



Joint United Nations Programme on HIV/AIDS  
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Follow-up to the 2001  
United Nations General Assembly  
Special Session on HIV/AIDS

Progress Report  
on the Global Response to  
the HIV/AIDS Epidemic, 2003

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Executive Summary

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# **Executive Summary**

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**Progress Report  
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## Introduction

At the close of the groundbreaking United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, 189 Member States adopted the ***Declaration of Commitment on HIV/AIDS***. The Declaration of Commitment reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV/AIDS epidemic by 2015.

Recognizing the need for multisectoral action on a range of fronts, the Declaration of Commitment addresses global, regional and country-level responses to prevent new HIV infections, expand health-care access, and mitigate the epidemic's impact. Although it was governments that initially endorsed the Declaration of Commitment, the document's vision extends far beyond the governmental sector – to private industry and labour groups, faith-based organizations, NGOs and other civil society entities, including organizations of people living with HIV/AIDS.

Under the terms of the Declaration of Commitment, success in the fight against AIDS is measured by the achievement of concrete, time-bound targets. The Declaration calls for careful monitoring of progress in implementing the agreed-on commitments, requiring the United Nations Secretary-General to issue progress reports annually. These reports would identify problems and constraints and recommend action to accelerate realization of the Declaration's targets.

In keeping with these mandates, in 2002 the UNAIDS Secretariat collaborated with

UNAIDS Cosponsors and other partners to develop a series of core indicators to measure progress in implementing the Declaration of Commitment. Over the last year, the UNAIDS Monitoring and Evaluation Unit has worked with countries and other actors to collect data needed to establish both monitoring baselines for each indicator and mechanisms for collecting information on an ongoing basis.

The core indicators (see Appendix 1) are grouped into four broad categories:

- A series of global-level indicators is designed to measure ***global commitment and action*** with a focus on international spending, policies and advocacy efforts.
- Another set of indicators monitors ***national commitment and action*** by tracking domestic government spending on HIV/AIDS and by assessing country-level policy development and implementation using a 20-item National Composite Policy Index.
- ***National programme and behaviour*** indicators measure the percentage of eligible individuals who receive key services and the degree to which particular populations adopt safer behaviour to reduce the risk of HIV transmission.
- ***National impact*** indicators track the number of new infections among young people (aged 15-24) and infants born to HIV-infected mothers.

In order to make an assessment of the various national indicators, UNAIDS examined national reports submitted to UNAIDS upon the request of the UN Secretary-General to the 189 Member States. Of these States, 103 submitted national reports (see Appendix 2), including 29 from sub-Saharan Africa, 17 from Asia and the Pacific, 21 from Latin America and the Caribbean, 14 from Eastern Europe and Central Asia, 8 from North Africa and the Middle East, and 14 from high-income countries.

In the majority of cases, the National AIDS Committees or equivalent bodies oversaw compilation of the national report, and more than three-quarters included the input of three or more government ministries. In roughly two-thirds of country reports, there was involvement by civil society. Fifty-three per cent of the country reports also recorded the involvement of people living with HIV/AIDS.

Almost all of the countries completed the National Composite Policy Index questionnaire. Only 40% of the countries that submitted reports, however, supplied information relating to the national programme and behaviour indicators or to the national impact indicators.

An important limitation to the collection of these data is the uneven level of reporting between regions, with the highest proportion of responding countries per region coming from sub-Saharan Africa and the lowest level of reporting from countries in North Africa and the Middle East. Furthermore, some countries tended to provide more extensive information on the national programme and behaviour indicators, while others provided little or no

information in this area, making regional and country comparisons difficult.

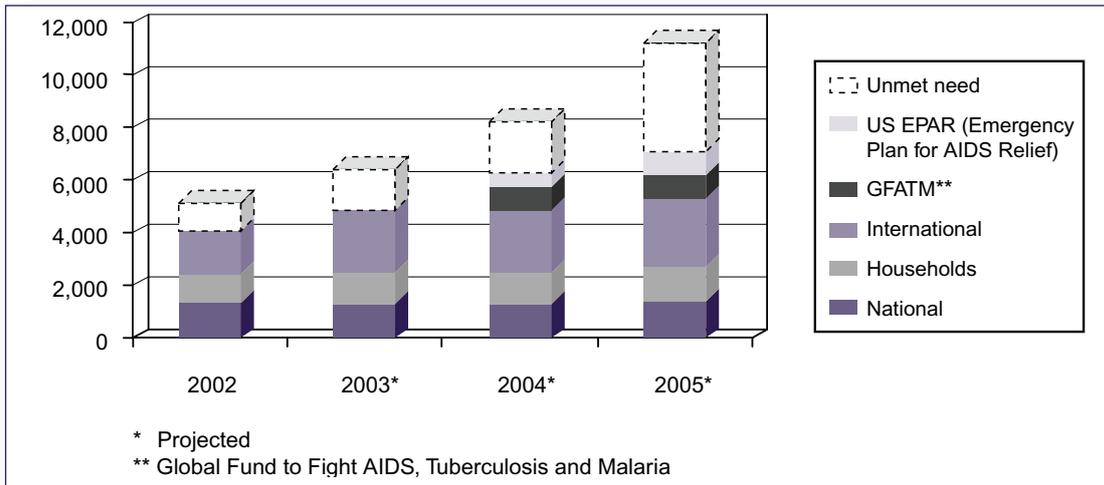
Country data presented in this report have been reviewed by UNAIDS and compared with other sources to consolidate validity. However, UNAIDS does not certify that the information contained in this document and derived from national reports is complete and correct.

## Key findings

### International and domestic spending

Spending on HIV/AIDS programmes in low- and middle-income countries will amount to nearly US\$4.7 billion in 2003 – a 20% increase over 2002 and a 500% increase over 1996. Increases have come both from international donors and from affected countries themselves. UNAIDS estimates that total domestic government spending on HIV/AIDS programmes in 2002 by 58 low- and middle-income countries equaled approximately US\$995 million – a doubling of the amount documented in 1999. Despite this important progress, however, current spending is less than one-half of what will be needed by 2005 and less than one-third of what will be needed by 2007 (see Figure 1).

**Figure 1: Estimated resource availability for HIV/AIDS 2002-2005**  
(US\$ disbursements in millions)



## Funding for research and development of vaccines and microbicides

UNAIDS/WHO estimates that public sector spending on HIV vaccine research and development amounted to US\$430 – US\$470 million in 2001, with the US National Institutes of Health accounting for 57-63% of global spending. Also, the US Government invested US\$62 million in microbicide research and development in 2001 – a figure expected to rise to US\$214 million in 2003.

## Advocacy and leadership

Monitoring of the media suggests that public awareness of HIV/AIDS is increasing in many parts of the world, including regions where the epidemic is now emerging as a serious problem, such as Eastern Europe and Central Asia. There is also evidence that advocacy

efforts are succeeding in many countries in motivating governments to adopt policy reforms to strengthen the response to the HIV epidemic. Nevertheless, monitoring indicates that senior political leaders in many countries, especially in countries where the HIV epidemic is low or concentrated, remain disengaged from the fight against the epidemic.

## National policy frameworks

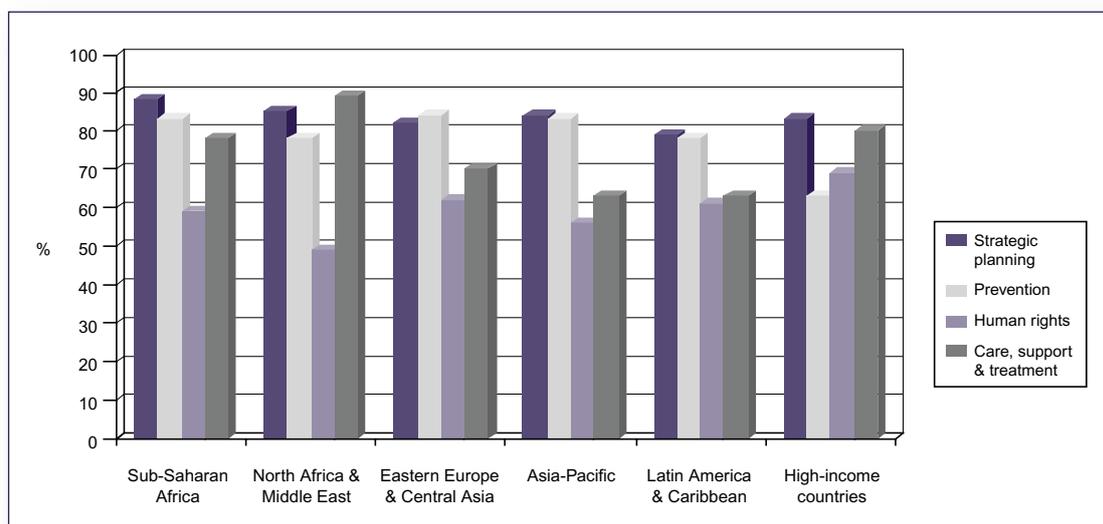
Recent years have seen a significant increase in the number of countries that have comprehensive, multisectoral national HIV/AIDS strategies, as well as government-led national bodies to coordinate the response to the epidemic (see Figure 2 for regional comparison by policy area). In 2003, virtually all heavily-affected countries have policy frameworks in place to mount a response to HIV/AIDS. However, numerous countries report that, notwithstanding the existence

of multisectoral strategies, the response to the epidemic often remains concentrated in the health sector, with limited collaboration among the full range of ministries that must become actively engaged in the fight against the epidemic.

## Weaknesses in national HIV/AIDS policies

Despite the important progress in developing national strategic frameworks for an effective response, numerous countries risk falling short of the Declaration of Commitment's 2003 policy targets due to critical weaknesses in national efforts. Of particular concern are the following:

- **HIV/AIDS discrimination.** Thirty-eight per cent of countries, including almost one-half of those in sub-Saharan Africa, have yet to adopt legislation to prevent discrimination against people living with HIV/AIDS.
- **Vulnerable populations.** Only 36% of countries have legal measures in place to prohibit discrimination against populations that are especially vulnerable to HIV/AIDS.
- **Cross-border migration.** Even though population migration often increases vulnerability to HIV/AIDS, less than one-half of countries have adopted strategies to promote effective HIV-prevention measures for cross-border migrants.
- **Addressing gender dimensions of the HIV epidemic.** The epidemic's burden on women and girls continues to grow. As of December 2002, women accounted for 50% of all people living with HIV/AIDS worldwide and for 60% in sub-Saharan Africa. Even though numerous and well-documented inequities contribute to the vulnerability of women and girls, nearly one-third of countries lack policies that ensure women's equal access to critical prevention and care services.
- **Access to medications.** On average, 80% of responding countries reported having a policy in place to ensure or improve access to HIV-related drugs. However, for the Asia-Pacific region, where more than 7 million people are currently living with HIV/AIDS, this proportion was lowest. In this region, over one-third of countries have not yet adopted policies to promote access to HIV-related medications, including antiretroviral drugs.
- **Mitigation of epidemic's social and economic impact.** More than 40% of countries with generalized epidemics (i.e., with an HIV prevalence rate of more than 1%) have yet to evaluate the socioeconomic impact of HIV/AIDS, impeding essential efforts to mitigate the epidemic's impact on society.

**Figure 2: National Composite Policy Index score by region and area**

This graph shows the proportion of responding countries in each region having in place national policies or strategies in the four areas mentioned above. Each area is composed of a set of 3-7 specific policy questions.

## Effectiveness of national policies

In addition to the findings of the National Composite Policy Index, the AIDS Program Effort Index was measured in 54 countries in 2003. This qualitative assessment tool suggests that Africa and Asia do relatively well on political support and policy formulation, and that all regions show evidence of improvement with respect to HIV prevention as compared to 2001. African countries are more likely to prioritize efforts to mitigate the epidemic's impact than countries in other regions, where the epidemic is less severe. The weakest areas of national efforts are resources, human rights and care. Almost all countries reported improvements in the availability of financial resources.

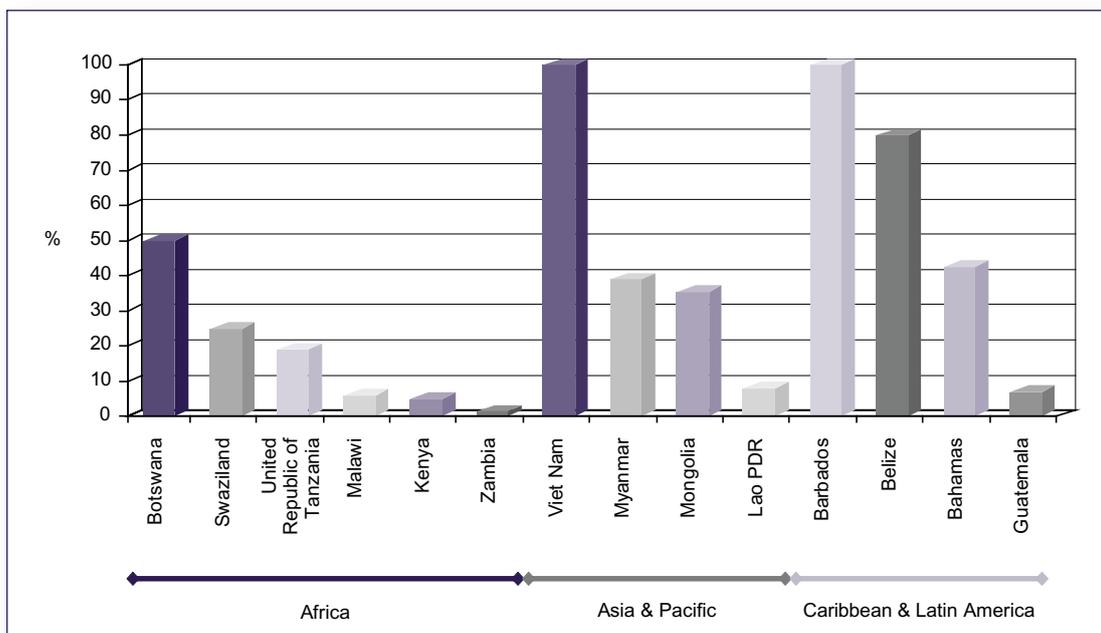
## Extremely low HIV-prevention coverage

While most countries have developed strategic frameworks for effective action, only a fraction of people at risk of HIV infection have access to basic prevention services.

### ■ *Life-skills-based education*

Of the 30 countries reporting on this indicator, only half are making efforts to incorporate a life-skills approach into their educational programmes (see Figure 3). With evidence that skills-based sexual and reproductive health education promotes healthy lifestyles and reduces risky behaviour, additional countries are in the process of integrating such an approach into their school curricula.

**Figure 3: Primary and secondary schools with trained teachers providing life-skills-based education**



#### ■ **Sexually transmitted infection management**

Because untreated sexually transmitted infections (STIs) dramatically increase the risk of HIV transmission, STI control is a fundamental element of effective HIV prevention. Yet, from the limited information received, only one in four countries in sub-Saharan Africa report that at least 50% of STI patients are appropriately diagnosed, counselled and treated.

#### ■ **Prevention of mother-to-child transmission**

Service coverage remains virtually non-existent in many heavily HIV/AIDS-affected countries. Apart from **Botswana**, where 34% of pregnant women were able to access these

services, by the end of 2002, coverage was extremely low (less than 1%) in the countries hit hardest by HIV/AIDS.

#### ■ **Service coverage for injecting drug users**

The limited information obtained from countries where injecting drug use is an established mode of HIV transmission reveals that fewer than 5% of injecting drug users receive the recommended prevention services. Perhaps as a result of such limited access to prevention services, a majority of drug users have yet to adopt behaviours that reduce the risk of HIV transmission.

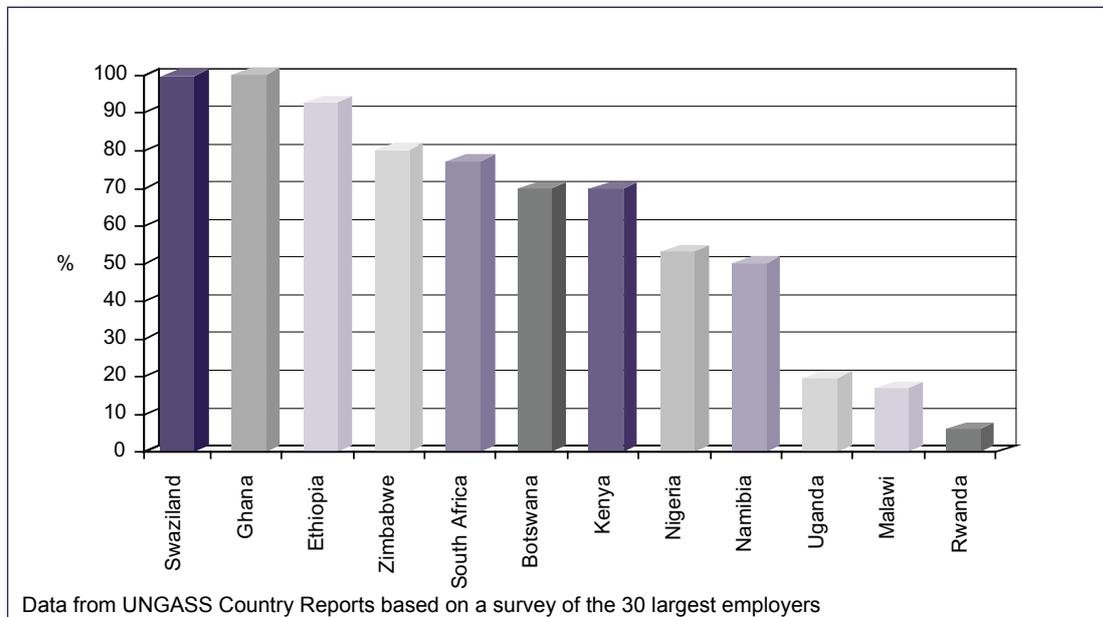
## HIV/AIDS in the workplace

While the engagement of the business community in the response to the epidemic has been significantly strengthened over the last year, most transnational companies do not regard HIV/AIDS as a serious corporate problem. Only 20% have adopted the comprehensive workplace policies envisioned by the Declaration of Commitment. Integration of HIV/AIDS into workplace policies among nongovernmental organizations is also uneven. Although UN agencies are more likely than NGOs to provide HIV treatments and other services

to HIV-positive staff, additional efforts are needed to implement recommended practices in UN work settings.

At national level, according to 26 responding countries, the percentage of large public and private companies with comprehensive HIV/AIDS workplace policies is very uneven and does not seem to be associated with the severity of the HIV epidemic (see Figure 4). Some countries, such as *Ethiopia* and *Ghana*, have put in place a strong HIV-prevention policy; *Botswana* has also integrated a strong care component into its workplace policy.

**Figure 4: Percentage of large companies with HIV/AIDS policies**



## Knowledge and sexual behaviour among youth

### Basic HIV/AIDS knowledge

Accurate information about HIV/AIDS is a prerequisite to effective HIV prevention. However, in 31 of 38 countries in which young women (aged 15-24) were surveyed on basic HIV/AIDS facts in 2000, less than 30% could accurately answer a set of standard questions on HIV transmission.

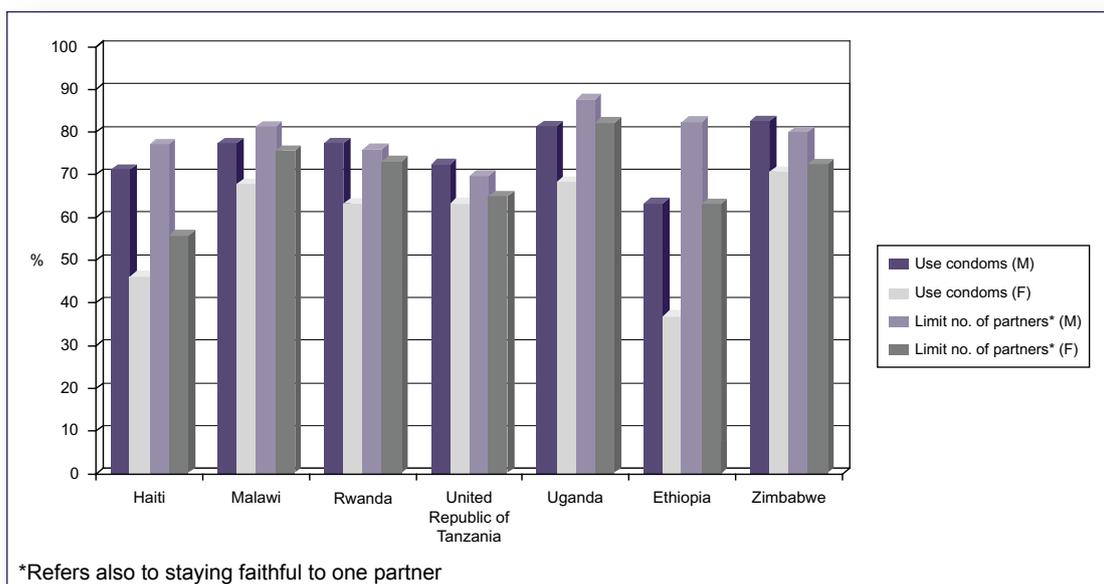
While comprehensive knowledge on HIV/AIDS was found to be low, percentages were higher for some individual questions and, more specifically, for those related to the following prevention methods: condom use, limiting the number of partners and being faithful to one uninfected partner (see Figure 5). Also, as highlighted in the graph below, HIV/AIDS-

related knowledge is consistently lower for young women than it is for young men.

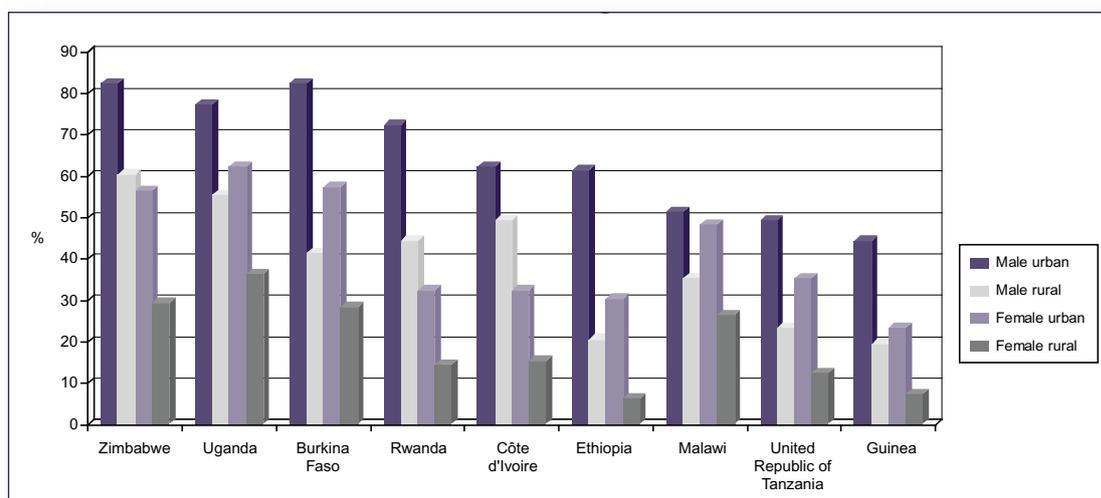
### Risk-reduction behaviour among young people

Survey results indicate that condom use with non-regular partners is higher in urban than rural areas and among young men than young women (see Figure 6). Young men, however, are more likely to report having had higher-risk sex in the prior year. Data also suggest that condom use varies considerably between countries, with scores for men ranging from as low as 30% to as high as 88% in sub-Saharan Africa. Between 15% and 20% of young people report having had sexual intercourse before the age of 15, with young women reporting an earlier median onset of sexual activity than young men.

**Figure 5: Percentage of young people (aged 15-24) who correctly identify two methods to avoid HIV infection**



**Figure 6: Condom use in last high-risk sexual encounter, men and women aged 15-24**



### Extremely low antiretroviral therapy coverage

While an estimated 5–6 million people currently need antiretroviral therapy (ART) in low- and middle-income countries, only 300,000 people in these regions were obtaining such medications as of December 2002. Although coverage remains low in sub-Saharan Africa, some countries, such as Botswana, Cameroon, Nigeria and Uganda, have made serious efforts to increase ART coverage through both the public and private sectors. Caribbean countries that provided information to UNAIDS report coverage of less than 1%. In Asia, where more than 7 million people are living with HIV/AIDS, no country has exceeded 5% ART coverage.

### Children orphaned or made vulnerable by AIDS

Thirty-nine per cent of countries with generalized HIV epidemics have no national policy in place to provide essential support to children orphaned or made vulnerable by HIV/AIDS. While four countries are in the process of developing such policies, one-quarter of countries with generalized epidemics reportedly have no plans at present to develop such strategies. With the number of children orphaned by AIDS projected to rise to at least 25 million by 2010, there is an urgent global need to develop and implement strategies to promote education for vulnerable children, provide critical psychosocial support, and ensure that children are protected from violence, discrimination and abuse. However, data on orphan school attendance in

sub-Saharan Africa suggest strong commitment on the part of some countries to assist vulnerable children: the ratio of current school attendance among orphans to that among non-orphans is almost 1:1 in more than half of the countries surveyed.

### HIV prevalence among youth, high-risk groups, and newborns

Country data indicate that the HIV epidemic continues to grow in all parts of the world, with sub-Saharan Africa remaining the hardest-hit region.

The epidemic remains most severe in Southern Africa, with extremely high HIV prevalence rates among pregnant women aged 15-24 reported in a number of countries, such as **Swaziland** (39%), **Botswana** (32%), **South Africa** (24%), **Kenya** (22%), **Namibia** (18%), **Zimbabwe** (18%) and **Malawi** (18%). In East Africa, prevalence in this population continues to decline in **Uganda**—from 30% in the early 1990s to 9% in 2002. In West and Central Africa, national prevalence rates remain relatively low, although there is evidence of recent HIV spread in countries such as **Cameroon** (12%).

The epidemic in Latin America and the Caribbean is well established. A total of 12 countries in the region have an *estimated* HIV prevalence of 1% or more among pregnant women. In other regions, national prevalence is relatively low, as the epidemic is mostly concentrated in specific populations. Exceptions to this rule include **Cambodia**, **Djibouti**, **Myanmar** and **Thailand**, where rates among pregnant women exceed 1%.

Among high-risk groups, numerous countries report concentrated epidemics. In Asia, HIV prevalence among IDUs is extremely high in certain parts of **China** (40%), **India** (68%), **Indonesia** (50%), **Myanmar** (70%), **Nepal** (50%), **Thailand** (85%) and **Viet Nam** (80%).

Eastern Europe and Central Asia continue to experience the fastest-growing epidemic in the world, mainly localized among injecting drug users. The **Russian Federation** remains at the forefront of the epidemic with an HIV prevalence among IDUs reaching almost 60% in some areas. However, many other countries in this region are now experiencing rapidly emerging epidemics.

With extremely low coverage for programmes to prevent mother-to-child transmission, rates of HIV transmission to newborns remain high in countries with generalized epidemics. Of the 17 countries in sub-Saharan Africa reporting on PMTCT, 12 have almost no ARV prophylaxis programme, with HIV prevalence among newborns reaching 25%.

### Monitoring and evaluation

Three-quarters of countries reported that monitoring and evaluation of national activities remained a major challenge. Countries frequently cited their limited capacity for monitoring and evaluation as impeding their ability to provide information relevant to the national indicators. Only 43% of countries reported having a national monitoring and evaluation plan and only 24% reported having a specific national budget to carry out these activities.

## Reaching the Declaration of Commitment targets: challenges ahead

In reporting on progress in implementing the Declaration of Commitment, 103 responding countries identified numerous barriers to a more effective and comprehensive response to the HIV epidemic. The following four challenges to reaching the UNGASS targets were among the most commonly reported by countries:

- ***Insufficient financial resources to implement and scale up interventions***
- ***Lack of human resources and technical capacity in many areas of HIV programming, especially at local level***
- ***Stigma and discrimination***
- ***Weak monitoring and evaluation systems***

In addition, countries identified a number of other key barriers, some of which are systemic problems that are seriously hampering efforts to turn the tide of the epidemic. In sub-Saharan Africa, poverty, conflict and famine are increasing vulnerability and mitigating societies' ability to cope with the burden placed on them by HIV/AIDS, which is, in turn, exacerbating poverty and reversing development gains. Malawi, in acknowledgement of the cyclical and deadly interplay between chronic poverty, famine and HIV/AIDS, highlighted the challenge of promoting a culture of hope and positive living within this environment. It is widely recognized that new approaches are required to integrate

HIV/AIDS into humanitarian responses and key macroeconomic plans.

One in five countries noted that greater political engagement, leadership, social mobilization and partnership development are required to create the right environment to strengthen the fight against HIV/AIDS. Several countries, such as the Philippines, recognized the need to further mainstream HIV/AIDS into existing development programmes and government departments. One in three countries stated that greater coordination among different actors was needed, as well as formalized mechanisms to facilitate the sharing of best practices, mapping-out of roles and responsibilities and coordination of activities. Haiti, for example, recommended the establishment of organized forums of discussion to ensure partnership and dialogue between government and other sectors of society.

The challenges faced by countries remain ever present and unconstrained by geography. Even in high-income countries, where many gains were made in the fight against the epidemic, it has been documented that complacency to HIV has taken root in some societies, new vulnerable groups have emerged, and HIV prevalence rates are on the rise once again, prompting the need for innovative approaches to prevention.

Increases in vigilance, commitment and effort are thus needed to overcome these surmountable challenges, in order to reach the targets established in the Declaration of Commitment and the Millennium Development Goal of reversing the epidemic by 2015.

## Conclusions and recommendations

Having assessed progress to date in implementing the Declaration of Commitment, it is apparent that many countries risk falling short of the targets agreed to at the UN Special Session held in June 2001. However, the aims of the UN Declaration of Commitment can still be achieved. Immediate implementation of a comprehensive set of interventions could prevent 29 million new infections by 2010 and reverse the AIDS epidemic. Therefore, with the necessary commitment and action, the goal of reducing global prevalence levels by 25% by 2010 can be met. Without this expanded response, UNAIDS estimates that there will be 45 million new HIV infections by 2010.

Achieving the rapid scale-up in prevention-and-care interventions needed to reach this target will require a substantial increase in resources. The cost of expanded prevention, care, treatment and support activities is estimated to be at least US\$10.5 billion annually by 2005. In addition to this, the human capacity to deliver the necessary interventions and an improved infrastructure will need to be developed to meet the demand of expanded services. To meet these challenges, financial and political commitment will be necessary. The costs of scaling up prevention programmes are high but any delay will be even more costly.

UNAIDS therefore urges countries to take the following steps to ensure that the Declaration of Commitment targets are reached:

1. With support from the highest levels of government, countries should immediately assess their national policies, in comparison with the Declaration's provisions for 2003, and accelerate the development and implementation of **policies** needed to bring countries into compliance with the Declaration.
2. Although **political commitment** to the HIV/AIDS cause has significantly increased in recent years, too few political leaders are aggressively leading national efforts to respond to the epidemic. Assertive political leadership is especially important in Asia and the Pacific, and in Eastern Europe, where effective action is immediately needed to prevent a major expansion of HIV/AIDS.
3. Although the response to HIV/AIDS now extends well beyond health ministries in most countries, **engagement of important constituencies** remains inadequate. Countries should make it a priority to involve people living with HIV/AIDS, in particular, and civil society in general. All companies doing business in low- and middle-income countries should adopt the *ILO Code of Practice on HIV/AIDS and the World of Work*.
4. Momentum for obtaining increased **funding** for HIV/AIDS efforts in low- and middle-income countries must accelerate. To finance the global response needed to ensure achievement of the Declaration's future commitments, annual funding for HIV/AIDS programmes must increase two-fold over current levels by 2005, and three-fold by 2007.

- In addition to financial support for HIV/AIDS programmes, support is urgently required for strategies to build the **institutional capacity** that countries will need to sustain an effective response over the long term. In scaling up financial support for HIV/AIDS efforts, donors should focus particularly on technology transfer, development of technical capacity at country level, and other mechanisms to build long-term national capacity to support an effective response, especially in the areas of resource management and monitoring and evaluation.
5. Countries urgently need to ensure that a comprehensive package of **HIV-prevention services** is implemented and coverage expanded to guarantee access to these services for highly vulnerable groups, including young girls and boys.
  6. All countries should develop and implement national strategies to ensure the delivery of comprehensive **care and treatment** to people living with HIV/AIDS. The global community is committed to the provision of ART to 3 million people living with HIV/AIDS by 2005, which would represent about 30–40% of those who would need treatment in that year (as compared with the 5% of those in need currently receiving treatment).
  7. Implementation and enforcement of measures to reduce HIV/AIDS **stigma and discrimination** are urgently needed to ensure that new resources and growing political commitment on HIV/AIDS are effectively translated into programmes that can halt and eventually reverse the global epidemic. As envisioned in the Declaration, countries should adopt, implement and enforce national policies that prevent discrimination against, and ensure the full enjoyment of human rights by, highly vulnerable populations.
  8. All countries with generalized epidemics should develop and implement national strategies to address the growing number of **children orphaned** and made vulnerable by the epidemic.
  9. In addition to enacting policies to ensure equal access to services, countries should assess and address laws, policies and practices that increase the vulnerability of **women and girls**. Donors should focus particularly on programmes to enhance the economic power of women, national governments should promote the necessary legal reforms, and international actors should collaborate to eradicate sexual trafficking and other practices that increase the vulnerability of women and girls to HIV/AIDS.
  10. Urgent international action is needed to respond to crisis conditions that exist in the countries of **Southern and Eastern Africa**. In particular, the loss of institutional capacity in key national sectors calls for the engagement of international sectoral partners to assist these countries in addressing the epidemic's growing impact. A broad array of donors and stakeholders should work together to help countries bring essential HIV/AIDS programmes to scale.

## Appendix 1. Core Indicators for implementation of the Declaration of Commitment

Indicators	Reporting schedule	Method of data collection
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### *Global commitment and action*

1. Amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition	Annual	Survey on financial resource flows
2. Amount of public funds for research and development of vaccines and microbicides	Annual	Survey on financial resource flows
3. Percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes	Annual	Desk review
4. Percentage of international organizations that have HIV/AIDS workplace policies and programmes	Annual	Desk review
5. Assessment of HIV/AIDS advocacy efforts	Annual	Qualitative desk assessment(s)

### *National commitment and action*

1. Amount of national funds spent by governments on HIV/AIDS	Biennial	Survey on financial resource flows
2. National Composite Policy Index	Biennial	Country assessment questionnaire

Indicators	Reporting schedule	Method of data collection
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### *National programme and behaviour*

1. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	Biennial	School-based survey and education programme review
2. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes	Biennial	Workplace survey
3. Percentage of patients with STIs at health-care facilities who are appropriately diagnosed, treated and counselled	Biennial	Health facility survey
4. Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	Biennial	Programme monitoring and estimates
5. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy	Biennial	Programme monitoring and estimates
6. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV*	Biennial	Special survey
7. Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission** ( <b>Target: 90% by 2005; 95% by 2010</b> )	Every 4-5 years	Population-based survey
8. Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner**	Every 4-5 years	Population-based survey
9. Ratio of current school attendance among orphans to that of non-orphans, aged 10-14**	Every 4-5 years	Population-based survey

### *Impact*

1. Percentage of young people aged 15-24 who are HIV-infected** <b>(Target: 25% in most affected countries by 2005 25% reduction globally by 2010)</b>	Biennial	HIV sentinel surveillance
2. Percentage of HIV-infected infants born to HIV-infected mothers <b>(Target: 20% reduction by 2005; 50% reduction by 2010)</b>	Biennial	Estimate based on programme coverage

\*Applicable to countries where injecting drug use is an established mode of HIV transmission

\*\*Millennium Development Goal indicators

## Appendix 2. List of countries that provided country reports on the implementation of the Declaration of Commitment\*

### Asia & Pacific

Bangladesh  
Cambodia  
China  
Cook Islands  
Fiji  
India  
Indonesia  
Lao PDR  
Mongolia  
Myanmar  
Nepal  
Pakistan  
Papua New Guinea  
Philippines  
Sri Lanka  
Thailand  
Viet Nam

### Eastern Europe & Central Asia

Armenia  
Belarus  
Czech Republic  
Hungary  
Kazakhstan  
Kyrgyz Republic  
Lithuania  
Poland  
Republic of Moldova  
Romania  
Russian Federation  
Tajikistan  
Ukraine  
Uzbekistan

### High-income countries

Australia  
Canada  
Finland  
France  
Germany  
Ireland  
Luxembourg  
Macedonia  
Malta  
Netherlands  
Portugal  
Serbia and Montenegro  
Spain  
Sweden

### Latin America & Caribbean

Antigua  
Argentina  
Barbados  
Belize  
Brazil  
Chile  
Colombia  
Dominican Republic  
El Salvador  
Guatemala  
Guyana  
Haiti  
Honduras  
Jamaica  
Mexico  
Nicaragua  
Paraguay  
Peru  
St Kitts & Nevis  
Suriname  
Uruguay

**North Africa & Middle East**

Jordan  
Lebanon  
Morocco  
Oman  
Qatar  
Saudi Arabia  
Syria  
Turkey

**Sub-Saharan Africa**

Benin  
Botswana  
Burkina Faso  
Burundi  
Cameroon  
Cape Verde  
Comoros  
Côte d'Ivoire  
Dem. Republic of the Congo  
Ethiopia  
Ghana  
Kenya  
Lesotho  
Madagascar  
Malawi  
Mauritius  
Mozambique  
Namibia  
Nigeria  
Rwanda  
Seychelles  
Sierra Leone  
South Africa  
Swaziland  
Togo  
Uganda  
United Rep. of Tanzania  
Zambia  
Zimbabwe

\* Received before 15 July 2003.



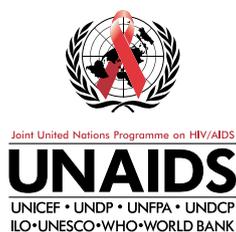
The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together eight UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International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

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

Produced with environment-friendly materials

Based on the mandates of the Declaration of Commitment, the UNAIDS Secretariat and Cosponsors collaboratively developed a series of global, regional and national indicators to measure the global community's progress in reaching the Declaration's targets in line with the Millennium Development Goals.

This summary of the 2003 Progress Report presents major findings and recommendations relating to the first use of these indicators by over 100 countries. The full report (*Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003: follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS*) represents the most comprehensive assessment to date of the state of global, regional and national responses on the broad range of challenges posed by HIV/AIDS. It describes, for example, the progress made in setting an enabling policy environment at national level as well as encouraging progress in resource mobilization. It also highlights the unacceptably low availability of antiretrovirals, and the inadequacy of HIV-prevention interventions (such as access to voluntary HIV testing and counselling and services to prevent mother-to-child transmission of the virus), as well as many countries' lack of legal protection to prohibit discrimination against vulnerable populations.



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