Tackling political barriers to end AIDS
Acknowledgements

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ActionAid is an international anti-poverty agency working over 40 countries, taking sides with poor people to end poverty and injustice together.

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Executive summary

Experts agree that AIDS is one of the most researched and written about diseases. Why then are AIDS denialism, quack cures and prevention strategies based on ideology rather than science on the rise?

While no cure exists, antiretroviral therapy is known to save lives and prevent mothers from transmitting the disease to their unborn children. Why then do 75% of HIV positive people and 90% of HIV positive pregnant women lack access to antiretrovirals?

Presidents and Prime Ministers have vied with each other at summits and conferences to proclaim the global security threat that AIDS poses. Why then is the war chest to fight AIDS US$8-10 billion short every year?

The answers lie in the stunning refusal of world leaders to mount an adequate response to what has been declared a global emergency.

In 2005, a quarter of a century into the pandemic, governments seemed on the verge of concerted action to end AIDS, as they finally promised to strive towards universal access to prevention, treatment and care by 2010. However, two years later there is still no financing plan to achieve universal access; clinics and hospitals are still starved of nurses and supplies; 90% of children in need are still not getting social support and the cost of much needed new drugs and diagnostics is unaffordable. As a result, 8000 people continue to die of AIDS each and every day.

Most concerning is the persistent and widespread denial of human rights, particularly those of women, people living with HIV and AIDS and vulnerable groups. This undermines treatment and prevention efforts and fuels the epidemic further. The increasing feminisation of HIV and AIDS is testament to this. The road towards Universal Access relies on the empowerment, involvement and the explicit promotion, protection and fulfilment of the human rights of women and girls, people living with HIV and AIDS and vulnerable groups, including sex workers, men who have sex with men and injecting drug users.
To overcome these barriers and deliver on the promise of Universal Access, ActionAid believes that governments must prioritise the following actions:

- **Respect, protect and fulfil the fundamental rights** of women, people living with HIV and AIDS and vulnerable and marginalised groups, as the central plank of the AIDS response.

- **Strengthen the health sector** by investing in health systems and health workers and providing free essential healthcare to all.

- **Ensure safe and affordable access to drugs, diagnostics and prevention tools**, including the review of the international patent regime and the establishment of a research and development agenda that meets the health needs of the poor.

- **Provide additional, sustained and predictable funding for the global AIDS response**, free from harmful conditions that are not based on evidence of what works.

ActionAid joins others in calling on the world’s governments to tear down the political and financial barriers that stand in the way of reversing the AIDS pandemic and confronting one of the most serious impediments to poverty eradication and the fulfilment of fundamental human rights.

The 2010 Universal Access goal is a powerful weapon in the armoury of all those committed to step up the global war against AIDS, be they parliamentarians, human rights lawyers, celebrities or people living with HIV and AIDS. It is time to mobilise together and ensure that governments in the North and South take every action needed to make Universal Access a reality for over 40 million people living with HIV and AIDS.
The road to the 2010 universal access goal

2001 UNGASS Declaration of Commitment

“HIV and AIDS constitutes a global emergency and one of the most formidable challenges to human life and dignity; (it) undermines social and economic development throughout the world and affects all levels of society.”

In June 2001, the international community acknowledged, for the first time, HIV&AIDS as a major threat to development. At the UN General Assembly Special Session on HIV&AIDS (UNGASS), governments of 189 nations committed to jointly respond to the pandemic, following a clear set of targets to be reached by 2005 and 2010. The Declaration: “Global Crisis – Global Action” contains time-bound HIV commitments for a comprehensive response; from increased leadership and resources, to targets on prevention, treatment and care. Most significantly, the Declaration stresses the central importance of promoting human rights, in particular of women, people living with HIV and AIDS and marginalised communities.

Making progress

Persistent campaigning by AIDS activists bore results when soon after the UNGASS Declaration of Commitment, in October 2001, the WTO Ministerial conference in Qatar approved the Doha Declaration on TRIPS and Public Health, a milestone in the fight between the international patent regime and the human rights framework. The declaration acknowledged that the right to health should prevail over intellectual property rights.

First discussed at UNGASS, the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) was launched in 2002 to dramatically and rapidly increase resources to fight the three most devastating diseases in the world. Today, the Global Fund is one of the most important aid instruments, channelling resources to diseases of the poor.

In 2003, the WHO and UNAIDS put forward an ambitious “3 by 5” initiative of providing antiretroviral therapy (ART) to three million people living with HIV and AIDS in low and middle income countries by the end of 2005. Although this target was not achieved, the number of people receiving ART in developing countries significantly increased – and continues to increase – tripling from 400,000 in December 2003 to approximately 1.3 million by the end of 2005.

Furthermore, in many countries, the 2001 UNGASS Declaration of Commitment fostered the creation of national multisectoral AIDS strategies and mechanisms. By 2006, 90% of countries reporting to UNAIDS had a national AIDS strategy. In 40 developing countries, heads of states lead the national AIDS response in order to ensure a multisectoral approach.

Still falling short

“HIV/AIDS is still in its early and middle stages in most countries and, without immediate large-scale action, the pandemic will spiral further out of control.”

Twenty five years into the epidemic and, despite all the available knowledge and resources, every single
day over 8,000 people die of AIDS and 12,000 people are infected with HIV. The world has failed to meet many of the targets set in the 2001 Declaration of Commitment and the response to the pandemic remains under funded and inadequate.

- Three out of four HIV positive people who urgently need ART still lack access.
- Only 9% of HIV positive pregnant women receive the antiretroviral prophylaxis to prevent mother to child transmission.
- Although most heavily affected countries in sub-Saharan Africa have national policies for children affected by AIDS, fewer than one in ten are reached by basic support services.

In spite of having successfully supported the scale up of prevention, treatment and care in many countries, the Global Fund persistently faces financial crises, leading to questions around the sustainability of its programmes. The cost of medicines remains unaffordable for many and the Doha Declaration on TRIPS and Public Health is constantly challenged by rich governments and powerful pharmaceutical companies. No country in the world is doing enough to promote and enforce the rights of women, HIV positive people and vulnerable groups, such as sex workers, men who have sex with men and injecting drug users. Increasingly, HIV transmission is being criminalised and AIDS activists face repression and threats in many countries.

2005 Universal Access Commitment

“We commit to develop and implement a package of HIV prevention, treatment and care, with the aim of coming as close as possible to universal access to treatment for all those who need it by 2010”.

Following the 2001 Declaration of Commitment, 2005 was another historic moment for the global AIDS response. In July 2005, at the G8 summit in Gleneagles, rich countries made a commitment to scale up HIV prevention, treatment and care to reach universal access to treatment by 2010. Later in 2005, at the World Summit, all world leaders adopted the commitment to develop and implement a package for HIV prevention, treatment and care, with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it, ‘including through increased resources, and working towards the elimination of stigma and discrimination, enhanced access to affordable medicines and the reduction of vulnerability of persons affected by HIV and AIDS and other health issues’.

After the Summit, UNAIDS and its co-sponsors were tasked with facilitating inclusive, country-driven processes for scaling up HIV prevention, treatment and care, as well as analysing and recommending ways to address the common obstacles to scaling up. At the 2006 UN High-Level Meeting on AIDS, countries reported back on the progress they had made on the targets set in the 2001 Declaration of Commitment and further committed to set ‘ambitious national targets [in 2006], including interim targets for 2008 (...) that reflect (...) the urgent need to
scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.\(^7\)

According to UNAIDS\(^8\), this must mean:

- At least 80% of people in need accessing antiretroviral treatment.
- At least 80% of pregnant women accessing antenatal care have information, counseling and other HIV prevention services available to them.
- At least 95% of young women and men having information, education, services and life skills that enable them to reduce their vulnerability to HIV infection.

While there is much debate about what ‘universal access’ means, people and communities directly affected by HIV and AIDS understand it as access to prevention, treatment, care and support for everyone who needs it. Governments in the North and South are accountable to these communities and must take every necessary action to achieve the universal access goal by 2010.

**Fighting apathy**

While the roadmap to universal access rightly stresses country-led processes and targets, there is concern about whether these will be inclusive and ambitious enough. Many are also concerned that without global targets to hold them accountable, the process may let the international community off the hook.

There is a real danger that the global fight against AIDS is dropping down the political agenda of world leaders. As campaigners we must mobilise wider civil society coalitions around the world to stop this.

The 2010 universal access goal is a powerful weapon in the armoury of all those committed to step up the global war against AIDS, be they parliamentarians, human rights lawyers, celebrities or people living with HIV and AIDS.

ActionAid supports the right to universal access to prevention, treatment and care as a crucial element in the goal to end poverty. In this paper we aim to provide key recommendations to tackle the main political barriers to achieving universal access, as widely acknowledged by the international community:

- Gender inequality and human rights violations
- Weak health systems and human resource capacity
- Unavailability of affordable commodities
- Lack of sufficient, predictable and sustainable funding

This paper does not intend to be an exhaustive analysis of all the barriers to universal access, but a tool to identify and call for the implementation of key political measures that, ActionAid believes, should be prioritised if we are to reverse the AIDS pandemic and achieve the goal to universal access by 2010.
AIDS activists from across the world march the streets of New York demanding universal access to HIV and AIDS treatment. During the UN High-Level Meeting on AIDS (June 2006)
1. Guarantee rights

“HIV and AIDS really enlivens a paradox. Paradoxically, the best way to deal with this epidemic is not to punish, to isolate, to put behind barbed wire because we don’t have enough barbed wire in the world to deal with this epidemic. (The best way is) to empower people, respect their individuality and their humanity and thereby to get them in a position to receive the messages to help them to protect themselves”,


The goal of universal access will not be met unless governments and international agencies respect, protect and fulfil the fundamental human rights of women, people living with HIV and AIDS and vulnerable groups.

While AIDS affects mainly the poor in a generalised and disproportionate way, it is women and vulnerable or marginalised communities that bear the brunt of the crisis.

During more than two decades of the AIDS pandemic, we have witnessed how the stigmatisation, discrimination and exclusion of certain groups of people, including people living with HIV and AIDS, and the persistent denial of their human rights, have undermined the effectiveness of AIDS responses and fuelled the pandemic. The protection of the rights of vulnerable groups is not only an obligation of the state but it is the best public health strategy to control the spread of HIV and AIDS.

Women, people living with HIV and AIDS, orphaned children, men who have sex with men, sex workers, prisoners, injecting drug users, people with disabilities, transgender communities, people affected by disasters and conflicts and other marginalised groups, such as migrant populations, must first be empowered if we are to come close to achieving universal and equitable access to HIV and AIDS services by 2010.

In 2001, national governments committed to enact specific legislation that prohibits discrimination against people living with HIV and vulnerable populations and to implement national strategies to empower women and promote their rights. By 2005, only 61% of countries had adopted anti-discrimination laws to protect HIV positive people. Where legislation exists, it is rarely enforced and scarce budget, if any, is allocated to monitoring it. Furthermore, in 45% of countries (70% of Asia, 83% of the Caribbean) laws exist that hinder the delivery of HIV services to populations most at risk; for example by criminalizing consensual sex between males or prohibiting condom and needle access for prisoners.

1.1 Tackle poverty

“At times I feel weak. Even an egg has to be divided. Any other nutritious food we cannot even imagine to have”.

– 35-year-old HIV positive woman with four children, Dhaka, Bangladesh

Governments must ensure that HIV and AIDS programmes are adequately integrated into poverty reduction strategies and that social protection schemes are put in place and implemented.
HIV and AIDS are fuelled by poverty, gender inequality and exclusion and, in turn, they increase the poverty and exclusion of affected communities and households in developing countries. Millions of vulnerable children, poor, elderly, ill people and people with disabilities in developing countries rely upon families and communities to provide social safety nets. Food insecurity, falling income, reduced livelihood, fewer caregivers or school absenteeism are all common symptoms of the growing AIDS pandemic and lead to increased impoverishment.

Household illness leads to neglect and abandonment of agricultural work and diminishing food security. At the same time, food and nutritional insecurity can precipitate HIV. Unless governments guarantee their fundamental right to food, hungry women in particular may be forced into high risk situations such as transactional sex, may put at risk their adherence to treatment and/or see their efforts to provide care and support undermined\(^1\). Lack of access to safe and adequate food, water and sanitation for the over 1 billion people who live on less than US$1 a day remains the foremost barrier to achieving the universal access goal.\(^2\)

Education is the single most powerful way to lift people out of poverty, helping men and women realise their potential in economic, political and social arenas. Governments have the obligation to guarantee people’s right to education. Good basic education is amongst the most efficient and cost-effective means of preventing HIV.\(^3\) However, the same HIV is increasingly threatening universal access to education. The decline in school enrolment is one of the most visible effects of the epidemic. Children, particularly girls, may be removed from school because they are HIV positive or because they have to care for their relatives. Many are unable to afford school fees or the cost of uniforms and other expenses, as they struggle to generate income for their families.

“Instead of giving us food directly, we should be supported to begin income generation activities so as to help us support ourselves and our children better. If we are given food daily, we will die the day that food supply will be stopped”

– Raphael Achucha, HIV positive man, Usigu, Kenya

Social protection schemes offer a means by which traditional community support structures can be strengthened or complemented. These schemes range from basic income grants to free school meals and subsidised or free access to public transport. If properly implemented, these schemes can also improve a person’s standard of living. For example, cash transfers in Zambia have been shown to increase food consumption within households, reduce absenteeism from school and significantly improve household nutrition.\(^4\) Recent studies have shown that effective national level social pensions need cost no more than 1% of GDP\(^5\) – or just US$760 million per year for all low income countries in sub-Saharan Africa.

Donors, governments and local authorities need to ensure that their HIV and AIDS programmes are holistic and comprehensive and use all existing mechanisms, such as poverty reduction strategies, to strengthen the links among sectoral policies.
It is crucial that all government sectors work together to put in place social protection schemes better integrate nutrition interventions into HIV and AIDS programmes and policies and invest further in basic and secondary education.

1.2 Promote women’s rights and end violence against women and girls

“Now, how can you go for antenatal, then test for HIV and tell your husband? He will chase you from the home saying that you are the one who brought it”

– HIV positive woman in a group discussion Katakwi, Uganda

Governments must work to eradicate gender inequality and effectively promote and enforce women’s rights. In particular, governments must end violence against women, which is both a cause and consequence of HIV and AIDS

Women and girls are the fastest growing group of people living with HIV and AIDS. Nearly 50% of adults infected globally are now women, and young women account for 76% of all new cases in sub-Saharan Africa. The increasing feminization of the pandemic is a testament to a critical gap in the AIDS response.

Women and girls’ increased vulnerability to HIV infection, in comparison to men and boys, is not just due to their differing physiology but also a symptom of the denial of their social, cultural, sexual, economic and political autonomy. Too often, women are denied control over their sexual life and the use of condoms. For girls around the world, even exercising their right to education is a very risky enterprise. Besides being at risk in the community, family or on the journey to school, in schools, girls can suffer aggressive sexual behaviour by male teachers, exacerbating their vulnerability to HIV.

In most developing countries, the majority of people living in absolute poverty are women. Independent from their HIV and health status, women and girls are not only carrying the increased burden of care, but also are increasingly taken out of the education and paid employment spheres, so as to care for the sick and dying family, household and community members. In rural areas, women invariably take on the responsibility to become head of the household after losing their husbands and suffering the consequent stigma. They are left in a precarious condition with little power for negotiating access to
and control over land and other resources; often being forced off property, accused of ‘bringing AIDS’ to the community.18

Governments must tackle the feminization of the pandemic within the wider framework of addressing gender inequality and the multiple discriminations faced by women. New ways to include women living with HIV and AIDS in the planning and implementation of programs locally need to be explored and put into practice.

Violence and abuse impact not only on women and girls’ vulnerability to HIV infection, but also on the extent to which women living with HIV are in the position to disclose their HIV status or access sexual and reproductive health services and HIV treatment, care and support. Gender discrimination and women’s lack of legal protection exacerbate the difficulties women living with HIV face in claiming their rights. Governments must fulfil their human rights obligations to prevent, prosecute and punish violence against women and girls. Addressing the human rights implications of HIV and violence against women and girls requires action at all levels – from policy reform to community education and behaviour change.

The AIDS response needs to prioritise programmes that tackle the deadly intersection of violence against women and HIV and AIDS in meaningful ways, for example by protecting and promoting their sexual and reproductive health and rights, including the provision of post-exposure prophylaxis to survivors of sexual assault and ensuring access to HIV treatment, care and support. This must include situations of conflict and emergencies where women are especially at risk.

1.3 End discrimination and stigma

“They simply handed me the results saying that my husband was going to die soon and I was also infected. They had no idea about counselling the family and gave us no information whatsoever as to how to deal with the situation. The hospital staff spent no time in shifting my husband to the worst room available, stopping all treatment and waiting for him to die. Even the senior-most doctors at the hospital would examine him while standing several feet away behind the partly open door.”

– Shukria Gull, HIV positive widow and mother of two, Lahore, Pakistan

National laws and policies must outlaw all forms of discrimination based on HIV status. Governments must commit themselves to working towards challenging stigma and address ‘taboo topics’, including sexuality, sex work or drug use, in line with their international human rights obligations

The AIDS pandemic has highlighted such great inequities, violent abuse and widespread stigma that human rights have been violated in a manner and on a scale rarely witnessed in the public health sphere.19

Discrimination and a hostile legal and political environment are seriously circumscribing efforts to address the health needs and rights of marginalized communities. Cases such as HIV positive people being refused treatment at some hospitals or outreach workers being arrested on sodomy
charges (using evidence of carrying condoms as an indication of prostitution) are simply the tip of the iceberg.\textsuperscript{20}

Governments in many parts of the world are persistently violating the rights of groups who are the most vulnerable to HIV. At the 2006 UN High-Level meeting on AIDS, government delegates even refused to name these groups in the final communiqué.

In 2005, globally, only 9% of men who have sex with men had access to targeted prevention services or outreach programmes.\textsuperscript{21} Governments must end the criminalisation and discrimination of men who have sex with men, and they must abolish harmful

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**ARE MOST AT RISK POPULATIONS ACCESSING HIV PREVENTION IN ASIA?**

<table>
<thead>
<tr>
<th>Country</th>
<th>% of those who correctly identified ways of preventing HIV sexual transmission and reject major misconceptions on HIV transmission</th>
<th>% of those who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men) and those injecting drug users who have adopted behaviours that reduce HIV transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>23.3 13.5 14.0</td>
<td>39.8 49.2 n.a.</td>
</tr>
<tr>
<td>China</td>
<td>23.5 37.3 36.0</td>
<td>68.5 41.1 n.a.</td>
</tr>
<tr>
<td>Nepal</td>
<td>16.9 27.3 49.9</td>
<td>67.1 n.a.</td>
</tr>
<tr>
<td>Pakistan</td>
<td>n.a. n.a. n.a.</td>
<td>22.6 7.6 n.a.</td>
</tr>
<tr>
<td>Vietnam</td>
<td>24.2 n.a. 34.4</td>
<td>90.4 n.a. 81.8</td>
</tr>
</tbody>
</table>

*Source: Summary of individual country tables in Annex.*

laws, such as the 377 section in criminal laws, which bans homosexuality in several countries. In 2005, sex workers’ access to targeted prevention programmes had not gone beyond 22.5% in sub-Saharan Africa and 35% in Latin America and the Caribbean. Governments should protect sex workers’ human rights. Practices by public and private clinics that deny sex workers’ right to health care – including sexual and reproductive health – should be prohibited.

In spite of the growing pandemic amongst injecting drug users (IDUs) in Asia, Latin America or Eastern Europe, only a few have access to harm reduction programmes and most of them are not benefiting from any progress made on access to treatment. In Eastern Europe and Central Asia, IDUs account for more than 70% of HIV cases and yet only 24% were receiving ARVs in 2005. States must enable and protect the rights of injecting drug users to access effective treatment and prevention services, including substitution therapy and clean needles, and general access to health care. Prisoners’ rights to access prevention, treatment and care services should be respected in all prisons.

Health care providers must be trained to respect human rights as well as the physical and psychological needs of HIV positive people. Governments should bring about laws to forbid and penalise discriminating practices by the public and private health sector that deny access to basic health services to HIV positive people and other vulnerable groups, violating their human right to health.

The workplace offers the clearest example of discrimination and its impact on HIV responses. Even in countries where anti-discrimination laws do exist, employers, especially in the private sector, find ways to deny HIV positive people’s access to jobs. They often require workers or job applicants to take an HIV test without their consent, violating their right to voluntary testing and ultimately hindering their access to prevention and treatment services.

Considering that HIV infection in the world is concentrated amongst people of working age, the workplace remains a key environment to scaling up measures towards universal access.

Discrimination in accessing or keeping a job based on HIV status must stop and the right to privacy and to voluntary testing must be effectively protected. The current shortage of health workers in developing countries and the numbers of workers from all sectors being infected every day requires urgent workplace policies that guarantee the right of all workers to access HIV prevention, treatment and care services.
AIDS kills about 10 people every hour in Malawi – Malawian Government, 2005
Almost 1 million people in Malawi living with HIV at the end of 2005 – UNAIDS, 2006

Malawi has 1 doctor per 100,000 people and 1 nurse per 10,000 people – UNDP, 2005

People’s Charter: Voices from Malawians on Universal Access
To mark the Global Week of Action, Malawians created the People’s Charter on Universal Access bringing to light realities and making demands in 5 key areas:

1. Sustainable Financing
“Malawi is among the most heavily indebted poor countries in the world. Malawi’s debt service burden absorbs 20% of the export earnings and 37% of the Government's revenue. The external debt stock stands at US$ 3 billion, over 150% of GDP. This makes it difficult to devote adequate resources to social service sectors, let alone devote additional resources to procure necessary drugs and supplies for treatment of HIV&AIDS.”
– People’s Charter

Malawians Demand:
* Meet Abuja commitments * 2% of Ministry Budget spent appropriately on HIV&AIDS
* Cancellation of debt * End to IMF policies * Increase in district allocation on health

2. Gender Equity, Stigma & Discrimination and Human Rights
“Despite their (women’s) high vulnerability, it is the Malawian male who has greater access to care and treatment while women face many barriers, including lack of financial resources and the need to care for others first.”
– People’s Charter

Malawians Demand:
* Accessible information, services and commodities for women and girls * Youth-friendly health systems * Sexual and reproductive health rights of women * Anti-discrimination legislation

3. Commodity Security and Technologies
“Commodity security is about putting in place measures to ensure that the right products are in the right place, for the right people, at the right price, at the right time and that they are being used for their intended purpose.”
– People’s Charter

Malawians Demand:
* Reduction in prices of second line ARV * Pediatric formulations * Nutrition as core component of treatment * Integrate TB and ART programs * Condoms and other prevention commodities included on the essential medicines list

4. Health Systems, Infrastructure and Human Resource
“Health care facilities are inadequate and mostly under equipped; and health care spending falls far short of commitments made by our leaders resulting in health care delivery systems being shouldered by untrained, overstretched, and frustrated health workers.”
– People’s Charter

Malawians Demand:
* 15% of national budget to health * Prioritize training of health workers * Engage with district level health and hospital committees and ensure downward accountability

5. Trade Related Intellectual Property Rights
“Governments must decide that their citizens have value and must make Anti Retrovirals available freely through the public health services.”
– People’s Charter

Malawians Demand:
* Affordable and accessible medicines * Governments’ position at the WTO are consistent with national interests

AIDS Activists and People Living with HIV and AIDS (PLHA) Scrutinize Country Progress Report

In a chain of consultative meetings around the country, PLHA and activists shared the progress report submitted by Pakistan for the UNGASS Review. Said an AIDS activist. Activists pointed out that the Government had an obligation to consult with all stakeholders to prepare the report, which they overlooked.

Combat HIV and AIDS Through Meaningful Involvement of PLHA!

More than 40 organizations joined hands with PLHA, human rights activists and media professionals to demand meaningful involvement of in fighting the pandemic. People living with HIV and AIDS, women’s rights activists, sex workers and transgender called to:

- End Stigma and Discrimination
- Protect the rights of PLHA
- Ensure care and support to PLHA
- Improve health infrastructure
- Commit to and implement the principles for Greater Involvement of PLHA
- Abolish user fees in public health system
- Support growth of generic industries
- Meet national targets on achieving universal access
- Cancel debt of world’s poorest countries by fair and transparent means so that countries can focus on national priorities

“Realities are being completely ignored,”

an AIDS activist.

Charter of Demands Read on FM Radio

Demands of PLHA and CSOs were shared through FM 103 Radio. A panel discussion on air expressed the activists’ views on the progress report to the general public.
2. Build health capacity

“Build a hospital that is accessible to us, that is not expensive and with friendly doctors and nurses,”
– discussion among a group of young men, Nassarawa, Nigeria

Achieving universal access is impossible without a well resourced, comprehensive and strengthened primary health care service that reaches the poor. The AIDS response depends on a larger, well trained and motivated health care workforce.

The AIDS pandemic is putting an additional strain on weakened health infrastructure in many developing countries. And on the other hand AIDS demands an even stronger and better healthcare system and workforce.

An effective health service is essential in the fight against poverty, in treating opportunistic infections like TB and malaria, as well as testing for HIV, distributing information, condoms and providing AIDS treatment.

Developing country governments must end what Physicians for Human Rights describes as ‘the chronic denial of health care to the poor’ and fulfil their repeated pledges to increase budgetary allocations to public health systems.

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”, WHO Constitution

2.1 Invest in health

In order to achieve universal access, the proportion of developing countries’ budgets allocated to health and health systems expenditure must increase. Donors and international agencies should not impose conditions that prevent a greater investment in health and in national AIDS plans.

A well resourced, sustainable health system is vital to deliver the requisite treatment, care and support of people affected by HIV and AIDS. Yet in sub-Saharan Africa, the region most affected by the pandemic, at least eleven countries – including Burundi, Ethiopia, Madagascar, Tanzania and Sierra Leone – still do not spend the minimum US$35 per person that WHO estimates is required to ensure a basic health service package in low income countries. As a result, an already inadequate health system is failing millions of HIV infected people at a time when they need it most. In many countries, women’s access to healthcare is much lower as they face additional barriers both economic and social.

Whilst some countries do meet US$35 per person minimum spending target, a significant disparity in health expenditure remains within regions. It is in the region of Southern Africa, where HIV prevalence rates are the highest, that we find the biggest differences within the continent. There, spending per capita ranges from US$669 spent in South Africa, US$375 in Botswana or US$324 in Swaziland, to the mere US$46 and US$45 spent in Malawi and in Mozambique, respectively.
Big differences can be found as well in the Caribbean, the second hardest hit region, with a spending of US$1,050 in Barbados, compared to the US$251 and the US$84 spent in Cuba and in Haiti respectively. In Asia, Malaysia spends US$374, double the spending in Cambodia of US$188 and seven times the spending in Pakistan of US$48. Differences are also evident between the two highly populated countries: China spend US$278, triple the amount of India’s spend on health per capita US$82. Latin America illustrates big disparities amongst middle income countries, with Argentina spending US$1,067 per person on health, against the US$597 and US$582 spent by Brazil and Mexico, respectively. 31

Before low income countries can deliver a basic healthcare package after years of under funding, the Commission on Macro Economics and Health believes an additional US$27 billion per annum in aid, as well as greater domestic spending, is needed to sufficiently build the capacity of health systems. For an effective response to the AIDS pandemic much more is needed to enable countries to move beyond a basic health package. To start with, the International Monetary Fund (IMF) policies promoting fiscal austerity must be reversed to allow greater investment in health.

### 2.2 Invest in health workers

The expansion of primary health care to millions who do not have access, as well as an effective response to the exceptional AIDS burden, require increased investment in human resources in the health sector.

An estimated 57 countries, including India and Bangladesh, face crippling shortages of health workers. Sub-Saharan Africa is particularly affected. 11% of the world’s population and almost 64% of all people living with HIV live in the region, yet it accounts for a mere 3% of the world’s health workers.37 It is the rural areas which suffer particularly severe shortages.

#### African commitment: 15% on health

In the 2001 Abuja Declaration, the member states of the African Union committed to spending 15% of their public budgets on health.

However, in 2005, ActionAid’s research findings highlighted that most countries were a long way from meeting this target.33 These figures were reiterated by the Assembly of the African Union in its January 2005 Framework on Action to accelerate health improvement in Africa. According to this, the current health expenditure in most African countries is below the US$35-40 minimum required to achieve basic functionality. This amounts to 2.5% of GDP on health against a world average of 5.4%. There is evidence that some countries are indeed increasing their health expenditure, but most remain well short of the 15% of public budget for health committed to in the Abuja Declaration.34 As of the end of 2005, only Botswana had achieved this target.35

On May 4th 2006, the African Heads of State met to review progress made since the Abuja Declaration in 2001 and recommitted to raise the health expenditure to a minimum of 15% of the national budget.36 Civil society is campaigning to hold African governments accountable to this promise.
One big cause of the human resources shortage in the health sector is the “brain drain” of qualified personnel from poor to richer countries. As a result of this, countries like Malawi have been left with approximately one doctor per 100,000 people. In Ghana, about 70% of young doctors leave the country within three years of qualifying, resulting in just 1,500 doctors serving a population of 20 million. Developed countries benefit from this brain drain. In May 2003, approximately 1 in 5 doctors registered in the UK qualified in developing countries. As a matter of urgency, rich countries must put in place guidelines for international recruitment of health professionals to reduce the brain drain. Donor governments should also explicitly compensate developing countries for the brain drain and invest in the training and salaries of their health workers who emigrate to work in richer countries.

Urgent plans must be made to finance the training and recruitment of at least the 4 million additional health workers needed for an effective AIDS response. In order to make possible the expansion of primary health care, the IMF and donors must drop rigid caps on public sector wages and work with countries to find sustainable options for expanding health spending.

However, it is not just a matter of numbers but of quality. The increasing feminisation of the AIDS pandemic demands gender and human rights training.
of health workers, especially to avoid bad practices and discrimination towards HIV positive women, sex workers, IDUs and other groups. The impact of the guidance, care and expertise provided by health workers on the wellbeing of those that seek prevention and treatment services must be taken into account in human resources strategies. As an example, well trained midwives can be a very effective means of taking care of women and children living with HIV, while increasing effective prevention of vertical infection (e.g. breastfeeding).

At the same time, bad guidance and care, as well as congestion in health centres, have shown the opposite effect, discouraging women from attending preventive and antenatal care. Human resources programmes must include strategies to sensitise health workers to adequately treat HIV positive people, in particular women, and respect their rights.

2.3 Abolish user fees

Health services should be accessible to all those who need them. Governments and donors need to abolish user fees and support essential healthcare free to all at the point of use.

User fees in public health systems have become a clear barrier for the poor to claim their right to health and, in the context of the AIDS pandemic, a threat to ensuring greater adherence to treatment. User fees rarely provide more than 5% of a health budget and block poor people, especially women, from accessing essential care.

The WHO has estimated that 178 million people suffer financial catastrophe every year as a result of health user fees, while a further 104 million people would be forced into poverty. Studies have shown that families undermine their future wellbeing by selling livestock to pay for health fees or endanger their immediate health by delaying going to a health facility or not going at all. It has been demonstrated as well that the abolition of user fees for women and children below the age of six, has resulted in drastically increased attendance for curative services. Informed by this, some countries have abolished user fees and have subsequently seen a rise in the number of people attending health centres. For example, Uganda has witnessed a 117% increase in outpatient attendance since abolishing user fees.

The abolition of user fees must be accompanied by increased resources for extra drugs, supplies and staff to avoid low staff morale or shortages undermining any progress made.
IMF policies failing the poor

“International financial institutions need to create mechanisms that alleviate countries’ debt service payments so they can devote additional resources to their AIDS response. The short-term inflationary effects of increased and additional resources applied towards tackling the HIV epidemic pale in comparison with what will be the long-term effects of half-hearted responses on the economies of hard hit countries. AIDS is an exceptional disease; it requires an exceptional response.” (UNAIDS 2004) 48

There is a growing contradiction between the higher levels of public spending on health and education required to confront challenges like HIV and AIDS effectively and the amount of spending possible under the dominant macroeconomic framework favoured by the International Monetary Fund (IMF).

Compliance with the IMF conditions for macroeconomic stability, such as setting excessively low inflation targets, results in imposing a ceiling on public expenditure and a cap on the wage bill of public sector workers. This undermines the ability of countries to expand their investment in health care systems and increase the wages of health workers – both essential to the fight against HIV and AIDS and to achieve the Millennium Development Goals (MDGs) to end poverty. 49

A review of eight low income African countries found that bans on recruitment and staffing had been only partially lifted in half of them. In Rwanda the wage bill is still considered beyond affordability, necessitating new staff cuts in the midst of worker shortages. Without lifting macroeconomic ceilings, workforce expansion, salary improvements and incentive payments will not be possible, no matter what the volume of funds pledged by donors.” 50

While the international community has committed to the MDGs, the World Bank, USAID, DFID and most other bilateral and multilateral donors will only offer assistance to poor countries if the IMF has first certified that the country is satisfactorily complying with its tight fiscal and monetary framework. Developing countries need to be given the space to follow an expansionary fiscal policy that is needed to mount an effective response to the AIDS pandemic.
AIDS activists being forcefully evicted from the UN headquarters in New York during the UN High Level Meeting on AIDS (June 2006)

Photo Credit: Andrew Kohan
“My name is Prince Udofa. I am six years old. When my father was alive, we used to enjoy! But today, he is gone and my mother and I find it difficult to eat. It is difficult for my mother to pay my school fees and our relatives have all gone away.”

Prince is one among more than 1.8 million AIDS orphans in Nigeria, struggling to survive, the country with the largest number of AIDS orphans in the world (UNICEF, 2005). Vulnerability of women to HIV, social acceptance of polygamy, poverty and restrictive policies are creating children like Prince.

Time to Listen to the Cries of Children!

As the country prepared to celebrate Children’s Day, activists demanded greater commitment of the Government provision of basic services for orphans and vulnerable children. Activists walked miles with posters and banners, shouting slogans to call attention to the escalation of HIV&AIDS among children. PLHA demanded more efforts to cushion the effects of HIV&AIDS on the family, particularly on children.

In marking the Global Week of Action, activists insisted that Nigeria is far from achieving the Millennium Development Goals (MDGs) to

- Eradicate extreme poverty and hunger
- Achieve free universal primary education
- Reduce child mortality and improve maternal health

Women Living with HIV and AIDS Give Clarion Call to the National Action Committee on AIDS

Women living with HIV and AIDS marched to the office of the National Action Committee on AIDS to demand for free treatment for all. They voiced that health services should be accessible to women in poor and rural communities. Critical on the agenda was the need to fast track passing the Anti-Stigmatization Bill at the National Assembly to end stigma and discrimination faced by women. The Association of Women Living with HIV and AIDS in Nigeria (ASWAN) insisted on increased and meaningful involvement of women living with HIV and AIDS.

Following this, the women moved to raise the same demands to the National Assembly. Despite prior notice, they were not welcomed. “This neglect is evident of the lack of political will in the country,” said an AIDS activist.

Light – A Symbol of Solidarity to HIV and AIDS

PLHA and activists held a candle light memorial to commemorate those who have succumbed to AIDS. Nancy Stewart, UNAIDS Coordinator for Civil Society, praised the positive women for coming out in the open despite stigma and discrimination and encouraged them to raise their voices.

More Action, Less Talk!

PLHA and activists made it clear that the time to act is now! They called for more funds and their prudent use to fight HIV and AIDS in the country. Mr. Ayodele Sebiotimo of the Media AIDS Project said, “We fought very hard for money and will continue to fight for more. But now, let’s fight equally hard for making more money work for people. The money should not be floating around while we are dying!”

Affordable and accessible health services are a key to fight HIV and AIDS, emphasized activists. They called on the Government to make health for all a reality.

Media, PLHA and AIDS activists joined hands to hold the Government accountable and create awareness among the general public on HIV and AIDS, right to health and the need for Government accountability.
AIDS pandemic similar to weapons of mass destruction and African Holocaust, says Gambian Newspaper

In a country where press freedom is said to be catastrophic (Reporters Sans Frontieres, 2006), people living with HIV and AIDS (PLHA) and AIDS activists used radio and print media to create awareness on HIV and AIDS. Through a phone-in radio program in the popular radio station City Limit, PLHA and AIDS activists called on the government and policy makers to live up to the promises made to tackle HIV and AIDS. They demanded that PLHA and civil society be made part of decision-making and planning on issues related to HIV and AIDS.

“Women in Africa face triple burden: poverty, black color and being female,” says Ms Fajou Jatta of the Society for Gambia Positive Women

Issues of women living with HIV and AIDS and those vulnerable to HIV were at the forefront. HIV positive women in the Gambia have many faces: young or old, urban or rural, married or single. Their common thread being their gender, which predetermines their roles, shapes their lives and ability to access information and treatment. Members of the Society for Gambian Positive Women (Mutapola Voices Gambia) and the Society for Women Against AIDS – The Gambia (SWAA-GAM) raised these issues during the Symposium for Civil Society Organizations and people living with HIV and AIDS. The duo urged the government to create an enabling environment for women and children in the country, wherein they can claim their rights, have access to health care, education and economic and socio-cultural opportunities.

From Silent Prayers to Powerful Demands – Support Groups of PLHA Speak Out

Six support groups of PLHA voiced their concerns and demands in separate meetings during the GWA. PLHA in The Gambia demand:

- African leaders meet their earlier pledges in Abuja (2001) to increase their Governments’ allocation to the health sector to 10% of GDP by 2010
- Nutritional support for PLHA
- End to stigma and discrimination
- Increase in resource allocation and programs for orphans and other vulnerable children
- Protection of rights of women and children living with HIV and AIDS
- Livelihood options for women
- Voices of PLHA are heard!

As a result, Mr Adama Cham, the Honorable Chairman of the National Assembly Select Committee on Health, assured completer support of the National Assembly to the PLHA and Civil Society Organizations in their endeavors to fight HIV and AIDS.
3. Ensure safe and affordable access

“There are these drugs that are sold at the district hospital at KShs 500 [US$6.54] per month. I was in the same hospital ward with another lady, her family raised money to buy her the drugs. Within months, she had regained strength and was up and about her business. I wish I could get those drugs but I cannot afford them, let alone buying our food in this house”,

– Charity Mbula, 33 year-old HIV positive single parent, Kianidutu slum area, Nairobi, Kenya

Universal Access will not be achieved unless developing countries are free to produce or purchase affordable and quality drugs, diagnostics and preventive tools, such as condoms

While campaigners have successfully driven down the cost of medicines, such as antiretroviral drugs (ARVs), many remain unaffordable in developing countries. Even where the ARVs are free, diagnostic tests are out of reach for the poor. Despite the victory of the Doha Declaration, the cost of new medicines is increasingly a concern, especially when the countries that manufacture generic drugs have to comply with narrowly interpreted WTO rules on intellectual property.

Recent initiatives to speed up the scaling up of access to affordable medicines, such as the William J. Clinton foundation’s initiative or the International Drug Purchasing Facility are welcome, but in no way should replace the responsibility of governments to move towards a long term solution to ensure access to medicines to all people in need.

It is time now for the international community to rethink the international patents system and work on a new international legal framework that will promote needs-based research and development (R&D) and enable stable generic competition on lifesaving medicines needed in developing countries.

3.1 Foster generic competition

“My biggest want now is to access HIV treatment so I could care for my son longer. I want to get ARV to keep my life longer, so I can earn more money for my family. A pill costs me US$2. That is extremely horrible for me.”

– Nguyen Thi Kieu, 19-year-old HIV positive woman, Ho Chi Minh City, Vietnam (also caring for her grandmother, her mother, her husband and their 3 month-old baby)

Rich countries must actively promote and support greater generic competition, which will ensure a sustainable supply of affordable medicines. The TRIPS agreement should be reviewed and pharmaceutical companies and drug exporting countries must stop strong arm tactics intended to tie governments into the purchase of expensive branded medicines

High prices remain a key barrier to scaling up towards universal access to treatment and the clearest example of lack of political will. Although the number of people in developing countries receiving ART has tripled since 2004, 3 out of 4 people who need treatment – around 5 million people – are still not getting it. Generic competition has helped prices for first-line HIV drug regime to fall by 99%,
from US$10,000 to roughly US$130 per patient per year since 2000. Lower prices have helped scaling up access to ARVs in many settings, however, despite these reductions, US$130 is still far beyond what the poor can afford.

Furthermore, there are new challenges such as unaffordable diagnostics and the increasing need of affordable second-line drugs by patients who have developed resistance over the years. The fierce protection of patents by pharmaceutical companies producing second-line drugs results in highly unaffordable prices. In Kenya, the NGO Medecins Sans Frontieres pays US$1,400 per patient per year for a second-line regimen, compared to only US$200 for first-line drugs. In Guatemala, a second-line regimen costs US$6,500 – 28 times more than the first-line treatment. In Brazil, where in 2006 HIV-related hospitalisations were cut by 80% thanks to their early years policy of providing universal drug
treatment, providing new patented medicines at a cost of US$17,000 has raised the country’s spending by 75% in the past two years.57

In order to improve generic competition and therefore drive down prices to essential medicines, rich countries must support poor countries to develop domestic drug manufacturing industries – stopping the barriers to south to south collaboration, supporting them with the technical capacity and strengthening the WHO pre-qualification programme. Poor countries must be empowered and capacitated to negotiate the legal minefield of TRIPS, using all its flexibilities and move away from restrictive interpretations pushed by rich countries.

2001 Doha Declaration on TRIPS and Public Health

Signed at the 2001 WTO Ministerial meeting in Doha, Qatar, the declaration was a landmark victory for AIDS activists fighting powerful multinationals in their campaign to improve access to treatment. Previous fierce attacks on public health policies in Brazil and South Africa convinced developing countries that there was a need to take action and reaffirm their rights.58

The Declaration states that the TRIPS Agreement does not and should not prevent governments from taking measures to protect public health and that it can and should be interpreted and implemented in a manner supportive of their right to protect public health and, in particular, access to medicines for all.59 The Declaration invites countries to use freely all TRIPS flexibilities (e.g. establish legal systems that promote parallel imports, compulsory licenses, etc) to overcome the barriers posed by patents in the fulfilment of their public health needs.

2003 WTO August 30th Decision on compulsory licenses

The August 2003 decision was supposed to address the issue of how to give poor countries, with no manufacturing capacity, the possibility to import generic medicines produced by another country under a compulsory license. Due to strong pressure from the US government and big pharmaceutical companies, the ‘solution’ resulted in a bureaucratic and cumbersome mechanism that has shown to be ‘inapplicable’60 – not a single developing country has succeeded in using the so-called ‘August 30th decision’ that allows countries that do not have the manufacturing capacity to import generics from other countries.

Even though the WHO CIPIH61 questioned its effectiveness and advised to keep it under review and consider appropriate changes, an agreement was made at 2005 WTO Ministerial Conference in Hong Kong to permanently integrate the 2003 August ‘solution’ in the TRIPS agreement, in spite of the opposition shown by developing countries. WTO member states have set the deadline of 1 December 2007 to formally build this decision into the TRIPS Agreement.
Pharmaceutical companies use strategic donations and aggressive litigation while rich countries use international and bilateral trade agreements to prevent countries exercising their right to use safe and affordable generic drugs. The recent litigation by the pharmaceutical company Novartis against the Indian government to force the modification of its Patent Law – which implements the principles contained in the 2001 Doha Declaration – is one example amongst many.\(^6\) In February 2007, a UN committee that monitors the UN Convention on the Rights of the Child expressed concern over the impact of free trade agreements (FTAs) on human rights in Malaysia, especially as they affect the provision of generic medicines, particularly for HIV.\(^6\) The international community must find ways to stop future threats to public health interests by the pharmaceutical lobby or rich countries protecting their interests.

### 3.2 Improve access to evidence-based prevention

“We should unveil issues that lead to people failing to abstain, being faithful and using a condom. Then develop ways of addressing these underlying factors that cause these inconsistencies in behaviour,”

– discussion among a group of women of mixed ages, Kasungu village, Malawi

Collective actions at all levels are needed to support countries’ efforts in condom procurement, promotion and distribution. Governments must implement effective education campaigns, especially targeting populations most at risk.

In generalised AIDS epidemics, like in most sub-Saharan Africa, sex accounts for the vast majority of HIV infections. There is enough evidence to show that the male latex condom is the single most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections.\(^6\) However access and availability of condoms remains shockingly low in the developing world.

There are several positive examples of the impact of increased condom use in particular countries. In Uganda in the 1990s, HIV prevalence declined after increased condom use. Brazil’s HIV epidemic has been sustainably controlled thanks to an early and strong condom promotion among the general population and vulnerable groups.\(^6\) Yet, the global public sector supply of condoms is less than 50% of that needed to ensure adequate condom coverage, creating a shortage of 8.3 billion condoms.\(^6\) According to UNAIDS, ensuring a sufficient condom supply to halt the AIDS epidemic by 2015 will require a threefold increase of funding for condom procurement and distribution.\(^6\)

Simultaneous and equal efforts need to be made to urgently scale up access to affordable, or free, female condoms, the only female-initiated effective STI prevention method currently available. Evidence shows that correct and consistent use of female condoms can reduce the risk of HIV infection by more than 90% in women having sex with an infected partner. Yet, disparities between female and male condom distribution are still great and in 2005, only 14 million female condoms were distributed worldwide, against 6 to 9 billion male condoms.\(^6\)
Governments and donors should act now to invest in bulk purchases of female condoms, reduce the price per unit, support their introduction and invest in the marketing and training programs needed to promote and sustain universal access to female condoms.69

Young girls and women are regularly and repeatedly denied information about, and access to, condoms and too often don’t have the power to negotiate their use.70 The scale up of female and male condom distribution must be accompanied by sexual education campaigns. There is enough evidence that shows the impact of increases in boys’ and girls’ education on the chances that young women and men use condoms and on the capacity of women to negotiate safer sex.71 Specific measures need to be put in place to ensure that girls actually access sexual education in schools. User fees in primary education, and over time in secondary education, should be abolished and governments should ensure that clear HIV awareness and sex education are built into the school curriculum, with a strong focus on gender and power relations.72 The international community should identify all structural barriers to girls’ education, followed up with clear targets and measurable indicators.

Given the gender realities, such as power imbalances between men and women and the impact of violence against women, there is great and
urgent need to ensure that HIV prevention programmes are appropriate and based on evidence of what works. For example, VCT – voluntary counselling and testing – programs often fail to understand that “voluntary” can become coercion in a context of gender inequality and a pervasive threat of violence. ABC – “abstain, be faithful, use condoms” – initiatives ignore the fact that many women and girls are not in a position to negotiate the conditions of a sexual encounter. PMTCT – prevention of mother-to-child transmission – programmes treat women only in their reproductive role and not in their own right. **Governments need to make greater efforts to ensure universal access to evidence-based HIV prevention information and tools.**

3.3 Promote and invest in R&D

“At the moment, we do not have enough equipment to test children for HIV, especially if they are below two years. …We can only be sure of the child’s status after 18 months, by which time the mother’s antibodies are expected to have cleared, and only then can we consider putting such a child on treatment if need be.”

– Mary Katepa, specialist in paediatric HIV at the University Teaching Hospital, Lusaka, Zambia

Financing for the Research & Development (R&D) of essential drugs, vaccines and microbicides must rapidly increase. The WHO should promote, and governments should commit to, the establishment of financing and legal mechanisms that will ensure an international R&D agenda that addresses the needs of the poor

Enormous gaps still exist in research and R&D for diseases that disproportionately affect people in developing countries. Since 1975 until today, a mere 1% of all the medicines reaching the market have been for neglected diseases affecting developing countries. This is because there are no financing mechanisms in place that will ensure that investing in R&D does not depend on market interests and monopolistic drug prices.

Despite increasing resistance to TB drugs and the spread of new forms of the disease – including the deadly multi-drug resistant TB in many developing countries – scientists have yet to come up with new and effective TB drugs.

There is little investment in diagnostic tools – there are no suitable tests to diagnose sexually transmitted infections. Even though every year 500,000 children become HIV infected, investment in ARV formulations for children is scarce and there are no reliable methods to diagnose HIV in infants. With the growing impact of AIDS on children and the large number of orphans and vulnerable children, governments and pharmaceutical companies must invest urgently in developing paediatric drugs and diagnostics.

Twenty six years have passed since the first HIV case was reported and still no vaccine is available. Furthermore, we are persistently witnessing how poverty and gendered HIV realities challenge the use of existing prevention measures, such as condoms. **New and better female controlled prevention**
tools are urgently required to address the additional biological and social challenges faced by women in terms of their protection from HIV infection. US$280 million per year over the next five years are needed to develop a partially effective microbicide, this means doubling the current annual spending. The recent closure of two microbicide clinical trials in India and Nigeria makes it critical for governments and the international community to join efforts for continued research. Likewise, in order to speed up the research of a HIV vaccine, global annual funding must increase by US$440 million, to reach the US$1.2bn needed per year.

Advocates must continue to work with researchers and policy makers to emphasise the need to address issues of access and affordability up front, in order to deliver these future preventive tools rapidly to all affected communities, once they are proven safe and effective.

**WHO global R&D framework**

On May 2006, the World Health Assembly adopted a resolution to create a global framework for essential health R&D, acknowledging that current medical R&D does not address the needs of developing countries.

This milestone was the result of the efforts of countries like Kenya or Brazil who, in spite of the obstacles posed by many of the rich countries, succeeded in proposing a sustainable framework for health research based on the needs of people and not simply on profit interests. Subsequently, a WHO Inter-Governmental Working Group on Public Health, Innovation and Intellectual Property was created and mandated to submit a plan of action to the May 2008 World Health Assembly. The WHO must take this unique opportunity to prioritise health above other concerns in the R&D agenda.

It is crucial that civil society organisations monitor the progress made by the group and demand that Southern governments actively participate and address the health needs of 90% of the world population, who live in poor countries.
Protesters dressed as health workers demand the right to healthcare during the UN High-Level meeting on AIDS (June 2006)
Miles Apart, Yet Common Experiences and Common Demands

People Living with HIV and AIDS (PLHA) in India Demand a Life of Dignity!

PLHA came face to face over the web with positive people and members of civil society from around the world in New York during the UNGASS Review through a novel concept called *advocasting*. PLHA realized that across the world, the plight of a person living with HIV and AIDS is the same; discrimination, lack of access to treatment and deep poverty penetrate boundaries, regional differences and development. Together the PLHA demanded equal opportunity, access to treatment and care, protection of rights and a life of dignity!

“We are dying, but be proud that we are not dying silently. We are fighting for our cause,”– said a PLHA

Make Universal Access a Reality!

People living with HIV and AIDS shared their experiences with the Parliamentary Forum on HIV&AIDS and demanded that more attention be given to care and support of PLHA in the country. PLHA demanded that: primary health care be strengthened, free Anti Retrovirals and diagnostics be made available for all those who need it. PLHA and AIDS activists called on the Parliamentarians to increase state and national expenditure on health and devote more resources into care and support services for PLHA. PLHA brought to light the stigma and discrimination they face, particularly in health care settings.

Mr J D Sheelam, who coordinated the meeting committed to fighting HIV&AIDS saying “*Given the gravity of the HIV issue, it will be taken forward irrespective of party lines and it is high time that the stigma and discrimination around HIV is wiped out.*”

VOICING THE EXPERIENCES OF MILLIONS OF PEOPLE LIVING WITH HIV AND AIDS

Testimonies of PLHA reverberated the public hearing on HIV&AIDS, raising the problems and fears of millions of PLHA worldwide. Through the public hearing, they insisted that the government, judiciary, civil society and media frame appropriate policies and implement programs to benefit people living with HIV and AIDS.

The jury verdict demanded:

- Anti-discriminatory legislation
- HIV&AIDS treatment and care should be an integral part of every hospital
- Pediatric dosages to be made available in all ART centers immediately
- Budget allocation for health must increase, with greater allocation for HIV and AIDS within the Health Budget
- Transparency and accountability within the Government sector is a real need, so that the money spent reaches the people who need it the most.
January 2007 – World Food Program warns that more than 700,000 hungry Cambodians – mostly young children, people living with HIV and AIDS and tuberculosis patients will not receive essential food.

“There is a chronic and persistent food insecurity situation in Cambodia,” said Dr Peter Piot, Executive Director of UNAIDS. “Food and nutrition are an essential part of the package of care for people receiving treatment for AIDS and efforts must be made to ensure that all people living with HIV have access to the food and nutrition they need.”

Cambodian Alliance of PLHA Demand Their Rights through the Media

To mark the Global Week of Action, the alliance of People living with HIV and AIDS (PLHA) called a press conference to voice their demands. PLHA brought to light pressing issues – dismissal from employment due to HIV status, being treated as “monkeys” in drug trials, abandonment by family, denial of access to health care in rural areas and Anti-Retrovirals and alienation of their children.

“Poor countries must be allowed to produce medicines!” demanded PLHA.

Cambodians demand:

● Affordable quality health care in the rural areas
● End violence against women
● Food security
● More commitment of Government and NGOs to end HIV and AIDS

Media Spreads Voices of PLHA

The voices of PLHA were carried to the nation and throughout the world through 6 TV channels, 10 radio stations and 25 national and international newspapers and a 16-minute TV spot.

PLHA highlighted issues of food insecurity, sexual violence, violence against women and children living with HIV and AIDS and protection of rights of PLHA.
4. Fund the commitment

“We are on the cusp of a huge financial crisis in response to the pandemic. We need US$22 billion in 2008. We’re billions and billions short (…). If these circumstances continue, universal access is doomed. This issue of resources makes or breaks the response to the pandemic. It is imperative that the delegates here assembled never let the G8 countries off the hook” 81

– Stephen Lewis, former UN Special Envoy for HIV/AIDS in Africa, Toronto, August 2006

Universal access will remain an empty promise unless rich countries provide full, sustained and predictable funding. Financing for HIV and AIDS requires both increasing the available money and using it effectively.

Having put forward the universal access goal, it is morally indefensible for donors not to fund both through additional monies as well as through support of greater domestic spending.

For every US$1 received in aid, low income countries spend twice that in debt repayments. Despite this financial imbalance, debt relief has been inadequate. Debts of the world’s poorest countries must be cancelled in full, by fair and transparent means, allowing countries to divert resources to agreed national priorities that guarantee predictable resources for HIV and health.

0.7% ODA target

If the rich countries met their long standing commitment of increasing their official development assistance (ODA) to 0.7% of national income, available funding would treble and universal access would be within reach. However, of the G8 countries, none have fulfilled their promise. The US, Japan, Russia and Canada have still not set a timetable to reach this target. France and the UK have committed to reach this target by 2012 and 2013 respectively, while Germany and Italy have committed to reach the target by 2015.

Innovative means of financing, such as the international financing facilities used to frontload aid money with bonds on the private market and levies on air tickets, can play a role in the global AIDS response. However, they must be additional to aid and must strengthen existing AIDS mechanisms, instead of diverting resources among several, small initiatives.
4.1 Funding plan to fill the annual US$10 billion gap

As developing countries meet their commitment to deliver national ‘roadmaps’ towards universal access, the rich countries, especially the G8, must deliver a funding plan to raise the additional monies needed to meet their own commitment to universal access.

According to UNAIDS, there is an AIDS funding gap of at least US$8.1 billion in 2007 and US$10 billion per year thereafter for what is needed for a comprehensive response to HIV and AIDS in low and middle income countries. These are conservative figures and real resource needs may be higher. For example, UNAIDS narrowly defined universal access to treatment as 80% coverage of people who would die within a year without treatment but if we used a wider definition like the one used in the 3x5 initiative as all those who have begun to develop AIDS related symptoms then estimates would be higher.

Whichever definition we may use, the need to significantly scale up global funding for HIV and AIDS is clear. As stated in the Secretary General’s report to the UN High-Level Meeting on AIDS, if the international community is to scale up the response, “no credible, costed, evidence-informed, inclusive and sustainable national AIDS plan should go unfunded”.

A G8 funding plan is crucial to show donors’ intention to deliver sufficient funding and provide greater incentives for countries to develop national targets. Developing countries need to know when and how this money is going to appear. A funding plan should map out how donor countries intend to raise and channel additional funding to ensure that work to meet national targets and achieve universal access by 2010 is fully resourced. Funding must be predictable to enable country governments to plan long-term investment. Funding must be untied, aligned with national targets and free from conditions beyond those necessary to ensure the aid is spent for its stated purpose.

A funding plan should set realistic and ambitious funding targets for donor governments, particularly for overseas aid. It is important however, that donors also focus upon making the most of existing AIDS funding. Funding must be equitably allocated, its impact measured and reported, transparently and disaggregated, including by gender, age and rural and urban areas. Donors must provide funds for the entire continuum of prevention, treatment and care. In the context of the feminisation of the pandemic it is critical that donors commit the necessary funds for programmes that explicitly empower women and seek to end violence against women to avoid continuing the current trend of “policy evaporation” on women’s rights issues.

Crucially, the funding plan should recognise lessons learned in the past: increased funding must be additional and not ‘recycled’ or at the expense of other key priorities, such as increased spending on health and education.
4.2 Fund the Fund

“The Global Fund money has been approved in our name, and for us positives to prolong our lives. The money should not be floating around, while we are dying!”

– HIV/AIDS activist, member of Navakiran Plus, Nepal

The Global Fund to fight AIDS, TB and Malaria must be funded in full and scaled up significantly to help achieve the universal access goal. Rich countries must contribute their fair share and ensure predictable and sustainable funding for HIV and AIDS responses.

By May 2006, the Global Fund had signed grant agreements worth US$4 billion for over 300 grants to 127 countries. As of June 2006, HIV and AIDS programs supported by the Global Fund had a reported 544,000 people on ARV treatment, 5.7 million people reached with HIV counselling and testing, 560,000 orphans receiving basic care and support and 1.5 million additional service deliverers trained to fight HIV, TB and malaria. Set up as the exceptional response from the world to address diseases that overwhelmingly affect the poor, the Global Fund has delivered measurable successes in a very short time.

However, rich countries have yet to back it with total conviction and full and predictable funding. Calls for proposals have been delayed and some proposals have been rejected. The scope of the Global Fund has been defined by the voluntary and ad hoc donors’ pledges rather than to meet the real needs in developing countries.

The Global Fund to fight AIDS, TB and Malaria

The Fund was created as a financial mechanism to dramatically increase resources to fight three of the world’s most devastating diseases and to direct those resources to areas of greatest need. Since then, it has become one of the most important aid agencies in the world, pioneering new approaches in foreign assistance.

The Global Fund’s performance-based funding model provides an effective vehicle for scarce resources, ensuring value for money. By channeling funds through the Global Fund, donors ensure that funds are spent effectively. The Fund’s financing model emphasizes accountability for grant targets and transparent use of funds.

In countries like Ethiopia, Honduras, Kenya or Lao PDR, performance-based funding proves to be providing crucial incentives to accelerate implementation.

While the Global Fund has many challenges to overcome, including promoting greater participation of civil society and ensuring the effective use of funds and resources at community and national level, participants of the Global Fund’s Partnership Forum in July 2006, “generally agreed that the Global Fund had excelled in terms of its flexibility and its ability to raise and move resources for HIV&AIDS, TB and malaria. The major concerns raised by participants were that partnerships at country level were not working at optimal efficiency and effectiveness. Participants generally agreed that the Global Fund needed to take a more substantive role in ensuring complimentarity, additionality and better division of labour and partnerships.”
Rather than a round by round, voluntary replenishment of funds, donor governments must establish a more predictable and sustainable framework that commits them to paying their fair share. The Global Fund now provides about 21% of total funds for HIV and AIDS and two-thirds of total funds for TB and Malaria. Assuming that the Global Fund’s share in funding the three diseases is maintained, the Global Fund estimates its own resource needs at US$6.7 billion to US$7.7 billion annually from 2008 to 2010. This is a conservative estimate, as it is based on the assumption that other funding sources will increase in parallel to meet global needs. Current funding trends do not bode well for this scenario.

ActionAid and other organizations believe that the share of the Global Fund in total funding will need to increase if we are to achieve universal access and Millennium Development Goals. Ensuring the sustainability of the Global Fund is crucial as it is the one vehicle that has rapidly delivered a scale up of the world’s response to the three neglected diseases. Campaigners clearly have their work cut out for them: the health of the Global Fund is critical to the health of millions of poor people.

### REAL vs FAIR G7 CONTRIBUTIONS TO THE GLOBAL FUND

- **Actual contributions ($ millions) for 2005**
- **Fair share contributions ($ millions) for 2005**

4.3 Stop inappropriate donor conditions

“The stakeholders in the field of HIV and AIDS should deal directly with PLWHA, because it is only the one who wears the shoe that knows where it pinches”

– Zainab Haruna, HIV positive woman, Nigeria

Donors should fund evidence-based interventions and not impose inappropriate or harmful conditions based on their own political and ideological agendas

Bilateral and multilateral aid programmes for HIV and AIDS that deny people their right to comprehensive and evidence-based information on prevention or discriminate against marginalised groups, such as sex workers, drug users and men who have sex with men, have a detrimental impact on the fight against AIDS.

There is some concern at the reversal of gains and an increase in HIV prevalence rates in some countries like Uganda. Following donor pressure, some African leaders have adopted a hostile attitude towards well established and effective prevention methods. President Museveni of Uganda once promoted the use of condoms as a proven preventative tool. But more recently, First Lady Janet Museveni, is reported to have declared that giving condoms to young people was the moral equivalent of murder or theft (and) a punishment from God for sexual immorality. In 2005, Uganda’s US funded HIV prevention budget was US $31.8 million.

Donor conditions sometimes ignore the drivers of the epidemic, such as human rights violations and marginalisation of injecting drug users or sex workers by not addressing particular group’s needs in their programmes. For example, through conditional funding, some donors, such as the USA, block the access to needle exchange programmes by IDUs or deny the access to prevention and treatment services to sex workers.

It is widely recognised that we will not halt the feminization of the pandemic or ensure universal access for women without addressing gender inequality and empowering women and girls. However, the current framework for AIDS funding fails to acknowledge and challenge the gender bias and therefore fails to reduce HIV infections among women and girls.

Donors should stop imposing conditions or promoting programmes that undermine an effective AIDS response in developing countries. Donor funding must be predictable, untied, aligned with national targets and free from conditions that go beyond those necessary to ensure that aid spending effectively addresses the AIDS pandemic.
President’s Emergency Plan for AIDS Relief-PEPFAR

The US President’s Emergency Plan for AIDS Relief (PEPFAR) is one of the largest single sources of money available for AIDS treatment in the world providing US$15 billion over 5 years.92

However, PEPFAR money is overtly influenced by the ideology of the US administration and its conservative approach to HIV prevention, rather than based on evidence of what works to address the real prevention needs of people.93 ‘Despite numerous and unrefuted government funded studies discrediting abstinence only programmes as an exclusive HIV prevention strategy, the US Congress requires that at least 33% of all HIV prevention money under PEPFAR be spent on abstinence-until-marriage approaches’.94

PEPFAR’s guidelines and spending requirements constrain and some would say effectively ban organisations receiving US funding from supporting programmes targeting commercial sex workers (the Prostitution Oath) or those that promote sexual and reproductive health choices and are not anti-abortion (Mexico City Policy/ Global Gag Rule) are having an equally damaging impact on AIDS responses targeting key populations and on the promotion of human rights, especially of women.95

PEPFAR’s unilateral and vertical approach, hardly aligned to national priorities, does little to support the US commitment to the ‘Three Ones’96 by failing to build countries’ capacity. Unless these failings are identified and challenged by national governments and the international community they will inevitably undermine the 2010 target.
Radio Discussion Kick Starts Global Week of Action

On the radio, AIDS activists called on the Government to meet Abuja and UNGASS Declarations. They questioned the claim that HIV prevalence rate was decreasing and that condom use was increasing in Ghana. Positive people and activists demanded effective tracking of HIV and AIDS funds. People living with HIV and AIDS (PLHA) demanded more voluntary counselling and testing (VCT) centres, access to HIV treatment and an end to stigma and discrimination.

Public Forum Issues Communiqué on HIV and AIDS

Positive people, religious leaders and key organizations developed the following communiqué:

- The deliberate referral of HIV and AIDS cases by health personnel to private clinics/hospitals must stop
- Government should provide adequate training and medical facilities to make the administration of antiretrovirals (ARV) possible at the district levels and in reasonable quantities.
- Health Workers should be awakened to the special treatment, care and support commensurate with the plight of PLHA
- Implementation of Programmes and Policies of HIV and AIDS should be championed by PLHA themselves
- Traditional Authorities and other Opinion Leaders must be organized and given regular training on HIV and AIDS to encourage ready acceptability of PLHA in the community
- Government should design specific training programmes targeted at close relatives of PLHA, who must be empowered economically to provide home based care
- Women and Children affected by HIV and AIDS should be given relevant employable skills and adequate support to live decent and better lives
- Mother to Child Transmissions of HIV and AIDS must be stopped through vaccination and legislations that would make the administration of those vaccines possible
- Provision of nutritional support to PLHA should form part of government’s interventions in the country
Recommendations

ActionAid supports the right to universal access to HIV and AIDS prevention, treatment and care in order to reverse the AIDS pandemic as well as a crucial element in the drive to end poverty.

Therefore, we ask governments in the North and South to be accountable to HIV-affected communities around the globe and take every necessary action to achieve the universal access goal by 2010. As an urgent starting point, governments must:

1. Guarantee rights
   ✦ Establish and enforce progressive legislation that protects the human rights of people living with HIV and AIDS and vulnerable and marginalised groups at all levels and interventions.

   ✦ Respect, protect and fulfil the rights of women and girls to education, sexual and reproductive health, land and property ownership and access to natural resources and livelihoods; prioritising, through action and resource commitment, the end of violence against women and girls.

   ✦ Provide adequate nutritional support for people living with HIV and invest in improving food security as part of a comprehensive response to tackle poverty.

2. Build health capacity
   ✦ Increase investment in strengthening health infrastructure and capacity and making it accessible to all, including by meeting the 15% health spending commitment by African governments and the abolishment of IMF imposed fiscal conditions and spending ceilings on public health, education and public sector wage bills.

   ✦ Train and recruit at least 4 million health workers, ensuring adequate investment in wages; while actively addressing the current global brain drain of health workers through international ethical guidelines and compensation mechanisms.
◆ Abolish user fees in public health systems and support essential healthcare free to all at the point of use.

3. Ensure safe and affordable access
◆ Promote generic competition and access to affordable drugs by reviewing the TRIPS agreement and ending the pressure on developing country governments to buy expensive branded medicines or introduce stronger patent legislation.

◆ Increase by threefold the funding for the distribution and procurement of male and female condoms, alongside the implementation of effective evidence-based HIV prevention information and education campaigns.

◆ Double current annual spending for microbicide research and development and increase by 60% the annual spending on HIV vaccine research; and invest in paediatric drugs and diagnostics while developing an adequate system to ensure a long term health needs based international R&D agenda.

4. Fund the commitment
◆ Scale up the funds to reach the minimum US$21-23bn needed annually to meet the commitment to universal access and establish a framework of long-term, predictable and sustainable funding in particular through a funding plan by G8 countries.

◆ Provide additional, sustained, predictable and full funding of the Global Fund to Fight AIDS, TB and Malaria, through donors’ fair share contributions.

◆ Stop imposing harmful conditions, such as limiting HIV prevention funding to abstinence-only programmes or blocking support to programmes targeting sex workers, that are not based on evidence of what works and fail to address gendered realities.
Endnotes


2 Progress on global access to HIV antiretroviral therapy: a report on “3 by 5” and beyond, WHO/UNAIDS, Geneva, March 2006


7 United Nations General Assembly Political declaration on HIV/AIDS, resolution A/RES/60/262, UNGASS, 2006

8 Considerations for Target Setting, UNAIDS, April 2006


10 See: Newsletter #20, Lawyers Collective HIV/AIDS unit, quoting Justice Michael Kirby of the Australian High Court, August 2005

11 Food, nutrition and HIV: what next? ODI/C are, August 2006

12 World Development Indicators 2006, World Bank http://devdata.worldbank.org/wdi2006/content/Table2_7.htm


14 Social Protection Briefing note series, number 2, DFID, November 2005

15 See: Can low income countries afford basic social protection? Model data, assumptions and results, Technical note, ILO, Geneva, 2004

16 A study on gender dynamics in access and utilisation of SRHR and HIV prevention, care and support services in conflict and post conflict areas of Uganda, ActionAid International Uganda, p. 19

17 Making the grade, ActionAid International, OSISA, January 2007, p. 3

18 Cultivating women’s rights for access to land, ActionAid International-Food Security Network, October 2005, p.6

19 Newsletter #20, Lawyers Collective HIV/AIDS unit, August, 2005, p. 1


22 In the Indian Penal Code, section 377, introduced during British rule, is used to criminalise homosexual activity. See: http://en.wikipedia.org/wiki/Section_377_of_the_Indian_Penal_Code 23 2006


24 Ibid


26 The Workplace: gateway to universal access, ILO, April 2006

27 According to the ILO, 73 countries have included AIDS-related provisions in their labour and discrimination laws and policies (for instance: Mozambique Act No. 5 of February 2002).


29 http://www.who.int/governance/eb/who_constitution_en.pdf


33 Tracking progress toward the Abuja target: are African states allocating 15% of their annual budgets for health?, ActionAid, October 2005
35 Progress report on the implementation of the plans of action of the Abuja Declarations for Malaria, HIV/AIDS and Tuberculosis, African Union, October 2005
37 WHO launches new plan to confront HIV-related health worker shortages, WHO, 15 August 2006
39 The NHS goes global, The Guardian, 18 May 2005
40 International Recruitment of health workers to the UK, DFID, February 2004
44 Social Health Insurance: report by the Secretariat, WHO EB115/8, Geneva
47 Burnham, G et al, Discontinuation of cost sharing in Uganda, Bulletin of the World Health Organization 82, 2004
49 Square pegs, round holes: issue briefing on how the IMF is blocking progress in the fight against HIV/AIDS, ActionAid USA, March 2005
50 The joint-learning initiative strategy report: human resources for health overcoming the crisis, Harvard University Press, January 2005
51 The William J Clinton foundation aims at bringing the price of generic drugs down yet further, http://www.clintonfoundation.org/cf-pgm-hs-ai-home.htm
52 International Drug Purchasing Facility/ UNITAID, aims to leverage price reductions for existing treatment through predictable financing raised partly by an air tax levy, http://www.unitaid.eu/EN-Inutaid-unis-pour-soigners.html
55 Five years after Doha, drug prices are on the rise, Countries must make more use of TRIPS flexibilities, MSF Access to Essential Medicines Campaign's press-release,13 November 2006
58 Patents, trade and health, http://www.geneva.quno.info
59 http://www.who.int/trade/glossary/story017/en_.html
60 See: Neither expeditious, nor a solution: the WTO August 30th decision is unworkable, MSF, Toronto, August 2006
62 See: www.msf.org
63 Free Trade Agreement, Malaysia, http://www.ftamalaysia.org/


Female condom: a powerful tool for protection, UNFPA/PATH, Seattle, 2006


Contribution of Dr Tido von Schoen-Angerer, Medecins Sans Frontieres to the WHO intergovernmental group, December 2006.


The word “microbicides” refers to a range of different products (still to be developed) that will be able to prevent the sexual transmission of HIV and other STIs when applied topically. It has been estimated that even a partially effective microbicide taken up by a small percentage of those using health services could save 2.5 million lives over three years (London School of Hygiene and Tropical Medicine).

See more at: http://www.global-campaign.org/releases.htm


Editorial Global strategies need truly global discussions, The Lancet, 368:2034 DOI:10.1016/S0140-6736(06)69814-0, 2006

Closing Session of the XVI International AIDS Conference 2006, Toronto, Canada


Secretary General’s report to the UN May 2006 http://data.unaids.org/pub/InformationNote/2006/20060324_hlm_ga_a60737_en.pdf?preview=true

Investing in Impact, the Global Fund Mid-Year Results Report, The Global Fund, 2006


ICASO Advocacy Alert, 8 June 2006, www.icaso.org


91 The less they know, the better, Human Rights Watch, Uganda, March 2005


94 The less they know, the better, Human Rights Watch, Uganda, March 2005


96 In 2004, key donors, including the US, endorsed the “Three Ones” principles to increase effectiveness in the use of resources, through: one agreed HIV&AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad-based multisectoral mandate; one agreed country-level Monitoring and Evaluation System. http://www.unaids.org/en/Coordination/Initiatives/three_ones.asp
Annex
Guarantee Rights

Have a domestic violence act
No

Have AIDS specific legislation in labour laws
No

Ratio of girls to boys in primary education
1.03

% of population completing primary level education
76.4

Orphans and vulnerable children whose households received free basic external support in caring for the child
Data not available

Build Health Capacity

Health Workers (density per 1000 population)
1.08

User fees for health services
No

Total debt service as % of health budget
27.21%

Ratio of dollars spent on debt to that spent on health
1.4

General government expenditure on health as % of general government expenditure
6.5

Health Expenditure (as % of GDP)
3.0

Ensure Access to Affordable Tools

% of most-at-risk populations who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men), and those injecting drug users who have who have adopted behaviours that reduce transmission of HIV
39.8 (sex workers) 49.2 (men who have sex with men)

% of most-at-risk populations who correctly identified ways of preventing HIV sexual transmission and reject major misconceptions on HIV transmission
23.3 (sex workers) 14.0 (IDU) 13.5 (MSM)

% of people with advanced HIV infection receiving antiretroviral combination therapy
8.9

% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission
< 50%

1. Data is for 2003
2. Data is for 2000
3. No gender breakdown available
4. From UNGASS country report 2005. Data was collected between 2002-2003. However, the most recent estimates from 2005 also put figures at 100%
5. Data is for 2004
### Cambodia

**Number of people living with HIV:** 130,000  
**Prevalence rate amongst adults aged 15–49:** 1.6%  
**Deaths due to AIDS:** 16,000

#### Guarantee Rights
- **Have a domestic violence bill:** Yes\(^1\)  
- **Have AIDS specific legislation in labour laws:** No  
- **Ratio of girls to boys in primary education:** 0.92  
- **% of population completing primary level education:** 81.7  
- **Orphans and vulnerable children whose households received free basic external support in caring for the child:** 14,000

#### Build Health Capacity
- **Health Workers (density per 1000 population):** 1.06\(^2\)  
- **User fees for health services:** Yes\(^3\)  
- **Total debt service as % of health budget:** 60.00%  
- **Ratio of dollars spent on debt to that spent on health:** 1:2  
- **General government expenditure on health as % of general government expenditure:** 12.0  
- **Health Expenditure (as % of GDP):** 6.8

#### Ensure access to affordable tools
- **% of most-at-risk populations who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men) and those injecting drug users who have who have adopted behaviours that reduce transmission of HIV:** 96 (sex workers)  
- **% of most-at-risk populations who correctly identified ways of preventing HIV sexual transmission and reject major misconceptions on HIV transmission:** Data not available  
- **% of people with advanced HIV infection receiving antiretroviral combination therapy:** 96%  
- **% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission:** Data not available

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2. Data is for 2000  

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### China

**Number of people living with HIV:** 650,000  
**Prevalence rate amongst adults aged 15–49:** 0.1%  
**Deaths due to AIDS:** 31,000

#### Guarantee Rights
- **Have a domestic violence act:** No\(^4\)  
- **Have AIDS specific legislation in labour laws:** No  
- **Ratio of girls to boys in primary education:** 1  
- **% of population completing primary level education:** 103.3\(^5\)  
- **Orphans and vulnerable children whose households received free basic external support in caring for the child:** Data not available

#### Build Health Capacity
- **Health Workers (density per 1000 population):** 8.01\(^3\)  
- **User fees for health services:** Yes  
- **Total debt service as % of health budget:** 17.85%  
- **Ratio of dollars spent on debt to that spent on health:** 1:6  
- **General government expenditure on health as % of general government expenditure:** 10  
- **Health Expenditure (as % of GDP):** 4.7

#### Ensure access to affordable tools
- **% of most-at-risk populations who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men) and those injecting drug users who have who have adopted behaviours that reduce transmission of HIV:** 41.1 (men who have sex with men)  
- **% of most-at-risk populations who correctly identified ways of preventing HIV sexual transmission and reject major misconceptions on HIV transmission:** 23.5 (female sex workers), 36.0 (IDU)  
- **% of people with advanced HIV infection receiving antiretroviral combination therapy:** 37.3 (men), 36.0 (IDU)  
- **% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission:** Data not available

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1. In 2001 there were revisions to the marriage law, which included local regulations of domestic violence however there is no national bill. [http://www.unifem-eseasia.org/resources/others/domesticviolence/PDF/China.pdf](http://www.unifem-eseasia.org/resources/others/domesticviolence/PDF/China.pdf)  
2. Data is for 1991  
3. Data is for 2001  
4. Data collected between 2003 and 2005  
5. Estimated data for 2005 using the latest available information at the time
### Gambia

**Number of people living with HIV:** 20,000  
**Prevalence rate amongst adults aged 15–49:** 2.4%  
**Deaths due to AIDS:** 1,300

<table>
<thead>
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<tbody>
<tr>
<td>Have a domestic violence act</td>
<td>No1</td>
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<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>No</td>
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<td>Ratio of girls to boys in primary education</td>
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<td>% of population completing primary level education</td>
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<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>3.3%</td>
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<th>Build Health Capacity</th>
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<tr>
<td>Health Workers (density per 1000 population)</td>
<td>2.53</td>
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<tr>
<td>User fees for health services</td>
<td>Yes</td>
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<tr>
<td>Total debt service as % of health budget</td>
<td>12.97%</td>
</tr>
<tr>
<td>Ratio of dollars spent on debt to that spent on health</td>
<td>1:8</td>
</tr>
<tr>
<td>General government expenditure on health as % of general government expenditure</td>
<td>10.9</td>
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<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>5.5</td>
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<th>Ensure access of affordable tools</th>
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<tbody>
<tr>
<td>% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner</td>
<td>25.4</td>
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<tr>
<td>% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge</td>
<td>30 (men) 19 (women)</td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>7.1</td>
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<tr>
<td>% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission</td>
<td>3.0</td>
</tr>
</tbody>
</table>

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1. Data is for 2005  
2. Data is for 1999  
3. Data is for 2003  
4. Data from The National AIDS Secretariat, UNGASS Country Progress Report, December 2005  
5. Ibid  
6. Data is an estimate for 2005 using the latest available information at the time  
7. Data is an estimate for 2005 using the latest available information at the time
<table>
<thead>
<tr>
<th>GHANA</th>
<th>INDIA</th>
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<td><strong>Guarantee Rights</strong></td>
<td><strong>Guarantee Rights</strong></td>
</tr>
<tr>
<td>Have a domestic violence act</td>
<td>Yes¹</td>
</tr>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>No</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>0.96²</td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>65.4</td>
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<td>Orphans and vulnerable children whose households received free basic</td>
<td>133,779</td>
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<td>external support in caring for the child</td>
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<td><strong>Build Health Capacity</strong></td>
<td><strong>Build Health Capacity</strong></td>
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<tr>
<td>Health Workers (density per 1000 population)</td>
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<td>User fees for health services</td>
<td>Yes³</td>
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<td>Total debt service as % of health budget</td>
<td>30.38%</td>
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<td>Ratio of dollars spent on debt to that spent on health</td>
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<td>General government expenditure on health as % of general government</td>
<td>8.4</td>
</tr>
<tr>
<td>expenditure</td>
<td></td>
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<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>6.3</td>
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<tr>
<td><strong>Ensure access to affordable tools</strong></td>
<td><strong>Ensure access to affordable tools</strong></td>
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<td>% of young women and men (combined) aged 15-24 reporting the use of a</td>
<td>40.9</td>
</tr>
<tr>
<td>condom last time they had sex with a non-regular partner</td>
<td></td>
</tr>
<tr>
<td>% of young women and men aged 15-24 with comprehensive HIV/AIDS</td>
<td>40.3 (men) 35.8 (women)</td>
</tr>
<tr>
<td>knowledge</td>
<td></td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral</td>
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<td>combination therapy</td>
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<td>% of HIV infected pregnant women receiving a complete course of</td>
<td>0.5</td>
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<td>antiretroviral prophylaxis to reduce the risk of mother to child</td>
<td></td>
</tr>
<tr>
<td>transmission</td>
<td></td>
</tr>
</tbody>
</table>

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1. Act was passed in 2007
2. Data is for 2005
3. As an alternative national policy there is a health insurance scheme, designed to offer more affordable health care, which is gradually becoming more widespread
5. Currently has a draft HIV and AIDS bill (anti discrimination)
6. Data is for 2004/03/05
7. Data collected between 2001 and 2005 for the Demographic and Health Survey. This survey the criteria for the data is based on the percentage of respondents who have correctly identified the 2 major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner) and who reject the 2 most common local misconceptions about HIV and who know that a healthy looking person can have HIV
   Metadata.aspx?IndicatorId=0&SeriesId=743
9. Estimated data for 2005 using the latest available information at the time
### Guatemala

**Number of people living with HIV:** 61,000  
**Prevalence rate amongst adults aged 15–49:** 0.9%  
**Deaths due to AIDS:** 27,000

**Guarantee Rights**
- Have a domestic violence act: Yes¹  
- Have AIDS specific legislation in labour laws: Yes²  
- Ratio of girls to boys in primary education: 0.92³  
- % of population completing primary level education: 90.2⁴  
- Orphans and vulnerable children whose households received free basic external support in caring for the child: Data not available

**Build Health Capacity**
- Health Workers (density per 1000 population): 5.13⁵  
- User fees for health services: Yes⁶  
- Total debt service as % of health budget: 53.701%  
- Ratio of dollars spent on debt to that spent on health: 1:0.2  
- General government expenditure on health as % of general government expenditure: 18.1  
- Health Expenditure (as % of GDP): 5.51⁷

**Ensure access to affordable tools**
- % of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner: Data not available  
- % of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge: 90.5⁸  
- % of people with advanced HIV infection receiving antiretroviral combination therapy: 46⁹  
- % of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission: 3.7¹⁰

1. Has decree to prevent intra-family violence which includes domestic violence (Decreto Numero 97–96)  
2. See HIV/AIDS law and regulation (Decreto 27–2000 and decreto 27–2002) and the social development law (Decreto 42–2001)  
3. 2005 data  
4. Annual statistics for 2005 from the Ministry of Education  
5. 1999 data  
6. There is no data about user fees for health services, however the coverage rate and quality of the public system means that the population must go to private centres and pay for their medicines  
7. 2006 State budget (Decreto 92–2005). WHO alternative figures stand at 5.7%  
8. Epidemiologic National Centre, 2005. This figure corresponds to the HIV/AIDS knowledge of men and women aged between 15–99  
9. Data collected between 2002-2003. Most recent estimates from 2005 put the figure at 35.1%  
10. Data is estimated for 2003 using the latest available information at the time

### Haiti

**Number of people living with HIV:** 190,000  
**Prevalence rate amongst adults aged 15–49:** 3.8%  
**Deaths due to AIDS:** 16,000

**Guarantee Rights**
- Have a domestic violence act: No  
- Have AIDS specific legislation in labour laws: No  
- Ratio of girls to boys in primary education: 0.94  
- % of population completing primary level education: 27.4⁴  
- Orphans and vulnerable children whose households received free basic external support in caring for the child: Data not available

**Build Health Capacity**
- Health Workers (density per 1000 population): 0.37⁵  
- User fees for health services: Yes⁶  
- Total debt service as % of health budget: 44.86%  
- Ratio of dollars spent on debt to that spent on health: 1:2  
- General government expenditure on health as % of general government expenditure: 23.8  
- Health Expenditure (as % of GDP): 7.2

**Ensure access to affordable tools**
- % of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner: 30.0 (men) 20.0 (women)  
- % of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge: 55.9 (men) 40.7 (women)  
- % of people with advanced HIV infection receiving antiretroviral combination therapy: 11.2  
- % of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission: 1.6²

2. Data is for 1991  
3. Data is for 1991  
4. However the UNGASS country report 2005, quotes figures from a 2004 study which says 1470 OVC have been helped via a state programme.  
5. Data is for 1998  
6. The government has introduced a cost recovery system see: http://www.aidandtrade.org/pdf2006/reiew/06-MSF.pdf  
9. Data is estimated for 2005 using the latest available information at the time
### Kenya

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
<th></th>
</tr>
</thead>
</table>
| Have a domestic violence act | No
| Have AIDS specific legislation in labour laws | No
| Ratio of girls to boys in primary education | 0.94
| % of population completing primary level education | 91.8
| Orphans and vulnerable children whose households received free basic external support in caring for the child | 10.3%

<table>
<thead>
<tr>
<th>Build Health Capacity</th>
<th></th>
</tr>
</thead>
</table>
| Health Workers (density per 1000 population) | 2.07
| User fees for health services | No
| Total debt service as % of health budget | 32.95%
| Ratio of dollars spent on debt to that spent on health | 1:3
| General government expenditure on health as % of general government expenditure | 7.9
| Health Expenditure (as % of GDP) | 4.0

<table>
<thead>
<tr>
<th>Ensure access to affordable tools</th>
<th></th>
</tr>
</thead>
</table>
| % of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner | 35.6
| % of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge | 79.5 (men) 58.3 (women)
| % of people with advanced HIV infection receiving antiretroviral combination therapy | 19.7
| % of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission | 9.3

### Lesotho

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
<th></th>
</tr>
</thead>
</table>
| Have a domestic violence act | No
| Have AIDS specific legislation in labour laws | Yes
| Ratio of girls to boys in primary education | 1
| % of population completing primary level education | 71
| Orphans and vulnerable children whose households received free basic external support in caring for the child | 25.00%

<table>
<thead>
<tr>
<th>Build Health Capacity</th>
<th></th>
</tr>
</thead>
</table>
| Health Workers (density per 1000 population) | 0.84
| User fees for health services | Yes
| Total debt service as % of health budget | 24.98%
| Ratio of dollars spent on debt to that spent on health | 1:4
| General government expenditure on health as % of general government expenditure | 11.9
| Health Expenditure (as % of GDP) | 6.7

<table>
<thead>
<tr>
<th>Ensure access to affordable tools</th>
<th></th>
</tr>
</thead>
</table>
| % of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner | 49.2
| % of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge | 18
| % of people with advanced HIV infection receiving antiretroviral combination therapy | 13.6
| % of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission | 5.3

---

1. To date there is a draft bill entitled the Domestic Violence (Family Protection) Bill.

---
Guarantee Rights

Have a domestic violence act
   Yes

Have AIDS specific legislation in labour laws
   Yes

Ratio of girls to boys in primary education
   1.02

% of population completing primary level education
   58.5

Orphans and vulnerable children whose households received free basic external support in caring for the child
   120,037

Build Health Capacity

Health Workers (density per 1000 population)
   0.67

User fees for health services
   No

Total debt service as % of health budget
   10.35%

Ratio of dollars spent on debt to that spent on health
   1:10

General government expenditure on health as % of general government expenditure
   8%

Health Expenditure (as % of GDP)
   9.3

Ensure access to affordable tools

% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner
   39.3

% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge
   36 (men) 23.5 (women)

% of people with advanced HIV infection receiving antiretroviral combination therapy
   17.7

% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission
   2.3

---

1. Entitled The Prevention of Domestic Violence Act, April 2006
3. Data is for 2004
4. Data is for financial year 2006/7. See: Overview of the essential health services in Malawi, Oxfam Malawi, August 2006 http://www.equinetafrica.org/bib/docs/IXFequity01022007.pdf
6. Data is for 2004

---

Guarantee Rights

Have a domestic violence act
   No

Have AIDS specific legislation in labour laws
   No

Ratio of girls to boys in primary education
   0.83

% of population completing primary level education
   29.0

Orphans and vulnerable children whose households received free basic external support in caring for the child
   Data not available

Build Health Capacity

Health Workers (density per 1000 population)
   1.07

User fees for health services
   Yes

Total debt service as % of health budget
   13.82%

Ratio of dollars spent on debt to that spent on health
   1:7

General government expenditure on health as % of general government expenditure
   9.1

Health Expenditure (as % of GDP)
   4.0

Ensure access to affordable tools

% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner
   33 (men) 29 (women)

% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge
   33 (men) 20.0 (women)

% of people with advanced HIV infection receiving antiretroviral combination therapy
   7.4

% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission
   4.9

---

1. There is no law on domestic violence but existing laws, including family law which prohibit rape, battery and assault, may be used in domestic violence cases
2. Data was collected between 2001 and 2005
3. Data was collected between 2001 and 2005
### NEPAL

**Number of people living with HIV:** 75,000  
**Prevalence rate amongst adults aged 15–49:** 0.5%  
**Deaths due to AIDS:** 5,100

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
</tr>
</thead>
</table>
| Have a domestic violence act | No\(^1\)  
| Have AIDS specific legislation in labour laws | No  
| Ratio of girls to boys in primary education | 0.91\(^1\)  
| % of population completing primary level education | 74.7\(^2\)  
| Orphans and vulnerable children whose households received free basic external support in caring for the child | Data not available

<table>
<thead>
<tr>
<th>Build Health Capacity</th>
</tr>
</thead>
</table>
| Health Workers (density per 1000 population) | 1.52  
| User fees for health services | No  
| Total debt service as % of health budget | 22.95%  
| Ratio of dollars spent on debt to that spent on health | 1.4  
| General government expenditure on health as % of general government expenditure | 7.8  
| Health Expenditure (as % of GDP) | 5.7

<table>
<thead>
<tr>
<th>Ensure access to affordable tools</th>
</tr>
</thead>
</table>
| % of most-at-risk populations who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men) and those injecting drug users who have who have adopted behaviours that reduce transmission of HIV | 67.1\(^3\) (sex workers)  
| % of most-at-risk populations who correctly identified ways of preventing HIV sexual transmission and reject major misconceptions on HIV transmission | 16.9 (sex workers)  
| % of people with advanced HIV infection receiving antiretroviral combination therapy | 4.9 (men)  
| % of people with advanced HIV infection receiving antiretroviral combination therapy | 2.8 (women)  
| % of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission | 11.1\(^4\)  
| % of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission | 2.1\(^5\)

---

1. However, in 2006 there was a reading of a proposed bill ‘The Domestic Violence and other related matters’ bill.  
2. Data is for 2003–2004  
3. Data was collected between 2001 and 2005. The criteria for the data is based on the percentage of respondents who have correctly identified the 2 major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner) and who reject the 2 most common local misconceptions about HIV and who know that a healthy looking person can have HIV.  
5. Data was collected between 2002–2003
### Pakistan

**Number of people living with HIV:** 85,000  
**Prevalence rate amongst adults aged 15–49:** 0.1%  
**Deaths due to AIDS:** 3000

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a domestic violence act</td>
<td>Yes¹</td>
</tr>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>No</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>0.73</td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>Data not available</td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Build Health Capacity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Workers (density per 1000 population)</td>
<td>3.19</td>
</tr>
<tr>
<td>User fees for health services</td>
<td>Yes</td>
</tr>
<tr>
<td>Total debt service as % of health budget</td>
<td>317.40%</td>
</tr>
<tr>
<td>Ratio of dollars spent on debt to that spent on health</td>
<td>10.3</td>
</tr>
<tr>
<td>General government expenditure on health as % of general government expenditure</td>
<td>2.0</td>
</tr>
<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>2.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ensure access to affordable tools</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of most-at-risk populations who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men) and those injecting drug users who have who have adopted behaviours that reduce transmission of HIV</td>
<td>7.6 (men who have sex with men) 22.6 (sex workers)</td>
</tr>
<tr>
<td>% of most-at-risk populations who correctly identified ways of preventing HIV sexual transmission and reject major misconceptions on HIV transmission</td>
<td>Data not available</td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>1.2¹</td>
</tr>
<tr>
<td>% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

2. Estimated data for 2005 using the latest available information at the time

### Rwanda

**Number of people living with HIV:** 190,000  
**Prevalence rate amongst adults aged 15–49:** 3.1%  
**Deaths due to AIDS:** 21,000

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a domestic violence act</td>
<td>No¹</td>
</tr>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>No</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>1.02</td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>37.4</td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Build Health Capacity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Workers (density per 1000 population)</td>
<td>2.16</td>
</tr>
<tr>
<td>User fees for health services</td>
<td>Yes²</td>
</tr>
<tr>
<td>Total debt service as % of health budget</td>
<td>3.08%</td>
</tr>
<tr>
<td>Ratio of dollars spent on debt to that spent on health</td>
<td>1:32</td>
</tr>
<tr>
<td>General government expenditure on health as % of general government expenditure</td>
<td>16.7</td>
</tr>
<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ensure access to affordable tools</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner</td>
<td>41.0 (men) 28.0 (women)¹</td>
</tr>
<tr>
<td>% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge (women)²</td>
<td>57.6 (men) 53.6</td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>&lt;0.1¹</td>
</tr>
<tr>
<td>% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission</td>
<td>9.4</td>
</tr>
</tbody>
</table>

1. However there is a draft bill, which is currently waiting to be approved by parliament  
2. Although the government has also been trialling an informal health insurance scheme in some districts http://www.id21.org/health/h1ps5g1.html  
3. Estimated data for 2005 using the latest available information at the time  
5. Data is for 2003
**Guarantee Rights**

- **Have a domestic violence act**: No¹
- **Have AIDS specific legislation in labour laws**: No
- **Ratio of girls to boys in primary education**: 0.72
- **% of population completing primary level education**: Data not available
- **Orphans and vulnerable children whose households received free basic external support in caring for the child**: Data not available

**Build Health Capacity**

- **Health Workers (density per 1000 population)**: 0.73
- **User fees for health services**: Yes²
- **Total debt service as % of health budget**: 25%
- **Ratio of dollars spent on debt to that spent on health**: 1.4
- **General government expenditure on health as % of general government expenditure**: 8.7
- **Health Expenditure (as % of GDP)**: 3.4

**Ensure access to affordable tools**

- **% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner**
- **% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge**
- **% of people with advanced HIV infection receiving antiretroviral combination therapy**
- **% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission**

---

2. However, there is however a code of good practice relating to HIV/AIDS and the workplace [http://www.labourguide.co.za/Code%20HIV%20AIDS%20and%20employment.pdf](http://www.labourguide.co.za/Code%20HIV%20AIDS%20and%20employment.pdf)
3. Data is for 2003 and covers women only
4. According to Sierra Leone national report on the UNGASS declaration of commitment on HIV/AIDS, 2006
5. Ibid
6. Data is for 2003
7. The number of OVC receiving care and support by the end of 2005
9. Progress Report on Declaration of Commitment to HIV and AIDS submitted for UNGASS, March 2006. These figures have been reached by taking the median of correct results given to key questions about knowledge and perception. Alternate figures from the UNAIDS Country Report 2003 report state that 20% of all women have this knowledge
10. Estimated data for 2005 using the most recently available information at the time
**Sri Lanka**

**Number of people living with HIV:** 5000  
**Prevalence rate amongst adults aged 15 - 49:** 0.1%  
**Deaths due to AIDS:** >500

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a domestic violence act</td>
<td>Yes¹</td>
<td></td>
</tr>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>0.99²</td>
<td></td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>97.0³</td>
<td></td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>Data not available</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Build Health Capacity</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Workers (density per 1000 population)</td>
<td>2.65</td>
<td></td>
</tr>
<tr>
<td>User fees for health services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total debt service as % of health budget</td>
<td>14.21%</td>
<td></td>
</tr>
<tr>
<td>Ratio of dollars spent on debt to that spent on health</td>
<td>1:2</td>
<td></td>
</tr>
<tr>
<td>General government expenditure on health as % of general government expenditure</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>4.2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ensure access to affordable tools</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of most-at-risk populations who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men) and those injecting drug users who have who have adopted behaviours that reduce transmission of HIV</td>
<td>64.9 (female sex workers)</td>
<td></td>
</tr>
<tr>
<td>% of most-at-risk populations who correctly identified ways of preventing HIV sexual transmission and reject major misconceptions on HIV transmission</td>
<td>Data not available</td>
<td></td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>6.0</td>
<td></td>
</tr>
<tr>
<td>% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission</td>
<td>Data not available</td>
<td></td>
</tr>
</tbody>
</table>

1. Entitled Prevention of Domestic Violence Act, No. 34, 2005  
2. Data is for 2003  
3. Data is for 2003  

---

**Swaziland**

**Number of people living with HIV:** 220,000  
**Prevalence rate amongst adults aged 15 - 49:** 33.4%  
**Deaths due to AIDS:** 16,000

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a domestic violence act</td>
<td>No¹</td>
<td></td>
</tr>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>0.96³</td>
<td></td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>61.3³</td>
<td></td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>31,500 OVC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Build Health Capacity</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Workers (density per 1000 population)</td>
<td>11.92</td>
<td></td>
</tr>
<tr>
<td>User fees for health services</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Total debt service as % of health budget</td>
<td>16.42%</td>
<td></td>
</tr>
<tr>
<td>Ratio of dollars spent on debt to that spent on health</td>
<td>1:6</td>
<td></td>
</tr>
<tr>
<td>General government expenditure on health as % of general government expenditure</td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>6.3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ensure access to affordable tools</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner</td>
<td>Data not available</td>
<td></td>
</tr>
<tr>
<td>% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge</td>
<td>26.9³</td>
<td></td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>29.7³</td>
<td></td>
</tr>
<tr>
<td>% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission</td>
<td>16.2</td>
<td></td>
</tr>
</tbody>
</table>

1. However in 2006 a draft Sexual Offences and Domestic Violence Bill was adopted  
2. Data is for 2003  
3. Data is for 2003  
4. Data is for 2003  
5. Information estimated for 2005 using the latest available information at the time
### Tanzania

**Number of people living with HIV:** 1,400,000  
**Prevalence rate amongst adults aged 15 - 49:** 6.5%  
**Deaths due to AIDS:** 140,000

#### Guarantee Rights

<table>
<thead>
<tr>
<th>Have a domestic violence act</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>Yes¹</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>0.96²</td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>54.2²</td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

#### Build Health Capacity

| Health Workers (density per 1000 population) | 1.33³ |
| User fees for health services | Yes |
| Total debt service as % of health budget | 23.67% |
| Ratio of dollars spent on debt to that spent on health | 1.4 |
| General government expenditure on health as % of general government expenditure | 8.8 |
| Health Expenditure (as % of GDP) | 4.2 |

#### Ensure access to affordable tools

| % of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner | 47.0 (men) 42.0 (women) ⁴ |
| % of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge | 49.0 (men) 44.0 (women) ⁵ |
| % of people with advanced HIV infection receiving antiretroviral combination therapy <0.1 ⁶ |
| % of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission | 0.3⁴ |

---

3. Data is for 2005
4. Data was collected between 2001 and 2005. The criteria for the data is based on the percentage of respondents who have correctly identified the 2 major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner) and who reject the 2 most common local misconceptions about HIV and who know that a healthy looking person can have HIV.
6. Taken from Uganda AIDS commission website [http://www.aidsuganda.org/HIVug.htm](http://www.aidsuganda.org/HIVug.htm); Accessed March 2007

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### Uganda

**Number of people living with HIV:** 1,000,000  
**Prevalence rate amongst adults aged 15 - 49:** 6.7%  
**Deaths due to AIDS:** 91,000

#### Guarantee Rights

<table>
<thead>
<tr>
<th>Have a domestic violence act</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>Yes²</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>1⁴</td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>57.1</td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

#### Build Health Capacity

| Health Workers (density per 1000 population) | 1.33 |
| User fees for health services | No |
| Total debt service as % of health budget | 5% |
| Ratio of dollars spent on debt to that spent on health | 1:20 |
| General government expenditure on health as % of general government expenditure | 10.0 |
| Health Expenditure (as % of GDP) | 7.2 |

#### Ensure access to affordable tools

| % of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner | 55 ⁵ |
| % of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge | 40 (men) 28 (women) ⁶ |
| % of people with advanced HIV infection receiving antiretroviral combination therapy | 30-50⁶ |
| % of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission | 12 |

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1. Currently there is a domestic relations bill but this does not specifically cover domestic violence.
3. Data is for 2005.
4. Data was collected between 2001 and 2005. The criteria for the data is based on the percentage of respondents who have correctly identified the 2 major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner) and who reject the 2 most common local misconceptions about HIV and who know that a healthy looking person can have HIV.
6. Taken from Uganda AIDS commission website [http://www.aidsuganda.org/HIVug.htm](http://www.aidsuganda.org/HIVug.htm); Accessed March 2007
### VIETNAM

**Number of people living with HIV:** 260,000  
**Prevalence rate amongst adults aged 15 - 49:** 0.5%  
**Deaths due to AIDS:** 13,000

<table>
<thead>
<tr>
<th>Guarantee Rights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a domestic violence act</td>
<td>No</td>
</tr>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>No</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>0.93</td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>100.8%</td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>Data not available</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Build Health Capacity</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Health Workers (density per 1000 population)</td>
<td>1.36</td>
</tr>
<tr>
<td>User fees for health services</td>
<td>Yes</td>
</tr>
<tr>
<td>Total debt service as % of health budget</td>
<td>5.90%</td>
</tr>
<tr>
<td>Ratio of dollars spent on debt to that spent on health</td>
<td>1:17</td>
</tr>
<tr>
<td>General government expenditure on health as % of general government expenditure</td>
<td>4.2</td>
</tr>
<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>5.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>% of most-at-risk populations who reported the use of a condom with their last client (sex workers), male partner (men who have sex with men) and those injecting drug users who have who have adopted behaviours that reduce transmission of HIV sexual transmission and reject major misconceptions on HIV transmission</td>
<td>81.8 (IDU) 90.4 (female sex workers) 24.2 (sex workers) 34.4 (IDU)</td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>58.9%</td>
</tr>
<tr>
<td>% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission</td>
<td>83.4%</td>
</tr>
</tbody>
</table>

1. Data is for 2003  
2. Data is for 2001  
3. Estimated data for 2005 using the latest available information at the time  
4. Data is for 2004

### ZIMBABWE

**Number of people living with HIV:** 1,700,000  
**Prevalence rate amongst adults aged 15 - 49:** 20.1%  
**Deaths due to AIDS:** 180,000

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<tbody>
<tr>
<td>Have a domestic violence act</td>
<td>No</td>
</tr>
<tr>
<td>Have AIDS specific legislation in labour laws</td>
<td>Yes</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary education</td>
<td>0.98</td>
</tr>
<tr>
<td>% of population completing primary level education</td>
<td>80.2%</td>
</tr>
<tr>
<td>Orphans and vulnerable children whose households received free basic external support in caring for the child</td>
<td>43%</td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Health Workers (density per 1000 population)</td>
<td>1.28</td>
</tr>
<tr>
<td>User fees for health services</td>
<td>Yes</td>
</tr>
<tr>
<td>Total debt service as % of health budget</td>
<td>9.44%</td>
</tr>
<tr>
<td>Ratio of dollars spent on debt to that spent on health</td>
<td>1:11</td>
</tr>
<tr>
<td>General government expenditure on health as % of general government expenditure</td>
<td>8.9</td>
</tr>
<tr>
<td>Health Expenditure (as % of GDP)</td>
<td>7</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner</td>
<td>49.6</td>
</tr>
<tr>
<td>% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge</td>
<td>55.2</td>
</tr>
<tr>
<td>% of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>9.1%</td>
</tr>
<tr>
<td>% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

1. However there is a draft bill which is due to become law in 2007.  
2. Zimbabwe Labour Relations Regulations  
3. Data is for 2003  
4. Data is for 2003  
5. Data is for 2004  
6. Estimated data for 2005  
7. Data is for 2004
For most countries the information is sourced as indicated below. Where information has been gained from another resource it is indicated on the relevant country table.

**Ratio of girls to boys in primary education:**

All data is for 2004 unless indicated. [http://millenniumindicators.un.org/unsd/mdg/Data.aspx](http://millenniumindicators.un.org/unsd/mdg/Data.aspx) Gender parity index in primary level education, this is the ratio of girls to boys in education is the ratio of the number of female students enrolled at primary level of education to the number of male students enrolled. To standardise the effects of the population structure of the appropriate age groups, the Gender Parity Index (GPI) of the Gross Enrolment Ratio (GER) for each level of education is used.

**% of population completing primary level education:**


The criterion for this indicator measures the first-time completion of primary education. It includes all new entrants to the last grade (regardless of age), therefore numbers may exceed 100%, due to over-aged or under-aged pupils entering the last grade of primary school for the first time.

**Orphans and vulnerable children whose households received free basic external support in caring for the child:**


**Health Workers (density per 1000 population):**

Data is for 2004 unless indicated otherwise. WHO Statistical Information Systems, WHO. The term health workers, includes physicians, nurses, dentists, midwives, pharmacists, community health workers, public and environmental health workers, lab technicians and other health workers.

**User fees for health services:**

See: Rob Yates *International experiences in removing user fees for health services – implications for Mozambique*, DFID Health Systems Resource Centre, June 2006 or Mark Pearson, *The case for abolition of user fees for primary health systems*, DFID Health Systems Resource Centre, 2004 (unless indicated otherwise)

**General government expenditure on health as % of general government expenditure:**


**Health Expenditure (as % of GDP):**

Ibid

**% of young women and men (combined) aged 15-24 reporting the use of a condom last time they had sex with a non-regular partner:**

2006 *Report on the global AIDS epidemic 2006*, UNAIDS, 2006. Data collected between 2003-2005 unless indicated otherwise. In countries which do not have a generalised epidemic, data is shown for the most at risk populations [sex workers, men who have sex with men and injecting drug user (IDU)]

**% of young women and men aged 15-24 with comprehensive HIV/AIDS knowledge**

Ibid

**% of people with advanced HIV infection receiving antiretroviral combination therapy**


**% of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission**

Ibid