

Executive Summary

UNDER EMBARGO
until 1100 GMT,
6 July 2004

2004 Report on the global **AIDS** epidemic



Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • WFP • UNDP • UNFPA • UNODC
ILO • UNESCO • WHO • WORLD BANK

UNAIDS/04.16E (English original, June 2004)

© Joint United Nations Programme on HIV/AIDS (UNAIDS) 2004.

All rights reserved. Publications produced by UNAIDS can be obtained from the UNAIDS Information Centre. Requests for permission to reproduce or translate UNAIDS publications—whether for sale or for noncommercial distribution—should also be addressed to the Information Centre at the address below, or by fax, at +41 22 791 4187, or e-mail: publicationpermissions@unaids.org.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of

UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by UNAIDS in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

UNAIDS does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

Cover design: Lewis Evans

UNAIDS – 20 avenue Appia – 1211 Geneva 27 – Switzerland
Telephone: (+41 22) 791 36 66 – Fax: (+41 22) 791 41 87
E-mail: unaids@unaids.org – Internet: <http://www.unaids.org>

2004 Report on the global AIDS epidemic

Executive Summary

**UNDER EMBARGO until 1100 GMT,
6 July 2004**



Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • WFP • UNDP • UNFPA • UNODC
ILO • UNESCO • WHO • WORLD BANK

I. Responding to AIDS

AIDS is an extraordinary kind of crisis; it is both an emergency *and* a long-term development issue. Despite increased funding, political commitment and progress in expanding access to HIV treatment, the AIDS epidemic continues to outpace the global response. No region of the world has been spared. The epidemic remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission.

Rates of infection are still on the rise in many countries in sub-Saharan Africa. In 2003 alone, an estimated 3 million people in the region became newly infected. New epidemics appear to be advancing unchecked in other places, notably Eastern Europe and Asia – regions that are experiencing the fastest-growing epidemics in the world.

More than 20 years and 20 million deaths since the first AIDS diagnosis in 1981, almost 38 million people (range 34.6 – 42.3 million) are living with HIV. Even though the cure is elusive, we have learned crucial lessons about what works best in preventing new infections and improving the quality and care for people living with HIV. There have been some major developments, including antiretroviral medicines.

Despite these signs of progress, there are still huge challenges to turning the tide of this epidemic. Funding has greatly increased but is still only half of what is needed and is not always effectively utilized. Many national leaders remain in denial about the impact of AIDS on their people and societies.

Today we are faced with life and death choices. Without major action, the global epidemic will continue to outstrip the response. But there is an alternative: together we can forge policies

grounded in science, not political rhetoric, and embark boldly on the 'Next Agenda' - an agenda for future action based on innovative approaches.

What are the major challenges?

- The female face of the epidemic. Women are increasingly at great risk of infection. As of December 2003, women accounted for nearly 50% of all people living with HIV worldwide and for 57% in sub-Saharan Africa. Women and girls also bear the brunt of the impact of the epidemic; they are most likely to take care of sick people, to lose jobs, income and schooling as a result of illness, and to face stigma and discrimination. There is an urgent need to address the many factors that contribute to women's vulnerability and risk – gender and cultural inequalities, violence, ignorance.
- Young people – 15-24 year olds – account for nearly half of all new HIV infections worldwide. They are the largest youth generation in history and need a protective environment—regular schooling, access to health and support services—if they are to play their vital part in combating the epidemic.

- Scaling up treatment programmes providing life-prolonging antiretroviral therapy. Only 7% of the people who need antiretroviral treatment in developing countries have access to ARVs – 400 000 at the end of 2003. Programmes must be sustainable to prevent the development of drug-resistant strains of the virus.
- Several countries in southern Africa face a growing crisis in delivering vital public services that are crucial to the AIDS response. Reasons for this range from migration of key staff from public to private sectors, migration abroad, to the deadly impact of the AIDS epidemic itself.
- Scaling up prevention programmes that currently reach only one in five people at risk of HIV infection. In low- and middle-income countries in 2003, only one in ten pregnant women was offered services for preventing mother-to-child HIV transmission. In high-income countries, treatment has been a much higher priority than prevention and as a result, there have been rises in HIV transmission for the first time in a decade.
- Tackling stigma and discrimination. They directly hamper the effectiveness of AIDS responses, stop people being tested for HIV, prevent the use of condoms or HIV-positive women breastfeeding to protect their babies against infection, and prevent marginalized groups such as injecting drug users receiving the care and support they need.
- Tackling the neglect of orphans. AIDS has killed one or both parents of an estimated 12 million children in sub-Saharan Africa and far too many of these orphans are not properly cared for.

Global AIDS Funding

In addition to providing up-to-date global, regional and country data, the report releases new estimates on global resources needed to effectively combat the epidemic in the developing world. For the first time, the revised estimates reflect data obtained from 78 countries, many on the frontlines of the AIDS epidemic.

Although global spending on AIDS has increased 15-fold from US\$300 million in 1996 to just under US\$5 billion in 2003, it is less than half of what will be needed by 2005 in developing countries. According to newly revised costing estimates, an estimated US\$12 billion (up from US\$10 billion) will be needed by 2005 and US\$20 billion by 2007 for prevention and care in low- and middle-income countries.

The estimated US\$20 billion would provide antiretroviral therapy to just over six million people (over four million in sub-Saharan Africa), support for 22 million orphans, HIV voluntary counselling and testing for 100 million adults, school-based AIDS education for 900 million students and peer counselling services for 60 million young people not in school. About 43% of these resources will be needed in sub-Saharan Africa, 28% in Asia, 17% in Latin American and the Caribbean, 9% in Eastern Europe, and 1% in North Africa and the Near East.

Fully funding the response to AIDS will require an extraordinary effort, which cannot be met from currently planned regular domestic and international development budgets. It will require extraordinary leadership and will have to use currently untapped resources.

II. Global Overview

In 2003, almost five million people became newly infected with HIV, the greatest number in any one year since the beginning of the epidemic. At the global level, the number of people living with HIV continues to grow - from 35 million in 2001 to 38 million in 2003. In the same year, almost three million were killed by AIDS; over 20 million have died since the first cases of AIDS were identified in 1981.

The epidemic varies in scale or impact within regions; some countries are more affected than others, and within countries there are usually wide variations in infection levels between different provinces, states or districts, for example.

New and revised estimates

The number of people living with HIV continues to grow – from 35 million in 2001 to 38 million in 2003. The UNAIDS report highlights the latest global trends and, for the first time, features revised HIV prevalence rates for previous years, allowing for a better understanding of how the epidemic is spreading. Comparing the latest estimates with those published in previous years is misleading.

For the first time, the report compares new estimates for 2003 with revised estimates for 2001 based on improved methodologies. This is the best way we know how to obtain a more accurate picture of the AIDS epidemic. Although the new global estimates are slightly lower than the previously published estimates, the actual number of people living with HIV has not decreased, rather the epidemic continues to grow based on revised 2001 estimates.

HIV estimates - whether they are based on household surveys or surveys of pregnant women - need to be assessed critically as the epidemic evolves. Achieving 100% certainty about the numbers of people living with HIV globally, for example, would require repeatedly testing every person in the world for HIV—which is logistically impossible.

Asia

The epidemic in Asia is expanding rapidly. This is most evident with sharp increases in HIV infections in China, Indonesia and Viet Nam. An estimated 7.4 million people are living with HIV in the region and 1.1 million people became newly infected last year alone – more than any year before. Home to 60% of

the world's population, the fast-growing Asian epidemic has huge implications globally.

In Asia, the HIV epidemic remains largely concentrated among injecting drug users, men who have sex with men, sex workers, clients of sex workers and their immediate sexual partners. Effective prevention coverage in these groups is inadequate, partly because of stigma

and discrimination. Asian countries such as Thailand and Cambodia, which have chosen to tackle openly high-risk behaviour, such as sex work, have been more successful in fighting HIV, as shown by the reduction in infection rates among sex workers.

However there is no room for complacency. Although there is a reduction in the numbers of young Thai men visiting brothels, for example, there is also an increase in casual sex. Behavioural surveillance between 1996 and 2002 shows a clear rise in the proportion of secondary school students who are sexually active, and at the same time consistently low levels of condom use.

If other Asian countries fail to target populations at higher risk, the epidemic will affect much greater numbers of people in the general population.

India has the largest number of people living with HIV outside South Africa – 5.1 million. But knowledge about the virus and its transmission is still scant and incomplete, and there is concern that many men who have sex with men may be infecting women with whom they also have sex.

Africa

An estimated 25 million people are living with HIV in sub-Saharan Africa. There appears to be a stabilization in HIV prevalence rates, but this is mainly due to a rise in AIDS deaths and a continued increase in new infections. Prevalence is still rising in some countries such as Madagascar and Swaziland, and is declining nationwide in Uganda.

Sub-Saharan Africa is home to just over 10% of the world's population – and almost two-thirds of all people living with HIV. In 2003, an estimated three million people became newly infected and 2.2 million died (75% of the three million AIDS deaths globally that year).

There is no such thing as the 'African' epidemic; there is tremendous diversity across the continent in the levels and trends of HIV infection. In six countries, adult HIV prevalence is below 2%, while in six other countries it is over 20%. In southern Africa all seven countries have prevalence rates above 17% with Botswana and Swaziland having prevalence above 35%. In West Africa, HIV prevalence is much lower with no country having a prevalence above 10% and most having prevalence between one and five percent. Adult prevalence in countries in Central and East Africa falls somewhere between these two groups, ranging from 4% to 13%.

African women are at greater risk, becoming infected at an earlier age than men. Today there are on average 13 infected women for every 10 infected men in sub-Saharan Africa – up from 12 for 10 in 2002. The difference is even more pronounced among 15 to 24 year olds. A review compared the ratio of young women living with HIV to young men living with HIV; this ranges from 20 women for every 10 men in South Africa to 45 women for every 10 men in Kenya and Mali.

In North Africa and the Middle East, around 480 000 are living with HIV but systematic surveillance of the epidemic is not well developed, particularly among high-risk groups such as injecting drug users. Yet in much of

the region HIV infection appears concentrated among this group. There is also concern that HIV may be spreading undetected among men who have sex with men, as male-male sex is widely condemned and illegal in many places.

Eastern Europe and Central Asia

Eastern Europe and Central Asia continue to have expanding epidemics, fuelled by injecting drug use. About 1.3 million people are living with HIV, compared with about 160 000 in 1995. Strikingly, more than 80% of them are under the age of 30. Estonia, Latvia, the Russian Federation and Ukraine are the worst-affected countries, but HIV also continues to spread in Belarus, Kazakhstan and Moldova.

The main driving force behind the epidemic in this region is injecting drug use. But in some countries sexual transmission is becoming increasingly common, especially among injecting drug users and their partners.

Russia, with over three million injecting drug users, remains one of the worst-affected countries in the region. Women account for an increasing share of newly diagnosed cases of HIV – up from one-in-four in 2001 to just one-in-three one year later in 2003.

Latin America

Around 1.6 million people are living with HIV in Latin America. The epidemic is concentrated among populations at high risk of HIV infection – injecting drug users and men who have sex with men.

Low national prevalence hides some serious local epidemics. For example, in Brazil (the

region's most populous country), national prevalence is below 1%, but in certain cities 60% of injecting drug users are infected with HIV.

In Central America, HIV is spread predominantly through sex – both heterosexual and among men who have sex with men.

Caribbean

Three Caribbean countries have national HIV prevalence rates of at least 3%: the Bahamas, Haiti, and Trinidad and Tobago. Around 430 000 people in the region are living with HIV.

The Caribbean epidemic is mainly heterosexual, and in many places it is concentrated among sex workers. But it is also spreading in the general population. The worst-affected country is Haiti where national prevalence is around 5.6%, the highest outside Africa.

High-income countries

An estimated 1.6 million people are living with HIV in these countries. Unlike the situation in other regions, the great majority of people living with HIV in high-income countries who need antiretroviral therapy have access to it, so they are staying healthy and surviving longer than infected people elsewhere.

The report finds that infections are on the rise in the United States and Western Europe. In the US, an estimated 950 000 people are living with HIV – up from 900 000 in 2001. Half of all new infections in recent years have been among African Americans. In Western Europe, 580 000 people are living with HIV compared to 540 000 in 2001.

III. Impact of AIDS

People and societies

In all affected countries with either high or low HIV prevalence, AIDS hinders development, exacting a devastating toll on individuals and families. In the hardest-hit countries, it is erasing decades of health, economic and social progress – reducing life expectancy by years, deepening poverty, and contributing to and exacerbating food shortages.

Population

Sub-Saharan Africa has the world's highest prevalence and faces the greatest demographic impact. In the worst-affected countries of eastern and southern Africa, if current infection rates continue and there is no large-scale treatment programme, up to 60% of today's 15-year-olds will not reach their 60th birthday.

The stark differences in access to antiretroviral treatment are reflected in mortality rates. In low- and middle-income countries, such rates among 15-49 year olds are now up to 20 times greater than death rates for people living with HIV in industrialized countries.

In seven African countries where HIV prevalence is more than 20%, the average life expectancy of a person born between 1995 and 2000 is now 49 years – 13 years lower than in the absence of AIDS. In Swaziland, Zambia and Zimbabwe, without antiretroviral programmes, average life expectancy is predicted to drop below 35.

Women

The epidemic's impact is particularly hard on women and girls as the burden of care usually falls on them. Girls drop out of school to care for sick parents or for younger siblings. Older women often take on the burden of caring for ailing adult children and later, when they die, adopt the parental role for the orphaned children. They are often also responsible for producing an income or food crops. Older women caring for orphans and sick children may be isolated socially because of AIDS-related stigma and discrimination. Stigma also means that family support is not a certainty when women become HIV-positive; they are too often rejected, and may have their property seized when their husband dies.

Poverty and hunger

In some of the worst-affected countries, the living standards of many poor people were already deteriorating before they experienced the full impact of the epidemic. In general, AIDS-affected households are more likely to suffer severe poverty than non-affected households; this is true for countries with low prevalence as well as those with high rates.

AIDS takes away the income and production capacity of family members that are sick, at the same time as creating extraordinary care needs and rising household expenditure on medical and other costs, such as funeral expenses.

On average, AIDS care-related expenses can absorb one-third of a household's monthly income. Families may have to use their savings, sell assets such as land and livestock, borrow money or seek support from their extended family. They also have to reduce spending on housing and clothing.

In South Africa and Zambia, studies of AIDS-affected households – most of them already poor – found that their monthly income fell by 66%-80% because of coping with AIDS-related sickness.

AIDS is intensifying chronic food shortages in many countries where large numbers of people are already undernourished. The epidemic is significantly reducing countries' agricultural workforce and families' income with which to buy food. This is especially damaging for people living with AIDS who need more calories than uninfected individuals.

Agriculture and rural development

A healthy agricultural sector is essential for the well-being and self-sufficiency of developing countries. It accounts for 24% of Africa's gross domestic product, 40% of its foreign exchange earnings and 70% of its employment. But the epidemic is attacking the agricultural base of many countries, especially those most affected; it is estimated that AIDS will have claimed the lives of one-fifth or more of agricultural workers in southern Africa by 2020.

Education

Globally, AIDS is a significant obstacle to children achieving universal access to primary education by 2015 (a key target of UNESCO's Education for All Initiative and the UN's Millennium Development Goals). An estimated US\$1 billion per year is the net additional cost to offset the results of AIDS – the

loss and absenteeism of teachers and demand incentives to keep orphans and other vulnerable children in school.

In many countries – for example, Kenya, Uganda, Swaziland, Zambia and Zimbabwe – the epidemic is expected to significantly contribute to future shortages of primary teachers. Without forward planning, there will be great difficulty for these countries meeting their school enrolment targets and an acceptable pupil-to-teacher ratio. As skilled teachers fall sick and die, the quality of education suffers. Many affected countries cannot afford to train more teachers.

Children, especially girls, from AIDS-affected families are often withdrawn from schools to compensate for loss of income through a parent's sickness and related expenses, to care for sick relatives and look after the home. These families may also take their children out of school because they cannot afford school fees.

Health sector

The epidemic has created a need for robust, flexible health systems at a time when many affected countries have been reducing public service spending to repay debt and conform to international finance institutions' requirements. So already weakened systems are being forced to cope with the extra burden of sickness and the loss of essential staff through sickness and death related to AIDS. In African countries, studies estimate that between 19% and 53% of all government health employee deaths are caused by AIDS. The epidemic is quickly outstripping growth in the supply of health sector workers.

Workforce

In hard-hit countries, AIDS is likely to reduce the growth rate of the labour force, as it primarily strikes the working-age population. The

International Labour Organization projects that the labour force in 38 countries (all but four in Africa) will be between 5% and 35% smaller by 2020 because of AIDS.

The epidemic also affects business in many ways, including increasing costs because of absenteeism, sickness and recruitment; organizational disruption and loss of skills, and increasing health expenses and funeral costs.

Next Agenda:

- More and better research into the socio-economic impact of the epidemic. More than 40% of countries with generalized epidemics have yet to evaluate this impact.
- Strengthen the coping capacity of AIDS-affected households – by providing direct financial assistance, home visits from health services, food and nutritional support, and waiving school fees.
- Implement strategies which take into account the disproportionate impact of HIV on women, girls and orphans including microcredit and income generation schemes, school support and food assistance programmes.
- Strengthen chronically weak health systems. Provide better protection for the safety of health workers – targeting health staff for antiretroviral treatment, improving salaries and benefits to retain staff or win back those who have migrated to higher income countries.
- Support workplace prevention programmes for employees and management, providing healthcare such as access to voluntary counselling and testing and to antiretroviral treatment in workplace settings, and endorsing policies of non-discrimination against employees living with HIV.

IV. Bringing comprehensive HIV prevention to scale

Although prevention is the mainstay of the response to AIDS, fewer than one in five people worldwide have access to HIV prevention services. Comprehensive prevention could avert 29 million of the 45 million new infections projected to occur this decade. Although antiretroviral treatment is bringing hope to millions, without sharply reducing the number of new HIV infections, expanded access to treatment becomes unsustainable. Providers of antiretroviral treatment will be swamped by demand.

Prevention programmes are not reaching the people who need them, especially two highly vulnerable groups – women and young people. In order to prevent the high infection rates among women, the root causes of their vulnerability – their legal, social and economic disadvantages – must be addressed.

For young people, knowledge and information are the first line of defence; AIDS education is still far from universal. In sub-Saharan Africa, only 8% of out-of-school young people and slightly more of those in-school have access to education on prevention. They also need access to confidential health information and condoms. Protecting the rights of young girls is also key to lowering HIV prevalence among young people.

There are success stories. A number of countries, including Brazil, the Dominican Republic, Uganda and Thailand, have succeeded in reducing HIV infection. There is

also a need for HIV prevention to evolve and be more innovative in addressing changes in the epidemic. In high-income countries, for example, risk behaviours and new infections are rising again, particularly among young men who have sex with men. The reasons probably include 'prevention fatigue' and complacency rising from the availability and promise of antiretroviral treatment.

Expanded access to antiretrovirals and other treatment offers a critical opportunity to strengthen prevention efforts by encouraging many more people to learn their HIV status. The promise of treatment should encourage greater use of voluntary counselling and testing. The current reach of HIV testing is poor. The proportion of adults needing voluntary counselling and testing who received it ranged from almost none in South East Asia to 7% in sub-Saharan Africa, and 1.5% in Eastern Europe. Where services do exist, uptake is also often low because of fear of stigma and discrimination.

Comprehensive prevention

Key elements in comprehensive HIV prevention include:

- AIDS education and awareness
- Behaviour change programmes especially for young people and populations at higher risk of HIV exposure, as well as for people living with HIV
- Promoting male and female condoms as a protective option along with abstinence, fidelity and reducing the number of sexual partners
- Voluntary counselling and testing
- Preventing and treating sexually transmitted infections
- Primary prevention among pregnant women and prevention of mother-to-child transmission
- Harm reduction programmes for injecting drug users
- Measures to protect blood supply safety
- Infection control in health-care settings
- Community education and changes in laws and policies to counter stigma and discrimination
- Vulnerability reduction through social legal and economic change

Next agenda:

- Create policies that help to reduce the vulnerability of large numbers of people – in effect, creating a social, legal and economic environment in which prevention is possible. This includes access to education, empowerment of women and international cooperation to prevent human trafficking for sexual exploitation.
- Close the ‘prevention gap’ – in 2004 less than one in five people has access to HIV prevention services.
- Ensure that prevention is comprehensive and involves a variety of interventions (see above), since no single element is enough.
- Eliminate AIDS-related stigma and discrimination through effective legal frameworks and by protecting the rights of all individuals.
- Tailor prevention to the specific needs of people, including vulnerable groups such as injecting drug users and men who have sex with men. Worldwide there are more than 13 million injecting drug users and in some regions more than 50% of them are infected with HIV. Experience in cities such as Dhaka, Bangladesh, and London, United Kingdom, shows it is possible to prevent and even reverse major epidemics among injecting drug users.
- Men who have sex with men account for 5-10% of all HIV cases worldwide. Prevention programmes must take into account that this group is highly stigmatized throughout much of the world – some 84 countries in 2002 had legal prohibitions against sex between men – and this hampers prevention efforts.

V. Treatment, care and support for people living with HIV

Access to antiretroviral treatment and other HIV-related disease care remains low. The World Health Organization estimates that nine out of ten people who urgently need HIV treatment are not being reached. Around five to six million people in developing countries will die in the next two years if they do not receive antiretroviral treatment.

In sub-Saharan Africa, an estimated 4.3 million people need AIDS home-based care but only about 12% receive it. In South Asia, coverage drops to 2%.

Yet the global movement to scale up access to HIV treatment has made critical gains during the past few years. There has never before been such a level of financial resources to fund treatment, care and support, nor the strength of political will in countries to provide them. The price of many medicines and diagnostics has fallen dramatically.

Improving access

- Most countries with national AIDS plans have incorporated antiretroviral treatment into them and have set specific antiretroviral treatment coverage targets. Some have allocated funds from national budgets and debt relief to support treatment service.
- Several countries in Latin America and the Caribbean now offer universal coverage for antiretroviral treatment; these include Argentina, Barbados, Chile, Costa Rica, Cuba, Mexico and Uruguay. The Government of Brazil has estimated that antiretroviral treatment has made savings of about US\$ 2.2 billion in hospital care that would otherwise have been needed by people living with HIV.
- Donors are increasingly focusing on treatment and care as part of their commitment

to scaling up the global HIV response. For example, the World Bank's Multi-country AIDS programme, which amounts to US\$ 1 billion for Africa and US\$ 155 million for the Caribbean, is allowing governments and other beneficiaries to use its funds flexibly for HIV treatment. Grant monies from the Global Fund to Fight AIDS, Tuberculosis and Malaria mean that 700 000 people will be able to receive antiretroviral treatment. Bilateral donors such as France and the United States of America have launched funds to help support antiretroviral programmes.

- Private sector efforts are growing. Increasing numbers of companies are establishing HIV treatment programmes for their employees – for example, Anglo American, Eskom, and Heineken.
- Nongovernmental organisations have been treatment pioneers – for example, Haiti's Zanmi Lasante (Partners in Health) and Médecins sans Frontières, proving that antiretroviral treatment can be delivered safely and effectively in places with limited resources.
- The '3 by 5' Initiative was launched by WHO and UNAIDS in September 2003. The aim – an interim target only, part of a global movement to mobilize support ultimately for universal access – is to provide antiretrovirals to three million people in developing countries by the end of 2005.

To date, 56 countries have formally said they want to participate in the Initiative.

Falling prices

- In recent years, the prices of antiretroviral medicine have fallen dramatically. In 2000, the price of a first-line WHO-recommended combination antiretroviral regimen to treat one patient for one year was between US\$ 10 000 and US\$ 12 000 on world markets. Now the price for certain generic combinations is US\$ 300 per person per year. Advocacy by people living with HIV and by world leaders has helped bring down prices. However the price for antiretroviral treatment remains extremely high in a number of middle-income countries such as Russia, Serbia and other central and Eastern Europe countries where the epidemic is rapidly growing.
- Cooperation continues to increase between those countries with antiretroviral medicine manufacturing capacity – for example, Brazil, India, Thailand, and those in Africa wishing to set up local production facilities. There is also cooperation between some developing countries and industrialized countries in Europe and North America, to jointly promote and undertake antiretroviral production technology transfer to developing countries interested and able to produce the medicines locally.

Next agenda:

- Strengthen human capacity in those countries whose scarcity of health workers is a barrier to antiretroviral programme success. In certain countries, the size of the health workforce must triple or quadruple if universal coverage of antiretroviral treatment is

to be achieved. In countries most affected by AIDS, vacancy rates for doctors, nurses and other health staff are extremely high; in 2001, for example, Malawi had only filled half its public sector nursing posts. Incentives and working conditions need to be improved to prevent migration to higher income countries.

- Expand voluntary counselling and testing to ensure widespread knowledge of HIV status, since it is the gateway to HIV treatment and prevention.
- Provide greater support for technology transfer and exports – from countries with antiretroviral manufacturing capacity to countries without it. All partners within the pharmaceutical industry must be part of the AIDS response to guarantee the huge increase in treatment access currently being planned.
- Ensure countries can take advantage of their rights to use trade agreement provisions to widen access to HIV medicines and technologies. This includes resisting stricter-than-necessary patent provisions in regional trade agreements that will otherwise undermine much of the flexibility provided in global trade agreements and declarations for developing countries.
- Reduce HIV-related stigma so that treatment can reach people in need.
- Place equity at the forefront of policies and programmes to ensure fair access to treatment. If universal access is to become a reality, the barriers to treatment for women, children and other groups such as sex workers, injecting drug users and men who have sex with men, must be removed.

VI. Financing the response to AIDS

Important progress has been made in raising additional funds to respond to the AIDS epidemic. By 2003, an estimated US\$ 5 billion was available, from donors, the UN system, international nongovernmental organizations, country governments and the 'out-of-pocket' spending by people living with HIV and their families. Yet this amount is less than half of what is required by 2005.

National governments of developing countries are spending increasing amounts on AIDS programmes – an estimated US\$ 2 billion in 2002, but this only accounts for 6-10% of AIDS expenditure. There are enormous global disparities in AIDS spending. Spending per person living with HIV in the United States exceeds that in the Latin America and Caribbean region by a factor of 35, and is 1000 times higher than in Africa.

As of early 2004, national governments, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Plan for AIDS Relief, and other bilateral donors and foundations had pledged just over US\$ 2 billion to scale up antiretroviral treatment access in 34 of the hardest-hit countries by the end of 2005. This leaves a shortfall of US\$ 3.5 billion. There are huge variations at country level. Some already have the funds to cover their proposed treatment targets while others have large funding gaps.

Even though financial resources are rising, in many heavily affected countries serious bottlenecks prevent effective spending of the money. These blockages include lack of human and institutional capacity, the persistent negative effects of stigma and discrimination, short-

falls in political commitment, slow transfer of funds from national to local and community levels, inadequate accounting and auditing mechanisms, and inconsistent funding processes of the global donor community.

Two-thirds of global funding for 2005 and subsequent years is expected to come from the international community. Most of this money will be spent to meet the needs of the poorest and worst-affected countries of Asia and sub-Saharan Africa; these countries will rely on external donors to meet up to 80% of their needs.

Resources for vaccine and microbicide research and development

Vaccines and microbicides are global public goods (goods that benefit others beyond those who use them directly); each prevented infection cuts off a potential chain of infections resulting from the primary infection. Both private and public sector investment is needed for vaccines and microbicides. According to the International AIDS Vaccine Initiative, public sector investment in vaccine research looks set to expand but overall funding is not keeping up with the challenges.

Next agenda:

- Increase the resources committed to the AIDS pandemic from all sources to provide the required US\$ 12 billion annually by 2005.
- Identify and remove potential bottlenecks in funding flows. Radically improve and harmonize mechanisms for delivering funds through all levels – international, national, regional, community and local.
- Use resources in a ‘smarter’ way. Build programme capacity to demonstrate results by using funds efficiently and effectively, and monitoring performance and impact.
- Incorporate the concept of AIDS ‘exceptionality’ into financing the AIDS response in countries in desperate need. Funds for AIDS must not draw away resources from other activities to the detriment of overall development. Action on AIDS should not further increase debt burdens. International financial institutions should think broadly and creatively about mechanisms to place more funds in the hands of countries now facing large debt-service payments.

VII. National responses to AIDS

In every country, HIV prevention and AIDS treatment and care are complex problems that exceed the capability of any one sector. For an effective response, it is important to:

- combine strong national leadership and ownership
- ensure good governance, resource mobilization, multisectoral planning and coordination
- reinforce capacity to use resources well and implement programmes
- closely monitor and evaluate the AIDS response
- significantly involve communities, civil society and the private sector.

Political commitment has recently increased in the hardest-hit countries. In sub-Saharan Africa, as well as some countries in Asia and the Caribbean, more leaders have taken personal responsibility for implementing the national AIDS response. For example, in Lesotho in March 2004, Prime Minister Pakalitha Mosisili and more than 80 senior civil servants were publicly tested for HIV, in an attempt to break the stigma that discourages testing.

However, in many countries where HIV is quickly spreading, such as those in Asia and Eastern Europe, a lack of leadership may result in a delayed response. Furthermore, in low prevalence countries where the epidemic is concentrated in key populations at high risk, such as sex workers and injecting drug users, many senior political leaders remain detached from the response to AIDS.

Leadership must translate into concrete action. Efforts to measure country-level commitment (carried out by the United States Agency for International Development, the UNAIDS Secretariat, WHO and the United States-based

Policy Project) have shown a general pattern of improvement, particularly in providing resources, treatment and care.

There has been an increase in the number of countries with comprehensive, multisectoral national AIDS strategies, and government-led national AIDS coordinating bodies. But the existence of plans and bodies does not always translate into efficient and concerted action. In several Latin American countries, for example, programmes for injecting drug users and men who have sex with men are scarce even though these populations suffer from high infection rates.

In some countries legislation has not kept up with policy and strategic planning. Nearly one-third of countries lack policies that ensure women's equal access to critical prevention and care services. Most countries have ratified international conventions on human rights but these are not effectively implemented. Only 40% of countries have legal measures that prohibit discrimination against populations vulnerable to HIV, such as men who have sex with

men. Almost 50% of countries in sub-Saharan Africa have yet to adopt legislation to prevent discrimination against people living with HIV.

Leadership has come from all sectors of society – faith-based organizations, community groups, groups of people living with HIV, and other civil society organizations.

National AIDS authorities are increasingly turning to formal partnership fora to stimulate civil society participation and increase national ownership of the response. But much more needs to be done. A recent assessment of NGO participation in the Global Fund's first round of grants showed government commitment to working with NGOs appeared to be somewhat hollow. Many appeared to cooperate with NGOs to secure funding, and then lost interest in collaborating.

Business can contribute to the AIDS response at different levels. Although workplace AIDS programmes are increasing in many affected countries, employers and trade unions could still play a much larger role. Only 20% of transnational companies have adopted comprehensive workplace policies on AIDS. At country level, implementation of workplace policies is generally poor.

Decentralizing AIDS efforts from central to district and local management is another challenge to countries. Strong financial and political investment is needed to create effective district and local coordination bodies.

As the number of AIDS funding and implementing agencies increases, there is also an urgent need to deal with the now well-documented risks of duplication of the response at a country level. In an effort to achieve greater harmonization of AIDS funding, UNAIDS led an effort with the US, UK and other leading donor countries to agree to what is known as the "Three Ones" – one national AIDS plan, one national AIDS authority and one monitoring and evaluation system in each country.

Next agenda:

- Strengthen and sustain national leadership in the fight against AIDS.
- Harmonize multisectoral responses, donor activities and monitoring and evaluation so that countries can succeed in their national responses. Three-quarters of countries report that monitoring and evaluation is a major challenge.
- Produce scientific data and strategic information to guide the response.
- Improve countries' capacity to use their AIDS funds.
- Establish accountability mechanisms to track resources and demonstrate that they are being used effectively.
- Create mechanisms for civil society and business to contribute to the AIDS response, through public-private partnerships.
- Ensure that decentralization is a cornerstone of national AIDS responses.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together nine UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its nine cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together nine United Nations system organizations.



For 58 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 a development agency with strong country presence. Its role is to promote an enabling policy, legislative and resource environment which helps create an effective response to AIDS. UNDP supports countries in placing AIDS at the centre of national development agendas; promotes government, civil society, private sector and community leadership; helps countries to develop capacity for action as well as to plan, manage and implement responses to the epidemic. UNDP also works to ensure that women and people living with HIV are empowered and directly involved in the response to AIDS.



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.



The **United Nations Office on Drugs and Crime (UNODC)** is responsible for coordinating and providing leadership for all United Nations drug control activities, and for international cooperation in preventing and combating transnational crime and terrorism. In this context, UNODC supports comprehensive approaches to HIV prevention and care among injecting drug users. In prison settings, UNODC assists in implementing international instruments, norms and standards, which ensure that all inmates receive health care, including for HIV and AIDS. UNODC helps governments to combat people trafficking, and provides guidance to reduce trafficked victims' health consequences, particularly from HIV infection and AIDS.



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.



Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • WFP • UNDP • UNFPA • UNODC
ILO • UNESCO • WHO • WORLD BANK

Joint United Nations Programme on HIV/AIDS (UNAIDS)
UNAIDS – 20 avenue Appia – 1211 Geneva 27 – Switzerland
Telephone: (+41 22) 791 36 66 – Fax: (+41 22) 791 41 87
E-mail: unaids@unaids.org – Internet: <http://www.unaids.org>