



PRESS RELEASE

UN Secretary-General outlines new recommendations to reach 2015 goals for AIDS response

In lead-up to June High Level Meeting, progress report presents overview of efforts needed to help countries achieve universal access to HIV services and zero new HIV infections, discrimination and AIDS-related deaths

NAIROBI, 31 March 2011—Thirty years into the AIDS epidemic, investments in the AIDS response are yielding results, according to a new report released today by United Nations Secretary-General Ban Ki-moon. Titled *Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths*, the report highlights that the global rate of new HIV infections is declining, treatment access is expanding and the world has made significant strides in reducing HIV transmission from mother to child.

Between 2001 and 2009, the rate of new HIV infections in 33 countries—including 22 in sub-Saharan Africa—fell by at least 25%. By the end of 2010, more than 6 million people were on antiretroviral treatment in low- and middle-income countries. And for the first time, in 2009, global coverage of services to prevent mother-to-child transmission of HIV exceeded 50%.

But despite the recent achievements, the report underscores that the gains are fragile. For every person who starts antiretroviral treatment, two people become newly infected with HIV. Every day 7 000 people are newly infected, including 1 000 children. Weak national infrastructures, financing shortfalls and discrimination against vulnerable populations are among the factors that continue to impede access to HIV prevention, treatment, care and support services.

The Secretary-General's report, based on data submitted by 182 countries, provides five key recommendations that will be reviewed by global leaders at a UN General Assembly High Level Meeting on AIDS, 8–10 June 2011.

“World leaders have a unique opportunity at this critical moment to evaluate achievements and gaps in the global AIDS response,” said Secretary-General Ban Ki-moon at the press briefing in the Kenyan capital. “We must take bold decisions that will dramatically transform the AIDS response and help us move towards an HIV-free generation.”

“Thirty years into the epidemic, it is imperative for us to re-energise the response today for success in the years ahead,” said UNAIDS Executive Director Michel Sidibé, who joined Mr Ban for the launch of the report. “Gains in HIV prevention and antiretroviral treatment are significant, but we need to do more to stop people from becoming infected—an HIV prevention revolution is needed now more than ever.”

Rebecca Auma Awiti, a mother living with HIV and field coordinator with the non-governmental organization Women Fighting AIDS in Kenya told her story at the press conference. “Thanks to the universal access movement, my three children were born HIV-free and I am able to see them grow up because of treatment access,” she said.

Mobilizing for impact

In the report there are five recommendations made by the UN Secretary-General to strengthen the AIDS response:

- Harness the energy of young people for an HIV prevention revolution;
- Revitalize the push towards achieving universal access to HIV prevention, treatment, care and support by 2015;
- Work with countries to make HIV programmes more cost effective, efficient and sustainable;
- Promote the health, human rights and dignity of women and girls; and
- Ensure mutual accountability in the AIDS response to translate commitments into action.

The Secretary-General calls upon all stakeholders to support the recommendations in the report and use them to work towards realizing six global targets:

- Reduce by 50% the sexual transmission of HIV—including among key populations, such as young people, men who have sex with men, in the context of sex work; and prevent all new HIV infections as a result of injecting drug use;
- Eliminate HIV transmission from mother to child;
- Reduce by 50% tuberculosis deaths in people living with HIV;
- Ensure HIV treatment for 13 million people;
- Reduce by 50% the number of countries with HIV-related restrictions on entry, stay and residence; and
- Ensure equal access to education for children orphaned and made vulnerable by AIDS.

As international funding for HIV assistance declined for the first time in 2009, the report encourages countries to prioritize funding for HIV programmes, including low- and middle-income countries that have the ability to cover their own HIV-related costs. It also stresses the importance of shared responsibility and accountability to ensure the AIDS response has sufficient resources for the coming years.

The report and more information about the High Level Meeting on AIDS can be found online at: unaids.org/en/aboutunaids/unitednationsdeclarationsandgoals/2011highlevelmeetingonaids/

Contacts

UNAIDS Geneva | Sophie Barton-Knott | +41 22 791 1697 | bartonknotts@unaids.org

UNAIDS Nairobi | Saira Stewart | +41 79 467 2013 | stewarts@unaids.org

UNAIDS Nairobi | Esther Gathiri-Kimotho | +254 20 762 6718 | gathirikimothoe@unaids.org

UN Department of Public Information New York | Vikram Sura | +1 212 963 8274 | sura@un.org

UN Department of Public Information New York | Pragati Pascale | +1 212 963 6870 | pascale@un.org



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S-26/2. Declaration of Commitment on HIV/AIDS

The General Assembly

Adopts the Declaration of Commitment on the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) annexed to the present resolution.

8th plenary meeting
27 June 2001

Annex

Declaration of Commitment on HIV/AIDS

“Global Crisis – Global Action”

1. We, heads of State and Government and representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly, convened in accordance with resolution 55/13 of 3 November 2000, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects, as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;
2. Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society – national, community, family and individual;
3. Noting with profound concern that by the end of 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa;
4. Noting with grave concern that all people, rich and poor, without distinction as to age, gender or race, are affected by the HIV/AIDS epidemic, further noting that

people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;

5. Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals we adopted at the Millennium Summit of the United Nations;

6. Recalling and reaffirming our previous commitments on HIV/AIDS made through:

- The United Nations Millennium Declaration, of 8 September 2000;¹
- The political declaration and further actions and initiatives to implement the commitments made at the World Summit for Social Development, of 1 July 2000;²
- The political declaration³ and further action and initiatives to implement the Beijing Declaration and Platform for Action,⁴ of 10 June 2000;
- Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, of 2 July 1999;⁵
- The regional call for action to fight HIV/AIDS in Asia and the Pacific, of 25 April 2001;
- The Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis and other related infectious diseases in Africa, of 27 April 2001;
- The Declaration of the Tenth Ibero-American Summit of heads of State, of 18 November 2000;
- The Pan-Caribbean Partnership against HIV/AIDS, of 14 February 2001;
- The European Union Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, of 14 May 2001;
- The Baltic Sea Declaration on HIV/AIDS Prevention, of 4 May 2000;
- The Central Asian Declaration on HIV/AIDS, of 18 May 2001;

7. Convinced of the need to have an urgent, coordinated and sustained response to the HIV/AIDS epidemic, which will build on the experience and lessons learned over the past 20 years;

8. Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden, and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action;

9. Welcoming the commitments of African heads of State or Government at the Abuja special summit in April 2001, particularly their pledge to set a target of

¹ See resolution 55/2.

² Resolution S-24/2, annex, sects. I and III.

³ Resolution S-23/2, annex.

⁴ Resolution S-23/3, annex.

⁵ Resolution S-21/2, annex.

allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help to address the HIV/AIDS epidemic; and recognizing that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance;

10. Recognizing also that other regions are seriously affected and confront similar threats, particularly the Caribbean region, with the second-highest rate of HIV infection after sub-Saharan Africa, the Asia-Pacific region where 7.5 million people are already living with HIV/AIDS, the Latin American region with 1.5 million people living with HIV/AIDS and the Central and Eastern European region with very rapidly rising infection rates, and that the potential exists for a rapid escalation of the epidemic and its impact throughout the world if no specific measures are taken;

11. Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner;

12. Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic;

13. Noting further that stigma, silence, discrimination and denial, as well as a lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed;

14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;

15. Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

16. Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

17. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic, and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

18. Recognizing the need to achieve the prevention goals set out in the present Declaration in order to stop the spread of the epidemic, and acknowledging that all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services;

19. Recognizing that care, support and treatment can contribute to effective prevention through an increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies;
20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;
21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;
22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services;
23. Recognizing that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs, including anti-retroviral therapy, diagnostics and related technologies, as well as increased research and development;
24. Recognizing also that the cost, availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies;
25. Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continues to hinder an effective response to HIV/AIDS in many countries, especially for the poorest people, and recalling efforts to make drugs available at low prices for those in need;
26. Welcoming the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines to protect the health of their populations, and noting that the impact of international trade agreements on access to or local manufacturing of essential drugs and on the development of new drugs needs to be evaluated further;
27. Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and the active promotion and protection of human rights; and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North-South, South-South and triangular cooperation;
28. Acknowledging that resources devoted to combating the epidemic both at the national and international levels are not commensurate with the magnitude of the problem;

29. Recognizing the fundamental importance of strengthening national, regional and subregional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, subregional and international cooperation;
30. Recognizing that external debt and debt-servicing problems have substantially constrained the capacity of many developing countries, as well as countries with economies in transition, to finance the fight against HIV/AIDS;
31. Affirming the key role played by the family in prevention, care, support and treatment of persons affected and infected by HIV/AIDS, bearing in mind that in different cultural, social and political systems various forms of the family exist;
32. Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental organizations, people living with HIV/AIDS and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector including generic and research-based pharmaceutical companies, trade unions, the media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders are important;
33. Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects, and recognizing that their full involvement and participation in the design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;
34. Further acknowledging the efforts of international humanitarian organizations combating the epidemic, including the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world;
35. Commending the leadership role on HIV/AIDS policy and coordination in the United Nations system of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS); and noting its endorsement in December 2000 of the Global Strategy Framework on HIV/AIDS, which could assist, as appropriate, Member States and relevant civil society actors in the development of HIV/AIDS strategies, taking into account the particular context of the epidemic in different parts of the world;
36. Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

Leadership

Strong leadership at all levels of society is essential for an effective response to the epidemic

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector

Leadership involves personal commitment and concrete actions

At the national level

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

38. By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact-mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans;

At the regional and subregional level

39. Urge and support regional organizations and partners to be actively involved in addressing the crisis; intensify regional, subregional and interregional cooperation and coordination; and develop regional strategies and responses in support of expanded country-level efforts;

40. Support all regional and subregional initiatives on HIV/AIDS including: the International Partnership against AIDS in Africa (IPAA) and the ECA-African Development Forum African Consensus and Plan of Action: Leadership to overcome HIV/AIDS; the Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis and other related infectious diseases in Africa; the CARICOM Pan-Caribbean Partnership against HIV/AIDS; the ESCAP regional call for action to fight HIV/AIDS in Asia and the Pacific; the Baltic Sea Initiative and Action Plan; the Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean; and the European Union Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction;

41. Encourage the development of regional approaches and plans to address HIV/AIDS;

42. Encourage and support local and national organizations to expand and strengthen regional partnerships, coalitions and networks;

43. Encourage the United Nations Economic and Social Council to request the regional commissions, within their respective mandates and resources, to support national efforts in their respective regions in combating HIV/AIDS;

At the global level

44. Support greater action and coordination by all relevant organizations of the United Nations system, including their full participation in the development and

implementation of a regularly updated United Nations strategic plan for HIV/AIDS, guided by the principles contained in the present Declaration;

45. Support greater cooperation between relevant organizations of the United Nations system and international organizations combating HIV/AIDS;

46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors, and by 2003 establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS;

Prevention

Prevention must be the mainstay of our response

47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

48. By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk of new infection;

49. By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS;

50. By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services;

51. By 2003, implement universal precautions in health-care settings to prevent transmission of HIV infection;

52. By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary

to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers;

54. By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV-prevention services available to them, increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;

Care, support and treatment

Care, support and treatment are fundamental elements of an effective response

55. By 2003, ensure that national strategies, supported by regional and international strategies, are developed in close collaboration with the international community, including Governments and relevant intergovernmental organizations, as well as with civil society and the business sector, to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia, affordability and pricing, including differential pricing, and technical and health-care system capacity. Also, in an urgent manner make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance; and to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law;

56. By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care, including that provided by the informal sector, and health-care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; and improve the capacity and working conditions of health-care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care;

57. By 2003, ensure that national strategies are developed in order to provide psychosocial care for individuals, families and communities affected by HIV/AIDS;

HIV/AIDS and human rights

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

Respect for the rights of people living with HIV/AIDS drives an effective response

58. By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

59. By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework;

61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

Reducing vulnerability

The vulnerable must be given priority in the response

Empowering women is essential for reducing vulnerability

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should

address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

63. By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly information and sexual health education and counselling services; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;

64. By 2003, develop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise;

Children orphaned and made vulnerable by HIV/AIDS

Children orphaned and affected by HIV/AIDS need special assistance

65. By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

67. Urge the international community, particularly donor countries, civil society, as well as the private sector, to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa;

Alleviating social and economic impact

To address HIV/AIDS is to invest in sustainable development

68. By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers, and in families affected by HIV/AIDS, and address their special needs; and adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit-creating pressures on public resources;

69. By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace;

Research and development

With no cure for HIV/AIDS yet found, further research and development is crucial

70. Increase investment in and accelerate research on the development of HIV vaccines, while building national research capacity, especially in developing countries, and especially for viral strains prevalent in highly affected regions; in addition, support and encourage increased national and international investment in HIV/AIDS-related research and development, including biomedical, operations, social, cultural and behavioural research and in traditional medicine to improve prevention and therapeutic approaches; accelerate access to prevention, care and treatment and care technologies for HIV/AIDS (and its associated opportunistic infections and malignancies and sexually transmitted diseases), including female-controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery, and to diagnostics, tests and methods to prevent mother-to-child transmission; improve our understanding of factors which influence the epidemic and actions which address it, inter alia, through increased funding and public/private partnerships; and create a conducive environment for research and ensure that it is based on the highest ethical standards;

71. Support and encourage the development of national and international research infrastructures, laboratory capacity, improved surveillance systems, data collection, processing and dissemination, and the training of basic and clinical researchers, social scientists, health-care providers and technicians, with a focus on the countries most affected by HIV/AIDS, particularly developing countries and those countries experiencing or at risk of a rapid expansion of the epidemic;

72. Develop and evaluate suitable approaches for monitoring treatment efficacy, toxicity, side effects, drug interactions and drug resistance, and develop

methodologies to monitor the impact of treatment on HIV transmission and risk behaviours;

73. Strengthen international and regional cooperation, in particular North-South, South-South and triangular cooperation, related to the transfer of relevant technologies suitable to the environment in the prevention and care of HIV/AIDS, the exchange of experiences and best practices, researchers and research findings and strengthen the role of UNAIDS in this process. In this context, encourage ownership of the end results of these cooperative research findings and technologies by all parties to the research, reflecting their relevant contribution and dependent upon their providing legal protection to such findings; and affirm that all such research should be free from bias;

74. By 2003, ensure that all research protocols for the investigation of HIV-related treatment, including anti-retroviral therapies and vaccines, based on international guidelines and best practices, are evaluated by independent committees of ethics, in which persons living with HIV/AIDS and caregivers for anti-retroviral therapy participate;

HIV/AIDS in conflict and disaster-affected regions

Conflicts and disasters contribute to the spread of HIV/AIDS

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;

76. Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence forces, and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities, including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations, while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;

Resources

The HIV/AIDS challenge cannot be met without new, additional and sustained resources

79. Ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results;

80. By 2005, through a series of incremental steps, reach an overall target of annual expenditure on the epidemic of between 7 and 10 billion United States dollars in low and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS, and take measures to ensure that the resources needed are made available, particularly from donor countries and also from national budgets, bearing in mind that resources of the most affected countries are seriously limited;

81. Call on the international community, where possible, to provide assistance for HIV/AIDS prevention, care and treatment in developing countries on a grant basis;

82. Increase and prioritize national budgetary allocations for HIV/AIDS programmes as required, and ensure that adequate allocations are made by all ministries and other relevant stakeholders;

83. Urge the developed countries that have not done so to strive to meet the targets of 0.7 per cent of their gross national product for overall official development assistance and the targets of earmarking 0.15 per cent to 0.20 per cent of gross national product as official development assistance for least developed countries as agreed, as soon as possible, taking into account the urgency and gravity of the HIV/AIDS epidemic;

84. Urge the international community to complement and supplement efforts of developing countries that commit increased national funds to fight the HIV/AIDS epidemic through increased international development assistance, particularly those countries most affected by HIV/AIDS, particularly in Africa, especially in sub-Saharan Africa, the Caribbean, countries at high risk of expansion of the HIV/AIDS epidemic and other affected regions whose resources to deal with the epidemic are seriously limited;

85. Integrate HIV/AIDS actions in development assistance programmes and poverty eradication strategies as appropriate, and encourage the most effective and transparent use of all resources allocated;

86. Call on the international community, and invite civil society and the private sector to take appropriate measures to help to alleviate the social and economic impact of HIV/AIDS in the most affected developing countries;

87. Without further delay, implement the enhanced Heavily Indebted Poor Country (HIPC) Initiative and agree to cancel all bilateral official debts of HIPC countries as soon as possible, especially those most affected by HIV/AIDS, in return for demonstrable commitments by them to poverty eradication, and urge the use of debt service savings to finance poverty eradication programmes, particularly for prevention, treatment, care and support for HIV/AIDS and other infections;

88. Call for speedy and concerted action to address effectively the debt problems of least developed countries, low-income developing countries, and middle-income

developing countries, particularly those affected by HIV/AIDS, in a comprehensive, equitable, development-oriented and durable way through various national and international measures designed to make their debt sustainable in the long term and thereby to improve their capacity to deal with the HIV/AIDS epidemic, including, as appropriate, existing orderly mechanisms for debt reduction, such as debt swaps for projects aimed at the prevention, care and treatment of HIV/AIDS;

89. Encourage increased investment in HIV/AIDS-related research nationally, regionally and internationally, in particular for the development of sustainable and affordable prevention technologies, such as vaccines and microbicides, and encourage the proactive preparation of financial and logistic plans to facilitate rapid access to vaccines when they become available;

90. Support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment and to assist Governments, inter alia, in their efforts to combat HIV/AIDS with due priority to the most affected countries, notably in sub-Saharan Africa and the Caribbean and to those countries at high risk, and mobilize contributions to the fund from public and private sources with a special appeal to donor countries, foundations, the business community, including pharmaceutical companies, the private sector, philanthropists and wealthy individuals;

91. By 2002, launch a worldwide fund-raising campaign aimed at the general public as well as the private sector, conducted by UNAIDS with the support and collaboration of interested partners at all levels, to contribute to the global HIV/AIDS and health fund;

92. Direct increased funding to national, regional and subregional commissions and organizations to enable them to assist Governments at the national, regional and subregional level in their efforts to respond to the crisis;

93. Provide the UNAIDS co-sponsoring agencies and the UNAIDS secretariat with the resources needed to work with countries in support of the goals of the present Declaration;

Follow-up

Maintaining the momentum and monitoring progress are essential

At the national level

94. Conduct national periodic reviews with the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments, identify problems and obstacles to achieving progress, and ensure wide dissemination of the results of these reviews;

95. Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, and develop appropriate monitoring and evaluation instruments, with adequate epidemiological data;

96. By 2003, establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV/AIDS;

At the regional level

97. Include HIV/AIDS and related public health concerns, as appropriate, on the agenda of regional meetings at the ministerial and head of State and Government level;

98. Support data collection and processing to facilitate periodic reviews by regional commissions and/or regional organizations of progress in implementing regional strategies and addressing regional priorities, and ensure wide dissemination of the results of these reviews;

99. Encourage the exchange between countries of information and experiences in implementing the measures and commitments contained in the present Declaration, and in particular facilitate intensified South-South and triangular cooperation;

At the global level

100. Devote sufficient time and at least one full day of the annual session of the General Assembly to review and debate a report of the Secretary-General on progress achieved in realizing the commitments set out in the present Declaration, with a view to identifying problems and constraints and making recommendations on action needed to make further progress;

101. Ensure that HIV/AIDS issues are included on the agenda of all appropriate United Nations conferences and meetings;

102. Support initiatives to convene conferences, seminars, workshops, training programmes and courses to follow up issues raised in the present Declaration, and in this regard encourage participation in and wide dissemination of the outcomes of the forthcoming Dakar Conference on access to care for HIV infection; the Sixth International Congress on AIDS in Asia and the Pacific; the Twelfth International Conference on AIDS and Sexually Transmitted Infections in Africa; the Fourteenth International Conference on AIDS, Barcelona, Spain; the Tenth International Conference on People Living with HIV/AIDS, Port-of-Spain; the Second Forum and Third Conference of the Horizontal Technical Cooperation Group on HIV/AIDS and Sexually Transmitted Infections in Latin America and the Caribbean, Havana; the Fifth International Conference on Home and Community Care for Persons Living with HIV/AIDS, Chiang Mai, Thailand;

103. Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing, in collaboration with non-governmental organizations and other concerned partners, systems for the voluntary monitoring and reporting of global drug prices;

We recognize and express our appreciation to those who have led the effort to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges;

We look forward to strong leadership by Governments and concerted efforts with the full and active participation of the United Nations, the entire multilateral system, civil society, the business community and private sector;

And finally, we call on all countries to take the necessary steps to implement the present Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society.



General Assembly

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Agenda item 10

Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declarations on HIV/AIDS

United to end AIDS: achieving the targets of the 2011 Political Declaration

Report of the Secretary-General

Summary

This is the first report to the General Assembly since the High-level Meeting on HIV/AIDS, held in June 2011. At that meeting, which reviewed progress made during the previous decade, Member States embraced the vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths. The 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, provides a road map towards this vision, adopting 2015 as the deadline for achieving concrete results. Member States pledged to deliver antiretroviral therapy to 15 million people living with HIV; work towards eliminating new infections in children and substantially reducing maternal AIDS-related deaths; reduce by 50 per cent new infections from sexual transmission and among people who inject drugs; substantially increase HIV funding, with the goal of mobilizing \$22 billion to \$24 billion annually; meet the needs of women and girls; and eliminate stigma and discrimination.

Today the international community has cause for hope and optimism in the response. Access to essential treatment and prevention services has increased, new infections and AIDS-related deaths are on the decline, and young people in high-prevalence countries are increasingly adopting safer sexual behaviours. With recent research results indicating that antiretroviral treatment reduces by 96 per cent the risk of HIV transmission within couples in which one partner is living with HIV and the other uninfected, leaders have begun speaking of a possible “beginning of the end of AIDS”. Yet at this unprecedented moment, critical challenges remain. Substantial access gaps persist for key services, with especially difficult obstacles experienced by populations at higher risk. Punitive laws, gender inequality, violence against women and other human rights violations continue to undermine national responses. Of special concern is the first-ever decline in HIV funding in 2010,



potentially jeopardizing the capacity of the international community to close access gaps and sustain progress in the coming years. Continued work is needed to maximize synergies and impact between HIV and broader health and development programmes.

The report summarizes results against the targets in the 2011 Political Declaration on HIV and AIDS. Although striking progress has been achieved, the world is not on track to meet the 2015 targets, underscoring the urgent need for all stakeholders to redouble their efforts to strengthen the HIV response.

Efforts must be refocused to achieve real results and end a global epidemic of historic proportions. The response must be smarter and more strategic, streamlined, efficient and grounded in human rights. To accelerate gains and seize new opportunities generated by scientific research, it is essential to recognize the shared responsibility for the response. International donors, emerging economies, affected countries and additional stakeholders must all actively contribute, in accordance with their respective capacities. As additional resources are mobilized and essential programmes brought to scale, intensified efforts should lay the foundation for increased ownership and sustainability of the response in sub-Saharan Africa. Courage and commitment will also be needed to tackle the challenges that continue to undermine progress, including a lack of access to social justice, equality and equity.

After more than three decades of struggle, success is finally in sight.

I. Introduction

1. Uniting around the shared vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths, Member States reaffirmed their collective commitment to achieving concrete results in the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. Specifying targets for 2015, the Political Declaration pledged to deliver antiretroviral therapy to 15 million people, eliminate new infections in children and achieve 50 per cent reductions in sexual transmission, maternal deaths and tuberculosis-related deaths among people living with HIV. Member States further committed to closing the resource gap, meeting the needs of women and girls, eliminating stigma and discrimination and promoting the integration of the HIV response in broader health and development efforts.

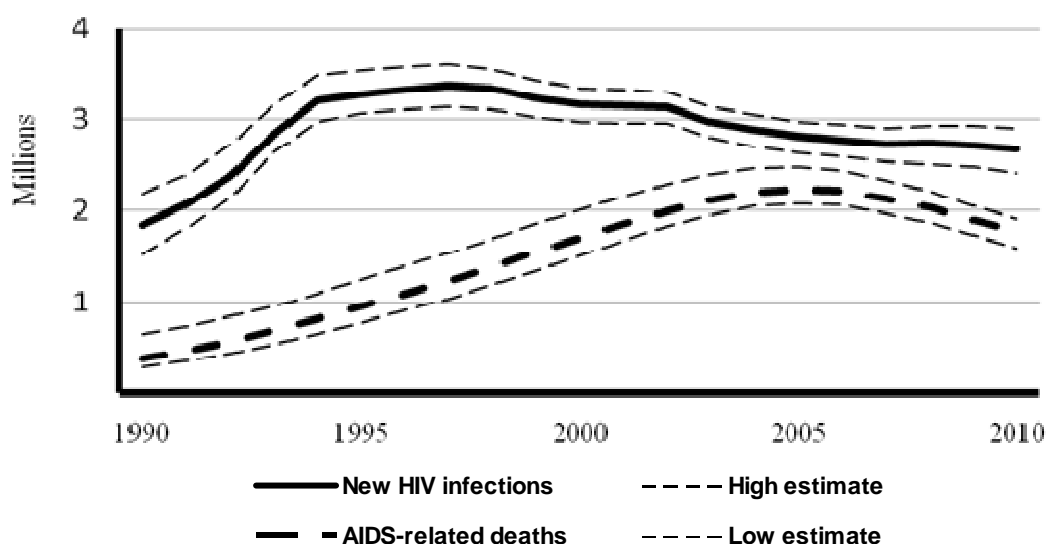
2. Substantial gains have been achieved in the response over the last decade, including heartening advances during the past 12 months. However, the current response is unlikely to result in the ambitious 2015 targets being reached. Recent declines in global spending underscore the critical need to redouble efforts to mobilize the resources necessary to achieve targets related to coverage for essential HIV services.

3. Achieving the 2015 targets is vital to the future health and well-being of our world. In the fourth decade of the global struggle against AIDS, there are available a wider array of lessons learned and a broader spectrum of effective tools than ever before. With less than four years until these targets are due, intensified commitment, evidence-based action and strategic focus are urgently needed.

4. AIDS remains one of the great challenges of our times. More people than ever, an estimated 34 million (31.6 million-35.2 million) as of December 2010, are living with HIV. Sub-Saharan Africa remains most heavily affected, accounting for 68 per cent of all people living with HIV and 70 per cent of all people newly infected in 2010. Women make up 50 per cent of adults (age 15-49) living with HIV globally and 59 per cent of all infections in sub-Saharan Africa. The impact on young women (age 15-24) in sub-Saharan Africa is particularly acute, with 72 per cent of young people infected being women. As at December 2010, an estimated 16.6 million children had lost one or both parents to AIDS — nearly 15 million of those children reside in sub-Saharan Africa.

5. Fewer people are dying of AIDS-related causes (see figure I). In low- and middle-income countries, antiretroviral treatment has averted 2.5 million deaths since 1995. Annual AIDS-related deaths (1.8 million [1.6 million-1.9 million] in 2010) have fallen by 18 per cent since the mid-2000s.

Figure I
New HIV infections and AIDS-related deaths, 1990-2010



Source: UNAIDS World AIDS Day Report 2011.

6. The number of people newly infected in 2010 (2.7 million [2.4 million-2.9 million]) was 21 per cent lower than the peak in 1997. However, the number of people newly infected remains far too high to meet the agreed 2015 target of reducing new infections by 50 per cent.

7. The number of children newly infected in 2010 (390,000 [340,000-450,000]) was 30 per cent lower than the peak in 2002 and 2003. Since 1995, prevention services are estimated to have averted 350,000 new infections in children.

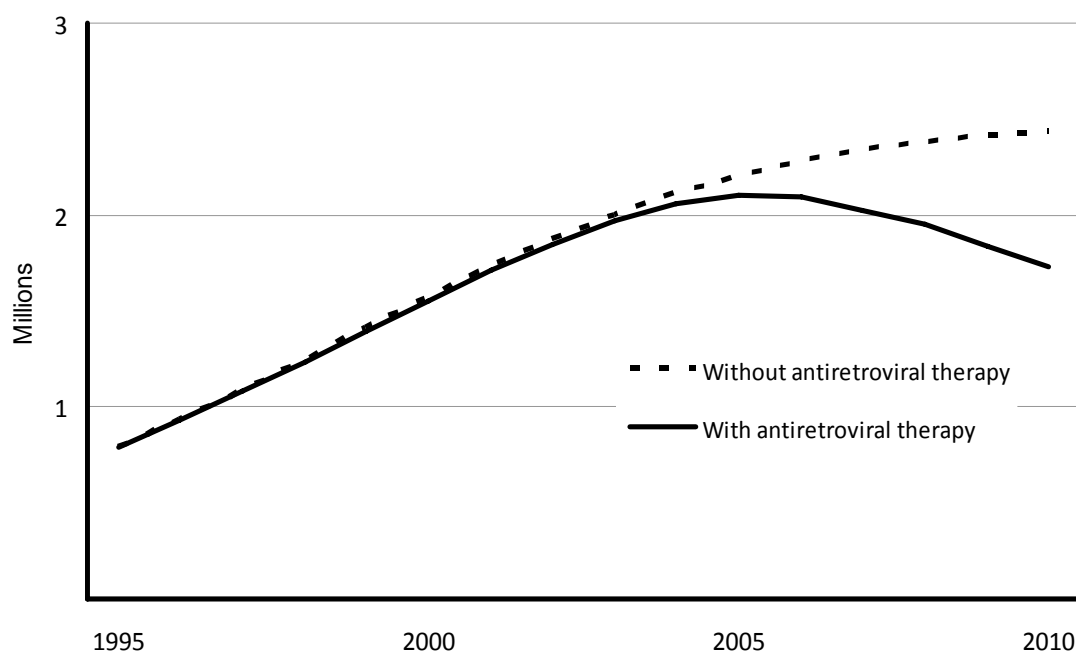
8. Young people age 15-24 account for 42 per cent of new infections among people 15 years and older worldwide. Here, too, progress is evident. In 21 of 24 countries with HIV prevalence of 1 per cent or greater, significant declines in HIV prevalence among young pregnant women (age 15-24) have been documented over the past decade. Favourable changes in sexual behaviour have been associated with delay in sexual initiation, reduction in multiple partners and increased condom use. In 11 of 19 African countries studied, the percentage of young men with multiple partners in the last 12 months has fallen significantly.

9. Epidemics vary considerably within and between countries and regions. While new infections are on the decline in sub-Saharan Africa and the Caribbean, HIV incidence is rising in Eastern Europe and Central Asia, in the Middle East and North Africa and in certain Asian countries. Regionally, the epidemic appears to have stabilized in Asia, Latin America, North America and Western and Central Europe.

10. Rates of AIDS-related deaths also vary. For example, while AIDS-related mortality has fallen substantially in sub-Saharan Africa, no decline has been reported in Asia. These disparities reflect differing degrees of success in bringing treatment to scale in low- and middle-income countries. Moreover, HIV remains a leading cause of death among women of reproductive age globally. While antiretroviral treatment coverage in 2010 reached 63 per cent [57-74 per cent] in

Latin America and the Caribbean and 56 per cent [53-59 per cent] in Eastern and Southern Africa, coverage was much lower in East, South and South-East Asia (39 per cent [36-44 per cent]), Western and Central Africa (30 per cent [28-33 per cent]), Eastern Europe and Central Asia (23 per cent [20-26 per cent]), and the Middle East and North Africa (10 per cent [8-13 per cent]). In low- and middle-income countries, treatment coverage is substantially higher among adults (51 per cent [48-54 per cent]) than in children (23 per cent [20-25 per cent]). In low- and middle-income countries, in the period 1995-2010 2.5 million deaths from AIDS-related causes were averted with the use of antiretroviral therapy (see figure II).

Figure II
Deaths from AIDS-related causes in low- and middle-income countries, 1995-2010



Source: World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund, *Global HIV/AIDS Response Progress Report 2011*.

11. HIV prevalence and incidence tend to be elevated in populations at higher risk, in both concentrated and generalized epidemics. This reflects their lack of access to proven prevention tools, attributable in large part to the effects of punitive laws, abusive police practices and high levels of stigma and discrimination. Unprotected paid sex continues to have a major impact on the spread of HIV in sub-Saharan Africa, including in mature epidemics, and high levels of infection among sex workers have also been reported in other regions. Injecting drug use persists as an epidemic driver in Eastern Europe and Central Asia and contributes to the expansion of the epidemic in other regions. In addition, a worldwide epidemic has been documented among men who have sex with men, including in sub-Saharan Africa.

II. Key targets for 2015: progress to date and challenges to overcome

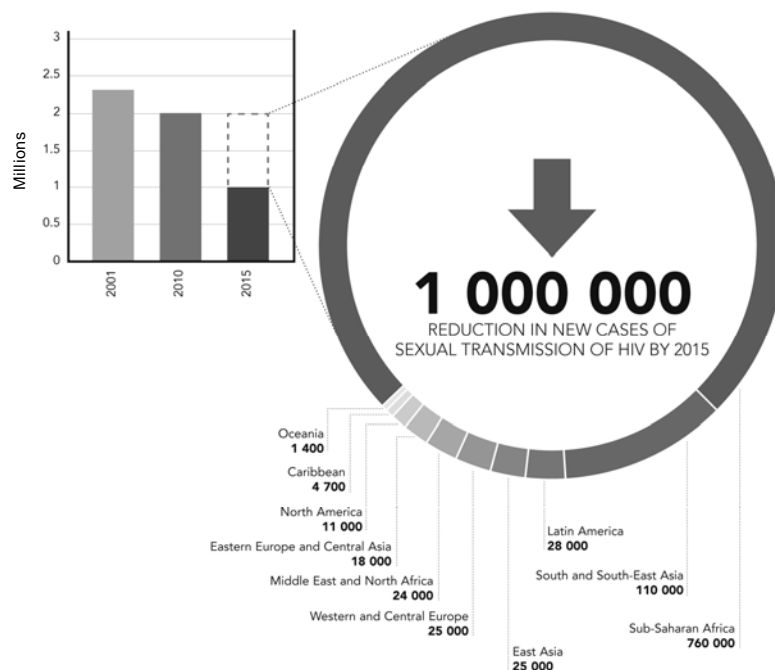
12. The following information describes progress made to date towards achieving the targets in the 2011 Political Declaration on HIV and AIDS, identifies obstacles that need to be overcome and describes key action steps to accelerate progress. Figures III to XII indicate the changes required in each region to reach various 2015 targets, based on available data and modelling by the Joint United Nations Programme on HIV/AIDS (UNAIDS).

A. Reduce sexual transmission of HIV by 50 per cent

13. Slowing the rate of sexual transmission is vital to achieving the vision of a world with zero new infections, as sexual transmission remains the primary mode of transmission globally. To meet the 2015 target, the annual number of new sexually transmitted infections will need to decline by at least 1 million.

14. Over the past decade, historic gains have been achieved in reducing sexual transmission, especially in numerous hyperendemic countries. In 22 countries, HIV incidence fell by more than 25 per cent between 2001 and 2009. HIV prevalence among pregnant women attending antenatal settings declined by an average of 31 per cent in 24 high-prevalence African countries from 2000 to 2010.

Figure III
Changes required to meet the target of a 50 per cent reduction in sexual transmission by 2015



Source: UNAIDS.

15. Effective prevention of sexual transmission builds on a foundation of knowledge and skills, respect for human rights, a commitment to gender equality and the elimination of sexual violence and the greater involvement of people living with HIV. Sound prevention programmes include the strategic combination of behavioural, biomedical and structural interventions, with robust investments in basic, high-impact programmatic activities and enabling policies.

16. The widespread adoption of safer sexual behaviours has driven declines in HIV incidence in many high-prevalence settings, although considerable challenges remain. Fewer than half of young people surveyed in Africa have accurate and comprehensive knowledge of HIV, and fewer than 10 male condoms are available for every man in sub-Saharan Africa annually, with considerable variation in condom access among countries.

17. Urgent efforts continue to generate new biomedical prevention tools. In 2011, two major clinical trials in sub-Saharan Africa found that a daily regimen of antiretroviral prophylaxis significantly reduced the risk of HIV acquisition among uninfected heterosexual adults. Less promising were study results in late 2011 that failed to demonstrate any prevention benefit from daily use of a vaginal antiretroviral-based microbicide. However, additional analyses of these trial data suggest that suboptimal adherence may be at least partially responsible for these disappointing results. Efforts must persist to develop new, safe and effective methods to reduce women's risk of sexual HIV transmission, including new forms of female condoms.

18. Evidence that antiretroviral treatment substantially reduces the risk of transmission underscores the need to enhance the integration of programming for HIV prevention, diagnosis and treatment. Moving to capture the prevention benefits of early initiation of antiretroviral treatment, 43 of 52 countries surveyed had, as at December 2010, revised their national criteria for when to start antiretroviral therapy.

19. A growing body of evidence is informing efforts to address the social and structural determinants of HIV. New data indicate that cash transfers help to reduce the vulnerability of young people to HIV; schooling is a protective factor, especially for girls; and laws and law enforcement practices affect access to services for key populations.

20. To date, populations at higher risk have not received the attention required to ensure their access to evidence-informed HIV prevention. Studies clearly demonstrate the effectiveness of rights-based prevention programmes focused on key populations. In 2011, the World Health Organization (WHO), in partnership with the United Nations Development Programme (UNDP), UNAIDS and other institutions, issued its first-ever guidelines for the prevention of HIV and other sexually transmitted infections among men who have sex with men, and transgender people. Other populations in urgent need of focused prevention support include women, young people, people in prison settings, migrants, populations in humanitarian crises, and sex partners of people who inject drugs or sell sex.

21. Although international human rights protections prohibit discrimination in the provision of health services, the access of key populations to prevention services remains extremely limited in many parts of the world. In sub-Saharan Africa, for example, most countries report having no individual- or community-level

behavioural interventions focused on men who have sex with men. Globally, at least 18 countries do not support the targeted promotion of condoms for sex workers, a key component of comprehensive prevention programmes for that population. This discriminatory neglect must end.

22. In 13 African countries with high HIV prevalence and low prevalence of male circumcision, studies indicate that achieving 80 per cent coverage of adult medical male circumcision would avert more than 20 per cent of new infections by 2025 and save an estimated \$16.6 billion in future medical costs. However, only 5 per cent of eligible adult men had been circumcised as at December 2010, although uptake accelerated in 2010. Over the last year, studies have been launched or planned in several countries to evaluate new circumcision devices that offer a potential avenue to increase demand and expedite scale-up.

23. Intensified HIV prevention efforts are needed to protect women from becoming infected. After a 2011 study in sub-Saharan Africa found that women's use of injectable progestogen-based hormonal contraception increased the risks of HIV transmission and acquisition within serodiscordant couples, international health experts determined that available evidence was inconclusive and did not warrant advising women to avoid hormonal contraception. However, women using progestogen-only injectable contraception are strongly advised to use condoms and other preventive measures. Further research on the relationship between hormonal contraception and HIV infection is essential.

24. Although surveys in several countries indicate that more young people are delaying their sexual debut, stronger, better-focused prevention efforts are needed, as young people under age 25 account for more than 4 in 10 new infections. Accurate knowledge of prevention remains low, and sexual and reproductive health information, comprehensive sexuality education and health services need to be tailored to the needs of young people and made accessible to them. Young people should be actively engaged in the development and implementation of policies and programmes that affect them; intensified efforts should focus on cultivating a new generation of HIV leaders; and social networking, media and other innovative tools should be employed to build the demand of young people for services.

B. Reduce HIV transmission among people who inject drugs by 50 per cent

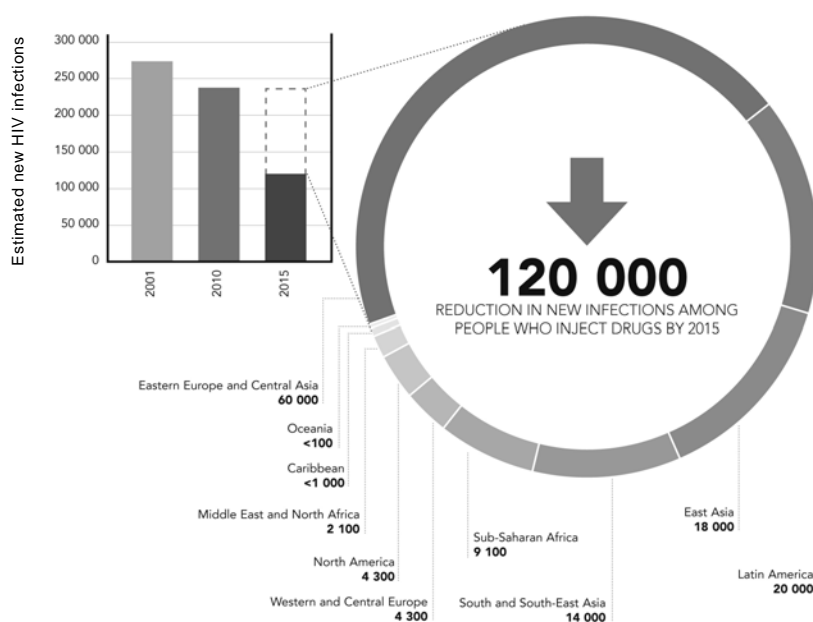
25. With an estimated 240,000 people who inject drugs being newly infected with HIV each year, the number of incident infections in this population must fall by at least 120,000 to meet the 2015 target and contribute towards the vision of a world with zero new infections. Transmission as a result of drug use is entirely preventable through the implementation of a package of proven prevention methods, including needle and syringe exchange programmes, opioid substitution therapy and comprehensive health and social support services.

26. There is a critical need to intensify prevention efforts and review current methods. In 2010, only 43 of 109 countries reported that they had any needle or syringe exchange programme in place, and only 58 countries provided opioid substitution therapy. Even where such services are available, coverage remains extremely low.

27. A rights-based approach is vital for all people living with or affected by HIV and is especially critical for people who inject drugs. Many people who inject drugs avoid health and social services owing to criminalization, overt discrimination and abusive law enforcement practices. As people who inject drugs and other low-income or socially marginalized people are often unable to pay out-of-pocket expenses for HIV services, meaningful access to services for such individuals requires non-discriminatory and non-stigmatizing social protection, outreach and universal health coverage.

Figure IV

Changes required to meet the target of a 50 per cent reduction in the number of new HIV infections among people who inject drugs



Source: UNAIDS.

C. Eliminate new infections in children and substantially reduce AIDS-related maternal deaths

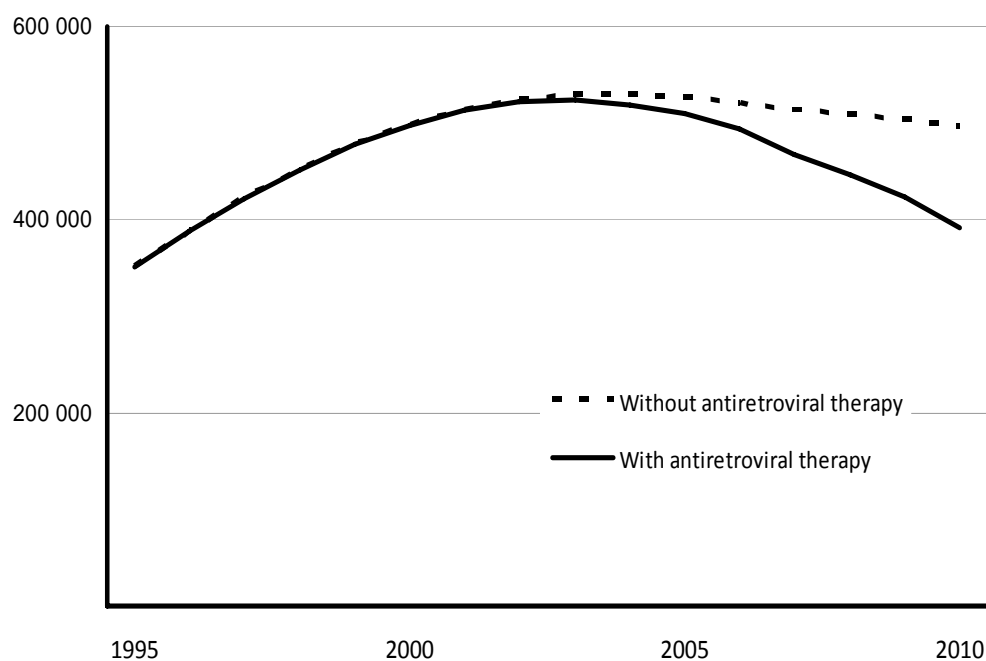
28. Achieving a world with zero new infections demands concerted efforts to protect children and promote the health and well-being of their mothers. To eliminate new infections in children and cut AIDS-related maternal deaths by 50 per cent by 2015, partners will need to implement a four-point plan outlined in the UNAIDS Global Plan Towards the Elimination of New Infections among Children by 2015 and Keeping Their Mothers Alive: (a) prevent HIV infection in women and girls; (b) close the access gap for women's family planning services, especially for those living with HIV; (c) implement the recommended package of services to ensure that pregnant women and their newborns obtain antiretroviral prophylaxis to reduce the risk of HIV transmission during pregnancy, delivery or breastfeeding;

and (d) ensure universal access to HIV treatment, care and support for women and children living with HIV, as well as their families. As comprehensive services help address barriers to service uptake and adherence, elimination programmes should be integrated with broader services for women's and children's health and nutrition.

29. Urgent efforts are needed to eliminate access gaps in services to prevent new infections in children. In 2010, 48 per cent of HIV-positive pregnant women in low- and middle-income countries received an effective combination antiretroviral prophylaxis to prevent transmission to their newborns. In 5 of the 22 countries prioritized in the Global Plan (Botswana, Lesotho, Namibia, South Africa and Swaziland), coverage with effective antiretroviral regimens exceeded 80 per cent. Efforts to prevent new infections in children urgently require strengthened prevention services for women, especially pregnant women who may be at higher risk, as well as immediate steps to meet the need for family planning services among all women, including HIV-positive women, while respecting their reproductive rights. In low- and middle-income countries, more than 350,000 new HIV infections among children were averted through antiretroviral prophylaxis in the period 1995-2010.

Figure V

Reduction of new HIV infections among children through antiretroviral prophylaxis in low- and middle-income countries, 1995-2010



Source: WHO, UNAIDS, UNICEF, *Global HIV/AIDS Response Progress Report 2011*.

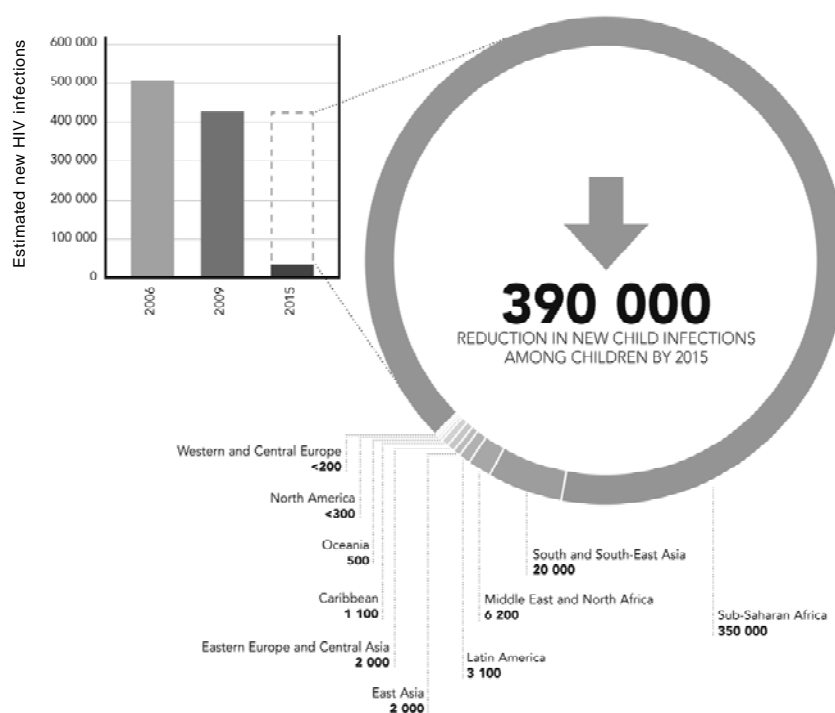
30. Programmatic shortcomings that undermine the impact of prevention programmes need to be immediately addressed. In six high-prevalence countries in sub-Saharan Africa, unmet need for family planning services among HIV-positive women ranges from 12 per cent to 21 per cent, according to surveys undertaken from 2006 to 2010. Children continue to lag in access to treatment, with only 23 per

cent of treatment-eligible children receiving antiretroviral therapy in 2010. Owing to persistent access gaps and use of suboptimal prophylactic regimens, only a modest decline in the transmission rate to children has been reported — from 29 per cent of children born to HIV-positive mothers in 2009 to 26 per cent in 2010.

31. In 2010, only 34 per cent of treatment-eligible women received antiretroviral therapy for their own health. Mothers of newborns in high-income countries generally benefit from treatment, allowing them to remain productive and keep their families together. Experience in all regions indicates that a family-centred approach is most effective in advancing the linked goals of reducing new infections in children, optimizing health outcomes for women and children living with HIV, reducing the number of children orphaned by AIDS and minimizing poverty among HIV-affected households.

32. In many countries, HIV-positive pregnant women are receiving suboptimal drug regimens to prevent transmission to their babies. In the 22 countries that account for the overwhelming majority of new infections among children, 13 per cent of HIV-positive pregnant women were prescribed single-dose nevirapine in 2010, and roughly one in three received the optimal dual prophylaxis. Eliminating the use of suboptimal regimens would prevent an estimated 20 per cent of all new infections in children.

Figure VI
Changes required to meet the target of virtually eliminating new HIV infections among children

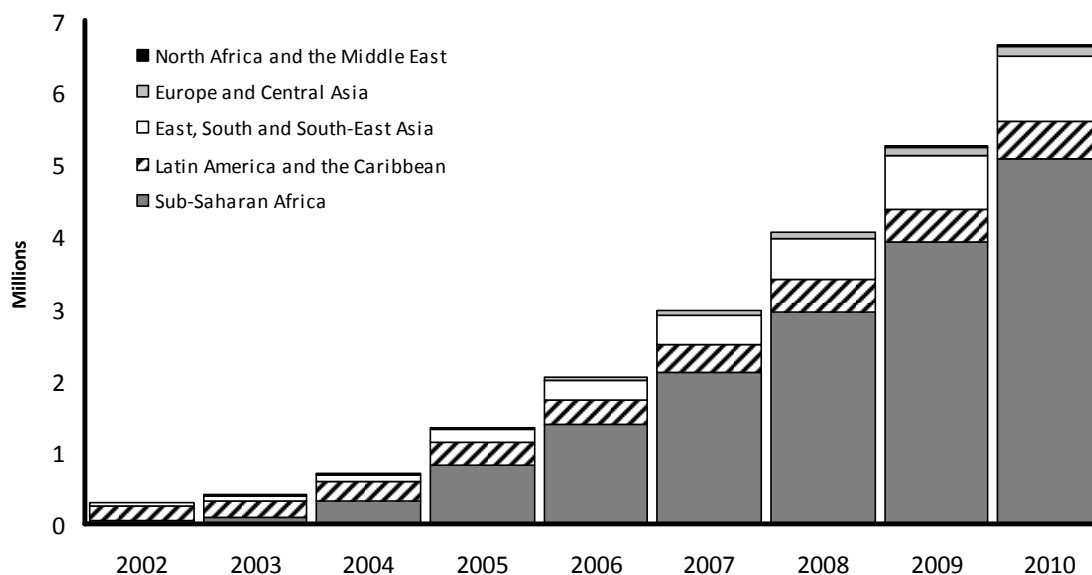


Source: UNAIDS.

D. Reach 15 million people living with HIV with antiretroviral treatment

33. While redoubling efforts to prevent new infections, renewed determination is needed to promote the health and quality of life of people living with HIV. The rapid expansion of antiretroviral therapy in low- and middle-income countries represents one of the most important achievements in global health and has engendered hope in the vision of a world with zero AIDS-related deaths. In a single decade, the number of people in low- and middle-income countries receiving antiretroviral therapy has increased more than 20-fold. Coverage for antiretroviral treatment reached 47 per cent in low- and middle-income countries in 2010. To achieve the 2015 targets, the number of people receiving antiretroviral treatment will need to increase by 57 per cent compared with 2010.

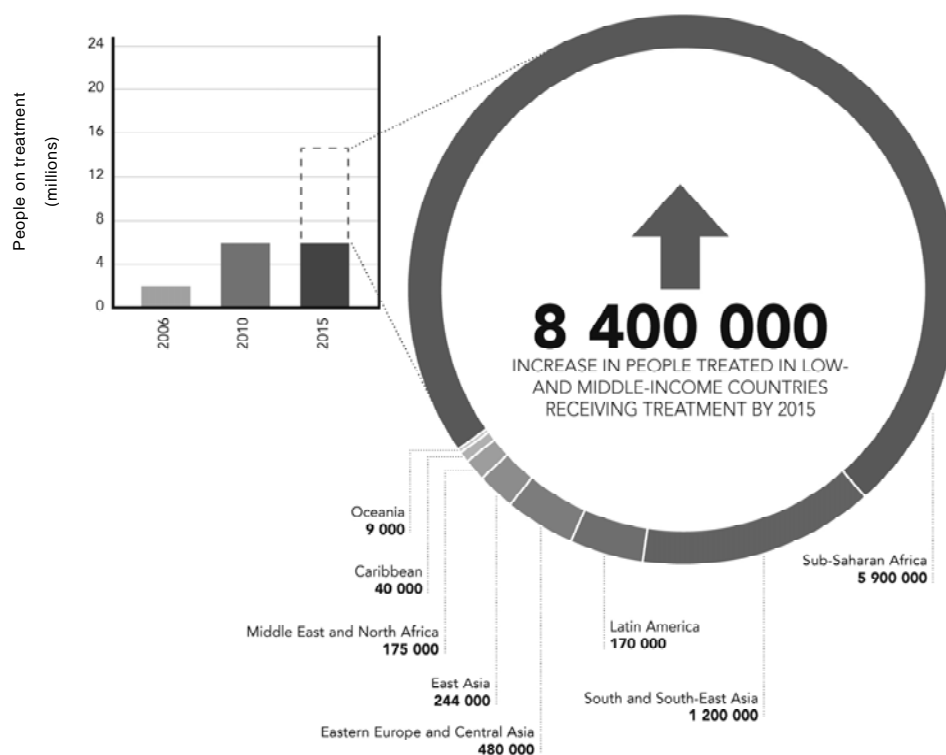
Figure VII
Number of people receiving antiretroviral therapy in low- and middle-income countries, by region, 2002-2010



Source: WHO, UNAIDS, UNICEF, *Global HIV/AIDS Response Progress Report 2011*.

34. Reaching the target of providing antiretroviral treatment to 15 million people by 2015 will require substantially greater progress across the entire diagnostic and treatment continuum. Although testing and counselling is the gateway to treatment, many people living with HIV remain unaware of their infection. Globally, the number of facilities offering testing and counselling services increased by 18 per cent in 2010. In a drive to increase the number of people who know their serostatus, efforts have been made to extend testing services beyond stand-alone voluntary counselling and testing centres, using provider-initiated testing in health-care facilities, community-based door-to-door testing campaigns, workplace testing programmes and technologies that permit self-testing at home.

Figure VIII
Changes required to meet the target of providing antiretroviral treatment to 15 million people living with HIV in low- and middle-income countries, by 2015



Source: UNAIDS.

35. Testing must always be linked to counselling and treatment. An estimated 41 per cent of people in sub-Saharan Africa who test positive do not receive CD4 monitoring tests or clinical staging, and 32 per cent determined to be eligible for antiretroviral treatment do not receive medications. Financial barriers to treatment access, such as user fees and heavy transportation costs, should be eliminated.

36. In resource-limited settings, food and nutrition support can be a cost-effective investment to enhance treatment success and to mitigate the consequences of HIV and tuberculosis on livelihoods, by reducing early mortality, supporting nutritional recovery, promoting treatment adherence and improving retention in care. Treatment should be accompanied by nutritional assessments, nutritional education and counselling and treatment for malnutrition.

37. Particular efforts are needed to ensure treatment access for populations at higher risk, who often experience access barriers owing to stigma and discrimination. Cambodia has implemented a comprehensive service continuum for these populations and has enhanced linkages between treatment programmes and community outreach initiatives.

38. People living with HIV among populations affected by humanitarian emergencies should have similar access to treatment as the surrounding host

communities. It is necessary to confront the increased risk and vulnerability of people in conflict and post-conflict settings and to ensure that HIV programmes become an integral part of all disarmament, demobilization, reintegration and peacebuilding processes and security-sector reforms.

39. Improving the efficiency and effectiveness of treatment services is central to long-term success in the response. The Treatment 2.0 framework aims to accelerate treatment scale-up and improve health outcomes by optimizing drug regimens, providing point-of-care and other simplified diagnostic and monitoring tools, reducing treatment costs, adapting service delivery models through decentralization and integration and mobilizing communities to support treatment efforts.

40. Advances have been reported towards the Treatment 2.0 vision. Although the use of the more toxic antiretroviral drug d4T in first-line regimens has declined since 2006, surveys indicate that many countries are experiencing bottlenecks in introducing more superior alternative regimens, available as a single, once-per-day fixed-dose pill. In Mozambique, operational research demonstrated that a point-of-care CD4 testing device reduced by 50 per cent the number of people lost to follow-up and lowered the number of days needed to obtain a CD4 result from 27 to 1 day.

41. While prices of first-line antiretroviral treatments in low- and middle-income countries have fallen by more than 99 per cent over the past decade, treatment costs may rise again in future. Although only an estimated 3 per cent of patients in low- and middle-income countries, other than in the Americas, were on second-line regimens in 2010, demand will inevitably increase for second-line regimens that currently remain far more expensive than first-line drugs. In addition, paediatric antiretroviral formulations continue to be too expensive, fuelling the continuing lag in treatment access for children.

42. Ensuring the affordability of a broad range of antiretroviral drugs and drugs for co-infections, including hepatitis C, will demand simplified, standardized first- and second-line regimens that are harmonized for use across different adult and paediatric populations. Countries must also make effective use of flexibilities available under international intellectual property rules. The 2001 Doha Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health recognized the right of countries to take public health considerations into account to promote patients' access to priority medicines. A number of countries have already used TRIPS flexibilities to promote access to essential medicines, but even greater action will be needed, as many countries have yet to exercise the full array of access-promoting options available under international rules. Intensified efforts are needed to establish robust capacity in sub-Saharan Africa and other regions for the domestic manufacture of pharmaceuticals, and immediate consideration should also be given to the creation of an African regional authority for the regulation of medicines. As free trade agreements are negotiated, care should be taken by all parties to avoid the imposition of measures that limit the flexibilities now permitted under TRIPS. In 2011, the Medicines Patent Pool announced its first licence with a pharmaceutical company, permitting the generic manufacture of compounds produced by Gilead Sciences.

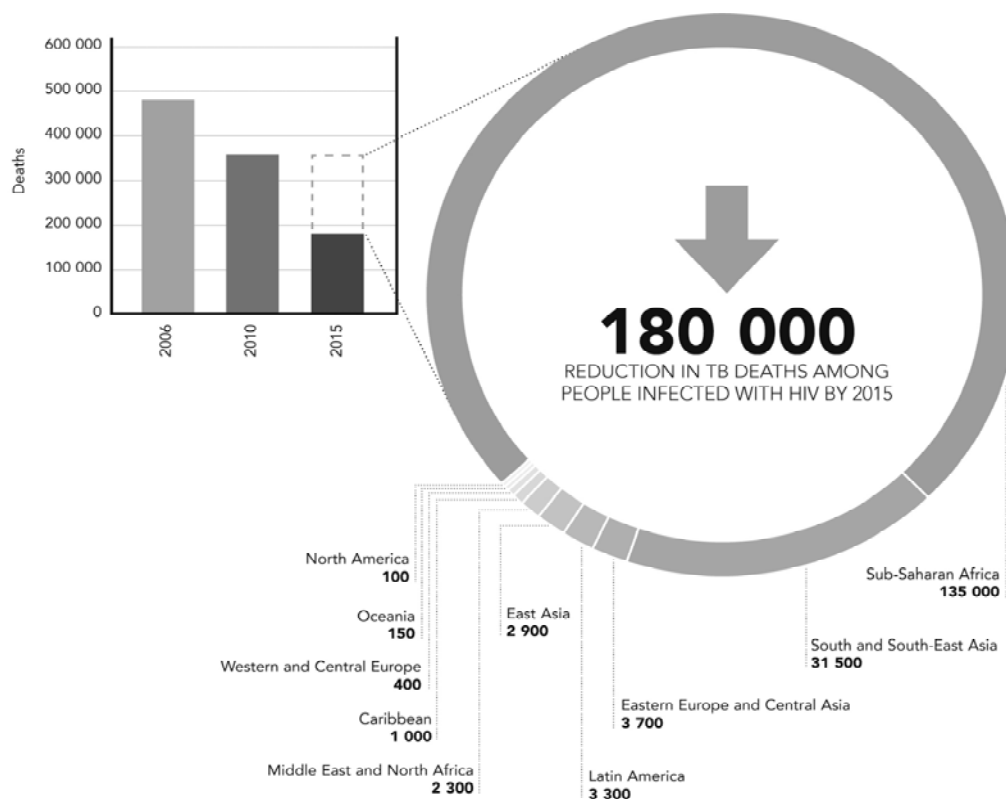
E. Reduce tuberculosis deaths among people living with HIV by 50 per cent

43. Achieving the vision of zero AIDS deaths requires success in efforts to prevent tuberculosis-related deaths among people living with HIV. Although the number of tuberculosis deaths among people living with HIV has declined for several years, tuberculosis remains a major cause of death for people living with HIV. In 2010, less than one in three people diagnosed with both HIV and tuberculosis accessed clinical care for tuberculosis.

44. In comparison with 2010, at least 180,000 fewer tuberculosis-related deaths among people living with HIV will be required by 2015 to meet the target in the 2011 Political Declaration on HIV and AIDS. From 2010 to 2015, tuberculosis cure rates should increase from 70 per cent to 85 per cent, rates of tuberculosis detection among people living with HIV must rise from 40 per cent to 80 per cent, and isoniazid preventive therapy needs to reach at least 30 per cent of people living with HIV who do not have active tuberculosis. According to recent modelling exercises, meeting these achievable aims would surpass the 2015 target, reducing tuberculosis-related deaths among people living with HIV by 80 per cent and saving a million lives.

Figure IX

Changes required to meet the target of reducing tuberculosis deaths among people living with HIV by 2015

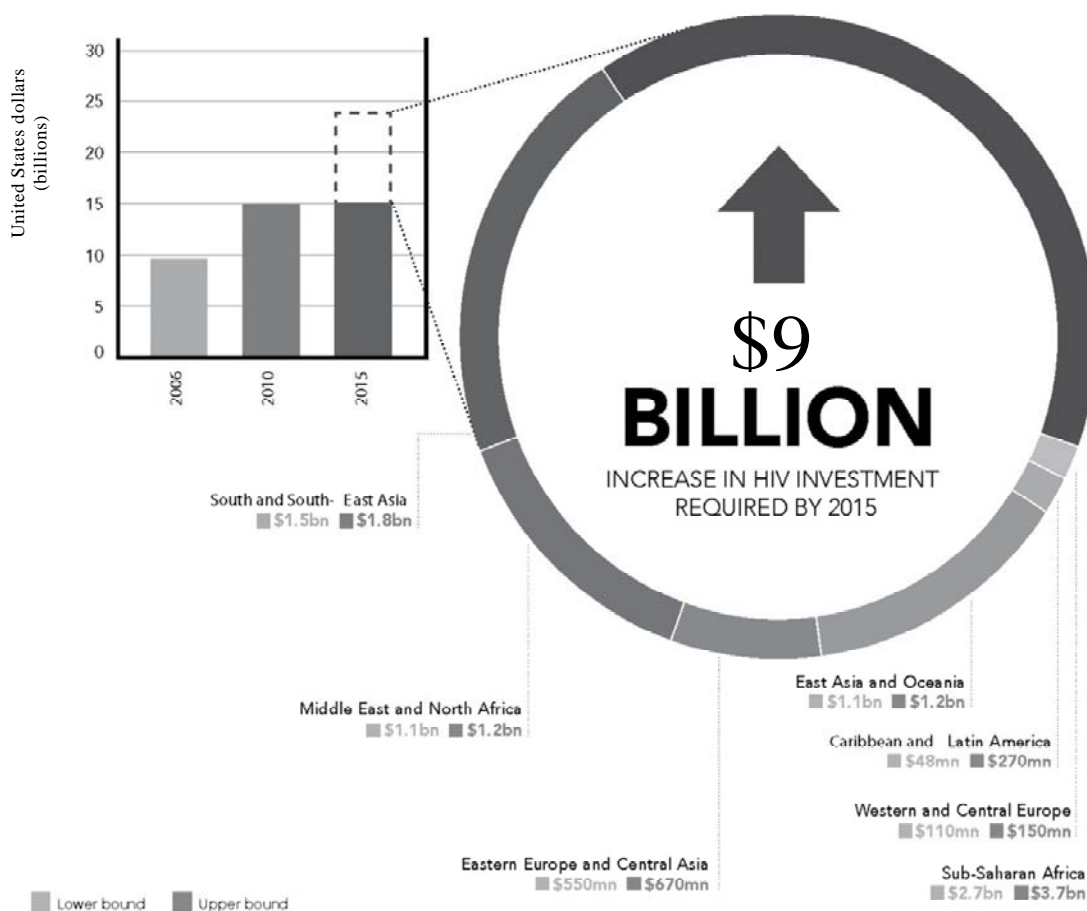


Source: UNAIDS.

F. Close the global AIDS resource gap and reach a significant level of expenditure

45. It will be impossible to achieve global targets without sufficient financial resources. Annual expenditure of \$22 billion to \$24 billion will be needed by 2015 to achieve the targets in the 2011 Political Declaration on HIV and AIDS. This will require a roughly 50 per cent increase over current outlays, as \$15 billion was available for the HIV response in 2010.

Figure X
Changes required to meet the target of reaching \$24 billion in HIV investment by 2015

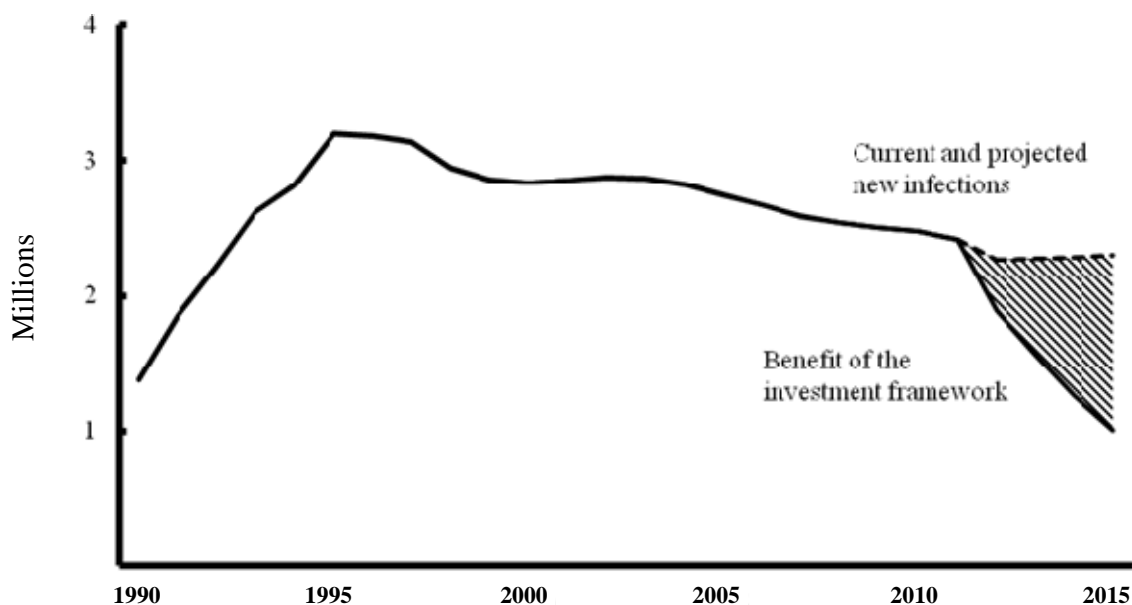


Source: UNAIDS.

46. In 2011, UNAIDS joined with partners to propose a new investment framework for the response, designed to promote efficiency while maximizing results. The investment framework encourages focused funding for six basic programmatic activities: (a) programmes for key populations; (b) elimination of new infections in children; (c) programmes for sexual risk reduction; (d) condom programming; (e) care, treatment and support for people living with HIV; and (f) voluntary medical male circumcision in priority countries. These basic

programmatic activities need to be supported by critical enablers and by well-resourced efforts to capture synergies between the HIV-specific and broader health and development initiatives. According to modelling exercises, improving the strategic use of resources according to the principles of the investment framework would avert 12.2 million new infections and 7.4 million AIDS-related deaths by 2020, with optimized investment leading to rapid declines in new HIV infections globally (see figure XI).

Figure XI
Investment framework projections for new HIV infections



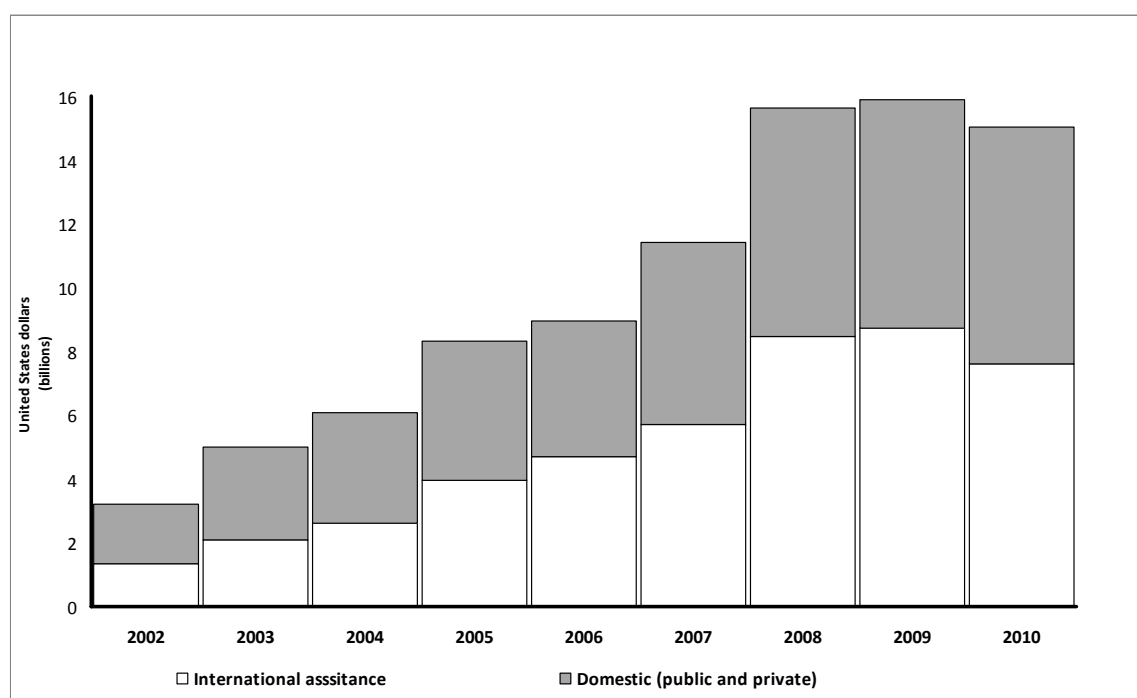
Source: UNAIDS World AIDS Day Report 2011.

47. Urgent efforts are needed to enhance the effective and strategic use of expenditure and to mobilize needed resources. Where they exist, parallel systems of financing, procurement, programming and reporting should be eliminated to promote efficiency, harmonization and alignment. New sources of sustainable financing should be actively explored, including enhanced support from the private sector, the implementation of national social protection mechanisms, the enhanced use of regional development banks and a proposed tax on financial transactions.

48. The stakes involved in future financing for the response are vividly illustrated by recent difficulties at the Global Fund to Fight AIDS, Tuberculosis and Malaria, which cancelled a planned competitive call for proposals owing to funding shortfalls. A new contribution of \$750 million to the Global Fund by the Bill and Melinda Gates Foundation, announced in 2012, serves as a critical vote of confidence in this essential funding mechanism. Consistent with the investment framework, the Global Fund has adopted a new model for negotiating grant agreements with countries, with the aim of focusing limited resources on cost-effective programmes that are tailored to local needs and likely to have the greatest impact.

49. By understanding the response as a shared responsibility, the global community will be able to ensure the financial means to achieve global goals. Were high-income countries to fulfil their pledges to devote 0.7 per cent of gross domestic product to official development assistance, the total resources available for development would more than double. With robust economic growth rates in sub-Saharan Africa, a decision by African Governments to raise the share of the health budget devoted to AIDS to reflect the relative burden of the epidemic in comparison with other diseases would generate an additional \$4.7 billion for HIV activities. In addition, emerging middle-income countries, such as Brazil, China, India, the Russian Federation and South Africa, should continue actively exploring ways to provide increased financial assistance to other countries for the response.

Figure XII
Global resources available for HIV in low- and middle-income countries, 2002-2010



Source: UNAIDS World AIDS Day Report 2011.

G. Meet the specific needs of women and girls, eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

50. Accelerating progress in the response will demand sustained advances towards gender equality and the empowerment of women and girls. With women age 15-24 accounting for more than one in four new infections, and with nearly 60 per cent of infections in sub-Saharan Africa occurring among women, the 2011 Political Declaration on HIV and AIDS recognized the harmful effects of unequal gender norms and practices and pledged concerted action to eliminate gender inequalities.

51. Although there is growing awareness and commitment to take action to advance gender equality and empower women and girls, the gap between aspiration and reality remains considerable. While many countries acknowledge the effects of the epidemic on women and girls, less than half of countries worldwide have dedicated budgets for programmatic activities that address its gender dimensions. Increasing access to rights-based sexual and reproductive health services and empowering women to exercise their reproductive rights is a critical element of an effective response for women and girls. Access to quality education also reduces gender inequalities, demonstrating synergies between the HIV response and other development sectors.

52. Like their male counterparts, women and girls living with and affected by HIV are broadly diverse, demanding programmatic and policy responses that take their variations in needs and circumstances into account. In most regions, many women and girls either belong to key populations at higher risk of HIV infection, or are at risk of HIV infection as the sex partners of members of key populations.

53. Violence against women is both a root cause of HIV infection and a consequence of living with HIV, a fact that underscores the importance of urgent action to eradicate gender-based violence. According to recent household surveys, women who experienced sexual violence as a child were more than twice as likely as those with no such experience to have been diagnosed with a sexually transmitted infection in the previous 12 months and almost half as likely to use condoms. The UNiTE to End Violence against Women campaign calls for concerted action to eliminate gender-based violence by 2015, including the adoption and enforcement of appropriate national laws, the implementation of multisectoral national plans and other key steps. As at 2011, only 40 of 94 countries surveyed reported having a health-sector strategy that specifically addresses gender-based violence.

54. The UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV is galvanizing strong momentum to address the impact of the epidemic on women and girls. In recent months, numerous countries, including Benin, Lesotho, Morocco, Namibia, the United Republic of Tanzania and Viet Nam, have either developed national action plans on women, girls, gender equality and HIV, or taken other steps to address gender-related drivers of their national epidemic. Malaysia has implemented a “one-stop crisis centre model” for women who have experienced physical or sexual violence, offering client-sensitive services, counselling and legal, social and welfare services in the same setting. In India, a multilevel intervention was launched to prevent violence, harassment and stigma against sex workers and other key populations.

55. Men and boys also play a pivotal role in forging the healthy social norms of gender equality, which underscores the importance of programmes and policies that engage men and boys. In 2011, only 7 of 94 countries had dedicated national funding for scaled-up programmes involving men and boys that challenge gender inequalities.

H. Eliminate stigma, discrimination and violence against people living with and affected by HIV and HIV-related travel restrictions, through laws, policies, strategies and programmes that advance human rights

56. Persistent stigma and discrimination undermine progress towards global targets by deterring individuals from accessing HIV services and exacerbating the burdens on people living with HIV. In the Asia and Pacific region, for example, the percentage of people living with HIV who reported loss of employment or income as a result of HIV status ranged from 16-50 per cent, between 4-33 per cent have experienced reduced access to health care owing to stigmatizing attitudes among health-care professionals, and between 9-50 per cent have had their HIV status disclosed to friends or neighbours without their consent. HIV-related stigma reinforces other forms of stigma, such as those affecting populations at higher risk. Women living with HIV often experience harsher and more frequent stigma and discrimination than HIV-positive men.

57. The urgent need for intensified action to address HIV-related stigma and discrimination is apparent. One in every three countries in 2010 reported not having laws in place prohibiting discrimination against people living with HIV. A growing number of countries have enacted unsound and counterproductive laws criminalizing HIV non-disclosure, exposure or transmission, with high-income countries leading in actual prosecutions under such laws.

58. In 2010, 46 per cent of countries reported having laws, regulations or policies that impede key populations at higher risk of HIV infection from accessing prevention, treatment, care and support services. Seventy-six countries criminalize same-sex sexual relations between consenting adults, most countries criminalize some aspect of sex work and most impose criminal penalties on people who are drug-dependent. Not only do these laws marginalize and expose members of key populations to violence, criminal sanctions and prison, they also result in the exclusion of these groups from national economic, health and social support programmes.

59. Consistent with commitments made in the 2011 Political Declaration on HIV and AIDS, countries should immediately review national legal and policy frameworks and, where indicated, enact strong anti-discrimination provisions and repeal or revise other laws that impede sound HIV responses. As only 51 per cent of countries had a legal aid system in place in 2010 for HIV-related cases, countries should strive to provide legal aid and invest in legal rights literacy programmes for people living with HIV and for key populations. Urgent efforts are also needed to sensitize judicial personnel and law enforcement officials.

60. Several important examples of human rights leadership have recently emerged. Thirty-two countries have developed national or sectoral policies and legislation to encourage stakeholders in the workplace to take steps to eliminate stigma, protect human rights and facilitate access to services. In Rwanda, civil society organizations have joined with the bar association and other partners to support legal services, legal literacy and capacity-building in the justice sector. The decriminalization of drug use in Portugal has been associated with a decline in the rates of lifetime drug use and increases in the number of people accessing treatment for drug dependency. Fiji decriminalized homosexuality in 2010, New Zealand reformed its laws to

decriminalize sex work and projects in the Philippines and Thailand work to sensitize law enforcement to the needs of key populations. In South Africa and Brazil, the International Labour Organization Recommendation concerning HIV and AIDS and the world of work, 2010 (No. 200) has been cited in court cases that reversed discriminatory actions against workers based on their HIV status.

61. Recognizing the urgent need to align legal frameworks with principles of human rights and a sound response, UNDP is leading an 18-month initiative, the Global Commission on HIV and the Law. The Commission will soon develop actionable, evidence-informed, rights-based recommendations for effective AIDS responses.

62. In addition to reforming laws and policies, important advances have been made towards expanding the evidence base for community-based programmes to alleviate HIV-related stigma. In particular, innovative anti-stigma projects in Afghanistan, Bangladesh, India, Nepal, Pakistan and Sri Lanka have generated insights and lessons that are informing anti-stigma efforts in other regions.

63. As at November 2011, 47 countries, territories and areas continued to impose discriminatory restrictions on the entry, stay or residence of people living with HIV. Since the 2011 special session, Fiji has removed HIV-related travel restrictions from its national AIDS decree. This courageous action follows the examples of other countries that have removed HIV-related travel restrictions since January 2010, including Armenia, China, Namibia, Ukraine and the United States of America.

I. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response

64. The response to HIV is inextricably linked with the broader development and human rights agenda. In particular, progress in the HIV response advances, and benefits from, progress towards other Millennium Development Goals.

65. The 2011 Political Declaration on HIV and AIDS pledges action to leverage the response to strengthening health and community systems and to integrate HIV into other health and development efforts. The response to HIV has brought unprecedented attention to the needs and rights of young people, women, sex workers, men who have sex with men, people who inject drugs, prisoners and numerous other populations. The response has also strengthened health governance; underwritten the training of tens of thousands of health workers and supported innovative human resource strategies; improved systems for health surveillance and for procurement and supply management of health commodities; and improved laboratory capacity and physical infrastructure of clinics.

66. To improve health outcomes, comprehensive, people-centred services are needed that integrate HIV with services for tuberculosis, sexual and reproductive health, including women's and children's health, and non-communicable diseases, such as drug dependency, cancers and cardiovascular diseases. Innovations in health systems arising from the scale-up of HIV treatment, such as the engagement of communities in service provision and demand creation, service decentralization and measures to enhance the affordability and accessibility of essential health commodities, are already contributing to improvements in programmes for other chronic and non-communicable conditions.

67. Social transfers of food, cash or vouchers, combined with community-based care, help to overcome barriers to service access and treatment adherence. Although social protection has a clear role to play in strengthening the response, intensified collaboration between HIV and social protection experts and stakeholders is necessary to ensure that social protection programmes respond to the needs of individuals and households affected by HIV.

68. The epidemic's effects on children demand continued action and commitment. There is encouraging news, as the number of children orphaned by HIV appears to have peaked in 2009 at 17 million, with a modest subsequent decline to 16.6 million by 2010. This was attributable primarily to the expansion of antiretroviral treatment and programmes to prevent new HIV infections among children. However, country reports indicate that most households with children affected by HIV do not receive assistance and there continue to be millions of new orphans every year. The most effective and non-stigmatizing approach involves situating HIV assistance within broader programmes that address the needs of all vulnerable households.

III. Mutual accountability and engaging diverse stakeholders in the response

69. Achieving a world with zero new infections, zero discrimination and zero AIDS-related deaths will require a collective response, as no sector or stakeholder category has the capacity on its own to undertake or oversee the urgent push to achieve agreed AIDS targets for 2015. Every stakeholder has a critical role to play in ensuring success, and each must commit to principles of mutual accountability, inclusivity, transparency and coordination in the response.

70. Leadership for results is evident across the breadth of the response. In recent months, parliamentarians in India convened a new forum to raise HIV awareness among political decision makers, and the Prime Minister of Mozambique convened a national dialogue to accelerate progress towards the targets in the 2011 Political Declaration on HIV and AIDS. In the face of economic challenges, some donors are also stepping up to the challenge: in 2011, the United States committed to reach at least 6 million people living with HIV with antiretroviral treatment by December 2013 and unveiled a new prevention strategy for its international HIV assistance that is aligned with the principles in the investment framework. The Ministers of Health of Brazil, China, India, the Russian Federation and South Africa formally committed to work together to fully implement the 2011 Political Declaration.

71. Civil society continues to play a leading role, bringing its unparalleled insights, passion and drive to the response. Organizations of people living with HIV have spearheaded the roll-out of the People Living with HIV Stigma Index and promoted the implementation of a holistic, rights-based approach known as "Positive Health, Dignity and Prevention". Civil society groups continue to lead advocacy efforts, at the country level and also globally, where diverse advocates have united to urge concerted action to secure the rights to treatment, non-discrimination and participation. In many countries, civil society organizations have an important role in service, underscoring the need for Governments to work with non-State actors to build sustainable national and local responses.

72. The active engagement of regional institutions is also vital to continued and accelerated progress. In February 2012, Governments of Asia and the Pacific endorsed a road map for improved coordination to accelerate regional progress towards the targets in the 2011 Political Declaration on HIV and AIDS. Similarly, African countries have joined together in a regional plan to eliminate new infections in children; revitalized the AIDS Watch Africa initiative; and joined together under the African Commission on Human and Peoples' Rights to establish the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV.

IV. Measuring results

73. Regular reporting on progress has helped to advance success in the HIV response, enhanced accountability and promoted greater transparency. By engaging civil society and other non-governmental partners, national reporting on core indicators has also contributed to a more inclusive and effective response.

74. The 2011 Political Declaration on HIV and AIDS reflects and reinforces the principles that have made the AIDS response so innovative, robust and successful. To measure the 2011 Political Declaration, the Monitoring and Evaluation Reference Group, supported by UNAIDS and bringing together experts from national Governments, civil society and international organizations, has developed a revised set of Global AIDS Response Progress Reporting indicators. These indicators have been integrated with the WHO system for health sector reporting. Progress reports from countries will be summarized in annual reports to the General Assembly to inform its annual debate on progress in implementing the 2011 Political Declaration.

75. Given the urgency of expediting progress towards the 2015 deadline, additional efforts should be taken to maximize the utility of national reporting to accelerate progress towards agreed targets. In particular, it is imperative that regional institutions increase their involvement and visibility with respect to monitoring and reporting on progress.

V. Recommendations

76. 2011 was a remarkable year for the AIDS response. More than 7 million people were receiving antiretroviral treatment and new scientific advances confirmed the potential of treatment for preventing new HIV infections. Great promise and hope were reflected in the ambitious targets and commitments of the General Assembly Political Declaration on HIV and AIDS, encouraging world leaders and community activists to speak of the beginning of the end of the AIDS epidemic. However, much urgent work remains. The Secretary-General calls on the international community to now stand up to meet the commitments it has made. It needs to do so in ways that shift from charity to justice and that build ownership and shared responsibility for a more sustainable AIDS response, in line with the call for a new social contract made in the Five-Year Action Agenda. In particular, the Secretary-General urges all stakeholders to join hands to:

(a) **Dramatically strengthen and intensify efforts to prevent new HIV infections.** By building on the advances of recent years in promoting safer sexual

behaviours, prevention programmes should enhance efforts to reinforce, sustain and extend behaviour change by promoting social norms of gender equality and mutual respect. Prevention programmes should be better focused on the localities and specific communities where new infections are occurring. Renewed determination is needed to eliminate new infections in children and keep their mothers alive in the 22 priority countries identified in the Global Plan, with particular efforts to ensure commitment and energy in all countries. Stakeholders in the response must summon the wisdom, courage and commitment required to implement strong, evidence-informed prevention programmes that empower key populations to protect themselves and their partners from HIV, including specific focus on the three key populations at higher risk of HIV infection recognized in the 2011 Political Declaration on HIV and AIDS: men who have sex with men, sex workers and people who inject drugs;

(b) **Renew and strengthen determination to deliver HIV treatment, care and support services to those who need them.** To reach the 2015 target of ensuring that 15 million people are on antiretroviral therapy, all partners must work together to enhance the efficiency and accountability of treatment scale-up, accelerate progress towards universal knowledge of HIV status, use lessons learned to increase treatment adherence and retention in care and implement specific steps to ensure equal treatment access for key populations and other socially excluded groups. Urgent attention is needed to catalyse the next phase of HIV treatment and care. Intensified research should focus on the development and deployment of simpler, affordable diagnostics and optimally effective combination regimens; countries should maximize use of flexibilities under international intellectual property provisions to lower the costs of medicines; and communities must be engaged and mobilized to support treatment scale-up. All countries must put into place proven programmatic strategies to increase timely diagnosis, prevention, treatment and cure of tuberculosis cases among people living with HIV;

(c) **The world must move from rhetoric to reality in the commitment to a rights-based approach to HIV.** All countries should undertake an immediate, comprehensive review of national legal and policy frameworks to remove obstacles to effective and rights-based AIDS responses. Meaningful laws prohibiting HIV-based discrimination should be in place in all settings and should receive implementation support and include concrete mechanisms and services to increase access to justice for all people affected by the epidemic. Countries and donors should work together to focus substantial new funding on community-based programming to overcome HIV-related stigma, promote norms of gender equality and eliminate gender-based violence. Criminal laws and other legal or policy impediments that act as obstacles to the effective enjoyment of health and other human rights for key populations at higher risk should be revised or eliminated. By leveraging opportunities through the AIDS response to forge stronger linkages with other health and social and human rights campaigns, women and young people must be empowered and gender equality promoted;

(d) **A new approach to HIV investment is needed that will mobilize necessary resources, enhance the strategic use of resources and accelerate Africa's transition to stronger ownership and sustainability of the response.** All current and potential providers of HIV funding, including international donors, emerging economies, affected countries and the private sector, should contribute financially to the response, taking advantage of opportunities to mobilize additional

resources and in accordance with each partner's capacity. While remaining energetically engaged as partners in the response, international donors and technical agencies should support countries to enhance coherence and control of programming and resources and to maximize value-for-money for results. Through such tools as the investment framework, international partners should support countries to develop robust investment cases to inform and accelerate programmatic scale-up, enhance rigorous and strategic prioritization and optimize synergies through programme integration and critical enablers. With the support of the international community, countries and partners in sub-Saharan Africa should leverage broader development efforts in the region to foster new industries and knowledge-based economies. Urgent efforts are needed to scale up domestic and regional production of antiretroviral drugs in sub-Saharan Africa and to increase South-South technical cooperation;

(e) **New partnerships and collaborative relationships should be forged that respond to the shared responsibility of HIV and reduce risks and advance protections for vulnerable people.** HIV and other health issues need to figure prominently in major international, regional and national forums and in the formulation of the post-2015 development agenda. We must invest in partnerships in which the United Nations, civil society, Governments, academia and the private sector work to address deep-seated issues such as empowering women and young people through strengthened linkages with other health and social movements, and the wider human rights campaigns. Relevant stakeholders also need to confront increased risk and vulnerability in conflict and post-conflict settings and ensure that HIV programmes become an integral part of all disarmament, demobilization, reintegration and peacebuilding processes and security sector reforms, using HIV programmes to strengthen the capacity of peacekeepers and uniformed personnel as agents of positive change.



General Assembly

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Agenda item 10

Resolution adopted by the General Assembly

[without reference to a Main Committee (A/65/L.77)]

65/277. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS

The General Assembly

Adopts the political declaration on HIV and AIDS annexed to the present resolution.

*95th plenary meeting
10 June 2011*

Annex

Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS

1. We, Heads of State and Government and representatives of States and Governments assembled at the United Nations from 8 to 10 June 2011 to review progress achieved in realizing the 2001 Declaration of Commitment on HIV/AIDS¹ and the 2006 Political Declaration on HIV/AIDS,² with a view to guiding and intensifying the global response to HIV and AIDS by promoting continued political commitment and engagement of leaders in a comprehensive response at the community, local, national, regional and international levels to halt and reverse the HIV epidemic and mitigate its impact;
2. Reaffirm the sovereign rights of Member States, as enshrined in the Charter of the United Nations, and the need for all countries to implement the commitments and pledges in the present Declaration consistent with national laws, national development priorities and international human rights;
3. Reaffirm the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and the urgent need to scale up significantly our

¹ Resolution S-26/2, annex.

² Resolution 60/262, annex.



efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support;

4. Recognize that, although HIV and AIDS are affecting every region of the world, each country's epidemic is distinctive in terms of drivers, vulnerabilities, aggravating factors and the populations that are affected, and therefore the responses from both the international community and the countries themselves must be uniquely tailored to each particular situation, taking into account the epidemiological and social context of each country concerned;

5. Acknowledge the significance of this high-level meeting, which marks three decades since the first report of AIDS, ten years since the adoption of the Declaration of Commitment on HIV/AIDS and its time-bound measurable goals and targets, and five years since the adoption of the Political Declaration on HIV/AIDS and its commitment to urgently scale up responses towards achieving the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010;

6. Reaffirm our commitment to the achievement of all the Millennium Development Goals, in particular Goal 6, and, recognizing the importance of rapidly scaling up efforts to integrate HIV and AIDS prevention, treatment, care and support with efforts to achieve those Goals, in this regard welcome the outcome document of the 2010 High-level Plenary Meeting of the General Assembly on the Millennium Development Goals, entitled "Keeping the promise: united to achieve the Millennium Development Goals";³

7. Recognize that HIV and AIDS constitute a global emergency, pose one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large and require an exceptional and comprehensive global response that takes into account the fact that the spread of HIV is often a consequence and a cause of poverty;

8. Note with deep concern that, despite substantial progress over the three decades since AIDS was first reported, the HIV epidemic remains an unprecedented human catastrophe inflicting immense suffering on countries, communities and families throughout the world, that more than 30 million people have died from AIDS, with another estimated 33 million people living with HIV, that more than 16 million children have been orphaned because of AIDS, that over 7,000 new HIV infections occur every day, mostly among people in low- and middle-income countries, and that less than half of the people living with HIV are believed to be aware of their infection;

9. Reiterate with profound concern that Africa, in particular sub-Saharan Africa, remains the worst-affected region and that urgent and exceptional action is required at all levels to curb the devastating effects of this epidemic, and recognize the renewed commitment of African Governments and regional institutions to scale up their own HIV and AIDS responses;

10. Express deep concern that HIV and AIDS affect every region of the world and that the Caribbean continues to have the highest prevalence outside sub-Saharan Africa, while the number of new HIV infections is increasing in Eastern Europe, Central Asia, North Africa, the Middle East and parts of Asia and the Pacific;

³ See resolution 65/1.

11. Welcome the leadership and commitment shown in every aspect of the HIV and AIDS response by Governments, people living with HIV, political and community leaders, parliaments, regional and subregional organizations, communities, families, faith-based organizations, scientists, health professionals, donors, the philanthropic community, the workforce, the business sector, civil society and the media;

12. Welcome the exceptional efforts at the national, regional and international levels to implement the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and the important progress being made, including a more than 25 per cent reduction in the rate of new HIV infections in over 30 countries, the significant reduction in mother-to-child transmission of HIV and the unprecedented expansion of access to HIV antiretroviral treatment to over 6 million people, resulting in the reduction of AIDS-related deaths by more than 20 per cent in the past five years;

13. Recognize that the worldwide commitment to the global HIV epidemic has been unprecedented since the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, represented by an over eight-fold increase in funding from 1.8 billion United States dollars in 2001 to 16 billion dollars in 2010, the largest amount dedicated to combating a single disease in history;

14. Express deep concern that funding devoted to HIV and AIDS responses is still not commensurate with the magnitude of the epidemic either nationally or internationally and that the global financial and economic crisis continues to have a negative impact on the HIV and AIDS response at all levels, including the fact that, for the first time, international assistance has not increased from the levels in 2008 and 2009, and in this regard welcome the increased resources that are being made available as a result of the establishment by many developed countries of timetables to achieve the target of 0.7 per cent of gross national product for official development assistance by 2015, stressing also the importance of complementary innovative sources of financing, in addition to traditional funding, including official development assistance, to support national strategies, financing plans and multilateral efforts aimed at combating HIV and AIDS;

15. Stress the importance of international cooperation, including the role of North-South, South-South and triangular cooperation, in the global response to HIV and AIDS, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation, and recognize the shared but differentiated responsibilities and respective capacities of Governments and donor countries, as well as civil society, including the private sector, while noting that national ownership and leadership are absolutely indispensable in this regard;

16. Commend the secretariat and the Co-sponsors of the Joint United Nations Programme on HIV/AIDS for their leadership role on HIV and AIDS policy and coordination and for the support they provide to countries through the Joint Programme;

17. Commend the Global Fund to Fight AIDS, Tuberculosis and Malaria for the vital role it is playing in mobilizing and providing funding for national and regional HIV and AIDS responses and in improving the predictability of financing over the long term, and welcome the commitment of over 30 billion dollars in funding from donors to date, including the significant pledges made by donors at the Global Fund replenishment conference held on 4 and 5 October 2010; note with concern that, while these pledges represent an increase in financing, they fall short of the amounts

targeted by the Global Fund to further accelerate progress towards universal access, and recognize that to reach that goal it is imperative that the work of the Global Fund be supported and also that it be adequately funded;

18. Commend the work of the International Drug Purchase Facility, UNITAID, based on innovative financing and focusing on accessibility, quality and price reductions of antiretroviral drugs;

19. Welcome the Secretary General's Global Strategy for Women's and Children's Health, undertaken by a broad coalition of partners in support of national plans and strategies, to significantly reduce the number of maternal, newborn and under-five child deaths, as a matter of immediate concern, including by scaling up a priority package of high-impact interventions and integrating efforts in sectors such as health, education, gender equality, water and sanitation, poverty reduction and nutrition;

20. Recognize that agrarian economies are heavily affected by HIV and AIDS, which debilitate their communities and families with negative consequences for poverty eradication, that people die prematurely from AIDS because, inter alia, poor nutrition exacerbates the impact of HIV on the immune system and compromises its ability to respond to opportunistic infections and diseases, and that HIV treatment, including antiretroviral treatment, should be complemented with adequate food and nutrition;

21. Remain deeply concerned that, globally, women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden, and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal legal, economic and social status, insufficient access to health care and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation;

22. Welcome the establishment of the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) as a new stakeholder that can play an important role in global efforts to combat HIV by promoting gender equality and the empowerment of women, which are fundamental for reducing the vulnerability of women to HIV, and the appointment of the first Executive Director of UN-Women;

23. Welcome the adoption of the Convention on the Rights of Persons with Disabilities,⁴ and recognize the need to take into account the rights of persons with disabilities as set forth in that Convention, in particular with regard to health, education, accessibility and information, in the formulation of our global response to HIV and AIDS;

24. Note with appreciation the efforts of the Inter-Parliamentary Union in supporting national parliaments to ensure an enabling legal environment supportive of effective national responses to HIV and AIDS;

25. Express grave concern that young people between the ages of 15 and 24 years account for more than one third of all new HIV infections, with some 3,000 young people becoming infected with HIV each day, and note that most young people still have limited access to good quality education, decent employment and recreational facilities, as well as limited access to sexual and reproductive health programmes

⁴ Resolution 61/106, annex I.

that provide the information, skills, services and commodities they need to protect themselves, that only 34 per cent of young people possess accurate knowledge of HIV, and that laws and policies in some instances exclude young people from accessing sexual health-care and HIV-related services, such as voluntary and confidential HIV testing, counselling and age-appropriate sex and HIV-prevention education, while also recognizing the importance of reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence, fidelity and correct and consistent use of condoms;

26. Note with alarm the rise in the incidence of HIV among people who inject drugs and that, despite continuing increased efforts by all relevant stakeholders, the drug problem continues to constitute a serious threat to, among other things, public health and safety and the well-being of humanity, in particular children and young people and their families, and recognize that much more needs to be done to effectively combat the world drug problem;

27. Recall our commitment that prevention must be the cornerstone of the global HIV and AIDS response, but note that many national HIV-prevention programmes and spending priorities do not adequately reflect this commitment, that spending on HIV prevention is insufficient to mount a vigorous, effective and comprehensive global HIV-prevention response, that national prevention programmes are often not sufficiently coordinated and evidence-based, that prevention strategies do not adequately reflect infection patterns or sufficiently focus on populations at higher risk of HIV, and that only 33 per cent of countries have prevalence targets for young people and only 34 per cent have specific goals in place for condom programming;

28. Note with concern that national prevention strategies and programmes are often too generic in nature and do not adequately respond to infection patterns and the disease burden; for example, where heterosexual sex is the dominant mode of transmission, married or cohabitating individuals, including those in sero-discordant relationships, account for the majority of new infections but are not sufficiently targeted with testing and prevention interventions;

29. Note that many national HIV-prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers, and further note, however, that each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context;

30. Note with grave concern that, despite the near elimination of mother-to-child transmission of HIV in high-income countries and the availability of low-cost interventions to prevent transmission, approximately 370,000 infants were estimated to have been infected with HIV in 2009;

31. Note with concern that prevention, treatment, care and support programmes have not been adequately targeted or made accessible to persons with disabilities;

32. Recognize that access to safe, effective, affordable, good quality medicines and commodities in the context of epidemics such as HIV is fundamental to the full realization of the right of everyone to enjoy the highest attainable standard of physical and mental health;

33. Express grave concern that the majority of low- and middle-income countries did not meet their universal access to HIV treatment targets, despite the major achievement of expansion in providing access to antiretroviral treatment to over 6 million people living with HIV in low- and middle-income countries, that there are at least 10 million people living with HIV who are medically eligible to start

antiretroviral treatment now, that discontinued treatment is a threat to treatment efficacy, and that the sustainability of providing life-long HIV treatment is threatened by factors such as poverty, lack of access to treatment and insufficient and unpredictable funding and by the fact that the number of new HIV infections is outpacing the number of people starting HIV treatment by a factor of two to one;

34. Recognize the pivotal role of research in underpinning progress in HIV prevention, treatment, care and support, and welcome the extraordinary advances in scientific knowledge about HIV and its prevention and treatment, but note with concern that most new treatments are not available or accessible in low- and middle-income countries and that even in developed countries there are often significant delays in accessing new HIV treatments for people not responding to currently available treatment, and affirm the importance of social and operational research in improving our understanding of factors that influence the epidemic and actions that address it;

35. Recognize the critical importance of affordable medicines, including generics, in scaling up access to affordable HIV treatment, and further recognize that protection and enforcement measures for intellectual property rights should be compliant with the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement)⁵ and should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all;

36. Note with concern that regulations, policies and practices, including those that limit legitimate trade in generic medicines, may seriously limit access to affordable HIV treatment and other pharmaceutical products in low- and middle-income countries, and recognize that improvements can be made, inter alia through national legislation, regulatory policy and supply chain management, noting that reductions in barriers to affordable products could be explored in order to expand access to affordable and good quality HIV prevention products, diagnostics, medicine and treatment commodities for HIV, including for opportunistic infections and co-infections;

37. Recognize that there are additional means to reverse the global epidemic and avert millions of HIV infections and AIDS-related deaths, and in this context also recognize that new and potential scientific evidence is available that could contribute to the effectiveness and scaling up of prevention, treatment, care and support programmes;

38. Reaffirm the commitment to fulfil obligations to promote universal respect for and the observance and protection of all human rights and fundamental freedoms for all in accordance with the Charter, the Universal Declaration of Human Rights⁶ and other instruments relating to human rights and international law; and emphasize the importance of cultural, ethical and religious values, the vital role of the family and the community and, in particular, of people living with and affected by HIV, including their families, and the need to take into account the particularities of each country in sustaining national HIV and AIDS responses, reaching all people living with HIV, delivering HIV prevention, treatment, care and support and strengthening health systems, in particular primary health care;

⁵ See *Legal Instruments Embodying the Results of the Uruguay Round of Multilateral Trade Negotiations, done at Marrakesh on 15 April 1994* (GATT secretariat publication, Sales No. GATT/1994-7).

⁶ Resolution 217 A (III).

39. Reaffirm that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV epidemic, including in the areas of prevention, treatment, care and support, recognize that addressing stigma and discrimination against people living with, presumed to be living with or affected by HIV, including their families, is also a critical element in combating the global HIV epidemic, and recognize also the need, as appropriate, to strengthen national policies and legislation to address such stigma and discrimination;
40. Recognize that close cooperation with people living with HIV and populations at higher risk of HIV infection will facilitate the achievement of a more effective HIV and AIDS response, and emphasize that people living with and affected by HIV, including their families, should enjoy equal participation in social, economic and cultural activities, without prejudice and discrimination, and that they should have equal access to health care and community support as all members of the community;
41. Recognize that access to sexual and reproductive health has been and continues to be essential for HIV and AIDS responses and that Governments have the responsibility to provide for public health, with special attention to families, women and children;
42. Recognize the importance of strengthening health systems, in particular primary health care and the need to integrate the HIV response into it, and note that weak health systems, which already face many challenges, including a lack of trained health workers and a lack of retention of skilled health workers, are among the biggest barriers to accessing HIV and AIDS-related services;
43. Reaffirm the central role of the family, bearing in mind that in different cultural, social and political systems various forms of the family exist, in reducing vulnerability to HIV, inter alia in educating and guiding children, and take account of cultural, religious and ethical factors to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV and AIDS in curricula for adolescents, ensuring safe and secure environments, especially for young girls, expanding good quality youth-friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning, implementing and evaluating HIV and AIDS prevention and care programmes, to the extent possible;
44. Recognize the role that community organizations play, including those run by people living with HIV, in sustaining national and local HIV and AIDS responses, reaching all people living with HIV, delivering prevention, treatment, care and support services and strengthening health systems, in particular the primary health-care approach;
45. Acknowledge that the current trajectory of costs of HIV programmes is not sustainable and that programmes must become more cost-effective and evidence-based and deliver better value for money, and that poorly coordinated and transaction-heavy responses and a lack of proper governance and financial accountability impede progress;
46. Note with concern that evidence-based responses, which must be informed by data disaggregated by incidence and prevalence, including by age, sex and mode of transmission, continue to require stronger measuring tools, data management systems and improved monitoring and evaluation capacity at the national and regional levels;

47. Note the relevant strategies on HIV and AIDS of the Joint United Nations Programme on HIV/AIDS and the World Health Organization;

48. Recognize that the deadlines for achieving key targets and goals set out in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS have now expired, while noting with deep concern that many countries have been unable to fulfil their pledges to achieve them, and stress the urgent need to recommit to those targets and goals and commit to new, ambitious and achievable targets and goals building on the impressive advances of the past ten years and addressing barriers to progress and new challenges through a revitalized and enduring HIV and AIDS response;

49. Therefore, we solemnly declare our commitment to end the epidemic with renewed political will and strong, accountable leadership and to work in meaningful partnership with all stakeholders at all levels to implement bold and decisive actions as set out below, taking into account the diverse situations and circumstances in different countries and regions throughout the world;

Leadership: uniting to end the HIV epidemic

50. Commit to seize this turning point in the HIV epidemic and, through decisive, inclusive and accountable leadership, to revitalize and intensify the comprehensive global HIV and AIDS response by recommitting to the commitments made in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and by fully implementing the commitments, goals and targets contained in the present Declaration;

51. Commit to redouble efforts to achieve, by 2015, universal access to HIV prevention, treatment, care and support as a critical step towards ending the global HIV epidemic, with a view to achieving Millennium Development Goal 6, in particular to halt and begin to reverse, by 2015, the spread of HIV;

52. Reaffirm our determination to achieve all the Millennium Development Goals, in particular Goal 6, and recognize the importance of rapidly scaling up efforts to integrate HIV prevention, treatment, care and support with efforts to achieve these goals;

53. Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and violence, in order to increase their ability to protect themselves from HIV infection, and take all necessary measures to create an enabling environment for the empowerment of women and to strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;

54. Commit to update and implement, by 2012, through inclusive, country-led and transparent processes, multisectoral national HIV and AIDS strategies and plans, including financing plans, which include time-bound goals to be reached in a targeted, equitable and sustained manner, to accelerate efforts to achieve universal access to HIV prevention, treatment, care and support by 2015, and address unacceptably low prevention and treatment coverage;

55. Commit to increase national ownership of HIV and AIDS responses, while calling upon the United Nations system, donor countries, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the business sector and international and regional organizations to support Member States in ensuring that nationally driven, credible, costed, evidence-based, inclusive and comprehensive national HIV and AIDS strategic plans are, by 2013, funded and implemented with transparency, accountability and effectiveness in line with national priorities;

56. Commit to encouraging and supporting the active involvement and leadership of young people, including those living with HIV, in the fight against the epidemic at the local, national and global levels, and agree to work with these new leaders to help to develop specific measures to engage young people about HIV, including in communities, families, schools, tertiary institutions, recreation centres and workplaces;

57. Commit to continue engaging people living with and affected by HIV in decision-making and planning, implementing and evaluating the response, and to partner with local leaders and civil society, including community-based organizations, to develop and scale up community-led HIV services and to address stigma and discrimination;

Prevention: expanding coverage, diversifying approaches and intensifying efforts to end new HIV infections

58. Reaffirm that prevention of HIV must be the cornerstone of national, regional and international responses to the HIV epidemic;

59. Commit to redouble HIV-prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including through, but not limited to:

(a) Conducting public awareness campaigns and targeted HIV education to raise public awareness about HIV;

(b) Harnessing the energy of young people in helping to lead global HIV awareness;

(c) Reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence, fidelity and consistent and correct use of condoms;

(d) Expanding access to essential commodities, particularly male and female condoms and sterile injecting equipment;

(e) Ensuring that all people, particularly young people, have the means to exploit the potential of new modes of connection and communication;

(f) Significantly expanding and promoting voluntary and confidential HIV testing and counselling and provider-initiated HIV testing and counselling;

(g) Intensifying national testing promotion campaigns for HIV and other sexually transmitted infections;

(h) Giving consideration, as appropriate, to implementing and expanding risk- and harm-reduction programmes, taking into account the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*,⁷ in accordance with national legislation;

⁷ Available from www.who.int/hiv/pub/idu/targetsetting/en/index.html.

(i) Promoting medical male circumcision where HIV prevalence is high and male circumcision rates are low;

(j) Sensitizing and encouraging the active engagement of men and boys in promoting gender equality;

(k) Facilitating access to sexual and reproductive health-care services;

(l) Ensuring that women of childbearing age have access to HIV-prevention-related services and that pregnant women have access to antenatal care, information, counselling and other HIV services, and increasing the availability of and access to effective treatment for women living with HIV and infants;

(m) Strengthening evidence-based health sector prevention interventions, including in rural and hard-to-reach places;

(n) Deploying new biomedical interventions as soon as they are validated, including female-initiated prevention methods such as microbicides, HIV treatment prophylaxis, earlier treatment as prevention and an HIV vaccine;

60. Commit to ensure that financial resources for prevention are targeted to evidence-based prevention measures that reflect the specific nature of each country's epidemic by focusing on geographic locations, social networks and populations vulnerable to HIV infection, according to the extent to which they account for new infections in each setting, in order to ensure that resources for HIV prevention are spent as cost-effectively as possible and to ensure that particular attention is paid to women and girls, young people, orphans and vulnerable children, migrants and people affected by humanitarian emergencies, prisoners, indigenous people and people with disabilities, depending on local circumstances;

61. Commit to ensure that national prevention strategies comprehensively target populations at higher risk and that systems of data collection and analysis about these populations are strengthened, and to take measures to ensure that HIV services, including voluntary and confidential HIV testing and counselling, are accessible to these populations so that they are encouraged to access HIV prevention, treatment, care and support;

62. Commit to working towards reducing sexual transmission of HIV by 50 per cent by 2015;

63. Commit to working towards reducing transmission of HIV among people who inject drugs by 50 per cent by 2015;

64. Commit to working towards the elimination of mother-to-child transmission of HIV and substantially reducing AIDS-related maternal deaths by 2015;

Treatment, care and support: eliminating AIDS-related illness and death

65. Pledge to intensify efforts that will help to increase the life expectancy and quality of life of all people living with HIV;

66. Commit to accelerate efforts to achieve the goal of universal access to antiretroviral treatment for those eligible based on World Health Organization HIV treatment guidelines that indicate timely initiation of quality assured treatment for its maximum benefit, with the target of working towards having 15 million people living with HIV on antiretroviral treatment by 2015;

67. Commit to support the reduction of unit costs and improve HIV treatment delivery, through, inter alia, provision of good quality, affordable, effective, less

toxic and simplified treatment regimens that avert drug resistance, simple, affordable diagnostics at point of care, cost reductions for all major elements of treatment delivery, mobilization and capacity-building of communities to support treatment scale-up and patient retention, programmes that support improved treatment adherence, directing particular efforts towards hard-to-reach populations far from physical health-care facilities and programmes and those in informal settlement settings and other locations where health-care facilities are inadequate and recognizing the supplementary prevention benefits from treatment alongside other prevention efforts;

68. Commit to develop and implement strategies to improve infant HIV diagnosis, including through access to diagnostics at point of care, significantly increase and improve access to treatment for children and adolescents living with HIV, including access to prophylaxis and treatments for opportunistic infections, as well as increased support to children and adolescents through increased financial, social and moral support for their parents, families and legal guardians, and promote a smooth transition from paediatric to young adult treatment and related support and services;

69. Commit to promote services that integrate prevention, treatment and care of co-occurring conditions, including tuberculosis and hepatitis and improve access to quality, affordable primary health care, comprehensive care and support services, including those which address physical, spiritual, psychosocial, socio-economic and legal aspects of living with HIV, and palliative care services;

70. Commit to take immediate action at the national and global levels to integrate food and nutritional support into programmes directed to people affected by HIV in order to ensure access to sufficient, safe and nutritious food to enable people to meet their dietary needs and food preferences, for an active and healthy life as part of a comprehensive response to HIV and AIDS;

71. Commit to remove before 2015, where feasible, obstacles that limit the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities and other pharmaceutical products, as well as treatment for opportunistic infections and co-infections, and to reduce costs associated with life-long chronic care, including by amending national laws and regulations, as deemed appropriate by respective Governments, so as to optimize:

(a) The use, to the full, of existing flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights specifically geared to promoting access to and trade in medicines, and, while recognizing the importance of the intellectual property rights regime in contributing to a more effective AIDS response, ensure that intellectual property rights provisions in trade agreements do not undermine these existing flexibilities, as confirmed in the Doha Declaration on the TRIPS Agreement and Public Health,⁸ and call for early acceptance of the amendment to article 31 of the TRIPS Agreement adopted by the General Council of the World Trade Organization in its decision of 6 December 2005;⁹

(b) Addressing barriers, regulations, policies and practices that prevent access to affordable HIV treatment by promoting generic competition in order to help to reduce costs associated with life-long chronic care and by encouraging all

⁸ World Trade Organization, document WT/MIN(01)/DEC/2. Available from <http://docsonline.wto.org>.

⁹ See World Trade Organization, document WT/L/641. Available from <http://docsonline.wto.org>.

States to apply measures and procedures for enforcing intellectual property rights in such a manner as to avoid creating barriers to the legitimate trade in medicines, and to provide for safeguards against the abuse of such measures and procedures;

(c) Encouraging the voluntary use, where appropriate, of new mechanisms such as partnerships, tiered pricing, open-source sharing of patents and patent pools benefiting all developing countries, including through entities such as the Medicines Patent Pool, to help to reduce treatment costs and encourage development of new HIV treatment formulations, including HIV medicines and point-of-care diagnostics, in particular for children;

72. Urge relevant international organizations, upon request and in accordance with their respective mandates, such as, where appropriate, the World Intellectual Property Organization, the United Nations Industrial Development Organization, the United Nations Development Programme, the United Nations Conference on Trade and Development, the World Trade Organization and the World Health Organization, to provide national Governments of developing countries with technical and capacity-building assistance for the efforts of those Governments to increase access to HIV medicines and treatment, in accordance with the national strategies of each Government, consistent with, and including through the use of, existing flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights, as confirmed by the Doha Declaration on the TRIPS Agreement and Public Health;

73. Commit by 2015 to address factors that limit treatment uptake and contribute to treatment stock-outs and delays in drug production and delivery, inadequate storage of medicines, patient dropout, including inadequate and inaccessible transportation to clinical sites, lack of accessibility of information, resources and sites, especially for persons with disabilities, sub-optimal management of treatment-related side effects, poor adherence to treatment, out-of-pocket expenses for non-drug components of treatment, loss of income associated with clinic attendance and inadequate human resources for health care;

74. Call upon pharmaceutical companies to take measures to ensure timely production and delivery of affordable, good quality and effective antiretroviral medicines so as to contribute to maintaining an efficient national system of distribution of these medicines;

75. Expand efforts to combat tuberculosis, which is a leading cause of death among people living with HIV, by improving tuberculosis screening, tuberculosis prevention, access to diagnosis and treatment of tuberculosis and drug-resistant tuberculosis and access to antiretroviral therapy, through more integrated delivery of HIV and tuberculosis services in line with the Global Plan to Stop TB 2011–2015, and commit by 2015 to work towards reducing tuberculosis deaths among people living with HIV by 50 per cent;

76. Commit to reduce the high rates of HIV and hepatitis B and C co-infection by developing, as soon as practicable, an estimate of the global treatment need, increasing efforts towards the development of a vaccine for hepatitis C and rapidly expanding access to appropriate vaccination for hepatitis B and to diagnostics and treatment of HIV and hepatitis co-infections;

Advancing human rights to reduce stigma, discrimination and violence related to HIV

77. Commit to intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support and non-discriminatory access to education, health care, employment and social services, provide legal protections for people affected by HIV, including inheritance rights and respect for privacy and confidentiality, and promote and protect all human rights and fundamental freedoms, with particular attention to all people vulnerable to and affected by HIV;
78. Commit to review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV and to consider their review in accordance with relevant national review frameworks and time frames;
79. Encourage Member States to consider identifying and reviewing any remaining HIV-related restrictions on entry, stay and residence in order to eliminate them;
80. Commit to national HIV and AIDS strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, including by sensitizing the police and judges, training health-care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support;
81. Commit to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan, by strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;
82. Commit to strengthen national social and child protection systems and care and support programmes for children, in particular for the girl child, and adolescents affected by and vulnerable to HIV, as well as their families and caregivers, including through the provision of equal opportunities to support the development to their full potential of orphans and other children affected by and living with HIV, especially through equal access to education, the creation of safe and non-discriminatory learning environments, supportive legal systems and protections, including civil registration systems, and the provision of comprehensive information and support to children and their families and caregivers, especially age-appropriate HIV information, to assist children living with HIV as they transition through adolescence, consistent with their evolving capacities;
83. Commit to promoting laws and policies that ensure the full realization of all human rights and fundamental freedoms for young people, particularly those living with HIV and those at higher risk of HIV infection, so as to eliminate the stigma and discrimination they face;
84. Commit to address, according to national legislation, the vulnerabilities to HIV experienced by migrant and mobile populations and support their access to HIV prevention, treatment, care and support;

85. Commit to mitigate the impact of the epidemic on workers, their families, their dependants, workplaces and economies, including by taking into account all relevant conventions of the International Labour Organization, as well as the guidance provided by the relevant International Labour Organization recommendations, including the Recommendation on HIV and AIDS and the World of Work, 2010 (No. 200), and call upon employers, trade and labour unions, employees and volunteers to eliminate stigma and discrimination, protect human rights and facilitate access to HIV prevention, treatment, care and support;

Resources for the AIDS response

86. Commit to working towards closing, by 2015, the global HIV and AIDS resource gap, currently estimated by the Joint United Nations Programme on HIV/AIDS to be 6 billion dollars annually, through greater strategic investment and continued domestic and international funding to enable countries to access predictable and sustainable financial resources and through sources of innovative financing and by ensuring that funding flows through country finance systems, where appropriate and available, and is aligned with accountable and sustainable national HIV and AIDS and development strategies that maximize synergies and deliver sustainable programmes that are evidence-based and implemented with transparency, accountability and effectiveness;

87. Commit to breaking the upward trajectory of costs through the efficient utilization of resources, addressing barriers to the legal trade in generics and other low-cost medicines, improving the efficiency of prevention by targeting interventions to deliver more efficient, innovative and sustainable programmes for the HIV and AIDS response, in accordance with national development plans and priorities, and ensuring that synergies are exploited between the HIV and AIDS response and the efforts to achieve the internationally agreed development goals, including the Millennium Development Goals;

88. Commit, by 2015, through a series of incremental steps and through our shared responsibility, to reach a significant level of annual global expenditure on HIV and AIDS, while recognizing that the overall target estimated by the Joint United Nations Programme on HIV/AIDS is between 22 billion and 24 billion dollars in low- and middle-income countries, by increasing national ownership of HIV and AIDS responses through greater allocations from national resources and traditional sources of funding, including official development assistance;

89. Strongly urge those developed countries that have pledged to achieve the target of 0.7 per cent of their gross national product for official development assistance by 2015, and urge those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard;

90. Strongly urge African countries that adopted the Abuja Declaration and Framework for Action for the fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases¹⁰ to take concrete measures to meet the target of allocating at least 15 per cent of their annual budget to the improvement of the health sector, in accordance with the Abuja Declaration and Framework for Action;

¹⁰ See Organization of African Unity, document OAU/SPS/ABUJA/3.

91. Commit to enhance the quality of aid by strengthening national ownership, alignment, harmonization, predictability, mutual accountability and transparency, and results orientation;
92. Commit to supporting and strengthening existing financial mechanisms, including the Global Fund to Fight AIDS, Tuberculosis and Malaria and relevant United Nations organizations, through the provision of funds in a sustained and predictable manner, in particular to those countries with low and middle incomes with a high disease burden or a large number of people living with and affected by HIV;
93. Recommit to fully implementing the enhanced Heavily Indebted Poor Countries Initiative and agree to cancel all eligible bilateral official debts of qualified countries within the Initiative that reach the completion point under the Initiative, in particular the countries most affected by HIV and AIDS, and urge the use of debt service savings, inter alia, to finance poverty eradication programmes, particularly for prevention, treatment, care and support for HIV and AIDS and other infections;
94. Commit to scaling up new, voluntary and additional innovative financing mechanisms to help to address the shortfall of resources available for the global HIV and AIDS response and to improving the financing of the HIV and AIDS response over the long term, and to accelerating efforts to identify innovative financing mechanisms that will generate additional financial resources for HIV and AIDS to complement national budgetary allocations and official development assistance;
95. Appreciate that the Global Fund to Fight AIDS, Tuberculosis and Malaria is a pivotal mechanism for achieving universal access to prevention, treatment, care and support by 2015, recognize the programme for reform of the Global Fund, and encourage Member States, the business community, including foundations, and philanthropists to provide the highest level of support for the Global Fund, taking into account the funding targets to be identified at the 2012 midterm review of the Global Fund replenishment process;

Strengthening health systems and integrating HIV and AIDS with broader health and development

96. Commit to redouble efforts to strengthen health systems, including primary health care, particularly in developing countries, through measures such as allocating national and international resources, appropriate decentralization of HIV and AIDS programmes to improve access for communities, including rural and hard-to-reach populations, integration of HIV and AIDS programmes into primary health care, sexual and reproductive health-care services and specialized infectious disease services, improving planning for institutional, infrastructure and human resource needs, improving supply chain management within health systems and increasing human resource capacity for the response, including by scaling up the training and retention of human resources for health policy and planning, health-care personnel, consistent with the World Health Organization voluntary Global Code of Practice on the International Recruitment of Health Personnel,¹¹ community health workers and

¹¹ See World Health Organization, *Sixty-third World Health Assembly, Geneva, 17–21 May 2010, Resolutions and Decisions, Annexes* (WHA63/2010/REC/1).

peer educators, with support from and in partnership with international and regional organizations, the business sector and civil society, as appropriate;

97. Support and encourage, through domestic and international funding and the provision of technical assistance, the substantial development of human capital, development of national and international research infrastructures, laboratory capacity and improved surveillance systems, and data collection, processing and dissemination, and training of basic and clinical researchers, social scientists and technicians, with a focus on those countries most affected by HIV and/or experiencing or at risk of a rapid expansion of the epidemic;

98. Commit, by 2015, to working with partners to direct resources to and strengthen the advocacy, policy and programmatic links between HIV and tuberculosis responses, primary health-care services, sexual and reproductive health, maternal and child health, hepatitis B and C, drug dependence, non-communicable diseases and overall health systems, leveraging health-care services to prevent mother-to-child transmission of HIV, strengthening the interface between HIV services, related sexual and reproductive health care and services and other health services, including maternal and child health, eliminating parallel systems for HIV-related services and information where feasible and strengthening linkages among national and global efforts concerned with human and national development, including poverty eradication, preventative health care, enhanced nutrition, access to safe and clean drinking water, sanitation, education and the improvement of livelihoods;

99. Commit to supporting all national, regional and global efforts to achieve the Millennium Development Goals, including those undertaken through North-South, South-South and triangular cooperation, to improve comprehensive and integrated HIV prevention, treatment, care and support programmes, as well as tuberculosis, sexual and reproductive health, malaria and maternal and child health care;

Research and development: the key to preventing, treating and curing HIV

100. Commit to investing in accelerated basic research on the development of sustainable and affordable HIV and tuberculosis diagnostics and treatments for HIV and its associated co-infections, microbicides and other new prevention technologies, including female-controlled prevention methods, rapid diagnostic and monitoring technologies, as well as biomedical operations and social, cultural and behavioural and traditional medicine research, and continuing to build national research capacity, especially in developing countries, through increased funding and public-private partnerships, and creating a conducive environment for research and ensuring that it is based on the highest ethical and scientific standards, and strengthening national regulatory authorities;

101. Commit to accelerate research and development for a safe, affordable, effective and accessible vaccine and for a cure for HIV, while ensuring that sustainable systems for vaccine procurement and equitable distribution are also developed;

Coordination, monitoring and accountability: maximizing the response

102. Commit to having effective evidence-based operational monitoring and evaluation and mutual accountability mechanisms between all stakeholders to support multisectoral national strategic plans for HIV and AIDS to fulfil the commitments in the present Declaration, with the active involvement of people living with, affected by and vulnerable to HIV, and other relevant civil society and private sector stakeholders;

103. Commit to revise by the end of 2012 the recommended framework of core indicators that reflect the commitments made in the present Declaration and to develop additional measures, where necessary, to strengthen national, regional and global coordination and monitoring mechanisms of HIV and AIDS responses through inclusive and transparent processes with the full involvement of Member States and other relevant stakeholders, with the support of the Joint United Nations Programme on HIV/AIDS;

Follow-up: sustaining progress

104. Encourage and support the exchange among countries and regions of information, research, evidence and experiences for implementing the measures and commitments related to the global HIV and AIDS response, in particular those contained in the present Declaration, facilitate intensified North-South, South-South and triangular cooperation, as well as subregional, regional and interregional cooperation and coordination, and in this regard continue to encourage the Economic and Social Council to request the regional commissions, within their respective mandates and resources, to support periodic, inclusive reviews of national efforts and progress made in their respective regions to combat HIV;

105. Request the Secretary-General to provide to the General Assembly an annual report on progress achieved in realizing the commitments made in the present Declaration and, with support from the Joint United Nations Programme on HIV/AIDS, to report to the Assembly on progress in accordance with global reporting on the Millennium Development Goals at the 2013 review of the Goals and subsequent reviews.