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Report on the global AIDS epidemic: Executive summary

A UNAIDS 10th anniversary special edition



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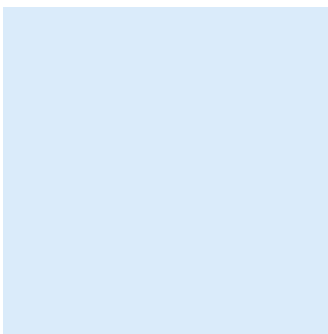
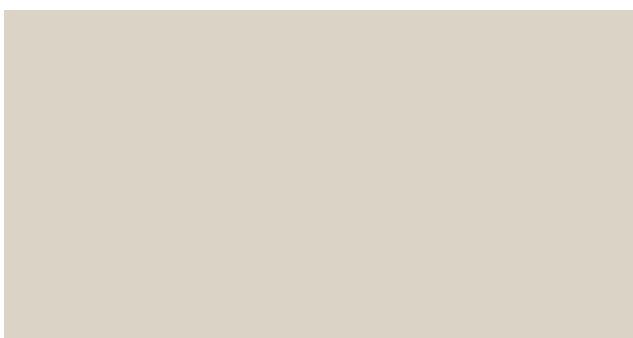
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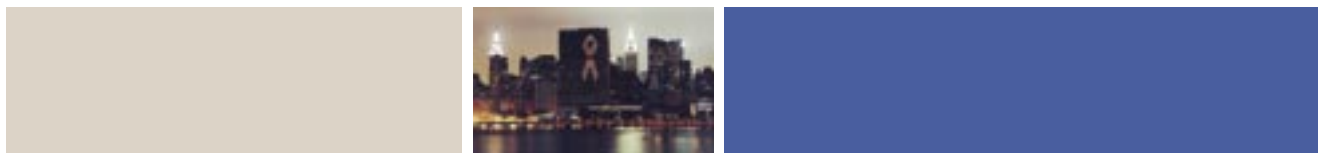
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2006 Report on the global AIDS epidemic

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Executive summary





In the Declaration of Commitment on HIV/AIDS, adopted at an historic special session of the UN General Assembly in 2001, leaders from 189 Member States committed to comprehensive, time-bound targets for the delivery of the effective HIV prevention, treatment, care and support needed to halt and begin to reverse the global epidemic by 2015.

Accountability and transparency are central to achieving these goals. The Declaration of Commitment on HIV/AIDS provides for regular reporting to the General Assembly on global progress, using indicators developed by UNAIDS, individual nations and a diverse range of partners. To inform the five-year assessment of progress by the UN General Assembly in 2006, UNAIDS reviewed country progress reports on core AIDS indicators, with particular attention to quantifiable targets that were to be reached by December 2005.

The *2006 Report on the global AIDS epidemic* contains the most comprehensive set of data on the country response to the AIDS epidemic ever compiled. Not only did 126 countries submit full reports, but, for the first time, civil society was actively engaged in the collection, review and analysis of these country data. In addition, UNAIDS received more than 30 separate reports

from civil society, allowing for a more comprehensive assessment of political commitment, quality and equity of service coverage, and the effectiveness of efforts to address stigma and discrimination.

Among the key findings of this comprehensive global review are the following:

- **Important progress has been made since the 2001 Special Session, yet there is extraordinary diversity in the response to HIV between countries and regions.**
 - While select countries have reached key targets and milestones for 2005, many countries have failed to fulfil the pledges specified in the Declaration.
 - Some countries have made great strides in expanding access to treatment, but have made little progress in bringing HIV prevention programmes to scale, while other countries that are

now experiencing a reduction in national HIV prevalence are making only slow progress to ensure that treatment is available to those who need it.

■ **In most countries, a strong foundation now exists on which to build an effective HIV response, with increasing political commitment and partner coordination at country level.**

- The rate of increase in HIV resources has accelerated since the 2001 Special Session, with an annual average increase of US\$ 1.7 billion between 2001–2004, compared with an average annual increase of US\$ 266 million between 1996 and 2001. Available funding in 2005 reached US\$ 8.3 billion.
 - Domestic public expenditure from governments has also significantly increased in low-income sub-Saharan African countries, and more moderately in middle-income countries. In 2005, domestic resources reached US\$ 2.5 billion.
 - Treatment access has dramatically expanded. From 240 000 people in 2001, 1.3 million people in low- and middle-income countries received antiretroviral therapy in 2005, and 21 countries met or exceeded targets under the “3 by 5” initiative to provide treatment to at least 50% of those who need it.
 - The number of people using HIV testing and counselling services quadrupled in the past five years in more than 70 countries surveyed, from roughly four million persons in 2001 to 16.5 million in 2005.
 - In 58 countries reporting data, 74% of primary schools and 81% of secondary schools now provide HIV and AIDS education.
 - In eight of 11 sub-Saharan countries studied, the percentage of young people having sex before age 15 declined and condom use increased.
 - Six of 11 African countries heavily affected by HIV reported a decline of 25% or more in HIV prevalence among 15–24-year-olds in capital cities.
 - Some countries have achieved nearly 60% coverage of HIV-positive pregnant women receiving antiretroviral prophylaxis to prevent mother-to-child transmission.
 - Blood for use in transfusions is now routinely screened for HIV in most countries.
- **However, there are still significant weaknesses in the response to HIV.**
- HIV prevention programmes are failing to reach those at greatest risk. Efforts to increase HIV knowledge among young people remain inadequate.
 - Although the Declaration of Commitment on HIV/AIDS aimed for 90% of young people to be knowledgeable about HIV by 2005, surveys indicate that fewer than 50% of young people achieved comprehensive knowledge levels.
 - Only 9% of men who have sex with men received any type of HIV prevention service in 2005; fewer than 20% of injecting drug

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

Figure 1 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 3.

- users received HIV prevention services.
- Services to prevent HIV infections in infants have not scaled up as rapidly as programmes to provide antiretroviral therapy, with just 9% of pregnant women being covered.
- Civil society reports from over 30 countries indicate that stigma and discrimination against people living with HIV remains pervasive.
- The HIV response is insufficiently grounded in the promotion, protection and fulfilment of human rights. Half of the countries submitting reports to UNAIDS acknowledged the existence of policies that interfere with the accessibility and effectiveness of HIV-related measures for prevention and care.
- National governments, international partners and communities are failing to provide adequate care and support for the 15 million children orphaned by AIDS, and for millions of other children made vulnerable by the epidemic.
- **A quarter century into the epidemic, the global AIDS response stands at a crossroads.** The AIDS response must become substantially

stronger, more strategic and better coordinated if the world is to achieve the 2010 Declaration of Commitment targets. The countries most affected by HIV and AIDS will fail to achieve Millennium Development Goals to reduce poverty, hunger and childhood mortality, and countries whose development is already flagging because of HIV and AIDS will continue to weaken, potentially threatening social stability and national security, if the response does not increase significantly.

THE GLOBAL EPIDEMIC TODAY

An estimated 38.6 million [33.4 million–46.0 million] people worldwide were living with HIV at the end of 2005. An estimated 4.1 million [3.4 million–6.2 million] became newly infected with HIV and an estimated 2.8 million [2.4 million–3.3 million] lost their lives to AIDS. Overall, the HIV incidence rate (the proportion of people who have become infected with HIV) is believed to have peaked in the late 1990s and to have stabilized subsequently, notwithstanding increasing incidence in several countries.

Favourable trends in incidence in several countries are related to changes in behaviour and prevention programmes. Changes in incidence along with rising AIDS mortality have caused global HIV *prevalence* (the proportion of people living with HIV) to level off (see Figure 2). However, the *numbers* of people living with HIV have continued to rise, due to population growth and, more recently, the life-prolonging effects of antiretroviral therapy. In sub-Saharan Africa, the region with the largest

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

Among the notable new trends are the recent declines in national HIV prevalence in two sub-Saharan African countries (Kenya and Zimbabwe), urban areas of Burkina Faso, and similarly in Haiti, in the Caribbean, alongside indications of significant behavioural change—including increased condom use, fewer partners and delayed sexual debut. In the rest of sub-Saharan Africa, the majority of epidemics appear to be levelling off—but at exceptionally high levels in most of southern Africa.

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

Africa remains the global epicentre of the AIDS pandemic. South Africa's AIDS epidemic—one of the worst in the world—shows no evidence of a decline. Based on its extensive antenatal clinic surveillance system, as well as national surveys with HIV testing and mortality data from its civil registration system, an estimated 5.5 million [4.9 million–6.1 million]

people were living with HIV in 2005. An estimated 18.8% [16.8%–20.7%] of adults (15–49 years) were living with HIV in 2005.¹ Almost one in three

pregnant women attending public antenatal clinics were living with HIV in 2004 and trends over time show a gradual increase in HIV prevalence.

FIGURE 2² Estimated number of people living with HIV, and adult HIV prevalence, globally and in sub-Saharan Africa, 1985–2005

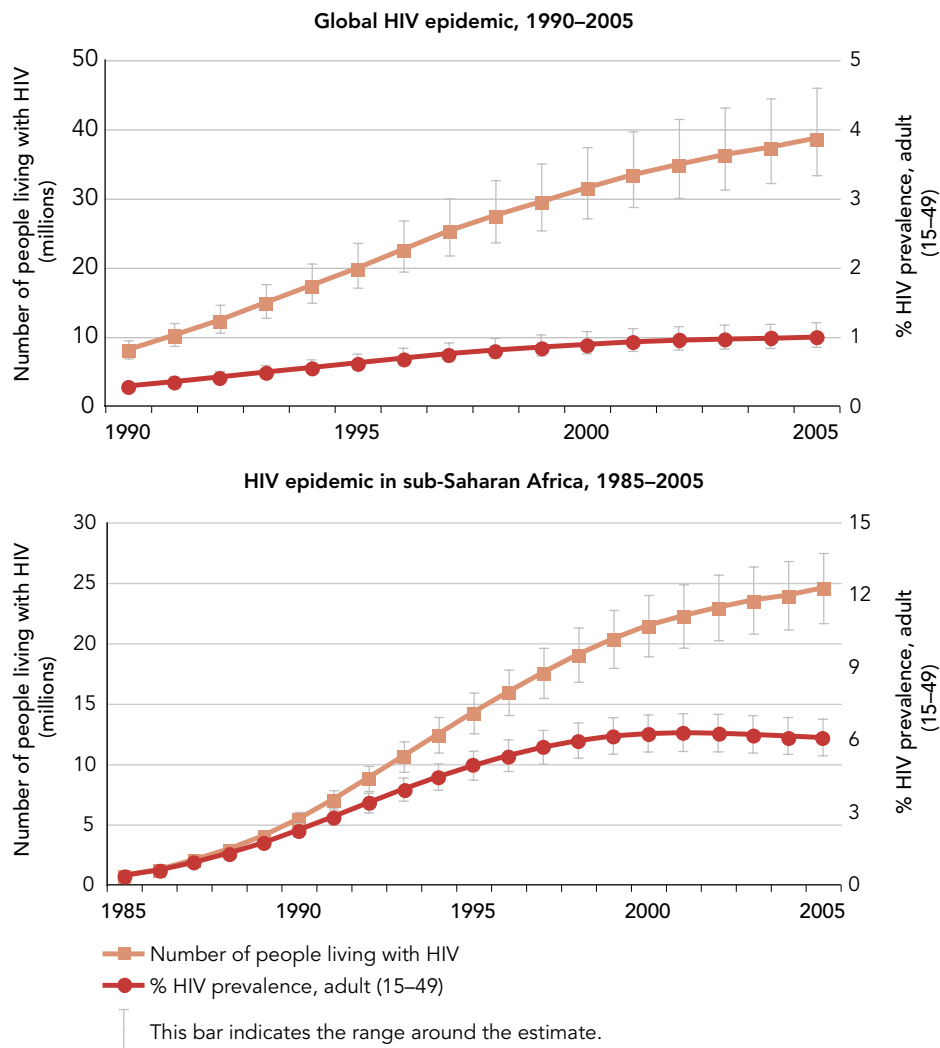


Figure 2 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 2.

¹UNAIDS' HIV prevalence estimates describe the percentage of adult men and women (15–49 years) living with HIV nationally. These estimates incorporate a variety of HIV data, including those gathered in household HIV surveys and at antenatal clinics. Antenatal clinic HIV data, meanwhile, reflect only HIV prevalence in pregnant women who use public antenatal facilities. Comparisons between these two sources of data have shown that antenatal clinic-based HIV estimates tend to be higher than those based on household HIV surveys.

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

IMPROVING HIV SURVEILLANCE DATA

The latest UNAIDS and WHO estimates are lower than those published in the AIDS epidemic update—December 2005, even though the new estimates of the number of adults living with HIV featured in this report now include all adults ‘15 years and older,’ as opposed to just adults between 15 and 49 years of age.

While UNAIDS and WHO previously restricted the estimates to this age group to ensure comparability across countries, it is now evident that a substantial proportion of people living with HIV are 50 years and older. Accordingly, UNAIDS and WHO now present estimates of adults living with HIV, new infections among adults and AIDS deaths among adults for all adults ‘15 years and older’. In addition, we continue to provide estimates of HIV prevalence for ‘adults 15–49 years’, to continue to allow for comparisons across countries.

UNAIDS and WHO estimates of the HIV epidemic show a downward revision in the current report as compared to estimates published in the AIDS epidemic update—December 2005. The lower estimates are partly due to genuine declines in HIV prevalence in several countries, as discussed elsewhere in this report.

However, most of the differences are due to increased availability of reliable data, including the growing number of population-based HIV prevalence surveys in sub-Saharan Africa, new and improved HIV surveillance data globally and improved analyses in countries, as well as improving quality and coverage of sentinel surveillance in many countries and the expansion of surveillance into rural areas where prevalence is known to be lower.

There are no clear signs of declining HIV prevalence elsewhere in southern Africa—including in Botswana, Namibia and Swaziland, where exceptionally high infection levels continue. In Swaziland, national adult HIV prevalence is estimated at 33.4% [21.2%–45.3%]. HIV prevalence among pregnant women attending antenatal clinics rose from 4% in 1992 to 43% in 2004. Botswana’s epidemic is equally serious, with national adult HIV prevalence estimated at 24.1% [23.0%–32.0%] in 2005. Lesotho’s epidemic seems to be relatively stable at very high levels, with an estimated national adult HIV prevalence of 23.2% [21.9%–24.7%]. On the eastern coastline, a dynamic epidemic is underway in Mozambique, where

the estimated national adult HIV prevalence is 16.1% [12.5%–20.0%]. HIV is spreading fastest in provinces linked by major transport routes to Malawi, South Africa and Zimbabwe.

Latest estimates show some 8.3 million [5.7 million–12.5 million] people (2.4 million among adult women [1.5 million–3.8 million]) were living with HIV in Asia at the end of 2005—more than two-thirds of them in one country, India. In Asia, about one in six people (16%) in need of antiretroviral treatment are now receiving it. While progress has been strongest in Thailand, coverage still remains well below 10% in India (which has more than 70% of the region’s total treatment need). Expanded HIV surveillance and improved esti-

mation methods are enabling a clearer picture of the AIDS epidemic in China. Approximately 650 000 [390 000–1.1 million] people in China were living with HIV in 2005.³ Injecting drug users (of whom there are at least one million registered in the country) account for almost half (44%) the people living with HIV. The overlapping risks of injecting drug use and unprotected sex feature in several other epidemics in Asia.⁴

An example is Viet Nam, where HIV has spread into all 59 provinces and all cities. In 2005, an estimated 360 000 [200 000–570 000] adults and children were living with HIV in Myanmar, and national adult HIV prevalence stood at 1.3% [0.7%–2%]. The HIV epidemics remain relatively limited in Bangladesh, the Philippines, Indonesia and Pakistan, although each of these countries risks a more serious epidemic if prevention methods are not improved. An especially troubling situation has emerged in the easternmost province of Papua, which borders on Papua New Guinea, where a serious HIV epidemic is underway.

The epidemics in eastern Europe and central Asia continue to expand. Some 220 000 [150 000–650 000] people were newly infected with HIV in 2005, bringing to about 1.5 million [1.0 million–2.3 million] the number of people living with HIV—a twenty-fold increase in less than a decade. The epidemic's death toll is rising sharply, too. AIDS killed an estimated 53 000 [36 000–75 000] adults and children

in 2005—almost twice as many as in 2003. Increasingly large numbers of women are being infected with HIV. The majority of people living with HIV in eastern Europe and central Asia are in two countries: the Ukraine, where the annual number of new HIV diagnoses keeps rising, and the Russian Federation, which has the biggest AIDS epidemic in all of Europe.

The Caribbean's epidemics—and countries' AIDS responses—vary considerably in extent and intensity. HIV infection levels have decreased in urban parts of Haiti and in the Bahamas and have remained stable in neighbouring Dominican Republic and Barbados. As well, expanded access to antiretroviral treatment in the Bahamas and Barbados appears to be reducing AIDS deaths. However, such progress has not been enough to undo the Caribbean's status as the second-most affected region in the world. AIDS is the leading cause of death among adults (15–44 years) and claimed an estimated 27 000 [18 000–37 000] lives in 2005. Overall, less than one in four (23%) persons in need of antiretroviral therapy was receiving it in 2005.⁵ National adult HIV prevalence exceeds 2% in Trinidad and Tobago, and 3% in the Bahamas and Haiti.

In Latin America, some 140 000 [100 000–420 000] people were newly infected with HIV in 2005, bringing to 1.6 million [1.2 million–2.4 million]

³ Ministry of Health China (2006). 2005 update on the HIV/AIDS epidemic and response in China. Beijing, Ministry of Health China, UNAIDS, WHO.

⁴ Monitoring the AIDS Pandemic Network (MAP) (2005a). Drug injection and HIV/AIDS in Asia—MAP Report 2005. July. MAP, Geneva.

⁵ WHO/UNAIDS (2006). Progress on global access to HIV antiretroviral therapy: a report on "3 by 5" and beyond. WHO/UNAIDS, Geneva.

the number of people living with the virus. The region's biggest epidemics are in the countries with the largest populations, notably Brazil, which is home to more than one-third of the people living with HIV in Latin America. The most intense epidemics, however, are underway in the smaller countries of Belize and Honduras, in each of which more than 1.5% or more of adults were living with HIV in 2005. While notable gains in access to HIV treatment have been made in contrast countries such as Argentina, Brazil, Chile, Costa Rica, Mexico, Panama, Uruguay and Venezuela, the poorest countries of Central America and those in the Andean region of South America are struggling to expand treatment access in the face of affordability barriers.⁶

Except for Sudan, national adult HIV prevalence in the countries of the Middle East and North Africa is very low, and does not exceed 0.1%. However, available data suggest that the epidemics are growing in several countries—including in Algeria, Islamic Republic of Iran, Libyan Arab Jamahiriya and Morocco. Across the region, an estimated 64 000 [38 000–210 000] people were newly infected with HIV in 2005, bringing the total number of people living with the virus to some 440 000 [250 000–720 000]. Sudan accounts for fully 350 000 [170 000–580 000] of those people.

While HIV infection levels remain low across Oceania, Australia's long-established AIDS epidemic is not dissipating,

while Papua New Guinea's relatively young but already serious epidemic accounts for more than 90% of all HIV infections reported in Oceania to date outside of Australia and New Zealand.

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

THE DECLARATION OF COMMITMENT ON HIV/AIDS: PROGRESS SINCE 2001

Leadership

Overall, leadership and political action on AIDS have increased significantly since 2001.

- Internationally, in 2005 the United Nations World Summit, the G8 industrialized countries⁷ and the African Union all endorsed the universal access goal, while the Group of 77 countries acted to prioritize enhanced South-South cooperation on HIV prevention, treatment, care and support. Increased regional collaboration has been demonstrated by the efforts of the Pan Caribbean Partnership against HIV/AIDS; the Asia Pacific Leadership Forum on HIV/AIDS and Development; the European Union and the Commonwealth of Independent

⁶ PAHO (2005). Care fact sheets. Pan American Health Organization, Washington.

⁷ In the final communiqué of the 2005 Gleneagles Summit, the G-8 nations committed to "working with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of coming as close as possible to universal access to treatment for all those who need it by 2010."

States focus on increased action against AIDS in eastern Europe; and the collaborative efforts of Latin American countries to negotiate anti-retroviral drug price reductions.

- Ninety per cent of reporting countries now have a national AIDS strategy; 85% have a single national body to coordinate AIDS efforts; and 50% have a national monitoring and evaluation framework and plan.
- Systems to implement these plans remain inconsistent, however, as does civil society involvement and, specifically, involvement of people living with HIV.

HIV Prevention

While some countries have significantly increased prevention coverage, prevention programmes still reach only a small minority of those in need, and a number of prevention targets are not being reached.

- Analyses consistently show that interventions to change behaviour reduce the frequency of sexual risk behaviours. Countries that have lowered HIV incidence have benefited from the emergence of new sexual behaviour patterns—fewer commercial sex transactions in Cambodia and Thailand, delayed sexual debut in Zimbabwe, increasing emphasis on monogamy in Uganda and an increase in condom use overall.
- Most countries, however, appear to have missed the Declaration target of ensuring that 90% of young people in 2005 have access to critical HIV prevention services including services to develop the life-skills needed to reduce vulnerability to HIV. In fact, none of the 18 countries in which young people were surveyed by the Demographic Health Survey/AIDS Indicator Survey between 2001 and 2005 had knowledge levels exceeding 50%.
- UNFPA, the largest public-sector purchaser of male condoms, estimates the global supply of public-sector condoms is less than 50% of that needed and that current funding for condom procurement and distribution must increase threefold.
- More than 340 million people contract a curable sexually transmitted infection each year, with women having greater vulnerability to infection than men. Despite the fact that untreated sexually transmitted infections increase the risk of HIV transmission by several orders of magnitude, coordination of diagnosis and treatment of sexually transmitted infections and HIV remains very low.
- There are also disturbing signs that support for HIV prevention may be diminishing in some regions. This represents a tremendous lost opportunity, as scaling up available prevention strategies in 125 low- and middle-income countries would avert an estimated 28 million new HIV infections between 2005 and 2015—more than half of those that are projected to occur during this period—and would save US\$ 24 billion.
- Unsafe injections and contaminated blood transfusions in health-

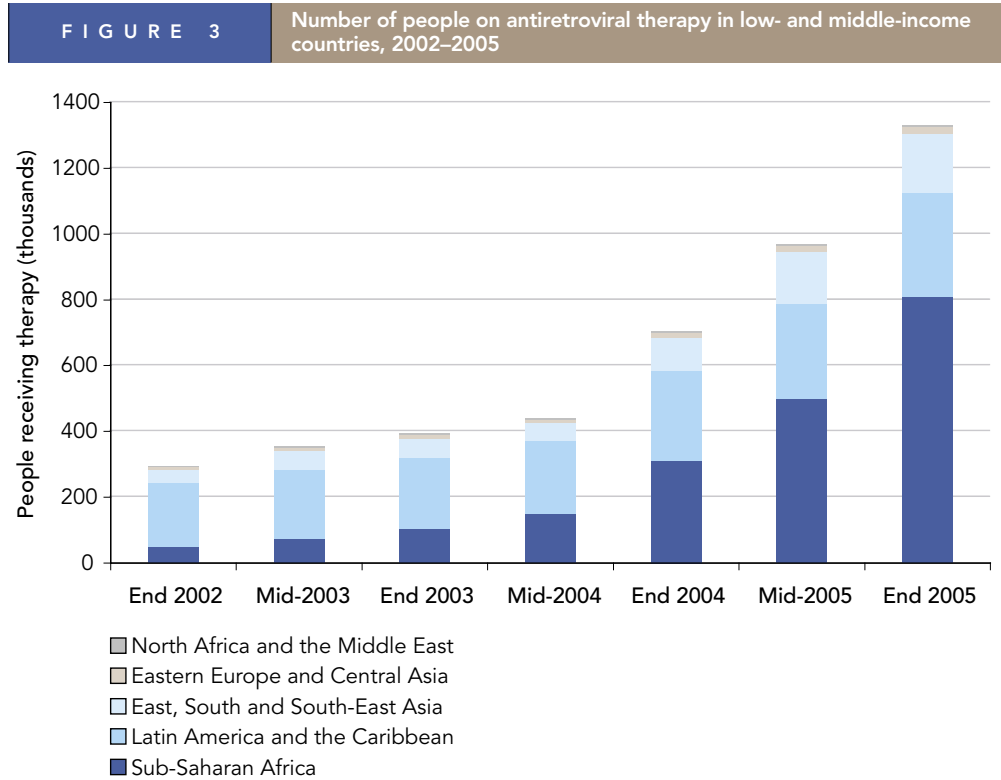


Figure 3 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 7.

care settings are still cause for concern. National HIV prevention programmes should promote adherence to sound infection control practices in health-care settings.

Care, Support and Treatment

In recent years, AIDS has helped drive a global revolution in the delivery of complex therapy in resource-limited settings. The 2001 Declaration of Commitment on HIV/AIDS embraced equitable access to care and treatment as fundamental to an effective global HIV response. Since then, the “3 by 5” initiative, the US President’s Emergency Plan for AIDS Relief, the Global Fund to Fight

AIDS, Tuberculosis and Malaria, and initiatives such as employer programs have definitively demonstrated the feasibility of delivering HIV treatment in resource-limited settings.

- Between 2001 and 2005, the number of people on antiretroviral therapy in low- and middle-income countries increased from 240 000 to approximately 1.3 million.
- The number of sites providing antiretroviral drugs increased from roughly 500 in 2004 to more than 5000 by the end of 2005.
- By the end of 2005, 21 countries met the “3 by 5” target of providing treat-

ment to at least half of those who need it.

- Expanded treatment access was estimated to have averted 250 000 to 350 000 AIDS deaths between 2003 and 2005.
- Globally, however, antiretroviral drugs still reach only one in five who need them.
- Ongoing obstacles to expanding treatment access include out-of-pocket costs for patients, the concentration of treatment sites in urban areas, and inadequate efforts to address the needs of vulnerable populations, including sex workers, men who have sex with men, injecting drug users, prisoners and refugees.
- As many second-line antiretroviral drugs remain too costly for use in many countries, further price declines are likely to be needed to sustain and expand treatment access initiatives.
- Maintaining and expanding momentum in treatment scale-up towards the universal access goal will require more leadership to overcome key barriers to treatment access through efforts to:
 - **increase individual knowledge of HIV status** through a sharp increase in use of voluntary HIV counselling and testing services;
 - **reduce HIV stigma** including fear, misinformation and discrimination against people living with or perceived to be at risk of HIV, both among health providers and among the general public;
 - **build human capacity** to sustain treatment through training and better use of current human

resources. WHO's training tools for the Integrated Management of Adolescent and Adult Illness and the Integrated Management of Childhood Illness have enabled the training of more than 15 000 providers of HIV-related services in an integrated approach to antiretroviral therapy, care and prevention;

- **improve supply management** to minimize delays in procurement and disbursement of antiretroviral drugs by building capacity to gauge future demand for antiretroviral drugs and to implement reliable procurement, delivery and supply systems; and
- **integrate HIV care** with other health services to increase uptake of antiretroviral therapy and deliver more comprehensive, higher-quality care, for example by linking HIV care with tuberculosis diagnosis and treatment, and with antenatal and reproductive health care.

Human Rights

Despite some improvements between 2003 and 2005, the global AIDS response in many countries is still insufficiently grounded in human rights.

- In 18 of 21 countries surveyed from sub-Saharan Africa, the Asia-Pacific region, eastern and western Europe, and north Africa, national reports cited improvement in policies, laws and regulations to promote and protect human rights.

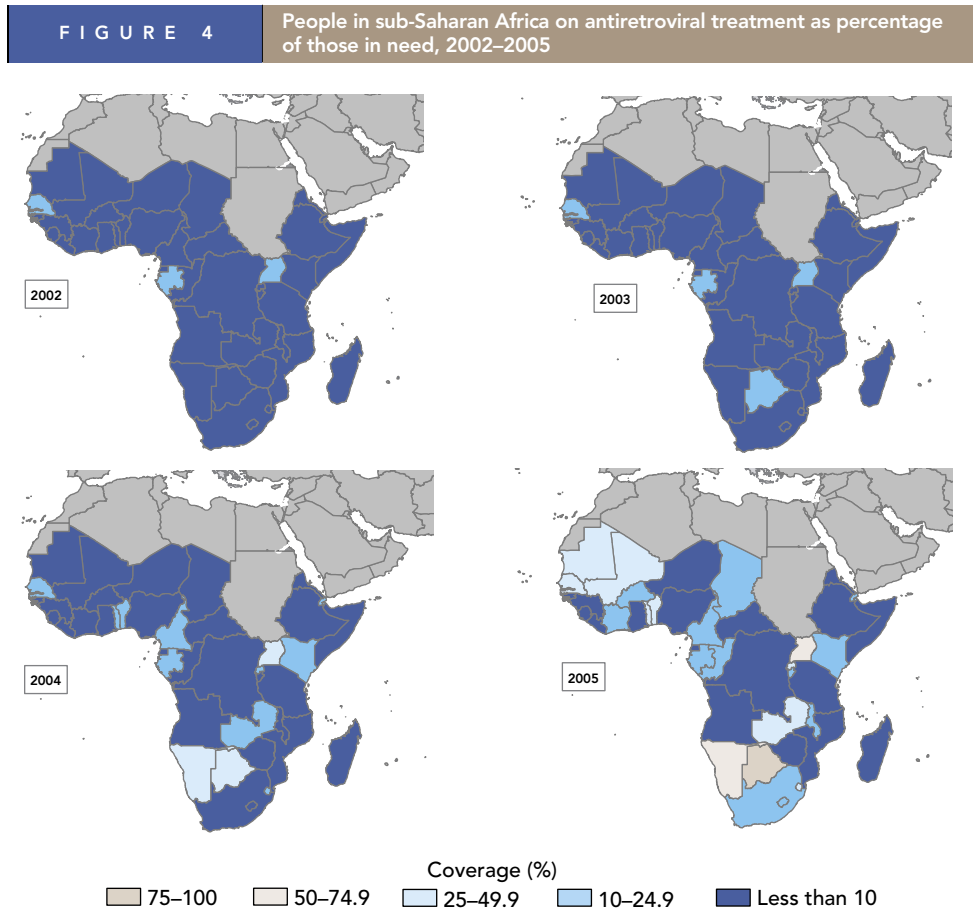


Figure 4 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 7.

- Although six out of every 10 countries surveyed report the existence of laws and regulations to protect people living with HIV from discrimination, many indicate that national laws have not been fully implemented or enforced, often due to lack of budget allocations.
- Half of reporting countries also acknowledge the existence of policies that interfere with the accessibility and effectiveness of HIV prevention and care measures, such as laws criminalizing consensual sex between

males, prohibiting condom and needle access for prisoners, and using residency status to restrict access to prevention and treatment services.

Reducing Vulnerability

While funding for HIV programmes has increased in recent years, many countries fail to direct financial resources towards activities that address the prevention needs of the populations at highest risk, opting instead to prioritize more general prevention

efforts that are less cost-effective and less likely to have an impact on the epidemic.

- Evidence from Uganda shows that a child who drops out of school is three times more likely to be HIV-positive in his or her twenties than a child who completes basic education. Three-quarters of responding countries have established structures to coordinate ministry of education responses to the epidemic. Yet, only 59% of these ministries in all countries and 70% in high-prevalence countries have a dedicated budget.
- In sub-Saharan Africa, 21 of 25 countries reported having reduced or eliminated school fees for vulnerable children and having implemented community-based programmes to support orphans and other vulnerable children.
- Some countries are adopting more progressive approaches to reduce vulnerability for injection drug users.
 - Despite a strong commitment to compulsory treatment for drug dependence and abstinence-based programmes, Malaysia recently decided to introduce harm reduction programmes.
 - In 2005, a judge in the Islamic Republic of Iran ordered that individuals who use illegal drugs no longer be targets of criminal repression but instead be treated as patients by the public health system.
 - In Central Asia, the Kyrgyz Government supports needle and syringe exchange programmes in three cities and in prisons in the country.
- Overall, however, fewer than 20% of people who inject drugs received HIV prevention services, with coverage of less than 10% reported in eastern Europe and central Asia, where drug use is a major driver of the rapidly expanding epidemic; counterproductive laws and policies in some countries still prohibit substitution therapy with buprenorphine or methadone, which were added in 2005 to the WHO Model List of Essential Medicines.
- Only 10 of 24 countries that reported data for sex workers achieved at least 50% coverage of prevention services for this population.
- Public health authorities are devoting fewer resources to men who have sex with men than epidemiological evidence suggests is necessary—a short-sighted policy in light of rising HIV prevalence among this population in many countries.

Research and Development

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

- Since the 2001 Special Session, momentum has increased in the field of research and development on vaginal microbicides to prevent HIV transmission.
 - Investment by public and philanthropic sectors in microbicide research and development has

more than doubled, increasing from US\$ 65 million in 2001 to an estimated US\$ 163 million in 2005.

- By early 2006, large-scale human trials had been initiated to assess the HIV prevention efficacy of microbicides, the female diaphragm and adult male circumcision.
- Funding for the development of preventive vaccines nearly doubled from US\$ 327 million in 2000 to nearly US\$ 630 million in 2005.
- Almost three-quarters (73%) of countries report having a policy requiring approval by an ethics review committee of all research protocols involving human subjects. This reflects the status quo compared to 2003.
- Regarding the inclusion of people living with HIV and their caregivers in the review of research protocols, 71% rate national efforts as average or below average, with 31% of countries assessing national efforts as extremely poor.

AIDS in conflict or disaster regions

Acknowledging the potential for conflicts and disasters to increase vulnerability and contribute to the spread of HIV, the Declaration of Commitment on HIV/ AIDS calls on countries to integrate HIV activities into programmes and action plans for emergency situations. It also provides for international and nongovernmental organizations to invest in HIV aware-

ness and training for personnel and for HIV to be incorporated into operations of national uniformed services and international peacekeepers.

- According to UNHCR, only 65% of national strategic plans in 2004 mentioned refugees and only 43% articulated specific refugee-related activities.⁸
- In 2005, 86% of countries had a formal strategy for addressing HIV among uniformed services, compared with 78% in 2003.
- The UNAIDS Secretariat and the UN Department of Peacekeeping Operations have fully integrated HIV awareness programmes into UN-sanctioned peacekeeping operations. Currently, all peacekeeping missions benefit from full- or part-time HIV advisers.

Resources

Resource mobilization is one of the few specified targets for 2005 that the global community achieved. Financial resources for AIDS, including domestic public expenditure from governments, have increased significantly since 2001.

- There have been significant advances in recent years with regard to financing AIDS globally. Funds dedicated to responding to AIDS in low- and middle-income countries in 2005, US\$ 8.3 billion (range of US\$ 7.5 billion–US\$ 8.5 billion) are well within the 2001 target range of US\$ 7–US\$ 10 billion for 2005.

⁸ UNAIDS/UNHCR (2005). Strategies to support the HIV-related needs of refugees and host populations. UNAIDS/UNHCR, Geneva.

- The global funding mechanism called for in the Declaration of Commitment on HIV/AIDS resulted in the launch of the Global Fund to Fight AIDS, Tuberculosis and Malaria in December 2002. An estimated 20% of all international financing for HIV is currently channelled through the Global Fund, which disbursed an estimated US\$ 1.1 billion in 2005. To date the Global Fund has approved a total of 350 grants to government and civil society partners and other recipient countries in 128 countries.
- The World Bank has also added significant support to HIV funding in low- and middle-income countries. By the end of 2005, the World Bank had committed a cumulative total of more than US\$ 2.5 billion to HIV programmes.
- The United States President's Emergency Program for AIDS Relief has also been a substantial addition to the AIDS funding arena, providing intensive assistance to 15 target countries and support to 100 more. It disbursed US\$ 570.2 million to the AIDS response in 15 countries in 2004 and committed to an additional US\$ 915.6 million in 2005.
- Despite the exponential increase in donor funding for AIDS over the years, however, bridging the gap between resource needs and resources available remains a challenge. Resource requirements in 2007 are estimated to be US\$ 18.1 billion, while resources expected to be available for the same year are estimated at US\$ 10 billion.
- Planning for the long-term response to AIDS increasingly requires more predictable and binding mechanisms for financial contributions from bilateral and multilateral donors and national governments.
- Major advances have been made in recent years in gathering data and tracking resources to better understand where support for AIDS is coming from and where it is going, but a clear challenge still exists to bridge the gap between resource requirements and resources available and to reform funding mechanisms.

THE ROAD AHEAD: FROM CRISIS MANAGEMENT TO STRATEGIC RESPONSE

Over the last quarter century nearly 65 million people were infected with HIV and an estimated 25 million have died of AIDS-related illnesses. Today it is estimated that close to 40 million live with HIV—yet the vast majority are unaware of their status.

AIDS is exceptional and the response to AIDS must be equally exceptional. It requires ongoing leadership on both the national and international levels. Twenty-five years into the epidemic, the global response to AIDS must be transformed from an episodic, crisis-management approach to a strategic response that recognizes the need for long-term commitment and capacity-building, using evidence-informed strategies that address the structural drivers of the epidemic.

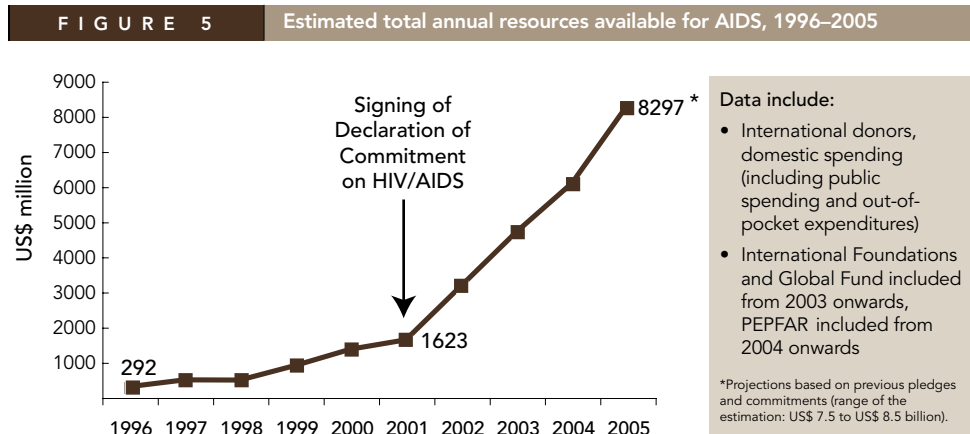


Figure 5 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 3.

Despite considerable progress since 2001, the consistent leadership necessary to slow, stop and reverse this epidemic is not yet evident. While the Secretary-General's Report to the UN General Assembly notes many improvements in the global AIDS response since 2001, it also clearly indicates that action overall has been insufficient, with progress uneven within and between countries and regions.

The *2006 Report on the global AIDS epidemic* makes the following strategic recommendations to enable countries to deliver on the promises made in 2001. Successful implementation of these recommendations is crucial to halt and reverse the epidemic.

Sustain and increase commitment and leadership

The Declaration of Commitment on HIV/AIDS calls for the development and implementation of sound national

multisectoral AIDS strategies that integrate the HIV response into mainstream development planning, with the full and active participation of civil society and the private sector. As AIDS is a matter of extreme national importance, active and visible leadership on the issue from heads of state and governments is essential to the success of the effort.

- National AIDS authorities, working with all partners and stakeholders, must develop or adapt prioritized and costed AIDS plans that are ambitious, feasible and aligned with national development plans.
- Civil society must be fully engaged in the development and implementation of national plans. The UNAIDS Secretariat, UNDP and the World Bank will facilitate a participatory process to provide criteria for the development and oversight of these plans.
- Countries should ensure the accountability of all partners through

transparent peer review mechanisms for public monitoring of targets and regular reporting of country and regional progress.

Sustain and increase financing

Global financing for AIDS has greatly increased, yet funding available today may be just one-third of what will be required to respond to the growing epidemic in a few years. Available funds for the AIDS response in low- and middle-income countries are expected to total US\$ 8.9 billion in 2006 and US\$ 10 billion in 2007, far short of the estimated need of US\$ 14.9 billion in 2006, US\$ 18.1 billion in 2007 and US\$ 22.1 billion in 2008. By 2008, UNAIDS and its research partners estimate that US\$ 11.4 billion will be needed for HIV prevention activities alone, in order to ensure that the world is on track to achieve the Millennium Development Goal of halting and beginning to reverse the global AIDS epidemic by 2015.

- National governments and international donors should significantly increase financing for AIDS by strengthening and fulfilling existing commitments, fully supporting the Global Fund and supporting other innovative financing mechanisms; current efforts to produce a substantial portion of this funding from domestic budgets, especially in middle-income countries, must continue.
- Equally important as maintaining and increasing the flow of resources are efforts to ensure that the money works for people in need. The “Three Ones” principles, which call for the

coordination of a national AIDS response around one agreed AIDS action framework, one national coordinating authority and one agreed country-level monitoring and evaluation system, are designed to increase effectiveness in prioritizing activities and targeting resources to achieve the greatest good for people in need.

- Innovative approaches to secure sustainable long-term funding for the AIDS response, including proposals for new international financing mechanisms, deserve serious consideration, as do any other proposals that will help to stabilize funding for a greatly enhanced response to the epidemic.

Aggressively address AIDS-related stigma and discrimination

Ending the AIDS pandemic will depend largely on changing the social norms, attitudes and behaviours that contribute to its expansion. Action against AIDS-related stigma and discrimination must be supported by top leadership and at every level of society, and must address women’s empowerment, homophobia, attitudes towards sex workers and injecting drug users, and social norms that affect sexual behaviour—including those that contribute to the low status and powerlessness of women and girls.

- Laws and policies that protect women and girls against sexual violence, disinheritance and gender discrimination of all kinds, including harmful traditional practices and sexual violence in and outside of marriage, must be enacted, publicized and enforced.

- Women must be adequately represented in policy- and decision-making on AIDS. A 2004 UNAIDS assessment found that women's participation in the development and review of national AIDS frameworks was non-existent in more than 10% of 79 countries and inadequate in more than 80%⁹.
- Laws and policies that directly challenge gender inequality and bias against people perceived to be at heightened risk for HIV, including sex workers, injecting drug users and men who have sex with men, are also essential. Changes in laws and policies must be accompanied by adequately funded social mobilization campaigns, which should involve networks and organizations of people living with HIV along with all other elements of civil society in their planning and implementation.
- A fully funded plan to achieve universal education and to address or remove barriers such as school fees, compulsory school uniforms and textbook charges is also fundamental to reducing HIV and related stigma.

THE MOVEMENT TOWARDS UNIVERSAL ACCESS

At the 2005 meeting of the G8 nations and the September 2005 United Nations World Summit, world leaders committed to a massive scale-up of HIV prevention, treatment and care, with the aim of coming as close as possible to the goal of universal access

to treatment by 2010 for all who need it. Making this commitment a reality will require commitment and action in each of the following key areas:

Strengthen AIDS prevention

A renewed emphasis on HIV prevention is critically needed to prevent millions of new infections each year.

- HIV prevention services and education must be targeted to vulnerable groups, including sex workers, injecting drug users, men who have sex with men, and prisoners. Access to services to prevent mother-to-child HIV transmission must increase significantly to reduce the unacceptable and largely preventable burden of HIV on newborns.
- Access to clear, factual HIV prevention information and to HIV testing should be a right. Countries should promote the idea that each person knows his or her HIV status and has access to AIDS information, counselling and related services, in an environment that is safe for confidential testing and voluntary disclosure of HIV status.
- Even though available evidence indicates that coverage of prevention programmes is higher in sex workers—compared to men who have sex with men and injecting drug users—additional efforts are critical to ensure an adequate rate of coverage in all three groups.

⁹ UNAIDS (2006). From advocacy to action: A progress report on UNAIDS at country-level. UNAIDS, Geneva.

- On a more encouraging note, the percentage of young people having sex before the age of 15 declined and condom use increased between 2000 and 2005 in nine of 13 sub-Saharan countries studied. However, HIV prevention efforts remain notably inadequate for young people, who account for over 40% of all new infections. Investing in prevention programmes for young people is critical.

Build treatment access

Continuing and expanding rapid scale-up of HIV treatment access will require:

- expanding and diversifying treatment access sites, which are now concentrated largely in urban areas, along with efforts to ensure equity in access among all affected populations, including children;
- expanded efforts to increase access to drugs that prevent common opportunistic infections, such as the antibiotic cotrimoxazole;
- broadening confidential and voluntary access to HIV testing, to increase knowledge of serostatus;
- efforts to reduce HIV-related stigma and discrimination, build human resource capacity in health systems settings and improve supply management; and
- expanded treatment advocacy and education to build awareness of treatment services, their benefits and how to use them.

Strengthen human resources and systems

The shortage of skilled workers in many developing countries leads to poor surveillance, planning and administration; bottlenecks in the distribution of funds; failures in the implementation, monitoring and evaluation of activities; and inadequate provision of services. Eliminating these human resource obstacles will require:

- speeding recruitment and training of health-care workers at all levels and improving working conditions, remuneration and other incentives to encourage trained health-care professionals to work in their home countries rather than migrating to industrialized countries;
- action by national governments and international donors to increase financing for training and accreditation centres in countries facing severe human resource shortages;
- the adoption, where needed, of alternative and simplified delivery models to strengthen the community-level provision of HIV prevention, treatment, care and support; and
- increased integration of AIDS interventions into programmes for primary health care, mother and child health, sexual and reproductive

health and diagnosis and treatment of tuberculosis, malaria and sexually transmitted diseases.

Ensure available and affordable products for HIV prevention and treatment

Increasing action to ensure the affordability of prevention and treatment products, from condoms to antiretroviral drugs, will require the following actions.

- National governments should remove barriers in pricing, tariffs and trade and regulatory policy to medicines, and diagnostics, and should reduce or eliminate user fees for AIDS-related prevention, treatment, care and support. Legal or regulatory barriers that block access to effective HIV prevention interventions and commodities such as condoms, harm reduction services and other prevention measures should also be removed.
- To speed the flow of treatment, governments should allow WHO prequalified medicines to obtain provisional marketing approval prior to full registration by national drug regulatory authorities.
- Access to the few paediatric formulations of antiretroviral drugs and drugs to prevent opportunistic infections is seriously inadequate. Leaders should review and enact the recommendations of the 2005 UNICEF and UNAIDS "call to action" to ensure that antiretroviral therapy or antibiotic prophylaxis, or both, reaches 80% of children in need by 2010.
- Ensuring the availability and affordability of vitally needed medicines—including second, third and fourth generations of drugs—means addressing the complex, sensitive and contentious issues of pharmaceutical patents. Where necessary, countries should employ the flexibilities of the WTO Agreement on *Trade-related Aspects of Intellectual Property Rights* to secure access to sustainable supplies of affordable HIV medicines and health technologies, including through local production where feasible.

Invest in research and development for drugs, microbicides and vaccines

Continued technological innovation is vital for the development of microbicides, new generations of drugs and a preventive vaccine.

- Substantially greater research funding must be mobilized, especially from the pharmaceutical and biomedical industries.
- The needs of children with HIV have been largely left out of the research agenda. Pharmaceutical companies, international donors, multilateral organizations and other partners should develop public-private partnerships to promote faster development of new paediatric drug formulations.
- HIV prevention clinical trials often generate controversy, highlighting the need for researchers to engage a broad range of community and

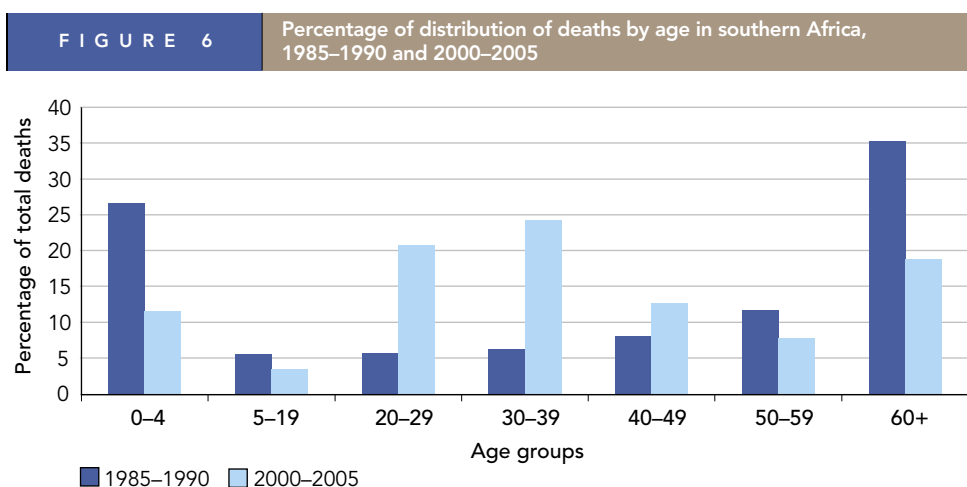


Figure 6 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 4.

national stakeholders in the planning and conduct of those trials.

- Government, civil society and private sector leaders must put into place the systems and agreements that will guarantee wide and equitable access to microbicides, new generations of drugs, and vaccines for HIV and sexually transmitted infections, as well as improved treatments for diseases such as tuberculosis, which now accounts for the largest proportion of global AIDS-related deaths.

Counter the impact of AIDS

AIDS exacerbates every other challenge to human development, from maintenance of public services to food security and conflict avoidance. Efforts to address the epidemic must simultaneously focus on preventing new infections, caring for those already infected and mitigating the economic, institutional and social impacts of AIDS.

- Efforts to mitigate the impact of AIDS must focus first on the individuals and families affected through interventions such as access to therapy, nutritional assistance and treatment for opportunistic infections and other health issues.
- The needs of children who have lost one or more parents to AIDS, which include approximately 9% of children under the age of 15 in sub-Saharan Africa, should be prominently included in national AIDS plans and strategies.
- Social protection measures to preserve livelihoods of people affected by AIDS, including welfare programmes, child and orphan support, public works to provide employment, state pension systems and micro-financing should be part of AIDS planning and services.
- Leaders of countries that host refugees or displaced persons must incorporate these large and

vulnerable populations into their prevention, care and treatment planning.

- China's "Four Frees and One Care" program, which offers free antiretroviral drugs, voluntary counselling and testing, drugs to prevent mother-to-child transmission, schooling for orphaned children, and care and economic assistance to affected households, may provide a model for other nations in supporting families and societies affected by AIDS.

When 189 nations signed the Declaration of Commitment that emerged from the 2001 United Nations General Assembly on HIV/AIDS, they recognized, in a rare, unanimous international consensus, that AIDS is among the greatest development crises in human history. Each committed to act nationally and internationally to stop the epidemic.

The Report of the Secretary-General on the Declaration of Commitment on HIV/AIDS Five Years Later states, "A quarter century into the epidemic, the

global AIDS response stands at a crossroads. For the first time ever the world possesses the means to begin to reverse the epidemic. But success will require unprecedented willingness on the part of all actors in the global response to fulfil their potential, to embrace new ways of working with each other, and to...sustain the response over the long term."

We know with increasing certainty what disaster awaits if the response to AIDS continues to be inadequate. We also know how to strengthen that response in ways that will save millions of lives and billions of dollars. This plan is achievable, but only with strong leadership at every level of society. We know what needs to be done to stop AIDS. What we need now is the will to get it done.

UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of ten UN system organizations to the global AIDS response. Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 75 countries worldwide.

Uniting the world against AIDS

This executive summary of the 2006 Report on the global AIDS epidemic provides information on the latest developments in the AIDS epidemic and the AIDS response. The special UNAIDS 10th anniversary edition of the report presents country profiles and estimates of the epidemic's scope and human toll.



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