evaluation to provide more reliable and comprehensive strategic information.

THE CURRENT STATE OF MONITORING AND EVALUATION

UNAIDS circulates a National Composite Policy Index questionnaire to guide countries when they report on their progress towards achieving the goals outlined in the 2001 Declaration of Commitment on HIV/AIDS. For the first time, the Index circulated for the 2005 progress reports had a significant focus on monitoring and evaluation. Of countries that responded:

- 51% reported having made modest to considerable progress on monitoring and evaluation since 2003, while 43% rated themselves average or below average for monitoring and evaluation;
- 50% had developed monitoring and evaluation plans and most of these had a dedicated monitoring and evaluation budget and were developing relevant human resources capacity, either within monitoring and evaluation units, departments, committees or working groups;
- Not surprisingly, that 50% was more likely than other countries to have multistakeholder agreement on sets of monitoring and evaluation indicators and also to have functional data management systems, more use of the data by stakeholders and more sharing of data among stakeholders;
- 54% had established central databases on HIV and AIDS; 85% had established Health Management Information Systems and 50% had established both. In addition, 63% of countries had Education Information Systems. These are all important tools enabling the gathering, analysis and reporting of data and ready access to that data by all stakeholders; and
- 49% reported moderate to high levels of data sharing between their governments and bilateral and multilateral institutions, including UN agencies. While this shows an encouraging trend, it also shows need for improvement so that governments have access to all the data they need for evidence-based decision-making.

The data reported by these countries contributed to monitoring of their progress on all of the “Three Ones.” Ninety percent reported that they had one national AIDS action framework,

85% had one national AIDS coordinating authority and 50% had one national monitoring and evaluation plan. The mere existence of these “Ones” is no indication of how well they function and the data confirm that considerably more attention needs to be paid to strengthening countries’ monitoring and evaluation systems.

One country commented, “Monitoring and evaluation of HIV and AIDS activities is an area that has lagged among the three components of the “Three Ones” principles apparently because many agencies implementing various activities have no legal requirement to report to the National AIDS Council and multiple powerful donors require different monitoring and evaluation reports.” Another stated, “Many stakeholders still consider that monitoring and evaluation for HIV programmes is the prime responsibility of a national coordinating body. However the implementation of the M&E framework will require the mobilisation of

resources at all levels and amongst many stakeholders: this includes the M&E capacity of civil society and faith-based organisations as well among relevant ministries.”

COMMUNITY PARTICIPATION IN MONITORING AND EVALUATION

The Collaborative Fund for HIV Treatment Preparedness is a global project that aims to increase community participation in stemming the tide of the AIDS epidemic, with participating sites around the world (Figure 11.2). As part of the project, participating groups encourage each other to monitor and evaluate the implementation of their programmes. They hold regional training workshops and have a web site that provides monitoring and evaluation support to all community-based participants in the project. Web site features include: (i) a non-technical introduction to evaluation basics; (ii) a glossary of common evaluation vocabulary; (iii) indicators for measuring project progress and results;

FIGURE 11.2

Sites involved with Collaborative Fund for HIV Treatment Preparedness, March 2006



Source: Sites involved with Collaborative Fund for HIV Treatment Preparedness, March 2006.

THE GLOBAL FUND'S PERFORMANCE-BASED FUNDING APPROACH

The Global Fund manages the flow of its grants by using the results achieved by grant-supported programmes. The Global Fund uses performance-based funding to hold programmes to the commitments made in their grant proposals.

Successful achievement of results releases the next stage of financing. Programmes that perform well are given money at an accelerated rate. Programmes that perform poorly are given money at a slower rate and may be given less, so unused money can be transferred to better performing programmes that could use more support. Special circumstances are taken into consideration at each stage, as are self-assessments that identify requirements for more technical assistance. In general, however, the flow of funding is determined by the speed of implementation and proven results.

Performance-based funding has two core requirements: (i) monitoring and evaluation; and (ii) transparency. Transparency ensures that information on grant implementation can be used by decision-makers at all levels everywhere, whether engaged as partners in grant-supported programmes or as interested observers from within or outside the countries where the programmes are based.

Countries are proving that performance-based funding works. To date, 80% of grant-supported programmes have shown documented results by month 18 of a 60-month period for each grant. The poorest countries are just as successful as others, as long as results are measured against strategies and targets they set themselves and as long as grants cover needs for technical assistance they identify themselves. In several countries—including Ethiopia, Honduras, Kenya and the Lao People's Democratic Republic—performance-based funding proves to be providing crucial incentives to accelerate implementation.

(iv) technical assistance in creating and using common evaluation tools; (v) discussion forums; (vi) answers to frequently asked questions; and (vii) a direct e-mail connection to monitoring and evaluation professionals who can provide technical support.

BILATERAL AND MULTILATERAL SUPPORT FOR MONITORING AND EVALUATION

The Monitoring and Evaluation Reference Group, coordinated by UNAIDS, brings together technical experts and representatives from bilateral and multilateral institutions and countries, including the countries' HIV programme managers and



directors of monitoring and evaluation units. The Monitoring and Evaluation Reference Group harmonizes activities across countries by, for example, creating standardized indicators, promoting the use of particular methods and developing training modules. In addition, a number of bilateral and multilateral institutions—for example, the United States’ Centers for Disease Control and Prevention and UNAIDS—deploy technical staff in over 60 countries to support their monitoring and evaluation efforts. These professionals work directly with countries’ professionals and support, among other things, harmonization and coordination of all stakeholders’ monitoring and evaluation activities within countries.

As a result of these efforts, a number of standard monitoring and evaluation indicators have been developed, but there is still much work to be done in harmonizing and simplifying the indicators used by the many different stakeholders involved in the AIDS response in countries.

MAPPING AND TRACKING RESOURCES

Chapter 10 discusses the significant mismatch in most countries between where financial resources are most required to mount an effective response to HIV and where financial resources are actually spent. Most countries still need to strengthen the use of strategic information to identify the financial and human resources and infrastructure they already have and to estimate where more resources are required.

Many countries fail to carry out surveillance that would tell them which populations are most in need of services and even when data from such surveillance are available, many countries fail to select such populations as beneficia-

ries of services. Often this is a result of the difficulty of accessing the key populations at higher risk and the weaknesses in policies (including human rights legislation) and procedures that ensure the delivery of services to people most in need of services. Clearly, the flow of limited resources should be managed so that they go to where they are most needed but often, government and donor policies intervene, so some key populations at higher risk are hardly served at all.

In 1995, the World Bank asked the Mexican Health Foundation to be the executing agency for the Regional AIDS Initiative for Latin America and Caribbean (SIDALAC). In 1996, after consulting with national AIDS coordinating authorities and securing funding from the European Commission, the Regional AIDS Initiative for Latin America and Caribbean initiated a mechanism for tracking AIDS spending in the region’s countries. Its approach was to encourage and support countries in establishing National AIDS Accounts, a process that required time and patience but that began producing good annual estimates of spending on AIDS in the health sector in 1999. Subsequently, with help from the Regional AIDS Initiative for Latin America and Caribbean, a similar approach was taken in West Africa. The best available data tracking spending over a number of years now come from the regions of Latin America and the Caribbean and West Africa.

The UNAIDS Global Resource Tracking Consortium and its many members now track resources on a global level. In the course of doing so, they advocate for and support better resource tracking by countries. In 2005, the Consortium launched a

new initiative to promote and support National AIDS Spending Assessments. Whereas the National AIDS Accounts focused on the health sector, the spending assessments are much broader and cover a range of sectors where action against AIDS contributes to the overall national AIDS response. The approach is the same as that taken by the Regional AIDS Initiative for Latin America and Caribbean: instead of commissioning one-off assessments by consultants, countries are supported in capacity-building so their AIDS accounting procedures become continual and sustainable.

More than 60 countries now participate in this initiative and some have already produced preliminary results. Where these assessments have been completed, countries are able to identify sources and amounts of financing (out-of-pocket spending, public spending, bilateral and multilateral donations and private philanthropy), spending by different service providers (in the health sector and in other areas, broken down into salaries, commodities, travel, etc.) and spending by type of programme (prevention, care, social mitigation, programme support) and by beneficiary (harm reduction to

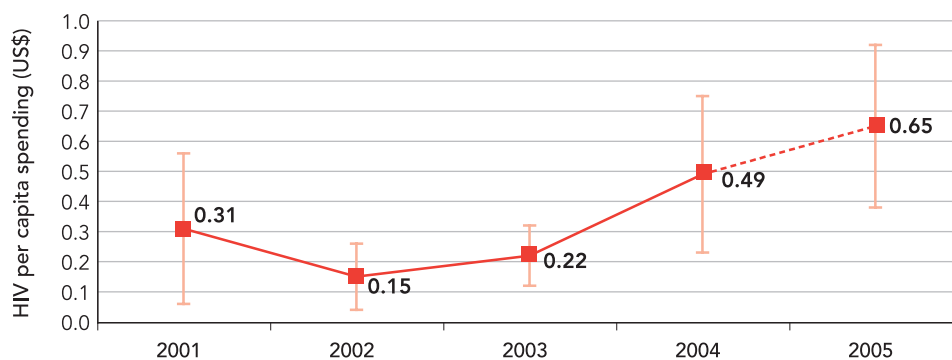
injecting drug users, life-skills training to young women, etc.). The results already achieved by the new initiative suggest that the situation could improve rapidly if bilateral and multilateral institutions and national AIDS coordinating authorities all support the initiative.

For the 2005 review of progress on the 2001 Declaration of Commitment, 82 countries reported their domestic public expenditure on AIDS. These estimates were based on continuing or past resource tracking and show a significant increase in per capita domestic public expenditure over the last four years. In 15 low-income countries of sub-Saharan Africa, for example, average per capita domestic public expenditure on AIDS doubled from US\$ 0.31 in 2001 to US\$ 0.65 in 2005 (Figure 11.3). If South Africa, a middle-income country, is included in the calculation, the average per capita domestic public expenditure on AIDS for 2005 goes up to US\$ 0.72.

THE COUNTRY RESPONSE INFORMATION SYSTEM

Historically, many factors have restricted a country's capacity to use data for improving monitoring and evaluation.

FIGURE 11.3 Trends in HIV and AIDS per-capita expenditures in current US\$
Selected sub-Saharan African countries



Sources: Countries reporting on UNGASS on domestic public expenditure; UNAIDS estimates.

These include limited human and financial resources, multiple reporting demands from stakeholders (including donors) and the lack of a national information system for data related to HIV. Programme managers find themselves having to report similar data in many different formats, while, at the same time, these data are seldom used at the national level as a basis for programme refinement and improvement. Even within and between national ministries, there is poor sharing and coordination of data.

A software program, the Country Response Information System, has been developed to address these problems. It provides the platform for a database to support monitoring and evaluation. More specifically, it provides countries with the ability to store and analyse indicator, project and research data and to exchange data with those from other systems.

The inability to easily and automatically exchange data between systems has been a long-standing barrier to gathering and analysing data from many different stakeholders and exchanging data among stakeholders. A working group, facilitated by the UNAIDS Secretariat, has overcome this barrier by developing a standard transmission format (XML schema) for monitoring and evaluation data. This format has now been integrated into the Country Response Information System and a number of other data management software programs including the World Health Organization's HealthMapper, the United Nations Development Group's DevInfo, the Food and Agriculture Organization of the United Nations' KIDS, the United States Government's Epi Info and the MACRO HIV Survey Indicators Database. Recently, a prototype based on the

Country Response Information System has been developed for the United States President's Emergency Plan for AIDS Relief.

More than 60% of the countries reporting progress in 2005 on the 2001 Declaration of Commitment are using the Country Response Information System, indicating that this system has been catalytic in supporting development of monitoring and evaluation systems in countries (Figure 11.4).

INDIVIDUAL AND HOUSEHOLD INFORMATION

Many of the monitoring and evaluation indicators developed for HIV and AIDS depend on gathering information from individuals or households. Ensuring that this information is useful has required considerable effort to ensure that standard definitions and sets of data are collected both from these and other sources, including clinics and hospitals. In 2004, for example, various international and national organizations agreed on a minimum set of data required for optimum patient management and monitoring and this data set is now being used for monitoring antiretroviral therapy at many different health facilities (WHO, 2004a, 2004b). Workshops have been held to develop guidelines and plan projects to develop tools for the electronic storage and transfer of data from individual patients (WHO, 2004c, 2004d).

LACK OF EVALUATION

Monitoring and evaluation activities to date have focused largely on developing indicators and establishing systems for monitoring. The Evaluation Working Group within the Monitoring and Evaluation Reference Group is now focused on improving evaluation, with the aim of producing new data about the

PILOTING THE COUNTRY RESPONSE INFORMATION SYSTEM IN BOTSWANA

Botswana's National AIDS Coordinating Committee developed its National Monitoring and Evaluation Plan 2003–2007. It has also established a related national monitoring and evaluation system called the Botswana HIV/AIDS Response Information Management System, based on the Country Response Information System. A technical working group has been set up to manage the system. As part of this process, the group developed a statement of user requirements and assessed various software options, including the Country Response Information System, to identify the program that most suited the needs of Botswana.

In one of the pilot projects, the Ministry of Local Government tested the Country Response Information System in two districts that had previously sent their raw data to the central office for analysis and report generation. The districts responded positively to the fact that the system enabled them to analyse and report their own data and maintain data integrity while allowing an easy exchange of data with the central office. The central office receiving the data responded positively to the fact that the system was compatible with other available software.

effectiveness of prevention and treatment programmes and identifying where improvement is needed. Improving evaluation involves facilitating evaluation efforts of many different agencies and helping them accumulate experiences and learn from those experiences. The Evaluation Working Group is also working towards better definition of evaluation terminology and methodology and better understanding of countries' evaluation needs.

STRENGTHENING HIV SURVEILLANCE

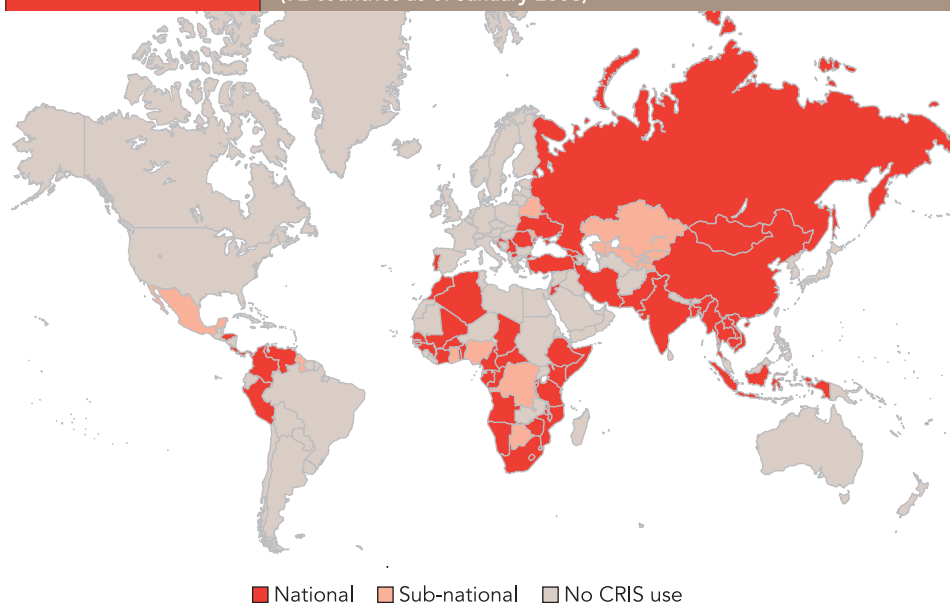
Surveillance, as carried out in the public health field, refers to the continuing and systematic collection, analysis, interpretation and dissemination of health information. It helps define the nature and extent of a health problem and the impact that programmes and services are having on the problem.

HIV surveillance based on case reports collects data from specific patients in clinical settings who have been tested for and

been diagnosed with HIV. In contrast, sentinel serosurveillance uses blood samples collected for other purposes (e.g. testing in antenatal clinics to screen for certain diseases or monitor patient progress) and is typically anonymous and unlinked to specific individuals. Since HIV-positive people often have no symptoms of infection for many years after they are infected and case reporting typically captures only a small fraction of all people living with HIV in countries with weak health systems, sentinel serosurveillance is a necessary component of HIV surveillance to monitor the epidemic's growth and keep track of who has become newly infected, how and where.

Surveillance for HIV infection is insufficient, however. It records infections that have already taken place but does not give early warning of the potential for infection. Thus, it does not monitor behaviour that may put people at risk (e.g. unprotected sex with multiple partners and use of contaminated or non-sterile injecting

FIGURE 11.4 Countries using the Country Response Information System (CRIS)
(92 countries as of January 2006)



Source: Countries reporting on UNGASS; UNAIDS [Country Coordinator Reports and Monitoring and Evaluation Officers' personal communications]

equipment), other biological markers (e.g. the presence of sexually transmitted infections) and knowledge or lack of knowledge about how HIV is transmitted. Second generation HIV surveillance expands the scope of surveillance systems to include these additional factors and also includes surveillance of related infections, mortality data and behavioural studies, such as the Demographic and Health Surveys, which provide data that can be used to track changes in sexual behaviour and condom use.

In many countries, HIV surveillance has focused on the general population. Often, blood donors and pregnant women are tested and when negligible levels of infection are found in those groups, it is assumed that infection levels are generally low or non-existent. Such surveillance can fail to detect a concentrated or emerging epidemic among subpopulations at higher risk of infection such as sex work-

ers, injecting drug users, men who have sex with men and people with sexually transmitted infections.

The UNAIDS/WHO *Guidelines for Second Generation HIV Surveillance* recommend different sets of surveillance measures according to the type of epidemic, i.e. low level, concentrated and generalized (UNAIDS/WHO, 2000).

A 2004 study examined HIV sentinel serosurveillance in 132 countries from 1995 to 2002 and found high-quality surveillance in only 58% of countries with generalized epidemics, 34% of countries with concentrated epidemics and 10% of countries with low-level epidemics. Overall, the number of countries with high-quality surveillance had decreased from 43% in 1995 to 36% in 2002, although it had increased from 45% to 58% in countries with generalized epidemics (García-Calleja et al., 2004). It

concluded that many countries still have poor HIV sentinel serosurveillance systems. The study did not look at other components of second generation surveillance, but these are likely to be weaker than sentinel serosurveillance in most countries.

Applying the “Three Ones” and the Global Task Team recommendations

In March 2005, the Paris Declaration gave greater definition to the framework for international cooperation on country-led development. This was followed in June 2005 by the Global Task Team’s recommendations, which gave further definition to the framework for international cooperation on country-led responses to AIDS. This ‘new aid architecture’, as some call it, is helping countries marshal international support for their efforts to apply the “Three Ones” and build their capacity to respond to AIDS. The ultimate aim is to make the best possible use of the limited resources at their disposal and accelerate access to prevention, treatment, care and support

In Nigeria, the National Action Committee on AIDS and the National Expanded Theme Group on HIV/AIDS

moved quickly to mobilize key stakeholders in an exercise that looked at the implications of the Global Task Team’s recommendations. In November 2005, they presented their own recommendations in a report entitled *Domestication of the Global Task Team Recommendations in Nigeria* (National Expanded Theme Group on HIV/AIDS Nigeria, 2005). Many other countries have been engaged in similar exercises, identifying where they fall short of complying with the “Three Ones” and referring to the Global Task Team’s recommendations for guidance as they outline strategies for action.

In Kenya, the National AIDS Control Council and a broad range of partners were strongly committed to applying the “Three Ones” as they developed the Kenya National HIV/AIDS Strategic Plan for 2006–2010, translating it into a detailed workplan and budget for each of the years it covers. The resulting document is one of the most comprehensive national AIDS plans currently on record (Kenya National AIDS Control Council, 2005). Soon there will be more such plans in place and each will be a useful reference for other countries in the continuing process of reviewing and updating national plans and otherwise building countries’ capacity to respond to AIDS.

Chapter 12

FROM CRISIS MANAGEMENT TO
STRATEGIC RESPONSE

“Please let us have no illusion that, one fine day, the world will return to what it was before AIDS. No, AIDS has simply rewritten the rules. And to prevail we too must rewrite these rules.”

Peter Piot, Rio de Janeiro, July 27th 2005

With 65 million people infected to date, nearly 25 million already dead, and the vast majority of the more than 35 million people living with HIV unaware of their status, AIDS is among the greatest development and security issues facing the world today.

A challenge of this magnitude requires exceptional, ongoing leadership on both the national and international levels. Twenty-five years into the epidemic, the global response to AIDS must be transformed from an episodic, crisis-management approach to a thoughtful, long-term response that emphasizes the use of evidence-based strategies and recognizes the need for long-term commitment.

Since the Declaration of Commitment on HIV/AIDS was approved in 2001, a number of programmes have been put into place to support global leadership

against AIDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria provides low- and middle-income countries with additional financing; the “3 by 5” initiative has helped to mobilize a substantial increase in people on antiretroviral therapy; the “Three Ones” principles have helped to establish broad agreement on the need to coordinate AIDS responses; and the recommendations of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors are helping to improve the efficiency and effectiveness of resource allocations.

Despite forward motion, however, the consistent leadership necessary to slow, stop and reverse this epidemic is not yet evident. While the Secretary General’s Report on the Declaration of Commitment on HIV/AIDS notes many improvements in the global AIDS response since 2001, it also clearly indicates that

action overall has been insufficient, with progress uneven within and between countries and regions, and many countries failing to fulfil their pledges. As the report succinctly states, “Several important global targets for 2005 in the Declaration of Commitment were missed.”

Leadership may be best defined as the ability and willingness to envision the future and to unite different elements of society to make it better. We know with increasing certainty what disaster awaits if the response to AIDS continues to be inadequate. We also know how to strengthen that response in ways that will save millions of lives and billions of dollars. Raising the funds, overcoming the physical, economic and cultural barriers to action, implementing the plans and staying the course until this epidemic is reversed will require consistent leadership on a global scale. The recommendations as outlined below can be considered a sort of blueprint for the leadership the world needs today.

SUSTAIN AND INCREASE COMMITMENT AND LEADERSHIP

The Declaration of Commitment on HIV/AIDS calls on the leaders of all 189

nations that signed it to develop and implement sound national multisectoral HIV and AIDS strategies and integrate their response into the mainstream of development planning, ensuring the full and active participation of civil society and the private sector. Yet, the Secretary General’s Report indicates that, while nearly 90% of countries report having developed a multisectoral strategic framework on AIDS, many have yet to convert these plans into action.

- National AIDS authorities, working with all partners and stakeholders, must develop or adapt prioritized and costed AIDS plans that have ambitious but feasible targets and that are aligned with national development plans.
- These plans should establish and support clear national priorities on reducing deaths from AIDS-related illnesses and caring for people with HIV; establish sustainable national financing for the AIDS response; combat stigma and discrimination, violence against women and other human rights abuses, including protecting and promoting the human rights of people living with HIV, women and children and people in vulnerable



Leadership may be best defined as the ability and willingness to envision the future and to unite different elements of society to make it better.

groups; strengthen human resources and systems; and remove barriers such as tariffs and unnecessary regulations to speed access to affordable quality HIV prevention commodities, medicines and diagnostics.

- Civil society must be fully engaged in the development and implementation of national plans. While many countries have extended their efforts to engage civil society in a comprehensive AIDS response, that effort is inconsistent in most countries and virtually absent in approximately one in four countries surveyed by UNAIDS, where civil society has been largely excluded from the AIDS response, a position that is unsustainable in a development crisis of this magnitude.
- The UNAIDS Secretariat, UNDP and the World Bank will facilitate a participatory process to provide criteria for the development and oversight of these plans.

To ensure greatly expanded responses to the AIDS epidemic, accountability and transparency are necessary.

- Countries should ensure the accountability of all partners through transparent peer review mechanisms for public monitoring of targets and regular reporting of country and regional progress.
- National governments, international donors, United Nations agencies, civil society and other stakeholders should ensure mutual accountability at country level through participatory review of national AIDS responses.

SUSTAIN AND INCREASE FINANCING

Global financing for HIV and AIDS has greatly increased, yet funding currently available is barely one-third of what will

be required to respond to the growing epidemic in just a few years.

- National governments and international donors should significantly increase the financial resources available for AIDS by strengthening and fulfilling existing commitments, fully supporting the Global Fund and other innovative financing mechanisms.
- International donors and partner countries should adhere to the “Three Ones” principles, which call for the coordination of a national AIDS response around one agreed AIDS action framework, one national coordinating authority (including government, civil society, people living with HIV, and the private sector) and one agreed country-level monitoring and evaluation system.
- Current funding efforts to produce a substantial portion of this funding from domestic budgets, especially in middle-income countries, must continue.

The unpredictability of funding is a significant barrier to a sustained and cost-efficient response to AIDS, which must be overcome through concerted efforts to make funding more predictable for the long term.

- Innovative approaches to secure sustainable long-term funding for the AIDS response, including proposals for new international financing mechanisms, deserve serious consideration, as do any other proposals that will help to stabilize funding for a greatly enhanced response to the epidemic.
- International finance institutions, health and finance ministries, national AIDS authorities and civil society should adjust macroeconomic and fiscal frameworks to address the reality of AIDS.



The low status and powerlessness of women and girls has increased their vulnerability to HIV infection and has been a driving force of the epidemic since its earliest days.

- National governments must also reduce conditions on donor funding to the levels necessary to ensure good governance, fiduciary safeguards and the effective use of these funds.
- National governments should also ensure that the impact of AIDS is included in the core indicators used to measure national development and poverty reduction.
- National governments, where needed, with the assistance of the International Monetary Fund and the World Bank, should initiate a transparent and inclusive dialogue with all stakeholders to ensure fiscal space is created for AIDS spending as high-priority social expenditures.

AGGRESSIVELY ADDRESS STIGMA AND DISCRIMINATION

Ending this pandemic depends in large part on implementing a range of efforts to change the social norms, attitudes and behaviours that drive it. Action against stigma and discrimination must be fully endorsed and supported by top national leadership and supported at every level of society, and must address women's empowerment, homophobia, attitudes towards sex workers and injecting drug

users, and social norms that affect sexual behaviour.

The low status and powerlessness of women and girls has increased their vulnerability to HIV infection and has been a driving force of the epidemic since its earliest days. Societal norms and values that make it acceptable to discriminate against and exploit females must be challenged and changed.

- Laws and policies that protect women and girls against sexual violence, disinheritance and gender discrimination of all kinds must be enacted, publicized and enforced from the national to the community levels.
- These efforts should include the enactment and enforcement of legislation to protect women and girls from harmful traditional practices and from sexual violence in and outside of marriage, ensure equality in domestic relations, including property and inheritance rights of women and girls and include providing the education and training that women need to exercise their rights
- Women must be adequately represented in policy- and decision-making

on AIDS, which at present is driven almost exclusively by men. A 2004 UNAIDS assessment of activities at country level found that women's participation in the development and review of national AIDS frameworks was non-existent in more than 10% of 79 countries and inadequate in more than 80% (UNAIDS, 2006).

- Rules and regulations of organizations, institutions and programmes must stipulate meaningful representation for women's groups in shaping programme design and delivery. Where necessary, women's organizations must be given help with capacity-building to enable them to play their part effectively.
- Laws and policies that directly challenge gender inequality and bias against people at or perceived to be at higher risk of HIV, including sex workers, injecting drug users, men who have sex with men and prisoners, are essential.
- Changes in laws and policies must be accompanied by adequately funded social mobilization campaigns to protect and promote AIDS-related rights and eliminate HIV-associated stigma and discrimination.
- Networks and organizations of people living with HIV, along with all other elements of civil society, must be included in the planning and implementation of these efforts.
- Data demonstrate that education is one of the most powerful tools for HIV prevention. A fully funded plan to achieve universal education and to address or remove barriers such as school fees, compulsory school uniforms, textbook charges and lack of recognition by parents of the importance of educating girls, is also fundamental to reducing HIV and related stigma.

Towards universal access

At the 2005 meeting of the G8 nations and the September 2005 United Nations World Summit, world leaders committed to a massive scale-up of HIV prevention, treatment and care, with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it. The UNAIDS Secretariat and Cosponsors moved to operationalize this pledge by helping to facilitate inclusive, country-led processes in more than 100 low- and middle-income countries, producing practical strategy recommendations that, if enacted, will promote equitable, affordable, comprehensive and sustainable access to HIV prevention, treatment, care and support for all who need them and help ensure that the goal of providing as close as possible to universal access to HIV treatment by 2010 can be reached.

STRENGTHEN AIDS PREVENTION

A renewed emphasis on HIV prevention is critically needed. Over four million new HIV infections each year will put an untenable burden on HIV treatment efforts that are struggling to reach all those in need today. The success of the movement towards universal access will largely depend on whether leaders maintain a strong focus on the goal of creating an HIV-free generation, mounting a massive social mobilization to dramatically decrease the number of new HIV infections. The internationally agreed-upon UNAIDS policy paper, *Intensifying HIV prevention* provides a framework for strengthening evidence-based HIV prevention.

- Key to this is ensuring that prevention, education, counselling and voluntary testing are universally available and

routinely offered in all appropriate clinical and community settings. UNAIDS and WHO recommend that for HIV prevention and treatment services to have maximum benefit, at least 50% of all people engaging in sexual risk behaviour should access voluntary counselling and testing each year.

- Access to clear, factual HIV prevention information and to HIV testing should be seen as a right, especially for vulnerable people in high-incidence areas. Countries should promote the idea that each person can know his or her HIV status and has access to HIV information, counselling and related services, in a social and legal environment that is supportive and safe for confidential testing and voluntary disclosure of HIV status.
- Countries are far behind the 2005 Millennium Declaration Goal of providing life-skills-based HIV prevention education to 90% of young people. An optimistic estimate is that half of children worldwide receive school-based HIV education, although coverage levels vary widely and none of the 18 countries in which young people were surveyed between 2001 and 2005 had knowledge levels exceeding 50%.

Educating young people in life-saving behavioural change should be viewed as a fundamental test of leadership against AIDS.

- HIV prevention services and education must be targeted to vulnerable groups, including sex workers, injecting drug users and men who have sex with men. In 2005, targeted prevention services reached only 36% of sex workers and only 9% of men who have sex with men. Harm reduction programmes in 2005 reached only 9% of injecting drug users in eastern Europe, where injecting drug use is driving the epidemic.
- Access to basic HIV prevention commodities such as condoms must improve. Coverage surveys indicate that, on average, a condom was used in only an estimated 9% of sex acts with a non-marital or non co-habiting partner in 2005, a decline from coverage estimates for 2003.
- Worldwide, HIV prevalence in prisons is almost invariably higher than in the general population. Oft-stated fears that providing condoms and harm reduction services in prisons would increase prohibited behaviour have been disproved in a number of studies.



Countries should promote the idea that each person can know his or her HIV status and has access to HIV information, counselling and related services, in a social and legal environment that is supportive and safe for confidential testing and voluntary disclosure of HIV status.

Leaders must recognize that prisons are an incubator for HIV, tuberculosis and hepatitis C infection, and must act humanely and in accordance with public health principles to reduce the vulnerability of prisoners.

- Access to programmes to prevent mother-to-child HIV transmission remains unacceptably low. In 2005, 7.9% 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.
- Enhanced diagnosis, treatment and prevention of the 340 million curable sexually transmitted infections contracted each year is important to improving HIV prevention, as untreated sexually transmitted infections greatly increase the risk of HIV transmission. Increased cooperation between HIV prevention programmes and sexually transmitted infection diagnosis and treatment efforts is essential to increasing the effectiveness of both.

STRENGTHEN HUMAN RESOURCES AND SYSTEMS

The world is now paying the price, in the form of the AIDS crisis, for decades of inadequate investment in public and private services to promote education and health. Lack of human capacity is the single biggest obstacle to an effective response to AIDS in many developing countries. Poor surveillance, planning and administration; bottlenecks in the distribution of funds; failures in the implementation, monitoring and evaluation of activities; and inadequate provision of services are all largely due to systems of too few people with too few skills.

Lack of human resource capacity has reached crisis levels in much of Africa,

but is also severe in a number of other countries and regions throughout the world. According to the WHO World Health Report 2006, there is currently an estimated shortage of almost 4.3 million doctors, midwives, nurses and support workers worldwide. The shortage of trained health-care workers is due in part to the ongoing “brain drain” of health-care providers from Africa and other heavily affected areas. Between 23% and 28% of physicians working in Australia, Canada, the United Kingdom and the United States are migrants from abroad, and up to three-quarters of these are medical graduates from developing countries (Mullan, 2005). The picture is similar for nursing staff. A recent study estimated that, to cope effectively with AIDS and other health emergencies, sub-Saharan Africa will need to find 620 000 new nurses over the next few years (Chaguturu and Vallabhaneni, 2005).

- Curbing this exodus of professional people calls for action at both ends. Measures to improve working conditions and remuneration and other incentives to keep trained people at home are essential, as are formal agreements between countries about recruitment practices.
- National governments and international donors should take measures, where needed, to retain and motivate health workers, educators and community workers, and to increase financing for training and accreditation centres in countries facing severe human resource shortages.
- Speeding recruitment and training of health workers at all levels is also urgent. Countries should identify opportunities for drawing in new players from populations or sectors that are not yet fully engaged with the



Education and other systems must be simultaneously strengthened. Most HIV prevention takes place outside the health-care delivery system, making the private and voluntary sectors particularly important.

response, and should consider innovative ways of educating and training people.

- Where needed, countries should adopt alternative and simplified delivery models to strengthen the community-level provision of HIV prevention, treatment, care and support, including measures to enable “task shifting.”
- National governments should also greatly expand their capacity to deliver comprehensive AIDS programmes in ways that strengthen existing health and social systems, including by integrating AIDS interventions into programmes for primary health care, mother and child health, sexual and reproductive health, and diagnosis and treatment of tuberculosis, malaria and sexually transmitted infections.
- Education and other systems must be simultaneously strengthened. Most HIV prevention takes place outside the health-care delivery system, making the private and voluntary sectors particularly important.

ENSURE AVAILABLE AND AFFORDABLE COMMODITIES

All players must increase action to ensure affordability of the basic commodities,

from condoms to antiretroviral drugs, needed for HIV prevention, diagnosis and treatment.

- National governments should remove major barriers in pricing, tariffs and trade, regulatory policy, to speed access to affordable quality HIV prevention commodities, medicines and diagnostics, and should similarly reduce or eliminate user fees for AIDS-related prevention, treatment, care and support.
- National authorities must also remove legal, regulatory or other barriers that block access to effective HIV prevention services and commodities such as condoms, harm reduction and other prevention measures.
- To speed the flow of treatment, governments should allow WHO prequalified medicines or those approved by other widely recognized stringent drug regulatory bodies to obtain provisional marketing approval prior to full registration by national drug regulatory authorities.
- National tax codes should be revised wherever necessary to exempt prevention treatment commodities including

medicines from taxes and tariffs.

- Access to medicines to treat common AIDS-related opportunistic infections is insufficient and must be strengthened.
- Access to the few paediatric formulations of antiretrovirals and drugs to prevent opportunistic infections is also seriously inadequate. Leaders should review and enact the recommendations of the 2005 UNICEF and UNAIDS “call to action” to ensure that antiretroviral therapy or antibiotic prophylaxis, or both, reaches 80% of children in need by 2010 (UNICEF/UNAIDS, 2005).

Ensuring the availability and affordability of vitally needed medicines, including second, third and fourth generations of drugs, as well as first-line medications, means addressing the complex, sensitive and contentious issues of pharmaceutical patents.

A balance must be struck between ensuring sufficient incentive for drug companies to invest in research and development, and enabling effective AIDS medications to be produced as cheaply and widely as possible to meet the needs of developing countries.

- Where necessary, countries should employ the flexibilities of the WTO *Agreement on Trade-Related Aspects of Intellectual Property Rights* to secure access to sustainable supplies of affordable HIV medicines and health technologies, including through local production where feasible.
- UNFPA, UNICEF and WHO will continue efforts, in collaboration with existing global and regional procurement facilities, to ensure reliable supply and reduced prices for prevention and treatment commodities through

informed demand forecasting, bulk procurement, differential pricing and, where appropriate, voluntary licensing.

BUILD TREATMENT ACCESS

The approximately 1.3 million people receiving antiretroviral therapy at the end of 2005 is both a significant increase over the past two years, and substantially short of the number of people who need access to HIV treatment today. Continuing and expanding rapid scale-up of HIV treatment access will require these action steps:

- While large numbers of HIV-positive people live in rural areas, treatment access is largely confined to urban centres. National leaders should focus on expanding and diversifying treatment access sites, and ensuring equity among all affected populations, including children, in access to HIV treatment.
- Efforts to expand access to antiretroviral drugs must also emphasize expanding access to drugs to prevent common opportunistic infections. For example, the antibiotic cotrimoxazole has been shown to reduce the risk of death in children by 40%. Yet, although cotrimoxazole costs as little as US\$ 0.03 a day, an estimated 4 million children who need the drug do not currently obtain it.
- Efforts to expand access to therapy must also included greater effort to reach particularly vulnerable groups, including sex workers, men who have sex with men, injecting drug users and prisoners.
- As mentioned above, lack of knowledge of HIV serostatus is one of the greatest obstacles to effective HIV prevention and access to treatment. Broadening confidential and voluntary

access to HIV testing must be a top priority in the years ahead.

- Efforts to reduce HIV-related stigma and discrimination, build human resource capacity in health systems settings and improve supply management—all discussed above—are equally important to improving treatment access and should be central to the AIDS leadership agenda.
- Treatment advocacy and education must be enhanced to ensure the public is aware of services and how to use them, as well as of the benefits of treatment and what it entails.

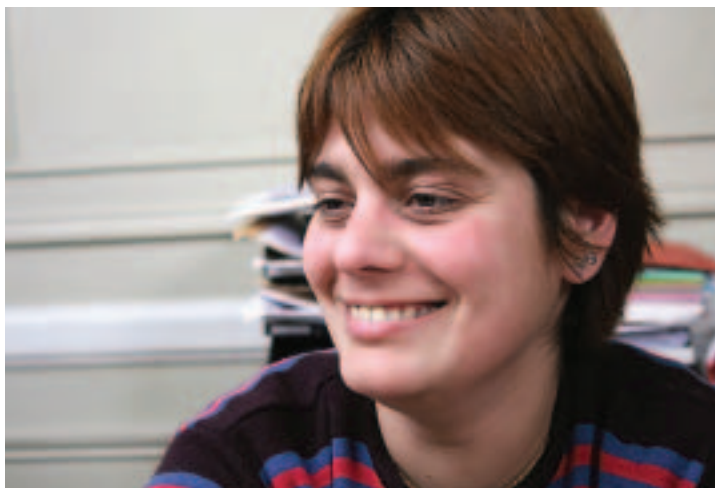
Invest in Research and Development

Continued technological innovation is vital for the development of microbicide and other female-controlled prevention methods, new generations of drugs and a preventive vaccine. Substantially greater research funding must be mobilized, especially from the pharmaceutical and biomedical industries.

- Development of an effective microbicide would significantly strengthen

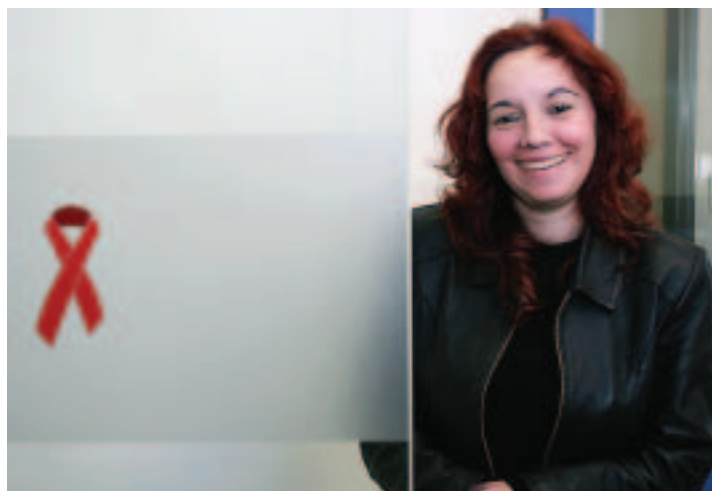
HIV prevention efforts by offering women an unobtrusive prevention method under their control. Microbicide research requires an estimated US\$ 280 million per year, yet in 2004 only around half of this was sent, with US\$ 142 million coming from governments, multilaterals and philanthropy, and between US\$ 3 million and US\$ 6 million from industry (HIV Vaccine and Microbicide Resource Tracking Working Group, 2005). Financial commitments to develop an effective and practical microbicide, which could be a major advance in HIV prevention for women, must increase.

- An estimated US\$ 1.2 billion per year is needed to maintain momentum in HIV vaccine research, yet 2004 spending totalled only about US\$ 600 million, with approximately 10% of these funds coming from the commercial sector (HIV Vaccine and Microbicide Resource Tracking Working Group, 2005). Spending and research activity in vaccines must increase. In 2005, the Global HIV Vaccine Enterprise, an alliance of independent entities dedicated to enhanced collaboration on AIDS vaccines, published a strategic scientific plan



Continued technological innovation is vital for the development of microbicide and other female-controlled prevention methods, new generations of drugs and a preventive vaccine.

AIDS exacerbates virtually every other challenge to human development, from maintenance of public services and governance to food security and conflict avoidance.



intended to guide the actions and resource allocations of key actors in the field.

- The needs of children with HIV have largely been left out of the research agenda. Pharmaceutical companies, international donors, multilateral organizations and other partners should develop public-private partnerships to promote quicker development of new paediatric drug formulations.
- HIV prevention clinical trials often generate controversy, highlighting the need for researchers to engage a broad range of community and national stakeholders in the planning and conduct of those trials. Researchers and stakeholders should consult the 2005 guidelines developed by UNAIDS through a global consultation process designed to promote durable partnerships in prevention research.
- In addition to accelerating technological development, government, civil society and private sector leaders must put into place the systems and agreements that will guarantee wide and equitable access to microbicides, new generations of drugs and vaccines for HIV and sexually transmitted infections, as well as improved treatments

for diseases such as tuberculosis, which now accounts for the largest proportion of global AIDS-related deaths.

Mitigate the impact of AIDS

AIDS exacerbates virtually every other challenge to human development, from maintenance of public services and governance to food security and conflict avoidance. The late Jonathan Mann's insight from the early 1990s—that AIDS shines a spotlight on human rights and societal issues—has been borne out in many ways (Mann et al., 1994). The very serious impact that AIDS has already had on many countries requires that efforts to address the epidemic simultaneously focus on preventing new infections, caring for those who are infected and mitigating the impact of AIDS on the economy, institutions and social structure of the community.

- Efforts to mitigate the impact of AIDS must focus first on the individuals and families affected through interventions such as access to therapy, nutritional assistance and treatment for opportunistic infections and other health issues

that complicate or exacerbate HIV infection.

- Comprehensive programming that includes psychosocial and financial support as well as medical treatment is likely to produce the best results at mitigating impact on individuals. China's "Four Frees and One Care" program, which offers free antiretroviral drugs, free voluntary counselling and testing, free drugs to prevent mother-to-child transmission, free schooling for orphaned children and care and economic assistance to affected households, may provide a model for other nations in supporting families and societies affected by AIDS.
- Social protection measures to preserve livelihoods of people affected by AIDS, including welfare programmes, child and orphan support, public works to provide employment, state pension systems and microfinancing should be part of comprehensive AIDS planning and services.
- The education sector is suffering from the impact of the HIV epidemic and must be strengthened. Evidence from Uganda shows that a child who drops out of school is three times more likely to be HIV positive in his or her twenties than one who completes basic education. Mitigating the impact of HIV on the education sector entails a number of priority actions. Leaders should prioritize national participation in international programmes outlined in this report to strengthen national education systems as well as support structures for children to finish their education.
- In many countries, the private sector is not playing nearly the role it must in addressing AIDS, and must improve. While 47% of private sector companies expect AIDS to affect their business in the next five years, only 6% of firms worldwide have HIV policies and very few have made provision for antiretroviral drug delivery.
- Businesses should also more actively participate in impact mitigation efforts in the world of work. The *Code of Practice on HIV/AIDS in the World of Work* (ILO, 2001) provides important guidelines for businesses, based on consensus between employers, employees, and government.
- Refugees frequently arrive from countries heavily affected by HIV and



Leaders should prioritize national participation in international programmes outlined in this report to strengthen national education systems as well as support structures for children to finish their education.

AIDS, yet often lack access to any type of HIV prevention care or treatment services in their host countries. Leaders of countries that have hosted refugees in the past years (in 2005, numbering 19.2 million in total) must incorporate these large and vulnerable populations into their prevention, care and treatment planning, and must ensure that services reach these populations and are not affected further by the stigma and discrimination they often already encounter.

- In sub-Saharan Africa, approximately 9% of children under the age of 15 have lost at least one parent to AIDS. Studies show that these orphans are likely to grow up in worse financial circumstances and with less education than their non-orphaned peers. They may also suffer abandonment and other harsh forms of stigma and discrimination. A key determinant of leadership is the ability to protect children, and the needs of children made vulnerable by AIDS should be prominently included in national AIDS plans and strategies.

Few international crises have been as extensively studied as AIDS. Thousands of highly qualified individuals have extended countless hours developing the evidence-based analyses and recommendations contained here, and in several other highly relevant documents and reports. When 189 nations signed the Declaration of Commitment that emerged from the

2001 United Nations General Assembly on HIV/AIDS, they recognized, in a rare, unanimous, international consensus, that AIDS is among the greatest development crises in human history, and each committed to act nationally and internationally to stop the epidemic.

To quote the Report of the Secretary General on the Declaration of Commitment on HIV/AIDS Five Years Later, “A quarter century into the epidemic, the global AIDS response stands at a crossroads. For the first time ever the world possesses the means to begin to reverse the epidemic. But success will require unprecedented willingness on the part of all actors in the global response to fulfil their potential, to embrace new ways of working with each other, and to . . . sustain the response over the long term.”

The goals have been agreed upon and the roadmap on how to achieve those goals has been painstakingly developed. Some positive action has been taken, but not early enough. What remains to be done, in too many cases, is for the heads of our societies to recognize that being a leader in the world today, whether in the world of government, business, religion or other elements of civil society, requires being a leader on AIDS. The struggle to implement the plans outlined in this report will be a daily and difficult one. Defeating AIDS must be a shared, global and nonpartisan agenda. To move forward, we must demand that commitment—from our leaders, our institutions and ourselves.

Annex 1



ANNEX 1: COUNTRY PROFILES

The following profiles contain key estimates and a sample of indicators describing the status of the HIV epidemic and the response by country. Demographic, Social and Economic indicators are also included.

Demographic, social and economic indicators

The indicators included in this section provide background for the HIV and AIDS estimates and country progress indicators. The Human Development Index, Human Poverty Index and the estimate of people living with \$ 2 a day or less come from the 2005 UNDP Human Development Report. Per Capita Gross National Income is from the World Bank (World development Indicators, World Bank, 15 July 2005). Estimated population and population growth rate are from the United Nations Population Division, Department of Social and Economic Affairs. Governments Health Expenditure per capita and life expectancy at birth are 2004 World Health Organization (WHO) estimates.

The quantities marked \$ (as opposed to US\$) are expressed in international dollars, which means that the amounts have been calculated in terms of purchasing power parity (PPP). This is intended to account for differences in cost of living

between countries, so that the equivalent quantity of goods and services that can be bought by one international dollar (which is a hypothetical unit) will be as close as possible to being the same in every country.

HIV and AIDS estimates

Global surveillance of HIV, AIDS and sexually transmitted infections is a joint effort of the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, initiated in 1996, compiles the best information available and works to improve the quality of data on the levels and trends of the AIDS epidemic and its impact needed for informed decision-making and planning at national, regional and global levels. The HIV and AIDS estimates contained in these country profiles are a product of the Working Group, and they are derived in close collaboration

with national AIDS programmes and many other partners.

Country progress indicators

Available information on country progress on national expenditures, HIV policies, prevention and treatment programmes and services, and population risk behaviours are provided in Section III. These key indicators provide an overview of the situation in a country regarding the overall response and were selected from the *UNGASS Monitoring the Declaration of Commitment Guidelines on the Construction of Core Indicators* (2005). The indicators selected are abbreviated here due to space limitations. For a full discussion of the indicator, its definition, methods and tools used to measure it, see the Notes section following Annex 3 in the 2006 Global Report or the reference document quoted above. The data reported come from a combination of sources, including the 2005 Country Progress Reports, including the National Composite Policy Index (NCPI), the 2005 Coverage Survey, the WHO/UNAIDS “3 by 5” 2005 Global Report, and the Demographic and Health Survey/AIDS Indicator Survey. These data sources are clearly described elsewhere in this report (See Notes section following Annex 3: Country Progress Indicators) and the actual data is provided in Annex 3 with a full discussion available in the ‘Progress in countries’ chapter. The numbers and percentages are given in rounded figures and may result in minor discrepancies.

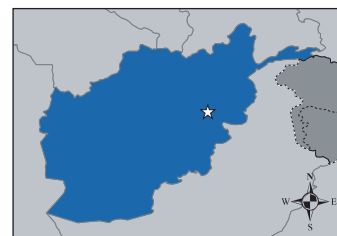
The indicator on domestic public expenditures was predominately obtained through desk reviews and budget analysis estimating actual expenditures, with a few

countries conducting the more accurate methods of a National AIDS Spending Assessment (NASA). Some countries are still reviewing their information to differentiate spending from their own sources from that obtained from international funds. Therefore information for this indicator is often not available or under revision.

Additionally, the indicators monitoring progress in concentrated and low-prevalence epidemics are new in 2005 and many countries are just beginning to report on these indicators. It is important to note that even in a generalized epidemic, there may be highly vulnerable populations at greater risk that need special services and programme monitoring. These indicators are designed to track progress in reaching the most-at-risk populations.

Please note: These figures were compiled by staff at UNAIDS headquarters in Geneva who cannot be responsible for the quality of the original data source, although reasonable efforts were made to check and clarify the data sources. Where there are no numbers provided this was because either the indicator was not appropriate, the data were not reported in the Country Progress Report, the country did not submit a progress report in time to be included in this report, the numbers are still under review, or there were no other data sources available at the time of preparation of these profiles. It is hoped that there will be more comprehensive reporting of data on these indicators in 2007.

Detailed explanations of the indicators can be found in the Annex Notes.



AFGHANISTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	29 863 000
Population Growth Rate	4.6%
Life expectancy at birth	
Women	42
Men	42
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	10

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<1000 [<2000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<1000 [<2000]
Women aged 15 and over living with HIV	<100 [<1000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

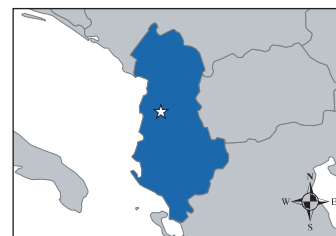
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ALBANIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 130 000
Population Growth Rate	0.4%
Life expectancy at birth	
Women	74
Men	69
Human Development Index	72
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	5070
Per Capita Government Expenditure on Health at Intl dollar rate	153

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	[<1000]
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

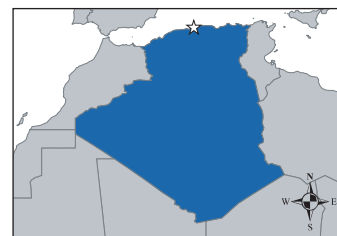
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	7.0% ¹
Sex workers	—
Men who have sex with men	—



ALGERIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	32 854 000
Population Growth Rate	1.5%
Life expectancy at birth	
Women	72
Men	64
Human Development Index	103
Human Poverty Index	
Rank	48
Value	21.3
Percentage of people with less than US\$ 2 a day	15.1%
Per Capita Gross National Income, ppp, Intl dollar rate	2090
Per Capita Government Expenditure on Health at Intl dollar rate	15

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	19 000 [9000 – 59 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [<0.2%]
Adults aged 15 and over living with HIV	19 000 [8800 – 60 000]
Women aged 15 and over living with HIV	4100 [1700 – 13 000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

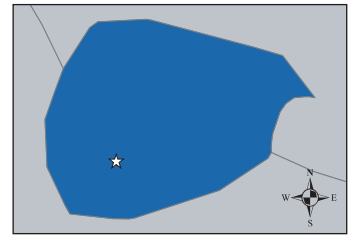
■ National funds spent by governments from domestic sources	US\$ 6 740 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	39.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	15.0% ¹
Sex workers	–
Men who have sex with men	–



ANDORRA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	67 000
Population Growth Rate	0.4%
Life expectancy at birth	
Women	83
Men	77
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	1683

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

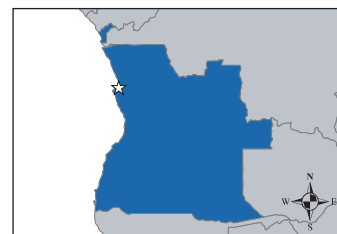
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ANGOLA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	15 941 000
Population Growth Rate	2.8%
Life expectancy at birth	
Women	42
Men	38
Human Development Index	160
Human Poverty Index	
Rank	83
Value	41.5
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	2030
Per Capita Government Expenditure on Health at Intl dollar rate	41

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	320 000 [200 000 – 450 000]
Adults aged 15 to 49 HIV prevalence rate	3.7 [2.3 – 5.3%]
Adults aged 15 and over living with HIV	280 000 [180 000 – 410 000]
Women aged 15 and over living with HIV	170 000 [90 000 – 260 000]
Deaths due to AIDS	30 000 [18 000 – 47 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	35 000 [12 000 – 76 000]
Orphans aged 0 to 17 due to AIDS	160 000 [95 000 – 230 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 8 897 303
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	2.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	6.0%
■ School attendance among orphans	73.0%
■ School attendance among non-orphans	81.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	35.2%
Men	42.7%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	32.7%
Men	61.4%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	24.3%
Men	46.7%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	55.2%
Men	63.6%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

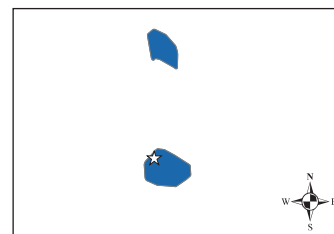
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



ANTIGUA AND BARBUDA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	81 000
Population Growth Rate	1.3%
Life expectancy at birth	
Women	75
Men	70
Human Development Index	60
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	10 360
Per Capita Government Expenditure on Health at Intl dollar rate	304

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	50.2%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 359 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	60.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ARGENTINA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	38 747 000
Population Growth Rate	1%
Life expectancy at birth	
Women	78
Men	71
Human Development Index	34
Human Poverty Index	
Rank	–
Value	–
Percentage of people with less than US\$ 2 a day	14.3%
Per Capita Gross National Income, ppp, Intl dollar rate	12 460
Per Capita Government Expenditure on Health at Intl dollar rate	518

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	130 000 [80 000 – 220 000]
Adults aged 15 to 49 HIV prevalence rate	0.6 [0.3 – 1.9%]
Adults aged 15 and over living with HIV	130 000 [78 000 – 220 000]
Women aged 15 and over living with HIV	36 000 [19 000 – 64 000]
Deaths due to AIDS	4300 [2600 – 6400]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission		87.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy		—
■ School attendance among orphans	— non-orphans	—

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

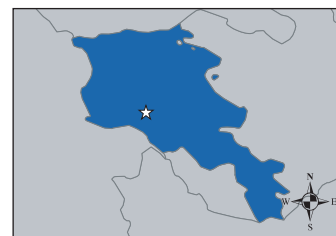
■ National funds spent by governments from domestic sources	US\$ 115 164 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	81.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	93.0% ¹
Sex workers	30.0% ²
Men who have sex with men	30.0% ³



ARMENIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 016 000
Population Growth Rate	-0.4%
Life expectancy at birth	
Women	72
Men	65
Human Development Index	83
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	4270
Per Capita Government Expenditure on Health at Intl dollar rate	61

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	2900 [1800 – 5800]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.6%]
Adults aged 15 and over living with HIV	2900 [1800 – 5800]
Women aged 15 and over living with HIV	<1000 [<2000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	-
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	-
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	-
Men	-

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 271 437
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	15.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	25.1% ¹
Sex workers	28.9% ²
Men who have sex with men	0.7% ³



AUSTRALIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	20 155 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	83
Men	78
Human Development Index	3
Human Poverty Index	
Rank	14 ¹
Value	12.8 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	29 200
Per Capita Government Expenditure on Health at Intl dollar rate	1939

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	16 000 [9700 – 27 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [<0.2%]
Adults aged 15 and over living with HIV	16 000 [9600 – 27 000]
Women aged 15 and over living with HIV	<1000 [<2000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

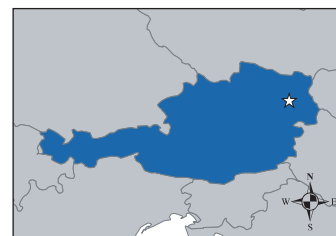
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



AUSTRIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	8 189 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	82
Men	76
Human Development Index	17
Human Poverty Index	
Rank	— ¹
Value	— ²
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	31 790
Per Capita Government Expenditure on Health at Intl dollar rate	1560

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	12 000 [7200 – 20 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.2 – 0.5%]
Adults aged 15 and over living with HIV	12 000 [7200 – 20 000]
Women aged 15 and over living with HIV	2300 [1200 – 4100]
Deaths due to AIDS	<100[<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

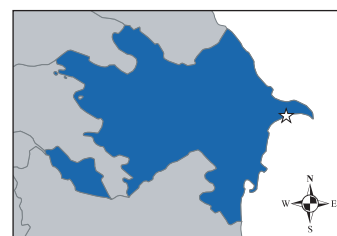
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



AZERBAIJAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	8 411 000
Population Growth Rate	0.6%
Life expectancy at birth	
Women	68
Men	63
Human Development Index	101
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	3830
Per Capita Government Expenditure on Health at Intl dollar rate	33

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5400 [2600 – 17 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	5400 [2600 – 17 000]
Women aged 15 and over living with HIV	<1000 [300 – 2300]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	1.0% ¹
Men	— ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

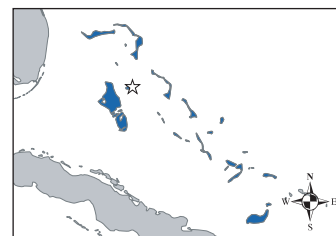
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



BAHAMAS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	323 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	76
Men	70
Human Development Index	50
Human Poverty Index	
Rank	–
Value	–
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	16 140
Per Capita Government Expenditure on Health at Intl dollar rate	579

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	6800 [3300 – 22 000]
Adults aged 15 to 49 HIV prevalence rate	3.3 [1.3 – 4.5%]
Adults aged 15 and over living with HIV	6500 [3100 – 21 000]
Women aged 15 and over living with HIV	3800 [1600 – 13 000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<500 [<1000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

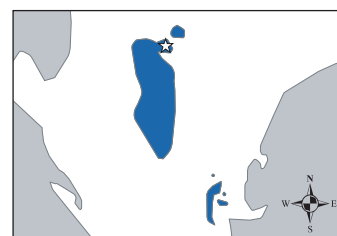
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BAHRAIN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	727 000
Population Growth Rate	1.6%
Life expectancy at birth	
Women	75
Men	73
Human Development Index	43
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	18 070
Per Capita Government Expenditure on Health at Intl dollar rate	562

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<1000 [<2000]
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

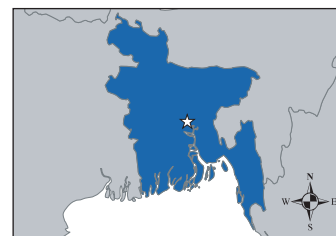
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



BANGLADESH

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	141 822 000
Population Growth Rate	1.9%
Life expectancy at birth	
Women	63
Men	62
Human Development Index	139
Human Poverty Index	
Rank	86
Value	44.1
Percentage of people with less than US\$ 2 a day	82.8%
Per Capita Gross National Income, ppp, Intl dollar rate	1980
Per Capita Government Expenditure on Health at Intl dollar rate	21

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	11 000 [6400 – 18 000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	11 000 [6400 – 18 000]
Women aged 15 and over living with HIV	1400 [710 – 2500]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

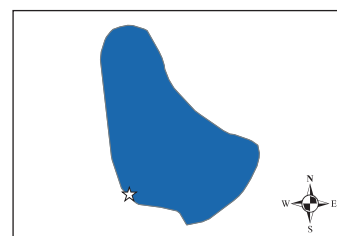
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	1.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	7.0% ¹
Sex workers	71.6% ²
Men who have sex with men	77.0% ³



BARBADOS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	270 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	78
Men	71
Human Development Index	30
Human Poverty Index	
Rank	4
Value	4.5
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	15 060
Per Capita Government Expenditure on Health at Intl dollar rate	729

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	2700 [1500 – 4200]
Adults aged 15 to 49 HIV prevalence rate	1.5 [0.8 – 2.5%]
Adults aged 15 and over living with HIV	2700 [1500 – 4200]
Women aged 15 and over living with HIV	<1000 [<2000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<100 [<200]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 3 349 169
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission		90.0% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy		95.0%
■ School attendance among orphans	— non-orphans	—

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	15.9%
Men	26.6%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	25.6%
Men	35.9%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	33.3%
Men	77.8%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BELARUS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	9 755 000
Population Growth Rate	-0.6%
Life expectancy at birth	
Women	74
Men	63
Human Development Index	67
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	6900
Per Capita Government Expenditure on Health at Intl dollar rate	501

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	20 000 [11 000 – 47 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.2 – 0.8%]
Adults aged 15 and over living with HIV	20 000 [11 000 – 48 000]
Women aged 15 and over living with HIV	5100 [2400 – 13 000]
Deaths due to AIDS	[<2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	-
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	-
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	-
Men	-

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

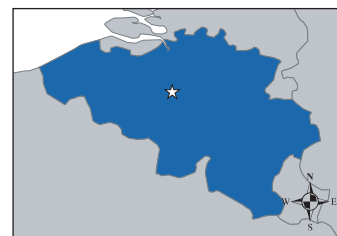
■ National funds spent by governments from domestic sources	US\$ 6 140 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	5.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	16.4% ¹
Sex workers	8.8% ²
Men who have sex with men	7.1% ³



BELGIUM

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	10 419 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	81
Men	75
Human Development Index	9
Human Poverty Index	
Rank	13 ¹
Value	12.4 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	31 360
Per Capita Government Expenditure on Health at Intl dollar rate	1902

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	14 000 [8100 – 22 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.2 – 0.5%]
Adults aged 15 and over living with HIV	14 000 [8100 – 22 000]
Women aged 15 and over living with HIV	5400 [2800 – 9500]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

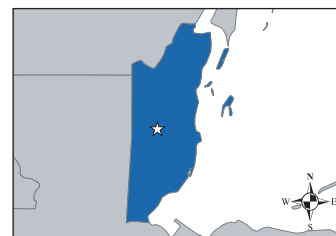
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BELIZE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	270 000
Population Growth Rate	2.1%
Life expectancy at birth	
Women	72
Men	65
Human Development Index	91
Human Poverty Index	
Rank	38
Value	16.7
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	6510
Per Capita Government Expenditure on Health at Intl dollar rate	152

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	3700 [2000 – 5700]
Adults aged 15 to 49 HIV prevalence rate	2.5 [1.4 – 4.0%]
Adults aged 15 and over living with HIV	3600 [2000 – 5600]
Women aged 15 and over living with HIV	1000 [<2000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<100 [<200]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 1 143 166
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	73.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	31.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

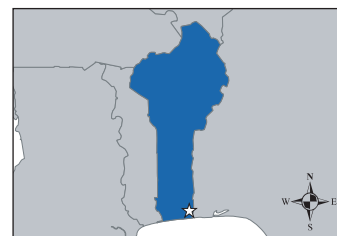
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BENIN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	8 439 000
Population Growth Rate	3.2%
Life expectancy at birth	
Women	53
Men	54
Human Development Index	162
Human Poverty Index	
Rank	95
Value	48.4
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1120
Per Capita Government Expenditure on Health at Intl dollar rate	16

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	87 000 [57 000 – 120 000]
Adults aged 15 to 49 HIV prevalence rate	1.8 [1.2 – 2.5%]
Adults aged 15 and over living with HIV	77 000 [50 000 – 110 000]
Women aged 15 and over living with HIV	45 000 [24 000 – 68 000]
Deaths due to AIDS	9600 [5900 – 15 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	9800 [3300 – 21 000]
Orphans aged 0 to 17 due to AIDS	62 000 [38 000 – 89 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 10 595 122 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	38.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	33.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	8.0%
Men	14.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	36.0%
Men	90.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	16.0% ²
Men	23.8% ³
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	19.0%
Men	34.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

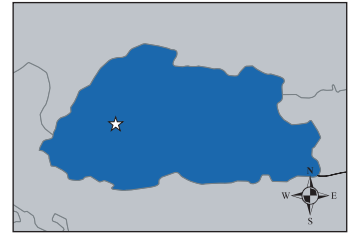
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BHUTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 163 000
Population Growth Rate	2.2%
Life expectancy at birth	
Women	65
Men	62
Human Development Index	134
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	49

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<2000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<500 [<2000]
Women aged 15 and over living with HIV	<100 [<200]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

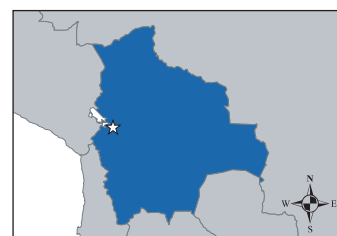
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



BOLIVIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	9 182 000
Population Growth Rate	2%
Life expectancy at birth	
Women	66
Men	63
Human Development Index	113
Human Poverty Index	
Rank	30
Value	13.9
Percentage of people with less than US\$ 2 a day	34.4%
Per Capita Gross National Income, ppp, Intl dollar rate	2590
Per Capita Government Expenditure on Health at Intl dollar rate	113

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	7000 [3800 – 17 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.3%]
Adults aged 15 and over living with HIV	6800 [3600 – 16 000]
Women aged 15 and over living with HIV	1900 [880 – 4700]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	18.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	32.0%
Men	70.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	6.0% ¹
Men	15.0% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	20.0%
Men	37.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	37.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BOSNIA AND HERZEGOVINA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 907 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	77
Men	70
Human Development Index	68
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	7430
Per Capita Government Expenditure on Health at Intl dollar rate	166

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1% [<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

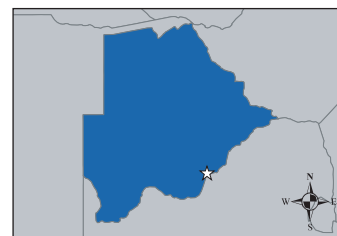
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



BOTSWANA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 765 000
Population Growth Rate	0.1%
Life expectancy at birth	
Women	40
Men	40
Human Development Index	131
Human Poverty Index	
Rank	94
Value	48.4
Percentage of people with less than US\$ 2 a day	50.1%
Per Capita Gross National Income, ppp, Intl dollar rate	8920
Per Capita Government Expenditure on Health at Intl dollar rate	218

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	270 000 [260 000 – 350 000]
Adults aged 15 to 49 HIV prevalence rate	24.1 [23.0 – 32.0%]
Adults aged 15 and over living with HIV	260 000 [250 000 – 330 000]
Women aged 15 and over living with HIV	140 000 [130 000 – 190 000]
Deaths due to AIDS	18 000 [17 000 – 25 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	14 000 [6100 – 32 000]
Orphans aged 0 to 17 due to AIDS	120 000 [110 000 – 150 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 165 000 000
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	85.0%
■ School attendance among orphans	92.0%
■ School attendance among non-orphans	93.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	40.0%
Men	33.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	75.0%
Men	88.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BRAZIL

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	186 405 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	74
Men	67
Human Development Index	63
Human Poverty Index	
Rank	20
Value	10.3
Percentage of people with less than US\$ 2 a day	22.4%
Per Capita Gross National Income, ppp, Intl dollar rate	8020
Per Capita Government Expenditure on Health at Intl dollar rate	270

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	620 000 [370 000 – 1 000 000]
Adults aged 15 to 49 HIV prevalence rate	0.5 [0.3 – 1.6%]
Adults aged 15 and over living with HIV	610 000 [370 000 – 1 000 000]
Women aged 15 and over living with HIV	220 000 [110 000 – 390 000]
Deaths due to AIDS	14 000 [8300 – 21 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	57.6% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

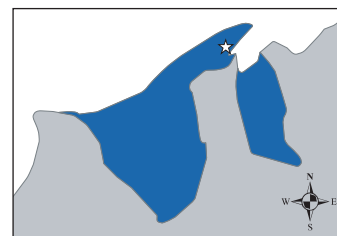
■ National funds spent by governments from domestic sources	US\$ 385 534 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	83.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



BRUNEI DARUSSALAM

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	374 000
Population Growth Rate	2.3%
Life expectancy at birth	
Women	78
Men	76
Human Development Index	33
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	545

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<100 [<200]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<100 [<200]
Women aged 15 and over living with HIV	<100 [<200]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



BULGARIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	7 726 000
Population Growth Rate	-0.7%
Life expectancy at birth	
Women	76
Men	69
Human Development Index	55
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	7870
Per Capita Government Expenditure on Health at Intl dollar rate	3112

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1% [<0.2%]
Adults aged 15 and over living with HIV	-
Women aged 15 and over living with HIV	-
Deaths due to AIDS	-

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	-
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	-
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	-
Men	-

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

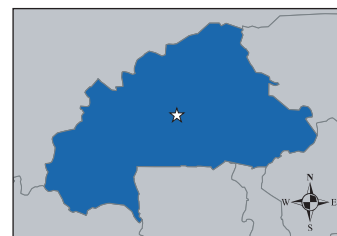
■ National funds spent by governments from domestic sources	-
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	-
■ Policy to expand access to essential preventive commodities among most-at-risk populations	-

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	-
Sex workers	-
Men who have sex with men	-



BURKINA FASO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	13 228 000
Population Growth Rate	3.2%
Life expectancy at birth	
Women	48
Men	47
Human Development Index	175
Human Poverty Index	
Rank	102
Value	64.2
Percentage of people with less than US\$ 2 a day	81.0%
Per Capita Gross National Income, ppp, Intl dollar rate	1220
Per Capita Government Expenditure on Health at Intl dollar rate	32

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	150 000 [120 000 – 190 000]
Adults aged 15 to 49 HIV prevalence rate	2.0 [1.5 – 2.5%]
Adults aged 15 and over living with HIV	140 000 [100 000 – 160 000]
Women aged 15 and over living with HIV	80 000 [49 000 – 110 000]
Deaths due to AIDS	12 000 [8400 – 17 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	17 000 [6100 – 34 000]
Orphans aged 0 to 17 due to AIDS	120 000 [89 000 – 150 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 8 013 260
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.1%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	24.0%
■ School attendance among orphans	35.0%
non-orphans	32.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	15.0%
Men	23.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	7.3% ¹
Men	4.7% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	54.0%
Men	67.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

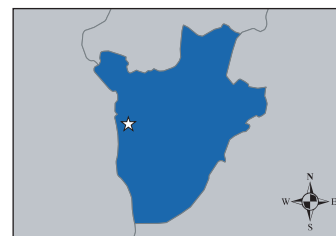
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	42.1% ³
Men who have sex with men	–



BURUNDI

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	7 548 000
Population Growth Rate	3%
Life expectancy at birth	
Women	47
Men	42
Human Development Index	169
Human Poverty Index	
Rank	80
Value	40.9
Percentage of people with less than US\$ 2 a day	89.2%
Per Capita Gross National Income, ppp, Intl dollar rate	660
Per Capita Government Expenditure on Health at Intl dollar rate	4

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	150 000 [130 000 – 180 000]
Adults aged 15 to 49 HIV prevalence rate	3.3 [2.7 – 3.8%]
Adults aged 15 and over living with HIV	130 000 [110 000 – 150 000]
Women aged 15 and over living with HIV	79 000 [68 000 – 91 000]
Deaths due to AIDS	13 000 [6800 – 18 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	20 000 [6500 – 37 000]
Orphans aged 0 to 17 due to AIDS	120 000 [94 000 – 170 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 44 000 000 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	2.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	14.0%
■ School attendance among orphans	46.0%
non-orphans	65.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	3.6%
Men	3.6%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	5.5%
Men	14.0%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	46.0%
Men	55.2%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

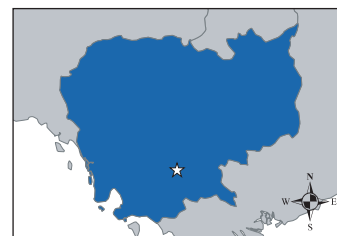
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	77.7% ²
Men who have sex with men	–



CAMBODIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	14 071 000
Population Growth Rate	2%
Life expectancy at birth	
Women	58
Men	51
Human Development Index	130
Human Poverty Index	
Rank	81
Value	41.3
Percentage of people with less than US\$ 2 a day	77.7%
Per Capita Gross National Income, ppp, Intl dollar rate	2180
Per Capita Government Expenditure on Health at Intl dollar rate	36

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	130 000 [74 000 – 210 000]
Adults aged 15 to 49 HIV prevalence rate	1.6 [0.9 – 2.6%]
Adults aged 15 and over living with HIV	130 000 [70 000 – 200 000]
Women aged 15 and over living with HIV	59 000 [28 000 – 99 000]
Deaths due to AIDS	16 000 [8500 – 26 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 1 012 000 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	36.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	2.6%
Men	26.3%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	0.2%
Men	0.0%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

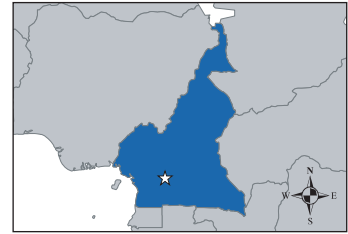
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	97.0% ²
Sex workers	60.0% ³
Men who have sex with men	17.0% ⁴



CAMEROON

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	16 322 000
Population Growth Rate	1.9%
Life expectancy at birth	
Women	51
Men	50
Human Development Index	148
Human Poverty Index	
Rank	67
Value	36.2
Percentage of people with less than US\$ 2 a day	50.6%
Per Capita Gross National Income, ppp, Intl dollar rate	2090
Per Capita Government Expenditure on Health at Intl dollar rate	19

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	510 000 [460 000 – 560 000]
Adults aged 15 to 49 HIV prevalence rate	5.4 [4.9 – 5.9%]
Adults aged 15 and over living with HIV	470 000 [430 000 – 510 000]
Women aged 15 and over living with HIV	290 000 [260 000 – 310 000]
Deaths due to AIDS	46 000 [36 000 – 55 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	43 000 [17 000 – 82 000]
Orphans aged 0 to 17 due to AIDS	240 000 [200 000 – 290 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 4 400 000 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	4.2%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	22.0%
■ School attendance among orphans	83.0%
■ School attendance among non-orphans	85.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	27.0%
Men	34.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	44.0%
Men	91.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	18.0% ²
Men	11.5% ³
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	46.0%
Men	57.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



CANADA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	32 268 000
Population Growth Rate	1%
Life expectancy at birth	
Women	83
Men	78
Human Development Index	5
Human Poverty Index	
Rank	9 ¹
Value	11.3 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	30 660
Per Capita Government Expenditure on Health at Intl dollar rate	2090

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	60 000 [48 000 – 72 000] ³
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.2 – 0.5%] ⁴
Adults aged 15 and over living with HIV	59 000 [47 000 – 71 000] ⁵
Women aged 15 and over living with HIV	9 600 [7 700 – 12 000] ⁶
Deaths due to AIDS	<1000 [<2000] ⁷

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	– ⁸
Orphans aged 0 to 17 due to AIDS	– ⁹

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

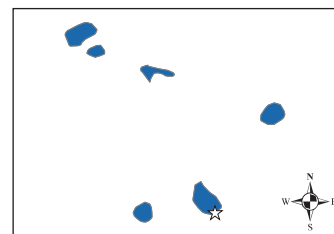
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



CAPE VERDE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	507 000
Population Growth Rate	2.4%
Life expectancy at birth	
Women	71
Men	67
Human Development Index	105
Human Poverty Index	
Rank	45
Value	18.7
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	5650
Per Capita Government Expenditure on Health at Intl dollar rate	135

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	–
Adults aged 15 to 49 HIV prevalence rate	–
Adults aged 15 and over living with HIV	–
Women aged 15 and over living with HIV	–
Deaths due to AIDS	–

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



CENTRAL AFRICAN REPUBLIC

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 038 000
Population Growth Rate	1.3%
Life expectancy at birth	
Women	41
Men	40
Human Development Index	171
Human Poverty Index	
Rank	92
Value	47.8
Percentage of people with less than US\$ 2 a day	84.0%
Per Capita Gross National Income, ppp, Intl dollar rate	1110
Per Capita Government Expenditure on Health at Intl dollar rate	18

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	250 000 [110 000 – 390 000]
Adults aged 15 to 49 HIV prevalence rate	10.7 [4.5 – 17.2%]
Adults aged 15 and over living with HIV	230 000 [100 000 – 350 000]
Women aged 15 and over living with HIV	130 000 [53 000 – 220 000]
Deaths due to AIDS	24 000 [10 000 – 39 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	24 000 [7200 – 61 000]
Orphans aged 0 to 17 due to AIDS	140 000 [62 000 – 200 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 742 927
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	16.4% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	3.0%
■ School attendance among orphans	49.0%
■ School attendance among non-orphans	54.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	9.9%
Men	9.6%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	60.6%
Men	83.2%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

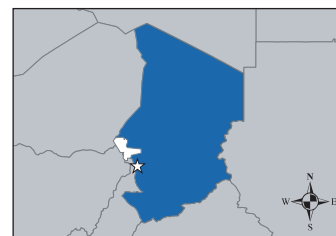
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



CHAD

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	9 749 000
Population Growth Rate	3.4%
Life expectancy at birth	
Women	48
Men	45
Human Development Index	173
Human Poverty Index	
Rank	100
Value	58.8
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1420
Per Capita Government Expenditure on Health at Intl dollar rate	20

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	180 000 [88 000 – 300 000]
Adults aged 15 to 49 HIV prevalence rate	3.5 [1.7 – 6.0%]
Adults aged 15 and over living with HIV	160 000 [81 000 – 270 000]
Women aged 15 and over living with HIV	90 000 [40 000 – 160 000]
Deaths due to AIDS	11 000 [5300 – 20 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	16 000 [4700 – 37 000]
Orphans aged 0 to 17 due to AIDS	57 000 [28 000 – 97 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 946 973
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.2%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	17.0%
■ School attendance among orphans	61.0%
non-orphans	57.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	8.0%
Men	21.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	7.0%
Men	76.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	19.0% ¹
Men	11.0% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	17.0%
Men	25.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

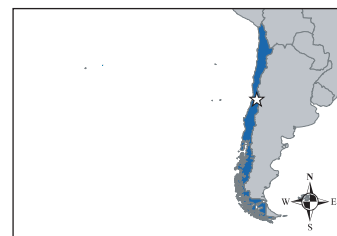
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	5.0% ³
Men who have sex with men	–



CHILE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	16 295 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	81
Men	74
Human Development Index	37
Human Poverty Index	
Rank	2
Value	3.7
Percentage of people with less than US\$ 2 a day	9.6%
Per Capita Gross National Income, ppp, Intl dollar rate	10 500
Per Capita Government Expenditure on Health at Intl dollar rate	345

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	28 000 [17 000 – 56 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.2 – 1.2%]
Adults aged 15 and over living with HIV	28 000 [17 000 – 56 000]
Women aged 15 and over living with HIV	7600 [4000 – 16 000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 25 240 460
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	No

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	75.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



CHINA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 323 345 000
Population Growth Rate	0.6%
Life expectancy at birth	
Women	74
Men	70
Human Development Index	85
Human Poverty Index	
Rank	27
Value	12.3
Percentage of people with less than US\$ 2 a day	46.7%
Per Capita Gross National Income, ppp, Intl dollar rate	1100
Per Capita Government Expenditure on Health at Intl dollar rate	101

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	650 000 [390 000 – 1 100 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [<0.2%]
Adults aged 15 and over living with HIV	650 000 [390 000 – 1 100 000]
Women aged 15 and over living with HIV	180 000 [90 000 – 310 000]
Deaths due to AIDS	31 000 [18 000 – 46 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 99 256 506
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	25.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	45.0% ¹
Sex workers	25.0% ²
Men who have sex with men	8.0% ³



COLOMBIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	45 600 000
Population Growth Rate	1.9%
Life expectancy at birth	
Women	77
Men	68
Human Development Index	69
Human Poverty Index	
Rank	8
Value	7.4
Percentage of people with less than US\$ 2 a day	22.6%
Per Capita Gross National Income, ppp, Intl dollar rate	6820
Per Capita Government Expenditure on Health at Intl dollar rate	439

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	160 000 [100 000 – 320 000]
Adults aged 15 to 49 HIV prevalence rate	0.6 [0.3 – 2.5%]
Adults aged 15 and over living with HIV	160 000 [100 000 – 320 000]
Women aged 15 and over living with HIV	45 000 [24 000 – 95 000]
Deaths due to AIDS	8200 [5200 – 12 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.8%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

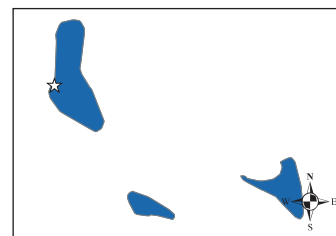
■ National funds spent by governments from domestic sources	US\$ 36 014 343
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	44.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	75.0% ¹
Men who have sex with men	30.0% ²



COMOROS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	798 000
Population Growth Rate	2.6%
Life expectancy at birth	
Women	67
Men	62
Human Development Index	132
Human Poverty Index	
Rank	57
Value	31.2
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1840
Per Capita Government Expenditure on Health at Intl dollar rate	14

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<500 [<1000]
Women aged 15 and over living with HIV	<100 [<1000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<100 [<200]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans
	60.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

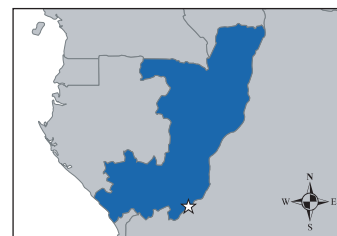
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



CONGO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 999 000
Population Growth Rate	3%
Life expectancy at birth	
Women	55
Men	53
Human Development Index	142
Human Poverty Index	
Rank	54
Value	30.1
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	750
Per Capita Government Expenditure on Health at Intl dollar rate	15

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	120 000 [75 000 – 160 000]
Adults aged 15 to 49 HIV prevalence rate	5.3 [3.3 – 7.5%]
Adults aged 15 and over living with HIV	100 000 [66 000 – 140 000]
Women aged 15 and over living with HIV	61 000 [33 000 – 89 000]
Deaths due to AIDS	11 000 [6700 – 17 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	15 000 [5600 – 32 000]
Orphans aged 0 to 17 due to AIDS	110 000 [70 000 – 150 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 4 719 207
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	98.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	17.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	64.7%
Men	72.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	9.9%
Men	10.1%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

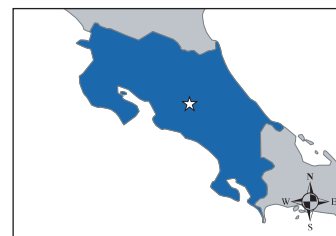
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	53.4% ¹
Men who have sex with men	33.3% ²



COSTA RICA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 327 000
Population Growth Rate	1.9%
Life expectancy at birth	
Women	80
Men	73
Human Development Index	47
Human Poverty Index	
Rank	3
Value	4.0
Percentage of people with less than US\$ 2 a day	9.5%
Per Capita Gross National Income, ppp, Intl dollar rate	9530
Per Capita Government Expenditure on Health at Intl dollar rate	486

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	7400 [3600 – 24 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.1 – 3.6%]
Adults aged 15 and over living with HIV	7300 [3500 – 24 000]
Women aged 15 and over living with HIV	2000 [860 – 6700]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

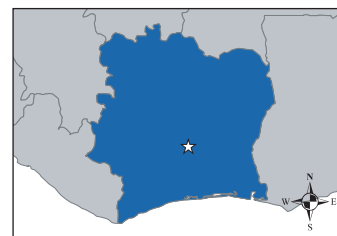
■ National funds spent by governments from domestic sources	US\$ 6 432 314
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	No

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	80.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



CÔTE D'IVOIRE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	18 154 000
Population Growth Rate	1.6%
Life expectancy at birth	
Women	47
Men	41
Human Development Index	163
Human Poverty Index	
Rank	84
Value	41.9
Percentage of people with less than US\$ 2 a day	38.4%
Per Capita Gross National Income, ppp, Intl dollar rate	1390
Per Capita Government Expenditure on Health at Intl dollar rate	16

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	750 000 [470 000 – 1 000 000]
Adults aged 15 to 49 HIV prevalence rate	7.1 [4.3 – 9.7%]
Adults aged 15 and over living with HIV	680 000 [420 000 – 920 000]
Women aged 15 and over living with HIV	400 000 [220 000 – 600 000]
Deaths due to AIDS	65 000 [39 000 – 96 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	74 000 [28 000 – 160 000]
Orphans aged 0 to 17 due to AIDS	450 000 [280 000 – 630 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 5 829 480
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National Programmes

National Programmes			
■	Percentage of pregnant women receiving treatment to reduce mother-to-child transmission		4.3%
■	Percentage of HIV-infected women and men receiving antiretroviral therapy		17.0%
■	School attendance among orphans	56.0%	non-orphans 67.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	64.3%
Men	57.9%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	14.5%
Men	13.3%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	71.0% ¹
Men who have sex with men	–



CROATIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 551 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	79
Men	72
Human Development Index	45
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	11 670
Per Capita Government Expenditure on Health at Intl dollar rate	701

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1% [<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	100.0% ¹
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	20.0% ²
Sex workers	—
Men who have sex with men	—



CUBA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	11 269 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	80
Men	75
Human Development Index	52
Human Poverty Index	
Rank	5
Value	4.8
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	218

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	4800 [2300 – 15 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.0 – 0.2%]
Adults aged 15 and over living with HIV	4700 [2300 – 15 000]
Women aged 15 and over living with HIV	2600 [1100 – 8500]
Deaths due to AIDS	<500 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	100.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



CYPRUS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	835 000
Population Growth Rate	1.2%
Life expectancy at birth	
Women	82
Men	77
Human Development Index	29
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	22 330
Per Capita Government Expenditure on Health at Intl dollar rate	561

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

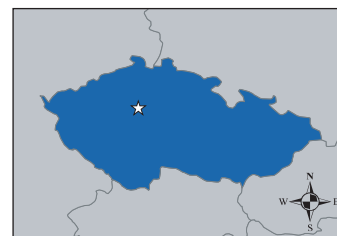
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



CZECH REPUBLIC

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	10 220 000
Population Growth Rate	-0.1%
Life expectancy at birth	
Women	79
Men	73
Human Development Index	31
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	18 400
Per Capita Government Expenditure on Health at Intl dollar rate	1172

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1500 [900 – 2500]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	1500 [900 – 2500]
Women aged 15 and over living with HIV	<1000 [<1000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	31.0%
Men	55.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

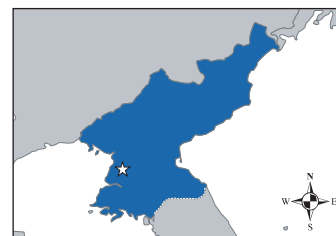
■ National funds spent by governments from domestic sources	US\$ 1 386 555
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	60.0% ¹
Sex workers	—
Men who have sex with men	—



DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	22 488 000
Population Growth Rate	0.6%
Life expectancy at birth	
Women	68
Men	65
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	68

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

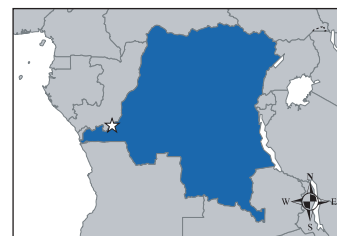
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



DEMOCRATIC REPUBLIC OF THE CONGO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	57 549 000
Population Growth Rate	2.8%
Life expectancy at birth	
Women	47
Men	42
Human Development Index	167
Human Poverty Index	
Rank	82
Value	41.4
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	680
Per Capita Government Expenditure on Health at Intl dollar rate	3

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 000 000 [560 000 – 1 500 000]
Adults aged 15 to 49 HIV prevalence rate	3.2 [1.8 – 4.9%]
Adults aged 15 and over living with HIV	890 000 [500 000 – 1 300 000]
Women aged 15 and over living with HIV	520 000 [250 000 – 850 000]
Deaths due to AIDS	90 000 [47 000 – 150 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	120 000 [40 000 – 270 000]
Orphans aged 0 to 17 due to AIDS	680 000 [380 000 – 1 000 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 3 621 653
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	4.0%
■ School attendance among orphans	50.0%
■ School attendance among non-orphans	70.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

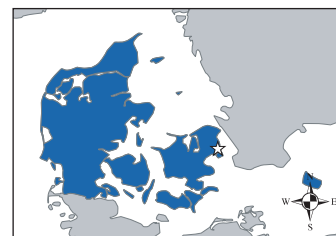
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



DENMARK

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 431 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	80
Men	75
Human Development Index	14
Human Poverty Index	
Rank	5 ¹
Value	8.9 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	31 550
Per Capita Government Expenditure on Health at Intl dollar rate	2292

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5600 [3400 – 9300]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	5500 [3300 – 9100]
Women aged 15 and over living with HIV	1300 [670 – 2300]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

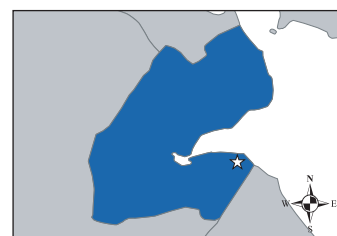
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



DJIBOUTI

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	793 000
Population Growth Rate	2.1%
Life expectancy at birth	
Women	57
Men	54
Human Development Index	150
Human Poverty Index	
Rank	53
Value	29.5
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	2270
Per Capita Government Expenditure on Health at Intl dollar rate	48

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	15 000 [3900 – 34 000]
Adults aged 15 to 49 HIV prevalence rate	3.1 [0.8 – 6.9%]
Adults aged 15 and over living with HIV	14 000 [3700 – 31 000]
Women aged 15 and over living with HIV	8400 [2200 – 19 000]
Deaths due to AIDS	1200 [350 – 2800]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	1200 [260 – 3600]
Orphans aged 0 to 17 due to AIDS	5700 [1900 – 12 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	16.0%
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

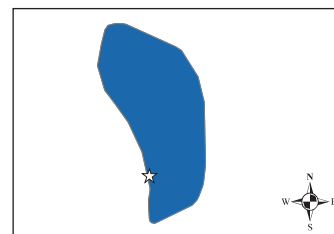
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



DOMINICA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	79 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	76
Men	72
Human Development Index	70
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	5250
Per Capita Government Expenditure on Health at Intl dollar rate	228

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	-
Adults aged 15 to 49 HIV prevalence rate	-
Adults aged 15 and over living with HIV	-
Women aged 15 and over living with HIV	-
Deaths due to AIDS	-

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	-
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	100.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	-
Men	-

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

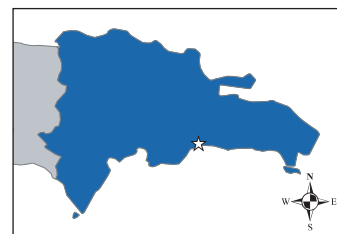
■ National funds spent by governments from domestic sources	US\$ 19 775 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	-
■ Policy to expand access to essential preventive commodities among most-at-risk populations	-

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	36.7%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	-
Sex workers	-
Men who have sex with men	-



DOMINICAN REPUBLIC

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	8 895 000
Population Growth Rate	1.5%
Life expectancy at birth	
Women	70
Men	64
Human Development Index	95
Human Poverty Index	
Rank	25
Value	11.8
Percentage of people with less than US\$ 2 a day	<2%
Per Capita Gross National Income, ppp, Intl dollar rate	6750
Per Capita Government Expenditure on Health at Intl dollar rate	111

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	66 000 [56 000 – 77 000]
Adults aged 15 to 49 HIV prevalence rate	1.1 [0.9 – 1.3%]
Adults aged 15 and over living with HIV	62 000 [53 000 – 73 000]
Women aged 15 and over living with HIV	31 000 [27 000 – 37 000]
Deaths due to AIDS	6700 [5100 – 8200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	3600 [1300 – 8000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	17.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	29.0%
Men	83.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	13.0% ¹
Men	18.0% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	29.0%
Men	52.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

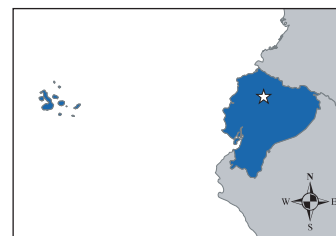
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	30.0% ³
Men who have sex with men	10.0% ⁴



ECUADOR

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	13 228 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	75
Men	70
Human Development Index	82
Human Poverty Index	
Rank	22
Value	10.6
Percentage of people with less than US\$ 2 a day	40.8%
Per Capita Gross National Income, ppp, Intl dollar rate	3690
Per Capita Government Expenditure on Health at Intl dollar rate	85

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	23 000 [11 000 – 74 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.1 – 3.5%]
Adults aged 15 and over living with HIV	22 000 [11 000 – 71 000]
Women aged 15 and over living with HIV	12 000 [5200 – 40 000]
Deaths due to AIDS	1600 [840 – 2900]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	8.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	7.0% ¹
Men	– ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

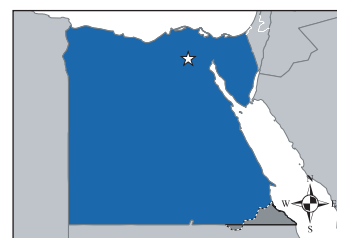
■ National funds spent by governments from domestic sources	US\$ 6 756 475
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	42.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	50.0% ³
Men who have sex with men	5.0% ⁴



EGYPT

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	74 033 000
Population Growth Rate	1.9%
Life expectancy at birth	
Women	70
Men	66
Human Development Index	119
Human Poverty Index	
Rank	55
Value	30.9
Percentage of people with less than US\$ 2 a day	43.9%
Per Capita Gross National Income, ppp, Intl dollar rate	4120
Per Capita Government Expenditure on Health at Intl dollar rate	100

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5300 [2900 – 13 000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	5200 [2800 – 13 000]
Women aged 15 and over living with HIV	<1000 [430 – 2300]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	7.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	12.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



EL SALVADOR

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	6 881 000
Population Growth Rate	1.8%
Life expectancy at birth	
Women	74
Men	68
Human Development Index	104
Human Poverty Index	
Rank	34
Value	15.9
Percentage of people with less than US\$ 2 a day	58.0%
Per Capita Gross National Income, ppp, Intl dollar rate	4980
Per Capita Government Expenditure on Health at Intl dollar rate	174

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	36 000 [22 000 – 72 000]
Adults aged 15 to 49 HIV prevalence rate	0.9 [0.5 – 3.8%]
Adults aged 15 and over living with HIV	35 000 [22 000 – 71 000]
Women aged 15 and over living with HIV	9900 [5300 – 21 000]
Deaths due to AIDS	2500 [1600 – 3700]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	20.8%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

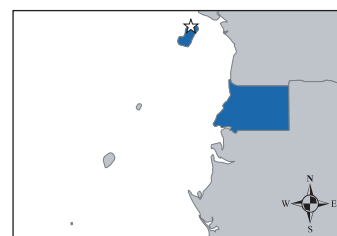
■ National funds spent by governments from domestic sources	US\$ 23 704 585
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	59.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	60.0% ¹
Men who have sex with men	17.0% ²



EQUATORIAL GUINEEA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	504 000
Population Growth Rate	2.3%
Life expectancy at birth	
Women	44
Men	42
Human Development Index	121
Human Poverty Index	
Rank	71
Value	38.1
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	7400
Per Capita Government Expenditure on Health at Intl dollar rate	121

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	8900 [7300 – 11 000]
Adults aged 15 to 49 HIV prevalence rate	3.2 [2.6 – 3.8%]
Adults aged 15 and over living with HIV	8000 [6600 – 9400]
Women aged 15 and over living with HIV	4700 [3900 – 5600]
Deaths due to AIDS	<1000 [<2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<1000 [<2000]
Orphans aged 0 to 17 due to AIDS	4600 [3500 – 5900]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ School attendance among orphans	85.0%
non-orphans	89.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



ERITREA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 401 000
Population Growth Rate	4.3%
Life expectancy at birth	
Women	62
Men	58
Human Development Index	161
Human Poverty Index	
Rank	73
Value	38.7
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1050
Per Capita Government Expenditure on Health at Intl dollar rate	23

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	59 000 [33 000 – 95 000]
Adults aged 15 to 49 HIV prevalence rate	2.4 [1.3 – 3.9%]
Adults aged 15 and over living with HIV	53 000 [30 000 – 84 000]
Women aged 15 and over living with HIV	31 000 [15 000 – 53 000]
Deaths due to AIDS	5600 [2900 – 9600]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	6600 [2300 – 16 000]
Orphans aged 0 to 17 due to AIDS	36 000 [20 000 – 56 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	5.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	37.0%
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	8.8% ¹
Men	– ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	81.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	– Sex workers
Men who have sex with men	–



ESTONIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 330 000
Population Growth Rate	-0.6%
Life expectancy at birth	
Women	78
Men	66
Human Development Index	38
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	13 190
Per Capita Government Expenditure on Health at Intl dollar rate	526

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	10 000 [4800 – 32 000]
Adults aged 15 to 49 HIV prevalence rate	1.3 [0.6 – 4.3%]
Adults aged 15 and over living with HIV	10 000 [4800 – 32 000]
Women aged 15 and over living with HIV	2400 [1000 – 7900]
Deaths due to AIDS	[<2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 526 565
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	17.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ETHIOPIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	77 431 000
Population Growth Rate	2.4%
Life expectancy at birth	
Women	51
Men	49
Human Development Index	170
Human Poverty Index	
Rank	99
Value	55.3
Percentage of people with less than US\$ 2 a day	80.7%
Per Capita Gross National Income, ppp, Intl dollar rate	810
Per Capita Government Expenditure on Health at Intl dollar rate	12

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	[420 000 – 1 300 000] ¹
Adults aged 15 to 49 HIV prevalence rate	[0.9 – 3.5%] ²
Adults aged 15 and over living with HIV	[380 000 – 1 200 000] ³
Women aged 15 and over living with HIV	[190 000 – 730 000] ⁴
Deaths due to AIDS	[38 000 – 130 000] ⁵

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	[30 000 – 220 000] ⁶
Orphans aged 0 to 17 due to AIDS	[280 000 – 870 000] ⁷

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	7.0%
■ School attendance among orphans	26.0%
non-orphans	43.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	7.4%
Men	37.9%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	41.5%
Men	40.3%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	14.6%
Men	36.1%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

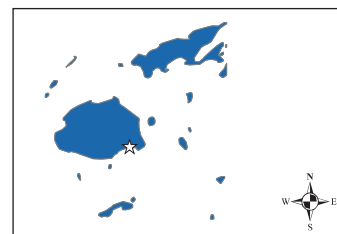
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



FIJI

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	848 000
Population Growth Rate	0.9%
Life expectancy at birth	
Women	72
Men	66
Human Development Index	92
Human Poverty Index	
Rank	49
Value	21.3
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	5770
Per Capita Government Expenditure on Health at Intl dollar rate	135

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<1000 [320 – 2100]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	<1000 [320 – 2100]
Women aged 15 and over living with HIV	<500 [<1000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	25.0% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

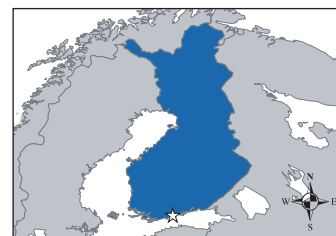
■ National funds spent by governments from domestic sources	US\$ 288 475
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	100.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



FINLAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 249 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	82
Men	75
Human Development Index	13
Human Poverty Index	
Rank	4 ¹
Value	8.2 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	29 560
Per Capita Government Expenditure on Health at Intl dollar rate	1163

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1900 [1100 – 3100]
Adults aged 15 to 49 HIV prevalence rate	0.1 [<0.2%]
Adults aged 15 and over living with HIV	1900 [1100 – 3200]
Women aged 15 and over living with HIV	<1000 [<2000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

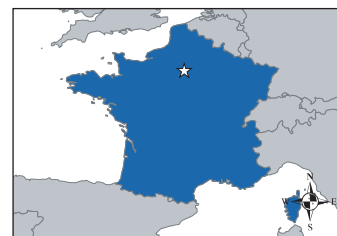
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



FRANCE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	60 496 000
Population Growth Rate	0.4%
Life expectancy at birth	
Women	83
Men	76
Human Development Index	16
Human Poverty Index	
Rank	10 ¹
Value	11.4 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	29 320
Per Capita Government Expenditure on Health at Intl dollar rate	2213

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	130 000 [78 000 – 210 000]
Adults aged 15 to 49 HIV prevalence rate	0.4 [0.3 – 0.8%]
Adults aged 15 and over living with HIV	130 000 [78 000 – 220 000]
Women aged 15 and over living with HIV	45 000 [23 000 – 79 000]
Deaths due to AIDS	1500 [<2500]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

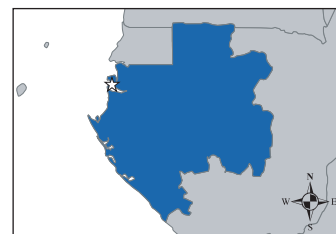
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



GABON

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 384 000
Population Growth Rate	1.7%
Life expectancy at birth	
Women	59
Men	55
Human Development Index	123
Human Poverty Index	
Rank	–
Value	–
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	5600
Per Capita Government Expenditure on Health at Intl dollar rate	170

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	60 000 [40 000 – 87 000]
Adults aged 15 to 49 HIV prevalence rate	7.9 [5.1 – 11.5%]
Adults aged 15 and over living with HIV	56 000 [37 000 – 81 000]
Women aged 15 and over living with HIV	33 000 [18 000 – 52 000]
Deaths due to AIDS	4700 [2800 – 7000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	3900 [1400 – 8900]
Orphans aged 0 to 17 due to AIDS	20 000 [13 000 – 29 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 6 709 107
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.7%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	23.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

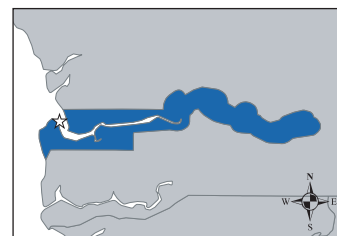
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



GAMBIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 517 000
Population Growth Rate	2.8%
Life expectancy at birth	
Women	59
Men	55
Human Development Index	155
Human Poverty Index	
Rank	88
Value	44.7
Percentage of people with less than US\$ 2 a day	82.9%
Per Capita Gross National Income, ppp, Intl dollar rate	1900
Per Capita Government Expenditure on Health at Intl dollar rate	38

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	20 000 [10 000 – 33 000]
Adults aged 15 to 49 HIV prevalence rate	2.4 [1.2 – 4.1%]
Adults aged 15 and over living with HIV	19 000 [9600 – 31 000]
Women aged 15 and over living with HIV	11 000 [5100 – 20 000]
Deaths due to AIDS	1300 [670 – 2200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	1200 [430 – 2800]
Orphans aged 0 to 17 due to AIDS	3800 [2200 – 6000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 5 543 227
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	16.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	10.0%
■ School attendance among orphans	58.0%
non-orphans	68.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

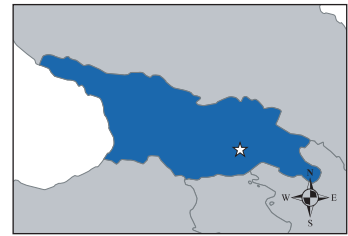
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



GEORGIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 474 000
Population Growth Rate	-1.1%
Life expectancy at birth	
Women	77
Men	70
Human Development Index	100
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	2930
Per Capita Government Expenditure on Health at Intl dollar rate	42

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5600 [2700 – 18 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 2.7%]
Adults aged 15 and over living with HIV	5600 [2700 – 18 000]
Women aged 15 and over living with HIV	<1000 [410 – 3200]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	-
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	-
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	-
Men	-

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 594 067
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	49.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	25.0% ¹
Sex workers	75.6% ²
Men who have sex with men	-



GERMANY

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	82 689 000
Population Growth Rate	0.1%
Life expectancy at birth	
Women	82
Men	76
Human Development Index	20
Human Poverty Index	
Rank	6 ¹
Value	10.3 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	27 950
Per Capita Government Expenditure on Health at Intl dollar rate	2348

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	49 000 [29 000 – 81 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.2%]
Adults aged 15 and over living with HIV	49 000 [29 000 – 81 000]
Women aged 15 and over living with HIV	15 000 [7700 – 26 000]
Deaths due to AIDS	<1000 [<2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	80.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

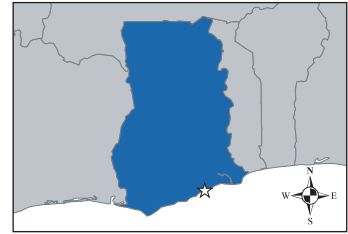
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



GHANA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	22 113 000
Population Growth Rate	2.1%
Life expectancy at birth	
Women	58
Men	56
Human Development Index	138
Human Poverty Index	
Rank	62
Value	35.1
Percentage of people with less than US\$ 2 a day	78.5%
Per Capita Gross National Income, ppp, Intl dollar rate	2280
Per Capita Government Expenditure on Health at Intl dollar rate	31

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	320 000 [270 000 – 380 000]
Adults aged 15 to 49 HIV prevalence rate	2.3 [1.9 – 2.6%]
Adults aged 15 and over living with HIV	300 000 [250 000 – 350 000]
Women aged 15 and over living with HIV	180 000 [150 000 – 210 000]
Deaths due to AIDS	29 000 [21 000 – 36 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	25 000 [9800 – 48 000]
Orphans aged 0 to 17 due to AIDS	170 000 [130 000 – 210 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 9 267 783
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	7.0%
■ School attendance among orphans	65.0%
■ School attendance among non-orphans	81.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	38.0%
Men	44.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	50.0%
Men	83.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	7.4% ¹
Men	3.9% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	33.0%
Men	52.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	50.0% ³
Men who have sex with men	–



GREECE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	11 120 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	82
Men	77
Human Development Index	24
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	22 000
Per Capita Government Expenditure on Health at Intl dollar rate	1025

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	9300 [5600 – 15 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.3%]
Adults aged 15 and over living with HIV	9300 [5600 – 15 000]
Women aged 15 and over living with HIV	2000 [1000 – 3500]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

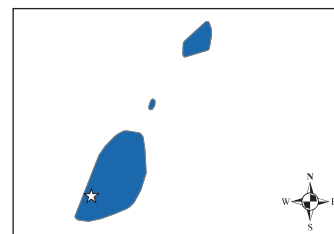
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



GRENADA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	103 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	69
Men	66
Human Development Index	66
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	7000
Per Capita Government Expenditure on Health at Intl dollar rate	348

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

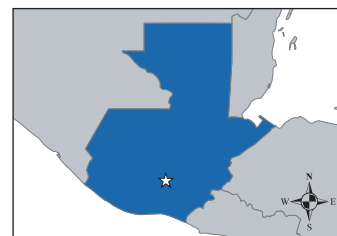
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



GUATEMALA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	12 599 000
Population Growth Rate	2.4%
Life expectancy at birth	
Women	71
Men	65
Human Development Index	117
Human Poverty Index	
Rank	51
Value	22.9
Percentage of people with less than US\$ 2 a day	37.4%
Per Capita Gross National Income, ppp, Intl dollar rate	4140
Per Capita Government Expenditure on Health at Intl dollar rate	93

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	61 000 [37 000 – 100 000]
Adults aged 15 to 49 HIV prevalence rate	0.9 [0.5 – 2.7%]
Adults aged 15 and over living with HIV	59 000 [35 000 – 97 000]
Women aged 15 and over living with HIV	16 000 [8300 – 29 000]
Deaths due to AIDS	2700 [1600 – 4000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 11 187 481 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	43.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	7.0% ²
Men	15.0% ³
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

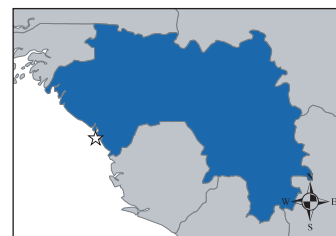
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	75.0% ⁴
Men who have sex with men	10.0% ⁵



GUINEA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	9 402 000
Population Growth Rate	2.2%
Life expectancy at birth	
Women	55
Men	52
Human Development Index	156
Human Poverty Index	
Rank	–
Value	–
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	2130
Per Capita Government Expenditure on Health at Intl dollar rate	16

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	85 000 [69 000 – 100 000]
Adults aged 15 to 49 HIV prevalence rate	1.5 [1.2 – 1.8%]
Adults aged 15 and over living with HIV	78 000 [62 000 – 91 000]
Women aged 15 and over living with HIV	53 000 [42 000 – 61 000]
Deaths due to AIDS	7100 [4700 – 9900]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	7000 [2400 – 16 000]
Orphans aged 0 to 17 due to AIDS	28 000 [18 000 – 43 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 271 052
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	9.0%
■ School attendance among orphans	38.0%
■ School attendance among non-orphans	33.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	17.6%
Men	15.7%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	27.0%
Men	42.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

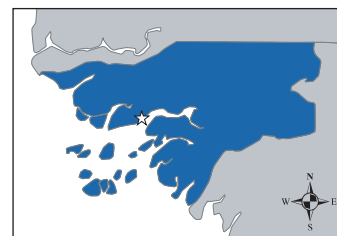
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	50.0% ¹
Men who have sex with men	–



GUINEA-BISSAU

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 586 000
Population Growth Rate	3%
Life expectancy at birth	
Women	48
Men	45
Human Development Index	172
Human Poverty Index	
Rank	93
Value	48.2
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	690
Per Capita Government Expenditure on Health at Intl dollar rate	21

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	32 000 [18 000 – 50 000]
Adults aged 15 to 49 HIV prevalence rate	3.8 [2.1 – 6.0%]
Adults aged 15 and over living with HIV	29 000 [16 000 – 45 000]
Women aged 15 and over living with HIV	17 000 [8100 – 29 000]
Deaths due to AIDS	2700 [1400 – 4400]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	3200 [1100 – 7500]
Orphans aged 0 to 17 due to AIDS	11 000 [6000 – 16 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 2 065 487 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	19.5%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	1.0%
■ School attendance among orphans	51.0%
non-orphans	50.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

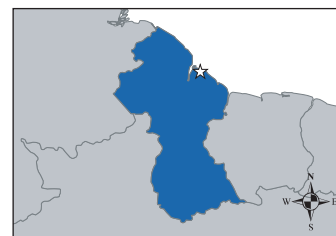
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



GUYANA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	751 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	64
Men	62
Human Development Index	107
Human Poverty Index	
Rank	31
Value	14.8
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	4110
Per Capita Government Expenditure on Health at Intl dollar rate	233

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	12 000 [4700 – 23 000]
Adults aged 15 to 49 HIV prevalence rate	2.4 [1.0 – 4.9%]
Adults aged 15 and over living with HIV	11 000 [4400 – 22 000]
Women aged 15 and over living with HIV	6600 [2300 – 14 000]
Deaths due to AIDS	1200 [440 – 2300]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<1000 [160 – 2000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 840 665
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	17.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	50.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	– Sex workers
Men who have sex with men	–



HAITI

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	8 528 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	56
Men	53
Human Development Index	153
Human Poverty Index	
Rank	70
Value	38.0
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1680
Per Capita Government Expenditure on Health at Intl dollar rate	32

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	190 000 [120 000 – 270 000]
Adults aged 15 to 49 HIV prevalence rate	3.8 [2.2 – 5.4%]
Adults aged 15 and over living with HIV	180 000 [100 000 – 250 000]
Women aged 15 and over living with HIV	96 000 [50 000 – 150 000]
Deaths due to AIDS	16 000 [9500 – 24 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	17 000 [5800 – 36 000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 115 609
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	20.0%
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



HONDURAS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	7 205 000
Population Growth Rate	2.3%
Life expectancy at birth	
Women	70
Men	65
Human Development Index	116
Human Poverty Index	
Rank	39
Value	16.9
Percentage of people with less than US\$ 2 a day	44.0%
Per Capita Gross National Income, ppp, Intl dollar rate	2710
Per Capita Government Expenditure on Health at Intl dollar rate	104

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	63 000 [35 000 – 99 000]
Adults aged 15 to 49 HIV prevalence rate	1.5 [0.8 – 2.4%]
Adults aged 15 and over living with HIV	61 000 [33 000 – 95 000]
Women aged 15 and over living with HIV	16 000 [7500 – 27 000]
Deaths due to AIDS	3700 [2000 – 6200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	2400 [790 – 5600]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 6 214 056 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	3.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	35.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	13.0% ²
Men	19.0% ³
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



HUNGARY

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	10 098 000
Population Growth Rate	-0.3%
Life expectancy at birth	
Women	77
Men	69
Human Development Index	35
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	15 620
Per Capita Government Expenditure on Health at Intl dollar rate	919

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	3200 [1900 – 5300]
Adults aged 15 to 49 HIV prevalence rate	0.1 [<0.2%]
Adults aged 15 and over living with HIV	3200 [1900 – 5300]
Women aged 15 and over living with HIV	<1000 [<2000]
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ICELAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	295 000
Population Growth Rate	0.9%
Life expectancy at birth	
Women	83
Men	79
Human Development Index	2
Human Poverty Index	
Rank	— ¹
Value	— ²
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	32 360
Per Capita Government Expenditure on Health at Intl dollar rate	2598

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.3%]
Adults aged 15 and over living with HIV	<500 [<1000]
Women aged 15 and over living with HIV	<100 [<200]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



INDIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 103 371 000
Population Growth Rate	1.6%
Life expectancy at birth	
Women	63
Men	61
Human Development Index	127
Human Poverty Index	
Rank	58
Value	31.3
Percentage of people with less than US\$ 2 a day	79.9%
Per Capita Gross National Income, ppp, Intl dollar rate	3100
Per Capita Government Expenditure on Health at Intl dollar rate	20

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5 700 000 [3 400 000 – 9 400 000]
Adults aged 15 to 49 HIV prevalence rate	0.9 [0.5 – 1.5%]
Adults aged 15 and over living with HIV	5 600 000 [3 400 000 – 9 300 000]
Women aged 15 and over living with HIV	1 600 000 [820 000 – 2 800 000]
Deaths due to AIDS	[270 000 – 680 000] ¹

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 73 300 000 ²
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	7.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	2.0%
Men	12.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	51.0%
Men	59.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	47.8% ³
Sex workers	52.4% ⁴
Men who have sex with men	45.0% ⁵



INDONESIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	222 781 000
Population Growth Rate	1.3%
Life expectancy at birth	
Women	68
Men	65
Human Development Index	110
Human Poverty Index	
Rank	41
Value	17.8
Percentage of people with less than US\$ 2 a day	52.4%
Per Capita Gross National Income, ppp, Intl dollar rate	3460
Per Capita Government Expenditure on Health at Intl dollar rate	40

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	170 000 [100 000 – 290 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.2%]
Adults aged 15 and over living with HIV	170 000 [100 000 – 290 000]
Women aged 15 and over living with HIV	29 000 [15 000 – 52 000]
Deaths due to AIDS	5500 [3300 – 8300]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.7%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 13 000 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	30.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	15.0% ¹
Sex workers	37.3% ²
Men who have sex with men	1.3% ³



IRAN (ISLAMIC REPUBLIC OF)

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	69 515 000
Population Growth Rate	0.9%
Life expectancy at birth	
Women	72
Men	68
Human Development Index	99
Human Poverty Index	
Rank	36
Value	16.4
Percentage of people with less than US\$ 2 a day	7.3%
Per Capita Gross National Income, ppp, Intl dollar rate	7550
Per Capita Government Expenditure on Health at Intl dollar rate	235

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	66 000 [36 000 – 160 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	66 000 [35 000 – 160 000]
Women aged 15 and over living with HIV	11 000 [5200 – 28 000]
Deaths due to AIDS	1600 [920 – 2700]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

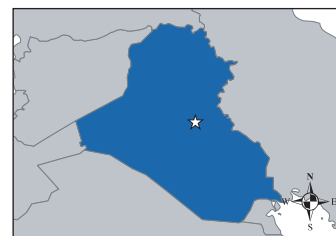
■ National funds spent by governments from domestic sources	US\$ 14 000 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	9.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	11.4% ¹
Sex workers	–
Men who have sex with men	–



IRAQ

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	28 807 000
Population Growth Rate	2.8%
Life expectancy at birth	
Women	61
Men	51
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	33

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

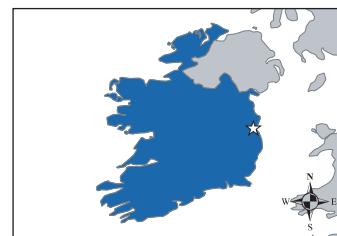
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



IRELAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 148 000
Population Growth Rate	1.7%
Life expectancy at birth	
Women	81
Men	75
Human Development Index	8
Human Poverty Index	
Rank	16 ¹
Value	15.2 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	33 170
Per Capita Government Expenditure on Health at Intl dollar rate	1968

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5000 [3000 – 8300]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	5000 [3000 – 8300]
Women aged 15 and over living with HIV	1800 [920 – 3200]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

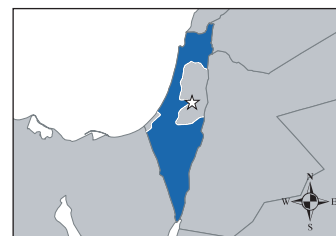
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



ISRAEL

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	6 725 000
Population Growth Rate	2%
Life expectancy at birth	
Women	82
Men	78
Human Development Index	23
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	23 510
Per Capita Government Expenditure on Health at Intl dollar rate	1303

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	4000 [2200 – 9800]
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ITALY

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	58 093 000
Population Growth Rate	0.1%
Life expectancy at birth	
Women	84
Men	78
Human Development Index	18
Human Poverty Index	
Rank	18 ¹
Value	29.9 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	27 860
Per Capita Government Expenditure on Health at Intl dollar rate	1703

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	150 000 [90 000 – 250 000]
Adults aged 15 to 49 HIV prevalence rate	0.5 [0.3 – 0.9%]
Adults aged 15 and over living with HIV	150 000 [90 000 – 250 000]
Women aged 15 and over living with HIV	50 000 [26 000 – 88 000]
Deaths due to AIDS	3000 [<4000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



JAMAICA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 651 000
Population Growth Rate	0.5%
Life expectancy at birth	
Women	74
Men	70
Human Development Index	98
Human Poverty Index	
Rank	21
Value	10.5
Percentage of people with less than US\$ 2 a day	13.3%
Per Capita Gross National Income, ppp, Intl dollar rate	3630
Per Capita Government Expenditure on Health at Intl dollar rate	109

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	25 000 [14 000 – 39 000]
Adults aged 15 to 49 HIV prevalence rate	1.5 [0.8 – 2.4%]
Adults aged 15 and over living with HIV	25 000 [14 000 – 39 000]
Women aged 15 and over living with HIV	6900 [3300 – 12 000]
Deaths due to AIDS	1300 [710 – 2200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<500 [<1000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 4 722 123
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	56.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

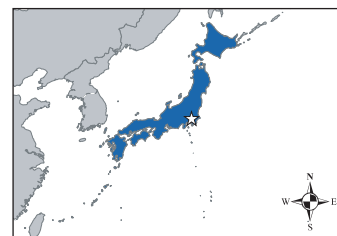
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	60.0% ¹
Men who have sex with men	–



JAPAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	128 085 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	86
Men	79
Human Development Index	11
Human Poverty Index	
Rank	12 ¹
Value	11.7 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	30 040
Per Capita Government Expenditure on Health at Intl dollar rate	1818

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	17 000 [10 000 – 29 000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	17 000 [10 000 – 28 000]
Women aged 15 and over living with HIV	9900 [5000 – 17 000]
Deaths due to AIDS	1400 [830 – 2100]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

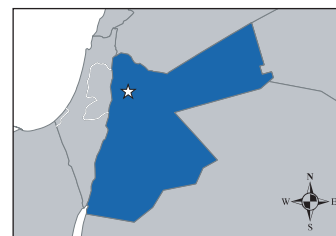
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



JORDAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 703 000
Population Growth Rate	2.7%
Life expectancy at birth	
Women	73
Men	69
Human Development Index	90
Human Poverty Index	
Rank	11
Value	8.1
Percentage of people with less than US\$ 2 a day	7.4%
Per Capita Gross National Income, ppp, Intl dollar rate	4640
Per Capita Government Expenditure on Health at Intl dollar rate	199

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<1000 [<2000]
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

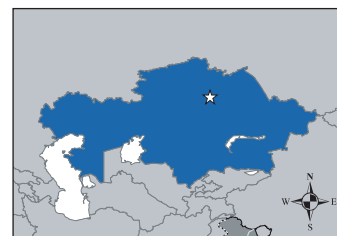
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	45.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



KAZAKHSTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	14 825 000
Population Growth Rate	-0.3%
Life expectancy at birth	
Women	67
Men	56
Human Development Index	80
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	6980
Per Capita Government Expenditure on Health at Intl dollar rate	180

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	12 000 [11 000 – 77 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 3.2%]
Adults aged 15 and over living with HIV	12 000 [11 000 – 76 000]
Women aged 15 and over living with HIV	6800 [5600 – 43 000]
Deaths due to AIDS	<1000 [<2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	9.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

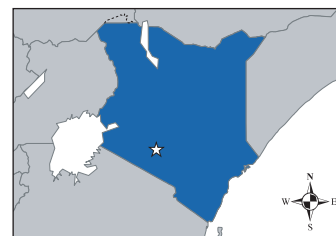
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	15.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	8.0% ¹
Sex workers	31.0% ²
Men who have sex with men	1.0% ³



KENYA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	34 256 000
Population Growth Rate	2.2%
Life expectancy at birth	
Women	50
Men	51
Human Development Index	154
Human Poverty Index	
Rank	63
Value	35.4
Percentage of people with less than US\$ 2 a day	58.3%
Per Capita Gross National Income, ppp, Intl dollar rate	1050
Per Capita Government Expenditure on Health at Intl dollar rate	25

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 300 000 [1 100 000 – 1 500 000]
Adults aged 15 to 49 HIV prevalence rate	6.1 [5.2 – 7.0%]
Adults aged 15 and over living with HIV	1 200 000 [990 000 – 1 300 000]
Women aged 15 and over living with HIV	740 000 [640 000 – 840 000]
Deaths due to AIDS	140 000 [110 000 – 170 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	150 000 [55 000 – 290 000]
Orphans aged 0 to 17 due to AIDS	1 100 000 [890 000 – 1 300 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 33 245 670 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	9.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	19.7%
■ School attendance among orphans	88.0%
non-orphans	92.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	34.0%
Men	47.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	30.0%
Men	84.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	14.5% ²
Men	30.9% ³
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	25.0%
Men	47.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

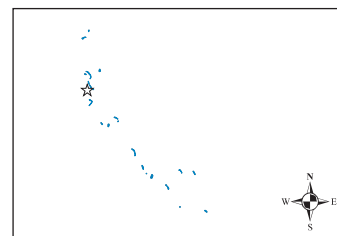
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	No

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	17.0% ⁴
Men who have sex with men	2.0% ⁵



KIRIBATI

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	99 000
Population Growth Rate	2.1%
Life expectancy at birth	
Women	67
Men	63
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	233

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	—
non-orphans	—

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

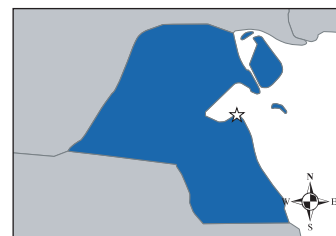
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



KUWAIT

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 687 000
Population Growth Rate	3.7%
Life expectancy at birth	
Women	78
Men	76
Human Development Index	44
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	19 510
Per Capita Government Expenditure on Health at Intl dollar rate	440

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<1000 [<2000]
Adults aged 15 to 49 HIV prevalence rate	[$<0.2\%$]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
---	---

National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

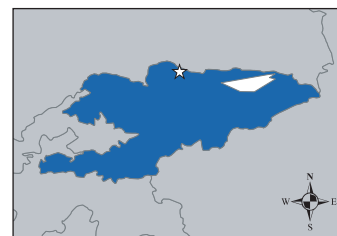
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



KYRGYZSTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 264 000
Population Growth Rate	1.2%
Life expectancy at birth	
Women	67
Men	59
Human Development Index	109
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	1840
Per Capita Government Expenditure on Health at Intl dollar rate	66

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	4000 [1900 – 13 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 1.7%]
Adults aged 15 and over living with HIV	4000 [1900 – 13 000]
Women aged 15 and over living with HIV	<1000 [290 – 2200]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
---	---

National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

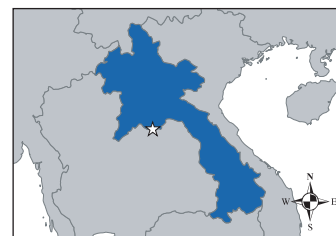
■ National funds spent by governments from domestic sources	US\$ 217 440 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	12.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	8.4% ²
Sex workers	75.3% ³
Men who have sex with men	79.2% ⁴



LAO PEOPLE'S DEMOCRATIC REPUBLIC

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 924 000
Population Growth Rate	2.3%
Life expectancy at birth	
Women	60
Men	58
Human Development Index	133
Human Poverty Index	
Rank	72
Value	38.2
Percentage of people with less than US\$ 2 a day	73.2%
Per Capita Gross National Income, ppp, Intl dollar rate	1850
Per Capita Government Expenditure on Health at Intl dollar rate	22

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	3700 [1800 – 12 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	3600 [1700 – 12 000]
Women aged 15 and over living with HIV	<1000 [260 – 2000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	2.5%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

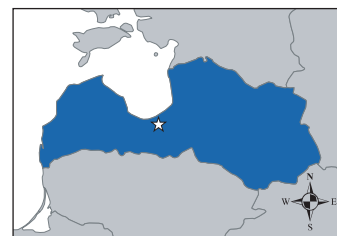
■ National funds spent by governments from domestic sources	US\$ 26 090
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	49.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	70.7% ¹
Men who have sex with men	–



LATVIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 307 000
Population Growth Rate	-0.6%
Life expectancy at birth	
Women	76
Men	66
Human Development Index	48
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	11 850
Per Capita Government Expenditure on Health at Intl dollar rate	348

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	10 000 [6100 – 17 000]
Adults aged 15 to 49 HIV prevalence rate	0.8 [0.5 – 1.3%]
Adults aged 15 and over living with HIV	10 000 [6100 – 17 000]
Women aged 15 and over living with HIV	2200 [1100 – 3900]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	58.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

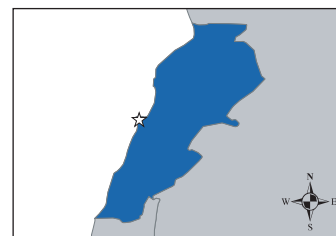
■ National funds spent by governments from domestic sources	US\$ 980 110
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	31.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	7.9% ¹
Sex workers	17.0% ²
Men who have sex with men	2.0% ³



LEBANON

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 577 000
Population Growth Rate	1%
Life expectancy at birth	
Women	72
Men	68
Human Development Index	81
Human Poverty Index	
Rank	18
Value	9.6
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	5380
Per Capita Government Expenditure on Health at Intl dollar rate	214

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	2900 [1400 – 9200]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.5%]
Adults aged 15 and over living with HIV	2900 [1400 – 9300]
Women aged 15 and over living with HIV	<1000 [270 – 2100]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

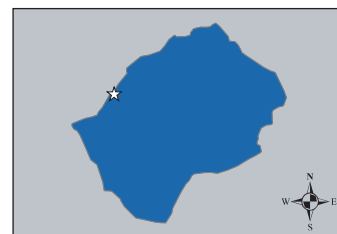
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	36.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



LESOTHO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 795 000
Population Growth Rate	0.1%
Life expectancy at birth	
Women	44
Men	39
Human Development Index	149
Human Poverty Index	
Rank	91
Value	47.6
Percentage of people with less than US\$ 2 a day	56.1%
Per Capita Gross National Income, ppp, Intl dollar rate	3210
Per Capita Government Expenditure on Health at Intl dollar rate	84

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	270 000 [250 000 – 290 000]
Adults aged 15 to 49 HIV prevalence rate	23.2 [21.9 – 24.7%]
Adults aged 15 and over living with HIV	250 000 [240 000 – 270 000]
Women aged 15 and over living with HIV	150 000 [140 000 – 160 000]
Deaths due to AIDS	23 000 [20 000 – 27 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	18 000 [6900 – 34 000]
Orphans aged 0 to 17 due to AIDS	97 000 [88 000 – 110 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 1 357 875
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	5.1%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	14.0%
■ School attendance among orphans	79.0%
■ School attendance among non-orphans	91.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	43.3%
Men	89.5%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	14.4%
Men	27.5%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	50.0%
Men	48.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

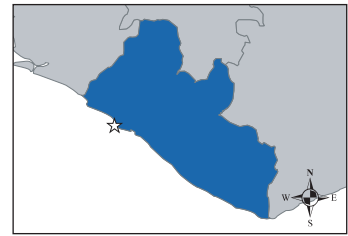
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



LIBERIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 283 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	44
Men	39
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	10

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[2.0 – 5.0%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 104 733
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	3.0%
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

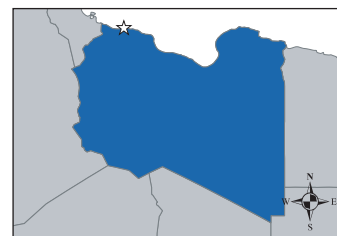
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



LIBYAN ARAB JAMAHIRIYA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 853 000
Population Growth Rate	2%
Life expectancy at birth	
Women	75
Men	70
Human Development Index	58
Human Poverty Index	
Rank	33
Value	15.3
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	206

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

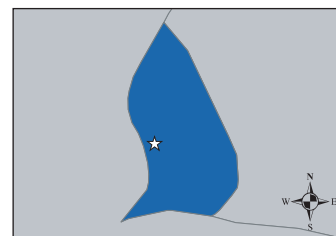
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	35.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



LIECHTENSTEIN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	35 000
Population Growth Rate	1%
Life expectancy at birth	
Women	—
Men	—
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	—

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	— Men

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

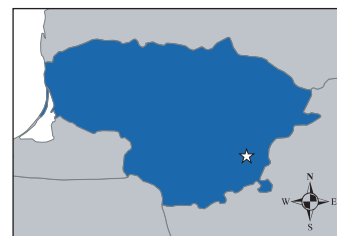
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	— Sex workers
Men who have sex with men	—



LITHUANIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 431 000
Population Growth Rate	-0.4%
Life expectancy at birth	
Women	78
Men	66
Human Development Index	39
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	12 610
Per Capita Government Expenditure on Health at Intl dollar rate	573

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	3300 [1600 – 10 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.6%]
Adults aged 15 and over living with HIV	3300 [1600 – 11 000]
Women aged 15 and over living with HIV	<1000 [<2000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

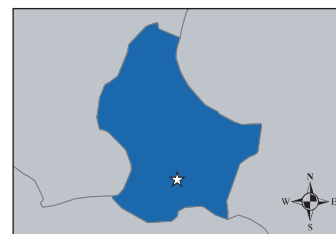
■ National funds spent by governments from domestic sources	US\$ 838 150
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	64.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



LUXEMBOURG

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	465 000
Population Growth Rate	1.3%
Life expectancy at birth	
Women	81
Men	76
Human Development Index	4
Human Poverty Index	
Rank	8 ¹
Value	11.1 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	61 220
Per Capita Government Expenditure on Health at Intl dollar rate	3341

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<1000 [<1000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	<1000 [<2000]
Women aged 15 and over living with HIV	–
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

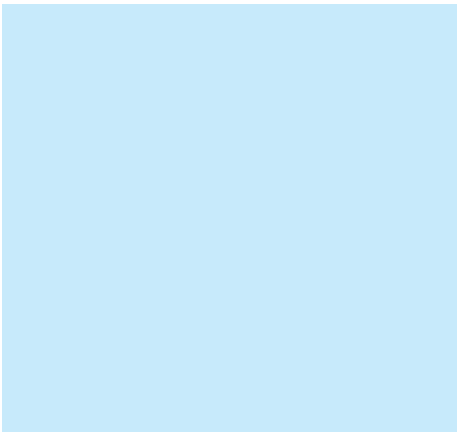
■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

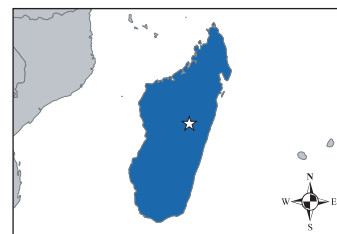
National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–

ANNEX 1:

Country profiles





MADAGASCAR

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	18 606 000
Population Growth Rate	2.8%
Life expectancy at birth	
Women	59
Men	55
Human Development Index	146
Human Poverty Index	
Rank	63
Value	35.3
Percentage of people with less than US\$ 2 a day	85.1%
Per Capita Gross National Income, ppp, Intl dollar rate	830
Per Capita Government Expenditure on Health at Intl dollar rate	15

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	49 000 [16 000 – 110 000]
Adults aged 15 to 49 HIV prevalence rate	0.5 [0.2 – 1.2%]
Adults aged 15 and over living with HIV	47 000 [16 000 – 110 000]
Women aged 15 and over living with HIV	13 000 [4000 – 33 000]
Deaths due to AIDS	2900 [1100 – 6500]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	1600 [470 – 4900]
Orphans aged 0 to 17 due to AIDS	13 000 [5000 – 24 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	61.0%
non-orphans	80.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	19.0%
Men	16.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	31.0%
Men	72.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	16.0% ¹
Men	7.7% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	5.0%
Men	12.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 187 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



MALAWI

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	12 884 000
Population Growth Rate	2.3%
Life expectancy at birth	
Women	42
Men	41
Human Development Index	165
Human Poverty Index	
Rank	85
Value	43.4
Percentage of people with less than US\$ 2 a day	76.1%
Per Capita Gross National Income, ppp, Intl dollar rate	620
Per Capita Government Expenditure on Health at Intl dollar rate	16

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	940 000 [480 000 – 1 400 000]
Adults aged 15 to 49 HIV prevalence rate	14.1 [6.9 – 21.4%]
Adults aged 15 and over living with HIV	850 000 [440 000 – 1 300 000]
Women aged 15 and over living with HIV	500 000 [220 000 – 800 000]
Deaths due to AIDS	78 000 [38 000 – 120 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	91 000 [28 000 – 190 000]
Orphans aged 0 to 17 due to AIDS	550 000 [310 000 – 780 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 8 704 000
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	2.3% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	20.0%
■ School attendance among orphans	81.0%
■ School attendance among non-orphans	87.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	23.5%
Men	36.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	13.9%
Men	62.1%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	35.0%
Men	47.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



MALAYSIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	25 347 000
Population Growth Rate	1.9%
Life expectancy at birth	
Women	74
Men	69
Human Development Index	61
Human Poverty Index	
Rank	16
Value	8.9
Percentage of people with less than US\$ 2 a day	9.3%
Per Capita Gross National Income, ppp, Intl dollar rate	9630
Per Capita Government Expenditure on Health at Intl dollar rate	218

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	69 000 [33 000 – 220 000]
Adults aged 15 to 49 HIV prevalence rate	0.5 [0.2 – 1.5%]
Adults aged 15 and over living with HIV	67 000 [32 000 – 220 000]
Women aged 15 and over living with HIV	17 000 [7300 – 57 000]
Deaths due to AIDS	4000 [2100 – 7200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	6.1%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

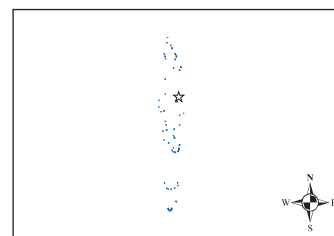
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	27.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	4.0% ¹
Sex workers	–
Men who have sex with men	10.0% ²



MALDIVES

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	329 000
Population Growth Rate	2.5%
Life expectancy at birth	
Women	68
Men	66
Human Development Index	96
Human Poverty Index	
Rank	37
Value	16.6
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	324

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

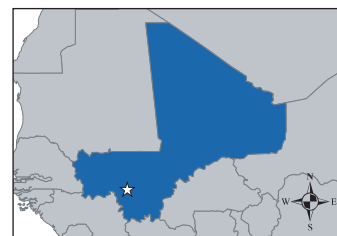
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



MALI

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	13 518 000
Population Growth Rate	3%
Life expectancy at birth	
Women	47
Men	44
Human Development Index	174
Human Poverty Index	
Rank	101
Value	60.3
Percentage of people with less than US\$ 2 a day	90.6%
Per Capita Gross National Income, ppp, Intl dollar rate	980
Per Capita Government Expenditure on Health at Intl dollar rate	22

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	130 000 [96 000 – 160 000]
Adults aged 15 to 49 HIV prevalence rate	1.7 [1.3 – 2.1%]
Adults aged 15 and over living with HIV	110 000 [86 000 – 140 000]
Women aged 15 and over living with HIV	66 000 [51 000 – 81 000]
Deaths due to AIDS	11 000 [7400 – 16 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	16 000 [6000 – 32 000]
Orphans aged 0 to 17 due to AIDS	94 000 [70 000 – 120 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 3 500 000
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.8%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	32.0%
■ School attendance among orphans	39.0%
non-orphans	37.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	9.0%
Men	15.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	18.0%
Men	85.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	26.0% ¹
Men	10.6% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	14.0%
Men	30.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

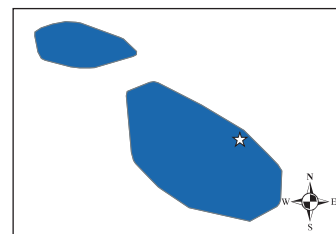
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	45.3% ³
Men who have sex with men	–



MALTA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	402 000
Population Growth Rate	0.5%
Life expectancy at birth	
Women	81
Men	76
Human Development Index	32
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	18 720
Per Capita Government Expenditure on Health at Intl dollar rate	1150

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.2%]
Adults aged 15 and over living with HIV	<500 [<1000]
Women aged 15 and over living with HIV	—
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

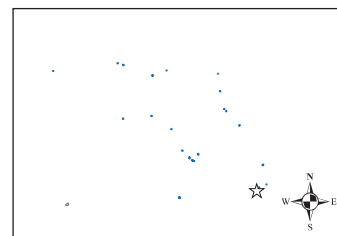
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



MARSHALL ISLANDS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	62 000
Population Growth Rate	3.5%
Life expectancy at birth	
Women	64
Men	60
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	461

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

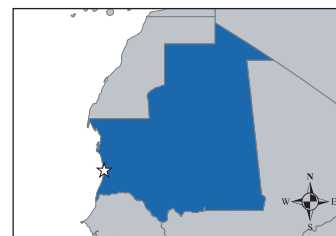
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



MAURITANIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 069 000
Population Growth Rate	3%
Life expectancy at birth	
Women	60
Men	55
Human Development Index	152
Human Poverty Index	
Rank	79
Value	40.5
Percentage of people with less than US\$ 2 a day	63.1%
Per Capita Gross National Income, ppp, Intl dollar rate	2050
Per Capita Government Expenditure on Health at Intl dollar rate	46

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	12 000 [7300 – 23 000]
Adults aged 15 to 49 HIV prevalence rate	0.7 [0.4 – 2.8%]
Adults aged 15 and over living with HIV	11 000 [6600 – 21 000]
Women aged 15 and over living with HIV	6300 [3300 – 13 000]
Deaths due to AIDS	<1000 [<2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	1100 [320 – 2600]
Orphans aged 0 to 17 due to AIDS	6900 [3900 – 10 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	13.2% ¹
Men	2.1% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

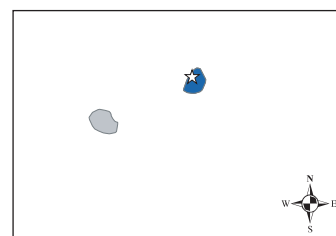
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	40.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



MAURITIUS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 245 000
Population Growth Rate	1%
Life expectancy at birth	
Women	75
Men	69
Human Development Index	65
Human Poverty Index	
Rank	24
Value	11.4
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	11 870
Per Capita Government Expenditure on Health at Intl dollar rate	261

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	4100 [1900 – 13 000]
Adults aged 15 to 49 HIV prevalence rate	0.6 [0.3 – 1.8%]
Adults aged 15 and over living with HIV	4100 [1900 – 13 000]
Women aged 15 and over living with HIV	<1000 [310 – 2400]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 128 341
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



MEXICO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	107 029 000
Population Growth Rate	1.3%
Life expectancy at birth	
Women	77
Men	72
Human Development Index	53
Human Poverty Index	
Rank	13
Value	8.4
Percentage of people with less than US\$ 2 a day	26.3%
Per Capita Gross National Income, ppp, Intl dollar rate	9590
Per Capita Government Expenditure on Health at Intl dollar rate	270

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	180 000 [99 000 – 440 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.2 – 0.7%]
Adults aged 15 and over living with HIV	180 000 [97 000 – 440 000]
Women aged 15 and over living with HIV	42 000 [17 000 – 91 000]
Deaths due to AIDS	6200 [3800 – 11 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	2.1%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

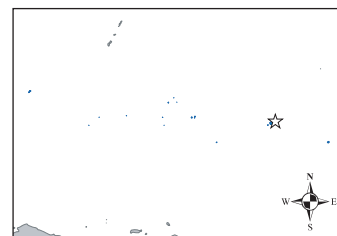
■ National funds spent by governments from domestic sources	US\$ 196 833 282
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	71.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



MICRONESIA (FEDERATED STATES OF)

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	110 000
Population Growth Rate	0.6%
Life expectancy at birth	
Women	71
Men	68
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	238

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

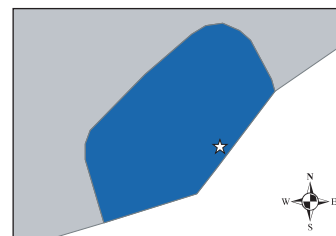
■ National funds spent by governments from domestic sources	US\$ 15 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



MONACO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	35 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	85
Men	78
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	3403

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



MONGOLIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 646 000
Population Growth Rate	1.2%
Life expectancy at birth	
Women	69
Men	61
Human Development Index	114
Human Poverty Index	
Rank	44
Value	18.5
Percentage of people with less than US\$ 2 a day	74.9%
Per Capita Gross National Income, ppp, Intl dollar rate	2020
Per Capita Government Expenditure on Health at Intl dollar rate	90

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<2000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<500 [<2000]
Women aged 15 and over living with HIV	<100 [<200]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	5.0%
Men	3.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	79.2%
Men	93.5%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	0.1%
Men	3.0%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	42.1%
Men	58.5%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

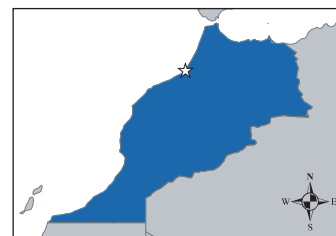
■ National funds spent by governments from domestic sources	US\$ 172 867 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	58.0% ²
Men who have sex with men	68.1% ³



MOROCCO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	31 478 000
Population Growth Rate	1.5%
Life expectancy at birth	
Women	73
Men	69
Human Development Index	124
Human Poverty Index	
Rank	61
Value	34.5
Percentage of people with less than US\$ 2 a day	14.3%
Per Capita Gross National Income, ppp, Intl dollar rate	4100
Per Capita Government Expenditure on Health at Intl dollar rate	72

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	19 000 [12 000 – 38 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	19 000 [12 000 – 38 000]
Women aged 15 and over living with HIV	4000 [2100 – 8400]
Deaths due to AIDS	1300 [850 – 2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	12.0%
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

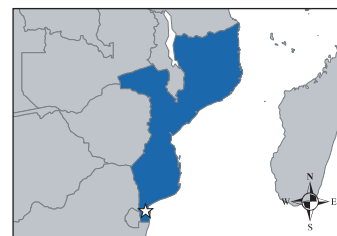
■ National funds spent by governments from domestic sources	US\$ 1 544 444
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	48.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



MOZAMBIQUE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	19 792 000
Population Growth Rate	2%
Life expectancy at birth	
Women	46
Men	44
Human Development Index	168
Human Poverty Index	
Rank	96
Value	49.1
Percentage of people with less than US\$ 2 a day	78.4%
Per Capita Gross National Income, ppp, Intl dollar rate	1160
Per Capita Government Expenditure on Health at Intl dollar rate	28

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 800 000 [1 400 000 – 2 200 000]
Adults aged 15 to 49 HIV prevalence rate	16.1 [12.5 – 20.0%]
Adults aged 15 and over living with HIV	1 600 000 [1 300 000 – 2 000 000]
Women aged 15 and over living with HIV	960 000 [590 000 – 1 300 000]
Deaths due to AIDS	140 000 [100 000 – 200 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	140 000 [57 000 – 310 000]
Orphans aged 0 to 17 due to AIDS	510 000 [390 000 – 670 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 2 564 600
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	3.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	9.0%
■ School attendance among orphans	63.0%
■ School attendance among non-orphans	78.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	20.0%
Men	33.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	37.0%
Men	84.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	27.7% ¹
Men	— ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	29.0%
Men	33.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

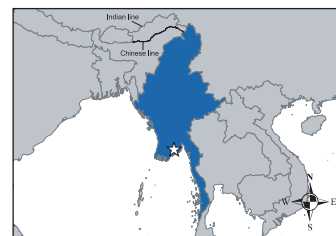
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	<0.5% ³
Sex workers	5.0% ⁴
Men who have sex with men	—



MYANMAR

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	50 519 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	63
Men	56
Human Development Index	129
Human Poverty Index	
Rank	50
Value	21.9
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	–
Per Capita Government Expenditure on Health at Intl dollar rate	10

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	360 000 [200 000 – 570 000]
Adults aged 15 to 49 HIV prevalence rate	1.3 [0.7 – 2.0%]
Adults aged 15 and over living with HIV	350 000 [200 000 – 550 000]
Women aged 15 and over living with HIV	110 000 [53 000 – 190 000]
Deaths due to AIDS	37 000 [20 000 – 62 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	7.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

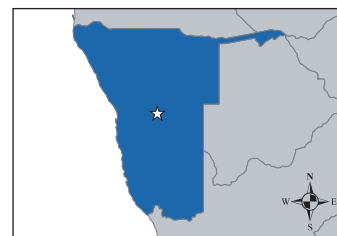
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



NAMIBIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 031 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	55
Men	52
Human Development Index	125
Human Poverty Index	
Rank	60
Value	33.0
Percentage of people with less than US\$ 2 a day	55.8%
Per Capita Gross National Income, ppp, Intl dollar rate	6960
Per Capita Government Expenditure on Health at Intl dollar rate	252

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	230 000 [110 000 – 360 000]
Adults aged 15 to 49 HIV prevalence rate	19.6 [8.6 – 31.7%]
Adults aged 15 and over living with HIV	210 000 [99 000 – 340 000]
Women aged 15 and over living with HIV	130 000 [54 000 – 220 000]
Deaths due to AIDS	17 000 [7800 – 27 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	17 000 [5800 – 40 000]
Orphans aged 0 to 17 due to AIDS	85 000 [42 000 – 120 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 38 558 000 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	25.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	35.0%
■ School attendance among orphans	83.0%
non-orphans	90.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

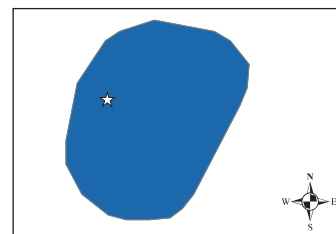
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



NAURU

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	14 000
Population Growth Rate	2.2%
Life expectancy at birth	
Women	65
Men	58
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	675

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

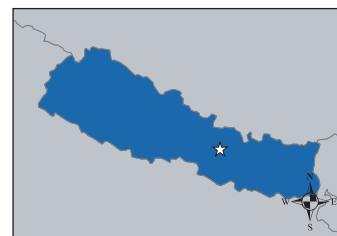
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



NEPAL

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	27 133 000
Population Growth Rate	2.1%
Life expectancy at birth	
Women	61
Men	61
Human Development Index	136
Human Poverty Index	
Rank	74
Value	38.7
Percentage of people with less than US\$ 2 a day	82.5%
Per Capita Gross National Income, ppp, Intl dollar rate	1470
Per Capita Government Expenditure on Health at Intl dollar rate	18

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	75 000 [41 000 – 180 000]
Adults aged 15 to 49 HIV prevalence rate	0.5 [0.3 – 1.3%]
Adults aged 15 and over living with HIV	74 000 [40 000 – 180 000]
Women aged 15 and over living with HIV	16 000 [7500 – 40 000]
Deaths due to AIDS	5100 [2800 – 8400]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.9%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
■ School attendance among non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	9.0% ¹
Men	20.0% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 82 000 ⁴
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	1.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	<0.5% ³
Sex workers	35.2% ⁴
Men who have sex with men	5.4% ⁵



NETHERLANDS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	16 299 000
Population Growth Rate	0.5%
Life expectancy at birth	
Women	81
Men	77
Human Development Index	12
Human Poverty Index	
Rank	3 ¹
Value	8.2 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	31 220
Per Capita Government Expenditure on Health at Intl dollar rate	1863

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	18 000 [11 000 – 29 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.4%]
Adults aged 15 and over living with HIV	17 000 [10 000 – 29 000]
Women aged 15 and over living with HIV	5900 [3000 – 10 000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

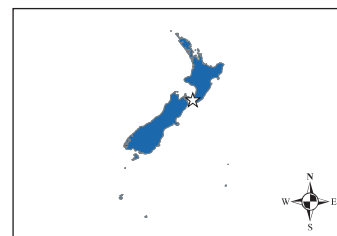
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



NEW ZEALAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 028 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	82
Men	77
Human Development Index	19
Human Poverty Index	
Rank	— ¹
Value	— ²
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	22 130
Per Capita Government Expenditure on Health at Intl dollar rate	1483

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1400 [840 – 2300]
Adults aged 15 to 49 HIV prevalence rate	0.1% [<0.2%]
Adults aged 15 and over living with HIV	1400 [840 – 2300]
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



NICARAGUA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 487 000
Population Growth Rate	2%
Life expectancy at birth	
Women	71
Men	67
Human Development Index	112
Human Poverty Index	
Rank	40
Value	17.7
Percentage of people with less than US\$ 2 a day	79.9%
Per Capita Gross National Income, ppp, Intl dollar rate	3300
Per Capita Government Expenditure on Health at Intl dollar rate	101

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	7300 [3900 – 18 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.6%]
Adults aged 15 and over living with HIV	7200 [3900 – 17 000]
Women aged 15 and over living with HIV	1700 [780 – 4200]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	10.0%
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	11.0% ¹
Men	– ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	17.0%
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

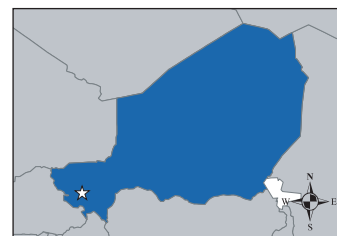
■ National funds spent by governments from domestic sources	US\$ 3 260 503
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	16.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



NIGER

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	13 957 000
Population Growth Rate	3.4%
Life expectancy at birth	
Women	41
Men	42
Human Development Index	177
Human Poverty Index	
Rank	103
Value	64.4
Percentage of people with less than US\$ 2 a day	85.3%
Per Capita Gross National Income, ppp, Intl dollar rate	830
Per Capita Government Expenditure on Health at Intl dollar rate	16

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	79 000 [39 000 – 130 000]
Adults aged 15 to 49 HIV prevalence rate	1.1 [0.5 – 1.9%]
Adults aged 15 and over living with HIV	71 000 [35 000 – 120 000]
Women aged 15 and over living with HIV	42 000 [17 000 – 75 000]
Deaths due to AIDS	7 600 [3 400 – 13 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	8 900 [2 900 – 23 000]
Orphans aged 0 to 17 due to AIDS	46 000 [20 000 – 85 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	5.0%
■ School attendance among orphans	–
non-orphans	45%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

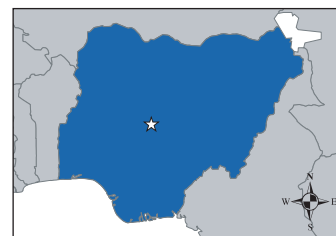
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	92.0% ¹
Men who have sex with men	–



NIGERIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	131 530 000
Population Growth Rate	2.2%
Life expectancy at birth	
Women	46
Men	45
Human Development Index	158
Human Poverty Index	
Rank	75
Value	38.8
Percentage of people with less than US\$ 2 a day	90.8%
Per Capita Gross National Income, ppp, Intl dollar rate	930
Per Capita Government Expenditure on Health at Intl dollar rate	13

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	2 900 000 [1 700 000 – 4 200 000]
Adults aged 15 to 49 HIV prevalence rate	3.9 [2.3 – 5.6%]
Adults aged 15 and over living with HIV	2 600 000 [1 600 000 – 3 800 000]
Women aged 15 and over living with HIV	1 600 000 [810 000 – 2 400 000]
Deaths due to AIDS	220 000 [120 000 – 330 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	240 000 [81 000 – 550 000]
Orphans aged 0 to 17 due to AIDS	930 000 [510 000 – 1 300 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 6 522 851
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.2%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	7.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	18.0%
Men	21.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	29.0%
Men	78.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	20.3% ¹
Men	7.9% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	24.0%
Men	46.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	– Sex workers
Men who have sex with men	–



NORWAY

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 620 000
Population Growth Rate	0.5%
Life expectancy at birth	
Women	82
Men	77
Human Development Index	1
Human Poverty Index	
Rank	2 ¹
Value	7.0 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	38 550
Per Capita Government Expenditure on Health at Intl dollar rate	3189

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	2500 [1500 – 4100]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.2%]
Adults aged 15 and over living with HIV	2500 [1500 – 4200]
Women aged 15 and over living with HIV	<1000 [<2000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

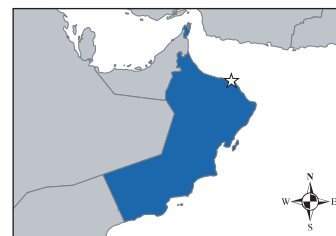
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



OMAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 567 000
Population Growth Rate	1%
Life expectancy at birth	
Women	77
Men	71
Human Development Index	71
Human Poverty Index	
Rank	46
Value	21.1
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	13 250
Per Capita Government Expenditure on Health at Intl dollar rate	348

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	–
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	–
Women aged 15 and over living with HIV	–
Deaths due to AIDS	–

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

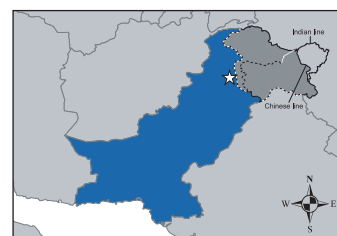
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



PAKISTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	157 935 000
Population Growth Rate	2%
Life expectancy at birth	
Women	63
Men	62
Human Development Index	135
Human Poverty Index	
Rank	68
Value	37.1
Percentage of people with less than US\$ 2 a day	65.5%
Per Capita Gross National Income, ppp, Intl dollar rate	2160
Per Capita Government Expenditure on Health at Intl dollar rate	13

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	85 000 [46 000 – 210 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.2%]
Adults aged 15 and over living with HIV	84 000 [45 000 – 210 000]
Women aged 15 and over living with HIV	14 000 [6600 – 36 000]
Deaths due to AIDS	3000 [1700 – 4900]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

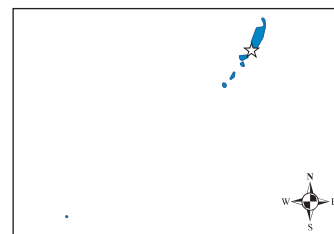
■ National funds spent by governments from domestic sources	US\$ 2 408 277
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	2.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	28.4% ¹
Sex workers	11.0% ²
Men who have sex with men	22.0% ³



PALAU

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	20 000
Population Growth Rate	0.7%
Life expectancy at birth	
Women	70
Men	67
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	691

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

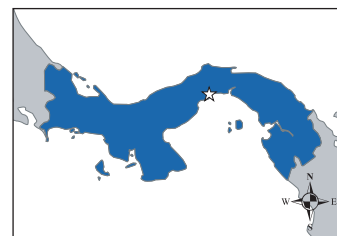
■ National funds spent by governments from domestic sources	US\$ 48 377
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	33.3%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



PANAMA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 232 000
Population Growth Rate	1.8%
Life expectancy at birth	
Women	78
Men	73
Human Development Index	56
Human Poverty Index	
Rank	9
Value	7.7
Percentage of people with less than US\$ 2 a day	17.6%
Per Capita Gross National Income, ppp, Intl dollar rate	6870
Per Capita Government Expenditure on Health at Intl dollar rate	368

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	17 000 [11 000 – 34 000]
Adults aged 15 to 49 HIV prevalence rate	0.9 [0.5 – 3.7%]
Adults aged 15 and over living with HIV	17 000 [10 000 – 33 000]
Women aged 15 and over living with HIV	4300 [2300 – 9200]
Deaths due to AIDS	<1000 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

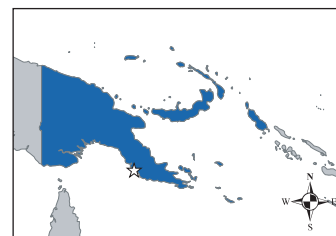
■ National funds spent by governments from domestic sources	US\$ 9 729 957
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	97.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	48.0% ¹
Men who have sex with men	43.8% ²



PAPUA NEW GUINEA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 887 000
Population Growth Rate	2.1%
Life expectancy at birth	
Women	61
Men	58
Human Development Index	137
Human Poverty Index	
Rank	70
Value	40.5
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	2300
Per Capita Government Expenditure on Health at Intl dollar rate	118

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	60 000 [32 000 – 140 000]
Adults aged 15 to 49 HIV prevalence rate	1.8 [0.9 – 4.4%]
Adults aged 15 and over living with HIV	57 000 [31 000 – 140 000]
Women aged 15 and over living with HIV	34 000 [16 000 – 85 000]
Deaths due to AIDS	3300 [1800 – 5400]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	15.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



PARAGUAY

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	6 158 000
Population Growth Rate	2.4%
Life expectancy at birth	
Women	74
Men	70
Human Development Index	88
Human Poverty Index	
Rank	17
Value	9.4
Percentage of people with less than US\$ 2 a day	33.2%
Per Capita Gross National Income, ppp, Intl dollar rate	4870
Per Capita Government Expenditure on Health at Intl dollar rate	95

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	13 000 [6200 – 41 000]
Adults aged 15 to 49 HIV prevalence rate	0.4 [0.2 – 4.6%]
Adults aged 15 and over living with HIV	13 000 [6000 – 41 000]
Women aged 15 and over living with HIV	3500 [1500 – 12 000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	2.1%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

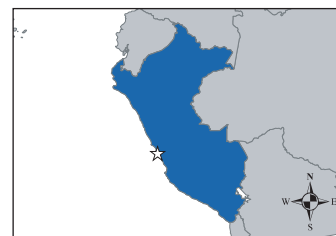
■ National funds spent by governments from domestic sources	US\$ 721 802 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	29.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	10.0% ²
Men who have sex with men	50.0% ³



PERU

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	27 968 000
Population Growth Rate	1.5%
Life expectancy at birth	
Women	73
Men	69
Human Development Index	79
Human Poverty Index	
Rank	26
Value	12.0
Percentage of people with less than US\$ 2 a day	37.7%
Per Capita Gross National Income, ppp, Intl dollar rate	5370
Per Capita Government Expenditure on Health at Intl dollar rate	112

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	93 000 [56 000 – 150 000]
Adults aged 15 to 49 HIV prevalence rate	0.6 [0.3 – 1.7%]
Adults aged 15 and over living with HIV	91 000 [55 000 – 150 000]
Women aged 15 and over living with HIV	26 000 [13 000 – 45 000]
Deaths due to AIDS	5600 [3400 – 8500]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	3.5%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

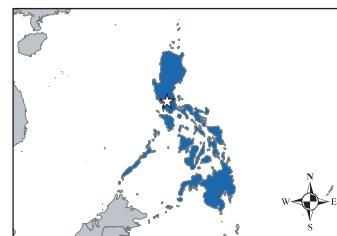
■ National funds spent by governments from domestic sources	US\$ 4 272 035
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	52.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	20.0% ¹
Men who have sex with men	22.6% ²



PHILIPPINES

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	83 054 000
Population Growth Rate	1.8%
Life expectancy at birth	
Women	72
Men	65
Human Development Index	84
Human Poverty Index	
Rank	35
Value	16.3
Percentage of people with less than US\$ 2 a day	46.4%
Per Capita Gross National Income, ppp, Intl dollar rate	4890
Per Capita Government Expenditure on Health at Intl dollar rate	76

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	12 000 [7300 – 20 000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	12 000 [7200 – 20 000]
Women aged 15 and over living with HIV	3400 [1800 – 6000]
Deaths due to AIDS	<1000 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 605 600 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	5.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	<0.5% ²
Sex workers	7.0% ³
Men who have sex with men	2.0% ⁴



POLAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	38 530 000
Population Growth Rate	-0.1%
Life expectancy at birth	
Women	79
Men	71
Human Development Index	36
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	12 640
Per Capita Government Expenditure on Health at Intl dollar rate	521

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	25 000 [15 000 – 41 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.2%]
Adults aged 15 and over living with HIV	25 000 [15 000 – 42 000]
Women aged 15 and over living with HIV	7500 [3800 – 13 000]
Deaths due to AIDS	-

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<1000 [<2000]
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	-
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	-
Men	-

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

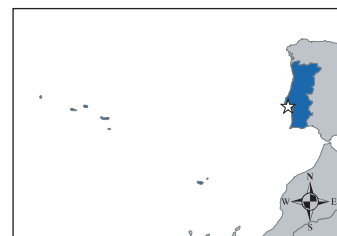
■ National funds spent by governments from domestic sources	-
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	-
■ Policy to expand access to essential preventive commodities among most-at-risk populations	-

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	100.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	-
Sex workers	-
Men who have sex with men	-



PORTUGAL

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	10 495 000
Population Growth Rate	0.5%
Life expectancy at birth	
Women	81
Men	74
Human Development Index	27
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	19 250
Per Capita Government Expenditure on Health at Intl dollar rate	1294

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	32 000 [19 000 – 53 000]
Adults aged 15 to 49 HIV prevalence rate	0.4 [0.3 – 0.9%]
Adults aged 15 and over living with HIV	32 000 [19 000 – 53 000]
Women aged 15 and over living with HIV	1300 [670 – 2300]
Deaths due to AIDS	<1000 [<2000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



QATAR

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	813 000
Population Growth Rate	5.9%
Life expectancy at birth	
Women	75
Men	76
Human Development Index	40
Human Poverty Index	
Rank	10
Value	7.8
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	506

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
---	---

National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

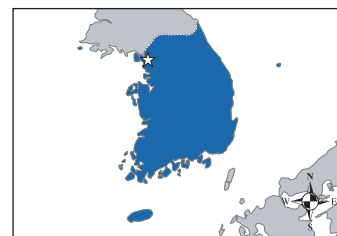
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



REPUBLIC OF KOREA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	47 817 000
Population Growth Rate	0.4%
Life expectancy at birth	
Women	80
Men	73
Human Development Index	28
Human Poverty Index	
Rank	–
Value	–
Percentage of people with less than US\$ 2 a day	<2.0%
Per Capita Gross National Income, ppp, Intl dollar rate	20 400
Per Capita Government Expenditure on Health at Intl dollar rate	531

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	13 000 [7900 – 25 000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	13 000 [7800 – 25 000]
Women aged 15 and over living with HIV	7400 [3900 – 16 000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

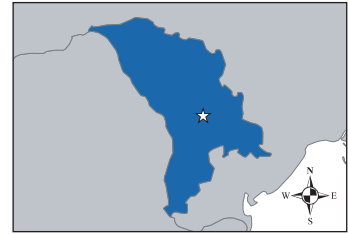
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



REPUBLIC OF MOLDOVA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 206 000
Population Growth Rate	-0.3%
Life expectancy at birth	
Women	71
Men	64
Human Development Index	115
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	1930
Per Capita Government Expenditure on Health at Intl dollar rate	96

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	29 000 [15 000 – 69 000]
Adults aged 15 to 49 HIV prevalence rate	1.1 [0.6 – 2.6%]
Adults aged 15 and over living with HIV	28 000 [15 000 – 69 000]
Women aged 15 and over living with HIV	16 000 [7400 – 40 000]
Deaths due to AIDS	1400 [810 – 2400]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	-
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	-
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	23.5%
Men	34.1%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	44.0%
Men	63.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 360 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	39.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	22.4% ¹
Sex workers	14.1% ²
Men who have sex with men	90.0% ³



ROMANIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	21 711 000
Population Growth Rate	-0.4%
Life expectancy at birth	
Women	76
Men	68
Human Development Index	64
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	8190
Per Capita Government Expenditure on Health at Intl dollar rate	340

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	7000 [3400 – 22 000]
Adults aged 15 to 49 HIV prevalence rate	<0.1% [<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.2% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 42 654 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	100.0% ²
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	9.3% ³
Sex workers	3.6% ⁴
Men who have sex with men	3.1% ⁵



RUSSIAN FEDERATION

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	143 202 000
Population Growth Rate	-0.5%
Life expectancy at birth	
Women	72
Men	59
Human Development Index	62
Human Poverty Index	
Rank	-
Value	-
Percentage of people with less than US\$ 2 a day	-
Per Capita Gross National Income, ppp, Intl dollar rate	9620
Per Capita Government Expenditure on Health at Intl dollar rate	325

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	940 000 [560 000 – 1 600 000]
Adults aged 15 to 49 HIV prevalence rate	1.1 [0.7 – 1.8%]
Adults aged 15 and over living with HIV	940 000 [560 000 – 1 600 000]
Women aged 15 and over living with HIV	210 000 [110 000 – 370 000]
Deaths due to AIDS	[22 000 – 56 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	-
Orphans aged 0 to 17 due to AIDS	-

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	-
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	14.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	-
■ School attendance among orphans	- non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	-
Men	-
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	8.2%
Men	17.2%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	-
Men	-

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

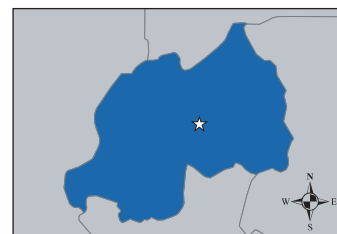
■ National funds spent by governments from domestic sources	US\$ 33 430 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	No

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	5.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	4.9% ¹
Sex workers	15.6% ²
Men who have sex with men	1.0% ³



RWANDA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	9 038 000
Population Growth Rate	2.4%
Life expectancy at birth	
Women	47
Men	44
Human Development Index	159
Human Poverty Index	
Rank	69
Value	37.7
Percentage of people with less than US\$ 2 a day	83.7%
Per Capita Gross National Income, ppp, Intl dollar rate	1300
Per Capita Government Expenditure on Health at Intl dollar rate	14

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	190 000 [180 000 – 210 000]
Adults aged 15 to 49 HIV prevalence rate	3.1 [2.9 – 3.2%]
Adults aged 15 and over living with HIV	160 000 [160 000 – 170 000]
Women aged 15 and over living with HIV	91 000 [86 000 – 95 000]
Deaths due to AIDS	21 000 [13 000 – 26 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	27 000 [11 000 – 53 000]
Orphans aged 0 to 17 due to AIDS	210 000 [170 000 – 260 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 1 705 474
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	9.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	39.0%
■ School attendance among orphans	64.0%
non-orphans	80.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	28.0%
Men	41.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

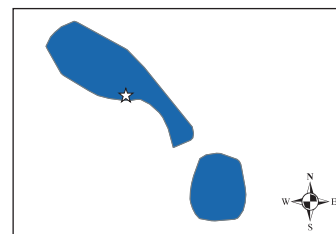
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SAINT KITTS AND NEVIS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	43 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	72
Men	69
Human Development Index	49
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	11 190
Per Capita Government Expenditure on Health at Intl dollar rate	427

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

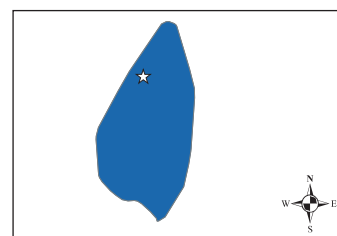
■ National funds spent by governments from domestic sources	US\$ 347 500 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SAINT LUCIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	161 000
Population Growth Rate	0.8%
Life expectancy at birth	
Women	77
Men	71
Human Development Index	76
Human Poverty Index	
Rank	12
Value	8.3
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	5560
Per Capita Government Expenditure on Health at Intl dollar rate	200

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	–
Adults aged 15 to 49 HIV prevalence rate	–
Adults aged 15 and over living with HIV	–
Women aged 15 and over living with HIV	–
Deaths due to AIDS	–

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	20.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

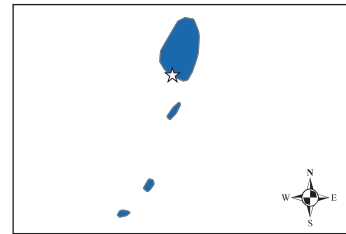
■ National funds spent by governments from domestic sources	US\$ 2 164 444
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	80.6%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SAINT VINCENT AND THE GRENADINES

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	119 000
Population Growth Rate	0.5%
Life expectancy at birth	
Women	73
Men	66
Human Development Index	87
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	6250
Per Capita Government Expenditure on Health at Intl dollar rate	259

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	61.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	37.0%
Men	63.0%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

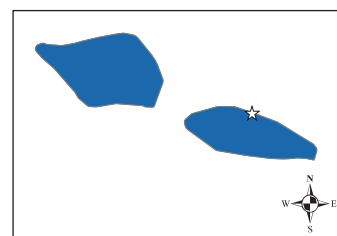
■ National funds spent by governments from domestic sources	US\$ 461 914 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	100.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SAMOA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	185 000
Population Growth Rate	0.8%
Life expectancy at birth	
Women	70
Men	66
Human Development Index	74
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	5670
Per Capita Government Expenditure on Health at Intl dollar rate	165

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	— Men

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

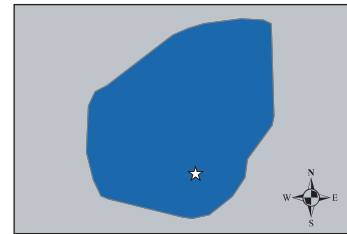
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	— Sex workers
Men who have sex with men	—



SAN MARINO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	28 000
Population Growth Rate	0.9%
Life expectancy at birth	
Women	84
Men	79
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	2467

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

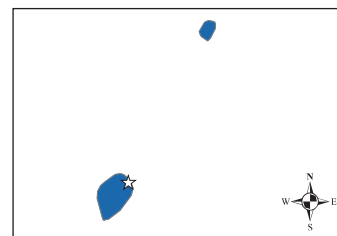
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SAO TOME AND PRINCEPE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	157 000
Population Growth Rate	2.3%
Life expectancy at birth	
Women	60
Men	57
Human Development Index	126
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	78

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	—
non-orphans	81.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SAUDI ARABIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	24 573 000
Population Growth Rate	2.7%
Life expectancy at birth	
Women	74
Men	68
Human Development Index	77
Human Poverty Index	
Rank	32
Value	14.9
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	14 010
Per Capita Government Expenditure on Health at Intl dollar rate	439

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	–
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	–
Women aged 15 and over living with HIV	–
Deaths due to AIDS	–

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	14.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SENEGAL

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	11 658 000
Population Growth Rate	2.4%
Life expectancy at birth	
Women	57
Men	54
Human Development Index	157
Human Poverty Index	
Rank	87
Value	44.2
Percentage of people with less than US\$ 2 a day	67.8%
Per Capita Gross National Income, ppp, Intl dollar rate	1720
Per Capita Government Expenditure on Health at Intl dollar rate	24

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	61 000 [29 000 – 100 000]
Adults aged 15 to 49 HIV prevalence rate	0.9 [0.4 – 1.5%]
Adults aged 15 and over living with HIV	56 000 [26 000 – 92 000]
Women aged 15 and over living with HIV	33 000 [14 000 – 58 000]
Deaths due to AIDS	5200 [2500 – 8600]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	5000 [1700 – 12 000]
Orphans aged 0 to 17 due to AIDS	25 000 [14 000 – 39 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 11 921 236
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	47.0%
■ School attendance among orphans	40.0%
non-orphans	54.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	34.0%
Men	54.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SERBIA AND MONTENEGRO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	10 503 000
Population Growth Rate	-0.1%
Life expectancy at birth	
Women	75
Men	70
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	282

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	10 000 [6000 – 17 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.3%]
Adults aged 15 and over living with HIV	10 000 [6000 – 17 000]
Women aged 15 and over living with HIV	2000 [1000 – 3500]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 6 697 551 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SEYCHELLES

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	81 000
Population Growth Rate	0.9%
Life expectancy at birth	
Women	78
Men	67
Human Development Index	51
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	15 590
Per Capita Government Expenditure on Health at Intl dollar rate	439

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	97.7% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

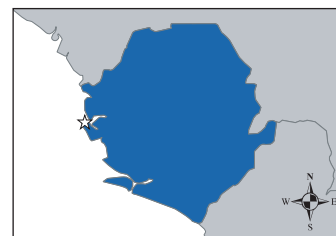
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SIERRA LEONE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 525 000
Population Growth Rate	4.1%
Life expectancy at birth	
Women	40
Men	37
Human Development Index	176
Human Poverty Index	
Rank	98
Value	54.9
Percentage of people with less than US\$ 2 a day	74.5%
Per Capita Gross National Income, ppp, Intl dollar rate	790
Per Capita Government Expenditure on Health at Intl dollar rate	20

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	48 000 [27 000 – 73 000]
Adults aged 15 to 49 HIV prevalence rate	1.6 [0.9 – 2.4%]
Adults aged 15 and over living with HIV	43 000 [25 000 – 66 000]
Women aged 15 and over living with HIV	26 000 [15 000 – 39 000]
Deaths due to AIDS	4600 [2600 – 7500]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	5200 [1800 – 12 000]
Orphans aged 0 to 17 due to AIDS	31 000 [19 000 – 49 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	2.0%
■ School attendance among orphans	35.0% non-orphans
	50.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

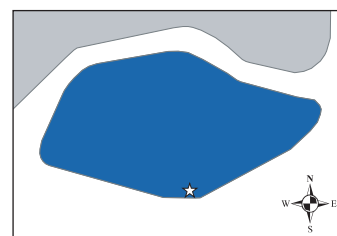
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SINGAPORE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 326 000
Population Growth Rate	1.5%
Life expectancy at birth	
Women	82
Men	77
Human Development Index	25
Human Poverty Index	
Rank	6
Value	6.3
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	26 590
Per Capita Government Expenditure on Health at Intl dollar rate	417

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5500 [3100 – 14 000]
Adults aged 15 to 49 HIV prevalence rate	0.3 [0.2 – 0.7%]
Adults aged 15 and over living with HIV	5500 [3000 – 14 000]
Women aged 15 and over living with HIV	1500 [700 – 3700]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

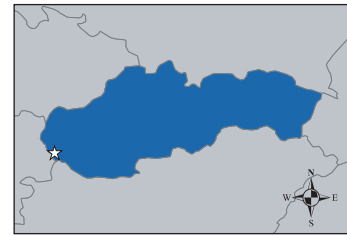
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SLOVAKIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	5 401 000
Population Growth Rate	0%
Life expectancy at birth	
Women	78
Men	70
Human Development Index	42
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	14 370
Per Capita Government Expenditure on Health at Intl dollar rate	687

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<500 [<1000]
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
---	---

National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

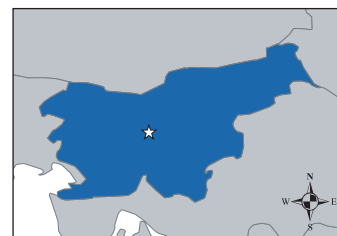
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SLOVENIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 967 000
Population Growth Rate	0%
Life expectancy at birth	
Women	81
Men	73
Human Development Index	26
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	20 730
Per Capita Government Expenditure on Health at Intl dollar rate	1274

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<500 [<1000]
Women aged 15 and over living with HIV	—
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
---	---

National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

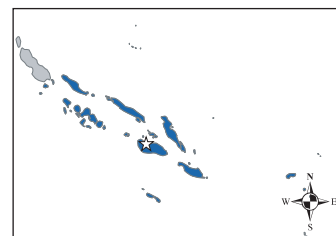
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SOLOMON ISLANDS

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	478 000
Population Growth Rate	2.6%
Life expectancy at birth	
Women	70
Men	66
Human Development Index	128
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	1760
Per Capita Government Expenditure on Health at Intl dollar rate	81

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

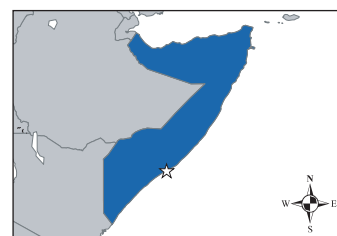
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SOMALIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	8 228 000
Population Growth Rate	3.2%
Life expectancy at birth	
Women	45
Men	43
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	—

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	44 000 [23 000 – 81 000]
Adults aged 15 to 49 HIV prevalence rate	0.9 [0.5 – 1.6%]
Adults aged 15 and over living with HIV	40 000 [21 000 – 72 000]
Women aged 15 and over living with HIV	23 000 [11 000 – 45 000]
Deaths due to AIDS	4100 [2000 – 8000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	4500 [1500 – 13 000]
Orphans aged 0 to 17 due to AIDS	23 000 [11 000 – 45 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	3.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	1.0%
■ School attendance among orphans	14.0%
non-orphans	21.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	7.9%
Men	12.5%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

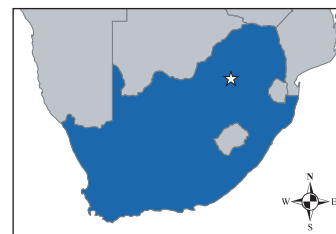
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	No
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



SOUTH AFRICA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	47 432 000
Population Growth Rate	0.8%
Life expectancy at birth	
Women	49
Men	47
Human Development Index	120
Human Poverty Index	
Rank	56
Value	30.9
Percentage of people with less than US\$ 2 a day	34.1%
Per Capita Gross National Income, ppp, Intl dollar rate	10 960
Per Capita Government Expenditure on Health at Intl dollar rate	258

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5 500 000 [4 900 000 – 6 100 000]
Adults aged 15 to 49 HIV prevalence rate	18.8 [16.8 – 20.7%]
Adults aged 15 and over living with HIV	5 300 000 [4 800 000 – 5 800 000]
Women aged 15 and over living with HIV	3 100 000 [2 800 000 – 3 400 000]
Deaths due to AIDS	320 000 [270 000 – 380 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	240 000 [93 000 – 500 000]
Orphans aged 0 to 17 due to AIDS	1 200 000 [970 000 – 1 400 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 446 461 994 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	14.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	21.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	– Sex workers
Men who have sex with men	–



SPAIN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	43 064 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	83
Men	77
Human Development Index	21
Human Poverty Index	
Rank	11 ¹
Value	11.6 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	25 070
Per Capita Government Expenditure on Health at Intl dollar rate	1321

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	140 000 [84 000 – 230 000]
Adults aged 15 to 49 HIV prevalence rate	0.6 [0.4 – 1.0%]
Adults aged 15 and over living with HIV	140 000 [84 000 – 230 000]
Women aged 15 and over living with HIV	32 000 [16 000 – 57 000]
Deaths due to AIDS	2000 [<3000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

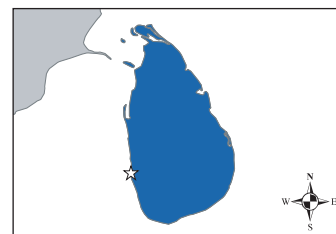
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SRI LANKA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	20 743 000
Population Growth Rate	0.9%
Life expectancy at birth	
Women	75
Men	68
Human Development Index	93
Human Poverty Index	
Rank	42
Value	18.0
Percentage of people with less than US\$ 2 a day	50.7%
Per Capita Gross National Income, ppp, Intl dollar rate	4000
Per Capita Government Expenditure on Health at Intl dollar rate	55

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5000 [3000 – 8300]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	5000 [3000 – 8 300]
Women aged 15 and over living with HIV	<1000 [<1000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 2 950 000
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	6.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SUDAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	36 233 000
Population Growth Rate	1.9%
Life expectancy at birth	
Women	60
Men	56
Human Development Index	141
Human Poverty Index	
Rank	59
Value	32.4
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1870
Per Capita Government Expenditure on Health at Intl dollar rate	23

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	350 000 [170 000 – 580 000]
Adults aged 15 to 49 HIV prevalence rate	1.6 [0.8 – 2.7%]
Adults aged 15 and over living with HIV	320 000 [160 000 – 530 000]
Women aged 15 and over living with HIV	180 000 [80 000 – 320 000]
Deaths due to AIDS	34 000 [18 000 – 58 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	30 000 [12 000 – 74 000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	0.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	1.0%
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

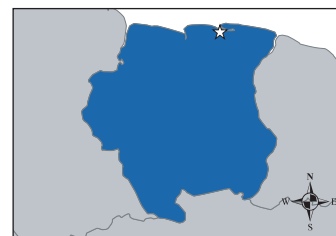
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SURINAME

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	449 000
Population Growth Rate	0.7%
Life expectancy at birth	
Women	70
Men	65
Human Development Index	86
Human Poverty Index	
Rank	23
Value	10.9
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	–
Per Capita Government Expenditure on Health at Intl dollar rate	142

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	5200 [2800 – 8100]
Adults aged 15 to 49 HIV prevalence rate	1.9 [1.1 – 3.1%]
Adults aged 15 and over living with HIV	5100 [2800 – 8000]
Women aged 15 and over living with HIV	1400 [690 – 2400]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<100 [<200]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	55.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

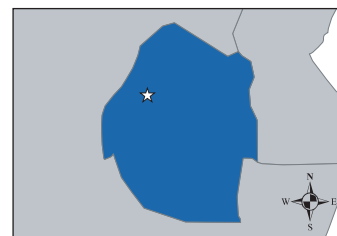
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SWAZILAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 032 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	39
Men	36
Human Development Index	147
Human Poverty Index	
Rank	97
Value	52.9
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	4970
Per Capita Government Expenditure on Health at Intl dollar rate	185

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	220 000 [150 000 – 290 000]
Adults aged 15 to 49 HIV prevalence rate	33.4 [21.2 – 45.3%]
Adults aged 15 and over living with HIV	210 000 [140 000 – 270 000]
Women aged 15 and over living with HIV	120 000 [70 000 – 180 000]
Deaths due to AIDS	16 000 [10 000 – 23 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	15 000 [5500 – 32 000]
Orphans aged 0 to 17 due to AIDS	63 000 [45 000 – 77 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 3 960 517
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	11.9%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	31.0%
■ School attendance among orphans	79.0%
non-orphans	87.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SWEDEN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	9 041 000
Population Growth Rate	0.4%
Life expectancy at birth	
Women	83
Men	78
Human Development Index	6
Human Poverty Index	
Rank	1 ¹
Value	6.5 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	29 770
Per Capita Government Expenditure on Health at Intl dollar rate	2305

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	8000 [4800 – 13 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.3%]
Adults aged 15 and over living with HIV	8000 [4800 – 13 000]
Women aged 15 and over living with HIV	2500 [1300 – 4400]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

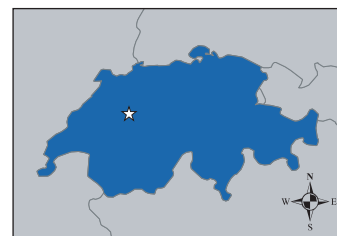
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SWITZERLAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	7 252 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	83
Men	78
Human Development Index	7
Human Poverty Index	
Rank	7 ¹
Value	11.0 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	35 370
Per Capita Government Expenditure on Health at Intl dollar rate	2209

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	17 000 [9900 – 27 000]
Adults aged 15 to 49 HIV prevalence rate	0.4 [0.3 – 0.8%]
Adults aged 15 and over living with HIV	16 000 [9900 – 27 000]
Women aged 15 and over living with HIV	5900 [3000 – 10 000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

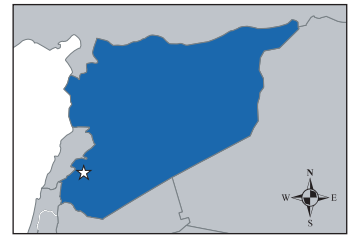
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



SYRIAN ARAB REPUBLIC

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	19 043 000
Population Growth Rate	2.5%
Life expectancy at birth	
Women	74
Men	70
Human Development Index	106
Human Poverty Index	
Rank	29
Value	13.8
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	3550
Per Capita Government Expenditure on Health at Intl dollar rate	56

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	–
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	–
Women aged 15 and over living with HIV	–
Deaths due to AIDS	–

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

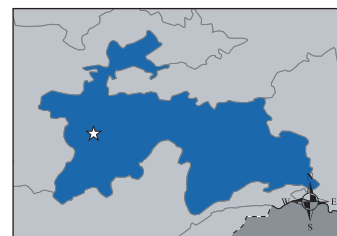
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	9.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



TAJIKISTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	6 507 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	64
Men	62
Human Development Index	122
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	1150
Per Capita Government Expenditure on Health at Intl dollar rate	15

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	4900 [2400 – 16 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 1.7%]
Adults aged 15 and over living with HIV	4900 [2300 – 16 000]
Women aged 15 and over living with HIV	<500 [<2000]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 330 891 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	16.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



THAILAND

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	64 233 000
Population Growth Rate	0.9%
Life expectancy at birth	
Women	73
Men	67
Human Development Index	73
Human Poverty Index	
Rank	28
Value	12.8
Percentage of people with less than US\$ 2 a day	32.5%
Per Capita Gross National Income, ppp, Intl dollar rate	8020
Per Capita Government Expenditure on Health at Intl dollar rate	160

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	580 000 [330 000 – 920 000]
Adults aged 15 to 49 HIV prevalence rate	1.4 [0.7 – 2.1%]
Adults aged 15 and over living with HIV	560 000 [320 000 – 900 000]
Women aged 15 and over living with HIV	220 000 [100 000 – 370 000]
Deaths due to AIDS	21 000 [14 000 – 42 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	16 000 [5400 – 38 000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 92 821 968 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	30.6%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	60.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	6.6%
Men	10.9%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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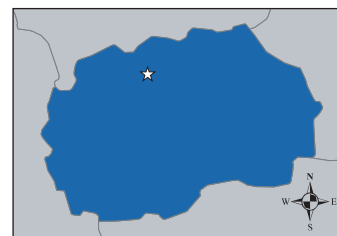
Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA



I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	2 034 000
Population Growth Rate	0.2%
Life expectancy at birth	
Women	76
Men	69
Human Development Index	59
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	6480
Per Capita Government Expenditure on Health at Intl dollar rate	329

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<500 [<1000]
Women aged 15 and over living with HIV	—
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

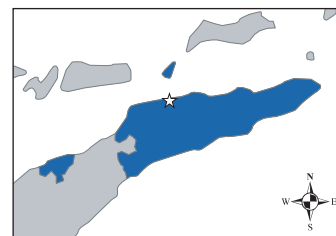
■ National funds spent by governments from domestic sources	US\$ 220 744
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



TIMOR-LESTE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	947 000
Population Growth Rate	5.4%
Life expectancy at birth	
Women	66
Men	61
Human Development Index	140
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	95

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

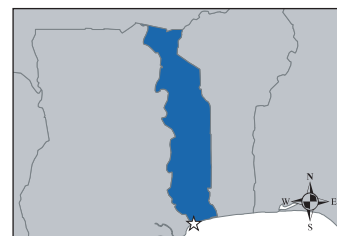
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



TOGO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	6 145 000
Population Growth Rate	2.7%
Life expectancy at birth	
Women	56
Men	52
Human Development Index	143
Human Poverty Index	
Rank	76
Value	39.5
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1690
Per Capita Government Expenditure on Health at Intl dollar rate	15

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	110 000 [65 000 – 160 000]
Adults aged 15 to 49 HIV prevalence rate	3.2 [1.9 – 4.7%]
Adults aged 15 and over living with HIV	100 000 [60 000 – 150 000]
Women aged 15 and over living with HIV	61 000 [31 000 – 95 000]
Deaths due to AIDS	9100 [5000 – 14 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	9700 [3700 – 22 000]
Orphans aged 0 to 17 due to AIDS	88 000 [51 000 – 130 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 587 123 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	1.8%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	27.0%
■ School attendance among orphans	74.0%
non-orphans	78.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

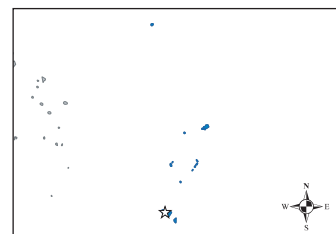
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	30.0% ²
Men who have sex with men	–



TONGA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	102 000
Population Growth Rate	0.4%
Life expectancy at birth	
Women	70
Men	71
Human Development Index	54
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	7220
Per Capita Government Expenditure on Health at Intl dollar rate	255

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

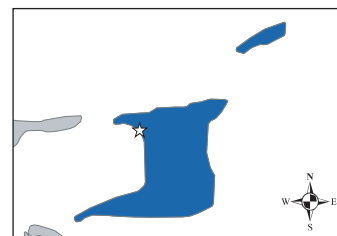
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



TRINIDAD AND TOBAGO

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	1 305 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	73
Men	67
Human Development Index	57
Human Poverty Index	
Rank	15
Value	8.8
Percentage of people with less than US\$ 2 a day	39.0%
Per Capita Gross National Income, ppp, Intl dollar rate	11 180
Per Capita Government Expenditure on Health at Intl dollar rate	201

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	27 000 [15 000 – 42 000]
Adults aged 15 to 49 HIV prevalence rate	2.6 [1.4 – 4.2%]
Adults aged 15 and over living with HIV	26 000 [15 000 – 41 000]
Women aged 15 and over living with HIV	15 000 [6900 – 24 000]
Deaths due to AIDS	1900 [990 – 3100]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	<1000 [<2000]
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 5 887 676
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	71.4% ¹
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	38.0%
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

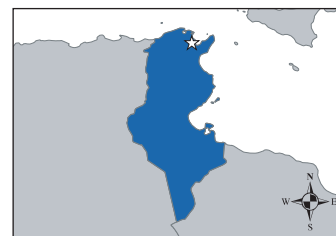
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



TUNISIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	10 102 000
Population Growth Rate	1.1%
Life expectancy at birth	
Women	74
Men	70
Human Development Index	89
Human Poverty Index	
Rank	43
Value	18.3
Percentage of people with less than US\$ 2 a day	6.6%
Per Capita Gross National Income, ppp, Intl dollar rate	7310
Per Capita Government Expenditure on Health at Intl dollar rate	187

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	8700 [4700 – 21 000]
Adults aged 15 to 49 HIV prevalence rate	0.1 [0.1 – 0.3%]
Adults aged 15 and over living with HIV	8600 [4600 – 21 000]
Women aged 15 and over living with HIV	1900 [860 – 4700]
Deaths due to AIDS	<100 [<200]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	34.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	2.0% ¹
Sex workers	20.0% ²
Men who have sex with men	5.0% ³



TURKEY

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	73 193 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	73
Men	69
Human Development Index	93
Human Poverty Index	
Rank	19
Value	9.7
Percentage of people with less than US\$ 2 a day	10.3%
Per Capita Gross National Income, ppp, Intl dollar rate	7680
Per Capita Government Expenditure on Health at Intl dollar rate	378

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<2000 [<5000]
Adults aged 15 to 49 HIV prevalence rate	[$<0.2\%$]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 3 030 802 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	9.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	13.8% ²
Men who have sex with men	—



TURKMENISTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 833 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	65
Men	56
Human Development Index	97
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	6910
Per Capita Government Expenditure on Health at Intl dollar rate	149

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	<500 [<1000]
Adults aged 15 to 49 HIV prevalence rate	<0.1 [<0.2%]
Adults aged 15 and over living with HIV	<500 [<1000]
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

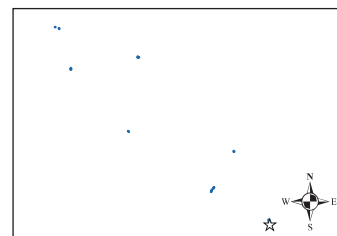
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



TUVALU

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	10 000
Population Growth Rate	0.5%
Life expectancy at birth	
Women	62
Men	61
Human Development Index	—
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	—
Per Capita Government Expenditure on Health at Intl dollar rate	62

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	—
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
---	---

National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	— Men
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	— Men

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

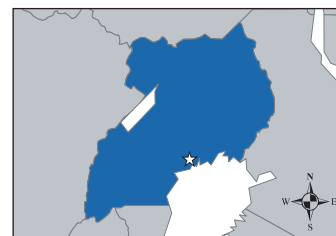
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	— Sex workers
Men who have sex with men	—



UGANDA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	28 816 000
Population Growth Rate	3.4%
Life expectancy at birth	
Women	51
Men	48
Human Development Index	144
Human Poverty Index	
Rank	66
Value	36.0
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	1520
Per Capita Government Expenditure on Health at Intl dollar rate	23

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 000 000 [850 000 – 1 200 000]
Adults aged 15 to 49 HIV prevalence rate	6.7 [5.7 – 7.6%]
Adults aged 15 and over living with HIV	900 000 [780 000 – 1 000 000]
Women aged 15 and over living with HIV	520 000 [450 000 – 590 000]
Deaths due to AIDS	91 000 [54 000 – 130 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	110 000 [39 000 – 200 000]
Orphans aged 0 to 17 due to AIDS	1 000 000 [870 000 – 1 300 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 18 778 886
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	12.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	56.0%
■ School attendance among orphans	88.0%
■ School attendance among non-orphans	93.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	26.0%
Men	74.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	12.2% ¹
Men	16.3% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	53.0%
Men	55.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	10.0% ³
Men who have sex with men	–



UKRAINE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	46 481 000
Population Growth Rate	-1.1%
Life expectancy at birth	
Women	73
Men	62
Human Development Index	78
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	6250
Per Capita Government Expenditure on Health at Intl dollar rate	201

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	410 000 [250 000 – 680 000]
Adults aged 15 to 49 HIV prevalence rate	1.4 [0.8 – 4.3%]
Adults aged 15 and over living with HIV	410 000 [250 000 – 680 000]
Women aged 15 and over living with HIV	200 000 [100 000 – 350 000]
Deaths due to AIDS	22 000 [13 000 – 33 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	31.8%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	65.1%
Men	73.2%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

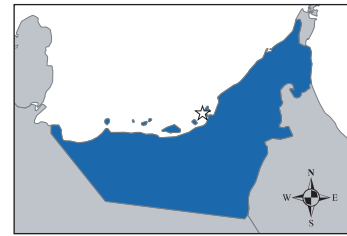
■ National funds spent by governments from domestic sources	US\$ 3 935 259
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	No

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	7.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	38.4% ¹
Sex workers	33.7% ²
Men who have sex with men	5.0% ³



UNITED ARAB EMIRATES

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	4 496 000
Population Growth Rate	6.5%
Life expectancy at birth	
Women	79
Men	76
Human Development Index	41
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	21 000
Per Capita Government Expenditure on Health at Intl dollar rate	465

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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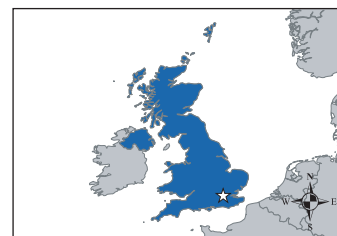
Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—

UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND



I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	59 668 000
Population Growth Rate	0.3%
Life expectancy at birth	
Women	81
Men	76
Human Development Index	15
Human Poverty Index	
Rank	15 ¹
Value	14.8 ²
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	31 460
Per Capita Government Expenditure on Health at Intl dollar rate	2047

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	68 000 [41 000 – 110 000] ³
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.4%] ⁴
Adults aged 15 and over living with HIV	67 000 [40 000 – 110 000] ⁵
Women aged 15 and over living with HIV	21 000 [11 000 – 37 000] ⁶
Deaths due to AIDS	<1000 [<2000] ⁷

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	– ⁸
Orphans aged 0 to 17 due to AIDS	– ⁹

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



UNITED REPUBLIC OF TANZANIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	38 329 000
Population Growth Rate	2%
Life expectancy at birth	
Women	49
Men	47
Human Development Index	164
Human Poverty Index	
Rank	65
Value	35.8
Percentage of people with less than US\$ 2 a day	59.7%
Per Capita Gross National Income, ppp, Intl dollar rate	660
Per Capita Government Expenditure on Health at Intl dollar rate	16

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 400 000 [1 300 000 – 1 600 000]
Adults aged 15 to 49 HIV prevalence rate	6.5 [5.8 – 7.2%]
Adults aged 15 and over living with HIV	1 300 000 [1 200 000 – 1 400 000]
Women aged 15 and over living with HIV	710 000 [640 000 – 780 000]
Deaths due to AIDS	140 000 [110 000 – 180 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	110 000 [43 000 – 210 000]
Orphans aged 0 to 17 due to AIDS	1 100 000 [910 000 – 1 200 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 45 000 000
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	7.0%
■ School attendance among orphans	73.0%
■ School attendance among non-orphans	90.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	44.0%
Men	49.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	36.0%
Men	81.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	10.1% ¹
Men	10.7% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	42.0%
Men	47.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

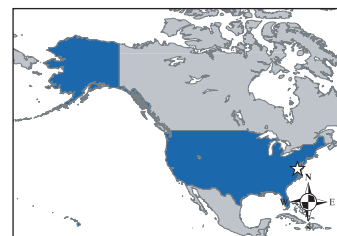
■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



UNITED STATES OF AMERICA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	298 213 000
Population Growth Rate	1%
Life expectancy at birth	
Women	80
Men	75
Human Development Index	10
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	39 710
Per Capita Government Expenditure on Health at Intl dollar rate	2548

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 200 000 [720 000 – 2 000 000]
Adults aged 15 to 49 HIV prevalence rate	0.6 [0.4 – 1.0%]
Adults aged 15 and over living with HIV	1 200 000 [720 000 – 2 000 000]
Women aged 15 and over living with HIV	300 000 [150 000 – 530 000]
Deaths due to AIDS	16 000 [9600 – 24 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

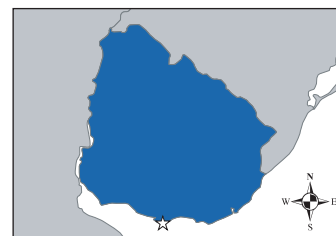
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	70.1% ¹
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



URUGUAY

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	3 463 000
Population Growth Rate	0.7%
Life expectancy at birth	
Women	79
Men	71
Human Development Index	46
Human Poverty Index	
Rank	1
Value	3.6
Percentage of people with less than US\$ 2 a day	9.5%
Per Capita Gross National Income, ppp, Intl dollar rate	9070
Per Capita Government Expenditure on Health at Intl dollar rate	224

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	9600 [4600 – 30 000]
Adults aged 15 to 49 HIV prevalence rate	0.5 [0.2 – 6.1%]
Adults aged 15 and over living with HIV	9500 [4500 – 31 000]
Women aged 15 and over living with HIV	5300 [2200 – 17 000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	19.3%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

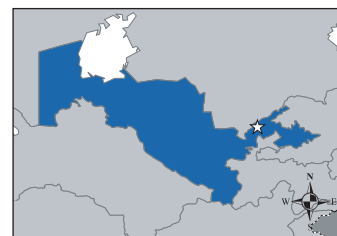
■ National funds spent by governments from domestic sources	US\$ 3 811 000 ¹
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	69.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



UZBEKISTAN

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	26 593 000
Population Growth Rate	1.5%
Life expectancy at birth	
Women	69
Men	63
Human Development Index	111
Human Poverty Index	
Rank	—
Value	—
Percentage of people with less than US\$ 2 a day	—
Per Capita Gross National Income, ppp, Intl dollar rate	1860
Per Capita Government Expenditure on Health at Intl dollar rate	68

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	31 000 [15 000 – 99 000]
Adults aged 15 to 49 HIV prevalence rate	0.2 [0.1 – 0.7%]
Adults aged 15 and over living with HIV	31 000 [15 000 – 100 000]
Women aged 15 and over living with HIV	4100 [1700 – 13 000]
Deaths due to AIDS	<500 [<1000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	8.0%
Men	7.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	1.0%
Men	45.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	50.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

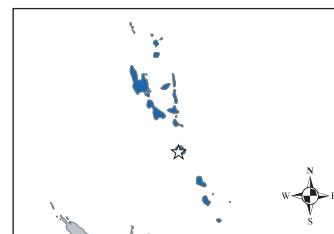
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



VANUATU

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	211 000
Population Growth Rate	2%
Life expectancy at birth	
Women	69
Men	67
Human Development Index	118
Human Poverty Index	
Rank	52
Value	24.7
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	2790
Per Capita Government Expenditure on Health at Intl dollar rate	81

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	–
Adults aged 15 to 49 HIV prevalence rate	–
Adults aged 15 and over living with HIV	–
Women aged 15 and over living with HIV	–
Deaths due to AIDS	–

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	–
Men who have sex with men	–



VENEZUELA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	26 749 000
Population Growth Rate	1.8%
Life expectancy at birth	
Women	78
Men	72
Human Development Index	75
Human Poverty Index	
Rank	14
Value	8.8
Percentage of people with less than US\$ 2 a day	32.0%
Per Capita Gross National Income, ppp, Intl dollar rate	5760
Per Capita Government Expenditure on Health at Intl dollar rate	102

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	110 000 [54 000 – 350 000]
Adults aged 15 to 49 HIV prevalence rate	0.7 [0.3 – 8.9%]
Adults aged 15 and over living with HIV	110 000 [52 000 – 350 000]
Women aged 15 and over living with HIV	31 000 [13 000 – 100 000]
Deaths due to AIDS	6100 [3100 – 11 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	4.2%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	–
non-orphans	–

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	–
Men	–
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	–

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

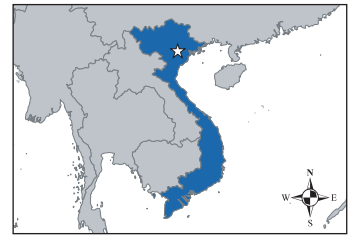
■ National funds spent by governments from domestic sources	US\$ 28 244 688
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	84.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	30.0% ¹
Men who have sex with men	1.0% ²



VIET NAM

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	84 238 000
Population Growth Rate	1.4%
Life expectancy at birth	
Women	74
Men	69
Human Development Index	109
Human Poverty Index	
Rank	47
Value	21.2
Percentage of people with less than US\$ 2 a day	–
Per Capita Gross National Income, ppp, Intl dollar rate	2700
Per Capita Government Expenditure on Health at Intl dollar rate	46

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	260 000 [150 000 – 430 000]
Adults aged 15 to 49 HIV prevalence rate	0.5 [0.3 – 0.9%]
Adults aged 15 and over living with HIV	250 000 [150 000 – 420 000]
Women aged 15 and over living with HIV	84 000 [43 000 – 150 000]
Deaths due to AIDS	13 000 [7800 – 20 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	–
Orphans aged 0 to 17 due to AIDS	–

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	–
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ School attendance among orphans	– non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	42.0%
Men	50.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	0.7%
Men	21.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	0.5% ¹
Men	0.3% ²
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	–
Men	68.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 5 590 000 ³
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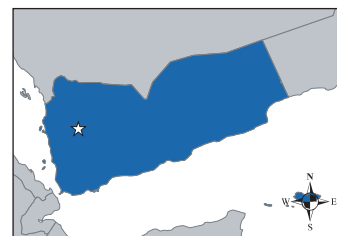
Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	12.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	69.1% ⁴
Sex workers	81.0% ⁵
Men who have sex with men	–

YEMEN



I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	20 975 000
Population Growth Rate	3.1%
Life expectancy at birth	
Women	61
Men	57
Human Development Index	151
Human Poverty Index	
Rank	77
Value	40.3
Percentage of people with less than US\$ 2 a day	45.2%
Per Capita Gross National Income, ppp, Intl dollar rate	820
Per Capita Government Expenditure on Health at Intl dollar rate	37

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	—
Adults aged 15 to 49 HIV prevalence rate	[<0.2%]
Adults aged 15 and over living with HIV	—
Women aged 15 and over living with HIV	—
Deaths due to AIDS	—

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	—
Orphans aged 0 to 17 due to AIDS	—

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	—
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	—
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ School attendance among orphans	— non-orphans

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	—
Men	—
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	—
Men	—

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

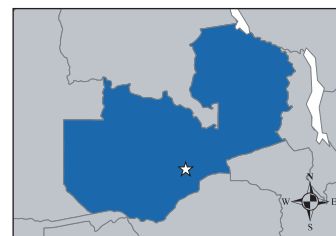
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	—
■ Policy to expand access to essential preventive commodities among most-at-risk populations	—

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	0.0%
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ZAMBIA

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	11 668 000
Population Growth Rate	1.7%
Life expectancy at birth	
Women	40
Men	40
Human Development Index	166
Human Poverty Index	
Rank	90
Value	46.4
Percentage of people with less than US\$ 2 a day	87.4%
Per Capita Gross National Income, ppp, Intl dollar rate	890
Per Capita Government Expenditure on Health at Intl dollar rate	26

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 100 000 [1 100 000 – 1 200 000]
Adults aged 15 to 49 HIV prevalence rate	17.0 [15.9 – 18.1%]
Adults aged 15 and over living with HIV	1 000 000 [950 000 – 1 100 000]
Women aged 15 and over living with HIV	570 000 [540 000 – 610 000]
Deaths due to AIDS	98 000 [77 000 – 120 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	130 000 [53 000 – 250 000]
Orphans aged 0 to 17 due to AIDS	710 000 [630 000 – 830 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 32 000 000 ¹
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	4.0%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	27.0%
■ School attendance among orphans	73.0%
■ School attendance among non-orphans	78.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	31.0%
Men	33.0%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	30.0%
Men	86.0%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	17.5% ²
Men	— ³
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	35.0%
Men	40.0%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

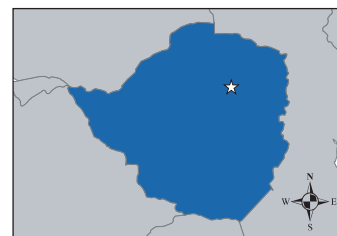
■ National funds spent by governments from domestic sources	—
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	Yes
■ Policy to expand access to essential preventive commodities among most-at-risk populations	Yes

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	—
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	—
Sex workers	—
Men who have sex with men	—



ZIMBABWE

I. DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Estimated Population	13 010 000
Population Growth Rate	0.6%
Life expectancy at birth	
Women	34
Men	37
Human Development Index	145
Human Poverty Index	
Rank	89
Value	45.9
Percentage of people with less than US\$ 2 a day	83.0%
Per Capita Gross National Income, ppp, Intl dollar rate	2180
Per Capita Government Expenditure on Health at Intl dollar rate	47

II. HIV AND AIDS ESTIMATES

Number of people living with HIV	1 700 000 [1 100 000 – 2 200 000]
Adults aged 15 to 49 HIV prevalence rate	20.1 [13.3 – 27.6%]
Adults aged 15 and over living with HIV	1 500 000 [1 000 000 – 2 000 000]
Women aged 15 and over living with HIV	890 000 [520 000 – 1 300 000]
Deaths due to AIDS	180 000 [120 000 – 250 000]

GENERALIZED EPIDEMICS

Children aged 0 to 14 living with HIV	160 000 [54 000 – 340 000]
Orphans aged 0 to 17 due to AIDS	1 100 000 [780 000 – 1 300 000]

III. COUNTRY PROGRESS INDICATORS

GENERALIZED EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	US\$ 12 052 578
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National Programmes

■ Percentage of pregnant women receiving treatment to reduce mother-to-child transmission	4.4%
■ Percentage of HIV-infected women and men receiving antiretroviral therapy	8.0%
■ School attendance among orphans	90.0%
■ School attendance among non-orphans	92.0%

Knowledge and Behaviour

■ Percentage of young women and men, aged 15 to 24, who correctly identify ways to prevent HIV	
Women	54.1%
Men	56.3%
■ Percentage of young women and men, aged 15 to 24, who had sex with a casual partner in the past 12 months	
Women	23.3%
Men	78.6%
■ Percentage of young women and men, aged 15 to 24, who had sex before age 15	
Women	8.1%
Men	8.5%
■ Percentage of young women and men, aged 15 to 24, who used a condom last time they had sex with a casual partner	
Women	42.6%
Men	56.5%

CONCENTRATED/LOW PREVALENCE EPIDEMICS

Expenditures

■ National funds spent by governments from domestic sources	–
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Policy Development and Implementation Status

■ Policy on information, education, communication and prevention for most-at-risk populations	–
■ Policy to expand access to essential preventive commodities among most-at-risk populations	–

National Programmes

■ Percentage of HIV-infected women and men receiving antiretroviral therapy	–
■ Percentage of most-at-risk populations reached by prevention programmes	
Injecting drug users	–
Sex workers	40.0% ¹
Men who have sex with men	–

NOTES

These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates.

Albania

- 1 Percentage of injecting drug users receiving harm reduction services

Algeria

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Argentina

- 1 Percentage of injecting drug users receiving harm reduction services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Armenia

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Australia

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Austria

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Azerbaijan

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

Bangladesh

- 1 Percentage of injecting drug users receiving harm reduction services
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Barbados

- 1 2004 data

Belarus

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Belgium

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Benin

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Bolivia

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

Brazil

- 1 2004 data

Burkina Faso

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Burundi

- 1 Country reports included multiple year estimates. Further work is needed to disaggregate by year
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Cambodia

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of injecting drug users receiving harm reduction services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 4 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Cameroon

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Canada

- 1 These are preliminary estimates. Final estimates for 2005 will be available in mid-2006
- 2 These are preliminary estimates. Final estimates for 2005 will be available in mid-2006
- 3 These are preliminary estimates. Final estimates for 2005 will be available in mid-2006
- 4 These are preliminary estimates. Final estimates for 2005 will be available in mid-2006
- 5 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 6 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 7 These are preliminary estimates. Final estimates for 2005 will be available in mid-2006
- 8 These are preliminary estimates. Final estimates for 2005 will be available in mid-2006
- 9 These are preliminary estimates. Final estimates for 2005 will be available in mid-2006

Central African Republic

- 1 2004 data

Chad

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

China

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Colombia

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Congo

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Côte d'Ivoire

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Croatia

- 1 Data under review at the time of printing
- 2 Percentage of injecting drug users receiving harm reduction services

Czech Republic

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Denmark

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Dominica

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Dominican Republic

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Percentage of 15–19-year-olds who had sex before exact age 15
- 4 Percentage of 15–19-year-olds who had sex before exact age 15

Ecuador

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Percentage of 15–19-year-olds who had sex before exact age 15
- 4 Percentage of 15–19-year-olds who had sex before exact age 15

El Salvador

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Eritrea

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

Ethiopia

- 1 In early 2006 important new data from a national community-based survey had become available in Ethiopia. At the time when this report went to press, those new data had only partially been analysed. As a result, the estimates for Ethiopia in this report should be considered preliminary. UNAIDS and WHO will make new estimates, based on a comprehensive analysis of all data, available on their websites as soon as possible
- 2 In early 2006 important new data from a national community-based survey had become available in Ethiopia. At the time when this report went to press, those new data had only partially been analysed. As a result, the estimates for Ethiopia in this report should be considered preliminary. UNAIDS and WHO will make new estimates, based on a comprehensive analysis of all data, available on their websites as soon as possible
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WHO will make new estimates, based on a comprehensive analysis of all data, available on their websites as soon as possible

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Fiji

- 1 2004 data

Finland

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

France

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Georgia

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Germany

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Ghana

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Guatemala

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 4 Percentage of 15–19-year-olds who had sex before exact age 15
- 5 Percentage of 15–19-year-olds who had sex before exact age 15

Guinea

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Guinea-Bissau

- 1 Country reports included multiple year estimates. Further work is needed to disaggregate by year

Honduras

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Iceland

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

India

- 1 Work is ongoing to produce a more precise estimate of AIDS mortality in India. An analysis using adult prevalence in past years and parameter estimates based on the international literature suggests that AIDS mortality lies within these ranges
- 2 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 4 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 5 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Indonesia

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Iran (Islamic Republic of)

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Ireland

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Italy

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Jamaica

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Japan

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Kazakhstan

- 1 Percentage of injecting drug users receiving harm reduction services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Kenya

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 4 Percentage of 15–19-year-olds who had sex before exact age 15
- 5 Percentage of 15–19-year-olds who had sex before exact age 15

Kyrgyzstan

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 4 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Lao People's Democratic Republic

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Latvia

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Luxembourg

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Madagascar

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

Malawi

- 1 2004 data

Malaysia

- 1 Percentage of injecting drug users receiving harm reduction services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Mali

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Mauritania

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

Mongolia

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Mozambique

- 1 Percentage of injecting drug users receiving harm reduction services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Percentage of 15–19-year-olds who had sex before exact age 15
- 4 Percentage of 15–19-year-olds who had sex before exact age 15

Namibia

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Nepal

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of injecting drug users receiving harm reduction services
Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 4 Percentage of 15–19-year-olds who had sex before exact age 15
- 5 Percentage of 15–19-year-olds who had sex before exact age 15

Netherlands

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

New Zealand

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Nicaragua

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

Niger

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Nigeria

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

Norway

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Pakistan

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Panama

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Paraguay

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Peru

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Philippines

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of injecting drug users receiving harm reduction services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 4 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Republic of Moldova

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Romania

- 1 Data under review at the time of printing
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 4 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 5 2003 data

Russian Federation

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Saint Kitts and Nevis

- 1 Country reports included multiple year estimates. Further work is needed to disaggregate by year

Saint Vincent and the Grenadines

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Serbia and Montenegro

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Seychelles

- 1 2004 data

South Africa

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Spain

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Sweden

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Switzerland

- 1 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 2 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States

Tajikistan

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Thailand

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Togo

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Trinidad and Tobago

- 1 2004 data

Tunisia

- 1 Percentage of injecting drug users receiving harm reduction services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Turkey

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

Uganda

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Ukraine

- 1 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment

United Kingdom of Great Britain and Northern Ireland

- 1 These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed
- 2 These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed

- 3 These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed
- 4 These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed
- 5 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 6 Organisation for Economic Co-operation and Development Countries, Eastern Europe and Commonwealth of Independent States
- 7 These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed
- 8 These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed
- 9 These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed

United Republic of Tanzania

- 1 Percentage of 15–19-year-olds who had sex before exact age 15
- 2 Percentage of 15–19-year-olds who had sex before exact age 15

United States of America

- 1 2003 data

Uruguay

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates

Venezuela

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services
- 2 Estimated percentage of sex workers or men who have sex with men covered with outreach services

Viet Nam

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 3 Percentage of most-at-risk population reached by at least one of the following intervention programmes: community outreach programmes that include peer education; exposure to targeted mass media; sexually transmitted infection screening and/or treatment
- 4 Percentage of 15–19-year-olds who had sex before exact age 15
- 5 Percentage of 15–19-year-olds who had sex before exact age 15

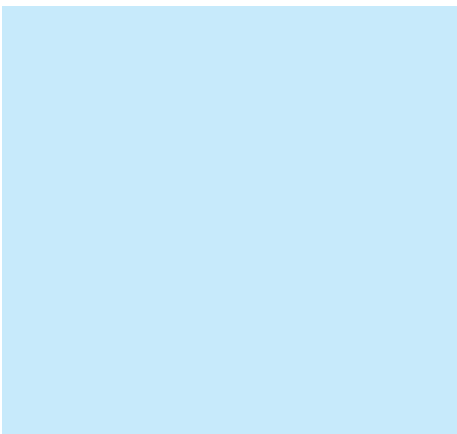
Zambia

- 1 These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates
- 2 Percentage of 15–19-year-olds who had sex before exact age 15
- 3 Percentage of 15–19-year-olds who had sex before exact age 15

Zimbabwe

- 1 Estimated percentage of sex workers or men who have sex with men covered with outreach services

ANNEX 2: HIV and AIDS estimates and data, 2005 and 2003



Annex 2



ANNEX 2: HIV AND AIDS ESTIMATES AND DATA, 2005 AND 2003

The estimates and data provided in Annex 2 relate to 2005 and 2003 unless otherwise stated. These estimates have been produced and compiled by UNAIDS/WHO. They have been shared with national AIDS programmes for review and comments, but are not necessarily the official estimates used by national governments. For countries where no recent data were available, country-specific estimates have not been listed in the table. In order to calculate regional totals, older data or regional models were used to produce estimates for these countries.

The estimates are given in rounded numbers. However, unrounded numbers were used in the calculation of rates and regional totals, so there may be minor discrepancies between the regional and global totals and the sum of the country figures.

The general methodology and tools used to produce the country-specific estimates in the table have been described in a series of papers in *Sexually Transmitted Infections*, “Improved methods and tools for HIV/AIDS estimates and projections,” 2006, 82 (Suppl) and 2004, 80 (Suppl). The estimates produced by UNAIDS/WHO are based on methods and on parameters that are informed by the UNAIDS Reference Group on HIV/AIDS Estimates, Modelling and Projections, available at <http://www.epidem.org/>.

This group is made up of leading researchers in HIV and AIDS, epidemiology, demography and related areas. The Reference Group assesses the most recent published and unpublished work drawn from research studies in different countries. It also reviews advances in the understanding of HIV epidemics, and suggests methods to improve the quality and accuracy of the estimates.

Based on suggestions from the Reference Group, software has been developed to model the course of HIV epidemics and their impact. Country analysts were trained in the use of these tools during a series of workshops in 2005. These changes in procedures and assumptions and improved coordination with countries have resulted in improved estimates of HIV and AIDS for 2005. To allow readers to assess recent trends in the

epidemic, we also present 2003 estimates developed using the same methodology and data as for the 2005 estimates.

The new estimates in this report are presented together with ranges, called ‘plausibility bounds’. These bounds reflect the certainty associated with each of the estimates. The wider the bounds, the greater the uncertainty surrounding an estimate. The extent of uncertainty depends mainly on the type of epidemic, and the quality, coverage and consistency of a country’s surveillance system and, in generalized epidemics, whether or not a population-based survey with HIV testing was conducted. A full description of the methods used to develop plausibility bounds can be found in *Sexually Transmitted Infections*, 2006, 82 (Suppl).

Adults in this report are defined as men and women aged 15 years and over (15+). This is different from previous reports where the estimates for adults were restricted to 15–49-year-olds. Since the burden of disease extends beyond the age of 49 and to better assess that need, the UNAIDS Reference Group on Estimates, Modelling and Projections has recommended changing the reporting to all ages. The HIV prevalence rate however continues to be for adults 15–49 to allow comparisons across countries.

Notes on specific indicators listed in Annex 2

1. ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV, 2005 AND 2003

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, in 2005 and 2003. For some countries where sufficient data from the last six years were not available, no estimates have been made.

Adults and children

Estimated number of adults and children living with HIV in 2005 and 2003.

Adults are 15 years and over. Children are defined as those aged 0–14 years.

Adults (15+ years)

Estimated number of adults living with HIV, 2005 and 2003.

Adult (15–49 years) prevalence rate (%)

To calculate the adult HIV prevalence rate, the estimated number of adults aged 15–49 living with HIV in 2005 was divided by the 2005 adult population (aged 15–49) and similarly for 2003.

Women (15+ years)

Estimated number of women aged 15 and over living with HIV in 2005 and 2003.

Children (0–14 years)

Estimated number of children under the age of 15 living with HIV in 2005 and 2003.

Young women (15–24) prevalence rate (%) 2005

Estimated percent of young women aged 15–24 living with HIV in 2005.

Young men (15–24) prevalence rate (%) 2005

Estimated percent of young men aged 15–24 living with HIV in 2005.

2. AIDS DEATHS ADULTS AND CHILDREN

Estimated number of adults and children who died due to AIDS during 2005 and 2003.

3. ORPHANS DUE TO AIDS

Orphans (0–17 years) currently living

Estimated number of children aged 0–17 years in 2005 and 2003 who have lost one or both parents to AIDS.

Plausibility bounds for the above indicators

Depending on the reliability of the data available, there may be more or less uncertainty surrounding each estimate. While a measure of uncertainty applies to all estimates, in this report the plausibility bounds are presented for the following estimates:

- Estimated number of adults (15+ years) and children (0–14 years) living with HIV in 2005 and 2003
- Estimated number of adults (15+ years) living with HIV in 2005 and 2003
- Estimated number of women (15+ years) living with HIV in 2005 and 2003
- Estimated number of children (0–14 years) living with HIV in 2005 and 2003
- Estimated HIV prevalence among young women and men (15–24 years) in 2005
- Estimated number of AIDS deaths in adults (15+ years) and children (0–14 years) during 2005 and 2003
- Orphans (0–17 years) due to AIDS in 2005 and 2003

4. TRENDS OF HIV PREVALENCE (%) IN YOUNG PREGNANT WOMEN (15–24 YEARS) IN CAPITAL CITY, ANTENATAL CLINIC SITES 2000 OR 2001 AND 2004 OR 2005

This indicator is taken from the 2001 United Nations General Assembly Special

Session on HIV/AIDS, and gives a reasonable estimate of relatively recent trends over time in HIV infection in countries with generalized epidemics that are predominantly heterosexually driven. The number of pregnant women aged 15–24 years attending antenatal clinics whose test results were positive is divided by the number of pregnant women aged 15–24 years who had an HIV test. The median of the capital city sites are included. The broadest trend (over the widest time period) is provided whenever possible. Trend data are provided by reporting either 2000 or 2001 data and 2004 or 2005 data when available.

5. TRENDS OF HIV PREVALENCE IN MOST-AT-RISK GROUPS IN CAPITAL CITY

These indicators are recommended for reporting against the goals of the 2001 United Nations General Assembly Special Session on HIV/AIDS in countries with low-level or concentrated HIV epidemics. Most of these data are from routine sentinel surveillance. For each of the populations the table gives the year of the most recent report and the median for the surveillance sites in the capital city. The specific populations at higher risk of HIV exposure in the tables include:

- Injecting drug users
- Female sex workers
- Men who have sex with men

Trend data are provided whenever possible by presenting 2000 or 2001 data and 2004 or 2005 data.

1. Estimated number of people living with HIV						
Adults and children 2005			Adults and children 2003		Adults (15 +) 2005	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Global	38 600 000	[33 400 000 – 46 000 000]	36 200 000	[31 400 000 – 42 900 000]	36 300 000	[31 400 000 – 43 400 000]
Sub-Saharan Africa	24 500 000	[21 600 000 – 27 400 000]	23 500 000	[20 800 000 – 26 300 000]	22 400 000	[19 900 000 – 25 100 000]
Angola	320 000	[200 000 – 450 000]	300 000	[190 000 – 430 000]	280 000	[180 000 – 410 000]
Benin	87 000	[57 000 – 120 000]	90 000	[59 000 – 130 000]	77 000	[50 000 – 110 000]
Botswana	270 000	[260 000 – 350 000]	260 000	[250 000 – 340 000]	260 000	[250 000 – 330 000]
Burkina Faso	150 000	[120 000 – 190 000]	150 000	[110 000 – 180 000]	140 000	[100 000 – 160 000]
Burundi	150 000	[130 000 – 180 000]	140 000	[120 000 – 170 000]	130 000	[110 000 – 150 000]
Cameroon	510 000	[460 000 – 560 000]	490 000	[450 000 – 540 000]	470 000	[430 000 – 510 000]
Central African Republic	250 000	[110 000 – 390 000]	240 000	[110 000 – 370 000]	230 000	[100 000 – 350 000]
Chad	180 000	[88 000 – 300 000]	160 000	[79 000 – 270 000]	160 000	[81 000 – 270 000]
Comoros	<500	[<1000]	<500	[<1000]	<500	[<1000]
Congo	120 000	[75 000 – 160 000]	110 000	[72 000 – 160 000]	100 000	[66 000 – 140 000]
Côte d'Ivoire	750 000	[470 000 – 1 000 000]	710 000	[440 000 – 950 000]	680 000	[420 000 – 920 000]
Democratic Republic of the Congo	1 000 000	[560 000 – 1 500 000]	940 000	[520 000 – 1 400 000]	890 000	[500 000 – 1 300 000]
Djibouti	15 000	[3900 – 34 000]	14 000	[3900 – 31 000]	14 000	[3700 – 31 000]
Equatorial Guinea	8900	[7300 – 11 000]	8400	[6900 – 10 000]	8000	[6600 – 9400]
Eritrea	59 000	[33 000 – 95 000]	55 000	[30 000 – 88 000]	53 000	[30 000 – 84 000]
Ethiopia (1)	...	[420 000 – 1 300 000]	...	[400 000 – 1 300 000]	...	[380 000 – 1 200 000]
Gabon	60 000	[40 000 – 87 000]	56 000	[36 000 – 79 000]	56 000	[37 000 – 81 000]
Gambia	20 000	[10 000 – 33 000]	17 000	[9000 – 27 000]	19 000	[9600 – 31 000]
Ghana	320 000	[270 000 – 380 000]	310 000	[250 000 – 360 000]	300 000	[250 000 – 350 000]
Guinea	85 000	[69 000 – 100 000]	80 000	[62 000 – 99 000]	78 000	[62 000 – 91 000]
Guinea-Bissau	32 000	[18 000 – 50 000]	30 000	[16 000 – 47 000]	29 000	[16 000 – 45 000]
Kenya	1 300 000	[1 100 000 – 1 500 000]	1 300 000	[1 200 000 – 1 500 000]	1 200 000	[990 000 – 1 300 000]
Lesotho	270 000	[250 000 – 290 000]	270 000	[250 000 – 290 000]	250 000	[240 000 – 270 000]
Liberia	...	...	...	...	...	...
Madagascar	49 000	[16 000 – 110 000]	40 000	[14 000 – 84 000]	47 000	[16 000 – 110 000]
Malawi	940 000	[480 000 – 1 400 000]	900 000	[460 000 – 1 300 000]	850 000	[440 000 – 1 300 000]
Mali	130 000	[96 000 – 160 000]	120 000	[92 000 – 150 000]	110 000	[86 000 – 140 000]
Mauritania	12 000	[7300 – 23 000]	11 000	[7000 – 16 000]	11 000	[6600 – 21 000]
Mauritius	4100	[1900 – 13 000]	1600	[760 – 5000]	4100	[1900 – 13 000]
Mozambique	1 800 000	[1 400 000 – 2 200 000]	1 700 000	[1 300 000 – 2 000 000]	1 600 000	[1 300 000 – 2 000 000]
Namibia	230 000	[110 000 – 360 000]	220 000	[100 000 – 330 000]	210 000	[99 000 – 340 000]
Niger	79 000	[39 000 – 130 000]	75 000	[36 000 – 110 000]	71 000	[35 000 – 120 000]
Nigeria	2 900 000	[1 700 000 – 4 200 000]	2 600 000	[1 500 000 – 3 800 000]	2 600 000	[1 600 000 – 3 800 000]
Rwanda	190 000	[180 000 – 210 000]	220 000	[200 000 – 240 000]	160 000	[160 000 – 170 000]
Senegal	61 000	[29 000 – 100 000]	57 000	[28 000 – 92 000]	56 000	[26 000 – 92 000]
Sierra Leone	48 000	[27 000 – 73 000]	45 000	[26 000 – 68 000]	43 000	[25 000 – 66 000]
Somalia	44 000	[23 000 – 81 000]	42 000	[22 000 – 77 000]	40 000	[21 000 – 72 000]
South Africa	5 500 000	[4 900 000 – 6 100 000]	5 300 000	[4 800 000 – 5 800 000]	5 300 000	[4 800 000 – 5 800 000]
Swaziland	220 000	[150 000 – 290 000]	210 000	[140 000 – 270 000]	210 000	[140 000 – 270 000]
Togo	110 000	[65 000 – 160 000]	100 000	[60 000 – 150 000]	100 000	[60 000 – 150 000]
Uganda	1 000 000	[850 000 – 1 200 000]	960 000	[810 000 – 1 100 000]	900 000	[780 000 – 1 000 000]
United Republic of Tanzania	1 400 000	[1 300 000 – 1 600 000]	1 400 000	[1 200 000 – 1 500 000]	1 300 000	[1 200 000 – 1 400 000]
Zambia	1 100 000	[1 100 000 – 1 200 000]	1 100 000	[1 000 000 – 1 200 000]	1 000 000	[950 000 – 1 100 000]
Zimbabwe	1 700 000	[1 100 000 – 2 200 000]	1 700 000	[1 200 000 – 2 300 000]	1 500 000	[1 000 000 – 2 000 000]

1. Estimated number of people living with HIV								
Adults (15 +) 2003			Adult (15–49) rate (%) 2005		Adult (15–49) rate (%) 2003		Women (15 +) 2005	
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]
Global	34 000 000	[29 500 000 – 40 500 000]	1.0	[0.9 – 1.2]	1.0	[0.8 – 1.2]	17 300 000	[14 800 000 – 20 600 000]
Sub-Saharan Africa	21 600 000	[19 200 000 – 24 100 000]	6.1	[5.4 – 6.8]	6.2	[5.5 – 7.0]	13 200 000	[11 400 000 – 15 100 000]
Angola	270 000	[170 000 – 380 000]	3.7	[2.3 – 5.3]	3.7	[2.3 – 5.3]	170 000	[90 000 – 260 000]
Benin	81 000	[53 000 – 110 000]	1.8	[1.2 – 2.5]	2.0	[1.3 – 2.9]	45 000	[24 000 – 68 000]
Botswana	250 000	[240 000 – 320 000]	24.1	[23.0 – 32.0]	24.0	[23.0 – 31.6]	140 000	[130 000 – 190 000]
Burkina Faso	130 000	[100 000 – 160 000]	2.0	[1.5 – 2.5]	2.1	[1.6 – 2.6]	80 000	[49 000 – 110 000]
Burundi	120 000	[110 000 – 140 000]	3.3	[2.7 – 3.8]	3.3	[2.8 – 3.7]	79 000	[68 000 – 91 000]
Cameroon	450 000	[410 000 – 490 000]	5.4	[4.9 – 5.9]	5.5	[5.0 – 6.0]	290 000	[260 000 – 310 000]
Central African Republic	220 000	[95 000 – 340 000]	10.7	[4.5 – 17.2]	10.8	[4.6 – 17.2]	130 000	[53 000 – 220 000]
Chad	150 000	[74 000 – 250 000]	3.5	[1.7 – 6.0]	3.4	[1.7 – 5.9]	90 000	[40 000 – 160 000]
Comoros	<500	[<1000]	<0.1	[<0.2]	<0.1	[<0.2]	<100	[<1000]
Congo	99 000	[63 000 – 140 000]	5.3	[3.3 – 7.5]	5.4	[3.4 – 7.7]	61 000	[33 000 – 89 000]
Côte d'Ivoire	640 000	[400 000 – 870 000]	7.1	[4.3 – 9.7]	7.0	[4.3 – 9.7]	400 000	[220 000 – 600 000]
Democratic Republic of the Congo	830 000	[470 000 – 1 300 000]	3.2	[1.8 – 4.9]	3.2	[1.8 – 4.9]	520 000	[250 000 – 850 000]
Djibouti	13 000	[3600 – 29 000]	3.1	[0.8 – 6.9]	3.1	[0.8 – 6.8]	8400	[2200 – 19 000]
Equatorial Guinea	7600	[6300 – 9000]	3.2	[2.6 – 3.8]	3.2	[2.6 – 3.8]	4700	[3900 – 5600]
Eritrea	49 000	[28 000 – 78 000]	2.4	[1.3 – 3.9]	2.4	[1.3 – 3.8]	31 000	[15 000 – 53 000]
Ethiopia (1)	...	[360 000 – 1 100 000]	...	[0.9 – 3.5]	...	[1.0 – 3.5]	...	[190 000 – 730 000]
Gabon	52 000	[34 000 – 74 000]	7.9	[5.1 – 11.5]	7.7	[5.0 – 11.0]	33 000	[18 000 – 52 000]
Gambia	16 000	[8400 – 26 000]	2.4	[1.2 – 4.1]	2.2	[1.2 – 3.6]	11 000	[5100 – 20 000]
Ghana	280 000	[240 000 – 330 000]	2.3	[1.9 – 2.6]	2.3	[1.9 – 2.7]	180 000	[150 000 – 210 000]
Guinea	74 000	[58 000 – 91 000]	1.5	[1.2 – 1.8]	1.6	[1.2 – 1.9]	53 000	[42 000 – 61 000]
Guinea-Bissau	27 000	[15 000 – 42 000]	3.8	[2.1 – 6.0]	3.8	[2.1 – 6.1]	17 000	[8100 – 29 000]
Kenya	1 200 000	[1 000 000 – 1 400 000]	6.1	[5.2 – 7.0]	6.8	[5.8 – 7.7]	740 000	[640 000 – 840 000]
Lesotho	250 000	[240 000 – 260 000]	23.2	[21.9 – 24.7]	23.7	[22.3 – 25.1]	150 000	[140 000 – 160 000]
Liberia	...	...	...	[2.0 – 5.0]	...	...	...	...
Madagascar	39 000	[14 000 – 82 000]	0.5	[0.2 – 1.2]	0.5	[0.2 – 1.0]	13 000	[4000 – 33 000]
Malawi	810 000	[420 000 – 1 200 000]	14.1	[6.9 – 21.4]	14.2	[7.0 – 21.5]	500 000	[220 000 – 800 000]
Mali	110 000	[82 000 – 130 000]	1.7	[1.3 – 2.1]	1.8	[1.3 – 2.2]	66 000	[51 000 – 81 000]
Mauritania	9800	[6400 – 15 000]	0.7	[0.4 – 2.8]	0.7	[0.4 – 1.0]	6300	[3300 – 13 000]
Mauritius	1600	[760 – 5100]	0.6	[0.3 – 1.8]	0.2	[0.1 – 0.7]	<1000	[310 – 2400]
Mozambique	1 600 000	[1 200 000 – 1 900 000]	16.1	[12.5 – 20.0]	16.0	[12.5 – 19.7]	960 000	[590 000 – 1 300 000]
Namibia	200 000	[92 000 – 310 000]	19.6	[8.6 – 31.7]	19.5	[8.7 – 30.6]	130 000	[54 000 – 220 000]
Niger	67 000	[33 000 – 100 000]	1.1	[0.5 – 1.9]	1.1	[0.5 – 1.7]	42 000	[17 000 – 75 000]
Nigeria	2 400 000	[1 400 000 – 3 500 000]	3.9	[2.3 – 5.6]	3.7	[2.2 – 5.5]	1 600 000	[810 000 – 2 400 000]
Rwanda	190 000	[170 000 – 200 000]	3.1	[2.9 – 3.2]	3.8	[3.5 – 3.9]	91 000	[86 000 – 95 000]
Senegal	53 000	[26 000 – 85 000]	0.9	[0.4 – 1.5]	0.9	[0.5 – 1.5]	33 000	[14 000 – 58 000]
Sierra Leone	40 000	[24 000 – 61 000]	1.6	[0.9 – 2.4]	1.6	[0.9 – 2.4]	26 000	[15 000 – 39 000]
Somalia	38 000	[20 000 – 69 000]	0.9	[0.5 – 1.6]	0.9	[0.5 – 1.6]	23 000	[11 000 – 45 000]
South Africa	5 100 000	[4 600 000 – 5 600 000]	18.8	[16.8 – 20.7]	18.6	[16.6 – 20.5]	3 100 000	[2 800 000 – 3 400 000]
Swaziland	190 000	[130 000 – 250 000]	33.4	[21.2 – 45.3]	32.4	[20.7 – 44.1]	120 000	[70 000 – 180 000]
Togo	95 000	[55 000 – 140 000]	3.2	[1.9 – 4.7]	3.2	[1.9 – 4.7]	61 000	[31 000 – 95 000]
Uganda	850 000	[740 000 – 960 000]	6.7	[5.7 – 7.6]	6.8	[5.8 – 7.8]	520 000	[450 000 – 590 000]
United Republic of Tanzania	1 300 000	[1 100 000 – 1 400 000]	6.5	[5.8 – 7.2]	6.6	[5.9 – 7.3]	710 000	[640 000 – 780 000]
Zambia	960 000	[900 000 – 1 000 000]	17.0	[15.9 – 18.1]	16.9	[15.9 – 18.0]	570 000	[540 000 – 610 000]
Zimbabwe	1 600 000	[1 100 000 – 2 100 000]	20.1	[13.3 – 27.6]	22.1	[14.6 – 30.4]	890 000	[520 000 – 1 300 000]

1. Estimated number of people living with HIV						
Women (15+) 2003			Children (0–14) 2005		Children (0–14) 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Global	16 300 000	[13 900 000 – 19 200 000]	2 300 000	[1 700 000 – 3 500 000]	2 100 000	[1 500 000 – 3 200 000]
Sub-Saharan Africa	12 600 000	[10 900 000 – 14 400 000]	2 000 000	[1 500 000 – 3 000 000]	1 900 000	[1 400 000 – 2 800 000]
Angola	160 000	[85 000 – 250 000]	35 000	[12 000 – 76 000]	31 000	[11 000 – 71 000]
Benin	48 000	[26 000 – 72 000]	9800	[3300 – 21 000]	9200	[3100 – 20 000]
Botswana	140 000	[130 000 – 180 000]	14 000	[6100 – 32 000]	13 000	[5100 – 31 000]
Burkina Faso	77 000	[48 000 – 100 000]	17 000	[6100 – 34 000]	16 000	[6000 – 33 000]
Burundi	73 000	[63 000 – 84 000]	20 000	[6500 – 37 000]	19 000	[7600 – 37 000]
Cameroon	280 000	[250 000 – 300 000]	43 000	[17 000 – 82 000]	40 000	[16 000 – 79 000]
Central African Republic	130 000	[51 000 – 220 000]	24 000	[7200 – 61 000]	22 000	[6700 – 59 000]
Chad	82 000	[37 000 – 150 000]	16 000	[4700 – 37 000]	13 000	[3800 – 31 000]
Comoros	<100	[<200]	<100	[<200]	<100	[<200]
Congo	58 000	[32 000 – 85 000]	15 000	[5600 – 32 000]	15 000	[5500 – 32 000]
Côte d'Ivoire	370 000	[210 000 – 560 000]	74 000	[28 000 – 160 000]	71 000	[26 000 – 150 000]
Democratic Republic of the Congo	490 000	[230 000 – 790 000]	120 000	[40 000 – 270 000]	110 000	[38 000 – 260 000]
Djibouti	7900	[2000 – 18 000]	1200	[260 – 3600]	1000	[220 – 3200]
Equatorial Guinea	4500	[3700 – 5300]	<1000	[<2000]	<1000	[<2000]
Eritrea	29 000	[14 000 – 50 000]	6600	[2300 – 16 000]	5900	[2000 – 14 000]
Ethiopia (1)	...	[180 000 – 700 000]	...	[30 000 – 220 000]	...	[27 000 – 220 000]
Gabon	31 000	[16 000 – 48 000]	3900	[1400 – 8900]	3400	[1100 – 7900]
Gambia	9400	[4300 – 17 000]	1200	[430 – 2800]	<1000	[340 – 2100]
Ghana	170 000	[140 000 – 200 000]	25 000	[9800 – 48 000]	23 000	[8900 – 43 000]
Guinea	51 000	[39 000 – 62 000]	7000	[2400 – 16 000]	6100	[2000 – 14 000]
Guinea-Bissau	16 000	[7600 – 27 000]	3200	[1100 – 7500]	2600	[890 – 6300]
Kenya	770 000	[660 000 – 880 000]	150 000	[55 000 – 290 000]	150 000	[53 000 – 290 000]
Lesotho	140 000	[140 000 – 150 000]	18 000	[6900 – 34 000]	16 000	[6000 – 32 000]
Liberia	...	...	...	...	...	...
Madagascar	11 000	[3200 – 26 000]	1600	[470 – 4900]	1200	[340 – 3400]
Malawi	480 000	[210 000 – 760 000]	91 000	[28 000 – 190 000]	92 000	[29 000 – 190 000]
Mali	63 000	[49 000 – 78 000]	16 000	[6000 – 32 000]	15 000	[5700 – 31 000]
Mauritania	5800	[3100 – 9500]	1100	[320 – 2600]	1000	[260 – 2500]
Mauritius	<500	[<1000]	...	...	...	...
Mozambique	920 000	[560 000 – 1 300 000]	140 000	[57 000 – 310 000]	120 000	[45 000 – 270 000]
Namibia	120 000	[50 000 – 210 000]	17 000	[5800 – 40 000]	15 000	[4900 – 35 000]
Niger	40 000	[16 000 – 72 000]	8900	[2900 – 23 000]	7900	[2500 – 21 000]
Nigeria	1 400 000	[740 000 – 2 200 000]	240 000	[81 000 – 550 000]	200 000	[64 000 – 470 000]
Rwanda	100 000	[96 000 – 110 000]	27 000	[11 000 – 53 000]	30 000	[12 000 – 59 000]
Senegal	31 000	[13 000 – 55 000]	5000	[1700 – 12 000]	4400	[1500 – 10 000]
Sierra Leone	24 000	[14 000 – 36 000]	5200	[1800 – 12 000]	4900	[1700 – 11 000]
Somalia	23 000	[11 000 – 43 000]	4500	[1500 – 13 000]	4000	[1300 – 12 000]
South Africa	2 900 000	[2 600 000 – 3 200 000]	240 000	[93 000 – 500 000]	200 000	[76 000 – 450 000]
Swaziland	120 000	[65 000 – 170 000]	15 000	[5500 – 32 000]	12 000	[4300 – 28 000]
Togo	56 000	[28 000 – 88 000]	9700	[3700 – 22 000]	8300	[3200 – 19 000]
Uganda	490 000	[420 000 – 550 000]	110 000	[39 000 – 200 000]	110 000	[37 000 – 200 000]
United Republic of Tanzania	680 000	[610 000 – 750 000]	110 000	[43 000 – 210 000]	120 000	[45 000 – 220 000]
Zambia	540 000	[510 000 – 580 000]	130 000	[53 000 – 250 000]	120 000	[51 000 – 240 000]
Zimbabwe	930 000	[540 000 – 1 300 000]	160 000	[54 000 – 340 000]	160 000	[51 000 – 340 000]

					2. AIDS deaths			
Young women (15–24) rate (%) 2005			Young men (15–24) rate (%) 2005		Deaths in adults and children 2005		Deaths in adults and children 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Global					2 800 000	[2 400 000 – 3 300 000]	2 600 000	[2 200 000 – 3 100 000]
Sub-Saharan Africa	4.3	[3.7 – 5.1]	1.5	[1.3 – 1.7]	2 000 000	[1 700 000 – 2 300 000]	1 900 000	[1 700 000 – 2 300 000]
Angola	2.5	[1.2 – 4.2]	0.9	[0.4 – 1.4]	30 000	[18 000 – 47 000]	29 000	[17 000 – 45 000]
Benin	1.1	[0.6 – 1.8]	0.4	[0.2 – 0.6]	9600	[5900 – 15 000]	9400	[5700 – 14 000]
Botswana	15.3	[15.2 – 20.3]	5.7	[5.6 – 7.5]	18 000	[17 000 – 25 000]	18 000	[16 000 – 23 000]
Burkina Faso	1.4	[0.8 – 2.0]	0.5	[0.3 – 0.6]	12 000	[8400 – 17 000]	14 000	[9600 – 19 000]
Burundi	2.3	[2.0 – 2.7]	0.8	[0.7 – 0.9]	13 000	[6800 – 18 000]	15 000	[11 000 – 19 000]
Cameroon	4.9	[4.4 – 5.3]	1.4	[1.3 – 1.6]	46 000	[36 000 – 55 000]	41 000	[33 000 – 50 000]
Central African Republic	7.3	[2.7 – 13.1]	2.5	[0.9 – 4.5]	24 000	[10 000 – 39 000]	23 000	[9900 – 38 000]
Chad	2.2	[0.9 – 3.9]	0.9	[0.4 – 1.6]	11 000	[5300 – 20 000]	11 000	[5100 – 20 000]
Comoros	<0.1	[<0.2]	<0.1	[<0.2]	<100	[<200]	<100	[<200]
Congo	3.7	[1.9 – 5.7]	1.2	[0.6 – 1.9]	11 000	[6700 – 17 000]	11 000	[6900 – 17 000]
Côte d'Ivoire	5.1	[2.6 – 7.9]	1.7	[0.9 – 2.7]	65 000	[39 000 – 96 000]	63 000	[38 000 – 93 000]
Democratic Republic of the Congo	2.2	[1.0 – 3.8]	0.8	[0.3 – 1.3]	90 000	[47 000 – 150 000]	85 000	[44 000 – 140 000]
Djibouti	2.1	[0.5 – 4.6]	0.7	[0.2 – 1.6]	1200	[350 – 2800]	1100	[320 – 2400]
Equatorial Guinea	2.3	[1.8 – 2.7]	0.7	[0.6 – 0.9]	<1000	[<2000]	<1000	[<2000]
Eritrea	1.6	[0.7 – 2.7]	0.6	[0.3 – 1.0]	5600	[2900 – 9600]	5300	[2700 – 8900]
Ethiopia (1)	...	[0.5 – 2.3]	...	[0.2 – 0.8]	...	[38 000 – 130 000]	...	[38 000 – 130 000]
Gabon	5.4	[2.7 – 8.7]	1.8	[0.9 – 3.0]	4700	[2800 – 7000]	3700	[2200 – 5700]
Gambia	1.7	[0.7 – 2.9]	0.6	[0.2 – 1.0]	1300	[670 – 2200]	<1000	[<2000]
Ghana	1.3	[1.1 – 1.5]	0.2	[0.2 – 0.3]	29 000	[21 000 – 36 000]	26 000	[19 000 – 33 000]
Guinea	1.4	[1.1 – 1.6]	0.5	[0.4 – 0.5]	7100	[4700 – 9900]	6000	[3700 – 9100]
Guinea-Bissau	2.5	[1.1 – 4.3]	0.9	[0.4 – 1.5]	2700	[1400 – 4400]	2200	[1200 – 3600]
Kenya	5.2	[4.5 – 6.0]	1.0	[0.9 – 1.2]	140 000	[110 000 – 170 000]	140 000	[110 000 – 180 000]
Lesotho	14.1	[13.3 – 15.0]	5.9	[5.5 – 6.2]	23 000	[20 000 – 27 000]	22 000	[20 000 – 26 000]
Liberia	...	...	...	...	...	...	...	...
Madagascar	0.3	[0.1 – 0.6]	0.6	[0.2 – 1.3]	2900	[1100 – 6500]	2100	[760 – 4400]
Malawi	9.6	[3.9 – 16.8]	3.4	[1.4 – 5.9]	78 000	[38 000 – 120 000]	86 000	[42 000 – 140 000]
Mali	1.2	[0.9 – 1.5]	0.4	[0.3 – 0.5]	11 000	[7400 – 16 000]	13 000	[8300 – 18 000]
Mauritania	0.5	[0.2 – 1.0]	0.2	[0.1 – 0.3]	<1000	[<2000]	<1000	[<2000]
Mauritius	...	...	...	...	<100	[<200]	<100	[<200]
Mozambique	10.7	[6.0 – 15.8]	3.6	[2.0 – 5.3]	140 000	[100 000 – 200 000]	120 000	[81 000 – 160 000]
Namibia	13.4	[5.2 – 24.7]	4.4	[1.7 – 8.1]	17 000	[7800 – 27 000]	16 000	[7300 – 25 000]
Niger	0.8	[0.3 – 1.4]	0.2	[0.1 – 0.4]	7600	[3400 – 13 000]	6800	[2900 – 12 000]
Nigeria	2.7	[1.3 – 4.4]	0.9	[0.4 – 1.5]	220 000	[120 000 – 330 000]	190 000	[100 000 – 290 000]
Rwanda	1.9	[1.9 – 2.0]	0.8	[0.7 – 0.8]	21 000	[13 000 – 26 000]	25 000	[17 000 – 33 000]
Senegal	0.6	[0.2 – 1.1]	0.2	[0.1 – 0.4]	5200	[2500 – 8600]	4000	[2000 – 6500]
Sierra Leone	1.1	[0.6 – 1.7]	0.4	[0.2 – 0.6]	4600	[2600 – 7500]	5000	[2800 – 7900]
Somalia	0.6	[0.3 – 1.1]	0.2	[0.1 – 0.4]	4100	[2000 – 8000]	3700	[1700 – 7600]
South Africa	14.8	[13.2 – 16.3]	4.5	[4.0 – 4.9]	320 000	[270 000 – 380 000]	290 000	[230 000 – 350 000]
Swaziland	22.7	[11.5 – 35.9]	7.7	[3.9 – 12.1]	16 000	[10 000 – 23 000]	12 000	[7800 – 18 000]
Togo	2.2	[1.0 – 3.6]	0.8	[0.4 – 1.2]	9100	[5000 – 14 000]	8100	[4500 – 13 000]
Uganda	5.0	[4.2 – 5.7]	2.3	[1.9 – 2.6]	91 000	[54 000 – 130 000]	110 000	[71 000 – 140 000]
United Republic of Tanzania	3.8	[3.4 – 4.2]	2.8	[2.5 – 3.1]	140 000	[110 000 – 180 000]	150 000	[120 000 – 180 000]
Zambia	12.7	[11.9 – 13.6]	3.8	[3.6 – 4.0]	98 000	[77 000 – 120 000]	100 000	[81 000 – 130 000]
Zimbabwe	14.7	[7.7 – 23.2]	4.4	[2.3 – 6.9]	180 000	[120 000 – 250 000]	200 000	[130 000 – 270 000]

3. Orphans due to AIDS					4. Trend of HIV prevalence (%) in young (15–24) pregnant women in capital city			
Orphans (0–17) currently living 2005			Orphans (0–17) living in 2003					
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Year	HIV (%)	Year	HIV (%)
Global	15 200 000	[13 300 000 – 17 000 000]	12 600 000	[11 000 000 – 14 200 000]				
Sub-Saharan Africa	12 000 000	[10 600 000 – 13 600 000]	10 200 000	[8 900 000 – 11 500 000]				
Angola	160 000	[95 000 – 230 000]	120 000	[72 000 – 180 000]	2001	6.3	2004	2.8
Benin	62 000	[38 000 – 89 000]	47 000	[28 000 – 69 000]	2001	4.1	...	...
Botswana	120 000	[110 000 – 150 000]	100 000	[95 000 – 140 000]	2000	33.6	2005	33.5
Burkina Faso	120 000	[89 000 – 150 000]	100 000	[76 000 – 140 000]	2002	3.3	2005	1.8
Burundi	120 000	[94 000 – 170 000]	120 000	[95 000 – 150 000]	2000	12.6	2004	8.6
Cameroon	240 000	[200 000 – 290 000]	190 000	[150 000 – 240 000]	...	...	...	...
Central African Republic	140 000	[62 000 – 200 000]	110 000	[52 000 – 170 000]	...	...	...	...
Chad	57 000	[28 000 – 97 000]	38 000	[19 000 – 66 000]	...	...	2005	3.6
Comoros	...	...	...	...	...	...	...	...
Congo	110 000	[70 000 – 150 000]	100 000	[67 000 – 140 000]	...	...	...	...
Côte d'Ivoire	450 000	[280 000 – 630 000]	410 000	[250 000 – 590 000]	2001	10.0	...	...
Democratic Republic of the Congo	680 000	[380 000 – 1 000 000]	640 000	[360 000 – 960 000]	...	...	...	...
Djibouti	5700	[1900 – 12 000]	4000	[1400 – 9400]	...	...	...	...
Equatorial Guinea	4600	[3500 – 5900]	3700	[2800 – 4800]	...	...	...	...
Eritrea	36 000	[20 000 – 56 000]	28 000	[15 000 – 44 000]	...	...	...	...
Ethiopia (1)	...	[280 000 – 870 000]	...	[230 000 – 730 000]	2000	15.0	2003	11.5
Gabon	20 000	[13 000 – 29 000]	15 000	[9100 – 22 000]	...	...	...	...
Gambia	3800	[2200 – 6000]	2800	[1600 – 4 300]	...	...	...	...
Ghana	170 000	[130 000 – 210 000]	130 000	[100 000 – 170 000]	2000	2.7	...	...
Guinea	28 000	[18 000 – 43 000]	20 000	[12 000 – 34 000]	...	...	2004	4.4
Guinea-Bissau	11 000	[6000 – 16 000]	7200	[4000 – 11 000]	...	...	...	...
Kenya	1 100 000	[890 000 – 1 300 000]	950 000	[770 000 – 1 200 000]	...	...	...	...
Lesotho	97 000	[88 000 – 110 000]	75 000	[67 000 – 85 000]	...	...	2005	27.3
Liberia	...	...	...	...	...	...	...	...
Madagascar	13 000	[5000 – 24 000]	8200	[3300 – 15 000]	...	...	...	...
Malawi	550 000	[310 000 – 780 000]	440 000	[250 000 – 630 000]	2001	15.0	...	...
Mali	94 000	[70 000 – 120 000]	83 000	[60 000 – 110 000]	...	...	...	...
Mauritania	6900	[3900 – 10 000]	5700	[2600 – 9200]	...	...	...	...
Mauritius	...	...	...	...	...	...	...	...
Mozambique	510 000	[390 000 – 670 000]	330 000	[240 000 – 450 000]	2000	11.7	...	...
Namibia	85 000	[42 000 – 120 000]	67 000	[33 000 – 99 000]	...	...	2004	7.5
Niger	46 000	[20 000 – 85 000]	35 000	[14 000 – 79 000]	...	...	...	...
Nigeria	930 000	[510 000 – 1 300 000]	660 000	[350 000 – 980 000]	...	...	...	...
Rwanda	210 000	[170 000 – 260 000]	220 000	[170 000 – 270 000]	2001	9.8	...	...
Senegal	25 000	[14 000 – 39 000]	18 000	[10 000 – 28 000]	...	...	...	...
Sierra Leone	31 000	[19 000 – 49 000]	28 000	[17 000 – 44 000]	...	...	...	...
Somalia	23 000	[11 000 – 45 000]	18 000	[7600 – 38 000]	...	...	...	...
South Africa	1 200 000	[970 000 – 1 400 000]	780 000	[620 000 – 950 000]	2001	23.1	2004	25.2
Swaziland	63 000	[45 000 – 77 000]	46 000	[32 000 – 59 000]	2000	34.4	2004	37.3
Togo	88 000	[51 000 – 130 000]	70 000	[40 000 – 110 000]	2001	5.4	2004	9.3
Uganda	1 000 000	[870 000 – 1 300 000]	1 000 000	[850 000 – 1 200 000]	2000	8.5	2005	5.2
United Republic of Tanzania	1 100 000	[910 000 – 1 200 000]	970 000	[830 000 – 1 100 000]	2000	7.5	...	...
Zambia	710 000	[630 000 – 830 000]	650 000	[570 000 – 770 000]	...	...	2004	20.7
Zimbabwe	1 100 000	[780 000 – 1 300 000]	1 000 000	[720 000 – 1 200 000]	2001	29.8	2004	18.6

5. Trends of HIV prevalence (%) in most-at-risk groups in capital city												
Injecting drug users					Female sex workers				Men who have sex with men			
Country	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)
Global												
Sub-Saharan Africa												
Angola	2001	33.3	...	...	...	...	...	...
Benin	2001	60.5	...	...	...	...	...	...
Botswana
Burkina Faso	2005	20.8	...	...	...	...
Burundi
Cameroon
Central African Republic
Chad
Comoros
Congo
Côte d'Ivoire	2000	28.0	...	...	...	...	...	...
Democratic Republic of the Congo	2004	12.4	...	...	...	...
Djibouti
Equatorial Guinea
Eritrea
Ethiopia (1)
Gabon	2005	40.4	...	...	...	...
Gambia
Ghana
Guinea	2001	39.7	...	...	...	...	...	...
Guinea-Bissau
Kenya	2000	25.5	...	...	...	...	...	...
Lesotho
Liberia
Madagascar	2001	0.2	...	...	...	...	...	...
Malawi
Mali	2000	21.0	2005	31.6	...	...	...	...
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Senegal	2000	13.0	2005	27.1	...	...	2005	21.5
Sierra Leone
Somalia
South Africa
Swaziland
Togo	2005	53.9	...	...	...	...
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

1. Estimated number of people living with HIV						
Adults and children 2005			Adults and children 2003		Adults (15 +) 2005	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
East Asia	680 000	[420 000 – 1 100 000]	560 000	[350 000 – 910 000]	680 000	[420 000 – 1 100 000]
China	650 000	[390 000 – 1 100 000]	530 000	[320 000 – 880 000]	650 000	[390 000 – 1 100 000]
Democratic People's Republic of Korea	...	...	...	...	...	...
Japan	17 000	[10 000 – 29 000]	17 000	[10 000 – 28 000]	17 000	[10 000 – 28 000]
Mongolia	<500	[<2000]	<500	[<1000]	<500	[<2000]
Republic of Korea	13 000	[7900 – 25 000]	9400	[6100 – 14 000]	13 000	[7800 – 25 000]
Oceania	78 000	[48 000 – 170 000]	66 000	[41 000 – 140 000]	75 000	[46 000 – 160 000]
Australia	16 000	[9700 – 27 000]	14 000	[8300 – 23 000]	16 000	[9600 – 27 000]
Fiji	<1000	[320 – 2100]	<500	[<2000]	<1000	[320 – 2100]
New Zealand	1400	[840 – 2300]	1400	[840 – 2300]	1400	[840 – 2300]
Papua New Guinea	60 000	[32 000 – 140 000]	51 000	[27 000 – 120 000]	57 000	[31 000 – 140 000]
South and South-East Asia	7 600 000	[5 100 000 – 11 700 000]	7 000 000	[4 700 000 – 10 800 000]	7 400 000	[5 000 000 – 11 500 000]
Afghanistan	<1000	[<2000]	<500	[<1000]	<1000	[<2000]
Bangladesh	11 000	[6400 – 18 000]	7500	[4500 – 12 000]	11 000	[6400 – 18 000]
Bhutan	<500	[<2000]	<100	[<1000]	<500	[<2000]
Brunei Darussalam	<100	[<200]	<100	[<200]	<100	[<200]
Cambodia	130 000	[74 000 – 210 000]	150 000	[83 000 – 230 000]	130 000	[70 000 – 200 000]
India (2)	5 700 000	[3 400 000 – 9 400 000]	5 300 000	[3 200 000 – 8 800 000]	5 600 000	[3 400 000 – 9 300 000]
Indonesia	170 000	[100 000 – 290 000]	110 000	[68 000 – 190 000]	170 000	[100 000 – 290 000]
Iran (Islamic Republic of)	66 000	[36 000 – 160 000]	37 000	[20 000 – 88 000]	66 000	[35 000 – 160 000]
Lao People's Democratic Republic	3700	[1800 – 12 000]	1700	[820 – 5500]	3600	[1700 – 12 000]
Malaysia	69 000	[33 000 – 220 000]	57 000	[27 000 – 180 000]	67 000	[32 000 – 220 000]
Maldives	...	...	...	...	...	...
Myanmar	360 000	[200 000 – 570 000]	390 000	[210 000 – 600 000]	350 000	[200 000 – 550 000]
Nepal	75 000	[41 000 – 180 000]	65 000	[35 000 – 160 000]	74 000	[40 000 – 180 000]
Pakistan	85 000	[46 000 – 210 000]	56 000	[30 000 – 130 000]	84 000	[45 000 – 210 000]
Philippines	12 000	[7300 – 20 000]	9500	[5700 – 16 000]	12 000	[7200 – 20 000]
Singapore	5500	[3100 – 14 000]	4700	[2600 – 12 000]	5500	[3000 – 14 000]
Sri Lanka	5000	[3000 – 8300]	3100	[1900 – 4400]	5000	[3000 – 8300]
Thailand	580 000	[330 000 – 920 000]	590 000	[320 000 – 900 000]	560 000	[320 000 – 900 000]
Timor-Leste	...	...	...	...	...	...
Viet Nam	260 000	[150 000 – 430 000]	210 000	[130 000 – 350 000]	250 000	[150 000 – 420 000]

1. Estimated number of people living with HIV								
Adults (15 +) 2003			Adult (15–49) rate (%) 2005		Adult (15–49) rate (%) 2003		Women (15 +) 2005	
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]
East Asia	560 000	[340 000 – 910 000]	0.1	[<0.2]	0.1	[<0.2]	190 000	[110 000 – 330 000]
China	530 000	[320 000 – 880 000]	0.1	[<0.2]	0.1	[<0.2]	180 000	[90 000 – 310 000]
Democratic People's Republic of Korea	...	...	...	[<0.2]	...	...	...	...
Japan	17 000	[10 000 – 28 000]	<0.1	[<0.2]	<0.1	[<0.2]	9900	[5000 – 17 000]
Mongolia	<500	[<1000]	<0.1	[<0.2]	<0.1	[<0.2]	<100	[<200]
Republic of Korea	9300	[6000 – 14 000]	<0.1	[<0.2]	<0.1	[<0.2]	7400	[3900 – 16 000]
Oceania	64 000	[40 000 – 140 000]	0.3	[0.2 – 0.8]	0.3	[0.2 – 0.7]	35 000	[17 000 – 86 000]
Australia	14 000	[8200 – 23 000]	0.1	[<0.2]	0.1	[<0.2]	<1000	[<2000]
Fiji	<500	[<2000]	0.1	[0.1 – 0.4]	0.1	[<0.1 – 0.3]	<500	[<1000]
New Zealand	1400	[840 – 2300]	0.1	[<0.2]	0.1	[<0.2]	...	...
Papua New Guinea	49 000	[26 000 – 120 000]	1.8	[0.9 – 4.4]	1.6	[0.9 – 3.9]	34 000	[16 000 – 85 000]
South and South-East Asia	6 900 000	[4 600 000 – 10 600 000]	0.6	[0.4 – 1.0]	0.6	[0.4 – 0.9]	2 200 000	[1 300 000 – 3 500 000]
Afghanistan	<500	[<1000]	<0.1	[<0.2]	<0.1	[<0.2]	<100	[<1000]
Bangladesh	7500	[4500 – 12 000]	<0.1	[<0.2]	<0.1	[<0.2]	1400	[710 – 2500]
Bhutan	<100	[<1000]	<0.1	[<0.2]	<0.1	[<0.2]	<100	[<200]
Brunei Darussalam	<100	[<200]	<0.1	[<0.2]	<0.1	[<0.2]	<100	[<200]
Cambodia	140 000	[79 000 – 220 000]	1.6	[0.9 – 2.6]	2.0	[1.1 – 3.1]	59 000	[28 000 – 99 000]
India (2)	5 200 000	[3 100 000 – 8 700 000]	0.9	[0.5 – 1.5]	0.9	[0.5 – 1.5]	1 600 000	[820 000 – 2 800 000]
Indonesia	110 000	[68 000 – 190 000]	0.1	[0.1 – 0.2]	0.1	[0.1 – 0.2]	29 000	[15 000 – 52 000]
Iran (Islamic Republic of)	37 000	[20 000 – 89 000]	0.2	[0.1 – 0.4]	0.1	[<0.1 – 0.2]	11 000	[5200 – 28 000]
Lao People's Democratic Republic	1700	[810 – 5500]	0.1	[0.1 – 0.4]	0.1	[<0.1 – 0.2]	<1000	[260 – 2000]
Malaysia	56 000	[27 000 – 180 000]	0.5	[0.2 – 1.5]	0.4	[0.2 – 1.3]	17 000	[7300 – 57 000]
Maldives	...	...	...	[<0.2]	...	...	...	...
Myanmar	380 000	[210 000 – 590 000]	1.3	[0.7 – 2.0]	1.4	[0.7 – 2.2]	110 000	[53 000 – 190 000]
Nepal	64 000	[34 000 – 150 000]	0.5	[0.3 – 1.3]	0.5	[0.3 – 1.2]	16 000	[7500 – 40 000]
Pakistan	55 000	[30 000 – 130 000]	0.1	[0.1 – 0.2]	0.1	[<0.1 – 0.2]	14 000	[6600 – 36 000]
Philippines	9400	[5700 – 16 000]	<0.1	[<0.2]	<0.1	[<0.2]	3400	[1800 – 6000]
Singapore	4700	[2600 – 12 000]	0.3	[0.2 – 0.7]	0.3	[0.1 – 0.6]	1500	[700 – 3700]
Sri Lanka	3100	[1900 – 4400]	<0.1	[<0.2]	<0.1	[<0.2]	<1000	[<1000]
Thailand	570 000	[310 000 – 880 000]	1.4	[0.7 – 2.1]	1.4	[0.7 – 2.1]	220 000	[100 000 – 370 000]
Timor-Leste	...	...	...	[<0.2]	...	...	...	...
Viet Nam	210 000	[130 000 – 350 000]	0.5	[0.3 – 0.9]	0.4	[0.3 – 0.7]	84 000	[43 000 – 150 000]

1. Estimated number of people living with HIV						
Women (15 +) 2003			Children (0–14) 2005		Children (0–14) 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
East Asia	140 000	[78 000 – 240 000]	6400	[2000 – 16 000]	4700	[1500 – 11 000]
China	130 000	[65 000 – 230 000]	...	...	...	...
Democratic People's Republic of Korea	...	...	...	...	...	...
Japan	9600	[4900 – 17 000]	...	...	...	...
Mongolia	...	...	...	...	...	...
Republic of Korea	5500	[3000 – 9000]	...	...	...	...
Oceania	30 000	[14 000 – 73 000]	3000	[830 – 7900]	2200	[630 – 5800]
Australia	<1000	[<2000]	...	...	...	...
Fiji	<100	[<1000]	...	...	...	...
New Zealand	...	...	...	...	...	...
Papua New Guinea	29 000	[13 000 – 72 000]	...	...	...	...
South and South-East Asia	2 000 000	[1 200 000 – 3 200 000]	170 000	[70 000 – 380 000]	150 000	[61 000 – 330 000]
Afghanistan	<100	[<200]	...	...	...	...
Bangladesh	<500	[<1000]	...	...	...	...
Bhutan	...	...	...	...	...	...
Brunei Darussalam	...	...	...	...	...	...
Cambodia	65 000	[31 000 – 110 000]	...	...	...	...
India (2)	1 500 000	[750 000 – 2 600 000]	...	...	...	...
Indonesia	15 000	[7700 – 26 000]	...	...	...	...
Iran (Islamic Republic of)	4800	[2300 – 12 000]	...	...	...	...
Lao People's Democratic Republic	<500	[<1000]	...	...	...	...
Malaysia	14 000	[5800 – 45 000]	...	...	...	...
Maldives	...	...	...	...	...	...
Myanmar	120 000	[57 000 – 200 000]	...	...	...	...
Nepal	13 000	[6000 – 32 000]	...	...	...	...
Pakistan	7300	[3400 – 18 000]	...	...	...	...
Philippines	1900	[970 – 3300]	...	...	...	...
Singapore	1200	[570 – 3000]	...	...	...	...
Sri Lanka	<100	[<200]	...	...	...	...
Thailand	220 000	[99 000 – 350 000]	16 000	[5400 – 38 000]	17 000	[5300 – 38 000]
Timor-Leste	...	...	...	...	...	...
Viet Nam	64 000	[33 000 – 110 000]	...	...	...	...

					2. AIDS deaths			
Young women (15–24) rate (%) 2005			Young men (15–24) rate (%) 2005		Deaths in adults and children 2005		Deaths in adults and children 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
East Asia	<0.1	[<0.2]	0.1	[<0.2]	33 000	[20 000 – 49 000]	28 000	[17 000 – 42 000]
China	31 000	[18 000 – 46 000]	26 000	[16 000 – 40 000]
Democratic People's Republic of Korea
Japan	1400	[830 – 2100]	1300	[<2000]
Mongolia	<100	[<200]	...	...
Republic of Korea	<500	[<1000]	<500	[<1000]
Oceania					3400	[1900 – 5500]	2300	[1300 – 3600]
Australia	<500	[<1000]	<500	[<1000]
Fiji	<100	[<200]	<100	[<200]
New Zealand
Papua New Guinea	3300	[1800 – 5400]	2100	[1200 – 3500]
South and South-East Asia	0.4	[0.2 – 0.6]	0.6	[0.4 – 1.1]	560 000	[370 000 – 810 000]	470 000	[310 000 – 680 000]
Afghanistan	<100	[<200]	<100	[<200]
Bangladesh	<500	[<1000]	<500	[<1000]
Bhutan	<100	[<200]	<100	[<200]
Brunei Darussalam	<100	[<200]	...	...
Cambodia	16 000	[8500 – 26 000]	17 000	[9100 – 28 000]
India (2)	[270 000 – 680 000]	...	[220 000 – 540 000]
Indonesia	5500	[3300 – 8300]	2300	[1400 – 3500]
Iran (Islamic Republic of)	1600	[920 – 2700]	<1000	[<1000]
Lao People's Democratic Republic	<100	[<200]	<100	[<200]
Malaysia	4000	[2100 – 7200]	1900	[990 – 3400]
Maldives
Myanmar	37 000	[20 000 – 62 000]	36 000	[19 000 – 59 000]
Nepal	5100	[2800 – 8400]	4000	[2200 – 6600]
Pakistan	3000	[1700 – 4900]	1500	[830 – 2500]
Philippines	<1000	[<1000]	<500	[<1000]
Singapore	<100	[<200]	<500	[<1000]
Sri Lanka	<500	[<1000]	<100	[<200]
Thailand	21 000	[14 000 – 42 000]	40 000	[22 000 – 67 000]
Timor-Leste
Viet Nam	13 000	[7800 – 20 000]	8900	[5300 – 13 000]

3. Orphans due to AIDS					4. Trend of HIV prevalence (%) in young (15–24) pregnant women in capital city			
Orphans (0–17) currently living 2005			Orphans (0–17) living in 2003					
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Year	HIV (%)	Year	HIV (%)
East Asia								
China
Democratic People's Republic of Korea
Japan
Mongolia
Republic of Korea
Oceania								
Australia
Fiji
New Zealand
Papua New Guinea
South and South-East Asia								
Afghanistan
Bangladesh
Bhutan
Brunei Darussalam
Cambodia
India (2)
Indonesia
Iran (Islamic Republic of)
Lao People's Democratic Republic
Malaysia
Maldives
Myanmar
Nepal
Pakistan
Philippines
Singapore
Sri Lanka
Thailand
Timor-Lesie
Viet Nam

5. Trends of HIV prevalence (%) in most-at-risk groups in capital city												
Injecting drug users					Female sex workers				Men who have sex with men			
Country	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)
East Asia												
China	2000	0.0	2005	8.3	2000	0.2	2005	0.5	...	...	2005	1.5
Democratic People's Republic of Korea	...	...	...	...	...	...	...	...	...	...	...	...
Japan	...	...	...	...	...	...	...	...	2000	2.9	...	...
Mongolia	...	...	...	...	...	...	2005	0.0	...	...	2005	4.8
Republic of Korea	...	...	...	...	...	...	...	...	...	...	...	...
Oceania												
Australia	...	...	...	...	...	...	...	...	...	...	...	...
Fiji	...	...	...	...	...	...	...	...	...	...	...	...
New Zealand	...	...	...	...	...	...	...	...	...	...	...	...
Papua New Guinea	...	...	...	...	2000	16.0	...	...	...	...	...	...
South and South-East Asia												
Afghanistan	...	...	...	...	...	...	...	...	...	...	...	...
Bangladesh	...	...	2005	4.9	...	...	2004	0.2	...	...	2005	0.4
Bhutan	...	...	...	...	...	...	...	...	...	...	...	...
Brunei Darussalam	...	...	...	...	...	...	...	...	...	...	...	...
Cambodia	...	...	...	...	2000	26.3	...	...	...	...	...	...
India (2)	2000	5.0	...	...	2000	9.4	...	...	...	...	...	...
Indonesia	2000	65.5	...	...	2000	0.0	...	...	...	...	...	...
Iran (Islamic Republic of)	...	...	...	...	...	...	...	...	...	...	...	...
Lao People's Democratic Republic	...	...	...	...	2001	1.1	...	...	...	...	...	...
Malaysia	...	...	...	...	2000	6.9	...	...	...	...	...	...
Maldives	...	...	...	...	...	...	...	...	...	...	...	...
Myanmar	2000	37.1	...	...	2000	26.0	...	...	...	...	...	...
Nepal	2000	50.0	...	...	2000	17.1	2005	2.0	...	...	2005	3.9
Pakistan	2001	0.0	2005	22.9	...	...	...	...	...	...	...	...
Philippines	...	...	2005	1.0	...	...	...	...	...	...	...	...
Singapore	...	...	...	...	...	...	...	...	...	...	...	...
Sri Lanka	...	...	...	...	2000	0.0	...	...	...	...	...	...
Thailand	2000	39.6	2004	38.0	2000	8.5	2004	4.3	...	...	...	...
Timor-Leste	...	...	...	...	...	...	...	...	...	...	...	...
Viet Nam	2000	17.5	2005	30.6	2000	10.0	...	...	...	...	2005	6.5

1. Estimated number of people living with HIV						
Adults and children 2005			Adults and children 2003		Adults (15 +) 2005	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Eastern Europe and Central Asia	1 500 000	[1 000 000 – 2 300 000]	1 100 000	[790 000 – 1 700 000]	1 500 000	[1 000 000 – 2 300 000]
Armenia	2900	[1800 – 5800]	2600	[1700 – 3900]	2900	[1800 – 5800]
Azerbaijan	5400	[2600 – 17 000]	1400	[680 – 4500]	5400	[2600 – 17 000]
Belarus	20 000	[11 000 – 47 000]	18 000	[9800 – 44 000]	20 000	[11 000 – 48 000]
Bosnia and Herzegovina	<500	[<1000]	...	...	...	...
Bulgaria	<500	[<1000]	...	...	...	...
Croatia	<500	[<1000]	...	...	...	...
Estonia	10 000	[4800 – 32 000]	8700	[4200 – 28 000]	10 000	[4800 – 32 000]
Georgia	5600	[2700 – 18 000]	2800	[1500 – 4700]	5600	[2700 – 18 000]
Kazakhstan	12 000	[11 000 – 77 000]	10 000	[9000 – 33 000]	12 000	[11 000 – 76 000]
Kyrgyzstan	4000	[1900 – 13 000]	1100	[<2000]	4000	[1900 – 13 000]
Latvia	10 000	[6100 – 17 000]	7500	[4500 – 12 000]	10 000	[6100 – 17 000]
Lithuania	3300	[1600 – 10 000]	1300	[650 – 4300]	3300	[1600 – 11 000]
Republic of Moldova	29 000	[15 000 – 69 000]	23 000	[13 000 – 56 000]	28 000	[15 000 – 69 000]
Romania	7000	[3400 – 22 000]	6500	[3100 – 21 000]	...	...
Russian Federation	940 000	[560 000 – 1 600 000]	760 000	[460 000 – 1 300 000]	940 000	[560 000 – 1 600 000]
Tajikistan	4900	[2400 – 16 000]	1300	[700 – 2300]	4900	[2300 – 16 000]
Turkmenistan	<500	[<1000]	...	...	<500	[<1000]
Ukraine	410 000	[250 000 – 680 000]	380 000	[240 000 – 550 000]	410 000	[250 000 – 680 000]
Uzbekistan	31 000	[15 000 – 99 000]	11 000	[5500 – 36 000]	31 000	[15 000 – 100 000]

1. Estimated number of people living with HIV								
Adults (15 +) 2003			Adult (15–49) rate (%) 2005		Adult (15–49) rate (%) 2003		Women (15 +) 2005	
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]
Eastern Europe and Central Asia	1 100 000	[780 000 – 1 700 000]	0.8	[0.6 – 1.4]	0.6	[0.4 – 1.0]	420 000	[270 000 – 680 000]
Armenia	2600	[1700 – 3900]	0.1	[0.1 – 0.6]	0.1	[0.1 – 0.2]	<1000	[<2000]
Azerbaijan	1400	[680 – 4600]	0.1	[0.1 – 0.4]	<0.1	[<0.2]	<1000	[300 – 2300]
Belarus	18 000	[9700 – 44 000]	0.3	[0.2 – 0.8]	0.3	[0.2 – 0.8]	5100	[2400 – 13 000]
Bosnia and Herzegovina	...	...	<0.1	[<0.2]	...	...	...	...
Bulgaria	...	...	<0.1	[<0.2]	...	...	...	...
Croatia	...	...	<0.1	[<0.2]	...	...	...	...
Estonia	8600	[4100 – 28 000]	1.3	[0.6 – 4.3]	1.1	[0.5 – 3.7]	2400	[1000 – 7900]
Georgia	2800	[1500 – 4800]	0.2	[0.1 – 2.7]	0.1	[0.1 – 0.2]	<1000	[410 – 3200]
Kazakhstan	10 000	[9000 – 33 000]	0.1	[0.1 – 3.2]	0.1	[0.1 – 0.4]	6800	[5600 – 43 000]
Kyrgyzstan	1100	[<2000]	0.1	[0.1 – 1.7]	<0.1	[<0.2]	<1000	[290 – 2200]
Latvia	7400	[4500 – 12 000]	0.8	[0.5 – 1.3]	0.6	[0.3 – 1.0]	2200	[1100 – 3900]
Lithuania	1300	[640 – 4300]	0.2	[0.1 – 0.6]	0.1	[<0.1 – 0.2]	<1000	[<2000]
Republic of Moldova	23 000	[12 000 – 56 000]	1.1	[0.6 – 2.6]	0.9	[0.5 – 2.2]	16 000	[7400 – 40 000]
Romania	...	...	<0.1	[<0.2]	...	...	...	...
Russian Federation	760 000	[450 000 – 1 300 000]	1.1	[0.7 – 1.8]	0.9	[0.5 – 1.5]	210 000	[110 000 – 370 000]
Tajikistan	1300	[700 – 2300]	0.1	[0.1 – 1.7]	<0.1	[<0.2]	<500	[<2000]
Turkmenistan	...	...	<0.1	[<0.2]	...	...	...	...
Ukraine	380 000	[240 000 – 540 000]	1.4	[0.8 – 4.3]	1.3	[0.8 – 1.9]	200 000	[100 000 – 350 000]
Uzbekistan	11 000	[5400 – 36 000]	0.2	[0.1 – 0.7]	0.1	[<0.1 – 0.3]	4100	[1700 – 13 000]

1. Estimated number of people living with HIV						
Women (15 +) 2003			Children (0–14) 2005		Children (0–14) 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Eastern Europe and Central Asia	310 000	[200 000 – 490 000]	6900	[3400 – 14 000]	5000	[2400 – 10 000]
Armenia	<1000	[<2000]	...	...	...	...
Azerbaijan	<100	[<1000]	...	...	...	...
Belarus	4400	[2100 – 11 000]	...	...	...	...
Bosnia and Herzegovina	...	...	...	...	...	...
Bulgaria	...	...	...	...	...	...
Croatia	...	...	...	...	...	...
Estonia	1900	[800 – 6200]	...	...	...	...
Georgia	<500	[<1000]	...	...	...	...
Kazakhstan	5600	[3800 – 20 000]	...	...	...	...
Kyrgyzstan	<500	[<1000]	...	...	...	...
Latvia	1500	[740 – 2600]	...	...	...	...
Lithuania	<500	[<1000]	...	...	...	...
Republic of Moldova	13 000	[6000 – 32 000]	...	...	...	...
Romania	...	...	...	...	...	...
Russian Federation	160 000	[80 000 – 280 000]	...	...	...	...
Tajikistan	...	...	...	...	...	...
Turkmenistan	...	...	...	...	...	...
Ukraine	180 000	[85 000 – 290 000]	...	...	...	...
Uzbekistan	<1000	[320 – 2500]	...	...	...	...

					2. AIDS deaths			
Young women (15–24) rate (%) 2005			Young men (15–24) rate (%) 2005		Deaths in adults and children 2005		Deaths in adults and children 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Eastern Europe and Central Asia	0.5	[0.3 – 0.8]	0.9	[0.5 – 1.7]	53 000	[36 000 – 75 000]	28 000	[19 000 – 39 000]
Armenia	<500	[<1000]	<100	[<200]
Azerbaijan	<100	[<200]	<100	[<200]
Belarus	[<2000]	...	[<1000]
Bosnia and Herzegovina
Bulgaria
Croatia
Estonia	[<2000]	...	[<1000]
Georgia	<500	[<1000]	<100	[<200]
Kazakhstan	<1000	[<2000]	<1000	[<2000]
Kyrgyzstan	<100	[<200]	<100	[<200]
Latvia	<500	[<1000]	<500	[<1000]
Lithuania	<100	[<200]	<100	[<200]
Republic of Moldova	1400	[810 – 2400]	<1000	[<2000]
Romania
Russian Federation	[22 000 – 56 000]	...	[11 000 – 28 000]
Tajikistan	<100	[<200]	<100	[<200]
Turkmenistan
Ukraine	22 000	[13 000 – 33 000]	14 000	[7300 – 22 000]
Uzbekistan	<500	[<1000]	<100	[<200]

3. Orphans due to AIDS					4. Trend of HIV prevalence (%) in young (15–24) pregnant women in capital city			
Orphans (0–17) currently living 2005			Orphans (0–17) living in 2003					
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Year	HIV (%)	Year	HIV (%)
Eastern Europe and Central Asia								
Armenia
Azerbaijan
Belarus
Bosnia and Herzegovina
Bulgaria
Croatia
Estonia
Georgia
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Republic of Moldova
Romania
Russian Federation
Tajikistan
Turkmenistan
Ukraine
Uzbekistan

5. Trends of HIV prevalence (%) in most-at-risk groups in capital city												
Injecting drug users					Female sex workers				Men who have sex with men			
Country	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)
Eastern Europe and Central Asia												
Armenia	2000	14.2	2005	9.3	2000	0.5	2005	0.4	...	...	...	...
Azerbaijan
Belarus	2005	30.9	...	...	...	...	...	...	...	...
Bosnia and Herzegovina
Bulgaria
Croatia
Estonia
Georgia	2005	1.0	...	...	2005	1.3	...	...	2005	3.2
Kazakhstan
Kyrgyzstan	2005	6.2	...	...	2005	1.7	...	...	...	...
Latvia	2000	19.0	...	...	2001	7.7	...	...	...	...	...	...
Lithuania	2000	1.4	...	...	...	...	...	...
Republic of Moldova	2005	8.5	...	...	2005	2.5
Romania	2005	1.4	...	...	...	...
Russian Federation	2005	12.4	2000	15.3	2005	3.1	...	...	2005	0.5
Tajikistan	2005	12.1	...	...	...	...	...	...	...	...
Turkmenistan
Ukraine	2000	64.0	2005	48.8	...	...	2005	8.0	...	...	...	...
Uzbekistan

1. Estimated number of people living with HIV						
Adults and children 2005			Adults and children 2003		Adults (15 +) 2005	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Western and Central Europe	720 000	[550 000 – 950 000]	680 000	[520 000 – 880 000]	710 000	[550 000 – 950 000]
Albania	...	[<1000]	...	...	...	...
Austria	12 000	[7200 – 20 000]	12 000	[7200 – 20 000]	12 000	[7200 – 20 000]
Belgium	14 000	[8100 – 22 000]	11 000	[6600 – 18 000]	14 000	[8100 – 22 000]
Czech Republic	1500	[900 – 2500]	1500	[900 – 2500]	1500	[900 – 2500]
Denmark	5600	[3400 – 9300]	5100	[3100 – 8400]	5500	[3300 – 9100]
Finland	1900	[1100 – 3100]	1900	[1100 – 3100]	1900	[1100 – 3200]
France	130 000	[78 000 – 210 000]	120 000	[72 000 – 200 000]	130 000	[78 000 – 220 000]
Germany	49 000	[29 000 – 81 000]	44 000	[26 000 – 73 000]	49 000	[29 000 – 81 000]
Greece	9300	[5600 – 15 000]	9200	[5500 – 15 000]	9300	[5600 – 15 000]
Hungary	3200	[1900 – 5300]	3000	[1800 – 5000]	3200	[1900 – 5300]
Iceland	<500	[<1000]	<500	[<1000]	<500	[<1000]
Ireland	5000	[3000 – 8300]	5000	[3000 – 8300]	5000	[3000 – 8300]
Italy	150 000	[90 000 – 250 000]	140 000	[84 000 – 230 000]	150 000	[90 000 – 250 000]
Luxembourg	<1000	[<1000]	<1000	[<1000]	<1000	[<2000]
Malta	<500	[<1000]	<500	[<1000]	<500	[<1000]
Netherlands	18 000	[11 000 – 29 000]	17 000	[10 000 – 27 000]	17 000	[10 000 – 29 000]
Norway	2500	[1500 – 4100]	2000	[1200 – 3300]	2500	[1500 – 4200]
Poland	25 000	[15 000 – 41 000]	25 000	[15 000 – 41 000]	25 000	[15 000 – 42 000]
Portugal	32 000	[19 000 – 53 000]	31 000	[19 000 – 51 000]	32 000	[19 000 – 53 000]
Serbia and Montenegro	10 000	[6000 – 17 000]	9000	[5400 – 15 000]	10 000	[6000 – 17 000]
Slovakia	<500	[<1000]	<500	[<1000]	<500	[<1000]
Slovenia	<500	[<1000]	<500	[<1000]	<500	[<1000]
Spain	140 000	[84 000 – 230 000]	140 000	[84 000 – 230 000]	140 000	[84 000 – 230 000]
Sweden	8000	[4800 – 13 000]	8000	[4800 – 13 000]	8000	[4800 – 13 000]
Switzerland	17 000	[9900 – 27 000]	15 000	[9200 – 25 000]	16 000	[9900 – 27 000]
The former Yugoslav Republic of Macedonia	<500	[<1000]	<500	[<1000]	<500	[<1000]
United Kingdom of Great Britain and Northern Ireland (3)	68 000	[41 000 – 110 000]	54 000	[32 000 – 89 000]	67 000	[40 000 – 110 000]

1. Estimated number of people living with HIV								
Adults (15 +) 2003			Adult (15–49) rate (%) 2005		Adult (15–49) rate (%) 2003		Women (15 +) 2005	
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]
Western and Central Europe	670 000	[510 000 – 880 000]	0.3	[0.2 – 0.4]	0.3	[0.2 – 0.4]	200 000	[150 000 – 290 000]
Albania	...	...	...	[<0.2]	...	...	...	...
Austria	12 000	[7200 – 20 000]	0.3	[0.2 – 0.5]	0.3	[0.2 – 0.5]	2300	[1200 – 4100]
Belgium	11 000	[6600 – 18 000]	0.3	[0.2 – 0.5]	0.2	[0.1 – 0.4]	5400	[2800 – 9500]
Czech Republic	1500	[900 – 2500]	0.1	[<0.2]	<0.1	[<0.2]	<1000	[<1000]
Denmark	5000	[3000 – 8300]	0.2	[0.1 – 0.4]	0.2	[0.1 – 0.3]	1300	[670 – 2300]
Finland	1900	[1100 – 3200]	0.1	[<0.2]	0.1	[<0.2]	<1000	[<2000]
France	120 000	[72 000 – 200 000]	0.4	[0.3 – 0.8]	0.4	[0.3 – 0.7]	45 000	[23 000 – 79 000]
Germany	44 000	[26 000 – 73 000]	0.1	[0.1 – 0.2]	0.1	[0.1 – 0.2]	15 000	[7700 – 26 000]
Greece	9200	[5500 – 15 000]	0.2	[0.1 – 0.3]	0.2	[0.1 – 0.3]	2000	[1000 – 3500]
Hungary	3000	[1800 – 5000]	0.1	[<0.2]	0.1	[<0.2]	<1000	[<2000]
Iceland	<500	[<1000]	0.2	[0.1 – 0.3]	0.2	[0.1 – 0.3]	<100	[<200]
Ireland	5000	[3000 – 8300]	0.2	[0.1 – 0.4]	0.2	[0.1 – 0.4]	1800	[920 – 3200]
Italy	140 000	[84 000 – 230 000]	0.5	[0.3 – 0.9]	0.5	[0.3 – 0.8]	50 000	[26 000 – 88 000]
Luxembourg	<1000	[<2000]	0.2	[0.1 – 0.4]	0.2	[0.2 – 0.4]	...	...
Malta	<500	[<1000]	0.1	[0.1 – 0.2]	0.1	[0.1 – 0.2]	...	...
Netherlands	16 000	[9900 – 27 000]	0.2	[0.1 – 0.4]	0.2	[0.1 – 0.4]	5900	[3000 – 10 000]
Norway	2000	[1200 – 3300]	0.1	[0.1 – 0.2]	0.1	[0.1 – 0.2]	<1000	[<2000]
Poland	25 000	[15 000 – 42 000]	0.1	[0.1 – 0.2]	0.1	[0.1 – 0.2]	7500	[3800 – 13 000]
Portugal	31 000	[19 000 – 51 000]	0.4	[0.3 – 0.9]	0.4	[0.3 – 0.9]	1300	[670 – 2300]
Serbia and Montenegro	9000	[5400 – 15 000]	0.2	[0.1 – 0.3]	0.2	[0.1 – 0.3]	2000	[1000 – 3500]
Slovakia	<500	[<1000]	<0.1	[<0.2]	<0.1	[<0.2]	...	...
Slovenia	<500	[<1000]	<0.1	[<0.2]	<0.1	[<0.2]	...	...
Spain	140 000	[84 000 – 230 000]	0.6	[0.4 – 1.0]	0.7	[0.4 – 1.1]	32 000	[16 000 – 57 000]
Sweden	8000	[4800 – 13 000]	0.2	[0.1 – 0.3]	0.2	[0.1 – 0.3]	2500	[1300 – 4400]
Switzerland	15 000	[9100 – 25 000]	0.4	[0.3 – 0.8]	0.4	[0.3 – 0.7]	5900	[3000 – 10 000]
The former Yugoslav Republic of Macedonia	<500	[<1000]	<0.1	[<0.2]	<0.1	[<0.2]	...	...
United Kingdom of Great Britain and Northern Ireland (3)	53 000	[32 000 – 88 000]	0.2	[0.1 – 0.4]	0.2	[0.1 – 0.3]	21 000	[11 000 – 37 000]

1. Estimated number of people living with HIV						
Women (15 +) 2003			Children (0–14) 2005		Children (0–14) 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Western and Central Europe	190 000	[140 000 – 260 000]	4000	<8000	4000	<8000
Albania	...	...	...	...	...	...
Austria	2300	[1200 – 4100]	...	...	...	...
Belgium	5000	[2600 – 8800]	...	...	...	...
Czech Republic	<1000	[<1000]	...	...	...	...
Denmark	1200	[610 – 2100]	...	...	...	...
Finland	<1000	[<2000]	...	...	...	...
France	40 000	[20 000 – 71 000]	...	...	...	...
Germany	13 000	[6600 – 23 000]	...	...	...	...
Greece	1900	[970 – 3400]	...	...	...	...
Hungary	<1000	[<2000]	...	...	...	...
Iceland	<100	[<200]	...	...	...	...
Ireland	1600	[820 – 2800]	...	...	...	...
Italy	47 000	[24 000 – 83 000]	...	...	...	...
Luxembourg	...	...	...	...	...	...
Malta	...	...	...	...	...	...
Netherlands	5400	[2800 – 9500]	...	...	...	...
Norway	<1000	[<2000]	...	...	...	...
Poland	7500	[3800 – 13 000]	...	...	...	...
Portugal	1200	[610 – 2100]	...	...	...	...
Serbia and Montenegro	2000	[1000 – 3500]	...	...	...	...
Slovakia	...	...	...	...	...	...
Slovenia	...	...	...	...	...	...
Spain	32 000	[16 000 – 57 000]	...	...	...	...
Sweden	2500	[1300 – 4400]	...	...	...	...
Switzerland	5400	[2800 – 9500]	...	...	...	...
The former Yugoslav Republic of Macedonia	...	...	...	...	...	...
United Kingdom of Great Britain and Northern Ireland (3)	16 000	[7900 – 27 000]	...	...	...	...

					2. AIDS deaths			
Young women (15–24) rate (%) 2005			Young men (15–24) rate (%) 2005		Deaths in adults and children 2005		Deaths in adults and children 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Western and Central Europe					12 000	<15 000	12 000	<15 000
Albania
Austria	<100	[<200]	<100	[<200]
Belgium	<100	[<200]	<100	[<200]
Czech Republic	<100	[<200]	<100	[<200]
Denmark	<100	[<200]	<100	[<200]
Finland	<100	[<200]	<100	[<200]
France	1500	[<2500]	1500	[<2500]
Germany	<1000	[<2000]	<1000	[<2000]
Greece	<100	[<200]	<100	[<200]
Hungary
Iceland	<100	[<200]	<100	[<200]
Ireland	<100	[<200]	<100	[<200]
Italy	3000	[<4000]	3000	[<4000]
Luxembourg	<100	[<200]	<100	[<200]
Malta	<100	[<200]	<100	[<200]
Netherlands	<100	[<200]	<100	[<200]
Norway	<100	[<200]	<100	[<200]
Poland	<1000	[<2000]	<1000	[<2000]
Portugal	<1000	[<2000]	<1000	[<2000]
Serbia and Montenegro	<100	[<200]	<100	[<200]
Slovakia
Slovenia	<100	[<200]	<100	[<200]
Spain	2000	[<3000]	2000	[<3000]
Sweden	<100	[<200]	<100	[<200]
Switzerland	<100	[<200]	<100	[<200]
The former Yugoslav Republic of Macedonia	<100	[<200]	<100	[<200]
United Kingdom of Great Britain and Northern Ireland (3)	<1000	[<2000]	<1000	[<2000]

3. Orphans due to AIDS					4. Trend of HIV prevalence (%) in young (15–24) pregnant women in capital city			
Orphans (0–17) currently living 2005			Orphans (0–17) living in 2003					
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Year	HIV (%)	Year	HIV (%)
Western and Central Europe								
Albania
Austria
Belgium
Czech Republic
Denmark
Finland
France
Germany
Greece
Hungary
Iceland
Ireland
Italy
Luxembourg
Malta
Netherlands
Norway
Poland
Portugal
Serbia and Montenegro
Slovakia
Slovenia
Spain
Sweden
Switzerland
The former Yugoslav Republic of Macedonia
United Kingdom of Great Britain and Northern Ireland (3)

5. Trends of HIV prevalence (%) in most-at-risk groups in capital city												
Country	Injecting drug users				Female sex workers				Men who have sex with men			
	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)
Western and Central Europe												
Albania
Austria
Belgium
Czech Republic
Denmark
Finland
France
Germany
Greece
Hungary	2000	2.2	...	...	...	...	...	...	...	...	...	...
Iceland
Ireland
Italy
Luxembourg
Malta
Netherlands	2005	6.5	...	...	2004	32.1
Norway	2005	0.4	...	...	...	...	...	...	...	...
Poland
Portugal
Serbia and Montenegro
Slovakia
Slovenia	2000	3.0	...	...
Spain
Sweden
Switzerland
The former Yugoslav Republic of Macedonia
United Kingdom of Great Britain and Northern Ireland (3)

1. Estimated number of people living with HIV						
Adults and children 2005			Adults and children 2003		Adults (15 +) 2005	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
North Africa and Middle East	440 000	[250 000 – 720 000]	380 000	[220 000 – 620 000]	400 000	[230 000 – 660 000]
Algeria	19 000	[9000 – 59 000]	9800	[4700 – 31 000]	19 000	[8800 – 60 000]
Bahrain	<1000	[<2000]	...	...	...	...
Cyprus	<500	[<1000]	...	...	...	...
Egypt	5300	[2900 – 13 000]	4300	[2300 – 10 000]	5200	[2800 – 13 000]
Iraq	...	...	...	...	...	...
Israel	4000	[2200 – 9800]	...	...	...	...
Jordan	<1000	[<2000]	...	...	...	...
Kuwait	<1000	[<2000]	...	...	...	...
Lebanon	2900	[1400 – 9200]	1600	[770 – 5100]	2900	[1400 – 9300]
Libyan Arab Jamahiriya	...	...	...	...	...	...
Morocco	19 000	[12 000 – 38 000]	17 000	[11 000 – 25 000]	19 000	[12 000 – 38 000]
Oman	...	...	...	...	...	...
Qatar	...	...	...	...	...	...
Saudi Arabia	...	...	...	...	...	...
Sudan	350 000	[170 000 – 580 000]	330 000	[170 000 – 540 000]	320 000	[160 000 – 530 000]
Syrian Arab Republic	...	...	...	...	...	...
Tunisia	8700	[4700 – 21 000]	4400	[2400 – 11 000]	8600	[4600 – 21 000]
Turkey	<2000	[<5000]	...	...	...	...
United Arab Emirates	...	...	...	...	...	...
Yemen	...	...	...	...	...	...
North America	1 300 000	[770 000 – 2 100 000]	1 200 000	[710 000 – 1 900 000]	1 200 000	[770 000 – 2 000 000]
Canada (4)	60 000	[48 000 – 72 000]	56 000	[46 000 – 66 000]	59 000	[47 000 – 71 000]
United States of America	1 200 000	[720 000 – 2 000 000]	1 100 000	[660 000 – 1 800 000]	1 200 000	[720 000 – 2 000 000]
Caribbean	330 000	[240 000 – 420 000]	310 000	[230 000 – 400 000]	300 000	[220 000 – 400 000]
Bahamas	6800	[3300 – 22 000]	5800	[3100 – 9800]	6500	[3100 – 21 000]
Barbados	2700	[1500 – 4200]	2700	[1500 – 4200]	2700	[1500 – 4200]
Cuba	4800	[2300 – 15 000]	4300	[2100 – 14 000]	4700	[2300 – 15 000]
Dominican Republic	66 000	[56 000 – 77 000]	66 000	[57 000 – 76 000]	62 000	[53 000 – 73 000]
Haiti	190 000	[120 000 – 270 000]	180 000	[110 000 – 260 000]	180 000	[100 000 – 250 000]
Jamaica	25 000	[14 000 – 39 000]	24 000	[13 000 – 38 000]	25 000	[14 000 – 39 000]
Trinidad and Tobago	27 000	[15 000 – 42 000]	25 000	[14 000 – 40 000]	26 000	[15 000 – 41 000]

1. Estimated number of people living with HIV								
Adults (15 +) 2003			Adult (15–49) rate (%) 2005		Adult (15–49) rate (%) 2003		Women (15 +) 2005	
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]
North Africa and Middle East	350 000	[200 000 – 580 000]	0.2	[0.1 – 0.4]	0.2	[0.1 – 0.3]	190 000	[95 000 – 350 000]
Algeria	9700	[4600 – 31 000]	0.1	[<0.2]	0.1	[<0.2]	4100	[1700 – 13 000]
Bahrain	...	...	...	[<0.2]	...	...	...	...
Cyprus	...	...	...	[<0.2]	...	...	...	...
Egypt	4200	[2300 – 10 000]	<0.1	[<0.2]	<0.1	[<0.2]	<1000	[430 – 2300]
Iraq	...	...	...	[<0.2]	...	...	...	...
Israel	...	...	...	[<0.2]	...	...	...	...
Jordan	...	...	...	[<0.2]	...	...	...	...
Kuwait	...	...	...	[<0.2]	...	...	...	...
Lebanon	1600	[760 – 5100]	0.1	[0.1 – 0.5]	0.1	[<0.1 – 0.3]	<1000	[270 – 2100]
Libyan Arab Jamahiriya	...	...	...	[<0.2]	...	...	...	...
Morocco	17 000	[11 000 – 25 000]	0.1	[0.1 – 0.4]	0.1	[<0.2]	4000	[2100 – 8400]
Oman	...	...	...	[<0.2]	...	...	...	...
Qatar	...	...	...	[<0.2]	...	...	...	...
Saudi Arabia	...	...	...	[<0.2]	...	...	...	...
Sudan	300 000	[160 000 – 500 000]	1.6	[0.8 – 2.7]	1.6	[0.8 – 2.7]	180 000	[80 000 – 320 000]
Syrian Arab Republic	...	...	...	[<0.2]	...	...	...	...
Tunisia	4400	[2400 – 11 000]	0.1	[0.1 – 0.3]	0.1	[<0.1 – 0.2]	1900	[860 – 4700]
Turkey	...	...	...	[<0.2]	...	...	...	...
United Arab Emirates	...	...	...	[<0.2]	...	...	...	...
Yemen	...	...	...	[<0.2]	...	...	...	...
North America	1 100 000	[700 000 – 1 900 000]	0.8	[0.5 – 1.1]	0.7	[0.4 – 1.0]	310 000	[170 000 – 550 000]
Canada (4)	55 000	[45 000 – 65 000]	0.3	[0.2 – 0.5]	0.3	[0.2 – 0.5]	9600	[7700 – 12 000]
United States of America	1 100 000	[660 000 – 1 800 000]	0.6	[0.4 – 1.0]	0.6	[0.4 – 1.0]	300 000	[150 000 – 530 000]
Caribbean	290 000	[210 000 – 370 000]	1.6	[1.1 – 2.2]	1.5	[1.1 – 2.0]	160 000	[100 000 – 220 000]
Bahamas	5500	[2900 – 9300]	3.3	[1.3 – 4.5]	2.9	[1.5 – 4.9]	3800	[1600 – 13 000]
Barbados	2700	[1500 – 4200]	1.5	[0.8 – 2.5]	1.6	[0.9 – 2.5]	<1000	[<2000]
Cuba	4200	[2000 – 14 000]	0.1	[<0.2]	0.1	[<0.2]	2600	[1100 – 8500]
Dominican Republic	63 000	[54 000 – 72 000]	1.1	[0.9 – 1.3]	1.2	[1.0 – 1.3]	31 000	[27 000 – 37 000]
Haiti	170 000	[98 000 – 230 000]	3.8	[2.2 – 5.4]	3.8	[2.2 – 5.4]	96 000	[50 000 – 150 000]
Jamaica	24 000	[13 000 – 37 000]	1.5	[0.8 – 2.4]	1.5	[0.8 – 2.4]	6900	[3300 – 12 000]
Trinidad and Tobago	25 000	[14 000 – 39 000]	2.6	[1.4 – 4.2]	2.6	[1.4 – 4.1]	15 000	[6900 – 24 000]

1. Estimated number of people living with HIV						
Women (15 +) 2003			Children (0–14) 2005		Children (0–14) 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
North Africa and Middle East	180 000	[84 000 – 320 000]	31 000	[12 000 – 75 000]	28 000	[11 000 – 69 000]
Algeria	2000	[850 – 6600]	...	...	...	...
Bahrain	...	...	...	...	...	...
Cyprus	...	...	...	...	...	...
Egypt	<1000	[<2000]	...	...	...	...
Iraq	...	...	...	...	...	...
Israel	...	...	...	...	...	...
Jordan	...	...	...	...	...	...
Kuwait	...	...	...	...	...	...
Lebanon	<500	[<2000]	...	...	...	...
Libyan Arab Jamahiriya	...	...	...	...	...	...
Morocco	3100	[1700 – 5100]	...	...	...	...
Oman	...	...	...	...	...	...
Qatar	...	...	...	...	...	...
Saudi Arabia	...	...	...	...	...	...
Sudan	170 000	[75 000 – 310 000]	30 000	[12 000 – 74 000]	28 000	[11 000 – 68 000]
Syrian Arab Republic	...	...	...	...	...	...
Tunisia	<1000	[410 – 2200]	...	...	...	...
Turkey	...	...	...	...	...	...
United Arab Emirates	...	...	...	...	...	...
Yemen	...	...	...	...	...	...
North America	290 000	[150 000 – 500 000]	11 000	[3500 – 27 000]	11 000	[3500 – 27 000]
Canada (4)	6700	[5400 – 8100]	...	...	...	...
United States of America	280 000	[140 000 – 490 000]	...	...	...	...
Caribbean	150 000	[99 000 – 200 000]	22 000	[9800 – 43 000]	22 000	[9700 – 43 000]
Bahamas	3300	[1100 – 5900]	<500	[<1000]	<500	[<1000]
Barbados	<1000	[<2000]	<100	[<200]	<100	[<200]
Cuba	2300	[980 – 7600]	...	...	...	...
Dominican Republic	31 000	[27 000 – 35 000]	3600	[1300 – 8000]	3600	[1200 – 8000]
Haiti	90 000	[47 000 – 140 000]	17 000	[5800 – 36 000]	17 000	[5800 – 36 000]
Jamaica	6500	[3100 – 11 000]	<500	[<1000]	<500	[<1000]
Trinidad and Tobago	14 000	[6500 – 23 000]	<1000	[<2000]	<1000	[<2000]

					2. AIDS deaths			
Young women (15–24) rate (%) 2005			Young men (15–24) rate (%) 2005		Deaths in adults and children 2005		Deaths in adults and children 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
North Africa and Middle East	0.2	[0.1 – 0.3]	0.1	[0.1 – 0.2]	37 000	[20 000 – 62 000]	34 000	[18 000 – 57 000]
Algeria	<500	[<1000]	<500	[<1000]
Bahrain
Cyprus
Egypt	<500	[<1000]	<500	[<1000]
Iraq
Israel
Jordan
Kuwait
Lebanon	<100	[<200]	<100	[<200]
Libyan Arab Jamahiriya
Morocco	1300	[850 – 2000]	1000	[<2000]
Oman
Qatar
Saudi Arabia
Sudan	34 000	[18 000 – 58 000]	32 000	[17 000 – 55 000]
Syrian Arab Republic
Tunisia	<100	[<200]	<100	[<200]
Turkey
United Arab Emirates
Yemen
North America					18 000	[11 000 – 26 000]	18 000	[11 000 – 26 000]
Canada (4)	<1000	[<2000]	<1000	[<2000]
United States of America	16 000	[9600 – 24 000]	16 000	[9600 – 24 000]
Caribbean	1.6	[0.9 – 2.3]	0.7	[0.4 – 0.9]	27 000	[19 000 – 36 000]	28 000	[19 000 – 38 000]
Bahamas	<500	[<1000]	<500	[<1000]
Barbados	<500	[<1000]	<500	[<1000]
Cuba	<500	[<200]	<100	[<200]
Dominican Republic	6700	[5100 – 8200]	6900	[4600 – 9000]
Haiti	16 000	[9500 – 24 000]	17 000	[10 000 – 26 000]
Jamaica	1300	[710 – 2200]	1300	[670 – 2100]
Trinidad and Tobago	1900	[990 – 3100]	1700	[870 – 2700]

3. Orphans due to AIDS					4. Trend of HIV prevalence (%) in young (15–24) pregnant women in capital city			
Orphans (0–17) currently living 2005			Orphans (0–17) living in 2003					
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Year	HIV (%)	Year	HIV (%)
North Africa and Middle East								
Algeria
Bahrain
Cyprus
Egypt
Iraq
Israel
Jordan
Kuwait
Lebanon
Libyan Arab Jamahiriya
Morocco
Oman
Qatar
Saudi Arabia
Sudan
Syrian Arab Republic
Tunisia
Turkey
United Arab Emirates
Yemen
North America								
Canada (4)
United States of America
Caribbean								
Bahamas
Barbados
Cuba
Dominican Republic
Haiti	2000	3.7	...	...
Jamaica
Trinidad and Tobago

5. Trends of HIV prevalence (%) in most-at-risk groups in capital city												
Injecting drug users					Female sex workers				Men who have sex with men			
Country	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)
North Africa and Middle East												
Algeria
Bahrain
Cyprus
Egypt
Iraq
Israel
Jordan
Kuwait
Lebanon
Libyan Arab Jamahiriya
Morocco	2005	1.9	...	...	2005	1.9
Oman
Qatar
Saudi Arabia
Sudan
Syrian Arab Republic
Tunisia
Turkey
United Arab Emirates
Yemen
North America												
Canada (4)
United States of America
Caribbean												
Bahamas
Barbados
Cuba
Dominican Republic	2000	4.0	2004	3.6	...	...	...	...
Haiti
Jamaica	2005	9.0	...	...	...	...
Trinidad and Tobago

1. Estimated number of people living with HIV						
Adults and children 2005			Adults and children 2003		Adults (15+) 2005	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Latin America	1 600 000	[1 200 000 – 2 400 000]	1 400 000	[1 100 000 – 2 000 000]	1 600 000	[1 200 000 – 2 400 000]
Argentina	130 000	[80 000 – 220 000]	120 000	[75 000 – 170 000]	130 000	[78 000 – 220 000]
Belize	3700	[2000 – 5700]	2900	[1600 – 4500]	3600	[2000 – 5600]
Bolivia	7000	[3800 – 17 000]	6400	[3500 – 16 000]	6800	[3600 – 16 000]
Brazil	620 000	[370 000 – 1 000 000]	560 000	[350 000 – 800 000]	610 000	[370 000 – 1 000 000]
Chile	28 000	[17 000 – 56 000]	25 000	[16 000 – 37 000]	28 000	[17 000 – 56 000]
Colombia	160 000	[100 000 – 320 000]	140 000	[90 000 – 210 000]	160 000	[100 000 – 320 000]
Costa Rica	7400	[3600 – 24 000]	6400	[3300 – 11 000]	7300	[3500 – 24 000]
Ecuador	23 000	[11 000 – 74 000]	22 000	[11 000 – 36 000]	22 000	[11 000 – 71 000]
El Salvador	36 000	[22 000 – 72 000]	34 000	[22 000 – 52 000]	35 000	[22 000 – 71 000]
Guatemala	61 000	[37 000 – 100 000]	55 000	[34 000 – 79 000]	59 000	[35 000 – 97 000]
Guyana	12 000	[4700 – 23 000]	12 000	[4700 – 23 000]	11 000	[4400 – 22 000]
Honduras	63 000	[35 000 – 99 000]	58 000	[32 000 – 91 000]	61 000	[33 000 – 95 000]
Mexico	180 000	[99 000 – 440 000]	170 000	[91 000 – 410 000]	180 000	[97 000 – 440 000]
Nicaragua	7300	[3900 – 18 000]	5900	[3200 – 14 000]	7200	[3900 – 17 000]
Panama	17 000	[11 000 – 34 000]	16 000	[10 000 – 24 000]	17 000	[10 000 – 33 000]
Paraguay	13 000	[6200 – 41 000]	11 000	[6000 – 19 000]	13 000	[6000 – 41 000]
Peru	93 000	[56 000 – 150 000]	84 000	[52 000 – 120 000]	91 000	[55 000 – 150 000]
Suriname	5200	[2800 – 8100]	4500	[2500 – 7000]	5100	[2800 – 8000]
Uruguay	9600	[4600 – 30 000]	8100	[4200 – 14 000]	9500	[4500 – 31 000]
Venezuela	110 000	[54 000 – 350 000]	96 000	[50 000 – 160 000]	110 000	[52 000 – 350 000]

1. Estimated number of people living with HIV								
Adults (15 +) 2003			Adult (15–49) rate (%) 2005		Adult (15–49) rate (%) 2003		Women (15 +) 2005	
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]
Latin America	1 400 000	[1 100 000 – 2 000 000]	0.5	[0.4 – 1.2]	0.5	[0.4 – 0.7]	480 000	[340 000 – 760 000]
Argentina	120 000	[73 000 – 170 000]	0.6	[0.3 – 1.9]	0.6	[0.4 – 0.8]	36 000	[19 000 – 64 000]
Belize	2800	[1600 – 4400]	2.5	[1.4 – 4.0]	2.1	[1.1 – 3.3]	1000	[<2000]
Bolivia	6300	[3400 – 15 000]	0.1	[0.1 – 0.3]	0.1	[0.1 – 0.3]	1900	[880 – 4700]
Brazil	550 000	[340 000 – 790 000]	0.5	[0.3 – 1.6]	0.5	[0.3 – 0.7]	220 000	[110 000 – 390 000]
Chile	25 000	[16 000 – 37 000]	0.3	[0.2 – 1.2]	0.3	[0.2 – 0.4]	7600	[4000 – 16 000]
Colombia	140 000	[89 000 – 210 000]	0.6	[0.3 – 2.5]	0.5	[0.3 – 0.8]	45 000	[24 000 – 95 000]
Costa Rica	6300	[3300 – 11 000]	0.3	[0.1 – 3.6]	0.3	[0.1 – 0.4]	2000	[860 – 6700]
Ecuador	21 000	[11 000 – 35 000]	0.3	[0.1 – 3.5]	0.3	[0.1 – 0.5]	12 000	[5200 – 40 000]
El Salvador	34 000	[22 000 – 51 000]	0.9	[0.5 – 3.8]	0.9	[0.6 – 1.4]	9900	[5300 – 21 000]
Guatemala	53 000	[33 000 – 76 000]	0.9	[0.5 – 2.7]	0.9	[0.5 – 1.2]	16 000	[8300 – 29 000]
Guyana	11 000	[4400 – 22 000]	2.4	[1.0 – 4.9]	2.4	[0.9 – 4.8]	6600	[2300 – 14 000]
Honduras	56 000	[31 000 – 88 000]	1.5	[0.8 – 2.4]	1.5	[0.8 – 2.4]	16 000	[7500 – 27 000]
Mexico	170 000	[90 000 – 410 000]	0.3	[0.2 – 0.7]	0.3	[0.1 – 0.7]	42 000	[17 000 – 91 000]
Nicaragua	5800	[3100 – 14 000]	0.2	[0.1 – 0.6]	0.2	[0.1 – 0.5]	1700	[780 – 4200]
Panama	15 000	[9900 – 23 000]	0.9	[0.5 – 3.7]	0.9	[0.6 – 1.3]	4300	[2300 – 9200]
Paraguay	11 000	[5800 – 19 000]	0.4	[0.2 – 4.6]	0.4	[0.2 – 0.6]	3500	[1500 – 12 000]
Peru	82 000	[51 000 – 120 000]	0.6	[0.3 – 1.7]	0.5	[0.3 – 0.8]	26 000	[13 000 – 45 000]
Suriname	4500	[2500 – 7000]	1.9	[1.1 – 3.1]	1.7	[0.9 – 2.7]	1400	[690 – 2400]
Uruguay	8100	[4200 – 14 000]	0.5	[0.2 – 6.1]	0.4	[0.2 – 0.7]	5300	[2200 – 17 000]
Venezuela	94 000	[49 000 – 160 000]	0.7	[0.3 – 8.9]	0.6	[0.3 – 1.1]	31 000	[13 000 – 100 000]

1. Estimated number of people living with HIV						
Women (15 +) 2003			Children (0–14) 2005		Children (0–14) 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Latin America	420 000	[290 000 – 630 000]	32 000	[19 000 – 59 000]	29 000	[17 000 – 54 000]
Argentina	32 000	[15 000 – 50 000]	...	...	...	...
Belize	<1000	[<2000]	<100	[<200]	<100	[<200]
Bolivia	1700	[800 – 4300]	...	...	...	...
Brazil	190 000	[89 000 – 300 000]	...	...	...	...
Chile	6600	[3500 – 11 000]	...	...	...	...
Colombia	37 000	[20 000 – 60 000]	...	...	...	...
Costa Rica	1700	[600 – 3100]	...	...	...	...
Ecuador	11 000	[4000 – 21 000]	...	...	...	...
El Salvador	9200	[5000 – 15 000]	...	...	...	...
Guatemala	14 000	[6600 – 22 000]	...	...	...	...
Guyana	6600	[2300 – 14 000]	<1000	[160 – 2000]	<1000	[170 – 2100]
Honduras	14 000	[6700 – 24 000]	2400	[790 – 5600]	1900	[640 – 4500]
Mexico	34 000	[15 000 – 79 000]	...	...	...	...
Nicaragua	1300	[580 – 3100]	...	...	...	...
Panama	3900	[2100 – 6300]	...	...	...	...
Paraguay	3000	[1100 – 5500]	...	...	...	...
Peru	22 000	[10 000 – 35 000]	...	...	...	...
Suriname	1200	[580 – 2100]	<100	[<200]	<100	[<200]
Uruguay	4500	[1600 – 8000]	...	...	...	...
Venezuela	26 000	[9100 – 47 000]	...	...	...	...

					2. AIDS deaths			
Young women (15–24) rate (%) 2005			Young men (15–24) rate (%) 2005		Deaths in adults and children 2005		Deaths in adults and children 2003	
Country	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]	Estimate	[low estimate– high estimate]
Latin America	0.3	[0.2 – 0.8]	0.5	[0.4 – 1.5]	59 000	[47 000 – 76 000]	51 000	[40 000 – 67 000]
Argentina	4300	[2600 – 6400]	3100	[1600 – 5000]
Belize	<500	[<1000]	<500	[<1000]
Bolivia	<500	[<1000]	<500	[<1000]
Brazil	14 000	[8300 – 21 000]	13 000	[6800 – 21 000]
Chile	<500	[<1000]	<500	[<1000]
Colombia	8200	[5200 – 12 000]	6800	[3800 – 10 000]
Costa Rica	<100	[<200]	<100	[<200]
Ecuador	1600	[840 – 2900]	1100	[450 – 2000]
El Salvador	2500	[1600 – 3700]	2800	[1500 – 4200]
Guatemala	2700	[1600 – 4000]	2100	[1100 – 3400]
Guyana	1200	[440 – 2300]	1300	[500 – 2600]
Honduras	3700	[2000 – 6200]	3500	[1900 – 5800]
Mexico	6200	[3800 – 11 000]	5500	[3300 – 9900]
Nicaragua	<500	[<1000]	<500	[<1000]
Panama	<1000	[<1000]	<1000	[<2000]
Paraguay	<500	[<1000]	<500	[<1000]
Peru	5600	[3400 – 8500]	5100	[2700 – 8100]
Suriname	<500	[<1000]	<500	[<1000]
Uruguay	<500	[<1000]	<500	[<1000]
Venezuela	6100	[3100 – 11 000]	4300	[1800 – 7800]

3. Orphans due to AIDS					4. Trend of HIV prevalence (%) in young (15–24) pregnant women in capital city			
Orphans (0–17) currently living 2005			Orphans (0–17) living in 2003					
Country	Estimate	[low estimate–high estimate]	Estimate	[low estimate–high estimate]	Year	HIV (%)	Year	HIV (%)
Latin America								
Argentina
Belize
Bolivia
Brazil
Chile
Colombia
Costa Rica
Ecuador
El Salvador
Guatemala
Guyana
Honduras
Mexico
Nicaragua
Panama
Paraguay
Peru
Suriname
Uruguay
Venezuela

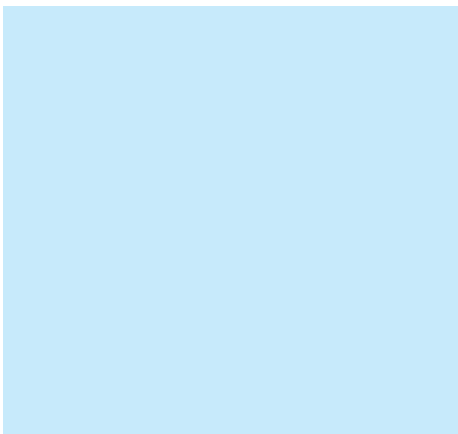
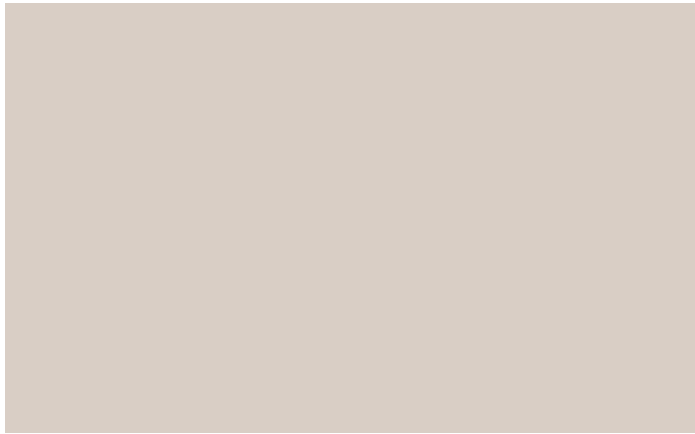
5. Trends of HIV prevalence (%) in most-at-risk groups in capital city

Country	Injecting drug users				Female sex workers				Men who have sex with men			
	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)	Year	HIV (%)
Latin America												
Argentina	2000	23.0	...	...	2001	3.4	...	...	2000	13.8	...	...
Belize
Bolivia	2000	14.6	...	...
Brazil	2000	46.0	...	...	2001	2.9	...	...	2001	13.0	...	...
Chile
Colombia
Costa Rica	2005	0.1	...	...	...	...
Ecuador
El Salvador	2001	3.9	...	...	...	...	...	...
Guatemala	2000	2.3	2005	8.7	...	...	2005	11.5
Guyana
Honduras	2000	12.5	2005	9.7	2001	8.2	2005	13.0
Mexico	2001	15.2	...	...
Nicaragua	2000	0.9	...	...	...	...	...	...
Panama	2001	1.8	...	...	...	...	...	...
Paraguay	2005	3.1	...	...	2005	13.0
Peru	2000	19.7	2005	23.6
Suriname
Uruguay
Venezuela

NOTES

- Ethiopia** | In early 2006 important new data from a national community-based survey and from rural surveillance sites had become available in Ethiopia. At the time when this report went to press, those new data had only partially been analysed. As a result, the estimates for Ethiopia in this report should be considered preliminary. UNAIDS and WHO will make new estimates, based on a comprehensive analysis of all data, available on their websites as soon as possible.
- India** | Work is ongoing to produce a more precise estimate of AIDS mortality in India. An analysis using adult prevalence in past years and parameter estimates based on the international literature suggests that AIDS mortality lies within these ranges.
- United Kingdom** | These ad hoc preliminary estimates for 2005 are based upon the official UK estimates for 2004—the official estimates for 2005 will be published in late 2006 once all the relevant surveillance data for 2005 have been analysed.
- Canada** | These are preliminary estimates. Final estimates for 2005 will be available in mid-2006.

ANNEX 3: Country progress indicators



Annex 3



ANNEX 3: COUNTRY PROGRESS INDICATORS

As of March 2006, 115 countries had reported indicators on progress towards implementing the Declaration of Commitment on HIV/AIDS in their 2005 Country Progress Reports submitted to UNAIDS. Indicators reported were derived from the original *UNGASS Declaration of Commitment on HIV/AIDS* (2001). The data in the following tables reflect Country Progress Report data as well as information taken from other sources.

Over 70 countries used the UNAIDS Country Response Information System (CRIS) to collect and report their relevant indicators. This not only represents a huge success in data reporting; it also provides what is likely to be the richest data source on the global commitment to responding to HIV, the status of the global epidemic and the country national responses.

Since the first UNGASS progress report *Follow-up to the 2001 UNGASS: Progress Report on the Global Response to HIV/AIDS* (2003) was compiled, core indicators for reporting have been consolidated and refined for 2005 reporting in collaboration with global partners and the UNAIDS Monitoring and Evaluation Reference Group (MERG), the international standards setting group for monitoring and evaluation. Instructions on how the indicators were constructed are available on the UNAIDS website in

the document: *UNGASS Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on the Construction of Core Indicators* (2005).

All countries, regardless of their economic or epidemiological status, were requested to report on all indicators, where appropriate. These indicators included expenditures on HIV/AIDS as part of the National Composite Policy Index. The Index was substantially expanded since 2003 reporting to cover the status of strategic planning, political support, monitoring and evaluation, prevention, care and support programs, human rights issues, and civil society participation. The full data sets will be made available on the UNAIDS website.

The indicators for generalized epidemics, referred to here as GE-Indicators, are designed to measure progress in generalized epidemics regarding national

programs (GE-3 to GE-9), knowledge and behaviour (GE-10 to GE-14), and impact (GE-15 to GE-17); 17 indicators in all. With the exception of the two impact indicators which are reported in Annex 1: Country Profiles; and Annex 2: HIV and AIDS estimates and data, 2005, all available data for the GE indicators are provided in this Annex.

The new indicators for situations where there are concentrated or low-prevalence epidemics, referred to here as CLPE-Indicators, may also be relevant for countries with generalized epidemics. They measure progress in HIV testing and prevention programs for most-at-risk populations (CLPE-3 to CLPE-4), knowledge and behaviour of most-at-risk populations (CLPE-5 to 8) and impact on most-at-risk populations (CLPE-9). With the exception of the impact indicator which is reported in the preceding annexes, all available data for the CLPE indicators are provided here. Thus, while there are 23 country progress indicators in total, there are data from 20 indicators provided in this Annex.

The indicator data tables

To allow the reader to examine changes over time, where indicators and methods were consistent across reporting years, data from both years were provided. Where possible the year that the data were collected was differentiated from the year of reporting. The percentages and numbers in the tables are given rounded

to the nearest decimal point. However, in calculations of weighted averages and medians, un-rounded numbers were used, so there may be minor discrepancies. The reader will note substantial variations for some indicators across countries and regions. These ranges are noted in the discussion of these data in the 'Progress in countries' chapter, where the actual global ranges are often given and discussed. Some of the country progress report data were still under review with countries at the time of production of this Annex. Where this is the case, it has been explicitly noted in the Indicator Data Tables. As more data become available, these tables will be updated and made available on the UNAIDS website.

Please note: where there were no data reported by a country for a specific indicator, but data were available from another source such as the Coverage survey, the WHO "3 by 5" Global Report, or the Demographic and Health Survey, these data were included in the tables and are not necessarily the official data provided by the national governments. Where this was the case, the data source and year were clearly noted in the Indicator Data Table and the specific indicator definition used is described and a reference for the source provided in the Notes Section following this Annex 3. These tables have been compiled and produced from the various data sources by staff at UNAIDS headquarters in Geneva who cannot take responsibility for the accuracy of the data from the original source.

2005 list of countries and territories that provided reports on implementation of the Declaration of Commitment (N = 126)

*No narrative report, indicator data only

EAST ASIA AND PACIFIC

1. China
2. Federated States of Micronesia
3. Mongolia

SOUTH AND SOUTH-EAST ASIA

1. Bangladesh
2. Cambodia
3. India
4. Indonesia
5. Iran (Islamic Republic of)
6. Lao People's Democratic Republic
7. Malaysia
8. Nepal
9. Pakistan
10. Philippines
11. Sri Lanka
12. Thailand
13. Viet Nam

OCEANIA

1. Fiji
2. Kiribati*
3. Marshall Islands*
4. Nauru*
5. Norfolk Islands*
6. Palau
7. Samoa*
8. Solomon Islands*
9. Tokelau*
10. Tuvalu*
11. Vanuatu*

EASTERN EUROPE AND CENTRAL ASIA

1. Armenia
2. Belarus
3. Czech Republic
4. Georgia
5. Kyrgyzstan
6. Latvia
7. Poland
8. Republic of Moldova
9. Romania

10. Russian Federation
11. Slovakia
12. Tajikistan*
13. Ukraine

WESTERN EUROPE

1. Albania
2. The former Yugoslav Republic of Macedonia
3. Serbia and Montenegro

LATIN AMERICA

1. Argentina*
2. Belize
3. Brazil*
4. Chile
5. Colombia*
6. Costa Rica
7. Ecuador
8. El Salvador
9. Guatemala
10. Honduras
11. Nicaragua
12. Panama
13. Paraguay*
14. Peru
15. Uruguay
16. Venezuela

CARIBBEAN

1. Antigua and Barbuda
2. Barbados
3. Cuba
4. Dominica
5. Haiti
6. Jamaica
7. Saint Kitts and Nevis
8. Saint Lucia
9. Saint Vincent and the Grenadines
10. Trinidad and Tobago

*no narrative, indicator data only

NORTH AFRICA AND MIDDLE EAST

1. Algeria
2. Morocco
3. Turkey

SUB-SAHARAN AFRICA

1. Angola
2. Benin
3. Botswana
4. Burkina Faso
5. Burundi
6. Cameroon*
7. Central African Republic
8. Chad
9. Comoros
10. Congo
11. Côte d'Ivoire
12. Democratic Republic of the Congo
13. Ethiopia
14. Gabon
15. Gambia
16. Ghana
17. Guinea
18. Guinea-Bissau
19. Kenya
20. Lesotho
21. Madagascar
22. Malawi
23. Mali
24. Mozambique
25. Namibia

26. Nigeria
27. Rwanda
28. Senegal
29. Seychelles*
30. Sierra Leone
31. Somalia
32. South Africa
33. Swaziland
34. Togo
35. Uganda
36. United Republic of Tanzania
37. Zambia
38. Zanzibar
39. Zimbabwe

HIGH-INCOME COUNTRIES

1. Australia
2. Austria
3. Germany
4. Guam*
5. Ireland
6. Israel
7. Japan
8. Malta
9. Netherlands
10. New Zealand
11. Norway
12. Sweden
13. Switzerland
14. United Kingdom of Great Britain and Northern Ireland
15. United States of America

*no narrative, indicator data only

GE-1: Amount of national funds spent by governments from domestic sources for AIDS								
Countries	Sources for the Estimation	Methodology Used	Type of Information Presented	Domestic Public Expenditures (Million US Dollars)				
				2001	2002	2003	2004	2005
Caribbean								
Antigua and Barbuda	UNGASS Report	Financial monitoring system						\$0.40
Barbados	SIDALAC and UNGASS Report	NASA	Expenditures			\$4.20	\$4.60	\$3.30
Dominica *	UNGASS Report	TBD	TBD					\$0.00
Haiti	SIDALAC	NASA	Expenditures		\$0.10	\$0.10		
Jamaica	Resource Flows Project and UNGASS Report	Budget Analysis	Expenditures			\$2.00	\$4.70	
Saint Kitts and Nevis *	UNGASS Report	Budget Analysis	Expenditure			\$0.10	\$0.10	\$0.10
Saint Lucia	UNGASS Report	Budget Allocation	Expenditures					\$2.20
Saint Vincent and the Grenadines*	UNGASS Report and PHR +	NAA embedded	Expenditures				\$0.50	\$0.50
Trinidad and Tobago	UNGASS Report and SIDALAC	NASA	Expenditures		\$3.00	\$4.50	\$5.90	
East Asia								
China	UNGASS Report	Budget Allocation	Budget			\$47.20	\$98.00	\$99.30
Mongolia*	UNGASS Report	Budget Allocation	Disbursements					\$0.20
Eastern Europe and Central Asia								
Armenia	UNGASS report	TBD	Expenditures	\$0.10	\$0.00	\$0.10	\$0.20	\$0.30
Belarus	UNGASS Report and RFP	Financial monitoring system	Expenditures	\$0.70			\$5.80	\$6.10
Czech Republic	UNGASS Report	TBD	Expenditures				\$1.00	\$1.40
Estonia	Resource Flows Project	Resource Flows Survey	Expenditures	\$0.50				
Georgia	UNGASS Report	Budget Analysis	Expenditures			\$0.40	\$0.50	\$0.60
Kyrgyzstan*	UNGASS Report	TBD	Expenditures				\$0.20	
Latvia	UNGASS Report	Budget Allocation	Estimated expenditures					\$1.00
Lithuania	Resource Flows Project	RF Survey	Expenditures	\$0.80				
Republic of Moldova	UNGASS Report	ad hoc survey	Expenditures			\$0.40	\$0.40	\$0.40
Romania	CRIS UNFPA/UNAIDS/NIDI	Desk Review	Expenditures			\$29.70	\$36.20	\$42.70
Russian Federation	UNGASS Report	NASA	Expenditures				\$33.40	
Tajikistan *	UNGASS Report	TBD	Expenditures					\$0.30
Ukraine	UNGASS Report	NAA embedded in NHA	Expenditures				\$3.90	
Latin America								
Argentina	SIDALAC and UNGASS Report	NASA	Expenditures	\$123.90	\$152.30	\$77.50	\$89.60	\$115.20
Belize	SIDALAC	NASA	Expenditures	\$0.40	\$0.50	\$1.10		
Brazil	UNGASS Report	Financial monitoring system	Federal Expenditures			\$ 376.40	\$401.70	\$385.50

GE-1: Amount of national funds spent by governments from domestic sources for AIDS								
Countries	Sources for the Estimation	Methodology Used	Type of Information Presented	Domestic Public Expenditures (Million US Dollars)				
				2001	2002	2003	2004	2005
Chile	UNGASS Report and SIDALAC	NASA	Expenditures	\$8.80	\$10.70		\$25.20	
Colombia	SIDALAC	NASA	Expenditures	\$35.90	\$36.00			
Costa Rica	SIDALAC	NASA	Expenditures	\$8.10	\$7.50	\$6.40		
Ecuador	UNGASS Report	Budget	TBD			\$0.60	\$2.50	\$6.80
El Salvador	UNGASS Report	NASA	Expenditures	\$7.90	\$16.90	\$22.30	\$23.70	
Guatemala*	SIDALAC	NASA	Expenditures		\$9.10	\$11.20		
Guyana	SIDALAC and RF 2003	NASA	Expenditures	\$0.40	\$0.70	\$0.80		
Honduras*	UNGASS Report and SIDALAC	Budget	Expenditures	\$6.60				\$6.20
Mexico	SIDALAC	NASA	Expenditures	\$183.90	\$196.80			
Nicaragua	UNGASS Report and SIDALAC	NASA	Expenditures	\$3.50	\$3.40	\$3.50	\$3.30	
Panama	SIDALAC and UNGASS Report	NASA	Expenditures	\$12.50	\$10.00	\$9.70		
Paraguay*	SIDALAC and UNGASS Report	Budget Allocation	Disbursements	\$0.90	\$0.80			\$0.70
Peru	UNGASS Report	Budget Allocation	Expenditures			\$2.10	\$4.30	
Uruguay*	UNGASS Report and SIDALAC	NASA	Expenditures	\$8.60	\$7.50			\$3.80
Venezuela	UNGASS Report	Budgetary allocations	Expenditures	\$44.50	\$36.80	\$30.20	\$29.20	\$28.20
Middle East and Northern Africa								
Algeria	UNGASS Report	Financial monitoring system	Commitments					\$6.70
Morocco	UNGASS Report	None	Disbursements			\$1.50	\$1.50	\$1.50
Turkey*	Resource Flows Project	RF Survey	Expenditures	\$1.40		\$3.00		
Oceania								
Fiji	UNGASS Report	Budget Allocation	Budget			\$0.10	\$0.20	\$0.30
Micronesia	UNGASS Report	TBD	Expenditures				\$0.00	
Palau	UNGASS Report	TBD	Expenditures				\$0.00	
South and South-East Asia								
Cambodia*	IHPP NASA and UNGASS Report	NASA	Expenditures	\$0.40	\$1.40	\$0.80	\$1.00	
India*	UNGASS and NASA Reports	NASA	Expenditures	\$41.70	\$44.40	\$41.10	\$73.30	
Indonesia	UNGASS Report	Simplified NASA	Budget Disbursements	\$3.00	\$3.50	\$6.40	\$9.60	\$13.00
Iran (Islamic Republic of)	RFP and UNGASS Report	Budget Allocation	Budget Disbursements	\$4.20			\$14.00	
Lao People's Democratic Republic	IHPP NASA Report	NASA	Expenditures	\$0.00	\$0.00	\$0.00	\$0.00	
Nepal*	UNGASS Report	Budget Allocation	Expenditures			\$0.10	\$0.10	

GE-1: Amount of national funds spent by governments from domestic sources for AIDS								
Countries	Sources for the Estimation	Methodology Used	Type of Information Presented	Domestic Public Expenditures (Million US Dollars)				
				2001	2002	2003	2004	2005
Pakistan	UNGASS Report	Budget Allocation	Expenditures	\$2.90	\$2.40	\$0.50	\$2.60	\$2.40
Philippines*	UNGASS and IHPP NASA Reports	NASA	Expenditures	\$0.60	\$0.80	\$0.70	\$0.60	\$0.60
Sri Lanka	UNGASS Report	Budget Allocation	Disbursements					\$3.00
Thailand*	IHPP NASA Report	NASA	Expenditures	\$50.00	\$62.70	\$70.20	\$92.80	
Viet Nam*	UNGASS Report and RFP	Budget Allocation	Budget	\$4.80		\$4.40	\$5.60	\$5.60
Sub-Saharan Africa								
Angola	UNGASS Report	ad hoc survey	Expenditures				\$8.90	
Benin*	UNGASS Report	Program activities report	TBD				\$10.60	
Botswana	UNGASS Report	Program activities report	Expenditures	\$69.80				\$165.00
Burkina Faso	UNGASS Report	NASA and Financial monitoring	Expenditures	\$2.20	\$5.40	\$9.30	\$11.00	\$8.00
Burundi**	UNGASS Report	Budget Allocation	Expenditures		\$5.70	\$5.70	\$18.60	\$14.00
Cameroon*	UNGASS Report	TBD	Expenditures					\$4.40
Central African Republic	UNGASS Report and RFP	Resource Flows Survey	Expenditures			\$0.60		\$0.70
Chad	UNGASS Report	TBD	Expenditures			\$0.20	\$0.50	\$0.90
Congo	UNGASS Report	TBD	Budget allocations			\$0.10	\$0.10	\$4.70
Côte d'Ivoire	UNGASS Report	TBD	Expenditures			\$1.80	\$5.20	\$5.80
Democratic Republic of the Congo	UNGASS Report	Budget Allocation	Budget					\$3.60
Gabon	UNGASS Report	Budget Allocation						\$6.70
Gambia	UNGASS Report	ad hoc survey	Expenditures				\$5.50	
Ghana	UNGASS Report and SIDLAC	NASA	Expenditures		\$2.50	\$9.30		
Guinea	UNGASS Report	Budget Allocation	Expenditures			\$0.20	\$0.20	\$0.30
Guinea-Bissau**	UNGASS Report	TBD	Expenditures	\$0.50	\$0.50	\$0.50	\$0.50	
Kenya*	PHR+ and UNGASS Report	Budget	Expenditures		\$22.10	\$33.10	\$33.20	
Lesotho	UNGASS Report	ad hoc survey	Expenditures				\$1.30	\$1.40
Liberia	NASA Report	Partial NASA	Expenditures				\$0.10	
Madagascar	UNGASS Report	Budget Allocation	Budget			\$0.10	\$0.20	\$0.20
Malawi	UNGASS Report	Budget Allocation	Expenditures	\$3.10	\$4.50	\$5.40	\$10.70	\$8.70
Mali	UNGASS Report	ad hoc survey	Expenditures				\$3.50	
Mauritius	NASA Report	NASA	Expenditures				\$0.10	

GE-1: Amount of national funds spent by governments from domestic sources for AIDS								
Countries	Sources for the Estimation	Methodology Used	Type of Information Presented	Domestic Public Expenditures (Million US Dollars)				
				2001	2002	2003	2004	2005
Mozambique	UNGASS Report	NASA	Expenditures				\$2.60	
Namibia*	UNGASS Report	Budget Allocation	Expenditures			\$35.00		\$38.60
Nigeria	UNGASS Report	NASA	Expenditures			\$6.40	\$6.50	
Rwanda	UNGASS Report	NHA or Stand Alone NASA	Expenditures			\$1.30	\$2.70	\$1.70
Senegal	UNGASS Report	NASA	Expenditures			\$5.90	\$11.90	
South Africa*	UNGASS Report	National Estimates of Expenditures	Expenditures	\$79.50	\$121.20	\$219.20	\$340.50	\$446.50
Swaziland	UNGASS Report	Budget Allocation	Budget			\$2.60		\$4.00
Togo*	UNGASS Report	TBD	Expenditures			\$0.70	\$0.90	\$0.60
Uganda	UNGASS Report	Budget Estimates	Expenditures				\$18.80	
United Republic of Tanzania	UNGASS Report	Budgetary allocations	Budget	\$2.80		\$5.60	\$22.10	\$45.00
Zambia*	UNGASS Report	Budget Allocation	Budget					\$32.00
Zimbabwe	UNGASS Report	TBD	Disbursements			\$6.30	\$9.90	\$12.10
Western Europe								
The former Yugoslav Republic of Macedonia	UNGASS Report	Budget Allocation	Expenditures					\$0.20
Serbia and Montenegro*	UNGASS Report	NASA	Expenditures	\$0.20†		\$0.20†	\$5.60‡	\$6.30‡ \$0.40†
		(N= 95)				(N= 63)		(N= 54)

*These figures are preliminary and under revision because of the need to assure that they are comprehensive and include domestic public funds exclusively or because there was inadequate time for clarifications, differences in the reference period or countries stated these to be partial estimates.

**Country reports included multiple year estimates. Further work is needed to disaggregate by year.

NASA = National AIDS Spending Assessment

TBD = To Be Determined

IHPP = International Health Policy Program, Thailand

SIDALAC = Regional AIDS Initiative for Latin America and the Caribbean

RF Survey = Resource Flows Project Survey

PHR+ = USAID Partnership for Health Reform

† Value for Montenegro

‡ Value for Serbia

GE-3: Life-skills-based HIV Education in Schools						
Country	2003			2005*		
	UNGASS Country Report 2003			UNGASS Country Report 2005		
	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last year			Percentage of schools with teachers who have been trained in life skills-based HIV education and who taught it during the last year		
	Primary	Secondary	Overall	Primary	Secondary	Overall
Sub-Saharan Africa						
Botswana			50.0			
Burundi				100.0	0.0	78.9
Cape Verde			0.0			
Central African Republic				-	-	-
Côte d'Ivoire				0.0	38.4	19.3
Ethiopia	100.0	77.0	97.0	75.0	81.8	
Guinea				-	-	-
Kenya			5.0	61.6	49.4	60.8
Malawi			6.2	100.0	100.0	100.0
Mali				82.7	73.8	77.2
Mauritius	100.0	30.0				
Nigeria						19.0
Seychelles	88.5	77.0	84.5			
Swaziland			25.0			90.2
Togo				0.0	40.4	7.1
Uganda	100.0					
United Republic of Tanzania			19.0			
Zambia			1.5			60.0
Zimbabwe			75.0			
East Asia and Pacific						
Mongolia	3.3	67.7	35.5			
South and South-East Asia						
Lao People's Democratic Republic			7.7			
Myanmar	32.0	46.5	39.0			
Thailand			100.0	-	-	-
Viet Nam	100.0	100.0	100.0			
Eastern Europe and Central Asia						
Armenia		15.5				
Kazakhstan	0.0	54.7				
Kyrgyzstan		13.0				
Russian Federation			100.0			
Tajikistan		3.0				
North Africa and Middle East						
Jordan		26.0				
Morocco			28.0			
Caribbean						
Antigua and Barbuda				-	-	-
Barbados			100.0			
Dominica				100.0	100.0	100.0
Dominican Republic			18.8			
Saint Lucia						11.1
Saint Vincent and the Grenadines						22.8
Trinidad and Tobago				-	-	-

GE-3: Life-skills-based HIV Education in Schools						
Country	2003			2005*		
	UNGASS Country Report 2003			UNGASS Country Report 2005		
	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last year			Percentage of schools with teachers who have been trained in life skills-based HIV education and who taught it during the last year		
	Primary	Secondary	Overall	Primary	Secondary	Overall
Latin America						
Belize			80.0			
Brazil	41.4					25.8
Guatemala			7.0			
Honduras				16.7	18.4	15.4
Mexico						75.1
High-income Countries						
Bahamas	44.0	41.0	42.5			
(<i>N</i> = 44)		(<i>N</i> = 30)			(<i>N</i> = 21)	

*Report date is 2005, but data collection can vary from 2000 to 2005

(-) = Under review at the time of printing

GE-4: Workplace HIV and AIDS Control				
Country	2003	2005*		
	UNGASS Country Report 2003	UNGASS Country Report 2005		
	Percentage of large public and private enterprises that adopted comprehensive HIV/AIDS workplace policies	Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes		
		Public	Private	All
Sub-Saharan Africa				
Angola		-	-	-
Botswana	70.0			
Burundi		-	-	-
Cameroon		35.7	5.0	17.6
Cape Verde	0.0			
Central African Republic		-	-	-
Comoros	0.0			
Congo		3.0	70.0	28.3
Congo, Democratic Republic of the		0.0	9.1	4.8
Côte d'Ivoire	48.0	-	-	-
Ethiopia	92.5	33.3	33.3	33.3
Gabon		0.0	16.0	13.3
Ghana	100.0	0.0	12.0	10.0
Guinea		60.0	24.0	30.0
Kenya	70.0	-	-	-
Lesotho		0.0	0.0	0.0
Malawi	17.5			47.0
Mali		0.2	0.2	0.2
Mauritius	40.0			
Mozambique		0.0	6.3	3.2
Namibia	49.5			
Nigeria	53.0			46.9
Rwanda	6.0			
Seychelles	50.0			
South Africa	77.0			
Swaziland	100.0			47.7
Uganda	20.0			
Zambia				80.0
Zimbabwe	80.0			
South and South-East Asia				
Lao People's Democratic Republic	97.2			
Malaysia				
Philippines	13.0			
Thailand		-	-	-
Viet Nam	87.5			
Eastern Europe and Central Asia				
Ukraine		0.0	0.0	0.0
Caribbean				
Jamaica	5.0			
Saint Kitts and Nevis		-	-	-
Saint Vincent and the Grenadines				14.3
Trinidad and Tobago				11.9
Latin America				
Honduras	0.5			
Suriname	24.0			
(N = 41)	(N = 23)	(N = 24)		

*Report date is 2003, but data collection can vary from 2001 to 2003

**Report date is 2005, but data collection can vary from 2003 to 2005

(-) = Under review at the time of printing

GE-5: Sexually Transmitted Infections—Comprehensive Case Management				
Country	2003	2005		
	UNGASS Country Report 2003	UNGASS Country Report 2005 ^a		
	Percentage of patients with sexually transmitted infections who are appropriately diagnosed (D), counselled (C) and treated (T)	Percentage of women and men with sexually transmitted infections at health-care facilities who are appropriately diagnosed, treated and counselled		
		Males	Females	All
Sub Saharan Africa				
Benin				100.0
Botswana	30.0 ¹			
Burkina Faso	4.0 (D+T) 13.0 (C)			
Guinea-Bissau		-	-	-
Kenya	50.0			
Madagascar	20.0 (D+T) 44.0 (C)			
Mauritius	100.0			
Nigeria		46.0 ²	41.0 ²	
Rwanda		36.6 ³	26.6 ³	28.3 ³
Seychelles	37.0			
Togo		97.9	91.8	92.4
Uganda	21.0			40.0 ⁴
Zambia				10.0
Zimbabwe	57.0			
East Asia and Pacific				
Mongolia	100.0 ⁶			
Samoa	100.0 ⁷			
South and South-East Asia				
Cambodia	88.0 ⁸			
Thailand		69.2 ⁴	71.5 ⁴	70.2 ⁴
Viet Nam	38.0			
Eastern Europe and Central Asia				
Belarus	75.0			
Kazakhstan	98.0			
Kyrgyzstan	82.0			
Slovakia	100.0 ⁹			
Tajikistan	76.0			
Ukraine		38.6	44.4	41.4
North Africa and Middle East				
Djibouti	16.0 ¹⁰			
Morocco	49.0			
Caribbean				
Antigua and Barbuda				100.0
Trinidad and Tobago		-	-	-
Latin America				
Honduras		80.0	80.2	80.2
High-income Countries				
Guam	100.0 (D), 34.0 (T), 18.0 (C) ⁵			
(N = 31)	(N = 20)		(N = 12)	

^aReport date is 2005, but data collection can vary from 2000 to 2005

(-) = Under review at the time of printing

¹1998 data

²2003 data

³2000 data

⁴2004 data

⁵Public and Private Clinic Survey 2002

⁶Annual Report of National Center Communicable Diseases 2002

⁷Ministry of Health 2002 (all treated and counselled, but diagnosis is not lab-based)

⁸WHO 2002

⁹National AIDS Control Programme 2002

¹⁰Ministry of Health 2002

GE-6: Prevention of mother-to-child-transmission—antiretroviral prophylaxis				
Country	2003		2005*	
	UNGASS Country Report 2003*	Coverage Survey**	UNGASS Country Report 2005†	Coverage Survey††
	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis
Sub-Saharan Africa				
Angola		0.0	2.3	
Benin	0.0 ¹	94.0	18.0	38.0
Botswana	34.0	18.8		
Burkina Faso	<1.0	0.1		1.1
Burundi		1.2	13.2	2.4
Cameroon		6.9		4.2
Central African Republic			16.4 ¹⁰	
Chad	0.0 ¹		-	0.2
Congo		13.3	98.6	
Côte d'Ivoire		1.5	4.4	4.3
Democratic Republic of the Congo	0.0 ¹	0.6		
Eritrea		0.9		
Ethiopia	<1.0	0.2	3.0	0.3
Gabon			10.7	0.7
Gambia		2.8		16.6
Ghana		1.3	0.5	1.3
Guinea		0.0		0.4
Guinea-Bissau			19.5	
Kenya	1.0	3.4	9.3	27.0
Lesotho			5.3 ¹⁰	5.1
Madagascar			0.0 ¹⁰	0.0
Malawi	<1.0	1.7	2.3 ¹⁰	
Mali		0.5	0.7	0.8
Mauritania				
Mauritius	100.0	40.4		
Mozambique		1.3	4.9	3.4
Namibia	7.0	1.3	25.0	17.4
Niger	0.0 ¹			
Nigeria	<1.0	0.1		0.2
Rwanda		13.8	9.4	
Senegal		0.4		1.4
Seychelles	100.0		97.7 ¹⁰	
Sierra Leone	0.0			
Somalia			3.3	
South Africa	<1.0 ¹	8.9	78.7	14.6
Swaziland		1.7	16.2	11.9
Togo		0.3	32.8	1.8
Uganda	4.6	6.6	12.0	25.9
United Republic of Tanzania	0.0	0.3		
Zambia		6.3	25.0	4.0
Zimbabwe		4.1	6.6 ¹⁰	4.4
East Asia and Pacific				
China		0.4		1.3
Mongolia	0.0			
Samoa	0.0 ⁴			

GE-6: Prevention of mother-to-child-transmission—antiretroviral prophylaxis				
Country	2003		2005*	
	UNGASS Country Report 2003*	Coverage Survey**	UNGASS Country Report 2005†	Coverage Survey††
	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis
Oceania				
Fiji			25.0 ¹⁰	
South and South-East Asia				
Afghanistan	0.0 ²			
Bhutan		25.7		
Cambodia	2.7 ³	0.3	5.0	1.4
India	<1.0	0.0		1.6
Indonesia		0.5		0.7
Iran (Islamic Republic of)		25.7		
Lao People's Democratic Republic		0.0		2.5
Malaysia	0.0 ¹	6.2		6.1
Myanmar	2.0			
Nepal	2.1 ¹	0.7		0.9
Philippines		0.5		0.4
Thailand		33.3	83.4 ¹⁰	30.6
Viet Nam	2.3	1.7		
Eastern Europe and Central Asia				
Armenia	3.0			
Belarus	87.5	9.4		
Kazakhstan	4.5	2.2		9.0
Kyrgyzstan	0.0 ⁸			
Latvia		9.2		58.6
Republic of Moldova	0.0 ⁹	3.5		
Romania			0.2 ¹¹	
Russian Federation	12.0			14.6
Tajikistan	0.0			
Ukraine	49.6 ⁴	21.3	86.7 ¹⁰	31.8
North Africa and Middle East				
Egypt				7.3
Morocco	1.0 ¹	1.5		
Oman		0.0		
Sudan				0.0
Caribbean				
Antigua and Barbuda			50.2	
Barbados	0.0 ¹	38.7	90.0 ¹⁰	
Cuba	2.5 ⁵	19.8		
Dominica			100.0	
Dominican Republic	0.0 ¹	14.2		15.7
Haiti	0.0 ¹	1.6		
Jamaica				
Saint Lucia			20.0	
Saint Vincent and the Grenadines			61.6	
Trinidad and Tobago	0.0 ¹	35.6	71.4 ¹⁰	

GE-6: Prevention of mother-to-child-transmission—antiretroviral prophylaxis				
Country	2003		2005*	
	UNGASS Country Report 2003*	Coverage Survey**	UNGASS Country Report 2005†	Coverage Survey††
	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis
Latin America				
Argentina	55.0	11.8	87.0	0.0
Belize	70.0	19.0	73.3	
Brazil	33.6	26.2	57.6 ¹⁰	0.0
Chile		10.8		
Colombia				1.8
Ecuador				8.3
El Salvador		21.1		20.8
Guatemala	10.0	3.7		
Guyana	<1.0	14.5		17.6
Honduras		1.9	3.4	
Mexico		3.5		2.1
Nicaragua		1.1		
Panama	0.0 ¹	7.5		0.0
Paraguay	40.0 ¹		2.1	
Peru	14.8 ³	9.6		3.5
Uruguay	97.8 ³	56.9	19.3	
Venezuela	0.0 ⁶			4.2
High-income Countries				
Cyprus	100.0 ⁷			
Germany			80.0	
Guam	0.0 ³			
Qatar	0.0 ⁴			
(N = 103)	(N = 53)	(N = 67)	(N = 45)	(N = 51)

*Report date 2003, but data collection can vary from 2002 to 2003

**Data are estimates for 2003 based on the latest available information at the time

†Report date is 2005, but data collection can vary from 2003 to 2005

††Data are estimates for 2005 based on the latest available information

(-) = Under review at the time of printing

¹WHO 2002²WHO country office³National AIDS Control Programme 2002⁴Ministry of Health 2002⁵National Target 2002⁶Global Report HIV/AIDS 2002⁷Department of Medical and Health Services⁸EURO Survey 2002⁹National AIDS Programme 2003¹⁰2004 data¹¹2003 data

GE-7: HIV Treatment—Antiretroviral Combination Therapy					
Country	2003	2005			
	UNGASS Country Report 2003*	UNGASS Country Report 2005**			Coverage Survey 2005†
		Percentage of people with advanced HIV infection receiving antiretroviral combination therapy			Estimated Coverage
		All	Males	Females	
Sub-Saharan Africa					
Angola	<1.0 ¹				6.0
Benin	2.5 ²				33.0
Botswana	7.9				85.0
Burkina Faso	1.4				24.0
Burundi	1.9 ²				14.0
Cameroon	1.5 ³	17.8			22.0
Central African Republic	<1.0 ³	4.2	4.4	4.0	3.0
Chad		-	-	-	17.0
Congo					17.0
Côte d'Ivoire	2.7	22.1	19.3	24.6	17.0
Democratic Republic of the Congo	0.0 ²	2.7			4.0
Djibouti	1.8 ⁸				16.0
Equatorial Guinea	6.8 ¹				0.0
Eritrea	<1.0 ¹				5.0
Ethiopia	<1.0 ¹	7.1	8.2	6.2	7.0
Gabon		-	-	-	23.0
Gambia	6.3 ¹				10.0
Ghana	1.8 ¹	5.0	5.6	4.6	7.0
Guinea					9.0
Guinea-Bissau		-	-	-	1.0
Kenya	3.0	19.7			24.0
Lesotho	<1.0 ¹				14.0
Liberia					3.0
Madagascar		0.4			0.0
Malawi	1.8	17.7	14.9	19.7	20.0
Mali	2.5 ¹⁴	11.0	16.8	8.1	32.0
Mauritania					40.0
Mauritius	100.0				
Mozambique	0.0 ¹	7.4	7.4	7.4	9.0
Namibia	0.0 ¹	35.0			71.0
Niger					5.0
Nigeria	1.5	7.0			7.0
Rwanda	<1.0	-	-	-	39.0
Senegal	<1.0 ²				47.0
Seychelles	68.2		78.0 ¹⁷	87.0 ¹⁷	
Sierra Leone	0.0 ¹				2.0
Somalia		0.8	0.6	1.1	1.0
South Africa	0.0 ¹				21.0
Swaziland	1.7	44.4			31.0
Togo		-	-	-	27.0
Uganda	6.3	56.0			51.0
United Republic of Tanzania	<1.0				7.0
Zambia	0.0 ¹	20.0			27.0
Zimbabwe	0.0 ¹				8.0

GE-7: HIV Treatment—Antiretroviral Combination Therapy						
Country	2003	2005				
	UNGASS Country Report 2003*	UNGASS Country Report 2005**			3 by 5 December 2005	Coverage Survey 2005†
		Percentage of people with advanced HIV infection receiving antiretroviral combination therapy			Estimated antiretroviral therapy coverage, December 2005	Estimated Coverage
		All	Males	Females		
East Asia and Pacific						
China	5.0 ³				25.0	18.3
Micronesia (Federated States of)		0.0	0.0	0.0		
Mongolia					0.0	
Samoa	100.0 ¹³					
Tonga	0.0 ⁶					
Oceania						
Fiji			100.0 ¹⁷	100.0 ¹⁷		
Papua New Guinea	0.0 ¹				15.0	
Palau		33.3	0.0	50.0		
South and South-East Asia						
Afghanistan	0.0 ⁴				0.0	
Bangladesh	0.0 ¹				1.0	8.9
Bhutan						
Cambodia	3.0 ⁵	57.0			36.0	35.1
India	2.0				7.0	6.8
Indonesia	2.7 ¹				30.0	94.3
Iran (Islamic Republic of)	100.0 ¹	12.7			9.0	
Lao, People's Democratic Republic					49.0	84.5
Malaysia					27.0	87.3
Maldives					0.0	
Myanmar	<1.0				7.0	
Nepal					1.0	11.1
Pakistan	2.2 ¹				2.0	1.2
Philippines	3.5 ¹				5.0	100.0
Sri Lanka	2.0 ³				6.0	
Thailand	4.0 ⁶	39.2 ¹⁷			60.0	57.9
Viet Nam	1.0				12.0	58.9
Eastern Europe and Central Asia						
Armenia	0.0 ⁹				15.0	
Azerbaijan	0.0 ⁹				0.0	
Belarus	<1.0				5.0	
Bosnia and Herzegovina	10.0 ⁹					
Bulgaria	44.5 ⁹					
Croatia	98.7 ⁹					100.0
Czech Republic						
Estonia	32.0 ⁹				17.0	
Georgia	8.0 ⁹	98.5	99.0	100.0	49.0	
Hungary	97.0 ⁹					
Kazakhstan	1.0				15.0	43.1
Kyrgyzstan	0.0 ¹⁰				12.0	
Latvia	51.0 ⁹				31.0	36.8
Lithuania	55.0 ⁹				64.0	
Poland	92.9 ⁹				100.0	
Republic of Moldova	8.3 ¹				39.0	100.0
Romania	64.4 ⁹					100.0
Russian Federation	83.3 ¹				5.0	3.7
Slovakia	95.0 ⁹					

GE-7: HIV Treatment—Antiretroviral Combination Therapy					
Country	2003	2005			
	UNGASS Country Report 2003*	UNGASS Country Report 2005**			Coverage Survey 2005†
		Percentage of people with advanced HIV infection receiving antiretroviral combination therapy			Estimated Coverage
		All	Males	Females	
Tajikistan	0.0				16.0
Turkmenistan					0.0
Ukraine	<1.0 ⁸	33.5	29.1	41.0	7.0
Uzbekistan	0.0 ⁹				7.3
					0.0
North Africa and Middle East					
Algeria					39.0
Egypt					12.0
Iraq					7.5
Jordan	21.3				45.0
Lebanon	100.0 ⁶				36.0
Libyan Arab Jamahiriya					35.0
Morocco	20.7				48.0
Oman					100.0
Sudan	<1.0 ¹				1.0
Syrian Arab Republic					9.0
Tunisia					34.0
Turkey			26.0 ¹⁷	23.5 ¹⁷	9.0
Yemen					0.0
Western Europe					
Albania	0.0 ⁹				100.0
Macedonia	20.0 ⁹				
Serbia and Montenegro	26.4 ⁹				
Slovenia	96.3 ⁹				
Caribbean					
Antigua and Barbuda		60.0			
Barbados					95.0
Cuba					100.0
Dominica		36.7			
Dominican Republic	0.0 ³				17.0
Haiti					20.0
Jamaica	<1.0 ²				56.0
Saint Lucia		80.6			
Saint Vincent and the Grenadines		100.0			
Trinidad and Tobago	<1.0 ²	97.0			38.0
Latin America					
Argentina	91.2	100.0			81.0
Belize	7.7				31.0
Bolivia	<1.0 ¹				37.0
Brazil	100.0				83.0
Chile					75.0
Colombia					44.0
Costa Rica					80.0
Ecuador					42.0
El Salvador					59.0
Guatemala	46.0				43.0
Guyana	0.0 ¹				50.0
Honduras	<1.0 ¹	36.5	26.0	53.7	35.0
Mexico					71.0
Nicaragua	0.0 ¹				16.0

GE-7: HIV Treatment—Antiretroviral Combination Therapy						
Country	2003	2005				
	UNGASS Country Report 2003*	UNGASS Country Report 2005**			3 by 5 December 2005	Coverage Survey 2005†
		Percentage of people with advanced HIV infection receiving antiretroviral combination therapy			Estimated antiretroviral therapy coverage, December 2005	Estimated Coverage
		All	Males	Females		
Panama					97.0	100.0
Paraguay	50.0				29.0	54.7
Peru	19.2 ⁷				52.0	76.1
Suriname					55.0	
Uruguay	50.5 ⁷				69.0	
Venezuela					84.0	100.0
High-income Countries						
Austrailia	53.2 ¹⁶					
Austria	92.6 ⁹					
Bahamas	<1.0 ¹					
Belgium	93.8 ⁹					
China, Hong-Kong Special Administrative Region	100.0 ¹					
Cyprus	100.0 ¹¹					
Democratic People's Republic of Korea					0.0	
Denmark	90.9 ⁹					
Finland	94.6 ⁹					
Germany	94.7 ⁹					
Iceland	87.5 ⁹					
Italy	72.7 ⁹					
Luxembourg	96.9 ⁹					
Malta	94.3 ⁹					
Netherlands	96.0 ⁹					
Norway	89.6 ⁹					
Qatar	64.9 ¹²					
Saudi Arabia					14.0	
Singapore	0.0 ¹⁵					
Spain	92.3 ⁹					
Sweden	95.0 ⁹					
Switzerland	95.0 ⁹					
United Kingdom	92.1 ⁹					
United States		70.1 ¹⁸				
(N = 163)	(N = 114)		(N = 41)		(N = 118)	(N = 61)

* Report date 2003, but data collection can vary from 2002 to 2003

** Report date is 2005, but data collection can vary from 2003 to 2005

† Data are estimates for 2005 based on the latest available information

(-) = Under review at the time of printing

¹WHO 2002²Accelerated Access Initiative 2002³National Target 2002⁴WHO country office⁵National Centre for HIV/AIDS, Dermatology and STIs 2002⁶National AIDS Control Programme 2003⁷National AIDS Control Programme 2002⁸Ministry of Health, WHO 2002⁹WHO EURO Survey of ARV access 2003¹⁰EURO Survey 2002¹¹Dept. Medical and Health Service¹²HIV Registry 2002¹³Ministry of Health 2002¹⁴WHO 2003¹⁵Ministry of Health¹⁶Annual Surveillance Report¹⁷2004 Data¹⁸2003 Data

GE-8: Support for Children affected by HIV and AIDS							
Country	2005						
	UNGASS Country Report 2005*						
	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child						
	Rural			Urban			All
	Males	Females	All	Males	Females	All	All
Sub-Saharan Africa							
Congo	-	-	-	-	-	-	-
Ethiopia	2.9	2.8	2.9	7.1	5.8	6.4	3.6
Kenya	6.6	6.4	6.5	10.3	18.1	14.0	10.3
Lesotho							25.0
Madagascar							7.4
Mali	-	-	-	-	-	-	-
Togo							9.7
Zambia							13.4
(N = 8)				(N = 8)			

*Report date is 2005, but data collection can vary from 2003 to 2005

(-) = Under review at the time of printing

GE-9: Blood Safety		
Country	2001	2005
	Coverage Survey*	UNGASS Country Report 2005**
	Donated blood screened for HIV	Percentage of transfused blood units screened for HIV
Sub-Saharan Africa		
Angola	100.0	
Benin	100.0	100.0
Botswana	100.0	
Burkina Faso	85.0	
Burundi	100.0	100.0
Central African Republic	80.0	
Chad	90.0	-
Congo	80.0	100.0
Côte d'Ivoire	100.0	100.0
Democratic Republic of the Congo	70.0	
Ethiopia	100.0	100.0
Eritrea	100.0	
Gabon		72.5
Gambia	100.0	
Ghana	100.0	
Guinea	100.0	
Guinea-Bissau		100.0
Kenya	98.0	100.0
Lesotho		100.0
Liberia	80.0	
Madagascar	100.0	99.4
Malawi		100.0
Mali	100.0	100.0
Mauritania	80.0	
Mauritius	100.0	
Mozambique	100.0	100.0
Namibia	100.0	100.0
Niger	100.0	
Nigeria		100.0
Rwanda	100.0	
Senegal	100.0	
Seychelles	100.0	
Sierra Leone	20.0	
South Africa	100.0	100.0
Swaziland	100.0	100.0
Togo	100.0	79.0
Uganda	100.0	100.0
United Republic of Tanzania	100.0	
Zambia	100.0	100.0
Zimbabwe	100.0	100.0
East Asia and Pacific		
China	100.0	
Oceania		
Fiji		100.0
Micronesia (Federated States of)		100.0
Palau		100.0
Papua New Guinea	0.0	
South and South-East Asia		
Bangladesh	10.0	
Bhutan	10.0	
Cambodia	100.0	100.0
India	100.0	

GE-9: Blood Safety		
Country	2001	2005
	Coverage Survey*	UNGASS Country Report 2005**
	Donated blood screened for HIV	Percentage of transfused blood units screened for HIV
Indonesia	100.0	
Iran (Islamic Republic Of)		100.0
Malaysia	100.0	
Myanmar	35.0	
Nepal	99.0	
Pakistan	95.0	
Sri Lanka	100.0	100.0
Thailand	100.0	100.0
Viet Nam	100.0	
Eastern Europe and Central Asia		
Belarus	100.0	
Croatia	100.0	
Latvia	100.0	
Republic of Moldova	100.0	
Romania	100.0	
Russian Federation	100.0	
Ukraine	100.0	100.0
Uzbekistan	100.0	
North Africa and Middle East		
Algeria		98.9
Morocco	100.0	
Tunisia	100.0	
Caribbean		
Antigua and Barbuda		100.0
Bahamas	100.0	
Barbados	100.0	
Cuba	100.0	
Dominica		92.8
Dominican Republic	100.0	
Saint Lucia		96.0
Saint Vincent and the Grenadines		99.7
Trinidad and Tobago	0.0	100.0
Latin America		
Argentina	96.0	100.0
Belize	100.0	96.8
Bolivia	35.0	
Brazil	100.0	
Chile	100.0	
Colombia	100.0	
Costa Rica	100.0	
Ecuador	100.0	
El Salvador	100.0	
Guatemala	100.0	
Guyana	100.0	
Honduras	100.0	
Jamaica	100.0	
Mexico	100.0	
Nicaragua	100.0	
Panama	100.0	
Paraguay	98.0	
Peru	0.0	100.0
Suriname	100.0	

GE-9: Blood Safety		
Country	2001	2005
	Coverage Survey [*]	UNGASS Country Report 2005 ^{**}
	Donated blood screened for HIV	Percentage of transfused blood units screened for HIV
Uruguay	100.0	
Venezuela	100.0	
High-income Countries		
Bahamas	100.0	
United States		100.0
(N = 100)	(N = 85)	(N = 40)

^{*}Data are estimates for 2001 based on the latest available information at the time

^{**}Report date is 2005, but data collection can vary from 2004 to 2005

(-) = Under review at the time of printing

GE-10: Young People—Knowledge about HIV Prevention														
Country	2003			2005										
	UNGASS Country Report 2003			UNGASS Country Report 2005*									DHS** (unless otherwise noted)	
	Percentage of young women (aged 15–24) with comprehensive HIV and AIDS knowledge			Percentage of young women and men (aged 15–24) with comprehensive HIV and AIDS knowledge									Percentage of young women and men (aged 15–24) with comprehensive HIV and AIDS knowledge	
	Females			Males			Females			All			Males	Females
	Urban	Rural	All	Urban	Rural	All	Urban	Rural	All	Urban	Rural	All		
Sub-Saharan Africa														
Angola				56.7	10.0	42.7	46.3	10.5	35.2	51.5	10.3	39.0		
Benin				7.9	13.1	10.6	3.4	11.8	8.1	5.7	12.4	9.3	14.0	8.0
Botswana	25.2	29.8	27.9										33.0 [†]	40.0 [†]
Burkina Faso													23.0	15.0
Burundi	40.0	21.0	24.0	0.6	3.9	3.6	0.3	3.8	3.6	0.4	3.9	3.6		
Cameroon	24.0	7.0	16.0	40.6	24.8	34.3	36.5	14.5	27.2	37.8	17.5	30.8	34.0	27.0
Central African Republic	1.5	8.7	5.1											
Chad	2.3	12.2	5.0										21.0	8.0
Comoros	9.8	10.4	9.9											
Congo				-	-	-	-	-	-	-	-	-		
Côte d'Ivoire	19.0	6.0	16.0	-	-	-	-	-	-	-	-	-		
Equatorial Guinea	1.1	6.1	3.8											
Eritrea														37.0
Ethiopia				56.7	25.1		44.4	14.0						
Gambia	20.0	11.0	15.0											
Ghana				54.4	28.8	40.3	43.8	29.3	35.8	48.2	29.0	38.0	44.0	38.0
Guinea-Bissau	16.0	2.0	8.0											
Kenya	35.0	22.0	26.0	77.8	80.0	79.5	61.5	57.1	58.3	68.2	66.7	68.9	47.0	34.0
Lesotho	27.0	16.0	18.0											
Madagascar						15.7			19.4				16.0	19.0
Malawi	44.0	31.0	34.0	43.3	34.4	36.0	30.9	22.0	23.5	33.7	24.3	29.8		
Mali				-	-	-	-	-	-	-	-	-	15.0	9.0
Mozambique													33.0	20.0
Niger	17.0	2.0	5.0											
Nigeria				33.6	19.8		30.5	14.8					21.0	18.0
Rwanda	40.0	23.0	23.0											
Sao Tome and Principe	13.0	7.0	11.0											
Sierra Leone	22.0	10.0	16.0											
Somalia				13.6	11.9	12.5	9.6	7.0	7.9	11.5	9.4	10.2		
South Africa	26.0	13.0	20.0											
Swaziland	26.1	28.4	26.9											
Togo	21.0	13.0	20.0											
Uganda	48.0	23.0	28.0											
United Republic of Tanzania	42.0	22.0	26.0										49.0 [†]	44.0 [†]
Zambia	32.0	20.9	25.6			46.1			40.5				33.0	31.0
Zimbabwe				57.7	55.5	56.3	57.8	51.4	54.1	57.7	53.4	55.2		
East Asia and Pacific														
Mongolia	28.1	36.9	32.1	4.1	2.2	3.0	5.5	4.6	5.0	4.8	3.4	4.0		
South and South-East Asia														
Cambodia	52.0	33.0	37.0	-	-	-	-	-	-	-	-	-		
Indonesia	4.2	10.2	6.8											
Thailand				-	-	-	-	-	-	-	-	-		
Viet Nam	20.8	41.3	25.4										50.0 [†]	42.0 [†]

GE-10: Young People—Knowledge about HIV Prevention															
Country	2003			2005											
	UNGASS Country Report 2003			UNGASS Country Report 2005*										DHS** (unless otherwise noted)	
	Percentage of young women (aged 15–24) with comprehensive HIV and AIDS knowledge			Percentage of young women and men (aged 15–24) with comprehensive HIV and AIDS knowledge										Percentage of young women and men (aged 15–24) with comprehensive HIV and AIDS knowledge	
	Females			Males			Females			All			Males	Females	
	Urban	Rural	All	Urban	Rural	All	Urban	Rural	All	Urban	Rural	All			
Eastern Europe and Central Asia															
Azerbaijan	0.8	3.2	2.1												
Republic of Moldova	16.2	22.7	18.9	-	-	-	-	-	-	-	-	-	-		
Russian Federation													48.0		
Ukraine				-	-	-	-	-	-	-	-	-	-		
Uzbekistan	2.6	5.3	3.4										7.0	8.0	
Western Europe															
Albania	0.3	0.0	0.2												
North Africa and Middle East															
Morocco														12.0	
Caribbean															
Barbados													1.0		
Cuba	40.2	56.2	51.8												
Dominican Republic	33.0	23.0	33.0												
Haiti	24.0	8.0	14.0												
Trinidad and Tobago			33.0												
Latin America and Caribbean															
Bolivia	9.3	29.2	21.6											18.0	
Brazil													58.4		
Guyana	35.2	36.4	35.6												
Suriname	21.0	36.8	26.5												
(N = 57)	(N = 38)			(N = 24)									(N = 18)		

*Report date is 2005, but data collection can vary from 2003 to 2005

**Date for 2005 based on data collected from 2001 to 2005

†Source: AIDS Indicator Survey

(-) = Under review at the time of printing

GE-11: Sex before the age of 15									
Country	2005								
	UNGASS Country Report 2005*							DHS** (unless otherwise noted)	
	Percentage of 15–24 year olds who had sex before age 15							Percentage of 15–19 year olds who had sex before age 15	
	Males			Females			All	Females	Males
	Urban	Rural	All	Urban	Rural	All	All		
Sub-Saharan Africa									
Angola	40.9	60.0	46.7	21.7	30.0	24.3	35.5		
Benin	15.7	15.7	15.7	9.9	7.5	8.5	12.1	16.0	23.8
Burkina Faso								7.3	4.7
Burundi	14.3	14.0	14.0	2.5	5.7	5.5	9.7		
Cameroon	23.4	22.3	23.0	28.8	42.5	34.6	28.8	18.0	11.5
Central African Republic	8.2	10.7	9.6	12.3	8.1	9.9	9.8		
Chad	-	-	-	-	-	-	-	19.0	11.0
Congo	10.0	10.4	10.1	10.0	9.9	9.9	10.0		
Côte d'Ivoire			13.3			14.5	14.1		
Eritrea								8.8	
Ethiopia	47.1	38.5	40.3	49.7	39.5	41.5	40.9		
Gabon	35.1			18.6					
Ghana								7.4	3.9
Guinea	16.5	15.0	15.7	23.0	14.4	17.6	16.6		
Kenya	23.7	19.5	20.4	19.6	16.2	17.1	18.7	14.5	30.9
Lesotho	27.9	27.3	27.5	9.5	16.2	14.4	20.9		
Madagascar			22.3			31.0		16.0	7.7
Mali								26.0	10.6
Mauritania								13.2	2.1
Mozambique								27.7	
Nigeria			4.9			14.7		20.3	7.9
United Republic of Tanzania								10.1 ¹	10.7 ¹
Uganda								12.2 ¹	16.3 ¹
Zambia								17.5	
Zimbabwe	6.3	9.7	8.5	5.8	9.8	8.1	8.3		
East Asia and Pacific									
Mongolia	5.7	1.1	3.0	0.3	0.0	0.1	1.6		
South and South-East Asia									
Cambodia	0.1	0.0	0.0	0.0	0.2	0.2	0.1		
Nepal								9.0	20.0
Thailand			10.9			6.6	8.7		
Viet Nam								0.5 ¹	0.3 ¹
Eastern Europe and Central Asia									
Azerbaijan								1.0 ²	
Republic of Moldova	45.8	26.6	34.1	30.9	19.0	23.5	28.8		
Russian Federation			17.2			8.2	13.3		
Caribbean									
Barbados			35.9			25.6	31.0		
Dominican Republic								13.0	18.0
Honduras								13.0 ²	19.0 ²
Saint Vincent and the Grenadines			63.0			37.0			
Latin America									
Argentina							22.6		
Bolivia								6.0	15.0
Ecuador								7.0 ²	
Guatemala								7.0 ²	15.0 ²
Nicaragua								11.0	
(N = 42)				(N = 24)				(N = 24)	

*Report date 2005, but data collection can vary from 2003 to 2005

**Data for 2005 based on data collected between 2001 and 2005

(-) = Under review at the time of printing

¹Source: AIDS Indicator Survey²Source: Reproductive Health Survey

GE-12: Higher Risk Sex among Young Women and Men													
Country	2003		2005										
	UNGASS Country Report 2003*		UNGASS Country Report 2005**									DHS† (unless otherwise noted)	
	Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months		Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months									The percentage of respondents aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months of all respondents reporting sexual activity in the last 12 months	
	Males	Females	Males	Females	All	Males	Females	All	Males	Females	All	Males	Females
Sub-Saharan Africa													
Angola			61.5	35.6	49.2	61.1	26.3	43.2	61.4	32.7	47.1		
Benin			31.0	2.0	9.6	32.6	4.5	13.0	31.8	3.4	17.6	90.0	36.0
Burkina Faso	82.0	19.0										78.0	23.0
Cameroon	86.0	41.0	95.2	57.2	68.6	82.0	27.3	40.1	89.9	44.7	67.3	91.0	44.0
Central African Republic			42.1	9.4	22.9	40.2	13.7	27.1	41.0	11.9	26.5		
Chad			-	-	-	-	-	-	-	-	-	76.0	7.0
Congo			72.0	63.5	67.6	72.0	65.4	68.6	72.0	64.7	68.4		
Côte d'Ivoire	91.0	51.0							57.9	64.3	61.0		
Ethiopia	64.0	7.0	43.5	24.8	30.1	36.5	3.0	12.0	37.9	7.4	22.7		
Ghana												83.0	50.0
Guinea	92.0	23.0											
Kenya	92.0	39.0	13.5	9.8	11.5	16.1	8.2	12.2	15.5	8.6	12.1	84.0	30.0
Lesotho			96.4	57.6	67.4	87.6	38.0	52.5	89.5	43.3	66.4		
Madagascar									71.9	30.9		72.0	31.0
Malawi	71.0	17.0							62.1	13.9			
Mali			100.0	100.0	100.0	0.0	0.0	0.0	16.0	17.0	16.5	85.0	18.0
Mozambique												84.0	37.0
Nigeria			90.5	42.9		73.0	27.7					78.0	29.0
Rwanda	42.0	10.0											
United Republic of Tanzania	87.0	40.0										81.0	36.0
Togo	89.0	51.0											
Uganda	59.0	22.0	-	-	-	-	-	-	-	-	-	74.0	26.0
Zambia									24.0	13.0		86.0	30.0
Zimbabwe	82.0	20.0	75.0	21.3	40.2	80.7	24.8	47.6	78.6	23.3	51.0		
East Asia and Pacific													
Mongolia			93.5	76.4	86.6	93.4	81.1	88.9	93.5	79.2	86.3		

GE-12: Higher Risk Sex among Young Women and Men													
Country	2003		2005										
	UNGASS Country Report 2003*		UNGASS Country Report 2005**									DHS† (unless otherwise noted)	
	Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months		Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months									The percentage of respondents aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months of all respondents reporting sexual activity in the last 12 months	
	Males	Females	Urban			Rural			All			Males	Females
			Males	Females	All	Males	Females	All	Males	Females	All	Males	Females
South and South-East Asia													
Cambodia			72.0	5.4	38.9	18.2	2.1	7.2	26.3	2.6	14.4		
India												12.0 ²	2.0 ²
Thailand											56.0		
Viet Nam												21.0 ¹	0.7 ¹
Eastern Europe and Central Asia													
Uzbekistan												45.0 ³	1.0 ³
Caribbean													
Barbados									26.6	15.9	21.6		
Dominican Republic												83.0	29.0
Latin America													
Bolivia												70.0	32.0
Nicaragua													10.0
(N = 34)	(N = 12)		(N = 21)									(N = 19)	

*Report date 2003, but data collection can vary from 1998 to 2000

**Report date 2005, but data collection can vary between 2003 and 2005

†Data for 2005 based on data collected between 2001 and 2005

(-) = Under review at the time of printing

¹Source: AIDS Indicator Survey²Source: Behavioral Surveillance Survey³Source: Health Examination Survey

GE-13: Young People—Condom use with Non-regular Partners													
Country	2003		2005										
	UNGASS Country Report 2003*		UNGASS Country Report 2005**									DHS† (unless otherwise noted)	
	Percentage of young people (aged 15–24) who used a condom the last time they had sex with a non-regular partner		Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-regular partner									Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-regular partner	
	Males	Females	Males	Females	All	Males	Females	All	Males	Females	All	Males	Females
Sub-Saharan Africa													
Angola			63.6	71.2	66.2	63.6	20.0	50.0	63.6	55.2	59.4		
Benin	34.0	19.0	53.3	25.0	49.1	65.1	71.4	66.7	59.5	50.8	55.2	34.0	19.0
Botswana	88.0	75.0										88.0 ¹	75.0 ¹
Burkina Faso	55.0	41.0										67.0	54.0
Burundi			50.0	7.1	20.0	55.7	48.7	51.1	55.2	46.0	50.6		
Cameroon	31.0	16.0	65.7	53.6	58.6	39.9	27.2	33.3	55.4	42.5	49.0	57.0	46.0
Central African Republic			84.1	79.4	83.0	82.5	46.7	72.7	83.2	60.6	71.9		
Chad			-	-	-	-	-	-	-	-	-	25.0	17.0
Côte d'Ivoire	56.0	25.0	-	-	-	-	-	-	-	-	-		
Democratic Republic of the Congo		12.0											
Ethiopia	30.0	17.0	84.4	46.3	69.5	23.3	6.7	19.5	36.1	14.6	25.4		
Eritrea												81.0	
Gabon	48.0	33.0											
Ghana	33.0	20.0	55.5	38.5	45.9	44.7	27.1	35.9	49.6	32.2	40.9	52.0	33.0
Guinea	32.0	17.0										42.0	27.0
Kenya	43.0	14.0	58.4	32.5	45.9	42.6	22.6	33.2	46.1	25.2	35.6	47.0	25.0
Lesotho			72.0	65.6	67.9	42.0	44.0	43.0	48.6	49.8	49.2	48.0	50.0
Madagascar												12.0	5.0
Malawi	38.0	32.0	56.5	51.8	53.8	43.2	29.2	35.6	45.6	33.0	39.3	47.0	35.0
Mali	30.0	14.0										30.0	14.0
Mozambique												33.0	29.0
Nigeria	38.0	21.0	66.8	50.9		54.1	34.1					46.0	24.0
Rwanda	55.0	23.0										41.0	28.0
Senegal												54.0	34.0
South Africa		20.0											
Togo	41.0	22.0											
Uganda	62.0	44.0	-	-	-	-	-	-	-	-	-	55.0 ²	53.0 ²
United Republic of Tanzania	31.0	21.0										47.0 ²	42.0 ²
Zambia	38.0	38.0							38.4	26.1		40.0 ³	35.0 ³
Zimbabwe	69.0	42.0	69.2	52.1	63.2	49.1	35.7	45.0	56.5	42.6	49.6		
East Asia and Pacific													
Mongolia			61.4	45.7	55.8	56.5	39.5	50.8	58.5	42.1	50.3		
South and South-East Asia													
Cambodia		43.0											
India	51.0	40.0										59.0 ⁴	51.0 ⁴
Nepal	52.0												
Thailand			-	-	-	-	-	-	-	-	-		
Viet Nam												68.0 ²	

GE-13: Young People—Condom use with Non-regular Partners													
Country	2003		2005										
	UNGASS Country Report 2003*		UNGASS Country Report 2005**									DHS† (unless otherwise noted)	
	Percentage of young people (aged 15–24) who used a condom the last time they had sex with a non-regular partner		Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-regular partner									Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-regular partner	
			Urban			Rural			All				
			Males	Females		Males	Females	All	Males	Females	All		
Males	Females	Males	Females	All	Males	Females	All	Males	Females	All	Males	Females	
Eastern Europe and Central Asia													
Czech Republic									55.0		31.0		
Republic of Moldova												63.0	44.0
Russian Federation												78.8	
Ukraine			73.5	67.0	71.8	72.2	60.0	69.2	73.2	65.1	69.1		
Uzbekistan												50.0 ⁵	
Caribbean													
Barbados									77.8	33.3	49.3		
Dominican Republic	48.0	12.0										52.0	29.0
Haiti	30.0	19.0											
Jamaica		38.0											
Latin America													
Argentina												46.0	
Bolivia	22.0	8.0										37.0	20.0
Brazil	59.0	32.0										74.1	
Chile	33.0	18.0											
Colombia		29.0											
Mexico	57.0	57.0											
Nicaragua													17.0
Paraguay		79.0											
Peru		19.0											
(N = 54)	(N = 34)		(N = 24)						(N = 27)				

*Report date 2003, but data collection can vary from 1996 to 2001

**Report date is 2005, but data collection can vary from 2000 to 2005

†Data for 2005 based on data collected from 2001 to 2005

(-) = Under review at the time of printing

¹Source: AIDS Impact Survey

²Source: AIDS Indicator Survey

³Source: Sexual Behavior Survey

⁴Source: Behavioral Surveillance Survey

⁵Source: Health Examination Survey

GE-14: Orphans—School Attendance					
Country	2003			2005	
	UNGASS Country Report 2003*			UNGASS Country Report 2005**	DHS† (unless otherwise noted)
	Ratio of school attendance—orphans versus non-orphans			Ratio of current school attendance among orphans to that among non-orphans, aged 10–14	Ratio of the proportion of orphans (mother and father both dead) aged 10–14 attending school to the proportion of non-orphans (living with at least one parent) aged 10–14 attending school
	Males	Females	All	All	All
Sub-Saharan Africa					
Angola			0.90		0.90 ¹
Botswana			0.99		0.99 ²
Burkina Faso					1.09
Burundi			0.70		0.70 ¹
Cameroon		0.64	0.94		0.99
Central African Republic			0.91		0.91 ²
Chad			0.96		1.07
Comoros			0.59		0.59 ¹
Côte d'Ivoire			0.83		0.83 ¹
Democratic Republic of the Congo			0.72	-	0.72 ¹
Equatorial Guinea			0.95		0.95 ¹
Eritrea					0.83
Ethiopia	0.58	0.64	0.60	-	0.60
Gabon			0.98		0.98
Gambia			0.85		0.85 ¹
Ghana			0.93		0.79
Guinea	0.86	1.55	1.13		1.13
Guinea-Bissau			1.03		1.03 ¹
Kenya	0.79	0.71	0.74	0.97	0.95
Lesotho			0.87		0.87 ¹
Madagascar			0.65	0.80	0.76
Malawi	0.96	0.90	0.93	0.97	0.93
Mali			0.72		1.04
Mozambique	0.44	0.50	0.47		0.80
Namibia			0.92	0.97	0.92
Niger			1.07		
Nigeria	0.69	1.07	0.87		0.64
Rwanda	0.76	0.86	0.80		0.80 ¹
Senegal			0.74		0.74 ¹
Sierra Leone			0.71		0.71 ¹
Somalia			0.65		0.65 ¹
South Africa	0.95	0.96	0.95		
Swaziland			0.91		0.91 ¹
Togo			0.96		0.96 ¹
Uganda	0.90	1.00	0.95		0.95
United Republic of Tanzania	0.66		0.74		0.82 ³
Zambia			0.87	0.17	0.92 ⁴
Zimbabwe	0.89	0.82	0.85		0.98 ²

GE-14: Orphans—School Attendance					
Country	2003			2005	
	UNGASS Country Report 2003*			UNGASS Country Report 2005**	DHS† (unless otherwise noted)
	Ratio of school attendance—orphans versus non-orphans			Ratio of current school attendance among orphans to that among non-orphans, aged 10–14	Ratio of the proportion of orphans (mother and father both dead) aged 10–14 attending school to the proportion of non-orphans (living with at least one parent) aged 10–14 attending school
	Males	Females	All	All	All
South and South-East Asia					
Cambodia					0.71
Indonesia					0.82
North Africa and Middle East					
Sudan			0.96		0.96 ¹
Caribbean					
Dominican Republic					0.96
Haiti					0.87
Saint Lucia				-	
Latin America					
Guatemala					0.98
Peru					0.85
Suriname					0.89 ¹
	(N = 47)	(N = 37)		(N = 9)	(N = 44)

*Report date 2003, but data collection can vary from 1997 to 2001

**Report date 2005, but data collection can vary from 2001 to 2005

†Data for 2005 based on data collection can vary from 1999 to 2004

(-) = Under review at the time of printing

¹Source: Multiple Indicator Cluster Survey²Source: Census³Source: AIDS Indicator Survey⁴Source: Sexual Behavior Survey

GE-16: HIV Treatment—Survival after 12 Months on Antiretroviral Therapy									
Country	2005								
	UNGASS Report 2005								
	Males			Females			All		
	<15	15+	All	<15	15+	All	<15	15+	All
Sub-Saharan Africa									
Chad	-	-	-	-	-	-	-	-	-
Côte d'Ivoire	-	-	-	-	-	-	-	-	-
Ethiopia			90.2			86.4			88.6
Madagascar									100.0
Malawi									83.0
Namibia									91.0
Nigeria									98.2
Somalia	-	-	-	-	-	-	-	-	-
Eastern Europe and Central Asia									
Georgia			85.0			100.0			88.0
Ukraine	100.0	67.6	68.9	100.0	73.7	75.4	100.0	70.3	71.9
Caribbean									
Barbados			92.5			94.0			93.3
Dominica	-	-	-	-	-	-	-	-	-
Saint Lucia									80.0
Saint Vincent and the Grenadines	-	-	-	-	-	-	-	-	-
Trinidad and Tobago	-	-	-	-	-	-	-	-	-
(N = 15)	(N = 15)								

(-) = Under review at the time of printing

CLPE-3: Most-at-risk-populations—HIV Testing				
Country	2005			
	UNGASS Report 2005*			
	Percentage most-at-risk population(s) who received HIV testing in the last 12 months and who knew the results			
	All	Sex workers	Injecting Drug Users	Men who have sex with men
Sub-Saharan Africa				
Burundi		37.6		
Congo		3.3		8.3
Senegal				10.8
East Asia & Pacific				
Mongolia		67		23.2
South and South East Asia				
Bangladesh	1.3	1.6**	3.2	
India	28.9			
Indonesia		14.8	18.1	15.4
Iran (Islamic Republic of)			9.4	
Lao People's Democratic Republic		8.9		
Viet Nam		-	-	
Eastern Europe & Central Asia				
Armenia		33.2	21.1	42
Belarus		48.5	39.2	55.4
Georgia		24.4	6.4	27.1
Romania		35.5	36	
Ukraine	17.9	32.4	27.1	24.6
Western Europe				
Serbia and Montenegro				52.5 ^{††}
The former Yugoslav Republic of Macedonia		66.7	31.8	7.4
North Africa and Middle East				
Algeria			15.1	
Morocco			12.5	
Turkey		26		
Caribbean				
Jamaica		43.0 [†]		
Latin America				
Argentina		35.9		96.3
Panama		76.5		44.8
(N = 23)			(N = 23)	

*Report date 2005, but data collection can vary from 2003 to 2005

**Female sex workers

†Commercial sex workers

††Value for Serbia

(-) = Under review at the time of printing

CLPE-4: Most-at-risk populations—Prevention Programmes						
Country	2005					
	Men who have sex with men		Injecting drug users		Sex workers	
	UNGASS Country Report 2005*	Coverage Survey**	UNGASS Country Report 2005*	Coverage Survey**	UNGASS Country Report 2005*	Coverage Survey**
	Percentage of most-at-risk population(s) reached by prevention programmes	Percentage of men who have sex with men covered with outreach programmes	Percentage of most-at-risk population(s) reached by prevention programmes	Percentage of injecting drug users covered with harm reduction services	Percentage of most-at-risk population(s) reached by prevention programmes	Percentage of sex workers covered with outreach programmes
Sub-Saharan Africa						
Benin						100.0 [±]
Burkina Faso					42.1	60.0
Burundi					77.7	
Chad						5.0
Congo	33.3				53.4	
Côte d'Ivoire				100.0 [±]		71.0
Ghana						50.0
Guinea				100.0 [±]		50.0
Kenya		2.0				17.0
Mali					45.3	
Mozambique				< 0.5		5.0
Niger						92.0
Senegal		100.0 [±]				100.0 [±]
Togo						30.0
Uganda						10.0
Zimbabwe						40.0
East Asia and Pacific						
China		8.0	45.0	8.0	25.0	38.0
Mongolia	68.1				58.0	
South and South-East Asia						
Bangladesh	77.0		82.0	7.0	71.6 [†]	
Cambodia		17.0		97.0		60.0
India	45.0	45.0	47.8	48.0	52.4	52.0
Indonesia	1.3	10.0	15.0	89.0	37.3 [†]	50
Iran (Islamic Republic of)			11.4			
Lao People's Democratic Republic of					70.7	100.0 [±]
Malaysia		10.0		4.0		
Nepal	5.4	36.0	8.6	<0.50	35.2 [†]	68.0
Pakistan	22.0	15.0	28.4	100.0 [±]	11.0 [†]	20.0
Philippines		2.0		<0.50		7.0
Viet Nam			69.1		81.0	
Eastern Europe and Central Asia						
Armenia	0.7		25.1		28.9	
Belarus	7.1		16.4		8.8	
Croatia				20.0		
Czech Republic			60.0			
Georgia			25.0		75.6	
Kazakhstan		1.0		8.0		31.0
Kyrgyzstan	79.2		8.4		75.3	
Latvia		2.0	7.9	2.0		17.0
Republic of Moldova		90.0	22.4	74.0	14.1 ^{††}	50.0
Romania	3.1		9.3	43.0	3.6	
Russian Federation		1.0	4.9	9.0	15.6	
Ukraine		5.0	38.4	13.0	33.7	5.0

CLPE-4: Most-at-risk populations—Prevention Programmes						
Country	2005					
	Men who have sex with men		Injecting drug users		Sex workers	
	UNGASS Country Report 2005*	Coverage Survey**	UNGASS Country Report 2005*	Coverage Survey**	UNGASS Country Report 2005*	Coverage Survey**
	Percentage of most-at-risk population(s) reached by prevention programmes	Percentage of men who have sex with men covered with outreach programmes	Percentage of most-at-risk population(s) reached by prevention programmes	Percentage of injecting drug users covered with harm reduction services	Percentage of most-at-risk population(s) reached by prevention programmes	Percentage of sex workers covered with outreach programmes
Western Europe						
Albania				7.0		
North Africa and Middle East						
Algeria			15.0			
Egypt				100.0 [±]		
Tunisia		5.0		2.0		20.0
Turkey					13.8	
Caribbean						
Dominican Republic		10.0		100.0 [±]		30.0
Jamaica					60.0	
Latin America						
Argentina		30.0		93.0		30.0
Colombia		30.0				75.0
Ecuador		5.0				50.0
El Salvador		17.0				60.0
Guatemala		10.0				75.0
Panama	43.8				48.0	71.0
Paraguay		50.0				10.0
Peru	22.6					20.0
Venezuela		1.0				30.0
(N = 57)	(N = 13)	(N = 24)	(N = 19)	(N = 24)	(N = 24)	(N = 36)

*Report date 2003, but data collection can vary from 2003 to 2005

**Data are estimates for 2005 based on the latest available information

†Female sex workers

††Commercial sex workers

‡Under review at the time of printing

CLPE-5: Most-at-risk-populations—Knowledge about HIV Prevention				
Country	2005			
	UNGASS Country Report 2005*			
	Percentage of most-at-risk population(s) who both correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission			
	All	Men who have sex with men	Injection drug users	Sex workers
Sub-Saharan Africa				
Benin		42.2		
Burundi				4.3
Congo		3.3		66.7
Mali				90.1
East Asia and Pacific				
China		37.3	36.0	23.5**
South and South-East Asia				
Bangladesh	28.2	13.5	14.0	23.3
Indonesia		43.3	6.7	23.8
Lao People's Democratic Republic				20.5
Nepal		27.3	49.9	16.9
Viet Nam			34.4	24.2
Eastern Europe and Central Asia				
Armenia		54.0	60.0	49.2
Belarus		62.8	61.4	23.8
Georgia			36.2	1.3
Kyrgyzstan		6.9		1.1
Republic of Moldova		38.3	37.1	34.7
Romania			18.0	14.1
Ukraine	39.4	48.9	21.2	8.1
Western Europe				
The former Yugoslav Republic Of Macedonia		33.9	26.7	9.9
North Africa and Middle East				
Morocco			6.9	72.2
Turkey				21.7
Caribbean				
Jamaica				26.1†
Latin America				
Argentina		55.9		69.4
Costa Rica		48.8		
Peru		72.6		
	(N = 24)		(N = 24)	

*Report date 2005, but data collection can vary from 2003 to 2005

**Female sex workers

†Commercial sex workers

CLPE-6: Sex Workers—Condom Use			
Country	2005		
	UNGASS Report 2005 [*]		
	Percentage of female and male sex workers who reported the use of a condom with their most recent client		
	All	Males	Females
Sub-Saharan Africa			
Burkina Faso	95.9		
Burundi	73.7		73.8
Senegal	86.3		86.6
East Asia and Pacific			
China			68.5
Mongolia	94.1	50.0	96.4
South and South-East Asia			
Bangladesh	39.8	44.1	31.8
Cambodia	96.0		96.0
Indonesia	54.7	47.5	56.2
Lao People's Democratic Republic	83.2	58.8	88.9
Nepal	67.1		
Pakistan	22.6	6.6	37.0
Sri Lanka			64.9
Viet Nam	90.4		90.4
Eastern Europe and Central Asia			
Armenia	89.2	100.0 [†]	89.2
Belarus	77.4	100.0 [†]	77.3
Georgia			95.0
Kyrgyzstan	80.9		
Republic of Moldova	98.4 ^{††}		
Romania			85.0
Russian Federation	77.0		
Western Europe			
The former Yugoslav Republic of Macedonia	85.9	87.5	84.4
North Africa and Middle East			
Morocco	37.7		37.8
Caribbean			
Jamaica	84.3		
Latin America			
Panama	91.5	90.8	91.6
(N = 24)		(N = 24)	

^{*}Report date 2003, but data collection can vary from 2003 to 2005

[†]Data under review at the time of printing

^{††}Commercial sex workers

CLPE-7: Men who have Sex with Men—Condom Use			
Country	2005		
	UNGASS Country Reports 2005*		
	Percentage of men who reported the use of a condom the last time they had anal sex with a male partner		
	All	Age <25	Age 25+
Sub-Saharan Africa			
Congo	23.3	23.5	23.1
Senegal	44.5		44.7
East Asia and Pacific			
China	41.1		
Mongolia	13.0	17.6	10.3
Oceania			
Fiji	20.0		
South and South-East Asia			
Bangladesh	49.2	52.9	48.8
Indonesia	47.6	45.6	48.6
Pakistan	7.6	9.8	4.9
Eastern Europe and Central Asia			
Armenia	30.4	40.0	12.5
Belarus	61.6	57.2	66.0
Georgia	53.6		
Kyrgyzstan	68.3		
Republic of Moldova	63.0	60.5	64.9
Russian Federation	38.8		
Ukraine	71.6	71.1	71.9
Western Europe			
The former Yugoslav Republic of Macedonia	29.2		
Latin America			
Panama	84.2	83.8	84.4
Peru	46.3	47.2	45.5
High-income Countries			
United States			50.5
(N = 19)		(N = 19)	

*Report date 2005, but data collection can vary from 2003 to 2005

CLPE-8: Injecting Drug Users - Safe Injecting and Sexual Practices					
Country	2005				
	UNGASS Country Report 2005*				
	Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e. who both avoid using non-sterile injecting equipment and use condoms, in the last month (for countries where injecting drug use is an established mode of HIV transmission).				
	All Ages	Age < 25		Age 25 +	
	All	Males	Females	Males	Females
East Asia and Pacific					
China	-	-	-	-	-
South and South-East Asia					
Bangladesh	-	8.3	31.3	16.2	68.3
Indonesia	-	18.9	27.3	19.2	8.7
Nepal	-	-	-	-	-
Pakistan	-	-	-	-	-
Thailand	-	18.8	28.6	27.4	15.6
Viet Nam	-	81.8		89.1	
Eastern Europe and Central Asia					
Armenia	-	46.4	66.7	30.6	33.3
Belarus	-	50.7	66.7	45.8	43.5
Georgia	-	-	-	-	-
Kyrgyzstan	-	-	-	-	-
Latvia	-	-	-	-	-
Republic of Moldova	-	61.9	57.1	37.3	36.2
Romania	-	-	-	1.5	0.9
Ukraine	-	18.3	21.3	20.6	17.4
Western Europe					
The former Yugoslav Republic of Macedonia	-	28.7	18.5	30.7	35
Serbia and Montenegro	20.1**	2.0 [†]	-	-	-
North Africa and Middle East					
Algeria	-				
(N = 18)			(N = 18)		

*Report date 2005, but data collection can vary from 2003 to 2005

**Value for Serbia

†Value for Montenegro

NOTES ON SPECIFIC INDICATORS

Additional details on the following indicators can be found in UNAIDS—Guidelines on Construction of Core Indicators (2005).

Generalized epidemic indicators

Since the *Progress Report on the Global Response to the HIV/AIDS epidemic* (2003), new core indicators were developed to better understand the nature and scope of the response to HIV and AIDS at national levels. In addition, there are now recommendations for use of separate sets of indicators for countries with generalized epidemics and those with concentrated or low-prevalence epidemics.

For countries with generalized epidemics, there are five new core indicators (see Box 1 below). (Please note that one of the original national indicators—percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV—has been shifted to the set of indicators for countries with concentrated or low-prevalence epidemics.)

BOX 1: FIVE NEW CORE INDICATORS FOR GENERALIZED EPIDEMICS

- Percentage of orphans and vulnerable children whose households received free basic external support in care for the child.
- Percentage of transfused blood units screened for HIV.
- Percentage of young women and men who have had sex before the age of 15.
- Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months.
- Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral treatment.

1. GE-1: AMOUNT OF NATIONAL FUNDS SPENT BY GOVERNMENTS FROM DOMESTIC SOURCES FOR AIDS

This indicator is a comprehensive approach to monitoring spending on HIV and AIDS across all sectors. It is measured through the execution of National AIDS Spending Assessments; alternatively through a desk review or other proxy measures. It applies to all countries, including those with concentrated and low-prevalence epidemics.

Indicator definition(s) and components:

- **UNGASS country report:** Amount of national funds disbursed by governments in low- and middle-income countries.

It aims to measure the spending from governmental and other public institutions from their own sources at central or decentralized levels and excludes funds from international sources (even if these are being disbursed through the country government).

The indicator summary chart was compiled to represent the evolution from 2001, when the Declaration of Commitment on HIV/AIDS was agreed on, until the end of 2005. Sources for this chart included reports from countries for the review of the Declaration and other sources produced by members of the UNAIDS Global Resource Tracking Consortium.

Most countries reported the last available year and several methodologies were used in the construction of this indicator. These include the application of the National AIDS Spending Assessments framework as recommended by UNAIDS, which measures the actual expenditures by policy-relevant functions for the provision of AIDS services. Other sources of information used by reporting countries include AIDS budget analysis, desk reviews of the budgets' execution, reports to the resource flows project (UNFPA/UNAIDS/NIDI) on expenditures, reviews of activities of national programmes and national health accounts AIDS sub-analysis.

The best estimates, reflecting actual expenditures for the period 2001–2005, were selected when available. There was an attempt to separate and deduct the international funds received by governments to isolate countries' own expenditure.

In cases where countries had an ongoing loan or credit from a development bank, there was an effort to separate the reimbursable part of these loans. This part was classified as domestic expenditure along with the national counterpart and fees paid for the performance of the project in the calendar year when this appeared.

Countries reporting on this indicator, but whose figures are under revision, were not included here. Others are preliminary estimates and totals might change when additional information is available.

2. GE-3: LIFE-SKILLS-BASED HIV EDUCATION IN SCHOOLS

The purpose of this indicator is to assess progress towards implementation of life-skills-based HIV education in all schools and it applies to all countries. It is measured biennially through school surveys or education programme reviews.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year.

Numerator: Number of schools with staff members trained in and regularly teaching life-skills-based HIV education.

Denominator: Number of schools surveyed.

3. GE-4: WORKPLACE HIV AND AIDS CONTROL

The purpose of this indicator is to assess progress in implementing workplace policies and programmes to combat HIV. It applies to all countries and is measured biennially. It is measured by surveying a representative sample of major employers in both the public and private sectors. Public-sector employers should, at a minimum, include the ministries of transport, labour, tourism, education and health. Private-sector employers should be selected on the basis of the size of their labour force.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of large enterprises or companies that have HIV and AIDS workplace policies and programmes.

Numerator: Number of employers with comprehensive HIV and AIDS policies and programmes (as defined in the UNAIDS guidelines on Construction of Core Indicators—2005)

Denominator: Number of employers surveyed.

4. GE-5: SEXUALLY TRANSMITTED INFECTIONS—COMPREHENSIVE CASE MANAGEMENT

The purpose of this indicator is to assess progress in preventing vertical transmission of HIV. The indicator applies to all countries and it is measured biennially through programme monitoring and estimates.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of women and men with sexually transmitted infections at health-care facilities who are appropriately diagnosed, treated and counselled.

Numerator: Number of sexually transmitted infection patients for whom the correct procedures were followed on: (a) history-taking; (b) examination; (c) diagnosis and treatment; and (d) effective counselling on partner notification, condom use and HIV testing.

Denominator: Number of sexually transmitted infection patients for whom provider-client interactions were observed.

5. GE-6: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION—ANTIRETROVIRAL PROPHYLAXIS

The purpose of this indicator is to assess progress in preventing vertical transmission of HIV. The indicator applies to all countries and it is measured biennially through programme monitoring and estimates.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.

Numerator: Number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce mother-to-child transmission according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months.

Denominator: Estimated number of HIV-infected pregnant women.

Other available data source:

- **Coverage survey:** for further details regarding the survey, please see USAID, UNAIDS, WHO, UNICEF, and POLICY Project—coverage of selected services for HIV/AIDS prevention, care and support in low- and middle-income countries in 2003 (June 2004).

6. GE-7: HIV TREATMENT—ANTIRETROVIRAL COMBINATION THERAPY

The purpose of this indicator is to assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection. It applies to all countries and is measured biennially through programme monitoring.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of people with advanced HIV infection receiving antiretroviral combination therapy.

Numerator: Number of people with advanced HIV infection who receive antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards); it is calculated as follows: number of people receiving treatment at the start of the year, plus number of people who commenced treatment in the preceding 12 months, minus number of people for whom treatment was terminated in the preceding 12 months (including those who died).

Denominator: Number of people with known advanced HIV infection (i.e. those in need of antiretroviral combination therapy).

Other available data sources:

Coverage survey—coverage for antiretroviral therapy for HIV/AIDS. For further details, please see USAID, UNAIDS, WHO, UNICEF, and POLICY Project—coverage of selected services for HIV/AIDS prevention, care and support in low- and middle-income countries in 2003 (June 2004).

“3 by 5” Initiative—antiretroviral therapy coverage (December 2005). For further details, please see WHO and UNAIDS—Progress on global access to HIV antiretroviral therapy: a report on “3 by 5” and beyond (March 2006).

7. GE-8: SUPPORT FOR CHILDREN AFFECTED BY HIV AND AIDS

The purpose of this indicator is to assess progress in providing support to households that are caring for orphaned and vulnerable children and the indicator is measured in countries with high HIV-prevalence. It is measured every 4–5 years through population-based surveys such as Demographic and Health Survey and Multiple Indicator Cluster Survey.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of orphaned and vulnerable children whose households received external support in caring for the child.

Numerator: Number of orphaned and vulnerable children who live in households that answered “yes” to at least one of four questions regarding the type and frequency of support received. (Household received medical support in the last 12 months; school-related assistance within the last 12 months; emotional/psychological support within the last 3 months; or social support within the last 3 months.)

Denominator: Total number of orphaned and vulnerable children.

8. GE-9: BLOOD SAFETY

The purpose of this indicator is to assess progress in screening transfused blood units for HIV. The indicator applies to all countries and it is measured biennially using the MEASURE Evaluation blood safety protocol.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of transfused blood units screened for HIV.

Numerator: Number of blood units screened for HIV in the last 12 months up to WHO or national standards.

Denominator: Number of blood units transfused in the last 12 months.

Other available data source:

Coverage survey—percentage of blood for transfusion that is tested for HIV. For further details, please see USAID, UNAIDS, WHO, UNICEF, and POLICY Project—coverage of selected services for HIV/AIDS prevention, care and support in low- and middle-income countries in 2003 (June 2004).

9. GE-10: YOUNG PEOPLE—KNOWLEDGE ABOUT HIV PREVENTION

The purpose of this indicator is to assess progress towards universal knowledge of the essential facts about HIV transmission. The indicator applies to all countries and should be measured, at minimum, every 4–5 years; however, a biennial measurement is preferred. The indicator is measured using population-based surveys such as Demographic and Health Survey, Multiple Indicator Cluster Survey, and Behavioural Surveillance Survey (youth section).

Targets: 2005—90%; 2010—95%

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions.

Numerator: Number of respondents aged 15–24 years who gave the correct answers to *all* five questions regarding HIV transmission.

1. Can the risk of HIV transmission be reduced by having sex with one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

Denominator: Number of respondents aged 15–24 who gave answers (i.e. including “don’t know”) to all five questions.

Other available data source:

Demographic and Health Survey: the percent of respondents who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can have HIV.

10. GE-11: SEX BEFORE THE AGE OF 15

The purpose of this indicator is to assess progress in increasing the age at which young men and women aged 15–24 first have sex. It applies to all countries and should be measured every 4–5 years through population-based surveys such as Demographic and Health Survey, Multiple Indicator Cluster Survey, and Behavioural Surveillance Survey (youth section).

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of young women and men who have had sex before the age of 15.

Numerator: Number of respondents aged 15–24 years who report their age at sexual initiation as less than 15 years.

Denominator: Number of respondents aged 15–24 years.

Other available data source:

Demographic and Health Survey—percentage of young women and men aged 15–19 who had first sexual intercourse by exact age 15.

11. GE-12: HIGHER RISK SEX AMONG YOUNG WOMEN AND MEN

The purpose of this indicator is to assess progress in reducing the percentage of young people aged 15–24 who have higher risk sex. It applies to all countries and should be measured every 4–5 years through population-based surveys such as Demographic and Health Survey, Multiple Indicator Cluster Survey, and Behavioural Surveillance Survey (youth section).

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months.

Numerator: Number of respondents aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months.

Denominator: Number of respondents aged 15–24 who reported sexual activity in the last 12 months.

Other available data source:

Demographic and Health Survey—the percent of respondents who have had sex with a non-marital, non-cohabiting partner in the last 12 months of all respondents reporting sexual activity in the last 12 months.

12. GE-13: YOUNG PEOPLE—CONDOM USE WITH NON-REGULAR PARTNERS

The purpose of this indicator is to assess progress towards preventing early-age exposure to HIV through unprotected sex with non-regular partners. The indicator applies to all countries and should be measured, at minimum, every 4–5 years; however, a biennial measurement is preferred. The indicator is measured using population-based surveys such as Demographic and Health Survey, Multiple Indicator Cluster Survey, and Behavioural Surveillance Survey (youth section).

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular partner.

Numerator: Number of the respondents aged 15–24 who reported having had a non-regular (i.e. non-marital and non-cohabiting) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.

Denominator: Number of respondents aged 15–24 who reported having had a non-regular sexual partner in the last 12 months.

Other available data source:

Demographic and Health Survey—the percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months.

13. GE-14: ORPHANS—SCHOOL ATTENDANCE

The purpose of this indicator is to assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans. This indicator applies to all countries and is measured using population-based surveys such as Demographic and Health Survey, Multiple Indicator Cluster Survey, and other representative surveys. It should be measured, at minimum, every 4–5 years; however, a biennial measurement is preferred.

Indicator definition(s) and components:

- **UNGASS country report:** Ratio of current school attendance among orphans to that among non-orphans aged 10–14.

Orphan school attendance

Numerator: Number of children who have lost both parents and are still in school.

Denominator: Number of children who have lost both parents.

Non-orphan school attendance

Numerator: Number of children, both of whose parents are still alive, who live with at least one parent and who are still in school.

Denominator: Number of children both of whose parents are still alive and who live with at least one parent.

Other available data source:

Demographic and Health Survey—ratio of the proportion of orphans (mother and father both dead) aged 10–14 attending school to the proportion of non-orphans (living with at least one parent) aged 10–14 attending school.

14. GE-16: HIV TREATMENT—SURVIVAL AFTER 12 MONTHS ON ANTIRETROVIRAL THERAPY

The purpose of this indicator is to assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy. It applies to all countries and is measured biennially through programme monitoring.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy.

Numerator: Number of adults and children continually on antiretroviral therapy at 12 months after initiating treatment.

Denominator:

- (a) Minimum survival: total number of adults and children who initiated antiretroviral therapy in the therapy start-up group 12 months earlier, including those who have stopped antiretroviral therapy, those who have transferred out, and people lost to follow-up.
- (b) Maximum survival: total number of adults and children who initiated antiretroviral therapy in the therapy start-up group 12 months earlier, excluding those who have stopped antiretroviral therapy, those who have transferred out, and people lost to follow-up.

Concentrated or low-prevalence epidemic indicators

Since the *Progress Report on the Global Response to the HIV/AIDS Epidemic* (2003), new core indicators were developed to better understand the nature and scope of the response to HIV and AIDS at the national level. In addition, there are now recommendations for use of separate sets of indicators for countries with generalized epidemics and those with concentrated or low-prevalence epidemics.

For countries with concentrated or low-prevalence epidemics, the set of nine priority indicators includes four indicators from the national commitment and action category, four from the knowledge and behaviour category and one from the impact category (see Box 2).

BOX 2: NINE CORE INDICATORS FOR CONCENTRATED OR LOW-PREVALENCE EPIDEMICS

- Amount of national funds disbursed by governments in low- and middle-income countries.
- National Composite Policy Index.
- Percentage of [most-at-risk population(s)] who received HIV testing in the last 12 months and know the results.
- Percentage of [most-at-risk population(s)] reached with HIV/AIDS prevention programmes.
- Percentage of [most-at-risk population(s)] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- Percentage of female and male sex workers reporting the use of a condom with their most recent client.
- Percentage of men reporting use of a condom the last time they had anal sex with a male partner.
- Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e. who avoid sharing equipment and use condoms, in the last month (*applies only to countries where injecting drug use is an established mode of HIV transmission*).
- Percentage of [most-at-risk population(s)] who are HIV infected (*impact indicator*).

Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, it would be valuable for them to calculate and report on indicators for those populations.

1. CLPE-3: MOST-AT-RISK POPULATIONS—HIV TESTING

The purpose of this indicator is to assess progress in implementing HIV testing and counselling among most-at-risk populations. The indicator applies to countries with concentrated or low-prevalence

epidemics, including countries with concentrated sub-epidemics within a generalized epidemic. It is measured biennially through programme monitoring or special surveys such as the Family Health International Behavioural Surveillance Survey.

Indicator definition(s) and components:

■ **UNGASS country report:** Percentage of [most-at-risk-population(s)] who received HIV testing in the last 12 months and who know the results.

The term “most-at-risk populations” included in the definition should be replaced with a defined segment of the population (e.g. sex workers, injecting drug users, men who have sex with men), which are being measured. In countries where there are multiple most-at-risk populations, the indicators should be reported for each population.

Numerator: Number of [most-at-risk population] respondents who have been tested for HIV during the last 12 months and who know the results of their test

Denominator: Number of [most-at-risk population] respondents included in the sample or prevalence estimation methods for the size of the most-at-risk population for the denominator.

2. CLPE-4: MOST-AT-RISK POPULATIONS—PREVENTION PROGRAMMES

The purpose of this indicator is to assess progress in implementing HIV prevention programmes for most-at-risk populations. The indicator applies to countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic. It is measured biennially through programme monitoring or special surveys such as the Family Health International Behavioural Surveillance Survey.

Indicator definition(s) and components:

■ **UNGASS country report:** Percentage of [most-at-risk-population(s)] reached with HIV-prevention programmes.

The term “most-at-risk populations” included in the definition should be replaced with a defined segment of the population (e.g. sex workers, injecting drug users, men who have sex with men), which are being measured. In countries where there are multiple most-at-risk populations, the indicators should be reported for each population.

Numerator: Number of [most-at-risk population] respondents who have been reached by at least one HIV-prevention programme during the last 12 months. Depending on local contexts, prevention programmes may include: outreach and peer education, exposure to targeted mass media, sexually transmitted infection screening and/or treatment, HIV counselling and testing, and substitution therapy and safer injection practices for injecting drug users.

Denominator: Number of [most-at-risk population] included in the sample or prevalence estimation methods for the size of the most-at-risk population for the denominator.

Other available data source:

Coverage survey—percentage of [most-at-risk population] reached by intervention per year. For further details regarding the coverage survey, please see USAID, UNAIDS, WHO, UNICEF, and POLICY Project—Coverage of Selected Services for HIV/AIDS Prevention, Care and Support in Low- and middle-income Countries in 2003 (June 2004).

3. CLPE-5: MOST-AT-RISK POPULATIONS—KNOWLEDGE ABOUT HIV PREVENTION

The purpose of this indicator is to assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations. It applies to countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic. It is measured biennially through special surveys such as the Family Health International Behavioural Surveillance Survey.

Indicator definition(s) and components:

■ **UNGASS country report:** Percentage of [most-at-risk-population(s)] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Numerator: Number of [most-at-risk population] respondents who gave the correct answers to *all* five questions regarding HIV transmission.

1. Can the risk of HIV transmission be reduced by having sex with one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV?

4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

Denominator: Number of [most-at-risk population] respondents who gave answers, including “don’t know,” to all five questions.

4. CLPE-6: SEX WORKERS—CONDOM USE

The purpose of this indicator is to assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients. It applies to countries with concentrated or low prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic. It is measured biennially through special surveys including the Family Health International Behavioural Surveillance Survey for sex workers.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of female and male sex workers reporting the use of a condom with their most recent client.

Numerator: Number of respondents who reported that a condom was used with their last client in the last 12 months.

Denominator: Number of respondents who reported having commercial sex in the last 12 months.

Other available data source:

Coverage survey—for further details regarding the survey, please see USAID, UNAIDS, WHO, UNICEF, and POLICY Project—Coverage of selected services for HIV/AIDS Prevention, Care and Support in low- and middle-income countries in 2003 (June 2004).

5. CLPE-7: MEN WHO HAVE SEX WITH MEN—CONDOM USE

The purpose of this indicator is to assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner. It applies to all countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic. It is measured biennially through special surveys including the Family Health International Behavioural Surveillance Survey for men who have sex with men.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.

Numerator: Number of respondents who reported that a condom was used the last time they had anal sex.

Denominator: Number of respondents who reported having had anal sex with a male partner in the last 6 months.

6. CLPE-8: INJECTING DRUG USERS—SAFE INJECTING AND SEXUAL PRACTICES

The purpose of this indicator is to assess progress in preventing injecting drug use-associated HIV transmission. The indicator applies to countries where injecting drug use is an established mode of HIV transmission and it is measured biennially through special surveys such as the Family Health International Behavioural Surveillance Survey for injecting drug users.

Indicator definition(s) and components:

- **UNGASS country report:** Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e. who both avoided using non-sterile injecting equipment and used condoms in the last 12 months.

Numerator: Number of respondents who report having never used non-sterile injecting equipment during the last month and who also reported that a condom was used the last time they had sex.

Denominator: Number of respondents who report injecting drugs and having had sexual intercourse in the last month.

Descriptions—additional resources

COVERAGE SURVEY

This study attempted to measure national coverage for several essential services by collecting service statistics and expert assessment. In each country the information was collected through national consultants. The consultants identified knowledgeable respondents for each service. Respondents were asked to provide statistics on the number of people receiving the service in the last year if this information was available. The respondents were also asked to estimate the percentage of the population needing the service that had access to that service. The consultants used a standard questionnaire.

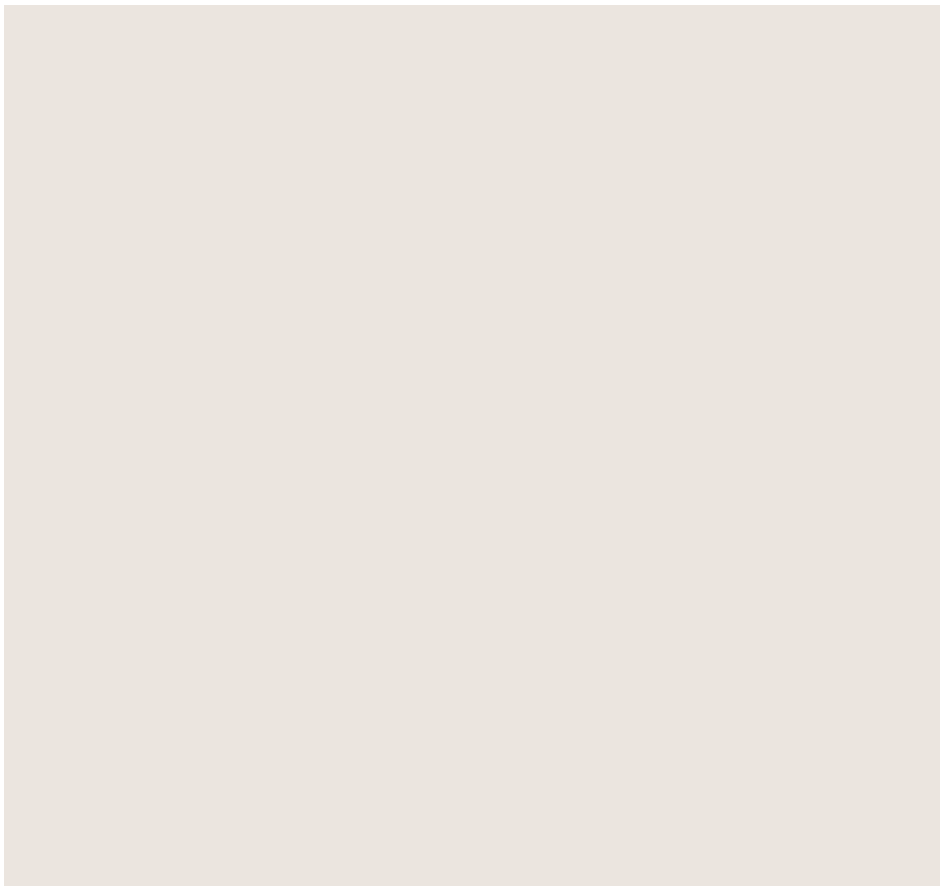
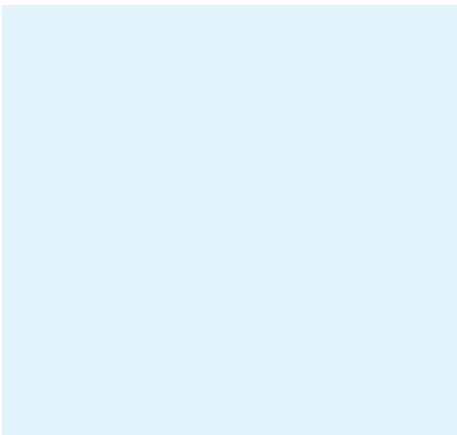
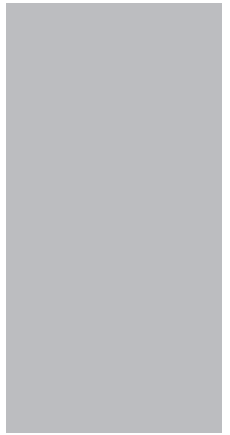
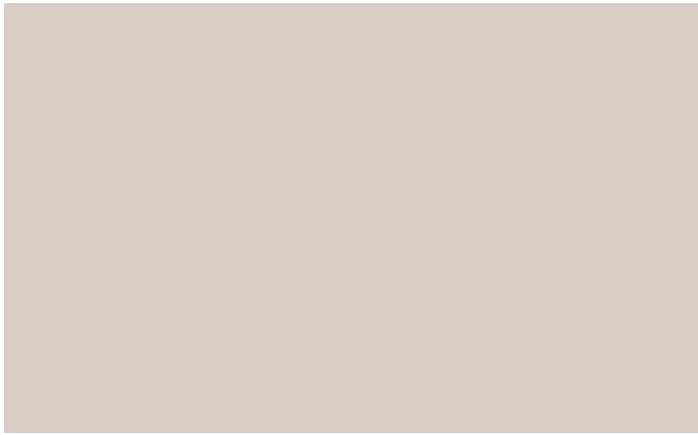
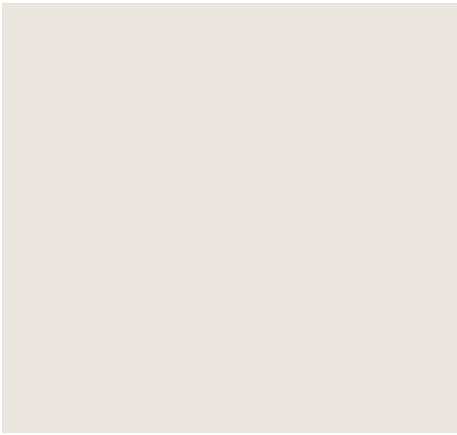
This study focuses on the services that can be measured most easily. Box 3 shows the services included in this study.

BOX 3: ESSENTIAL HIV AND AIDS SERVICES INCLUDED IN THIS STUDY

- **Voluntary counselling and testing.** Services providing pre-test counselling, testing for HIV infection and post-test counselling for anyone wanting to know their HIV status. It does not include testing done on hospital patients for medical purposes.
- **Prevention of mother-to-child transmission.** Services that provide voluntary counselling and testing for pregnant women and provide prevention services to those who are HIV-positive. Prevention services should include treatment with zidovudine, nevirapine or other antiretroviral drugs and may also include breastfeeding counselling and supplemental feeding.
- **Condoms.** The number of condoms distributed annually.
- **Harm reduction.** Services to reduce the risks associated with injecting drug use including risk reduction education and support, needle and syringe exchange and drug substitution.
- **Education.** AIDS education for primary and secondary school students.
- **Home-based care.** Services that reach HIV-infected people in their homes and provide basic palliative care, psychosocial support and planning services.
- **Treatment of opportunistic infections.** The standard of care available for HIV-positive patients needing treatment for specific conditions.
- **Prophylaxis for opportunistic infections.** Providing cotrimoxazole or isoniazid for people who are identified as HIV-positive.
- **Antiretroviral therapy.** Treatment of HIV-positive adults or children with a combination of at least three antiretroviral drugs.
- **Orphans and vulnerable children.** Service to support orphans and vulnerable children including food aid, education support, health care, protection services, psychosocial support and economic self-sufficiency.

Coverage is calculated by dividing the number of people using the service by the population needing the service.

References and photography credits



REFERENCES

Chapter 1 | INTRODUCTION

- UNAIDS (2005). *Intensifying HIV prevention: policy position paper*. UNAIDS, Geneva. August 2005.
- United Nations (2006). The Declaration of Commitment on HIV/AIDS Five Years Later, Report of the Secretary-General. Geneva.
- WHO (1994). *AIDS: images of the epidemic*. World Health Organization, Geneva. See also: <http://aidshistory.nih.gov/transcripts/transcripts/Broder97.pdf>

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- Abdulrahman A et al. (2004). Mode of transmission of HIV-1 in Saudi Arabia. *AIDS*, 18(10):1478–1480.
- Aids Prevention Centre (2006). Statistics fact sheets. Riga. Available at <http://aids.gov.lv/?sadala=146>.
- Altaf A et al. (2004). *Harm reduction among injection drug users in Karachi, Pakistan*. Paper presented at the 15th International AIDS Conference. Bangkok. 11–16 July.
- Balakireva O et al. (2003). The prospects for development of HIV prevention programmes among injecting drug users. Kiev, UNICEF, UNAIDS, Social Monitoring Centre.
- Baltazar G (2005). HIV sentinel surveillance 2004. Slide presentation. Nairobi, Ministry of Health.
- Bautista CT et al. (2004). Seroprevalence of and risk factors for HIV-1 infection among South American men who have sex with men. *Sexually Transmitted Infections*, 80:498–504.
- Beckerleg S, Telfer M, Hundt GL (2005). The rise of injecting drug use in east Africa: a case study from Kenya. *Harm Reduction Journal*, 2(12).
- Beyrer C et al. (2006). The emerging epidemics of HIV-1 and HCV among injecting drug users in Tajikistan. Poster abstract. 13th Conference on Retroviruses and Opportunistic Infections. 5–8 February. Denver.
- Buckingham RW et al. (2005). Factors associated with condom use among brothel-based female sex workers in Thailand. *AIDS Care*, 17(5):640–647.
- Burrows D (2003). *Policy and environment assessment: illicit drug use, the burden of drug-related harm, and HIV vulnerability in Cambodia*. Phnom Penh, The Policy Project.
- Buseh AG (2004). Patterns of sexual behaviour among secondary school students in Swaziland, southern Africa. *Culture, Health & Sexuality*, 6(4):355–367.
- Caribbean Epidemiology Centre, PAHO, WHO (2003). *Success stories in the fight against HIV/AIDS in the Caribbean—an update*. December. Port of Spain, CAREC.
- Caribbean Epidemiology Centre, PAHO, WHO (2004). *Status and trends analysis of the Caribbean HIV/AIDS epidemic 1982–2002*. May. Port of Spain, CAREC.
- Caribbean Technical Expert Group (2004). *Strengthening the Caribbean regional response to the HIV epidemic: report of the Caribbean technical expert group meeting on HIV prevention and gender*. Draft working document. 28–29 October. Jamaica.
- Cellule de Planification et de Statistique du Ministère de la Santé (CPS/MS), Direction Nationale de la Statistique et de l'Informatique (DNSI), ORC Macro (2002). *Enquête Démographique et de Santé au Mali 2001*. Calverton, Maryland, USA: CPS/MS, DNSI et ORC Macro.
- Center for Health Research and Ministry of Health Indonesia (2002). *A study of injecting drug use behaviour in three cities: Surabaya, Jakarta and Bandung*. University of Indonesia.
- Central Bureau of Statistics, Ministry of Health, ORC Macro (2004). *Kenya Demographic and Health Survey 2003*. Calverton, Maryland, USA.
- Central Statistical Authority, ORC Macro (2006). *Ethiopia Demographic and Health Survey 2005. Preliminary Report*. Calverton, Maryland, USA.

- Central Statistical Office, Central Board of Health, ORC Macro (2003). *Zambia Demographic and Health Survey 2001–2002*. Calverton, Maryland, USA.
- Centre de recherche pour le développement humain et MEASURE DHS+ (2005). Enquête démographique et de santé 2005: rapport préliminaire. Dakar and Calverton, CRDH and MEASURE Demographic Health Survey Plus.
- Cheluget B, Marum L, Stover J (2006). *Evidence for population-level declines in adult HIV prevalence in Kenya. Sexually Transmitted Infections*, 82(2).
- Day C et al. (2005). Patterns of drug use among a sample of drug users and injecting drug users attending a general practice in Iran. *Harm Reduction Journal*, 3(2).
- Department of Health Myanmar (2004). Sentinel surveillance data for March–April 2004. Yangon, Department of Health.
- Department of Health Philippines (2003). *Status and trends of HIV/AIDS in the Philippines: the 2002 technical report of the National HIV/AIDS Sentinel Surveillance System*. Manila, Department of Health.
- Department of Health Philippines (2005). *Consensus report on HIV and AIDS epidemiology 2005: integrated HIV behavioral and serologic surveillance findings*. Manila, National Epidemiology Center.
- Department of Health South Africa (2005). *National HIV and syphilis antenatal sero-prevalence survey in South Africa 2004*. Pretoria, Department of Health.
- Department of Public Health The Bahamas (2004). HIV Surveillance 1992–2003. Nassau, Department of Public Health.
- Des Jarlais DC et al. (2002). HIV risk behaviour among participants of syringe exchange programmes in Central/Eastern Europe and Russia. *International Journal of Drug Policy*, 13:165–170.
- Dougan S et al. (2005). HIV infections acquired through heterosexual intercourse in the United Kingdom: findings from national surveillance. *British Medical Journal*, 330:1304–1305. June.
- Duke V et al. (2004). Sero-prevalence of HIV, HSV-1 and HSV-2 among women in Tobago: a cord blood-based survey. *CAREC Surveillance Report*, 24(3). November.
- Elford J et al. (2005). *Unsafe sex among MSM living in London: still increasing?* Abstract no. MP-096. Paper presented to the 16th biennial meeting of the International Society for Sexually Transmitted Diseases Research. 10–13 July. Amsterdam.
- Elshimi, Warner-Smith, Aon (2004). *HIV risk-behavior of problem drug users in greater Cairo*. Geneva, UNAIDS/UNODC.
- Eroshina K et al. (2005). Cohort study on the effectiveness of Russian needle exchange programs. Handbook of the 16th conference on the reduction of drug-related harm. 20–25 March. Belfast.
- EuroHIV (2005). *HIV/AIDS surveillance in Europe: end-year report 2004*. No. 71. Saint-Maurice, Institut de Veille Sanitaire.
- Fairley CK, Hocking JS, Medland N (2005). Epidemic syphilis among homosexually active men in Sydney. *Medical Journal of Australia*, 183(4):179–183.
- Fares G et al. (2004). *Rapport sur l'enquête nationale de sero-surveillance sentinelle du VIH et de la syphilis en Algérie en 2004*. Alger, Ministère de la santé, de la population et de la réforme hospitalière.
- Federal Service of the Russian Federation in Consumer Rights Protection and Human Welfare (2005). *Epidemiological Review of HIV/AIDS in the Russian Federation*. Moscow.
- Gaillard EM et al. (2006). Understanding the reasons for decline of HIV prevalence in Haiti. *Sexually Transmitted Infections*, 82(2).
- García R et al. (2005). Reducción de la Transmisión Madre-Hijo del VIH en Colombia: dos años de experiencia nacional: 2003–2005. *Biomédica*, 25(4).

- Ghana Statistical Service (GSS). Noguchi Memorial Institute for Medical Research (NMIMR), ORC Macro (2004). *Ghana Demographic and Health Survey 2003*. Calverton, Maryland, USA.
- Gibson DR, Flynn NM, Perales D (2001). Effectiveness of syringe exchange programs in reducing HIV risk behavior and HIV sero-conversion among injecting drug users. *AIDS*, 15:1329–1341.
- Glynn M, Rhodes P (2005). Estimated HIV prevalence in the United States at the end of 2003. Abstract No. 595. National HIV Prevention Conference. 12 June. Atlanta.
- Go VF et al. (2004). High HIV prevalence and risk behaviors in men who have sex with men in Chennai, India. *Journal of Acquired Immune Deficiency Syndrome*, 35(3):314–319.
- Gomes do Espirito Santo ME and Etheredge GD (2005). Male clients of brothel prostitutes as a bridge for HIV infection between high risk and low risk groups of women in Senegal. *Sexually Transmitted Infections*, 81:342–344.
- Grayman JH et al. (2005). Factors associated with HIV testing, condom use, and sexually transmitted infections among female sex workers in Nha Trang, Vietnam. *AIDS and Behavior*, 9(1):41–51.
- Gregson S et al. (2006). HIV decline associated with behaviour change in Eastern Zimbabwe. *Science*, 311(5761):664–666.
- Grund JP et al. (2005). *QUO VADIS? Role of injecting drug users in the development of the epidemic of HIV-infection in Ukraine* (Rus.). Kiev, Ukrainian AIDS Centre.
- Hamers FF and Downs AM (2004). The changing face of the HIV epidemic in Western Europe: what are the implications for public health policies? *Lancet*, 364:83–94.
- Hargrove JW et al. (2005). Declining HIV prevalence and incidence in women attending maternity clinics in greater Harare, Zimbabwe. (Submitted for publication).
- Health Protection Agency United Kingdom (2005). *Mapping the issues: HIV and other sexually transmitted infections in the UK—2005*. London, The UK Collaborative Group for HIV and STI Surveillance. Available at http://www.hpa.org.uk/hpa/publications/hiv_sti_2005/contents.htm
- Health Protection Agency United Kingdom, Health Protection Scotland, Institute of Child Health (London) (2006). *AIDS/HIV quarterly surveillance tables: cumulative UK data to end-December 2005*. No 69:05/4. January. London, Health Protection Agency United Kingdom. Available at http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv/epidemiology/hars_tables.htm
- Health Protection Inspectorate Estonia (2006). HIV infections in Estonia. 1988–2005. Tallinn. Available at <http://www.tervisekaitse.ee/tkuus.php?msgid=3466>
- HelpAge International (2005). *Coping with love: older people and HIV/AIDS in Thailand*. London, HelpAge International. Available at <http://www.helpage.org/Resources/Researchreports>.
- Hien NT et al. (2004). HIV/AIDS epidemics in Vietnam: evolution and responses. *AIDS Education and Prevention*, 16(Suppl. A):137–154.
- Hladik W et al. (2006). HIV/AIDS in Ethiopia—where is the epidemic heading? *Sexually Transmitted Infections*, 82(2).
- Holtgrave DR (2006). Causes of the decline in AIDS deaths, United States, 1995–2002: prevention, treatment or both? *International Journal of STD & AIDS*, 16(12):777–781.
- Huang M, Hussein H (2004). The HIV/AIDS epidemic country paper: Malaysia. *AIDS Education and Prevention*, 16(Suppl. A):1001–09.
- Inciardi JA, Syvertsen JL, Surratt HL (2005). HIV/AIDS in the Caribbean Basin. *AIDS Care*, 17(Suppl. 1): S9–S25.
- Institut de Formation Paramédicale de Parnet (2004). *Rapport de la réunion d'évaluation a mis-parcours de l'enquête de sero-surveillance du VIH*.
- Institut National de la Statistique et de la Démographie (INSD), ORC Macro (2003). *Enquête Démographique et de Santé du Burkina Faso 2003*. Calverton, Maryland, USA.

- Institut National de la Statistique (INS), ORC Macro (2004). *Enquête Démographique et de Santé du Cameroun 2004*. Calverton, Maryland, USA.
- Institut National de la Statistique, Ministère des Finances et de la Planification Economique, Commission Nationale de Lutte contre le Sida, Centre de Traitement et de Recherche sur le Sida, Laboratoire National de Référence, ORC Macro (2005). *Rwanda Enquête Démographique et de Santé 2005. Rapport Préliminaire*. Calverton, Maryland, USA.
- Kaiser R et al. (2006). HIV, syphilis, Herpes Simplex Virus 2, and behavioral surveillance among conflict-affected populations in Yei and Rumbeck, southern Sudan. *AIDS*, (20):937–947.
- Kang H et al. (2005). *HIV/AIDS in South Asia: understanding and responding to a heterogeneous epidemic*. Washington & Winnipeg, World Bank & University of Manitoba.
- Kayirangwa E et al. (2006). Current trends in Rwanda's HIV/AIDS epidemic. *Sexually Transmitted Infections*, 82(2).
- Khalsa JH, Francis H, Mazin R (2003). Bloodborne and sexually transmitted infections in drug abusers in the United States, Latin America, the Caribbean and Spain. *Clinical Infectious Diseases*, 37(Suppl. 5): S331–7.
- Khoury J and Aaraj E (2005). *VIH/SIDA—usage de drogues injectables et actions de réduction de risques innovantes au Liban*. Paper presented at 3ème Conférence Latine de Réduction de Risques Liés aux Usages de Drogues. Barcelona.
- Kumar et al. (2005). *HIV-1 trends, risk factors and growth in India*. National Commission on Macroeconomics and Health (NCMH) background papers—burden of disease in India. September. New Delhi, Ministry of Health and Family Welfare.
- Ladnaya NN (2005). HIV/AIDS epidemiological situation in Russia. Presentation to the Meeting on Universal Access to HIV Prevention, Treatment, Care and Support in the Russian Federation. 15–16 December.
- Leone P et al. (2005). HIV transmission among black women—North Carolina, 2004. *Morbidity and Mortality Weekly Report*, 54(4):89–94. 4 February. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5404a2.htm>
- Leukefeld CG et al. (2005). Tailoring an HIV-prevention intervention for cocaine injectors and crack users in Porto Alegre, Brazil. *AIDS Care*, 17(Suppl. 1):S77–S87.
- Lithuanian AIDS Center (2006). Fact sheets. Vilnius. Available at <http://old.aids.lt>
- Liu H et al. (2006). Drug users: potentially important bridge population in the transmission of sexually transmitted diseases, including AIDS, China. *Sexually Transmitted Diseases*, 33(2):111–117.
- Magis-Rodriguez et al. (2002). People living with HIV estimate in Mexico. Abstract C10847. Presented at the 14th International AIDS Conference. 7–12 July. Barcelona.
- Magis-Rodriguez C et al. (2004). Migration and AIDS in Mexico: an overview based on recent evidence. *Journal of Acquired Immune Deficiency Syndromes*, 37(Suppl. 4):S215–S226.
- Mahomva A et al. (2006). HIV prevalence and trends from data in Zimbabwe, 1997–2004. *Sexually Transmitted Infections*, 82(2).
- Marcus U et al. (2005). Relation between the HIV and the re-emerging syphilis epidemic among MSM in Germany: an analysis based on anonymous surveillance data. *Sexually Transmitted Infections*, 81:456–457.
- Mateo RJ et al. (2003). HIV/AIDS in the Philippines. *AIDS Education and Prevention*, 16(Suppl. A):43–52.
- McMahon et al. (2004). Increased sexual risk behaviour and high HIV sero-incidence among drug-using low-income women with primary heterosexual partners. XV International AIDS Conference. Abstract TuOrD1220. 11–16 July. Bangkok.
- Mejía A et al. (2002). HIV-1, syphilis and hepatitis B virus prevalence and risk factors among commercial sex workers, Bogota, Colombia, 2002. XV International Conference AIDS—Bangkok 2004. Abstract Number: WePeC6251.

Mills E et al. (2005). The HIV/AIDS epidemic in Cambodia. *Lancet*, 365:596–597.

Mimouni B, Remaoun N (2005). *Etude du lien potentiel entre l'usage problématique de drogues et le VIH/ SIDA en Algérie 2004–2005*. Paper presented at 3ème Conférence Latine de Réduction de Risques Liés aux Usages de Drogues. Barcelona.

Ministère de la santé Djibouti (2002). *Etude nationale de séroprévalence VIH*. Mars. Djibouti, Ministère de la santé, Djibouti.

Ministère de la Santé Publique et de la Lutte contre les Endémies du Niger (2002). *Enquête Nationale de Séroprévalence de l'infection par le VIH dans la population générale âgée de 15 à 49 ans au Niger 2002*. Niger, CERMES.

Ministère de la Santé et de la Prévention Médical, Centre de Recherche pour le Développement Humain, ORC Macro (2005). *Sénégal Enquête Démographique et de Santé 2005. Rapport préliminaire*. Calverton, Maryland, USA.

Ministère de la santé et Laboratoire National de Référence VIH/SIDA (2005). *Enquête Nationale ANC Madagascar*. Antananarivo, Direction Générale de la Lutte contre le SIDA.

Ministère de la santé Maroc (2005). *Bulletin épidémiologique de surveillance du VIH/SIDA et des infections sexuellement transmissibles*. Rabat, Ministère de la santé Maroc.

Ministère de la santé publique Burundi (2005). *Bulletin épidémiologique annuel de surveillance du VIH/ SIDA/IST pour l'année 2004*. August. Bujumbura, Ministère de la santé publique.

Ministère de la santé publique Cameroon (2004). *EDSC–III 2004 Résultats Préliminaires*. Octobre. Institut national de la statistique. Yaoundé and Claverton, Ministère de la santé publique and ORC Macro.

Ministère de la santé République Démocratique du Congo (2004). *Rapport du passage de la surveillance sentinelle du VIH chez les femmes enceintes fréquentant les services de CPN, mai 2003 à mai 2004*. June. Kinshasha, Ministère de la santé.

Ministère de la santé République du Congo (2004). *Evaluation de la séroprévalence des infections par VIH: Rapport d'analyse provisoire*. Brazzaville, Ministère de la santé.

Ministère de la santé Togo (2004). *Rapport de surveillance de l'infection par le VIH dans le groupe des consultantes prénatales, Année 2003*. February. Lomé, Ministère de la santé.

Ministère de l'économie, des finances et du budget (2005). *Enquête démographique et de santé Madagascar 2003–2004*. February. Antananarivo and Claverton, Institut National de la Statistique and ORC Macro.

Ministère de l'économie et du développement Burkina Faso (2004). *Enquête démographique et de sante 2003: Rapport préliminaire*. Ouagadougou, Calverton, Ministère de l'économie du développement, Measure DHS+.

Ministère du Plan Guinée (2005). *Enquête démographique et de santé 2005: Rapport préliminaire*. Guinée and Calverton, Ministère du Plan & MEASURE DHS ORC Macro.

Ministerio da saude do Angola (2004). *Relatório preliminar do estudo de seroprevalência de VIH, sífilis e hepatite B, mulheres grávidas em consulta prenatal*. Luanda, Ministerio da saude.

Ministerio da saude do Brasil (2004). *Boletim Epidemiológico—Aids e DST. Ano I – No. 01–26 de 2004—semanas epidemiológicas. Janeiro a junho 2004*. Brasília, Ministerio da saude.

Ministerio de salud de Argentina (2004). *Boletín sobre el SIDA en la Argentina*. October. Buenos Aires, Programa Nacional de Lucha contra los Retrovirus del Humano, SIDA y ETS

Ministerio de salud de Argentina (2005). *Boletín sobre el VIH/ SIDA en la Argentina*. September. Buenos Aires, Programa Nacional de Lucha contra los Retrovirus del Humano, SIDA y ETS.

Ministerio de salud de Ecuador (2005). *Epidemiología del virus de inmunodeficiencia humana y síndrome de inmunodeficiencia adquirida en el Ecuador*. June. Quito, Ministerio de salud.

- Ministerio de salud de Peru (2004). *Redes de intercambio sexual en la dinámica de transmisión poblacional del VIH según niveles de la epidemia*. Lima, Ministerio de salud de Peru.
- Ministerio de salud de Peru (2005). *Sentinel surveillance report*. Lima, Ministerio de salud de Peru.
- Ministerio de salud pública y asistencia social de Guatemala (2003). *Estudio Multicéntrico Centroamericano de Prevalencia de VIH/ITS y Comportamientos en Hombres que tienen sexo con otros hombres en Guatemala* (EMC). Ciudad de Guatemala, Ministerio de salud pública y asistencia social de Guatemala.
- Ministry of Health and Family Welfare Bangladesh (2005). *National HIV serological surveillance, 2004–2005 Bangladesh: sixth round technical report*. Dhaka, Ministry of Health and Family Welfare.
- Ministry of Health and Medical Education Iran (2004). *AIDS/HIV surveillance report*. April. Tehran, Ministry of Health and Medical Education.
- Ministry of Health and Population Malawi (2003). *HIV sentinel surveillance report 2003*. November. Lilongwe, Ministry of Health and Population.
- Ministry of Health and Sanitation Sierra Leone (2005). *National population-based HIV seroprevalence survey of Sierra Leone*. Freetown, Ministry of Health and Sanitation.
- Ministry of Health and Social Services Namibia (2004). *Report of the 2004 national HIV sentinel survey*. Windhoek, Ministry of Health and Social Services.
- Ministry of Health and Social Welfare, Bureau of Statistics, ORC Macro (2005). *Lesotho Demographic and Health Survey 2004*. Calverton, Maryland, USA.
- Ministry of Health and Social Welfare Lesotho (2005a). Report of the sentinel HIV/syphilis survey 2005. September. Maseru, STI/HIV and AIDS Directorate, Ministry of Health and Social Welfare.
- Ministry of Health and Social Welfare Swaziland (2005). Ninth round of national HIV serosurveillance in women attending antenatal care services at health facilities in Swaziland: survey report. March. Mbabane, Ministry of Health and Social Welfare Swaziland.
- Ministry of Health Belarus (2005). *Modern methods of HIV sentinel surveillance in the Republic of Belarus: report on the results of studies*. Minsk, Ministry of Health.
- Ministry of Health Belize (2004). *Annual HIV/AIDS epidemiological profile: Belize*. Belize.
- Ministry of Health China (2006). *2005 update on the HIV/AIDS epidemic and response in China*. Beijing, Ministry of Health China, UNAIDS, WHO.
- Ministry of Health Eritrea (2006). *Results from the 2005 round of HIV sentinel surveillance in pregnant women*. Asmara, Ministry of Health.
- Ministry of Health Iran (2004). *HIV/AIDS in Iran*. Presentation to the Regional Consultation on HIV/AIDS and the Uniformed Services in the Middle East and North Africa: mobilizing a potential for change. 15–17 December. Marrakech.
- Ministry of Health Jamaica (2004). *Jamaica HIV sentinel surveillance serosurvey report, 2004*. Division of Health Promotion and Protection. Jamaica, Ministry of Health.
- Ministry of Health Kenya (2005). *AIDS in Kenya, 7th edition*. Nairobi, National AIDS and STI Control Programme (NASCOP), Ministry of Health.
- Ministry of Health Kenya et al. (2003). *Kenya demographic and health survey 2003: preliminary report*. Nairobi & Calverton, Ministry of Health, Central Bureau of Statistics, Kenya Medical Research Institute, Center for Disease Control, and ORC Macro.
- Ministry of Health Malaysia, WHO (2004). *Consensus report on HIV and AIDS—epidemiology in 2004: Malaysia*. Kuala Lumpur, Ministry of Health and WHO.
- Ministry of Health Mozambique (2005). *Report on the update of the HIV epidemiological surveillance data: 2004 round*. August. Maputo, Ministry of Health.
- Ministry of Health New Zealand (2006). *AIDS—New Zealand*. Issue 57. February. Available at <http://www.moh.govt.nz/moh.nsf>.

- Ministry of Health Pakistan, DfID, Family Health International (2005). *National study of reproductive tract and sexually transmitted infections: survey of high-risk groups in Lahore and Karachi*, 2005. Karachi, Ministry of Health, Department for International Development, Family Health International.
- Ministry of Health Sudan (2005). *Annual report*. Khartoum, Sudan National HIV/AIDS Surveillance Unit.
- Ministry of Health Sudan (2006). *2005 ANC sentinel sites results*. Khartoum, Ministry of Health.
- Ministry of Health Uganda (2003). STD/AIDS Control Programme. *STD/HIV/AIDS Surveillance report*. Kampala, Ministry of Health.
- Ministry of Health Uganda (2005). *Uganda HIV/AIDS sero-behavioural survey 2004–2005*. Preliminary report. Kampala & Calverton, Ministry of Health, Uganda Virus Research Institute, Centre for Disease Control and Prevention, Measure DHS ORC Macro.
- Ministry of Health Viet Nam (2005). *HIV/AIDS estimates and projections 2005–2010*. Hanoi, General Department of Preventive Medicine and HIV/AIDS Control, Ministry of Health.
- Ministry of Health Zambia (2005). *Zambia antenatal clinic sentinel surveillance report, 1994–2004*. November. Lusaka, Ministry of Health.
- Monitoring the AIDS Pandemic Network (MAP) (2003). *HIV infection and AIDS in the America*. Havana, MAP.
- Monitoring the AIDS Pandemic Network (MAP) (2004). *AIDS in Asia: Face the facts—a comprehensive analysis of the AIDS epidemics in Asia*. Geneva, MAP.
- Monitoring the AIDS Pandemic Network (MAP) (2005a). *Drug injection and HIV/AIDS in Asia—MAP Report 2005*. July. Geneva, MAP.
- Monitoring the AIDS Pandemic Network (MAP) (2005b). *Sex work and HIV/AIDS in Asia—MAP Report 2005*. July. Geneva, MAP.
- Montano SM et al. (2005). Prevalences, genotypes and risk factors for HIV transmission in South America. *Journal of Acquired Immune Deficiency Syndromes*, 40(1):57–64.
- Montgomery JP et al. (2003). The extent of bisexual behaviour in HIV-infected men and implications for transmission to their female sex partners. *AIDS Care*, 15:829–837.
- Msobi N, Fimbo B, Msumi Z (2004). *AIDS among elderly people in the rural community, Lake Zone, Tanzania*. Poster presentation to 16th International AIDS Conference National Aids Control Programme.
- Mugurungi O et al. (2005). HIV in Zimbabwe. In: Glynn JR, Carael M (eds.) *HIV, resurgent infections and population change in Africa*. Springer.
- NACO (2004a). *Annual Report 2002–2003, 2003–2004*. Delhi, Ministry of Health and Family Welfare.
- NACO (2004b). *State-wise HIV prevalence (1998–2003)*. Delhi, Ministry of Health and Family Welfare.
- National AIDS Centre (2005). *HIV and AIDS in Poland: from the beginning of the epidemic in 1985 till the end of 2004*. Slide presentation. Krakow.
- National AIDS Commission Chile (2003). *Epidemiological surveillance report*, December 2003. Santiago, CONASIDA.
- National AIDS Commission Tanzania (2005). *Tanzania HIV/AIDS indicator survey 2003–2004*. March. Dar es Salaam and Calverton, Tanzania Commission for AIDS, National Bureau of Statistics, ORC Macro.
- National AIDS Coordinating Agency, Botswana (2003). *Botswana 2003 second generation HIV/AIDS surveillance: technical report*. December. Gaborone, Republic of Botswana.
- National AIDS Coordinating Agency, Botswana (2005). *Botswana AIDS impact survey II: popular report*. March. Gaborone, Republic of Botswana.
- National AIDS Coordinating Agency, Central Statistics Office (2005). *Botswana AIDS Impact Survey II 2004. Statistical Report*. Central Statistics Office, Gaborone, Botswana.
- National AIDS Council, National Department of Health Papua New Guinea (2004). *The report of the 2004 national consensus workshop of Papua New Guinea*. Port Moresby, National Department of Health.

- National Center for HIV/AIDS, Dermatology and STIs Cambodia (NCHADS) (2004). *HIV sentinel surveillance (HSS) 2003: trends results, and estimates*. Phnom Penh, National Center for HIV/AIDS, Dermatology and STIs.
- National Centre in HIV Epidemiology and Clinical Research (2005). HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2005. Sydney, National Centre in HIV Epidemiology and Clinical Research. Available at <http://www.med.unsw.edu.au/nchecr>.
- Ni M et al. (2006). HIV/AIDS prevalence and behaviour in drug users and pregnant women in Kashgar Prefecture: a case report. *Harm Reduction Journal*, 3(7).
- Odek-Ogunde M, Lore W, Owiti FR (2003). Risky behaviours among injecting drug users in Kenya. Proceedings of 14th International Conference on the Reduction of Drug-related Harm, 6–10 April. Chiang Mai.
- Open Health Institute, (2004). Rapid situation assessment carried out in 15 cities, June–July. Moscow.
- PAHO (2005). Care fact sheets. Washington, Pan American Health Organization.
- Pando de los A et al. (2003). HIV immunodeficiency virus type I seroprevalence in men who have sex with men from Buenos Aires, Argentina: risk factors for infection. *International Journal of Epidemiology*, 32: 735–740.
- Phimphachanh C and Sayabounthavong K (2004). The HIV/AIDS/STI situation in Lao People's Democratic Republic. *AIDS Education and Prevention*, 16(Suppl. A): 91–99.
- Pisani E and Dili STI survey team (2004). HIV, STIs and risk behaviour in East Timor: an historic opportunity for effective action. Dili, Family Health International.
- Pokrovskiy V (2005). HIV/AIDS in Russia. Presentation to HIV/AIDS in the Russian Federation and Ukraine workshop. January. Geneva.
- Présidence du Faso (2005). Suivi de la déclaration d'engagement sur le VIH/SIDAA (UNGASS): cadre pour la présentation des reports pays—période concernée janvier–décembre 2004. Ouagadougou.
- Prieto F (2003). Veinte años del VIH en Colombia, 1983-2003. Datos de la vigilancia epidemiológica. *Inf Quinc Epidem Nac (Colombia)* 2003, 8(22):355–366.
- Programa Nacional de Lucha contra el Sida, Proyecto Centro de Referencia para el control de endemias en Guinea Ecuatorial (2004). *Informe de la Encuesta de Seroprevalencia del VIH en Guinea Ecuatorial, 2004*. Guinea Ecuatorial.
- Proyecto Acción SIDA de Centroamérica (PASCA) (2003). *Central American multi-site HIV/STI prevalence and behaviour study*. Proyecto Acción SIDA de Centroamérica (PASCA). Guatemala. Available at http://www.pasca.org/english/estudio_eng.htm
- Public Health Agency of Canada (2004). *HIV/AIDS among aboriginal peoples in Canada: a continuing concern*. HIV/AIDS Epi Update—May 2004. Public Health Agency of Canada. Available at http://www.phac-aspc.gc.ca/publicat/epiu-aepe/epi_update_may_04/9_e.html
- Public Health Agency of Canada (2005). *HIV and AIDS in Canada: surveillance report to June 30, 2005*. Surveillance and Risk Assessment Division, Public Health Agency of Canada. Ottawa. Available at http://www.phac-aspc.gc.ca/hast-vsmtp/public_e.html
- Punpanich W et al. (2004). Thailand's response to the HIV epidemic: yesterday, today and tomorrow. *AIDS Education and Prevention*, 16(Suppl. A):119–136.
- Rahbar AR, Rooholamini S, Khoshnood K (2004). Prevalence of HIV infection and other blood-borne infections in incarcerated and non-incarcerated injecting drug users (IDUs) in Mashdad, Iran. *International Journal of Drug Policy*, 15(2):151–155.
- Reproductive Health Research Unit, Medical Research Council (2004). *National survey of HIV and sexual behaviour among young South Africans*. Johannesburg, Reproductive Health Research Unit.
- Rhodes T et al. (2004). HIV transmission and HIV prevention among injecting drug users in Russia. *International Journal of Drug Policy*, 15(2):1–16.

- Rhodes T, Simic M (2005). Transition and the HIV risk environment. *British Medical Journal*, 331:220–223.
- Riono P, Jazant S (2004). The current situation of the HIV/AIDS epidemic in Indonesia. *AIDS Education and Prevention*, 16(Suppl. A):78–90.
- Robert Koch Institut (2005). HIV-Infektionen/AIDS: Halbjahresbericht I/2005. *Epidemiologisches Bulletin*, 30. September. Available at <http://www.rki.de/>
- Ruan Y et al. (2005). HIV incidence and factors contributed to retention in a 12-month follow-up study of injection drug users in Sichuan Province, China. *Journal of Acquired Immune Deficiency Syndrome*, 39(4): 459–463.
- Sammud A (2005). *HIV in Libya*. August. Ministry of Health. Tripoli.
- St John MA et al. (2003). Efficacy of Nevirapine administration on mother-to-child transmission of HIV using a modified HIVNET 012 regimen. *West Indian Medical Journal*, 51 (Suppl. 3):1–87.
- Secretaría de Estado de Salud Pública y Asistencia Social de Republica Dominicana (2005a). *Encuestas de vigilancia del comportamiento sobre VIH/ SIDA/ ITS en RSX y HSH del Área V de Salud*. January. Santo Domingo, Secretaría de Estado de Salud Pública y Asistencia Social de Republica.
- Secretaría de Estado de Salud Pública y Asistencia Social de Republica Dominicana (2005b). *De Segunda Generación Encuestas De Seroprevalencia de la Infección VIH Basadas en Puestos Centinelas 2004*. March. Santo Domingo, Secretaría de Estado de Salud Pública y Asistencia Social, USAID–FHI/CONECTA.
- Secretariat of the Pacific Community, AIDS Section (2005). Cumulative reported HIV, AIDS and AIDS death cases, crude incidence rates, gender & cases with missing details: all Pacific Islands countries and territories, New Zealand & Australia to 31st December 2004. Table. December. Available at <http://www.spc.org.nc/aids/>
- Segura M et al. (2005). *Cohort of men who have sex with men: recruitment, retention and seroincidence of HIV and other sexually-transmitted infections*. Poster presentation to the IAS Pathogenesis conference 2005. 24–27 July 2005. Rio de Janeiro.
- Shakarishvili A et al. (2005). Sex work, drug use, HIV infection and spread of sexually transmitted infections in Moscow, Russian Federation. *Lancet*, 366:57–60.
- Shisana O et al. (2005). *South African national HIV prevalence, HIV incidence, behaviour and communication survey*. Human Sciences Research Council. Pretoria. Available at http://www.hsarc.ac.za/media/2005/11/20051130_1.html
- Smolenskaya TT et al. (2005) Sentinel surveillance among population groups with risk behavior in North-West Russia (press release). Project supported by the First Data Western Union Fund.
- Solomon S et al. (2004). A review of the HIV epidemic in India. *AIDS Education and Prevention*, 16(Suppl. A):155–169.
- Sullivan EA et al. (2003). Prevalence of sexually transmitted diseases among antenatal women in Vanuatu, 1999–2000. *Sexually Transmitted Diseases*, 30:362–366.
- Sullivan EA et al. (2004). Prevalence of sexually transmitted diseases and human immunodeficiency virus among pregnant women attending prenatal services in Apia, Samoa. *International Journal of STD & AIDS*, 15:116–119.
- Susman E (2003). US could learn from Cuban AIDS policy. *AIDS*, 17:N7–8.
- Thwe M (2004). HIV/AIDS education and prevention in Myanmar. *AIDS Education and Prevention*, 16(Suppl. A):170–177.
- Todd CS et al. (2005). Human immunodeficiency virus (HIV) infection in female sex workers in Tashkent, Uzbekistan. Abstract MP–025. Paper presented to the 16th biennial meeting of the International Society for Sexually Transmitted Diseases Research. 10–13 July. Amsterdam.
- Toole M et al. (2005). *Study of young men's sexual behaviour: Vientiane, Lao People's Democratic Republic, August–November*. Burnet Institute.

Toro-Alfonso J, Varas-Díaz (2005). *Proyecto de identificación y descripción de conocimiento, actitudes, creencias y comportamientos de riesgo para la transmisión del VIH en población de homosexuales y hombres que tienen sexo con hombres en la República Dominicana*. January. Santo Domingo, CESDEM, CONECTA.

Tran TN et al. (2005). HIV infections and risk characteristics among female sex workers in Hanoi, Vietnam. *Journal of Acquired Deficiency Syndromes*, 39(5):581–586.

Ukrainian AIDS Centre (2005a). HIV infection in Ukraine. *Information Bulletin*, 24. Kiev.

Ukrainian AIDS Centre (2005b). *Epidemiological surveillance of HIV-infection and sexually transmitted infections— as a component of the system of second generation epidemiological surveillance of HIV-infection in Ukraine*. Kiev, Ukrainian AIDS Centre.

UNAIDS (2004). *2004 Report on the global AIDS epidemic*. Geneva, UNAIDS.

UNDP (2004). *Thailand's response to HIV/AIDS: progress and challenges*. Bangkok, UNDP.

US Centers for Disease Control and Prevention (2004a). *HIV/AIDS surveillance report*, 15. Atlanta, Centers for Disease Control and Prevention. Available at <http://www.cdc.gov/hiv/stats/hasrlink.htm>.

US Centers for Disease Control and Prevention (2004b). HIV/AIDS among African Americans. Fact Sheet. Atlanta, Centers for Disease Control and Prevention. Available at <http://www.cdc.gov/hiv/pubs/facts/afam.htm>

US Centers for Disease Control and Prevention (2005a). *HIV/AIDS surveillance report, 2004*, 1(16)1:46. Atlanta, Centers for Disease Control and Prevention.

US Centers for Disease Control and Prevention (2005b). HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five US cities, June 2004–April 2005. *Morbidity and Mortality Weekly Report*, 54:597–601.

US Centers for Disease Control and Prevention (2005c). Trends in HIV/AIDS diagnoses—33 states, 2001–2004. *Morbidity and Mortality Weekly Report*, 54:1149–1153. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5445a1.htm>

US Centers for Disease Control and Prevention (2006). *A glance at HIV/AIDS among men who have sex with men*. January. Atlanta, Centers for Disease Control and Prevention. Available at http://www.cdc.gov/hiv/resources/factsheets/msm_glance.htm

Vall Mayans M et al. (2004). Outbreaks of infectious syphilis and other STIs in men who have sex with men in Barcelona, 2002–2003. *Eurosurveillance*, 9(4):60

Valleroy LA et al. (2004). The bridge for HIV transmission to women from 15 to 29-year-old men who have sex with men in 7 US cities. XV International AIDS Conference. Abstract ThOrC1367. Bangkok. 11–16 July.

Van de Laar M and Op de Coul ELM (2004). Increase in STIs in the Netherlands slowed in 2003. *Eurosurveillance*, 9(4).

Van Griensven F et al. (2006). *HIV surveillance among men who have sex with men (MSM) populations in Thailand: evidence for high prevalence and incidence*. Poster abstract. 13th Conference on Retroviruses and Opportunistic Infections. 5–8 February. Denver.

Verevchkin SV et al. (2005). High prevalence of HIV infection among IDUs: no significant changes. *Russkii Zhurnal. SPID, Rak i obshchestvennoe zdorov'ye*, 9 (2). Presented at the 14th International Conference on AIDS, Cancer and Public Health. 23–27 May. St. Petersburg.

Walensky RP et al. (2005). 2 Million Years of Life Saved: the survival benefits of AIDS therapy in the United States. Abstract 143LB. 12th Conference on Retroviruses and Opportunistic Infections, 22–25 February. Boston.

Wawer M et al. (2005). Declines in HIV prevalence in Uganda: not as simple as ABC. Abstract 27 LB, 12th Conference on Retroviruses and Opportunistic Infections. 22–25 February. Boston.

Weissenbacher M et al. (2003). AIDS National Center of Reference, Argentina. High seroprevalence of bloodborne viruses among street-recruited injection drug users from Buenos Aires, Argentina. *Clinical Infectious Diseases*, 37(Suppl. 5):S348–52.

- WHO (2005a). *HIV/AIDS epidemiological surveillance report for the WHO African region—2005 update*. Harare, WHO Regional Office for Africa.
- WHO (2005b). *The 2004 first national second generation HIV/AIDS/STI sentinel surveillance survey among antenatal care women attending maternity and child health clinics, tuberculosis and STD patients*. July. WHO.
- WHO (2005c). Development of harm reduction programmes within the project, 'Complex partnerships strategies of HIV/AIDS prevention among young people in the Russian Federation'. Project Best Practice Examples, Moscow.
- WHO/UNAIDS (2006). *Progress on global access to HIV antiretroviral therapy: a report on "3 by 5" and beyond*. Geneva.
- Wi T et al. (2002). *RTI/STD prevalence in selected sites in the Philippines*. Manila, Department of Health and Family Health International.
- Wiwat P, Brown T, Calleja-Garcia JM (2005). *Report from the technical working group on HIV/AIDS projection and demographic impact analysis in Myanmar*. September. Yangon.
- Wright M et al. (2005). Fulfilling prophecy? Sexually transmitted infections and HIV in indigenous people in Western Australia. *Medical Journal of Australia*, 183(3):124–128.
- Yang H et al. (2005). Heterosexual transmission of HIV in China: a systematic review of behavioral studies in the past two decades. *Sexually Transmitted Diseases*, 32(5):270–280.
- Zamani S (2005). Prevalence of and factors associated with HIV-1 infection among drug users visiting treatment centers in Tehran, Iran. *AIDS*, 19:709–716.

Chapter 3 | PROGRESS IN COUNTRIES

- Aran-Mantero D, Aran C, Izazola-Licea JA (2003). Por qué el gasto de bolsillo en América Latina es necesario en respuesta al VIH/SIDA? [Why is the out-of-pocket expenditure in Latin America necessary in the response to HIV/AIDS?] In: *El financiamiento de las respuestas nacionales contra el SIDA en América Latina y el Caribe y el flujo de financiamiento internacional*. JA Izazola-Licea, Daniel Aran and Ricardo Valladares. Mexico City, FUNSALUD/SIDALAC. 73–82.
- Dehne KL and Riedner G (2005). Sexually transmitted infections among adolescents: the need for adequate health services. Geneva, WHO and Deutsche Gesellschaft fuer Technische Zusammenarbeit. 2005. Available at http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_156288_9.pdf
- G8 (2005). The Gleneagles Communiqué. Gleneagles, United Kingdom, G8 Gleneagles 2005. Available at http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique,0.pdf
- Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) (2006). Website information accessed March 28, 2006. Available at <http://www.theglobalfund.org>
- Group of 77 (2005). 2005 Doha Declaration. Available at www.g77.org/southsummit2/en/intro.html
- Gutierrez JP, Bertozzi S (2004). Resources availability for HIV/AIDS and the funding gap. National Health Institute, Mexico. Document presented during the Fifth UNAIDS Global Resource Tracking Consortium. September 2004. Johannesburg.
- Izazola-Licea JA (2003). Financiamiento y Gasto en respuesta al VIH/SIDA: lecciones aprendidas en América Latina y el Caribe. [Financing and expenditure in response to HIV/AIDS: lessons learned from Latin America and the Caribbean]. Sustainable Development Department Technical papers series; SOC-133. Washington, Inter-American Development Bank.
- MEASURE DHS (2006). Measure, Demographic and Health Surveys/AIDS Indicator Surveys. Website information accessed March 1, 2006. Available at <http://www.measuredhs.com/>

Organisation for Economic Co-operation and Development (OECD) (2006). Creditor reporting system—aid activities in support of HIV/AIDS control database.

Stover J, Fahrenstock M (2006 in press). Coverage of selected services for HIV/AIDS prevention and care in low and middle income countries in 2005, funded by UNAIDS, USAID, and UNFPA. Washington, DC, Futures Group/POLICY Project. Forthcoming, July 2006.

UK Collaborative Group for HIV and STI Surveillance (2005). *Mapping the issues: HIV and other sexually transmitted infections in the UK*. London, Health Protection Agency Centre for Infections. Available at http://www.hpa.org.uk/hpa/publications/hiv_sti_2005/pdf/Mtl_FC_report.pdf

UNAIDS (2003). Follow up to the 2001 United Nations general assembly special session on HIV/AIDS: progress report on the global responses to the HIV/AIDS epidemic. 2003.

UNAIDS (2004). Financing the expanded response to AIDS. Executive summary. 15th PCB Meeting. December 2004. Jamaica.

UNAIDS (2005a). Monitoring the declaration of commitment on HIV/AIDS: guidelines on construction of core indicators.

UNAIDS (2005b). CRIS V2.1 User Guide (Rev. 0.2). Country response information system. Available at <http://www.unaids.org>

UNAIDS (2005c). Resource needs for an expanded response to AIDS in low and middle income countries. Document presented at the Programme Coordinating Board. Seventeenth meeting. Geneva 27–29 June 2005. (Update August, 2005).

UNAIDS (2006). National AIDS spending assessment. A notebook on methods, definitions and procedures for resource tracking and measurement of AIDS financing flows and expenditures. (Draft).

UNAIDS/UNHCR (2005). *Strategies to support the HIV-related needs of refugees and host populations*. Geneva, UNAIDS and the United Nations High Commissioner for Refugees. Available at http://www.unaids.org/html/pub/publications/irc-pub06/jc1157-refugees_en_pdf.pdf

United Nations (2000). United Nations Millennium Declaration: United Nations General Assembly, 55th session, 6 September 2000. New York.

United Nations (2001). Declaration of commitment on HIV/AIDS. United Nations General Assembly, special session on HIV/AIDS, 25–27 June 2001. New York. Available at http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf

United Nations (2005). *2005 World Summit Outcome*. New York. Available at <http://www.un.org/summit2005/>.

US Centers for Disease Control and Prevention/Global AIDS Program (CDC/GAP) (2005). Atlanta, US, International Strategic Information/Monitoring and Evaluation Field Officer Directory.

WHO/UNAIDS (2005). Progress on global access to HIV antiretroviral therapy: an update on “3 by 5.” June 2005.

WHO/UNAIDS (2006). Progress on global access to HIV antiretroviral therapy: a report on “3 by 5” and beyond. March 2006.

Chapter 4 | THE IMPACT OF AIDS ON PEOPLE AND SOCIETIES

Abadia-Barrero CE, Castro A (2005). Experiences of stigma and access to HAART in children and adolescents living with HIV/AIDS in Brazil. *Social Science and Medicine*.

Aliber M et al. (2004). *The impact of HIV/AIDS on land rights*. Cape Town, Integrated Rural and Regional Development Research Programme, Human Sciences Research Council, and the Food and Agriculture Organization (FAO). Available at http://www.fao.org/sd/dim_pe3/docs/pe3_040902d1_en.pdf

Avirgan T, Bivens LJ, Gammage S (2005). *Good jobs, bad jobs, no jobs: labor markets and informal work in Egypt, El Salvador, India, Russia, and South Africa*. Washington, Economic Policy Institute.

Barany M, Holding-Anyonge C, Rugalema G (2005). *Firewood, food, and medicine: interfaces between forest resources, vulnerability, and rural responses to HIV/AIDS*. HIV/AIDS and food and nutrition security: from evidence to action. Durban, South Africa. Available at <http://www.ifpri.org/events/conferences/2005/durban/papers/baranyWP.pdf>

- Barnett T, Whiteside A (2002). *AIDS in the twenty-first century: disease and globalization*. New York, Palgrave Macmillan, Houndmills, Basingstoke, Hampshire.
- Bell C et al. (2003). *The long-run economic costs of AIDS: theory and an application to South Africa*. Washington, DC, World Bank Human Development Network Office of the Vice President. Available at <http://econ.worldbank.org/resource.php?type=5>
- Bonnel R, Temin M, Tempest F (2004). *Poverty reduction strategy papers: do they matter for children and young people made vulnerable by HIV/AIDS?* New York, UNICEF, World Bank. Available at http://www.unicef.org/publications/files/Poverty_Reduction_Strategy_Papers_EY_final.pdf
- CAREC/PAHO/WHO (2004). *Status and trends analysis of the Caribbean HIV/AIDS epidemic 1982–2002*. Port of Spain, Caribbean Epidemiology Centre, Pan American Health Organization, World Health Organization. Available at http://www.catin.org/pubs/status_trends1982–2002.pdf
- Case A, Paxson C, Ableidinger J (2004). Orphans in Africa: parental death, poverty, and school enrolment. *Demography*, 41(3):483–508. Available at http://www.princeton.edu/rpds/downloads/case_paxson_orphansafrica.pdf
- Chapoto A, Jayne TS (2005). *Characteristics of individuals afflicted by AIDS-related mortality in Zambia*. Lusaka, Zambia Food Security Research Project (FSRP). Available at http://www.aec.msu.edu/agecon/fs2/zambia/Chapoto-Jayne_FSRP_WP_final_for_pdf.pdf
- Das J et al. (2005). *Teacher shocks and student learning: evidence from Zambia*. Washington, DC, World Bank.
- de Waal A (2005). *HIV/AIDS and democratic governance (issue paper 2)*. AIDS, security and democracy: expert seminar and policy conference. The Hague, Clingendael Institute. Available at http://www.ssrc.org/programs/HIV/publications/hague2005/issue_paper2.pdf
- de Waal A, Whiteside A (2003). New variant famine: AIDS and food crisis in southern Africa. *Lancet*, 362(9391):1234–1237. Available at <http://www.thelancet.com/journals/lancet/article/PIIS0140673603145485/fulltext>
- Deininger K, Garcia M, Subbarao K (2003). AIDS-induced orphanhood as a systemic shock: magnitude, impact and program interventions in Africa. *World Development*, 31(7).
- Evans D, Miguel AM (2005). *Orphans and schooling in Africa: a longitudinal analysis*. Berkeley, Center for International and Development Economics Research, University of California. Available at <http://repositories.cdlib.org/iber/cider/C05–143>
- FAO (2004). *HIV/AIDS, gender inequality and rural livelihoods: the impact of HIV/AIDS on rural livelihoods in Northern Province, Zambia*. Rome, Food and Agriculture Organization, Development Cooperation Ireland (DCI), Government of Zambia. Available at http://www.fao.org/sd/dim_pe1/pe1_040602_en.htm
- Fox MP et al. (2004). The impact of HIV/AIDS on labour productivity in Kenya. *Tropical Medicine and International Health*, 9(3):318–24. Available at <http://info.worldbank.org/etools/library/latestversion.asp?135887>
- Frolov V (2004). The national security implications of the HIV/AIDS epidemic in Russia. *Reversing the epidemic: facts and policy options. HIV/AIDS in Eastern Europe and the Commonwealth of Independent States*. New York, United Nations Development Programme. Available at <http://rbec.undp.org/hiv/>
- Garrett L (2005). *HIV and national security: where are the links?* Washington, Council on Foreign Relations. Available at http://www.cfr.org/publication/8256/hiv_and_national_security.html
- Gillespie S, Kadiyala S (2005). *HIV/AIDS, food and nutrition security: from evidence to action*. Washington, DC, International Food Policy Research Institute. Available at <http://www.ifpri.org/pubs/fpreview/pv07/pv07.pdf>
- Grant KB, Gorgens M, Kinghorn A (2004). *Mitigating the impact of HIV on service providers study: what has been attempted, what is working, what has not worked, where and why?* Johannesburg, Mobile Task Team on the Impact of HIV/AIDS on Education (MTT), University of Kwazulu-Natal. Available at <http://www.mttaids.com/site/awdep.asp?dealer=5562&depnum=8535>

- Greener R (2004). The impact of HIV/AIDS on poverty and inequality. *The macroeconomics of HIV/AIDS*, (Ed. Haacker M). Washington, International Monetary Fund. Available at <http://www.imf.org/external/pubs/ft/AIDS/eng/index.htm>
- Griekspoor A et al. (2004). The health sector gap in the southern Africa crisis in 2002/2003. *Disasters*, 28(4):388–404.
- Haacker M (2004). The impact of HIV/AIDS on government finance and public services. *The macroeconomics of HIV/AIDS*, (Ed. Haacker M). Washington, International Monetary Fund. Available at <http://www.imf.org/external/pubs/ft/AIDS/eng/index.htm>
- IAVI (2005). *Putting it together: AIDS and the Millennium Development Goals*. New York, International AIDS Vaccine Initiative. Available at <http://www.iavi.org/viewfile.cfm?fid=33078>
- ILO (2003). *Socio-economic impact of HIV/AIDS on people living with HIV/AIDS and their families*. New Delhi, Delhi Network of Positive People, Manipur Network of People Living with HIV/AIDS, Network of Maharashtra by People Living with HIV/AIDS, Positive Women's Network of Southern India, International Labour Organization.
- ILO (2004). *HIV/AIDS and work: global estimates, impact and response*. Geneva, International Labour Organization. Available at <http://www-ilo-mirror.cornell.edu/public/english/protection/trav/aids/publ/research/>
- ILO (2005). *Study report on economic impact of HIV/AIDS on Singareni Collieries Company Limited (SCCL), Andhra Pradesh*. New Delhi, International Labour Organization, Andhra Pradesh State AIDS Control Society and Singareni Collieries Company Limited.
- ILO (2006). *HIV/AIDS and work in a globalizing world*. Geneva. (In press).
- ILO/GTZ (2004). *HIV/AIDS, work and development in the United Republic of Tanzania*. Geneva. Available at http://www.ilo.org/public/english/protection/trav/aids/publ/cp_2_tanzania.pdf
- ILO/IPEC (2003). *HIV/AIDS and child labour in sub-Saharan Africa: synthesis report. A state-of-the-art review with recommendations for action*. Geneva, International Labour Organization, International Programme on the Elimination of Child Labour (IPEC). Available at <http://www.ilo.org/public/english/standards/ipec/publ/hiv/>
- Intigrinova T, Hauslohner P (2004). *Abandoned children born to HIV-positive women: analysis of the situation in Russia*. Moscow, Transatlantic Partners Against AIDS, USAID, UNICEF, IREX. Available at <http://www.tpaa.net/files/upload/publications/846.pdf>
- Korenromp EL (2005). Malaria attributable to the HIV-1 epidemic, sub-Saharan Africa. *Emerging Infectious Diseases*, 11(9):1410–9.
- Lee MB et al. (2005). HIV-related stigma among market workers in China. *Health Psychology*, 24(4):435–8.
- Lieber E et al. (2005). HIV/STD stigmatization fears as health-seeking barriers in China. *AIDS Behavior*, 1–9.
- Mackay V (2003). *Best practices in HIV/AIDS prevention in the informal sector*. Geneva, Inter-regional tripartite meeting on best practices in workplace policies and programmes on HIV/AIDS. Available at <http://www.ilo.org/public/english/protection/trav/aids/publ/informalecoprev.pdf>
- Mahal A, Rao B (2005). HIV/AIDS epidemic in India: an economic perspective. *Indian Journal of Medical Sciences*, (April 2005), 582–600. Available at <http://icmr.nic.in/ijmr/2005/April/0428.pdf>
- Mann JM et al. (1994). Health and human rights. *Health Human Rights*, 1(1):6–23.
- Manning R (2002). *The impact of HIV/AIDS on civil society: assessing and mitigating impacts: tools and models for NGOs and CBOs*. Durban, Health Economics & HIV/AIDS Research Division (HEARD), University of Natal. Available at <http://www.eldis.org/static/DOC11102.htm>
- Marais H (2005). *Buckling: the impact of AIDS in South Africa 2005*. Centre for the Study of AIDS, University of Pretoria. Available at <http://www.csa.za.org/article/articlestatic/7/1/2/>

- Measure DHS and ORC Macro International (2002). *Encuesta Demográfica y de Salud (ENDESA 2002)*. Washington.
- Monasch R, Boerma JT (2004). Orphanhood and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries. *AIDS*, 18(Suppl. 2):S55–65. Available at <http://www.aidsonline.com/pt/re/aids/pdfhandler.00002030-200406002-00007.pdf;jsessionid=DGtO53PaurRS2x1Sf2VYh4eJ2U1TWs4XF9EsCJ8R0T0qDDj0dkkW!-1660146838!-949856145!9001!-1>
- Mount AM et al. (2004). Impairment of humoral immunity to *Plasmodium falciparum* malaria in pregnancy by HIV infection. *Lancet*, 363(9424):1860–7.
- Murray U (2005). *Promoting gender-sensitive entrepreneurship via microfinance institutions*. Rome, Paper presented at FAO Headquarters on International Women's Day. Available at http://www.fao.org/sd/dim_pe1/pe1_050401_en.htm
- Nyamukapa C, Gregson S (2005). Extended family's and women's roles in safeguarding orphans' education in AIDS-afflicted rural Zimbabwe. *Social Science and Medicine*, 60(10):2155–67.
- Paxton S et al. (2005). *AIDS-related discrimination in Asia*. Asia Pacific Network of People living with HIV/AIDS (APN+). Available at <http://www.gnpplus.net/regions/files/AIDS-asia.pdf>
- Peltzer K et al. (2005). *Educator supply and demand in the South African public education system: integrated report*. Johannesburg, Human Sciences Research Council. Available at <http://www.hsrcpress.ac.za/index.asp?id=2119>
- SABCOHA (2004). *The economic impact of HIV/AIDS on business in South Africa, 2003*. Johannesburg, South African Business Coalition on HIV and AIDS (SABCOHA). Available at <http://www.synergyaids.com/documents/SAfricaEconomicImpactOnBusiness.pdf>
- Safman RM (2004). Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers. *AIDS Care*, 16(1):11–9.
- Schatz E, Ogunmefun C (2005). *Caring and contributing: the role of older women in multigenerational households in the HIV/AIDS era*. Research Program on Population Processes, University of Colorado at Boulder. Available at <http://www.colorado.edu/ibs/pubs/pop/pop2005-0004.pdf>
- Shapiro RL et al. (2003). Low adherence to recommended infant feeding strategies among HIV-infected women: results from the pilot phase of a randomized trial to prevent mother-to-child transmission in Botswana. *AIDS Education and Prevention*, 15(3):221–30.
- Shisana O et al. (2004). HIV/AIDS prevalence among South African health workers. *South African Medical Journal*, 94(10):846–50.
- Sitoe A et al. (2004). *HIV/AIDS and the Miombo. Woodlands of Mozambique & Malawi: an exploratory study*. Washington, Conservation International Annual Meeting. Available at <http://www.fao.org/forestry/foris/data/hiv/HIV-AIDSWoodlands.pdf>
- Spiegel P (2004). HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action. *Disasters*, 28(3). Available at <http://www.unhcr.ch/cgi-bin/texis/vtx/protect/opendoc.pdf?tbl=PROTECTION&id=4162693e4>
- Stanecki KA (2004). *The AIDS pandemic in the 21st century*. Washington, USAID, US Department of Commerce. Available at <http://www.census.gov/ipc/prod/wp02/wp02-2.pdf>
- Strand P et al. (2004). *HIV/AIDS and democratic governance in South Africa— illustrating the impact on electoral processes*. Pretoria, Institute for Democracy in South Africa (IDASA). Available at <http://www.idasa.org.za/gbOutputFiles.asp?WriteContent=Y&RID=1176>
- Tanzarn N, Bishop-Sambrook C (2003). *The dynamics of HIV/AIDS in small-scale fishing communities in Uganda*. Rome, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), FAO HIV/AIDS Programme. Available at <http://www.sflp.org/fr/003/faogtzreport.pdf>
- Treacy M (2003). In India, integrating the informal sector into the global economy. *International Trade Forum*, October 2003.

UN Population Division (2005a). *Population, development and HIV/AIDS with particular emphasis on poverty: the concise report*. New York, Dept. of International Economic and Social Affairs, United Nations. Available at <http://www.un.org/esa/population/publications/concise2005/PopdevHIVAIDS.pdf>

UN Population Division (2005b). *World population prospects: the 2004 revision*. New York, Dept. of International Economic and Social Affairs, United Nations. Available at http://www.un.org/esa/population/publications/WPP2004/2004Highlights_finalrevised.pdf

UNAIDS/UNHCR (2005). *Strategies to support the HIV-related needs of refugees and host populations*. Geneva, UNAIDS and the United Nations High Commissioner for Refugees. Available at http://www.unaids.org/html/pub/publications/irc-pub06/jc1157-refugees_en_pdf.pdf

UNDP (2003a). *The socio-economic impact of HIV/AIDS in Viet Nam: a preliminary note*. United Nations Development Programme. Available at <http://www.undp.org.vn/undp/docs/2003/seimpact/seimpact.pdf>

UNDP (2003b). *Zimbabwe human development report 2003: redirecting our responses to HIV and AIDS*. Harare, Institute of Development Studies, University of Zimbabwe. Available at http://hdr.undp.org/docs/reports/national/ZIM_Zimbabwe/Zimbabwe_2003_en.pdf

UNDP (2004). *HIV and human development in Central and Eastern Europe and the Commonwealth of Independent States. Reversing the epidemic—facts and policy options*. Bratislava. Available at <http://rbec.undp.org/hiv/>

UNDP (2005). *Human development report 2005. International cooperation at a crossroads: aid, trade and security in an unequal world*. New York. Available at <http://hdr.undp.org/reports/global/2005/>

UNESCO (2000). *The Dakar framework for action, education for all: meeting our collective commitments*. Dakar, World Education Forum, 26–28 April 2000.

UNESCO (2005). *EFA global monitoring report 2005: the quality imperative*. Paris. Available at http://portal.unesco.org/education/en/ev.php-URL_ID=35939&URL_DO=DO_TOPIC&URL_SECTION=201.html

UNESCO (2006). *EFA global monitoring report 2006: literacy for life*. Paris, UNESCO. Available at http://portal.unesco.org/education/en/ev.php-URL_ID=43283&URL_DO=DO_TOPIC&URL_SECTION=201.html

UNFPA (2003). *The impact of HIV/AIDS: a population and development perspective*. New York. Available at http://www.unfpa.org/upload/lib_pub_file/197_filename_PDS09.pdf

UNICEF (2005). *Children: the missing face of AIDS*. New York, UNICEF. Available at http://www.unicef.org/publications/files/AIDS_Launch_final_14Oct.pdf

Voronin Y et al. (2005). *Children, women and HIV-infection in the Russian Federation*. Moscow, Ministry of Health and Social Development of the Russian Federation, Center for the Prevention and Treatment of HIV-Infection in Pregnant Women and Children, and UNICEF.

WHO (2005). *Global tuberculosis control: surveillance, planning, financing*. Geneva. Available at http://www.who.int/tb/publications/global_report/2005/en/

World Bank (2005a). *HIV/AIDS in the Caribbean region: a multi-organization review (draft final report)*. Review team from DFID, WHO/PAHO, The Global Fund, UNAIDS and the World Bank.

World Bank (2005b). *Workers in the informal economy (webpage)*. Available at <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTLM/0,,contentMDK:20224904%7EmenuPK:584866%7EpagePK:148956%7EpiPK:216618%7EtheSitePK:390615,00.html> (accessed 17 December 2005)

Yamano T, Jayne TS (2004). *Measuring the impacts of working-age adult mortality on small-scale farm households in Kenya*. *World Development*, 32(1):91–119. Available at <http://www.csae.ox.ac.uk/conferences/2004-GPRaHdA/papers/1r-Jayne-CSAE2004.pdf>

Chapter 5 | AT RISK AND NEGLECTED: FOUR KEY POPULATIONS

Asian Harm Reduction Network (2005). *Targeting HIV/AIDS and drug use in Asia*. *AHR News*, Number 39. August–December 2005.

- Beckley Foundation (2005). UNAIDS and the prevention of HIV infection through injecting drug use. Briefing Paper 9. Available at http://www.internationaldrugpolicy.net/reports/BeckleyFoundation_BriefingPaper_09.pdf
- Belza J (2005). Risk of HIV infection among male sex workers in Spain. *Sexually Transmitted Infections*, 81: 85–88. 2005. Available at <http://sti.bmjournals.com/cgi/content/full/81/1/85>
- Burkhalter H (2003). Sex traffic and the HIV/AIDS pandemic. Washington, Testimony for Physicians for Human Rights before the House International Relations Committee. Available at <http://www.phrusa.org/campaigns/aids/news062403.html>
- Central and Eastern European Harm Reduction Network/OSI (2005). *Sex work, HIV/AIDS, and human rights in Central and Eastern Europe and Central Asia*. July 2005. Available at http://www.soros.org/initiatives/health/articles_publications/publications/sexwork_20051018?skin=printable
- Chicago Department of Public Health (2005). *STD/HIV/AIDS surveillance report—summer 2005*.
- Dandona L, Dandona R, Gutierrez JP, Kumar GA, McPherson S (2005). Sex behaviour of men who have sex with men and risk of HIV in Andhra Pradesh, India. *AIDS*, 19(6):611–619.
- De Groot AS (2005). HIV infection among women in prison: considerations for care. *Infectious diseases in corrections report*. Available at <http://www.idcronline.org/archives/mayjune05/article.html>
- De Herrera PA et al. (2005). Amphetamine (“meth”) use trends at the Los Angeles Gay and Lesbian Center’s HIV counseling and testing program from 2001 to 2004. Abstract M1–B0604. Atlanta, National HIV Prevention Conference. 12–15 June 2005.
- Dolan K, Lowe D, Shearer J (2004). Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine and Ethics*, 32(1):124–128.
- Gibson DR, Han L, Guo Y (2004). High levels of unprotected sex with men and women among men who have sex with men: a potential bridge of HIV transmission in Beijing, China. *AIDS Education and Prevention*, 16(1):19–30.
- Gorbach PM, Galea JT, Amani B, Shin A, Celum C (2004). Don’t ask, don’t tell: patterns of HIV disclosure among HIV positive men who have sex with men with recent STI practising high risk behaviour in Los Angeles and Seattle. *Sexually Transmitted Infections*, 80:512–517.
- Gordon RJ, Lowy FD (2005). Bacterial infections in drug users. *New England Journal of Medicine*, 353(18): 1945–1954. 3 November 2005.
- Goyer K (2003). *HIV/AIDS in prison: problems, policies and potential*. Available at <http://www.iss.co.za/Pubs/Monographs/No79/Content.html>
- Guanira J et al. (2004). Second generation of HIV surveillance among men who have sex with men in Peru during 2002. XV International AIDS Conference. Abstract WePeC6162. Bangkok. 11–16 July.
- Huang M, Hussein H (2004). The HIV/AIDS epidemic country paper: Malaysia. *AIDS Education and Prevention*, 16(Suppl. A):1001–09.
- ILO (2002). *Every child counts: new global estimates on child labour*. Geneva. Available at <http://www.ilo.org/public/english/standards/ipecc/simpoc/others/globalest.pdf>
- ILO (2004). *Protecting migrant women workers from going into exploitive work situations*. Geneva. Available at <http://www.ilo.org/public/english/employment/gems/advocacy/protect.htm>
- ITPC (2005). *Missing the target: a report on HIV/AIDS treatment access from the frontlines*. International Treatment Preparedness Coalition. Available at <http://www.aids-treatment-access.org/itpcfinal.pdf>
- Longfield K, Astatke H, Smith R, McPeak G, Ayers J (2004). *Promoting safer sexual behavior among MSMs in southeastern Europe: sexual norms, common beliefs, and risk*. Washington, DC, Population Services International, Research Division, 41 p. (PSI Research Division Working Paper No. 60).
- MAP (2005). *Sex work and HIV/AIDS in Asia*. MAP Network, 2005. Available at http://www.mapnetwork.org/docs/MAP_SW%20in%20Asia%20Final%2004July05_en.pdf

- Mattick RP, Breen C, Kimber J, Davoli M (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Cochrane Review). The Cochrane Library, Issue 1. Oxford.
- Ministerio de Salud Pública y Asistencia Social de El Salvador (2003). Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en hombres que tienen sexo con otros hombres en El Salvador.
- Ministry of Health Jamaica (2002). *Jamaica HIV/AIDS/STI National Strategic Plan 2002–2006*. Ministry of Health.
- Ministry of Health Malaysia, WHO (2004). Consensus report on HIV and AIDS—epidemiology in 2004: Malaysia. Ministry of Health and WHO. Kuala Lumpur.
- Ministry of Health People's Republic of China/UNAIDS (2005). *Update on the HIV/AIDS epidemic and response in China*. Beijing.
- Ministry of Health Ukraine (2005). Ukraine: national report on the follow-up to the UNGASS declaration of commitment on HIV/AIDS—reporting period 2003–2004.
- Molotilov V et al. (2003). Rapid increase in HIV rates—Orel Oblast, Russian Federation, 1999–2001. *Morbidity and Mortality Weekly Report*, 52:657–660.
- OSI (2004). Harm reduction news: fighting for prison health. Open Society Institute. Fall 2004, volume 5, issue 3.
- Pan-Caribbean Partnership on HIV/AIDS (2002). *The Caribbean regional strategic framework for HIV/AIDS 2002–2006*. Available at <http://www.caricom.org/jsp/projects/hiv-aidsstrategicframework.pdf>
- Peck JA et al. (2005). Sustained reductions in drug use and depression symptoms from treatment for drug abuse in methamphetamine-dependent gay and bisexual men. *Journal of Urban Health*, 82(Suppl.1): 100–108.
- Pisani E, Dili STI survey team (2004). *HIV, STIs and risk behaviour in East Timor: an historic opportunity for effective action*. Dili, East Timor, Family Health International. Available at http://www.oxfam.org.au/world/asia/east_timor/hivsti.pdf
- Pisani et al. (2004). HIV, syphilis infection, and sexual practices among transgenders, male sex workers, and other men who have sex with men in Jakarta, Indonesia. *Sex Transmitted Infection*, 80(6):536–40. December 2004.
- Russian Ministry of Justice (2004). Information from the Department of Corrections and Russian Federal AIDS Center.
- Secretaría de Estado de Salud Pública y Asistencia Social de Republica Dominicana (2005). De Segunda Generación Encuestas De Seroprevalencia de la Infección VIH Basadas en Puestos Centinelas 2004. March. Santo Domingo, Secretaría de Estado de Salud Pública y Asistencia Social, USAID–FHI/CONECTA.
- Shakarishvili A et al. (2005). Sex work, drug use, HIV infection, and spread of sexually transmitted infections in Moscow, Russian Federation. *Lancet*, 366:57–60.
- Simoooy O, Sanjobo N (2006). HIV/AIDS is still a double sentence in prisons. *BMJ*, 332(7533):119–20. 14 January 2006. Available at <http://press.psprings.co.uk/bmj/january/ltr118.pdf>
- Stöver H, Nelles J (2003). Ten years of experience with needle and syringe exchange programmes in European prisons. *International Journal of Drug Policy*.
- South China Morning Post (2005). High-risk HIV threat for gays in Shenzhen. 23 May 2005.
- Sullivan LE et al. (2005). Decreasing international HIV transmission: the role of expanding access to opioid agonist therapies for injection drug users. *Addiction*, 100:150–58.
- Tran TN et al. (2004). *Drug use among female sex workers in Hanoi, Viet Nam, 2004*. Available at http://www.ph.ucla.edu/epi/faculty/publications/Tran_Addiction_04-05.pdf

- UNAIDS (1996). *HIV/AIDS in prisons—statement by the Joint United Nations Programme on HIV/AIDS*. Geneva, Presentation to the United Nations Commission on Human Rights. April 1996.
- UNAIDS (1998). *Expanding the global response to HIV/AIDS through focused action: reducing risk and vulnerability: definitions, rationale and pathways*. Geneva, UNAIDS Best Practice Collection. Available at http://data.unaids.org/Publications/IRC-pub01/JC171-ExpGlobResp_en.pdf
- UNAIDS (2000a). Female sex worker HIV prevention projects: lessons learnt from Papua New Guinea, India and Bangladesh. Geneva, Best Practice Collection. Available at http://wmc.who.int/images/uploaded/Female_sex_worker%20%20.pdf
- UNAIDS (2000b). AIDS and men who have sex with men. Technical update, May 2000.
- UNAIDS (2002). *Sex work and HIV/AIDS. Technical Update*. Available at http://data.unaids.org/Publications/IRC-pub02/JC705-SexWork-TU_en.pdf
- UNAIDS (2003). *Progress report on the global response to the HIV/AIDS epidemic, 2003*. Annex 16. Available at http://hivaidsclearinghouse.unesco.org/ev_en.php?ID=2773_201&ID2=DO_TOPIC
- UNAIDS (2005a) *AIDS epidemic update 2005*. Geneva, Joint United Nations Programme on HIV/AIDS, World Health Organization.
- UNAIDS (2005b). A scaled-up response to AIDS in Asia and the Pacific. Geneva. Available at http://data.unaids.org/UNA-docs/REPORT_ICAAP_01July05_en.pdf
- UNAIDS (2005c). Joint UNAIDS statement on HIV prevention and care strategies for drug users. Geneva. Available at http://www.unaids.org/html/pub/una-docs/cco_idupolicy_en.pdf
- UNAIDS (2005d). *Intensifying HIV prevention: UNAIDS policy position paper*. Geneva.
- UNODC (2004). *2004 World drug report*. Vienna.
- USAID (2004). *How to integrate gender into HIV/AIDS programs: using lessons learned from USAID and partner organizations*. Gender and HIV/AIDS Task Force Interagency Gender Working Group (IGWG), United States Agency for International Development (USAID).
- USAID et al. (2004) *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*. USAID, UNAIDS, WHO, CDC and the Policy Project. Available at http://www.who.int/hiv/pub/prev_care/coverage/en/
- US Department of State (2004). *Victims of trafficking and violence protection act of 2000: trafficking in persons report 2004*. Washington, United States Department of State. Available at <http://www.state.gov/g/tip/rls/tiprpt/2004/>
- Vancouver Coastal Health Authority (2005). Unpublished data.
- Walmsley R (2005). *World prison population list* (sixth edition). Kings College London, International Centre for Prison Studies. Available at <http://www.kcl.ac.uk/depsta/rel/icps/world-prison-population-list-2005.pdf>
- WHO (2005). *Status paper on prisons, drugs and harm reduction*. World Health Organization, May 2005. Available at <http://www.euro.who.int/document/e85877.pdf>
- Wolfe D (2005). *Opportunities lost: HIV prevention, harm reduction and the Russian funding gap*. International Harm Reduction Development Program (IHRD). 31 August 2005.
- World Bank (2005). Global HIV/AIDS Program of Action. Available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1127498796401/GHAPAFinal.pdf>

Chapter 6 | COMPREHENSIVE HIV PREVENTION

Auvert B et al. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. *PloS Medicine*, 2(11):e298.

- Bunnell R (2006). Changes in sexual behavior and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda. *AIDS*, 20(1):85–92.
- CDC (2001). Updated U.S. public health service guidelines for the management of occupational exposures to HBV, HCV and HIV and recommendations for post-exposure prophylaxis. *Morbidity and Mortality Weekly Report*, 50:RR11:1–42.
- CDC (2003). Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *Morbidity and Mortality Weekly Report*, 52(RR–12).
- Cohen DA, Farley TA (2004). Social marketing of condoms is great, but we need more free condoms. *Lancet*, 364:13–14.
- Cowan F (2002). Adolescent reproductive health interventions. *Sexually Transmitted Infections*, 78:315–18.
- Crepaz N et al. (2005). Systematic review of HIV prevention interventions in reducing sexual risk behaviors among HIV+ persons. Abstract No. TP–50. Atlanta, National HIV Prevention Conference. 12–15 June 2005.
- Dallabetta G, Neilson G (2004). Efforts to control sexually transmitted infections as a means to limit HIV transmission: what is the evidence? *Current HIV/AIDS Report*, 1(4):166–71.
- Degraft-Johnson J et al. (2005). HIV voluntary counseling and testing service preferences in a rural Malawi population. *AIDS Behavior*, 27:1–10.
- Denning PH, Campsmith ML (2005). Unprotected anal intercourse among HIV-positive men who have a steady male sex partner with negative or unknown HIV serostatus. *American Journal of Public Health*, 95(1):152–58.
- Elwy R et al. (2002). Effectiveness of interventions to prevent sexually transmitted infections and human immunodeficiency virus in heterosexual men. *Archives of Internal Medicine*, 162:1818–30.
- Fleming DT, Wasserheit JN (1999). From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections*, 75:3–17.
- Flys T et al. (2005). Sensitive drug-resistance assays reveal long-term persistence of HIV-1 variants with the K103N nevirapine (NVP) resistance mutation in some women and infants after the administration of NVP: HIVNET 012. *Journal of Infectious Diseases*, 192:24–29.
- Freeman E et al. (2005). Herpes simplex virus type 2 infection increases HIV acquisition in men and women: systematic review and meta-analysis of longitudinal analysis. (In press).
- Gallant M, Maticka-Tyndale E (2004). School-based HIV prevention programmes for African youth. *Social Science & Medicine*, 58(7):1337–51.
- Global HIV Prevention Working Group (2004). HIV prevention in the era of expanded treatment access. Seattle, Bill and Melinda Gates Foundation and Henry J. Kaiser Family Foundation.
- Global HIV/AIDS Vaccine Enterprise (2005). The Global HIV/AIDS Vaccine Enterprise: scientific strategic plan. *Public Library of Science, Medicine*, 2(2):e25.
- Grown C, Gupta GR, Pande R (2005). Taking action to improve women's health through gender equality and women's empowerment. *Lancet*, 365:541–43.
- Halperin DT, Epstein H (2004). Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. *Lancet*, 364:4–6.
- Halperin DT et al. (2004). The time has come for common ground on preventing sexual transmission of HIV. *Lancet*, 364:1913–15.
- Hauri AM, Armstrong GL, Hutin YJF (2004). The global burden of disease attributable to contaminated injections given in health care settings. *International Journal of STD & AIDS*, 15:7–16.
- Hoffman S et al. (2004). The future of the female condom. *International Family Planning Perspectives*, 30(3):139–45.

- Hook EW, Peeling RW (2004). Syphilis control—a continuing challenge. *New England Journal of Medicine*, 351(2):122–24.
- ILO (2005). Guidelines for the transport sector. Geneva.
- International AIDS Society (2005). Building collaboration to advance HIV prevention: global consultation on tenofovir pre-exposure prophylaxis research. International AIDS Society.
- IPPF (2003a). Vision 2000 funds: PROFAMIL project, Haiti. International Planned Parenthood Federation.
- IPPF (2003b). Vision 2000 funds: male involvement project, Kenya. International Planned Parenthood Federation.
- Jackson JB et al. (2003). Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: 18-month follow-up of the HIVNET 012 randomised trial. *Lancet*, 362:859–68.
- Johnson J et al. (2005). Emergence of drug-resistant HIV-1 after intrapartum administration of single-dose nevirapine is substantially underestimated. *Journal of Infectious Disease*, 192:16–23.
- Jourdain G et al. (2004). Intrapartum exposure to nevirapine and subsequent maternal responses to nevirapine-based antiretroviral therapy. *New England Journal of Medicine*, 351(3):229–40.
- Kirby D et al. (2005). Impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries. FHI/YouthNet. Youth Research Working Paper No. 2.
- Lowicki-Zucca M, Spiegel P, Ciantia F (2005). AIDS, conflict and the media in Africa: risks in reporting bad data badly. *Emerging Themes in Epidemiology*. doi:10.1186/1742–7622–2–12.
- MAP (2005). Sex work and HIV/AIDS in Asia. Bangkok, Monitoring the AIDS Pandemic Network.
- Meekers D, Agha S, Klein M (2005). The impact on condom use of the “100% Jeune” social marketing program in Cameroon. *Journal of Adolescent Health*, 36(6):530.
- Merson MH et al. (2000). Effectiveness of HIV prevention interventions in developing countries. *AIDS*, 14(Suppl. 2):S68–S84.
- Moore JP (2005). Topical microbicides become topical. *New England Journal of Medicine*, 352(3): 298–300.
- Pettifor AE et al. (2004). Early age of first sex: a risk factor for HIV infection among women in Zimbabwe. *AIDS*, 18:1435–42.
- Prata P, Vahidnia F, Fraser A (2005). Gender and relationship differences in condom use among 15–24-year-olds in Angola. *International Family Planning Perspectives*, 31(4):192–99.
- Reynolds SJ et al. (2004). Male circumcision and risk of HIV-1 and other sexually transmitted infections in India. *Lancet*, 363:1039–40.
- Richardson JL et al. (2004). Effect of brief safer-sex counseling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment. *AIDS*, 18(8):1179–86.
- Ross JS, Labbok MH (2004). Modeling the effects of different infant feeding strategies on infant survival and mother-to-child transmission of HIV. *American Journal of Public Health*, 94(7):1174–80.
- Salomon JA, Hogan DR, Stover J, Stanecki KA, Walker N, et al. (2005). Integrating HIV prevention and treatment: from slogans to impact. *Public Library of Science, Medicine*, 2(1):e16.
- Santelli J et al. (2006). Abstinence and abstinence-only education: a review of U.S. policies and programs. *Journal of Adolescent Health*, 38(1):72–81.
- Schmid GP et al. (2004). Transmission of HIV-1 infection in sub-Saharan Africa and effect of elimination of unsafe injections. *Lancet*, 363:482–88.

- Siegfried N et al. (2005). HIV and male circumcision—a systematic review with assessment of the quality of studies. *Lancet Infectious Diseases*, 5:165–73.
- Singh S et al. (2005). HIV in Nepal: is the violent conflict fuelling the epidemic? *PLoS Medicine*, 2(8):e216.
- Stover J (2005). Estimating the global impact of an AIDS vaccine. International AIDS Vaccine Initiative.
- Stover J et al. (2006). The global impact of scaling-up HIV/AIDS prevention programs in low- and middle-income countries. *Science*. DOI:10.1126/science1121176.
- Thielman NM et al. (2006). Cost-effectiveness of free HIV voluntary counseling and testing through a community-based AIDS service organization in Northern Tanzania. *American Journal of Public Health*, 96(1).
- UNAIDS (2001). *AIDS epidemic update*. Geneva.
- UNAIDS (2005a). Intensifying HIV prevention: UNAIDS policy position paper. Geneva.
- UNAIDS (2005b). Resources needs for an expanded response to AIDS in low and middle income countries. Geneva.
- UNAIDS (2006). Creating effective partnerships for HIV prevention trials: report of a UNAIDS Consultation, Geneva 20–21 June 2005. *AIDS*, 20(6):W1–W11.
- UNAIDS et al. (2005c). Joint UNAIDS statement on HIV prevention and care strategies for drug users. Geneva.
- UNAIDS/ILO/ICFTU (2006). Global reach: how trade unions are responding to HIV and AIDS, case studies of union actions. Geneva.
- UNAIDS/UNHCR (2005). Strategies to support the HIV-related needs of refugees and host populations. Geneva.
- UNAIDS/WHO (2004). UNAIDS/WHO policy statement on HIV testing. Geneva.
- Underwood C et al. (2006). Reducing the risk of HIV transmission among adolescents in Zambia: psychosocial and behavioral correlates of viewing a risk-reduction media campaign. *Journal of Adolescent Health*, 38(1):55.e1–55.e13.
- UNDP/UNAIDS (2004). Thailand's response to HIV/AIDS: progress and challenges.
- UNFPA (2004a). The New York call to commitment: linking HIV/AIDS and sexual and reproductive health. Available at http://www.unfpa.org/upload/lib_pub_file/321_filename_New%20York%20Call%20to%20Commitment.pdf
- UNFPA (2004b). The Glion call to action on family planning and HIV/AIDS in women and children. 3–5 May 2004. Available at http://www.unfpa.org/upload/lib_pub_file/333_filename_glion_cal_to_action.pdf
- UNFPA (2005). Sexual and reproductive health & HIV/AIDS: a framework for priority linkages. Available at http://www.unfpa.org/upload/lib_pub_file/501_filename_framework_priority_linkages.pdf
- UNFPA et al. (2004). Position statement on condoms and HIV prevention. Available at http://data.unaids.org/una-docs/condom-policy_jul04_en.pdf
- UNFPA et al. (2005). UNAIDS statement on South African trial findings regarding male circumcision and HIV. Available at <http://www.who.int/mediacentre/news/releases/2005/pr32/en/>
- UNHCR (2005). Refugees, HIV and AIDS: UNHCR's strategic plan 2005–2007. Geneva.
- UNICEF (2005). Girls, HIV/AIDS and education. Geneva.
- USAID et al. (2004). Coverage of selected services for HIV/AIDS prevention, care and support in low- and middle-income countries in 2003. Policy Project for USAID.
- Weber J et al. (2005). The development of vaginal microbicides for the prevention of HIV transmission. *PLoS Medicine*, 2(5):e142.
- Weiss H et al. (2000). Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS*, 14:2361–70.

- WFP (2004). Getting started: WFP support to the prevention of mother-to-child transmission of HIV and related programmes. Geneva. Available at http://www.wfp.org/food_aid/doc/Getting_Started.pdf
- WFP (2006). Getting started: WFP support to HIV/AIDS training for transport and contract workers. Geneva.
- WHO (2005a). Countries offering free access to HIV treatment—fact sheet. Geneva.
- WHO (2005b). Sexually transmitted and other reproductive tract infections. Geneva.
- WHO (2005c). The safety of immunization practices improves over last five years, but challenges remain. News Release, 11 November 2005. Geneva.
- WHO et al. (1999). WHO/UNICEF/UNFPA joint statement on the use of auto-disable syringes in immunization services. Geneva.
- Wilson TE et al. (2004). Changes in sexual behavior among HIV-infected women after initiation of HAART. *American Journal of Public Health*, 94(7):1141–47.
- Wong ML, Chan R, Koh D (2004). Long-term effects of condom promotion programmes for vaginal and oral sex on sexually transmitted infections among sex workers in Singapore. *AIDS*, 18(8):1195–99.

Chapter 7 | TREATMENT AND CARE

- Baigana F, Thomas R, Comblain C (2004). HIV/AIDS and mental health. HNP discussion paper. World Bank.
- Bates I et al. (2004). Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part II: determinants operating at environmental and institutional level. *Lancet Infectious Disease*, 4:368–75.
- Beckmann S et al. (2005). HIV/AIDS workplace programmes and public-private-partnerships (PPP) through co-investment: extension of treatment and care into the community. ILO.
- Bicanic T et al. (2005). Antiretroviral roll-out, antifungal roll-back: access to treatment for cryptococcal meningitis. *Lancet Infectious Diseases*, 5:530–31.
- Bonacini M et al. (2004). Survival in patients with HIV infection and viral hepatitis B or C: a cohort study. *AIDS*, 18(15):2039–45.
- Bonnett F et al. (2005). Opportunistic infections as causes of death in HIV-infected patients in the HAART era in France. *Scandinavian Journal of Infectious Disease*, 37(6–7):482–87.
- Bonolo PD et al. (2005). Non-adherence among patients initiating antiretroviral therapy: a challenge for health professionals in Brazil. *AIDS*, 19(Suppl. 4):S5–13.
- Bunell R et al. (2006). Changes in sexual behaviour and risk of HIV transmission after ART and prevention interventions in rural Uganda. *AIDS*, 20:85–92.
- CDC (2003). Hepatitis C Virus and HIV Coinfection. Available at http://www.cdc.gov/idu/hepatitis/hepc_and_hiv_co.pdf.
- Chintu C et al. (2004). Co-trimoxazole as prophylaxis against opportunistic infections in HIV-infected Zambian children (CHAP): a double-blind randomised placebo-controlled trial. *Lancet*, 364:1865–71.
- Cooper CL (2005). Therapeutic interventions for HIV infection and chronic viral hepatitis. *Clinical Infectious Diseases*, 41(Suppl. 1):S69–72.
- Da Silva CG et al. (2005). Optimistic perception of HIV/AIDS, unprotected sex and implications for prevention among men who have sex with men, Sao Paulo, Brazil. *AIDS*, 19(Suppl. 4):S31–36.
- Degraft-Johnson J et al. (2005). HIV voluntary counseling and testing service preferences in a rural Malawi population. *AIDS Behaviors*, 9(4):475–484.

- Deutsche Press-Agentur (2005). Doctors Without Borders blasts Nigeria's approach to HIV/AIDS. 6 December 2005.
- Ellman T, Culbert H, Torres-Feced V (2005). Treatment of AIDS in conflict-affected settings: a failure of imagination. *Lancet*, 365(9456):278–8.
- Felkin DR et al. (2004). Global strategies to prevent bacterial pneumonia in adults with HIV disease. *Lancet Infectious Diseases*, 4:445–55.
- Gayle H, Lange JM (2004). Seizing the opportunity to capitalize on the growing access to HIV treatment to expand HIV prevention. *Lancet*, 364:6–7.
- Global HIV Prevention Working Group (2004). HIV prevention in the era of expanded treatment access.
- Gordillo V et al. (1999). Sociodemographic and psychological variables influencing adherence to antiretroviral therapy. *AIDS*, 13:1767.
- Harding R, Higginson IJ (2005). Palliative care in sub-Saharan Africa. *Lancet*, 365:971–77.
- Havir DV, Hammer SM (2005). Patents versus patients? Antiretroviral therapy in India. *New England Journal of Medicine*, 353(8):749–51.
- IASC (2004). *Guidelines for HIV/AIDS Interventions in Emergency Settings*. Inter-Agency Standing Committee (IASC) Task force on HIV/AIDS in Emergency Settings. Available at http://www.unfpa.org/upload/lib_pub_file/249_filename_guidelines-hiv-emer.pdf
- Karim S et al. (2004). Implementing antiretroviral therapy in resource-constrained settings: opportunities and challenges in integrating HIV and tuberculosis care. *AIDS*, 18(7):975–79.
- Karuru JW et al. (2005). Prevalence of HCV and HCV/HIV co-infection among in-patients at the Kenyatta National Hospital. *East African Medical Journal*, 82(4):170–72.
- Kontorinis N, Agarwal K, Dieterich DT (2005). Treatment of hepatitis C virus in HIV patients: a review. *AIDS*, 19(Suppl. 3):S166–73.
- Lucas GM (2005). Antiretroviral adherence, drug resistance, viral fitness and HIV disease progression: a tangled web is woven. *Journal of Antimicrobial Chemotherapy*, 55(4):413–16.
- McArthur JC, Brew BJ, Nath A (2005). Neurological complications of HIV infection. *Lancet Neurology*, 4: 543–55.
- McComsey GA, Leonard E (2004). Metabolic complications of HIV therapy in children. *AIDS*, 18(13): 1753–68.
- Narasimhan V et al. (2004). Responding to the global human resources crisis. *Lancet*, 363:1469–72.
- Nelson LJ et al. (2005). Antituberculosis drug resistance and anonymous HIV surveillance in tuberculosis patients in Botswana, 2002. *Lancet*, 366:488–90.
- Nemes MIB et al. (2004). Antiretroviral adherence in Brazil. *AIDS*, 18(Suppl. 3):S15–S20.
- Norrby SR et al. (2005). Lack of development of new antimicrobial drugs: a potential serious threat to public health. *Lancet Infectious Diseases*, 5:115–19.
- Obaro SK, Pugatch D, Luzuriaga K (2004). Immunogenicity and efficacy of childhood vaccines in HIV-1-infected children. *Lancet Infectious Diseases*, 4:510–18.
- Okere IN et al. (2005). Antimicrobial resistance in developing countries. Part I: recent trends and current status. *Lancet Infectious Diseases*, 5:481–93.
- Open Society Institute (2004). Breaking down barriers: lessons on providing HIV treatment to injection drug users. New York.
- Osterberg L, Balsche T (2005). Adherence to medication. *New England Journal of Medicine*, 353(5): 487–97.

- Over M et al. (2004). HIV/AIDS treatment and prevention in India: modelling the cost and consequences. World Bank.
- Paterson D et al. (2000). Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. *Annals of Internal Medicine*, 133:21–30.
- Petersen PE et al. (2005). The global burden of oral diseases and risks to oral health. Bulletin of the World Health Organization. Print ISSN 0042–9686.
- Quinn TC et al. (2000). Viral load and heterosexual transmission of Human Immunodeficiency Virus Type 1. *New England Journal of Medicine*, 342(13):921–29.
- Salomon JA et al. (2005). Integrating HIV prevention and treatment: from slogans to impact. *PloS Medicine*, 2:e16.
- Severe P et al. (2005). Antiretroviral therapy in a thousand patients with AIDS in Haiti. *New England Journal of Medicine*, 353(22):2325–34.
- Siegel K, Karus D, Dean L (2004). Psychosocial characteristics of New York City HIV-infected women before and after the advent of HAART. *American Journal of Public Health*, 94(7):1127–32.
- Singh N et al. (1999). Adherence of Human Immunodeficiency Virus-infected patients to antiretroviral therapy. *Clinical Infectious Diseases*, 29(4):824–30.
- Sobhani I et al. (2004). Anal carcinoma: incidence and effect of cumulative infections. *AIDS*, 18(11): 1561–69.
- Spiegel PB, Qassim M (2003). Forgotten refugees and other displaced populations. *Lancet*, 362:72–74.
- Spiegel P, Harroff-Tavel H (2006). HIV/AIDS and internally displaced persons in 8 priority countries. Geneva, UNHCR and IDD, OCHA. January 2006.
- Thielman N et al. (2006). Cost-effectiveness of free HIV voluntary counseling and testing through a community-based AIDS service organization in Northern Tanzania. *American Journal of Public Health*, 96(1):114–9.
- UNAIDS (2005a). Access to treatment in the private-sector workplace: the provision of antiretroviral therapy by three companies in South Africa. UNAIDS Best Practice Collection. Geneva.
- UNAIDS (2005b). *AIDS epidemic update*. Geneva.
- UNAIDS (2005c). Making the money work through greater UN support for AIDS responses: the 2006–2007 consolidated UN technical support plan for AIDS. Geneva.
- UNAIDS Global Resource Tracking Consortium (2004). National spending for AIDS 2004. Geneva.
- UNDP (2005). Human Development Report. New York.
- UNHCR (2005). Refugees, HIV and AIDS: UNHCR's strategic plan 2005–2007. Geneva.
- UNHCR (2006). Antiretroviral therapy for refugees (draft). Geneva.
- UNHCR/WFP (2004). Integration of HIV/AIDS activities with food and nutrition support in refugee settings: specific programme strategies. Geneva, UNHCR and WFP.
- USAID et al. (2003). The level of effort in the national response to HIV/AIDS: the AIDS Program Effort Index (API), 2003 round. POLICY Project, Futures Group.
- WHO (2004). Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach. Geneva.
- WHO (2005a). Technical and operational recommendations for scale-up of laboratory services and monitoring HIV antiretroviral therapy in resource-limited settings. Geneva.
- WHO (2006a). Antiretroviral therapy of HIV infection in infants and children in resource-limited settings, towards universal access: recommendations for a public health approach (2006 revision).

- WHO (2006b). IMAI (website) Available at <http://www.who.int/hiv/pub/imai/en/>
- WHO/UNAIDS (2004). Guidance on ethics and equitable access to HIV treatment and care. Geneva.
- WHO/UNAIDS (2005b). Progress on global access to HIV antiretroviral therapy: An update on “3 by 5.” Geneva.
- Wood E et al. When to initiate antiretroviral therapy in HIV-1-infected adults: a review for clinicians and patients. *Lancet Infectious Diseases*, 5:407–14.
- World Bank (2005). The World Bank’s global HIV/AIDS programme of action. Washington.

Chapter 8 | REDUCING THE IMPACT OF AIDS

- Abadia-Barrero CE, Castro A (2005). Experiences of stigma and access to HAART in children and adolescents living with HIV/AIDS in Brazil. *Social Science and Medicine*. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=16099573
- Agha S, Balal A, Ogojo-Okello F (2004). The impact of a microfinance program on client perceptions of the quality of care provided by private sector midwives in Uganda. *Health Services Research*, 39(6.2): 2081–100. Available at <http://www.blackwell-synergy.com/links/doi/10.1111/j.1475-6773.2004.00333.x/enhancedabs/>
- Boler T, Jellema A (2005). *Deadly inertia: a cross country study of educational responses to HIV/AIDS*. Brussels, Global Campaign for Education. Available at <http://www.campaignforeducation.org/resources/Nov2005/ENGLISHdeadlyinertia.pdf>
- Brown L, Macintyre K, Trujillo L (2001). *Interventions to reduce HIV/AIDS stigma: what have we learned?* The Population Council. Available at <http://www.popcouncil.org/pdfs/horizons/litrwstigdisc.pdf>
- Centre for Development Policy Research (2005). *Unequal prospects: disparities in the quantity and quality of labour supply in sub-Saharan Africa (World Bank employment issues regional stocktaking review paper 1: labour supply)*. London, Centre for Development Policy Research, School of Oriental and African Studies, University of London. Available at <http://siteresources.worldbank.org/INTLM/Resources/UnequalProspects.pdf>
- CGAP (2003). *Microfinance and HIV/AIDS*. Washington, Consultative Group to Assist the Poor. Available at http://www.cgap.org/docs/DonorBrief_14.pdf
- Chaguturu S, Vallabhaneni S (2005). Aiding and abetting—nursing crises at home and abroad. *New England Journal of Medicine*, 353(17):1761–3. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=16251530
- FAO (2004). *Property and a piece of land give women peace of mind*. Harare, FAO, UNIFEM and National AIDS Council Joint National Workshop on HIV and AIDS, Women’s Property Rights and Livelihoods in Zimbabwe. Available at http://www.sahims.net/doclibrary/Sahims_Documents/FAO,%20UNIFEM%20NAC%20report.pdf
- FAO (2006). Junior farmer field and life schools (webpage). Available at http://www.fao.org/bestpractices/content/11/11_04_en.htm
- FAO/Government of Zambia (2004). *Strengthening institutional capacity in mitigating HIV/AIDS impact on the agricultural sector—potential mitigation interventions*. Rome, FAO–Lusaka and Ministry of Agriculture and Cooperatives, Republic of Zambia. Available at <ftp://ftp.fao.org/docrep/fao/007/y5656e/y5656e00.pdf>
- FHI (2005). *Adolescents: orphaned and vulnerable in the time of HIV/AIDS*. Washington. Available at <http://www.fhi.org/en/Youth/YouthNet/Publications/YouthIssuesPapers.htm>
- Foan L, Irwin B (2004). Mitigation of the economic impact of HIV/AIDS on women, vulnerable children and orphans through asset protection (abstract). Available at http://www.iasociety.org/abstract/show.asp?abstract_id=2174501 (accessed 12 January 2006)

- GBC (2006). Global Business Coalition on HIV/AIDS website. Available at <http://www.businessfightsaids.org/site/apps/nl/content.asp?c=gwKXJfNVJtFandb=1009003andct=1366193>
- Global Partners Forum (2006). Free up and open up: the elimination of school fees. Background paper at the technical consultation of Global Partners Forum on Children Affected by HIV and AIDS, February 2006, convened by UNICEF and the UK Department for International Development (DFID).
- HelpAge International (2005). *AIDS: the frontline. Supporting older carers of people living with HIV/AIDS and orphaned children in Mozambique, South Africa and Sudan*. London, HelpAge International. Available at <http://www.helpage.org/Resources/Researchreports>
- Human Rights Watch (2005). *Letting them fail: government neglect and the right to education for children affected by AIDS*. New York, Human Rights Watch. Available at <http://hrw.org/reports/2005/africa1005/index.htm>
- IATT (2003). *HIV/AIDS and education: a strategic approach*. Paris, UNAIDS Inter Agency Task Team on Education (IATT), UNESCO/IIEP.
- IATT (2006). *Education sector global HIV & AIDS readiness survey 2004: policy implications for education & development*. Paris, UNAIDS Inter Agency Task Team on Education (IATT), UNESCO/IIEP.
- ILO (2001). *The ILO code of practice on HIV/AIDS and the world of work*. Geneva. Available at <http://www.ilo.org/public/english/protection/trav/aids/code/codemain.htm>
- ILO et al. (2006). *Global reach: how trade unions are responding to HIV/AIDS*. Geneva, ILO, UNAIDS, ICFTU, Global Unions.
- ILO/IPEC (2003). *HIV/AIDS and child labour in sub-Saharan Africa: synthesis report. A state-of-the-art review with recommendations for action*. Geneva, International Labour Organization, International Programme on the Elimination of Child Labour (IPEC). Available at <http://www.ilo.org/public/english/standards/ipec/publ/hiv/>
- ILO/WHO (2005). *Joint ILO/WHO guidelines on health services and HIV/AIDS*. Geneva, International Labour Organization and World Health Organization. Available at www.who.int/hiv/pub/prev_care/healthservices/en/index.html
- Jayne TS et al. (2004). *Interactions between the agricultural sector and the HIV/AIDS pandemic: implications for agricultural policy*. Rome, Food and Agriculture Organization (FAO). Available at <ftp://ftp.fao.org/docrep/fao/007/ae061e/ae061e00.pdf>
- Joint Learning Initiative (2004). *Human resources for health: overcoming the crisis*. Global Equity Initiative. Cambridge, Mass., Harvard University Press. Available at <http://www.globalhealthtrust.org/Report.html>
- Kourta D (2005). Un atelier régional à Alger. *Al Watan*. Alger. 13 November 2005.
- Mahendra VS, Gilborn L (2006). *Improving the hospital environment of HIV-positive people in India: findings from a pilot study on addressing AIDS-related stigma and discrimination*. Horizons/Population Council.
- Mather D et al. (2004). *A cross-country analysis of household responses to adult mortality in rural sub-Saharan Africa: implications for HIV/AIDS mitigation and rural development policies*. Department of Agricultural Economics, Michigan State University. Available at <http://www.aec.msu.edu/agecon/fs2/papers/idwp82forreview.pdf>
- Mathison S (2005). *Economy and epidemic. Microfinance and HIV/AIDS in Asia*. Brisbane, The Foundation for Development Cooperation. Available at <http://www.fdc.org.au/Files/Microfinance/Microfinance%20and%20HIV-AIDS.pdf>
- Meintjes H et al. (2003). *Children in need of care or in need of cash? Questioning social security provisions for orphans in the context of the South African AIDS pandemic*. Children's Institute, University of Cape Town. Available at http://hivaidsclearinghouse.unesco.org/ev_en.php?ID=3347_201andID2=DO_TOPIC
- Mobile Task Team (2005). *Education access and retention for educationally marginalised children: innovations in social protection*. Johannesburg, Mobile Task Team on the Impact of HIV/AIDS on

Education (MTT), University of Kwazulu-Natal. Available at <http://www.mttaids.com/site/files/5562/MTT%5FUNICEF%5FReport%2Epdf>

Murray U (2005). *Promoting gender-sensitive entrepreneurship via microfinance institutions*. Rome, Paper presented at FAO Headquarters on International Women's Day. Available at http://www.fao.org/sd/dim_pe1/pe1_050401_en.htm

Onwujekwe O and Uzochukwu B (2005). Socio-economic and geographic differentials in costs and payment strategies for primary healthcare services in Southeast Nigeria. *Health Policy*, 71(3):383–97. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15694504

Pal K et al. (2005). Can low income countries afford basic social protection? First results of a modelling exercise. *Issues in Social Protection*. Discussion Paper 13. ILO. June 2005.

PDA (2005). The positive partnership project: micro credit loans for people living with and affected by HIV/AIDS in Thailand (and border areas). Population and Community Development Association (PDA). Available at http://www.pda.or.th/eng/posivite_project.htm (accessed 8 January 2005)

Peltzer K et al. (2005). *Educator supply and demand in the South African public education system: integrated report*. Johannesburg, Human Sciences Research Council. Available at <http://www.hsrcpress.ac.za/index.asp?id=2119>

Prywes M et al. (2004). *Costs of projects for orphans and other vulnerable children: case studies in Eritrea and Benin*. Washington, DC, Social Protection Team, World Bank Human Development Network. Available at <http://www-wds.worldbank.org/servlet/WDS%5FIBank%5FServlet?pcont=details&eid=000012009%5F20041012101822>

Russell S (2004). The economic burden of illness for households in developing countries: a review of studies focusing on malaria, tuberculosis, and human immunodeficiency virus/acquired immunodeficiency syndrome. *American Journal of Tropical Medicine and Hygiene*, 71(Suppl. 2):147–55. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15331831

Russell S (2005). *Justice for widows and orphans in Zambia*. Geneva, The Global Coalition on Women and AIDS. Available at http://www.womenandaids.unaids.org/regional/jwop1_13%20May05.doc

Save the Children, HelpAge International and Institute of Development Studies (2005). *Making cash count: lessons from cash transfer schemes in east and southern Africa for supporting the most vulnerable children and households*. London, Save the Children UK. Available at http://www.savethechildren.org.uk/scuk_cache/scuk/cache/cmsattach/3604_Making_Cash_Count_final.pdf

Schuler N et al. (2005). *Lessons and experiences from mainstreaming HIV/AIDS into urban/water (AFTU1 and 2) projects, Vol. 1 of 1*. Washington, World Bank. Available at http://www-wds.worldbank.org/servlet/WDS_IBank_Servlet?pcont=details&eid=000012009_20051019135310

Sengwana M, Quinlan T (2004). *Review of studies of socio-economic impact of HIV/AIDS in sub-Saharan Africa*. Durban, Health Economics and HIV/AIDS Research Division (HEARD) of the University of KwaZulu Natal, Durban.

Sibale B, Kachale E (2004). *Educational perspectives related to the impact of the HIV/AIDS pandemic on child labour in Malawi*. Geneva, ILO International Programme on the Elimination of Child Labour (IPEC). Available at <http://www.ilo.org/iloroot/public/english/standards/ipec/doc-view.cfm?id=121>

Stillwaggon E (2005). *The ecology of poverty: nutrition, parasites, and vulnerability to HIV/AIDS*. HIV/AIDS and Food and Nutrition Security: From Evidence to Action, Durban, South Africa. Available at <http://www.ifpri.org/events/conferences/2005/durban/papers/stillwaggonWP.pdf>

Thirumurthy H, Graff-Zivin J, Goldstein M (2005). *The economic impact of AIDS treatment: labor supply in Western Kenya*. NBER Working Paper No. 11871.

UBS, FandC Asset Management (2005). *HIV/AIDS beyond Africa: managing the financial impacts*. London, FandC Asset Management. Available at http://www.fandc.com/uploadFiles/co_gsri_hivaidas_report_may_05.pdf

UN Population Division (2005). *World population prospects: the 2004 revision*. New York, Dept. of International Economic and Social Affairs, United Nations. Available at http://www.un.org/esa/population/publications/WPP2004/2004Highlights_finalrevised.pdf

UNAIDS (2005). *HIV-related stigma, discrimination and human rights violations: case studies of successful programmes*. Geneva, UNAIDS Best Practice Collection. Available at http://www.unaids.org/html/pub/unadocs/jc999-hrviolations_en_pdf.pdf

UNAIDS (2006). *2005 update on the HIV/AIDS epidemic and response in China*. Beijing, Ministry of Health, People's Republic of China and UNAIDS.

UNAIDS/UNHCR (2005). *Strategies to support the HIV-related needs of refugees and host populations*. Geneva, UNAIDS and the United Nations High Commissioner for Refugees. Available at http://www.unaids.org/html/pub/publications/irc-pub06/jc1157-refugees_en_pdf.pdf

UNDP (2005). *Hoping and coping: a call for action—the capacity challenge of HIV/AIDS in least developed countries*. New York, United Nations Development Programme and the Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States. Available at http://www.undp.org/hiv/docs/hoping_and_coping_final.pdf

UNESCO (2005a). *EFA global monitoring report 2006*. Paris.

UNESCO (2005b). *Towards an AIDS-free generation: the global initiative on HIV/AIDS and education*. Paris, International Institute for Educational Planning. Available at <http://www.unesco.org/iiep>

UNICEF (2005a). *Innovations in social protection in eastern and southern Africa: reaching the most vulnerable children in the context of HIV and AIDS. An integrated summary report on education, public works and cash transfer programmes*. Nairobi, UNICEF Eastern and Southern Africa.

UNICEF (2005b). *Progress for children: a report card on gender parity and primary education*. New York, UNICEF. Available at <http://www.unicef.org/progressforchildren/2005n2/>

UNICEF/UNAIDS (2004). *Framework for the protection, care and support of orphans and vulnerable children*. New York. Available at http://www.unicef.org/aids/files/Framework_English.pdf

USAID et al. (2005). *Working report measuring HIV stigma: results of a field test in Tanzania*. Washington, USAID, ICRW, Department of Psychiatry at Muhimbili University College of the Health Sciences, Policy Project, Horizons, Synergy Project. Available at http://www.synergyaids.com/documents/StigmaIndicatorsReportFinal_JuneEdited.pdf

WHO (2001). *Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization Commission on Macroeconomics and Health. Available at <http://www.un.org/esa/coordination/ecosoc/docs/RT.K.MacroeconomicsHealth.pdf>

WHO (2002). *World report on violence and health*. Geneva, World Health Organization. Available at http://www5.who.int/violence_injury_prevention/main.cfm?p=0000000682 WHO (2005a). *The World Health Report 2005: make every mother and child count*. Geneva. Available at <http://www.who.int/whr/2005/en/index.html>

WHO (2005b). *WHO multi-country study on women's health and domestic violence against women*. Geneva, World Health Organization. Available at http://www.who.int/gender/violence/who_multicountry_study/en/index.html

Wilton Park/UNICEF (2005). *Wilton Park/UNICEF high level policy consultation. Strengthening national responses to children affected by HIV/AIDS: what is the role of the state and social welfare in Africa?* Geneva.

World Bank (2006). *HIV/AIDS and education: accelerating the education sector response to HIV/AIDS*. Geneva. Available at <http://www.schoolsandhealth.org/HIV-AIDSandEd/Introduction-HIV-AIDSandEducation-Accelerate.htm>

Wu Z et al. (2002). Diffusion of HIV/AIDS knowledge, positive attitudes, and behaviors through training of health professionals in China. *AIDS Education and Prevention*, 14(5):379–90. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=12413184

Chapter 9 | THE ESSENTIAL ROLE OF CIVIL SOCIETY

Atlani-Duault L (2005). *Au bonheur des autres: anthropologie de l'aide humanitaire*. Nanterre, Société d'ethnologie.

Berkman A, Parker R, et al. (2005). A critical analysis of the Brazilian response to HIV/AIDS: lessons learned for controlling and mitigating the epidemic in developing countries. *American Journal of Public Health*, Vol. 95, No.7. July 2005.

Bloom DE, Bloom LR, Steven D, Weston M (2006). Business and HIV/AIDS: a healthier partnership? A global review of the business response to HIV/AIDS 2005–2006. Geneva, World Economic Forum, 2006. Available at http://www.weforum.org/pdf/initiatives/gbs2006_reports.pdf

Boler T, Jellema A (2005). *Deadly inertia: a cross country study of educational responses to HIV/AIDS*. Brussels, Global Campaign for Education. Available at <http://www.campaignforeducation.org/resources/Nov2005/ENGLISHdeadlyinertia.pdf>

Cornman H, Duvvury N (2005). Civil society participation in Global Fund governance: recommendations and actionable items. Working Paper Series, International Center for Research on Women. April 2005.

Dimmock F (2006). Christian health associations in Africa. PowerPoint presentation to Christian Connections for International Health Annual Conference, May 2006. Available at http://www.ccih.org/conferences/presentations/2005/CHAs-dimmock_files/frame.htm

Global Fund (2005a). *Revised guidelines on purpose, structure and composition of country coordinating mechanisms and requirements for grant eligibility*. Geneva, Technical Evaluation Reference Group.

Global Fund (2005b). *Report on the assessment of country coordinating mechanisms: performance baseline*. Geneva, Technical Evaluation Reference Group.

Global Fund (2006). Available at <http://www.theglobalfund.org>

Halmshaw C, Hawkins K (2004). Capitalising on global HIV/AIDS funding: the challenge for civil society and government. *Reproductive Health Matters*, 12(24):35–41.

IATT (2006). *Education sector global HIV & AIDS readiness survey 2004: policy implications for education & development*. Paris, UNAIDS Inter Agency Task Team on Education (IATT), UNESCO/IIEP.

ICASO (2004a). In-country monitoring of the implementation of the Declaration of Commitment adopted at the UN General Assembly Special Session on HIV/AIDS: a four-country pilot study.

ICASO (2004b). *NGO perspectives on the Global Fund: a report prepared by the International Council of AIDS Service Organisations*. International Council of AIDS Service Organisations.

ICASO (2005). *Civil society and the "Three Ones": capacity building towards effective multisectoral national AIDS responses*. International Council of AIDS Service Organisations.

IFRC (2006). Available at <http://www.ifrc.org/what/health/hivaids/antistigma>

IFRC (2006). Available at http://www.ifrc.org/cgi/pdf_pubs.pl?health/hivaids/NGOCode.pdf

International AIDS Alliance (2004). *NGO capacity analysis: a toolkit for assessing and building capacities for high quality responses to HIV/AIDS*. Frontiers Prevention Project, International AIDS Alliance. July 2004.

Manning R (2002). *The impact of HIV/AIDS on civil society: assessing and mitigating impacts: tools & models for NGOs and CBOs*. Durban, Health Economics & HIV/AIDS Research Division (HEARD), University of Natal. Available at <http://www.eldis.org/static/DOC11102.htm>

- NGO HIV/AIDS Code of Practice Project (2004). *Renewing our voice: code of good practice for NGOs responding to HIV/AIDS*. Geneva, NGO HIV/AIDS Code of Practice Project. Available at http://www.ifrc.org/cgi/pdf_pubs.pl?health/hivaids/NGOCode.pdf
- Ogden J, Nyblade L (2005). Common at its core: HIV-related stigma across contexts. ICRW (International Center for Research on Women). 2005. Available at http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf
- Piot P (2005). Speech to the 17th Meeting of the UNAIDS Programme Coordinating Board. Geneva. 27 June 2005.
- Rawstone P, Prestage G et al. (2005). Trends and predictors of HIV positive community attachment among PLWHA. *AIDS Care*, 17(5):589–600. July 2005.
- Sidaction, UNAIDS/WHO (2005). Expanding access to HIV treatment through community-based organizations. Geneva, Sidaction, UNAIDS/WHO, Best Practice Collection.
- Terrence Higgins Trust and GNP+ (2005). *Criminalisation of HIV transmission in Europe*. Available at <http://www.tht.org.uk/home/informationresources/publications/policyreports/criminalisationeurope.pdf>
- UNAIDS (2005a). Meeting on development of index on human rights, stigma and discrimination by and for people living with HIV: report of the meeting. Geneva, Switzerland. 22–23 August 2005.
- UNAIDS (2005b). *The five pillars of UNAIDS*. Available at <http://www.unaids.org>
- UNAIDS (2005c). Report from an Eastern and Southern Africa Regional Think Tank Meeting on identifying obstacles, challenges and opportunities faced by people living with HIV and AIDS. 23–25 October 2005.
- UNAIDS (2005d). Time for Conscientizacao: revitalising the global movement of people living with HIV. Communiqué from the Nairobi Think Tank meeting of people living with HIV. 28–30 November 2005.
- UNAIDS (2006). *The global coalition on women and AIDS: 2005 progress report*. Geneva.
- UNAIDS/ILO/ICFTU (2006). *Global reach: how trade unions are responding to HIV and AIDS. Case studies of union action*. UNAIDS, ILO, ICFTU, Global Unions. 2006 (in print).
- WHO (2004). *World Health Report 2004*. Geneva.
- World AIDS Campaign (2006). *Stop AIDS, keep the promise*. Available at http://ungasshiv.org/index.php/ungass/ungass/monitoring_ungass_2006

Chapter 10 | FINANCING THE RESPONSE TO AIDS

- European HIV/AIDS Funders (2005). *European philanthropy and HIV/AIDS*. European Foundation Centre, European HIV/AIDS Funders Group. Available at http://www.efc.be/ftp/public/Orpheus/HIV/EFC10_904__newprint.pdf
- Henry J. Kaiser Family Foundation (2005). HIV/AIDS policy fact sheet: The HIV/AIDS epidemic in the United States. Menlo Park, California, Henry J. Kaiser Family Foundation. Available at <http://www.kff.org/hivaids/us.cfm>
- Funders Concerned about AIDS (2005). *US philanthropic commitments for HIV/AIDS*. New York, Funders Concerned about AIDS. Available at <http://www.fcaids.org/publications/documents/resourcetracking2005.pdf>
- G8 (2005). *The Gleneagles Communiqué*. Gleneagles, United Kingdom, G8 Gleneagles 2005. Available at http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique_0.pdf
- Global Fund (2005). Sustaining performance, scaling up results: third progress report 2005. Geneva.
- HIV Vaccines and Microbicides Resource Tracking Working Group (2005). *Tracking funding for microbicide research & Development: estimates of annual investments and expenditures 2000 to 2005*. Geneva, AIDS Vaccine Advocacy Coalition, Alliance for Microbicide Development, International AIDS Vaccine Initiative, Joint United Nations Programme on HIV/AIDS. Available at <http://www.iavi.org/viewfile.cfm?fid=32580>

HIV Vaccines and Microbicides Resource Tracking Work Group (2005). *Tracking funding for preventive HIV vaccine research & development: estimates of annual investments and expenditures 2000 to 2005*. Geneva, AIDS Vaccine Advocacy Coalition, Alliance for Microbicide Development, International AIDS Vaccine Initiative, Joint United Nations Programme on HIV/AIDS. Available at <http://www.iavi.org/viewfile.cfm?fid=30892>

Kates J (2005). Financing the response to HIV/AIDS in low and middle income countries: funding for HIV/AIDS from the G7 and the European Commission. Menlo Park, California, Henry J. Kaiser Family Foundation. Available at <http://www.kff.org/hiv/aids/upload/Financing-the-Response-to-HIV-AIDS-in-Low-and-Middle-Income-Countries-Funding-for-HIV-AIDS-from-the-G7-and-the-European-Commission-Report.pdf>

Mullen P (2005). Review of national HIV/AIDS strategies for countries participating in the World Bank's Africa multi-country AIDS program (MAP). Washington, World Bank.

NACC (2004). *Report on the implementation of the Kenyan National HIV/AIDS Strategic Plan*. Nairobi, National AIDS Control Council, Office of the President. Quoted in Kioko U and Njeru E. Kenya. In Hickey and Guthrie, 41.

Ndlovu (2005). An exploratory analysis of HIV and AIDS donor funding in South Africa. Budget Brief No. 155. UNDASA.

OECD (2005). *OECD health data 2005*. October 2005. Paris, Organisation for Economic Co-operation and Development. Available at <http://www.oecd.org/dataoecd/60/27/35529803.xls>

OECD (2006). *Aid rising sharply according to final ODA figures for 2004*. Paris, Organisation for Economic Co-operation and Development. Available at <http://www.oecd.org/dataoecd/0/41/35842562.pdf>

Office of the United States Global AIDS Coordinator (2005). *Engendering bold leadership: the president's emergency plan for AIDS relief, first annual report to congress*. Washington, United States Department of State.

SIDALAC, FUNSALUD (2004). Financial indicators of the national responses to HIV/AIDS in Latin America and the Caribbean, 1999–2002. Mexico City, Regional AIDS Initiative for Latin America and Caribbean (SIDALAC) and Mexican Health Foundation (FUNSALUD). Data tables available at <http://www.sidalac.org.mx>

Stover J, Bollinger L, Walker N, Monasch R (2005). *Resources required to support orphans and vulnerable children in sub-Saharan Africa*. New York, United Nations Children's Fund.

UNAIDS (2003). *Directions for the future: unifying and intensifying country support*. Geneva, Joint United Nations Programme on HIV/AIDS.

UNAIDS (2003). *UNAIDS unified budget and workplan 2004–2005*. Geneva.

UNAIDS (2004). *Financing the expanded response to AIDS*. Geneva.

UNAIDS (2005). *Resource needs for an expanded response to AIDS in low- and middle-income countries*. Geneva. Available at http://data.unaids.org/Publications/IRC-pub06/ResourceNeedsReport_en.pdf

UNAIDS (2005). *The global response to AIDS: making the money work—the Three Ones in action*. Communiqué from the High Level Meeting on the Global Response to AIDS in London. 9 March 2005. Available at: http://www.unaids.org/html/pub/media/information-notes01/in_three_ones_09mar05_en.pdf.pdf

UNAIDS Resource Tracking Consortium (draft not yet published). *National AIDS spending assessments: absorptive capacity, bottlenecks, and out-of-pocket spending*. Geneva.

United Nations (2005). *World population prospects: the 2004 revision, highlights*. New York, United Nations Secretariat, Department of Economic and Social Affairs, Population Division. Available at <http://www.un.org/esa/population/publications/WPP2004/wpp2004.htm>

United Nations (2005). *2005 World Summit outcome: resolution adopted by the General Assembly, 16 September 2005*. New York. Available at <http://daccessdds.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement>

World Bank (2005). Country Classification. Available at <http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20420458~menuPK:64133156~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html>

World Bank (2005). The World Bank's Global HIV/AIDS Program of Action. Washington.

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AMICAALL (2006). Available at <http://www.amicaall.org/>.

APLF et al. (2005). Act now: Asia-Pacific leaders respond to HIV/AIDS. Bangkok, Asia Pacific Leadership Forum on HIV/AIDS and Development. Available at (http://www.aplfaids.com/avocacy_tools.php#act).

Barcellos NT (2005). Consultancy report of Mozambique "Three Ones"/Global Task Team assessment mission. Geneva and London, United Nations Joint Programme on HIV/AIDS and United Kingdom Department for International Development.

European Health Group (2006 draft). Assessment of the proposal development and review process of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Søborg, Denmark, European Health Group.

Garcia-Calleja et al. (2004). A global analysis of trends in the quality of HIV sero-surveillance. *Sexually Transmitted Infections*, 80(Suppl. 1):i25–i30. London, BMJ Publishing Group Ltd.

Global Fund (2005). Harmonization of Global Fund programs and donor coordination: four case studies with a focus on HIV/AIDS. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria. Available at http://www.theglobalfund.org/en/files/about/replenishment/harmonization_paper_3dreplenishment.pdf

International HIV/AIDS Alliance and International Council of AIDS Service Organizations (2005). Discussion paper: civil society and the "Three Ones." Brighton and Toronto, International HIV/AIDS Alliance and International Council of AIDS Service Organizations.

Kenya National AIDS Control Council (2005). Kenya National HIV/AIDS Strategic Plan (KNASP) for 2005/06 to 2009/10. Nairobi, National AIDS Control Council.

Monitoring the AIDS Pandemic (MAP) (2004). AIDS in Asia: face the facts. Bangkok, Monitoring the AIDS Pandemic Network.

Montano SM et al. (2005). Prevalences, genotypes, and risk factors for HIV transmission in South America. *Journal of Acquired Immune Deficiency Syndrome*, 40(1):57–64. September 2005.

National Expanded Theme Group on HIV/AIDS Nigeria (2005). *Domestication of the global task team recommendations in Nigeria*. Geneva, Joint United Nations Programme on HIV/AIDS.

PAHO et al. (2005). *HIV and AIDS in Latin America and the Caribbean: the evolving epidemic and response and the challenges ahead*. Washington, Pan American Health Organization. (Unpublished draft).

Paris Declaration on Aid Effectiveness (2005). High level forum on joint progress toward enhanced aid effectiveness. 28 February–2 March 2005. Available at <http://www.oecd.org/dataoecd/11/41/34428351.pdf>

PASCA et al. (2003). Central American multi-site HIV prevalence and behaviour study. Central American AIDS Prevention Project. Available at http://www.pasca.org/english/estudio_informes_eng.htm

Roseberry W, Seale A, Mphuka S (2005). Assessing the application of the "Three Ones Principles" in Zambia, 31 January–11 February 2005. London, Department for International Development Health Systems Resource Centre.

- Secretariat of the Pacific Community (2005). *The Pacific regional strategy on HIV/AIDS*. New Caledonia, Secretariat of the Pacific Community. Available at <http://www.aplfaids.com/documents/Final%20Pacific%20Regional%20Strategy%20on%20HIVAIDS.pdf>
- Shakow A (2006). Global Fund—World Bank HIV/AIDS programs: comparative advantage study. Geneva and Washington, The Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank.
- SIDALAC (2005). Country spending estimates can be found on the web site of the Regional AIDS Initiative for Latin America and the Caribbean (SIDALAC). Available at <http://www.sidalac.org.mx/english/home.html>
- Tobias R (2005). Coming together to support national strategies. Statement to the high level forum on the global response to AIDS: making the money work—the “Three Ones” in action, London, 9 March 2005.
- UNAIDS (2004). Consultation on harmonization of international AIDS funding, Washington, 25 April 2004. End of meeting agreement. Available at http://www.unaids.org/html/pub/una-docs/three-ones_agreement_en_pdf.pdf
- UNAIDS (2005a). Making the money work through greater UN support for AIDS responses: the consolidated UN technical support plan for AIDS. Geneva. Available at http://www.unaids.org/html/pub/una-docs/techsupportplan_aug05_en_pdf.pdf
- UNAIDS (2005b). Global task team on improving AIDS coordination among multilateral institutions and international donors: final report. Geneva, Joint United Nations Programme on HIV/AIDS. Available at http://www.unaids.org/html/pub/publications/irc-pub06/jc1125-globaltaskteamreport_en_pdf.pdf
- UNAIDS (2005c). UNAIDS technical support division of labour. Geneva. Available at http://www.unaids.org/html/pub/una-docs/divisionoflabour_aug05_en_pdf.pdf
- UNAIDS (2005d). Mainstreaming HIV and AIDS in sectors and programmes: an implementation guide for national responses. Geneva, New York, Washington, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme and World Bank.
- UNAIDS (2005e). “Three Ones” country mission Viet Nam: mission report. Geneva. March 2005.
- UNAIDS (2005f). Strengthening the response to HIV and AIDS at local, country and global level: the role and opportunities for civil society in tracking progress toward UNGASS targets. Report on a joint UNAIDS and civil society planning meeting on UNGASS 2006 preparation held at Recife, Brazil, 15–17 September 2005. Geneva.
- UNAIDS (2005g). The “Three Ones” in action: where we are and where we go from here. Geneva.
- UNAIDS/UNHCR (2005). Strategies to support the HIV-related needs of refugees and host populations. Geneva, UNAIDS and the United Nations High Commissioner for Refugees. Available at http://www.unaids.org/html/pub/publications/irc-pub06/jc1157-refugees_en_pdf.pdf
- UNAIDS/WHO (2000). Guidelines for second generation HIV surveillance. Geneva, Joint United Nations Programme on HIV/AIDS and World Health Organization.
- UNHCR (2005 and 2006). Reports on UNHCR’s HIV and AIDS programmes and activities for 2004 and 2005. Geneva, United Nations High Commissioner for Refugees. The 2005 report was not yet published at the time of this writing. The 2004 report is available at <http://www.unhcr.org/cgi-bin/texis/vtx/protect/opedoc.pdf?tbl=PROTECTION&id=430591752>
- United Nations (2000). United Nations Millennium Declaration: United Nations General Assembly, 55th session, 6 September 2000. New York.
- United Nations (2002). Report of the international conference on financing for development, Monterrey, Mexico. 18–22 March 2002. New York. Available at <http://www.un.org/esa/ffd/aconf198-11>.
- WHO (2004a). Available at <http://www.who.int/hiv/pub/guidelines/patientmonitoring.pdf>.

WHO (2004b). Available at <http://www.who.int/3by5/publications/documents/en/hivpatientartmonitoringmeeting2004.pdf>.

WHO (2004c). Available at http://www.who.int/kms/initiatives/EMR_Meeting_Report_2004.pdf

WHO (2004d). Available at http://www.who.int/kms/initiatives/HL7_ART_meeting_report_FINAL.pdf.

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Chaguturu S, Vallabhaneni S (2005) "Aiding and abetting—nursing crises at home and abroad," *New England Journal of Medicine*, 353 (17), 1761–3.

HIV Vaccine and Microbicide Resource Tracking Working Group (2005).

Mullan F (2005). The metrics of the physician brain drain. *New England Journal of Medicine*, 353(17): 1810–18.

UNAIDS (2006). *From advocacy to action: A progress report on UNAIDS at country-level*. Geneva.

UNICEF/UNAIDS (2005). *A call to action: Children, the missing face of AIDS*. New York.

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