



## PROGRAMME COORDINATING BOARD

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### **Report of the Executive Director, 2002–2003**

#### **Executive Summary**

This Report of the Executive Director to the 15<sup>th</sup> meeting of the UNAIDS Programme Coordinating Board (PCB) updates the PCB on the status of the HIV epidemic, summarizes major developments to date in advancing the global and UN system response to the epidemic during the 2002-2003 biennium, and articulates the Programme's strategic approaches to implementation of the action steps agreed to by the PCB in December 2002 following the external evaluation of the Joint Programme.

In 2002-2003, UNAIDS support to countries significantly grew, with the adoption of a new operational framework for country support, strengthening of UN Theme Groups on HIV/AIDS, development of UN System Implementation Plans, and the allocation of substantial new resources to country support activities. The UNAIDS Secretariat and Cosponsors intensified their technical support to national programmes, and also laid the groundwork for Technical Support Facilities that will serve several key regions by the end of 2005. The UN system is leading global efforts to address the multi-dimensional crisis facing Southern Africa, and in all regions the Joint Programme strengthened its efforts to bring essential prevention, treatment, care and support programmes to broad scale. In 2002-2003, UNAIDS achieved important progress in the development and deployment of strategic information, harmonization and strengthening of monitoring and evaluation efforts, and mobilization of unprecedented new resources for AIDS programmes.

In all these efforts, the Joint Programme has drawn inspiration and guidance from several key overarching frameworks. The UN Declaration of Commitment on HIV/AIDS provides a framework for a comprehensive and effective response and has emerged as a critical global tool for advocacy and accountability. The "3 by 5" strategy, which envisions the delivery of antiretroviral therapies to 3 million people by the end of 2005, is involving all components of the Joint Programme in a collective effort to forge an integrated, equitable response to AIDS. The "Three Ones", which has been embraced by UNAIDS as an organizing approach for its assistance to countries and by all major donors as a set of governing principles, seeks to maximize the effectiveness of human and financial resources for AIDS, accelerate scaling up, and ensure that all efforts are directed toward achievement of nationally determined objectives and strategies.

#### **Action required at this meeting**

The PCB is requested to endorse the report of the Executive Director.

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**Abbreviations and acronyms used**

AIDS	Acquired immunodeficiency syndrome
ASEAN	Association of South-East Asian Nations
CARICOM	Caribbean Community Secretariat
CIS	Commonwealth of Independent States
DFID	United Kingdom Department for International Development
FAO	Food and Agriculture Organization
GIPA	Greater involvement of people living with or affected by HIV/AIDS
GNP+	Global Network of People Living with HIV/AIDS
HIV	Human immunodeficiency virus
ICASO	International Council of AIDS Service Organizations
ICW	International Community of Women Living with HIV/AIDS
IMF	International Monetary Fund
IPAA	International Partnership against AIDS in Africa
ILO	International Labour Organization
MAP	World Bank's Multi-Country HIV/AIDS Program
NEPAD	New Partnership for Africa's Development
NGO	Nongovernmental organization
OECD	Organisation for Economic Cooperation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
PAF	Programme Acceleration Funds
PMTCT	Prevention of Mother To Child Transmission
UCC	UNAIDS Country Coordinator
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization



## SECTION I: INTRODUCTION

This Report of the Executive Director to the 15<sup>th</sup> meeting of the UNAIDS Programme Coordinating Board (PCB) updates the PCB on the status of the HIV epidemic, summarizes major developments to date in advancing the global and UN system response to the epidemic during the 2002-2003 biennium, and articulates the Programme's strategic approaches to implementation of the action steps agreed to by the PCB in December 2002 following the external evaluation of the Programme.

This Report does not attempt to provide a comprehensive listing of all UNAIDS activities in the previous biennium but instead summarizes key developments and issues. The Executive Director is separately submitting for the PCB's review **an analysis of challenges** facing the Joint Programme and UNAIDS' strategies for addressing them. In addition, UNAIDS is submitting at this meeting two technical documents that comprehensively summarize progress on HIV/AIDS in 2002-2003—a **Performance Monitoring Report on the UNAIDS Unified Budget and Workplan 2002-2003**, as well as a mid-term assessment of the **UN System-wide Strategic Plan on HIV/AIDS 2001-2005**. In accordance with direction provided by the PCB in December 2002, these reports reflect the Programme's commitment to increased accountability, performance monitoring, and strategic effectiveness.

## SECTION II: STATUS OF THE HIV EPIDEMIC

The global epidemic continued to expand in 2002-2003, generating unprecedented numbers of people living with HIV. The latest evidence dispels hopes that the epidemic might soon plateau; more AIDS deaths and new HIV infections occurred in 2003 than in any prior year. As of December 2003, an estimated 40 million people worldwide were living with HIV, including 2.5 million children under age 15. UNAIDS and WHO recently revised downwards their estimates of adult HIV prevalence and total number of infected people in a number of African countries. This has sometimes been incorrectly interpreted as an easing or reversal of the HIV/AIDS epidemic. In fact, these new estimates are the result of steady improvements in the modelling methodology used by UNAIDS/WHO and partners, along with better data from country surveillance. This has led to lower global HIV/AIDS estimates, not just for 2003, but also for past years. Therefore, the overall pattern of the course of the epidemic remains unchanged—HIV is spreading at an alarming rate. Also, during the last biennium for the first time, the number of women living with HIV equalled the number of men; in sub-Saharan Africa, women represent 58% of all HIV-infected people. In 2002-2003, the epidemic's impact also became more acute, especially in Southern Africa, where HIV/AIDS severely worsened a regional food shortage, threatening the well-being of 6.5 million people.

*Sub-Saharan Africa* remains the region most heavily by HIV/AIDS, accounting for 64% (3.2 million) of all new infections in 2003 and 77% (2.3 million) of all AIDS deaths. An estimated 26.6 million people in the region were living with HIV at the end of 2003, with women in sub-Saharan Africa being at least 20% more likely than men to be HIV-infected. Although scattered cities in Southern Africa provide some indication that HIV prevention programmes may be having an impact, the region as a whole offers little in the way of good news on the rate of new infections. At best, HIV prevalence in Southern Africa is stabilizing, albeit at devastatingly high levels.

Outside Southern Africa, Nigeria, Côte d'Ivoire, and other countries confront serious epidemics that have yet to decline. Prevention strategies remain grossly under-utilized in the region—only 5% of pregnant women in 2003 were offered services to prevent mother-to-child transmission (PMCTC), and studies suggest that condoms were used in fewer than one in five episodes of sexual intercourse. Although 4.3 million people in the region could immediately benefit from antiretroviral therapy, fewer than 100 000 received such therapies in 2003.

In *Eastern Europe and Central Asia*, the epidemic continued its steady advance, generating 230 000 new infections in 2003 giving a total of 1.5 million people living with HIV. The epidemic has most heavily affected the Russian Federation, Ukraine and the Baltic States, although HIV is also spreading rapidly in Kyrgyzstan and Uzbekistan. Injecting drug use is the primary driver of the epidemic in the region, although the epidemic's spread is being accelerated by unsafe sex, high prevalence of sexually transmitted infections, and earlier initiation of sexual activity. The epidemic in the region is most heavily affecting the young, with people under 20 accounting for 25% of all individuals diagnosed with HIV in Ukraine. The epidemic has primarily involved men, but the proportion of cases among women is quickly increasing—from 24% in the Russian Federation in 2001 to 33% in 2002. Although HIV/AIDS has already reached serious proportions in the region, the epidemic is still in its early stages, with indications that infection is swiftly spreading from injecting drug user networks to the broader population. Unfortunately, the response in the region is not commensurate with the growing threat. Only a small fraction of injecting drug users in the region have access to harm-reduction programmes, and laws in some countries prohibit key elements of harm reduction, such as syringe and needle exchange and methadone maintenance programmes.

In *Asia*, home to three of the world's four most populous countries, 1 million people contracted HIV in 2003, bringing the total number infected to 7.4 million. The region's epidemic is highly varied, including mature epidemics in Cambodia, Myanmar and Thailand, as well as epidemics that are rapidly spreading in countries where, until recently, HIV was barely present, such as China, Indonesia and Viet Nam. While overall prevalence remains low (below 1% of adults in most countries), the region includes serious pockets of infection that potentially threaten the broader population. In India, five states have estimated adult prevalence higher than 1%, while studies in the Xinjiang province of China have detected HIV infection rates as high as 80% among injecting drug users. In Indonesia, where infection is fast increasing, fewer than 10% of the 7–10 million men who frequent sex workers use condoms consistently. Signs are also troubling in Viet Nam, where high infection rates exist among injecting drug users and sex workers, and in Myanmar, where only piecemeal activities have been undertaken to address a serious epidemic. While these and other trends have made Asia a major focus of global concern on HIV/AIDS, the region is also home to some of the world's most impressive prevention successes, most notably in Thailand and Cambodia.

In *Oceania*, Papua New Guinea, which shares an island with one of Indonesia's worst affected provinces, Irian Jaya, has the highest prevalence of HIV infection. Prevalence among pregnant women in the capital, Port Moresby, and also in Lae and Goroka suggest the epidemic is generalized and largely heterosexually-driven. High levels of other sexually transmitted infections indicate behaviour patterns that would also

facilitate HIV transmission beyond sex workers and their clients. In other islands in the region, HIV infection levels are still very low, but sexually transmitted infection levels are high.

In *Latin America and the Caribbean*, at least 100 000 people died of AIDS in 2003, the second highest regional toll after sub-Saharan Africa. Two million people in the region are living with HIV, with the highest rates in the Caribbean, where adult HIV prevalence has surpassed 1% in 12 countries. Epidemiological patterns differ markedly within the region. While men who have sex with men represent the largest share of cases for the region as a whole, heterosexual transmission predominates in the Caribbean basin. In parts of the region, most notably the Southern Cone of South America, injecting drug use is the primary route of transmission. Haiti, where more than 200 000 children have been orphaned by AIDS, is the region's most heavily affected country, with a national HIV prevalence rate that has remained relatively stable since the 1980s at 5–6%. Brazil's success in controlling a potentially severe epidemic remains impressive, with median HIV prevalence below 1% for pregnant women attending antenatal clinics; much higher infection rates detected recently in other populations, however, underscore the importance of reinforcing prevention messages and strategies. While Brazil has led efforts in recent years to expand access to antiretroviral treatment, providing medications to more than 125 000 individuals through its public health sector, treatment coverage in some countries in the region has yet to reach 25%.

Although the absolute numbers of HIV/AIDS cases are much lower in the *Middle East and North Africa* than in other regions, the virus has gained a foothold and in some places is quickly spreading. As of December 2003, 600 000 people were living with HIV in the region, including 55 000 who became infected last year. Of immediate concern is the Sudan, where national adult HIV prevalence now exceeds 2%. In many countries in the region, injecting drug users represent the largest group of infections, but limited information indicates that sex workers and men who have sex with men are also at risk. The response to AIDS in the region is impeded by weak surveillance systems, inadequate prevention measures, and the stigma attached to drug use, sex work, and sex between men. Nevertheless, several countries are beginning to strengthen national efforts on AIDS. Algeria, Iran, Lebanon, Libya and Morocco, for example, are implementing stronger national prevention efforts, while Tunisia has for several years provided free and universal antiretroviral treatment.

In *high-income countries*, the positive impact of antiretroviral treatment is reflected in AIDS mortality rates that are sharply lower than those recorded in the years before these drugs were widely available. Unfortunately, declines in AIDS deaths have begun to plateau in many high-income countries, and there are worrying signs that new HIV infections may be on the rise. In 2002-2003, numerous special studies, as well as sexually transmitted infection surveillance figures, indicated that sexual risk behaviours were increasing. A recent analysis by the US Centers for Disease Control's Divisions of HIV/AIDS Prevention on case reporting in 29 states with longstanding HIV reporting systems found that the rate of new infections has increased over the last several years, primarily among men who have sex with men. Indeed, new HIV cases appear to be on the rise in nearly all high-income countries. Men who have sex with men remain an important component of the epidemic in virtually all high-income countries—accounting, for example, for 86% of new HIV

diagnoses in Australia. In Western Europe, heterosexual intercourse may now be the most common mode of HIV transmission; a large share of such cases involve persons who are believed to have been infected elsewhere in countries with high HIV prevalence. Injecting drug use continues to contribute to the spread of HIV in many high-income countries; in Portugal, for example, injecting drug users accounted for nearly half of all new HIV infections in 2002.

### **SECTION III: UNAIDS SUPPORT FOR ACTION IN COUNTRIES**

In accordance with direction provided by the PCB in 2002, UNAIDS has undertaken concerted action to enhance its effectiveness at country level. Movement to strengthen country support was initiated in the prior biennium and has accelerated under the 2004-2005 Unified Budget and Workplan, which elevates the profile of UNAIDS personnel at country level, creates UNAIDS Country Coordinator positions in 10 additional countries, and adds 47 professional staff at country level focusing on monitoring and evaluation, social mobilization and resource mobilization and tracking. UNAIDS assistance to countries has also been strengthened and sharpened by a series of global initiatives in the prior biennium, such as momentum created by the comprehensive framework provided by the United Nations General Assembly Special Session on HIV/AIDS *Declaration of Commitment*, the “3 by 5” initiative to expand treatment access, and the strategic approach for coordinated national action set forth in the “Three Ones” principles for concerted AIDS action at country level.

*United Nations Declaration of Commitment on HIV/AIDS*. Unanimously approved by 189 Member States attending the first-ever United Nations General Assembly Special Session on HIV/AIDS in 2001, the *Declaration of Commitment* provides the framework for a comprehensive response to the epidemic. In 2002-2003, the UNAIDS Secretariat and Cosponsors used the *Declaration of Commitment* as a tool to gauge national responses, identify shortcomings, cultivate partners, and better target advocacy, technical support, and strategic information. As noted below, many other partners have also embraced the *Declaration* as a key mechanism for advocacy and accountability.

“3 by 5”. In December 2003, UNAIDS and WHO unveiled a strategy to ensure the equitable delivery of antiretroviral treatment to 3 million people in low- and middle-income countries by 2005. Led by WHO, the “3 by 5” strategy envisions the active participation of each UNAIDS Cosponsor and the Secretariat in a global effort to bring antiretroviral treatment to countries with limited resources. As described more fully below in the discussion of different facets of UNAIDS support to countries, “3 by 5” includes a broad array of activities by the Programme, including extensive technical support to countries, rapid development of sufficient and sustainable national capacity, active involvement of people living with HIV and other stakeholders in treatment scale-up, and mobilization of unprecedented financial resources for care and treatment.

The “3 by 5” strategy represents the latest chapter in the Programme’s longstanding efforts to enhance treatment access, including sponsorship of early antiretroviral treatment pilot projects in developing countries and the negotiation with major pharmaceutical companies of large price reductions through the UNAIDS *Accelerating Access Initiative*. These efforts resulted in 150 000 people in sub-



Saharan Africa receiving antiretroviral treatment by early 2004. Under the UN system's imprimatur, "3 by 5" significantly strengthens global advocacy efforts on treatment access and provides a critical platform for strategic planning, capacity development, and trouble-shooting.

The Joint Programme's advocacy and technical support under "3 by 5" aim to produce a comprehensive, integrated response to the epidemic. Both the World Health Assembly and the UNAIDS PCB have determined that HIV prevention and care are mutually reinforcing and should no longer be viewed as separate, competing strategies. In keeping with the Joint Programme's recognition of the epidemic's gender dimensions, the importance of human rights, and the linkages between HIV/AIDS and development, activities by the UNAIDS Secretariat and Cosponsors on "3 by 5" and other initiatives—including the Global Coalition on Women and AIDS and the interagency Education and HIV/AIDS strategic framework—seek to ensure fair, equitable global access to HIV/AIDS treatments.

The "*Three Ones*". At the International Conference on AIDS and Sexually Transmitted Infections in Africa, held in Nairobi (Kenya) in September 2003, national officials, donors, international organizations, NGOs and the private sector gathered to assess key principles for national-level coordination of HIV/AIDS responses. Prior to the meeting, a consultative process initiated by UNAIDS, the World Bank, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, identified a set of guiding principles for optimal coordination at country level. Following a discussion at the September 2003 meeting of opportunities and challenges facing national HIV/AIDS programmes, strong consensus was achieved on three principles for coordinated action by all stakeholders at country level. A donor consultation in Washington D.C. in April 2004, spearheaded by UNAIDS and co-sponsored by the USA and United Kingdom governments, produced consensus among all major donors recognizing the "Three Ones" as governing principles for HIV/AIDS assistance to developing countries. They are:

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One National AIDS Coordinating Authority, with a broad based multi-sectoral mandate.
- One agreed country level Monitoring and Evaluation System.

The "Three Ones" which UNAIDS has incorporated as an organizing approach for its assistance to countries, seeks to maximize the effectiveness of human and financial resources for HIV/AIDS, accelerate scaling up of effective action, and ensure that all efforts are directed toward achievement of nationally determined objectives and strategies.

#### **A. Leadership and advocacy for effective action**

UNAIDS advocacy, recognized by the external evaluation as one of the Programme's primary strengths, was enhanced in 2002-2003 in accordance with PCB mandates. In particular, UNAIDS has increased its own advocacy capacity and directed substantial efforts toward improving the coherence and effectiveness of UN advocacy at country level.

*i) Nationally*

*Supporting strategic national leadership.* Virtually all heavily-affected countries and many of those with emerging epidemics now have multi-ministry national AIDS councils or commissions that oversee the implementation of national HIV/AIDS strategies. In at least 36 countries, Heads of State/Government or their deputies lead the national HIV/AIDS council, a sign that high-level political leaders are spearheading national efforts to address the epidemic. Supporting national AIDS authorities' capacity to coordinate, monitor, evaluate and ensure coherency with overarching national development frameworks, remains a critical aspect of UNAIDS work at country level. In the 14 African and Caribbean countries supported by the US President's Emergency Plan for AIDS Relief, UNAIDS supported efforts to ensure this large increase in funding and programming is harmonized with existing AIDS efforts. In 2002-2003, the Programme provided extensive support to governmental and non-governmental partners at country level to take the action required to ensure achievement of the time-bound commitments set forth in the UN *Declaration of Commitment*. UNAIDS helped governments establish national AIDS commissions in several countries that previously lacked a multisectoral AIDS authority. Advocacy by UNFPA contributed to the formation of parliamentary caucuses in Benin and Uganda focusing on HIV prevention for young people.

In 2002-2003, there were signs of a quickening in the political response to the epidemic in Asia, as three of the world's four most populous countries substantially bolstered national HIV/AIDS responses. In each case, national authorities benefited from extensive advocacy and technical support by UNAIDS. In China, visits by the Secretary-General and the UNAIDS Executive Director reinforced consistent advocacy by the UN Theme Group on HIV/AIDS. National leaders increasingly acknowledged the threat posed by HIV/AIDS and expanded the level of national resources devoted to HIV/AIDS programmes. In December 2003, the Chinese Ministry of Health and the UN Theme Group jointly issued an assessment of HIV/AIDS prevention, treatment and care that identified specific follow-up steps to strengthen the national response. On World AIDS Day, Chinese Premier Wen Jiabao made an unprecedented hospital visit during which he met AIDS patients, and promised the government would protect their rights, provide free schooling for their children, and offer free treatment for poor patients. And most importantly, the government launched in 2003 a comprehensive prevention, treatment and care pilot project in 127 counties.

In India, national leaders are speaking openly about the epidemic and displaying greater political commitment. In 2003, the Health Minister generated national and international media coverage when she publicly embraced two AIDS orphans who had been barred from their school. The Chief Minister of Andhra Pradesh instructed all ministers to mention HIV/AIDS in their public speeches. In July 2003, an unprecedented parliamentary forum on HIV/AIDS—supported by UNAIDS and attended by the UNAIDS Executive Director—drew more than 1200 political leaders from *panchayat*, state and national levels and produced strong statements of political commitment from the country's most senior leaders. UNAIDS is now supporting follow-up activities from this historic meeting, including state-level meetings to strengthen sub-national commitment and coordination.

In Indonesia, where HIV/AIDS is rapidly emerging as a serious problem, UNAIDS provided both technical assistance and funding to support the development of the country's five-year National HIV/AIDS Strategy, which was launched in May 2003 during a visit by the UNAIDS Executive Director. The strategy reflects the government's stated commitment to tackle HIV and AIDS on all fronts. Shortly after the strategy's launch, UNAIDS developed a UN Joint Action Programme for the country, which has generated US\$ 5.6 million in AIDS funding for 2004-2005 and strengthened the UN system's partnerships with the government and civil society.

Many hard-hit countries in sub-Saharan Africa made concrete moves in 2002-2003 to increase the provision of antiretroviral treatment. Following years of intensive advocacy, led primarily by people living with HIV, the government of South Africa committed to nationwide expansion of antiretroviral treatment, offering new hope to the world's largest national population of HIV-infected people. In neighbouring Botswana, strong leadership by the nation's top elected officials had by early 2004 expanded treatment access to about 12000 people through a joint programme led by the Ministry of Health, the Bill and Melinda Gates Foundation, and the Merck Company Foundation. Another 6000 were accessing antiretrovirals through the private sector. UNAIDS also assisted the government in revising its HIV testing strategy to ensure it encouraged widespread testing while respecting individuals human rights. In Uganda, national leaders embarked on a major effort to match the country's unparalleled prevention successes with a rapid expansion of access to AIDS treatment and care. The UN Country Team in Lesotho is assisting national efforts to ensure that all 1 million adults in the country know their serostatus by December 2004. The Lesotho voluntary counselling and testing initiative is part of a broad effort by the country to radically expand the national response and to engage all sectors in the fight against the disease.

In other regions, signs of greater leadership on AIDS also became more apparent in 2002-2003. Colombia, for example, developed a new multi-sectoral HIV/AIDS plan, and national authorities publicly committed to prioritise the fight against the epidemic. In Brazil, UNAIDS supported government efforts to respond to the *Declaration of Commitment*. In the Russian Federation, UNDP and the UNAIDS Secretariat assisted national authorities in establishing the country's first multi-sectoral body to address the epidemic, the Advisory Council on HIV/AIDS. In Algeria and Sudan, Heads of State marked World AIDS Day 2003 with landmark statements on the importance of an inclusive, multi-sectoral response to AIDS that actively engages people living with HIV.

*Inclusive responses.* The UN's commitment to multi-sectoral leadership development was confirmed and strengthened by the November 2003 communication from the UN Development Group to UN Resident Coordinators and UN agency country representatives, which re-emphasized the importance at country level of broad-based, government-led partnership forums that include civil society, people living with HIV, the private sector, and other key stakeholders. The potential benefits of a multi-sectoral approach were evident in the Philippines, where the Foreign Affairs and Labour ministries collaborated to implement AIDS education courses for Filipinos working overseas.

UNDP implemented Leadership Development Programmes in Botswana, Cambodia, Dominican Republic, Ethiopia, Ghana, Haiti, India, Malaysia, Nepal, Senegal, South Africa, Swaziland, and Ukraine. These programmes generated strong partnerships at country level, supporting a broad range of actors, including government, civil society, the private sector and the UN system. Following a UNDP-sponsored programme in Ukraine, for example, participants from diverse ministries, civil society, and the private sector collaborated in developing the first-ever testing campaign for men who have sex with men, a multi-media campaign on AIDS, and the first home-based care project for people with late-stage AIDS. A similar UNDP-facilitated leadership programme in Ethiopia triggered numerous collaborative initiatives, including introduction of antiretroviral treatment through a pilot programme in the Oromiya region, as well as implementation of behaviour change interventions targeting police and employees of the Justice Ministry. In South Asia, UNODC supported a youth-oriented advocacy campaign on AIDS and drug use, commissioning well-known artists to create messages to raise AIDS awareness and mobilize young people. In Cambodia, UNESCO's strong working relationship with the education ministry resulted in greater engagement by the ministry in the national response to the epidemic.

## ***ii) Regionally***

*Asia.* UNAIDS supported the development of the Association of South East Asian Nations (ASEAN) Work Programme on HIV/AIDS for 2003-2005 and subsequently facilitated the ASEAN Cooperation Forum, which was attended by bilateral donors and international organizations. Key initiatives under the 2003-2005 ASEAN Work Programme include inter-country initiatives addressing HIV/AIDS among mobile populations and the creation of a supportive environment for sound AIDS policies and programming. In September 2003, the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) drew ministers and senior officials from 62 countries under the theme "Integrating economic and social concerns, especially HIV/AIDS, in meeting the needs of the region," resulting in adopting of an UNESCAP resolution committing to implementation of the *Declaration of Commitment* and recognizing the need to tackle AIDS as a central development challenge. Additional efforts in Asia led to the execution in April 2004 of a Memorandum of Understanding between UNAIDS and the South Asian Association for Regional Cooperation to increase HIV prevention and care services in the region. Due in part to sustained work by UNESCO, the response of education sectors in Asia significantly strengthened in 2002-2003, although additional progress is needed. In September 2003, a major address to South Asian Parliamentarians by the Global HIV/AIDS Coordinator for UNFPA focused on parliamentary strategies to create, build and sustain national and regional leadership on HIV/AIDS.

The UNAIDS Southeast Asia and Pacific Inter-Country Team is supporting efforts by the Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF) to strengthen political and civil society leadership on AIDS at national and regional levels. In 2003, APLF provided "shared learning courses" in three sub-regions for senior government officials and also assisted in the development of country-level plans in 13 countries. The first meeting of the APLF Steering Committee identified key issues in the region, and an evidence-based advocacy plan is currently in development. The focus in 2004 will be on fully exploiting APLF's potential to mobilize the media and high-level political and community leadership on AIDS at

regional and national levels in a few selected countries, including the Philippines, Sri Lanka, Cambodia and Fiji.

*Sub-Saharan Africa* UNAIDS is assisting the New Partnership for Africa's Development (NEPAD) as it mainstreams AIDS in all its sectors and strengthens the AIDS component of its health sector. The African Union, which emerged from the Organization of African Unity in 2003, is being supported by UNAIDS as it develops an HIV/AIDS framework and strategy to help address key regional policy issues and continues to monitor implementation of the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. The Commission on HIV/AIDS and Governance in Africa was established by the UN Secretary-General in 2002 to spur effective responses to the governance and development threats posed by the AIDS epidemic in Africa. UNAIDS is providing institutional support to the Commission's secretariat, the UNAIDS Executive Director is a Commissioner and UNAIDS staff members are active members of the working groups of the Commission. The World Bank is supporting the Great Lakes Initiative on HIV/AIDS with a sub-regional Multi-Country HIV/AIDS Programme (MAP) project of US\$ 15 million that primarily targets refugees, internally displaced persons, mobile populations, networks of people living with HIV, and the health sector. The UNAIDS Secretariat is providing guidance, technical support and facilitation at every step of the project development. UNFPA provided funding to the Network of African Women Ministerial and Parliamentary Bureau to support planning for their October 2004 meeting, which will focus on AIDS and gender.

In 2002-2003, substantial progress was made in mainstreaming AIDS into the policies, practices and strategies of major subregional institutions, such as the Economic Community of West African States (ECOWAS), the Economic Community of Central African States (ECCAS), and the West African Rice Development Association (WARDA). UNFPA and UNICEF jointly provided technical support for the first ECOWAS Youth Forum in Abuja in August 2003. UNICEF and its partners in the Interagency Task Team on Orphans and Vulnerable Children intensified advocacy on support programmes for AIDS orphans and technical assistance in the region.

The Organization of African First Ladies against HIV/AIDS was launched in Geneva in July 2002. UNAIDS has been an active partner in this development process by providing technical and financial support to the Organization's Secretariat and its national-level projects. Several First Ladies have since raised resources and designed national projects on the prevention of mother-to-child transmission of HIV and the support to orphans and other vulnerable groups. Leadership by UNAIDS and its UN partners to address HIV/AIDS and food security in Southern Africa is summarized in Section VI.

In September 2003, delegates gathered in Nairobi, Kenya, at the 13<sup>th</sup> International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA). UNAIDS released a major report at ICASA that hailed advances against HIV/AIDS in sub-Saharan Africa but noted that the regional response was only half-funded. The UN Secretary-General's Special Envoy on HIV/AIDS in Africa challenged donor nations to substantially increase their financial assistance for scaling up access to treatment and to energetically support the use of generic antiretroviral drugs. The UNAIDS Executive Director addressed the closing of the conference, urging

continued progress in the fight against the epidemic in Africa and attention to issues of equity in the introduction of antiretroviral treatment.

*The Caribbean.* In 2002-2003, regional leadership on HIV/AIDS strengthened and matured in the Caribbean. The Pan Caribbean Partnership Against HIV/AIDS—supported by the UNAIDS Secretariat and Cosponsors, bilateral donors, and regional organisations—consolidated its structure and accelerated its activities in 2002-2003. Under the umbrella of the Partnership, substantial new resources were mobilized through the World Bank and Global Fund to support priority activities of the Caribbean Regional Strategic Framework on HIV/AIDS (2002-2006). A regional Leadership Development Programme undertaken in the Caribbean by UNDP bolstered regional commitment and partnership development. Regional leadership on HIV/AIDS has especially benefited from the strong and continuing commitment of the Caribbean Community (CARICOM), which has made the fight against AIDS a top priority. UNAIDS and WHO/PAHO worked with CARICOM on regional negotiations that led to an agreement with pharmaceutical companies to significantly lower the prices of antiretroviral drugs. Lower prices and the increased inflow of resources to the region for treatment are expected to increase access to antiretrovirals in the near future.

*Latin America.* In the Southern Cone, UNAIDS' advocacy efforts contributed to the recent political engagement of top leaders, such as the participation in the promotion of World AIDS Day 2003 by the President of Argentina and the involvement of parliamentarians in Uruguay and Paraguay. Programme Acceleration Funds were used in Argentina to assist government's political commitment to expand HIV prevention in prisons. In early 2004, Panama City, Panama, was the site of the first in a series of planned regional HIV prevention advocacy workshops for young people hosted by UNFPA.

*Eastern Europe and Central Asia.* UNAIDS, WHO and other partners assisted the Commonwealth of Independent States' (CIS) Coordinating Council in the development and implementation of national plans to ensure treatment access. UNAIDS has also actively supported legal reform in the CIS regions, helping draft and promote a model law on HIV/AIDS. In Russia, UNODC facilitated amendment of the criminal code to permit harm reduction projects to operate on a legal basis. A South Eastern European Conference on HIV/AIDS in Bucharest—organized by the Government of Romania, UNICEF, UNDP and UNAIDS—boosted both national commitment and donor interest. In February 2004, high-level government representatives from 53 countries attended the European Union's "Breaking the Barriers" Conference in Dublin, and pledged to achieve concrete AIDS targets within Europe and Central Asia.

*Middle East and North Africa.* UNAIDS and UNDP's HIV/AIDS Regional Programme in the Arab States provided financial and technical assistance to the Regional Arab Network Against AIDS as it expanded its activities to country-level work. The Network strengthens NGO and civil society involvement in the regional AIDS response through the sharing of information, exchange of experiences and the establishment of national NGO networks on AIDS. UNFPA undertook advocacy needs assessments in Egypt and Lebanon, while the UNFPA/OPEC Fund for

International Development supported HIV/AIDS awareness programmes in 13 countries in the Arab region, Central America and the Caribbean.

*iii) Globally*

UNAIDS employed a broad array of strategies to advocate for greater global attention to the epidemic. The personal commitment of the United Nations Secretary-General remained the cornerstone of the UN's advocacy on AIDS. As well as incorporating HIV-related activities into his numerous country missions, the Secretary-General gave prominence to AIDS in a range of international forums, including summits of the African Union, the first meeting of the G-8 Contact Group on Food Security in Africa which he chaired in 2002, and the World Summit on Sustainable Development also that year. The Secretary-General continued to encourage greater involvement in the response to AIDS from the private sector, building on his advocacy with the pharmaceutical industry at the start of the biennium. In January 2004, the Secretary-General convened a meeting of the heads of over 20 leading international broadcasters to launch the Global Media Initiative, to bring the full force of their communications expertise to raise awareness about AIDS. UNDP's *Human Development Report 2003* emphasized the impact of AIDS on the international development agenda, and the Millennium Development Goals swiftly became a strong advocacy tool that placed the fight against AIDS squarely at the centre of the global development agenda. A major report by UNICEF in 2003 highlighted the epidemic's growing toll on orphans and other vulnerable populations and urged adoption of proven policy responses. UNFPA has embarked on a multi-faceted advocacy campaign to raise global awareness of the linkages between AIDS and reproductive health and to generate worldwide support for related policies and programmes. Strong and continuing support from UNFPA helped give birth in September 2003 to Global Youth Partners, a global advocacy initiative by and for young people to promote HIV prevention. For the upcoming 2004 UNAIDS *Report on the Global HIV/AIDS Epidemic*, UNAIDS used data from key indicators to develop a "Global Report Card" on progress or lack of progress in key thematic areas of the global AIDS response.

*UNAIDS Advocacy Capacity.* A grant from the Bill & Melinda Gates Foundation enabled the UNAIDS Secretariat to significantly strengthen its advocacy capacity. An advocacy team was established within the Secretariat in 2003, partially supported by the grant, and has been active in bringing partners into the response and solidifying their commitment. Examples include work with the Stop TB Partnership to highlight the links between AIDS and tuberculosis, as well as new and expanded partnerships with sports entities. The grant has enabled UNAIDS to strengthen its advocacy work at country level with position papers on key issues, guides to advocacy at country level, and materials documenting advocacy successes by the Secretariat and the Joint Programme.

*Improving Access to Treatment.* The "3 by 5" campaign has become a major avenue for UNAIDS advocacy. Release of the "3 by 5" strategy by WHO to coincide with World AIDS Day 2003 helped ensure that the heightened media coverage associated with the annual commemoration emphasized the importance of treatment access.

*World AIDS Campaign.* In 2003, the World AIDS Campaign and World AIDS Day triggered a number of high profile innovative events—including concerts, celebrity

initiatives, media debates and sports events—and secured unprecedented take-up and use of UNAIDS campaign materials. More than 300 000 posters were distributed; a campaign public service announcement was broadcast on major global networks (including TV5, BBC World and MTV) and on many national networks.

During the biennium, UNAIDS decided to revamp the World AIDS Campaign to enhance its visibility, adaptability and ownership by civil society. Whereas the Campaign has historically been administered by the UNAIDS Secretariat under a single theme, it was determined that governance of the campaign would transition in the 2004-2005 biennium to civil society, with the UNAIDS Secretariat providing ongoing support. A key aim of the transition is to enhance national advocacy and resource mobilization in donor countries. In preparation for the transition, the Campaign in 2002-2003 focused on eliminating stigma and discrimination, while the 2004 campaign emphasizes the burden of HIV/AIDS upon women and girls.

*International meetings.* In September 2003, a follow-up meeting of the UN General Assembly from the 2001 Special Session on HIV/AIDS attracted 18 Heads of State/Government, as well as hundreds of civil society representatives from around the world. The Secretary-General submitted a report to the General Assembly on progress in implementation of the Declaration of Commitment. It stated that many UN Member States will not meet basic AIDS prevention and care goals established at the 2001 meeting unless efforts are dramatically scaled up. The 2003 meeting also generated high-level media attention to HIV/AIDS and to the approaching time-bound targets in the Declaration of Commitment.

The XIV International AIDS Conference in Barcelona in 2002 generated extraordinary global media attention, much of it featuring UNAIDS and individual Cosponsors. As with previous international conferences, release of the UNAIDS *Global Report on the HIV/AIDS Epidemic* immediately prior to the meeting attracted substantial media coverage. The report applauded the building of a “new global resolve” on AIDS, while criticizing the “unacceptable number” of governments and civil society institutions that were still ignoring the epidemic. It also urged Member States use the UN *Declaration of Commitment* as a roadmap for bringing the epidemic under control.

## **B. Policy and strategic information required to guide the efforts of partners**

Effective action at country level depends on timely access to information that is accurate, relevant and strategic. As a unique repository of critical information on HIV/AIDS, the Joint Programme helps countries implement science-based strategies, overcome impediments to scale-up, and forge environments that support an effective response. Drawing upon the thematic strengths of UNAIDS’ nine Cosponsoring agencies, policy guidance has been provided to countries in key areas of the response, including HIV testing, antiretroviral treatment and the care of orphans.

Surveys in 2003 and 2004 by the International AIDS Economics Network (IAEN) of members and other respondents identified UNAIDS as the world’s most trusted source of information on AIDS. The survey, which was evenly divided between respondents from developing and developed countries, also identified the World Bank and WHO as leading providers of information on HIV/AIDS.



*i) Nationally*

In 2002-2003, the Joint Programme significantly intensified its generation and use of strategic information to help countries bring effective responses to scale. In Malawi, UNAIDS assisted in the development of a groundbreaking National HIV/AIDS Policy, which charts a new course for the country that includes significantly expanded promotion of HIV testing, promotion of beneficial disclosure (encouraging people to determine their HIV status by offering services/benefits to those living with the virus), and provision of condoms to prisoners. Similar guidance on HIV testing was provided by UNAIDS to Botswana. A study in Côte d'Ivoire co-sponsored by UNFPA found that integration of voluntary counselling and testing in reproductive health settings helped reduce stigma, increased awareness of healthy sexual behaviour, and enhanced utilization of key services. The UN Country Team in Lesotho assisted national efforts to develop and publish a national manual on bringing HIV/AIDS initiatives to scale. In China, a Joint Assessment of HIV/AIDS Prevention, Treatment and Care was carried out by the Ministry of Health and the UN Theme Group. The resulting report, launched on 1 December 2003, is a comprehensive review of past efforts and lessons learned, and it puts forward recommendations for future actions. The document is a significant step towards achieving a common understanding of the current AIDS situation, the country's prevention and care needs, and the strengthening of a multi-sectoral response. In India, Lebanon, Malawi, and Trinidad and Tobago, UNDP collaborated with UN Habitat and the Urban Management Programme to establish the "City Responses to HIV/AIDS" project that facilitates the development and implementation of multi-sectoral responses at the local level. In 2003, costing of national strategic plans was completed in numerous countries, including Algeria, Morocco, Nepal, Tunisia and Sudan.

As HIV/AIDS emerged in recent years as a serious problem for the Asian and Oceania regions, UNAIDS identified numerous programmes for documentation as UNAIDS Best Practice publications, including an innovative health promotion model for men who have sex with men in Bangladesh, a prison initiative in India, and a 100% condom-use programme in China. The UNAIDS Inter-Country Team for Eastern and Southern Africa produced several UNAIDS Best Practice documents during the biennium: on the pursuit of antiretroviral therapy in Botswana, South Africa and Uganda; on the UNAIDS-brokered partnership between the Global Network of People Living with HIV/AIDS and the International Federation of Red Cross and Red Crescent Societies; on nursing and midwifery champions in HIV/AIDS in South Africa; and on HIV/AIDS prevention and care among armed forces and peacekeepers in Eritrea. In China, 30 UNAIDS publications have been translated and distributed widely, both in hard copy and electronically. Country-by-country analyses of HIV/AIDS epidemiology, national responses and key challenges were made available on the UNAIDS and WHO web sites.

Strategic information is helping drive national implementation of treatment access initiatives, particularly "3 by 5". In 2003, WHO issued revised guidelines for national programmes and for clinicians on introduction of antiretroviral treatment in resource-limited settings. The guidelines addressed such issues as when to initiate antiretroviral treatment, how best to monitor patients, selection of front-line drugs, and deciding when to alter therapeutic regimens. Information collected by UNAIDS and WHO, available on the Internet, is assisting countries in selecting and purchasing the most

affordable and effective antiretroviral treatment drugs for national treatment programmes. Technical assistance by WHO and UNAIDS Country Coordinators are helping countries plan key elements of treatment scale-up, including expansion of voluntary counselling and testing and training of health care workers. WHO, UNFPA, UNICEF, World Bank and other partners worked to prepare new guidelines on treatment, care and support for HIV-infected women and their children. WFP hosted a meeting in March 2004 involving technical experts from WHO, WFP and the UNAIDS Secretariat to strategize on mechanisms for sharing relevant health and food security information to facilitate antiretroviral treatment introduction.

## ***ii) Regionally***

UNAIDS comprehensively mapped AIDS programmes and financial resources in the 15 member countries of ECOWAS and in Mauritania, Chad and Cameroon, helping identify service gaps and facilitate more strategic assistance by donors. To facilitate stronger, data-driven planning on HIV/AIDS in Africa, the UNAIDS Secretariat, UNDP, and the World Bank have joined with Shell, the African Development Bank, and the Economic Commission for Africa to undertake a visionary project to build future scenarios for the region. A handbook, developed by UNDP's Regional Programme for HIV and Development in Sub-Saharan Africa, advises countries on effective strategies for integrating AIDS into national, sub-regional and regional development agendas. Efforts to preserve and enhance capacity in the face of HIV/AIDS in sub-Saharan Africa benefited from research conducted by ILO that assessed the epidemic's impact on human capital and labour markets. In 2002-2003, ILO provided technical assistance to the African Union aimed at incorporating recommended workplace approaches in national AIDS plans and socio-economic development programmes.

In the Middle East and North Africa, the Cairo-based UNAIDS Inter-Country Team began in late 2003 to consolidate available data and case studies in the region, with the goal of identifying best practices and analysing vulnerabilities in the region. In Egypt, UNODC launched a survey of injecting drug users in Egypt, and UNAIDS mapped the national response in the country. UNICEF and WHO supported a comprehensive evaluation of the surveillance system in Algeria.

In Eastern Europe and Central Asia, the World Bank conducted surveys on the epidemic in the region and on national responses. A major World Bank report, *Averting AIDS Crises in Eastern Europe and Central Asia: A Regional Support Strategy*, was launched in 2003, providing the basis for significantly enhanced AIDS assistance by the Bank to countries in the region, including Moldova, the Russian Federation and Ukraine. UNDP's report on HIV/AIDS in Eastern Europe and the Commonwealth of Independent States, *Reversing the Epidemic, Facts and Policy Options*, describes high-risk groups and the behaviours that make them vulnerable to infection, and discusses why human rights is an essential ingredient for fighting the epidemic. The report also touches upon the issues of decriminalising injecting drug use and undertaking comprehensive prison reform.

In Latin American and the Caribbean, UNAIDS provided financial support, and devoted staff time, to efforts by SIDALAC, a regional scientific institution focusing on AIDS, to map the flow of financial resources and expenditures in the fight against

the epidemic in the region. Since 1997, 87 mapping exercises have been completed in 20 countries. Also in the region, UNFPA developed a guide on HIV prevention and assisted national programmes in bringing prevention efforts to scale. The UNAIDS Caribbean team collaborated with UN Volunteers in supporting the “Life Histories Project,” which created a documentary film profiling people living with HIV in the region.

When journal publications suggested that official AIDS estimates exaggerated the role of sexual transmission in sub-Saharan Africa and ignored the role of unsafe injections, UNAIDS and WHO rapidly convened leading technical experts who, after reviewing available data, concluded that sexual transmission was responsible for the overwhelming majority of new HIV infections in the region. WHO experts also developed global and regional estimates of the percentage of new infections caused by unsafe injections.

The World Bank collaborated with UNAIDS in publication of a manual on monitoring and evaluation, as well as comprehensive guidelines for the Bank’s Multi-Country AIDS Programme. The World Bank, frequently in collaboration with such partners as the UNAIDS Secretariat and the Futures Group, took the lead in assessing and modelling programmatic costs and the economic impact associated with the epidemic in different regions.

### *iii) Globally*

In 2003, UNAIDS revamped its web site, making it more attractive, user-friendly and more inclusive of Cosponsors and their HIV/AIDS-related activities and information. The number of visits to the site has increased by 150% over the biennium. In 2002-2003, the UNAIDS Secretariat produced or co-produced 96 printed or CD-ROM publications, including six advocacy documents, 20 Best Practice publications, 34 corporate publications (including a new brochure that explains the structure, activities and strategies of the Joint Programme), three partnership menus for country-based fund raising (see Section III-D) and 20 miscellaneous publications. Web downloads of UNAIDS publications grew tremendously. For example, the UNAIDS 2002 Epidemic Update was downloaded 275 000 times, compared to a total print run of about 27 000 copies.

Important new information resources generated by the Joint Programme include guidelines for peer education and young people (jointly produced by UNFPA and the UNAIDS Secretariat), a policy brief on mobilization of debt relief for HIV/AIDS, articulation by UNICEF of best practices for AIDS orphans and other vulnerable children, the launch by UNIFEM and UNAIDS of an on-line web portal on gender and AIDS, publication by WHO of a revised manual for clinicians on management of HIV/TB co-infection, and new UNFPA programme tools on adolescent HIV prevention and condom programming. Led by UNODC and WHO, the Joint Programme clarified its policy approach to HIV/AIDS among injecting drug users, emphasizing the UN system’s support for the full array of harm reduction interventions, including substitution therapy in drug dependence treatment. UNESCO is sponsoring research that aims to identify optimal strategies to transfer learning and technologies on preventive education. As part of its global campaign promoting the linkages between AIDS and reproductive health, UNFPA is co-hosting with WHO a consultative process that is generating analytic papers on the programmatic relation between family planning and prevention of mother-to-child transmission.

A significant amount of information generated by UNAIDS is aimed at accelerating efforts to bring antiretroviral treatment to scale. WHO added antiretroviral treatment drugs to its list of essential medications and certified the acceptability of certain generic equivalents to standard antiretroviral treatment medications. As noted earlier, WHO, UNICEF and UNAIDS also issued technical guidance on the introduction of antiretroviral treatment in resource-limited settings. National assessments by WHO technical staff have identified training needs and other issues that must be addressed to facilitate rapid treatment scale-up. WHO has also published case studies of early efforts in diverse countries to introduce antiretroviral treatment and has initiated in concert with various partners a global network to monitor HIV drug resistance.

Dissemination of information vital to treatment access has been facilitated by establishment of a financing network at the School of Public Health in Rio de Janeiro, initiation of a price observatory in West Africa, and creation of pre-qualification procedures for antiretroviral drugs. To assist in the roll out of the US President's Emergency Plan for AIDS Relief, UNAIDS has piloted enhanced communications systems to better connect and coordinate the UNAIDS Secretariat, the UNAIDS Washington office, and UNAIDS Country Coordinators in the United States' 14 priority countries. This new approach has enabled UNAIDS country staff to remain abreast of key developments in the execution of the Plan, and to be prepared to provide strategic information to the US ambassadors and UN Theme Groups in the 14 countries.

*Condoms.* More than 20 years into the epidemic, condoms remain a source of controversy in many countries, in part due to claims by some that condoms may not be as effective as other approaches in reducing the risk of sexual transmission. In 2003, UNFPA and UNAIDS developed a new guide, to be published in 2004, that analyses the evidence of the condom's effectiveness as an HIV prevention tool and the role of condom promotion in HIV prevention successes in different parts of the world. It re-emphasized UNAIDS' strong science-based stance that condoms are an effective way to dramatically reduce the risk of sexual HIV transmission.

### **C. Monitoring and evaluation of the epidemic and the response**

Consistent with PCB decisions and recommendations following the external evaluation of UNAIDS, the Joint Programme took major steps in 2002-2003 to strengthen its capacity to monitor the epidemic, assess national responses, and track programmatic resources. UNAIDS increased the number of monitoring and evaluation staff at global, regional and country levels. UNAIDS also spearheaded efforts to harmonize diverse monitoring and evaluation systems through the development of standard indicators and directed substantial resources toward efforts to increase monitoring and evaluation capacity at country level. In all these endeavours, the UN *Declaration of Commitment* proved to be an invaluable framework for monitoring the epidemic and promoting greater accountability.

#### ***i) Monitoring and evaluation of the epidemic***

In the 2002-2003 biennium, UNAIDS issued three major publications on key trends in the epidemic: the *Report on the global HIV/AIDS epidemic 2002*, a biennial reporting of HIV estimates by country and a summary of evidence on key features of the global epidemic, as well as *AIDS Epidemic Updates* in December 2002 and December 2003.

In 2003, preparation began on development of the *Report on the global HIV/AIDS epidemic 2004*, which will be released at the XV International AIDS Conference in Bangkok 11–16 July 2004, and will include updated national prevalence estimates. Epidemiological reports by UNAIDS in 2002-2003 generated high-level media coverage worldwide and enabled the Programme to focus global attention on key aspects of the epidemic, including the growing burden of HIV/AIDS among women and girls and the rapid expansion of HIV in Eastern Europe and Asia.

*Enhancing Surveillance Capacity at Country Level.* In 2003, the UNAIDS Secretariat worked with WHO, the Futures Group, the US Centers for Disease Control and Prevention, Family Health International, and the East-West Center to improve capacity in 130 countries to capture, validate, interpret and model HIV-related data. These efforts included 12 regional, and one national, training workshops on methods for HIV/AIDS estimation and projections. Additional data sources, such as national household surveys, also improved the evidence base for epidemiological estimates. As epidemiological capacity improved, however, comparison of recent estimates with those from earlier years, when capacity was weaker, became more difficult. In December 2003, using improved data collection and interpretation methods, UNAIDS and WHO released estimates for the number of people living with HIV providing ranges to indicate their level of precision. Substantial media outreach by UNAIDS explained the findings and improved methodology to key reporters. In general, leading media outlets explained the findings accurately and disseminated key UNAIDS messages about the epidemic's growth. In some cases, however, the publication of new household surveys, such as the Kenya Demographic and Health Survey, led to claims in the media that UNAIDS and WHO were overestimating HIV prevalence in sub-Saharan Africa. UNAIDS and WHO noted that the Kenyan survey result fell within the range of their own estimates, and stressed that the UN uses both household and antenatal surveys in its estimates.

*Monitoring programmes and measuring impact.* As part of its strategy to enhance national monitoring and evaluation capacity, UNAIDS in 2003 assessed national efforts in Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Nigeria and Senegal. In Haiti, UNAIDS initiated a process that led to creation of a national database on AIDS programmes and funding. UNAIDS provided an array of services to partners in Guatemala, who collaborated on creation of a general monitoring and evaluation system and tools that will be used to develop a national AIDS strategy. Advocacy by UNAIDS helped persuade Viet Nam to add a detailed monitoring and evaluation component to its national AIDS strategy.

ILO has measured the impact of AIDS on the world of work and will present findings at the XV International AIDS Conference in Bangkok. ILO is developing indicators and initiating a database to monitor the impact of workplace initiatives and is working with social security experts to assess the epidemic's impact on insurance schemes. In response to the AIDS-related erosion of human capacity among civil servants in Malawi, UNDP assisted the government in assessing the epidemic's impact on the police and in five national ministries. As the convening agency on Governance and Development Planning, UNDP collaborated with the UNAIDS Secretariat, Cosponsors and bilateral donors to develop a joint two-year plan to monitor and evaluate initiatives to strengthen governance and the integration of AIDS into

development instruments. A *Guide to Supporting National HIV and AIDS Responses* was also finalized.

WFP uses its vulnerability analysis and mapping capacity to improve understanding of the epidemic's impact. To strengthen capacity to target and monitor food security and nutritional interventions in HIV/AIDS programming, WFP collaborated with WHO, the UNAIDS Secretariat, host governments and key NGO partners in selected African countries to create a technical development group charged with harmonizing monitoring and evaluation initiatives on HIV/AIDS and food security.

UNICEF made a major contribution to improved monitoring and evaluation through its Multiple Indicator Cluster Survey, one of the largest population-based surveys of social indicators for children in 70 countries. In 2003, WHO and UNAIDS partners, in collaboration with health and education agencies in 10 African countries, launched the Global School-Based Student Health Survey to obtain behavioural data on students between ages 13–15.

*Harmonizing and strengthening monitoring and evaluation capacity at country level.* Using the provisions of the *Declaration of Commitment* as an organizing framework, the UNAIDS Monitoring and Evaluation Reference Group oversaw the selection of core monitoring and evaluation indicators. To coordinate and support national monitoring and evaluation efforts, UNAIDS established the Global HIV/AIDS Monitoring and Evaluation Support Team (GAMET) at the World Bank. GAMET facilitates coordination among existing sources of monitoring and evaluation expertise, including the monitoring and evaluation units in the UNAIDS Secretariat and Cosponsoring agencies, including the Country Response Information System. UNAIDS also focused substantial efforts toward helping national programmes build monitoring and evaluation capacity. In 2003, UNAIDS conducted sub-regional trainings on monitoring and evaluation in Algeria, Djibouti, Morocco and Tunisia. In Asia, where national responses to the epidemic are increasing, seven of 16 countries with significant UNAIDS presence had established monitoring and evaluation units within the national AIDS coordinating body.

## *ii) The response and future challenges*

*Declaration of Commitment on HIV/AIDS.* With the first concrete targets in the *Declaration of Commitment* approaching, UNAIDS reoriented and strengthened its monitoring and evaluation programme to track global progress in meeting these goals. Relying on a broad array of data sources—including country reports, information supplied by UNAIDS country staff, and surveys by UNICEF and WHO—UNAIDS published a major report in September 2003 comparing the global response to the provisions in the *Declaration of Commitment*. The report was submitted to the United Nations General Assembly as a complement to a report by the Secretary-General on progress toward implementing the *Declaration of Commitment*. The UNAIDS report, which received extensive media attention and included national data from 103 countries, concluded that both political commitment and financial resources for HIV/AIDS had increased since the Special Session of the General Assembly in 2001 but remained inadequate. The report also noted the insufficiency of national measures to prevent discrimination, address the epidemic's gender dimensions, and mitigate the epidemic's economic and social impact. The report further determined that national

responses suffered from low levels of HIV-related knowledge among young people, poor coverage for key prevention and treatment interventions, and insufficient commitment to address the growing problem of AIDS orphans. Three out of four countries that submitted data for the report indicated that monitoring and evaluation of national activities remained a major challenge.

*Country Response Information System.* The UNAIDS Secretariat's Country Response Information System, the first multi-country mechanism to track national responses using standard indicators, represents a major step forward in the ability of the Programme—and the world—to understand how diverse countries are responding to the epidemic. UNAIDS convened 18 training workshops relating to monitoring and evaluation and Country Response Information System since October 2002, resulting in the introduction of the System in all regions and the training of more than 350 people in the collection and management of monitoring and evaluation data. These capacity development efforts have included representatives from cosponsors and bilateral partners. UNAIDS also provided funding to China, Ethiopia, Eritrea, Haiti, Papua New Guinea, Rwanda and Viet Nam to accelerate operationalization of the Country Response Information System and link it with national monitoring and evaluation plans. More than 20 countries have now reported using the System for data storage and the first reports from countries are expected for the 2005 Annual Report of the UN Secretary-General to the UN General Assembly on Progress towards Implementing the UN Declaration of Commitment. UNAIDS convened a working group of UN agencies and other partners to develop a mechanism to transfer indicator and project data between systems and tools of UN and other agencies. This initiative will accelerate the integration of UN system efforts to improve management of strategic information for national responses as well as to facilitate enhanced reporting on indicator and project data. Using a similar participatory approach, UNAIDS also developed two new sets of monitoring and evaluation guidelines, one primarily tailored to project managers working with the Global Fund, and another focused on care and support activities.

*Monitoring coverage of key interventions.* UNAIDS improved its capacity to monitor coverage levels for key HIV/AIDS interventions, enhancing the ability of national programmes, donors and technical agencies to develop targeted initiatives for programmatic scale-up. In 2003, WHO published global and regional coverage data from 2001 on key HIV/AIDS interventions, including voluntary counselling and testing, programmes to prevent mother-to-child transmission, antiretroviral treatment and TB prophylaxis. The study found that an estimated 12% of people worldwide were able to obtain voluntary counselling and testing in 2001 and that only 5% of pregnant women have access to interventions that prevent the transmission HIV to their children. In all coverage estimates, sub-Saharan Africa, the region most affected by HIV/AIDS, had substantially lower coverage levels than other regions for key HIV/AIDS prevention and treatment interventions. In December 2003, UNAIDS and WHO estimated that 6 million people worldwide were in need of antiretroviral treatment but that only 400 000 people in developing countries were receiving the medications, reflecting global coverage of 7%. An analysis by UNAIDS, WHO and the Futures Group, published in 2002, concluded that 63% of infections projected to occur worldwide during this decade could be prevented through optimal coverage of available prevention interventions. UNFPA also quantified the global condom supply, noting supply gaps in a major new report.

## **D. Civil society engagement and partnership development**

Both the *Declaration of Commitment* and decisions taken by the PCB following the external evaluation underscore the importance of UN leadership in involving civil society, people living with HIV, and vulnerable groups as key partners in the response to HIV/AIDS. In the 2002-2003 biennium, UNAIDS placed greater priority than ever on forging meaningful partnerships with a broad array of actors at national, regional and global levels. Especially encouraging is the degree to which diverse civil society partners have embraced the Declaration of Commitment as a primary tool for advocacy and accountability.

### *i) Nationally*

Through partnerships with community organizations, UNAIDS helps generate stronger community responses to the epidemic. The World Bank helps strengthen community capacity by channelling much of its HIV-related financial assistance directly to community organizations and the private sector. In Ethiopia, a block grant earmarked for village-level projects had distributed US\$ 11.5 million to 6343 Kebeles (or villages) by the end of 2003. In countries in Africa and Asia, UNDP has implemented Community Capacity Enhancement Initiatives that use a process of community dialogue and self-reflection to strengthen community capacity to participate in national processes and responses. In Egypt, UNAIDS, UNDP, and UNICEF partnered with Caritas Internationalis to create a national NGO network on HIV/AIDS.

*National people living with HIV networks.* UNAIDS continued to provide institutional and technical support to RENSIDA, the national network of organisations of people living with HIV/AIDS, in Mozambique, helping it achieve legal status in 2003 and providing assistance in RENSIDA's strategic planning process. In Angola, the UNAIDS Greater Involvement of People living with HIV/AIDS (GIPA) initiative supports Luta pela VIHda, an NGO that assists 700 people living with HIV. UNAIDS, UNICEF and UNDP helped develop support groups for people living with HIV and build the capacity of people living with HIV organisations in Algeria, Djibouti, Egypt and Sudan. UNAIDS used small grants from its Programme Acceleration Fund to assist in the establishment of national networks of people living with HIV in Algeria, Gambia and Morocco. This Fund also helped develop information systems for people living with HIV networks in the Dominican Republic, Jamaica, and Trinidad and Tobago.

*Partnership forums.* The Joint Programme promotes and supports the establishment of government-led partnership forums at country level that convene international organisations, community organisations, and the private sector. Forty-three such partnership forums now exist, 20 in Africa, 12 in Eastern Europe and Central Asia, and 11 in Asia and the Pacific. In Bangladesh, an expanded UNAIDS Theme Group—including government, civil society, people living with HIV, development partners, and UN agencies—played a key role in development of a multi-sectoral national HIV/AIDS plan for 2004–2008. Advocacy by UNAIDS contributed to the inclusion of seven non-governmental representatives on the new Governmental Multi-sectoral HIV/AIDS Commission in Romania.



*Global Fund Country Coordinating Mechanism.* The Country Coordinating Mechanisms have proven to be useful in convening and mobilizing diverse partners, especially when these bodies work in concert with the national AIDS authority. UNAIDS participates in these Mechanisms in many countries, often providing extensive technical support. In Morocco, UNAIDS played a central role in the establishment of the Country Coordinating Mechanism and its working groups. The country currently is receiving regular disbursements of a five-year, US\$ 9.2 million grant that supports the development of a national strategic plan for the AIDS response. National NGOs directly manage 30% of these funds. The Global Fund is now documenting Morocco's experience as a best practice for Country Coordinating Mechanisms. In Haiti, the Mechanism has filled a gap and acts as the country's national AIDS coordinating body. However, in other countries these Mechanisms have either not meshed well with existing structures or have not adhered to the Global Fund's principles of broad-based members. The International AIDS Alliance found in some countries that government commitment to working with NGOs appeared to stem more from the desire to secure funding than from a genuine interest in their collaboration. As it did in Morocco, UNAIDS is working to ensure that civil society participation in these Mechanisms is genuine and robust.

*Engaging media and entertainment sectors.* The UNAIDS Secretariat has built relationships with several international and national media agencies, including the BBC, China's CCTV Indonesia's Metro TV, France's TV5 and Russia's Gazprom-Media. UNDP is working with the media and with artists to generate stronger society-wide responses that recognize the epidemic's gender dimensions and encourage respect for people living with HIV. In the Arab States, for example, UNDP-facilitated workshops have enrolled key media and entertainment personalities, helping generate new leadership and break the silence in the region about the HIV/AIDS threat.

*Business and labour.* To engage the private sector at different levels, UNAIDS provides technical guidance, brokers partnerships, develops tools and builds capacity of business organizations. Involving membership associations is a key focus. At country level, partnerships are formed with business associations/coalitions; chambers of commerce; and trade unions. In Guyana, UNAIDS facilitated the adoption of a comprehensive HIV/AIDS policy by the Guyana Sugar Corporation, which was approved by the company's board of directors and is being mainstreamed in all company policies and operations. The UNAIDS Secretariat also supported the formation of the Namibia Business Coalition on HIV/AIDS (NABCOA) and the Indonesian National Business Alliance (NBA); and facilitated a global review of the Rotary Club's country-level AIDS work. The Secretariat worked with Harvard University and WEF at the China Business Summit to engage business and the government, catalyzing an important declaration by the government on the threat posed by AIDS. The ILO *Code of Practice on HIV/AIDS and the world of work* has been embraced worldwide as the recognized standard for HIV/AIDS policies and practices in the world of work. ILO supports multi-sectoral action through its tripartite membership in more than 175 Member States and its facilitation of dialogue between key actors at country level.

*Religious leaders and faith-based organizations.* UNAIDS engages faith-based organizations at country level to assist national efforts to boost care and increase their constituents awareness of AIDS. In Ethiopia, UNAIDS supported religious groups in

the organization of a national religious HIV/AIDS week in May 2003. Particular focus was placed on the issues of stigma discrimination, frank discussions on AIDS, and enhanced care for people living with HIV. In Namibia, UNAIDS organized a groundbreaking HIV/AIDS workshop for leading theologians focused on strategies for countering HIV/AIDS stigma and discrimination. Using its Programme Acceleration Funds, UNAIDS assisted the Russian Orthodox Church in designing and implementing its HIV/AIDS prevention and care programme.

***ii) Regionally and Globally***

At regional and global levels, UNAIDS cultivates partnerships with leaders in key sectors, such as private industry, religion, NGOs, and organizations of people living with HIV. These regional and global partnerships ultimately manifest themselves in greater advocacy and stronger programmatic responses at country level.

*Regional partnership mechanisms.* UNAIDS collaborated with umbrella organizations in numerous regions to ensure a stronger and more inclusive response to the epidemic. Under the International Partnership Against AIDS in Africa (IPAA), UNAIDS has worked closely with regional institutions, including the African Union and the New Partnership for Africa's Development. In the Indian Ocean region, the UN Theme Group on HIV/AIDS is supporting a commission of the Indian Ocean Initiative on HIV/AIDS as it harmonizes AIDS approaches in the islands, develops advocacy strategies and produces strategic information. With the help of a small UNAIDS grant, this commission leveraged US\$ 8 million in AIDS-related funding from the African Development Bank and US\$ 2 million from the French government. The Pan-Caribbean Partnership on HIV/AIDS, which benefits from secondment of a staff member from the UNAIDS Secretariat, has achieved reductions of 85–90% in the prices of antiretroviral treatment drugs.

*Business engagement.* UNAIDS also strengthened its ties in 2002-2003 with the business community at the regional and global levels, which significantly increased its involvement in the global response. UNAIDS has focused on large, influential business membership associations. Key players are the Global Business Coalition on HIV/AIDS, the World Economic Forum, and regional business associations. The membership of the Global Business Coalition has grown since its founding in 1997 to more than 140 companies, including some of the world's largest and most influential private enterprises. UNAIDS, UNDP and WHO have also provided extensive support to the World Economic Forum, whose annual gatherings of key global opinion leaders have focused high-level attention on the role of the private sector in responding to AIDS. With these influential business hubs and Cosponsors such as ILO, the World Bank, WHO and UNDP, the UNAIDS Secretariat hosted a series of capacity building exercises involving governments, Theme Groups, civil society and business representatives from 35 countries in Asia, Africa, Latin America and the Caribbean. Outputs included new business associations, tools and case studies, strategy and organizational development and country action plans for private sector engagement in HIV/AIDS work. In Asia, the UNAIDS Secretariat and ILO worked closely with the Asian Business Coalition on AIDS (ABC on AIDS) on training, and the production and dissemination of strategic information. Partnership menus developed in collaboration with the ILO and the World Economic Forum provide business

organizations with readily-usable options for implementation of workplace and community programmes.

Positive developments in the business response to the epidemic took various forms in the prior biennium. Numerous major companies, including mining enterprises that employ thousands of HIV-positive workers in Southern Africa, committed to provide antiretroviral treatment to their employees, a potentially critical contribution to treatment scale-up and to meeting the goals of “3 by 5”. With the strong leadership and support of the Henry J. Kaiser Family Foundation and other partners, the UN Secretary-General brought together leading media companies in high-income and developing countries to a major meeting in early 2004 that generated concrete commitments to use state-of-the-art media strategies to increase awareness of AIDS. These commitments by media industry leaders build on the already-considerable work of BBC World, CCTV, TV Globo, Univision, Viacom, MTV and other media leaders in disseminating HIV/AIDS messages and programming.

Numerous pharmaceutical companies are contributing to public-private partnerships that facilitate scale-up of treatment and PMTCT initiatives; these include the African Comprehensive HIV/AIDS Partnership in Botswana, which unites the Government of Botswana, the Bill & Melinda Gates Foundation, and Merck & Co. to scale up a comprehensive, nationwide response over five years.

*Religious leaders and faith-based organizations.* UNAIDS intensified its collaborations in 2002-2003 with religious organizations, which have played an important role in responding to HIV/AIDS since the epidemic's inception. In collaboration with the UNAIDS Secretariat and the World Conference on Religion and Peace, UNICEF produced a handbook on HIV/AIDS for religious leaders. Over the last two years, UNAIDS assisted a broad array of religious groups in developing HIV/AIDS strategies, including the Buddhist Leadership Initiative in East Asia, Ecumenical Advocacy Alliance, Caritas International, Lutheran World Federation, Anglican Communion, Presbyterian Church (USA), and African Jesuit AIDS Network. The UNAIDS Secretariat also renewed its memorandum of understanding with Caritas Internationalis, which formalizes cooperation on the promotion HIV/AIDS awareness and responsible behaviour, particularly amongst young people; promotion of activities to mitigate the social and economic impact of the epidemic on individual, families, communities and nations; advocacy in line with the UN *Declaration of Commitment*; and work to eliminate all forms of stigma and discrimination. Ongoing technical support from UNAIDS informed the Second International Muslim Leaders Consultation on HIV/AIDS in Kuala Lumpur in May 2003.

*The greater involvement of people living with or affected by HIV/AIDS (GIPA).* UNDP partners with the Asia Pacific Network of People Living with HIV/AIDS, which advocates for a rights-based approach to AIDS that reduces stigma, engages people living with HIV, and breaks the silence surrounding the epidemic. UNAIDS supported the emergence of a people living with HIV network in Eastern and Central Europe, collaborating with bilateral donors in hosting a regional forum for people living with HIV activists. UNAIDS also supported passage of anti-discrimination legislation in numerous countries (see Section VI—Human Rights) and facilitated linkages in numerous regions between people living with HIV organizations and community networks. Globally, UNAIDS facilitated a partnership between the Global

Network of People Living with HIV/AIDS and the International Federation of Red Cross and Red Crescent Societies to address HIV-related stigma. This partnership has led to the creation of people living with HIV groups in Red Cross offices, high-profile campaigns to combat stigma, and countrywide partnerships. The arrangement also ensures that people living with HIV play a major role in antiretroviral-treatment programmes, particularly in helping people gain access to care, and in assisting patients with treatment compliance. UNAIDS also provided technical and financial support to the Global Network of People Living with HIV/AIDS and the International Community of Women Living with HIV/AIDS.

*Improving Access to Treatment.* The “3 by 5” strategy envisions the development of strategic partnerships to accelerate treatment scale-up. Through the Accelerating Access Initiative, UNAIDS negotiated price reductions from major pharmaceutical companies, resulting in 150 000 people in sub-Saharan Africa receiving antiretroviral treatment by early 2004. Additionally, a UNAIDS/WHO roundtable for representatives of generics manufacturers in 2003 explored strategies for maximizing the accessibility and affordability of generic medications. The William J. Clinton Foundation has also played a role in negotiating price reductions for antiretroviral drugs and especially HIV diagnostics for developing countries. In 2002, UNAIDS supported the first meeting of NGOs, people living with HIV, and community organisations working on treatment access, which gave rise to the Pan African Treatment Action Movement. Similar assistance supported a global civil society meeting in Cape Town in March 2003 on “HIV treatment preparedness”. UNAIDS has also assessed the field of religious organizations for potential “3 by 5” partners. Underscoring the potential of religious groups to facilitate treatment scale-up, Caritas Internationalis organised a workshop on AIDS care and treatment and produced its own set of treatment guidelines.

*Key sectoral partnerships.* Consistent with the need for an extraordinary and multi-sectoral response to the epidemic, UNAIDS cultivates partnerships from all walks of life. WFP embarked on a strategic partnership in six African countries with World Vision International to address AIDS through school-feeding initiatives. UNAIDS supported the work of the International Council of AIDS Service Organisations (ICASO) to monitor follow-up on the *Declaration of Commitment*. The Secretariat’s partnership with civil society organisations is being strengthened by the above-noted transition to civil society of the governance of the World AIDS Campaign. UNAIDS collaborates with a broad array of philanthropic organisations and advocates for greater attention to AIDS in the philanthropic community. In 2002-2003, the UN Foundation prioritized the issue of AIDS, including making AIDS grants in India, Eastern Europe, and Central and South America, as well as initiating a campaign of public service announcements to raise awareness of the global epidemic in donor countries. UNAIDS was instrumental in the implementation of this initiative.

In all regions, the UNAIDS Secretariat and Cosponsors work in concert with community organisations and NGOs and help build community-based capacity through funding, trainings, and technical assistance. UNFPA, for example, has facilitated the training of 241 peer educators in Eastern Europe and Central Asia, who in turn have reached 70 000 young people.

*Key thematic partnerships.* The UNAIDS convening agency mechanism (see Section V-B) has facilitated the cultivation and mobilization of partners in key thematic areas, including injecting drug use, gender, men who have sex with men, and young people. UNFPA, convening agency for young people, supports the African Youth Alliance, which collaborates with government, NGO and community-based organisations in four African countries to equip young people with necessary knowledge, skills and attitudes. Similar youth-oriented partnerships supported by UNFPA include the Youth Peer Education Electronic Resource in Eastern Europe and Central Asia, and the EU/UNFPA Reproductive Health Initiative for Youth in seven South and Southeast Asian countries.

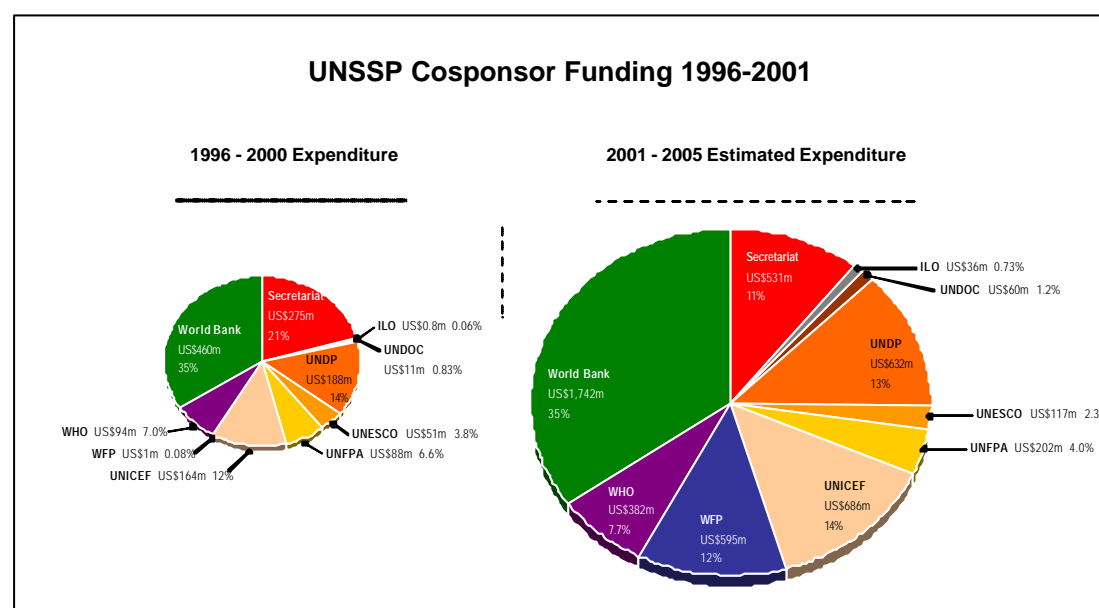
## **E. Financial, technical and political resource mobilization and tracking**

*Mobilizing new and greater financial resources.* Since UNAIDS was established, funding for AIDS programmes in low- and middle-income countries has increased from less than US\$ 300 million in 1996 to an estimated US\$ 4.7 billion in 2003. This growth in spending reflects increased support from a broad range of sources, including bilateral donors, NGOs and philanthropic foundations. Funding by bilateral donors (including the European Community), for example, grew from US\$ 116 million in 1996 to more than US\$ 1.3 billion in 2002. In 2003, the US government embarked on the US President's Emergency Plan for AIDS Relief, a US\$ 15 billion, five-year initiative that aims to deliver antiretroviral treatment to 2 million people and sharply reduce HIV infection rates in 15 countries. Projected disbursements by the government of the United Kingdom in 2003 amounted to US\$ 452 million, second only to the USA. The Bill & Melinda Gates Foundation continued its efforts AIDS, supporting antiretroviral treatment scale-up in Botswana, committing US\$ 200 million for HIV prevention services in India, and devoting substantial new resources to public-private initiatives to develop vaccines and microbicides.

As instructed by its Programme Coordinating Board, UNAIDS has continued its efforts to develop a comprehensive strategy for global HIV/AIDS resource mobilization. The underlying principle of this strategy development process lies in the recognition that, while the ultimate aim should be the integration of AIDS responses into broader sustainable development processes, it is also clear that an even greater allocation of resources will still be required for some time in order to intensify the scaling-up of treatment, prevention and care programmes. The need for "emergency funding" has to be properly positioned. The strategy will therefore be advocating for a mix of additional grant funding from the developed world, together with a whole range of longer-term measures, such as appropriate national budgetary allocations, the mitigation of structural factors, and the building-up of national resources (human, infrastructural and financial). This resource mobilization exercise is being structured as part of an overall advocacy plan.

The UN system has contributed to the growth in resources for AIDS, and will continue to do so in 2004-2005. To illustrate, expenditures over 1996-2000 were US\$ 1.3 billion, compared to estimated expenditures in 2001-2005 of US\$ 5 billion, a 274% increase (see table for details). Of particular note is the increase in World Bank funding, the majority of which is grants and loans for African and Caribbean countries through its Multi-Country AIDS Programme. Additionally, like bilateral donors, UN agencies are increasingly mainstreaming their activities into AIDS-related

programmes such as life skills education, rural development, reproductive health services, food security, tuberculosis treatment and intravenous drug-use prevention.



*Resource mobilization for HIV treatment and care.* A major focus of resource mobilization is the need to attract substantial new funding to increase access to HIV treatment. WHO estimates that achievement of “3 by 5” (providing treatment to 3 million people in low- and middle-income countries by the end of 2005) will require at least US\$ 5.5 billion in spending on treatment-related activities in 2004-2005, including outlays for expansion of voluntary counselling and testing, training of health care workers, and purchase and distribution of antiretroviral treatment. Both the World Bank and the Global Fund committed to include HIV treatment within the scope of activities they fund. In its second round of grant-making by the Global Fund in February 2003, medicines and commodities represented approximately one-half of all approved expenditures.

*Resource mobilization at country level.* UNAIDS not only assists countries in developing national AIDS strategies, but the Secretariat and Cosponsors devote substantial energy toward mobilization of the resources needed to implement strategic plans. A UN-brokered donor roundtable on AIDS in Burkina Faso generated US\$ 94 million in pledges to implement national AIDS strategies. In Burkina Faso, Burundi, Cameroon, Ethiopia, Madagascar and other countries, UNDP and the UNAIDS Secretariat supported the inclusion of AIDS in Poverty Reduction Strategy Papers. At the end of 2003, a rapid UNAIDS Secretariat survey of 64 low- and middle-income countries found that 15 had Poverty Reduction Strategy Papers with AIDS indicators. UNAIDS provided critical assistance to Mozambique in attracting more than US\$ 500 million in AIDS resources over the next five years from the Global Fund, the World Bank, and other sources. In Myanmar, where adult HIV prevalence is among the highest in Asia, the UNAIDS Secretariat and the UN Theme Group developed the Fund for HIV/AIDS in Myanmar (FHAM), which is channelling US\$ 24 million in funding (mostly from the United Kingdom, Norway and Sweden) to AIDS projects that are part of an integrated workplan developed by UN agencies, civil society, and

government bodies. In Central America, UNAIDS is supporting donor roundtables in Costa Rica and Honduras.

*The Global Fund to fight AIDS, Tuberculosis and Malaria.* The 2002-2003, the Joint Programme collaborated closely with the Global Fund, the creation of which was proposed by the UN Secretary-General in April 2001 following acknowledgement for the need of such a funding mechanism by G8 countries. The initiative was endorsed later in the year by the *Declaration of Commitment* and in 2002 by the G8. UNAIDS, WHO and the World Bank sit on the Fund's board, and a Memorandum of Understanding between UNAIDS and the Fund clarifies respective roles and responsibilities and promotes synergy between the two entities. The ILO has also developed a Memorandum of Understanding with the Fund. UNDP serves as principal recipient for the Fund in 20 countries. The UNAIDS Secretariat provides extensive support to countries in the development and implementation of country proposals, as well as expert guidance to the Fund's technical review panel. Since the Fund's beginning, this support has totalled US\$ 5.4 million in direct and staff costs, including US\$ 1 million for the third round of grant proposals. As noted in Section III-C, UNAIDS has worked extensively to enhance the monitoring and evaluation capacity of project managers for Fund-approved initiatives. As of April 2004, following three grant cycles, the Fund had approved more than US\$ 2.1 billion in funding for 227 programmes in 122 countries and three territories, and had disbursed US\$ 285 million. AIDS programmes accounted for approximately 60% of approved grants in the Global Fund's first three rounds.

The role of UNAIDS in maximizing the impact of the Global Fund is apparent from a review of the outcomes of the Joint Programme's assistance to countries in developing proposals. In 2003, UNAIDS provided technical assistance in proposal development to all countries that requested it. Countries that received UNAIDS assistance proved 4.5 times more likely to received funding in the Global Fund's third round than countries that did not request assistance. This success rate is especially heartening, given that many of the countries supported by UNAIDS in sub-Saharan Africa, such as the Democratic Republic of the Congo and Côte d'Ivoire, are facing extraordinarily difficult economic and political circumstances. In the Middle East and North Africa, where an enormous resource gap exists for AIDS, UNAIDS staff and consultants provided technical advice for five of the six proposals in the region that were funded during the Fund's first three rounds. In 2003, UNAIDS supported the development of Fund proposals in 13 of 15 countries surveyed in the Asia and Pacific region.

*Tracking Resources.* Closing the HIV/AIDS resource gap in low- and middle-income countries requires a clear understanding of the cost of an effective response and how much is currently being spent. In 2002-2003, UNAIDS significantly strengthened its capacity to track resource flows for AIDS programming in low- and middle-income countries. UNAIDS enhanced its collaboration with UNFPA and the Netherlands Interdisciplinary Demographic Institute on the Resource Flows Project for AIDS and Population. This collaboration undertook a special study in 2003 to attempt to estimate in real time expenditures by donors and selected developing countries. In 2003, UNAIDS also worked more closely with the Organization for Economic Cooperation and Development, (OECD) to improve the quality and timeliness of information on donors' HIV/AIDS assistance. At UNAIDS' request, the OECD is conducting a special study on donor financing, results from which will be presented at

the XV International AIDS Conference in Bangkok. In the prior biennium, UNAIDS also improved the usefulness of its resource tracking for national strategic planning by enhancing its ability to estimate expenditures on AIDS by the private sector, including spending by households and individuals. Information from Kenya, for example, indicates that payments by households represent 41 % of all spending in the country on HIV/AIDS activities.

The Joint Programme provided reports to the PCB on AIDS resources in 2002 and 2003. UNAIDS also estimated resource needs for HIV prevention, care, treatment and support through 2007, enabling stakeholders to assess the gap between available resources and actual financial needs. In 2003, UNAIDS estimated that resources available that year for AIDS (an estimated US\$ 4.7 billion) represented less than half of what would be required by 2005.

Through establishment of improved ties with the International AIDS Vaccine Initiative and the International Partnership for Microbicides, UNAIDS has sharpened its ability to track resources devoted by public and private sectors worldwide to HIV-related research and development. UNAIDS estimates on research and development for HIV vaccines show an increase from US\$ 430–470 million in 2001 to US\$ 540–570 million in 2002.

*UNAIDS financial resources.* In 2002–2003, donors fully funded the 2002–2003 Unified Budget and Workplan of US\$ 195 million. Thirty-one donor governments, the highest number ever, contributed to the Joint Programme, accounting for 95% of all contributions. (The World Bank, along with miscellaneous contributions, account for the remainder of the Programme's income.) New Zealand made its first contribution to UNAIDS in 2003, with Austria and the Regional Government of Extremadura (Spain) joining the Joint Programme's expanding list of donors with first-time contributions in the first quarter of 2004.

*Technical resources.* The PCB directed the Joint Programme in 2002 to increase its efforts to develop meaningful, accessible technical resource networks to facilitate implementation and expansion of programmes at country level. UNAIDS has responded by expanding its ongoing cooperation with regional networks and institutions in several regions. This cooperation is country-driven and based on the principles national ownership, decentralization, cross-regional support and the utilization of existing national and regional institutions. In Latin America and the Caribbean, UNAIDS partners with the Horizontal Cooperation Group, Brazil's FIOCRUZ, Mexico's National Institute of Public Health and SIDALAC. In Eastern Europe, UNAIDS produced an electronic directory of technical resources to facilitate the linking between countries and regional institutions in key areas such as Monitoring and Evaluation and access to treatment. UNAIDS has also undertaken substantial planning and implementation of Technical Support Facilities, which will be operational by the end of 2005 in several regions, including Southern and Eastern Africa, West and Central Africa and Southeast Asia. These Facilities, which will be managed by existing regional institutions, will focus on providing technical assistance to national programmes in five priority areas: strategic planning (e.g. situation analysis, response analysis, strategic plan formulation, resource mobilization, costing and budgeting), financial management, mainstreaming HIV/AIDS, monitoring and evaluation, and partnership development. In addition, as requested by countries, the



Facilities will also facilitate technical assistance in key thematic areas. It is anticipated that Technical Support Facilities will evolve over time, as technical assistance needs change and new issues emerge.

UNAIDS Cosponsors are helping expand access to technical resources at regional and country levels. ILO's technical cooperation programme on AIDS and the world of work includes projects in more than 25 countries in Africa, Asia, Eastern Europe, and the Caribbean. WHO in 2003 developed a generic training module for health care workers engaged in activities to prevent mother-to-child transmission of HIV. In addition, the World Bank-housed Global AIDS Monitoring and Evaluation Team is helping build national monitoring and evaluation capacity. UNFPA has altered its internal travel policy to require that at least 50% of travel by headquarters-based AIDS staff involve the direct provision of technical assistance and capacity-building in the field.

*Political resources.* As noted above in Sections III-A and III-B, UNAIDS provides extensive support to national AIDS programmes throughout the world. Although virtually all heavily-affected countries have now adopted high-level, multi-sectoral mechanisms to coordinate national responses, an analysis by UNAIDS indicates that funding and programmatic initiatives often remain concentrated in health ministries. With the significantly increased UNAIDS capacity at country level in the current biennium, the Joint Programme is strengthening in the 2004-2005 biennium its advocacy, technical assistance, partnership cultivation and resource mobilization efforts to encourage greater leadership by other key ministries.

#### **SECTION IV: RESEARCH ON NEW TECHNOLOGIES**

Although existing prevention and treatment tools have the potential to help reverse the global epidemic if brought to scale, the likelihood of long-term success against AIDS will be much greater if additional strategies are rapidly developed and effectively deployed. Accordingly, UNAIDS in 2002-2003 continued to engage in substantial advocacy, technical advice, partnership cultivation, and generation of strategic information to accelerate the development of microbicides, new medications, and preventive vaccines.

*Microbicides.* In 2002-2003, major new developments increased momentum toward the development of a safe and effective vaginal microbicide to reduce the risk of sexual HIV transmission. The Alliance for Microbicide Development reports that, as of March 2004, 18 candidate microbicides were in clinical development, and 44 additional agents were in preclinical development. WHO is among those sponsoring studies of candidate microbicides. Extensive planning in 2002-2003 focused on the initiation in early 2004 of two major Phase III studies involving three microbicide candidates. In 2002, WHO convened two meetings involving private industry, public sector research agencies, microbicide advocates and national regulatory officials from developing and high-income countries to analyze potential regulatory hurdles to future licensure of microbicides. Countries in sub-Saharan Africa discussed mechanisms to facilitate the earliest possible access in the region.

Momentum toward greater global support for microbicide research and development was accelerated by the creation in 2002 of the International Partnership for

Microbicides. The Rockefeller Foundation helped create the Partnership, and UNFPA provided important seed funding. In 2003, the Bill & Melinda Gates Foundation awarded the Partnership more than US\$ 60 million over five years to accelerate microbicide development.

*Treatments.* In developing countries, the most immediate research need involves the development of safe, effective, reliable and affordable compounds that simplify antiretroviral treatment regimens. Simplification of regimens not only improves rates of treatment adherence but also facilitates the accelerated scaling-up of treatment in countries with weak health care systems and few trained health professionals. The “3 by 5” guidelines issued by WHO and UNAIDS reduced the number of recommended first-line treatment regimens from 35 to 4. In the meantime, research is continuing to explore such potential innovations as once-a-day regimens and additional pill combinations.

*Prevention of mother-to-child transmission.* While an estimated 700 000 infants contract HIV infection each year through mother-to-child transmission, programmes to prevent mother-to-child transmission (PMTCT) have yet to obtain significant coverage in the regions hit hardest by HIV/AIDS. To facilitate scale-up of PMTCT, UNAIDS provided scientific and policy guidance regarding the optimal approach to PMTCT. Given the value of breastfeeding and its simultaneous contribution to HIV transmission, countries, UNICEF, UNAIDS Secretariat, WHO and UNFPA developed guidelines for decision-makers on HIV and infant feeding. In addition, WHO developed new recommendations advising that single-dose nevirapine is no longer the standard of care for PMTCT. Citing clinical data from Thailand, WHO now recommends a combination of AZT and nevirapine.

*Vaccines.* In 2003, disappointing results were reported for the world’s first Phase III efficacy trial for an HIV vaccine candidate, AIDSVAX B/E, with no protection found for an antibody-inducing product produced by VaxGen. The trial, however, yielded important information on which future trials can build and conclusively demonstrated the feasibility of conducting a large, multi-country trial in an ethical and scientifically rigorous manner. The second Phase III trial of a candidate vaccine, priming with a canarypox-HIV vaccine and boosting with gp120, is taking place in Thailand. In 2002-2003, it became increasingly apparent that the search for a preventive vaccine will be a lengthy, difficult process but one that the world must aggressively pursue. While the International AIDS Vaccine Initiative (IAVI) reports that annual spending on vaccine research and development has increased to US\$ 540–570 million, IAVI estimates that such amounts are roughly half of what is needed.

Nevertheless, 2002-2003 witnessed important and encouraging developments in the vaccine field. The UNAIDS/WHO Vaccine Initiative helped launch the African AIDS Vaccine Programme (AAVP), which seeks to promote the development and testing of vaccines specifically developed to be used in sub-Saharan Africa. The UNAIDS/WHO initiative also began working with other partners, such as IAVI and the US Centers for Disease Control, to plan for rapid introduction of future vaccines in regions where they are most needed. To maximize the coordination of diverse actors in vaccine development, 24 leaders in immunology, HIV/AIDS science, and public health, including the UNAIDS Executive Director, proposed together in a June 2003 *Science* article that all major players in HIV vaccine research and development join together in a collaborative global HIV vaccine enterprise with the support of the

Bill & Melinda Gates Foundation. Since publication of the proposal, six working groups have been formed to implement the proposed enterprise, involving 50 leaders from the global HIV vaccine community.

## **SECTION V: EXPANDING THE UN SYSTEM RESPONSE TO AIDS**

### **A. Intensified UN system action in countries**

In 2002-2003, UNAIDS and the entire UN system actively embraced the PCB's call to increase effectiveness and coordination at country level. Following issuance of the external evaluation, the Executive Director identified enhanced support to countries as a core priority for the Joint Programme. Development of the 2004-2005 Unified Budget and Workplan, approved by the PCB in June 2003, provided substantially enhanced financial allocations for UNAIDS support to countries and significantly increased the Joint Programme's requirements for reporting on impact at country level. Individual Cosponsors also increased their own HIV-related staffing at country level.

*Implementation of new framework for country support.* In early 2003, the UNAIDS Secretariat developed a new framework for more effective country assistance, based on the five cross-cutting functions adopted by the PCB in 2002. Six regional management meetings—two in sub-Saharan Africa, two in Asia, one in Eastern Europe, and one in Latin America—were held in 2003 to operationalize the plan in all country and regional offices of the Secretariat.

*Improving UN Theme Groups on HIV/AIDS.* Substantial attention in 2002-2003 focused on improving the effectiveness of UN Theme Groups on HIV/AIDS, which serve as the country-level forum for joint UN action on the epidemic. In November 2003, the Chair of the UN Development Group circulated a memorandum to all Resident Coordinators and UN System Heads at country level calling for strong efforts to enhance HIV-related coordination by the UN system. In particular, this guidance note clarified the roles and relationships of the Resident Coordinator, Theme Group Chair and UNAIDS Country Coordinator; regularized UNAIDS Country Coordinators as members of UN Country Teams, the designation of an agency head other than the Resident Coordinator to act as Theme Group Chair; and called for regular progress reports from the Theme Groups as part of the UN Resident Coordinator's Annual Report.

*Joint Implementation Support Plans.* While the UN system still struggles to engage in true joint programming at country level, coherence of the UN system's advocacy and support for strategic leadership at country level has improved due to the development in 2003 of new guidelines for UN Country Team Implementation Support Plans. The guidelines respond to the Programme Coordinating Board's insistence that UNAIDS do a better job of planning UN activities to support the national AIDS response—rather than more independent projects in agencies' area of focus. Along with the UN Development Group's recent guidelines on broader joint UN programming, these Implementation Support Plans are on the cutting edge of the Secretary-General's UN reform agenda. They focus on concrete results and transparent reporting of achievements and challenges, with particular emphasis on the five cross-cutting themes of the Joint UNAIDS Programme. The guidelines also advance collective programming principles contained in UN system tools, such as the Common Country

Assessment (CCA) and the UN Development Assistance Framework (UNDAF). UNAIDS has already achieved significant success integrating AIDS into CCAs and UNDAFs. In a survey conducted at the end of 2003, 54 out of 64 responding UNAIDS offices reported that AIDS had been integrated into at least the CCA, and in most cases both the CCA and the UNDAF. Even while the guidelines were being drafted, many UN Country Teams were eager to take the mandate provided by the Board's decision and re-work their collective UN plans. At the end of 2003, 26 countries reported that they had already finalized Implementation Support Plans using draft versions of the guidelines. In Asia alone, UN Country Teams had by the end of 2003 finalized Plans in Bangladesh, Cambodia, China, India, Indonesia, Myanmar, Pakistan, Papua New Guinea, Thailand and Viet Nam. Appropriate implementation of new Support Plans will determine the effectiveness of the new guidelines. As part of this enhanced strategic cooperation at country level, UN Theme Groups are also developing joint advocacy strategies to maximize leadership development at country level.

## **B. Wider engagement of the UN system**

As described in greater detail in the mid-term assessment of the UN System Strategic Plan 2001–2005, the UN system substantially enhanced the breadth and depth of its engagement in HIV/AIDS work in the prior biennium. The Inter-Agency Advisory Group on AIDS (IAAG) has been working on key AIDS issues including food security, conflict situations and displaced populations and the UN workplace. IAAG is also now strengthening its role in preparing and reviewing the UN System Strategic Plan.

In 2002-2003, ILO became a recipient of resources from the Unified Budget and Workplan and provided critical leadership at all levels to strengthen multisectoral responses through implementation of the ILO *Code of Practice on HIV/AIDS and the world of work*. During the prior biennium, discussions led to agreement that WFP would become the ninth Cosponsor of the Joint Programme. Within all Cosponsor agencies, the profile of HIV/AIDS significantly grew during the 2002-2003 biennium, in large measure due to the catalytic influence of the *Declaration of Commitment*. In April 2003, the Commission for Narcotics and Drugs (the central policy-making body within the United Nations system dealing with drug-related matters) resolved that a specific HIV programme would be established within UNODC, and substantial progress has since been made in initiating and expanding this new unit. UNODC also incorporated HIV/AIDS in its national drug abuse needs assessment tool. Unified Budget and Workplan funding has facilitated significantly greater inter-departmental collaboration within UNFPA, as well as regional trainings to improve the HIV/AIDS competency of UNFPA's regional and country staff. Partner Programme Reviews—which were conducted for six different Cosponsors in the 2002-2003 biennium, with an additional Cosponsor review to be completed in early 2004—continue to provide opportunities for UNAIDS Partners to contribute constructive criticism and strategize on ways to improve coordination and effectiveness. Regional and thematic consultations used in 2003 in development of the 2004–2005 Unified Budget and Workplan significantly increased the level and quality of strategic discussions by diverse UN system partners on enhanced coordination at global, regional and country levels. In October 2003 the World Food Programme joined as the ninth UNAIDS Cosponsor, bringing to the Joint Programme its ability to address nutritional needs related to AIDS, such as through school-feeding programmes

Available evidence indicates that human resources devoted to AIDS within the UN—both full-time and those whose jobs include AIDS-related duties—have significantly grown. Cosponsors have reported significant increases in the number of staff devoted to AIDS work. Full-time equivalent staff at UNDP increased from 24 in 2002 to 76 in the current biennium; at UNFPA from 19 to 51; at WHO from 155 to 265; at ILO from 31 to 80; at the World Bank from 74 to 130; and at UNODC from 12 to 26. UNICEF reported 408 full time equivalent staff in 2004, UNESCO 70, and WFP 72. Since 2001, 18 of 29 UN agencies participating in the UN System Strategic Plan have also expanded the geographical reach of their HIV/AIDS activities. In 2003, the governing boards of 23 of 29 UN agencies participating in the UN System Strategic Plan considered HIV/AIDS as a formal agenda item at a scheduled meeting. In 2003, nine different agencies served as chair of a UN Theme Group on HIV/AIDS.

Emblematic of the UN's broader and deeper engagement on HIV/AIDS is the series of actions adopted by the High Level Committee on Programmes (HLCP) in response to the growing crisis in Southern Africa involving HIV/AIDS, governance and food security. Composed of senior representatives of UN system agencies, HLCP determined in 2003 to undertake unprecedented, coordinated action to address the region's worsening crisis. (See Section VI, below.) This plan was further endorsed by the UN Chief Executives Board, which is chaired by the UN Secretary-General.

Appointment by the Secretary-General of special AIDS envoys in Africa, Asia and Pacific, Caribbean, and Eastern Europe enhanced advocacy, improved greater awareness of the particular challenges faced by different regions in responding to AIDS. The UNAIDS Secretariat coordinates the funds and activities of the special envoys. Executive heads of UN agencies have also increasingly addressed AIDS in their public speeches.

In addition to facilitating stronger partnership development, the convening agency mechanism also promoted greater leadership within the UN system on key thematic issues. Recognizing the comparative advantage of individual UN agencies (see table) the convening agency mechanism encourages the development of joint UN strategies and policy frameworks in 14 thematic areas.

<b>UN Convening Agencies on Thematic HIV/AIDS Issues</b>	
UNAIDS Secretariat	Men who have sex with men, sex workers, greater involvement of people living with HIV, evaluation of AIDS programming at global level
UNICEF	Orphans and vulnerable children
UNDP	Governance and development planning
UNFPA	Gender, young people, condoms
UNODC and UNDCP	injecting drug users
ILO	World of work
UNESCO	education
WHO	Care, support and treatment; prevention of mother-to-child transmission of HIV
World Bank	Evaluation of AIDS programming at country level
UNIFEM	Gender

### **C. The UN workplace.**

The 2002-2003 biennium witnessed implementation of substantial improvements in UN system workplace policies and practices on AIDS. On World AIDS Day 2003, the UN Secretary-General reiterated his commitment to provide a supportive workplace for UN employees, regardless of their HIV status. In a bulletin to UN staff, the Secretary-General restated key aspects the UN Personnel Policy on HIV/AIDS, including access to information on prevention and treatment, the provision of health insurance to HIV-positive staff and assurances that prospective and current staff will not face compulsory HIV tests.

By implementing sound workplace policies on AIDS, the UN system seeks to lead by example, to ensure that UN employees are able to make informed decisions, and to build the UN system's capacity and competence to support national responses to the epidemic. In November 2003, the UN Development Group directed all UN Country Teams to implement the UN *Personnel Policy on HIV/AIDS* and the *ILO Code of Practice*.

In consultation with Cosponsors, the UNAIDS Secretariat and UNICEF led efforts to create a UN Learning Strategy on HIV/AIDS, which was endorsed by the Committee of Cosponsoring Organizations and promoted by the Secretary-General. The learning strategy was informed by a survey in 2002 of UN system staff worldwide, which found high levels of concern among UN personnel regarding the wisdom of disclosing personal HIV-related information in the workplace. As part of the learning strategy, workshops were held in the Russian Federation and in Namibia to train HIV/AIDS learning facilitators. UN Country Teams in different regions subsequently developed their own learning strategies. In 2003, work began on an update to the UN system's HIV/AIDS handbook for employees, scheduled for printing and distribution in 2004.

The UN system made important strides in ensuring that HIV-positive staff have access to comprehensive medical services. Through the ACTION (Access, Care, Treatment, and Inter-Organizational Needs) initiative, UNAIDS is supporting a country-by-country assessment by the UN Medical Services of the availability of voluntary counselling and testing, antiretroviral treatment, and other elements of HIV/AIDS care.

In addition to system-wide initiatives, several UNAIDS Cosponsors undertook targeted efforts to implement sound workplace policies and practices. 'Caring for Us' is a UNICEF-initiated programme that now includes UNFPA. The programme promotes a caring environment for people living with, or affected by, HIV, as well as for staff members affected by other health and personal issues. Measures to help staff members and their families cope with illness or death are complemented by learning opportunities on related topics, such as access to antiretroviral treatment. UNDP's 'We Care' initiative supports the implementation of the UN system's workplace policy on HIV/AIDS, ensures protection of the rights of those living with HIV, and promotes a supportive work environment. We Care enhances HIV/AIDS awareness among UNDP and other UN system staff members and facilitates a workplace environment free of discrimination and stigma. It is hoped that additional UN agencies will undertake similar initiatives in the 2004-2005 biennium.

## **D. UNAIDS Headquarters**

In May 2002 the PCB welcomed a loan offer from the Swiss Federal Government for the construction of premises to house the UNAIDS Secretariat's headquarters in Geneva and provide additional accommodation for WHO. This change will house the UNAIDS Secretariat under one roof (as opposed to its current split between the WHO V-building and a wing of the World Council of Churches building), which will improve efficiency and reduce accommodation costs. Construction work should start in May 2004 with completion in early 2006. The construction cost—to be shared equally by the UNAIDS Secretariat and WHO—was estimated in June 2003 at CHF 66 million. In December 2003, the Swiss Federal Government approved a 50-year, interest-free loan in the amount of CHF 59.8 million (UNAIDS' share being CHF 29.9 million). The difference between the loan and the estimated construction cost is CHF 6.2 million, which must be financed by UNAIDS and WHO from other sources (UNAIDS' share being CHF 3.1 million). UNAIDS will also have to fund installation and other related costs incidental to moving to the new premises. The installation, equipping and moving costs are now estimated at US\$ 3 million. A proposal for a supplemental budget in the amount of CHF 3.1 million and US\$ 3 million to cover these additional costs is being submitted to the PCB in June 2004.

## **SECTION VI: CROSS-CUTTING ISSUES**

*Women and AIDS.* Taking account of the epidemic's rapidly growing burden on women and girls, the Programme significantly enhanced its efforts in 2002–2003 to address the growing burden of HIV/AIDS among women and girls. UNAIDS spearheaded efforts to develop the Global Coalition on Women and AIDS, which was launched in early 2004 and includes the UNAIDS Executive Director and the UNFPA Executive Director on its steering committee. The Global Coalition is an informal grouping of partners and organizations working to mitigate the epidemic's impact on women and girls worldwide, with staff support provided by the UNAIDS Secretariat. The Coalition's efforts focus on:

- preventing new HIV infections;
- promoting equal access to treatment;
- addressing legal inequities; and
- reducing the epidemic's harmful consequences for women and girls.

The Coalition has created a Web portal and disseminated fact sheets on women and AIDS. Several regional initiatives are currently underway under the Coalition umbrella, including the UN Secretary-General's Task Force on Women, Girls and AIDS in Southern Africa (chaired by the UNICEF Executive Director), and the Mekong Coalition on Women and AIDS.

Strategies developed in an array of areas by the Joint Programme emphasize the necessity to protect and advance the rights of women. The "3 by 5" initiative, for example, provides that women will represent at least one-half of the targeted 3 million people to receive antiretroviral treatment by the end of 2005. The UN system's inter-agency action plan in Southern Africa identified the scaling-up of actions to empower women as one of five priority approaches. A manual developed by UNDP on integration of AIDS into development agendas in sub-Saharan Africa focuses particular attention on initiatives that address the epidemic's gender dimensions.

UNDP-sponsored community capacity initiatives have helped communities challenge cultural practices that aid the spread of HIV, such as wife-sharing and female genital mutilation, contributing to the abandonment of such practices in some communities. WFP has joined with the MTCT-Plus initiative at Columbia University to assess the role of food in supporting the prevention and treatment components of programmes that address mother-to-child HIV transmission. At the full-day session of the General Assembly devoted to HIV/AIDS in September 2003, UNFPA and UNIFEM called attention to the epidemic's gender dimensions by hosting a panel discussion on HIV-related challenges facing women.

*Food security.* WFP, FAO, UNAIDS and UN country teams spearheaded global efforts to mobilize political commitment and financial resources to address the food crisis in Southern Africa, which was significantly exacerbated by AIDS. WFP, for example, collaborated with NGOs to feed 185 000 people in urban centres in Zambia. In recognition of the growing impact of AIDS in the region, a meeting of UNAIDS Cosponsors' Regional Directors in Maputo (Mozambique) in July 2003 (see Section V-B, above) committed to extraordinary UN regional action to strengthen leadership, preserve and build national capacity, and advocate for effective policy responses and programmatic resources. To promote accountability and achievement of agreed-on objectives, the Regional Director's Group on HIV/AIDS in Africa agreed to serve as oversight body on implementation of the regional plan. To support inter-agency efforts to enhance food security in mitigate the epidemic's impact in the hardest-hit region, UNAIDS located its Inter-Country Team in Eastern and Southern Africa with the Regional Inter-Agency Coordination and Support Office, and the regional offices of UNDP and WFP in Johannesburg.

*Humanitarian response.* The UNAIDS Office on AIDS, Security and Humanitarian Response facilitates efforts to address AIDS in relief operations. During the acute phase of the conflict in Côte d'Ivoire, UNAIDS initiated an AIDS emergency response that was subsequently adapted as a sub-regional strategy. The UNAIDS Secretariat, individual Cosponsors, and other UN agencies promote HIV-related coordination through participation in the Inter-Agency Standing Committee Task Force on HIV/AIDS in emergencies. In 2003, the UNAIDS Secretariat and UNIFEM renewed their agreement to collaboratively support an AIDS gender advisor in Sierra Leone to address the post-conflict needs of women and girls. WFP, UNHCR and UNICEF are undertaking a joint study to explore optimal use of food aid to improve HIV/AIDS prevention, care and treatment and to reduce HIV-related discrimination in refugee camp settings.

*National security in the context of uniformed services.* Substantial efforts in the prior biennium focused on implementation of Security Council Resolution 1308, adopted in July 2000, which acknowledged the linkages between HIV/AIDS, peace and security and called for initiation of comprehensive AIDS programmes in national uniformed services and UN peacekeepers. In collaboration with the UN Department of Peacekeeping Operations, UNFPA, UNIFEM and other UN system partners, the UNAIDS Secretariat spearheaded efforts to strengthen the response to AIDS in these sectors. This work was facilitated by the placement in UN Department of Peacekeeping Operations of a UNAIDS programme advisor in January 2003.



Through its Global Initiative on “Engaging uniformed services in the fight against HIV/AIDS,” UNAIDS had by the end of 2003 facilitated partnerships with 50 countries. UNAIDS produced a *Guide for Developing and Implementing HIV/AIDS/sexually transmitted infection Programming for Uniformed Services*, as well as a peer-education kit for uniformed services. UNAIDS also produced an AIDS awareness card in 11 languages for distribution to peacekeepers and other uniformed services. In the Russian Federation, UNAIDS provided awareness cards and condoms to the All-Russian Advanced Training Police Academy. UNAIDS produced a comprehensive review of policies and programmes to address AIDS among peacekeepers and uniformed services. At the 2003 International Conference on AIDS and Sexually Transmitted Infections in Africa, UNAIDS released a case study on HIV prevention among peacekeepers and armed forces in Eritrea.

Pursuant to Resolution 1308, the UN Department of Peacekeeping Operations and UNAIDS have prioritized the integration of AIDS activities in UN peacekeeping operations. The Department of Peacekeeping Operations has begun establishing voluntary counselling and testing facilities in missions and finalized its policy on HIV testing, which reiterates the UN’s support for voluntary counselling and testing. Pre-deployment training in HIV/AIDS was provided to Namibian troops deployed to Liberia and to peacekeepers assigned to the Ethiopia-Eritrea operation. The Department of Peacekeeping Operations committed to name AIDS policy advisors in all major peacekeeping operations and to identify AIDS focal points in remaining missions.

*Human rights.* Monitoring by UNAIDS underscores the continued need for implementation of national laws, policies and practices to prohibit HIV-related discrimination and to promote the human rights of people living with and affected by HIV. According to the September 2003 report by UNAIDS on national responses, 38% of countries, including almost one-half of those in sub-Saharan Africa, have yet to adopt legislation to prevent discrimination on the basis of HIV status. Nearly two-thirds (64%) of countries lack laws to protect vulnerable populations.

Although substantial work remains to ensure the centrality of human rights in national responses, important progress was made in 2002-2003. With the support and assistance of UNAIDS, Cambodia enacted on a comprehensive law on HIV/AIDS in January 2003 and Malawi gave parliamentary approval in January 2004 to a rights-based policy on HIV/AIDS. Reforms on policies and laws are underway in a number of countries, including Belarus, India, Lesotho, Liberia, and the Russian Federation. UNAIDS provided regional trainings on human rights and HIV/AIDS in the Middle East, Francophone Africa, and Eastern Europe. UNESCO and UNAIDS established a small grants facility to support implementation of anti-discrimination initiatives, including projects begun in 2003 in Bangladesh, Malawi, Mozambique, Sri Lanka and Zambia.

In the prior biennium, UNAIDS enhanced the integration of human rights work in the Programme’s activities. UNDP-sponsored Leadership Development Programmes in Cambodia, Haiti, Nepal and Ukraine focused on building commitment and collaborative initiatives to address HIV-related discrimination and stigma. The World AIDS Campaign in 2003 emphasized the importance of reducing stigma, taking as its slogan the phrase “Live and Let Live.” Human rights figured prominently in a toolkit produced by UNAIDS and UNICEF for parliamentarians, entitled *What parliamentarians can do about HIV/AIDS: Action for children and young people*. In

January 2003, the first General Comment on AIDS by a Treaty Monitoring Mechanism focused on HIV/AIDS and the rights of the child.

## **SECTION V: CONCLUSION**

The global AIDS epidemic has entered a new phase. AIDS has continued to intensify in already heavily-affected countries, and new epidemics threaten Asia, Eastern Europe, the Pacific and Central America. At the same time, the world has dramatically increased its response to AIDS. There is unprecedented momentum of political leadership, financial resources and a body of expertise of effective interventions. However, this new phase brings new challenges—most significantly how to build urgently AIDS responses with national scope and impact and sustain them over the long term. It is not just a question of raising more resources, but ensuring that they are spent wisely to help countries mount sustainable and effective AIDS strategies, particularly in joining forces to assist them in strengthening their capacity to deliver these strategies. The world's increased recognition of the need to improve access to HIV treatment has been a welcome development during the last biennium. Treatment must be at the heart of every comprehensive AIDS strategy. Equally important however, is prevention. It is important that the world not lose sight of doing everything it can keep people from becoming infected in the first place.

Over 20 years of AIDS provides us with compelling evidence that unless we act now, we will be paying later—a trenchant message for the countries of Eastern Europe, Asia and the Pacific regions. AIDS demands that we do business differently; not only do we need to do more and do it better, we must transform both our personal and our institutional responses in the face of a truly exceptional global threat to security and stability.