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Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Report of the Secretary-General

In most countries, discrimination remains legal against women, men who have sex with men, sex workers, drug users and ethnic minorities. This must change. I call on all countries to live up to their commitments to enact or enforce legislation outlawing discrimination against people living with HIV and members of vulnerable groups … In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us.

Secretary-General Ban Ki-moon
International AIDS Conference
Mexico City, 3 August 2008

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Summary

The present report provides an update on developments in the AIDS response, looks forward to the agreed 2010 milestones, recommends key actions to accelerate progress and urges renewed commitment to the goal of universal access to HIV prevention, treatment, care and support.

In June 2008, the General Assembly, at its High-level Meeting on HIV/AIDS, assessed progress in the response to the global HIV epidemic. Reports from 147 countries showed that important progress had been made, including in the areas of access to antiretroviral therapy and the prevention of mother-to-child transmission. Numerous actors have contributed to those gains, including national Governments, civil society and people living with HIV. The Government of the United States of America has mobilized $18.8 billion for the AIDS response in the past five years, and the Global Fund to Fight AIDS, Tuberculosis and Malaria has delivered antiretroviral therapies to approximately 2 million people.

Despite such encouraging developments, considerable challenges remain, including significant access gaps for key HIV-related services. The pace of new infections continues to outstrip the expansion of treatment programmes, and commitment to HIV prevention remains inadequate. While funds available for HIV in low- and middle-income countries increased from $11.3 billion in 2007 to $13.7 billion in 2008, there has been a global economic downturn since the 2008 High-level Meeting. As the HIV response represents one of the soundest of all possible global investments, it is critical that commitment to HIV efforts be maintained and strengthened in the midst of these economic challenges.

Building on the commitments agreed to during the twenty-sixth special session of the General Assembly on HIV/AIDS, held in 2001, Member States agreed in 2006 to move towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010. As of February 2009, 111 countries had established country-specific targets for universal access through broad, consultative national processes.

The universal access commitment reflects a human rights imperative and is supported by the many other commitments made by Member States to protect the rights of people living with HIV and people vulnerable to HIV infection. However, many countries have laws and policies that are inconsistent with the commitments and result in reduced access to essential HIV services and commodities. In 2007, one third of countries reported that they still lacked laws to prohibit HIV-related discrimination, and many countries with anti-discrimination legislation have problems with adequate enforcement. A total of 84 countries reported that they have laws and regulations that present obstacles to effective HIV prevention, treatment, care and support for vulnerable subpopulations. Furthermore, some 60 countries have laws that restrict the entry, stay and residence of people living with HIV based on HIV-positive status only. Finally, an increasing number of countries have enacted overly broad laws that criminalize transmission or exposure to HIV, as well as non-disclosure of HIV status. Such measures are likely to lead people to avoid HIV testing, thereby undermining efforts to achieve universal access.

Improved analytic methods have enabled countries to better characterize the magnitude and dynamics of their epidemics, to select appropriate interventions and tailor evidence-informed strategies to address their specific national context. The

strategic tailoring of national responses magnifies the results of HIV programmes and reduces waste and inefficiency. Improved monitoring and evaluation systems also permit countries to revise national strategies as their epidemics evolve over time. In their efforts to closely align national strategies with actual national circumstances, countries should work to understand and address the social and structural determinants of HIV risk and vulnerability, such as gender inequalities, social marginalization and stigma and discrimination.

The HIV epidemic presents a long-term global challenge and requires a sustained commitment for an effective long-term response. As the coverage and quality of HIV programmes increase, intensified efforts are needed to strengthen the health, education, social welfare and other key sectors, and to integrate HIV with tuberculosis, sexual and reproductive health and other health services. The long-term AIDS response will be sustainable only if substantially greater success is achieved in slowing the rate of new HIV infections, while providing optimal services for people living with HIV. Bringing to scale the appropriate mix of behavioural, biomedical and structural HIV-prevention strategies would more than halve the number of all new HIV infections between now and 2015. Access to such a combination of prevention strategies, however, remains sharply limited in most countries. It is estimated that achieving national universal access targets by 2010 will require an annual outlay of $25 billion within two years, necessitating renewed commitment from all providers of HIV-related funding. Sustaining an effective AIDS response will require unprecedented leadership at all levels, including from Governments, civil society and affected communities.

Key recommendations

All stakeholders must reaffirm their commitment to move towards universal access to HIV prevention, treatment, care and support by 2010.

National prevention strategies should address national and local needs, taking into account the dynamics of national epidemics and evidence of what works to prevent HIV transmission at the individual, community and societal levels.

Annual financing from all sources must increase to $25 billion by 2010 in order to achieve national universal access targets. Global leaders should explore and support innovative financing mechanisms for HIV and other development challenges.

Laws and law enforcement should be improved and programmes to support access to justice should be taken to scale to prevent discrimination against people living with HIV and populations vulnerable to infection. HIV-related travel restrictions should be eliminated; the criminalization of HIV transmission should be limited to intentional transmission; and laws that burden or impede service access among sex workers, men who have sex with men, and injecting drug users should be repealed.

All stakeholders must fully commit to maximum transparency and accountability in the global response, including regular reporting on their national and global commitments.

I. Introduction

1. The General Assembly, at its High-level Meeting on HIV/AIDS, held in June 2008, assessed progress in the response to the global HIV epidemic and achievements to date in meeting the time-bound targets unanimously adopted by Member States in the 2001 Declaration of Commitment on HIV/AIDS. Those commitments were reaffirmed in the 2006 Political Declaration on HIV/AIDS, in which Member States pledged to move towards universal access to HIV prevention, treatment, care and support by 2010.

2. Reports from 147 countries identified the following key achievements:

(a) Access to antiretroviral therapy rose by 47 per cent in 2007, reaching 3 million adults in low- and middle-income countries. Coverage for paediatric antiretroviral treatment increased nearly threefold in the period from 2005 to 2007. In only five years, antiretroviral coverage in resource-limited settings increased tenfold, resulting in the first decline in the annual number of AIDS deaths since the epidemic was first recognized in the early 1980s;

(b) The percentage of HIV-infected pregnant women receiving services to prevent mother-to-child transmission increased from 15 per cent in 2005 to 33 per cent in 2007;

(c) The decline in HIV prevalence among young pregnant women in several high-prevalence countries in Africa suggest that HIV-prevention efforts in the region are resulting in significant changes in sexual behaviour.

3. Those encouraging advances reflect the impact of the immense efforts of those engaged in the response. The High-level Meeting, however, also highlighted critical weaknesses and shortcomings in current efforts:

(a) In all, 70 per cent of people who needed antiretroviral treatment in 2007 did not have access to it;

(b) In 2007, for every two people who started antiretroviral treatment, five people were newly infected with HIV;

(c) In 11 high-prevalence countries, 85 per cent of children orphaned or made vulnerable by HIV lived in households that received no form of assistance in 2007;

(d) Among people between the ages of 15 and 24, only about 40 per cent had accurate and comprehensive knowledge about HIV;

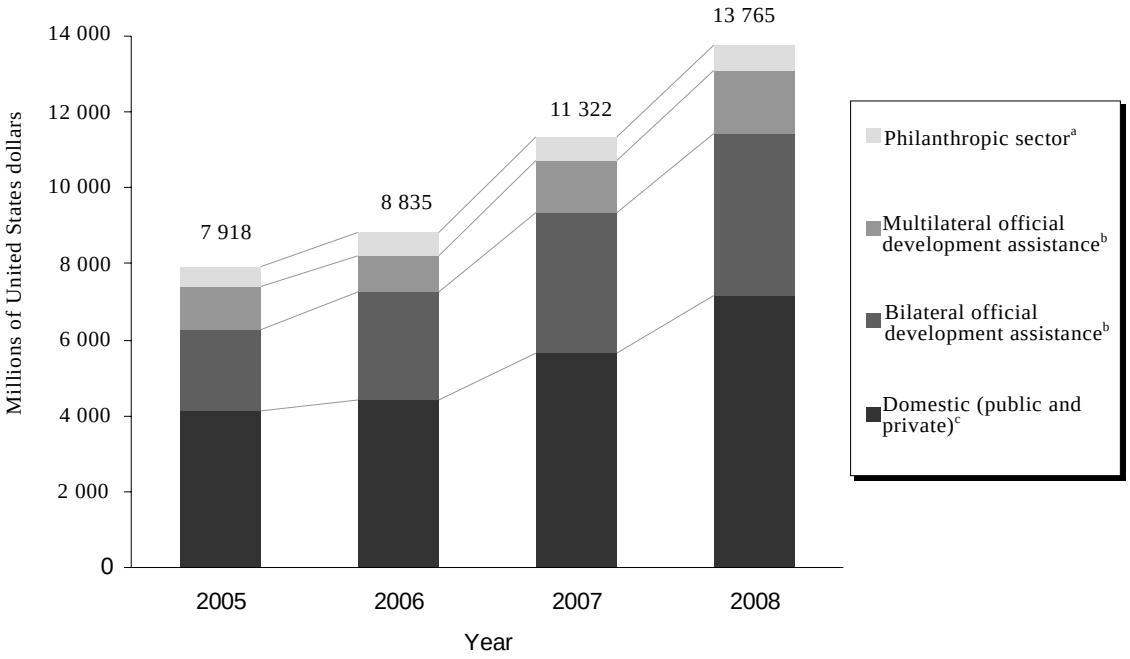
(e) Nearly two thirds of countries have laws and policies in place that impede the access of vulnerable populations to HIV services, and nearly half provide no financial support for programmes focused on women;

(f) With HIV causing a resurgence of tuberculosis, there is an urgent need to improve service integration and coverage for people co-infected with HIV and tuberculosis.

4. Approximately $11.3 billion was available for HIV programmes in low- and middle-income countries in 2007, and nearly $13.7 billion in 2008 (see fig. I). From 2007 to 2008, resources available for HIV programmes increased by 21 per cent. In terms of funding, domestic sources accounted for 53 per cent in 2008, followed by

31 per cent from bilateral donors, 12 per cent from multilateral institutions, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, and 5 per cent from philanthropic institutions.

Figure I
Annual funding available for HIV/AIDS programmes



[a] Reports of Funders Concerned About AIDS (2008) and the European HIV/AIDS Funders Group (2008).
[b] Development Assistance Committee of the Organization for Economic Cooperation and Development, as at 19 December 2008.
[c] Joint United Nations Programme on HIV/AIDS, 2008.

5. At the 2008 High-level Meeting, many countries indicated that they were at risk of falling short of achieving their universal access goals for 2010. Since that meeting, a deepening global economic downturn has occurred, rendering even more acute the challenges of meeting the global AIDS commitments. As Governments grapple with the consequences of the economic downturn, it is critical that their investments in the AIDS response be maintained and strengthened in order to yield important returns in the immediate future and in decades to come.

6. The present report has four objectives: (a) to provide an update on developments in the AIDS response; (b) to look forward to the 2010 milestones and to describe their vital role in a sustainable, long-term response to the epidemic; (c) to recommend key actions to accelerate progress towards the commitments that have been made; and (d) to renew commitment to the goal of universal access to HIV prevention, treatment, care and support.

II. Ensuring accountability for human rights commitments

7. In the 2001 Declaration of Commitment on HIV/AIDS, Member States unanimously agreed that respect for the rights of people living with HIV/AIDS drives an effective response, and pledged to undertake specific actions to protect the rights of people living with HIV, women and girls, young people, migrants and members of vulnerable populations. Those commitments were confirmed and elaborated in the 2006 Political Declaration on HIV/AIDS. However, Governments have failed to take sufficient political, legal and programmatic steps to realize those pledges. Achieving those human rights commitments is essential if accelerated progress in the response to HIV and the goal of universal access are to be achieved.

Prohibiting HIV-related discrimination

8. Evidence presented at the 2008 High-level Meeting indicated that a growing number of countries have adopted laws to protect people living with HIV from discrimination. However, in 2007, one third of countries reported that they lacked such laws. In accordance with the commitments made by States under international human rights instruments and the 2006 Political Declaration to enact, strengthen or enforce, as appropriate, legislation to eliminate all forms of discrimination against people living with HIV and members of vulnerable groups, countries that lack anti-discrimination legislation should put such laws in place.

9. Anti-discrimination laws will achieve their aim only if they are properly enforced and buttressed by broader anti-stigma initiatives. Many countries do not systematically measure HIV-related stigma and discrimination, implement or take to scale programmes to reduce stigma and discrimination or prioritize programmes in their national responses that would empower those affected to benefit from legal protections.

Lifting HIV-related restrictions on entry, stay and residence

10. In 2008, some 60 countries had provisions restricting people's entry, stay or residence based on their HIV-positive status only. Not only are such restrictions discriminatory, but they may also have devastating consequences for individuals seeking to migrate, obtain asylum, reunite with family, study, do business or participate in conferences on HIV policy and practice.

11. In 2008, the International Task Team on HIV-related Travel Restrictions, which comprises Governments, international organizations and civil society representatives, emphasized that such discriminatory restrictions do not protect the public health or represent a rational, fair strategy to avoid costs associated with HIV treatment. Some progress in repealing such counterproductive laws has recently been reported. Tajikistan recently dropped its restrictions, and the Governments of China, Namibia and the United States of America are reportedly taking steps to remove their restrictions.

Criminalization of HIV transmission: a growing threat to a sound response

12. Although a number of high-income countries have, for many years, criminalized HIV transmission or exposure, more than 15 African countries adopted such laws in 2007 or 2008. As a general rule, such HIV-specific laws impose criminal penalties on people who transmit or expose others to HIV. There is no

evidence that such overly broad and ill-defined laws deter people from transmitting HIV, and there is great concern that they both reinforce HIV-related stigma and discourage people from learning or disclosing their HIV status.

13. Malicious conduct involving the intentional transmission of HIV to another person justifies punishment. However, evidence indicates that such conduct is exceedingly rare, as most people who test positive for HIV take steps to avoid exposing others to infection. Where such cases do occur, general criminal laws already exist to punish such harmful conduct. Enacting HIV-specific laws and applying them to broad categories of behaviour perpetuates the idea that people living with HIV are dangerous and undeserving of social solidarity. This is at odds with the evidence, as well as with the commitment in the 2006 Political Declaration to create a social and legal environment safe for voluntary disclosure of HIV status.

14. Overly broad laws may result in the prosecution of individuals who are unaware that they are infected or do not understand how HIV is transmitted, or even of those who disclosed their HIV infection to their partner or took precautions to reduce the risk of transmission. There is also evidence that such laws are disproportionately applied to members of marginalized groups.

15. Proponents of laws criminalizing HIV transmission often cite the need to protect women, who are frequently put at risk because of the sexual behaviours of their husbands or other male partners. However, such laws may actually result in the disproportionate prosecution of women. As women often use health services more frequently than men because of pregnancy or to access family planning services, women are often the first to be diagnosed with HIV infection and may be prosecuted for "bringing HIV into the relationship" or charged with exposing their newborn child to HIV.

16. In addition to criminalizing HIV transmission, many countries impose criminal sanctions for same-sex sex, commercial sex and drug injection. Such laws constitute major barriers to reaching key populations with HIV services. Those behaviours should be decriminalized, and people addicted to drugs should receive health services for the treatment of their addiction.

17. Instead of relying on criminal laws, Governments should expand and enforce laws that protect people from HIV-related discrimination and sexual violence and ensure that all have access to HIV-related health information, services and commodities. Extensive experience demonstrates that programmes to change risky behaviours, complemented with strong human rights protections, are far more effective in controlling HIV than the counterproductive use of criminal sanctions or other forms of coercion.

III. Universal access

18. The promotion of universal access has united the international community in scaling up HIV services throughout the world. As of February 2009, 111 countries had established national coverage and outcome targets for universal access. New sources of technical support delivery and coordination have been developed, such as regional technical support facilities, HIV knowledge hubs and the Global Implementation Support Team, to assist countries in bringing HIV programmes to scale. Country-level monitoring and evaluation systems have also improved,

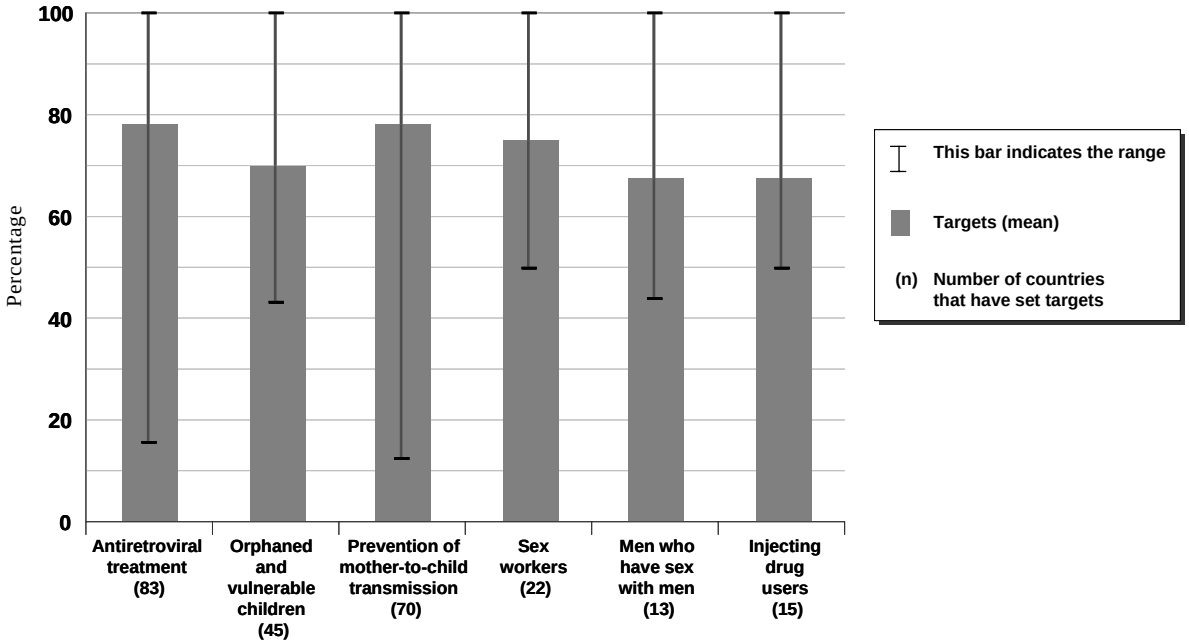
providing more transparent and timely tracking of achievements and identification of remaining gaps in service coverage and quality.

Understanding universal access

19. The term “universal access” does not imply that 100 per cent of individuals will have access to all prevention, treatment, care and support interventions. Rather, it reflects a worldwide commitment to make measurable, sustained advances towards a significantly higher level of coverage for effective interventions needed to manage diverse epidemics. Universal access means that services must be equitable, accessible, affordable, comprehensive and responsive to individual needs. Universal access not only focuses on the achievement of measurable results, but also represents a new way of approaching international health and development. It is rights- and solution-based, grounded in national ownership and problem-solving and premised on maximum accountability and transparency.

20. As figure II shows, countries have adopted a range of coverage targets for various components of universal access, with most countries aiming at ambitious, but achievable, goals. Some country-defined targets for 2010 are lower than others, which mostly reflects differences in anticipated timelines for those countries to scale up their HIV services, rather than a lack of commitment to universal access.

Figure II
Number of countries that have coverage targets for various services by 2010



21. Countries with different types of epidemics are prioritizing different HIV services. The specific mix of interventions depends on a variety of factors, including HIV prevalence, the relative importance of different modes of HIV transmission, the magnitude and distribution of prevailing service gaps and the specific populations most affected by the epidemic.

22. The co-sponsors and the secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS) have spearheaded efforts to assist countries in achieving universal access, facilitating country-led dialogues and target-setting processes, working with partners to estimate resource needs for universal access and placing the move towards universal access at the centre of the joint UNAIDS workplan. With new leadership, UNAIDS has reinforced universal access as its top priority.

Universal access: ambitious but achievable

23. Although universal access is an ambitious undertaking, experience in various regions demonstrates that it is achievable. The use of antiretroviral drugs increased more than fivefold in Cambodia in the period from 2004 to 2007. In Senegal, South Africa and Thailand, the number of people receiving antiretroviral treatment doubled in the period from 2005 to 2007. Even faster rates of increase in access to antiretroviral drugs were reported in Central and Eastern Europe.

24. Similar progress has been reported for services to prevent mother-to-child transmission. By 2007, Botswana had achieved national universal access targets for HIV prevention services in antenatal settings. Other countries, including Argentina, Belarus, Benin, Brazil, Georgia, Kazakhstan, Kenya, Namibia, the Republic of Moldova, the Russian Federation, Rwanda, Swaziland and Ukraine, have also made major progress towards universal access in preventing the transmission of HIV from mother to child.[1]

25. Evidence demonstrates that major HIV prevention gains are possible. In 14 of 17 African countries surveyed, the percentage of pregnant women aged 15 to 24 and living with HIV decreased between 2000 and 2007, with 9 countries having already achieved the 25 per cent reduction in HIV prevalence called for in the 2001 Declaration of Commitment.

A continuing imperative

26. As the rate of new HIV infections continues to exceed the number of AIDS deaths, the number of people living with HIV continues to rise, thereby increasing the number of people who will need future therapeutic services. The imperative to deliver treatment to those who need it highlights the urgent need to reinforce and expand infrastructure to deliver antiretroviral treatment in low- and middle-income countries.

27. Without greater progress in preventing new HIV infections, the pace of new infections will continue to outstrip the expansion of treatment programmes. The experiences of a variety of countries have demonstrated that a combination of prevention measures can sharply lower the rate of new HIV infections. In Namibia, for example, a combination of life-skills-based HIV education, voluntary counselling and testing and widespread condom distribution contributed to a decrease in HIV prevalence among young pregnant women from 18 per cent in 2003 to 14 per cent in 2007. It has been estimated that meeting the country-defined

[1] In addition to adopting country-specific targets for the prevention of mother-to-child transmission as part of universal access, Member States adopted the global goal set in the 2001 Declaration of Commitment of achieving 80 per cent coverage of comprehensive prevention services in antenatal settings by 2010.

universal access targets in low- and middle-income countries by 2010 would avert 2.6 million new infections and 1.3 million deaths in 2009 and 2010.

28. “Combination prevention” relies on the appropriate mix of behavioural, biomedical and structural HIV-prevention strategies to address the specific needs of those at risk of HIV infection.[2] Effective HIV prevention focuses particular efforts on young people, who are disproportionately affected by HIV in all regions.

Focusing on those who are most at risk

29. Neither the risk of HIV infection nor the impact of the disease is distributed equally. In southern Africa, for example, adolescent girls are between 2 and 4.5 times more likely to be infected than boys of the same age. In nearly all countries, HIV prevalence is much higher among certain groups than in the population at large.

30. As services are further expanded, they should be better focused on those who need them and should take into account the special needs and access barriers experienced by particular communities. For example, in Eastern Europe, people who inject drugs represent more than 80 per cent of all people living with HIV but account for less than 25 per cent of those receiving antiretroviral treatment. UNAIDS reports that national prevention programmes are well matched with national needs in only 10 per cent of countries.

31. In addition to increasing access to prevention services among women and girls, countries should redouble their efforts to address the gender inequalities that increase the vulnerability of women and girls to HIV. National partners should work to ensure universal access to primary and secondary education, enforce measures to prevent gender-based violence and ensure the adoption and enforcement of sound legal frameworks that recognize women’s rights to property, inheritance, equal political participation and economic opportunities.

Reaching children living with or affected by HIV

32. Special efforts are required to ensure access to services for children living with or affected by HIV. As emphasized in the February 2009 report of the Joint Learning Initiative on Children and AIDS, the AIDS response is neglecting millions of children and their families. In the absence of treatment, HIV-infected children have a 50 per cent chance of dying before the age of 2. Yet only 8 per cent of children born to HIV-infected women are tested within their first two months of life, and children in sub-Saharan Africa are less likely than adults to receive antiretroviral treatment. Rapid progress is possible in increasing children’s access to treatment. In 2008, the number of children receiving antiretroviral treatment through the President’s Emergency Plan for AIDS Relief (PEPFAR) of the United States of America increased by 51 per cent.

33. Approximately 15 million children — 80 per cent of whom live in sub-Saharan Africa — have lost one or both parents to AIDS. The number of children orphaned or rendered vulnerable by the epidemic underscores the pressing need to strengthen child welfare and child protection systems.

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[2] See UNAIDS, *Intensifying HIV prevention: UNAIDS policy position paper*, 2005, available at http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/UmbrellaPolicies/Prevention_Umbrella_Policies.asp.

Universal access: 2010 and beyond

34. The achievement of universal access will have an impact that lasts long after the milestone date of 2010. Increasing access to HIV prevention services could prevent more than half of all new HIV infections that would otherwise occur between now and 2015. Achieving Millennium Development Goal 6, which calls for the world to have halted and begun to reverse the spread of HIV/AIDS by 2015, will advance the achievement of other Millennium Development Goals, particularly Goals 4 and 5, which focus on the health of children and women, respectively.

35. The goal of universal access has already had important benefits, promoting increased decentralization of national responses, increasing the engagement of civil society and people living with HIV, strengthening the links between sexual and reproductive health and contributing to national systems for drug procurement and supply management, drug regulation and human resources.

Involving multiple sectors in achieving universal access

36. Although national Governments are responsible for leading the AIDS response, universal access requires the participation of an array of non-governmental partners. Among the diverse stakeholders actively engaged in the push for universal access, the Coalition of Asia Pacific Regional Networks on HIV/AIDS has developed minimum standards for civil society participation in universal access. The International Treatment Preparedness Coalition issues periodic reports that draw on civil society research in low- and middle-income countries to assess progress in expanding treatment access. Regional harm-reduction networks are actively promoting universal access to HIV services for people who inject drugs.

37. Sustaining the momentum towards universal access through 2010 and beyond will continue to demand the broad, sustained participation of diverse sectors. The AIDS response has helped forge inclusive new participatory mechanisms for policy development, programme implementation and monitoring and evaluation. This approach must be further strengthened and accelerated if the long-term challenge of AIDS is to be met with a commensurate long-term, broadly owned response.

IV. Tailoring the AIDS response to national and local contexts

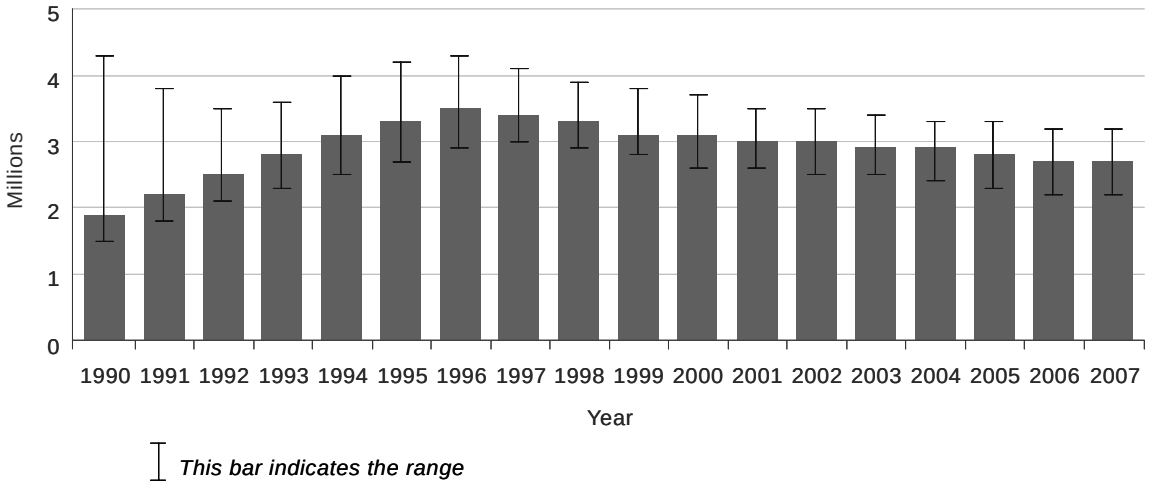
38. Countries should know their epidemic and their response so that they can select appropriate interventions and tailor evidence-informed strategies to address specific national and subnational situations. Fitting responses to the dynamics of the epidemic not only reduces waste and inefficiency but also magnifies the impact of national efforts.

Current status of the epidemic

39. An estimated 33 million people were living with HIV in 2007. The annual number of new HIV infections has incrementally decreased over the past decade, from a peak of 3.5 million in 1996 to 2.7 million in 2007 (see fig. III), while the annual number of people dying from AIDS has also fallen, from 2.2 million in 2005 to 2.0 million in 2007. In all, 96 per cent of new HIV infections in 2007 occurred in low- and middle-income countries. In 2007, 80,000 fewer children under the age of

15 were newly infected with HIV than in 2000, owing in part to increasing coverage for services to prevent mother-to-child transmission.

Figure III
Estimated number of people newly infected with HIV globally, 1990-2007

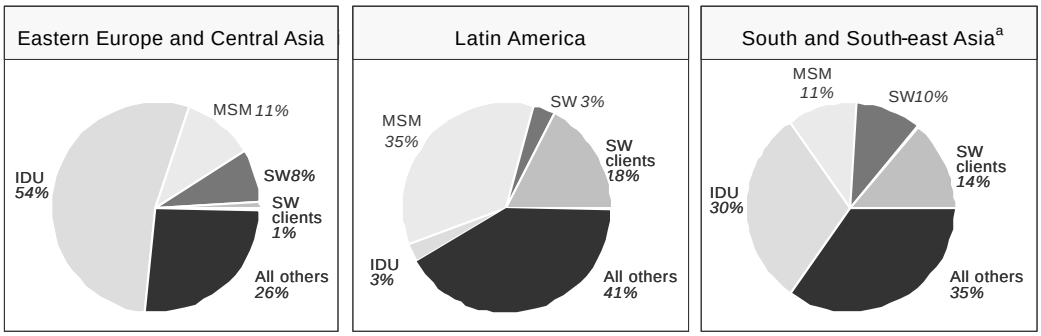


Diversity of the HIV pandemic

40. The HIV epidemic is not homogeneous, and it affects different populations and geographic settings in different ways (see fig. IV). Women account for 60 per cent or more of new HIV infections in sub-Saharan Africa, while men represent the majority of people living with HIV in other regions. Adolescents and young adults are most likely to become infected.

41. In sub-Saharan Africa, heterosexual transmission predominates, with especially high HIV prevalence in southern Africa, which accounted for 35 per cent of all new HIV infections worldwide in 2007. Epidemiological profiles in other regions are diverse. In Latin America, men who have sex with men constitute the group most likely to be infected, with significant infections also occurring among sex workers and their clients and among people who inject drugs. Likewise, Asian epidemics are characterized by diverse transmission routes, with many national epidemics driven by high levels of infection among injecting drug users and sex workers and their clients. While the use of contaminated injecting equipment remains the primary source of new infections in Eastern Europe and Central Asia, a growing proportion of new infections are sexually transmitted.

Figure IV
Proportions of HIV infections in various population groups by region, 2007

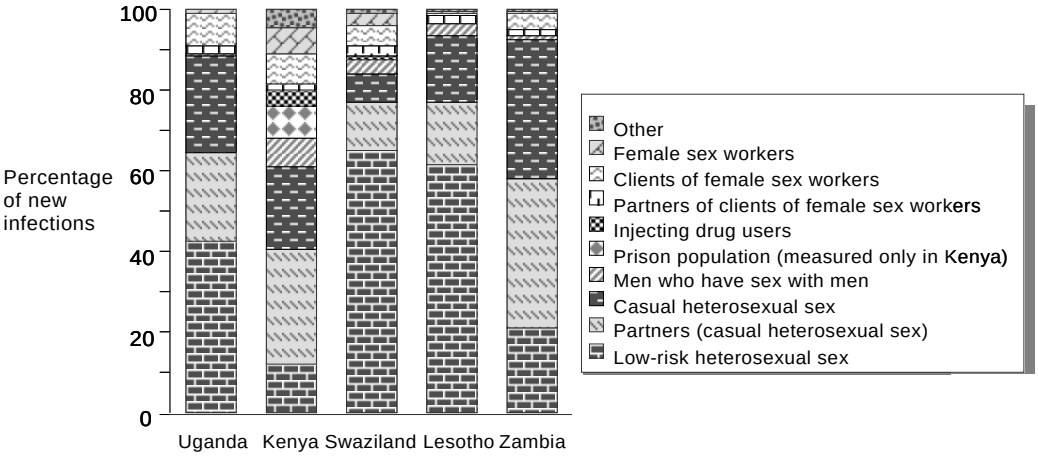


IDU: Injecting drug users
MSM: Men who have sex with men
SW: Sex workers

[a] India was omitted from this analysis because the scale of its HIV epidemic (largely heterosexual transmission) masks the extent to which other at-risk populations feature in the region's epidemics.

42. The striking diversity of national epidemics can be seen in figure V. Although heterosexual transmission is an important source of new HIV infections in each of the African countries profiled, the heterosexual subpopulations most at risk vary. While heterosexuals in married or cohabiting partnerships account for a minority of new infections in Kenya, Uganda and Zambia, they represent the majority of new infections in Lesotho and Swaziland.

Figure V
Modes of transmission in people newly infected with HIV in various sub-Saharan countries



43. High HIV prevalence rates have long been documented among sex workers in sub-Saharan Africa and other regions. In recent years, evidence has also emerged of high HIV prevalence among men who have sex with men and among injecting drug users in sub-Saharan Africa, where their contribution to national epidemics was previously not well understood. In Malawi, more than one in five men who have sex

with men are currently living with HIV, and in south-western Nigeria, HIV prevalence among men who have sex with men is 3.5 times higher than for the country as a whole. In Kenya, more than 4 out of 10 injecting drug users are living with HIV, and 1 in 8 people who inject drugs are infected in South Africa.

Emerging strategies to help countries know their epidemic and their response

44. In order to effectively tailor national responses to address their national context, countries need access to sound, timely evidence regarding their epidemic. New tools and improved methods have emerged to assist countries in collecting and analysing the information they need to tailor their national responses to the epidemic. A growing number of countries are using analyses of modes of transmission to learn about both the rate at which new HIV infections are occurring and the groups that are most affected.

45. Such studies are assisting countries in revising their AIDS strategies in response to epidemiological evidence. In Uganda, for example, it was estimated that 43 per cent of new infections occurred among married or cohabiting couples. That information directed policymakers in Uganda towards strategies to prevent HIV transmission within couples, such as couples counselling and programmes to encourage people to avoid concurrent partnerships or to reduce the number of their sexual partners.

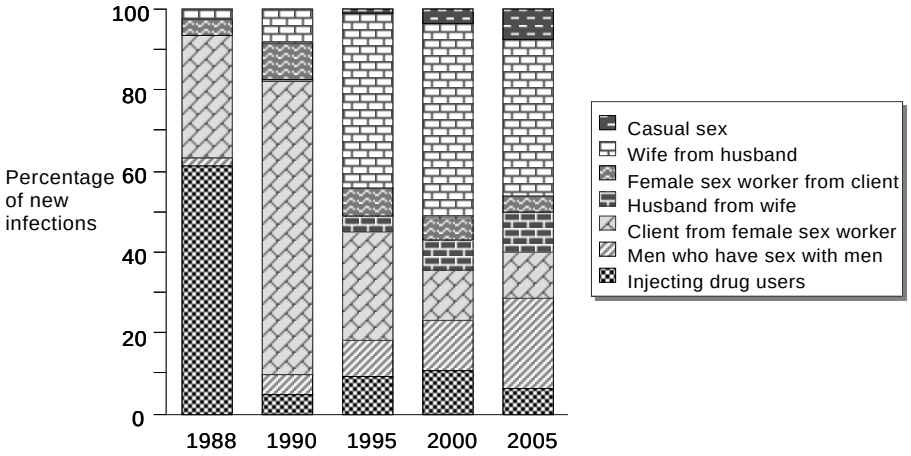
46. Emerging data have highlighted prevention needs that were previously either unknown or poorly documented. For example, as a result of epidemiological findings, national officials in Kenya are now taking steps to supplement strategies to promote risk reduction in the general population with focused initiatives to prevent new infections among men who have sex with men and among injecting drug users and in high-prevalence communities.

47. Relationship patterns and the dynamics of sexual networks also facilitate the rapid spread of HIV. Analyses suggest that, in particular, a high prevalence of concurrent sexual partnerships accelerates the diffusion of HIV throughout sexual networks after its introduction. In countries where the epidemic is concentrated among injecting drug users, an increasing proportion of new infections occur among the sexual partners of injecting drug users. To identify the precise array of strategies that will most effectively address national needs, epidemiological surveillance should be accompanied by appropriate social, ethnographic and behavioural research.

Responding to changing needs

48. Ongoing epidemiological studies monitor the degree to which national and subnational epidemics change over time, highlighting the need to refocus HIV-prevention or therapeutic programmes. While the epidemic in Thailand was once driven by HIV transmission associated with sex work, recent evidence indicates that many new HIV infections are now occurring in the general population, including through transmission from husband to wife, and that there is a substantial number of new infections among men who have sex with men (see figure VI).

Figure VI
Changing patterns of new infection in Thailand, 1988-2005



Revising policy and programmatic responses

49. The continually evolving nature of national epidemics highlights the importance of maintaining robust national HIV monitoring, evaluation and surveillance systems. Such systems provide programme managers with the necessary strategic information to improve and extend services, promote greater accountability among stakeholders and assist countries in mobilizing resources by identifying national successes or shortcomings. Maintaining the flexibility to redirect resources where they are most needed depends on sound national leadership and management, as reflected in a strong national AIDS authority and vibrant multisectoral engagement.

50. Countries should be prepared to adopt and scale up new technologies and strategies and to ensure their acceptability once they have been introduced. For example, the persistently low uptake of voluntary counselling and testing prompted a number of countries to implement provider-initiated testing and counselling, which has significantly increased the number of people who know their HIV status.

51. Similarly, a number of countries with high HIV prevalence and a low proportion of circumcised males are taking steps to introduce or expand adult male circumcision services, which studies have shown reduces the risk of female-to-male sexual transmission by approximately 60 per cent. Policymakers should avail themselves of guidance, technical support and funding to support increased access to safe, appropriate male circumcision services, taking steps to ensure that such strategies are complemented by strong condom-promotion efforts. In the coming years, additional prevention tools may emerge, such as microbicides or pre-exposure antiretroviral prophylaxis for sexual transmission, further underscoring the need for policymakers to adopt and implement new strategies.

52. National vigilance and flexibility are similarly required with regard to HIV treatment. With support from international technical agencies and donors, countries should evaluate the emergence of resistance to antiretroviral drugs, monitor drug toxicities and anticipate the need for new antiretroviral drugs and regimens. Further progress in integrating HIV and tuberculosis services is urgently required.

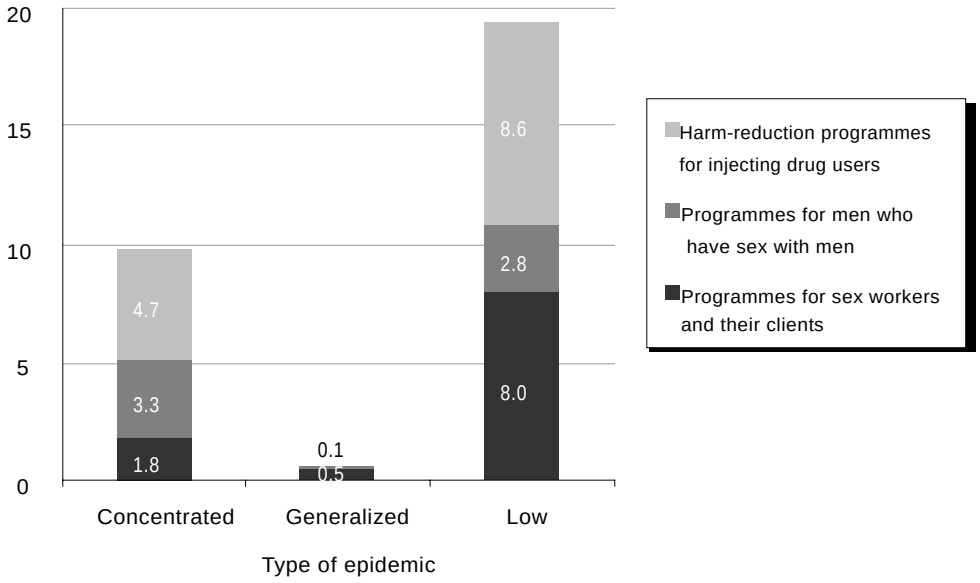
Services for marginalized populations

53. Marginalized populations who are most at risk of HIV infection merit special efforts to ensure access to HIV prevention, treatment, care and support (see figure VII). In many countries with concentrated epidemics, less than 10 per cent of HIV-prevention expenditure in 2006 was directed towards populations most at risk. Surveys from 40 countries indicated that only about one in four people who inject drugs were reached by the most basic prevention services in 2007, and fewer than half had adequate knowledge about how to prevent HIV transmission. The number of countries that have established coverage targets for services for injecting drug users remains low (see figure II).

54. Similarly, few countries have formulated service targets for men who have sex with men (see figure II). The impact of limited access to services is vividly illustrated by the rapid rise in HIV infection rates in many Asian settings among men who have sex with men. Similarly, even though a significant percentage of new infections in many generalized epidemics are among sex workers or their clients, in 2006 only 0.5 per cent of prevention spending in high-prevalence countries focused on programmes to prevent HIV transmission during sex work.

55. HIV service coverage in refugee settings has dramatically increased, with antiretroviral treatment and prevention of mother-to-child transmission reaching 75 per cent and 68 per cent, respectively, of refugees in need in 2008. However, important programmatic and policy challenges remain in reaching emergency-affected populations, including the failure of many national strategic plans and donor grants to prioritize services for migrants, refugees and internally displaced persons.

Figure VII
Percentage of spending on most-at-risk populations out of total prevention spending by type of epidemic, latest data available, 2005-2007



Addressing the social and structural determinants of HIV risk and vulnerability

56. In order to match policy and programmatic strategies with national needs, countries should understand the social and structural factors that increase vulnerability to HIV. If such forces are not addressed, they may impede progress towards universal access. HIV-related stigma and gender inequalities disempower people, making it difficult for them to reduce their risk of infection or access HIV-related services. Specific programmes can reduce the prevalence and effects of stigma and gender inequalities, although such projects have typically not been brought to national scale to achieve major impact.

57. Failure to address the factors that increase the vulnerability of the groups most at risk of HIV will slow progress towards universal access. Fearing ostracism or mistreatment, many members of those populations avoid being tested for HIV or seeking HIV-related information or services. Discriminatory attitudes also often deter policymakers from implementing sound HIV prevention and treatment measures focused on those groups that are most in need. In 2007, more than 90 countries had laws in place that prohibited consensual sexual conduct among adults of the same gender. In 2008, opioid substitution therapy was available in only 52 countries, with a wide variation in the size, scale and quality of such programmes. Furthermore, even in countries where opioid substitution therapy is available in the community, it is frequently discontinued for drug users when they enter prison.

58. Recent experiences highlight the feasibility of overcoming impediments to sound policy development through strong and courageous leadership. Several countries, including China, the Islamic Republic of Iran, Malaysia, Ukraine and Viet Nam, have taken steps to increase access to drug-substitution therapy, heeding evidence that such therapy helps to reduce HIV transmission among injecting drug users. India has expanded health services for sex workers in areas with high HIV prevalence. In 2008, Nicaragua and Panama implemented legal reforms that removed criminal prohibitions on sex between men, and in February 2009, the Senate of Burundi rejected a legislative bill to impose criminal penalties for homosexual conduct.

V. Sustaining a long-term response to HIV

59. First recognized nearly three decades ago, the HIV pandemic will remain a major global challenge for generations to come. To date, the response has been characterized by a short-term crisis approach with a view to achieving rapid results. It is becoming increasingly clear that sustained commitment, support and financial resources will be needed in the coming decades to prevent new infections, lower HIV-related morbidity and mortality and help societies, communities and households cope with the burdens of the epidemic.

Building sustainable national capacity

60. Sustaining a long-term response requires investing in measures to build durable capacity in many low- and middle-income countries. For example, while sub-Saharan Africa accounts for two thirds of all people living with HIV, only 3 per cent of the world's health-care providers live in the region. Shortages of public-sector health-care workers in HIV-affected countries are exacerbated by low

remuneration, poor working conditions and out-migration of workers to better-paying jobs in the private sector or to other countries. In addition, efforts to increase the reach of key HIV services are also often impeded by other capacity limitations, such as inadequate physical infrastructure, shortages of laboratory and other equipment and poorly developed systems for drug regulation, procurement and supply management.

61. Achieving and sustaining universal access to HIV prevention, treatment, care and support depends on sound, well-functioning health systems. However, the rapid scale-up of HIV services in resource-limited settings has led to charges that the AIDS response may be undermining fragile health systems by skewing local health priorities and drawing resources from other high-priority health issues. However, there has been a marked increase in official development assistance over the past eight years for both HIV-related and non-HIV-related health-care delivery.

62. Evidence from Haiti, Rwanda and other countries indicates that the creation of new HIV-specific services can improve non-HIV-related services, such as immunizations, measures to control tuberculosis and malaria, sexual and reproductive health services and maternal and child health care. HIV scale-up is also helping to empower patients and engage communities in patient education, health-care advocacy and initiatives to promote patient adherence and improve medical outcomes. Moreover, increasing access to antiretroviral therapies and HIV-prevention services will reduce the burden on health-care systems and help ensure that health-care workers living with HIV can continue to lead productive lives. Scale-up of HIV services has also contributed to increased shifting of responsibilities in health-care settings from physicians to nurses or other staff, which has helped stretch limited human resources.

63. Given the importance for universal access of strong health systems, every effort should be made to incorporate measures to strengthen health systems while scaling up HIV services. There are already encouraging signs that this is occurring. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria is actively encouraging countries to incorporate the strengthening of health systems into funding proposals. The Government of the United States of America has moved to permit its HIV financing to support the strengthening of general health systems in low- and middle-income countries, as well as interventions to address tuberculosis and malaria. In Ghana, HIV financing has supported governmental efforts to improve pay for all cadres of health-care workers.

64. Efforts to use the scale-up of HIV services to strengthen health systems are curtailed by limited evidence on optimal strategies to maximize synergies between so-called vertical, or disease-specific, programmes and more broad-based, horizontal services. Multiple institutions are conducting research to inform the development of policies to strengthen health systems in the context of HIV scale-up. Substantially greater attention is required to generate the evidence base needed to aid national policymakers. Likewise, sustained energy should focus on better integrating HIV with tuberculosis, sexual and reproductive health and other relevant services.

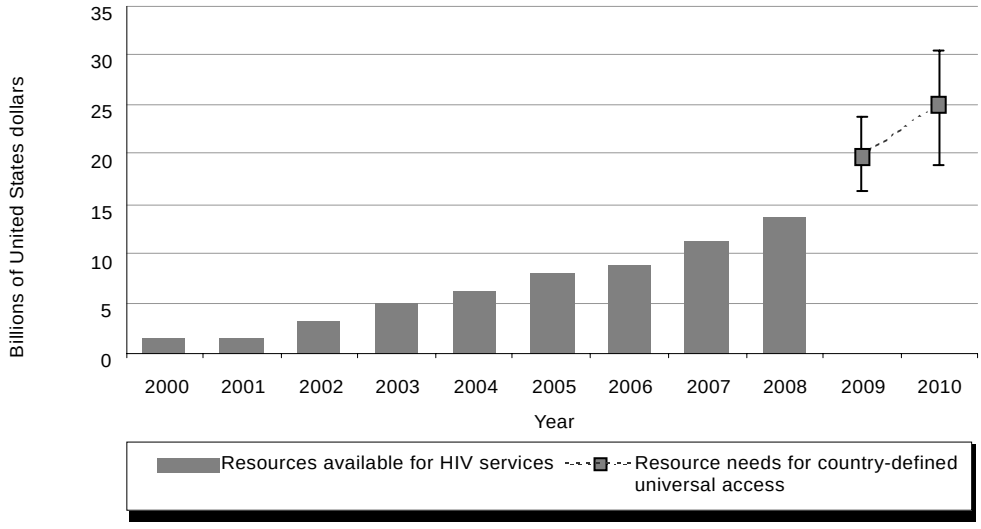
65. Although vital for an effective long-term response, health is only one of the many national systems that must be bolstered to ensure success in containing HIV. Sustainable progress will also depend on stronger, durable capacity in other sectors of society, including the social services, education and labour sectors.

Mobilizing sustainable financing for HIV in order to achieve long-term results

66. The recent increase in global and national funding is the result of leadership and commitment from a broad array of agencies, bilateral and multilateral organizations, foundations and other stakeholders. Through PEPFAR, the Government of the United States of America has provided $18.8 billion for HIV assistance over the past five years, saving an estimated 3.3 million adult years of life to September 2009. As of December 2008, the Global Fund to Fight AIDS, Tuberculosis and Malaria had supported the delivery of antiretroviral drugs to 2 million people and reached 62 million people through HIV counselling and testing services. Countries are themselves investing increasing amounts of their domestic resources in expanding HIV services. In the period from 2004 to 2007, per capita HIV expenditures from domestic public sources nearly doubled in low-income and lower-middle-income sub-Saharan countries.

67. While funds mobilized for HIV programmes have sharply increased in the past several years, the current rate of growth is insufficient to achieve country-defined targets for universal access to HIV prevention, treatment, care and support by 2010. As figure VIII shows, recent projections indicate that achieving country targets to move towards universal access by 2010 will require an estimated annual outlay of $25 billion within two years. UNAIDS advises that international donors will need to cover roughly two thirds of those costs to ensure universal access. Despite their commitment to supporting universal access, international donors may not be able to fully close the projected resource gap, underscoring the continued need for national Governments in low- and middle-income countries to increase domestic investments to scale up and sustain HIV services.

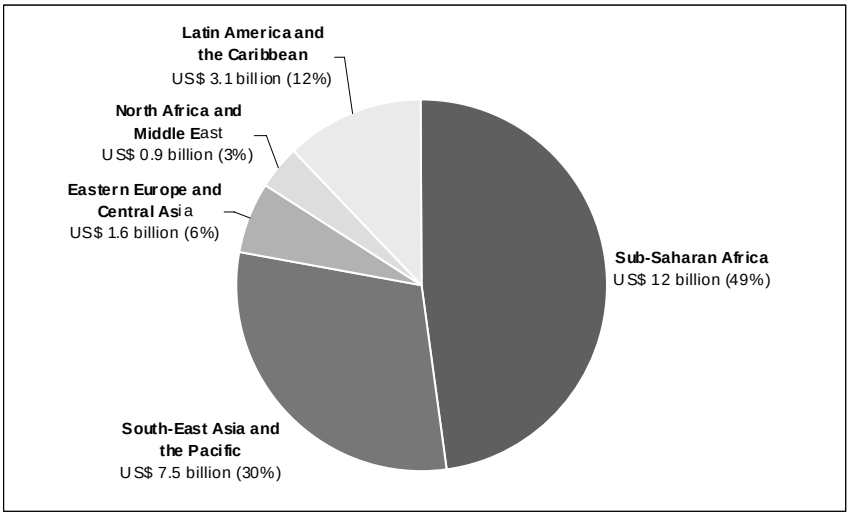
Figure VIII
Resources available for HIV, 2000-2008, and estimated financial resource needs, 2008-2010



68. The nature of national and local epidemics should determine the distribution of resources to achieve country-defined universal access targets. UNAIDS estimates that sub-Saharan Africa will require 49 per cent of resources, followed by 30 per

cent for South-east Asia and the Pacific, 12 per cent for Latin America and the Caribbean, 6 per cent for Eastern Europe and Central Asia and 3 per cent for the Middle East and North Africa (see figure IX).

Figure IX
Regional breakdown of investments needed



69. Although the current global economic downturn might make such figures seem daunting, policymakers must consider the costs of failing to make such investments. Closing the resource gap between 2008 expenditures and investments needed to achieve country-defined targets in 2010 will require an additional $11.3 billion. That sum represents only a fraction of the massive economic stimulus packages that Governments have recently implemented around the world. Such an ambitious, yet manageable, investment towards universal access would yield extraordinary dividends (see table).

70. Donors should honour their commitments and make AIDS funding more predictable. Uncertain, year-to-year funding impedes effective national planning and inhibits implementation of long-term strategies to build sustainable national capacity. A number of innovative options are currently under consideration with a view to making AIDS financing more dependable. These include the conversion of grant programmes into standing lines of credit on which countries can draw and increased use of basket funding or sector-wide approaches, whereby multiple donors pool their resources to support national strategies and priorities.

71. To address the long-term challenge posed by the epidemic, robust funding must be maintained for many years. The AIDS response has already generated numerous creative resource-mobilization mechanisms, including multilateral channels such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the international drug purchase facility UNITAID, as well as private-sector initiatives such as the Product (RED) Project. The need for long-term financing highlights the importance of identifying additional innovative and durable financing mechanisms to support the AIDS response.

Expected outcomes and impacts if full investments were made on country-defined targets in low- and middle-income countries by 2010

(In millions)

Number of new HIV infections averted (2009-2010)	2.6
Number of deaths averted (2009-2010)	1.3
People on antiretroviral treatment	6.7
Primary schoolteachers trained	1.0
Sex workers reached	7.5
Voluntary counselling and testing	40.9
Condoms provided	8 153.7
Workers reached in the workplace	46.2
Units of safe blood produced	42.6
Pregnant women offered comprehensive prevention of mother-to-child transmission services	74.5
Injecting drug users reached with harm-reduction programmes	9.6
Men who have sex with men reached	20.4
Prisoners reached	6.2
Safe injections provided	4 247.1
Male circumcisions performed	1.5
Orphans supported	6.7
People receiving treatment for opportunistic infections and palliative care	2.1

Increasing the efficiency of HIV expenditure

72. The global economic downturn underscores the imperative of ensuring that AIDS investments are used to maximum effect. As reflected in the Paris Declaration on Aid Effectiveness, the development field has increasingly recognized the necessity of harmonization and alignment of diverse international assistance efforts in order to reduce duplication, acknowledge national ownership and leadership and encourage more focused efforts for greater strategic impact. In the AIDS response, the push for improved harmonization and alignment is reflected in the “three ones” principle that provides for one national strategic framework to guide country-level efforts, one national coordinating authority and a single agreed framework for monitoring and evaluation.

73. AIDS harmonization and alignment has improved in many countries. Countries are increasingly using their national AIDS frameworks to support national development planning processes. The AIDS Strategy and Action Plan service has assisted more than 50 countries in developing, assessing or revising national strategic frameworks. Yet further progress is urgently needed to reduce unnecessary administrative and reporting burdens on countries and to enhance strategic coordination in support of nationally owned strategies that match the dynamics of local epidemics. Further harmonization of monitoring and evaluation efforts is a particular priority.

Other critical priorities in the AIDS response

74. Sustaining an effective AIDS response will require unprecedented leadership at all levels and in diverse sectors. When problems are no longer “new”, there is a danger that policymakers may relax their focus on them, regardless of whether the challenges have been effectively addressed. Given the millions of lives at stake, such complacency with regard to HIV/AIDS would have deadly consequences.

75. While strong and enduring political leadership is a prerequisite for a successful long-term response, the meaningful engagement of civil society and affected communities is equally critical. In particular, the leadership and visibility of people living with HIV are essential to long-term progress. As the robust involvement of civil society at the 2008 High-level Meeting illustrated, important strides have been made in strengthening community engagement in the HIV response. Yet civil society organizations confront continuing barriers to effective involvement in the response to the epidemic, such as governance challenges, infrastructure limitations and resistance from some national Governments. According to information supplied to UNAIDS by non-governmental informants, civil society organizations in only about 20 per cent of countries have access to financial support for capacity-development to help enhance their engagement in the response.

VI. Accelerating progress towards universal access: recommendations for action

76. Less than two years remains before the agreed deadline to move towards universal access to HIV prevention, treatment, care and support. In some countries, country-defined targets for universal access have already been achieved or are within reach for critical components of the response. In many other countries, however, substantial additional progress is needed to meet universal access targets. With the universal access milestone in mind, all stakeholders — national Governments, international donors, the United Nations and other international technical agencies, civil society, affected communities and people living with HIV — must redouble their efforts to strengthen and accelerate action on HIV/AIDS. The UNAIDS co-sponsors and secretariat must reaffirm their role to support countries in those efforts. To that end, urgent attention should be paid to the implementation of the recommendations set out below.

Reaffirming the commitment to universal access

77. At the global, regional and national levels, all stakeholders must reaffirm their commitment to move towards universal access to HIV prevention, treatment, care and support by 2010. Using all sources of technical and financial support available, countries should assess the barriers to scale-up, and devise evidence-informed and rights-based strategies for overcoming such obstacles. International stakeholders must further improve access to technical and financial support to countries. Universal access must remain a high-priority agenda item at all summit meetings in 2009, 2010 and 2011. In collaboration with national and international partners, UNAIDS should continue and intensify its assistance to countries to assess progress, identify obstacles and expedite scale-up.

Realizing the commitments made to human rights and legal and policy environments that support universal access

78. Countries should review and, where appropriate, revise, their legal and policy frameworks and associated enforcement mechanisms to protect the rights of people living with HIV and vulnerable populations. Sound legal frameworks should be supported by programmes to reduce stigma and discrimination. Countries should repeal HIV-specific restrictions on entry, stay and residence based on HIV status, and limit the application of criminal law to the intentional transmission of HIV only. Countries should take to scale programmes that empower those affected by HIV to access justice, such as legal services, legal literacy campaigns and programmes to protect women's property and inheritance rights.

Intensifying the commitment to HIV prevention

79. National prevention strategies should be intensified and tailored to address national and local realities, taking into account the dynamics of national epidemics and evidence of what works. Countries should employ "combination prevention" approaches that combine an appropriate mix of behavioural, biomedical and structural programmes. Sufficient programmes to address the underlying social, legal and economic factors that increase HIV risk and vulnerability must be implemented and taken to scale.

Financing universal access

80. Annual funding must increase to $25 billion by 2010 in order to achieve national targets for universal access. Increased financing from international donors will be required to close the resource gap for universal access in low-income countries, although all countries should increase their funding for the AIDS response. Donors should increase the predictability of HIV-related and other development financing, actively exploring viable strategies to facilitate strategic long-term planning at the country level. Global leaders should explore and support innovative financing mechanisms. To maximize long-term success, ongoing financing should support research efforts for the development and implementation of new technologies and strategies for HIV prevention and treatment.

Strengthening health, education and welfare systems as HIV services are brought to scale

81. Universal access will require strong HIV-specific financing, policy and programmatic actions and solid support for the broad-based strengthening of health and other critical systems. All low- and middle-income countries should develop and implement national strategic plans to build and preserve a strong workforce in the health, education and welfare sectors. Focused technical support should be available to assist countries in implementing promising strategies to strengthen health systems, such as task-shifting and e-health approaches.

Accountability in the AIDS response

82. All stakeholders must fully commit to maximum transparency and accountability in the global response. Donors and national Governments should fully disclose how their HIV-related funds are spent. All country-level partners must immediately align and harmonize their actions within a single national monitoring

and evaluation system pursuant to the “three ones” principle. All countries must ensure that they are ready to collect and report in a timely manner standardized data on agreed performance indicators for the monitoring of universal access and other commitments set out in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS.