

PPD Membership participation nearly universal at the United Nations' High-level Meeting on HIV/AIDS in New York

INTRODUCTION

The General Assembly concluded its three-day High-level Meeting on AIDS, held during 8-10 June 2010 at United Nations Headquarters in New York. The Meeting was aimed to shape the future global response. Many members of the PPD Board were in attendance, including H E Ghulam Nabi Azad, the Minister of Health and Family Welfare of India and the President of the PPD Board.

The Opening session of the Meeting was addressed by the Secretary-General of the United Nations Ban Ki-moon, the President of the 65th Session of the General Assembly Joseph Deiss of Switzerland and Dr. Michel Sidibe, the Executive Director of UNAIDS. The Meeting was attended by several thousand representatives of governments, international organizations, bi-lateral and multi-lateral agencies, civil society organizations, people affected by HIV and others. At the end of the three-day Meeting, the General Assembly adopted a comprehensive resolution to address the pressing challenges of the pandemic (see the Resolution attached, for details).

The High-level Meeting was very well attended by the PPD member countries. The level of participation by the member countries was indeed very high, with the Presidents of Mali and Nigeria; Vice Presidents or Deputy Prime Ministers of Ghana, South Africa and Viet Nam; Ministers from Bangladesh, Benin, China, India, Indonesia, Kenya, Mexico, Morocco, Senegal, Tunisia and Zimbabwe; and Senior Officials from Colombia, Egypt, Ethiopia, the Gambia, Pakistan, Thailand and Uganda. All the representatives of the PPD member countries made important statements to the General Assembly on their national experiences and called for important actions by the international community.

Given the strong presence of its membership at the High-level Meeting, the PPD Office in New York has compiled, in verbatim, the following summary statements of all the twenty-three participating countries, issued by the UN Department of Public Information as daily summaries of the meetings (GA 11086, GA 11090 and GA 11093).

BANGLADESH

RUHAL HAQUE, Minister of Health and Family Welfare of Bangladesh, said that he believed the High-level Meeting would result in a strong declaration regarding the care and treatment of HIV/AIDS. The international community had achieved success in fighting the epidemic in the past, but it was a matter of great concern that more than 7,000 new cases of infection occurred every day, with women and adolescent girls facing the highest risk. Worldwide estimates also showed that 5 million young people were living with HIV. That was the result of factors like social inequality, neglect and social exclusion. It was time to protect adolescent girls and young women, so that their journey to adulthood was not affected by HIV. Bangladesh advocated for a full range of services, so that the HIV/AIDS epidemic did not inflict a disproportionate burden on women. Mr. Haque asked Member States to support the development of national health systems, so that women living with HIV were provided with sufficient assistance.

Bangladesh was considered a low-HIV-prevalent country, but there were cases of full-blown AIDS patients and it was possible that cases of HIV/AIDS went unreported because of the stigma, he said. Underlying causes of the cases included poverty, gender inequality and the high level of mobility of the population, including immigration to other countries for employment. Bangladesh had made progress in fighting the epidemic, but factors such as low condom use and men having sex with men all contributed to the spread of HIV in the country. The Government had to continue to provide support to the most at-risk populations. Global and regional efforts also had to continue. Bangladesh called upon developed countries to enhance their financial support, as well as to eliminate intellectual property and lower the costs of drugs. There was no room for complacency; the international community had to aim for zero infections, zero discrimination and zero related deaths.

BENIN

NASSIROU BAKO-ARIFARI, Minister for Foreign Affairs of Benin, said his country had a low prevalence of 2 per cent, with 60,914 cases in 2010. There was a large difference between urban and rural areas, and women were the most vulnerable, reflecting a feminization of the disease, with two women for every man infected. The risk of an epidemic explosion continued to exist, considering that HIV prevalence was thought to be at 26.5 per cent for sex workers. The epidemic was the focus of the Government's work, and a multisector committee was presided over by the President. There was also a presidential decree creating a national body that coordinated the efforts of all stakeholders. Benin had a national strategic framework, and financing was provided through budget allocations in each ministry to support the implementation of policies and measures. The Government was working with the Global Fund, the World Bank and the United Nations system, among other partners.

The country's efforts in the fight against HIV and AIDS had allowed for greater care and treatment, as the number of people receiving antiretroviral treatment had increased from 40 to 84 per cent, and the prevention of mother-to-child transmission had also greatly improved, he said. The country's national strategy to eliminate mother-to-child transmission and its national plan to reduce mortality among women addressed vulnerabilities among that population. In 2006, the Government had also voted in a law that fought stigma and discrimination. Personnel had been trained on the link between human rights and HIV/AIDS. Civil society, private organizations and religious organizations were participating actively in the fight. Expressing support for UNAIDS, he said progress had been made, but results were still fragile because of the lack of resources. He urged the international community to continue to support Benin, so that results would be achieved by 2015.

CHINA

YIN LI, Vice Minister for Health of China, said his Government was fulfilling its commitments to halt the spread of HIV by providing universal access to prevention measures and treatment, and by eliminating social discrimination. A series of laws, regulations and policy measures had also been introduced as part of a broader mechanism to confront the disease. Through several years' effort, the spread of the epidemic had slowed, mortality had decreased and the quality of life for those living with HIV had significantly improved.

Expressing support for the UNAIDS “three zeros” campaign, he stressed that, in order to achieve those goals, developed and developing countries needed to face their common challenge together, with the latter making HIV control as important as economic development. The private sector and relevant organizations should shoulder more social responsibility, and more resources should be mobilized. Multinational drug manufacturers should greatly reduce the costs of drugs, testing equipment and reagents. For its part, China was contributing positively to the global struggle, and planned to strengthen Government leadership, multisectoral coordination and participation by the whole society.

COLOMBIA

MIGUEL CAMILO RUIZ (Colombia) said her country’s implementation of inclusive strategies had reduced barriers to comprehensive HIV prevention, treatment and care. Though the epidemic was concentrated in the most vulnerable groups, Colombia shared the concern that more than 50 per cent of those living with HIV were women. As such, it had adopted gender equality and empowerment strategies for women and girls to reduce their vulnerability. Given the large percentage of adolescents living with HIV, Colombia also had improved access to sexual and reproductive health and condom use, and developed approaches to reduce risk. The Government had also set more demanding goals for reducing HIV prevalence.

She went on to insist that free trade barriers, and the costs of both diagnostic tests and antiretroviral drugs be brought down. Stigma and discrimination also must end. A successful international response to the HIV epidemic must include strategies to improve prevention, and Colombia fully supported the goal of zero new cases, zero discrimination and zero AIDS-related deaths. Underlining the need to strengthen health systems, and research and development, she called for new, sustainable funding sources. Also, there must be more international interest in understanding specific country contexts.

EGYPT

AHMED MOHAMED ABDEL HALIM (Egypt) said the elimination of HIV infection required that special attention be given to strengthening national capacities, particularly of African States, to take into account the specific community and social aspects of each State in order to enhance efforts for prevention. That would also strengthen the ability to implement national awareness campaigns to address harmful traditional practices, reduce risk behaviour and encourage responsible practices with regard to sexual activity.

He said the international community had a responsibility, not only to provide the necessary financial resources, but to find radical solutions to the problems of trade-related intellectual property, especially regarding medicine and vaccines. The spread of HIV often was caused by poverty and underdevelopment, and therefore successful elimination of the infection required a successful sustainable development process where support was given to develop infrastructure and economic, educational and social systems. The transfer of knowledge and technology also was crucial in that effort. Also instrumental to curb the spread of infection was combating illicit drug trafficking, decreasing gender inequalities and working to eliminate all forms of violence against and exploitation of women.

ETHIOPIA

TEKEDA ALEMU (Ethiopia) aligning with the African Group, said much progress had been made in the fight against HIV and AIDS around the world, while in Ethiopia, new HIV infections had significantly declined. HIV prevention, treatment, care and support programmes had become part of the overall national development agenda. The accelerated expansion of primary health-care facilities, coupled with decentralization of HIV and AIDS services, had increased access to HIV services. The number of people tested annually had grown from 564,000 in 2005 to 9.4 million in 2010. Free antiretroviral therapy had been expanded, while progress also had been made in preventing mother-to-child transmission. The deployment of health extension workers in rural areas had helped create a popular movement against HIV and AIDS and increased active engagement at the local level.

He said that, despite the progress made, however, the fight was not yet won. That was particularly the case for low-income countries. Insufficient and unpredictable funding and costly treatment programmes threatened countries' ability to provide universal access to drug therapy. In many low-income countries, a significant proportion of people living with HIV still lacked access to treatment. Similarly, millions of babies were born with HIV and many more were orphaned by the epidemic because of low access to services that prevented mother-to-child transmission. Stressing that it was vital to renew political commitment and partnership to sustain the progress made, he said it was also critical to accelerate access to treatment to millions of people in low-income countries to prevent deaths and stop the spread of HIV. International cooperation and the availability of predictable funding were paramount in supplementing national efforts. The sixteenth International Conference on AIDS and Sexually Transmitted Infections in Africa would be held from 4 to 8 December in Addis Ababa, he noted.

GAMBIA

USAN WAFFA-OGOO (Gambia) said this week's forum should galvanize more action and see a recalibration of all strategies that had borne fruit over the decades in the fight against AIDS. Lauding the work of UNAIDS and the Global Fund, she said this week's Meeting also marked another opportunity to reinforce and improve the performance.

Gambia, she said, had the strong political will to respond to HIV and AIDS, as shown by its creation of the National AIDS Council, chaired by the President, and the National AIDS Secretariat. Her Government also had championed partnerships across the social spectrum. Prevalence was relatively low in Gambia, but in 2008, HIV-1 prevalence had shown an increase. Over 2,500 people with advanced HIV infection were receiving antiretroviral treatment, while about 3,000 orphans and vulnerable children were receiving external support. "We need to do more," she said, noting that resource mobilization, a goal of Gambia's strategic framework, was a major challenge. Stigma and discrimination also had hampered the response

GHANA

JOHN DRAMANI MAHAMA, Vice-President of Ghana, said that HIV/AIDS was a key component of the Ghana Shared Growth and Development Agenda from 2010 to 2016 and was accorded a high level of political commitment, with the Ghana AIDS Commission placed directly under the Office of the President. Ghana was among the 29 African countries reported by the World Health Organization to have been able to reduce prevalence of HIV/AIDS over the past decade, with a reduction from a national high of 3.6 per cent in 2003 to 1.5 per cent in 2010. Those modest achievements were attributable to a massive scale up under the programme dubbed “Towards Universal Access — Ghana’s Comprehensive Antiretroviral Therapy Plan,” which resulted in an increase in the number of persons on antiretroviral treatment from under 6,000 in 2006 to over 58,000 by March 2011. Additionally, Ghana had developed a new five-year Preventing Mother-to-child Transmission plan, aimed at reaching 95 per cent of all pregnant women by 2013. Civil society organizations, such as People Living with HIV/AIDS Associations, were also active members in the national response.

Ghana recognized that the main challenge in the fight against HIV/AIDS globally was how to ensure universal access to prevention and treatment, as well as zero transmission of new HIV infections in children by 2015, he said. There was a need, especially in sub-Saharan Africa, to invest in improving the weak health systems and guaranteeing access to the poor living in remote and peri-urban slums. In Ghana, the community-based health planning and services initiative was being expanded to provide much-needed basic services to all. To implement universal access, second- and third-generation antiretroviral medicines would need to be developed and the costs of these drugs needed to be affordable. Ghana called on all developing countries to increase their domestic sources of funding for implementation, as a basis for calling on development partners to assist with needed resources. Ghana also called for increased funding for the overall response, including support to civil society organizations, expanding the health care delivery systems and making antiretroviral drugs available.

INDIA

GHULAM NABI AZAD, Minister of Health and Family Welfare of India, called for effectively scaling up actions and resources to implement the international declarations on combating HIV/AIDS. “Our actions must match our words,” he said. Thanks to India’s strong prevention, care, support and treatment programme, the prevalence of the epidemic had been contained to just 0.3 per cent. New infections had been reduced by half. In the last decade, there was evidence that the epidemic had stabilized and even reversed in some parts of the country. The Government’s focus had been on helping high-risk groups, expanding services and improving access to antiretroviral therapy. Universal access to second-line anti-retroviral therapy and early infant diagnosis were being rolled out.

The “Red Ribbon Express” train traversed the country to disseminate awareness about HIV/AIDS and provide services to some 8 million people annually, he said. The Government was posed to begin the next phase of the National AIDS Control Programme. Mother-to-child transmission of infection continued to be a challenge. The Government hoped to achieve zero transmission in newborns and to prevent mother-to-child transmission of HIV through better testing of the some 27 million pregnant women who gave birth every year. It intended to provide, free of charge, diagnostic tests, drugs, food and transport for all pregnant women and newborns with HIV, to help eliminate

mother-to-child transmission. The Government was launching an initiative to deliver door-to-door male and female contraceptives in 17 provinces, covering 200 million people. The initiative would be expanded thereafter to the rest of the country. Pharmaceutical companies in India provided high quality, affordable drugs for use in India and about 200 other countries. He urged the international community to work together to remove trade barriers to disseminating quality, low-cost drugs to those in need.

INDONESIA

AGUNG LAKSONO, Coordinating Minister for People's Welfare of Indonesia, said the global community must do four things to maintain momentum of efforts to bring the epidemic under control: learn from experience; focus efforts and resources on strategically important interventions; address critical social and human rights issues that reduced access to information and services; and work in broad partnerships, bringing together the knowledge, influence and expertise of all players. He asked whether the global community, which had the necessary knowledge and technology, had the will and courage to mitigate the impact of HIV and AIDS. Indonesia had worked hard to achieve agreed-upon goals and move towards universal access. It had developed collaborative networks, increased coverage and moved towards sustainability.

He said the Government took pride in the birth of five national networks of key affected populations — HIV-positive women, people living with the virus, survivors of drug use by injection, sex workers, as well as men who have sex with men and transgender persons. In 2010, national expenditures had reached \$90 million, with 49 per cent coming from domestic sources and 51 per cent from international sources, primarily the Global Fund. However, there were many challenges ahead, as too many people remained out of reach and unserved, he said. Too many were still victims of ignorance and counterproductive stigma and discrimination. Indonesia had identified three new categories to whom it would direct additional attention: girls and women, who represented the growing proportion of HIV-positive people; high-risk men, millions of whom were in the mobile workforce; and young people aged 15 to 24, who were at risk because of their lifestyles, or their involvement in sex work or drug use by injection. Without increasing prevention and services for such people, it would not be possible to bring the epidemic under control, he warned.

KENYA

ESTHER MURUGI MATHENGE, Minister of State for Special Programmes of Kenya, said her country had taken stock of progress made in its national response to HIV/AIDS since the Declaration of 2001, and was employing a multisector response.

Kenya's National Strategic Plan for 2009 to 2013 was based on the premise of "know our epidemic, know your response", and the Government hoped to scale up treatment to 80 per cent of all eligible people by 2015. Prevention of mother to child transmission was also high, at more than 83 per cent prevention, and the goal was to achieve 100 per cent prevention by 2013.

On the issue of orphans and vulnerable children, she said that by 2009, close to 1.2 million children had lost one or both parents. A cash transfer program now reached over 100,000 of those girls and boys. Another challenge was the feminization of the

epidemic, driven largely by biological factors, inadequate empowerment, and gender-based violence. The number of annual infections was still very high, and she expressed the hope to decrease all infections, and to have zero infections in children, by 2015. She called on the international community to invest in new strategies to combat HIV/AIDS, and applauded the United Nations vision of zero new infections, zero discrimination, and zero AIDS-related deaths.

MALI

AMADOU TOUMANI TOURE, President of Mali, emphasized the need to fine tune the response to the epidemic, based on today's improved knowledge of it. Mali hosted the World Youth Summit on AIDS. It had been an opportunity to take advantage of youth's outlook on health care needs and a way of meeting their needs, as well as drawing on youth leadership, in that regard. He said that during the Summit, youth has asked him to speak for them during today's meeting and to convey that youth had already taken the lead in responding to the HIV/AIDS epidemic. But, their efforts alone were not enough to end the epidemic. Those young people had invested hope in the Assembly's work and declarations. They had asked that the Assembly implement resolution 58/133, which called for a role for young people in the fight against HIV/AIDS.

Young people, he said, have asked for greater decision-making power. Young people wanted to see resources funnelled to HIV/AIDS prevention, treatment, education and care. They wanted the stigma against people living with the disease to end. They wanted to have readily available information and services on HIV/AIDS, particularly for key population groups. Young people must accept their responsibility in dealing with the epidemic. At the Summit, they had agreed to do so.

MEXICO

JOSE ANGEL CORDOVA VILLALOBOS, Minister for Health of Mexico, said that 33.3 million people were living with HIV in the world today and new infections had declined by 20 per cent in the last decade. Latin America had the highest coverage rate for antiretroviral treatment, with 51 per cent. It was necessary to establish global and regional alliances, including people living with HIV, academics, scientists, and the United Nations, to respond in a coordinated fashion and comply with international goals and political declarations. Today was the time to reaffirm the obligation to adopt a multisector response which was vigorous and sustainable for the coming decades. To promote a more effective response, all countries must have timely and sustainable mechanisms for treatment. The costs of antiretroviral drugs needed to be reduced. Efforts had to be stepped up to increase prevention strategies focused on groups that were most at risk, without overlooking actions concerning the general population.

Following the idea of UNAIDS to "know your epidemic, know your response," Mexico generated national data to understand the social and health factors surrounding the HIV/AIDS epidemic. The Government gave greater attention to men who had sex with men, sex workers, drug users, and transgendered, as well as paid attention to migrant populations, vulnerable women and prison inmates. Another priority was to eliminate vertical transmission, as it was unacceptable that boys and girls were born today with HIV or syphilis. It was necessary to promote user-friendly health services and sex education to prevent new infections in present and future generations. Mexico called

upon all countries to ensure that their actions were based on respect for human rights and a gender-equity perspective, free of discrimination, homophobia and violence. It was not a time for complacency or censorship, but rather a time to work together and move forward united.

MOROCCO

YASMINA BADDOU, Minister for Health for Morocco, said that over the past two decades, her country had taken steps to fight HIV/AIDS, extending support for patient care. Despite Morocco's low HIV incidence, at less than 0.1 per cent, the rate of infection among at-risk groups remained high. The low prevalence was due to constant vigilance and joint Government action with civil society and international organizations, she said.

The National Strategic Plan enabled universal access to prevention, treatment and support, she said, adding that it had achieved important results, particularly among high-risk groups. The budget for implementing the Plan was estimated at about \$47.76 million, 31 per cent of which had been contributed by the Global Fund. Emphasizing that the global fight against HIV/AIDS depended on international solidarity, the sharing of experiences among Member States and the development of best practices, she said those elements must be decisive in meeting the goals of the "three zeros" by 2015.

NIGERIA

GOODLUCK EBELE JONATHAN, president of Nigeria, said the international community stood on the "doorsteps of history", with an opportunity to build on the gains of the past ten years. An AIDS diagnosis was no longer an automatic death-sentence, and HIV was now better understood. Africa continued to bear a disproportionate burden of HIV and AIDS, but that continent's leaders were committed to increasing access to services for HIV and AIDS, Tuberculosis, and Malaria. In 2006, the African Union adopted the Continental Framework for Harmonisation of Approaches among Member States and the Integration of Policies on Human Rights and People Infected by HIV and AIDS. This and other efforts were aimed towards a sustained, coordinated and resolute continental action to stop new infections, maximize efficiency in the delivery of treatment, and achieve sustainable financing for the HIV response.

In Nigeria, HIV/AIDS services were currently the most rapidly expanding health interventions, with a multisector approach that better mobilized resources and improved coordination among public, private and civil society stakeholders. Among Nigeria's relevant successes were the Youth Leadership in AIDS programme, the promotion of behavioural change and awareness through media and film, an annual journalists' award for excellence in HIV/AIDS programming, and a bill presently before Nigeria's parliament seeking to address the specific issues of stigmatization and discrimination directed at those living with HIV.

He said his administration remained determined to provide new impetus to the HIV/AIDS response by integrating the health sector into the country's human

development agenda. For example, from now until 2015 the Government would lead and coordinate the multisectoral implementation of its National Strategic Framework and Plan for HIV/AIDS. As for universal access, it aimed to increase government funding from 7 per cent to 50 per cent by 2015. Also by 2015, his administration would strive to eliminate mother-to-child transmission, and would work with the Nigerian National Assembly to allocate at least 15 per cent of the federal budget for the health sector, as agreed in the Abuja Declaration. Such objectives would greatly contribute to achieving the joint objectives of the Millennium Development Goals and the elimination of new HIV infections, including AIDS-related deaths, by 2015. He said it was not the time for the international community to take its eyes off the target, but rather for it to retain the resolve and focus of the Declarations of 2001 and 2006, if the gains of the past 10 years were not to be eroded.

PAKISTAN

RAZA BASHIR TARAR (Pakistan) echoed the call made by the Secretary-General to all stakeholders to renew and strengthen their commitment to universal access, which should form part of the bridge towards achieving the Millennium Development Goals. Until recently, Pakistan was a “low-prevalence, high-risk country”, but it was now in a “concentrated phase” of the epidemic, with HIV prevalence at more than 5 per cent among injecting-drug users. The proportion of HIV infection among other categories — such as sex workers, unemployed youths and urban injecting-drug users — was still increasing. The geographic trend of the epidemic was also expanding from major urban cities to smaller cities and towns. The country’s response was coordinated by the Government, along with bilateral and multilateral donors, the United Nations system and civil society. The National AIDS Control Programme had come a long way since 1986 in developing a comprehensive response, which took a multisectoral approach starting in 2003. Over the next five years, gains would be consolidated and services scaled up across wider geographic coverage.

He stressed that combating HIV/AIDS and eradicating poverty must proceed hand-in-hand, emphasizing that that coordination could not be achieved without the international community’s active and determined cooperation. He called for the special participation of the developed countries, which had a moral obligation to set aside part of their wealth to reduce the burden of poverty and alleviate human suffering. Further, low-cost drugs, lower profits, new scientific research and knowledge sharing and facilities were also needed to achieve common and sustainable solutions. He called on international donors not to reduce HIV spending as a result of the global economic downturn, urging them instead to commit to further funding to meet agreed commitments on universal access.

SENEGAL

MODOU DIAGNE FADA, Minister for Health and Prevention of Senegal, speaking on behalf of the African States and the African Group, said “alarming” indicators in the Secretary-General’s report had noted that more and urgent efforts were required to eradicate HIV/AIDS. Against that backdrop, he called for an appropriate carrying out of the objectives in Assembly resolution 60/262 (2006) by strengthening

national capacities to combat HIV/AIDS, especially in low-income countries. Efforts must be supported in order to apply various programmes and scale-up campaigns to end prejudice.

While steps to achieve equitable access to prevention, treatment and care were a major step forward in preventing mother-to-child transmission, he said the international community had a duty to provide adequate financial resources, as well as “wise” solutions for intellectual property rights issues. Microbicides and vaccines must be available to all at affordable prices. Such work must go hand-in-hand with the optimal use of national resources. A framework for cooperation must be created to guarantee coordination between national Governments and civil society, a model that also must be applied to the peaceful settlement of armed conflict, which increased the incidence of sexual violence and, thus, HIV and AIDS. In sum, the African Group would spare no effort in implementing the Declaration to be adopted at the end of the current high-level meeting.

SOUTH AFRICA

KGALEMA MOTLANTHE, Deputy President of South Africa, said that the HIV and AIDS epidemic was a leading cause of death in a number of developing countries, particularly in sub-Saharan Africa, because of the lack of scientific breakthrough in medications and lack of financial resources to access antiretroviral and other drugs.

Women bore the biggest brunt of the disease, but reproductive health and HIV prevention programmes did not adequately address that group. The recent results of tenofovir-based gel had raised hopes that a female-initiated prevention alternative could become available soon. Although the recent financial crisis had impacted developing countries in particular, the fight against HIV and AIDS should not be compromised, and costs needed to be reduced to facilitate universal coverage. In Africa, a number of strategies were adopted to address challenges posed by HIV and AIDS, including the adoption of the Kampala Declaration at the African Union Summit of Heads of State meeting in Uganda in July.

South Africa had embarked on programmes coordinated through the South African National AIDS Council that were rooted in partnerships with various stakeholders and addressed the social determinants of the HIV, AIDS and tuberculosis epidemics, he said. The Government plan of actions improved citizens’ lives through the provision of houses, poverty eradication strategies, economic policies and interventions focusing on youth development. The National Strategic Plan from 2007-2011 aimed to reduce new infections by 50 per cent and to achieve 80 per cent coverage with respect to access to antiretroviral therapy. Great progress was made in areas such as the reduction of new infections among young people and reducing mother-to-child transmission of HIV, using dual therapy, from 8.3 per cent to 3.5 per cent. Through the HIV Counselling and Testing Initiative, started in April 2010, 12 million to date were tested. 1.4 million people were put on antiretroviral therapy through public health facilities alone. Public expenditure on HIV and AIDS increased by 40 per cent per annum and, in the current financial year, \$1 billion was allocated to HIV and AIDS programmes. Additionally, South Africa was hosting its 5th AIDS Conference, which would contribute towards the development of a new Strategic Framework for 2012-2016.

THAILAND

PAIJIT WARACHIT, Permanent Secretary of the Ministry of Public Health of Thailand, said that his country had made substantial progress in the prevention of HIV infection among the general population and Prevention of mother-to-child transmission. Current coverage included nearly 97 per cent of women in need. Access to HIV treatment, care and support was now a reality for nearly 80 per cent of all in need. In addition, some services had been expanded to non-nationals and people in remote areas, including migrant workers and ethnic minorities. The Government projected that, for the next five years, certain key affected populations would account for 90 per cent of new infections, including men having sex with men, sex workers, injecting drug users and partners in a relationship with someone HIV positive. Thailand was working to emphasize innovation, focus on prevention and address the legal, social and environmental factors that hindered access to services and that fuelled discrimination. A rights-based and gender-sensitive approach was also integral to providing prevention services.

In order to scale up its prevention response, Thailand had decided to pilot innovative financing models, including a “country prevention fund,” he said. Thailand also recognized that HIV was more than a health challenge and that it was necessary to maximize synergies from government and non-government services in an integrated manner. Thailand was currently providing HIV prevention and care for migrant workers from neighbouring countries, with a substantial contribution from the Global Fund. Additionally, Thailand had scaled up treatment programmes that relied on domestic funding and little on international sources. In that respect, trade-related intellectual property rights (TRIPs) were essential in efforts to achieve universal access. The international community needed to work together to reach global targets, and Thailand reaffirmed its commitment to working with all nations to end the scourge of HIV/AIDS.

TUNISIA

HABIBA ZAHI ROMDHANE, Minister for Public Health of Tunisia, noted that the High-Level Meeting had come at the same time as the “Arab Spring”, which had been a driving force for the people of the world to use all their energies to combat inequality, whether economic or social. She commended the United Nations for its positive stand with regard to Tunisia, including the Secretary-General’s visit to the country, during which he had saluted the efforts of all Tunisians in all fields. Tunisia expressed a commitment to work with the international community to fight HIV and AIDS, and lift all the obstacles to halting the disease. To confront the pandemic, Tunisia would work in cooperation with all stakeholders and all organizations throughout society and the private sector. Tunisia had been able to control transmissions through controlling blood transfusions and providing free testing and care to all people living with HIV, including antiretroviral treatment to all those requiring it, without any discrimination. That treatment was guaranteed through a special endowment for HIV/AIDS.

More coordinated international efforts and more collaboration with civil society were needed to lower risky behaviour, she said. Tunisia would take all the necessary steps, with full respect for the highest principles of human rights. Tunisia was committed to protecting vulnerable groups, such as women, children and youth. The Meeting was an excellent opportunity for the country to stress its concern for youth and to address all the health risks they faced. Tunisia paid tribute to the vast efforts of all United Nations bodies, but stressed the need to continue technical and financial support through further

funding from the Global Fund. Tunisia welcomed the proposed declaration of the Meeting and was committed to contributing and putting an end to the pandemic by preventing more infections and ensuring no discrimination.

UGANDA

KIHUMURO APUULI, Director General of the AIDS Commission of Uganda, said that, while global figures showed that efforts to combat AIDS were bearing fruit, the response demanded a high level of solidarity. Like many developing countries, Uganda faced challenges in meeting the Millennium Development Goals. About 1.2 million Ugandans, of a total population of 32 million, were HIV-positive. “The task for us is enormous,” he said, calling for a shift in resources to enhance efficiencies and generate results. Political commitment at the highest level would be invaluable to mobilizing resources, especially from the private sector. With support from the Joint United Nations Programme on HIV/AIDS (UNAIDS), among others, studies had reviewed the changing face of the epidemic.

He went on to say that in Uganda, 550,000 needed antiretroviral drugs, but as of December 2010, only 270,000 people had access to them. He noted with optimism research breakthroughs, however, saying that HIV-positive persons should be given hope to live a normal life. The biggest challenge on that front was to mobilize resources. Commendable efforts had been made to find new drugs and implement other strategies, and he called on partners to increase research funding in order to find a cure. Uganda supported the African Union’s position on implementing programmes in line with national laws and due respect for religious and ethical values. In Uganda, women and girls bore the brunt of the epidemic.

Viet Nam

TRUONG VINH TRONG, Deputy Prime Minister of Viet Nam, said his country had achieved many of the Millennium Development Goals ahead of schedule, including those on poverty reduction, universal education, gender equality, and improving maternal and child health. Those living with HIV/AIDS accounted for about 0.26 per cent of Viet Nam’s population. The prevalence of infection from injected drug users had declined, as had the number of HIV/AIDS-related deaths. Frequent awareness campaigns and legal measures undertaken over the past twenty years had increased the participation of the population and social organizations. The National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control, founded over ten years ago, had effectively strengthened efforts to prevent and combat the disease.

However, Viet Nam remained a poor county facing numerous difficulties, and these initial gains remained fragile. Resources would be prioritized to implement national targets on HIV/AIDS prevention, care, treatment, and support, and the new United Nations initiative on zero new infections, zero discrimination, and zero AIDS-related death. That major threat to global sustainable development could only be averted by joint efforts and shared responsibility by each and every member of the international community. Necessary resources must be secured to develop national and international AIDS responses, emphasis must be placed on prevention measures, and those living with HIV/AIDS must be given better access to health-care services, particularly antiretroviral treatments and methadone.

ZIMBABWE

HENRY MADZORERA, Minister of Health and Child Welfare of Zimbabwe, said thanks to Zimbabwe's commitment to universal access to treatment, the HIV prevalence rate in the country fell from more than 29 per cent in 1999 to 13.7 per cent at present. The decline was a result of expanded HIV prevention services, testing, counselling, and awareness campaigns. The Government had begun to incorporate male circumcision in its HIV prevention programmes, based on evidence that it could help prevent transmission. In 2006, Zimbabwe was among the first countries worldwide to develop and implement an evidence-based behavioural change strategy, which had since bolstered demand for and use of HIV prevention services. Despite funding challenges, Zimbabwe had achieved significant progress in treatment and care. By the end of 2010, it had achieved 77 per cent coverage towards its universal access target. Moreover, 350,000 of the estimated 593,000 people in the country in need of anti-retroviral therapy had access to it now.

Zimbabwe had adopted WHO's newly revised HIV treatment guidelines, raising the threshold for initiating treatment for a CD4 cell count from 200 to 350, he said. That move had bolstered the demand for treatment services from 340,000 people seeking treatment to 593,000. The number of children receiving treatment — 10 per cent of the population — had doubled in the last two years and efforts were under way to further expand services to children in need. Coverage of programmes to prevent mother-to-child transmission had been expanded. The Government had set up a National AIDS Council and a National AIDS Trust Fund to promote universal access to care. Since the adoption of a multicurrency regime, the Government's AIDS Levy had played a significant role in financing the national response to HIV/AIDS. The 2011-2015 national HIV and AIDS strategic plan aimed to scale up availability of, and access, to prevention, care and treatment.



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

Draft resolution submitted by the President of the General Assembly

**Political Declaration on HIV/AIDS: Intensifying our Efforts to
Eliminate HIV/AIDS**

The General Assembly,

Adopts the Political Declaration on HIV/AIDS annexed to the present resolution.

Annex

**Political Declaration on HIV/AIDS: Intensifying our Efforts to
Eliminate HIV/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 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 that the spread of HIV is often a consequence and 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 by 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 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, workforces, 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 achieved, 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 in 2001 to \$16 billion 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/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 in funding from donors to date, including the significant pledges made by donors at the 2010 Global Fund

replenishment meeting; note with concern that while these pledges represented 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 also the work of the International Drug Purchase Facility, based on innovative financing and focusing on accessibility, quality and price-reduction of antiretroviral drugs;

19. Welcome the United Nations 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 care-giving 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 against them;

22. Welcome the establishment of 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

⁴ Resolution 61/106, annex I.

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 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 they 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 been inadequately 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 number of new HIV infections 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 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 Trade-Related Aspects of Intellectual Property Rights Agreement 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 of 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, and note 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 of the United Nations, the Universal Declaration of Human Rights⁵ 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 people living with and affected by HIV, including their families, and the need to take into account the

⁵ Resolution 217 A (III).

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;

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 and retention of skilled health workers, are among the biggest barriers to access HIV/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 in reducing 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 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 of the Joint United Nations Programme on HIV/AIDS and the World Health Organization on HIV and AIDS;

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 10 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 in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence, and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;

54. Commit by 2012 to update and implement, through inclusive, country-led and transparent processes and 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 on the United Nations system, donor countries, the Global Fund to Fight AIDS, TB 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 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: expand coverage, diversify approaches and intensify 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* in accordance with national legislation;

(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 child-bearing 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 ensuring 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 by 2015 and substantially reducing AIDS-related maternal deaths;

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, including 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, 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 on 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 Trade-Related Aspects of Intellectual Property Rights Agreement specifically geared to promoting access to and trade of medicines, and, while recognizing the importance of the intellectual property rights regime in contributing towards a more effective AIDS response, ensure that intellectual property rights provisions in trade agreements do not undermine these existing flexibilities, as confirmed by the Doha Declaration on the TRIPS Agreement and Public Health, 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;

(b) Addressing barriers, regulations, policies and practices that prevent access to affordable HIV treatment by promoting generic competition in order to help reduce costs associated with life-long chronic care, and by encouraging all States to apply measures and procedures for enforcing intellectual property rights in such a manner as to avoid creating barriers to the legitimate trade of 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 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 Trade-Related Aspects of Intellectual Property Rights Agreement, 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 drop-out, including inadequate and inaccessible transportation to clinical sites, lack of accessibility of information, resources and sites, especially to 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 on 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 in 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 vaccination for hepatitis C and rapidly expanding access to appropriate vaccination for hepatitis B and 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 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 so as 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 through 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, through 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 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 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 Recommendation No. 200, and call on 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 the global HIV and AIDS resource gap by 2015, currently estimated by the Joint United Nations Programme on HIV/AIDS to be \$6 billion annually, through greater strategic investment, continued domestic and international funding to enable countries to access predictable and sustainable financial resources and 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 of 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 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 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 which have pledged to achieve the target of 0.7 per cent of 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 Diseases 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;

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 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, who 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 address the shortfall of resources available for the global HIV and AIDS response and to improve 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 into 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, community health workers and peer educators, and 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, improved surveillance systems, and data collection, processing and dissemination, and training 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, leverage health-care services to prevent mother-to-child transmission of HIV, strengthen the interface between HIV services, related sexual and reproductive health care and services and other health services, including maternal and child health, eliminate parallel systems for HIV-related services and information where feasible, and strengthen 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, social, cultural and behavioural and traditional medicine research and continue to build national research capacity, especially in developing countries, through increased funding and public-private partnerships, and create a conducive environment for research and ensure 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 and in particular those contained in the present Declaration, facilitate intensified North-South, South-South and triangular cooperation, as well as regional, subregional 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 an annual report to the General Assembly on progress achieved in realizing the commitments made in the present Declaration, and, with support from the Joint United Nations Programme on HIV/AIDS, report progress to the Assembly in accordance with global reporting on the Millennium Development Goals at the 2013 and subsequent Millennium Development Goal reviews.