JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNAIDS Biennial Progress Report

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1996 1997

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Table of contents

I. Introduction

1. The 1996–1997 biennium represents the first two years of programme activities of the Joint United Nations Programme on HIV/AIDS. This period has been crucial to the development of the Programme, largely in terms of determining how UNAIDS would operate and in which areas it could be most effective, within the framework of the worldwide response to the HIV epidemic.

2. By the early 1990s it had become clear to an increasing number of United Nations Member States that the HIV epidemic was undermining the efforts of national governments, non-governmental organizations and their partners to improve the health, economic well-being, and political stability of many countries, particularly in the developing world. As part of the need for an expanded response to a growing problem, there was a need for the United Nations system to better coordinate its efforts to deal with HIV/AIDS, and to increase the value of its contribution by speaking with a stronger and more unified voice.

3. It was in this context that UNAIDS was established. Its goals, as stated in the 1996–2000 Strategic Plan, are to expand and strengthen United Nations system efforts to reduce the transmission of HIV and sexually transmitted diseases (STD); to increase the quality and accessibility of treatment, care and support for people living with HIV/AIDS; to reduce individual and collective vulnerability to HIV infection and AIDS; and to reduce the adverse impact of HIV/AIDS on the health, livelihood and well-being of individuals and communities (SEE PANEL 1).

4. UNAIDS' first biennium marked a striking paradox in the evolution of the HIV epidemic and the response to it. In November 1997, just prior to World AIDS Day, UNAIDS and WHO announced that analysis of more accurate surveillance data had yielded startling new statistics on HIV/AIDS. The new data revealed that, by the end of 1997, more than 30 million people were estimated to be living with HIV—in addition to 12 million people who already had died from HIV-related causes. It was estimated that 5.8 million adults and children became infected with HIV in 1997 alone—equalling an average of about 16 000 new infections every day. These statistics were rendered all the more alarming by the fact that many in western nations had the perception that the 'AIDS crisis' was over. This misconception was further reinforced by the popular but erroneous belief that the introduction of antiretroviral therapy had somehow solved the problem. The paradox facing the world during the 1996–1997 biennium was that although people the world over acknowledged the HIV epidemic as being more serious than they had previously believed, the response was hampered by a growing sense of complacency.

5. This paradox of more accurate estimates of HIV infections—revealing an epidemic even larger and more widespread than had previously been evident—and growing public complacency with the epidemic, constitutes an enormous challenge to efforts to strengthen the global response to HIV/AIDS. Over the course of the past two years, UNAIDS has focused on developing its strategic approach, and using lessons learned about how the epidemic spreads, how best to respond to it, and how to harness the collective resources of the United Nations system. To effectively leverage the organizational resources of its Cosponsors in response to the epidemic, UNAIDS employs two equally important and mutually reinforcing strategies. First, it seeks to build worldwide commitment and political support for the response to HIV/AIDS through advocacy based on the most current information and technically sound analysis. Second, it seeks to improve access to and use of the best and most effective practices employed in responding to the epidemic.

6. The following report highlights the activities, achievements, progress and challenges of the UNAIDS Secretariat, and, to the extent possible, of the Programme's Cosponsors. It reflects a significant improvement in coordination within the United Nations system in response to the epidemic, as well as an expanding collaboration with civil society. These points are covered in sections detailing the current status of the epidemic and the global response; the strategic approach viewed as critical in shaping the response to the epidemic; the United Nations system response to HIV/AIDS; improving the functioning of the UNAIDS Secretariat; and challenges, opportunities and strategic options. The report aims to offer the reader an overview of key activities conducted during the 1996–1997 biennium and their significance, as well as of the work and priorities anticipated in the future. Information on how the specific recommendations issued by the Programme Coordinating Board (PCB) in its meetings of April 1997 and November 1997 were addressed is provided separately.

PANEL 1

UNAIDS MISSION STATEMENT

As the main advocate for global action on HIV/AIDS, UNAIDS will lead, strengthen and support an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

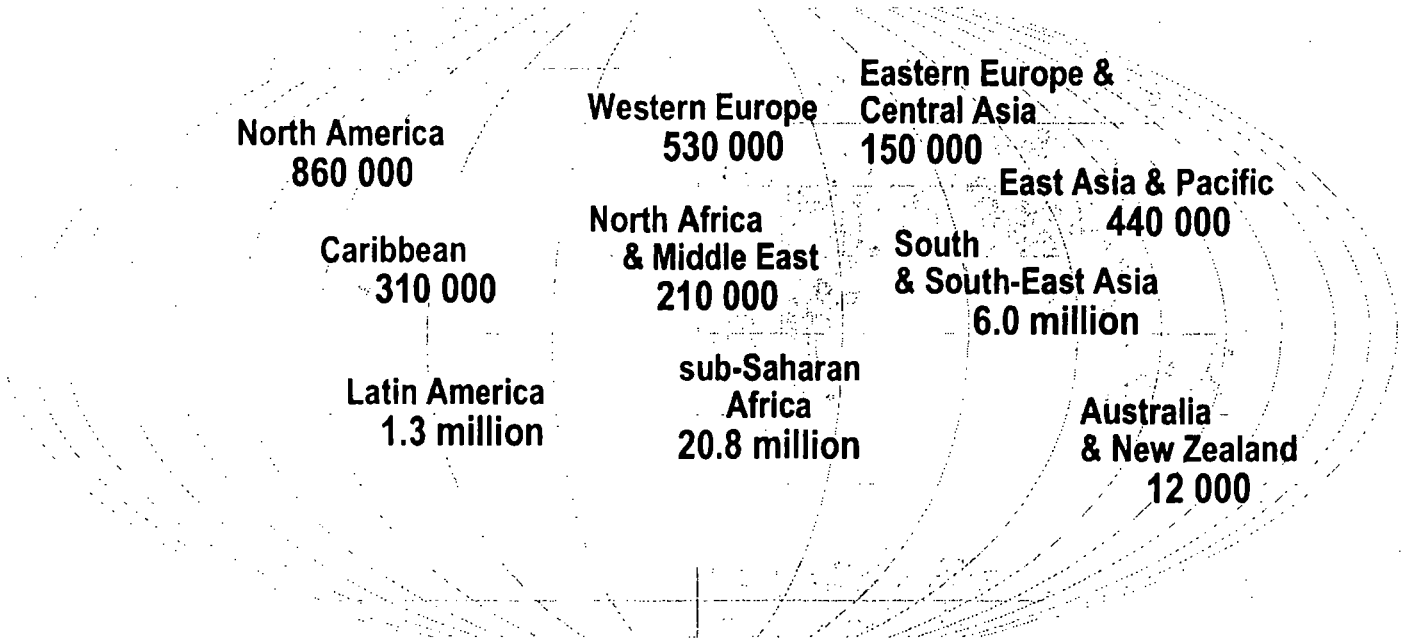
II. Current status of the HIV epidemic and the global response

A. Overview

7. Estimates available at the end of 1997 show that infection with the human immunodeficiency virus (HIV), which causes AIDS, is far more prevalent than previously thought—UNAIDS and WHO estimate that over 30 million people were living with HIV infection by the end of 1997 (SEE PANEL 2). Included in the figure of 30 million people are 1.1 million children under the age of 15. The overwhelming majority of HIV-infected people—more than 90%—live in the developing world. Due to limited access to counselling and testing, nine out of ten do not know that they are infected.

8. Even more alarming than the enormous number of people living with HIV/AIDS is the fact that the spread of the virus—about 20 years into the pandemic—continues largely unabated in many countries. Altogether, some 5.8 million people are believed to have acquired HIV infection in 1997 alone, including 590 000 children infected at birth or through breastfeeding. Overall, this is equivalent to nearly 16 000 new infections every day of the year. Assuming that current trends in many parts of the world will continue, it is estimated that more than 40 million people will be living with HIV by the year 2000.

Adults and children estimated to be living with HIV/AIDS as of end 1997



Total: 30.6 million

FSE/1 – 1 December 1997

UNAIDS Global HIV/AIDS and STD Surveillance WHO

9. An estimated 2.3 million people died of AIDS in 1997, about the same number as those who died of malaria. These deaths represent one-fifth of the total 11.7 million AIDS deaths since the beginning of the epidemic in the late 1970s. Of the people who died of AIDS in 1997, 46% were women and 460 000 were children. AIDS is already well established within the list of the top ten global killers. But the epidemic's worst impact is still to come. For example, more than twice as many people acquired HIV in 1997 than died of AIDS the same year. Because the vast majority of people living with HIV are in the developing world, access to antiretroviral drugs for most is difficult, if not impossible, and consequently mortality rates are unlikely to decline.

10. Although nearly every country is touched by HIV, the virus spreads very differently in different parts of the world and there are important differences in patterns of spread within the various communities and geographic areas of the same country (SEE PANEL 3).

11. Sub-Saharan Africa remains the region with the fastest-growing epidemic. The African epidemic is also the one that has been most underestimated in previous years. Now thought to have fully two-thirds of the total number of people living with HIV in the world, sub-Saharan Africa as a whole has reached the unprecedented level of 7.4% of all those aged 15 to 49 infected with HIV. Southern Africa remains the part of the continent worst affected by HIV. In some areas of the region, the proportion of the adult population living with HIV has doubled over the last five years and it is not unusual to see infection rates estimated at one in five adults and one in three pregnant women or even higher.

12. The epidemic is newer in Asia than in Africa, and only a few countries in the region have developed systems sufficient for monitoring the spread of HIV. For this reason, estimates of HIV in Asia often have to be made on the basis of less information than in other regions. Because over half of the world's population lives in the region, small differences in rates can make big differences in the absolute numbers of people infected. The Government of China reported at the end of 1996 that up to 200 000 people were living with HIV/AIDS, a figure estimated to have doubled by the end of 1997. In India, infection rates, believed to be less than 1% of the total adult population, and still low in comparison with many countries, are nevertheless over 10 times higher than in neighbouring China. Surveillance is uneven, but indications are that between 3 and 5 million people in India are living with HIV, the largest number within any one country in the world. Rates of HIV infection remain well under 1% in several South-East Asian nations, while other countries in the region show much higher levels of HIV spread. The reasons for these differences are not entirely clear. Nor is there any assurance that currently low rates will remain so, given the prevalence of risk behaviour, including commercial sex and, in some places, injection of drugs.

13. Thailand, with probably the best-documented epidemic in the developing world, is continuing to produce evidence of a fall in new infections, especially among sex workers and their clients. These groups accounted for the majority of the 750 000 persons currently infected, representing 2.3% of the adult population. The decrease in new infections is the outcome of concurrent and sustained prevention efforts aimed at increasing condom use among heterosexuals, boosting respect for women, discouraging men from visiting sex workers, and offering young women better educational and other prospects to discourage their entry into commercial sex. Notwithstanding this progress, HIV rates among Thailand's injecting drug users have stabilized at a relatively high level (around 40%), and a survey among men who have sex with men in Northern Thailand reported low AIDS awareness and condom use.

HIV/AIDS: Regional statistics and features, December 1997

Region	Epidemic started	Adults & Children living with HIV/AIDS	Adult prevalence rate (1)	Cumulative number of orphans (2)	% of HIV-positive adults who are women	Main mode(s) of transmission for adults living with HIV/AIDS*
Sub-Saharan Africa	late '70s early '80s	20.8 million	7.4%	7.8 million	50%	Hetero
North Africa & Middle East	late '80s	210 000	0.13%	14 200	20%	IDU - Hetero
South & South-East Asia	late '80s	6.0 million	0.6%	220 000	25%	Hetero
East Asia & Pacific	late '80s	440 000	0.05%	1 900	11%	IDU - Hetero - MSM
Latin America	late '70s early '80s	1.3 million	0.5%	91 000	19%	MSM - IDU - Hetero
Caribbean	late '70s early '80s	310 000	1.9%	48 000	33%	Hetero - MSM
Eastern Europe & Central Asia	early '90s	150 000	0.07%	30	25%	IDU - MSM
Western Europe	late '70s early '80s	530 000	0.3%	8 700	20%	MSM - IDU
North America	late '70s early '80s	860 000	0.6%	70 000	20%	MSM - IDU - Hetero
Australia & New Zealand	late '70s early '80s	12 000	0.1%	300	5%	MSM - IDU
TOTAL		30.6 million	1.0%	8.2 million	41%	

** IDU: transmission through injecting drug use – Hetero: heterosexual transmission – MSM: men who have sex with men*

GE-98001-21 – 1 April 1998

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(1) The proportion of adults living with HIV/AIDS in the adult population (15 to 49 years of age).

(2) Orphans are defined as children who lost their mother or both parents to AIDS when they were under age 15.

PANEL 3

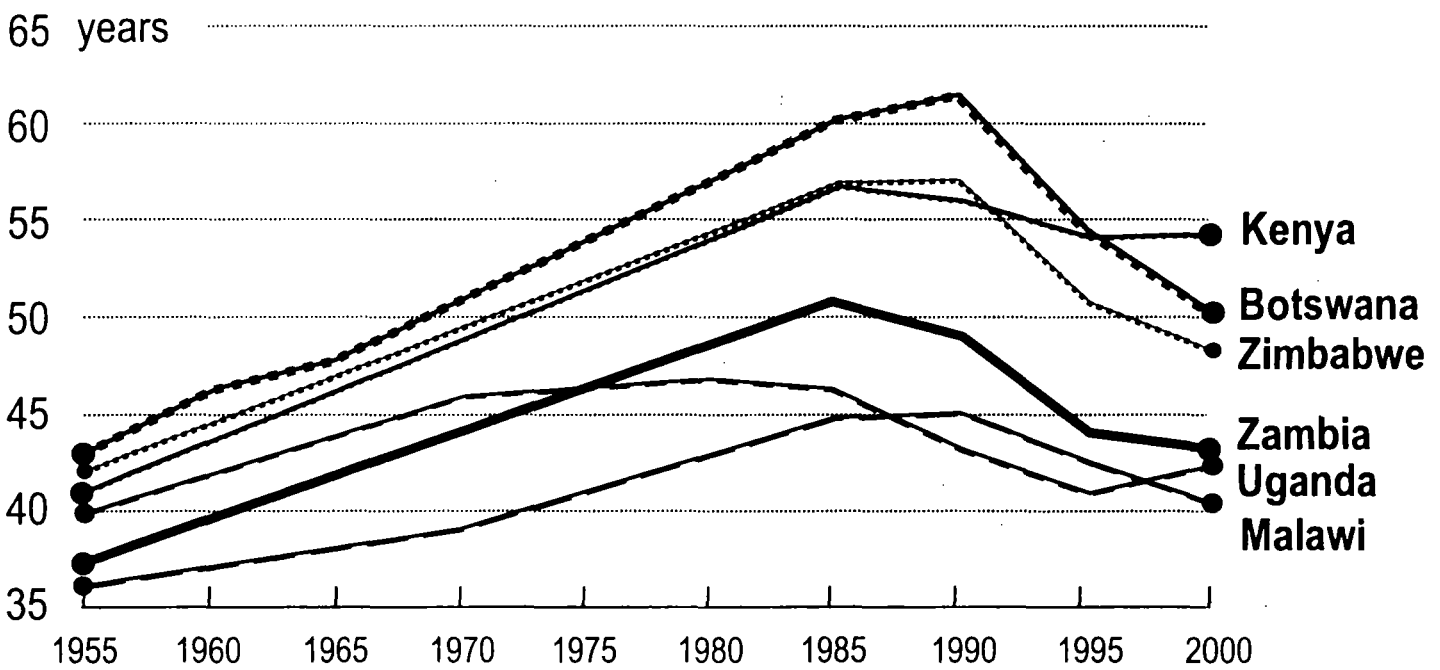
14. In Latin America, the picture is also heterogeneous. For the most part, HIV is concentrated in neglected populations living on the social and economic margins of society. The epidemic has taken its greatest toll on men who have sex with men and injecting drug users. Systematic data collection is difficult in these groups and information remains rather scarce. Nevertheless, studies on Mexican men who have sex with men show that, on average, as many as 30% of them may be living with HIV. Rates in drug users vary from between 5% and 11% in Mexico to close to 50% in Argentina and Brazil. Rising rates in women show that heterosexual transmission is becoming more prominent. In Brazil, the male/female ratio of AIDS cases has dropped from 16:1 in 1986 to 3:1 today. Although HIV rates in pregnant women are still comparably low in general, they have reached levels of 1% in Honduras and more than 3% in localities in Brazil. Rates remain substantially higher in the Caribbean with reports of up to 8% of pregnant women carrying the virus already in a number of localities.

15. Drug injection is a major factor behind the dramatic surge in HIV infection in several Eastern European nations, accounting for the majority of the 100 000 new infections estimated to have occurred in 1997. In Ukraine, where around 70% of infections have been in drug users over the past three years, it is estimated that approximately 110 000 people are living with HIV at present. Russian officials estimate there are about 350 000 regular drug users in the country, many of whom share injecting equipment. In Belarus, Moldova and Russia, new cases of syphilis rocketed from very low levels in the late 1980s to well above 2 per 1 000 population by 1996, with continuously increasing trends. An untreated sexually transmitted disease not only makes HIV, when present, spread much more easily from one partner to the other, but is important as a marker of potential HIV spread.

16. The growing gap between the developed and the developing world concerns not only the scale of HIV spread, but also mortality from AIDS. In North America, Western Europe, Australia and New Zealand, newly-available antiretroviral drugs are reducing the speed at which HIV-infected people develop AIDS. In Western Europe, evidence suggests that new AIDS cases will have fallen by around 30% in 1997 compared with 1995, before antiretroviral treatment became available. The fall is greatest in countries in which infection has been concentrated in homosexual men, in whom HIV rates began dropping 5–10 years earlier, demonstrating that the decline in AIDS cases is often the combined result of better prevention and better treatment. In the United States, newly-published figures indicate that the first-ever annual decrease in new AIDS cases—6%—occurred in 1996, and an even bigger decrease is expected in 1997. Again, the largest fall—a drop of 11%—was in homosexual men.

17. AIDS continues to have a significant impact on reducing life expectancy—one of the most accepted indicators for development (SEE PANEL 4). The gains achieved over the last few decades in much of the developing world will in some places be cancelled out by HIV. By the end of the decade, a number of countries in Southern and Eastern Africa will see a reduction in life expectancy of 10 years or more, compared with 1990. Another well-established indicator for development is the rates of infant and child survival. HIV continues to erode the substantial gains achieved in this area. Already, in the countries most affected by the epidemic, one-quarter more babies under 12 months old are dying than would be the case if there were no HIV. In these same countries, infant and child mortality rates are expected to rise by up to 100% or more compared with 1990 figures because of AIDS. Since the beginning of the epidemic, it is also estimated that more than 8 million children have lost their mothers to AIDS when they were less than 15 years old; many of them also lost their fathers. This figure is expected to almost double by the year 2000.

Projected life expectancy at birth
Selected sub-Saharan countries



Source: World Population Prospects: The 1996 revision, *United Nations Population Division, 1996*

FSE/4 – 1 December 1997

UNAIDS Global HIV/AIDS and STD Surveillance | WHO

PANEL 4

18. In many countries, AIDS is the leading cause of death in adults. In the United States, after introduction of combination therapy to slow down the progression of HIV disease in 1996, AIDS dropped into second place among leading causes of death in people aged 25–44 for the first time since 1992. In heavily-impacted countries in Africa, AIDS accounts for more than one-third of adult deaths and for women between the ages of 20 and 44, as many as seven out of every 10 deaths. In trading centres which are home to large numbers of younger adults, nearly nine out of 10 deaths in 15-to-49-year-olds are HIV-related.

19. Despite progress made in a limited number of countries in slowing the spread of HIV and a growing sense in many wealthier countries that the major threat of the epidemic is over—following the introduction of highly active antiretroviral therapy—the virus continues its expansion at a staggering rate in most parts of the world.

B. New developments in the response to HIV/AIDS

20. The 1996–1997 period witnessed a number of significant developments in the response to the epidemic, as well as important lessons learned and reinforced in the area of HIV prevention and treatment (SEE PANEL 5).

PANEL 5

HIV PROGRAMMES WORK

- Prevention strategies to promote safer sexual behaviour can significantly reduce HIV transmission rates.
- Voluntary counselling and testing can be effective in reducing transmission of HIV.
- Mother-to-child transmission of HIV can be cut in half by a relatively short zidovudine (AZT) regime feasible in developing countries.
- Sexual health and life-skills education for young people helps postpone first intercourse and decrease the risk of acquiring HIV or other sexually transmitted diseases or pregnancy among those already sexually active.
- Male condoms protect against sexual transmission of HIV.
- The female condom is acceptable, effective, and can be widely distributed.
- Treating sexually transmitted diseases reduces HIV transmission.
- Needle exchange, integrated with AIDS education through peer-outreach programmes, helps keep HIV rates low in drug users when started early.
- New combination antiretroviral therapies significantly reduce morbidity and mortality.

Prevention programmes can lead to a lower rate of HIV transmission

21. The 1996–1997 biennium marked considerable progress in documenting the success of HIV prevention programmes in demonstrating that behavioural change on a national scale can change the course of the epidemic. With the help of data from behavioural surveys repeated over time and HIV sentinel surveillance in pregnant women, researchers and programme managers in Thailand and Uganda have documented reduction in sexual risk behaviour since the early 1990s. This change in behaviour has led to a significant decline in HIV prevalence, especially among young people.

22. In Uganda, over the past five years, there was an overall decline of 40% in the rate of HIV prevalence among pregnant women in urban areas. This decline was closely linked to a two-year delay in first sexual intercourse, a large increase in condom use, and a small reduction in the number of non-regular sexual partners.

23. In Thailand, behavioural surveys indicated that the majority of sexual risk activities were associated with commercial sex. This has resulted in a national policy of '100% condom use', established with the active involvement of brothel owners and sex workers. National mass media and peer education among young people help to reinforce the policy. Researchers have documented a clear reduction in the incidence of HIV, illustrated by the decline in HIV prevalence from 8% in 1992 to less than 3% in 1997, among young military conscripts.

The role of voluntary counselling and testing in preventing HIV infection

24. A randomized, controlled trial to test the effectiveness and consequences of voluntary counselling and testing for prevention of new HIV infections confirmed that counselling and testing can reduce risk behaviour. These findings come from the Multisite Voluntary Counselling and Testing Study, conducted from 1995 to 1997 with Muhimbili University College of Health Sciences, Dar es-Salaam, Tanzania, Kenya Association of Professional Counsellors and University of Nairobi, Nairobi, Kenya, and Queen's Park Counselling Centre, Port-of-Spain, Trinidad[1]. The study also provided crucial data on the practical aspects of voluntary counselling and testing services in resource-constrained settings (SEE PANEL 6).

PANEL 6

THE MULTISITE VOLUNTARY COUNSELLING AND TESTING STUDY

This study, conducted in 1995-1997 in Kenya, Tanzania and Trinidad, compared voluntary counselling and testing to a health-information control programme. Preliminary results have indicated that:

- voluntary counselling and testing produced greater reductions in unprotected sexual intercourse with non-primary partners;
- voluntary counselling and testing were more effective in reducing unprotected intercourse with commercial sex partners;

[1] This study was a collaborative effort with WHO, the Center for AIDS Prevention Studies of the University of California in San Francisco, Family Health International's AIDS Control and Prevention Project, the United States Agency for International Development and the UNAIDS Secretariat.

- voluntary counselling and testing were more effective in reducing unprotected sexual intercourse among couples who had been tested and counselled together;
- client-centred counselling methods were effective in helping clients trust that their confidentiality would be respected;
- client-centred counselling strengthened the ability of individuals to cope with their HIV diagnosis, and facilitated early referrals to care and support
- there was no evidence that voluntary counselling and testing increased the incidence of negative life events (e.g., relationship break-up, discrimination, etc.), although there were indications that women who test HIV-positive may need additional support services; and
- prospective clients were willing to pay a minimal fee for voluntary counselling and testing.

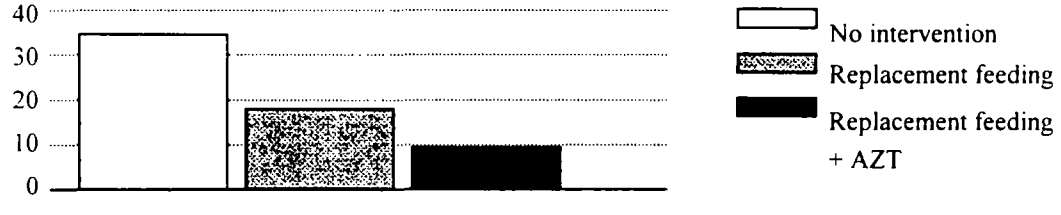
Preliminary results from the Voluntary Counselling and Testing Efficacy Study.
Data presented at the satellite workshop 'Making Counselling and Testing Work: Efficacy and Feasibility of Voluntary Counselling and Testing in Developing Countries', Tenth International Conference on AIDS and STDs in Africa, December 1997, Abidjan, Côte d'Ivoire

Use of AZT in preventing mother-to-child transmission of HIV

25. In February 1998, a trial in Thailand, sponsored by the Thai Ministry of Public Health and the United States Centers for Disease Control and Prevention, demonstrated that the use of a relatively short zidovudine (AZT) regimen, involving the administration of the drug to mothers during the last four weeks of pregnancy and during delivery, reduces mother-to-child transmission of HIV by half among women who do not breastfeed (SEE PANEL 7). Combined with access to safe alternatives to breastfeeding, zidovudine therefore offers an effective and feasible way to reduce mother-to-child transmission, particularly in developing countries. In light of this study, the UNAIDS Secretariat, in collaboration with UNICEF and WHO, hosted a meeting in March 1998 to plan programme implementation for the prevention of mother-to-child transmission of HIV. Further research needs to explore the efficacy of the shorter regimen among breastfeeding populations.

PANEL 7

PERCENTAGE OF CHILDREN INFECTED BY THEIR MOTHER, IF THE MOTHER IS HIV INFECTED, WITH AND WITHOUT INTERVENTION



Adapted from the results of a study conducted by the Ministry of Public Health, Thailand, and the United States Centers for Disease Control and Prevention, announced on 18 February 1998.

Female condoms bring results in slowing the spread of HIV and other sexually transmitted diseases

26. In 1997, research sponsored by UNAIDS compared female and male condom use. The study showed that in the group of women who were given the choice of using either the male or the female condom, the average incidence of sexually transmitted diseases decreased by 34%. The number of unprotected sex acts decreased by 25% compared to the group of women who had only the choice of using male condoms. Other studies indicate that the female condom is an acceptable option for women, providing greater opportunities to communicate about safer sex.

27. In an effort to increase the availability of female condoms, UNAIDS negotiated a lower price with its manufacturer, the Female Health Company, resulting in the availability of the female condom in developing country public sectors. More than four million female condoms were purchased as of April 1998 in the developing world and substantial sales were registered in South Africa, Uganda, Zambia and Zimbabwe

Increasing acceptance of harm reduction approaches for the prevention of HIV infection among injecting drug users

28. Initiatives based on a public-health approach to HIV prevention among injecting drug users have long proven effective in reducing the spread of HIV infection among those who inject drugs. Both developing and industrialized countries are now adopting an increasing range of harm reduction measures such as needle exchange programmes and substitution therapy. A recent international review[2] compared rates of change of seroprevalence among drug users in cities with and without needle exchange programmes. On average, HIV prevalence increased by 5.9% per year in the 52 cities without needle exchange programmes, and decreased by 5.8% per year in the 29 cities with needle exchange programmes.

Preventing and treating tuberculosis in people living with HIV/AIDS

29. In February 1998, WHO organized a consultation with UNAIDS on preventive therapy for tuberculosis in people living with HIV. Given that HIV is a major cause of the large increase over the last decade in the incidence of tuberculosis, meeting participants maintained that preventive therapy is a public health need in populations with a high prevalence of HIV infection. In addition to energetic treatment for active tuberculosis using the DOTS strategy[3], participants recommended that preventive therapy be part of a package of care for people living with HIV/AIDS. Recommendations on appropriate drug regimens and their administration and supervision have also been disseminated.

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2 *Lancet*, 21 June 1997; **349**(9068): 1797–1800

3 (Directly Observed Treatment, Short Course). The components of the DOTS strategy are a recording and reporting system to monitor programme efficiency; case detection and diagnosis; patient management; drug supply and management; and political commitment.

Augmenting the availability and affordability of essential drugs

30. In December 1997, WHO revised its essential drug list to include several drugs of special interest to people living with HIV, including sulfadiazine (to treat toxoplasmosis), acyclovir (to treat herpes), and fluconozole (to treat systemic yeast infections). AZT is now also part of the list, as an important therapy for preventing mother-to-child transmission of HIV. Inclusion of these drugs on the WHO essential list leads to a reduction in price through bulk purchases, with consequent greater availability of the drugs for people living with HIV/AIDS.

Highly-active antiretroviral treatment (HAART)

31. In 1996, a new approach to antiretroviral therapy named 'highly-active antiretroviral treatment', or HAART, was developed. This treatment involves the combination of at least two nucleoside reverse transcriptase inhibitors and a protease inhibitor drug. While HAART cannot be considered a cure for HIV infection, in some cases it can halt replication of HIV, and resulting damage to the immune system. Consequently, patients receiving HAART develop AIDS more slowly, and live longer. However, the usefulness of HAART is limited by the relatively high cost of therapy (approximately US$ 10 000 per year), which is prohibitive in most countries; the side effects of the drugs; its difficult treatment schedule; and variable tolerance and response to therapy. In areas where HAART has been introduced on a wide scale, significant decreases in AIDS cases and mortality (down 30% to 50% over a one-year period), and shifts in the pattern of clinical problems encountered by people living with HIV/AIDS have been observed.

Including HIV/AIDS on the highest political agendas

32. In an increasing number of countries, senior government officials and legislative bodies addressed AIDS for the first time during the 1996–1997 biennium. HIV/AIDS received acknowledgement as a critical issue at major international fora, as well. These included the address by President Nelson Mandela of South Africa, with the support of UNAIDS, to the 1997 World Economic Forum in Davos on the impact of HIV/AIDS on development in Africa. The declaration of the G-8 Summit in 1997 also referred to HIV/AIDS, urging that governments take strong action to address the epidemic in their own countries and to assist developing countries and UNAIDS.

33. On 1 December 1997, the United Nations General Assembly, in conjunction with UNAIDS, organized a special session on HIV/AIDS to commemorate World AIDS Day. High-level representatives, including the Secretary-General of the United Nations, the President of the General Assembly, and United States Secretary of State Madeleine Albright, attended the session. In 1997, discussions and resolutions of other political bodies, such as the Association of South-East Asian Nations, also addressed the epidemic.

34. During the 1996–1997 period, some countries enacted proactive HIV-related legislation. An example is the Philippines, whose new legislation comprehensively promotes and protects the human rights of people suspected or known to be living with HIV/AIDS, outlaws compulsory testing, guarantees privacy, and expands provision of HIV education and information for children and youth (SEE PANEL 8). In 1998, the Inter-Parliamentary Union adopted a UNAIDS-promoted resolution at its meeting in Namibia. Despite several notable expressions of political commitment to an effective and expanded response to the HIV epidemic, denial of the epidemic's multiple consequences and the need to address HIV/AIDS as a top priority continue.

PANEL 8

POLITICAL ADVOCACY IN THE PHILIPPINES

President Ramos of the Philippines has displayed a keen understanding of HIV/AIDS and the impact of a significant epidemic on the Philippines. After meeting with two HIV-infected women in the Presidential Palace on World AIDS Day in 1992, he formed the Philippine National AIDS Council.

Since that time, he and his Cabinet have shown continued concern about HIV. At the end of 1996, he declared 1997 as National AIDS Prevention Year in the Philippines, the year in which the Philippines hosted the Fourth International Congress on AIDS in Asia and the Pacific.

During his opening speech to the Congress delegations, he declared the AIDS Bill pending before the Philippine Congress as urgent, resulting in its enactment in February 1997. The United Nations system assisted the process by providing technical support in the preparation and passing of the Bill.

The AIDS Law institutes a nation-wide HIV/AIDS information and education programme, in schools and workplaces, and for departing workers and tourists entering and leaving the country. It establishes a comprehensive HIV/AIDS monitoring system; strengthens the Philippine National AIDS Council; creates a special HIV/ AIDS service within the Department of Health, outlaws discrimination, bans mandatory testing, strengthens and expands the social support and testing services in the country, and insists on confidentiality for people living with HIV.

A copy of the Law is available via the web site of the Department of Health, The Philippines (http://www.doh.gov.ph/aids/index.htm).

III. Expanding the response to HIV/AIDS: the strategic approach

35. Notwithstanding the 16 000 new HIV infections that occur every day, the epidemic is not out of control everywhere. Some countries and communities have managed to stabilize HIV rates or achieve a turnaround. Some have made progress on care and support for people infected and affected. A closer look at individual country responses, and at the corresponding achievements and failures, helps identify the correlates of success (SEE PANEL 9).

PANEL 9

SOME IMPORTANT FEATURES OF EFFECTIVE PROGRAMMES

- Effective programmes are those which receive **political commitment** stretching up from the community to a country's highest level.
- To be effective, programmes have to promote openness about HIV, make people aware that HIV exists and why it exists, make them comfortable talking about the epidemic and how to cope with it, and **dissipate fear and prejudice** against people already living with HIV or AIDS.
- It is essential to establish scientifically and ethically sound **systems that give information** on where people in the country are infected and why, and ensure analysis of the factors affecting their vulnerability to HIV. Such mapping is the best basis for programme planning.
- Effective programmes have **focused action** with steadily expanding coverage. To begin with, action should be focused on locally important vulnerable populations and geographic areas where HIV is an emergency. Planners must nevertheless take into account the need to reach many different populations of this kind, including those who will become exposed tomorrow. Action must also be focused on achieving safer behaviour through multiple, complementary interventions of known effectiveness.
- As a complement to focused action, effective programmes create **general awareness** and knowledge in the rest of the population, especially among young people, who represent more than half of all of those infected after infancy. They are essential to counter stigma and discrimination. This can be accomplished cost-effectively through mass-media campaigns, peer-outreach education and life-skills programmes.
- Effective programmes offer both **prevention and care.** Care services have benefits that extend even beyond the human rights and needs of the sick individual. They help convince others that the threat of HIV is real and make prevention messages more credible.
- Because the epidemic and our understanding of it are highly dynamic, programmes have to be **flexible** enough to keep up with the changes. This requires careful monitoring and evaluation of interventions and programmes.
- To be successful, programmes need to involve **multisectoral and multilevel partnerships** in and between government and civil society, with AIDS being routinely factored into the individual and joint agendas. Not only do they have a stake in participating, but the various partners have valuable contributions to make to HIV prevention, care and support at levels ranging from the national to the district and community.
- **Mainstreaming and resource mobilization** are corollaries of the preceding feature. Effective programmes identify opportunities to involve partners with similar goals and objectives, and capitalize on synergies between AIDS and other programmes.
- Effective programmes are those which take a **long-term approach** and build societal resistance to HIV. We must promote safer attitudes and behaviour in society, especially in the younger generation, that will ultimately offer serious resistance to the spread of HIV.

36. The initial reaction to the epidemic was to persuade individuals and selected groups to change their behaviour by informing them about HIV/AIDS. Over time, it became understood that behaviour change required not only information, but also decision-making skills, accessibility of tools and services, and supportive peer norms.

37. By the mid-1980s, it was more generally appreciated that individuals do not always control their own risk situations and that societal behaviour affects the vulnerability of individuals. At the same time, as individuals infected with HIV earlier in the epidemic gradually fell ill and died, rocking the foundations of families and communities, the need to provide health care and cushion the epidemic's impact acquired prominence—action that required the input of different sectors of society.

38. More recently, a growing appreciation has emerged that HIV/AIDS is also a development challenge. To the extent that people's vulnerability has social and economic roots, often including marginalization, poverty and women's subordinate status, these conditions need to be tackled as a way of making society as a whole less vulnerable to HIV over the long term—and as a way of advancing other social and economic goals.

39. The strategic approach that UNAIDS advocates draws on all of these approaches: focused programmes to promote safer behaviour by individuals and groups at higher risk of infection; societal action to reduce the vulnerability of those most at risk of HIV infection and to mitigate the impact on those affected by the epidemic; and more active mainstreaming of approaches to dealing with HIV/AIDS within broader development efforts (SEE PANEL 10). Rather than propose a universal blueprint, the Programme has promoted a set of principles on the basis of which each society can find its own locally relevant path to action:

- Development of a country strategy should begin with a serious analysis of the local HIV/AIDS situation, risk behaviour and vulnerability factors, with the resulting data serving to prioritize and focus initial action.

- Ignoring simplistic solutions, the strategy should build from tried and tested methods of HIV/AIDS prevention, care and impact alleviation, even when these are culturally sensitive (e.g. condom promotion among sex-work clients) or require hard political choices (e.g. needle exchange for drug injectors).

- From the outset, an appropriate balance of interventions should address the needs of both people at higher risk and those at potential risk (e.g. young people and married women).

- The strategy should seek to build expanded partnerships between governments and civil society at all levels in order to gear up the response, and to progressively encourage the involvement of all relevant sectors and resource mobilization that taps into a diversity of human and institutional sources (SEE PANEL 11).

PANEL 10

PATHWAYS TO EXPAND THE RESPONSE TO HIV/AIDS

- Expanding coverage of programmes
- Focusing action
- Expanding partnerships in the design, implementation and evaluation of HIV/AIDS-related policies and programmes
- Involving all relevant sectors
- Increasing resources mobilized in support of HIV/AIDS prevention and care
- Enhancing the sustainability of HIV/AIDS programmes over time

Source: *Expanding the Global Response to HIV/AIDS through Focused Action,* UNAIDS *Best Practice* Collection, Key Material, 1998.1, pp.12–14

PANEL 11

WHY IT MAKES SENSE TO ALL SECTORS OF SOCIETY TO BE INVOLVED

- Each sector has a stake in prevention because it stands to suffer the impact of an out-of-control epidemic—an education sector where 30% of the teachers are infected, or a defence sector with infection rates in the military of over 60%.
- Each sector has easy access to populations that they can help inform and educate at relatively little extra cost.
- Most sectors have the mandate of promoting human development and quality of life, and these are compatible and synergistic with vulnerability reduction, e.g. through the promotion of the basic right to education and participation.
- Multisectoral action that draws on the resources of multiple government ministries, non-governmental organizations, academic institutions, businesses and communities can make for a large-scale expanded response that is sustainable over time.

IV. The United Nations system response to HIV/AIDS

A. Overview

40. One of the Programme's critical goals during the 1996–1997 biennium has been to develop a coherent United Nations system response to HIV/AIDS. Fulfilling this goal was a central reason for creating UNAIDS. Stimulated by the United Nations reform efforts, the UNAIDS Secretariat and the Cosponsoring Organizations have made a considerable investment in meeting this challenge. At the country level, 127 United Nations Theme Groups on HIV/AIDS were established in 152 countries. The Programme and its Cosponsors developed a global workplan for 1996–1997. The foundation for an integrated plan for global activities was also created through the preparation of the Coordinated Appeal for Supplemental Funded Activities. UNAIDS and its Cosponsors collaborated successfully with several United Nations agencies and programmes, such as the United Nations International Drug Control Programme (UNDCP), the International Labour Organisation (ILO), the Food and Agriculture Organization of the United Nations (FAO), the Office of the United Nations High Commissioner for Human Rights (UNHCR), the United Nations Development Fund for Women (UNIFEM), the United Nations Secretariat in New York and regional economic commissions, including the Economic and Social Commission for Asia and the Pacific and the Economic Commission for Latin America and the Caribbean.

41. The response of the United Nations system as a whole to the epidemic is governed by a common approach, as stated in the UNAIDS 1996–2000 Strategic Plan. The Strategic Plan commits the United Nations to assisting countries to respond to HIV/AIDS. It also signals the need to have accurate and up-to-date information on the evolution of the epidemic. The Plan focuses collective efforts on areas in which the United Nations is best equipped to act and influence the course of the HIV epidemic. Finally, the Strategic Plan, together with the Memorandum of Understanding signed by the Programme's Cosponsors in March 1996, stipulates that the six Cosponsoring Organizations will work together and with other partners in a manner commensurate with the comparative advantages of each.

Monitoring the epidemic

42. Effective strategies to respond to HIV/AIDS are critically dependent on an understanding of its dynamics and determinants. As a consequence, surveillance and monitoring are core elements of the United Nations response. The UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, together with its partners, such as the Collegial Network for the Monitoring of the Status and Trends of the HIV/AIDS Pandemic (the MAP Network) is now in a position to ensure better coordination on data-gathering, and a reliable and acceptable common source of data on the epidemic for the world has been established. UNAIDS conferred with the Cosponsors and governments at country level to develop a system for preparing and maintaining country profiles. These profiles, which are updated regularly, contribute significantly to common information and understanding. Epidemiological surveys and country profiles demonstrate, for example, that much remains to be done to address women's vulnerability to HIV/AIDS. In some cities, HIV prevalence among young women between the ages of 15 and 19 is as high as 16% to 20%, as compared to between 1% and 4% for young men of the same age.

Advocating for an expanded response

43. Increasing the level of awareness of the global epidemic and building a sense of urgency about the need to mount an effective response is another area in which UNAIDS has focused its efforts. Intense efforts have been necessary to overcome denial that a pervasive HIV epidemic exists, even in countries where prevalence rates are well over 10 per cent, or in places where the rate of new infections is clearly alarming. During the 1996–1997 biennium, UNAIDS and its Cosponsors focused on the needs of children, in particular.

44. Over the past two years, UNAIDS has also advocated for the greater involvement of political leaders and the business sector in the response to HIV/AIDS. The Secretary-General of the United Nations, the Heads of all Cosponsoring Agencies and the Executive Director of UNAIDS have mobilized special efforts to reach the highest levels of political leadership, though country visits and regional and global meetings. The Secretary-General, Mr Kofi Annan, also issued a statement and a video message for television on the occasion of World AIDS Day in 1997. On a visit to India in 1996, Mr James D. Wolfensohn, President of the World Bank, emphasized the need to take swift and effective action to address a growing epidemic in his public messages and meetings with Indian Government officials. In 1997, the World Bank also published a policy research report strongly advocating for early and vigorous action by governments in response to the HIV/AIDS epidemic. The Executive Director of UNFPA determined that the featured theme for World Population Day in 1996 would be HIV/AIDS. The Director-General of WHO initiated several major consultations on topics related to HIV/AIDS, including one on antiretroviral drugs and one on breastfeeding and HIV/AIDS. The Director-General of UNESCO has called the attention of the scientific community to the need for accelerated development of an HIV vaccine, and has strongly encouraged political leaders to close the widening ethical gap between the treatment available to people living with HIV/AIDS in the industrialized and developing worlds. In addition to serving as the principal cosponsor of the 1997 and 1998 World AIDS Campaigns (on children and young people, respectively), UNICEF published its annual *Progress of Nations* in 1997, with a discussion of children and HIV/AIDS as a major issue affecting development. The Executive Director of UNDP has continued to advocate for model standards on HIV/AIDS in the United Nations workplace. Several UNDP publications, such as the *Human Development Report* and, at country level, the 1997 *Namibia Human Development Report*, now highlight the effect of the HIV epidemic on development indices.

45. Among the examples of how non-traditional resources can contribute to a response to the epidemic, as discussed in this report's section on advocacy and public information, are:

- the creation of the Global Business Council on HIV/AIDS;
- the high-level coverage on HIV/AIDS at annual meetings of the World Economic Forum; and
- UNAIDS' partnership with the Rotary Club.

Strengthening the national response

46. Key to the success of the United Nations response has been the development of mechanisms to shape and strengthen United Nations efforts to respond to the HIV epidemic at country level. The United Nations Theme Groups on HIV/AIDS, assisted in many countries by UNAIDS Country Programme Advisers or Focal Points, facilitate this process. Theme Groups largely

focus on providing support for the strategic planning and review required to develop an expanded response to HIV/AIDS at country level; strengthening national technical and financial resource-mobilization capacities; supporting advocacy on HIV/AIDS at country level; and harmonizing United Nations system[4] initiatives on HIV/AIDS. The section on country-level responses to HIV/AIDS contains a detailed review of the problems encountered and progress made in these areas.

47. In 1996 and 1997, the United Nations Theme Groups on HIV/AIDS have grown in number and progressed from an information-sharing stage to one of more active coordinated planning. United Nations agencies and programmes at country level have taken on increasing ownership of the UNAIDS approach during this time. Evolution of Theme Groups over the past two years has also taken place within the framework of overall United Nations reform. It is still too early to draw definitive conclusions, but where there is a United Nations Development Assistance Framework (UNDAF) in place (some 18 countries at the present time), there is strong potential for better planning and coordination on HIV/AIDS. Conversely, the UNDAF process can also use the Theme Group experience in some countries as a map towards more collaborative efforts in other areas.

Mechanisms for collaboration

48. The Programme and its Cosponsors have channelled a great deal of energy and resources into developing global and regional mechanisms for technical cooperation. One such mechanism is the Coordinated Appeal, which has served both to mobilize supplementary funds for Cosponsors' HIV/AIDS-related activities and to harmonize activities among Cosponsors at global level. Although funding of the proposals contained in the Appeal has met with mixed success, it has served to clarify responsibilities among the Cosponsors; increase mainstreaming of HIV/AIDS into the core programmes of the cosponsoring organizations; and provide a basis for more concerted efforts to build an integrated workplan of the Cosponsors at global and regional levels.

49. Interagency working groups (IAWG) in several thematic areas related to the HIV epidemic have been useful in coordinating and stimulating activities; these groups help to build policy consensus and harmonize programme planning.

50. Another global and regional mechanism for developing technical cooperation on HIV/AIDS is the technical resource network. The primary objective of this mechanism is to strengthen institutional capacity for the response to the epidemic in regions and between countries. The designation of collaborating centres in many areas, support to several global and regional networks, and the establishment of three UNAIDS intercountry teams in Asia and Africa have moved this development forward. The section on regional collaboration with Cosponsors outlines new regional and global partnerships for expanding the response to HIV/AIDS.

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[4] The United Nations system at country level refers to the combined human, financial and logistic resources of the member agencies of the United Nations Theme Group on HIV/AIDS and technical working groups, with the support of their regional and headquarters offices, and with the support of the UNAIDS Country Programme Advisers and Secretariat.

Best Practice development

51. UNAIDS' first biennium has also been a critical time for improving the content and use of the body of knowledge constituting the 'best practice' needed to accelerate the global response to HIV/AIDS. The past biennium has seen the development and dissemination of the Programme's *Best Practice* Collection, concentrating particularly on what works in the area of HIV prevention, and the launching of several collaborative ventures with key institutions and partners in the area of human rights, care and support, migration, gender, development, sex work, and injecting drug use, among others. Together with its Cosponsors and other partners, UNAIDS has initiated or continued innovative work in areas such as religion, the military, prisons and police forces.

Access to care

52. The one issue to most capture the attention of those working in the field of HIV/AIDS is the implication for the developing world, of therapeutic advances made in 1996 and 1997. No other area emphasizes more clearly the linkage between prevention and care, and the ethical and pragmatic dimensions of programmatic decisions. The newly available data and information increase the responsibility to act in such areas as mother-to-child transmission. UNAIDS and its Cosponsors need to think critically about the strategic options in relation to a range of factors, together with affected countries as well as partners from within and outside the United Nations system, including pharmaceutical companies, infant food manufacturers, groups promoting breastfeeding and women's organizations. These include limited funds for HIV/AIDS programming, the difficulty of ensuring access to care for people living with the virus, disparities between countries in terms of HIV prevalence and resources to deal with it, in addition to issues such as the need to give clear and consistent advice on breastfeeding, in the case of mother-to-child transmission.

53. In the area of increasing access to care for people living with HIV/AIDS, UNAIDS has launched pilot projects in developing countries. Despite the limits of their scope, these projects are a first step toward gaining valuable information about how to operationalize programmes promoting access to care on a broader scale. While UNAIDS has not advocated for the widespread use of antiretroviral drugs in resource-poor settings, countries are increasingly under pressure to provide better access to treatment, including antiretrovirals, and are seeking guidance in this area.

54. The current status of the United Nations system response to HIV/AIDS suggests that progress made in some areas continues to be balanced by dilemmas and difficulties in others. While partnerships within and outside the United Nations are getting stronger, they will need constant nurturing and expansion.

B. Dynamics and determinants of the HIV epidemic

55. In 1996, the UNAIDS Secretariat and WHO formed a Working Group on Global HIV/AIDS and STD Surveillance, with the goal of ensuring the timely and consistent flow of information at national, regional and global levels. With the same objective of reinforcing surveillance activities, the UNAIDS Secretariat has provided a combination of financial and staff support (mainly in the area of epidemiological surveillance) to WHO regional offices in Africa, Europe, South-East Asia

and the western Pacific, as well as to the Pan American Health Organization. As a supplement to these activities, UNAIDS also established a partnership with the François-Xavier Bagnoud Center on Health and Human Rights (located at the Harvard School of Public Health in Boston, U.S.A.) and with Family Health International's AIDS Control and Prevention Project (AIDSCAP—recently reconceptualized as the Implementing AIDS Prevention and Care Project, IMPACT). This resulted in the creation of the Collegial Network for the Monitoring of the Status and Trends of the HIV/AIDS Pandemic (the MAP Network). The MAP Network met prior to the Eleventh International Conference on AIDS held in Canada in 1996 and, in 1997, in Brazil, as well as around major regional conferences on AIDS held in Côte d'Ivoire and the Philippines. In order to contribute to a better understanding of specific epidemic patterns and factors influencing the spread of the virus, the MAP Network published its meeting reports in several languages. The Network will meet again in June 1998, to focus on the HIV epidemic in Eastern Europe.

56. As another tool for monitoring the epidemic, WHO and UNAIDS initiated the development of country-specific epidemiological fact sheets, including estimates of the current number of individuals infected with HIV. The fact sheets serve the dual purpose of tracking key indicators on the status and trends of the HIV epidemic in nearly every country and supplying a basis for a better understanding of the underlying dynamics of the epidemic in a given country. Based on feedback provided by nearly 140 countries representing all regions, the WHO/UNAIDS Working Group produced the fact sheets through a close collaboration with the MAP Network, the United States Bureau of the Census, the European Centre for the Epidemiological Monitoring of AIDS in Paris, the East-West Center in Hawaii, U.S.A., and others. In preparing the epidemiological fact sheets, the revision of country-specific data on people living with HIV and AIDS at the end of 1997 was based on more reliable estimates. The higher quality of the data facilitated the use of simpler models for the calculation of past and present cases of AIDS and HIV, on a country-by-country basis. This approach, including some 90 country models, provided a more accurate picture of the current situation and trends over time.

57. In 1997 in a related activity, UNAIDS and WHO, in collaboration with the European Collaborating Centre on the Monitoring of AIDS and the national AIDS programmes of Poland, Russia and Ukraine, undertook several intensive assessments of the dynamics of the spread of HIV and other sexually transmitted diseases in Eastern Europe, with the purpose of identifying vulnerable populations and providing technical guidance for decision-makers in the region. Beyond the fact that the HIV epidemic in many Eastern European countries is at present mainly fuelled by injecting drug use, the assessments have shown that some of the well-established prevention tools, such as needle exchange and clean-needle programmes, may not be sufficient to slow the epidemic. In addition, sexually transmitted diseases in Eastern Europe are spreading more rapidly than ever, denoting the potential for the spread of HIV beyond injecting drug users as those primarily affected.

58. UNAIDS coordinated several behavioural studies in Thailand and Uganda during 1996 and1997, carried out by local anthropologists, population experts and institutions, including the national AIDS programmes of the two countries. The purpose of the studies was to document behaviour change among youth, such as delaying the age of beginning sexual intercourse, fewer casual and commercial sexual partners, and increasing condom use. Through a workshop organized in collaboration with the Wellcome Trust Centre for the Epidemiology of Infectious Disease in Oxford, England, a clear conclusion emerged that the observed decreases are indeed

the result of behaviour change, especially among young people. UNAIDS has incorporated these encouraging results into two case studies, as part of its *Best Practice* Collection, so that the lessons may be shared with other countries[5].

59. Trends over time in HIV prevalence among pregnant women in various cities in Africa are very different, even for cities where the HIV epidemic most probably started around the same time, such as Kampala (Uganda), Kinshasa (Congo), Lusaka (Zambia), Nairobi (Kenya). In Central African cities, the HIV prevalence rate rarely reaches 10% among pregnant women whereas in Eastern and Southern Africa, HIV prevalence among this group is consistently above 20%, reaching up to 30%. There is still no clear explanation why the infection appears to have stabilized at very different levels. UNAIDS is investigating the role of the main determinants of the risk of HIV infection in this differential spread of HIV infection and to be able to advise policy makers on the best way to influence the course of the HIV epidemic. To this end, UNAIDS is coordinating a standardized comparative study in four African cities, namely Cotonou (Benin), Kisumu (Kenya), Ndola (Zambia), and Yaounde (Cameroon), in collaboration with many local and international institutions (SEE PANEL 12).

PANEL 12

MULTISITE HIV/AIDS STUDY IN FOUR AFRICAN CITIES

In 1996–97, to better understand the wide variations in the course of the HIV epidemic in sub-Saharan Africa, the Programme initiated a comparative multisite study on factors determining the differential spread of HIV, in collaboration with the European Commission and the French *Agence nationale de recherche sur le SIDA*. In Benin, the *Institut national des statistiques et d'analyses économiques* and the *Centre de recherche en reproduction humaine et en démographie* implemented the study.

In Cameroon, the implementing partners were the *Institut de formation et de recherche démographique*, and the *Laboratoire central du ministère de la Santé publique*. In Kenya, the Population Council and the University of Nairobi's Department of Community Health undertook the study, whereas in Zambia the Tropical Diseases Research Centre was responsible. The study is coordinated by the Institute of Tropical Medicine in Antwerp, Belgium, with the collaboration of the London School of Hygiene and Tropical Medicine as well as the French *Institut national de la santé et de la recherche médicale* and the *Centre français sur la population et le développement*.

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[5] *A measure of success in Uganda: The value of monitoring both HIV prevalence and sexual behaviour.* UNAIDS *Best Practice* Collection Case Study, in press, 1998

Connecting lower HIV infection rates with changes in sexual behaviour in Thailand: Data collection and comparison. UNAIDS *Best Practice* Collection Case Study, in press,1998.

The study involved four cities with different epidemic patterns: Cotonou, Benin and Yaounde, Cameroon, where HIV prevalence has been relatively low and stable over the past five years; and Kisumu, Kenya and Ndola, Zambia, where the prevalence of HIV infection among pregnant women is over 25%. Using a standard protocol in each of the cities, investigators have collected data from a representative sample among the general population as well as among sex workers on critical factors determining the extent of the spread of HIV.

Preliminary results of the study, completed in early 1998, indicate that, in Kisumu and Ndola, HIV prevalence among young women aged 15 to 19 is as high as 16% to 20%, as compared to 1% to 4% among young men in the same age group. Among the factors which help to explain the particular vulnerability of young women to HIV infections are the early average age of their first sexual intercourse (approximately 16 years) and high rates of chlamydial infection (*circa* 10%). Differences in sexual behaviour and sexual networks between the four sites are not immediately evident, but further analysis may yield greater insight. Consistent condom use during sexual relations with non-regular partners is still very limited.

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60. Together with WHO and experts from several countries, the UNAIDS Secretariat has developed a curriculum for workshops in second-generation surveillance methods, adapted to the differing needs and specific epidemiological patterns of national programmes in various regions. Second-generation surveillance aims at broadening the classic sentinel surveillance approach by focusing on age-specific data (especially by increasing the sample sizes in young adults) and supplementing the serosurveillance data with information on risk behaviour—if possible in the same catchment populations. Within this activity, two regional workshops were organized in Nairobi, Kenya and in Bangkok, Thailand, respectively, with participants from several neighbouring countries in each region, including national expert teams with epidemiologists, social/behavioural scientists and national AIDS programme managers. A series of additional workshops has been planned, in order to fine-tune the training module, in collaboration with the Fogarty International Center of the United States National Institutes of Health, the European Commission and other partners.

61. Much remains to be done in the area of surveillance and monitoring of the factors which determine the dynamics and spread of the HIV epidemic. National programmes will need to improve the functioning of traditional HIV/AIDS surveillance systems (based on serosurveillance in selected populations and case reporting), and to complement them with monitoring and surveillance of behaviours impacting on the epidemic, other sexually transmitted diseases, and research in other areas affecting the interpretation of surveillance results, such as HIV-induced infertility. Strengthening and improving surveillance and monitoring systems is an essential link for obtaining the key information needed for informed decision making. These elements will all form part of guidelines for integrated HIV/AIDS surveillance systems which UNAIDS and its collaborators are developing, with the goal of assisting countries to meet their specific needs.

C. Advocacy and public information

62. One of the central functions of UNAIDS is to catalyse an expanded global response to the epidemic. Advocacy with partners such as the media, political leaders, business leaders and non-governmental organizations is an important element of this function.

63. To date, UNAIDS has pursued several goals in the area of advocacy:

- raising awareness of the extent of the global epidemic, and the feasibility of an effective response;
- drawing attention to the need to establish a more effective and expanded response, in order to alleviate the severity of the impact and slow its spread in many countries; and
- mobilizing support for international solidarity in addressing HIV/AIDS.

The media

64. UNAIDS has intensified its work with the international media on prevention priorities which were accorded substantial coverage at the Eleventh International Conference on AIDS, held in Vancouver in July 1996, at international regional conferences on AIDS held in 1997, and in the context of global reports issued on World AIDS Day each year, dealing with current trends of the epidemic. The Programme's priority has been to keep the focus on the epidemic in the developing world, where over 90% of people with HIV/AIDS live. The Programme highlighted broader concerns around access to medicines, treatment and health services in many developing countries, and emphasized the overwhelming burden that the epidemic places on many societies and economies with scarce resources. The severity of the epidemic and issues surrounding the developing world's access to care have remained in the media spotlight ever since.

65. The report on the global HIV epidemic issued prior to World AIDS Day in 1997 resulted in broad media coverage and headline news in many countries. The media, in many cases, directly endorsed and adopted the leading messages of the report: the epidemic is far worse than previously thought, and its most significant impact is still to come.

66. Together with its Cosponsors, UNAIDS now needs to further reinforce the public's understanding of the epidemic and to consolidate and strengthen its global advocacy on HIV/AIDS. CARMA International recently undertook a media analysis on behalf of the Programme. The analysis revealed that UNAIDS has already obtained substantial results not only when raising awareness about the epidemic but also when efforts were focused on obtaining media coverage of what needs to be done and what UNAIDS is currently doing to respond to the epidemic. The report noted that cosponsoring organizations have received excellent coverage in connection with UNAIDS media initiatives and have helped successfully to convey the Programme's messages, particularly in connection with World AIDS Days and the World AIDS Campaign.

World AIDS Campaign

67. In 1997, UNAIDS launched the first World AIDS Campaign, with a view to capitalize on efforts and resources invested in World AIDS Day and to channel these into a campaign lasting several months. The campaign aims to highlight one issue each year and to achieve specific objectives in advocacy and programming areas. Each year-long campaign is intended to serve as a

catalyst for initiating new activities and approaches, and as a platform for achieving consensus about what we need to do in response to HIV/AIDS in both the immediate future and the longer term.

68. The 1997 campaign focused on the theme *Children living in a world with AIDS*. A steering committee composed of the Programme's Cosponsors and four other leading institutions in the field[6] advised the Programme on the framework of the campaign and contributed throughout the year to activities. Reports from countries showed a high level of enthusiasm for the initiative and active participation in promoting its objectives. These included activities to increase public understanding of the impact of the epidemic on children; to involve children and young people in the development of national and local policies; to improve services and the access of children to prevention and care; to increase their access to quality education and information; and to increase understanding of the interaction between children's rights and HIV/AIDS. Additional groups at country level mobilized religious leaders and held seminars on sexual health education for policy-makers. Children participated in the production of radio shows and were interviewed for documentary films. Young volunteers found opportunities to develop media-reporting skills on HIV/AIDS issues. Health and community workers received training in special communication skills to work with children and young people.

69. The theme selected for the 1998 campaign is *Force for change: World AIDS Campaign with young people* (SEE PANEL 13). Six additional partners have joined UNAIDS and its Cosponsors this year on the steering committee. This group helps to ensure that the campaign is used as a real opportunity to establish and strengthen processes for involving young people in reducing the spread of HIV, as well as mobilizing support for young people who are already suffering from the impact of the epidemic on their own lives, families and communities. The campaign also provides a platform for emphasizing the links between HIV/AIDS and other factors that are critical to young people's health and development, including the promotion and protection of their rights.

PANEL 13

FORCE FOR CHANGE: WORLD AIDS CAMPAIGN WITH YOUNG PEOPLE

UNAIDS, its Cosponsors and partners (the Association François-Xavier Bagnoud, Education International, the International Federation of Red Cross and Red Crescent Societies, Music Television International, Rotary International, and the World Assembly of Youth) have chosen to focus the 1998 World AIDS Campaign on young people.

The main reasons for this focus are:

- Over 50% of new infections with HIV are now occurring in young people in the 10-to-24 age group. Young people are particularly vulnerable to HIV infection and are increasingly affected by the epidemic.

[6] Children and AIDS International NGO Network; François-Xavier Bagnoud Center for Health and Human Rights, Harvard University; NGO Group on the Convention on the Rights of the Child; PANOS Institute.

- Young people have the power to change the course of the epidemic. They are not only being infected and affected by HIV/AIDS, they are also a key resource in mobilizing an expanded and effective response.

The theme for the 1998 campaign is 'Force for Change: World AIDS Campaign with Young People'. The campaign's intention is to set up and strengthen processes for involving young people in reducing the spread of HIV, as well as mobilizing support for young people who are already suffering from the impact of the epidemic on their own lives, their families and their communities.

Outreach at country level

70. UNAIDS recently conducted a survey to assess media and information outreach at country level and to identify what further support might be required from the Secretariat to help improve and expand efforts at this level. Chairpersons of United Nations Theme Groups on HIV/AIDS, as well as UNAIDS Country Programme Advisers and Focal Points, reported using materials produced at the global level to good effect. In virtually all cases, they had developed an active approach to the media, often with additional support provided by government ministries or Cosponsoring Organizations.

71. The media and information outreach survey also disclosed that additional time and resources are necessary to translate and adapt more substantive materials for local use. Respondents cited the need to develop ways of including regional and national perspectives and examples in order to make these materials more culturally relevant. Another issue is the need to address information dissemination in countries where there is no UNAIDS presence. The UNAIDS Secretariat is working to initiate more systematic media-training activities for journalists at the regional level.

Partnerships for advocacy

72. Over the past two years, UNAIDS has formed strategic alliances with key groups and individuals traditionally working outside the HIV/AIDS area but with the potential to greatly expand and strengthen the Programme's advocacy and outreach activities. This has covered an expanding array of partners, including intensified work with religious institutions. In the sports arena, UNICEF and the Programme are collaborating in a joint initiative to involve football associations and players in promoting prevention messages with young people in countries in Africa and, more recently, in Latin America. UNAIDS has also established partnerships with outlets such as Music Television International (MTV), which reaches young people in over 300 million households worldwide, as well as with international associations of concert promoters, in order to promote prevention messages and HIV/AIDS awareness during events that attract large numbers of young people and are broadcast nationally or internationally.

Advocacy with political leaders, business leaders and non-governmental organizations

73. UNAIDS' advocacy for an expanded response to HIV/AIDS at the political level seeks to reach leaders at all levels of government, from Heads of State and parliamentarians to policy-makers responsible for government action in areas affected by HIV/AIDS. Experience shows that an effective response to the epidemic is directly linked to strong political support from the highest level of government (SEE PANEL 14). UNAIDS' work in the area of advocacy aims to support the efforts of national bodies promoting an effective response to HIV/AIDS.

74. The Inter-Parliamentary Union (IPU), an association of parliamentarians from around the world, is an important partner of UNAIDS in reaching out to political decision-makers. At an IPU conference held in Cairo in 1997, UNAIDS was successful in persuading parliamentarians to include HIV/AIDS on the agenda of future meetings, and to develop resolutions on how they would respond to the epidemic. In December 1997, UNAIDS participated in a symposium sponsored by UNDP in Abidjan, Côte d'Ivoire, which brought together a group of African mayors, with the objective of mobilizing political commitment and consensus on urgent action in response to HIV/AIDS in urban centres in Africa. The meeting resulted in a resolution on the steps to be taken in implementing the response and a pledge to convene another continent-wide mayors' forum in the near future.

PANEL 14

WORLD AIDS DAY IN MOZAMBIQUE

The National AIDS Control Programme and UNAIDS commemorated World AIDS Day 1997 in Mozambique with a major rally in Beira, Sofala, one of the regions most affected by HIV/AIDS. President Joaquim Alberto Chissano spoke at the rally held on 1 December, dedicating his comments to children worldwide living with AIDS. In his speech, he said: "*There are thousands of children who need our help, our love. They need to live with the hope to have a better life, to be able to go to school, to be able to be treated when they are sick; and ... to be able to live like many other children in the world.*"

More than a thousand people attended the rally. The representatives of UNDP, UNESCO, UNICEF, the World Bank, the World Food Programme, WHO and the United States Agency for International Development were joined by the Dutch Ambassador, non-governmental organizations and the head of the main opposition party in Mozambique, Renamo.

After the rally, President Chissano attended a luncheon with children who were either living with HIV or had lost one or both parents to AIDS. He then launched the UNAIDS-Mozambique Internet web-site, which provides a focus for receiving relevant information about HIV/AIDS and encourages local researchers to publish their findings about HIV/AIDS in Mozambique.

75. In addition to advocating for an expanded response to the epidemic together with political leaders, UNAIDS is engaged in a number of collaborations with the global business community. At the 1997 annual meeting of the World Economic Forum, in Davos, Switzerland, leaders from both political and business arenas attended a plenary session featuring speeches by President Nelson Mandela of South Africa and Sir Richard Sykes, Chairman and Chief Executive of Glaxo Wellcome, an international pharmaceutical company, who are serving as Honorary President and Chairperson, respectively, of the Global Business Council for HIV/AIDS. Both speakers urged participants to integrate an expanded response to the epidemic into their political and economic agendas.

76. In December 1996, UNAIDS took part in a major advocacy event in Geneva. The event, featuring music and a world-class tennis exhibition, was sponsored mainly by the Swiss Bank Corporation and benefited the *SidAide* Foundation, mobilizing resources to support community-based projects responding to HIV/AIDS. The Fourth International Conference on Health Promotion, held in Jakarta, Indonesia, in July 1997, provided another opportunity to advocate for increased involvement of business leaders in dealing with the epidemic. In cooperation with the Prince of Wales Business Leaders' Forum and the Malaysian Business Council, UNAIDS gave a presentation on the significance of and techniques for expanding partnerships between the public and private sectors in the response to HIV/AIDS.

77. The 'Partners Fighting HIV/AIDS' initiative is a broad-based campaign to reach out to companies involved in development work worldwide. The Programme has contacted over 10 000 companies in an effort to convince them to place the response to the epidemic higher on their agendas and develop workplace and community programmes. Through this initiative, several companies contacted made contributions in kind or financially towards community-based HIV/AIDS programmes in developing countries.

D. The country-level response to HIV/AIDS

1. Overview

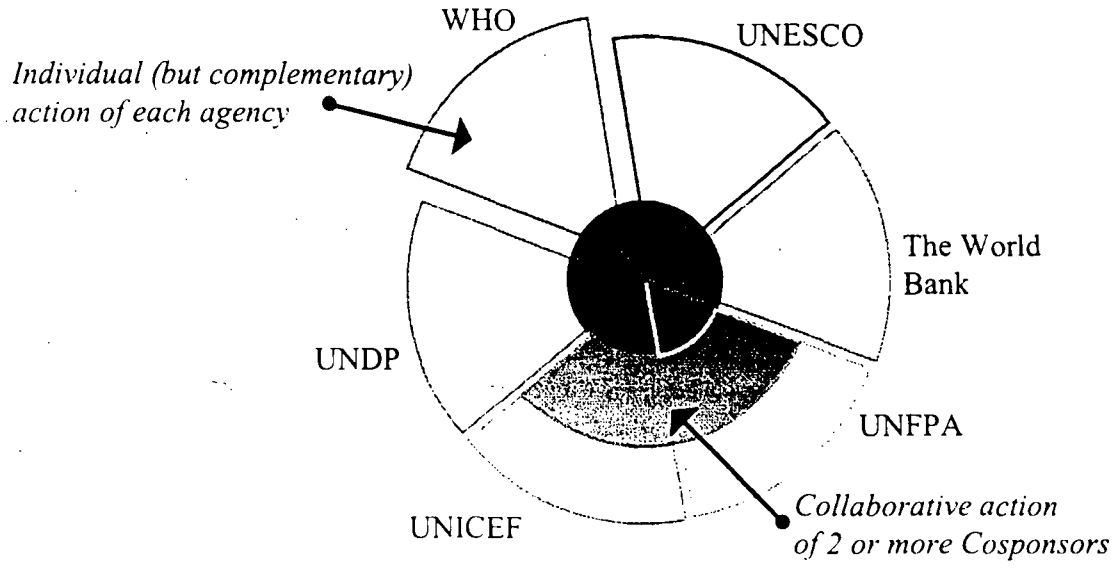
78. During 1996, the principal focus of UNAIDS was the establishment of mechanisms to better enable United Nations system organizations to work together on HIV/AIDS at country level. This focus led to the elaboration of a framework of action to guide and assess the response of the United Nations system (SEE PANEL 15). 1996 saw the establishment of over 100 United Nations Theme Groups on HIV/AIDS and Technical Working Groups, in addition to the recruitment of UNAIDS Country Programme Advisers. 1997 witnessed the increasing functionality of the United Nations system, as Theme Groups progressed first from information exchange to more coordinated planning and joint advocacy, then further to supporting national strategic planning and mobilization of resources.

79. In many countries there has been a significant increase in partnerships (SEE PANEL 16) not only between United Nations agencies but also with the private sector, non-governmental sector and people living with HIV/AIDS. In addition, by virtue of the formation of the United Nations Theme

Groups on HIV/AIDS, a large number of United Nations system country representatives, who in the past had rarely dealt with issues of HIV prevention and care, have increasingly come to a more common understanding of this difficult and complex area of human development.

PANEL 15

UNITED NATIONS SYSTEM AT COUNTRY LEVEL: INTEGRATED WORKPLAN OF A THEME GROUP



Source: *Resource Guide for Theme Groups: Working together on HIV/AIDS*, UNAIDS, in press

PANEL 16

INNOVATIVE PARTNERSHIPS IN GHANA

The Ghana Football Association, the Coca-Cola Company, the National AIDS Control Programme, the National Youth Council and a local non-governmental organization, supported by UNAIDS and UNICEF, organized a football match between an all-male team and an all-female team on 13 June 1997 in Accra. George Weah, the footballer and UNICEF Ambassador, addressed the young team members and spectators during half-time celebrations. A highlight of the talk was his demonstration of 'how to use a condom'. Dignitaries in the audience included a local traditional Chief, the Minister of Youth and Sports, the UNICEF representative, other representatives of the United Nations system, and the Mayor of Accra. The Coca-Cola Company also endorsed the celebrations, in addition to providing free beverages to spectators and players.

The event was so successful that the Minister of Youth and Sports has instructed his staff to continue educating young people on HIV/AIDS during special sports events. This led to the formation of a special committee, chaired by the Deputy Minister of Youth and including UNICEF and the UNAIDS Country Programme Adviser. The committee is responsible for developing a comprehensive plan to integrate HIV/AIDS education into every aspect of sports.

The Ministry of Youth and Sports now has AIDS messages on the air during the Africa Cup of Nations matches. Local football stars have received HIV/AIDS training and are featured in TV messages about HIV prevention.

Elements of successful interagency collaboration

80. Successful interagency collaboration seeks to increase capacity to learn from existing experience; to more effectively advocate for policy reform and political commitment; to reduce duplication of effort; and to improve the capacity for resource mobilization. Experience during this first biennium suggests a number of key characteristics of successful efforts:

- *A common identification of needs and issues to be addressed.* For example, the members of the United Nations Theme Group on HIV/AIDS in China, working with the Government, conducted the first needs assessment at national scale and identified priority areas of action in order to mobilize national and international resources for the Chinese response to the epidemic (SEE PANEL 17);
- *A common understanding of each partner's interest and expectations of benefits.* For example, the Mekong Project, supported by the Government of the Netherlands working through UNICEF, collaborates with the United Nations Theme Group to assist local organizations in implementing programmes on HIV prevention and care for ethnic minorities;
- *An integrated workplan to support the national response.* This includes projects sponsored by all members of the Theme Group, projects jointly carried out by two or more Cosponsors and those projects carried out by individual agencies, as a complement to a common workplan. In Vietnam, through the Theme Group and the HIV Action Group, the United Nations system has developed a well-recognized and common identity, which encourages increased efforts by member agencies while increasingly supporting joint efforts (SEE PANEL 18);
- An understanding of the mutual dependence between partners and acceptance of each other's role;
- The presence of a facilitating individual or organization. UNAIDS Country Programme Advisers have been a key factor in assisting Theme-Group functioning; and
- Commitment of bilateral agencies, national governments and non-governmental organizations to a strong and coordinated United Nations system response. Many

individuals have played crucial roles in negotiating collaborative agreements among Cosponsors and in mobilizing resources for HIV prevention and care.

PANEL 17

CHINA RESPONDS TO AIDS

The establishment of UNAIDS coincided in China with mounting national concern about HIV/AIDS. This was underlined by State Councillor Peng Peiyun, who, in a National AIDS Conference in October 1996, referred to the enormous potential for further spread of HIV/AIDS and characterized the next few years as critical for China's efforts.

In the past year, the United Nations system has sought to complement and strengthen China's response in a number of ways.

UNAIDS cosponsors in China collaborated with the Ministry of Health in carrying out a national HIV/AIDS situation and needs assessment and, subsequently, in preparing a report entitled *China Responds to AIDS*, which is proving to be a major advocacy tool at all levels. The Ministry of Health and UNAIDS China also cohosted a donors' meeting in January 1998 to strengthen international cooperation and mobilize resources for China's efforts.

The regular monthly meetings of the United Nations Theme Group on HIV/AIDS, which assemble United Nations agencies, international non-governmental organizations, major bilateral agencies, donors and the National AIDS Programme, have enabled more effective coordination of the many HIV/AIDS-related initiatives supported by UNAIDS Cosponsors and others, such as the European Union, Ford Foundation and Australian Agency for International Development. At a time when China's National AIDS Programme is increasingly recognizing the need for an expanded response, UNAIDS is promoting and supporting innovative outreach activities among youth, migrant workers within China, and vulnerable populations, including drug users. These activities are implemented by mass organizations, national non-governmental organizations and non-health sectors such as the Railways.

As part of the World AIDS Campaign in 1997, an AIDS education train travelled from Kowloon, Hong Kong to Beijing, stopping in several cities on the way to deliver AIDS education messages. Jointly organized by the Hong Kong AIDS Foundation and the Chinese Association of STD/AIDS Prevention, with the collaboration of the Chinese Ministry of Railway Administration, the AIDS education train departed from Kowloon Station, Hong Kong SAR on 24 November, passing through Guangzhou, Changsha, Wuchang, Zhengzhou, Shijiazhuang and arrived in Beijing on 1 December. During the trip, AIDS prevention material was distributed.

In the coming months, UNAIDS China will also be working closely with the Ministry of Health, national institutions and others in support of strategic approaches to HIV/AIDS planning at the provincial level.

PANEL 18

THE UNAIDS EXPERIENCE IN VIETNAM

The establishment of UNAIDS in Vietnam signalled a move toward a much stronger coordinated response from the United Nations system in support of the National AIDS Programme. The elevation of the National AIDS Committee to ministerial status since late 1997 and the strong leadership of the National AIDS Bureau have also greatly facilitated coordination among most of the major agencies active in HIV/AIDS programmes.

Under the impetus of the United Nations Theme Group on HIV/AIDS, an ongoing mechanism and process for information sharing and technical coordination known as the HIV/AIDS Action Group (HAG) has been set up with leadership from the National AIDS Bureau. The HAG meetings are held alternatively in Hanoi and Ho Chi Minh City and are proving to be effective fora, not simply for information exchange but for direct contact and policy dialogue between implementers and policy-makers, government and non-governmental organizations, as well as groups of people living with HIV/AIDS.

The Theme Group/HAG mechanism has thus been instrumental in advocating and generating support for policies favouring a more supportive environment for people living with HIV/AIDS and for HIV prevention programmes for young people, including condom promotion.

UNAIDS Cosponsors and other United Nations agencies recently gathered in a retreat to elaborate an integrated United Nations system workplan for the next two years, which seeks to address the needs and priorities of the National AIDS Programme. This will also facilitate mobilization of additional resources from donors and bilateral agencies.

Problems encountered in mobilizing United Nations system coordination for the response to HIV/AIDS

81. In many countries, there remains much to be done to maximally support country responses. During the Programme's initial phase, it faced a number of problems in seeking to coordinate the work of the United Nations system in response to the HIV epidemic at country level. Some countries perceived a lack of support from the UNAIDS Secretariat and from cosponsor headquarters. In addition, there were delays in appointing staff and instances of late disbursement of funds by the Secretariat, as well as differing perceptions of ownership of the Programme among Cosponsors. The overall workload of members of United Nations Theme Groups on HIV/AIDS posed a problem for Theme Group functioning and effectiveness. There was sometimes an initial lack of understanding about the roles and functions of UNAIDS, as well as different views among organizations and individuals on United Nations coordination, and a lack of understanding about the respective roles of the various UNAIDS Cosponsors. The development of the administrative structures underpinning a cosponsored programme have particularly required a great deal of attention during UNAIDS' first two years.

82. With the transition from the WHO Global Programme on AIDS (GPA) to the Joint United Nations Programme on HIV/AIDS, the primary partner for national programmes has become the

United Nations system at country level in the form of the Theme Group, rather than the regional or headquarters office of any one agency. In addition, as directed by the PCB, funds provided through UNAIDS for the core financial support of national AIDS programmes have been phased out over the first biennium, resulting in a great deal of dissatisfaction in a number of countries.

83. An analysis of the situation of official development assistance funding over the past several years has indicated a general decline. The Organisation for Economic Co-operation and Development reported a 16% overall drop in development assistance funding over the past six years. To assist in addressing this situation, one approach UNAIDS is taking is advocacy for the inclusion and mobilization in the national strategic planning process of new partners with built-in human and financial resources, such as government ministries focusing on sectors other than health, non-governmental organizations focusing on development, the private sector, or maximizing local and regional technical capacity. A good example of mobilizing regional capacity, is the Horizontal Technical Collaboration Group created by national programmes in Latin America. A number of programmes have developed a collaborative network in the region to build, maintain and share technical capacity in key areas such as surveillance of HIV and its determinants, access to drugs and national strategic planning.

84. Many opportunities exist for the development of better United Nations support for HIV prevention and care at country level. These include the broader reforms of the United Nations system such as the United Nations Development Assistance Framework (UNDAF) process, which has as its goal the harmonization of United Nations planning, finances and action at country level. In the coming biennium, UNAIDS will continue to build on its collaboration in the UNDAF process. Similarly, the inclusion of HIV prevention and care in World Bank health-sector loans as well as HIV 'impact assessments' in major non-health sector programmes, such as pipeline development in Chad, dam construction in Laos and road construction in Mozambique, present major avenues for broader investment in the response to HIV/AIDS.

2. National Strategic Planning for HIV/AIDS

85. Today, there is no doubt that HIV/AIDS has multiple determinants which necessitate the involvement of numerous sectors. For this reason, every country needs a national HIV/AIDS strategic plan, which not only defines the fundamental principles, broad strategies and institutional structure for the national response but also the immediate, priority actions to be carried out. The development and implementation of such a strategic plan are the responsibility of government.

86. The United Nations system supports a nationally-led, participatory process to develop such a national plan. This plan is based on a situation analysis leading to a more profound understanding of the determinants of the epidemic, as well as an analysis of the response, with the aim of judging how relevant and effective the response has been in relation to the determinants of the epidemic. The process is designed to identify priority actions that are both politically supported, and technically and financially feasible. The participatory process encourages all major actors at national level—including relevant government departments, people living with HIV/AIDS, non-governmental organizations, bilateral agencies and the United Nations system—to participate in the development of and to support the nationally-led plan. It also means that all major loans and grants from multilateral, bilateral and non-governmental agencies in support of the national response to HIV/AIDS are included in the national strategic plan (SEE PANEL 19).

87. To encourage use of the situation analysis, response analysis, and strategic plan formulation, UNAIDS has developed guides in English, French, Russian and Spanish. The Programme developed these guides with the assistance of many partners including Cosponsors, national programme managers, community leaders and technical experts from bilateral agencies and regional training institutions. A fourth module on resource mobilization is currently under development. In addition, the Programme is elaborating a guide for planners on how to facilitate and implement the national strategic planning process. UNAIDS is also producing modules to provide specific guidance on strategic planning in individual technical areas, such as mother-to-child transmission, human rights, prevention in vulnerable populations and access to care.

PANEL 19

RESOURCE MOBILIZATION IN BRAZIL

A United Nations Theme Group on HIV/AIDS has been functioning in Brazil since September 1997. The Brazilian Government was interested in having the support of the United Nations system for the renewal process of its World Bank project for the national response to the epidemic, which will be funded through a World Bank loan of US$ 165 million and a Government contribution of US$ 135 million over a four-year period. This interest gave an impetus to the setting up of the United Nations Theme Group on HIV/AIDS. United Nations system agencies, bilateral organizations, non-governmental organizations and the National AIDS Programme participate in the Theme Group. Activities in support of the project for renewal of the World Bank loan include the following:

- The Theme Group convened a strategic planning workshop addressing HIV and children living in poverty.
- The United Nations system agencies are preparing a workplan in collaboration with the loan renewal project.
- The Theme Group supported a national meeting for the coordination of non-governmental organization input into the project.
- The Theme Group is facilitating international technical input into the project.

88. UNAIDS is working through its intercountry teams to develop links with regional institutions, Cosponsors, and bilateral agencies to establish intercountry technical-support networks in the area of strategic planning. In Latin America, UNAIDS works closely with the Horizontal Technical Collaboration Group, and the regional institutions Oswaldo Cruz Foundation in Brazil, the National Institute of Public Health in Mexico, Economic Commission for Latin America and the Caribbean, and the Caribbean Epidemiology Centre (CAREC). These networks help to build and maintain the regional capacity and quality necessary to support country-level planning and action for the response to HIV/AIDS. Theme Groups, the UNAIDS Secretariat and Cosponsors have been active in supporting the national strategic planning process. Examples of countries where the national

strategic planning process has been fruitful include Cambodia, Honduras, Kyrgyz Republic, Lao PDR, Morocco, Namibia, Romania, Uganda and Venezuela (SEE PANELS 20 TO 22).

89. In 1997, the UNAIDS Secretariat provided technical support for 22 situation analyses, 10 response reviews and 10 strategic plan formulations in 29 countries in Africa, including Angola, Botswana, Burundi, Eritrea, Ethiopia, Malawi, Namibia, and Rwanda. In Latin America and the Caribbean, UNAIDS is collaborating with different partners such as the Horizontal Technical Collaboration Group, the Caribbean Epidemiology Centre (CAREC) and USAID in providing technical support in strategic planning to countries such as Brazil, Dominican Republic, Honduras and Venezuela.

90. In Asia and the Pacific, UNAIDS has supported efforts in six countries in 1997: Bangladesh, Cambodia, China, Lao PDR, Nepal and Papua New Guinea. In Europe, UNAIDS lent support to Belarus, Moldova and Poland in 1997.

PANEL 20

RESOURCE MOBILIZATION AND STRATEGIC PLANNING IN LAO PDR

The establishment of the United Nations Theme Group on HIV/AIDS in the Lao People's Democratic Republic (Lao PDR) has engendered a change in the approach to dealing with the HIV epidemic within an increasing number of sectors. The development of task forces in key sectors has been an important step in coordinating and focusing action and advocacy within these sectors.

In the past year, the development of the National HIV/AIDS/STD Plan, 1997–2001, has met with considerable support. The process involved advocacy efforts, reaching a national consensus and developing tools to enable each sector (government ministries, mass organizations, private and public sector enterprises) to produce its own strategic plan and budget, in keeping with the objectives set forth in the National Plan. With assistance from the UNAIDS Cosponsors, there has been a 'scaling up' of existing responses, e.g. within the Ministry of Defence, as well as integration of new partners, such as the Lao Revolutionary Youth Union, Lao Women's Union, Lao Federation of Trade Unions, Lao Front for National Construction, National Tourism Authority, Ministry of Culture and Lao Beer Company (the largest private company in the country).

Through the Theme Group, successful mobilization of resources for procurement and social marketing of condoms took place over the past year. The Theme Group has also collaborated with the Government to establish a Lao PDR AIDS Trust Fund to mobilize and provide flexible funding support to national partner initiatives. Several bilateral donors have expressed strong interest in providing support to the national response through this mechanism.

In the coming months, the efforts of UNAIDS in Lao PDR will continue to focus on collaborating with the different sectors to operationalize their plans and to mobilize additional resources through the Trust Fund mechanism.

PANEL 21

THE UNAIDS EXPERIENCE IN NAMIBIA

"The past two years have represented a sea-change in both national and United Nations approaches to the epidemic in Namibia. A heightened sense of urgency has permeated the highest levels of political leadership, and senior-level managers of leading Government ministries have taken a much more pragmatic approach to planning and management needs linked to strengthening the national response ... ".

Dr Patricio Rojas, Chairperson of the United Nations Theme Group on HIV/AIDS and WHO Representative to Namibia

Since its inception in 1996, UNAIDS has found willing partners, both national and international, to bolster Namibia's national response to the HIV/AIDS epidemic. Operating within the framework of UNAIDS' focus on joint action by the United Nations system, several of the local Cosponsors have successfully continued to support various activities of the National AIDS Programme.

Among the most significant achievements of the United Nations Theme Group on HIV/ AIDS is the joint publication with UNDP of the 1997 *Namibia Human Development Report,* which examines the impact of the HIV/AIDS epidemic on the future of human development in Namibia. All UN agencies pooled their expertise in HIV/AIDS and human development to produce this in-depth social, demographic, epidemiological and economic study of recent trends and future projections.

In Namibia, UNAIDS support to the national strategic planning process is a concrete expression of expanding the response to HIV/AIDS beyond the health sector. Led by the Ministry of Health and the newly formed National Multisectoral Committee on HIV/AIDS, and supported by UNAIDS core funding, all national actors in the response to HIV/AIDS have come together to contribute to a comprehensive national five-year plan.

The United Nations Theme Group has also worked closely with other partners active in the national response. These include other donors, non-governmental organizations, the press, trade associations, students and groups of people living with HIV/AIDS. Theme Group efforts to facilitate communication and collaboration among partners have resulted in significant resource mobilization at the local level.

PANEL 22

STRATEGIC PLANNING IN UGANDA

National strategic planning for the HIV epidemic in Uganda has recently led to the development of a National Strategic Framework for HIV/AIDS activities. The framework is the culmination of a protracted process of consultation organized by the Uganda AIDS Commission together with a core group of stakeholders. The composition of the task force responsible for the conceptual design of the framework reflects the comprehensive approach to the epidemic adopted in Uganda. Core members of the team include representatives of the Ministries of Health, Local Government, and Planning and Economic Development, The AIDS Support Organization (TASO), the Joint Clinical Research Centre, the Islamic Medical Association of Uganda, the Uganda Youth Network, organizations of people living with HIV/AIDS, and UNAIDS Cosponsors.

The terms of reference for the core group provide not only for traditional review of the HIV epidemic in Uganda and how the Government has responded, but also innovative projects, such as establishing a mechanism to generate ideas from social partners; recruiting an economist/consultant to prioritize ranked solutions in terms of cost-effectiveness and impact on existing infrastructures; and mobilizing consensus and resources by involving major actors in the review and implementation phases of the framework development.

Combining an innovative approach and involvement of local partners helped to pave the way for implementation of the Strategic Framework for HIV/AIDS activities in Uganda. The next phase requires translation of national goals and objectives into actual programmes and projects at the national, district, and sub-county levels, in partnership with non-governmental and community-based organizations. This phase will determine the role of Government in facilitating the integration and decentralization of projects for task forces at the grassroots levels.

3. Country-level United Nations coordination on HIV/AIDS

91. The need for United Nations system coordination on HIV/AIDS is the subject of frequent discussion, but the rationale for this coordination and the difficulties encountered in bringing it about are less often articulated. The many determinants of the spread of HIV, such as inequitable distribution of wealth, illiteracy, gender inequality, and rural-to-urban migration, cut across nearly all sectors of government and society. Regardless of where the national response may originate—most often in health ministries—to be effective it must mobilize active partnerships across different sectors.

92. Similarly, no single United Nations agency has the capacity to deal with the multiple determinants of HIV, nor to assist governments to take national programmes to scale. Individual United Nations agencies make substantial contributions on specific aspects of HIV/AIDS prevention and care. However, the need to act simultaneously and synergistically in areas such as health services, communications, legal reform, education, rural development and the status of women, requires that the United Nations system develop and maintain collaborative action and coordination among its member agencies and with the major actors in the national response. This, however, does not happen unless Cosponsors at country level commit time, personnel and resources to a collective effort in response to HIV/AIDS. Country representatives, in turn, need strong support and recognition from their agency's headquarters to commit these efforts.

93. The UNAIDS Secretariat, with guidance from United Nations Theme Groups on HIV/AIDS, Cosponsors and the PCB Working Group on Evaluation, has developed a model for action and assessment at country level, following on the establishment of the United Nations Theme Groups on HIV/AIDS[7], and associated technical working groups[8]. The goal of this model is to mobilize effective information exchange, joint planning and coordinated action. The *Resource guide for Theme Groups: working together on HIV/AIDS*[9] further elaborates this concept.

94. Assessments of the Theme Groups carried out in 1996 and 1997 and informal review of Theme Group functioning, as well as of reports prepared by the Resident Coordinators, show that UNAIDS at country level has provided an effective way to coordinate financial and technical support to the national response; a way to encourage team work and innovative strategies; a forum for more powerful advocacy; a forum for resource mobilization; and a forum for interaction with bilateral agencies, non-governmental organizations and people living with HIV/AIDS (SEE PANELS 23 AND 24).

95. Weaknesses exist where there is insufficient involvement of Cosponsor representatives, insufficient importance attributed to HIV/AIDS, insufficient support offered by the UNAIDS Secretariat and a lack of establishment of common vision and an integrated work-plan by the members of the United Nations Theme Group on HIV/AIDS. However, despite difficulties inherent to interagency collaboration, Cosponsors in many countries have overcome these obstacles through a common identification of needs and issues to be addressed; a common understanding of each partner's interests, comparative advantages and expectations; a common vision of what needs to be done; an understanding of the mutual interdependence between partners; and a common workplan. Summary data on the establishment of United Nations Theme Groups on HIV/AIDS and on the deployment of UNAIDS country-based staff are included within PANEL 25.

PANEL 23

THE UNITED NATIONS SYSTEM SUPPORTS THE NATIONAL RESPONSE IN UKRAINE

When transmission of HIV through injecting drug use became a clear problem in Ukraine, the United Nations Theme Group on HIV/AIDS got together with the local authorities in Odessa to discuss an appropriate response. First, three seminars were held to explore the creation of a more supportive environment for injecting drugs users (IDUs), so that the problem could be brought out in the open. Representatives of the city department of health, police, youth and sports, education, legislation, internal affairs, water transport systems, and of AIDS centres attended. This led the National AIDS Committee, in collaboration with UNAIDS and WHO, to draft a project entitled 'Capacity building in preventive interventions among injecting drug users', involving most sectors having participated in the seminars.

In addition to epidemiological behaviour studies among IDUs, the project called for a review of current legislation, training of local staff and the establishment of outreach centres and mobile outreach services, to facilitate needle exchange, condom distribution, education,

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7 United Nations Theme Groups on HIV/AIDS generally consist of heads of agencies, and focus on issues such as policy guidance, advocacy and resource mobilization.

8 The Theme Groups have set up technical working groups to carry out their day-to-day activities. Working groups often include representation from all major partners in a country.

9 UNAIDS, 1998 (forthcoming).

counselling and anonymous testing. When the local Government accepted the project, the Theme Group acted quickly to seek funding, procuring commitments from the City of Odessa, UNDP, UNICEF, and the UNAIDS Secratariat.

The first in-depth evaluation found that injecting drug users attended and appreciated the outreach centres. In the first four months of operation, staff recorded 4 889 visits by 1 216 people, with the mobile outreach service reaching an average of 150 people in a single morning shift. Behavioural studies have revealed much lower levels of needle sharing and risky sexual behaviour. Significantly, the social environment in Odessa is now more supportive to IDUs and people living with HIV, as compared with many other parts of the former Soviet Union. Plans are in progress for extending the project to other regional capitals of Ukraine, with the assistance of the Odessa team.

PANEL 24

MOVING TO AN INTERSECTORAL RESPONSE IN BELARUS

Although the first cases of HIV infection in the Republic of Belarus were reported in 1987, it was not until quite recently that the virus began to spread more rapidly, particularly among injecting drug users, triggering growing concern among Government authorities and other key players in the field of HIV/AIDS in the country.

The Belarusian United Nations Theme Group on HIV/AIDS was established in February 1996. The tasks of the Theme Group included advocating for the implementation of a multisectoral approach to the response to the epidemic at all levels of Government; a harm-reduction strategy to help reduce the spread of HIV among injecting drug users; and the creation of a coordinating body to organize these and other HIV-related activities. At first the agencies concerned were not convinced that the threat of HIV/AIDS in Belarus was serious enough to warrant the establishment of a new structure. Paradoxically, however, an outbreak of HIV infection in the Gomel region played a positive role in persuading the Government that the problems of HIV/AIDS in Belarus were both present and daunting.

The result of this realization was the development of a project, in collaboration with the Theme Group, entitled 'HIV prevention among injecting drug users in Svetlogorsk' (a town in the Gomel region). The project employs a multisectoral approach, and provides for designated locations for drug users to drop off used syringes and pick up new ones, as well as disinfectants and condoms.

A further outgrowth of mounting national concern about the epidemic was the elaboration of the National State Programme on HIV Prevention for 1997–2000, endorsed by the Belarusian Prime Minister in August 1997. This programme involves ministries from various sectors in HIV prevention and aims to prevent mother-to-child transmission of HIV and sexual transmission in the military and in prisons; provide a safe blood supply for medical needs; and organize prevention activities among young people, injecting drug users, other vulnerable groups and people already living with HIV.

PANEL 25

UPDATE ON UNAIDS AT COUNTRY LEVEL (DECEMBER 1997)

The UNAIDS Cosponsors have established 127 United Nations Theme Groups on HIV/ AIDS covering 152 countries. Sixty-two per cent of Theme Group chair persons are from WHO, 22% from UNDP, 11% from UNICEF, and 5% from UNFPA. In mid-1996, 77% were from WHO, 16% from UNDP, 4% from UNICEF and 2% from UNFPA. Technical working groups have been established in over 80 countries.

As of the end of 1997, 28 international Country Programme Advisers and 10 Intercountry Programme Advisers (covering two or more countries) are in place, in addition to nine nationally-recruited Programme Advisers and three Junior Programme Officers. Thirty-nine UNAIDS Focal Points* have been identified. Sixty-seven per cent of the Country Programme Advisers are from countries outside of the Organisation for Economic Co-operation and Development (OECD), and 43% are women.

4. Financial support and resource mobilization for strengthening the national response

96. Over the years, the funds provided by the WHO Global Programme on AIDS as direct core support to national AIDS programmes declined, as countries were expected to provide such support. However, despite the fact that in many countries there has been an increasing number of national and international sources of funding for HIV/AIDS activities, many national AIDS programmes were still dependent on WHO/UNAIDS funding for core activities in recognition of the need for a smooth transition. Funds amounting to US$ 18.1 million were allocated to countries by the Secretariat, including US$ 12.8 million as direct financial support to the implementation of national AIDS programme activities in over 150 countries in 1996–1997 (SEE PANEL 26). These funds were used by the national AIDS programmes to support advocacy and the mobilization of new sectors and partners (14%); for programme development and implementation of national AIDS programme activities (55%); and for financing other activities such as research, information, education and communication and procurement of test kits, equipment and supplies (31%)

97. In addition to these core funds, in 1997, UNAIDS provided US$ 5.3 million within the framework of the strategic planning and development funds (SPDF—earlier called programme development funds) to support HIV/AIDS activities that would:

- enhance and facilitate programme design and development in new sectors and with new partners;
- leverage commitment and contributions from UNAIDS Cosponsors, bilaterals and others partners; and

* UNAIDS Focal Points are staff members of one of the Cosponsors who serve the Theme Groups and technical working groups).

- expand the coverage of the national response in new geographic areas or in new populations.

98. The planning and the implementation of the projects funded were meant to be carried out in close collaboration with Theme Group members and national partners. The discussion around those projects was in many countries an important part of the dialogue on how the United Nations system could better coordinate and strengthen its support to the national response. The main beneficiaries of the project funds were governments and other national partners.

99. The Theme Groups and national AIDS programmes were informed about the availability of these funds at the end of 1996. However, the Programme faced some difficulties in identifying a suitable mechanism for the management of these funds. Following further consultations with the Cosponsors, the approach of relying on any single mechanism had to be abandoned for the 1996-1997 biennium. Instead it was agreed that, where possible, for each approved project the Theme Group would identify the executing agency from among the Cosponsors. Specific agreements for the channelling and management of these funds, appropriate for each agency, were developed.

100. As the funds were limited, it was decided to make them available on a competitive basis. UNAIDS received over 150 proposals from 94 countries, of which 76 project agreements with the Cosponsors and other partners were completed by the end of 1997.

101. At its meeting in April 1996, the PCB requested the Secretariat to prepare in advance of its next annual meeting, an overview analysis of the funding status of the national AIDS programmes that have received core funding from UNAIDS in 1996 and1997. In collaboration with the François-Xavier Bagnoud Center, School of Public Health, Harvard University, UNAIDS has conducted a study to respond to this request[10]. The study is also seen as a first step in the development of a mechanism that would assist countries monitor their needs and availability of resources for the national response to HIV/AIDS. The information is being collected through mail surveys sent to over 70 countries and to 20 official development assistance agencies.

102. Preliminary results of the overview analysis of the funding status of national AIDS programmes indicate that, at US$ 260 million, the level of official development assistance funding for the global response to HIV/AIDS in 1996 was approximately the same as in 1993, the last year for which data were available. The distribution of funding, however, changed considerably during this period, with an increase in bilateral funding and a decrease in multi/bilateral funding.

103. Between 1996 and 1997, funds available at the national level (including World Bank loans) increased by nearly one third, from a reported US$ 374 million to US$ 492 million, in the 64 countries for which data were available. Assuming that funding was stable from 1996 to 1997 in those official development assistance agencies for which detailed information was not yet available for the 1997 fiscal year (e.g. United States Agency for International Development, European Union), national and international contributions to the global response to the HIV epidemic increased by more than 20%, from approximately US$ 560 million in 1996 to US$ 690 million in 1997.

104. This initial attempt to establish a system for monitoring sources and uses of funds for HIV/AIDS has serious limitations, although improvement for subsequent studies is imminent. Nevertheless, even these preliminary data provide valuable information for the purposes of

[10] PCB Document PCB(6)/98.3

international strategic planning. The study clearly reveals that the distribution of funds available to confront the epidemic—whether at national or international level—is not equal to the distribution of needs. Countries with relatively abundant resources should certainly not scale back their response to HIV/AIDS, but large amounts of both national and international funding must still be mobilized if a sufficient response is to be made possible in all regions and countries.

105. To strengthen capacities in resource mobilization at the country level, a fourth module of the Strategic Planning Guide, entitled *Guide for Resource Mobilization through Strategic Planning for HIV/AIDS* is now under development. It stresses the importance of appropriately addressing allocation, use and mobilization of resources in the entire strategic planning process. It thus describes how to include resource mobilization in the national situation assessment, response analysis and the preparation of a strategic plan.

106. UNAIDS is also developing a training manual on resource mobilization which will focus on mobilizing expertise and human, financial and in-kind resources in the public, private and non-governmental sectors for the national response to HIV/AIDS. Planning and implementing partnership in community awareness programmes, such as special events, and how to develop other possible joint initiatives with the public and private sectors will also be an important part of the training material. Workshops on resource mobilization techniques will be held by UNAIDS in partnership with the International Fund Raising Group, London, U.K., in ten countries around the world. Strategic workshops in this area have already been held in Africa, Asia and Latin America.

PANEL 26

COUNTRY-LEVEL FUNDING BY REGION, 1996-1997

	Core funding		SPDF		Total	
	US$	%	US$	%	US$	%
Africa/ Middle East	5,584,505	44	1,524,140	29	7,108,645	39
Asia/Pacific	3,720,625	29	926,553	17	4,647,178	26
Latin America/ Caribbean	2,838,460	22	1,474,681	28	4,313,141	24
Eastern Europe	654,675	5	1,406,315	26	2,060,990	11
Total	**12,798,265**	**100**	**5,331,689**	**100**	**18,129,954**	**100**

E. Global and regional mechanisms for developing technical cooperation on HIV/AIDS

1. The Coordinated Appeal

107. All HIV/AIDS-related activities of the cosponsoring organizations at global level, and to the extent possible at regional level, which require additional funds beyond the core resources allocated by their agency, are now included in the UNAIDS Coordinated Appeal, by prior agreement of the UNAIDS Cosponsors. The UNAIDS Secretariat facilitated the process of preparing the Coordinated Appeal for the 1996–1997 biennium, and presented the plan to donor agencies in June 1996. A number of separate proposals assembled activities requiring approximately US$ 18 million in financial resources. Despite the efforts of Cosponsors and the UNAIDS Secretariat to secure funding for the first Coordinated Appeal, it was not successful in mobilizing the resources required by Cosponsors. The Appeal mobilized only about US$ 4.4 million out of the US$ 18 million requested. Approximately US$ 1.7 million came from three donors, with US$ 2.7 million supplied from the UNAIDS core budget.

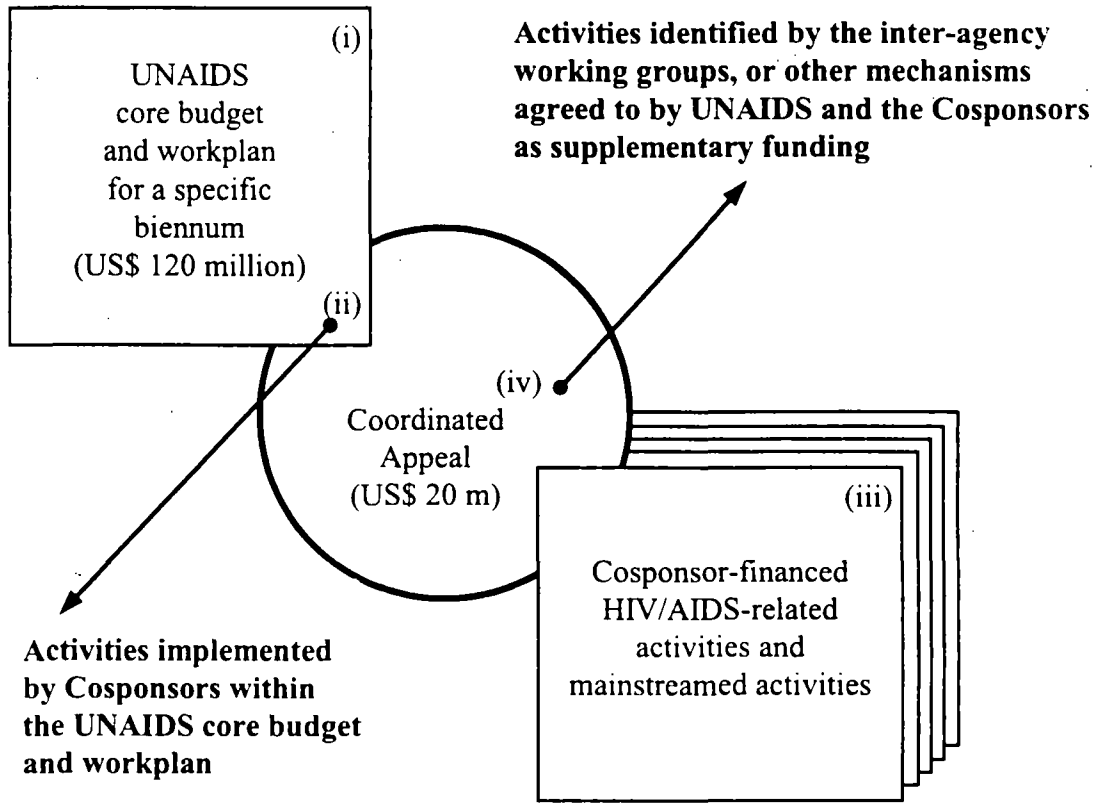
108. Following a review of the problems which appeared to impede the success of the first Appeal, the Programme and its Cosponsors initiated development of the Coordinated Appeal for the 1998–1999 biennium. The aim was to ensure the completion of its preparation a full year earlier in the programme cycle than was possible for 1996–1997. The 1998–1999 Coordinated Appeal, which includes 73 proposals from five of the Cosponsors and requires a total of approximately US$ 22 million, was launched in November 1997. It covers the most critical areas of the United Nations response to HIV/AIDS, and is limited to the highest priority projects. While virtually all activities of the first Coordinated Appeal were global in scale, the second Appeal includes a number of proposals to be implemented at regional level. In addition, as requested by the Programme Coordinating Board, it also includes a limited number of country-level activities on an experimental basis. The Appeal's mutually agreed-upon programme components correspond to those defined within the *UNAIDS Proposed Programme Budget and Workplan for 1998–99* (SEE PANEL 27).

109. As a result of stronger advocacy efforts and more intensive marketing, both on behalf of the UNAIDS Secretariat and as a part of the Cosponsoring Organizations' ongoing dialogue with donors, the initial responses to the current Appeal from donor agencies are promising. To date, the Appeal has generated some US$ 3 million in contributions and approximately US$ 2 million in pledges. In addition, UNAIDS allocated US$ 4.1 million from its 1996–1997 core budget as matching funds to accelerate start-up activities included in the 1998–1999 Appeal proposals.

110. The launching of the second Coordinated Appeal marks a considerable step forward in identifying supplementary resources to finance essential HIV/AIDS-related activities of the Programme's Cosponsors, early in the new biennium. In addition, its development has significantly contributed to harmonizing programme approaches and activities, as well as to further clarifying roles and responsibilities among Cosponsoring Organizations and the UNAIDS Secretariat.

PANEL 27

RELATIONSHIP BETWEEN THE UNAIDS BUDGET AND WORKPLAN AND THE HIV/AIDS-RELATED ACTIVITIES OF THE COSPONSORING ORGANIZATIONS, 1996-1997



Source: *UNAIDS Proposed Programme Budget & Workplan for 1998-1999, p. 16*

2. Interagency Working Groups

111. In order to build consensus for policy and technical guidance, to share information, and to provide strategic input and peer review on HIV/AIDS-related activities, UNAIDS, its Cosponsors and other United Nations systems partners coordinate their work through a variety of mechanisms.

112. The interagency working group (IAWG) is one mechanism for harmonizing and integrating such programme efforts. The working group serves as a forum for communication at all levels, joint planning and technical development. Members have contributed resources for implementing activities, with UNAIDS providing extra-budgetary funding in 1997 to working group members for activities linked to established priorities.

113. The interagency working groups generally consist of staff members from each organization's headquarters, with occasional attendance by staff members from regional or country offices.

Gender and HIV/AIDS

114. Over the course of three meetings held during the 1996–1997 biennium, the Interagency Working Group on Gender and HIV/AIDS reviewed and endorsed the UNAIDS strategy on gender and HIV and priorities for action, and reviewed and funded proposals from UNICEF, UNDP, UNESCO and the World Bank through UNAIDS' 1996–1997 core budget (SEE PANEL 28). The IAWG on Gender and HIV/AIDS recently opened its membership to other United Nations organizations. New members may include the International Labour Organisation (ILO), the United Nations Division for the Advancement of Women (UNDAW), the United Nations International Drug Control Programme (UNDCP), the Office of the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Development Fund for Women (UNIFEM).

PANEL 28

GENDER AND HIV/AIDS

Understanding the links between gender and HIV/AIDS means appreciating how being a girl or a boy, or a woman or a man, influences how a person experiences and responds to the HIV epidemic. The goal of a gender-based response to HIV/AIDS is to explore ways of reducing inequalities between men and women, and to re-examine prevalent definitions of masculinity and femininity so that a supportive environment can be created to enable both sexes to protect themselves against the infection and cope better with its impact.

UNAIDS' key strategic objectives in the area of gender and HIV/AIDS are:

- To develop and promote key components for a gender-based response to HIV/AIDS;
- To document, analyse and promote ongoing efforts in policy, strategy and research addressing gender issues relevant to HIV/AIDS;
- To advocate with Cosponsors for a coordinated response in the United Nations system to gender issues in HIV/AIDS prevention, care, support and impact alleviation;
- To strengthen national capabilities for a gender-based response to HIV/AIDS;
- To develop and promote evaluation indicators to measure gender-sensitivity of the response to HIV/AIDS.

Integrating HIV/sexually transmitted disease prevention in the school setting

115. During 1996-1997, the Interagency Working Group on Integrating HIV/Sexually Transmitted Disease Prevention in the School Setting completed a position paper articulating United Nations system goals, principles and approaches in this area; drafted quality standards for policy and school curricula; and began to document best practices and resource materials in the field. The Group is currently reviewing nine case studies for 'best practices' designation and documentation. With direct financial support from UNAIDS, the Cosponsors jointly planned activities to be conducted from 1997 through 1999, funded eight country-level projects and commissioned a research review.

The UNAIDS School Education Adviser, seconded to the Education Section of UNICEF headquarters, has facilitated the work of this Group.

Especially vulnerable young people

116. The Interagency Working Group on HIV and Sexually Transmitted Disease Prevention among Especially Vulnerable Young People has been established to facilitate collaboration between the Programme's Cosponsors and UNDCP, UNHCR and ILO. The working group met three times during the biennium and is now in the final stages of developing a position paper which includes a framework for action on the subject of especially vulnerable young people. Within the framework of the IAWG, the WHO Adolescent Health and Development Programme is documenting approaches to make sexual and reproductive health services available and accessible to displaced adolescents. WHO's Programme on Substance Abuse has developed and produced a training manual entitled '*Street children, substance use, HIV/AIDS/STD and health: training for street educators*'. UNDCP is working with CARICOM (the Caribbean Community), on a research and training programme to promote health and family life education in the Caribbean. UNDP is working on community mobilization and non-governmental organization networking in Ukraine and Western Russia. UNESCO has translated and published four issues in four languages of *Peddro*, a document on networking of information in the field of drug-abuse prevention through education.

Communications

117. HIV/AIDS communications is an expanding area of programming for several of the UNAIDS Cosponsors. To help facilitate collaboration, the Interagency Working Group on Communications was established to identify areas for integrating planning efforts, to develop a coordinated plan of action, and to review proposals for the 1998–1999 Coordinated Appeal. At its second meeting, the IAWG identified priority areas for action, including mobilizing communications partners; advocacy for the response to HIV/AIDS and for communication as part of an effective response; strengthening integrated national strategies; developing examples of quality products; identifying and disseminating examples of best practice; and increasing community participation, especially that of people infected or affected by HIV/AIDS.

Global surveillance of HIV/AIDS and sexually transmitted diseases

118. WHO and UNAIDS established the Working Group on Global HIV/AIDS and STD Surveillance to ensure the timely and consistent flow of information at national, regional and global levels (see section IV.B).

Other interagency coordination mechanisms

119. In other programme areas where formal interagency working groups do not exist, UNAIDS, Cosponsors and other United Nations system partners have identified other ways to coordinate their activities. Examples of these are listed below.

♦ Vaccine development

120. The Vaccine Advisory Committee has been established to provide technical guidance to the Programme in relation to trials and other vaccine-related research. Representatives of UNESCO and WHO have attended this committee's meetings.

♦ Vaginal microbicides

121. Research and development in vaginal microbicides is a much neglected area internationally and offers important potential for prevention of HIV for women. UNAIDS acts as the secretariat for the International Working Group on Vaginal Microbicides[9]. The Working Group has published Recommendations for the development of vaginal microbicides[10], a document used for the development of and regulatory action on microbicides.

♦ Sexually transmitted diseases

122. UNAIDS will serve as the secretariat for the Sexually Transmitted Diseases Diagnostics Initiative (SDI) through the end of 1998. Major partners include the Rockefeller Foundation, the United States National Institutes of Allergy and Infectious Diseases, the United States Agency for International Development and the European Commission. The goal of the SDI is to accelerate the identification of simple, reliable diagnostic technologies for sexually transmitted diseases, appropriate for developing countries. The initiative has directly funded several new research projects to identify such technologies, with other projects funded bilaterally by one of the major partners.

123. Through a working group on sexually transmitted diseases, WHO and the UNAIDS Secretariat prepared technical documentation on policies and principles for prevention and care of sexually transmitted diseases[11]. Region specific strategies to control sexually transmitted diseases are now being developed.

♦ Mother-to-child transmission

124. UNAIDS is serving as the secretariat for an informal working group on mother-to-child transmission of HIV. The group includes UNICEF, WHO, representatives of international research agencies and the principal country-level investigators carrying out trials on mother-to-child transmission of the virus. The objective of the working group is to help build consensus on research priorities and to harmonize the study designs of clinical trials to enable improved cross-trial comparability. Trials are currently underway in Durban and Johannesburg, South Africa; Dar-es-Salaam, Tanzania; and Kampala, Uganda.

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9 The group includes WHO, the United States National Institutes of Allergy and Infectious Diseases, the United States National Institutes of Child Health and Human Development, Contraceptive Research and Development Program, Family Health International, the United States Centers for Disease Control and Prevention, the Population Council, the United States Food and Drug Administration, the Society for Women Against AIDS, the European Commission, and the United Kingdom Medical Research Council

10 *AIDS*, 1996; **10**: pp. UNAIDS1–6

11 *Sexually transmitted diseases: policies and principles for prevention and care*. WHO/UNAIDS, 1997

- Inter-agency advisory group on AIDS

125. The Inter-Agency Advisory Group on AIDS (IAAG), which has been in existence since 1988, serves as a forum for regular dialogue on an array of HIV/AIDS-related issues among a full range of the agencies and organizations of the United Nations system. It meets annually, in most cases immediately following the meetings of the UNAIDS Programme Coordinating Board. IAAG membership consists of 24 offices and organizations of the United Nations system, including all six UNAIDS Cosponsors. The chair of the IAAG rotates among the members. In addition to examining issues of HIV/AIDS in the United Nations workplace during 1997, the IAAG reviewed the actions of the United Nations system in the context of migration and HIV/AIDS. The forthcoming 1998 session will focus on emergencies and peacekeeping operations as they relate to the epidemic, in addition to HIV/AIDS in the United Nations workplace.

3. Development of technical resource networks

126. UNAIDS' primary strategy to help respond to the need for a broader range of technical resources is to support the development of technical resource networks. These are not only primary mechanisms for technical cooperation in a given region, but should also contribute to strengthening institutional capacity in cooperating countries. Interagency Working Groups, UNAIDS Collaborating Centres and Intercountry Teams (ICTs) are taking the lead in creating resource networks and catalysing efforts at the regional and subregional levels to strengthen the capacities of the United Nations system to respond to HIV/AIDS. In addition to collaboration on specific programmes and project activities with Cosponsors, the UNAIDS Secretariat has initiated a series of consultations at the regional and sub-regional levels to assist in identifying joint strategies, and to serve as a basis for jointly mobilizing resources. The Programme is organizing these consultations in cooperation with regional/sub-regional development bodies in each region. Additional details are provided in document UNAIDS/PCB(6)/98.5. An overview of specific regional networking activities follows.

Africa and the Middle East

- The UNICEF Regional Office for Eastern and Southern Africa supports an active HIV/AIDS network of programme officers and counterparts. In addition, to regional information exchanged through the Internet, the network members periodically meet for more detailed discussions on subject areas related to the HIV/AIDS epidemic;
- The UNDP Regional Project on HIV and Development for sub-Saharan Africa has provided support for the African Network on Ethics, Law and HIV and the Network of African People Living with HIV/AIDS (NAP+);
- The West African Initiative on HIV/AIDS, sponsored by the World Bank, (SEE PANEL 29) supports action research projects on migration and sex work and networks of people living with HIV/AIDS in Burkina Faso, Côte d'Ivoire, Mali, Niger and Senegal;
- The African Council of AIDS Service Organizations (AFRICASO) and the Society for Women and AIDS in Africa (SWAA) constitute important networks within the region ;
- Networks on Strategic Planning in Southern Africa, and in West Africa and Central Africa aim to facilitate national strategic planning, epidemiological networks and evaluation of interventions; and

- The Middle East, the International Planned Parenthood Federation (IPPF), and UNAIDS established a partnership within a project that emphasizes expansion of the capacity of the IPPF/Arab World Region and its partners by upgrading existing reproductive health training at both regional and country levels through the International Centre for Training, at the national office for family planning in Tunis. This project is being carried out in collaboration with UNFPA.

PANEL 29

SUPPORT FOR CROSS-BORDER EFFORTS: THE WEST AFRICAN HIV/AIDS INITIATIVE

In September 1994, following meetings with a number of countries in West Africa, the World Bank and WHO convened a meeting in Burkina Faso to discuss cooperation on HIV/AIDS in the region. The West African HIV/AIDS Initiative (WAI) is the outcome of this regional consultation, initially including 11 but later expanded to 17 countries of West Africa, involving National AIDS Programmes, the African Council of AIDS Service Organizations (AFRICASO) and the network of NGOs (AFRICASO) and the Network of African People Living with HIV/AIDS (NAP+). This has enabled the identification of priority areas for action-oriented research and programme development on cross-border migration and sex work, as well as support for the West African chapter of the NAP+.

Since October 1996, the UNAIDS Intercountry Team for West and Central Africa has provided technical and administrative assistance to the implementation of the West African HIV/AIDS Initiative workplan. Activities carried out under the Initiative touch on the following areas:

- *cross-border issues, migration and mobility.* This includes action-research projects on major transportation and border districts in Burkina Faso, Côte d'Ivoire, Mali, Niger and Senegal. The projects aim to enhance understanding of mobility and migration, as well as suggesting ways to reduce related risks and vulnerabilities.
- *vulnerability in the context of sex work.* To reinforce knowledge and innovative actions in the context of sex work, a situational analysis guide was elaborated then pre-tested in Burkina Faso in collaboration with the Muraz Center of the Organization for Coordination and Cooperation against Endemic Diseases. With the Regional AIDS Programme of the *Gesellschaft für Technische Zusammenarbeit*, an evaluation of community-based approaches to reducing the vulnerability of sex workers was carried out in Côte d'Ivoire, Mali, Senegal and Togo.
- support to networks and associations of people living with HIV/AIDS. In collaboration with NAP+ and UNDP, the West African HIV/AIDS Initiative is helping to reinforce associations of people living with HIV/AIDS by sponsoring 'ambassador' missions to Benin, Burkina Faso, Mali, Mauritania and Togo. The same partners came together in Côte d'Ivoire in October 1997, to support and organize the Second Regional Workshop of NAP+.
- community mobilization and advocacy. The Initiative has provided support to regional meetings of opinion-makers and community leaders, to encourage wider involvement in the expanded response to the epidemic. This included support for the First International Symposium on AIDS and Religion, held in Dakar, Senegal, in November 1997.

Asia

- The Asian Harm Reduction Network (AHRN) is engaged in sharing of information, conducting needs assessments, and developing locally relevant information, and advocacy and resource mobilization with United Nations agencies, governments and bilateral agencies;
- The Asia/Pacific Council of AIDS Service Organizations (APCASO) is a network of community organizations in the region which has focused on strengthening national capacity to monitor and document human rights and to advocate for better policies and services, particularly for people living with HIV/AIDS;
- The Asia-Pacific Network of People Living with HIV/AIDS (APN+), set up by people from eight countries in the Asia-Pacific region, is working with UNAIDS to advocate for the rights of people living with HIV/AIDS within the United Nations system as well as with national governments. With the support of UNAIDS, APN+ is setting up APN+ SHARE, an electronic-mail facility to support people with HIV/AIDS in the region; and
- SEA-AIDS, an electronic information-exchange network, was established in 1995 and funded by the World Bank. The project produces a bi-weekly update of HIV/AIDS-related developments relevant to the region and has established an indexed electronic archiving system, which is available to all networks.

127. The first of a series of regional consultations to assist in identifying joint strategies, and to serve as a basis for jointly mobilizing resources took place in Nepal, in July 1997, under the auspices of the South Asian Association for Regional Cooperation (SAARC). The consultation, which was planned jointly by the UNAIDS Secretariat and the European Commission, was attended by representatives of all SAARC countries, the Cosponsors, representatives of Canada, European Union countries, Japan, the United States, the Asian Development Bank, and resource persons drawn from leading non-governmental organizations in the region. Participants made recommendations on specific areas requiring joint action on priority cross-border and intercountry concerns such as migration and HIV/AIDS, the effects of cross-border trade, transport and tourism in relation to the epidemic, drugs and HIV/AIDS, and the use of media.

Latin America and the Caribbean

- Regional Initiative for AIDS Prevention and Control in Latin America and the Caribbean (SIDALAC) (SEE PANEL 30);
- Collaborative efforts with UNDP, the Pan American Health Organization (PAHO) and the Latin America/Caribbean Council of AIDS Service Organizations (LACCASO) have been undertaken to support the establishment of national human rights networks;
- The Horizontal Technical Collaboration Group (HTCG), was established by national AIDS programme managers in Latin America and the Caribbean to facilitate national strategic planning, epidemiological network, evaluation of interventions, counselling and communications;
- A subregional project to address the injecting drug user-related HIV epidemic in the Southern Cone (Argentina, Chile, Paraguay and Uruguay) is being developed by

UNAIDS in collaboration with national AIDS control programmes, non-governmental organizations, and the United Nations International Drugs Control Programme (UNDCP);

- The Programme has also established close collaboration with the UNICEF Regional Office in Colombia to develop and strengthen cooperation in the area of communication and advocacy, particularly in the context of the World AIDS Campaigns of 1997 and 1998; and
- Close links have been established with the Pan American Health Organization in the areas of epidemiological surveillance in the Latin American sub-region, as well as on projects dealing with access to care and antiretroviral therapy in several countries.

PANEL 30

SIDALAC

SIDALAC is the Regional Initiative for HIV/AIDS and Sexually Transmitted Disease Prevention and Control in Latin America and the Caribbean. It was sponsored by the World Bank and has now become an integral part of the UNAIDS technical collaboration resources available in the region.

The main objectives of SIDALAC are to contribute to the mobilization of national and international efforts in Latin America and the Caribbean to deal with HIV/AIDS and other sexually transmitted diseases through increased advocacy and awareness among decision-makers in the region; support for the development of a new generation of programmes which can affect an expanded response to HIV/AIDS; and support for the development of region-specific approaches corresponding to the socio-economic and cultural situation in Latin America and the Caribbean.

The Mexican Health Foundation (FUNSALUD), a private non-profit institution, is the implementing agency of the SIDALAC initiative. Some examples of activities conducted within the framework of the SIDALAC project include:

- the establishment, maintenance and support of an electronic communications network based in FUNSALUD designed to improve exchange of and access to information through e-mail, electronic discussion fora and web pages;
- documentation and analysis of the characteristics of health-care systems in the region in relation to HIV/AIDS, including an estimation of the economic impact of HIV/AIDS on those systems and documentation of their response to the epidemic;
- estimates of the national AIDS-related expenditures in 20 countries in Latin America and the Caribbean;
- support for studies analysing the situation and response related to access to anti-retroviral treatments in selected countries in the region;
- and support for HIV/AIDS awareness activities with the private sector and to the establishment of national/sub-regional business councils.

Europe

128. A network of Eastern European harm reduction projects, CEE-HRN, works with governmental bodies and non-governmental organizations to help develop and support activities in the field of prevention and reduction of harm related to non-medical drug use. CEE-HRN also aims to evaluate the efficiency of harm reduction programmes in the region, to publicize results of these activities and to inform communities, governments and the international community of the situation in these countries.

129. Other networks at different phases of development include the Working Group on HIV Prevention among Sex Workers, which held an exploratory meeting with the main Western European networks in September 1996; a network on ethics, law, human rights and HIV, in liaison with UNDP and interested legal institutions in the region; and a regional network of social science institutions to facilitate behavioural research necessary for strategic planning and to encourage more work with marginalized groups.

130. UNAIDS has also initiated and/or facilitated Regional Task Forces in Eastern Europe, as follows:

- The Task Force on HIV Prevention among Injecting Drug Users has produced materials in Russian targeted at the injecting drug users in the former Soviet Union, and is producing a training package on HIV prevention among injecting drug users. The Task Force has supported several new outreach projects and an information network of Eastern European harm reduction projects together with the UNDP country office in Poland, WHO, UNICEF, *Médecins du monde*, *Médecins sans frontières*, The Lindesmith Center, the Trimbos Institute and UNAIDS. The Task Force Secretariat is located at the UNDP office in Warsaw, Poland;
- WHO's Regional Office for Europe (WHO/EURO) has drafted a regional strategy paper on the reorientation of sexually transmitted disease services in Eastern Europe. This led to the establishment of a regional Task Force on care and prevention of sexually transmitted diseases and the launching of a number of pilot projects. Founding members include WHO/EURO, WHO/Geneva, UNICEF, UNFPA, the World Bank, UNAIDS, the German *Gesellschaft für Technische Zusammenarbeit* (GTZ), the Department for International Development, United Kingdom, the Universities of London, Antwerp and Heidelberg, *Médecins sans frontières* (Belgium) and the Swedish and Finnish public health institutes. The Secretariat is located at WHO/EURO;
- In collaboration with UNAIDS, WHO and a number of partner agencies and donors have established a regional Task Force on Blood Safety in Eastern Europe. Members include WHO/Geneva, WHO/EURO and the Council of Europe. The World Bank, the International Federation of Red Cross and Red Crescent Societies, the Department for International Development, United Kingdom, and *Médecins sans frontières* have shown interest in participating in future activities; and
- UNAIDS is collaborating with UNESCO on a regional project to promote HIV/AIDS awareness which focuses on journalists, young people and health personnel, among others, and with UNICEF to develop a regional strategy for AIDS education among young people.

The Intercountry Teams (ICTs)

131. The role of the Intercountry Teams has evolved over the biennium[12]. Their broad aim is to ensure that, through the United Nations system, high quality and up-to-date technical advice and support are made available by:

- developing regional technical resource networks;
- mobilizing technical support to be provided through the United Nations system and Country Programme Advisers;
- identifying and promoting best practices at regional level;
- developing partnerships with regional entities of Cosponsors; and
- developing and supporting programmes on selected cross-border issues relevant to the region.

132. There are currently three Intercountry Teams in the UNAIDS secretariat. One team is based in Abidjan, Côte d'Ivoire, and covers Western and Central Africa. Another is based in Pretoria, South Africa, and covers Southern and Eastern Africa. A third Intercountry Team is based in Bangkok, Thailand, to cover Asian and Pacific countries. A new UNAIDS Intercountry Team will be placed in the Caribbean, bringing together three Intercountry Programme Advisers based in the region.

The Intercountry Team for Asia and the Pacific

133. The Intercountry Team for Asia and the Pacific focuses on facilitating joint action by countries and regional bodies to address cross-border issues, such as migrant labour and drug abuse, that are widely recognized as major priorities by many countries of the region. The activities of WHO and the World Bank, supported through the South-East Asia HIV/AIDS Project (SEAHAP), were formally incorporated into the Intercountry Team for Asia and the Pacific with its establishment in July 1996.

134. The Team manages SEA-AIDS, the electronic network, as well as the InfoDev Project, designed by SEAHAP in 1995 and supported by the World Bank. This project provides hardware, software and human resources training to link organizations electronically within 10 countries of the region. Ten Information Support Centres[13] facilitate and promote the availability of materials produced by UNAIDS and cosponsor organizations at the country level. The Intercountry Team for Asia and the Pacific has set up information system networks, including 'Gender-AIDS' for UNIFEM, ASEAN AIDS Information Network, and APN+ Share Information Network.

135. The Team has undertaken several technical collaboration activities with UNICEF and WHO's Regional Offices for the Western Pacific and for South-East Asia, particularly on cross-border programming, young people, media and strategic planning. Close collaboration exists with the UNFPA Country Support Team in the region. The UNAIDS Intercountry Team has also collaborated with the Association of South-East Asian Nations (ASEAN) Task Force on HIV/AIDS and Economic and Social Commission for Asia and the Pacific (ESCAP) on specific projects.

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[12] See PCB6 Doc /98.5 for complete details of the structure, function and activities of each Intercountry Team

[13] Asian Institute for Health and Development (Thailand), Population and Community Development Association (Thailand), Health Action and Information Network (Philippines), AIDS Concern (Hong Kong Special Administrative Region of China), Yayasan Pakta (Indonesia), Albion Street Centre (Australia), Korean AntiAIDS (Korea), Ministry of Health (Mongolia), Ministry of Health (Malaysia), Action for AIDS (Singapore).

136. In partnership with Cosponsors, key donors and implementers, the ICT has established two task forces for South-East Asia and two working groups for South Asia on migrant labour and HIV, and on drug use and HIV, with the goal of identifying priority areas, conducting situation assessments and applied research, and developing joint action programmes. The ICT has collaborated with the Government of Japan in organizing HIV/AIDS workshops in Asia. It has also facilitated intercountry collaboration in HIV vaccine development, as well as subregional strategic planning within the framework of the UNICEF's Mekong project which covers several countries in South-East Asia. These activities have been conducted in partnership with the Australian Agency for International Development.

West and Central African Intercountry Team

137. This Intercountry Team was set up in the last quarter of 1996. It is responsible for facilitating the implementation of the West African HIV/AIDS Initiative, a regional project funded by the World Bank and UNAIDS, which promotes action-oriented research and programme development in the areas of migration and sex work, and provides support to networks of people living with HIV/AIDS.

138. The strategic focus of the West and Central African Intercountry Team is on building and reinforcing regional partnerships with diverse actors involved in the response to HIV/AIDS; providing support to countries in strategic planning; facilitating the implementation of cross-border initiatives, such as the West African HIV/AIDS Initiative; developing regional networks and technical resources; supporting the development of information exchange in the region; and contributing to the implementation of WHO's Regional Office for Africa (WHO/AFRO) workplan in the area of blood safety and sexually transmitted disease prevention and control.

139. The ICT implements a common workplan with WHO/AFRO, conducts joint activities with UNDP's Regional Project on HIV and Development for sub-Saharan Africa, regularly coordinates with UNFPA's Information/Communication/Education Regional Team in Côte d'Ivoire, and implements a common work plan with the UNICEF West and Central Africa Office in priority areas. The ICT has developed linkages with regional bodies such as the African Development Bank and the Organization of African Unity. Partnerships also exist on specific projects with multilateral and bilateral agencies such as the Regional AIDS Programme of the German *Gesellschaft für Technische Zusammenarbeit (GTZ)* in Ghana, the Regional Project of the Canadian International Development Agency, in Burkina Faso, and the Regional Project on Family Health and AIDS in West and Central Africa, based in Côte d'Ivoire and supported by the United States Agency for International Development. The ICT also works with non-governmental organizations, including the International Planned Parenthood Federation, the African AIDS Research Network and many community-based groups.

Eastern and Southern African Intercountry Team

140. This Intercountry Team began work in December 1996. Through 1997, the focus of the Eastern and Southern African Intercountry Team was on collaborating with regional initiatives of Cosponsors and other partners; supporting the development of regional networks; facilitating information and experience sharing; and providing technical support to countries through the United Nations Theme Groups on HIV/AIDS.

141. The Team works closely with regional offices of the Cosponsors, especially the UNICEF Regional Office for Eastern and Southern Africa and UNFPA. It has initiated some joint projects with the Southern Africa Tuberculosis Control Initiative, the WHO Southern African Development Council, and the Department for International Development of the United Kingdom. This ICT has helped to initiate pilot projects aiming to facilitate the greater involvement of people living with HIV/AIDS in Malawi and Zambia, in collaboration with UNDP and the United Nations Volunteers. The Team has supported many regional initiatives, such as the adoption of the Southern African Development Council code on AIDS and employment, in collaboration with the Organization of African Trade Union Unity, Family Health International and the International Labour Organisation. The Team has also engaged in promotion of the female condom with WHO, UNFPA, International Planned Parenthood Federation and Population Services International. Along with the Swedish International Development Agency, the Intercountry Team has also provided technical assistance to the Southern Africa Network of AIDS Service Organizations, collaborated with the Southern Africa AIDS Information Dissemination Service and provided technical assistance to Botswana, Lesotho, Malawi, South Africa, Swaziland and Zambia, on a range of issues, the most notable being strategic planning and review.

142. In the coming biennium, the Intercountry Team will make efforts to consolidate the gains made in regional collaboration, further develop intercountry technical resource networks in specific areas of regional importance and strengthen technical cooperation with countries, particularly through the UNAIDS Cosponsoring Organizations.

4. Collaborating centres

143. During the 1996–1997 biennium, the Programme sought the partnership of diverse institutions worldwide by designating them as UNAIDS Collaborating Centres. This initiative seeks to strengthen partnerships among institutions with specific areas of expertise in the HIV/AIDS and related fields. This initiative will help to strengthen technical resource networks with the technical expertise required to support the response at national and regional levels. It will also facilitate creative dialogue and networking among Collaborating Centres and with other actors. In addition, Collaborating Centres will assist UNAIDS and its Cosponsors in carrying out certain aspects of their workplans.

144. Designation as a UNAIDS Collaborating Centre lasts for a fixed period of three years and involves the following areas of collaboration:

- identifying, developing and disseminating 'best practices' by producing and/or reviewing guidelines and other documentation; and participating in technical resource networks established by UNAIDS;
- promoting, supporting and implementing relevant research, and disseminating and utilizing results of such research, including participating in collaborative research projects with UNAIDS; and
- providing selected technical support focused on strengthening national capacities for an expanded response to HIV/AIDS, especially in developing countries.

145. In 1997, the Executive Director of UNAIDS nominated forty-one UNAIDS Collaborating Centres[14]. Criteria for identification of Collaborating Centres include:

- the professional quality of the institution/organization in its particular area of expertise;

[14] Refer PCB Document reference PCB(6)/98.5 for list of nominated Collaborating Centres.

- the working relationships which the institution has established with other groups/ institutions in the country, in the region, and elsewhere in the world; and
- the institution's ability and readiness to contribute to the implementation of the UNAIDS' Workplan, whether in support of country programmes or by participating in international or regional cooperative activities.

146. During the coming biennium, UNAIDS will consolidate its collaborative activities with various institutions and will expand its list of Collaborating Centres to continue to ensure broad geographical/cultural representation, as well as representation of different areas of expertise relevant to HIV/AIDS.

5. Mobilizing partnerships

- Collaboration with non-governmental organizations

147. Non-governmental organizations (NGOs) have worked with the United Nations system since its founding. In the case of HIV/AIDS, the response of NGOs has been impressive and at times has predated that of governments. Recognizing their importance as key partners in the development of an expanded response, UNAIDS and its Cosponsors have been working closely with NGOs, organizations of people living with HIV/AIDS and various networks at the country, regional and global levels. In addition, UNAIDS actively encourages the inclusion of HIV/AIDS-related activities on the agendas of other NGOs, particularly organizations of young people and organizations working on women's issues. For example, the Programme's initiative on improving access to drugs, UNDP's efforts to strengthen community-based approaches to HIV/AIDS, and UNICEF's initiatives in HIV prevention among street children all build on active partnerships with the NGO community.

148. The UNAIDS Secretariat has played an active role in working with larger networks of AIDS service organizations, including the International Council of AIDS Service Organizations and its regional affiliates, the International Community of Women Living with HIV/AIDS and the Global Network of People Living with HIV/AIDS. Local, country-based NGOs seeking assistance are directed to Cosponsors and United Nations Theme Groups on HIV/AIDS at national level, and to national authorities.

149. An important partnership is underway in Asia, where UNAIDS is working with 12 national Red Cross and the Red Crescent Societies on a study of best practices in the area of peer education programmes among young peoples. A textbook on peer education for young people has been translated and culturally adapted for country level use. In the context of the current World AIDS Campaign, UNAIDS is collaborating with a number of NGOs, particularly youth organizations. This collaboration includes having the International Red Cross and Red Crescent Federation's youth office as a partner in the campaign, in order to establish awareness among young Red Cross and Red Crescent members about HIV/AIDS, and UNAIDS' involvement in the United Nations Youth Forum in Braga, Portugal. The International HIV/AIDS Alliance is also being supported by UNAIDS to produce and disseminate a tool kit on *Mobilization, strategies, participation, community assessment and project design* and developing strategies involving Indian NGOs in HIV/AIDS activities.

150. Collaboration with NGOs has also been an important element of preparation for national and international meetings on HIV/AIDS. One example is the collaboration between the Liga

Colombiana de Lucha contra el SIDA and networks of people with HIV/AIDS in preparation for the Panamerican Conference on AIDS, held in Peru in 1997.

151. A full report on the Programme's activities related to NGOs will be published in mid-1998.

- Mobilizing new partnerships

152. In addition to strengthening existing partnerships, UNAIDS is seeking to catalyse a broader approach to dealing with HIV/AIDS by bringing new partners into the global response. These partners bring additional expertise and resources to the response to HIV/AIDS, as well as providing new perspectives on how to respond to the epidemic. New partners play an important role as advocates for a more effective response to HIV/AIDS, helping influence decision-makers worldwide. They work together with UNAIDS to help mobilize an expanded and more effective response to HIV/AIDS at the global, national and community levels.

153. One key sector is business which UNAIDS has sought to engage by linking up with well established associations of business leaders. A number of examples are given below.

154. Rotary International: In July 1996, UNAIDS and Rotary International launched an initiative called 'Working with new generations for a safer world' (SEE PANEL 31). Since the launch of this initiative, and through the active leadership of the president of Rotary International, Rotary Clubs around the world are now using their community-based networks to launch public-awareness campaigns promoting AIDS awareness and safe practices among youth.

PANEL 31

ROTARY INTERNATIONAL: WORKING WITH NEW GENERATIONS FOR A SAFER WORLD

In July 1996, Rotary International and UNAIDS launched the 'Working with new generations for a safer world' initiative at the Eleventh International AIDS Conference in Vancouver. In the context of this initiative, the President of Rotary International advocated for an active response to HIV/AIDS in his meetings with heads of state and other political and business leaders during 1996 and 1997. In June 1997, Rotary International invited UNAIDS to deliver a plenary address to over 15 000 Rotarians from around the world.

Building on the interest generated through the signing of the UNAIDS/Rotary agreement, as well as the presentation made by UNAIDS at their world meeting, Rotary Clubs are using their community-based networks to launch public awareness campaigns promoting AIDS awareness and safe practices among young people. For example, Rotary Clubs in Bangladesh, Bulgaria, India, South Africa and Venezuela are working with UNAIDS and its Cosponsoring Organizations at country level to create an effective grass-roots response to HIV/AIDS, including support for community care centres, HIV/AIDS education drives, and wider-awareness initiatives. The Rotary Club of Sandown, South Africa has created partnerships with leading non-governmental organizations and companies to support community HIV/AIDS care and awareness centres in disadvantaged areas of the country.

155. The Prince of Wales Business Leaders' Forum, London, UK, has been working with UNAIDS to help mobilize the private sector in the response to HIV/AIDS since 1996. The Forum is a global network of business leaders and their companies, drawn from Africa, Asia-Pacific, Europe, the Middle East, and North and South America. The Forum works with its member companies and local affiliated organizations in over 30 countries, including developing and transition economies. It also coordinates an International Partnership Network, consisting of some 1,000 individual 'partnership practitioners' drawn from business, non-governmental organizations, community-based organizations, the media, academia, international development agencies and government.

156. One outcome of this partnership was a publication entitled *The business response to HIV/AIDS: innovation and partnership*, an in-depth analysis of the corporate response to HIV/AIDS around the world, including 17 case studies. UNAIDS and the Forum will work together to build the capacity of non-governmental organizations to develop public and private-sector partnerships at country level, particularly in Southern Africa, South-East Asia and Latin America; to foster active partnerships among businesses and other groups to deal with the impact of the epidemic; and to stimulate and disseminate research on best practices in the corporate response to the epidemic and in HIV/AIDS-related public and private-sector partnerships.

157. The World Economic Forum, a leading association of business leaders from around the world, has provided the Programme with opportunities to engage additional political and business leaders in the response to HIV/AIDS, in the context of the Forum's international conferences. During the annual meeting of the Forum in Davos in February 1997, President Nelson Mandela of South Africa, Sir Richard Sykes, Chairman and Chief Executive of Glaxo-Wellcome, and the UNAIDS Executive Director, spoke during a plenary session to an audience of over 1,500 political and business leaders about the importance of an active and expanded response to HIV/AIDS. UNAIDS staff and members of the Global Business Council on HIV/AIDS made similar presentations to World Economic Forum regional conferences held in Zimbabwe and India.

158. In collaboration with UNAIDS, **the Conference Board**, a global business-membership organization based in New York, U.S.A., conducted a major survey of leading companies from around the world regarding their response to HIV/AIDS in and beyond the workplace. This large-scale international survey, the first of its kind, yielded a valuable status report of the corporate response and identified areas for further action by companies for the response to HIV/AIDS. The report found that companies in nearly every branch of industry now have HIV/AIDS-related programmes. The most common corporate responses were providing confidential help within the company for employees concerned about HIV/AIDS, in the form of employee-assistance programmes, and providing benefits for medical leave, where necessary. Areas for further collaboration include increasing HIV/AIDS-specific education and training opportunities at the workplace, improving the evaluation of these programmes and expanding the level of participation in tackling HIV/AIDS-related issues in the wider community.

159. The Global Business Council on HIV/AIDS. To date, public health authorities and NGOs have taken the lead in responding to the HIV/AIDS epidemic. However, these sectors need support to make their efforts more effective. Business resources and skills can complement the skills of others, creating a wider response to HIV/AIDS. In partnership with the public sector and NGOs, the private sector has an important stake in ensuring an effective global response to HIV/AIDS.

160. In 1996, UNAIDS initiated collaboration with companies and NGOs active in HIV/AIDS-related programmes, in order to catalyse a stronger and more effective corporate response to the epidemic[15]. Part of this effort has been the establishment of the Global Business Council on HIV/AIDS.

161. The Global Business Council has three main activities:

- encouraging and supporting the development of networks of country-level companies active in the response to HIV/AIDS;
- sponsoring awards to commend select companies involved in HIV/AIDS prevention, education and care; and
- developing, promoting and supporting a code of conduct for an appropriate business response to the epidemic, through such means as presentation at high-level political and business fora. The code will recommend the establishment of ethical employment practices and issues of corporate social responsibility.

162. The Council is made up of a core group of companies characterized by a commitment to HIV/AIDS-related causes, a strong reputation as corporate citizens and an ability to mobilize and inspire colleagues in the response to HIV/AIDS. Council membership is drawn from a wide variety of industries and is internationally representative. President Nelson Mandela of South Africa is the Council's Honorary President. The Council's chairperson for the first two years is Sir Richard Sykes, Chief Executive and Chairman of Glaxo Wellcome plc. Non-corporate partners of the Global Business Council include the National AIDS Trust (UK) and The Prince of Wales Business Leaders Forum. Members of the Business Council to date include The Body Shop (United Kingdom), Calvin Klein (USA), Cargill (USA), Edelman Communications (USA), Glaxo Wellcome (United Kingdom), Godrej & Boyce (India), Industrias Villares S.A. (Brazil), London International Group (United Kingdom), Music Television International (USA), Tata Iron and Steel (India), Telepar (Brazil), Levi Strauss (USA) and Polaroid (USA).

163. In South Africa, the establishment of the Global Business Council on HIV/AIDS has led to the formation of the South African National Business Council on HIV/AIDS. Members include Southern Life, Gold Fields of South Africa, Glaxo Wellcome (South Africa), ESCOM, Unilever (South Africa), Metropolitan Life, Shell S.A., Sanlam Health, South African Breweries, and Old Mutual. A Zimbabwean Business Council on AIDS is also in the process of being formed. The example of the Global Business Council has also catalysed the creation of the European Enterprise and AIDS Network, as well as business councils in Mexico and South-East Asia.

164. In an attempt to engage elected political leadership and major non-profit charitable foundations as partners, UNAIDS has established collaboration with the following:

165. UNAIDS' cooperation with the **Inter-Parliamentary Union** (IPU), a global network of national parliamentarians, has permitted the Programme to bring HIV/AIDS higher on the agenda of parliamentarians from around the world. At an IPU conference held in Cairo in 1997, UNAIDS was successful in persuading the parliamentarians to include HIV/AIDS on the agenda of future meetings and to develop resolutions on how they could respond to the epidemic. At the semi-annual

[15] In November 1996, UNAIDS, Glaxo Wellcome plc and the National AIDS Trust (UK) co-organised a 'Strategy Meeting on International HIV/AIDS Public/Private Sector Partnership'. Participants in this meeting included representatives from Levi Strauss, Unilever, Guinness plc, Siel Ltd, The Body Shop, AECI Ltd, Anglo-American Corporation of South Africa, Motech SAM, Schieffelin and Somerset Marketing, The Conference Board, National Leadership Fund, The Thai Business and AIDS Coalition, Fundación Anti-sida España, SidAlerte Internationale, and the International HIV/AIDS Alliance. The meeting recommended the establishment of a Global Business Council on HIV/AIDS.

conference of the IPU in Windhoek, Namibia, in 1998, parliamentarians from 122 countries passed a resolution calling for action on HIV/AIDS with respect to a number of issues, including human rights, funding for HIV/AIDS, involvement of people living with HIV/AIDS, and public/private sector partnerships. The partnership with IPU is contributing to the development of a handbook for parliamentarians on HIV/AIDS.

166. Funders Concerned About AIDS (FCAA) is an association of foundations and companies committed to supporting HIV/AIDS programmes in communities. By reporting on UNAIDS' activities and initiatives in their newsletters and inviting representatives of UNAIDS to their meetings, FCAA has helped UNAIDS advocate to a broad audience of foundations and companies about the importance of an active response to HIV/AIDS. Furthermore, FCAA has helped UNAIDS to mobilize support from foundations in the private sector across the United States interested in expanding their HIV/AIDS focus internationally.

F. Best practices in the response to HIV/AIDS

1. Development and dissemination of Best Practices

167. Best practices in the response to HIV/AIDS are principles, policies, strategies and activities that, according to collective experience, have proven to be sound, based on the criteria of effectiveness, relevance, efficiency, sustainability and ethical considerations. The goal of best practice development is to identify effective examples of responses to the epidemic that can be considered or adapted for use in other areas to strengthen new or existing programmes. Issues, strategies and responses to different aspects of the epidemic are identified at country level based on practical experience from projects, programmes, governments, institutions and individuals.

168. The major objective is to provide information that is concise and easy to use. While the audience for best practice documents may be broad, materials are more specifically conceived for UNAIDS Cosponsors and other United Nations system agencies and programmes, including United Nations Theme Groups on HIV/AIDS, national AIDS programmes, policy-makers and opinion leaders, non-governmental organizations and the media. Selected materials may also be specific to research institutions.

169. Creating and expanding the UNAIDS *Best Practice* Collection has helped considerably to redress the challenge of insufficient documentation of successes attained in responding to the HIV epidemic (SEE PANEL 32). In taking on this challenge, the Programme studied the work of its Cosponsors and other United Nations agencies, and established criteria for identifying effective, valuable and replicable practices in HIV/AIDS-related programme development. To date, the *Best Practice* Collection consists of some 32 documents covering 22 thematic areas, many of which now exist in three or four languages (SEE PANEL 33). UNAIDS has made the *Best Practice Collection* widely available through the growing network of Cosponsors and collaborators, as well as through electronic technology. The growing demand for these materials has been an indicator of the continued need for synthesized and analytical information on the epidemic.

170. Collaboration with Cosponsors on publications has occurred in a variety of ways. UNAIDS has assumed responsibility for distribution of documents originally published by the WHO Global Programme on AIDS; of these documents, the joint WHO/UNESCO kit for school health education remains particularly popular. UNDP continues to produce documents on issues around HIV and development, including study papers, workshop reports (for example, on injecting drug use and HIV in Eastern Europe), books and monographs (see also the UNDP and UNAIDS websites). UNAIDS has been active in distributing these publications.

171. During its first biennium, the Programme contributed to and supported the development of the World Bank's policy research report, *Confronting AIDS: public priorities in a global epidemic*. Together with UNICEF and WHO, UNAIDS developed and issued a policy statement on HIV and infant feeding. With both WHO and UNHCR, UNAIDS published *Guidelines for HIV interventions in emergency settings*, while continuing extensive copublication with WHO, including *The implications of antiretroviral treatments*, *Guidelines for organizing national external quality assessment schemes for HIV serological testing* and *A deadly partnership: TB in the era of HIV*.

PANEL 32

UNAIDS *BEST PRACTICE* COLLECTION

UNAIDS is producing a collection of Best Practice materials on approximately 50 specific topics relevant to HIV/AIDS. The file on each such topic generally contains the following:

1. UNAIDS Point of View

This eight-page advocacy document, aimed primarily at journalists and community leaders, lists key facts and figures, outlines the problems, myths and misconceptions about the topic, and summarizes what needs to be done.

2. UNAIDS Technical Update

This eight-page document, aimed primarily at managers of HIV/AIDS projects and programmes, provides a technical overview of the topic. It summarizes the main problems and challenges involved as well as the Best Practice responses, with short examples.

3. Best Practice Case Studies

These are detailed real-life examples of Best Practice in a specific region, country or community. They include case studies published outside UNAIDS.

4. Presentation Graphics

This is a selection of up to 20 slides and/or overheads on the topic that can be used for speeches and other presentations. Each slide is accompanied by a list of the main messages illustrated ('talking points').

5. Key Materials

This is a set of up to 10 written and audiovisual materials—reports, articles, books, CDs, videos, etc., authored outside or inside UNAIDS—that represents up-to-date authoritative thinking on the topic, including best practice in the field. UNAIDS policy statements and reviews are included here.

Each file has a list of contents showing all the components of the file, including lists of the key materials and presentation graphics.

PANEL 33

LIST OF *BEST PRACTICE* COLLECTION

BPC Subject File	Document Produced	PoV*	TU**
1. Blood safety	*Blood safety*	✓	
	Blood safety		✓
2. Community mobilization	*Community mobilization and AIDS*		✓
3. Prisons	*Prisons and AIDS*	✓	
	Prisons and AIDS		✓
4. Refugees	*Refugees and AIDS*	✓	
	Refugees and AIDS		✓
	• BPC Key Material: *Guidelines for HIV Interventions in Emergency Settings. UNAIDS. UNHCR.* WHO. 1996		
5. Men who have sex with men	*AIDS and men who have sex with men*		✓
6. Schools	*Learning and teaching about AIDS at school*		✓
	• BPC Key Material: *Integrating HIV/STD prevention in the school setting: A position paper.* UNAIDS. 1997		
	• *Impact of HIV and sexual health education on the sexual behaviour of young people: a review update.* UNAIDS. 1997		
7. Tuberculosis	*Tuberculosis and AIDS*	✓	
8. Gender and HIV/AIDS	*Woman and AIDS*	✓	
9. Counselling/Testing	*Counselling and HIV/AIDS*		✓
	• BPC Key Material: *UNAIDS Policy on HIV testing and Counselling.* UNAIDS. 1997		
10. HIV Diagnostic Tests	*HIV testing methods*		✓
11. Mother-to-Child-Transmission	*Mother-to-child transmission of HIV*		✓
12. Development (Impact on Children & Families)	• BPC Key Material: *Report of a consultation on the socio-economic impact of HIV/AIDS, Chiangmai, 1995.* UNAIDS. 1998		
13. Sexually Transmitted Diseases	• BPC Key Material: *Sexually transmitted diseases: policies and principles for prevention and care.* WHO/UNAIDS. 1997		
14. Children & Youth	• BPC Key Material: *Impact of HIV and sexual health education on the sexual behaviour of young people: a review update.* UNAIDS. 1997		
15. Human Rights, Ethics, Law	• BPC Key Material: *The UNAIDS Guide to the United Nations Human Rights Machinery.* UNAIDS. 1997		
16. Country Responses	• BPC Key Material: *China Responds to AIDS: HIV/AIDS Situation and Needs Assessment Report.* UNAIDS & China Ministry of Health. 1997		
17. Determinants & Dynamics	• BPC Key Material: *The relationship of HIV and STD declines to behavioral change in Thailand: a synthesis of existing studies.* UNAIDS. 1998		
	• Case Study : *Connecting lower HIV infection rates with changes in sexual behaviour in Thailand : data collection and comparison.* UNAIDS 1998. in press		
	• Case Study : *A measure of success in Uganda : The value of monitoring both HIV prevalence and sexual behaviour.* UNAIDS 1998. in press		
18. National Strategic Planning	• BPC Key Material: *Expanding the Global Response to HIV/AIDS through Focused Action.* UNAIDS. 1998		
19. Vaccines	• Presentation Graphics		
20. Estimates & Projection	• Presentation Graphics		
21. Female Condom	*Female Condom* –first revision being produced	✓	
22. Microbicides	• BPC Technical Update (TU). UNAIDS. 1998		

* Point of View ** Technical Update

172. In Asia and the Pacific, the UNAIDS Intercountry Team has published a number of documents, including one describing people's experiences and perceptions about the HIV epidemic in the Philippines, Thailand and Vietnam[16] as well as an inventory of sources of information on HIV/AIDS in the region[17]. The Chinese Ministry of Health and the United Nations Theme Group on HIV/AIDS in China published a report entitled *China responds to AIDS: HIV/AIDS situation and needs assessment report*, in 1997. With growing emphasis on information, other Intercountry Teams will similarly be focusing on specific regional areas of interest including information about the activities of Cosponsors and other agencies. Annex A provides a list of other documents on HIV/AIDS published in this biennium by the UNAIDS Secretariat and its Cosponsors, either jointly or independently.

2. HIV/AIDS prevention

173. In most of the world's regions, HIV is now an established epidemic. Nevertheless, new groups of vulnerable populations continue to emerge, necessitating the development or adaptation of prevention strategies to address the characteristics of transmission within various populations.

174. Continuing changes and improvements in scientific and technological sectors which affect the response to HIV/AIDS also influence the evolution of the HIV epidemic. While these changes have had a profound effect on mother-to-child transmission of HIV and antiretroviral therapies, among others, some of the most basic concepts, such as integration of prevention and care into responses to HIV/AIDS, have yet to be put into practice in most countries. Where integration of prevention and care has found its way onto national HIV/AIDS agendas, the value of HIV counselling and testing as a strategy for care and prevention activities is increasingly recognized. Despite a constantly changing epidemic, behavioural and social change remain the most important approaches for responding to HIV/AIDS.

175. Soon after its inception in 1996, UNAIDS initiated a number of cost-effectiveness studies on HIV-prevention strategies. The studies yielded costing guidelines for HIV-prevention strategies; a Point of View document on cost-effectiveness analysis; and three computerized models covering blood safety, programmes for sex workers and school education. The costing guidelines, the document on cost-effectiveness and the model on the cost-effectiveness of blood safety will all become available by mid-1998. The models on programmes for sex workers and school education will follow shortly thereafter.

176. In 1997, the results of 16 multisite comparative studies conducted by WHO/GPA between 1993 and 1995 in developing countries in the areas of contextual factors affecting risk-related sexual behaviour among young people in developing countries, gender-relations, sexual negotiations and the female condom, and household and community responses to HIV and AIDS, became available. Three synthesis reports with comparative analysis of findings are now available and will be published toward the end of 1998.

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[16] *My experience with. A document describing people's experiences and perceptions about HIV/AIDS epidemic from Thailand, Philippines and Vietnam.* UNAIDS Asia-Pacific Intercountry Team, Bangkok, Thailand, 1996

[17] *Inventory of HIV/AIDS information sources in the Asia-Pacific region.* UNAIDS Asia-Pacific Intercountry Team, in association with the Asia-Pacific Network of People Living with HIV/AIDS and the Asia-Pacific Council of AIDS Service Organizations, 1997

177. In July 1996, UNAIDS cosponsored a satellite meeting entitled 'HIV prevention works' at the Eleventh International AIDS Conference, held in Vancouver, Canada, together with the Canadian Public Health Association, Health Canada, the United States Centers for Disease Control and Prevention, and the United States National Institutes of Health. The meeting provided a forum for presenting experiences in successful HIV prevention, and focused on revitalizing the key prevention messages[18]. A follow-up meeting has been proposed for the Twelfth International AIDS Conference, to be held in Geneva in June 1998. The meeting will be cosponsored by the same institutions, as well as the Swiss AIDS Federation, Swiss Federal Office of Public Health, Family Health International, and the United States Agency of International Development.

Mother-to-child transmission of HIV

178. Transmission of HIV from mother to child during pregnancy and delivery, as well as through breastfeeding, represents a major cause of morbidity and mortality among young children, particularly in developing countries with a high prevalence of HIV infection. In February 1998, a trial held in Thailand and sponsored by the Ministry of Public Health, Thailand, and the United States Centers for Disease Control and Prevention showed that the use of a short zidovudine (AZT) regimen given to non-breastfeeding women resulted in an average reduction of 50% in mother-to-child transmission of HIV. This development prompted the UNAIDS Secretariat, in collaboration with UNICEF and WHO, to convene an international meeting in March 1998 to plan for implementation of a programme for wider use of AZT in developing countries. The meeting concluded with a joint statement addressing the urgency of the situation and specific follow-up actions required to support accelerated programming in this area. Subsequent to the March meeting, UNAIDS, UNICEF and WHO agreed to establish an international coordination mechanism of all interested parties; to refine strategies through accelerated technical development and carefully monitored pilot projects; and to intensify negotiations with industry to ensure provision of affordable test kits, antiretrovirals and breast milk substitutes. A related meeting was also organized by WHO in April 1998 with UNICEF and the UNAIDS Secretariat to discuss the implementation of the guidelines that support the use of alternatives to breastfeeding for infants born to HIV positive women.

179. Since 1995, WHO and later, UNAIDS, have also supported a clinical trial, the PETRA study, in South Africa, Tanzania and Uganda, to test the efficacy of a short-term regimen of AZT and 3TC, two antiretroviral drugs for reducing the risk of mother-to-child transmission of HIV. The preliminary results will be available by mid-1998. From this trial we will learn whether a very short course of two antiretroviral drugs are as efficacious as longer regimens that include one drug only. If a shorter drug regimen were efficacious it would provide significant operational benefits for prevention programmes, without increasing their cost. Collaborating hospitals are in Durban and Johannesburg, South Africa; Dar-es-Salaam, Tanzania; and Kampala, Uganda. The study's sponsors also include the Swedish International Development Agency, the Australian Agency for International Development, and NATEC, the Netherlands. Drugs are made available free-of-charge by the Glaxo Wellcome pharmaceutical company.

180. UNAIDS coordinates the informal working group on mother-to-child transmission of HIV, which focuses on the coordination and design of clinical trials on the prevention of HIV transmission

[18] *HIV prevention works*, Canadian Public Health Association, 1996

from mothers to their children. UNAIDS also supports the Ghent international working group on perinatal transmission of HIV sponsored by the European Union, which conducts studies on the acceptability of prenatal voluntary counselling and testing in the context of ongoing clinical trials in Africa, as well as cost-effectiveness studies related to the use of AZT and alternatives to breastfeeding.

Voluntary counselling, testing and support

181. Voluntary HIV counselling and testing are critical elements of an effective response to HIV/AIDS, from the perspective of both prevention and care. With the increasing availability of new technologies (such as antiretrovirals to significantly lower viral loads and to prevent mother-to-child transmission), voluntary counselling and testing become even more critical to help individuals understand that, despite the successes of these new treatments, prevention is still essential.

182. The multisite Voluntary Counselling and Testing study, carried out in Kenya, Tanzania and Trinidad, was the first randomized, controlled trial of the effectiveness and consequences of voluntary counselling and testing for the prevention of new HIV infections. Preliminary results showed that voluntary counselling and testing for HIV significantly reduce sexual-risk behaviour and do not increase the incidence of negative life events, such as disintegration of relationships and discrimination (see panel 6 and Section II.B).

183. In addition to this study, several voluntary counselling and testing field services in Chile, Honduras and Jamaica have been documented and are being included as UNAIDS *Best Practice* Collection case studies[19]. Also for the *Best Practice* Collection, UNAIDS is currently documenting case studies on field services that try to reach vulnerable sections of society and increase advocacy for national policies on voluntary counselling and testing, such as the AIDS Information Centre in Uganda and the Thai Red Cross.

184. In 1996, UNAIDS supported a study in Zambia to examine the supportive and psychosocial effects of voluntary counselling and testing for individuals. This study, which was completed in 1997, found that counselling has positive effects in helping people to cope with being diagnosed as HIV positive and making informed decisions about sexual behaviour. A case study on the experiences of the Kara Counselling and Training Trust is now under preparation. A workshop held in Bangkok in December 1996 brought together counselling experts from eight countries in Asia to review data from the Myanmar counselling study, sponsored by WHO and UNAIDS. This exercise has helped to create a network of experts to assist in the strengthening of counselling services in Asia.

185. UNAIDS issued a policy statement on HIV counselling and testing in 1997[20]. The statement promotes the development of stronger national HIV counselling and testing policies and improved voluntary counselling and testing services. The Programme is also supporting pilot projects, such as those in Africa, South-East Asia, Eastern Europe and the former Soviet Union, and Latin America and the Caribbean.

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19 *Counselling and community outreach programme*, National HIV/STD Control Programme, Epidemiology Unit/Ministry of Health, Kingston, Jamaica; *HIV/AIDS counselling and testing in Chile*, WHO/CONASIDA/Municipality of Santiago Cooperative Centre, Santiago, Chile; *HIV/AIDS counselling*, Honduras, Central America (under review).

20 *UNAIDS policy statement on HIV counselling and testing*, UNAIDS, 97.2

186. In the context of preventing mother-to-child transmission of HIV, the delivery of voluntary counselling and testing in antenatal care services will be an important element of the Programme's workplan in the future. With UNICEF and WHO, the Secretariat will accelerate its efforts to introduce/ implement counselling and testing in antenatal services through pilot projects and other means.

Gender issues

187. Within the framework of HIV/AIDS prevention, gender issues have proven to be a critical consideration. In 1996, UNAIDS commissioned a paper on how to strategically integrate gender into its policies and programmes, the outcomes of which are now being implemented. In 1997, the Programme published a Point of View document entitled *Women and AIDS*, as part of its *Best Practice* Collection. The Programme also collaborated with the International Center for Research on Women, Washington D.C., U.S.A., to engage in a 'stock-taking' exercise on research and programmes dealing with gender and HIV/AIDS. A paper detailing the results of the exercise will be published in 1998[21].

188. The Interagency Working Group on Gender and HIV[22], which met for the first time in July 1996, identified priorities for 1996-1997 and supported projects among the Cosponsors which underwent a peer review in this group. UNDP is preparing a series of issues papers on gender and the HIV epidemic; UNICEF is developing resource materials for integrating gender awareness into adolescent sexual-health programmes; and UNESCO is implementing a project to reduce the rate of HIV transmission among women by empowering them with the required awareness, knowledge and skills. WHO is providing technical support to a project on reproductive-health rights of HIV-positive women, for which UNAIDS is providing financial support to the International Community of Women Living with HIV/AIDS. In addition, the Programme is supporting *Fundacio para Estudio e Investigación de la Mujer* in its work with low income women in Argentina on the provision of sexual and reproductive health services, including services linked to HIV/AIDS. A UNAIDS adviser on gender and community mobilization, assigned to the HIV and Development Programme at UNDP headquarters in New York, is working with the Cosponsors on integrating gender and HIV efforts, as well as with other United Nations agencies such as the United Nations Division for the Advancement of Women (UNDAW) and the United Nations Development Fund for Women (UNIFEM).

Condoms and safer sex technologies

189. In the context of prevention, the Programme also emphasizes the promotion of safer sex and condom use as one of the basic strategies to impede sexual transmission of HIV. In November 1997, WHO and the UNAIDS Secretariat organized a consultation on male condoms, together with United Nations agencies, non-governmental organizations, manufacturers and standards organizations, to determine new guidelines and specifications on male condoms. A set of *Condom fact sheets* on various aspects of condom programming has been developed, and the WHO technical document entitled *Specifications and guidelines for condom procurement* was updated following consultations with UNFPA, Population Services International, (PSI), Washington D.C., USA, and condom procurement and distribution agencies. UNAIDS and its collaborators have

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21 *Taking stock on research and programmes on gender and HIV/AIDS*, UNAIDS (forthcoming)

22 Please see Section IV.E – Interagency Working Groups

disseminated the information which resulted from the consultation; it is now being used in countries by national AIDS programmes and other key actors for condom procurement and distribution purposes.

190. UNAIDS is collaborating with PSI, a highly experienced organization in social marketing of condoms, to accelerate condom-promotion initiatives. This unique collaboration facilitates a two-pronged approach of assisting national AIDS prevention programmes to include condom programming and of ensuring affordable access to condoms by the general population. Thus far, the programme has been implemented in Armenia, Bulgaria, China, Georgia, Kazakstan, Myanmar, Romania, Russia and Ukraine.

191. Condom use, the only method with proven efficacy in decreasing sexual transmission of HIV, is ultimately controlled by men. Recognizing the need for protection methods controlled by women, UNAIDS has advocated for the development of vaginal microbicides, which are products for vaginal or rectal administration that decrease the transmission of HIV and other sexually transmitted diseases. UNAIDS also serves as the secretariat for the International Working Group on Microbicides. The results of the UNAIDS-sponsored study on the safety of the vaginal microbicide COL-1492, which contains the active ingredient nonoxynol-9 in a gel form, were published[23]. In 1996/1997, UNAIDS launched a multicentre study on the efficacy of COL-1492 in preventing HIV infection and sexually transmitted diseases among female sex workers in Benin, South Africa and Thailand. In addition, preparatory work is proceeding in Côte d'Ivoire and Senegal. A first interim analysis is expected in 1999 but final results will not be available before the end of 2001.

192. After reaching agreement with the Female Health Company on the price of the female condom, UNAIDS launched a successful promotion campaign for the product in developing countries with Population Services International. In 1997, the sales objectives were surpassed, enabling UNAIDS to further expand its promotion.

Information, education and communication

193. In collaboration with UNICEF, WHO, and UNESCO, UNAIDS has continued to highlight that school-based sex education reduces the likelihood of risk behaviour. In 1997, within the framework of the *Best Practice* Collection, the Programme published a position paper on *Integrating HIV/STD prevention in the school setting*, as well as a technical update on *Learning and teaching about AIDS at school*. Also in 1997, UNAIDS participated in the organization of seminars on school-based AIDS education at the three regional conferences on AIDS held in Côte d'Ivoire, Peru and the Philippines, where specialists described the experiences of programmes from their respective countries.

194. The Cosponsoring Organizations have been involved in a variety of efforts in this area during this biennium, including at the field level. A few examples include: (i) UNESCO's work in curriculum development and teacher training in India, and planning seminars in Nepal and Cambodia; (ii) UNFPA's focus on integration of HIV/STD prevention in family life/reproductive health programmes in more than 150 countries; (iii) WHO's efforts to integrate school-related health services for adolescents with action-research projects in six African countries; to integrate HIV/STD prevention into the 'Health Promoting Schools Network' in six regions; and to support the Government of China to extend HIV/STD education in all schools in the most affected Southern provinces; (iv) the World Bank's efforts to include HIV/STD education in its negotiations on loans for

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[23] *AIDS*. 1998; **12**

improved efficiency of school systems and in its training programmes for World Bank Task Managers, for which UNAIDS will collaborate in designing the training package; and (v) UNICEF's efforts to develop youth-friendly health services and promote life-skills education which integrate AIDS information.

195. In the communications area, UNAIDS has carried out wide-ranging consultations with specialists in behaviour-change communications, mass-media practitioners, communications researchers, communications programmers, and programme implementers from Africa, Asia and Latin America. This process, conducted in collaboration with UNESCO, UNICEF and the World Bank, will result in development of communications strategies for national AIDS and health-promotion programmes. The development of regional networks to improve communications frameworks and strategies for the response to HIV/AIDS will also be an outgrowth of the consultation process.

196. In 1997, in collaboration with the Southern Africa AIDS Information Dissemination Service, the Programme participated in the development of innovative HIV/AIDS communications strategies with heads of communications, media and journalism training institutions in Eastern and Southern Africa, with the goal of integrating information on health and HIV/AIDS into the curricula of these institutions.

197. UNAIDS collaborated with UNICEF's Eastern and Southern Africa Regional Office to adapt the materials of the SARA Initiative for use in French-speaking countries. The SARA Initiative is an educational project for girls and youth, aimed at building life skills, including making informed decisions for safer behaviour. One of the priorities of UNICEF has been to develop more effective ways to harness the power of communication for HIV/AIDS prevention and care. In Kenya, Malawi, Tanzania and Uganda, UNICEF gives technical and training support to 'Straight Talk', a radio programme and newspaper where young people act as peer educators on health, including to members of over one thousand AIDS prevention clubs. UNICEF also provides support for the development of 'Soul City', a South African health communication programme that includes a significant focus on HIV/AIDS. Under the Coordinated Appeal, funding support was provided to UNESCO and UNICEF to develop 'communications for behaviour change' programmes in Africa, Asia and Latin America.

198. As part of its efforts to broaden the *Best Practice* Collection, the Programme signed a special agreement with Family Health International in 1997. The partnership will result in the compilation of 20 best practice documents on communication from around the world.

Religious institutions

199. In Africa, religious leaders confronted AIDS early in the epidemic; religious communities were the first to care for the sick and dying. In many parts of Asia, Buddhist monks and nuns and other religious leaders are very much involved in care for people with HIV/AIDS. Monks working in harm reduction centres are active in HIV prevention work, in addition to caring for infected people.

200. A two-pronged approach is being taken to expand the engagement of the religious sector. The first is to promote mechanisms for the exchange of ideas and training aimed at strengthening capacities for community-based prevention and care programmes. The second is to encourage religious institutions to strengthen life-skills training approaches for HIV/AIDS education in schools operated by their congregations.

201. The International Conference on Religion and AIDS held in Dakar in 1997, and the International Symposium on AIDS Prevention which took place in Argentina in early 1998 are recent examples of valuable collaboration with the religious sector (SEE PANEL 34). UNAIDS also collaborates with CARITAS International, based at the Vatican. Such contacts are vital, since, over time, they create mutual respect for different points of view and approaches on how to deal with HIV/AIDS.

202. Under the *Best Practice* Collection, a set of case studies and materials on the contributions to and involvement of Buddhist, Christian and Islamic religious congregations in the national response to HIV/AIDS in Africa, Asia and Latin America are being prepared for completion in the next biennium.

PANEL 34

WORKING WITH THE RELIGIOUS SECTOR

In November 1997, Buddhist, Christian and Islamic leaders from across the African continent gathered in Dakar, Senegal, to participate in the First International Symposium on AIDS and Religion. The symposium, facilitated by UNAIDS, resulted in a consensus to form an 'interfaith alliance' in Africa to facilitate information exchange and joint action, particularly in support of people living with HIV/AIDS. The gathering of African religious leaders served several purposes:

- It provided a forum for spiritual leaders to discuss how to address the difficult questions which HIV/AIDS often poses to theology.
- It enabled the establishment of new contacts for continued dialogue on the response to the epidemic in the future.
- It yielded valuable material for case studies on the HIV/AIDS-related activities of numerous religious institutions in Africa, now being written up by UNAIDS.

Recent events in Latin America have also helped to strengthen collaboration with the religious on issues linked to the HIV epidemic. In May 1998, in Argentina, the Catholic Church Commission on Health organized an International Symposium on AIDS Prevention. Participants included clergy and lay leaders from Argentina, Brazil, Chile, Paraguay, Portugal, Spain, Uruguay and the Vatican. The symposium concluded that the Church, governments and international organizations must work together to address important aspects of prevention and care, as well as alleviation of the epidemic's impact. SIDALAC (Mexico), the World Bank and UNAIDS provided technical and financial support for the meeting.

Other institutional settings: prisons, the military and workplaces

203. The Programme's efforts to reduce risk and vulnerability in institutional settings such as prisons and workplaces have largely focused on strengthening national and regional networks, and facilitating information exchange on effective programming. A joint undertaking with the Civil-Military

Alliance to Combat HIV/AIDS, and its regional affiliates, will help to establish and strengthen HIV/AIDS programmes with military services in Africa, Asia and Latin America. This partnership covers a range of programmes that include strengthening strategic planning capacities of the military, police, maritime, and prisons sectors in South-East Asia and Russia; support of technical networks in the ASEAN region and among English-speaking African countries; and dissemination of best practices, including case studies and sector-specific training materials. Activities organized in collaboration with the Civil-Military Alliance during the 1996-1997 biennium included a seminar for North Atlantic Treaty Organization and 'Partnership for Peace' countries, held in Belgium; a policy workshop for 13 countries in Eastern and Southern Africa, held in Malawi; a plenary panel at the International Congress on Military Medicine, in China; a military seminar for 15 nations of Eastern and Southern Africa, culminating in the formation of a Civil-Military Network for training and mutual support, in Namibia; an Interagency Consultation on the Prevention of HIV/AIDS in the maritime/seaport sector, in the United Kingdom; and a seminar on AIDS in the Military for 18 French-speaking countries in West and Central Africa, held in Senegal. In Africa and Europe, UNAIDS also provided support for key international conferences such as the Conference on AIDS in African Prisons, in Senegal, and the African Regional Seminar on HIV/AIDS in Military Populations, held in Namibia.

204. In addition, a technical update and a Point of View document on *Prisons and AIDS*, published in 1997 as part of the *Best Practice* Collection, describe important issues and approaches to dealing with HIV in prison settings. The Programme is developing a field manual on the assessment, monitoring, surveillance and evaluation of HIV/AIDS programmes in the military, aimed at enhancing the capacity of military systems to establish their own programmes.

205. Together with the Organization of African Trade Unions Unity and non-governmental organizations, such as Family Health International, the Programme has developed partnerships with the International Labour Organisation and the Organization of African Unity on workplace programming to respond to HIV/AIDS. The Thai Business Coalition is working with UNAIDS to document the success of businesses in South-East Asia in implementing workplace programmes dealing with HIV/AIDS, with the goal of producing documents for the *Best Practice* Collection. Plans are currently underway to produce a case study on a successful multisectoral approach to mainstreaming HIV/AIDS workplace policy and programming into public policy.

Migration

206. One of the major documented socio-economic determinants of sexual risk and injecting drug use is migration. HIV and other sexually transmitted diseases are probably more closely related to migration than any other type of infectious disease. This is largely because mobility can be a primary cause of engaging in risk behaviour and of seeking partners who are at increasing risk of HIV infection.

207. Under the West African HIV/AIDS initiative, five action research projects on the main transportation routes in the region and frontier zones were initiated. The study sites are in Burkina Faso, Côte d'Ivoire, Mali, Niger and Senegal. The objective of these projects is to increase understanding of the linkages between migration and mobility, and HIV/AIDS, and to propose strategies to reduce resulting vulnerability and risk. As a result of extensive consultations with regional partners, the UNAIDS Asia Pacific Intercountry Team identified cross-border issues as a

priority area of work for the coming biennium. More information on this work is provided in UNAIDS/PCB(6)/98.5.

208. As the issue of migration is also related to prostitution, in 1996, UNAIDS reviewed the situation in Eastern Europe and organized a meeting with the Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project (TAMPEP), Social Pedagogical Institute (Germany) and AIDS and Mobility (Netherlands). These networks, which are supported by the European Commission, have implemented information, education and communication activities among migrant sex workers in the region. This meeting aimed to establish a working group on HIV prevention among sex workers in Eastern Europe and to expand the coverage of these networks further.

209. In 1996, UNAIDS also took on the collaboration formerly established by WHO/GPA with the AIDS and Mobility Network. As part of this collaboration, the Programme provided funding and technical assistance, and co-facilitated a working group on human rights documentation related to HIV/AIDS, migrants and ethnic minorities, at the Fourth European Meeting on Migrants, Ethnic Minorities and HIV/AIDS held in Barcelona, Spain, in 1996.

210. After the dissolution of the Soviet Union, the United Nations High Commission for Refugees (UNHCR) responded to the needs of the growing number of political migrants, refugees and internally displaced persons. One of their activities was the establishment of a programme on reproductive health, including STDs and HIV/AIDS in the Caucasus Region, namely Armenia, Azerbaijan and Georgia. UNHCR and UNAIDS are exploring the most effective ways to coordinate their activities in this region in the context of this work.

211. In March 1998, together with the International Office for Migration (IOM) and the participation of the Food and Agriculture Organization of the United Nations (FAO), the Office of the United Nations High Commissioner for Refugees (UNHCR) and the International Labour Organisation (ILO), UNAIDS co-organized a consultation on migration and HIV. The resulting joint policy paper emphasizes the need to initiate coordinated efforts to address the root causes of large-scale labour movements and to eradicate the trafficking of women and children.

Injecting drug use

212. Injecting drug use is a core factor in the spread of HIV in many parts of the world. Recognizing this, UNAIDS signed a Memorandum of Understanding with the United Nations International Drug Control Programme (UNDCP) in September 1996. This agreement articulated the commitment of both Programmes to cooperate and mobilize their expertise and resources to ensure that complementary issues are covered in their respective initiatives. UNAIDS is a member of the Administrative Committee on Coordination Subcommitee on Drug Control, which works to ensure interagency coordination on programming and information exchange to address HIV/AIDS issues related to drug use. At country level, UNDCP participates as a member of the United Nations Theme Groups on HIV/AIDS in such countries as Bangladesh, India, Myanmar and Nepal, which has facilitated coordinated action in response to the drug-related spread of the virus. UNDCP and UNAIDS are also working together at country level on continuing projects such as an HIV prevention programme among injecting drug users in Vietnam, a life-skills education programme as a strategy for drug-use prevention among street children in Indonesia, and similar drug use-related projects in Cambodia, Eastern Europe, Ecuador, Ghana, Kenya, Mexico, Nepal, the Philippines, Thailand and Zambia.

213. Since 1996, UNAIDS has been working closely with the WHO Programme on Substance Abuse through common projects and a shared staff member, who facilitates the collaboration and implementation of joint efforts to respond to drug use as a factor in HIV transmission. In addition, an Interagency Working Group on HIV and Sexually Transmitted Disease Prevention among Especially Vulnerable Young People, where the issue of drug use is addressed, has been established to facilitate the cooperation of UNAIDS with its Cosponsors and UNDCP, UNHCR and ILO.

214. UNAIDS provided support to the development of a WHO Programme on Substance Abuse guidebook entitled *Injecting drug use: rapid assessment and response*, and funds the implementation of a multisite project and development of a manual entitled *Substance abuse and sexual risk behaviour rapid assessment and response*. Also in collaboration with the WHO Programme on Substance Abuse, UNAIDS is supporting the development and production of a training manual entitled *Street children, substance use, HIV/AIDS and health: training for street educators*. A technical update on injecting drug use issues is under development, as is a collection of case studies to describe and assess programmes for injecting drug users, through strategies such as a long-term peer-outreach programme and an HIV/AIDS-prevention education programme covering the issue of needle exchange.

215. UNAIDS has been instrumental in strengthening regional HIV/injecting drug use harm reduction networks, focusing on exchanging lessons learned and sharing technical resources. More recently, the Programme held a consultation with various regional networks in order to facilitate greater collaboration between networks. UNAIDS has also extended cosponsorship to conferences that have led to enhanced advocacy and best practice for a linked response to HIV/AIDS and drug abuse. The Programme's sponsorship of participants from developing countries to the International Conference on the Reduction of Drug-Related Harm in 1996 and 1997 provided them with the opportunity to enrich their national and local programmes with ideas for an expanded response (SEE PANEL 35).

Sex work

216. In this area, UNAIDS' principal efforts in 1996 and 1997 have been in the area of identification and dissemination of best practices in HIV prevention and care, strengthening of regional networks, and development of tools and guidelines to facilitate project development. The Programme has supported specific initiatives in the Asia-Pacific region, Central and Eastern Europe, and West and Central Africa.

PANEL 35

INJECTING DRUG USE IN KAZAKSTAN

Since June 1996, Kazakstan has been experiencing a dramatic increase in HIV infection among injecting drug users in Timertau City, a small industrial community with a population of about 200 000. It is believed that there may be 3 000 to 5 000 injecting drugs users among people aged 15 to 25. The local health authorities have reported over 460 cases of HIV infection in the area.

To address the problem, the United Nations Theme Group on HIV/AIDS, together with the national government, local and international non-governmental organizations, and the UNAIDS Intercountry Programme Adviser, launched an interagency team mission to assess the situation in Timertau City. Following the mission, the government, the Theme Group and other partners collaborated to develop a joint project document on 'Promotion of a multisectoral effective response to HIV/AIDS and STD epidemics and drug use spread in Karaganda Oblast and nation-wide' (region containing Timertau City). UNDP, the United Nations International Drug Control Programme, UNAIDS and ISPAT-KARMER, a local private company, joined efforts to provide funding, and the project began in July 1997. This is one of the first cases of a private company in Eastern Europe investing in the response to HIV/AIDS.

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217. Within the Asia-Pacific region, UNAIDS participated in a process initiated in 1997 to identify best practices. This resulted in a meeting on best practices in programmes dealing with sex work at the Third International Conference on AIDS in Asia and the Pacific, held in the Philippines. Since then, the Programme and its partners have elaborated documents for the *Best Practice* Collection on projects from Bangladesh, Cambodia, India and Papua New Guinea. UNAIDS has also supported the Asia-Pacific Network of Sex-Work Projects, in an effort to reinforce its structure and further facilitate the exchange of experiences within the region.

218. In West and Central Africa, the UNAIDS Intercountry Team has undertaken a review and analysis, in collaboration with the *Gesellschaft für Technische Zusammenarbeit* (GTZ) Regional Programme on HIV/AIDS, of community-based approaches in sex-work settings in Côte d'Ivoire, Mali, Senegal and Togo. Based on the experiences from this region, efforts are being made to develop a resource pool to support the elaboration and expansion of such programmes. To facilitate this process, UNAIDS has helped to develop a situational analysis guide. In 1996, The Programme also organized a meeting of networks and projects that reach sex workers and clients in Europe. These projects include those which focus on the mobility of sex workers and clients, and on the changing context of sex work within Central and Eastern Europe. The establishment of programme links between countries has been promoted to deal more effectively with HIV prevention in sex-work settings.

Men who have sex with men

219. In an effort to address HIV/AIDS among men who have sex with men, UNAIDS has provided support to activities in Latin America and the Caribbean, with similar support planned for Eastern and Central Europe and the Asia-Pacific region. In Latin America and the Caribbean, the Programme helped to organize and finance a regional consultation on HIV/AIDS prevention, care and support programmes for men who have sex with men, held in Bogotá, Colombia, in June 1997. This consultation resulted in a recommendation to develop practical guidelines on HIV/AIDS prevention, care and support for men having sex with men in the region.

220. For the *Best Practice* Collection, UNAIDS is supporting the documentation of the experiences of programmes on men having sex with men in India and Morocco. The Programme also provided funding for a pilot project on HIV/AIDS prevention among men who have sex with men in Chennai, India. These activities were initiated under WHO/GPA.

3. Improving care and support for people living with HIV/AIDS

221. The need to provide basic health care and support services, specific to AIDS, has become critical. While this need is being acknowledged, the gap in needs and services in resource-constrained settings continues to grow. A false dichotomy between prevention and care creates unnecessary competition for already insufficient resources. With the promising news on antiretroviral therapy, the issues of access to these therapies, and to palliative care itself, needs to be addressed urgently from the programmatic perspective. It remains a major challenge for the United Nations system to determine how it can best mobilize its collective resources to assist governments and non-governmental organizations much more effectively in their efforts to increase access and enhance the quality and coverage of health care.

Access to drugs and care

222. In 1996 and 1997, UNAIDS developed a strategy to improve access to HIV-related drugs as an entry point for improved access to care for people living with the virus. The strategy is based on partnerships with agencies of the United Nations, the pharmaceutical industry, governments, communities and non-governmental organizations. WHO, with support from the UNAIDS Secretariat, held a meeting on anti-retroviral therapy in April 1997, at which participants discussed implications of antiretroviral therapy availability, especially issues related to prevention and access. As a follow-up to this meeting, UNAIDS organized a consultation in June 1997, with selected country representatives and the pharmaceutical industry, to explore how access to drugs could be improved in developing countries. The Programme's Cosponsors endorsed this approach, as did non-governmental organizations and government representatives.

223. UNAIDS is now initiating pilot projects to improve access to drugs of special interest to people living with HIV/AIDS, in Chile, Côte d'Ivoire, Uganda and Vietnam, in collaboration with the Ministries of Health and an increasing number of pharmaceutical companies. These projects include setting up a financial mechanism to lower the price of drugs and improving service delivery; strengthening the infrastructure and human-resource base of the pilot centres; providing assistance for the development of national policies on management and care of people living with HIV; and assessment of the feasibility of extending the pilot initiatives. The pilot projects are by definition limited in scope and only the first steps in broadening access to care. It is hoped that they will provide insights and approaches that can be adapted and scaled up in other countries.

224. Increased awareness of the needs of people living with HIV/AIDS led to the inclusion of several drugs, including AZT to prevent mother-to-child transmission, on the WHO essential drugs list. UNAIDS is currently collaborating with local partners and SIDALAC to document case studies on the process of introducing antiretrovirals in Argentina, Brazil, Colombia and Mexico, where, despite resource constraints, antiretrovirals have been made available. The objective of the studies was to

assess the extent to which their introduction was successful, and learn which difficulties had been encountered in introducing the new technology to serve as a learning tool for other countries.

225. The Programme is supporting a collection of case studies on the activities of non-governmental organizations to improve access to care and drugs in Asia, Latin America and the Caribbean, and west Africa. Three review exercises on how such organizations support care and access to drugs have been commissioned to one organization in each region. The Programme is also providing assistance to the Horizontal Technical Cooperation Group for its preparatory work to explore the establishment of a regional drug fund.

226. Together with the UNAIDS Secretariat, the WHO Action Programme on Essential Drugs is also participating in efforts to develop an operational plan to improve access to drugs for HIV infection and has contributed to the development of a UNAIDS technical update on access to drugs. In 1998, the Programme on Essential Drugs will expand its work on promoting the access to and the rational use of drugs of special interest to people living with HIV. A consultation on this subject was organized by the *Institut de Médecine et d'Epidémiologie africaine*, France, and the National Programme on AIDS, Senegal. Another meeting was organized by the WHO Regional Office for Africa in Senegal, in July 1997, on the subject of antiretroviral therapy in Africa. The recommendations of these meetings were consolidated at a consensus meeting held in Côte d'Ivoire in December 1997.

227. The European Union and UNAIDS joined together to sponsor a meeting held in Paris in September 1997 on paediatric AIDS care and research. The meeting defined an agenda for research on paediatric HIV infection.

228. The Programme finalized a number of studies initiated by the WHO Global Programme on AIDS during the 1996–1997 biennium. These included a study, undertaken with the University of Chiang Mai in Chiang Mai, Thailand, on penicilliosis, a common opportunistic infection in South-East Asia. A tuberculosis prophylaxis study in Bangkok has been in place since November 1993. The study will be completed in September 1998. In February 1997, UNAIDS prepared guidelines on how to develop and validate clinical guidelines for the management of HIV/AIDS in adults, which will be published in mid-1998. The guidelines are intended to empower local decision makers to develop their own institutional or national guidelines on the management of people living with HIV/AIDS.

229. The UNAIDS Secretariat became a member of the Coordination, Advisory and Review Group of WHO's Global Programme on Tuberculosis (GTB). It is working with GTB to develop an agenda dealing with the dual tuberculosis and HIV epidemics and to support the Adult Lung Initiative. The Secretariat is providing financial and technical support to a range of activities in GTB, including a situation assessment on how countries deal with the dual epidemic and a joint consultation on preventive therapy for tuberculosis in HIV-infected persons.

Sexually transmitted diseases (STDs)

230. There is a strong link between other sexually transmitted diseases (STDs) and HIV infection, as emphasized by a study in Mwanza, Tanzania[24]. The presence of an untreated STD can enhance both the acquisition and transmission of HIV by a factor of up to 10. Thus, STD treatment is an important HIV prevention strategy in a general population. In order to improve STD management

[24] *The Lancet*, Vol. **34b**, pp. 530-536, 1995

as a means to reduce the transmission of HIV, and at the same time reduce the burden of sexually transmitted diseases, UNAIDS and WHO have reviewed the literature to examine the validation of the syndromic approach in the management of STDs in women and adolescents. A preliminary analysis document to rationalize and optimize the use of sexually transmitted disease treatment protocols in all STDs will be published in 1998.

231. UNAIDS has collaborated with the WHO Regional Office for Africa in convening meetings, such as the one held in Dakar, Senegal in October 1997. This meeting brought together representatives of the World Bank, the European Union, UNICEF, the United States Agency for International Development, UNFPA, DFID-UK, and other partners, to agree on the creation of a task force for implementing the WHO Regional Strategy for STD Prevention and Care in Africa. WHO and UNAIDS have also published a document entitled *Sexually transmitted diseases: policies and principles for prevention and care*. This is intended to assist Ministry of Health officials who have the responsibility of developing and implementing STD programmes to take into account issues such as quality of care and integration of human rights principles.

232. The Programme also helped to found a regional task force on care and prevention of STDs in Eastern Europe (details are provided in Section IVE3). In collaboration with UNAIDS, WHO has engaged the services of Heidelberg University, Germany, to document and evaluate the integration of STD services into reproductive health services in Uganda. UNAIDS is in the process of conducting a similar exercise in Zimbabwe, in collaboration with the University of Zimbabwe.

233. In partnership with the Department of Obstetrics and Gynaecology, Guangxhou Maternal and Neonatal Hospital, China, and the Division of Public Health and Environment, Amsterdam Municipal Health Services, the Netherlands, UNAIDS is funding a pilot project for the establishment of an STD Prevention and Treatment Centre for sex workers in Guangzhou, China. The Programme also provided funding for a communications study on the subject of sexually transmitted diseases in Masaka, Uganda. The project has the goal of establishing the roles of information, education and communication in the management of sexually transmitted diseases and transmission of HIV. UNAIDS also supported analysis of data from a review report in Zimbabwe prepared by local researchers, which resulted in three case studies focusing on STD management in primary health care. The Programme has continued to monitor the study initiated by the WHO Global Programme on AIDS and conducted by the University of Nairobi on the treatment of chancroid in patients with concomitant HIV infections.

The role of communities in care and support

234. Communities have a major role to play in both helping to enable their members to avoid HIV infection, and in providing a caring environment for those already infected. UNAIDS has actively promoted the involvement of community organizations in response to the HIV epidemic, with the objective of enabling those most affected to participate in shaping the response and to work towards creating non-discriminatory and supportive environments.

235. In collaboration with UNDP and the United Nations Volunteers, UNAIDS is providing technical and financial support for pilot projects in Malawi and Zambia to train, place and support people living with HIV/AIDS at various levels of the national response in both countries (SEE PANEL 36). Those involved in the projects are considering expanding the project to French-speaking African countries and the Asia/Pacific region. A report on the lessons learned from the project, entitled *Report on country selection and consultative processes for UNV support to PLHA projects*, is available.

236. As part of its *Best Practice* Collection, UNAIDS published a technical update entitled *Community mobilization and AIDS*, in May 1997. The update provides an overview of the special challenges facing the organization of HIV/AIDS activities at local level—notably problems of representation and sustainability—and describes how communities in several parts of the world deal with these challenges. Additional publications have included a case study on *AIDS education through imams: a spiritually motivated community effort in Uganda*, in the form of a booklet and a video which will be completed in 1998. The case study describes how some 8 000 religious leaders and teams of local volunteers have been mobilized in the fight against AIDS since 1992.

237. Within the framework of the *Strategies for Hope* series, the Programme has supported publication of two booklets: *Common cause* and *Youth to youth*, on community mobilization among youth in Botswana, Kenya, Nigeria and Tanzania. UNAIDS sponsored a consultative meeting in 1997 to prepare case studies on successful community care projects from Brazil, Kenya, Malaysia, South Africa, Thailand and Zimbabwe. Assisted by UNAIDS staff, representatives of the projects presented the case studies at the Third International Conference on Home and Community Care for People with HIV/AIDS, held in Amsterdam in May 1997. The case studies demonstrate considerable diversity in approaches to home and family care for infected and affected persons, as well as providing an important opportunity to test the validity of the Programme's community-mobilization strategies. These studies will also be available as part of the *Best Practice* Collection in 1998.

238. UNAIDS also supported the preparation of four case studies on successful community/government partnerships in Australia, Canada, Thailand and Uganda. The case studies illustrated the importance of cooperation between the governmental and non-governmental sectors, as well as explaining how this may be undertaken in different ways, depending on local political structures, administrative cultures, and available resources. A monograph presenting these four cases is scheduled for publication in 1998.

239. Lessons learned in the area of home and community-care initiatives in Africa have been documented in four case studies presented at the Tenth International Conference on AIDS and STDs in Africa, held in Côte d'Ivoire in December 1997. These studies describe communities which have successfully balanced the right to confidentiality with the responsibility of families and communities to provide care to people living with HIV/AIDS. In the same vein, UNAIDS and WHO are conferring to produce a rapid-assessment methodology, tested in Malawi, to build partnerships between communities and health systems. Together with *Médecins sans frontières*, the Programme sponsored a participatory evaluation of a project on traditional and modern health practitioners working together against AIDS in Uganda. The study concludes that traditional healers can be very useful as a liaison to the community, mainly as a vehicle for prevention messages, but also as a source of health and psychological support.

PANEL 36

GREATER INVOLVEMENT OF PEOPLE LIVING WITH HIV/AIDS THROUGH UNITED NATIONS VOLUNTEERS IN MALAWI AND ZAMBIA

UNDP, the United Nations Volunteers and UNAIDS are collaborating to support a pilot project in Malawi and Zambia, together with the Malawi and Zambia national chapters of the Network of African People Living with HIV/AIDS (NAP+). The project aims to define mechanisms through which people living with HIV can contribute to their national responses to the epidemic.

The primary objective of this collaborative project is to increase the effectiveness of national programmes by ensuring that the expertise and knowledge of those most directly affected contribute to national policy development.

This groundbreaking initiative followed on the Paris AIDS Summit resolution to enhance the 'Greater Involvement of People Living with HIV/AIDS' (GIPA) in national responses throughout the world. In the context of the project, people living with HIV/AIDS in Malawi and Zambia will be recruited as national United Nations Volunteers, and trained and placed at various levels of the national responses in their countries, thereby providing their unique expertise and infusing the human voices and faces of those directly affected into efforts to deal with the epidemic. Their work will focus primarily on policy-making, planning and implementation of the national responses to HIV/AIDS.

In Malawi, a total of five people living with HIV/AIDS will be recruited to work with government ministries, non-governmental and community-based organizations, the Secretariat of the National AIDS Control Programme, hospitals and workplace programmes.

Health sector reform

240. An effective, expanded response to HIV/AIDS is also dependent on health systems which are able to meet the needs of the epidemic. The global interest in health-sector reform provides an opportunity for addressing systemic constraints to an effective response to HIV/AIDS. Working together with WHO, the UNAIDS Secretariat has initiated case studies to assess the extent and capacity of districts to respond to the HIV epidemic; the results of these studies will be available in 1998.

241. The District Response Initiative aims at broadening the spectrum of HIV/AIDS activities from a vertical, health sector-focused approach toward an integrated, multisectoral and development-oriented approach. The initiative has a dual focus of reducing both risk and potential vulnerability. The aim is to achieve greater responsiveness of services to communities' needs and to promote a more holistic approach to creating healthy lives. UNAIDS is collaborating with national colleagues in five sub-Saharan countries (Burkina Faso, Ghana, Tanzania, Uganda, and Zambia), as well as WHO and the GTZ, to conduct district-level case studies.

242. In collaboration with the Ministry of Public Health of Thailand, the Programme is analysing the health-sector response to HIV/AIDS in Phayao, the Thai province hit hardest by AIDS.

Implementation of the study recommendations should begin in July 1998, with support from the Government of Japan. To facilitate analysis of health-care reform needs in other Thai provinces, UNAIDS developed a tool: *HIV and health care reform: reforming health care systems to implement an effective response to HIV and AIDS*. The proposed framework allows local managers and communities to participate in the assessment of the response to HIV/AIDS at sub-district, district and national level; to analyse obstacles to improving the response; and to link this analysis to action planning and implementation at local level.

243. To provide health-sector decision-makers with a tool enabling them to make rational allocations of resources to HIV, a technical update on the cost-effectiveness of HIV/AIDS interventions will be made available through the *Best Practice* Collection in 1998.

4. Impact alleviation

244. Research in Africa and Asia has provided information on the impact of HIV/AIDS, both at the societal level and at the level of specific populations. We know now that affected households have substantially reduced incomes; that school-age children are taken away from school to restore income; that death due to AIDS produces a large number of orphans; that children often become heads of households; and that elderly people may be left to take care of themselves. The coping strategies for these households are reduction of consumption, exhaustion of savings, selling of assets (land, vehicle and livestock) and borrowing of money. It is against this background that UNAIDS and its Cosponsors have undertaken a number of projects, including support for key studies and publications aimed at sharing experience among regions, countries and districts in an attempt to alleviate the impact of HIV/AIDS.

245. In 1996, the United States Agency for International Development and UNAIDS jointly published a series of *AIDS briefs on integrating HIV/AIDS into sectoral planning*. The briefs address how individual sectors might be affected and what types of response might be required. They cover commercial agriculture, subsistence agriculture (original brief initiated by WHO/GPA in 1995), education, manufacturing, mining, tourism and military populations (original brief initiated by USAID in 1996). USAID offices are widely disseminating the briefs in Africa; they are currently being used for multidisciplinary training. In 1997, UNAIDS and WHO jointly published the report of a WHO consultation held in Chiang Mai, Thailand, on the socio-economic impact of HIV/AIDS on households. The report synthesizes and assesses the lessons learnt and the research approaches taken in this area, and suggests priorities for research. In 1997, the Programme also prepared a chapter for the 1998 edition of the *World Population Monitoring Report* of the United Nations Population Division on the demographic, public health and socio-economic aspects of HIV/AIDS.

246. In early 1998, the World Bank, the London School of Hygiene and Tropical Medicine and the UNAIDS Secretariat organized a workshop in Washington D.C. on the demographic impact of HIV/AIDS, including the effects of mortality, fertility and orphanhood, as well as on methodological issues such as modeling and forecasting of impact. The dramatic decline in life expectancy at birth in many African countries was discussed. It was established that further research was needed to understand the larger implications of the changes in population structure, for example, the loss of well-educated sections of society and those in the workforce. It was agreed that UNAIDS would set up a reference group on issues of modeling of the epidemic and its demographic impact.

247. The Programme also engaged in activities at the country level with Cosponsors, such as with UNDP in 1997 in preparing the Namibia *Human development report* focusing on HIV/AIDS. The growing HIV epidemic in Eastern Europe and Central Asia has led to increasing concern in this part of the world, which has so far been spared a major impact. In order to develop a common understanding and examine the options for national policies, UNAIDS organized a conference on the socio-economic impact of HIV/AIDS in Kiev in April 1998, in collaboration with the British Council and with the participation of the World Bank, the WHO Regional Office for Europe, UNDP and UNICEF. The conference brought together high-level policy makers from Belarus, Kazakhstan, the Russian Federation and Ukraine.

248. The main focus of the efforts of UNAIDS and its Cosponsors in the area of impact alleviation among specific populations has been on young people and their families. In 1996 and 1997, UNDP issued a number of relevant publications, including *The socio-economic impact of HIV/AIDS on rural families in Uganda: an emphasis on youth* and *The emergence of youth headed households.* At the Regional AIDS Conference held in Côte d'Ivoire in 1997, a satellite workshop was sponsored by the François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, UNICEF and UNAIDS. It provided broader approaches and solutions to the critical issues raised by HIV/AIDS, health and the rights of children. Based on this workshop and the lessons learned, the François-Xavier Bagnoud Center produced *Guidelines for training on children: HIV/AIDS, health and rights.*

249. During 1997, a number of initiatives, to be carried out in the following biennium, were formulated with and by Cosponsors. A UNFPA project on 'Planning for the Impact and Consequences of the HIV Epidemic on Social and Economic Development' has been funded through the Coordinated Appeal. Its objective is to improve national abilities to plan for the impact and consequences of HIV in selected sectors, by improving capacity to assess the current and future impact, enhancing the sharing of information on assessments done in other countries, and demonstrating the additional benefits by coordinated impact planning. The initiative will be carried out in close collaboration with UNDP, UNFPA and UNICEF. The UNAIDS Interagency Working Group on Development and HIV, which includes Cosponsors and other key United Nations agencies, will act as adviser for this project.

250. Cosponsors have also focused on highlighting the impact of HIV/AIDS through their other activities (SEE PANEL 37). In the 1997 *Human Development Report* of UNDP, the HIV/AIDS pandemic is specifically addressed as creating a new wave of impoverishment' and revising earlier gains. Among 30 countries with declines in Human Development Index values, several suffered these setbacks in part because of HIV/AIDS. A UNDP publication entitled *The economics of HIV and development: The case of South and South-East Asia,* covering India, Sri Lanka and Thailand, was prepared by the UNDP Regional Project in Asia and the Pacific.

251. UNAIDS collaborated with the World Bank in the production of its policy research report, *Confronting AIDS: public priorities in a global epidemic.* Published in 1997, this report is directed at encouraging governments to act early and decisively to deal with the epidemic. In 1997, the World Bank, USAID and the UNAIDS Secretariat agreed to launch a website on the economic aspects of AIDS. This initiative began in 1998 and already has more than 300 subscribers from all over the globe. One of its first initiatives has been to make *Confronting AIDS* and its background material available on the web site, followed by the *AIDS briefs.* Through another initiative, the World Bank

prepared a tool kit entitled *Considering HIV/AIDS in development assistance* to assist staff of the Commission of the European Community and consultants working in this area. In addition, efforts are ongoing to ensure that HIV/AIDS impact is assessed and planned for in the process of loan negotiations with senior officials of the World Bank advocating for AIDS prevention as part of their high-level negotiations.

PANEL 37

ALLEVIATION OF IMPACT IN MALAWI

In Malawi, UNICEF supports community-based orphan assistance programmes, for children who have lost one or both parents to AIDS. These initiatives involve community members who take responsibility for fact finding, decision making and planning through well-established local councils. These groups emphasize developmental approaches, not charity, and stress a preference for absorbing children in extended families and foster families. Key activities include systematic registration, needs assessment, and monitoring of orphans and other vulnerable children; the creation of day-care centres to provide protection, stimulation, nutrition and education for vulnerable children; and the establishment of communal gardens to support families. Such programmes also place an emphasis on income generation and self-reliance, in combination with access to loans and credit. The participation of women, children and young in decision making and committee affairs is also a guiding principle for these programmes.

UNICEF-Malawi also collaborates with government organizations, including the National Orphan Task Force, which was instrumental in developing a national orphan policy and orphan-care guidelines to encourage appropriate community responses. Government organizations have also organized district-level, sub-regional and national 'best practice' conferences, to enhance innovation in programme development and implementation. Government ministries are strengthening legal frameworks for child protection; decentralizing planning and decision making for child-protection matters; expanding partnerships with non-governmental, religious and community-based organizations; and providing free primary education to all children. Two of several key lessons learned include the need to improve monitoring of vulnerable children, and the need for better data on numbers and needs of vulnerable children.

Source: *Community based orphan assistance in Malawi: demographic crisis as development opportunity*—a draft report of a Malawi site visit by a CEDC (Children in Especially Difficult Circumstances) team from UNICEF/New York, March 1998

252. As identified in *Children on the brink: strategies to support children isolated by HIV/AIDS*, (USAID, 1997), Cosponsors and UNAIDS propose to focus their work on impact alleviation in 1998-1999 on the following:

- strengthen the capacity of families to cope with their problems;
- stimulate and strengthen community-based responses;
- ensure that governments protect the most vulnerable children and provide essential services;
- build the capacity of children to support themselves;
- create enabling environments for affected children and families; and
- monitor the impact of HIV/AIDS on children and families.

5. Human rights, ethics and law

253. Human rights, ethics and law constitute a cross-cutting theme for UNAIDS in its activities. They focus on:

- strengthening the United Nations system's capacity in defining policies and positions on key and critical issues in human rights, ethics and law in the context of HIV/AIDS;
- promoting a better understanding among governments, non-governmental organizations, local communities, people living with HIV/AIDS and other key partners to better understand the link between human rights and the reduction of vulnerability to HIV infection, and reduction of the negative impact of the infection; and
- assisting countries to develop a positive national policy, as well as a legislative and administrative framework for the promotion of the rights of people living with HIV/AIDS and those who may be vulnerable or otherwise affected by HIV/AIDS.

254. UNAIDS' activities in human rights, ethics and law during the 1996-1997 biennium have included assisting countries in drafting appropriate policies and legislation in the context of HIV/AIDS and in developing instruments for collecting data on HIV/AIDS-related discrimination and stigmatization. In consultation with national partners, UNAIDS has produced practical handbooks for national implementation of international guidelines on human rights and HIV/AIDS. In all its work, the Programme has worked in partnership with people living with HIV/AIDS.

255. UNAIDS provides secretariat services to the Ethical Review Committee, established in 1996. The UNAIDS Ethical Review Committee conducts ethical assessments of research projects and proposals being considered by UNAIDS for financial and/or technical support, where the research involves human subjects or biological material obtained from human subjects. The Committee comprises nine experts with diverse backgrounds in clinical research, epidemiology, behavioural research, ethics and community work, and includes a person living with HIV/AIDS. In addition to reviewing proposals, the Committee considered general matters of ethical significance in the context of HIV/AIDS. The Committee also supported the UNAIDS submission to the World Medical Association on the revision of the Declaration of Helsinki.

256. During its first biennium, UNAIDS has been active in assessing the level of HIV-related discrimination by public authorities in legislation, internal regulations and in policy and practices. A draft protocol for the identification of discrimination against people living with HIV has been field-tested in Côte d'Ivoire, the Philippines and Switzerland. The protocol for the identification of discrimination against people living with HIV is now complete and will soon be published. Qualitative studies on discrimination, stigmatization and denial are currently being supported in India, Uganda and Venezuela. Results will be available in 1998.

257. In September 1996, the Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS jointly hosted the Second International Consultation on HIV/AIDS and Human Rights. This meeting produced a series of international guidelines on HIV/AIDS and human rights which provide governments with recommendations on concrete measures they can take to address HIV-related discrimination and human rights abuses. These guidelines were published by OHCHR in 1998.

258. To further publicize the guidelines and to make them more user-friendly, UNAIDS also provided funding to the International Council of AIDS Service Organizations (ICASO) to prepare an *NGO summary and advocates' guide* to assist non-governmental organizations in utilizing the guidelines on HIV/AIDS and human rights. ICASO produced English, French, and Spanish versions of the guide and facilitated its distribution at three regional conferences on HIV/AIDS held during 1997.

259. The UNAIDS Secretariat has developed close working relationships in the area of human rights with its Cosponsors as well as OHCHR. In 1997, UNAIDS and OHCHR agreed on a joint pilot project to provide technical support to two national human rights commissions in different regions. A national project officer on HIV/AIDS will be placed in each commission; training and other activities will be undertaken at the national level. Human rights commissions in India and Uganda have agreed to take part in the project. Implementation will commence in 1998. In 1997, UNAIDS and OHCHR also agreed to co-fund a human rights adviser post, to be based at OHCHR, with the mission of raising the profile of HIV/AIDS in the United Nations human rights system.

260. Since 1997, UNAIDS has continued to provide input to the work of the treaty bodies, namely the Committee on Human Rights, Committee Against Racial Discrimination, Committee on the Rights of the Child, Committee Against Torture and Committee on Economic, Social and Cultural Rights, through briefings and distribution of materials on human rights and HIV/AIDS. The Programme also provided technical advice to countries for the development of HIV/AIDS-related legislation, including a recent law in the Philippines (see panel 8).

261. UNAIDS has identified the François-Xavier Bagnoud Center for Health and Human Rights (FXB), located at Harvard University in the United States, as a UNAIDS Collaborating Centre for the field of human rights. In this context, FXB/Harvard will prepare a policy document on human rights, ethics and law, as well as two model-treaty country reports on the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women.

262. In order to promote the integration of HIV/AIDS and human rights as a positive response to the epidemic and to increase collaboration, sharing of information and activities relating to human rights, ethics and law, UNAIDS will establish an interagency reference group on HIV, human rights, ethics and law in 1998.

6. Young people and children

263. During the 1996–1997 biennium, young people and children have been a major priority for programmes dealing with HIV/AIDS. With a focus on the future, their status shifted from that of a group 'at risk' of infection to a force for change in responses to the epidemic. The United Nations system's promotion of policies and programmes concerning young people and children is grounded in the Universal Declaration of Human Rights, the United Nations Convention on the Rights of the Child, and the United Nations Convention on the Elimination of all Forms of Discrimination against Women.

264. During its first biennium, the Programme made concerted efforts to work closely with a wide range of partners representing children and young people, taking advantage of various media. Through support to Save the Children in the United Kingdom, UNAIDS cosponsored a workshop, publication and video on approaches to including children and young people vulnerable to and affected by HIV/AIDS in the response to the epidemic. Working with the PANOS Institute in London, the Programme co-produced 'Children's Voices on AIDS', a series of radio programmes in which children shared their ideas and views of the situation in their communities. Together with Street Kids International, Canada and the United Nations International Drug Control Programme, UNAIDS participated in the production of 'Goldtooth', an award-winning animated film on drug use among young people. The programme produced youth-focused HIV/AIDS messages for Music Television International, a cable television company which reaches young people in over 300 million households all over the world, to use in their work with musical celebrities.

265. The UNAIDS Secretariat is working closely at regional and country levels with Programme Cosponsors, particularly UNICEF and WHO, on strategic approaches to address the needs of young people in the context of the HIV epidemic. Close collaboration with UNICEF's Inter-regional Programming Group on Young People in Crisis is producing significant progress in the response to the epidemic in Brazil, Côte d'Ivoire, Gambia, Malawi, Nicaragua, Palestine, Senegal, Sierra Leone, the Philippines, the Russian Federation, Turkey, Uganda, Vietnam, and the Arab population in the occupied Arab territories including Palestine. This collaboration has taken the form of financial support to projects, direct technical assistance and the establishment of a joint technical resource network, including a Young People's Knowledge Network, via the Internet.

266. The Cosponsors also produced publications in 1996–1997 on subjects related to young people that have relevance for HIV/AIDS. UNFPA published *Promoting responsible reproductive health behaviour—the youth perspective*, within the context of the International Youth Essay Contest, and, together with the International Planned Parenthood Federation, issued a publication entitled *Generation 97: voices of young people*. Another important publication in this area produced by UNICEF is entitled *Youth health—for a change: a UNICEF notebook on programming for young people's health and development*.

267. During the 1997 World AIDS Campaign on 'Children living in a world with AIDS', UNAIDS worked with Cosponsors and other key organizations to develop and strengthen partnerships, share experiences of successful programmes, and to mobilize support for broader agendas necessary to confront how HIV/AIDS impacts on children and young people, as well as how young people affect the epidemic. In the same vein, the Programme has employed a young person to work specifically on youth strategies and activities, and has welcomed the participation of several young people as advisers on the current World AIDS Campaign.

268. In 1997, UNAIDS produced several publications on education and HIV/AIDS. These included a document entitled *Impact of HIV and Sexual health education on the sexual behaviour of young people* (1997), which assesses the effects of HIV/AIDS education on young people's sexual behaviour (SEE PANEL 38). Of 53 studies that evaluated specific interventions, 22 reported that HIV and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and sexually transmitted disease rates. Of the remaining 31 studies, 27 reported that HIV/AIDS and sexual health education neither increased nor decreased sexual activity and attendant rates of pregnancy and sexually transmitted diseases. Little evidence was found to support the contention that sexual health and HIV education increases sexual activity among young people. The review also discusses such topics as the effects of the epidemic on age at first intercourse, sexual activity and protected sex, gender and media issues in the context of education programmes and features of successful programmes.

PANEL 38

SEXUAL HEALTH EDUCATION LOWERS THE RISK OF EXPOSURE TO HIV

Young people have a right to information and education affecting their health. A WHO review of programmes around the world, recently updated by UNAIDS, found that sex education does not lead to earlier or increased sexual activity, contrary to what many parents feared. The review concluded that the life skills needed for responsible and safe behaviour can be learned, and that well-conceived educational programmes help to delay first intercourse and protect sexually active young people from HIV, other sexually transmitted diseases and pregnancy.

Many educators agree that sex education encourages safer sexual behaviour. *"When I first came to this school in 1994, we had several drop-outs from girls who fell pregnant"*, explained Patience Ruyeko-Miengamero, a teacher at a rural school in Zimbabwe. *"But last year, following sex-education programmes in 1995, we never experienced that, and for this year as yet there are no reports of pregnancies"*.

A separate study of an AIDS prevention programme among high school students in the Philippines found that, although there had been little impact on condom use during sex, the programme had led to a delay in the age of first sex and increased students' understanding of HIV/AIDS. The same trend toward postponement of first sexual intercourse is now being documented in Switzerland, Uganda and the United States. The UNAIDS review found that effective programmes share certain features:

- they include both delayed first intercourse and protected intercourse as specific aims;
- they encourage the learning of life skills (the same skills that also help build self-confidence and avoid unwanted pregnancy, sexual abuse and substance use);
- they discuss clearly the results of unprotected sex and ways to avoid it;
- they help young people 'personalize' the risk through role-playing;
- they reinforce group values against unsafe behaviour, both at school and in the community.

269. The Interagency Working Group on HIV and Sexually Transmitted Diseases Prevention in the School Setting also produced a position paper on *Integrating HIV/STD prevention in the school*

setting, which describes programming principles, best practices to date, and goals in school AIDS education. A technical update on *Learning and teaching about AIDS at school,* summarizing the main issues, challenges and responses, was also produced. In another partnership endeavour, the Programme funded and reviewed an AHRTAG (Appropriate Health Resources and Technologies Action Group) briefing paper entitled *Caring with confidence: practical information for health workers who prevent and treat HIV infection in children*[26].

270. During 1997, at the three regional conferences on AIDS held in Côte d'Ivoire, Peru and the Philippines, UNAIDS participated in satellite sessions, panels and seminars on young people and children, during which specialists presented policy and programming experiences in their countries.

271. Priorities for the 1998–1999 biennium will include strengthening partnerships and joint initiatives with Cosponsors and others in addressing young people's health and development (SEE PANEL 39). UNAIDS intends to promote genuine youth participation in planning and programming as a driving force for these initiatives. Particular attention will be paid to reducing the trafficking and commercial sexual exploitation of children.

PANEL 39

AWAKE BEYOND AWARENESS

Three members of the Global Business Council (Calvin Klein, Polaroid, and Music Television International – MTV) have joined together to create an innovative HIV/AIDS awareness and fund-raising initiative called 'Awake Beyond Awareness'. A corporate-sector advocacy initiative, 'Awake beyond Awareness' is designed to teach young people about the dangers of HIV/AIDS through peer education and public awareness activities. The initiative will involve the use of a new AIDS symbol created by designers at Calvin Klein. One-half of all net proceeds raised through the sale of 'Awake Beyond Awareness' merchandise in developed countries will benefit local programmes, while the other half will be donated to designated AIDS service organizations in developing countries. The Calvin Klein/MTV initiative is a prototype of UNAIDS' resource mobilization strategy, in that it develops private/public/NGO-sector partnerships, brings new actors into the response to HIV/AIDS, improves ties among non-governmental organizations inter-nationally, expands capacities of national actors, and improves HIV/AIDS awareness and prevention efforts. Rotary International is also supporting this initiative in working with young people.

[26] Published by Appropriate Health Resources and Technologies Action Group (AHRTAG) UK, 1997

7. Vaccine research

272. The need for a safe, effective and affordable HIV vaccine for worldwide use is increasingly recognized as a major priority for the control of the HIV epidemic. The development of such a vaccine, however, is complicated by a number of scientific, logistic, political and ethical issues, which require extensive international collaboration. As part of this complex panorama, the main role of UNAIDS is to provide guidance on how HIV vaccine trials in developing countries should be conducted (SEE PANEL 40). A corollary of the Programme's role is to build the capacity of countries to ensure that the highest scientific and ethical standards are respected, in the context of HIV vaccine research. A Vaccine Advisory Committee provides guidance to UNAIDS on these issues.

273. In collaboration with the Vaccine Advisory Committee, UNAIDS has identified the following areas as priorities:

- information analysis and dissemination with regard to HIV vaccine research and clinical trials in developing countries;
- creation of collaborative international networks of scientists and institutions working on HIV vaccine development and evaluation;
- provision of assistance and capacity building in developing countries to support HIV vaccine research and clinical trials;
- provision of independent and authoritative scientific and ethical advice to developing countries on conducting HIV vaccine trials;
- addressing ethical, regulatory and legal barriers to international development and future availability of HIV vaccines; and
- advocacy for worldwide commitment to ensure progress in the development and future availability of HIV vaccines, especially in developing countries.

274. The Programme implements these complex objectives in close collaboration with various national and international partners (e.g. the United States National Institutes of Health, Walter Reed Army Institute of Research, International AIDS Vaccine Initiative), the pharmaceutical industry (e.g., Chiron Vaccines, Pasteur Merieux Connaught, VaxGen), individual countries such as Australia, Brazil, Germany, Japan, Thailand, Uganda and the United States, and non-governmental organizations (e.g., AIDS Vaccine Advocacy Coalition in the United States, Grupo Pela Vidda in Brazil, The AIDS Support Organization, TASO, in Uganda). During the 1996–1997 biennium, UNAIDS provided technical and financial support for activities included in the national plans for HIV vaccines in Brazil, Thailand and Uganda. UNAIDS' support in these three countries relates to preparation for future large-scale vaccine efficacy trials, including identification of epidemiologically suitable populations, surveillance of HIV genetic subtypes, vaccine-related social and behavioural research, public information and communication. These activities are conducted in close collaboration with Ministries of Health, local institutions and collaborating international agencies.

275. With technical support, a Phase I trial has been conducted in Brazil, at the Hospital Evandro Chagas in Rio de Janeiro, and at the University of Minas Gerais in Belo Horizonte, using a peptide-based candidate vaccine developed by United Biomedical Inc. (UBI). Three Phase I vaccine trials have been completed in Thailand, using the UBI peptide candidate vaccine and gp120 candidate vaccines produced by VaxGen and Chiron Vaccines. Two Phase I/II trials are well

advanced, using bivalent gp120 candidate vaccines produced by Chiron Vaccines and VaxGen. These bivalent candidate vaccines include both HIV-1 subtypes prevalent in Thailand (B and E). These trials are being conducted within the framework of a National AIDS Vaccine Plan developed in collaboration with UNAIDS. Activities are being implemented in collaboration with multiple national organizations (e.g., Vaccine Trial Center of Mahidol University, Bangkok Metropolitan Administration, Armed Forces Research Institute of Medical Sciences, the HIV/AIDS Collaboration, Chiang Mai University) and international partners, with financial cosponsorship from UNAIDS.

PANEL 40

SUPPORT FOR THE IMPLEMENTATION OF NATIONAL AIDS VACCINE PLANS IN DEVELOPING COUNTRIES

Different types of HIV preventive candidate vaccines have been evaluated in Phase I/II trials, involving more than 2 000 HIV-negative volunteers. These trials, which have been conducted mainly in France and the United States of America, have shown that the vaccines are safe and capable of inducing HIV-specific immune responses. Information on their potential efficacy will follow the conduct of Phase III efficacy trials. Multiple trials will have to be conducted world-wide before researchers can develop a safe and broadly-effective HIV vaccine. These trials will be designed to assess the efficacy of different types of candidate vaccines, against different HIV-1 subtypes, and in different populations.

UNAIDS is assisting selected developing countries to conduct HIV vaccine trials with the highest scientific and ethical standards. National AIDS Vaccine plans are being implemented in Brazil, Thailand and Uganda, with technical and financial support from UNAIDS. These plans describe national policies, and identify research needs in preparation to future Phase III trials (testing protective efficacy). The implementation of these plans has included research on HIV isolation and characterization, establishment of cohorts of HIV-negative volunteers, and vaccine-related social and behavioural research, including ethical issues. Phase I/II (safety and immunogenicity) HIV candidate vaccine trials are also an integral part of these Plans. Brazilian scientists conducted a trial with a peptide-based vaccine. With the collaboration of different partners, a total of five Phase I/II trials have been, or are being conducted in Thailand. In collaboration with the United States National Institutes of Health, Uganda is planning its first Phase I/II trial.

To ensure that Phase III trials are not delayed because of the unavailability of appropriate study populations, UNAIDS is presently identifying additional countries where new national AIDS vaccine plans could also be developed.

Finally, UNAIDS is organizing a series of regional consultations on ethical aspects of HIV vaccine efficacy trials, which should result in a set of ethical guidelines to be finalized at a meeting hosted by the UNAIDS Secretariat in collaboration with WHO and UNESCO.

276. In view of the future need to conduct multiple HIV-vaccine efficacy trials (to assess the efficacy of multiple vaccine concepts against different HIV-1 subtypes being transmitted in different populations by different routes). UNAIDS is in the process of identifying new potential HIV-vaccine evaluation sites in developing countries and discussing this with the relevant government authorities.

277. The UNAIDS Network for HIV Isolation and Characterization[27] provides important information and makes vaccine-related reagents available to scientists and the pharmaceutical industry. The first candidate vaccines based on virus strains, obtained through the UNAIDS Network, are presently under development (e.g., subtype E vaccines for testing in Thailand, and A and D for testing in Uganda). In 1997, the Programme launched an international collaborative study on 'Characterization of globally-prevalent HIV strains in relation to HIV vaccines', which will provide updated information and fully characterized reagents for the development of antigenically and epidemiologically appropriate HIV vaccines. As part of national capacity building, the UNAIDS Network for HIV Isolation and Characterization is evaluating modern techniques for detailed HIV characterization, which are being transferred to HIV vaccine sites in developing countries. The Programme sponsored a series of workshops to provide training to scientists from Africa (Senegal and Uganda), Asia (China and Thailand), Latin America and the Caribbean (Brazil and Peru), and Eastern Europe (the Russian Federation). In collaboration with Germany and the European Community, UNAIDS has also provided a forum for scientific discussions on HIV variability and its implications for various aspects of HIV/AIDS prevention and control, including HIV vaccines, by co-sponsoring scientific meetings in Berlin and Dar es Salaam.

278. As part of its normative role, and in anticipation of forthcoming large-scale vaccine trials in developing countries, the UNAIDS Secretariat, in collaboration with WHO and the Council for International Organizations of Medical Sciences (CIOMS) has initiated a process of developing a guidance document for ethical standards in the conduct of HIV vaccine trials. The document is being developed through a series of discussions, involving representative communities, scientists, industry, national regulatory authorities and mass media at regional and global levels. Five vaccine ethics consultations were conducted, including three community workshops in Brazil, Thailand and Uganda, respectively.

279. The UNAIDS Secretariat is collaborating with the WHO Global Programme for Vaccines and Immunization on a project to promote the development of novel vaccines approaches, especially those which could be more appropriate for developing countries. Japan has earmarked funds to support targeted research projects on BCG/HIV-vectored vaccines, naked DNA, and mucosal immunization. As part of this project, UNAIDS, in collaboration with the Japanese National Institute of Infectious Diseases and the Australian Ministry of Health, is organizing a regional meeting in Tokyo on HIV Vaccine Research in Asia: Needs and Opportunities, to be held at the end of 1998, with the aim of mobilizing advocacy and establishing regional partnerships in support of HIV vaccine development and evaluation.

280. The future directions of the work of UNAIDS in the area of HIV vaccines will emphasize further strengthening of the existing and newly identified HIV vaccine sites, with the ultimate goal of conducting the first HIV vaccine efficacy trials to meet the highest scientific, ethical and regulatory requirements. The Programme also intends to expand collaborative networks with national and international partners, with a major focus on sustaining advocacy for accelerated progress for the development and future availability of HIV vaccines for developing countries.

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[27] The UNAIDS Network for HIV Isolation and Characterization includes institutions from 21 countries, namely, Belgium, Brazil, Burkina Faso, China, Ethiopia, Finland, France, Germany, India, Italy, Netherlands, Russian Federation, Senegal, Spain, Sweden, South Africa, Tanzania, Thailand, Uganda, United Kingdom and United States of America.

V. Improving the functioning of the UNAIDS Secretariat

A. Management and organizational development

281. Based on a clarified strategic approach developed over the past two years, UNAIDS has identified five areas in which to focus the Programme's efforts during the 1998–1999 biennium:

- Advocating for an expanded and effective response to the epidemic;
- Engaging in the monitoring and provision of accurate and up-to-date information on HIV/AIDS and the response;
- Fostering the creation and maintenance of technical resource networks (at global, regional and country levels) for the identification, collection and dissemination of best practices, as well as providing technical assistance to these networks;
- Developing an extensive best practice collection and providing proactive policy advice; and
- Facilitating the formulation of national strategic plans for countries and integrated workplans for the United Nations system, in response to HIV/AIDS, as well as monitoring the implementation of these plans.

Strategic management and leadership development

282. Beginning in mid-1996, the UNAIDS Executive Director initiated a series of retreats for staff and managers, to conduct an assessment of the Secretariat's internal strengths and weaknesses. The purpose of these retreats was to increase the Secretariat's capacity to respond to the HIV epidemic.

283. As part of this effort, in January 1997, the Programme held a workshop to sharpen the focus of its strategic vision. Following this exercise, it became increasingly clear that UNAIDS should concentrate its efforts on the United Nations system, particularly its Cosponsors, with the goal of increasing the capacity of the United Nations system to support and strengthen national responses to the epidemic. However, it was also evident that in order to do this well, UNAIDS needed to play equally important—and more direct—roles in building world-wide political support for HIV/AIDS, and in improving the content of, and access to, the body of knowledge required to accelerate the global response. The workshop devoted a great deal of attention to the challenge for UNAIDS to develop synergy between these two approaches and helped focus the *UNAIDS Proposed Programme Budget and Workplan* in this direction.

284. The Programme held a three-day leadership workshop for all senior and mid-level managers, including intercountry team leaders, in July 1997. This workshop included a feedback questionnaire on leadership behaviour, completed by the supervisor, staff and peers of each manager, as well as by managers themselves. One follow-up session has taken place and it is anticipated that others will be held every three to four months. In addition, UNAIDS has made efforts to improve the efficiency of its senior management team.

Organization and structure

285. In late 1997, a review of the internal management and organization of the Programme's Secretariat was conducted. The Programme is undertaking some fine-tuning of its broad structure, as a result of this review. Each department is strengthening its internal management and organization. These activities have included strategic planning; clarification of the roles and responsibilities of the departments and units; strengthening the management team at the departmental level; team-building for individual units within the departments; and improving working relationships between departments. Many of these activities will continue in 1998.

286. During 1997, under the guidance of a senior manager, a team of administrative assistants began work on improving the efficiency of administrative systems. During 1998, UNAIDS will continue its efforts to streamline and further decentralize administrative procedures for country-level operations. The Programme has organized a number of training workshops for general staff and managers in such areas as HIV/AIDS sensitivity, performance management and media training. In 1998, these activities will be expanded, following an assessment of UNAIDS' training needs. It is anticipated that training activities will focus on functional competency and computer training linked to the introduction of new information systems.

B. Performance monitoring and evaluation

287. In order for UNAIDS to effectively fulfil its global advocacy mission on HIV/AIDS, it must be able to draw on accurate monitoring and evaluation data. As the Programme is still young, intensive activities in this area still lie ahead, with a monitoring and evaluation adviser having been recruited only during the first quarter of the second biennium. In anticipation of the need to ensure monitoring and evaluation in the future, the PCB formed a working group to examine these issues. This resulted in the development of a monitoring and evaluation plan setting forth a conceptual framework with three primary components: impact, outcome, and output (SEE PANEL 41).

288. The framework recommends that the roles, responsibilities and accountability of relevant partners be clarified, including those of national governments, non-governmental organizations, Cosponsors and donors. The framework also incorporates qualitative tools to ensure that monitoring and evaluation measure both UNAIDS' progress in stimulating an expanded response to HIV/AIDS at country level and its success as a coordinating and advisory body for the United Nations system response to the epidemic.

289. The country-specific epidemiological fact sheets, developed by UNAIDS and WHO, constitute one tool for measuring progress made in slowing the spread of the epidemic and, indirectly, UNAIDS' effectiveness in coordinating the worldwide response. A checklist is also being developed to monitor the performance of United Nations Theme Groups for HIV/AIDS. This tool is intended to help determine how well Theme Groups have been able to assist in strengthening national responses to HIV/AIDS.

290. Another assessment has taken the form of user satisfaction surveys of the Theme Groups, two of which have taken place since 1996. The 1996 assessment revealed that Theme Groups had begun to function, with coordinated planning efforts for the response to HIV/AIDS having started in a limited number of countries. Some of the positive achievements highlighted by the assessment include strong commitment to coordination and good working relationships among

Theme Group members, in addition to the support and involvement of the cosponsoring organizations' country representatives, including the United Nations Resident Coordinators. Problems reported in the assessment include the difficulties experienced by the United Nations system at country level in handling its new role of coordinating the response to HIV/AIDS and a perceived lack of support from the headquarters of the organizations involved.

291. The 1997 assessment included questionnaires designed to monitor Theme Group functioning, the progress of joint planning and coordinated action, and progress made in strengthening national responses. Participants in the 1997 Theme Group assessment include national governments, non-governmental organizations, donors present in each country, and United Nations agencies. The results of the 1997 assessment are currently being analysed and collated.

PANEL 41

UNAIDS CONCEPTUAL FRAMEWORK FOR PERFORMANCE MONITORING AND EVALUATION

	Progress towards global HIV/AIDS goals including:			
Impact	Reduction in the transmission of HIV and STDs	Increased quality and accessibility of treatment, care and support for people with HIV/AIDS	Reduced individual and collective vulnerability	Reduced adverse impact of HIV/AIDS on individuals and communities
Outcomes	**An expansion of the national response** to HIV/AIDS leading to both risk and vulnerability reduction, including expanded and increased partnerships, coverage and quality of effective interventions, multi-sectoral involvement, resources mobilized, scope and diversity of programmes, sustainability and improved policy environment			
Intermediate	Effective and expanded **United Nations system response** particularly that of Cosponsors			
Outputs	**Goods and services delivered** by UNAIDS Secretariat through its roles: 1. A facilitating, catalytic, coordinating and advisory role, primarily directed towards the Cosponsors; 2. A role related to improving the access to—and content of—the body of knowledge required to advance the global response to the epidemic; 3. An advocay role aimed at building an aware, committed and supportive international community of governments, the media and civil society, UNAIDS brokers and facilitates technical collaboration to fulfil theses roles			

Source: *Proposed Programme Budget & Workplan for 1998-1999*, UNAIDS 1997, p. 114

292. With the aim of enhancing exchange and learning among different organizations and contributing to best practices in the response to HIV/AIDS, a Monitoring and Evaluation Reference Group (MERG) is being formed to advise UNAIDS on technical aspects of performance monitoring and evaluation, at both national and global level. The group will consist of representatives of national governments, universities, research institutions, programmers and policy makers, donors and UNAIDS Cosponsors. Members of the group will also assist in technical resource mobilization for UNAIDS monitoring and evaluation activities and the dissemination of the lessons learned from evaluation.

293. Based on lessons learned from the fairly limited monitoring and evaluation activities which have taken place thus far, future strategies will aim to strengthen HIV-transmission surveillance systems. In cooperation with the Programme's partners, the monitoring and evaluation framework will include indicators and analyses for monitoring the impact of programmes which address vulnerability and risk behaviour. At the level of national responses to the epidemic, in-depth qualitative assessments will help to measure impact and progress. At the level of the UNAIDS Secretariat, the performance monitoring and evaluation plan will assist in evaluating processes stimulated through dissemination of the *Best Practices* Collection.

C. Administration and support

294. The Programme's first biennium was clearly its most critical period for administrative areas such as staff recruitment, development of human resources and management, and establishing appropriate information systems. One of the key priorities in 1996 and 1997 was to strengthen management capacity within UNAIDS. Balancing sound administrative and management principles with the inherent difficulties and often daunting workload associated with establishing a new programme has been an enormous challenge.

Financial planning and management

295. In November 1995, the Programme Coordinating Board approved UNAIDS' first Biennial Programme Budget at a level of US$ 120 million. As at 31 December 1997, the Programme had received US$ 100.3 million for the 1996–1997 budget, with approximately US$ 23 million in pledges for 1997 still expected. A portion of the outstanding pledges arrived in the first quarter of 1998. Obligations incurred for the first biennium amounted to US$ 101.7 million, resulting in a shortfall of US$ 1.4 million between income received specifically for the 1996/1997 core budget and expenditure. Fortunately, UNAIDS had a sufficient carryover of funds from the WHO Global Programme on AIDS, from which it was authorized to commit funds against written outstanding pledges. Nevertheless, the Programme will clearly need to ensure that pledged contributions for the calendar year are deposited in the Trust Fund by donors as soon as possible. UNAIDS acknowledges with gratitude the constant support received from donors to ensure that the 1996–1997 budget would be funded. The audited financial report on the 1996–1997 biennium, supplying details of all contributions, was released in April 1998[28], with information on income and obligations presented in annexes B and C of this report.

[28] Document UNAIDS/PCB/(6)/98.7

296. The Programme also made efforts, following the recommendations of the PCB, to align the UNAIDS financial reporting formats with those being used by its Cosponsors and other United Nations system organizations, with respect to harmonizing budget presentations. This exercise also informed the process of preparing the format of the UNAIDS Proposed Budget and Workplan for 1998–1999, approved by the PCB in April 1997 at a level of US$ 120 million.

297. Total funds received as at 31 December 1997 against the estimated US$ 45 million (undesignated) carried over from the WHO Global Programme on AIDS amounted to US$ 32.6 million. As recommended by the PCB, the Programme set aside an initial provisional amount of US$ 20 million, derived from the remaining income of the WHO Global Programme on AIDS, to establish an interim UNAIDS operational reserve fund. This enabled the Programme to operate on funding advanced against written pledges, in case of income deficit problems, as mentioned above.

Staff management

298. The approved programme Budget for 1996–1997 provided for a total of 127 professional and 43 general-service posts worldwide. As at 1 January 1996, 34 professional and 32 general service posts had been filled. By 31 December 1997, UNAIDS had completed recruitment for 77. 6% of approved posts, including 47 professional and 33 general-service posts at headquarters, as well as 37 Country Programme Advisers and 15 Intercountry Technical Advisers in the field. Out of a total of 99 professional staff, 41% were female, 54% were from countries outside of the Organisation for Economic Co-operation and Development, with 55 nationalities represented (see annexes D and E). As of 17 March 1998, 107 professional posts and 42 general-service posts were filled.

299. In addition to staff recruited by UNAIDS, Cosponsors and governments have entered into a number of collaborative staffing arrangements with the Programme. These included secondments from UNICEF, UNDP, UNFPA, UNESCO and the World Bank, as well as from the Governments of Australia, Belgium, Japan and Norway. In addition, Belgium, Canada, Germany, the United Kingdom and the United States have provided consultant assistance as a contribution to the Programme. The UNAIDS Secretariat seconded staff to UNICEF headquarters and WHO regional offices, in addition to initiating staff cost-sharing arrangements with a number of Cosponsors including WHO, UNICEF and UNDP. At the end of 1997, the Programme established a system for working with Junior Professional Officers (JPO). The JPO scheme is designed to provide young professionals, usually financed by their own government, to work in development activities of the United Nations system organizations for a period of one to two years.

300. With the rapid rate of recruitment in 1996 and 1997, staff development activities focused primarily on providing programme and administrative briefing, and management training to newly recruited staff, particularly to country-level staff.

Administrative arrangements

301. During its start-up period, particularly the first year, the Programme devoted considerable effort to establishing administrative arrangements with WHO and UNDP, necessary for programme support. In constituting these arrangements, UNAIDS sought to use existing infrastructures and systems wherever possible, benefiting from economies of scale and closer integration of its operations with its Cosponsors. The Programme revised its administrative agreement with WHO for the then-current biennium to take into account an agreed reduction in the

rental of premises. This reduced rent has been paid by the Canton de Genève, which the Programme would like to gratefully acknowledge.

Country-level administrative support

302. As more UNAIDS staff were appointed to country-level posts, and operations of the United Nations Theme Groups on HIV/AIDS expanded, the Programme began to take advantage of the 'Working Arrangement' with UNDP in an increasing number of countries. Implementing new procedures created initial difficulties in some countries, but the system was generally effective in channeling funds from UNAIDS to various countries. UNDP country offices also provided valuable assistance for travel, mail and general administrative services. According to a survey conducted by UNDP among its staff on time allocation for tasks, 8% of UNDP staff time at country level was reported to be allocated in support of HIV-related activities in 1996[29].

303. The Programme's Cosponsors have not, as hoped, been able to absorb a significant proportion of administrative costs associated with UNAIDS' country-based staff and Theme Group operations[30]. However, Theme Groups in some countries managed to find innovative ways of providing administrative support, supplementing the direct financing supplied by UNAIDS. In Tanzania, the Theme Group contributed to a common fund for its operations. In Laos and Vietnam, the Theme Groups received funds from projects for which UNAIDS Country Programme Advisers provided technical support. In Botswana, the Dominican Republic and Zimbabwe, the Theme Groups accessed United Nations Resident Coordinator funds to support coordination efforts. A detailed report on the contributions made by the UNAIDS Cosponsors at country level is available in UNAIDS/PCB(6)/98.7 Addendum I.

Information technology support

304. In the area of systems implementation, UNAIDS undertook several initiatives to improve office efficiency and to support information systems supplied by WHO, tailored specifically to UNAIDS' needs, including improved LAN and document management systems. Electronic mail and the Internet greatly facilitate communication between the Programme and its many partners. UNAIDS established a World Wide Web site to share and publish information in collaboration with the Secretariat and country-level staff, Cosponsors and the general public.

305. UNAIDS is currently initiating several new efforts to benefit from information technology developments for better access and effective use of information, with the aim of achieving objectives and increasing administrative efficiency. These include:

- Implementation of the WHO-developed 'Activity-Management System' for effective monitoring of workplan activities;
- Web-based Intranet and UNAIDS 'Virtual Office' systems to enable Programme staff to operate from any part of the world using telephone communication links and laptop computers;
- Document imaging and record-management systems to improve administrative efficiency;
- Informatics support to regional, technical resource networks.

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29 UNDP, *Information paper on UNDP support for and collaboration with UNAIDS*, Executive Board of UNDP and UNFPA, Annual Session 1997, 12–23 May 1997, New York

30 See Document UNAIDS/PCB(6)/98.7

D. Resource mobilization

306. The objectives of UNAIDS' resource mobilization efforts are threefold:

- To finance the core budget of the Secretariat and the Coordinated Appeal for extra-budgetary funding to augment Cosponsors' core resources for HIV/AIDS-related programming;
- To promote/ensure funding for country-level responses to the epidemic; and
- To mobilize expertise and in-kind resources by expanding the response from the non-governmental sector at global and country levels.

307. Twenty-five countries have made financial contributions to UNAIDS' core budget. Countries donated a further US$ 14 million for additional specific projects conducted in collaboration with bilateral donor agencies and for the Coordinated Appeal. UNAIDS' resource mobilization efforts have also expanded the donor base for its operations, including such non-traditional donors as Andorra, China, Monaco, Russia, South Africa and Thailand. The PCB Working Group on Resource Mobilization, a group of country representatives from the UNAIDS Programme Coordinating Board, advises the Programme on its resource-mobilization strategy and supports its efforts. Created at the specific request of the PCB, the working group examines options for ensuring the sustainability and stability of funding for the Programme's administration and activities, and reviews UNAIDS' resource-mobilization strategies.

308. The UNAIDS resource-mobilization strategy to promote and ensure funding for country-level responses to the epidemic consists of several elements. One component is building alliances and involving all partners working within the response to HIV/AIDS in resource-mobilization processes. A second element is cooperation with countries on issues of advocacy and political awareness. National capacity building for mobilizing resources also constitutes a significant factor of the Programme's strategy.

309. In cooperating with countries, UNAIDS aims to increase political awareness and advocacy for an active response to HIV/AIDS at multiple levels of government and society, involving as many of these levels as possible in resource mobilization to deal with the epidemic. For this reason, UNAIDS' strategy also aims to train people to undertake resource mobilization at the country, inter-country and global levels. This includes conducting an examination of existing and potential resources in the situation analysis for a country and creating a strategy on mobilizing resources within the strategic plan itself.

310. UNAIDS has also helped to expand national capacities through training workshops held in different regions of the world, such as Eastern Europe (Riga, Latvia) and South-East Asia (Chiang Mai, Thailand) as well as through integrating resource mobilization into all aspects of the national strategic planning process, to ensure that this process will be sustainable. UNAIDS is cooperating with the International Fund Raising Group, London, UK, a non-governmental organization specialized in training other non-governmental organizations in resource mobilization. This partnership has resulted in the creation of a series of ten training workshops in effective resource-mobilization techniques. The workshops will take place in countries in Africa, Asia and the Pacific, Latin America and the Caribbean, and the former Soviet Union, benefiting non-governmental organizations, national AIDS programme managers, and other groups active in the response to HIV/AIDS. The Programme

is also working with the International Fund Raising Group to develop best practice documents on resource mobilization for country-level use.

311. Mobilizing resources from the non-governmental sector, particularly the private sector, is an important part of UNAIDS' resource mobilization effort. Current partners include Rotary International, Calvin Klein, Music Television International, Levi Strauss, The Prince of Wales Business Leaders Forum, the Inter-Parliamentary Union, and Glaxo Wellcome. These partners have worked with UNAIDS on increasing HIV/AIDS-related advocacy, as well as specific awareness initiatives. During the past biennium, the Programme has mobilized funds for country and global activities from non-governmental sources such as the Rockefeller Foundation, Toshiba, Inc., the Sasakawa Foundation, and the Swiss Bank Corporation.

E. Strengthening governance

312. During the Programme's first biennium, the Programme Coordinating Board met three times, including two regular meetings and one ad hoc thematic meeting. Prior to the 1996–1997 biennium, the Board also met twice in 1995.

313. The Board held its ad hoc thematic meeting in November 1997, in response to requests from PCB members that meetings be more substantive and provide them with an opportunity to interact with the Programme's management team on issues of mutual concern. The topics of discussion for the ad hoc meeting were: access to drugs and treatment; UNAIDS at country level; and national strategic planning. In addition to Board members, participants included representatives of some national governments, local non-governmental organizations, and country-level United Nations system Cosponsor respresentatives. The participants felt that such thematic meetings helped them to better understand the strategic approach of UNAIDS and its Cosponsors, as well as their approach to collaborating on the most important priorities in the response to HIV/AIDS.

314. At this thematic meeting, the PCB called on UNAIDS and the Cosponsors to develop a strategy to facilitate greater accessibility to various drugs to treat sexually transmitted diseases and opportunistic infections, and to prevent the transmission of HIV from mother to child. They also encouraged the elaboration of a strategy to facilitate a step-by-step approach for increasing accessibility of antiretroviral drugs, with full consideration of the need for local and sustainable solutions. The PCB, in referring to the operations of UNAIDS at country level, called for better collaboration between all the Cosponsors and for the strengthening of Theme Groups in resource-mobilization efforts. (UNAIDS/PCB(5)/97.6).

315. Additional informal fora of the PCB consist of quarterly meetings for Geneva-based diplomatic missions. Subjects have included monitoring and evaluation, global statistics on the HIV epidemic and the Programme's financial situation. The schedule for the four meetings is established at the beginning of the year. Different diplomatic missions in Geneva host each meeting. Attendance is high, and includes representation from the host missions' capitals.

316. The PCB also established two working groups, one on indicators and evaluation and the other on resource mobilization. Chaired by the United States, the PCB Working Group on Indicators and Evaluation gave overall guidance for the establishment of a system which is now being implemented. Although the Working Group has been formally disbanded, the monitoring and evaluation plan continues to receive frequent input from a number of sources, including PCB members. The PCB Working Group on Resource Mobilization was initially chaired by Sweden, and more recently by Denmark. It has played an active role in working on a more predictable system of contributions to UNAIDS, helping to ensure that the income and budget are adequate. Recently, the Working Group on Resource Mobilization has undertaken to identify an optimal level for an operating reserve fund for UNAIDS.

317. The Committee of Cosponsoring Organizations, (CCO) has also refined its operations over the course of the biennium, during which it met four times. At its October 1997 meeting, the Committee agreed to hold two meetings per year from that point onward, including one annual meeting of organization heads, and one annual meeting of cosponsoring-organization focal points. A pre-CCO meeting will precede the heads-of-agency meeting by approximately one month, so that agency heads may be in a position to take decisions by the time their own meeting takes place.

318. With the objective of identifying better ways to work together in addressing the growing challenges of HIV/AIDS in developing countries, UNAIDS Cosponsors met in a three-day retreat session in March 1998 (SEE PANEL 42). The Programme's management team and its Cosponsors agreed on priorities for the coming year, including the development of a joint strategic plan and an integrated workplan at global and country level, and resource mobilization efforts at global and regional levels to subsume the Coordinated Appeal in the future. Participants in the Cosponsor retreat also recommended that their respective organizations, together with the other Cosponsors, complete joint planning exercises for HIV/AIDS programming in all countries by the year 2000. The April 1998 CCO meeting of organization heads endorsed these and other recommendations of the retreat group. A timetable for action is now being prepared.

319. In an attempt to increase the active participation of the non-governmental organization members of the Programme Coordinating Board, and in consideration of their importance as pioneers within the United Nations system, a consultation was held in Geneva in April 1998 to examine their roles and responsibilities. Representatives of the United Nations Non-governmental Organization Liaison Office took part in the consultation and expressed the view that the conclusions reached were a significant step toward enhancing the participation of non-governmental organizations throughout the United Nations system, with the UNAIDS experience serving as a useful model.

PANEL 42

UNAIDS COSPONSOR RETREAT IN 1998

A UNAIDS Cosponsor retreat was held in March 1998 with the overall aim of strengthening the response of the United Nations system to HIV/AIDS. All Cosponsors participated actively, with representation from both the respective headquarters and country offices. Recommendations from the retreat were presented to the Committee of Cosponsoring Organizations in April 1998. There was unanimous agreement to move forward on the following action points as soon as possible:

- a comprehensive HIV/AIDS strategy by UNAIDS with its Cosponsors, delineating respective responsibilities;
- a coordinated workplan for the 2000–2001 biennium, reflecting resources available and those to be mobilized;
- a framework for timely policy development and technical guidance. a plan for ensuring more effective multisectoral action at the country level; and
- a heightened focus on particular regions, especially in sub-Saharan Africa and Asia.

VI. Challenges, opportunities and strategic options

A. New opportunities for mobilizing an expanded response to the epidemic

Moving from assessment and analysis to action

320. In his report to the Programme Coordinating Board in April 1997, the UNAIDS Executive Director cautioned that we must not allow ourselves to be trapped within the conceptual space he referred to as the triangle of inaction. This triangle was defined, first, by the continuing denial of the epidemic, even in heavily affected countries; second, by a new complacency eroding the urgency of our response, fueled in part by media reports of potentially successful—but still experimental—treatments; and third, by continued widespread ignorance of the evidence that HIV prevention works and that the knowledge, tools and strategies required to prevent HIV infections are available and affordable.

321. Collectively, we have made progress in escaping from this triangle's strong gravitational pull, but not completely. We cannot yet describe the global response as one of galvanized support for concerted action on a common set of priorities. We need to constantly remind ourselves that we are not simply observers and analysts of the determinants of this epidemic, but actors capable of fundamentally changing its course. We need to constantly remind ourselves that those most affected by the epidemic are also our potential partners; they are best placed to affect the epidemic's course.

And we need to remind ourselves that we are still very much at the beginning of what must be a significantly more intensive and sustainable response to the epidemic.

322. As devastating as the impact of the HIV epidemic has been thus far, its future impact will be even more devastating, if we choose to wait for better solutions rather than to collectively make the best use of the successful approaches available to us today. Nowhere is this more the case than in Africa, where, despite the experience accumulated through successful approaches in a number of countries, there is a worsening epidemic over much of the continent. Too many countries have yet to apply the lessons painfully learned by their neighbours. In other cases, the international community has yet to sufficiently support countries in their efforts to accelerate their response to the epidemic. These two factors have combined with economic stagnation, a general deterioration in public health infrastructure, and declining official development assistance in general, to create a genuine HIV/AIDS emergency of almost unimaginable proportions in a growing number of African countries.

323. Notwithstanding this emergency, the elements for success are as much in evidence in Africa as in every other region of the globe:

- Increasingly, we see that where the most senior political leadership comes to understand the determinants of the epidemic in a country, along with its current magnitude and potential impact, a stronger national response inevitably follows.
- Increasingly, we can see greater success in national programmes which have broadened their focus from one of short-term risk reduction in limited population groups to one which encompasses general awareness, targeted programmes and longer-term vulnerability reduction.
- Increasingly, we can see examples of successful programmes which incorporate synergistic approaches to primary prevention, access to essential care, and impact alleviation.
- Increasingly, we can see more and more examples of country responses that have successfully expanded beyond the health sector, particularly those that include vigorous programming in the communication, education and social service sectors.

324. Certainly, there is much more to learn about how countries can best intensify, strengthen and strategically focus their responses to the epidemic. While HIV/AIDS is not unique among public health or social development problems in requiring a multisectoral approach, it is unique with respect to the rate at which the epidemic is expanding, in some cases virtually unchecked by public health measures of proven effectiveness. In contrast to almost all other fatal health problems, it is also unique in that it affects adults during the most economically productive years of their lives. As such, there is an urgent need to translate successful experience and best practices in addressing the epidemic from one setting to another. Collectively, we are now poised to do this, provided that we are prepared to build a broad consensus on priorities and approach and to mobilize the political will necessary to confront the epidemic on the scale required.

Global strategy process

325. Perhaps the most significant of the recommendations of the Cosponsor retreat recently endorsed by the Committee of Cosponsoring Organizations is that the UNAIDS Secretariat should take responsibility over the coming months to engage the Cosponsoring Organizations and other partners in the process of updating the global strategy for addressing the epidemic. The lack of a

common understanding among the various agencies on the core issues of the epidemic has been increasingly recognized by the Cosponsors as a significant impediment to accelerating the global response to the epidemic. A more common understanding of the key technical, ethical and policy issues surrounding the epidemic is a necessary precondition to develop a common strategy including explicit HIV/AIDS-related goals to which the United Nations system can hold itself accountable. This common understanding will also be required if the United Nations system is to be in an effective position to offer support, in turn, to countries as they undertake the development of realistic national goals in their response to the epidemic.

326. There is both urgency and opportunity in undertaking a global strategy process. It serves both as a means to advance common priorities for action and to clarify more common language through which to discuss and communicate those priorities. Such a process also provides an opportunity to harmonize individual institutional approaches and to reinforce responsibility and accountability among the partners. Recognizing the challenge in making such a process inclusive while still being bound by time, decisive without being divisive, this effort will be given the highest priority by the Executive Director and the Secretariat over the second half of 1998.

327. Several of the major priorities likely to emerge from the dialogue can be anticipated and will be a major focus of the UNAIDS Secretariat's efforts in the interim:

- Epidemiology system strengthening will be a continuing priority, serving as the basis for the strategic planning process; the design, implementation and evaluation of targeted interventions; and 'data-based' advocacy efforts of the Secretariat and the Cosponsors.
- The World AIDS Campaign theme, 'Youth: a force for change', will continue to focus attention on the section of the general population where behaviour patterns are being established, the majority of new HIV cases are occurring, and whose pivotal role in the epidemic is yet to be acknowledged in many countries.
- New breakthroughs in reducing mother-to-child transmission of HIV challenge UNAIDS to rapidly build the partnerships required to introduce voluntary counselling and testing services on a broad scale within antenatal care services. It also challenges UNAIDS and its Cosponsors to join the partnership of efforts to help expand and strengthen antenatal care services where they do not yet exist. The corporate partnerships which will be forged as a part of this initiative are likely to serve as examples of the type of innovative partnerships possible in addressing other aspects of the epidemic.
- The Secretariat will also continue to prioritize the identification of more effective strategies to expand access to essential care. Particular focus will be on people who live in developing countries, the vast majority of those affected by the epidemic. This will include as a core element efforts to strengthen partnerships between the health and social sectors and non-governmental organizations, the most likely partners in extending basic services to the home. An additional core element will be continuing work with the corporate sector in order to make access to essential drugs and commodities more affordable.

B. Further development of the united nations response to HIV/AIDS and strengthening Cosponsorship

328. United Nations system organizations represent a unique and potentially powerful resource in the global response to the HIV epidemic. Together, they are capable of facilitating policy dialogue and advocacy, providing normative guidance, and leveraging both innovation and development funding. The effectiveness of UNAIDS in mobilizing the United Nations system to respond to the epidemic cannot be viewed in isolation from the broader and more systemic reform efforts underway within the United Nations. UNAIDS' dependence on the reform process for its own effectiveness is probably greater than that of any other programme currently operating within the system. In addition to being the youngest cosponsored programme, UNAIDS is unique in that it was designed to work through its Cosponsors in the area of country programmes, and designed to work on behalf of its Cosponsors in the area of global advocacy and technical development. UNAIDS assists its Cosponsors to strengthen their capacities to work together and as individual agencies. Its success is predicated on the assumption that its Cosponsors are willing and able to integrate their efforts effectively with one another, each emphasizing their institutional comparative advantage.

329. The greater the confidence of the global community in the United Nations reform process and in the capacity of the United Nations to undertake external partnerships, the more likely UNAIDS will be to forge the external partnerships required for concerted action in response to the epidemic, on the basis of this confidence. Within the United Nations system, the greater the commitment to a more integrated approach among the Cosponsors, and the more clear the understanding of the implications such an approach would have, the more likely it will be for UNAIDS to accomplish its primary mission.

330. Though the effort has at times been criticized for promoting collaboration for the sake of collaboration, a review of the experience of UNAIDS and its Cosponsors during the 1996–1997 biennium suggests that the concept is indeed working. While there are many obstacles and exceptions to address, most observers would agree that:

- the Cosponsors are taking the epidemic and the collaboration increasingly seriously, compared to three years ago;
- the Cosponsors are doing more of greater relevance to the epidemic, and of higher quality, than three years ago; and
- the clear direction of efforts over the next three years is towards greater integration of larger portfolios of programming to address the HIV epidemic.

331. At country level, there are tensions between the urgency of the public health agenda established by an expanding epidemic, and the timeline of the United Nations reform process. In countries with a broad sense of ownership by Cosponsors within the United Nations Resident Coordinator system, and where members of United Nations Theme Groups on HIV/AIDS easily reach consensus, the work of Theme Groups and Country Programme Advisers is greatly facilitated. However, in countries where consensus is not easily reached, UNAIDS is faced with a difficult choice. Choosing to operate at the pace of consensus is likely be at the expense of credibility with host governments and Cosponsors most active in addressing the epidemic. Alternatively, operating in the absence of consensus requires the UNAIDS Secretariat to choose between the differing views of Cosponsors, a choice which inevitably has consequences in terms of institutional relations.

332. Making United Nations Theme Groups on HIV/AIDS truly functional is a major responsibility that will continue to challenge the Cosponsors and the Secretariat, requiring long-term political, managerial, and financial commitment. The principal measure of effectiveness for Theme Groups and the UNAIDS Secretariat at country level must be whether there is an integrated workplan for the United Nations country team, the quality of that workplan, and the workplan implementation.

333. UNAIDS will benefit substantially from the strengthening of the United Nations Resident Coordinator system and can be expected to make a contribution to this effort. However, the Programme is insufficiently leveraged to drive the process where there is not a strong interest in more integrated approaches, and it should not be held captive to inaction where consensus does not exist. The first biennium has witnessed good examples of where Theme Groups have been successful because one or more of the agency representatives have been determined to make them successful; where host countries have insisted that they be successful; and where bilateral agencies have assisted to make them successful. The effective functioning of a United Nations Theme Group on HIV/AIDS requires not only commitment by the Cosponsors, but also resources. In only a limited number of countries have Cosponsor country offices provided administrative and financial support to Theme Groups and Country Programme Advisers. During the next biennium, the Secretariat will need to re-evaluate its policy with regard to the placement of Country Programme Advisers in countries where Theme Group members have not provided a minimum of office space and administrative support.

Integrated workplan

334. A second conclusion of the Cosponsor retreat was that Cosponsors and the UNAIDS Secretariat should prepare a fully integrated workplan at global and regional level for the next biennium. This effort will build on existing agreements on each Cosponsor's area of responsibility and comparative advantage, as established through the Coordinated Appeal process, interagency working groups and ongoing discussions among Cosponsor headquarters, regional offices and teams, and the Secretariat. Though some disagreements persist within the CCO working group on the division of responsibility in certain areas, they are fairly minor. The time for preparing an integrated workplan by early 1999 is short, particularly because part of the preparation will need to be completed in parallel with the global strategy exercise. Nevertheless, prospects are good for achieving this objective, provided that cooperation is forthcoming from all sides.

335. Once the integrated workplan is in place, the emphasis can shift from 'who is doing what?' to 'how can we all do more and do it better?'. Participants in the Cosponsor retreat identified collaboration on improving the flow of programme and technical information as a continuing priority. Improving communication with and among the numerous programmes, offices, regional offices and teams of the Cosponsors is a formidable challenge. While there has been some progress in this area, overall progress has been slow and will require a more intensive effort in the coming biennium. Implementation of the monitoring and evaluation framework will help to guide the flow of technical and financial information intended to strengthen Cosponsors' internal programmes.

C. Strengthening partnerships

336. Beyond the strengthening of partnerships within the United Nations system lies the objective of strengthening partnerships with the scientific, political, business, labour, religious, sports, and entertainment communities, required to support an expanded response to the epidemic.

337. At the conceptual level, we must forge a partnership between prevention and care efforts. There is ample experience to demonstrate the synergism between these efforts, and we can ill afford a polarized division between proponents of either approach, especially when there is such great potential for complementarity between prevention and care strategies. The Programme will need to continue to promote a combination of approaches focused on reducing individual risk, while simultaneously advocating for policy changes to affect positively the social environments that foster the transmission of HIV and the neglect of those affected by the virus. UNAIDS will also continue to seek opportunities to broaden the collective focus from the urgency of encouraging individual behaviour change, to include the urgency of addressing how societies behave towards the vulnerable and infected and affected individuals and families.

338. The Programme needs to help strengthen government partnerships with the non-governmental organization community, particularly in the areas of protecting human rights and promoting care. The HIV epidemic has challenged us with numerous controversial social and programmatic issues. The United Nations system, with its historic basis in protecting and promoting human rights and long history of partnership with non-governmental organizations, is uniquely placed to provide assistance to governments interested in addressing these issues on a partnership basis with these communities.

339. Stronger partnerships between the programming and research communities will be required, particularly as they relate to influencing the overall agenda for research to include topics of greater relevance to the epidemic in the developing world. The development of a vaccine against HIV infection must remain a global priority of the first order. Research and development efforts in scientific institutions and within industry should be intensified to develop an effective vaccine, as well as other essential technological tools needed to control the epidemic. UNAIDS has an important role to play in helping to assure that vaccine efficacy trials on humans are conducted under the highest scientific and ethical standards. The Programme and its Cosponsors will also need to continue to promote the critical principle of equity in developing the international research agenda, in addition to the testing of, and timely access to, its products.

340. At the programme level, it will be important over the next biennium to forge more functional partnerships between programme planners and managers with the epidemiology and evaluation communities. In many settings, the response to the epidemic remains insufficiently evidence-based. We have yet to fully apply the power of modern monitoring and evaluation approaches to accelerate our learning about what works in which situations. Insufficient documentation of positive experiences has handicapped our efforts to prevent the rejection of effective programmes and to redirect investments from ineffective programmes. Stronger partnership across thematic lines—for example, between tuberculosis and reproductive health programmes, or between youth-health promotion and substance-abuse prevention programmes—are likely to improve programme efforts in both domains.

341. Within the private sector, a more regular dialogue with the pharmaceutical, communications, and entertainment industries can be anticipated and is likely to be intensified as a part of new initiatives, such as those related to mother-to-child transmission of HIV. Religious institutions are major care providers in the poorest parts of the developing world and can be expected to serve as major providers of confidential counselling and testing as a part of forthcoming initiatives to reduce mother-to-child transmission.

342. Finally, the partnership between and among countries merits some reflection, in light of the growing disparity in both HIV prevalence and in access to care in different parts of the world. We can no longer justify doing little on the basis that there is little that can be done. The successes of the last few years in confronting HIV/AIDS demand that we rethink our approach to the epidemic – and reconsider whether or not we are doing what history will demand from us. In light of recent breakthroughs, the issues of technical collaboration and development assistance must be faced squarely. To begin with, there must be a renewed commitment to acting more promptly on research findings from studies performed in poorer countries. To do otherwise would be unethical and unwise. Such inaction would both threaten the prospects for future international research collaborations, and polarize broader relationships between people at a time when genuine partnership is required to control this epidemic.

343. Strengthening the United Nations response to HIV/AIDS will only be possible if Cosponsors increase their resources at country, regional and global levels. While several Cosponsors have increased their budgets for HIV/AIDS-related activities, this has not been the case in all instances or at all levels. Continued support from the Cosponsoring Organizations' senior management, as well as from their governing bodies and donor agencies, will be required to achieve appropriate funding levels. The Secretariat can advocate for and provide analysis to support increased and more effective HIV/AIDS expenditures on behalf of Cosponsors. However, it is the members of the Programme Coordinating Board, who also serve on the governing boards of the United Nations system organizations and in decision-making roles within donor agencies, who are best placed to advocate for making investments in HIV/AIDS prevention and care a high priority. The Executive Director and the Secretariat of UNAIDS look forward to receiving the continued guidance of the PCB on the issues raised within this report, and on how it can best serve to mobilize the response of the entire United Nations system in addressing the HIV/AIDS epidemic.

Annex A

Additional UNAIDS Secretariat and Cosponsor Publications on HIV/AIDS

I. UNAIDS Secretariat and UNAIDS/Cosponsor Joint Publications:

1. *Blood transfusions in Africa: situation in 1997.* UNAIDS West and Central Africa Intercountry Team, 1997.
2. *Compilation of intercountry HIV/AIDS projects of Cosponsors and key partners in the Asia-Pacific region during the period 1995-2000, and documentation of their experiences on priority issues.* UNAIDS Asia-Pacific Intercountry Team, 1996-1997.
3. *Compilation of intercountry modes of sharing of experiences on HIV/AIDS in the Asia-Pacific region.* UNAIDS Asia-Pacific Intercountry Team, 1996-1997.
4. *Condom promotion for AIDS prevention: a guide for policy-makers, managers, and communicators.* WHO/UNAIDS, 1996 (French version).
5. *Confronting AIDS: public priorities in a global epidemic.* World Bank/UNAIDS, 1997.
6. *Counselling for HIV/AIDS: a key to caring.* WHO/UNAIDS, 1996 (French version).
7. *A deadly partnership: tuberculosis in the era of HIV.* WHO/UNAIDS, 1996.
8. *Effective approaches for prevention of HIV/AIDS in women: report of a meeting.* WHO/UNAIDS, 1996 (French version).
9. *Facts about UNAIDS. UNAIDS in individual countries.* UNAIDS, 1996.
10. *Facts about UNAIDS. UNAIDS : an overview.* UNAIDS, 1996.
11. *The female condom kit: an information pack.* WHO/UNAIDS, 1997.
12. *Final report: the status and trends of the global HIV/AIDS pandemic.* UNAIDS/AIDSCAP/The François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health, 1996.
13. *A guide on situational analysis of sex work in West Africa: a working document* (1st draft). UNAIDS West and Central Africa Intercountry Team, 1997.
14. *Guidelines for HIV interventions in emergency settings.* WHO/UNAIDS, 1996.
15. *Guidelines for organizing national external quality assessment schemes for HIV serological testing.* WHO/UNAIDS,1996.
16. *HIV/AIDS and human rights: international guidelines.* UNHCHR/UNAIDS, 1998.
17. *HIV and infant feeding: a policy statement developed collaboratively by UNICEF/WHO/UNAIDS* (1997).
18. *HIV prevention works reports.* Produced in collaboration with the Canadian Public Health Association's AIDS Program, National AIDS Strategy, Health Canada, United States Centers for Disease Control and Prevention, United States National Institutes of Health. UNAIDS, 1996.
19. *Inventory of HIV/AIDS information sources in the Asia-Pacific region.* UNAIDS Asia-Pacific Intercountry Team, in association with the Asia-Pacific Network of People Living with HIV/AIDS and the Asia-Pacific Council of AIDS Service Organizations, 1997.
20. *Management of sexually transmitted diseases.* WHO/UNAIDS, 1996.
21. *Methodology of research-action projects on migration and HIV/AIDS: Burkina Faso, Côte d'Ivoire, Mali, Niger, and Senegal.* UNAIDS West and Central Africa Intercountry Team, 1997.
22. *My experience with: a document describing people's experiences and perceptions about HIV/AIDS epidemic from Thailand, Philippines and Vietnam.* UNAIDS Asia-Pacific Intercountry Team, 1996.
23. *Preventing HIV transmission in health care facilities.* WHO/UNAIDS, 1996 (French version).
24. *Report of the second workshop of persons living with HIV in West Africa* (Yamoussoukro, Côte d'Ivoire, 21-24 October 1997). UNAIDS West and Central Africa Intercountry Team, 1997.

25. *Report of the workshop on strategies of donor recruitment*. UNAIDS West and Central Africa Intercountry Team, 1997.
26. *Report of the workshop on the use of distance training material for blood safety measures*. UNAIDS West and Central Africa Intercountry Team, 1997.
27. *Report on the global HIV/AIDS epidemic*. UNAIDS, December 1997.
28. *Revised recommendations for the selection and use of HIV antibody tests*. WHO/UNAIDS, 1996.

II. Other Cosponsor Publications:

UNICEF

1. *Gender perspectives in school-based HIV/AIDS education resources in the Asia-Pacific region*. UNICEF/EAPRO and UNAIDS, 1997.
2. *Mr Ugly AIDS: children writing for children series, level 3 A*. UNICEF-Zambia, 1996.
3. *Regional HIV/AIDS Communications and Media, Assessment and Recommendations. Report for Cambodia*. UNICEF/EAPRO, 1997
4. *Sara: Sara saves her friend*. UNICEF/ESARO, 1997
5. *Regional HIV/AIDS communications & media: assessment & recommendations* (report for Cambodia). UNICEF/EAPRO, 1997.
6. *Regional HIV/AIDS communications & media: assessment & recommendations* (report for Lao PDR). UNICEF/EAPRO, 1997.
7. *Regional HIV/AIDS communications & media: assessment & recommendations* (report for Yunnan Province, People's Republic of China). UNICEF/EAPRO, 1997.
8. *Regional HIV/AIDS communications & media: assessment & recommendations* (report for Myanmar). UNICEF/EAPRO, 1997.
9. *Regional HIV/AIDS communications & media: assessment & recommendations* (report for Viet Nam). UNICEF/EAPRO, 1997.
10. *Regional HIV/AIDS communications & media: assessment & recommendations* (report for Thailand). UNICEF/EAPRO, 1997.

UNDP

1. *Development for health: selected articles from 'development in practice'*. UNDP, 1997.
2. *Development and the HIV epidemic: a forward looking evaluation of the approach of the UNDP HIV Development Programme*. UNDP, 1996.
3. *The economics of HIV and AIDS: the case of south and southeast Asia*. UNDP, 1997.
4. *Governance and HIV: report of a joint planning meeting*. UNDP, 1997.
5. *HIV counselling and testing: its evolving role in HIV prevention*. UNDP, 1997.
6. *Impact of HIV and AIDS on families and children*. UNDP, 1997.
7. *Making things happen – getting it done: 1996 project achievement reports, Europe and the CIS*. UNDP, 1996.
8. *NGOs working with sex workers: a personal perspective. A report of NGO projects in four countries*. UNDP, 1996.
9. *Research on behavioral interventions to reduce STD/HIV risk*. UNDP,1997.
10. *Research on behavioral interventions to reduce STD/HIV risk: null findings, replications efforts, and recommendations*. UNDP, 1997.
11. *UNDP in Africa: supporting the processes of change*. UNDP, 1996.
12. *Tackling the impact of the HIV epidemic*. UNDP, 1997.

UNFPA

1. *AIDS update 1996*. UNFPA, 1996.
2. *AIDS update 1997*. UNFPA, 1997.
3. *Expert consultation on operationalizing reproductive health programmes: technical report no. 37*. UNFPA, 1997.

UNESCO

1. *Prévenir le VIH/SIDA en milieu scolaire : un défi pour l'Afrique francophone*. (séminaire régional sur l'éducation et le SIDA dans le système scolaire). UNESCO, 1997.
2. *Prevention of HIV/AIDS and drug abuse through quality improvement of curriculum and teaching/learning materials in Asia and the Pacific*. Final report of the regional workshop, Beijing, 25-29 August 1997. UNESCO, 1997.
3. *Resource package on school health education to prevent AIDS and STD*. UNESCO, 1997 (French version).
4. *Rapport final: séminaire régional sur l'éducation et le SIDA dans le système scolaire* (21-25 avril 1997, Dakar). UNESCO, 1997.
5. *Seminario-taller sobre formulación de políticas y toma de decisiones para potenciar el aporte de la enseñanza formal a la prevención del VIH/SIDA en America Latina y el Caribe* (Informe final, Santiago de Chili, 1 al 5 de septiembre de 1997). UNESCO, 1997.
6. *Trilingual Internet website on education for the prevention of HIV/AIDS*. UNESCO, 1997.

WHO

1. *Acquired immunodeficiency syndrome report on the intercountry workshop on the logistics management of AIDS supplies and condom social marketing* (Rabat, Morocco, 13-17 November 1995). WHO Regional Office for the Eastern Mediterranean, 1996.
2. *AIDS: no time for complacency*. WHO Regional Office for South-East Asia, 1997.
3. *Capacity-building in secondary prevention of sexually transmitted diseases in countries of eastern Europe and central Asia: report on a WHO meeting* (Copenhagen, Denmark, 30 June- 1 July 1997). WHO, 1997.
4. *Control of communicable diseases in border areas: report*. WHO South-East Asia and Western Pacific Region, 1996.
5. *Epidemic of sexually transmitted diseases in eastern Europe: report on a WHO meeting* (Copenhagen, Denmark, 13-15 May 1996). WHO, 1996.
6. *Epidemiological analysis of 692 retrospective cases of leishmania/HIV co-infections*. WHO, 1996.
7. *Health legislation and human rights: the AIDS experience report of three WHO workshops*. WHO Regional Office for Europe, 1996.
8. *HIV/AIDS and sexually transmitted diseases: meeting of headquarters and regional HIV/AIDS and STD focal points/advisers* (Geneva, 18 October, 1996).WHO 1886
9. *HIV/AIDS and sexually transmitted diseases: meeting of headquarters and regional HIV/AIDS and STD focal points/advisers* (Geneva, 6 may 1996). WHO, 1996.
10. *HIV/AIDS and sexually transmitted diseases: report of the second WHO strategic planning meeting on HIV/AIDS and STD* (Geneva, 15-17 October 1996). WHO, 1996.
11. *HIV/AIDS and sexually transmitted diseases: WHO policy and strategic orientations*. WHO, 1996.
12. *HIV/AIDS and sexually transmitted diseases: WHO strategic plan for HIV/AIDS and STD, 1997-2001*. WHO, 1996.
13. *HIV/AIDS and STD surveillance data management and use: report of an intercountry meeting* (Bangkok, Thailand, 6-9 December 1995). WHO Regional Office for South-East Asia, 1996.

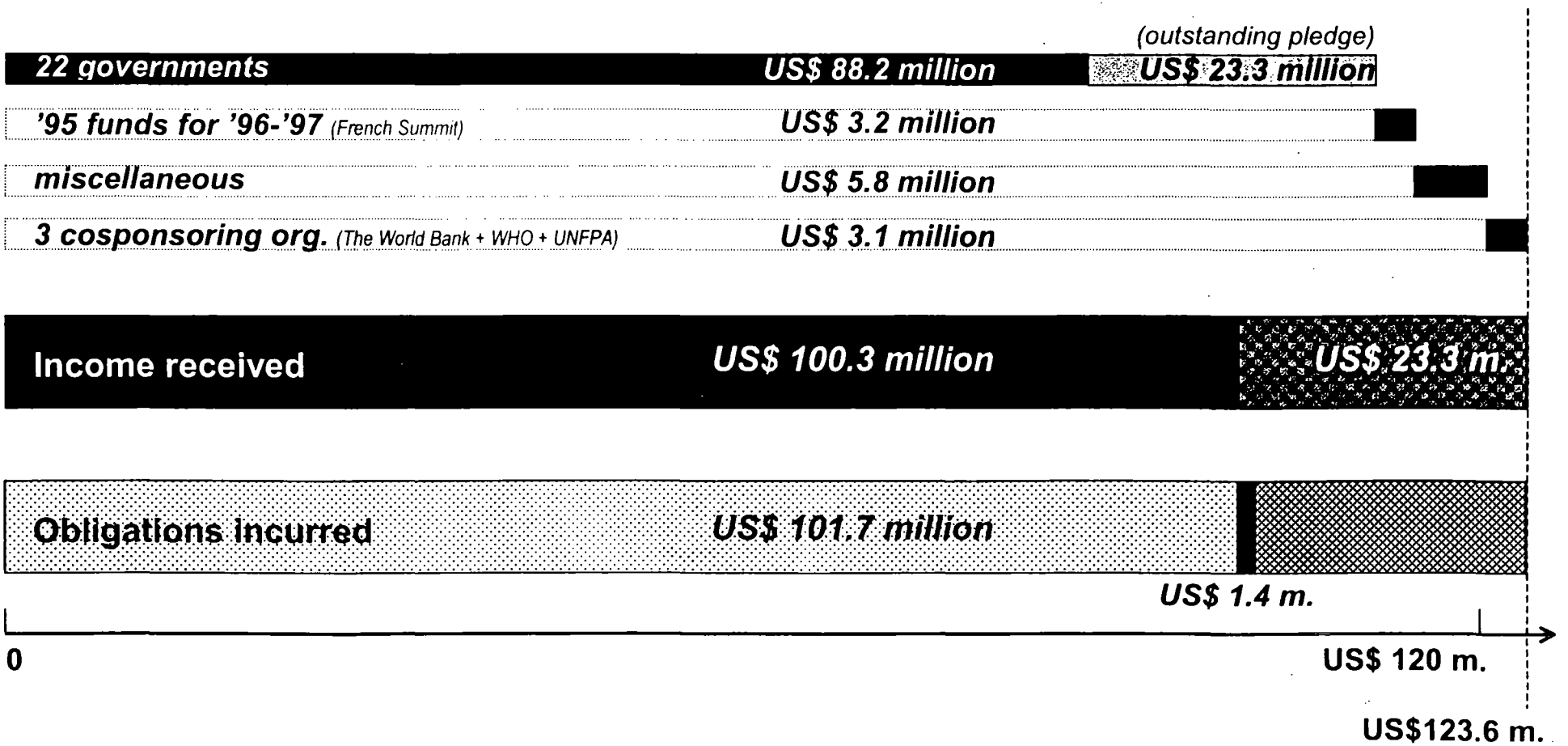
14. *Informal consultation on the implications of antiretroviral treatments* (29-30 April 1997). WHO, 1997.
15. *Meeting report on fourth regional workshop on HIV/STD surveillance* (Cairo, Egypt, 7-10 October 1996). WHO Regional Office for the Eastern Mediterranean, 1997.
16. *National AIDS control programmes in countries of South-East Asia region: report of the twelfth meeting of national AIDS programme managers* (Dhaka, Bangladesh, 25-28 November 1996). WHO, 1997.
17. *Progress towards prevention and control of AIDS in South-East Asia: report of the eleventh meeting of national AIDS programme managers* (Jakarta, Indonesia, 22-24 November 1995). WHO Regional Office for South-East Asia, 1996.
18. *Shared rights- shared responsibilities: European consultation on collaboration between government sectors, non-governmental organizations and ethnic minority organizations in AIDS prevention, support and care* (report on a WHO meeting, London, 5-9 October 1995). WHO Regional Office for Europe, 1996.
19. *The sixth annual report on the work of the AIDS Information Exchange Centre (AIEC) of the WHO Regional Office for the Eastern Mediterranean*. WHO, 1997.
20. *STD/HIV/AIDS surveillance report: special edition*. WHO Regional Office for the Western Pacific, 1997.
21. *TB/HIV: a clinical manual*. WHO, 1996.
22. *Young people and sexually transmitted diseases*. WHO, 1997.

The World Bank

1. *AIDS prevention and mitigation in sub-Saharan Africa: an updated World Bank strategy*. World Bank, 1996.
2. *Indonesia: HIV/AIDS and STD prevention and management project*. (staff appraisal report). Population and Human Resources Division, East Asia and Pacific Regional Office, World Bank, 1996.

1996–97 CORE BUDGET: INCOME AND OBLIGATIONS (IN US$ MILLION)

AS AT 31 DECEMBER 1997 (EXCLUDING CARRIED-OVER FUNDS)



INCOME FOR 1995, 1996 AND 1997 AND FOR THE PERIOD 1995-97 (EXPRESSED IN US DOLLARS)*

	Source of funds	1996	1997	1996-1997
I.	***Governments***			
	Andorra	5,000	8,000	13,000
	Australia	1,132,650	1,248,320	2,380,970
	Austria	63,416		63,416
	Belgium	1,889,610	1,565,128	3,454,738
	Canada	2,564,635	2,432,989	4,997,624
	China	99,985	99,985	199,970
	Denmark	6,760,183	3,762,587	10,522,770
	Finland	228,378	582,702	811,080
	France	1,139,223		1,139,223
	Germany	2,291,057	1,398,844	3,689,901
	Italy	132,013	175,953	307,966
	Japan	3,300,000		3,300,000
	Luxembourg	272,436	370,802	643,238
	Monaco		5,103	5,103
	Netherlands	5,847,953	5,118,162	10,966,115
	Norway	2,822,682	2,315,046	5,137,728
	South Africa	100,000		100,000
	Spain	520,855	167,586	688,441
	Sweden	6,749,142	3,270,730	10,019,872
	Switzerland	1,705,426	1,549,296	3,254,722
	Switzerland (Canton de Geneve)	368,000	326,241	694,241
	United Kingdom	5,630,432	3,529,570	9,160,002
	United States of America	16,569,500		16,569,500
		60,192,576	27,927,044	88,119,620
II.	***Cosponsoring Organizations***			
	UNFPA		107,500	107,500
	WHO	360,000	360,000	720,000
	The World Bank	1,000,000	1,230,000	2,230,000
		1,360,000	1,697,500	3,057,500
III.	***Other Income***			
	Other contributors	126,539	347,444	473,983
	Miscellaneous	14,921	5,355	20,276
	Share of administrative costs		158,789	158,789
		141,460	511,588	653,048
IV.	***Interest received***			
	Interest	1,818,490	3,382,380	5,200,870
		1,818,490	3,382,380	5,200,870
	Total income	**63,512,526**	**33,518,512**	**97,031,038**

* *excluding WHO/GPA carried-over funds*

UNAIDS—PROFFESSIONAL STAFF

BREAKDOWN BY NATIONALITY AS AT 31 DECEMBER 1997

No.	COUNTRY	NUMBER OF STAFF	PER CENT
1	Albania	1	1.0%
2	Argentina	2	2.0%
3	Armenia	1	1.0%
4	Australia	3	3.0%
5	Austria	1	1.0%
6	Belgium	3	3.0%
7	Belarus	1	1.0%
8	Botswana	1	1.0%
9	Brazil	1	1.0%
10	Canada	1	1.0%
11	Chile	1	1.0%
12	China	1	1.0%
13	Côte d'Ivoire	3	3.0%
14	Croatia	1	1.0%
15	Denmark	2	2.0%
16	Ethiopia	1	1.0%
17	France	4	4.0%
18	Germany	3	3.0%
19	Ghana	2	2.0%
20	Guinea	1	1.0%
21	Guyana	1	1.0%
22	India	1	1.0%
23	Ireland	2	2.0%
24	Iraq	1	1.0%
25	Italy	3	3.0%
27	Luxembourg	1	1.0%
28	Mauritius	1	1.0%

No.	COUNTRY	NUMBER OF STAFF	PER CENT
29	Malta	1	1.0%
30	Myanmar	1	1.0%
31	Netherlands	1	1.0%
32	Nigeria	1	1.0%
33	Philippines	1	1.0%
34	Poland	1	1.0%
35	Romania	1	1.0%
36	Russian Federation	2	2.0%
37	Saint Vincent	1	1.0%
38	Senegal	3	3.0%
39	Singapore	1	1.0%
40	Spain	1	1.0%
41	Sweden	2	2.0%
42	Switzerland	2	2.0%
43	Swaziland	1	1.0%
44	Tanzania	1	1.0%
45	Thailand	3	3.0%
46	Togo	2	2.0%
47	Tonga	1	1.0%
48	Trinidad & Tobago	1	1.0%
49	Tunisia	1	1.0%
50	Uganda	3	3.0%
51	United Kingdom	3	3.0%
52	USA	14	14.1%
53	Venezuela	2	2.0%
54	Zambia	2	2.0%
55	Zimbabwe	2	2.0%
	TOTAL	**99**	**100.0%**

UNAIDS STAFFING TABLE - EXECUTIVE SUMMARY - AS AT 31 DECEMBER 1997

I. BUDGET AND STAFFING

ANNEX E

GENEVA AND NEW YORK	POSTS IN 1996-97 BUDGET		POSTS IN STAFFING TABLE		No. OF OCCUPIED POSTS		No. OF VACANT POSTS	
	P	G	P	G	P	G	P	G
Office of Executive Director (OED) — *a*	3	3	2	3	2	3	0	0
External Relations Department (EXR) — *b*	6	5	7	5	7	4	0	1
Policy, Strategy and Research Department (PSR) — *a & c*	21	12	24	12	18	9	6	3
Programme Administration Department (PAD)	8	9	8	9	8	9	0	0
Country Support Department (COS) — *b & c*	16	8	13	8	12	8	1	0
GENEVA TOTAL	54	37	54	37	47	33	7	4
FIELD								
Country Programme Advisers — *d*	45 (70)	*N/A*	45 (70)	N/A				
International Country Programme Advisers	*10*	*N/A*	*10*	N/A	32	*N/A*	8	*N/A*
National Country Programme Advisers	*12*	*N/A*	*12*	N/A	5	*N/A*	7	*N/A*
Intercountry Technical Advisers	28	*N/A*	28	N/A	15	*N/A*	13	*N/A*
General Service	*N/A*	6	*N/A*	6	*N/A*	0	*N/A*	6
FIELD TOTAL	73	6	80	6	52	0	28	6
GENEVA AND FIELD TOTAL	127	43	134	43	99	33	35	10
OVERALL TOTAL *e*	170		177		132		45	

II. SECONDMENTS

DONOR	NUMBER OF STAFF
UNDP	1
UNFPA	1
UNICEF	1
World Bank	1
Norway	1
Japan	2
Belgium	1
TOTAL	**8**

III. UNAIDS OUTPOSTED STAFF

AGENCY	NUMBER OF STAFF
UNICEF	1
WHO	4
WORLD BANK	1
UNDP/OUNS	1
TOTAL	**7**

IV. PROJECT POSTS

Department	NUMBER OF STAFF
PSR	1

KEY

a = One Monitoring & Evaluation post moved from OED to PSR

b = One NGO Liaison post reassigned from COS to EXR

c = Two Epidemiologist posts transferred from COS to PSR

d = For budgetary purposes a ceiling has been established on the basis of 45 posts. However, a provision for up to 70 International and National Country Programme Advisers has been made

e = Difference between 96-97 Budget and Staffing Table due to 7 NCPAs

UNAIDS STAFFING TABLE - EXECUTIVE SUMMARY - AS AT 31 DECEMBER 1997

PROFESSIONAL STAFF—Breakdown by gender and OECD/non OECD countries	Total appointments	Male	Female	OECD	Non OECD
GENEVA	47	28	19	26	21
FIELD					
Country Programme Advisers					
International Country Programme Advisers	32	18	14	13	19
National Country Programme Advisers	5	2	3	0	5
Intercountry Technical Advisers	15	10	5	7	8
TOTAL	99	58	41	46	53
		59%	41%	46%	54%

UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

PRESS RELEASE

Joint United Nations Programme on HIV/AIDS

Paris, 26 November 1997

NEW UN WORLD AIDS DAY REPORT WARNS THAT HIV EPIDEMIC IS FAR WORSE THAN PREVIOUSLY THOUGHT

- **Updated surveillance techniques uncover 16 000 new infections a day; 30 million people now living with HIV/AIDS**

- **1 in 100 adults in 15-49 age group infected with HIV; only 1 in 10 infected persons aware of HIV status**

A new report released today by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) shows that infection with HIV, the virus that causes AIDS, is far more common than previously thought. Over 30 million adults and children are now believed to be living with HIV infection -- one in every 100 sexually active adults worldwide – and if current transmission rates hold steady, by the year 2000 the number of people living with HIV/AIDS will soar to 40 million.

"The more we know about the AIDS epidemic, the worse it appears to be," said Dr Peter Piot, Executive Director of UNAIDS. "We are now realizing that rates of HIV transmission have been grossly underestimated – particularly in sub-Saharan Africa, where the bulk of infections have been concentrated to date. South Africa now estimates that one in 10 adults are living with HIV – up by more than a third since 1996. And in Namibia, AIDS now kills nearly twice as many people as malaria, the next most common killer."

UNAIDS and WHO now estimate that 5.8 million people were infected in 1997, at a rate of 16 000 new infections every day. This includes 590 000 new infections among children, bringing the total number of children under the age of 15 currently living with HIV/AIDS to 1.1 million. Because over 90% of people with HIV live in the developing world, where there are few facilities for voluntary testing and counselling, UNAIDS estimates conservatively that 9 out of 10 HIV-positive people have no idea they are infected. Many would probably want to know, provided they felt protected from stigma and discrimination.

It is estimated that 2.3 million people died of AIDS in 1997 -- a 50% increase over 1996. Nearly half of those deaths were in women, and 460 000 were in children under 15. The full impact of the epidemic in terms of AIDS mortality is only just beginning.

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Unprecedented infection rates in sub-Saharan Africa

In sub-Saharan Africa, an alarming 7.4% of all those aged between 15 and 49 years are now thought to be infected with HIV. Levels of infection vary, however, widely across the continent.

Southern Africa continues to be the worst affected area. By early 1997, the Government of South Africa had estimated that 2.4 million South Africans were living with HIV. In Botswana, the number of adults infected with HIV has doubled over the last five years, now reaching 25% to 30% of the adult population. In Zimbabwe, infection was estimated at one in five adults in 1996 and, in one town with a large population of migrant workers, seven pregnant women in 10 were already testing HIV-positive in 1995. In Beit Bridge, another major city, the proportion of pregnant women infected shot up from 32% in 1995 to 59% in 1996.

In very badly affected countries such as these, the development gains achieved over the last few decades are already being wiped out by the epidemic. In Botswana, life expectancy, which rose from under 43 years in 1955 to 61 years in 1990, has now fallen to levels previously found in the late 1960s. Already a quarter more infants are dying in Zambia and Zimbabwe than would be the case if there were no HIV. On current trends, Zimbabwe's infant mortality rate can be expected to rise by 138% by the year 2010 because of AIDS, and its under-five mortality rate by 109%.

Infection rates in Asia are lower, but the numbers are large

In Asia, the epidemic is more recent than in Africa, and only a few countries in the region have developed sophisticated systems for monitoring the spread of HIV.

In India, infection rates, at under 1% of the total adult population, are still low by the standards of many countries, although well over 10 times higher than in neighbouring China. While surveillance remains patchy, the indications are that between 3 and 5 million people are living with HIV, making India, even at the most conservative estimate, the country with the largest number of HIV-infected people in the world.

In China, even as the epidemic continues to spread among injecting drug users in the southwest of the country, a second major focus is now surfacing among heterosexuals living along the prosperous eastern seaboard. At the end of 1996, the Chinese government estimated that up to 200 000 people were living with HIV/AIDS. Some estimates indicate that this figure may have already doubled by now.

In southeast Asia the picture is mixed. It is bleakest in Cambodia, where one in 20 pregnant women, one in 16 soldiers and policemen, and one in two sex workers tested HIV-positive in the most recent monitoring surveys. Myanmar and Viet Nam are also seeing a rapid spread of HIV. In Myanmar, HIV infection among sex workers rose from 4% in 1992 to over 20% in 1996, while two-thirds of injecting drug users are infected. In contrast, sustained prevention efforts in Thailand are continuing to produce evidence of a fall in new infections, especially among sex workers and their clients - the groups which account for the majority of the some 750 000 persons currently infected in the country.

Latin America and the Caribbean: a window of opportunity

In Latin America and the Caribbean, the HIV/AIDS epidemic is taking a heavy toll, especially on men who have sex with men and injecting drug users. Now, there is increasing evidence of spread among poorer and less educated parts of the populations, as well as among women. Although rates in pregnant women are still comparably low in general, they have reached levels of 1% in Honduras, more than 3% in Porto Allegre, Brazil, and over 8% in Haiti.

"AIDS is now one of the leading causes of death among young men in significant parts of this region", said Dr Piot. "However, there is still an important opportunity to be grasped here to slow the spread of HIV into the rest of the population. This can be done if special attention is given to the HIV prevention needs of poor and marginalized communities."

Drug use drives HIV in Eastern Europe

Drug injection is behind the dramatic surge in HIV infection in several Eastern European nations, accounting for the majority of the 100 000 new infections estimated to have occurred in 1997. In Ukraine, where around 70% of infections have been in drug users over the last three years, some 25 000 cases of HIV infection have been reported so far, half of them in 1997. Russian officials estimate there are about 350 000 regular drug users in the country, many of them sharing injecting equipment.

With the number of cases of sexually transmitted diseases rocketing in countries such as Belarus, Moldova and Russia, concern is also increasing over the potential for HIV spread in this region through unprotected sex.

AIDS is falling in the industrialized world

The growing gap between the developed and the developing world concerns not only the scale of HIV spread but also mortality rates from AIDS. In North America, Western Europe, Australia and New Zealand, newly available antiretroviral drugs are reducing the speed at which HIV-infected people develop AIDS.

In Western Europe evidence suggests that new AIDS cases will drop by around 30% in 1997 compared with 1995 before antiretroviral treatment became available. In the United States, newly-published figures indicate that the first-ever annual decrease in new AIDS cases - 6% percent - occurred in 1996 and an even bigger decrease is expected in 1997. AIDS cases, however, continue to rise in minority communities which often find it harder to access the new drugs and which have benefited less from prevention efforts.

Vulnerability of young people and children

Since the beginning of the epidemic, 3.8 million children under the age of 15 are estimated to have become infected with HIV and 2.7 million to have died. Over 90% of

these children acquired the virus through their HIV-positive mothers, whether before or during birth or through breastfeeding. Children are also affected by the epidemic through the impact of HIV/AIDS on their parents, siblings and friends. So far, more than 8 million children have lost their mothers to AIDS when they were less than 15 years old - and many of these also lost their fathers. It is estimated that this figure will almost double by the year 2000.

In most parts of the world, the majority of new infections are in children and young people between the ages of 15 and 24, sometimes younger. Girls appear to be especially vulnerable to infection, but Uganda has recently shown encouraging evidence that in some city sites infection rates have halved among teenage girls since 1990. Even there, however, the rates remain unacceptably high, with up to one pregnant teenager in 10 testing HIV-positive. This infection rate is six times higher than in boys of the same age.

This year, World AIDS Day is the culmination of the first World AIDS Campaign launched by UNAIDS and its partners with the theme "Children living in a world with AIDS".

Said Dr Piot: "The World AIDS Campaign has helped to draw the attention of political leaders and communities around the world to the devastating effect of the HIV/AIDS epidemic on the lives of young girls and boys. Much of the future course of this epidemic will be determined by our ability to ensure that the rights of these children and young people are protected - not only that they are given essential care and support but also that they are given access to education and information about how HIV is transmitted and to the means to avoid it."

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Talking points on UNAIDS Report

- most dramatic statistic is doubling of estimate of new HIV infections - 5.8 million
- over 90% in developing countries
- if trend continues, more than 40 million will be living with HIV by 2000
- 40 million orphans by 2010
- 2.3 million died of AIDS in 1997
  + 46% were women
  + 20% were children < 15
- sub-Saharan Africa is hardest hit
  + 7.4% of those 15-49 are infected
  + 2.4 million living with HIV in South Africa - up by 1/3 since 1996
  + in Francistown, 43% of pregnant women tested HIV+
- West Africa, with exception of Nigeria, has stabilized
- Asia rates are lower
  + many different epidemics, even in same country
  + rapid growth in China among IDUs and prostitution-involved
  + India has largest number of HIV+ persons in the world
  + Thailand's aggressive prevention campaigns have resulted in lower rates of infection
  + neighboring Cambodia is out of control
- Latin America and Caribbean
  + mostly among MSM and IDU
  + leading cause of death
- Russia and FSU
  + staggering growth, particularly among IDUs
- Developing world
  + deaths are dropping, except in marginalized populations
- Young people around the world at high risk
  + many studies report that aggressive, early prevention works in reducing risky sex and delaying first sexual intercourse
- OVER 27 MILLION OF THE 30 MILLION LIVING WITH HIV DON'T KNOW IT

Report on the Global HIV/AIDS Epidemic

DECEMBER 1997

EMBARGOED

until

26 November, 1997, 10:00 G.M.T.

Global HIV/AIDS and STD Surveillance

Surveillance of HIV/AIDS and STDs is conducted as a joint effort of UNAIDS and WHO. The data in this report have been compiled by the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance in collaboration with National AIDS Programmes.

Global summary of the HIV/AIDS epidemic, December 1997

People newly infected with HIV in 1997	**Total**	**5.8 million**
	Adults	5.2 million
	Women	*2.1 million*
	Children <15 years	590 000
No. of people living with HIV/AIDS	**Total**	**30.6 million**
	Adults	29.5 million
	Women	*12.1 million*
	Children <15 years	1.1 million
AIDS deaths in 1997	**Total**	**2.3 million**
	Adults	1.8 million
	Women	*820 000*
	Children <15 years	460 000
Total no. of AIDS deaths since the beginning of the epidemic	**Total**	**11.7 million**
	Adults	9.0 million
	Women	*4.0 million*
	Children <15 years	2.7 million
Total no. of AIDS orphans[1] since the beginning of the epidemic		**8.2 million**

[1] Defined as HIV-negative children who lost their mother or both parents to AIDS when they were under the age of 15.

Global estimates

❒ HIV: close to 16 000 new infections a day

New estimates show that infection with the human immunodeficiency virus (HIV) which causes AIDS is far more common in the world than previously thought (see box on page 12). UNAIDS and WHO estimate that over 30 million people are living with HIV infection at the end of 1997. That is one in every 100 adults in the sexually active ages of 15 to 49 worldwide.[2] Included in the 30 million figure are 1.1 million children under the age of 15. The overwhelming majority of HIV-infected people – more than 90% – live in the developing world, and most of these do not know that they are infected (see page 10).

Around 16 000 new HIV infections a day in 1997

- **More than 90% are in developing countries**
- **1 600 are in children under 15 years of age**
- **About 14 000 are in adults, of whom:**
  - ➢ **over 40% are women**
  - ➢ **over 50% are 15–24-year-olds**

This year's estimates also point up the continuing rapid spread of HIV. Altogether, 5.8 million people are believed to have acquired HIV infection in 1997, 590 000 of them children. Overall, that is equivalent to nearly 16 000 new infections every day of the year, including those in children infected at birth or through breastfeeding.

Assuming that currently unbroken trends in many parts of the world will continue, it is estimated that more than 40 million people will be living with HIV in the year 2000.

An estimated 2.3 million people died of AIDS in 1997. These deaths represent a fifth of the total 11.7 million AIDS deaths since the beginning of the epidemic in the late 1970s. Of the people who died of AIDS this year, 46% were women and 460 000 were children.

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[2] In this report, adults are defined as those aged 15-49, children as those under 15. To make it easier to compare prevalence rates (proportion of people currently living with HIV/AIDS) between countries and regions, the total number of adults aged 15-49 living in a given country or region is used as the denominator.

Regional round-up

It is becoming increasingly clear that, although almost every country is touched by HIV, the virus spreads very differently in different parts of the world. There are even important differences in patterns of spread in different communities and geographic areas within the same country.

Regional HIV/AIDS statistics and features, December 1997

Region	Epidemic started	Adults & children living with HIV/AIDS	Adult prevalence rate[3]	Cumulative no. of orphans[4]	Percent of HIV-positive adults who are women	Main mode(s) of transmission[5] for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s - early '80s	20.8 million	7.4%	7.8 million	50%	Hetero
North Africa & Middle East	late '80s	210 000	0.13%	14 200	20%	IDU, Hetero
South & South-East Asia	late '80s	6.0 million	0.6%	220 000	25%	Hetero
East Asia & Pacific	late '80s	440 000	0.05%	1 900	11%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.3 million	0.5%	91 000	19%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	310 000	1.9%	48 000	33%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	150 000	0.07%	30	25%	IDU, MSM
Western Europe	late '70s - early '80s	530 000	0.3%	8 700	20%	MSM, IDU
North America	late '70s - early '80s	860 000	0.6%	70 000	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	0.1%	300	5%	MSM, IDU
TOTAL		**30.6 million**	**1.0%**	**8.2 million**	**41%**	

❒ Infection reaches unprecedented levels in sub-Saharan Africa

Sub-Saharan Africa is the region with the fastest-moving epidemic. The African epidemic has also been the most underestimated one up to now (see box on page 12). Now thought to have fully two-thirds of the total world number of people living with HIV, sub-Saharan Africa as a whole has reached the unprecedented level of 7.4% of all those aged 15 to 49 infected with HIV.

Unprotected sex between men and women accounted for most of the 3.4 million new HIV infections estimated among adults in sub-Saharan Africa in 1997. In addition, high fertility combined with poor access to information and services for the prevention of mother-to-child transmission resulted in some 530 000 infected children being born to mothers with HIV – around 90% of the world total.

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[3] The proportion of adults living with HIV/AIDS in the adult population (15 to 49 years of age).

[4] Orphans are defined as HIV-negative children who lost their mother or both parents to AIDS when they were under age 15.

[5] MSM (men who have sex with men), IDU (injecting drug users), Hetero (heterosexual transmission).

Although heterosexual transmission accounts for most infections throughout Africa, levels of infection vary widely across the continent.

Southern Africa continues to be the part of the continent worst affected by HIV. By early 1997, the Government of South Africa estimated that 2.4 million South Africans were living with HIV, up by more than a third over 1996. In Botswana, the proportion of the adult population living with HIV has doubled over the last five years. In 1997, 43% of pregnant women tested in the major urban centre of Francistown were HIV-positive. In Zimbabwe, infection was estimated at one in five adults in 1996. In Harare, 32% of pregnant women were already infected in 1995; in Beit Bridge, another major city, the proportion shot up from 32% in 1995 to 59% in 1996. Although levels in cities were slightly higher than in rural areas, the difference was not great. In one town near the South African border with a large population of migrant workers, 7 pregnant women in 10 tested HIV-positive in 1995.

In general, West Africa has seen its rates of infection stabilize at much lower levels than in East and Southern Africa. However, some of the most populous countries in West Africa are the exception to this rule. For example, the National AIDS Programme estimates that 2.2 million people are currently living with HIV in Nigeria, a country whose response to the epidemic needs strengthening.

East Africa was one of the first areas to suffer a massive regional epidemic, and one country in the region, Uganda, was among the first to respond with open and concerted efforts to prevent the spread of the virus. For Uganda, this seems to be paying off. 1997 data currently being analysed show that the proportion of Ugandan adults infected is continuing to drop. All three of the surveillance sites for which figures are now available show infection levels of between 5% and 9%, representing a decrease of about one-fifth compared with 1996. The fall has been particularly marked in the younger age groups, which is in line with behaviour studies showing that young people nowadays are adopting safer sexual behaviour – later sexual initiation, fewer partners, more condom use – than was common a decade ago.

❒ Infection rates in Asia are lower than Africa's, but the numbers are large

The diversity within Asia is greater even than that in Africa. Levels of infection vary enormously, and so do routes of transmission. Often there are a number of different epidemics running concurrently within a single country. New genetic typing procedures (which allow researchers to investigate how different strains of the virus are spreading through the population) show that there is often remarkably little overlap between the HIV epidemics among injecting drug users and sex workers, for instance.

The epidemic is newer in Asia than in Africa, and only a few countries in the region have developed sophisticated systems for monitoring the spread of HIV. So estimates of HIV in Asia often have to be made on the basis of less information than in other regions. Because over half of the world's population lives in the region, small differences in rates can make huge differences in the absolute numbers of people infected.

The Government of China estimated that at the end of 1996 up to 200 000 people were living with HIV/AIDS. According to some estimates, this figure may have doubled by the end of 1997.

At present, there are two major epidemics under way in China. One is in injecting drug users in the mountainous southwest of the country. The other, newer epidemic is now surfacing among heterosexuals, especially along the prosperous eastern seaboard where prostitution is re-emerging as the gap grows between rich and poor. The warning signs of high-risk behaviour are worryingly clear: sexually transmitted diseases (STDs) have shot up in recent years, and there are no suggestions that the upward trend will be broken.

In India, infection rates, at under 1% of the total adult population, are still low by the standards of many countries, although well over 10 times higher than in neighbouring China. Surveillance is patchy, but all indications are that between 3 and 5 million people in India are living with HIV. Even at the bottom of that range, India is the country with the largest number of HIV-infected people in the world.

Recent testing of pregnant women in Mumbai shows infection rates around 2.4% in 1996. In Pondicherry, the rate among pregnant women is around 4%. Among truck drivers in the southern state of Madras, HIV infection quadrupled from 1.5% in 1995 to 6.2% just one year later. In the northeastern state of Manipur, where the epidemic took off quickly among male drug injectors, some drug clinics were registering HIV rates of as high as 73% in 1996.

There is limited information about HIV infection in other parts of south Asia, but it is clear that many people are having unprotected sex with non-monogamous partners. A recent study among sex workers in Bangladesh showed that 95% had contracted genital herpes, mostly from their clients, while 60% had syphilis.

Rates of HIV infection remain low in several southeast Asian nations. In Indonesia, Malaysia, the Philippines and Singapore, for instance, infection rates are well under 1%. However, other countries in the region show much higher levels of HIV spread. The reasons for these differences are not entirely clear. Nor is there any assurance that currently low rates will remain low, given the widespread occurrence of risk behaviour including commercial sex and, in some places, drug injecting.

Thailand, which has experienced what is probably the best-documented epidemic in the developing world, is continuing to produce evidence of a fall in new infections, especially among sex workers and their clients. These are the groups who have accounted for the majority of the some 750 000 persons currently infected, representing 2.3% of the adult population. The decrease in new infections is the outcome of concurrent and sustained prevention efforts aimed at increasing condom use among heterosexuals, boosting respect for women, discouraging men from visiting sex workers, and offering young women better educational and other prospects to discourage their entry into commercial sex. HIV rates among Thailand's injecting drug users have stabilized at a relatively high level (around 40%), and a survey among men who have sex with other men in northern Thailand reported low AIDS awareness and condom use.

Elsewhere in southeast Asia the picture is mixed. It is bleakest in Cambodia, where 1 in 20 pregnant women, 1 in 16 soldiers and policemen and 1 in 2 sex workers tested positive in sentinel HIV

surveillance. While condom use has grown very rapidly (condom sales have risen from virtually nothing to around a million units a month in the space of under three years) commercial sex remains very common: in a recent survey three-quarters of respondents in the military and the police force and two-fifths of male students said they had visited a sex worker in the last year. Viet Nam and Myanmar are also seeing a rapid spread of HIV. In Myanmar, HIV infection among sex workers rose from 4% in 1992 to over 20% in 1996, while two-thirds of injecting drug users are infected. Among pregnant women in the general population, an estimated 2% are infected.

Overall, about 6.4 million people are currently believed to be living with HIV in Asia and the Pacific – just over 1 in 5 of the world's total. By the end of the year 2000, just three years from now, that proportion is expected to rise to 1 in 4. Around 92 000 children now live with HIV in Asia.

❒ Latin America and the Caribbean: neglected groups and a window of opportunity

In Latin America the picture is heterogeneous. For the most part, HIV is concentrated in neglected populations living on the social and economic margins of society. The epidemic has taken its greatest toll on men who have sex with men and injecting drug users. Systematic data collection is difficult in these groups and information is rather scarce as of today. Nevertheless, studies on Mexican men who have sex with men show that, on average, as many as 30% of them may be living with HIV. Rates in drug users vary from 5% to 11% in Mexico to close to 50% in Argentina and Brazil. In some places there is clear evidence of increasing spread among poorer and less educated parts of the population. For example, in Brazil most of the early AIDS cases were in individuals with secondary or university education; today 60% of cases are in people with primary schooling or less.

Rising rates in women show that heterosexual transmission is becoming more prominent. In Brazil, the male/female ratio of AIDS cases has dropped from 16:1 in 1986 to 3:1. Although HIV rates in pregnant women are still comparably low in general, they have reached levels of 1% in Honduras and more than 3% in Porto Allegre, Brazil. Rates are substantially higher in the Caribbean. Haiti found over 8% of pregnant women carrying the virus already in 1993; the same prevalence was reported from one surveillance site in the Dominican Republic in 1996.

For the most part, however, this region of the world still has an important window of opportunity: it is not too late to stop HIV from spreading to the population at large. This will require a much greater focus on meeting the special prevention needs of marginalized and impoverished populations.

As limited as the region's epidemic has been thus far, AIDS has already had a major impact. In Mexico, AIDS was the third leading cause of death in men between 25 and 34 years of age in 1995 with increasing trends. In the state of São Paulo, Brazil, AIDS became the leading cause of death in 20 to 34-year-old women in 1992. In Latin America and the Caribbean as a whole, AIDS has already overtaken traffic accidents as a cause of death. However, a recent drop in AIDS mortality – similar to that seen in Western Europe and North America (see below) – has been recorded in São Paulo and is attributed to the increasing use of antiretroviral therapy.

❒ Drug use drives HIV in Eastern Europe

Drug injection is behind the dramatic surge in HIV infection in several Eastern European nations, accounting for the majority of the 100 000 new infections estimated to have occurred in 1997. In Ukraine, where around 70% of infections have been in drug users over the last three years, some 25 000 cases of HIV infection have been reported so far, half of them in 1997. It is possible that a similar pattern will be seen elsewhere in the region. Russian officials estimate there are about 350 000 regular drug users in the country, many of them sharing injecting equipment.

The potential for sexual spread also exists. In Russia, Belarus and Moldova, new cases of syphilis rocketed from very low levels in the late 1980s to well above 2 per 1000 population by 1996, with continuously increasing trends. An untreated sexually transmitted disease not only makes HIV (when present) spread much more easily from one partner to the other but is important as a marker of potential HIV spread because it has the same transmission route – unprotected sex (intercourse without a condom).

❒ AIDS is falling in the industrialized world

The growing gap between the developed and the developing world concerns not only the scale of HIV spread but mortality from AIDS. In North America, Western Europe, Australia and New Zealand, newly-available antiretroviral drugs are reducing the speed at which HIV-infected people develop AIDS.

In Western Europe evidence suggests that new AIDS cases will drop by around 30% in 1997 compared with 1995, before antiretroviral treatment became available. The fall is greatest in countries in which infection has been concentrated in homosexual men, in whom HIV rates began dropping 5-10 years earlier. This shows that the decline in AIDS cases is often the combined result of better prevention and better treatment. Only in Portugal and Greece, where unsafe drug injecting is the main mode of transmission, are new AIDS cases still showing substantial rises compared with a year ago.

In the United States, newly-published figures indicate that the first-ever annual decrease in new AIDS cases – 6% – occurred in 1996, and an even bigger decrease is expected in 1997. Again, the largest fall – a drop of 11% – was in homosexual men, the very group which sought and benefited from the most open exchange of information about the risks of unprotected sex in the early years of the epidemic. In some disadvantaged sections of society, however, AIDS continues to rise. Among African-Americans, new AIDS cases rose by 19% among heterosexual men and 12% among heterosexual women in the USA in 1996. In the Hispanic community, there were 13% more cases among men and 5% more among women than a year earlier. This is partly because these communities may find it hard to access the expensive new drugs that could stave off the onset of AIDS. It is partly, too, because prevention efforts in minority communities, where transmission is often through heterosexual intercourse and drug injecting, have been less successful than in the predominantly well-educated and well-organized white gay community.

It is estimated that 30 000 Western Europeans were newly infected with HIV in 1997. Antiretroviral treatment given to women during pregnancy and the availability of safe alternatives to breastfeeding kept mother-to-child infection low – it is estimated that fewer than 500 children under the age of 15 were infected with HIV in 1997. North America estimated it had around 44 000 new HIV infections in 1997. As in Western Europe, transmission from mother to child was low, with fewer than 500 new cases.

AIDS wipes out gains in life expectancy and child survival

AIDS is systematically cutting down life expectancy in the countries where the disease is most common. The gains achieved over the last few decades in much of the developing world will in some places be cancelled out by HIV. Life expectancy in Botswana rose from under 43 years in 1955 to 61 years in 1990. Now, with between 25% and 30% of the adult population infected with HIV, life expectancy is expected to drop back to levels last seen in the late 1960s. By the end of the decade, Zimbabwe will see 10 years wiped off the life expectancy of a child born in 1990. In Uganda, one study in a rural area measured the lifespan of the population as a whole and compared it with that of the people who were not HIV-infected. It concluded that where some 8% of the population was HIV-positive, the presence of AIDS in the community cut overall life expectancy by 16 years.

In many countries AIDS is the leading cause of death in adults. In the United States, after combination therapy to slow down the progression of HIV disease was introduced in 1996, AIDS dropped into second place among leading causes of death in people aged 25-44 for the first time since 1992. Accidental injury took over in first place. In rural Uganda, AIDS accounted for 41% of adult deaths in one study. For men between 25 and 44, and for women between 20 and 44, AIDS caused 7 out of every 10 deaths. In trading centres which are home to large numbers of younger adults, a third of whom are HIV-infected, nearly 9 out of 10 adult deaths are HIV-related. In Namibia, HIV causes nearly twice as many deaths across all ages as malaria, the next most common killer.

The high mortality due to HIV/AIDS also has major impacts on families. It is estimated that since the beginning of the epidemic more than 8 million children have lost their mothers to AIDS when they were less than 15 years old – and many of these also lost their fathers. It is estimated that this figure will almost double by the year 2000.

The worst is still to come. Since the beginning of the epidemic, it is estimated that 11.7 million people around the world have died of AIDS and HIV-related causes. That is just a third of the number currently infected. Indeed, half as many people were infected this year alone as have died in the whole epidemic to date. Because the vast majority of people living with HIV are in the developing world, access to antiretrovirals is often difficult or impossible. And these drugs do not constitute a cure: they are not effective in everyone, and at this point it is impossible to say how long their effects will last. Thus, many if not most of the 30 million people currently infected may well die in the relatively near future, perhaps within the next decade.

Developing nations have made great strides in increasing infant and child survival in recent decades. These gains, too, are threatened by HIV. Already, a quarter more babies under 12 months old in Zimbabwe and Zambia are dying than would be the case if there were no HIV. By 2010 Zimbabwe's

infant mortality rate is expected to rise by 138% because of AIDS, and its under-five mortality rate by 109%. In Côte d'Ivoire, child mortality will rise by over two-thirds.

Young people at risk

In some parts of the world, the proportion of the total adult population living with HIV/AIDS has stabilized or begun to fall. While this is good news, it can hide an unpleasant truth: new infections in the younger age groups can continue unabated or even go on rising as the overall proportion of people living with HIV/AIDS falls.

❒ High infection rates and risk behaviour among some young people

In most parts of the world, the majority of new infections are in young people between the ages of 15 and 24, sometimes younger. In one study in Zambia, over 12% of the 15 and 16-year-olds seen at antenatal clinics were already infected with HIV.

Girls appear to be especially vulnerable to infection, but Uganda has recently shown encouraging evidence that in some city sites infection rates have halved among teenage girls since 1990. Even there, however, the rates remain unacceptably high, with up to 1 pregnant teenager in 10 testing HIV-positive. That rate is six times higher than in boys of the same age.

In South Africa, the proportion of pregnant 15-19-year-olds infected with HIV rose to 13% in 1996 from around half that level just two years earlier. In Botswana the infection rate stood at 28% for the same group in 1997. In Maharashtra state in India, where the epidemic is in its early years, some 3.5% of pregnant teenagers tested HIV-positive in a recent study.

What is abundantly clear is that some young people all over the world engage in risky sexual behaviour. In Mongolia, there has been a recent jump in sexually transmitted diseases in children under 15, indicating that they are exposed to unprotected intercourse. One study shows that since 1994, STDs in those under 15 have shot up more than ten-fold. In Namibia, 37% of 12-18-year-olds reported that they had had sex, nearly half of them with more than one partner. Most said that they believed their own partners had had other partners, too. In Tanzania, 12% of teenage males and 37% of 20-24-year-olds reported that they had multiple sex partners in the last year. In Mali, 2 out of 5 sexually active boys in their teens said they last had sex with a prostitute or casual partner. In the United States, some studies indicate that genital herpes has jumped more than four-fold among white teenagers since the 1970s, with close to 1 in 20 now infected. Among white Americans in their 20s, the rate is 1 in 7.

Sometimes, young people know of the risks of unprotected sex but feel AIDS could not possibly happen to them. In Malawi, most young men and women know how HIV is transmitted and how it can be prevented. When asked, however, many said they felt invulnerable to the virus. Some 90% of teenage boys said they were at no risk or at minimal risk of infection, even though nearly half of them reported at least one casual sex partner over the last year, and condom use was low.

Even in countries such as Thailand – which has been among the most successful in encouraging young people to adopt safer sexual behaviour and has been rewarded by seeing a marked fall in both HIV infection and other STDs – there are groups of young people that fall through the net, such as those living on the street.

❒ More education translates into lower risk

In many countries, young people are denied access to education about HIV including safe behaviour skills, or are unable to buy condoms or attend STD clinics. This is usually because older adults believe such education and services will actually encourage young people to increase their sexual activity.

In fact, the reverse is true according to a newly-published UNAIDS review of data from four continents. Good-quality sex education helps delay first intercourse and leads to lower levels of teenage pregnancy and STDs. In the years after Switzerland launched an active and very open campaign aimed at informing young people about healthy sexual behaviour, the proportion of 17-year-old girls and boys who never had sex – a proportion that had been dropping for many years – began to show a marked rise. The same trend toward postponement of first sexual intercourse is now being observed in the USA and in Uganda.

Educational efforts are also resulting in greater condom use among those who have become sexually active. Thailand and Uganda have already been mentioned. In Tanzania, 16% of sexually active teenage women had used a condom in 1996. While this may seem woefully low, it is certainly a vast improvement on the 5% recorded in 1990. The proportion of teenage boys who had ever used a condom rose from 14% to 38% in the same period. In Zambia, too, condom use has risen from very low levels in the 1980s. In 1996 about one-third of sexually active teenage girls nationwide reported having used a condom – a level previously reported only from the capital Lusaka, where condom use has always been highest. In Switzerland, levels of casual sex among young people have remained more or less constant since the late 1980s, but consistent use of condoms with those partners has risen four-fold – a more impressive increase than seen in older people.

Over 27 million do not know they are infected

UNAIDS estimates that of the some 30 million people currently living with HIV, the vast majority have no idea they are infected. As with so many other features of the epidemic, when it comes to knowledge of HIV status there is a gaping divide between the developing and industrialized world.

In the United States, the Centers for Disease Control and Prevention (CDC) estimate that two-thirds of people living with HIV know about their infection. In Germany, the proportion of AIDS patients who knew their HIV status at least six months before an AIDS diagnosis remained steady at close to three-quarters in 1994 and 1995. Since 1995, when drugs that can delay the onset of AIDS came onto the market, the proportion has actually dropped to two-thirds. This is because people who knew their status early have already been treated and have been able to delay the onset of AIDS.

People who do not know their status are more likely to go on and develop AIDS. The availability of treatment is a powerful incentive to get tested early.

In the developing world, where the epidemic is increasingly concentrated, the picture is very different. HIV testing is done mostly for purposes of surveillance, which involves very small population samples and is done "anonymously" (with no identification by name of those tested). Few people have any hope of treatment, so they feel little incentive to get tested. But even those who would want to know may not be able to find out. In many countries, there simply are no voluntary testing and counselling facilities; people have no acceptable way of learning if they are HIV-infected. An ongoing study at a rural hospital in South Africa suggests that only 2% of people who are HIV-positive know their status. The situation in urban Kenya seems to be as bad. Of 63 randomly chosen women who tested HIV-positive in one study, just one was already aware that she was infected.

The fact that current testing procedures usually require at least two visits to a test site further complicates access to testing. This can be difficult or expensive for people living in isolated areas. In rural South Africa, just 17% of the people who asked to be tested came back for the result and the advice and support that goes with it. When an on-the-spot test was tried, nearly everyone (96%) chose to know the result.

Since the epidemic is concentrated in the developing world, a conservative estimate might suggest that 9 out of 10 infected people in the world do not know their HIV status. At current estimates, that would suggest there are over 27 million people in the world today who have no idea they are infected.

There are many reasons why HIV testing and counselling for those who want to know their infection status should become part of the broad package of interventions used for AIDS prevention, care and support. Increasingly, ways are being found to delay symptomatic HIV disease including the late stage called AIDS, and to prevent or treat the infections which afflict people whose immune systems have been damaged by the virus. Not all of these treatments are prohibitively expensive. The earlier people know they are infected, the greater the opportunity for them to access treatment – or put pressure on their communities and countries for improved access, where this is inadequate. Another benefit would flow to individuals and their families. The earlier individuals are aware of their infection, the better they can make informed and responsible decisions about childbearing, transmission to spouses or partners, and plans for their family's welfare after they fall ill or die.

Perhaps the most important benefit of self-knowledge is that it helps unmask the invisible epidemic and permits a genuine community response. The experience of the past decade shows that as long as HIV spreads silently and unnoticed, it remains at best a theoretical threat to people and does not get taken seriously. If individuals become aware of their infection early on, while they are still relatively healthy, this would give them the time and energy to support one another as well as alert their community to the epidemic, helping others avoid the disease or cope with its consequences.

However, these benefits to individuals, families and communities are realistically achievable only where people feel safe enough to find out whether they are infected. Efforts by governments and civil society to combat rejection and discrimination directed at people with HIV are vital.

Improved estimation techniques reveal epidemic is worse than previously thought

These newly-released figures reveal that there are about one-third more people living with HIV than was estimated in December 1996. There are two reasons for this increase. First, new infections are occurring at an alarming rate – some 16 000 infections a day have added 5.8 million HIV infections to the total in 1997 alone. Secondly, it now appears that previous calculations grossly underestimated the rate of transmission, particularly in sub-Saharan Africa where the bulk of infections are concentrated.

❒ Why do estimates change?

Estimates are based on certain assumptions about the start of the epidemic, the rate of new infections in urban and rural areas, the time between infection and death, and the maximum level of infection in the population. Until a few years ago these data were available for only a handful of countries. It was assumed that the pattern of infection in other countries in the same region would follow that seen in countries where data was available. It seemed reasonable, then, to construct models to estimate the epidemic region by region.

This was first done for 1995. Information about levels of infection dating from 1994 or earlier was collected from as many countries as possible. From the proportion of people currently infected in various sentinel groups in each region and other available data, models were constructed to estimate the rate of growth of the epidemic and the total number of people currently infected, region by region. Extrapolations from this model were used to calculate the magnitude of the epidemic in 1996. This yielded an estimate of 3.1 million new infections over the year and brought to 22.6 million the number of people thought to be living with HIV.

By 1997, far more data were available and it became clear that there were huge differences in the way the epidemic was developing in different countries and communities within the same region. So this year, UNAIDS improved its estimation techniques. The regional models were replaced by separate models constructed for each country, which were based on better measures of levels of infection and took into account the variations in patterns of infection, in survival time, and so on. New estimates were made country by country, and then added together to yield new regional totals. The resulting estimates, given in this report, showed that global levels of infection in 1996 had been underestimated by over a third.

New infections in 1996 were in fact closer to 5.3 million than to the 3.1 million reported last year. The total number of people living with HIV in 1996 was in the range of 27 million, rather than 22.6 million as previously believed. That means that although this year's estimates are still shockingly high, there has been nothing like the doubling of new cases that might be suggested by looking at last year's published figures. Accounting for previous underestimates, there have been around 9% more new infections this year than last, and the number of people living with HIV has grown by 13%.

❒ Where did the differences appear?

To see how much of the new total was due to a rise in new infections and how much due to underestimates of previous levels, UNAIDS recalculated the totals for 1996 using the new estimation methods. The results showed that previous estimates were correct for most of the world.

The difference was found largely in sub-Saharan Africa. While the number of people living with HIV/AIDS there was originally estimated at 14 million in 1996, new information shows that the regional total at that time was probably closer to 18.6 million, as against 20.8 million in 1997. New infections in 1996 would, on the basis of current information, have been estimated at 3.8 million in Africa alone.

❒ Why was infection in Africa underestimated by so much?

At the time the regional model for sub-Saharan Africa was constructed, few countries had much reliable data and some, notably Nigeria and South Africa with their large populations, had virtually none. The country with the best surveillance system was Uganda, and that showed that infection rates were beginning to level off, with new infections dropping in younger age groups. This was taken as a model for the whole region.

Unfortunately, the epidemic in other countries has not followed the pattern seen in Uganda. In many, infection rates have continued to climb beyond the levels thought possible in 1994, when data for the regional models used for previous estimates were collected.

❒ Are the new estimates definitive?

The figures given in this report each represent a best estimate out of a range, rather than a precise number. UNAIDS and WHO believe that these new estimates are as accurate as is possible to generate with available data. But there is much that is still not known about HIV. More information about the course of infection, its impact on fertility and mortality, and the transmissibility of different strains of the virus will change some of the assumptions made in the current models. A clearer picture of current levels of infection, particularly for countries with large populations and inadequate data such as India, will improve future estimates. And the efforts governments and communities put into changing the course of the epidemic in their countries should have an impact on the rate of new infections and so on estimates and projections.

UNAIDS and WHO will continue to improve estimation methods as new information becomes available.

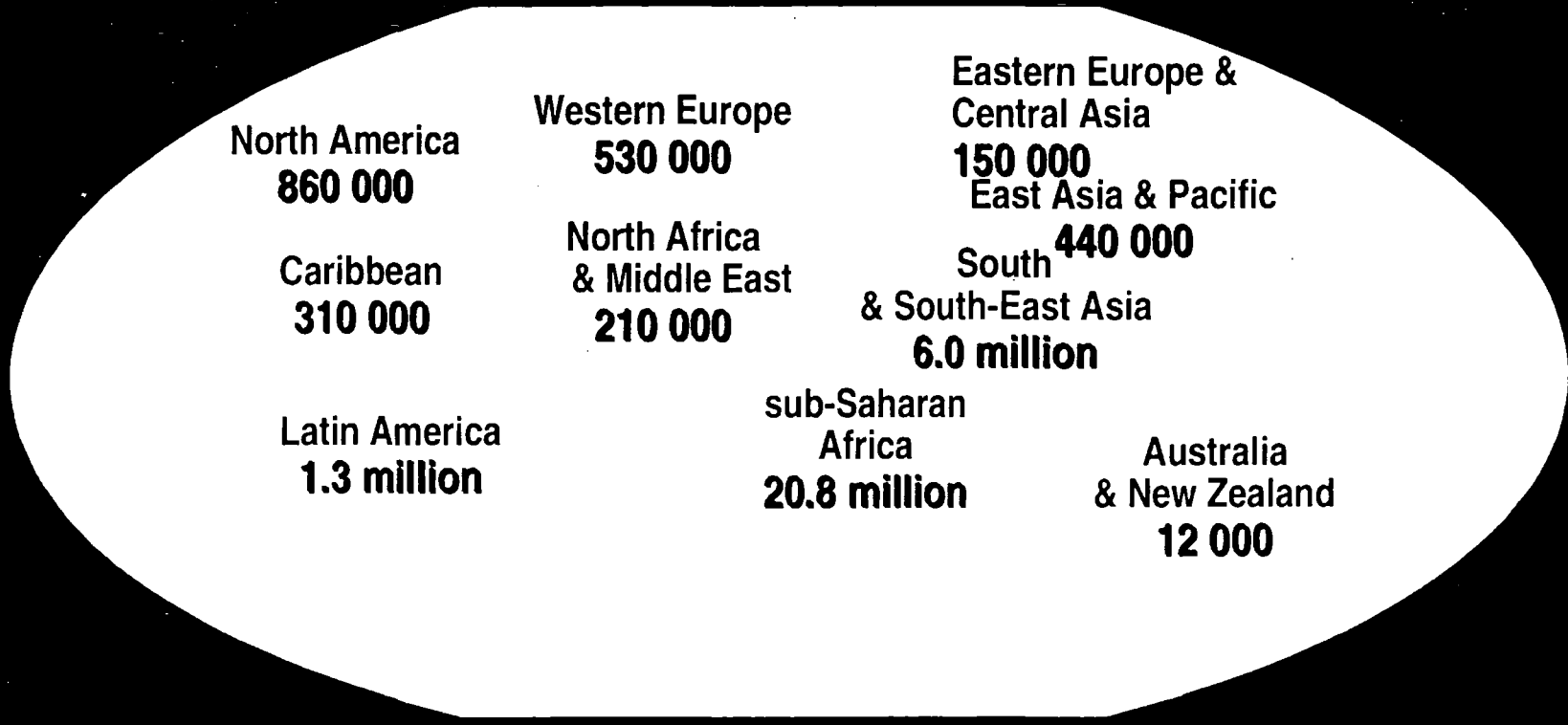
End-1997 global estimates
Children and adults

People living with HIV/AIDS	30.6 million
New HIV infections in 1997	5.8 million
Deaths due to HIV/AIDS in 1997	2.3 million
Cumulative number of deaths due to HIV/AIDS	11.7 million

GE-98001/12 – 1 December 1997

Global HIV AIDS and STD Surveillance WHO

Adults and children estimated to be living with HIV/AIDS as of end 1997

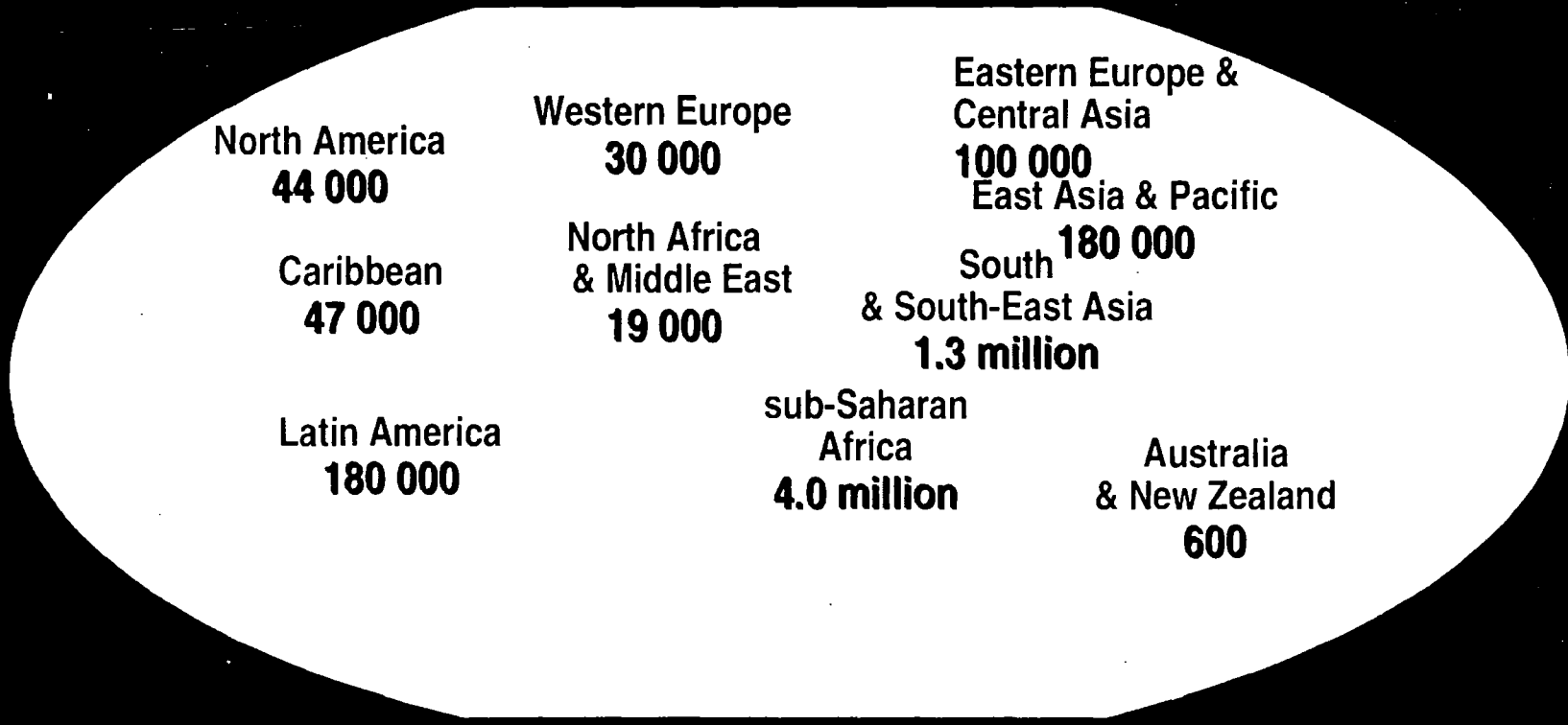


Total: 30.6 million

GE-98001/1 – 1 December 1997

Global HIV AIDS and STD Surveillance WHO

Estimated number of adults and children newly infected with HIV during 1997

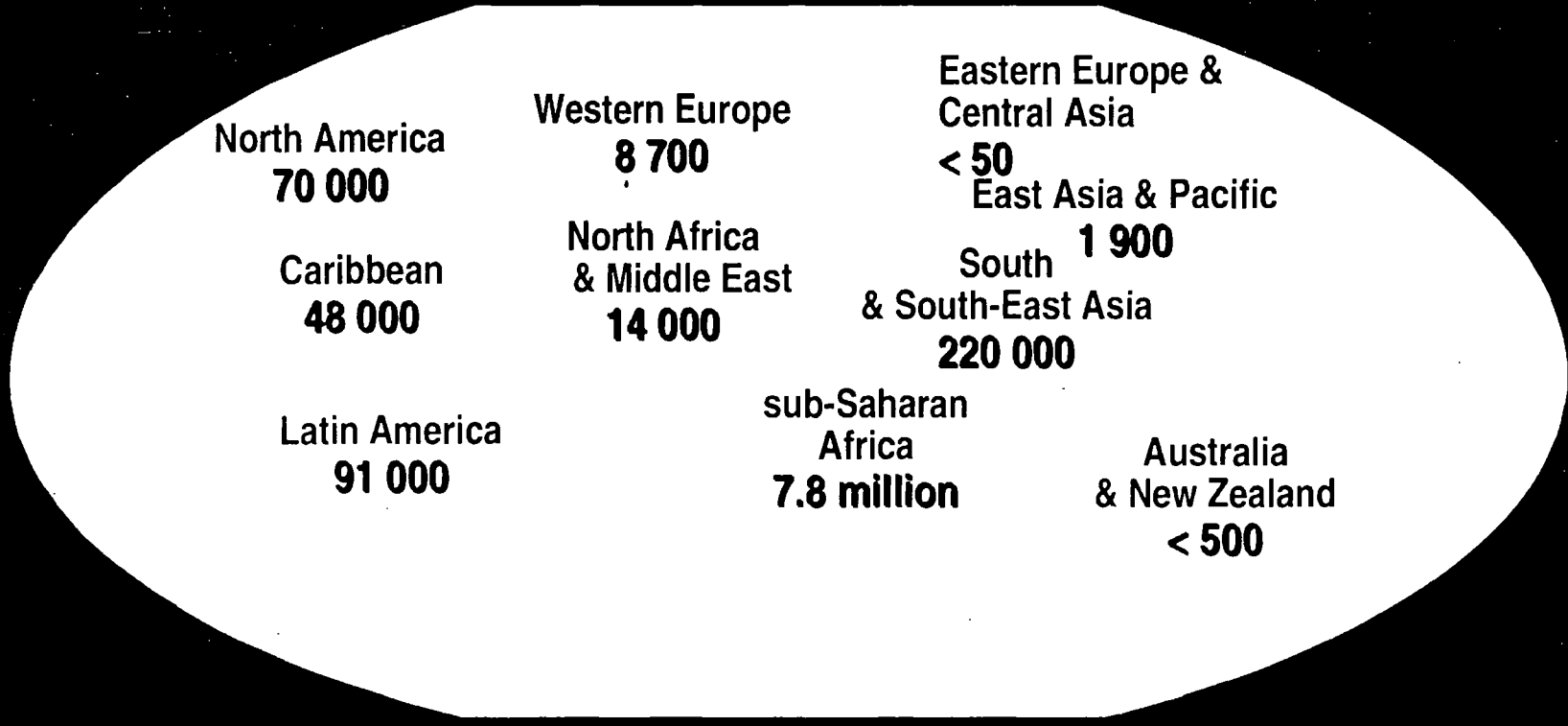


Total: 5.8 million

GE-98001/7 – 1 December 1997

Global HIV AIDS and STD Surveillance | WHO

Cumulative number of children estimated to have been orphaned by AIDS* at age 14 or younger



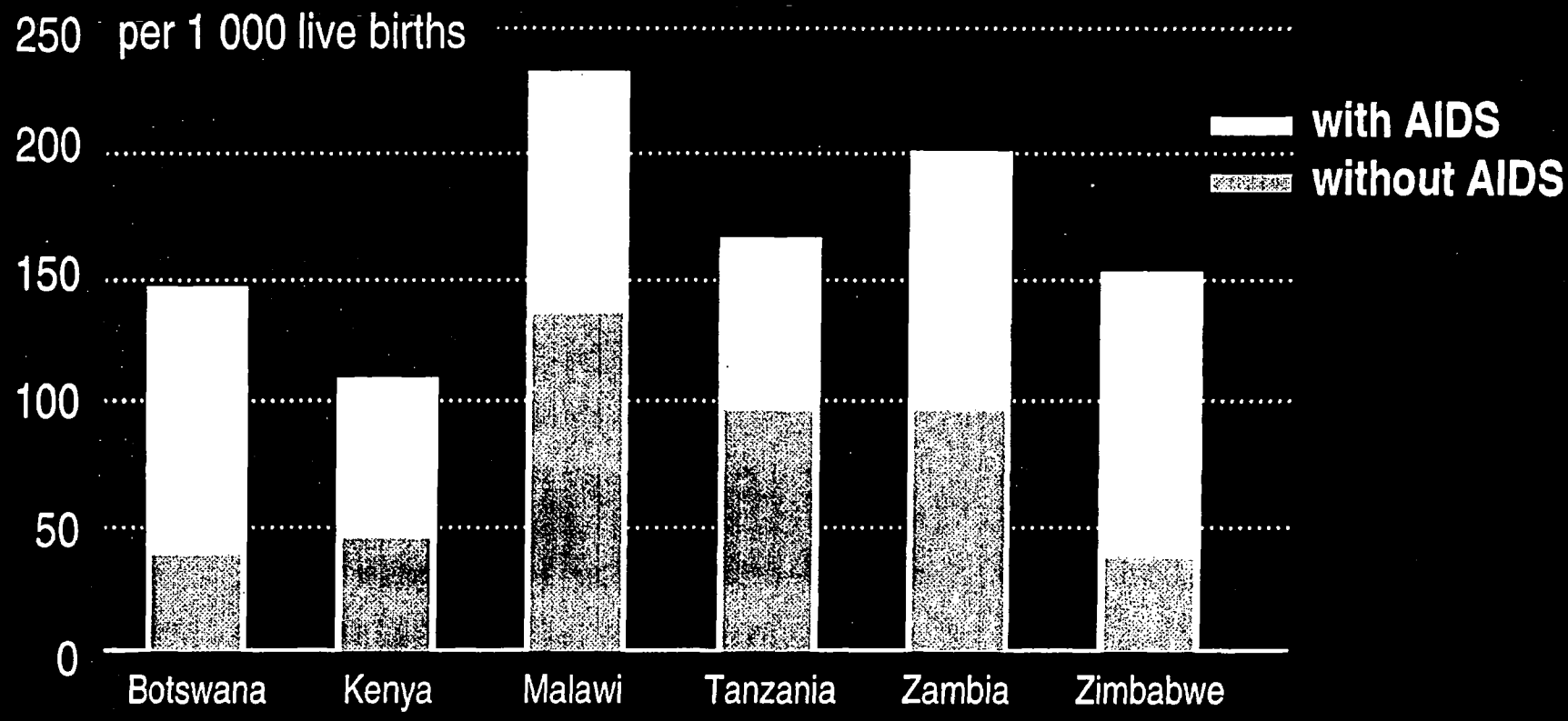
Total: 8.2 million

GE-98001/9 – 1 December 1997

* Orphans are defined as HIV-negative children having lost their mother or both parents due to AIDS

Global HIV AIDS and STD Surveillance | WHO

Estimated impact of AIDS on under-5 child mortality rates – *Selected African countries, 2010*

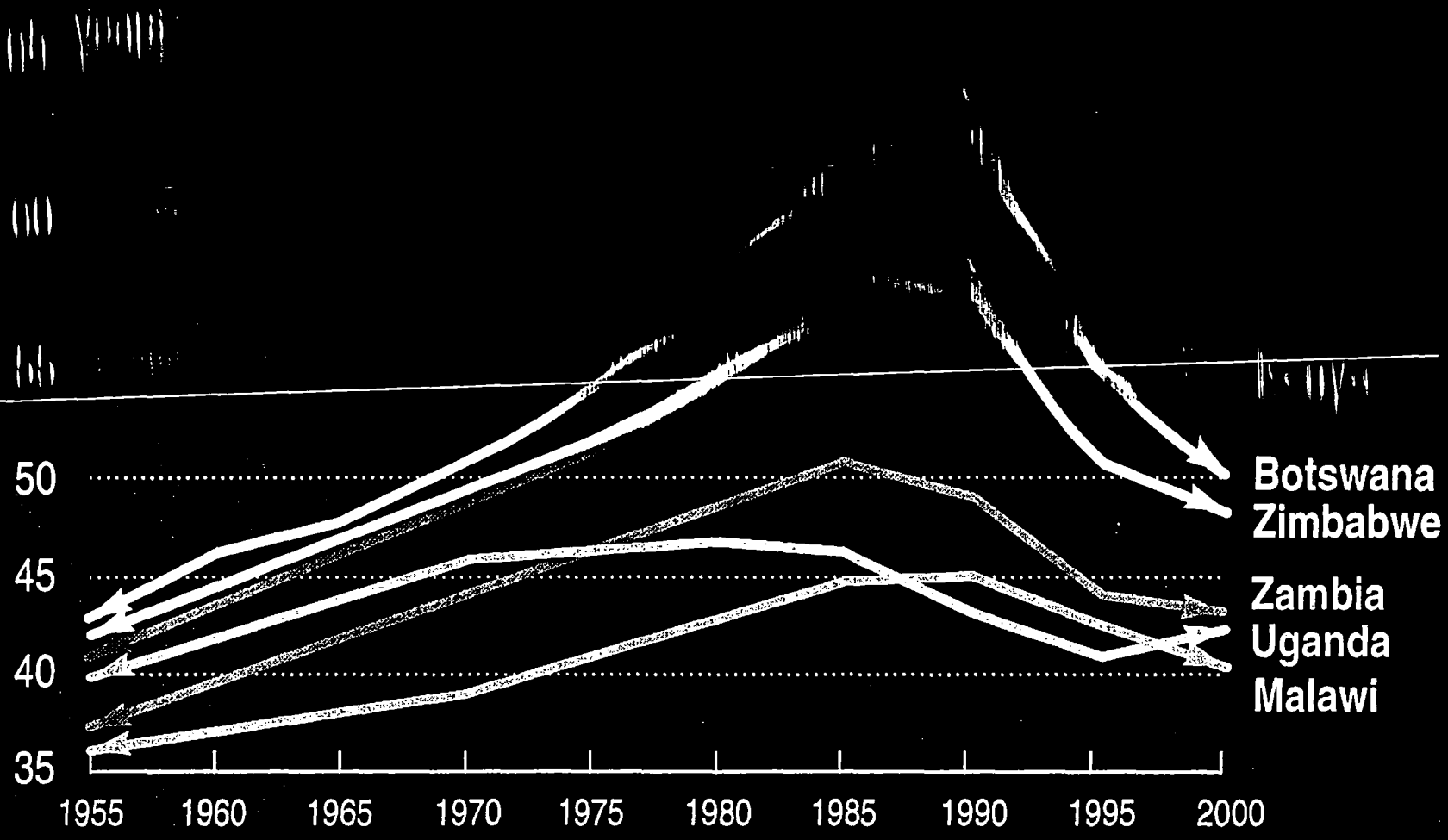


Source: *US Bureau of the Census*

GE-98001/15 – 1 December 1997

Global HIV AIDS and STD Surveillance WHO

Projected life ex[illegible]
Selected sub-Saharan countries



Source: World Population Prospects: The 1996 revision, *United Nations Population Division, 1996*

GE-98001/10 – 1 December 1997

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FACT SHEET

Joint United Nations Programme on HIV/AIDS

December 1996

UNAIDS

The HIV/AIDS epidemic continues to progress. Each day, over 8,500 people are newly infected with HIV, the virus that causes AIDS. UNAIDS estimates that over 22 million people are currently living with HIV/AIDS, 90% of whom live in the developing world.

Meeting the complex long-term challenge of HIV/AIDS calls for an expanded response. Direct health interventions and action to influence the immediate aspects of AIDS prevention and care must be pursued and intensified, while innovative action must be undertaken to address the broader context of the epidemic, including its socio-economic causes and consequences.

A major reform

In recognition of this concern, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was established in January 1996. UNAIDS is a co-sponsored programme that brings together the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank in a common effort against the epidemic. It is the first programme of its kind in the UN system: a small programme with a large outreach and the potential to lever significant resources and action through the creation of strategic partnerships.

The UNAIDS cosponsors bring to this joint endeavour complementary mandates and multisectoral expertise, ranging from education and socio-economic development to women's reproductive health. They are committed to joint planning and action, giving UNAIDS a "cooperative advantage" that translates into greater synergy and efficiency. Benefits include more effective advocacy, more effective use of UN system resources through the sharing of costs, and greater coherence in United Nations support to national AIDS programmes.

Mission of UNAIDS

As the main advocate for global action on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

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Guiding principles of UNAIDS

- *Long-term response:* HIV/AIDS requires a long-term sustainable response, including coping capacity on the part of individuals and communities. UNAIDS helps to strengthen national capacity for action ranging from prevention and care to impact alleviation.
- *Technical soundness:* Action in response to the HIV/AIDS epidemic must be not only expanded but also improved in quality through the identification and use of technically sound policies, strategies, tools and approaches.
- *Focus on vulnerability:* An effective response requires societal and structural change to reduce the vulnerability of women, young people, migrants, drug users, sexual and ethnic minorities and other population groups.
- *Support, not coercion:* A supportive social, political and legal environment helps individuals exercise their responsibilities to protect themselves and others from HIV infection.
- *Human rights:* People are entitled to enjoy all human rights without discrimination, including discrimination based on HIV infection status. These include the right to health, travel and privacy, the right to freedom from sexual violence and coercion, and the right to the information and means to prevent infection.
- *Participation and partnership:* A multisectoral response to HIV/AIDS can best be achieved through partnership.
- *National autonomy:* It is a national responsibility to design, implement and coordinate the response to HIV/AIDS at the country level. The role of external partners, including UNAIDS, is to support and build on national action.
- *Complementarity:* Rather than undertaking itself what can be or is already being done by others, UNAIDS attempts to facilitate these efforts and to fill gaps in action and research.

Global and local impact

At the global level, UNAIDS is the AIDS programme of the six cosponsors, carrying out the roles of policy development and research, technical support, advocacy, and coordination. At the same time, the six cosponsoring organizations integrate HIV/AIDS-related issues and UNAIDS policies and strategies into their ongoing work.

At the country level, UNAIDS can best be seen as the sum of AIDS-related activities carried out by its six cosponsors with the backing of UNAIDS technical guidance and resources. In countries where some or all of the cosponsors are present, their representatives meet regularly in a special "Theme Group" to jointly plan, programme and evaluate their AIDS-related activities.

In addition, UNAIDS has staff known as Country Programme Advisers posted in selected countries to support the Theme Groups on HIV/AIDS, to strengthen cooperation with national partners, and to provide technical support.

Important partners in national AIDS activities include governments (through both political leadership and the relevant ministries); community-based organizations; nongovernmental organizations (NGOs); the private sector; academic and research institutes; religious and other social and cultural institutions; and people living with HIV/AIDS.

Governance

UNAIDS is the first programme of the United Nations system to have NGO representation on its governing body. The Programme Coordinating Board (PCB) is comprised of representatives of 22

Member States of the UN system, (including both donor and recipient countries), of the six cosponsors, of NGOs, and of people living with HIV/AIDS.

Strategic areas

Country support: The overriding goal of UNAIDS at country level is to enhance national capabilities to mount an expanded, multisectoral response to HIV/AIDS. Priority is given to nationally determined needs, in particular those of developing countries and economies in transition.
International best practice: Garnering practical experience from around the world, UNAIDS identifies sound policies and strategies that have proven to be effective - what is known as "international best practice". These approaches are analysed and promoted with a view to their adaptation at country level.

The programme also supports research to develop new tools and innovative approaches for slowing the spread of HIV and improving the quality of life of people living with HIV/AIDS. Examples are vaccine development, vaginal microbicides for women, methods of reducing mother-to-child transmission of HIV, and improved methods for preventing and treating the common opportunistic infections in HIV-infected individuals.

Structure & staffing

UNAIDS has adopted a flat organizational structure, with as few layers of management as possible. The programme consists of four departments: Policy, Strategy and Research; Country Support; External Relations; and Programme Administration. A total of 162 posts have been budgeted: 52 professionals and 36 support staff at UNAIDS Geneva Headquarters, 45 Country Programme Advisers and 29 Inter-country Technical Advisers working at the country level. The working culture values partnership, team work and facilitation.

Funding

With its modest resource base of US $ 120 million for the 1996-97 biennium, UNAIDS is not a funding agency. It is a small programme that aims to increase its impact and outreach through strategic alliances with its cosponsors and other partners. UNAIDS cosponsors fund their own HIV/AIDS country-level programmes and activities. A further US $ 20 million is being raised for joint UNAIDS/cosponsor activities at the global and regional levels. Funds are received from traditional donor countries, but also from developing countries (e.g. China and Thailand) and the private sector. UNAIDS aims to increase the resources available to national AIDS programmes by supporting fund-raising activities at the national level and providing training in resource mobilization to its national partners.

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Joint United Nations Programme on HIV/AIDS

31 January 1997

UNAIDS IN ACTION 1996-1997

INTRODUCTION

The Joint United Nations Programme on HIV/AIDS (UNAIDS), established on 1 January 1996, is the leading advocate for global action on HIV/AIDS. It brings together six UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses of its six co-sponsoring organizations to the epidemic and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners -- governmental and NGO, business, scientific and lay -- to share knowledge, skills and best practice across boundaries.

Mobilizing an expansion of the response to AIDS is an important aspect of UNAIDS' work. An expanded response is one that focuses on reducing both risk-taking and societal vulnerability to HIV. In another key aspect of the expanded response, UNAIDS encourages communities, NGOs and governments to expand their partnerships for designing, funding, implementing and evaluating AIDS policies and programmes. Existing programmes also need to be expanded geographically and in terms of population coverage. Last, and very important, expanding the response to the epidemic means raising the level of resources mobilized in support of prevention and care so as to improve the sustainability of AIDS programmes.

Some examples of activities initiated by UNAIDS in its first year of existence are summarized below:

GLOBAL INITIATIVES

HIV Vaccine:

A vaccine is urgently needed to control the AIDS epidemic, especially in developing countries, where more than 90% of all new infections are occurring. Although AIDS vaccines are being tested in the US and Europe, it is important that these vaccines are also evaluated in developing country populations, who must be among the beneficiaries of

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any safe and effective vaccine as soon as it is developed. To facilitate this process, UNAIDS is monitoring the presence of different HIV subtypes in the world, helping the vaccine industry to produce vaccines against HIV subtypes present in developing countries. By strengthening the research infrastructure in selected developing countries, UNAIDS has made possible the initiation of HIV vaccine trials in Brazil and Thailand, and soon in Uganda.

Mother-to-child transmission of HIV

Some 3 million children born to HIV-infected women are estimated to have acquired HIV infection from their mothers during pregnancy. To date, 85% of these children have been in sub-Saharan Africa. Although studies in North America and Europe have shown that such transmission can be significantly reduced by anti-viral medication, such treatment regimens are too costly and too complicated for use in most developing country settings. Therefore, UNAIDS is conducting clinical trials in South Africa, Tanzania, and Uganda to evaluate the efficacy of shorter, less expensive and more feasible regimens that would be appropriate for preventing mother-to-child transmission of HIV in developing countries.

The female condom

In an effort to provide more options for preventing the spread of HIV, the virus that causes AIDS, the female condom was developed as a reversible, barrier method that can be used by women. A UNAIDS-supported study in Thailand shows that making this vaginal sheath available to women as an extra protective option leads to an increase in protected sex acts and hence increased protection against HIV transmission. UNAIDS has played a leading role in increasing access to female condoms in developing countries by negotiating a lower price for the public sector with the manufacturer, the Female Health Company, for sales in such countries.

Vaginal microbicides

All currently available methods for protecting women from the transmission of HIV require the cooperation of their male partner, which is not always forthcoming. Therefore, a key priority is to develop women-controlled prevention methods which protect both partners. UNAIDS is conducting field trials of such a method in Europe, Africa and Asia.

Alliance with Rotary International

Rotary International and UNAIDS have signed an agreement to work together on AIDS education of young people who are at risk from the threat of HIV. The business and professional leaders who belong to Rotary Clubs are uniquely positioned to improve AIDS awareness thanks to their leading positions in their communities.

Children in a world of HIV/AIDS

UNAIDS, UNICEF and several non-governmental organizations are working on an action plan to identify key partners and successful approaches for preventing and reducing the impact of the epidemic on the lives of children including those already or soon to be orphaned because of AIDS.

Focus on military personnel

Working closely with the Civil-Military Alliance to Combat HIV and AIDS, as well as with a number of the cosponsors (World Bank, UNDP and UNICEF in particular), UNAIDS has supported efforts to expand prevention programmes in the armed forces through individual country visits, training programmes and regional seminars for military leaders in Africa, Asia and Latin America. UNAIDS will co-sponsor with the UN Department of Peace-keeping Operations (DPKO) the "First United Nations International Conference on Medical Support for Peace-Keeping Operations" to be held in March 1997.

Improved access to drugs

UNAIDS works together with WHO as well as major bilateral donors, NGO suppliers and pharmaceutical companies to improve the access to HIV/AIDS related medications in developing countries. Furthermore, it negotiates partnerships at the country level to improve access of local communities to needed medication and improve the rational use of drugs.

WORKING WITH COUNTRIES

UNAIDS in Eastern Europe

As the epidemic in Eastern Europe increases, so does UNAIDS' involvement in that region. In **Russia**, information materials and activities for users of injection drugs are being developed, as is a school education programme in collaboration with UNESCO. In **Kazakhstan**, a joint UNDP, WHO and UNAIDS project on tuberculosis and HIV prevention is being created. In **Ukraine**, UNAIDS (in cooperation with UNDP) assists the government in planning an information and education campaign for injecting drug users.

UNAIDS in Asia

In **China**, UNAIDS has been instrumental in facilitating the involvement of key new partners such as the Ministry of Railways and the China Family Planning Association and, together with the National AIDS Programme, in getting the State Council to advocate for greater participation of all sectors in AIDS prevention. In **Laos**, UNAIDS is working closely with national and international NGOs, notably in the areas of care and support, promoting the sharing and learning of experiences from neighboring **Thailand**. Similarly, in **Nepal**, UNAIDS is strengthening collaboration between NGOs and the government to increase AIDS awareness and to create an appropriate response to the epidemic, while in **Pakistan**, UNAIDS has facilitated greater involvement in HIV-related work of over twenty NGOs from the provinces, including religious organizations. In **Viet Nam**, the provision of seed funds by UNAIDS has enabled the United Nations International Drug Control Programme (UNDCP) to mobilize the resources needed for a major project on drug use and HIV prevention. In addition, UNICEF and UNAIDS are working together on a major AIDS programme in the **Mekong region** with funding from the Netherlands Government and the Netherlands National UNICEF Committee. The project's aims are to expand community-level efforts in the areas of prevention, reproductive health education, and care for people with or affected by HIV/AIDS.

UNAIDS in Africa

UNAIDS coordinates the West Africa HIV/AIDS Initiative, involving 17 countries, which is sponsored by the World Bank and other international organizations. Actions of the Initiative focus on migration, mobility, sex work and the involvement of people living with HIV in **Burkina Faso, Cote d'Ivoire, Mali, Niger and Senegal.** The Initiative will assess the situation in key frontier market towns and urban areas, develop community-based and regional HIV prevention and health care programmes, and facilitate regional research networks. UNAIDS is also developing guidelines for best practices in the corporate sector, drawing upon examples in **Tanzania, Uganda, Botswana, South Africa, Namibia and Zambia.** Furthermore, the national AIDS control programmes are supported through UNAIDS' efforts in information, education and communication.

UNAIDS in Latin America

UNAIDS coordinates SIDALAC (Regional Initiative for HIV/AIDS and other STDs prevention and control in Latin America and the Caribbean), a project which was begun by the World Bank. SIDALAC is mobilizing international and national efforts in the region to increase awareness, and to develop programmes to control the epidemic. In cooperation with the International Labor Office (ILO) and other partners, UNAIDS is focusing on analyzing and advocating workplace policies on HIV/AIDS. In addition, UNAIDS is working together with UNDCP on a project on injecting drug use and HIV/AIDS in **Argentina, Chile, Paraguay and Uruguay.**

The World Bank and HIV/AIDS

The World Bank provides more money to prevent and control the impact of HIV/AIDS than any other single funding source. By the end of 1996, the Bank committed nearly US$ 700 million to more than 60 projects on HIV/AIDS and other sexually-transmitted diseases around the world. Nearly half of these projects are in Sub-Saharan Africa, but the Bank is also focusing strongly on **China**, **India** and **Indonesia**. The Bank works closely together with UNAIDS in the planning and coordination of these projects.

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UNAIDS *Best Practice* Collection

UNAIDS is producing a collection of *best practice* materials on approximately 50 specific topics relevant to HIV/AIDS. The file on each such topic will normally contain the following:

1. ***UNAIDS Point of View***

   This 8-page advocacy document, aimed primarily at journalists and community leaders, lists key facts and figures, outlines the problems, myths and misconceptions about the topic, and summarizes what needs to be done.

2. ***UNAIDS Technical Update***

   This 8-page document, aimed primarily at managers of HIV/AIDS projects and programmes, provides a technical overview of the topic. It summarizes the main problems and challenges involved as well as the *best practice* responses, with short examples.

3. ***Best Practice case studies***

   These are detailed real-life examples of *best practice* in a specific region, country or community. They include case studies published outside UNAIDS.

4. ***Presentation graphics***

   This is a selection of up to 20 slides and/or overheads on the topic that can be used for speeches and other presentations. Each slide is accompanied by a list of the main messages illustrated ("talking points").

5. ***Key materials***

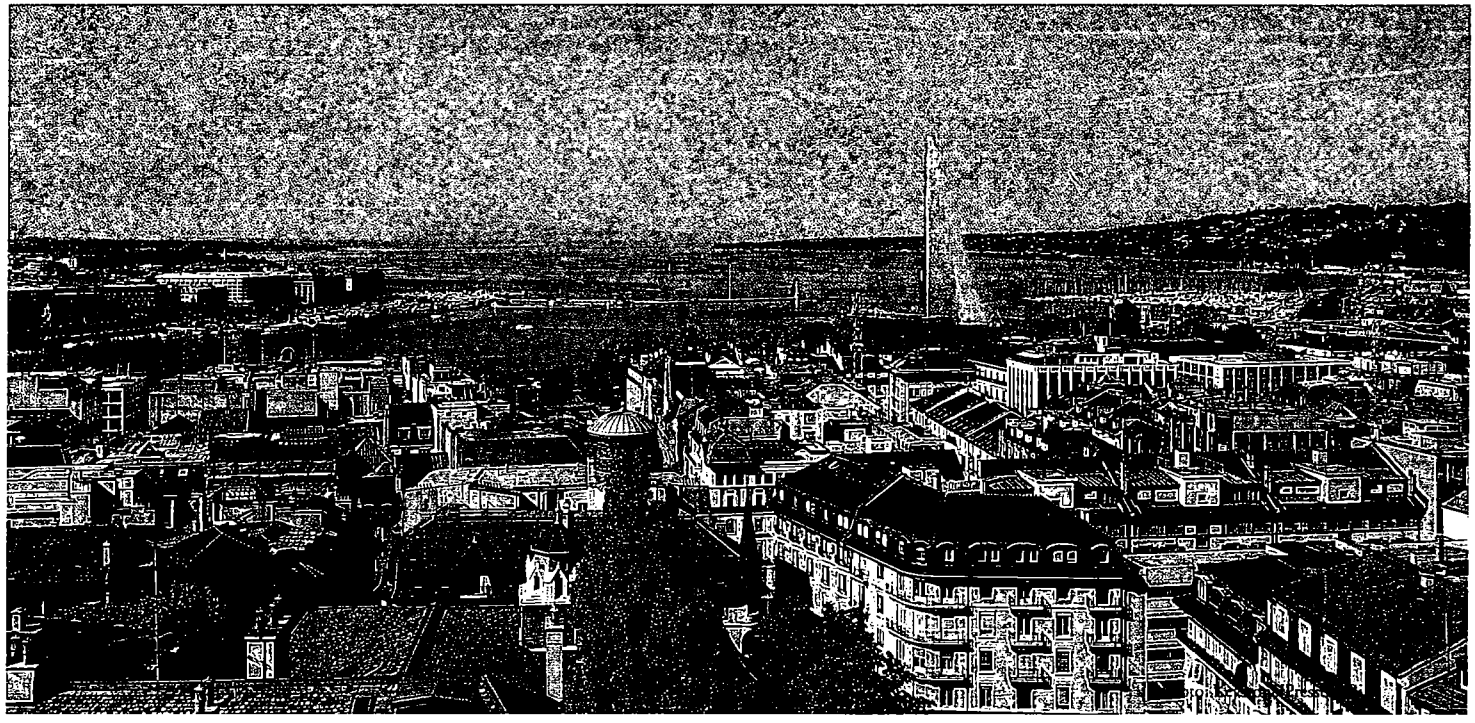
   This is a set of up to 10 written and audiovisual materials - reports, articles, books, CDs, videos, etc., authored outside or inside UNAIDS - that represents up-to-date authoritative thinking on the topic, including *best practice* in the field. UNAIDS policy statements and reviews are included here.

Each file has a *list of contents* showing all the components of the file, including lists of the key materials and presentation graphics.

UNAIDS Best Practice Collection:	Technical Staff Responsible
COMMUNITY MOBILIZATION, PLHAs, & NGOs	
Community Mobilization	Kaleeba
Persons Living with HIV/AIDS	Clark
Nongovernmental Organizations and Networks	Clark
CONDOMS/BARRIER METHODS	
Female Condoms	Saba
Male Condoms	Makinwa
COUNSELLING & HIV TESTING	
Counselling	Kallbala
HIV Testing	Kallbala
COUNTRY RESPONSES	
Theme Groups - UN System Action at the Country Level	Moodie
National Strategic Planning	Farza
Local-level Responses	Wernette
Cost Effectiveness Analysis	Bertozzi
DEVELOPMENT AND HIV/AIDS	
Impact on Children & Families	Connolly
Impact on Agriculture and Rural Households	Bertozzi
Sectoral Impact	unassigned
EPIDEMIOLOGY OF HIV/AIDS	
Determinants of Epidemic	Carael
Surveillance & Reporting	Schwartlander
Estimates & Projections	Schwartlander
GENDER AND HIV/AIDS	Mane
HEALTH PROMOTION, COMMUNICATION & EDUCATION	
Communications Programming	Makinwa
Schools	Baldo
The Workplace	Kingma
The Military	Kingma
Prisons	Kingma
Injecting Drug Use	Werasit
Men Who Have Sex With Men	Werasit/Makinwa
Refugees	Wernette
Sex Workers & Clients	Makinwa
Children and Youth	Connolly
Migration	Carael
Religion	Kingma
HEALTH SYSTEM & CARE	
Health System Personnel and Training	Anderson
Tuberculosis and HIV/AIDS	Perriens
Opportunistic Diseases	Perriens
Antiretroviral Therapy	Perriens
Access to Drugs	Mslska
Blood Safety	Emmanuel - WHO
Paediatric AIDS	Kalibala
HIV DIAGNOSTIC TESTS	Vercauteren - WHO
HUMAN RIGHTS, ETHICS AND LAW	Timberlake
MICROBICIDES	Perriens
MOTHER TO CHILD TRANSMISSION	Saba/de Vincenzi
REPRODUCTIVE HEALTH (Family Planning & Abortion)	Islam - WHO
RESOURCE MOBILIZATION	Llados
SEXUALLY TRANSMITTED DISEASES	Ndowa
UNAIDS	Cowal
VACCINE	Esparza
VIROLOGY, IMMUNOLOGY AND LABORATORY PRACTICES	Osmanov
TOTAL NUMBER OF BPCs: 47**	

**Additional areas are on hold and are not listed here.

12th World AIDS
Conference Geneva
June 28–July 3 1998



12th World AIDS Conference, Geneva 1998

Co-Sponsors

The Global Network of People Living with HIV/AIDS

The International AIDS Society

The International Council of AIDS Service Organisations

The International Community of Women Living with HIV/AIDS

The Joint United Nations Programme on HIV/AIDS

and

The Swiss Federal and Cantonal Governments

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