The World Bank's Global HIV/AIDS Program of Action

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Foreword

The world has been fighting the relentless march of HIV/AIDS for two decades now. While there have been significant victories in Brazil, Thailand, and Uganda in turning back the disease, it continues to infect more people every day, and further strain the ability of governments to care for, and treat, the millions already suffering from its debilitating effects. Today there are more than 40 million people worldwide living with HIV/AIDS. Over 15 million children—more than the total number of children in France or Germany or the United Kingdom—are orphans, their parents taken from them at the most vulnerable point in their young lives.

Global efforts to reverse the spread of HIV/AIDS face a mixture of long-standing, as well as newly emerging challenges in developing and implementing sound strategies to fight the disease. Even though HIV/AIDS is a household word everywhere, discrimination, denial, and silence persist.

I will never forget the woman in Nigeria who told me "the stigma killed me before the disease." She described how she lost her job, her family, her home and her will to live after contracting HIV/AIDS from her husband. Fortunately, she regained her will to live from a remarkable support group for similar victims of the disease. But it is important that she receives the treatment she needs to sustain life itself. And AIDS is not just an African epidemic. I heard similar heart-rending stories in China and India. Indeed, throughout the developing world, the combination of AIDS and extreme poverty compounds the tragedy.

The international '3 by 5' target to provide treatment to three million people in developing countries by 2005 has sparked momentum across the world to fight HIV/AIDS. But there is still a long road ahead. Today, about one million people in low- and middle-income countries are receiving treatment—more than double the number since the end of 2003—but it is still far short of the target and far short of the need. With increasing numbers of people on treatment, AIDS is becoming a chronic disease, requiring long-term solutions and sustained financing. It is also placing an additional burden on the ability of health systems to deliver the required services.

But there is renewed hope as the world's response to the epidemic enters a new phase. We can see an unprecedented outpouring of resources, significant advances in the costs and science of treatment, and more effective 'tried and true' lessons in prevention and treatment. AIDS is now acknowledged as a central long-term development issue backed by growing political commitment. It is an opportune time to take stock, and do some careful strategic thinking—with our key partners and stakeholders—on the future direction of the Bank's work on AIDS.

This Global HIV/AIDS Program of Action describes how the World Bank Group will work over the coming three years to strengthen the response to the HIV/AIDS epidemic at country, regional, and global levels, through lending, grants, analysis, technical support and policy dialogue. The Program links global and national efforts and builds partnerships with civil society, and people living with HIV/AIDS. It builds on the "Three Ones" principles, agreed with our development partners, which call for one national HIV/AIDS authority, one

national strategic plan and one monitoring and evaluation system

There is an urgent need to do more and to do it better, so that the results of our efforts can be counted in millions of infections prevented, millions of people with HIV/AIDS living more productive, healthy lives, and millions of children, so heartlessly orphaned by the disease, being properly cared for.

Paul Wolfowitz
President
World Bank
November 2005

ACKNOWLEDGMENTS

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This Program of Action was discussed at a technical briefing for the World Bank Board of Executive Directors on August 25th, 2005. Speakers strongly endorsed the Program of Action and asked Bank staff to present a plan for its implementation to the Board (scheduled for early January 2006).

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Acronyms and Abbreviations

ACT*Africa*	AIDS Campaign Team for Africa (World Bank)
AIDS	Acquired immune deficiency syndrome
ARD	Agriculture and Rural Development Department (World Bank)
ART	Antiretroviral therapy
ARV	Antiretroviral drug
CAS	Country Assistance Strategy
CSO	Civil society organization
CST	Country Support Team
DEC	Development Economics Vice Presidency (World Bank)
DFID	Department for International Development (U.K.)
EAP	East Asia and Pacific region
ECA	Europe and Central Asia region
ESW	Economic and sector work
FBO	Faith based organization
GAMET	Global HIV/AIDS Monitoring and Evaluation Team (World Bank)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHAP	Global HIV/AIDS Program (World Bank)
GTT	Global Task Team on Improving AIDS Collaboration Among Multilateral Institutions and International Donors
HDNED	Education Team (World Bank)
HDNSP	Social Protection Team (World Bank)
HIV	Human immunodeficiency virus
HNP	Health, Nutrition and Population Team (World Bank)
IAS	Implementation Advisory Service
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDF	Institutional Development Fund
IDU	Injecting drug user
IEC	Information, education and communication
IFC	International Finance Corporation
ILO	International Labour Organization
IMF	International Monetary Fund
JSDF	Japanese Social Development Fund
LAC	Latin America and the Caribbean region
LEG	Legal Vice Presidency (World Bank)
M&E	Monitoring and evaluation
MAP	Multi-Country AIDS Program
MDG	Millennium Development Goal
MNA	Middle East and North Africa region
MSM	Men who have sex with men
NGO	Non-governmental organization
OED	Operations Evaluation Department (World Bank)
OPCS	Operations Policy and Country Services (World Bank)
PATH	Program for Appropriate Technology in Health

PEPFAR	President's Emergency Program for HIV/AIDS Relief
PEP	Private Enterprise Partnership Program
PLWHA	People Living with HIV/AIDS
PLWA	People Living with AIDS
PREM	Poverty Reduction and Economic Management Network (World Bank)
PRSP	Poverty Reduction Strategy Paper
SAR	South Asia region
SW	Sex Workers
TB	Tuberculosis
TF	Trust fund
TTL	Task Team Leader
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WBI	World Bank Institute
WFP	World Food Programme
WHO	World Health Organization

Executive Summary

> We have made a good start, but . . . we are only at the beginning of the efforts that we really need to make on AIDS.
>
> —James Wolfensohn

The World Bank is committed to long-term, strong support for comprehensive national HIV/AIDS responses for effective prevention, care and treatment, and mitigation. The Bank works closely with client countries and other development partners, including civil society and people living with HIV/AIDS (PLWHA). This Program of Action describes the steps the World Bank will take over the coming three years to strengthen the Bank's response to the HIV/AIDS epidemic at country, regional, and global levels, through lending, grants, analysis, technical support and policy dialogue. The scope of this Program of Action is Bank-wide and global, drawing on and complementing the Bank's regional HIV/AIDS strategies (summarized in Annex 1). This Program of Action supports the "Three Ones" principles, and is aligned with the recommendations of the Global Task Team on Improving AIDS Collaboration Among Multilateral Institutions and International Donors (the GTT) and the division of labor agreed among the UNAIDS co-sponsors.

The document was written for the World Bank's Executive Directors, management and staff, and for readers beyond the Bank, especially for our counterparts in client countries and partner organizations. It translates into concrete actions the Bank's commitment to work with client countries and partner agencies, to more effectively prevent new infections and treat and care for people infected and affected by HIV/AIDS. Several internal reviews of the Bank's HIV/AIDS work and an independent evaluation by the Operations Evaluation Department (OED) provided useful input.[1] Discussions within the Bank, especially with regional HIV/AIDS focal points, managers and Task Team Leaders as well as with stakeholders outside the Bank have led to a consensus on the priority actions in the Program of Action for the next three years.

The World Bank is committed to long-term, strong support for comprehensive national HIV/AIDS responses

AIDS today: Continuing and emerging challenges

AIDS has been called "an unprecedented crisis . . . that demands an exceptional response".[2] More than 40 million people are now infected with HIV, over 20 million have died, and there are more than 15 million AIDS orphans.[3] Yet prevention efforts remain small-scale and half-hearted in most countries, new infections continue to grow and treatment coverage is limited. In 2005 more people will become infected with HIV and die from AIDS than in any previous year. Despite international efforts to expand access to treatment and much lower prices for antiretroviral drugs, most people living with AIDS (PLWA) are not being treated.

The epidemic is evolving in diverse patterns across countries and regions. In most countries, overall adult prevalence is below 1 percent, with the epidemic concentrated in sub-populations, notably injecting drug users, sex workers and men who have sex with men. In some countries, prevalence has risen to as high as 80 percent of some sub-populations. Ominously, in a growing number of countries, the epidemic is spreading among the general population. In Sub-Saharan Africa, adult prevalence is over 7 percent, and in the next-hardest hit region,

the Caribbean, it is over 2 percent. Whether concentrated or generalised, high and rising prevalence rates are of serious concern. Women—particularly young women and girls—are made especially vulnerable to infection by physiological and social factors, resulting in an increasing feminization of the epidemic, particularly in Sub-Saharan Africa and South Asia. Increasing HIV infection rates among young people globally are also of great concern.[4]

The AIDS epidemic has entered a new phase

More than twenty years on, the AIDS epidemic has entered a new phase. There has been an unprecedented outpouring of resources, significant advances in treatment, accumulated understanding of how to implement prevention efforts and deliver treatment and care, and growing political commitment to stop the spread of HIV. Once seen as a health emergency, AIDS is now recognized as a broad, long-term development issue. There is also growing recognition that international development partners and countries must address HIV/AIDS through harmonized, coordinated actions, in order to promote common approaches.

A number of longstanding challenges continue to undermine our efforts to confront the epidemic, jeopardizing the enormous investment of resources and blunting the impact of thousands of international, national, and local initiatives. The growing emphasis on treatment offers hope and healthy years of life to those infected people who can access treatment, but also brings new challenges. In developing this Program of Action, we have analyzed the continuing and emerging threats and the most pressing needs of country HIV/AIDS programs for strengthening and support, and then identified five priority action areas for the World Bank's HIV/AIDS response. This Program of Action takes advantage of the Bank's particular strengths, seeking to support country and regional HIV/AIDS programs, to enhance their effectiveness in reducing new infections and providing care and treatment, and in working together in constructive and harmonious ways with our partners. It also harnesses the Bank's capacity to address HIV/AIDS through multisectoral and broad developmental approaches.

Continuing challenges

Although much has been learned about HIV/AIDS in two decades, there are major obstacles to applying that knowledge systematically and effectively. National HIV/AIDS *planning tends to be poor*: too little planning (in the rush to apply for funding and then spend it), too many plans (to please a variety of donors) with very little coordination, and an inability to plan effectively (especially at the national level) because of a *lack of good epidemiological surveillance and monitoring and evaluation information*, minimal collaboration among government sectors, and donors bypassing "official" planning mechanisms. This results in misallocated funds and little chance of impact; in one country only 1 percent of program resources target the particular risk groups that cause 75 percent of new infections.

Even the best planned programs face *implementation constraints*: a lack of resources, especially skilled personnel; unpredictable or conditional funding; burdensome disbursement and procurement processes; government reluctance to contract implementation out to civil society or the private sector; and multiple management and monitoring and evaluation systems to meet differing donor requirements. One of the most intractable problems is that in many countries *health systems are overwhelmed.* Inadequate, understaffed and underfunded health facilities, strained to the limits, are faced with rapidly rising numbers of people with AIDS who need treatment. Newly available donor funding for antiretroviral (ARV) drugs raises demand and expectations, but also exacerbates pressures on health care providers, especially if donors are reluctant to pay for salaries and other essential operating costs.

Many HIV/AIDS *programs are too small* in scale or too narrowly targeted to make a real difference. And the *social, political and legal climate is often inimical* to effective AIDS programming. Populations at high risk of infection are overlooked/underserved because of stigma, taboos and denial, or because governments shy from controversial services or serving marginalised groups (such as clean needle programs for drug users or promot-

ing condom use among sex workers and men who have sex with men).

Donor demand for quick and visible results discourages efforts to solve long-term, less visible problems such as weak health systems and lack of health personnel. Conflicting donor demands frustrate coordinated planning, and conditional funding reduces efficiency and raises costs.

Emerging challenges

Much still remains to be done to provide life-saving *antiretroviral therapy (ART) on a large scale* in resource-poor settings. To do this, health system capacity and infrastructure need to be strengthened and long-term funding is needed to make expanded treatment programs sustainable. Widespread access to treatment could have enormous benefits, prolonging healthy life, and enabling infected parents to remain productive and raise and care for their children. Treatment adherence and the impact of wide access to treatment on risky behaviours need careful monitoring, and promoting safe behaviours must be unrelenting. There are huge unmet needs for treatment and care, at the same time as prevention and mitigation programs are still under-resourced and inadequate. *Preventing new infections should still remain the highest priority* for all countries—at all prevalence levels. Successful prevention relies on widespread efforts in many sectors and by many groups in society. The more successful countries are at preventing new infections, the more feasible they will find it to provide treatment and care to those who are infected.

Prevention and treatment have important synergies. Effective prevention makes treatment more affordable and sustainable by reducing the number of new infections and hence the number of people who will need treatment. Availability of treatment and care can bring large numbers of people into health care settings, providing new opportunities for health care workers to deliver and reinforce HIV prevention messages and interventions. Improved access to HIV testing provides an entry point for both prevention and treatment services. Prevention can enhance access to treatment, by reducing stigma and improving community knowledge and treatment readiness. Integrated prevention and treatment ensures that prevention activities are not neglected and can provide important opportunities to address vulnerable groups more effectively. Treatment investments can help improve infrastructure and human resources for prevention and other health services, by strengthening health facilities and health worker training. As recognized by the Global Task Team (GTT) and the Gleneagles G8 Communiqué, both prevention and treatment and care are critical and related components for an effective response.

Prevention, treatment and care are all critical and related parts of an effective response

The recent outpouring of AIDS funding has raised expectations among donors and affected populations but overwhelmed weak administrative systems and fragile infrastructures. This has caused an *"implementation gap"*—a temporary resource bottleneck, as financial resources arrive faster than they can be spent effectively, even though a "resource gap" remains between available funding and what is needed for a comprehensive and adequate response. The UN agencies, the Global Fund to Fight AIDS, TB and Malaria (GFATM) and HIV/AIDS stakeholders have redefined the division of labor among agencies through the GTT in order to improve implementation and use of funds. Harmonized and coordinated international support will significantly reduce the implementation burden.

While the demographic consequences of HIV are increasingly apparent in many countries, the extent of the economic and social impact is only beginning to be understood. And yet HIV/AIDS is still largely being *overlooked in the broader development agenda*, especially in countries with emerging epidemics, whose poverty reduction strategies are often silent or cursory about HIV/AIDS, including its links to gender, youth and development.

AIDS and the Bank

In two decades of involvement the Bank has learned important lessons about fighting HIV, including the need for countries to own and lead their individual campaigns, for AIDS efforts to be part of overall development

planning, for programs to be based on the best available evidence, and for more effective monitoring and evaluation to add continually to that evidence and to guide program improvements.

In recent years, the Bank has dramatically scaled up its financial support to countries, helping jump-start expanded programs in many of the hardest-hit places. Cumulative lending for HIV since the first project in 1988 is now over US$2.5 billion, and commitments in sub-Saharan Africa have grown from $10 million annually ten years ago to $250-300 million in each of the last four years.[5]

The Program of Action describes five integrated action areas to focus Bank support for more effective AIDS responses

The Bank has contributed more than financing to global efforts against HIV/AIDS. Through strong economic and policy analysis it has helped countries identify the development implications of the epidemic and the potentially high returns to investments in prevention, care and treatment and mitigation programs (and how to choose the best ones). And through policy dialogue it has helped redefine AIDS as a development issue. This is not to suggest that the Bank and Bank-supported initiatives have done nearly enough—the Bank's record on HIV is, in fact, uneven, and the Bank was slow to respond at the required scale. But the Bank does offer certain unique expertise which, if effectively applied, can contribute, along with others, to turning the tide against the epidemic.

The World Bank's Global HIV/AIDS Program of Action

The Global HIV/AIDS Program of Action will support more effective AIDS responses in five integrated action areas, which reflect: country needs; the Bank's mandate, capacity and comparative advantage; the findings of reviews of the Bank's work in AIDS; the agreed division of labor among the major agencies working on HIV/AIDS; and the Bank's commitment to the "Three Ones" vision of one national strategic plan, one national coordinating authority and one national monitoring and evaluation system in each country.[6] The Program of Action coincides with the publication of the report of the Global Task Team on Improving AIDS Collaboration among Multilateral Institutions and International Donors (GTT) and the G8 Gleneagles communiqué. The Global Task Team recognizes that the world must do more to effectively tackle AIDS. Strengthening coordination, alignment and harmonization, in the context of the "Three Ones" principles, UN reform, the Millennium Development Goals, and the OECD/DAC Paris Declaration on Aid Effectiveness, is essential for rapid, effective scale-up of the AIDS response.

This Program of Action will contribute to these goals, through a range of activities, including lending and technical support, analytic work and policy engagement, that the Bank's regional units plan for the coming three years in HIV/AIDS and health system strengthening, as well as actions that will be taken to support and facilitate the regional and country plans. It also describes additional cross-cutting activities led by the Global HIV/AIDS Program, and actions planned by other Bank units to mainstream HIV/AIDS responses in key sectors and areas such as education, transport, infrastructure, gender, youth, legal and the private sector.

The work will be done through partnerships across Bank units, working closely with client countries, UNAIDS co-sponsors, GFATM and other development partners to achieve strong, well focused, concerted and harmonized AIDS responses. The Bank's engagement across many different sectors is an important comparative advantage, especially in addressing the increasing feminization of the epidemic, which requires progress in many related areas, including girls' education, poverty alleviation, and growth.

The action areas are:

- Support for *strengthening national HIV/AIDS strategies*, to ensure they are truly prioritized and strategic, integrated into development planning and linked to gender and equity issues;
- Continued *Bank funding for national and regional HIV/AIDS programs*, and for strengthening health systems, to support

responses that are of sufficient scale and scope;

- *Accelerating implementation*, to increase the scope and quality of priority activities, through harmonized, well aligned actions;
- Strengthening *country monitoring and evaluation systems* and evidence-informed responses, to enable countries to assess and improve their programs;
- *Knowledge generation and sharing and impact evaluation* about what works, as well as other analytical work to improve program performance.

Consistent with the Global Task Team process and the division of labor among agencies, the World Bank will focus intensively on improving national HIV/AIDS strategies and annual action plans and on improving program implementation.

Practical guidelines, good practice notes and examples, technical training and support for a network of country practitioners will be provided to help countries to develop strategic, prioritized national plans, soundly based on epidemiology and evidence, with well-defined priorities, goals and targets, timeframes, responsible actors, cost estimates, and plans for monitoring, evaluation and knowledge utilization. Analytic and advisory services and enhanced Country Assistance Strategy (CAS) and Poverty Reduction Strategy (PRSP) guidelines and assessment criteria will aim to support better integration of HIV/AIDS into national development planning and better aligned national AIDS responses.

The Bank will remain one of the major financers of AIDS activities globally, including using its flexibility to fund countries and activities that others cannot or will not finance. Particular efforts will be made to work with countries to ensure that program and funding decisions are informed by evidence on risk behaviours, epidemiology, and effectiveness and impact of interventions, as well as links to gender, youth, minorities and equity issues.

The Bank will continue to provide funding and support to strengthen health systems and client country capacity for service delivery, as part of HIV/AIDS program funding, and/or within broader health sector support, given the heavy demands that HIV/AIDS prevention and treatment makes on the health sector and the weaknesses in health services delivery in many countries. Areas that will receive particular emphasis include human resources for health, health planning, key public health functions (including surveillance and governance), procurement, management and other logistics of drugs and other essential supplies, and enhancing laboratory and diagnostic capacity.

Ongoing work to mainstream HIV/AIDS into the work of key sectors in addition to health—including education, transport, legal, gender and youth—will continue, and be expanded. The education sector has the capacity to reach millions of children (and their parents) and empower future generations to protect themselves against HIV infection. Schoolchildren are a "window of hope" for the future. Nearly all school age children are free of HIV infection, even in the worst affected countries, and if they remain so as they grow up, they could change the face of the epidemic within a generation.

To further accelerate and strengthen HIV/AIDS program implementation, the Bank will continue to provide financial and technical support through project/program support and IDF grants to enhance country capacity and systems to implement national HIV/AIDS plans; seek to ensure adequate funding for project supervision and additional implementation support; work with countries and Bank project teams to further improve planning, budgeting, program design, financial management, disbursement and procurement, monitoring and evaluation and expenditure tracking. Depending on individual country situations, appropriate actions will be taken to help make it possible for the private sector, civil society organizations including non-governmental organizations (NGOs) and faith-based organizations (FBOs) and communities to play a strong role in the HIV/AIDS response. Good practice notes will capture and widely share knowledge about effective implementation practices and promote more evidence-informed approaches. Networks of program practitioners will be supported,

Five focus areas: national strategies, funding HIV/AIDS programs and health systems; accelerating implementation; M&E; analysis and knowledge

to facilitate exchanges of experiences, knowledge and practical advice on general operational issues, fiduciary architecture, and special programmatic themes.

As a member of the Joint United Nations Programme on HIV/AIDS (UNAIDS) family, and in line with the implementation of the Three Ones, the Bank has particular responsibility for strengthening country monitoring and evaluation systems. The Global HIV/AIDS Monitoring and Evaluation Team (GAMET) will continue to provide practical, in-country support to country counterparts to develop and strengthen their national monitoring and evaluation (M&E) systems. The goal is to work with partners to build national capacity to carry out M&E and to use the data for making decisions. Specific activities include joint country support visits with other major M&E partners to ensure coordinated country support, participatory collaborative development of one national monitoring and evaluation framework in each country, operational plans and indicators, troubleshooting, working closely with partners to harmonize, align and coordinate efforts, and preparing and sharing guidelines, good practice notes and training.

The Program of Action endorses the Bank's approach to HIV/AIDS. But we must do even more and do it better

Building on lending and non-lending activities, the Bank will establish a continuous and deliberate process of learning more about what works and about the impact of AIDS programs, and will systematically share and apply this knowledge in program design. Bank project task teams will be supported to carry out impact evaluations of interventions funded through projects, and new HIV/AIDS projects will include prospective evaluations. Working with researchers within the Bank and beyond, especially those with a strong client-country presence, new analytical work will be supported in priority areas to supplement the analytic work included in regional and country work plans, and to focus on cross-cutting and cross-country areas, and on research that has "international public good" attributes, particularly in relation to impact evaluation. More emphasis will be given to: (i) sharing research findings and emerging lessons of experience widely and quickly, using a range of distribution and dissemination channels, and especially targeting potential users; and (ii) supporting coordinated country efforts to translate evidence into improved national programming.

Partnerships are essential to ensure coordinated and harmonized national AIDS responses of sufficient focus, scope and quality to reduce HIV transmission, and achieve the international AIDS targets outlined in the United Nations General Assembly Special Session (UNGASS) and the Millennium Development Goals (MDGs).[7] The Bank will continue to work closely with other international organizations and donors, with people living with HIV/AIDS, with civil society groups, with the private sector, and through public-private partnerships.

In the end, HIV will be defeated one village at a time, one household after another. But essential grassroots efforts will reach more people and save more lives if they are part of carefully coordinated national strategies, with national programs being supported in a harmonized and coordinated way, to try to guarantee the most effective use of all available resources. This Program of Action endorses the Bank's present approach to HIV/AIDS. But we must do even more and do it better to prevent new infections and treat and care for those who are infected and affected by HIV/AIDS. Millions of lives and the development gains and prospects of many countries are at stake.

Notes

1. World Bank. 2004. *Interim Review of the Multi-Country HIV/AIDS Program for Africa.* Washington, DC. and World Bank 2005. *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance*. An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control. Washington, D.C. Available on line at: www.worldbank.org/OED.

2. Peter Piot, "AIDS: The Need for an Exceptional Response to an Unprecedented Crisis", Presidential fellows Lecture, delivered on November 20, 2003 at the World Bank, and published by the World Bank, Global HIV/AIDS Program, Washington DC.

3. UNAIDS (Joint United Nations Program on HIV/AIDS) 2004. 2004 *Report on the Global AIDS Epidemic: 4th Global Report*. Geneva: UNAIDS.

4. UNAIDS/UNFPA/UNIFEM 2004. *Women and HIV/AIDS: Confronting the Crisis*.

5. World Bank data prepared April 30, 2005 by the Global HIV/AIDS Program, World Bank. Washington, DC. These data include the total committed amounts of HIV/AIDS projects, as well as HIV/AIDS components of over $1 million in projects classified under other sectors, using information provided by Task Team Leaders. The AIDS lending data recorded in the Bank's "Business Warehouse" (BW) differ because part of HIV/AIDS projects may be coded and counted under other topics such as gender, population, health systems, etc., and because BW coding of HIV/AIDS components may differ from the information provided directly to GHAP by TTLs.

6. UNAIDS (Joint United Nations Program on HIV/AIDS) 25 April 2004. "Three Ones" Key Principles: Coordination of National Responses to HIV/AIDS: Guiding Principles for National Authorities and their Partners. Conference Paper 1. Washington Consultation, Washington, DC.

7. UN General Assembly 2000. "United Nations Millennium Declaration." [www.un.org/]

INTRODUCTION

The Bank is committed to staying the course in the fight against AIDS

The 40 million people now living with HIV/AIDS, along with the families of the 20 million who have already died, are a stinging indictment of the world's collective failure to forestall a major—and preventable—epidemic. The human, social, and financial costs are incalculable. In many countries, AIDS has reversed the development achievements of the past generation and now jeopardizes the prospects of the next. In some countries in sub-Saharan Africa AIDS has slashed life expectancy by half.[1] It has closed schools and overwhelmed health care services. It has orphaned 15 million children.

And this is only the beginning. More people were infected last year than ever before, and more still will be infected in 2005. If this trend continues, the world will fail to achieve the Millennium Development Goal (MDG) of halting the spread of HIV by 2015, and other important MDGs also will not be met.[2]

In recent years, the world has finally come to a firm consensus on the need to respond aggressively to AIDS—to save lives, secure the future, and safeguard societies. Global funding grew twenty-fold between 1996 and 2004. New global institutions have been created. Programs to prevent new infections, provide care and treatment to those already infected, and mitigate the impact of AIDS have proven effective in thousands of small settings.

Yet despite these successes, our collective efforts remain unequal to the task. More money is on the table than ever before, but its promise has yet to be realized. Few countries have programs of sufficient scale; too few programs are evidence-informed or carefully prioritized; too little of the money is reaching those in greatest need; and we have scant evidence of what approaches work best when scaling up.

The Bank is committed to a long-term response to the pandemic—to staying the course in the fight against AIDS. We must stem the tide of the epidemic, keeping the crucial focus on prevention to protect current and future generations. We must support people who need a lifetime of treatment and care. We must protect and nurture millions of orphans through to adulthood. We must ensure that our collective investments in HIV are undertaken in coordination with investments in health, education, and social protection systems and reinforce rather than undermine them.

As recognized through the Global Task Team process and by the G8 leaders, most recently at Gleneagles, strong productive partnerships with countries, with other funding organizations and with civil society are needed to overcome the formidable challenges of the epidemic. Success will depend on working together to build country ownership and capacity, especially to develop strong strategies, implement them well and monitor and evaluate programs; leverage funds from client countries and the development community; and link the fight against HIV/AIDS to broader efforts to alleviate poverty, reduce gender disparities, increase equity and promote development.

In recent years, the World Bank has dramatically expanded its support for HIV/AIDS programs, and intensified its activities as a cosponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The Bank's finance, influence, country presence, multisector scope, analytic skills, and ability to support effective implementation, provide a

unique capacity to contribute to the global effort against AIDS. The mainstay of the World Bank's work in HIV/AIDS is of course the lending, analysis and policy discussions led by the six regions, and described in their regional strategies and business plans (summarized in Appendix 1). This Program of Action explains (for internal and external audiences) the steps the World Bank will take over the next three years, to strengthen the Bank's response to the epidemic, and to complement and contribute to the work of our partners. These include the lending, analytic work and policy engagement led by the Regions, the actions that the Global HIV/AIDS Program (GHAP) will take to support, facilitate and augment country- and region-specific operational work, additional cross-cutting activities, efforts to integrate AIDS interventions into the work of other key sectors and the International Finance Corporation (IFC), and the capacity-building work of the World Bank Institute (WBI).

Before describing the specific actions (in Part 2), this document reviews how the HIV/AIDS epidemic has evolved, and the persisting and emerging challenges we face in addressing it. The Bank's response to HIV/AIDS so far is summarized as well as the lessons of experience and joint agency and bilateral work to harmonize global and country efforts that have helped guide the choice of priorities for this Program of Action.

Notes

1. UNAIDS. *2004 Report on the Global AIDS Epidemic: 4th Global Report.*

2. United Nations 4 April 2005. *Progress Made in the Implementation of the Declaration of Commitment on HIV/AIDS,* Report of the Secretary-General to the fifty-ninth session of the United Nations General Assembly. Agenda item 43. New York.

PART 1: OVERVIEW

HIV/AIDS Today: Continuing and Emerging Challenges

An epidemic in transition

Much has changed in the 24 years since the first HIV infection was documented. The epidemic has evolved differently across regions, and our ability to track and understand it has grown markedly. While the epidemic is ever-evolving, in most of the world HIV infections remain at low levels, largely concentrated among sub-populations: injecting drug users (IDU), sex workers (SW), and men who have sex with men (MSM). In most countries, therefore, preventing new infections in these subgroups and their sexual partners through reducing risk needs to be the main focus.

The epidemic varies across and within regions, with some countries more affected than others. In Latin America and the Caribbean, for example, 11 countries have an estimated national HIV prevalence of one percent or more, while the rest of the region has much lower general prevalence. Within countries, there are often wide variations among subgroups and geographic areas. Some of the most heavily populated countries in the world (e.g., China and India) currently report an overall prevalence of less than one percent, yet the infection rate is much higher—and rapidly rising—among a number of high-risk subpopulations. For example, in Chennai, India, HIV prevalence among drug injectors rose from 26 percent in 2000 to 64 percent in 2003. HIV among sex workers in Myanmar rose from around 5 percent in 1992 to 31 percent in 2003, and from 1.7 percent in 2000 to 9 percent in 2004 among 70 sex workers in Tamanrasset, Algeria. Prevalence in a random sample of inmates in a West Java prison went from one percent in 1999 to 21 percent in 2001 and 2003.[1]

There are regions, such as the Middle East and North Africa (MNA), where the pattern, level and spread of the epidemic is not well understood due to limited surveillance and behavioral risk data.

In some countries—largely in Southern and Eastern Africa and in parts of the Caribbean—the epidemic has spread widely into the general population, with adult prevalence over two percent in the Caribbean and over seven percent in Sub-Saharan Africa as a whole. A range of strategies is required to prevent new infections, ensure care and treatment for all those affected, mitigate the sweeping impact, and support sustained programs. With so many people infected in these countries and increasing priority being given to treatment, efforts to prevent new infections still must be sustained and enhanced. Even in countries with the highest prevalence, the majority of the population is not infected, and adults and new generations of young people need to be able to protect themselves from the risk of infection.

The tremendous diversity across and within regions and countries poses its own set of challenges: the need for good surveillance, to understand the specific transmission dynamics in each context or country in order to design effective interventions; the need to ensure that interventions reach target groups in concentrated or low-level epidemics; the need for a comprehensive approach in generalized epidemics; the overarching need for strong political commitment and broad social mobilization to end stigma, silence and denial no matter what the epidemic stage, and to change the cultural norms, beliefs, roles, and practices in which sexual behavior is deeply rooted.

The diversity of the AIDS epidemic across and within regions and countries poses challenges

There have been successful prevention programs, but they have rarely been of sufficient scale or implemented widely around the world. We now have extensive experience with prevention and, more recently, with treatment and mitigation programs, and we learn new lessons every day. It is more difficult to target individuals with risky behaviours when they are subject to social taboos, or are marginalised, or not clearly identified—for example, widely dispersed informal and part time sex workers who do not work in establishments or "red-light" districts, injecting drug users, highly sexually active men, and most of the MSM who do not identify themselves as gay. Prevention campaigns may have to address the entire population to reach those at most risk. Reaching people at highest risk of infection is also more complex, and less epidemiologically effective, in a generalized epidemic than in a concentrated one.

The possibility of widespread treatment has transformed the epidemic but access remains very limited

The possibility of widespread treatment has transformed the epidemic, extending the years of healthy life of people who have access to effective and affordable antiretroviral therapy. Access remains very limited, however, representing a missed opportunity to save lives and safeguard development. Greater access to treatment would give years of healthy life to people with scarce needed skills and expertise, and keep parents alive and well to care for their children, who would otherwise join the millions of children orphaned by AIDS. So the challenges in highly-affected countries are more varied: to build local capacity to manage a long-term, chronic disease; to ensure long-term maintenance of safer behaviors; to provide long-term support to survivors; and to plan for cohorts of young people who may begin risky behaviors in the future.

Young people are increasingly at the center of the HIV/AIDS epidemic. More than half of those newly infected with HIV are aged 15-24, and there are more than 12 million young people now living with HIV/AIDS. But young people also represent the future and biggest hope in fighting the epidemic.[2] Nearly all school age children are free of HIV infection, even in the worst affected countries, and if they remain uninfected as they grow up, they could change the face of the epidemic within a generation. Promoting positive and safe behaviours must start before young people become sexually active or begin to use drugs.

Many adolescents are sexually active and engage in unprotected sex, and adolescence is also the time when drug use often begins. This is a critical age to provide appropriate information, education and communication (IEC) interventions.[3] Yet many young people do not have the knowledge or means to protect themselves from HIV/AIDS. For example, even in countries with generalized epidemics such as Cameroon, Central African Republic and Lesotho, over 80 percent of young women have insufficient knowledge of HIV/AIDS.

To prevent infections, young people need youth-friendly and gender-specific information, health services and counselling and access to condoms. Providing HIV/AIDS prevention in schools is critical but programs must also reach youth living in the streets, and those involved in commercial sex work or injecting drug use. Including young people in the design and implementation of programs is an effective way to reach and relate to their peers.

As the epidemic and the worldwide response to it continue to evolve, new challenges and new obstacles are emerging. Identifying these challenges and devising appropriate responses must be part of any effort going forward.

Unresolved longer-standing challenges also remain, for which solutions are increasingly understood. The refrain—"We know what works!"—may be an exaggeration in some cases, but in many others it is not. Our knowledge is incomplete, but it is substantial. The task with these recurring challenges is not so much to figure out what needs to be done but to figure out how to do it.

As background to this Program of Action, an overview of the continuing and emerging challenges is presented below. This is not a list of problems the Bank intends to fix; it is, rather, a list of realities that the Bank, other major donors, and countries need to be aware of in planning HIV/AIDS strategies in the new millennium.

Continuing challenges

If we really have learned so much about HIV over the last two decades, then why is the epidemic still growing? Why will more people be infected with HIV and die of AIDS in 2005 than in any previous year? In short, why aren't we applying what we know?

We *are* applying some of it, of course, although not systematically nor on a scale commensurate with the need, and it is certainly true that we have a great deal more to learn. But there are major obstacles that stand in the way of doing what works.

Limited strategic planning

By and large, efforts against AIDS are not coordinated well at the national level and are not part of an overall strategic plan. There are many plans, no plans, or different plans in different sectors; some efforts duplicate others, some address problems that are not priorities (see box on Strategic Planning), and some problems are ignored altogether. HIV/AIDS

Many national plans do not strategically target the main ways HIV is transmitted

Looking for the "strategic" in strategic planning

Many countries have developed national plans, often through extensive consultation with stakeholders. These plans have helped to elevate national commitment, foster engagement and promote social openness about HIV/AIDS. But they have often not been truly strategic; that is, they have not identified and targeted the primary ways HIV is transmitted in a given country.

One country in Africa prepared a consultative and strategic plan which presupposed a highly generalized epidemic and emphasized the widest possible engagement of society and a broad range of interventions. HIV prevalence in the country's general adult population is 1.8 percent and antenatal data indicate that the epidemic has been stable for approximately a decade. The data also suggest that the peak age of HIV infection is relatively high, between 35-39 years, for men and women. In contrast to relatively low rates in the general adult population and among youth in the country, HIV prevalence among sex workers is exceptionally high—78 percent and 82 percent in the two largest cities. The great difference between rates among sex workers and the general adult population suggests that a significant proportion of infections in this country arise from commercial sex. A recent study estimated that 75 percent of infections among sexually active men in the capital were acquired from sex workers. Yet a recent review indicated that only 0.8 percent of this country's HIV/AIDS investments were aimed at sex work interventions.

This is not an isolated phenomenon. In one Asian country, HIV infection in the general population remains low, at under 0.3 percent of pregnant women for example. In contrast, rates among injecting drug users approach 80 percent in the largest city, and rates of 30 percent have been reported among sex workers in selected sites. This country is clearly experiencing a concentrated epidemic, with exceptional vulnerability among marginalized populations. Epidemiological analyses indicate that injecting drug use contributes perhaps three-quarters of HIV infections, and injecting drug use and sex work together account for more than 90 percent. Despite these data, interventions to protect these two vulnerable groups are just one of this country's nine major strategic priorities.

In one Latin American country, the epidemic is largely concentrated among men who have sex with men. A study of over 7,500 such men between 1991 and 1997 found that more than 15 percent were HIV-positive, against an overall adult prevalence of 0.3 percent. Given the likelihood that bisexual men are one route by which AIDS enters the heterosexual community, low condom use among this population is worrisome. In the survey cited above, 85 percent of bisexual men in this country never used condoms during anal sex with their female partners, and 69 percent never used them during vaginal intercourse. Yet the majority of HIV prevention funds in the country are directed towards the "general population" and less than 10 percent are targeted towards men who have sex with men.

and its financing are often not integrated into overall development and financial planning.

There are a number of reasons why countries do not plan more strategically or, if they do, why they do not always follow these plans:

- Missing data, especially on risky behaviors, on the patterns and drivers of infection, on program effectiveness and on economic and social impact.
- Inadequate mechanisms to analyze and use data (when they are available), especially for prioritizing HIV/AIDS investments.
- Reluctance to prioritize, because of the difficult choices that must be made.
- Limited capacity to conduct regular planning that involves many sectors of government and society, in particular to help each sector assess realistically its comparative advantage in responding to HIV/AIDS.
- Limited ability of governments to plan a national response when significant external resources are channeled directly to non-government entities with limited consultation, and external resource flows are unpredictable or uncertain.
- Competition among stakeholders, in both the public sector and civil society, due to unclear roles and responsibilities and lack of ownership.
- Persistent knowledge gaps in some key areas, such as effective prevention strategies and how to scale up service delivery.

HIV/AIDS makes especially strong demands on health systems, which must be strengthened

Management and implementation constraints

Even well-planned programs will have limited results if they are not well managed and implemented. In many countries there is insufficient support for implementation, especially for scaling up programs in both the public sector and civil society. And where there has been support, programs rarely benefit from lessons learned in other parts of the country or from other countries. Many countries, especially those hardest hit by HIV, and implementing agencies within countries face obstacles to successfully managing and implementing their programs:

- The tendency of management entities to "control" resources rather than to pass them on to and "empower" those who actually carry out programs.
- Systems of fiduciary accountability—financial management and disbursement and procurement of goods and services in particular—that are more burdensome than relevant and do not take local conditions into account.
- Implementation units with insufficient resources, skilled personnel, and regional and international knowledge about what works, especially with regard to the challenges of scaling up HIV prevention, care and treatment, and mitigation programs.
- The reluctance of many in the public sector to contract program implementation and administration to existing civil society and private sector agencies in the country.
- Unnecessary duplication of management and monitoring and evaluation systems to meet the requirements of different donors.
- Unpredictable, erratic, or narrowly targeted disbursements of donor funding, often outside of national budgetary planning processes and cycles.

Weak and overburdened health systems[4]

While the causes and consequences of HIV affect many sectors, it makes especially strong demands on the health sector, which has a central role in surveillance, prevention, diagnosis and treatment of HIV/AIDS and of opportunistic infections. Despite efforts over the years to improve health systems, they remain very weak in many countries, including some that are the worst affected by HIV/AIDS. Health systems *must* be strengthened—to fight HIV/AIDS and to address numerous other diseases and health problems. With the caveat that there are significant variations across and within countries, the major obstacles to effective health system responses to HIV/AIDS, and, more broadly, to improved health outcomes and sustainability, include:

- Not enough investment in health systems. Donor and government efforts to improve health systems generally—and human resources, provision of pharmaceuticals and surveillance and other core public health functions specifically—have been inadequate.[5] Nor has adequate at-

tention been paid to the coherence of investments in health systems and their medium- to long-term sustainability.

- Inadequate understanding of what works in health system development, and under-appreciation of the complexity of health systems and service delivery. The record of external efforts to support health sector strengthening is mixed. While there is evidence of improved capacity for program planning and local leadership in some contexts, these often do not translate into improved performance.
- To some extent, global initiatives may sometimes supplant rather than support country-led strategies and work plans in health. The High-Level Forum (HLF) on the health MDGs is discussing approaches to harmonizing and coordinating investments in health systems at the country and global levels.[6] The proliferation of initiatives on AIDS and other diseases has brought additional financing, primarily for disease control efforts. Donor support for building the capacity of health systems has not kept pace with increasing demands to scale up the delivery of services. The HLF Working Group has identified an urgent need for clear, coherent guidance on how health initiatives can contribute to improving health systems components.
- Inadequate numbers, skills and distribution of health workers, due to weak incentives, shortages of training facilities, brain drain and losses of health sector workers to AIDS (see box on "People", p18).
- Inequities in access to and utilization of health services.[7]
- Restrictions on the use of some development assistance funds for recurrent costs, including salaries. ARV drug costs have declined, but other costs associated with treatment—e. g., medical and support personnel, non-ARV drugs, biological monitoring—have remained constant. Many donors traditionally have been unwilling to pay for these "local operating costs".
- Emphasis by donors on reaching many people with ARVs, without adequate attention to the quality of care and to sustainability, given that ARV treatment is a lifelong commitment.
- Resistance among public sector staff to expanding the role of the private sector and civil society to deliver services.

Limited reach of prevention, care and treatment services

The sense of emergency that has characterized much of the response to HIV has combined with the natural inclinations of many funding organizations to produce an explosion of pilot projects and other small-scale activities. Large-scale, long-term sustained interventions, underpinned by reinforcing developmental investments and actions are what are needed now. Efforts to expand care, treatment and prevention programs have been frustrated by a number of obstacles:

Large-scale, long-term sustained care, treatment and prevention programs are needed

- HIV programs, particularly prevention efforts, have often focused on changing the behavior of a small group of individuals rather than on designing comprehensive or structural approaches to an entire at-risk group.
- Without clear HIV/AIDS communications strategies, messages have not always been consistent or effective.
- Too little effort and resources have been invested in HIV prevention. As access to treatment expands, care should be taken that prevention is not neglected, which will result in an unsustainable growth in demand for treatment.
- The effort to make treatment widely available to the millions who need it, needs to be intensified, along with building the required infrastructure to make access possible.
- Stigma and denial deter people from coming forward and prevent programs from reaching many infected people, notably men who have sex with men, injecting drug users, and sex workers.
- The staff available to deliver programs on a large scale is limited, especially in countries where those most in need of services are widely dispersed, highly mobile, in rural areas or concealed.
- Many governments are reluctant to contract program management and service delivery outside the public sector, even where this would increase coverage, efficiency, and quality—and significantly close the implementation gap.

People: A key factor in the resource equation

With new resources available for large-scale treatment, countries affected by AIDS confront a critical shortage of health workers, and expertise, including in epidemiology, virology, designing and managing prevention and treatment programs, and monitoring and evaluation. The severity and types of human resource constraints vary across countries. Africa has a quarter of the world's disease burden but only one percent of its health workers.[1] Even if vacant posts could be filled, staffing levels still would not be adequate to meet the rising demand for care.

The shortage of health workers has many causes.[2] Too few health workers are trained, too many die or move abroad, those in post are maldistributed relative to needs. Forty percent of the new graduate nurses in Zambia and Malawi each year are needed just to replace nurses who die – many of AIDS. There are more Malawian nurses in Manchester, England than in all of Malawi. Tanzania has 26 times more nurses per capita in Dar es Salaam than in some rural areas. Weak public sector management and poor incentives and working environments erode productivity, and donors contribute by luring senior managers away from the public sector. Kenya's civil service payroll was estimated to include 5,000 "ghost" health workers. Doctors in many developing countries earn as little as $50 per month. Low salaries sap morale and force health workers to undertake multiple jobs or activities.

Needs and solutions vary, but these options could help in many countries: Some countries have under-employed doctors and nurses, and other unemployed university graduates who, with appropriate training and supervision, could be deployed to meet shortfalls in program planning and management. More training schools are needed, and rapid courses to train intermediate level para-professionals who can later upgrade their skills. Contracting private sector suppliers may help, but nursing agencies are rare in Africa. Better salaries need to be arranged, and better working conditions and career development prospects are also needed. Staff could be distributed better, with incentives for rural service. Better public sector management is needed, combined in some cases with decentralization. All these are to be considered within a framework of sustainable financing.

1. High Level Forum on the Health MDGs, "Addressing Africa's Health Workforce Crisis: an Avenue for Action", Paper prepared for the meeting in Abuja, in December 2004. Accessed online on 06/03/05 at: http://www.hlfhealthmdgs.org/Documents/AfricasWorkforce-Final.pdf
2. High Level Forum on the Health MDGs, "Health Workforce Challenges: Lessons from Country Experiences", Paper prepared for the meeting in Abuja, in December 2004. Accessed online on 06/03/05 at: http://www.hlfhealthmdgs.org/Documents/HealthWorkforceChallenges-Final.pdf

Stigma, discrimination, laws and social norms can undermine HIV/AIDS prevention, care and treatment

- There is still not enough money for salaries and operating costs and for some services, especially if the service is expensive (such as treatment) or politically unpopular (such as services for injecting drug users or sexual health services for adolescent girls).

Social and political factors

Social and political circumstances and laws can greatly influence the success of HIV prevention, care and treatment services. Where people may be persecuted, for example, or subjected to stigma and discrimination because of HIV/AIDS, they are less likely to seek out prevention, testing, and treatment services. If use of preventive methods such as condoms or clean injecting equipment is discouraged, prevention programs are weakened. Approaches that violate the rights of people in need of services have also been shown to be counter-productive. Some social gender norms make girls and women more vulnerable and have resulted in women and girls now being the most affected by the epidemic (see Box on Feminization of the HIV/AIDS Epidemic). Progress in changing social and political obstacles has been inhibited by:

Feminization of the HIV/AIDS epidemic

The HIV/AIDS epidemic is increasingly affecting women and young girls, especially where heterosexual sex is the main mode of transmission. In Sub-Saharan Africa, 57 percent of PLWHA are female, and in Russia, the proportion of women among newly infected people rose from 24 percent in 2001 to 38 percent in 2003.

Several factors increase women's vulnerability to infection and limit their access to HIV care and treatment. These include biological and cultural factors, social and economic gender inequalities, violence against women, women's unequal access to information, education and services, and their role as caregivers. In addition, in many societies women take on most of the care of people infected with HIV/AIDS. In Viet Nam, women make up 75 percent of all caregivers for PLWHA.

Among adolescents (aged 15-19) in regions hardest hit by the epidemic, for every boy five or six girls are infected. Young girls are physiologically more at risk of infection, are often poor and powerless, and are frequently coerced or enticed into sexual activity with older men in exchange for money, gifts and favors. For many young women marriage does not provide protection either, as young brides often lack the power to negotiate safe sex practices.

The feminization of the epidemic is an additional impetus for redressing the social, economic and legal inequalities women face and working to end violence against women. HIV/AIDS prevention and treatment programs must consider women and gender issues. Preventive methods that are controlled by women—such as microbicides and female condoms—can help reduce their vulnerability. As antiretroviral treatment is scaled up, more than ever there is a need to ensure equal access to services. Integrating HIV/AIDS with reproductive health programs may help improve women's access, especially where stigma and discrimination against people with HIV make women reluctant to seek HIV/AIDS services.

Source: UNAIDS 2004; UNAIDS/UNFPA/UNIFEM 2004, Women and HIV/AIDS: Confronting the Crisis.

- Lack of effective tools to measure environmental effects, obstacles and interventions, and the related tendency of programs to neglect whatever cannot be measured or reported as a "deliverable."
- Insufficient assessment of social factors in planning and implementing programs to trigger ongoing feedback from stakeholders.
- Lack of mechanisms to ensure that social and political environments support efforts to prevent and reduce HIV/AIDS.
- Lack of empirical evidence and widely differing views on the relative roles of legislation and education in reducing stigma and protecting human rights.
- Political unwillingness of governments and some donors to invest in potentially effective but controversial interventions, such as harm reduction for drug users in favor of more politically "acceptable" interventions that may have limited effect on the national epidemic.
- Frequent exclusion of security and correctional services from the national dialogue around HIV, despite the high vulnerability of prisoners and military personnel and the ease of reaching them. Law enforcement's cooperation can also be helpful for interventions targeting injecting drug users.
- Focusing exclusively on women and working only with women's groups when considering gender issues, instead of also reaching out to men, recognizing that most decision-makers are men.

Donor challenges

AIDS programs are funded by four broad sources: countries themselves; bilateral donors, especially the United States' President's Emergency Plan for AIDS Relief (PEPFAR) and the United Kingdom's Department for International Development (DFID); private foundations, with the Bill & Melinda Gates Foundation and the Global

Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) being by far the largest; and multilateral donors including the regional development banks and the World Bank. A number of agencies, in particular UNAIDS and its cosponsors, provide technical assistance. Responses to HIV/AIDS have suffered from the distorting effect on program planning and implementation of the numerous policies and priorities of such a wide variety of donors. Some of these distortions occur out in the field and are the responsibility of the countries themselves, but others can be laid at the door of external partners and the way they go about providing assistance (and are common to many development aid programs).

Uncertain, short-term and tied funding; duplication; and donor pressure and politics can create distortions and difficulties

Problems include:

- Uncertainty about future funding, which discourages countries from making the large up-front investments needed to strengthen systems and leads to too much investment in short-term measures.
- Funding that is tied to specific sources of technical assistance or to a particular product, which distorts allocations, raises prices and reduces efficiency.
- Diverting funds from other development programs, undermining the AIDS effort in the long run by further weakening crucial sectors such as health and education.
- Inadequate support to countries to integrate HIV/AIDS programs into their national budget planning and management processes, including in Medium-Term Expenditure Frameworks and Poverty Reduction Strategies (in countries that have them).
- Competition among donors and among recipient agencies, leading to expensive duplication—or even conflicts—in programming.
- Pressure from donors to attribute concrete, politically prominent results to their specific funding, which can fragment national monitoring and evaluation systems and discourage investment in less visible outcomes such as strengthening national systems or infrastructure.
- Excessive influence of donor country domestic politics in funding decisions can result in inappropriate prevention and care schemes in local settings.

Emerging challenges: new issues for a changing epidemic

Growing awareness of the devastating impact of HIV/AIDS has translated into greater political commitment to confront the epidemic and its consequences. This commitment has resulted in an outpouring of new resources and initiatives, including the World Bank's Multi-Country HIV/AIDS Program (MAP), the Global Fund, and major new commitments by government bilateral donors, such as DFID and PEPFAR. There are also significant funds from private institutions—notably the Bill & Melinda Gates Foundation. Altogether, total HIV/AIDS funds available in developing countries grew from an estimated US$300 million in 1996 to US$6.1 billion in 2004, including about US$ 2 billion in domestic funding, and to US$8 billion in 2005.[8] However, this is still $4-6 billion short of what is needed for effective prevention, care and treatment.

This increase in funding is a dramatic change and poses new challenges with which the AIDS community is still grappling.

Providing large-scale antiretroviral therapy

Evidence from developed and developing countries has shown that current treatment regimens can dramatically prolong the lives of persons living with HIV, enabling them to remain productive and raise their children. But only about one million of the six million people who currently need antiretroviral therapy in developing countries are receiving it.[9]

The delivery of ART in resource-limited settings, once thought impossible, has been shown to be feasible. For example, universal access to ART in Brazil has, since 1996, enabled the country to avert more than 60,000 new cases of AIDS and 90,000 HIV-related deaths.[10] To extend these benefits to other parts of the world, the Bank supports a comprehensive approach to care for people infected with HIV which includes antiretroviral treatment. The Bank provides technical and financial support to national ARV treatment programs in several countries, has developed a technical guide on procurement of AIDS medicines and supplies which has been en-

dorsed by UN agencies, and has entered into an agreement with the Clinton Foundation to ensure that Bank funds may be used to procure ARVs and diagnostics at the Foundation's negotiated reduced prices.

Achieving the goal set by the World Health Organization and UNAIDS of putting three million people on treatment by the end of 2005 ("3 by 5") will require much more than money, and poses new challenges.[11] To maximize individual benefit and to minimize the risk of patients developing resistance to ARVs, measures need to be taken to ensure that treatment is made widely available, can be sustained and that people adhere to their regimen. The need to strengthen health services is made even more urgent by the greater emphasis on treatment. Health systems are already overburdened and understaffed. Expanding treatment will require substantial new resources, especially investments in operational infrastructure, in training and retaining more health workers, and sustained additional funding. Staff need to be trained to prescribe ARVs appropriately and to monitor patients and treatment outcomes. Reliable, sustainable supplies of the drugs must be ensured; which may require additional investments in the supply chain and its management and improved procurement procedures. Additional laboratory capacity is needed to support HIV testing and management of ARV treatment. Much of this work will fall on the public sector, but private providers have an important role too, with appropriate stewardship from the public sector.

Another critical issue is to ensure equitable access to treatment programs. In some countries, gender inequalities already prevent many women from accessing care and treatment services. The design and implementation of treatment programs need to address gender and other dimensions of equity such as access for poor and marginalized groups and in rural areas.

The "Gleneagles" G8 summit in July 2005 recognized the need for additional efforts and funding to implement a package for HIV prevention, treatment and care, and to strive for universal access to treatment for all who need it.[12]

Staying the course on prevention

Preventing HIV infections should remain a priority for all countries, whatever the level of prevalence, while also treating and caring for people who are infected and affected. Since HIV is invisible in its early stages, countries with low HIV prevalence are often slow to respond and especially reluctant to use limited resources and budgets on prevention efforts. However, inaction is costly in all contexts. It inhibits response in low-prevalence countries at all levels: from policy formulation to prevention planning, implementation and ultimately to individual behaviour change. Intervening early, however, and working steadily and closely with key at-risk and vulnerable populations has proven effective in many countries.

Efforts to prevent new infections must be unrelenting, alongside activities to expand treatment and care

Efforts to prevent new infections must be unrelenting. Even in the highest prevalence countries, the majority of people are uninfected, and need the information and means to remain uninfected. Effective prevention may require changes in social norms, attitudes and behaviours which are difficult to achieve. Populations at high risk of infection may be overlooked or underserved because of stigma, taboos and denial, or because governments shy away from controversial services or serving marginalised groups (such as clean needle programs for drug users or promoting condom use by sex workers and men who have sex with men). Even with respect to prevention in the general population, some institutions find it difficult to overcome the social barriers to dealing with sensitive issues surrounding AIDS. Sustained, strong political commitment, effective multi-sectoral efforts and broad community engagement are all needed for normative and behavioural changes that prevent HIV infection.

Integrating prevention and treatment

It will be important to make sure that the promise of treatment programs does not slow momentum on prevention, especially as governments may find it easier to support treatment regimens than more controversial measures such as condom distribution and promoting clean needles.

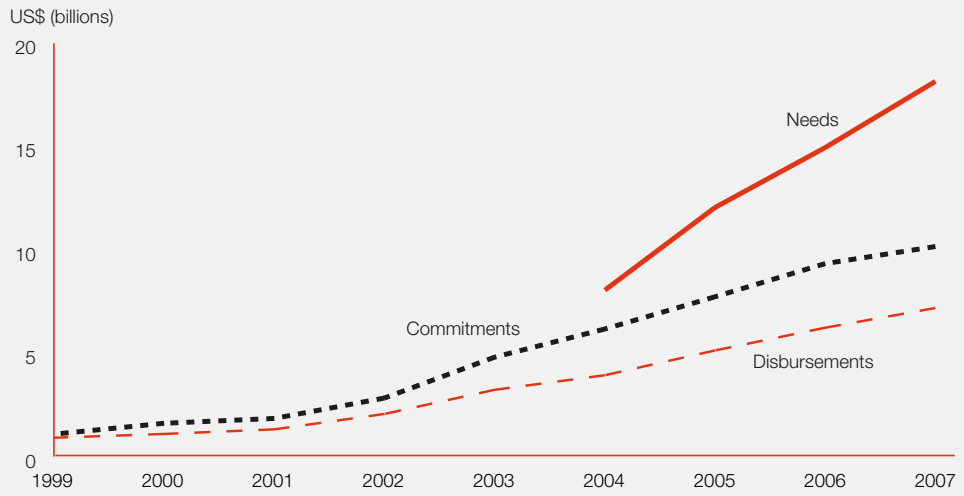
The impact of widespread treatment on prevention efforts is currently unknown: there can be important synergies, but there are also concerns about unintended consequences. For individuals, the possibility of treatment may provide the incentive and rationale for being tested, and testing provides an entry point for delivering prevention and treatment services. An HIV-negative test result could reinforce motivation to practice safe behaviors. Availability of treatment and care can bring large numbers of people into health care settings, providing additional opportunities for health-care workers to deliver and reinforce HIV prevention messages and interventions. In some developed countries, wide availability of treatment has coincided with an increase in risky behavior, perhaps because people are worrying less about becoming infected. The impact of expanded treatment programs on risky behaviours must be carefully monitored, and promotion of safe behaviours integrated into treatment programs. It would be a sad irony if increased access to treatment came at the expense of a general lowering of vigilance against infection and a greater number of new infections. Conversely, the more successfully countries prevent new infections, the more feasible, affordable and sustainable it will be for them to provide ARV and other treatment to people who are infected. In addition, prevention can enhance access to treatment, by reducing stigma and improving community knowledge and treatment readiness. Integrating prevention and treatment ensures that prevention activities are not neglected and can provide important opportunities to address vulnerable groups more effectively.

The funding paradox

Funding commitments have surged ahead of their use, but are still far below needs

The recent surge of funding has created a paradox: there is still not enough money available for HIV/AIDS programs, but the money that is available is not being spent as fast as it is being committed. Figure 1 shows the June 2005 UNAIDS estimate of annual needs for HIV/AIDS programs along with the best current estimate of available commitments and actual and projected disbursements.[13] Funding commitments are still substantially below estimated needs, leaving a "resource gap". Disbursements are increasing, but they are not keeping pace with commitments, resulting in an "implementation gap."There are not always adequate systems in place—in recipient countries as well as in donor institutions—to put increased funding to use in a timely and effective manner, creating disbursement bottlenecks. Funding increases have raised expectations among donors and people living with HIV/AIDS, but overwhelmed many of the in-country mechanisms through which those expectations must be met.

Figure 1. Estimated financial needs, commitments and disbursements



This implementation gap threatens to dash rising expectations (to be treated with ART, for example), and risks alienating donors who assume that more money means more and faster results. In the rush to bridge the gap and produce results, there is a real risk that planning will become even more neglected, that funds will be spent inefficiently, and that accountability will be minimal. This intensifies the need for donors and others working on HIV/AIDS to harmonize their efforts and align their activities, to make the most efficient use of resources and to support country-owned and implemented strategies. Many hard-pressed governments find themselves spending more time managing competing donor demands than establishing their own priorities and implementing their own programs.

The Three Ones and the Global Task Team process is critical both in raising increased resources and in ensuring that these resources are allocated well and used effectively to improve implementation and use of existing funds (See Box on The Three Ones).

To close the resources gap, more progress is needed towards closing the implementation gap. This requires that donors and recipients do more to promote faster disbursements while at the same time maintaining high levels of efficiency, effectiveness, transparency and accountability. Neither recipients nor donors can continue to do "business as usual". Dr. Peter Piot, Executive Director of UNAIDS, has called AIDS "an exceptional epidemic . . . that demands exceptional actions."[14] The Bank has begun to use nonstandard implementation arrangements in the Multi-country AIDS Program (MAP)[15], and to change its procedures to speed up implementation. This flexibility has not always been matched by governments, many of whom continue to address HIV through existing and often rigid bureaucratic procedures.

HIV is often overlooked in the poverty reduction strategy process and medium term expenditure frameworks

In many countries, AIDS has a disturbingly low profile, for a number of reasons: stigma or denial may prevent political commitment or a vocal civil society from materializing; concentrated epidemics may be invisible to the general public; and AIDS authorities may carry little weight in government circles. This is evident in some Poverty Reduction Strategy Papers (PRSPs). A recent study of HIV/AIDS in PRSPs in Africa showed that while it was addressed by many—but not all—countries with a high prevalence, it was less likely to appear in PRSPs in countries with emerging epidemics.[16] Moreover, even if HIV was prominent in PRSPs, it was rarely costed, and the institutional framework for implementation was detailed in only 10 percent of cases.

As a consequence, funding for HIV/AIDS can easily be ignored when donors pledge support for PRSP implementation. Country-level stakeholders and international partners need to keep HIV on the agenda during the PRSP process and during other national budgetary processes such as developing Medium-Term Expenditure Frameworks (MTEF). National HIV/AIDS strategies need to be embedded in national public expenditure planning and taken into account during macroeconomic policy debate. With renewed global focus on Africa, there is a pressing need to ensure that HIV/AIDS is addressed in the wider development agenda and development instruments.

AIDS needs to be better integrated into broad national development planning and budgeting

PRSP and MTEF processes and macroeconomic policy dialogue also offer opportunities for considering broader policies and actions that are linked to a country's ability to respond to HIV/AIDS (for example, investments in the health sector including expanding the health workforce and retaining health workers) and to gender factors such as girls' access to education and women's property rights, that can affect poverty and vulnerability and women's ability to protect themselves from infection.

Predicting the social impact of a still growing and diverse epidemic

While the demographic impact of the HIV epidemic is becoming increasingly apparent in much of Africa, we can only speculate about its full economic and social impact. At the household level, the main effect of AIDS is to increase poverty, especially among the poorest. Because AIDS affects mainly adults in the prime of their lives, it results both in a

Making the money work—"The Three Ones" in action

In April 2004, the UNAIDS co-sponsors, the Global Fund, the World Bank and key bilaterals including the U.K. and the U.S. agreed to support the "Three Ones" at country level in order to improve the efficiency and effectiveness of HIV/AIDS funding.[1]
The "Three Ones" are:

- One agreed HIV/AIDS action framework to coordinate the work of all partners;
- One national AIDS coordinating authority with a broad-based multi-sectoral mandate; and
- One agreed country-level monitoring and evaluation system.

Eleven months later donors and recipient countries met in London to assess the "Three Ones". While there was progress in some countries, not enough countries and donors were putting the "Three Ones" into practice. UNAIDS was asked to facilitate formation of a Global Task Team to issue within 80 days recommendations on improving AIDS coordination among multilateral institutions and international donors. Task forces were established on strategy and funding, technical assistance, and monitoring and evaluation. The Bank co-chaired the task force on strategy and funding and was a member of the group on monitoring and evaluation as well as the overall Global Task Team.

The Global Task Team (GTT) presented its recommendations within the 80 day deadline.It also reached agreements on improved coordination between the Global Fund and theWorld Bank, and the division of labor among the UNAIDS co-sponsors, particularly with regard to rationalizing the provision of technical support. The division of labor suggested that the World Bank take the lead in assisting countries to enhance their HIV/AIDS strategies by making them more prioritized, evidence based and inclusive and by establishing annual actions plans for better implementation. Together with UNDP, the Bank will help countries better integrate their HIV/AIDS programs into the broader development agenda, including in PRSPs and Medium Term Expenditure Frameworks.

The World Bank is also participating in costing the implementation of the GTT recommendations with regard to technical support and in the creation of two new mechanisms for promoting coordination: (i) joint country support teams for monitoring and evaluation; and (ii) a UN system-Global Fund problem-solving team to operate at both country and global levels.

1. The "Three Ones" agreement was endorsed by representatives of the governments of Australia, Belgium, Brazil, Canada, Côte d'Ivoire, Denmark, Finland, France, India, Ireland, Italy, Japan, Luxembourg, Malawi, Netherlands, Norway, South Africa, Sweden, UK and USA, and of the following organizations: UNAIDS, UNDP, WHO, World Bank, OECD, OECD/DAC, International Council of AIDS Service Organizations (ICASO), and the Global Network of People Living with HIV/AIDS (GNP+). For more details on the Three Ones, see UNAIDS 2004, *Coordination of National Responses to HIV/AIDS, Guiding principles for national authorities and their partners.*

rapid increase in the number of people needing treatment and in the number of orphans, who are often deprived of access to education. Even if governments are able to provide long-term ARV treatment to rapidly growing numbers of people, many infected adults will still die before their children reach maturity.

Given current trends, vulnerabilities and patterns of behavior, it seems unlikely that the large nations of Asia will suffer HIV epidemics in the general population such as those now seen in Southern Africa. However, behavioral patterns do change, and AIDS specialists have been wrong before in predicting the course of the epidemic. Even if current"worst case"scenarios for large countries do not come to pass, at the very least, Eastern Europe and parts of Asia are likely to see large, concentrated epidemics affecting millions of people—and creating vast new demands for prevention, care, support, and treatment.

Notes

1. UNAIDS. *2004.*
2. UNAIDS. *2004*

3. World Health Organization Department of Child and Adolescent Health and Development. The Talloires consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS. Information Brief 11.10.04, http://www.who.int/child-adolescent-health/New_Publications/ADH/IB_SRG.pdf

4. "Health systems" include a range of functions whose *primary* purpose is promoting, restoring and maintaining health. The areas of concern most relevant to this Program of Action are stewardship (oversight and the roles of the state); financing (revenue generation, collection, pooling, allocation, use and sustainability); epidemiological surveillance as an input into evidence-informed planning, implementation and evaluation of programs; service delivery, including supply chains and the multiple dimensions of quality care; human resources (quality, quantity and performance incentives); and infrastructure for effective prevention and treatment, including laboratory facilities and communications.

5. Wagstaff A, and M. Claeson, 2004. The Millennium Development Goals for Health—Rising to the Challenges, World Bank, Washington DC.

6. UNAIDS 2005. *Information Update.* General Assembly High Level Meeting on HIV/AIDS. New York, 2 June 2005.

7. Wagstaff A, and M. Claeson, 2004.

8. UNAIDS. *2005.* "Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries", Discussion Paper: 'Making the Money Work', The Three Ones in Action, United Kingdom, 9 March 2005.

9. WHO and UNAIDS, 2005, "The 3 by 5 Initiative", report on progress as of June 2005, accessed online on August 8, 2005 at: http://www.who.int/3by5/progressreportJune2005/en/

10. Teixera, Paulo R., Marco A. Vitoria, and Jhoney Barcarolo. 2004. "Antiretroviral treatment in resource-poor settings: the Brazilian experience." *AIDS* 18(3): S5-S8.

11. WHO (World Health Organization). 2003. *Treating 3 Million by 2005: Making It Happen: The WHO Strategy.* Geneva: WHO Department of HIV/AIDS. [www.who.int/3by5/].

12. Gleneagles Communiqué, Page 22, paragraph 18 (d).

13. UNAIDS 2005. Resource needs for an expanded response to AIDS in low and middle-income countries. Presented at the Programme Coordinating Board; seventeenth meeting. Geneva, 27-29 June 2005.

14. Piot, Peter. *AIDS: The Need for an Exceptional Response to an Unprecedented Crisis.* Presidential Fellows Lecture delivered on November 20, 2003 at the World Bank, Washington, D.C.

15. As described in the MAP operations manual published as "Turning Bureaucrats into Warriors", Brown, Ayvalikli and Mohammad, World Bank, 2004.

16. World Bank and UNICEF, 2004. Poverty reduction strategy papers—Do they matter for children and young people made vulnerable by HIV/AIDS? UNICEF, New York. On line at http://www.unicef.org/publications/index_24887.html

HIV/AIDS and the Bank: The Story Thus Far

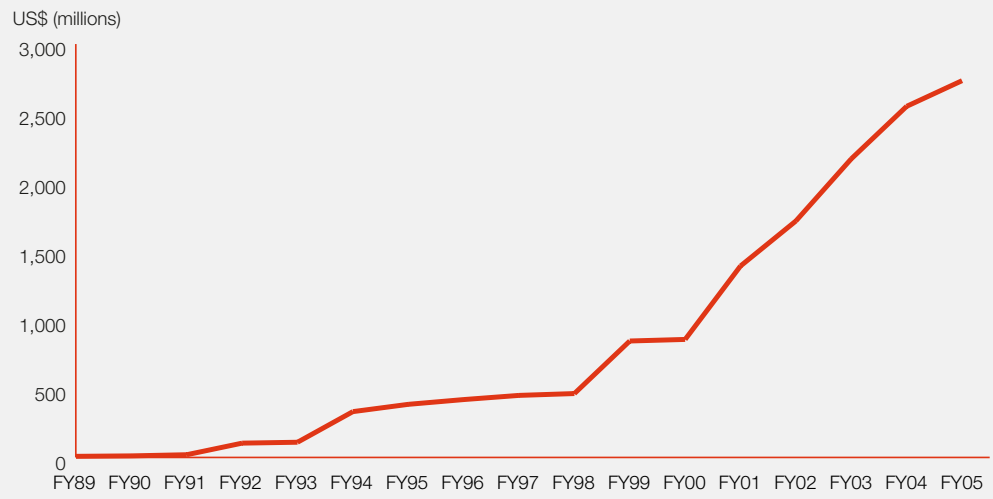
World Bank support for HIV/AIDS has increased dramatically, with total commitments over US$ 2.5 billion

In the past 5 years, the World Bank has dramatically increased its support for HIV/AIDS programs. Cumulative total Bank commitments now exceed US$ 2.5 billion (Figure 2). Funding increases for AIDS in Africa have been particularly impressive, from an average of US$ 10 million annually 10 years ago to $250-300 million annually in each of the last four years. The Africa MAP has committed US$1.12 billion for 29 countries and four regional projects, and the Caribbean MAP has committed US$118 million for nine countries and one regional project.[1]

Although it started lending for HIV/AIDS in 1988, more than a decade passed before the Bank began to apply the full range of its tools and talents to confronting the epidemic. Some of the Bank's early work produced important and lasting results, but the failure to make HIV a priority kept those results from evoking or informing a broader institutional response. Neither its shareholders nor its managers gave AIDS the priority it warranted, and few Bank clients asked for advice or funding for HIV/AIDS. Most other public organizations were also slow to react in those early years, but as a leader in development, the Bank bore a special responsibility—which it failed to fulfil.[2]

India and Brazil stand out in Bank lending: they were among the first countries with dedicated HIV/AIDS projects (in 1992 and 1993), and in both, support has been sustained, with second projects approved in 1999 and 1998, and a third project under implementation in Brazil and being prepared in India. This support has helped build robust HIV/AIDS institutions and capacity at na-

Figure 2. Cumulated new AIDS commitments, fiscal years 1989–2005



tional and state level, engage NGOs in prevention and care efforts, build public awareness and bolster political commitment, and improve surveillance. Brazil is especially notable for the focus on prevention among the most marginalized groups

Since the late 1990s, Bank support for HIV/AIDS programs has risen fast, particularly in the hardest hit regions. Regional HIV/AIDS strategies have been developed to guide the Bank's work (Appendix 1). Still one of the three largest funders worldwide, the Bank also provides policy analysis and advice, is a leading source of implementation support to countries, a cosponsor of UNAIDS and a core member of other major global partnerships. The Bank has deepened its expertise, learned valuable lessons (see box), and become increasingly aware of its strengths and limitations.

These lessons, together with assessments of where programs most need strengthening especially to overcome implementation bottlenecks, countries' most pressing needs for support, the Bank's particular strengths, and the directions set out in the regional strategies, have determined which of the many challenges described earlier the Bank has chosen to focus on in this Program of Action.

Experience in analysis and policy advice

Through analysis, policy dialogue and advocacy at the highest levels, the Bank has helped put HIV/AIDS on the development agenda. Analytic efforts have identified the broader development dimensions of the epidemic, demonstrated the high returns from investing in HIV/AIDS programs, and provided tools for selecting and costing appropriate interventions. In its policy dialogue, the Bank has helped legitimise HIV/AIDS as a development concern and a priority for public action.

This work has helped convince many client countries to increase funding for HIV/AIDS programs from domestic and external resources, and likewise prodded donor countries to commit billions more for HIV/AIDS—two key developments that were especially important in countries that had been reluctant to acknowledge or address their epidemics.

Analysis, policy dialogue and high level advocacy have helped raise political commitment and funding for AIDS

Since 1988 the Bank has published over two hundred analytical and research reports and papers on HIV/AIDS covering many different sectors, including education, transport, local government and the private sector.[3] However,

Twenty years—five lessons: What the Bank has learned from its HIV/AIDS programs

In recent years, the Bank has carried out several studies of its AIDS work. Five key lessons have emerged from these reviews and have guided the development of this global HIV/AIDS Program of Action.

- **The Bank—by its acts *and* its omissions—influences both developed and developing countries in their actions on HIV/AIDS.**
- **Country ownership, leadership, and capacity are crucial for successful action.** Countries that have had success in fighting the epidemic have been supported to lead their own programs and build on local institutions. The Bank's policy advice and country-led approach are important assets to countries in pursuing these goals.
- **HIV/AIDS needs to be better integrated into development policy and planning—**and the Bank is uniquely positioned to assist countries with this.
- **HIV/AIDS strategies, policies and programs should be evidence-informed, with priorities based on local epidemic conditions.** Activities should also continually generate new evidence and channel it to managers to inform ongoing program refinements.
- **Monitoring and evaluation are essential—and consistently neglected.**

analytical gaps remain, at both the macro- and micro-levels. For instance, there has not been enough attention to the links between HIV/AIDS and poverty, which may explain in part the general neglect of HIV/AIDS in Poverty Reduction Strategy processes and other national development planning exercises. At the micro-level, more economic and sector work is needed on a host of important issues, such as the sector impact of HIV/AIDS, the effectiveness of various HIV/AIDS interventions, and the factors explaining household and individual behavior changes. In policy dialogue, Bank performance is uneven, with HIV/AIDS emphasized with some clients and overlooked with others. In addition, in most cases the Bank has not done enough to help countries develop effective, prioritized HIV/AIDS programs, or to absorb key findings from Bank projects as to which interventions work, under what circumstances, and at what scale.

The overall impact of Bank support for HIV/AIDS in 67 countries is mixed, with successes and weaknesses

Experience in financing and supporting implementation

Since 1988, the Bank has funded HIV/AIDS projects and activities in 67 countries.[4] In the early years, these projects supported countries as different as Brazil, Cambodia, and India in laying the foundations for effective national programs. The Africa MAP was the first to fund African HIV programs on a billion-dollar scale. Responding to client demand, the MAP also introduced a set of innovations, including multisector reach, funding for both operating and recurrent costs, flexible programming, simplified procedures, and direct flow of funds to civil society. These activities jump-started a rapid scaling up of HIV initiatives in Africa, where today most national governments have programs of unprecedented scope and where the Bank has funded more than 50,000 civil society subprojects.[5] Bank investments in HIV/AIDS initiatives have also climbed steadily in most other regions.

The Bank has also developed new tools and practices to enhance its HIV/AIDS support. To address targets that individual country programs cannot reach, it has begun funding subregional HIV/AIDS projects in the Caribbean, Central America, Central Asia and Africa. In addition, the Bank has begun to integrate HIV/AIDS into other sectors, such as transport and education, and to require HIV safeguards in projects where there are risks of HIV transmission. To help alleviate debt concerns, it has increasingly used grants to finance HIV/AIDS projects in IDA countries.

The Bank has been among the foremost sources of support for implementation and has reaffirmed its commitment to improving implementation through the Global Task Team division of labor among agencies. It has provided considerable support to countries in areas where their programs have traditionally been weakest, especially financial management and disbursement, procurement, and monitoring and evaluation. This support has helped channel resources to an unparalleled number of stakeholders, and also strengthened the capacity of countries to carry out programs funded by other donors. Internally, the Bank has created dedicated HIV/AIDS units in Africa, South Asia, and the Human Development Network (Global), and, recently, in the International Finance Corporation, the World Bank Institute and the Legal Department, as well as a Bank-wide HIV/AIDS Implementation Acceleration Team, all of which share a key mandate to ensure rapid and consistent support to project teams and clients. Some of these units have sponsored broad initiatives to disseminate lessons learned from ongoing programs, which has made it possible for new projects to benefit from earlier experience. These units have also helped develop new policies to simplify project processing and implementation.

An uneven record

Overall, the impact of this work has been mixed. Within the portfolio, some operations have succeeded, while many others have not. The reasons for the latter vary widely. Some projects suffered from poor design and not enough analysis before being approved; others foundered because of government disinterest or neglect; and others were undermined by a weak strategic framework for AIDS.[6] Other projects failed to perform because of poor governance or because governments were reluctant to pass on the

flexibility of Bank funding to implementing agencies. Many projects had sound technical designs but stumbled when it came to implementation, hampered by poor institutional capacity and intra-governmental relationships or weak national ownership. Even some projects that succeeded (achieving their own specific objectives) were too small in scale to affect the country's epidemic. Owing to a general neglect of monitoring and evaluation, especially impact evaluation, opportunities have been missed to learn from previous projects.

While the Bank's support for implementation has assisted countries to improve their fiduciary architecture—financial management, disbursement of funds, and procurement of goods and services—the Bank has done less well in supporting two other vital areas: strategic planning and monitoring and evaluation. Very few countries have developed a true strategic framework for HIV/AIDS based on the most recent country level information about the epidemic, let alone viable and costed implementation plans that have the support of national funders, especially Ministries of Finance and Planning. The Bank could do more to work with other UNAIDS partners to help countries undertake a systematic, comprehensive and participatory process of strategic planning that fits within the overall development framework, including the PRSP process.

In supporting program monitoring and evaluation, no country, donor, or partner has done an adequate job—the Bank included—and few countries have an adequate national system in place. Individual large-scale projects rarely include prospective evaluation of impact. With billions of dollars at stake, improving monitoring and evaluation has become one of the highest priorities. At this stage of the response to the epidemic, there can no longer be any excuse for not knowing whether and how AIDS activities are making a difference.

The Bank's comparative advantages

Although many global institutions are now engaged in the fight against AIDS, the World Bank retains a special role and responsibility, which its partners are relying on it to fulfill. As the largest single provider of development assistance and an important repository of knowledge and advisory services, the Bank has a unique set of strengths to bring to bear on the epidemic, as summarized below.

Advocacy and Access

- The Bank has access to key decision makers, including in the area of finance, who are critical to giving HIV/AIDS appropriate emphasis and putting it at the center of the development agenda, both globally and in individual countries.

A Longer-term, More Independent Perspective

- Less fettered by national electoral politics and budget cycles than other major donors, the Bank is in a position to take a sustained, long-term approach to the epidemic.
- Bank funding is longer term, more flexible, and better rooted in national ownership.
- Gaps in human resources—the biggest obstacle to rapid scale-up of promising interventions in the hardest-hit countries—can best be addressed by long-term investments across sectors, an approach the Bank is particularly well suited to support.

Breadth of Action across Sectors and Countries

- The Bank engages across the full range of sectors and government ministries, from health to education, transport and defence, giving it unmatched advocacy and influence among external actors.
- In some countries the Bank is still the only major provider of funding for HIV/AIDS work. The Bank can provide funds to countries that are not able to access funding from other major sources.
- The Bank's privileged relationship with the IMF and its central role in national development planning in low-income countries enable it to link HIV/AIDS planning to broader development planning and ensure that the latter address the epidemic. It is also well placed to assist Ministries of Finance and Planning to improve their understanding of the epidemic.
- The Bank can easily finance projects with multiple objectives.

The Bank has a special role and responsibility and set of strengths in the fight against AIDS

Ability to Jointly Provide Funding, Analysis and Technical Assistance

- The Bank provides access to highly concessional IDA funding, in some cases directly for HIV/AIDS programs. It provides this financial assistance in tandem with analytical work, policy dialogue and multisector convening power.
- The Bank has the capacity to support multisector strategic planning to encourage rational allocation of resources.
- The Bank has unique expertise in supporting program implementation around the world and in all the key economic and social sectors; working with governments, civil society and the private sector from the community level to the national level to develop a relevant and flexible fiduciary architecture of appropriate financial management and procurement systems and other structures that enable implementation of HIV/AIDS activities.
- The Bank's extensive expertise in analysis, particularly in development economics, positions it uniquely to explore the HIV/AIDS-poverty-gender-development dynamic and to support the design and analysis of the impact of large-scale, multisector, multi-output programs.

Bank regional HIV/AIDS strategies are tailored to address specific and diverse issues and needs

Taken together, these strengths enable the Bank to play a central role in developing an effective and lasting response to the epidemic. They also position the Bank as uniquely credible to advise government and other partners on the proper emphasis to be given to HIV-related initiatives within the context of a country's overall development agenda.

Diversity and commonality across regions

Many of the challenges discussed earlier are common across many countries and regions. But there is also great diversity within each region, and even within countries, with respect to the epidemic, the country response and the barriers to effective action. The Bank regional HIV/AIDS strategies[7] are tailored to address specific issues and needs.

In **African countries** with very high prevalence and generalized epidemics, the economic and social impact of AIDS is severe—worsened poverty, millions of orphaned children and losses of productivity and scarce skilled people. Implementation and funding gaps are wide, and the differing requirements of funders make heavy demands on hard-pressed managers. The unmet need for treatment and care is vast, while prevention remains the priority for the uninfected majority of the population. With increasing focus on development in Africa, HIV/AIDS plays a critical role because of its devastating impact on development.

The epidemic is highly diverse across the **East Asia and Pacific** region, and Government response has also varied, with decisive action in Thailand, Cambodia and Philippines showing success in preventing infections, whereas some countries still hesitate, and political commitment remains low. Other big issues include the difficulty of mobilizing multisectoral action and achieving the enabling legal environment needed to work effectively with high risk groups; poor surveillance especially of high risk groups; high rates of TB; and changing social patterns that increase vulnerability to infection.

In **Eastern Europe and Central Asia,** prevalence is still fairly low, but new infections are rising very fast, especially among young people, with injecting drug use driving the epidemic in many countries. TB has emerged as a parallel epidemic in some countries, because HIV-positive people are especially vulnerable to TB. Growing numbers of young women are infected, suggesting an increase in heterosexual transmission.

Much higher HIV prevalence in some **Caribbean** countries than in most of the rest of the **Latin America** region makes it a very heterogeneous group of countries. Some of the low prevalence countries are not doing enough to prevent infections, and program funding has been low and poorly targeted in many countries. Although most Caribbean governments are now responding, donors tend to overestimate their implementation capacity. Inadequate government ownership of programs also hampers implementation progress.

Although general prevalence rates are low in most of **South Asia,** large numbers of

Diversity and commonality across regions

	AFR	EAP	ECA	LAC	MNA	SAS
HIV/AIDS Situation						
Adult Prevalence Rates 2004	7.4	0.1	0.8	0.6/2.3*	0.3	0.6
PLWHA (millions)	25.4	1.1	1.4	2.1	0.5	7.1
Main bottlenecks/issues						
National Program not strategic, focused	X	X	X	X	X	X
Lack of donor harmonization	X	X	X	X	X	X
Implementation capacity shortfall	X			X		X
Overwhelmed health systems	X	X	X	X*		X
Inadequate surveillance data	X	X	X	X	X	X
Too little monitoring and evaluation	X	X	X	X		X
Denial ("not in our country")		X		X	X	X
Stigma—IDU, SW, MSM	X	X	X	X	X	X
High/growing prevalence among IDUs		X	X			

* Caribbean
Source: UNAIDS December 2004 (for prevalence rates and numbers of PLWHA)

people are infected in India, and many populations are made vulnerable by structural and socio-economic factors, including poverty and illiteracy, widespread denial, stigma and discrimination against PLWHA, women's low status, and high levels of commercial sex activity. Recent sharp rises in HIV among some groups with identified risky behaviors and in general adult prevalence in some Indian states are worrying. Although there are some effective prevention efforts underway, better targeting, coverage and quality are needed, and access to care and treatment is very low. Institutional and governance weaknesses in AIDS programs and health services delivery remain major challenges.

Data are so sparse that many countries in the **Middle East and North Africa** do not really know what their HIV situation is. Prevalence is low in the general population, but appears to be climbing in some high risk groups for whom data are available. Strong social stigma attaches to high risk groups where HIV typically takes hold first (injecting drug users, sex workers, men having sex with men) and there are few programs that address their needs. Vulnerability to the epidemic is increased by migration, high youth unemployment, conflict and security problems that make it difficult to implement programs, and cultural taboos against talking about sex that keep people ill-informed about HIV/AIDS.

Taking account of the commonalities and differences across countries and regions, this global Program of Action complements and supports the regional strategies, focusing its priority action areas on key common bottlenecks and barriers.

Notes

1. World Bank data prepared April 30, 2005 by the Global HIV/AIDS Program, World Bank. Washington, D.C. These data include the total committed amounts of HIV/AIDS projects, as well as HIV/AIDS components of over $1 million in projects classified under other sectors, using information provided by Task Team Leaders. The AIDS lending data recorded in the Bank's "Business Warehouse" (BW) differ because part of HIV/AIDS projects may be coded and counted under other topics such as gender, population, health systems, etc., and because coding of HIV/AIDS components may differ from the information provided directly to GHAP by TTLs.
2. World Bank 2005. Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance.
3. World Bank 2005.
4. World Bank 2005.
5. World Bank, October 2005. ACT*Africa* internal project monitoring data.
6. World Bank 2005.
7. See Annex 1 for summaries of the regional strategies and www.worldbank.org/aids for the full documents.

PART 2

The World Bank's Global HIV/AIDS Program of Action

This Global HIV/AIDS Program of Action commits the Bank to supporting more effective and comprehensive AIDS responses in five integrated action areas, which reflect: country needs; the Bank's mandate, capacity and comparative advantages; the findings of reviews of the Bank's work in AIDS; and the Bank's commitment to the "Three Ones" vision of one national strategic plan, one national coordinating authority and one national monitoring and evaluation system in each country. In addition to financial, technical and analytical support included in the six Bank regional HIV/AIDS business plans and strategies, and actions to mainstream AIDS into sectors beyond health, there are also actions to complement and support the regional operational work. Discussions with regional HIV/AIDS focal points, managers and Task Team Leaders in the Bank as well as with stakeholders outside the Bank have led to a consensus on the priority actions chosen.

The action areas endorsed are:

- Support for *strengthening national HIV/AIDS strategies,* to ensure they are truly prioritized and evidence-based , and integrated into development planning;
- Continued and sustained *funding* for national and regional HIV/AIDS programs, and for strengthening health systems, *to support effective HIV/AIDS* responses that are of sufficient scale and scope;
- *Accelerating implementation,* to increase the scope and quality of priority activities;
- Strengthening *country monitoring and evaluation systems* and evidence-informed responses, to enable countries to assess and improve their programs;
- *Knowledge generation and impact evaluation* of what works, as well as other analytical work to improve program performance.

These areas are closely interlinked. Strengthened strategic plans will require improved monitoring and evaluation systems and analytic work, and will guide the allocation of new funding. Accelerated implementation requires more effective partnerships. Strengthened national monitoring and evaluation systems and more evidence-informed programming requires rigorous analytic work, which in turn, requires more comprehensive and timely data from national monitoring and evaluation systems.

Bank support aims to be comprehensive, large scale, flexible, grounded in evidence, complementary, coordinated and aligned

The key principles that underlie the Program of Action are:

- The objective of the Bank's HIV/AIDS work is to support client country efforts to prevent new infections, and to treat and care for people who are infected and affected by HIV/AIDS.
- The Bank HIV/AIDS program needs to be at a scale capable of making a significant impact on the HIV/AIDS epidemic and its consequences.
- Bank activities must be firmly grounded in available and emerging evidence.
- It is important to be flexible, adapting to meet different needs in different locations, and to adjust actions in the light of new evidence.
- Bank resources will be used to complement funding available from other donor and national sources, in support of the efforts of the Global Task Team on Improving AIDS Collaboration Among Multilateral Institutions and International Donors
- The Bank will focus its efforts in areas where it has a comparative advantage and

can provide the most value-added. These areas include the ability to respond across many sectors; to provide long-term investments in health system strengthening; to access a wide range of policy makers including especially those responsible for finance, planning and macroeconomics; experience and commitment to participatory approaches that help empower communities; and extensive experience, know-how and lessons learned in program preparation and implementation.
- Partnerships are essential, to achieve concerted, harmonized AIDS responses aligned around country systems.

The goal is strategic, prioritized, costed national plans with clear targets, timeframes and accountability, informed by evidence

Strengthening strategic, prioritized responses

The MAP Interim Review and OED review drew particular attention to national strategic planning.[1] Under the agreements flowing from the Global Task Team on Improving AIDS Collaboration Among Multilateral Institutions and International Donors, the Bank, UNDP and UNAIDS have particular responsibility to assist countries to improve strategic and action planning. The MAP Interim and OED reviews note that few countries have adequately incorporated AIDS into PRSPs or other overall national planning and budgeting processes. They acknowledge that many countries have now prepared national strategic AIDS plans, which have elevated commitment, broadened the response, and increased stakeholder engagement. However, they note that national plans do not serve as genuinely strategic tools for guiding and prioritizing action. Most plans are not informed by epidemiological information or rigorous analysis of effective approaches. They are all-encompassing and do not prioritize. They lack clear goals and responsibilities. They tend to be uncosted or unrealistically costed. They seldom identify the specific actors and responsibilities required to realize their strategic vision.

Under the aegis of the program of action of the GTT, the Bank, in collaboration with UNDP and other partners, will make a major commitment to assist countries to strengthen strategic, prioritized national plans, which have: a sound epidemiological foundation and evidence-informed approaches; well defined goals and targets; explicit priorities; systematic planning; well identified timeframes; clear plans for monitoring, evaluation and knowledge utilization; clearly specified implementing actors and responsibilities; detailed cost estimates; strategies for resource mobilization; and analysis of the institutional and human resources required for effective action.

The following activities will be undertaken to strengthen national strategic planning as the basis for results-oriented actions:

- develop practical guidelines for effective, strategic, prioritized planning that guides results-oriented actions
- prepare good practice notes, highlighting examples of sound national strategic planning
- develop strategic planning training courses and train Bank staff, consultants, development partners and national counterparts in multi-sectoral strategic planning
- provide technical support for national strategic planning
- support the development of a network of country practitioners, enabling clients to develop and share national expertise in strategic planning
- strengthen the links from knowledge generation and impact evaluation to prioritization of interventions and program design
- encourage and support countries to write synthesis papers, analyzing their HIV epidemiological data and responses, and identifying priorities, as a basis for better informed strategic planning.

HIV/AIDS needs to be integrated into national development planning efforts. The Regions and the Global HIV/AIDS Program (GHAP) will continue working with PREM colleagues, client country counterparts, the IMF and other international partners such as UNDP and the UNAIDS Secretariat to better integrate HIV/AIDS planning into national development planning and financing, and especially in Poverty Reduction Strategies (PRSPs), CASs and Medium-Term Ex-

penditure Frameworks (MTEFs). An HIV/AIDS dimension will be added to the Operational Guidelines for PRSPs and Joint Staff Assessment criteria for PRSPs in countries with high or rapidly rising HIV levels. The Global HIV/AIDS Program Monitoring and Evaluation Team (GAMET) will provide more analytical and advisory services to assist key stakeholders (especially Ministries of Finance and Planning and Bank Country Teams) to give appropriate priority to HIV/AIDS interventions in PRSPs and MTEFs. CASs should make explicit (i) the rationale for including or excluding interventions to support the national AIDS response, and, where relevant, (ii) how Bank projects and policy-based lending will help a country attain its HIV/AIDS objectives.

Rigorous, genuinely strategic national plans provide an essential platform for concerted, coordinated, effective AIDS responses that, along with the other action areas, will help the Bank to contribute to better success in preventing new infections and increasing the healthy years of life of people with AIDS.

Funding national and regional HIV/AIDS responses and strengthening health systems

Bank funding for HIV/AIDS

The Bank will remain a major financer of AIDS activities globally, alongside the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Government and the United Kingdom (DFID) and other financing partners. The Bank's financing role increasingly will reflect its greater flexibility with respect to both the countries and range of activities it can finance. Thus the Bank is likely to remain a major source of finance for HIV/AIDS in many of the lowest income IDA countries, particularly those in central and west Africa with limited access to other AIDS funding. The Bank can also lend to middle-income IBRD countries that are ineligible for other sources of financing. The Bank has demonstrated an ability to establish AIDS programs in post-conflict countries, often more rapidly than other major financing mechanisms. The ability to fund regional programs enables the Bank to support HIV/AIDS efforts in countries that are ineligible for national assistance, and for cross-border activities. Predictable, multi-year Bank funding can help countries ensure sustainability of their HIV/AIDS programs.

Within countries, the Bank will use its flexibility to finance major gaps in HIV/AIDS programs that other funders cannot address as effectively. Specific examples include financing long-term institutional and operating costs, and activities and commodities that may be controversial, including clean needle programs to reduce HIV transmission among injecting drug users and condoms to prevent HIV transmission among sex workers and their clients. Bank procurement procedures that require countries to purchase competitively at least cost can have positive spill-over into better use of other sources of funds as well.

AIDS financing will increasingly reflect the Bank's flexibility with respect to the countries and activities it can fund

The Bank will support country efforts to ensure that prevention and treatment interventions are informed by the evidence on quality and outcomes. In prevention, the Bank's support will take into account the fact that epidemiological risks vary across and within populations and age groups. The Bank will support countries to address the dual TB/HIV problem, particularly in sub-Saharan Africa and Eastern Europe and Central Asia.

The Bank's ability to fund HIV/AIDS programs is subject to client countries' decisions to borrow. The Bank hopes to commit additional funding for HIV/AIDS programs in the following countries in the coming three years (either in dedicated HIV/AIDS projects, or as part of broader support): Albania, Argentina, Benin, Bhutan, Burkina Faso, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Ethiopia, Eritrea, the Gambia, Ghana, Guinea, Guinea Bissau, India, Kenya, Kyrgyz Republic, Madagascar, Mali (within a transport project), Niger, Nigeria, Senegal, Sierra Leone, Suriname, Togo, Uganda, Zambia, and multi-country projects in the Abijan-Lagos Corridor, and in the Mercosur countries.

The current three-year round of concessional financing, IDA14, has no resources earmarked specifically for HIV/AIDS, and

eligibility for grant funding (rather than repayable credits) has changed to depend primarily on each country's risk of debt distress.[2] Countries whose IDA funds are not given as grants may be less willing to request IDA funding for investing in HIV/AIDS than during the previous three years, when all IDA funding for HIV/AIDS was provided as grants.

Strengthening health systems and the capacity for service delivery

Strengthening health systems and services is a crucial part of HIV/AIDS programs and broader health sector support

Given the demands that HIV/AIDS makes on the health sector in its key role in prevention and treatment, and the weaknesses in health services delivery in many countries, the HIV/AIDS interventions that the Bank supports in the health sector need to be designed to help strengthen the health care delivery system. The Bank will continue to provide funding and support to strengthen health systems and client country capacity for service delivery, as part of HIV/AIDS program funding, and/or within broader health sector support.

Depending on country decisions, new health sector funding may be committed in the coming three years in Africa in Burundi, Cameroon, Democratic Republic of Congo, Côte d'Ivoire, the Gambia, Ghana, Lesotho, Madagascar, Mali, Mauritania, Niger and Zambia; in the East Asia and Pacific region in Cambodia, Indonesia, Lao People's Democratic republic, the Philippines, Timor-Leste and Vietnam; in Europe and Central Asia in Albania, Azerbaijan, Croatia, Kyrgyz Republic, Moldova, Poland, Tajikistan, Turkey and Ukraine; in Latin America in Brazil, Colombia, Ecuador, Panama, Paraguay, Peru, Uruguay and Venezuela, as well as in India, Lebanon and the West Bank and Gaza.

Several key aspects of health systems are likely to receive particular attention:

- To strengthen governments' *capacity to perform key public health roles,* in collaboration with specialized institutions, the Bank will support the following cross-cutting issues that are relevant to HIV/AIDS: (i) formulation of public health policies for disease control and services with positive externalities, (ii) epidemiological surveillance, reporting and response, (iii) standard setting and regulation of the public and private sectors and civil society organisations (CSOs); (iv) improvement of local capacity in public health and epidemiology; (v) monitoring social and geographic inequities in outcomes that are amenable to affordable services and to changes in individual or household behaviour; and (vi) enhancing capacity for behaviour change communication.
- *Health human resources:* Upgrading skills and expanding capacity for training different cadres of health care workers, and better incentives to retain and deploy health care workers where they are needed most.
- The Bank will provide financing and advisory services to improve local capacity for managing logistics of pharmaceuticals and other supplies, procurement and financial management, health management information systems, and health care waste management systems.
- Upgrading of health care *facilities,* medical laboratory infrastructure and services to enhance diagnostic capacity.
- Some countries are working with the Bank to design incentives for better outcomes in the health sector; if successful, this approach could be expanded.

The Bank will continue to participate with partners in efforts to seek common approaches and policies to key areas of health system strengthening, and to take forward the work of the Global Task Team on Improving AIDS Collaboration Among Multilateral Institutions and International Donors, the High Level Forum, Joint Learning Initiative, Global Health Council and the recommendations of the World Health Assembly, to strengthen key aspects of health systems and health service delivery at country level, within a sustainable fiscal framework.

Supporting stronger HIV/AIDS responses in other key sectors

The Bank is also working with client countries and other key partners to support stronger HV/AIDS responses in selected key sectors and areas (in addition to health), es-

pecially in education, legal, gender, youth, transport, infrastructure and the private sector. GHAP and other Bank staff working on AIDS will support and encourage efforts to mainstream effective HIV/AIDS interventions into the work of other sectors in the Bank.

In the **education sector,** HDNED's School Health program will continue working, at the request of the regions, to support Africa, LAC and SAR's efforts to accelerate and enhance the education response to HIV/AIDS. This will be done by working through national education systems, in the context of efforts to achieve the MDG and Education for All goals. The country level work focuses on implementing activities in schools and communities, and regional level work focuses on strengthening leadership and sharing knowledge. The emphasis is on prevention—especially for girls—and ensuring access to education for orphans and vulnerable children, and addresses the response at all educational levels. A key element is to help the education sector make use of resources within the sector as well as funds available specifically for HIV/AIDS efforts. Good practice examples in school-based prevention programs, in programs to increase access to school for HIV/AIDS orphans, and explaining the role that teachers can play in addressing HIV/AIDS will be documented and widely disseminated. This work benefits from the collaborative effort of the Working Group of the UNAIDS Inter Agency Team for Education to accelerate the education sector response to HIV/AIDS.

Transport and infrastructure: All construction contracts with Bank funding should include HIV/AIDS activities (condom distribution and IEC, and treatment could also be included). "Good practices" will be highlighted to help companies do this in an effective way. The Transport Sector Board, with GHAP and health sector colleagues, will develop an action plan to ensure a more proactive HIV/AIDS response in the transport sector across the Bank. In India and Africa, HIV/AIDS activities will be incorporated into all new transport and infrastructure projects, and added to existing projects in Africa during mid-term reviews. In West Africa, the HIV/AIDS project for the Abidjan-Lagos transport corridor is beginning to offer useful lessons that could be applied in other corridors, specifically in a proposed new HIV/AIDS transport corridor project in Southern Africa. The Africa Transport Group are working with key transport sector decision makers in Anglophone and Francophone countries, to support development of policies on HIV/AIDS for transport workers, implementation plans, and local networks for sharing information and advice.

The **Urban Sector** will continue to support Local Government Responses to HIV/AIDS in several ways, including: (1) supporting urban operational units to mainstream HIV/AIDS responses into their policy dialogue and projects; (2) supporting local governments directly by providing them with updated and enhanced training material and toolkits; (3) ensuring that local governments and decentralized responses are adequately taken account of in the design and implementation of multi-sectoral HIV/AIDS programmes; and (4) supporting relevant analytical work including analysis of the impact of HIV/AIDS on the urban sector. In addition, the Bank will continue to coordinate and engage with external partners to share best practice, knowledge and practical guidance.

Work will continue to mainstream effective HIV/AIDS interventions in key sectors in addition to health

In the **legal** sector, the work will focus mainly on how to improve laws that could protect PLWHA against discrimination and protect children orphaned or made vulnerable by AIDS; and advice on intellectual property rights (patents) and international trade law relating to pharmaceuticals (especially generic ARV drugs).

With respect to **gender dimensions** of HIV/AIDS, the PREM Gender and Development Group (PRMGE) will continue and expand analytical and operational work to integrate a gender dimension into HIV/AIDS policy and operations, building on the new Operational Guide on Gender and HIV/AIDS.[3] The main focus will be collaboration with associations of judges and women's lawyers, government agencies and civil society groups, to strengthen capacity among law, justice, medical and health sector institutions and professionals to address the gender and legal dimensions of

HIV/AIDS. Relevant topics will include the gender-responsiveness of existing legal frameworks in the HIV/AIDS setting, in such areas as customary law/practices, religious laws, land law, inheritance and property rights, family law, women's rights issues in the context of gender-based violence, and the links between HIV/AIDS and conflict, post-conflict reconstruction and trafficking in women and girls.

Accelerating implementation

Ongoing and new efforts will support faster, more efficient, effective and transparent implementation of HIV/AIDS programs

The GTT noted that improving program implementation at country level and ensuring better coordination and harmonization on the part of donors are essential to accelerating and maintaining the world's response to the HIV/AIDS epidemic. The "implementation gap" can be substantially reduced if countries and donors use exceptional policies and procedures commensurate with the exceptional nature of the epidemic, and if implementation by key stakeholders in the public and private sector and in civil society becomes faster, more efficient, effective and transparent. While the most flexible and least bureaucratic Bank instrument—the Africa MAP—is disbursing at about 90 percent of original projections, higher than average for Bank lending in general, this pace is still insufficient to deal with the challenges in prevention, care and treatment and impact mitigation. The Bank has reaffirmed its commitment to improving implementation as one of its areas of focus in the division of labor between agencies through the Global Task Team.

To further accelerate and strengthen HIV/AIDS program implementation, the Bank will:

- Continue to provide financial and technical support through lending and Institutional Development Fund grants to countries to enhance capacity and systems, improve human resources, infrastructure and equipment, and fund essential administrative and operating costs of their HIV/AIDS programs over the medium to long term.
- Continue to support the global partnership on ARV procurement and logistics management capacity building, including holding national and regional training workshops.
- Based on learning and experience, continue to simplify operational processes and guidelines for HIV/AIDS projects and encourage countries to use exceptional implementation procedures (such as outsourcing fiduciary management).
- GHAP will continue to work with the regions to ensure that AIDS project supervision is adequately funded, and to raise and use TF resources to provide the additional implementation support needed to deliver the comprehensive, flexible and adaptable "program support" on which the MAP approach is built.
- The Bank's Implementation Acceleration Team (IAT) comprises key staff from across the Bank working with OPCS and TTLs to see where Bank policies need to be streamlined or simplified to facilitate MAP implementation. This team will be strengthened, drawing on expertise from across the Bank, to become an AIDS Implementation Advisory Service (IAS) that will work with countries and Bank project teams, especially in the areas of planning, budgeting, program design, financial management, disbursement and procurement, expenditure tracking, and scaling up programs in the public and private sectors and in civil society. This will build on the work of the IAT and of ACT*Africa*, moving into a new phase that goes beyond looking at Bank policies and procedures to the way they are in fact practiced, and work with Bank teams and country counterparts to improve practice on-the-ground. We will use country, regional and global publications, workshops for regional learning, implementation advisory service missions to countries, and operational guidelines for the Bank, and potentially for other donors, to carry out this work.
- The private and non-profit sectors, civil society groups, communities and people living with HIV/AIDS are essential partners in every country. The regions and GHAP will continue to support the active involvement of private sector and civil society organizations, including FBOs, to scale up and manage HIV programs. Depending on country needs, this may include (i) supporting policy changes to

allow scaled-up contracting of services to NGOs (e.g., legal frameworks, registering of NGOs); (ii) providing conditional cash transfers to communities to help care for those most affected by the epidemic and continuing to ensure wide access to MAP and other donor funds, through competitive, transparent and results-based processes; (iii) encouraging governments to promote greater diversity in service delivery systems; (iv) hands-on in-country work with national AIDS commissions, ministries, donors, business and labor organisations, civil society groups including FBOs and communities to create mechanisms and energize partnerships to address HIV/AIDS.

- GHAP and the Bank's regional units will generate and capture knowledge about good HIV/AIDS implementation practices, which GHAP will make widely and readily available. GHAP will assist the Bank's regional units to create networks of program practitioners to exchange experiences, knowledge and practical advice across countries and globally that will encompass general operational issues, the fiduciary architecture, and special programmatic themes. These efforts will support the GTT's commitment to better implementation of the Three Ones.

Accelerated implementation of AIDS projects and programs—especially care and treatment for infected people—requires strong health systems. The broader work of the Bank's HNP sector in strengthening health care systems is crucially important, and the GHAP will look for opportunities to work with the HNP group and relevant units in WHO to enhance and support this work.

Strengthening country monitoring and evaluation systems and evidence-informed responses

AIDS resources have grown rapidly in recent years, from US$300 million in 1996 to US$8 billion in 2005.[4] As the GTT noted, the critical need to ensure that available resources are used effectively places unprecedented responsibility upon country monitoring and evaluation systems. Improved national systems require a sustained commitment to capacity building and systems development, particularly in countries with limited public sector capacity and human resources, challenges exacerbated by poverty and AIDS mortality.

Many countries have elements of an HIV/AIDS monitoring and evaluation system in place, but few countries have comprehensive monitoring and evaluation systems, which track both the epidemic and national responses to the epidemic and use the results for program improvement. A comprehensive M&E system comprises the following components:

- One overall national M&E system, with a guiding flowchart, which specifies precisely how data flows from each M&E component and each level, to a single overall national data repository.
- Biological surveillance (of HIV status), to assist countries to implement sound, regular, credible, affordable, HIV surveillance of the general population and vulnerable groups, in keeping with international best practice.
- Behavioral and social surveillance, to assist countries to implement sound, regular, credible, affordable surveillance of key behaviors among the general population and priority groups, based on international best practice.[5] When combined, biological and behavioral surveillance constitute a second generation surveillance system, in which behavioral and biological data and trends are examined together, for reciprocal elucidation and greater understanding of the epidemic and behaviors contributing to it.
- Health facility surveillance, to continually assess the coverage and quality of essential HIV related health services.
- Research, to address key AIDS prevention, care and treatment research questions.
- Program activity monitoring, to assist countries to track HIV/AIDS related activities and services. The goal is for all implementing partners to submit regular, structured program monitoring reports to a well-functioning system, to enable national AIDS program coordinators continuously to assess the scope and quality of key interventions and identify and address gaps and limitations promptly.

Good monitoring and evaluation systems track the epidemic and national response, informing decisions to improve program impact

- Financial monitoring, to enable countries to track expenses, cost services and corroborate program activity reports.
- Program impact evaluation, to guide allocation of resources and effort.

The GTT recently reaffirmed the Bank's particular responsibility, in collaboration with the UNAIDS Secretariat, for strengthening country monitoring and evaluation systems.[6] The Bank established the Global HIV/AIDS Monitoring and Evaluation Team (GAMET) to provide country support. In cooperation with UNAIDS cosponsors and other partners within the framework of the Monitoring and Evaluation Reference Group (MERG), GAMET will continue to provide M&E support through the following activities:

The Global AIDS Monitoring and Evaluation Team (GAMET) provides practical, in-country support

- Developing and regularly revising guidelines for national monitoring and evaluation systems.
- Preparing good practice notes that highlight examples of promising national responses.
- Co-facilitating global, regional and national M&E training courses.
- Continuing to build one unified, multi-agency, global country support team (CST) of international monitoring and evaluation specialists, who provide intensive practical monitoring and evaluation field support to countries.

As a major source of practical, in-country M&E support, the country support team undertakes the following activities in order to support the development of national monitoring and evaluation systems:

- Coordinated, multi-agency country support visits, to understand monitoring and evaluation needs and priorities.
- Harmonized and participatory development of national monitoring and evaluation frameworks, with indicators.
- Working with development partners and countries to: develop operational plans, including detailed descriptions of essential actions to strengthen biological, behavioral and health facility surveillance; enhance evaluation research; and develop program and financial monitoring systems.
- Jointly training national AIDS authorities and implementing partners; and
- Working together to provide case-specific assistance, including diagnosis and troubleshooting, using the complementary strengths of major development partners.

Through these activities, GHAP and partners will collectively and jointly assist a progressively larger number of countries to develop comprehensive, functioning monitoring and evaluation systems. This work will be done in collaboration with technical staff of other agencies who are also assigned to help build country M&E capacity, to work together to realize this part of the "Three Ones" vision at country level.

The Bank and partners will also assist countries to use their monitoring and evaluation systems to promote effective, evidence-informed prevention, care and treatment responses. Few countries base their responses on a rigorous analysis of national HIV transmission dynamics and priorities for effective interventions, or undertake rigorous impact evaluation. Numerous reviews draw attention to the need for more selective, evidence-informed national responses. By strengthening national monitoring and evaluation systems as described above and intensifying analytic work as outlined below, the Bank, working with specialized technical agencies and research institutions, will assist countries to implement strategic, data-driven, evidence-informed approaches. This will increase the impact of investments in HIV/AIDS programs.

The Bank HD Network Chief Economist leads a team that provides advice and help to Bank staff for designing ways to generate knowledge about good practices and to evaluate the impact of Bank-funded projects, with the goal of learning what works, what doesn't, and why. The regions and GHAP will encourage TTLs of HIV/AIDS projects to take advantage of this support, and will document and share good practice examples and evaluation results.

Knowledge generation and sharing, impact evaluation and analysis

There are many aspects of the epidemic about which much remains to be learned.

There is a need for country-specific analytic work to help make important policy and program decisions. The analytic work included in regional and country work plans will address key country-specific issues. GHAP will support cross-cutting and cross-country analytical work in priority areas, working with DEC, PREM, the IMF and other researchers, especially those with a strong client-country presence. Working with specialized technical agencies, the Bank will sponsor or conduct operational research on key issues related to large-scale antiretroviral treatment in resource-limited settings, including quality, effectiveness, impact and outcomes, and risk behaviors of people on ARV treatment.

Knowledge generation and impact evaluation about what works

The international community must significantly improve the effectiveness of HIV/AIDS responses in order to reduce new infections and meet the needs of people affected by and living with HIV/AIDS. Currently, there is insufficient evidence on "what works" when it comes to issues as diverse as fighting communicable diseases among groups with high-risk behavior or ensuring access to health care in resource-poor communities. As a result, national strategic plans and donor funding decisions are frequently devised without the benefit of sound evidence-based analysis.

By virtue of its focus on long-term development, the World Bank is in a unique position to play a leading role in providing policy advice and programs that are evidence-based. By building upon its lending and non-lending activities, the World Bank can establish a continuous and deliberate process of learning and sharing information and applying the acquired knowledge to program design. Establishing such a systematic process will assist governments, the Bank and its development partners to devise increasingly effective AIDS responses. To implement this, the Bank will do the following:

- *Carry out impact evaluations of development programs.* Through its involvement in HIV/AIDS projects, the Bank supports implementation of the AIDS response in over 70 developing countries. The Bank will use this existing project infrastructure to carry out impact evaluations of its interventions. To do this, additional resources and technical assistance will be provided to project task teams by GHAP which will mobilize trust funds to support this effort.
- *Carry out prospective evaluations of new HIV/AIDS projects.* Prospective evaluations are time sensitive and need to be designed, and baseline data collected, before the implementation of a project begins. An expert consultative group will be formed to help develop carefully planned and scientifically sound prospective evaluations of new HIV/AIDS projects.

Analytical and advisory activities

Planned country-specific and regional analytic work covers the following areas:

- *HIV/AIDS country situational analyses* in Maldives, Afghanistan
- *Analysis of treatment options* in Nepal, Bhutan, Thailand
- *Evaluation of different prevention strategies* in Bangladesh, Pakistan, Bahamas, comparative assessments of the Ukrainian and Russian National HIV/AIDS Programs, assessment of the HIV/AIDS public information campaign in Russia
- *Estimates of the economic impact of HIV/AIDS or links with poverty* in Argentina, India, Jamaica and Grenada
- *Studies on mobile populations* in Caribbean and Central America
- *Analysis of AIDS expenditures* in India, China, Cambodia
- *Local government, community or NGO responses to HIV/AIDS:* Africa (local governments) and Ethiopia (communities), Caribbean (NGOs and private sector)
- *Assessments of legal and regulatory issues* (including implications of trade agreements) relating to pharmaceuticals, discrimination against PLWHA, protection of children orphaned by AIDS in Africa, Caribbean and Central America and in selected countries in South Asia.
- *Operationalizing the "Three Ones"*, joint work with WHO, DFID, SIDA and UNAIDS in Russia

New country-specific and cross-cutting analyses will increase our understanding of HIV/AIDS and what works

- *Analysis of health systems, health sector service delivery issues or institutional issues* in Argentina, Azerbaijan, Bulgaria, Burundi, Indonesia, Jordan, Madagascar, Mauritius, Nepal, Nigeria, Oman.
- *Analysis of implementation constraints* in the Caribbean.

New global and cross-cutting analysis to be funded or undertaken by GHAP, DEC, PREM, HDNED, LEGVP and other key units in the Bank is likely to include:

- *Analysis of the links between poverty, gender and HIV,* including the likely interaction between HIV programs and broader efforts to reduce poverty; and the long-term impact of HIV and higher mortality. The work will assess the extent to which public expenditures on HIV/AIDS treatment, care and impact mitigation reach poor people, and mechanisms for improving targeting.
- *Analysis of the economic and budgetary implications and fiscal impact of HIV,* looking at expenditures and revenues, costing the national HIV response, and assessing the impact on economic performance and on the skilled labor market in the public and private sectors, notably health, education, agriculture and the civil service. GHAP will offer funding to key sectors in the Bank (such as education and social protection) to analyze the impact of AIDS in specific sectors and actions to mitigate the effects.
- *Analysis of potential policy and program trade-offs,* including how to ensure enough attention is given to prevention, care and treatment and mitigation, the implications of long-term and short-term responses, the comparative costs and benefits of different approaches, and operational research on quality and cost tradeoffs, and resource requirements for deploying new diagnostics and treatments. This research will contribute to policy discussions and decisions at the country level.
- *Analysis of institutional and structural factors that influence program effectiveness and response effectiveness of public sector agencies,* including decentralization, human resource policies, service delivery capacity, means of delivery (whether public, private or CSOs, for example) and market incentives.
- *Lessons from operational experience,* including evidence of the effects of Bank support on service delivery, and on the performance of key entities with the biggest responsibility for aspects of HIV/AIDS programs that depend on health systems; comparisons of the effectiveness of different programs; and donor coordination and harmonization efforts especially at country level.

Knowledge sharing, dissemination and use

Research findings and lessons of experience need to be shared widely and quickly, to inform decisions

Research findings and emerging lessons of experience need to be shared widely and quickly, so they can be incorporated into programming decisions. More will be done to share analytic and program/project results broadly and to target potential users during program/project planning and implementation. Full use will be made of existing distribution and dissemination channels, including conferences and workshops, journals, newsletters and list-serves and communities of practice. State-of-the-art workshops, conferences and debates will be convened as needed, to discuss latest research and thinking, good practice and lessons of experience on current controversial and cross-cutting issues on HIV/AIDS prevention, care and treatment.

The Bank will develop and implement a *core learning program for Bank staff* on the epidemiology of HIV/AIDS, with emphasis on the analytical basis for improved decisions in program design, as well as appropriate indicators for monitoring and evaluation, and on the "Three Ones" principles and how Bank staff can help realise the vision in the countries where they work.

The Bank's *AIDS website* will be improved and used to provide quick and easy, user-friendly access to information on Bank supported HIV/AIDS project and Bank reports, papers, manuals, etc. on HIV/AIDS. The "revamping" will ensure that the users will easily be able to find information on the Bank's work on HIV/AIDS. The country HIV/AIDS synthesis papers referred to earlier will be published and posted on the website, and a new series of HIV/AIDS Discussion Papers will speed up publication and dissemination

of new analysis. The Bank will make its work available in a wider range of languages, to increase accessibility.

A *new series of short reports and notes* highlighting examples of HIV/AIDS work will be developed in collaboration with UNAIDS, to share operationally useful information and experience.[7] These notes will help to publicize national and cross-country lessons of experience quickly. The topics will include examples of GAMET's work on monitoring and evaluation, good examples of work with and being done by CBOs and NGOs; good examples of school-based HIV prevention programs and efforts to ensure access to school for orphaned children; and good examples of country-level donor harmonization and coordination.

New *Guidelines* to be developed and published include the following topics:

- preparing HIV/AIDS projects in a post-conflict setting
- legal aspects of HIV/AIDS (primarily for Bank staff)
- legal protection for children orphaned or made vulnerable by HIV/AIDS (primarily for governments)
- Guidelines on how India's new patent law relates to HIV/AIDS drugs.

The Bank will support opportunities for countries to share their experiences, through networks of practitioners and "south-south" consultations on topics of shared importance, such as the consultation planned among Pakistan, Afghanistan and Iran on harm reduction and high risk groups. Other examples of similar efforts being supported by the Bank include technical cooperation visits and virtual meetings among Moldova, the Ukraine, Russia and Brazil; "twinning" arrangements between the Caribbean and Central Asian regional HIV/AIDS organisations, and between the Russian business council on HIV/AIDS and the European Branch of the Global Business Council and the Brazilian Business Council on HIV/AIDS.

Working together

The GTT emphasizes that effective partnerships are essential to ensure coordinated and harmonized national AIDS responses of sufficient focus, scope and quality to reduce HIV transmission, and achieve the international AIDS targets outlined in the MDGs and UNGASS. Strong working partnerships at country level are also key to putting the "Three Ones" vision into practice. The importance of the "Three Ones" principles was also reaffirmed in the G8 Gleneagles Communiqué.

Within the Bank, the Global HIV/AIDS Program and regions will continue to work closely together, to ensure that the overall and regional AIDS strategies are coordinated and complementary and reflect an optimal division of responsibilities. GHAP will intensify its cooperation with PREM, to strengthen economic analysis of the epidemic and its links to poverty, gender and vulnerability. With the IMF, the Bank will help countries to integrate HIV/AIDS into their overall budget planning and management processes, including Medium Term Expenditure Frameworks and PRSPs. GHAP will work closely with HNP, whose leadership in efforts to strengthen health systems and health services delivery and health financing is crucial to country capacity to address HIV/AIDS. Work with the Education group (HDNED) will continue, to promote a broader, more effective education sector response, and to extract and build on what has been learned so far. GHAP will also continue to work with the Legal Unit and Gender group. New work will be initiated with the Transport Sector Board, to better integrate HIV/AIDS into transport activities, and with HDNDE, to understand how the Bank can best work with religious and faith leaders and institutions on HIV/AIDS. GHAP and the regions will also continue to work in close concert with IFC Against AIDS, in order to strengthen private sector AIDS responses. The work led by WBI will continue to provide training to staff and clients in priority areas, especially program management, and ARV procurement and supply management.

Strong global and country-level partnerships will help realize the "Three Ones" and ensure coordinated, harmonized, effective support

The World Bank's many external AIDS partnerships include the UNAIDS secretariat and other cosponsors, major international financing agencies, PLWHA and other civil society groups, and the private sector. The

Bank's partnership with UNAIDS and other cosponsors will continue to be of the utmost importance, particularly in light of joint actions recently agreed as part of the GTT. Within the UNAIDS family, the Bank has formal responsibility for economic analysis and the development of country monitoring and evaluation systems and is also recognized for its leading role in strategic planning, institution building and implementation, which are all reflected in the priority areas of this Program of Action.[8]

Civil society, including people living with HIV/AIDS, and the private and non-profit sectors all have key roles

With respect to civil society, including people living with HIV/AIDS, a large and growing literature attests to the importance of continued strong Bank efforts to foster community leadership and engagement in AIDS prevention, care and treatment. The Bank will strengthen its partnerships and continue to provide financing, through national structures, to civil society at all tiers, including non-government, faith-based and community organizations, and local universities and researchers.

The Bank will also strengthen its partnerships with the private sector to leverage increased private sector resources for AIDS, enlist the private sector's expertise and capacity in the fight against AIDS and utilize the private sector's enormous reach to increase the coverage of essential AIDS prevention, treatment and care services. The interests of private and public sector players can diverge, so public-private partnerships need to be structured well, to take advantage of potential synergies.

The broader perspective

Recognizing that a "business as usual" response to HIV/AIDS was grossly inadequate, in the new Millennium the Bank launched its innovative MAP program to support quick, forceful, substantial and sustained action against the epidemic in as many client countries as possible. Many lessons have been learnt in the process and are reflected in the priority actions in this program. Momentum must be maintained, because millions of lives and the development gains and prospects of many countries are at stake. The effect of AIDS in slowing or even reversing progress towards many of the Millennium Development Goals (MDGs) is clearly evident in Africa.

The MDGs envision that by 2015 the world will have halted and begun to reverse the AIDS epidemic.[9] The *Declaration of Commitment* on HIV/AIDS—unanimously adopted by UN Member States at the unprecedented UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001—includes a comprehensive set of concrete, time-bound targets to elicit effective global, regional and national responses to the epidemic.[10] This Program of Action reflects and furthers the

Civil society and communities play key roles in responding to AIDS

Civil society plays a vital *advocacy* role, spurring countries to intensify AIDS prevention, care and treatment programs. Widespread community engagement *reduces stigma,* pierces denial, promotes personal risk perception, and instils personal proximity to the epidemic, helping *change community norms and individual behaviors* in ways that reduce HIV transmission. In addition, civil society and community partners can play a critical role in *implementing* AIDS activities in both concentrated and generalized epidemics, and promoting interventions that reach marginalised groups at high risk and with high rates of HIV infection.

In Brazil's concentrated epidemic, for example, vulnerable community members played a major role in mobilizing effective prevention, care and treatment responses among men having sex with men, injecting drug users and sex workers. In Uganda's generalized epidemic, the involvement of community and faith-based leaders played a major role in reducing stigma, increasing communication about AIDS, increasing personal risk perception, changing community norms and promoting safer sexual practices. In Thailand and elsewhere, civil society and community partners have demonstrated an ability to motivate people with AIDS to seek antiretroviral therapy and to adhere to treatment regimens.

Millennium Development Goal	Africa Progress	AIDS effect
Reduce poverty/hunger	Stagnant at best	Large
Universal primary education	Lagging	Moderate
Gender equality	Lagging	Large
Child & infant mortality	Worsening	Large
Maternal health	Worsening	Large
Combat AIDS & diseases	Worsening	Large
Environmental sustainability	On track	Minimal
Improve global partnerships	On track	Favorable

Bank's commitment to support national governments and programs as they strive towards these important goals.

The fight against HIV/AIDS has entered a new phase. In the 24 years since the virus was identified, much has been learned about its epidemiology and about prevention, treatment and care. The recent enormous increase in funding offers new potential to put our accumulated knowledge into action, on an unprecedented scale. HIV/AIDS used to be seen as a health problem, now it is recognized as a broad development problem. What started as an emergency response has become a long-term commitment. The initial few agencies working on HIV/AIDS have been joined by many more, and the efforts and resources of all are desperately needed. But these efforts must be harmonized and coordinated to provide efficient and effective support to countries, instead of deluging countries with multiple demands and pulling them in many different directions.

This Program of Action embodies the World Bank's commitment to work with our colleagues, partner agencies and client countries, doing all we can, as best we can, to prevent new infections and treat and care for people infected and affected by HIV/AIDS, guided in each country by one strong national HIV/AIDS program, coordinated by one national authority, and monitored and evaluated within one national system.

Notes

1. World Bank. October, 2004. Interim Review of the Multi-Country HIV/AIDS Program for Africa, and World Bank. 2005. Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance.
2. The changes in criteria for financing terms (all grant, half grant/half credit, or all credit) are summarized and explained in a note issued to Word Bank staff in March 2005: "Summary of IDA14 Policies for Operational Staff". IDA14 resources for grant funding are 20% greater than under IDA13. The net effect on funding that will be extended for HIV/AIDS as grants under IDA14 remains to be seen, although it is expected that about 30% of all IDA14 funding will be provided as grants. Only the 81 poorest countries with per capita GNI below $895 are eligible for IDA funding; these changes have no effect on Bank financing on IBRD terms available to higher-income countries. More information is available at: www.worldbank.org/IDA
3. Integrating Gender Issues into HIV/AIDS, An Operational Guide. 2004, Gender and Development Group (PREM), World Bank. http://www.worldbank.org/afr/aids/map/Gender_and_HIV-AIDS_Guide_Nov-04.pdf
4. UNAIDS. 2004 Report on the Global AIDS Epidemic.
5. Key behaviors to monitor are: age of sexual debut, multiple partners, commercial sex and condoms use.
6. UNAIDS. 8 April 2002. *Convening Agencies: Role and Responsibilities.* Geneva: UNAIDS.
7. These would complement the UNAIDS "Best Practice" collection.
8. UNAIDS. 8 April 2002. *Convening Agencies: Role and Responsibilities.*
9. United Nations General Assembly. 2000. "United Nations Millennium Declaration." [www.un.org/].
10. United Nations General Assembly 2001. "Declaration of Commitment on HIV/AIDS." New York.

Matrix 1: Global AIDS Program of Action—Matrix of goals, actions, timing and accountability

Goal	Specific Actions	Timeline	Key Accountability
Action Area: Assist countries to strengthen strategic, prioritized costed national planning, as agreed by the GTT			
Countries develop strategic, prioritized, costed national HIV/AIDS plans	Develop practical guidelines for effective, strategic, prioritized planning	FY06	GHAP, UNAIDS
	Prepare good practice notes, highlighting examples of sound national strategic planning	FY06-FY08	GHAP, Regions
	Develop strategic planning training courses and train National counterparts, Bank staff, development partners and consultants in strategic planning	FY06-FY08	GHAP, WBI
	Provide technical support for national strategic planning	FY06-FY08	GHAP, Regions
	Support the development of a network of country practitioners, enabling clients to develop and share national expertise in strategic planning	FY06-FY08	GHAP, Regions
	Strengthen links from knowledge generation and impact evaluation to improve prioritization and program design	FY06-FY08	GHAP, Regions, DEC
	Assist countries to write synthesis papers, analyzing their epidemics and optimal responses, as a basis for better informed strategic planning.	FY06-FY08	GHAP, Regions
HIV/AIDS is better integrated into national development planning	Add HIV/AIDS to Operational Guidelines for PRSPs and Joint Staff Assessment criteria for PRSPs in countries with high or rapidly rising HIV levels.	FY06	UNDP,OPCS,PREM, GHAP, HDNHE
	Expand GAMET's mandate to assist countries to give appropriate priority to HIV/AIDS in PRSPs	FY06-FY08	UNAIDS, UNDP, GHAP, GAMET
	Incorporate HIV/AIDS into guidelines and process for preparing Medium Term Expenditure Frameworks	FY06-FY07	GHAP, PREM, IMF, UNDP, HDNHE
	Build MOH and MOF capacity to address macroeconomic policies that might impede rapid scale-up of HIV/AIDS activities	FY06-FY08	WBI, UNDP
	Engage high-level policy makers to advocate for HIV/AIDS response	FY06-FY08	Regions, HDNHE, WBI, UNDP, UNAIDS
	CAS's to provide, when relevant, rationale for including or excluding support for HIV/AIDS, and how the Bank program will help the country attain its HIV/AIDS goals.	FY06-FY08	OPCS, PREM, GHAP, UNDP
Action Area: Fund national and regional HIV/AIDS programs and health sector strengthening			
The Bank remains a major and flexible financer for HIV/AIDS	Lend and provide grants to countries and for regional HIV/AIDS response	FY06-FY08	Regions, GF and other major funders, GHAP
Health systems are strengthened, i.a. to improve capacity to handle HIV/AIDS prevention and treatment	Provide long-term funding and support for health system strengthening	FY06-FY08	Regions, HDNHE, WHO, GHAP
	Take forward, in practical ways, the work on health system strengthening of the High Level Forum and other global initiatives	FY06-FY08	HDHNE, Regions, partners, GHAP
Support mainstreamed HIV/AIDS response in key sectors	Education: strengthen school health programs in Africa, SAR, LAC; disseminate good practice examples in school-based prevention programs, programs to increase access to school of HIV/AIDS orphans and role of teachers in addressing HIV/AIDS; coordinate with partners and local experts.	FY06-FY08	HDNED (at request of Regions), UNESCO, GHAP
	Transport and infrastructure: Develop plan for mainstreaming HIV/AIDS in Bank transport work, include HIV/AIDS activities in new transport and infrastructure projects in India and Africa, and add to existing projects in Africa during mid-term reviews. Work with transport policy makers in Anglophone and Francophone Africa to develop HIV/AIDS policies and implementation plans. Prepare HIV/AIDS Transport Corridor project in Southern Africa. Construction contracts with Bank-funding to incorporate IEC and condom distribution.	FY06-FY08	AFTTR, SASHD and SASEI, Transport Sector Board, GHAP
	Urban: continue ongoing work to support local governments' response to HIV/AIDS, including developing and updating training tools for municipalities; providing support to Bank operational units to incorporate HIV/AIDS response in Urban operational work, and to involve local governments in HIV/AIDS programs; and working with external partners to share knowledge, good practices, and practical suggestions.	FY06-FY08	TUDUR, regions, Urban Sector Board, key partners including Cities Alliance, GHAP
	Gender and Law: learning dialogues, operational guidelines and training to improve capacity to address gender and legal dimensions of AIDS among law, justice, medical and health professionals.	FY06-FY08	Gender and Law TG, GHAP, UNAIDS
	Legal: review and advise on improving laws to protect PLWHA and orphaned children. Give advice on laws relating to ARV patents and trade.	FY06-FY08	LEGVP, Regions, GHAP, UNAIDS

Goal	Specific Actions	Timeline	Key Accountability
Action Area: Support to accelerate project implementation			
HIV/AIDS projects and programs are well implemented and disburse on schedule	Provide financial and technical support through lending, IDF grants, seminars and training to enhance country capacity and systems to implement national HIV/AIDS plans.	FY06-FY08	GHAP, Regions, WBI, GIST, WHO
	Ensure adequate BB funding for AIDS project supervision, and make available TF resources for additional implementation support.	FY06-FY08	GHAP, Regions, UNAIDS
	Continue to support the global partnership on ARV procurement and logistics management capacity building	FY06-FY08	WBI, GHAP, WHO, UNICEF
	Build on the Implementation Acceleration team, and work of ACT*Africa*, to set up a Bank-wide AIDS implementation advisory service (IAS) to work with countries and Bank project teams to further improve planning, budgeting, program design, financial management, disbursement and procurement, expenditure tracking.	FY06	GHAP, WBI, GIST, Regions
	Based on learning, experience and need, further simplify operational processes and guidelines for HIV/AIDS projects, and encourage countries to use exceptional processes for more rapid and effective implementation	FY06-FY08	GHAP, Regions, OPCS, GIST
Private sector, civil society organizations, NGOs and communities play strong role in HIV/AIDS response	Actions depend on country needs, and may include (i) supporting policy changes; (ii) establishing and funding transparent, results-based processes to channel funds to communities; (iii) encouraging governments to work more with other service delivery systems; (iv) in-country work to create mechanisms and energize partnerships to address HIV/AIDS.	FY06-FY08	GHAP, Regions, partners, IFC and UNAIDS
Knowledge on good implementation practices is captured and shared widely and influences practice	Use networks of program practitioners to exchange experiences, knowledge and practical advice on general operational issues, fiduciary architecture, and special programmatic themes.	FY06-FY08	GHAP, Regions, UNAIDS
Action Area: Strengthen country monitoring and evaluation systems and evidence-informed responses			
Countries gain capacity to monitor and evaluate their programs, setting up sound HIV/AIDS M&E systems and using the data in program planning	Develop and regularly revise guidelines for national monitoring and evaluation systems	FY06-FY08	GAMET, UNAIDS GF, PEPFAR
	Prepare good practice notes that highlight examples of promising national responses to HIV/AIDS	FY06-FY08	GHAP, Regions, UNAIDS
	Hold global, regional and national M&E training courses	FY06-FY08	GHAP, Regions, WBI, UNAIDS, GF, PEPFAR
	Work as tasked by the GTT with key partners to harmonize and strengthen national M&E systems	FY06-FY08	GHAP/GAMET, UNAIDS
	Continue to build and train unified, multi-agency global country support team (CST) of international monitoring and evaluation specialists, who provide intensive practical M&E field support to countries.	FY06-FY08	GHAP/GAMET, UNAIDS
	Train M&E specialists in each country, building national capacity, gradually reducing the need for CST support.	FY06-FY08	GAMET/CST, UNAIDS, GF, PEPFAR
Action Area: Knowledge generation and sharing, impact evaluation and analytic work, to improve program performance			
Knowledge generation and impact evaluation	Carry out outcome, impact and operational evaluations of HIV/AIDS programs and establish a system for prospective evaluations of new HIV/AIDS projects	FY06-FY08	Regions, DEC, GAMET, HDN Chief Economist, UNAIDS, URGE
New analytical work in priority areas is carried out.	Work with DEC, PREM, IMF and researchers with strong country knowledge to define and carry out new analysis in key cross-cutting and cross-country areas.	FY06-FY08	PREM, DEC, IMF, URGE, GHAP, researchers
Research findings and lessons of experience are easy to access and shared widely	Distribute reports etc widely using a range of distribution and dissemination channels.	FY06-FY08	GHAP
	Improve and continuously add content to the Bank HIV/AIDS website, to provide quick, easy access to all Bank reports, papers, manual etc on HIV/AIDS.	FY06-FY08	GHAP
	Produce new publication series: (i) short reports and notes on HIV/AIDS work in the field, (ii) HIV/AIDS analytic reports. Publish country HIV/AIDS synthesis papers.	FY06-FY08	GHAP
	Convene state-of-the-art workshops, conferences and debates to discuss current controversial and cross-cutting issues on HIV/AIDS prevention, care and treatment.	FY06-FY08	GHAP, WBI and partners

Goal	Specific Actions	Timeline	Key Accountability
Work closely with partners to achieve concerted and harmonized AIDS responses, in keeping with the GTT vision			
GHAP, regions and other Bank units work closely together, for stronger Bank impact on HIV/AIDS	Work closely with regions, supporting their HIV/AIDS strategies and work programs.	FY06-FY08	GHAP, Regions
	Work more closely with PREM and DEC on economic analysis, links between AIDS and poverty, gender and vulnerability; with HNP on health systems and health services delivery and health financing issues. Continue ongoing work with WBI on training, and IFC on private sector initiatives.	FY06-FY08	GHAP, HDNHE, PREM, DEC, WBI, IFC, URGE
	Develop new HIV/AIDS work with Education, transport, urban and other sectors.	FY06-FY08	GHAP, HDNED, Transport & Urban units, partners, others tbd
Bank engagement in external partnerships contributes to a more effective global response and complements, and/or strengthens Bank's own HIV/AIDS work	Fulfill UNAIDS cosponsor role tasks and GFATM Board and Committee Meetings	FY06-FY08	GHAP

Appendix 1: Regional HIV/AIDS Strategies, and IFC and WBI HIV/AIDS Initiatives

The mainstay of the World Bank's work in HIV/AIDS is of course the lending, analysis and policy discussions led by the six regions. This Appendix briefly summarizes the regional HIV/AIDS strategies or business plans, and the IFC and WBI programs to address AIDS.

Africa (AFR)

The 1999 Africa regional strategy, *Intensifying Action Against HIV/AIDS in Africa; Responding to a Development Crisis*[1] notes the inadequacy of Bank efforts against the ferocious spread of the epidemic in Africa and its unprecedented impact on regional development. It states that HIV/AIDS must become a central element of the Bank's development agenda in Africa and called on African leaders, civil society and the private sector also to put HIV/AIDS at the center of their agendas.

The strategy rests on four pillars:

1. Advocacy to position HIV/AIDS as a central development issue and to increase and sustain an intensified response;
2. Increased resources and technical support for African partners and Bank country teams to mainstream HIV/AIDS activities in all sectors;
3. Prevention efforts targeted to both general and specific audiences, and activities to enhance HIV/AIDS treatment and care; and
4. An expanded knowledge base to help countries design and manage prevention, care, and treatment programs based on epidemic trends, impact forecasts, and identified best practices.

To help realize the strategy, Africa established a multisectoral AIDS Campaign Team, ACT*Africa*, to provide operational support in all sectors. ACT*Africa's* role includes (i) equipping and supporting Bank country teams to mobilize African leaders, civil society, and the private sector to intensify action against HIV/AIDS; (ii) retrofitting projects with HIV/AIDS components where possible, helping develop new dedicated HIV/AIDS projects, and building AIDS-mitigation measures into other projects where necessary; and (iii) supporting Bank country teams in addressing HIV/AIDS in their country assistance strategies.

When the Africa region strategy was developed, Bank lending and economic and sector work (ESW) for HIV/AIDS had diminished to a trickle, many governments lacked the political commitment to tackle HIV/AIDS, and resources and capacity were sparse.

UNAIDS had recently been created and although the Bank was a cosponsor, it was not as active as it could have been.

The strategy was innovative in the central role it saw for HIV/AIDS in the Bank's development agenda for sub-Saharan Africa. It also broke new ground in advocating multisectoral approaches, with country AIDS Control Programs coordinated from outside the Ministry of Health; flexible financing of programs that were open-ended, client driven and collaborative; and innovative mechanisms for channeling resources to the private sector, civil society and communities. The innovative, intensive new efforts incorporated a process of learning from experience, adapting and improving.

Since 2000, when the Bank's first Multi-Country HIV/AIDS Program was approved, the Bank has committed US $1.2 billion to 29

countries and 4 sub-regional projects in Africa. Of this, approximately US $440 million has been disbursed, about forty percent channeled directly to implementing organizations in the public and private sectors, civil society and communities in over 30,000 subprojects. In 2002, IDA rules were changed to allow 100 percent grant financing for HIV/AIDS in IDA-only countries, and up to 25 percent in blend (IDA/IBRD) countries. HIV/AIDS was also made a priority for Institutional Development Fund (IDF) grants that allow the Bank to provide up to US $500,000 for capacity building in IDA and IBRD countries.

An interim review of the MAP program in 2004[2] recommended that it do more to help realize the "Three Ones" goals of one national authority for HIV/AIDS, one strategic framework and one M&E system; help governments to develop stronger national HIV/AIDS strategies; help improve governance and accountability; incorporate incentives for performance; support differentiated projects as a flexible donor of last resort; and better address the overall needs of the health sector. The review also suggested that the Bank improve its own effectiveness and technical capacity to support MAP projects, particularly in the areas of M&E, communications and institutional design. In addition to responsive actions by the Africa region and ACT*Africa,* the key recommendations of the interim review have guided this Global Program of Action.

Outputs targets for the near future include the following:

- Lending: Second MAP projects are expected to begin implementation soon in Ghana and Ethiopia, preparation is underway in Kenya and Eritrea. MAP follow-on projects are also likely to be needed in the following countries: Nigeria, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Madagascar, Sierra Leone, Uganda, Senegal, Guinea Bissau, Zambia, Niger and Guinea. Supervision of programs will have high priority.
- Analytic and advisory services: Policy dialogue and analytic work will be integrated with supervision and preparation of projects. A study of community response to HIVAIDS is being done in Ethiopia.

Latin America and the Caribbean (LAC)

In 2001, the Bank was supporting three HIV/AIDS projects in the Latin America and the Caribbean region: a Brazil HIV/AIDS project loan approved in 1993, a health and disease project loan in Argentina approved in 1997, a Haiti health project that included HIV/AIDS activities, and a small regional Latin American and Caribbean initiative that was being integrated into UNAIDS' regional technical support.

Recognizing that intensified efforts were needed, a strategy was developed for the Caribbean sub-region, where the epidemic was most advanced.[3] The strategy suggested five key steps to intensify national responses to HIV/AIDS: (i) increase national government commitment, attention and funding to combat the HIV/AIDS epidemic; (ii) scale up HIV/AIDS prevention activities at national and community levels using communications to induce behavior change; make condoms, treatment of STIs and VCT more accessible; ensure a safe blood supply and reduce MTCT; (iii) scale up national and community level HIV/AIDS care activities; (iv) support more HIV/AIDS-related research at national level, and (v) strengthen regional responses to the epidemic in the Caribbean.

The Bank acted upon the Caribbean strategy by approving a US$155 million Caribbean Multi-Country HIV/AIDS Adaptable Lending Program in 2001. Since then, US$117.6 million has been committed to nine country programs and one regional project using the multisectoral approach outlined in the strategy.

The region also has HIV/AIDS projects in Brazil, where a third loan in 2003 brought total AIDS lending to US$425 million.[4] A number of health and other projects in Argentina, Venezuela, Honduras, Mexico and El Salvador include significant funding for HIV/AIDS. These projects follow a broadly

similar strategy: prevention activities implemented by NGOs and the government, services for AIDS patients, and institutional development and monitoring and evaluation. A US$8 million HIV/AIDS regional grant was approved in March, 2005 for a capacity strengthening project for Central America (El Salvador, Costa Rica, Guatemala, Honduras, Nicaragua and Panama).

In 2003, the region published two reports that review the state of the epidemic and country responses and suggest priority actions. *HIV/AIDS in Latin America: The Challenges Ahead*[5] notes that although many Latin American countries are not faced with full-scale HIV/AIDS epidemics, in several countries the epidemic appears to be expanding beyond the highest risk groups (MSMs and IDUs) into the general population. It warns that the epidemic may become generalized unless appropriate strong preventive measures are taken in the very near future. The priority areas in low endemic settings are suggested to be: (i) strong efforts to prevent new infections in high risk groups; (ii) epidemiological surveillance; and (iii) care and support for PLWHA.

"HIV/AIDS in Central America: An Overview of the Epidemic and Priorities for Prevention" reports the work and conclusions of three country workshops (in Honduras, Panama and Guatemala) in which teams of local and international experts explored the likely impact on new infections of different resource allocations across HIV/AIDS activities, using a modelling tool designed to help strategic planning.

In all three countries, the most cost-effective preventive interventions were condom social marketing, free condom distribution to high risk groups, IEC for high-risk groups including MSM, sex workers and prisoners, and voluntary counselling and testing. The difficulty of reaching high risk groups was a strong constraint on preventing infections, pointing to the importance of going beyond traditional prevention interventions. The modelling showed that existing funding levels were inadequate and poorly targeted. In 2005, similar analysis was published for Argentina: "Optimizing the allocation of resources among HIV prevention interventions in Argentina".

The region intends to develop a new HIV/AIDS strategy in 2005 that will build upon the earlier response, and take account of the diverse nature of the epidemic across sub-regions and countries and within countries; the specific needs of low prevalence countries with epidemics concentrated in small high risk population groups; the need for different responses by the Bank given that middle income countries may seek technical rather than investment support from the Bank; and the rapidly changing external funding scenario.

Outputs targets for the near future include the following:

- Lending: The region will seek additional opportunities to take advantage of scale economies using sub-regional projects and programs that support HIV/AIDS and strengthen health system capacity. A specific effort will be made to strengthen the implementation of existing projects in the Caribbean. A health project for Argentina (FY06) will include support for HIV/AIDS. The region may also consider support for HIV/AIDS in Dominica and Suriname.
- Analytic and advisory services: Policy dialogue will continue in the course of project supervision and developing and discussing a new regional HIV/AIDS strategy. The recently published report on application of the Allocation by Cost-Effectiveness (ABC) Model in Argentina will be discussed with the government. The model will be applied to a number of other countries in the region. Other analytic and advisory work envisaged includes: an assessment of implementation weaknesses of Bank-financed and other donor projects in the Caribbean; analysis of the private sector response to HIV/AIDS (focusing on the tourism sector); assessment of interventions for reaching mobile populations; assessment of experience in the use of NGOs and community based groups to deliver interventions to target populations. In addition, analytic work will be conducted through the two regional HIV/AIDS proj-

ects for the Caribbean and for Central America that will include studies on the following areas: linkages between HIV/AIDS and poverty in the Caribbean (with Jamaica and Grenada as case studies); lessons from the Bahamas experience on HIV/AIDS; HIV risk factors in mobile populations; and an assessment of the pharmaceuticals patent and registration systems of the CARICOM countries. The Central American regional project will support a review of the HIV/AIDS legal framework for civil rights, integrated treatment and drug and laboratory supplies regulation. Two GDLN dialogues are scheduled in FY06 to discuss regional cooperation and the potential for a new regional operation in the Mercosur countries (Chile, Argentina, Bolivia, Brazil, Paraguay and Uruguay).

- Accelerating AIDS response in selected sectors: The LAC region plans to strengthen the multi-sectoral response to the HIV/AIDS epidemic. A process has already been initiated for strengthening the role of the education sector in the Caribbean. This effort will be a collaboration of the Caribbean Management Unit HIV/AIDS and Education team, the Education team at the Human Development Network, UNESCO, the Pan-Caribbean HIV/AIDS Partnership (PANCAP) Secretariat and other members of PANCAP.
- Capacity Building. The LAC region will continue to provide technical support for cross-cutting areas through the two regional projects in a number of areas including: monitoring and evaluation; legal and regulatory aspects; and strengthening the education sector response.
- Donor Coordination/Partnerships. The region will help strengthen ongoing collaboration with bilateral donors and multi-lateral agencies including: the Pan-American Health Organization (PAHO/WHO); the Inter-American Development Bank, the Global Fund and the Clinton Foundation. The region will continue to contribute to regional partnerships and provide technical support for strengthening regional agencies including the Pan-Caribbean Partnership against HIV/AIDS of CARICOM and the Central American Secretariat for Social Integration (SISCA).

Europe and Central Asia (ECA)

The 2003 regional HIV/AIDS strategy[6] notes the rapid speed at which the HIV/AIDS and TB epidemics are growing in some parts of the region, threatening to undermine economic growth, drive up health expenditures and worsen dependency ratios. New cases are heavily concentrated among young people, chiefly injecting drug users, commercial sex workers and mobile populations. The strategy sees a compelling case for reducing vulnerability to infection especially among "high risk core transmitters and bridge populations", and supporting targeted, nonstigmatizing prevention programs on a much larger scale than most existing pilot projects.

The strategy commits the Bank to efforts to raise social and political commitment to addressing the epidemics of HIV/AIDS and TB in the region. It gives priority to helping countries to generate and use essential information in program design, implementation and evaluation, including: epidemiological and behavioral surveillance as the basis for effective prevention; identifying the interventions that yield the most value in terms of preventing new infections; estimates and projections of the economic and social impacts of HIV/IDS and TB and of the resource requirements for prevention and treatment.

The strategy emphasizes that preventing new infections is 'the ultimate priority for the Bank's work on HIV/AIDS" in the region. It identifies key actions as: programs to prevent transmission among sex workers and their clients; harm reduction among injecting drug users; interventions among prison inmates and ex-inmates; and increasing blood safety. It calls for ensuring affordable, good quality care and support for PLWHA, but cautions that use of ARVs should be subject to international peer review and improvement of health systems to ensure quality and reduce the emergence of drug-resistant strains of HIV. It offers Bank support to increase country capacity for implementing large-scale HIV/AIDS and TB programs.

At the time the ECA strategy was produced, the Bank had completed a country HIV/AIDS study in Georgia, and sub-re-

gional studies in Poland and the Baltic States and in south-eastern Europe, and a sub-regional study in Central Asia was underway (now completed). In 2003 the Bank also co-financed two regional studies with UNAIDS, including an inventory of resources for HIV/AIDS programs in the region. Bank lending currently supports HIV/AIDS programs in the Ukraine, Russian Federation, Moldova, and a new regional Central Asia HIV/AIDS project. There are grant financed projects for Moldova and Central Asia.

Outputs targets for the coming 2-3 years include the following:

- Lending: Supervision of programs in Moldova, Russia, Ukraine and Central Asia. New operations in Azerbaijan and Albania will include activities to strengthen the health sector, including capacity to respond to HIV/AIDS.
- Analytic and advisory services: Analysis and policy dialogue will focus on: TB and HIV/AIDS in Central Asia; a regional HIV/AIDS assessment of South Eastern Europe; in Russia, assessment of patents and registration systems for ARV drugs, the public information campaign on HIV/AIDS, and a comparative evaluation of the Russian and Ukrainian HIV/AIDS programs.
- Capacity Building: ECA will support partnerships, twinning and technical cooperation visits, meetings and other activities to support program implementation among countries in the region (especially those with a common language), as well as between countries in the region and Brazil, between the Central Asian and Caribbean regional organisations for HIV/AIDS, and between the Business Councils for HIV/AIDS in Russia, Brazil and Europe.
- Donor coordination: ECA will work with WHO, UNAIDS, DFID and SIDA on an assessment and activities to operationalize the "Three Ones" in Russia.

South Asia (SAR)

The South Asia region, with its immense population, has the second highest number of newly infected cases per year despite the low overall regional HIV prevalence rate. There are significant intra and inter-country variations, with some geographic pockets already experiencing a generalized epidemic[7] and some a concentrated epidemic.[8] The prevalence of risk behaviors is significant in the region; unprotected commercial sex remains the most risky behavior but HIV has also been increasing among IDUs and MSMs. The regional HIV/AIDS business plan points out that the window of opportunity exists now to prevent concentrated epidemics from generalizing further and that there is urgent need to scale up support to country responses.[9]

The region's strategic approach emphasizes (i) focusing on high impact preventive services targeting the right people and influencing the multi-sector determinants that create an enabling environment, facilitate and reinforce safe practices, and de-stigmatize HIV/AIDS; and (ii) using country specific approaches, taking into account the dynamics of the epidemic in each country and the high level of risk and vulnerability throughout the region. It also recognizes the need for harmonization and donor coordination, and ensuring that the Bank's contribution is strategic, considering the changing donor landscape.

Outputs targets in the current three-year work program include the following:

- Lending: National programs will be strengthened and expanded in India, Bangladesh, Bhutan[10], Sri Lanka and Pakistan and supervision of programs will be improved.
- Analytic and advisory services: Policy dialogue will be initiated in Afghanistan and Maldives. Treatment options and plans will be developed in Sri Lanka and Nepal.
- Capacity Building: HIV/AIDS prevention will be incorporated into education and transport, private and rural development sector operations, and second generation surveillance and M&E systems will be developed in all countries.
- Donor coordination: Partnerships with the Global Fund and Gates Foundation will be established and the Bank's collaboration with UN partners will be strengthened.

A regional multisectoral team has been established to support this action agenda, with a regional AIDS program coordinator in place since January 2005.

East Asia and Pacific Region (EAP)

The strategy note, "Addressing HIV/AIDS in East Asia and the Pacific" (2004) describes the diversity of the epidemic in the world's most populous region.[11] It points out lessons learned from successful and unsuccessful attempts to curb the epidemic in the region. The strategy notes that even where commitment has been strong, government funding for HIV/AIDS has been low, with a key role for the Bank and other development agencies. New sources of external funding make future demand for Bank lending uncertain, but there is likely to be an important role for the Bank in mobilizing resources, providing analytic and advisory services and capacity building, helping ensure a multi-sectoral response and perhaps as donor of last resort.

Five key challenges every country faces in combating the epidemic are outlined: (i) political commitment and multisectoral support; (ii) public health surveillance and monitoring and evaluation, (iii) prevention; (iv) care, support and treatment; and (v) health services delivery. It proposes to develop country-specific strategies to respond to these challenges based on each country's needs and stage of the epidemic, national strategic HIV/AIDS plans developed by governments, and World Bank Country Assistance Strategies. The country HIV/AIDS strategy notes will outline flexible and innovative specific work plans that incorporate some mix of analytic and advisory work, lending, and regional activities in focusing on the five key challenges.

The strategy outlines critical actions for addressing each of the key challenges. Political commitment and multisectoral support across a broad spectrum of sectors can be built using communications that increase public awareness and support. Modern methods of public health surveillance are needed to gather information on the numbers of people practicing high-risk behavior and their interactions with other groups. This requires regular behavioral surveys, research on sexual and drug-using behaviors, and increased local capacity to conduct research. Monitoring and evaluation systems are needed to collect information on interventions for prevention and care, support, and treatment.

Larger scale prevention interventions must be established, maintained and strengthened based on sound local knowledge. Access to a range of care, support and treatment services for people infected and affected will require better policies for the public and the private sectors, and analytic work to understand how best to provide ARV therapy in the context of relatively weak health systems. Strengthening health care systems and absorptive capacity within the broader government are both key for implementing successful HIV/AIDS interventions.

Cumulative regional lending for HIV/AIDS is US$138 million, as components of ten broader health project and two projects exclusively for HIV/AIDS (Indonesia and Vietnam).[12] Projects currently under implementation are a project in four target provinces in China—Fujian, Guangxi, Shanxi, and Xinjiang (US$ 25 million), a safe blood project in Vietnam (US$ 47.5 million) and the newly approved Vietnam HIV/AIDS Project (US $35 million), and support for ARVs under a health program in Cambodia.

Looking ahead, planned activities include the following:

- Lending: Efforts will focus on strong implementation of the existing portfolio, and preparation of new HIV/AIDS projects, depending on country demand.
- Analytic and advisory services: In China, new analytic work focuses on policy options to address HIV/AIDS in China. In Papua New Guinea, a joint strategy for HIV/AIDS is being developed, as part of a broader human development strategy together with AusAID and the ADB. In Thailand, a recently completed analysis of policy options for treatment while promoting effective prevention will generate various follow-up activities, and several knowledge sharing activities are planned for Vietnam and PNG. Proposed new an-

alytical work is under discussion with the Indonesian government.

- Capacity Building: In Vietnam, there is a strong focus on monitoring and evaluation in close collaboration with other partners as part of the newly approved project on HIV prevention. The lending operations in Vietnam and China also include capacity building efforts. All the analytic work listed above also involves specific capacity building efforts.
- Donor coordination: The region will keep on strengthening collaboration with other key players in the region, such as UNAIDS, AusAID, the ADB and UN. This is an integral part of the approach and the regional strategy highlights this.

Middle East and Northern Africa (MNA)

The MNA region strategy[13] notes that although adult prevalence in the region is estimated at only 0.3 percent and appears to be concentrated among high risk groups such as injecting drug users, sex workers and prisoners, the absence of reliable surveillance data among these groups makes the actual level of infection uncertain. It notes that low prevalence does not mean a low risk of an epidemic. Despite social and cultural values that have helped prevent rapid spread of HIV/AIDS in MNA countries, there are many vulnerabilities that could lead to increased transmission: widespread migration; silence and stigma; civil conflicts and security problems that could undermine government ability to respond effectively; and a large youth population that bears the brunt of unemployment.

The strategy calls for decisive action in four areas: (i) establish a reliable surveillance system to identify and target support to the most vulnerable groups; (ii) vigorously pursue cost-effective public health measures to stem the spread of HIV/AIDS, targeted at injecting drug users and their sex partners, sex workers, prison inmates, males who have sex with males and youth; (iii) expand public information and education, and encourage greater public discourse on HIV/AIDS; and (iv) promote cooperation between governments and civil society to mobilize all levels of the society to participate in preventing HIV/AIDS, and raise the effectiveness of programs.

Four areas are identified where the World Bank could support MNA countries in preventing the epidemic and expanding access to information on HIV/AIDS:

- Engage political leaders, policy makers and key stakeholders to raise awareness and priority given to HIV/AIDS programs within national development agenda
- Support upgrading of surveillance systems and strengthening research and evaluation of epidemiological, economic, and behavioral aspects of HIV/AIDS
- Support the development of National HIV/AIDS strategy and programs, based on country-specific epidemiological, social and economic conditions and contexts
- Support capacity building and knowledge sharing for comprehensive management of HIV/AIDS programs.

The Bank supports one HIV/AIDS project in the region, the Djibouti HIV/AIDS, Tuberculosis and Malaria Control Project which is a grant for US$ 12 million for capacity building, prevention and support to community-based initiatives. In addition, the Djibouti International Road Corridor Rehabilitation Project (approved in 2000) includes some HIV/AIDS activities. The Bank has also supported the development of national AIDS plans in Morocco and Lebanon, held regional workshops to raise awareness, and engaged in advocacy.

Outputs targets for the coming years include the following:

- Lending: No new lending specifically focused on HIV/AIDS is expected, but HIV/AIDS prevention programs will be incorporated in new lending projects with a high degree of community-based and NGO activities (e.g., Egypt Social Fund, Iran Local Development Project and Yemen Population project). MNA also plans to identify specific components and investment activities related to HIV/AIDS prevention and selected priority health and social services which should be inte-

grated into new lending operations in education, health and social protection.

- Regional Technical Assistance: (i) Advocacy and Building Partnership for Prevention of HIV/AIDS activities will include launching the Regional HIV/AIDS Strategy, follow up consultative processes with key partners, and identification of and preparation of priority investment and analytical work to be undertaken by the Bank in partnership with other stakeholders, including the Global Fund. (ii) An Inter-regional Program on HIV/AIDS Prevention among High Risk Groups will involve cooperation with SAR and ECA for countries bordering Afghanistan and affected by the rapid expansion of drug trafficking and IDU use. In the first phase, a conference is proposed to be held in Tehran in 2006, to discuss how to address drug trafficking, drug addiction and the spread of HIV/AIDS in Afghanistan, Pakistan, Iran, Tajikistan and Uzbekistan.
- Capacity Building: Under a new Lebanon IDF Grant project, NGO-based HIV/AIDS projects will be promoted. Funds (JSDF or IDF) will be sought for local capacity building grant projects to complement Global Fund activities, in selected countries in the region (to be selected based on readiness and political will) in FY07-FY08. Capacity building activities will be identified based on the outcome of the Advocacy and Partnership TA.

The World Bank Institute Leadership Program on AIDS

The Leadership Program on AIDS supports the World Bank's intensified efforts in HIV/AIDS lending and research and contributes to a critically important but still neglected need for leadership and capacity building. The Program focuses on: building capacity of clients including local institutions to strengthen implementation; mobilizing policy makers to focus on HIV/AIDS; sharing knowledge of best practices within and between counties; and using technology to create mass awareness and to share knowledge. The Program targets a wide range of stakeholders including policy-makers and analysts in government ministries and other public institutions; national PRSP teams; community leaders and NGO representatives; managers from the private sector; staff from international organizations, HIV/AIDS program staff and trainers and academicians. WBI develops and delivers more than half of its activities with partners in client countries and has formal partnership agreements with nearly 200 organizations that provide expertise, content, facilities, staff, funding and other inputs.

To respond to country demand, in the coming 3-5 years, WBI will focus on building implementation capacity for HIV/AIDS programs by: i) building the management capacity of the public sector and civil society organizations to overcome the current planning, management and implementation constraints, ii) continued collaboration with WHO, UNAIDS, Global Fund and PEPFAR to harmonize ARV procurement and supply management efforts at country level, iii) continuing to hold training workshops on procurement and supply management at regional and country level, iv) building the technical capacity of program managers using technology to rapidly disseminate evidence-informed knowledge across geographical borders, v) engaging high level policy makers to advocate for HIV/AIDS, and vi) building the capacity of ministry of health and ministry of finance officials to address the macroeconomic polices that might impede rapid scaling-up of HIV/AIDS activities.

Business and HIV: IFC against AIDS

Businesses feel the impact of the AIDS epidemic most clearly through their workforce, with direct consequences for a company's bottom line. These include increased medical expenditures and health insurance costs, funeral and death benefits, higher recruitment and training needs due to lost personnel, higher absenteeism and staff turnover, reduced productivity, declining morale and a shrinking consumer base.

The International Finance Corporation, the private sector investment arm of the World Bank Group, recognizes that HIV/AIDS is as much a business issue as a development and humanitarian concern. Since 2000, the IFC

AIDS program—IFC Against AIDS—has worked to increase the private sector's role in fighting the epidemic. The overarching goal is to accelerate the role of the private sector in the fight against HIV/AIDS. The program has honed its approach and tools and worked with over 30 client companies, of which 25 are in sub-Saharan Africa. The program has also included companies in the Caribbean and South Asia.

Africa will remain a priority for the program, in moving forward to intensify existing activities (facilitated by increased staff capacity in the Africa region), and to launch an innovative program to reach small and medium-sized enterprises (SMEs).

IFC Against AIDS has four areas of activity:

1. *Raising awareness:* IFC Against AIDS works with IFC clients to help them analyze and acknowledge the risks that AIDS poses to their companies, making the business case for action. This work will continue in African countries, and expand to countries in other regions, including India, Russia, and China. Tools are being developed and used, and a communications strategy guides activities to demonstrate how private companies can respond to the challenge of HIV/AIDS.
2. *Guidance:* Once companies are aware of the risk that HIV/AIDS poses to their operations, they typically do not know where to start. Through one-on-one interaction with clients, IFC Against AIDS helps companies develop an appropriate and tailored response, working with clients to design and implement programs that include HIV/AIDS education, prevention, and care interventions for the workforce and/or communities in which they operate. This demand-driven support is expected to expand to more companies in future.

   In the coming year, IFC Against AIDS will pilot a more systematic and client-based monitoring and evaluation (M&E) tool with selected clients in sub-Saharan Africa. This tool will help clients to assess the relative success of activities and interventions and enable them to make more informed decisions concerning their HIV/AIDS workplace programs.
3. *Training:* IFC Against AIDS will deliver a 3-year training program in Africa for small and medium enterprises (SMEs), which can be just as affected by HIV/AIDS as larger companies. A package of tools and approaches is being developed that will be able to be used by others in the field, increasing reach to this important part of the private sector. The strategy includes building capacity of local trainers and NGOs to deliver the training program, which should increase the ability of SMEs to respond to HIV/AIDS. This program has been developed in cooperation with the IFC Private Enterprise Partnership program (PEP Africa), and will be managed jointly with PEP Africa from October 2005 till September 2008.
4. *Financing:* Close collaboration with the IFC Corporate Citizenship Facility (CCF) has enabled IFC Against AIDS to leverage financing on a cost-sharing basis for clients for whom a compelling case for support can be made. Financing will be provided to clients that can show a demonstration effect for a particular sector, such as tourism, or a particular geographic area or country, such as Nigeria. These examples will be used to capture lessons learned that can be replicated internally with other IFC clients and externally, and add to the body of knowledge within the field. This collaboration with the CCF is expected to continue, but there is also the possibility of establishing an IFC Against AIDS Facility in the future if warranted.

IFC Against AIDS has been working in closer cooperation with AIDS units in the Bank, seeking ways to concretely partner, such as in Kenya with IDA to jointly promote the role of private companies in the National HIV/AIDS Strategic Plan and in the implementation of coordinated activities. Another example is the work with the World Bank Institute in Africa and India. This cooperation should intensify in future.

Considerable attention will be focused on India in the coming years. Proactive engagement in HIV/AIDS in the private sector in India remains piecemeal. After evaluation of what IFC could do to bring value to its clients and contribute to India's response to the epidemic, IFC Against AIDS and the IFC South

Asia department launched a program in January 2005 that aims at increasing the ability of clients to proactively address HIV/AIDS in three possible areas:

- workplaces—by raising awareness about HIV/AIDS and promoting prevention across company operations, and by extending education programs throughout their groups and to supply chain partners;
- company clinical facilities—by training medical and clinical staff on HIV/AIDS and sexually transmitted infections (STIs), i.e. modes of transmission, prevention (with a special focus on universal precautions related to HIV infection in clinical settings), basic counseling skills, syndromic management of STIs, opportunistic infections related to HIV and anti-retroviral treatment therapies;
- their communities—by supporting or scaling-up the awareness and prevention efforts around their operations, particularly among migrant workers and trucking communities with whom companies interact.

This project is financed from FY05 to FY07 by the CCF: clients may submit project proposals that address any one, two or three components, IFC supporting up to half of the eligible costs incurred for up to 18 months. The goal is to involve about five major corporates under this scheme, and to develop the capacity of local organizations to play an intermediary role in local capacity building, which would enable the project to be extended later to smaller companies or SMEs in the supply chains of larger clients. IFC clients already involved in HIV/AIDS include Apollo Tyres, Ambuja Cement, L&T, Usha Martin and Ashok Leyland.

www.ifc.org/ifcagainstaids

Notes

1. World Bank 1999. *Intensifying action against HIV/AIDS in Africa: Responding to a development crisis.* Washington, DC: The World Bank, Africa Region.
2. World Bank. 2004. *Interim Review of the MAP.*
3. World Bank. 2001. *HIV/AIDS in the Caribbean: Issues and Options.* Washington, DC.
4. This includes $255.05 million committed under the three AIDS projects as well as funding for HIV/AIDS activities in other projects.
5. Anabela Garcia-Abreu, Isabel Noguer and Karen Cowgill. 2003. *HIV/AIDS in Latin America The Challenges Ahead.* HNP Discussion Paper, Washington, DC: The World Bank.
6. "Averting AIDS Crises in Eastern Europe and Central Asia"2003, Eastern Europe and Central Asia Region, World Bank.
7. Generalized: greater than 1 percent HIV prevalence among women attending antenatal clinics.
8. Concentrated: greater than 5 percent among STD patients and other groups whose behavior places them at risk e.g. sex workers, injecting drug users.
9. South Asia Human Development Sector. (2004). HIV/AIDS Business Plan South Asia FY04-FY06.
10. The first ever Bhutan HIV/AIDS project was approved with grant financing in 2004.
11. Borowitz, Michael,Wiley, Elizabeth, Sadaah, Fadia and Enis Baris. December 2003. *Responding to HIV/AIDS in theEast Asia and Pacific Region: A Strategy Note for the World Bank.* HNP Discussion Paper, Washington, DC: The World Bank.
12. Lending data supplied by the EAP region, which may differ from data in the"Business Warehouse" database because of differences in coding.
13. The World Bank. (2005). Preventing the Spread of HIV/AIDS in the Middle East and North Africa: The World Bank Regional Strategy. Washington, DC.

Appendix 2: Country-Level HIV/AIDS Data

Table of country-specific HIV and AIDS estimates and data, end 2003 (UNAIDS, July 2004)

	1. Estimated number of people living with HIV					
	Adults and Children end 2003		Adults and Children end 2001		Adults (15-49) end 2003	
Country	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
Global Total	**37,800,000**	**[34,600,000 - 42,300,000]**	**34,900,000**	**[32,000,000 - 39,000,000]**	**35,700,000**	**[32,700,000 - 39,800,000]**
Sub-Saharan Africa	**25,000,000**	**[23,100,000 - 27,900,000]**	**23,800,000**	**[22,000,000 - 26,600,000]**	**23,100,000**	**[21,400,000 - 25,700,000]**
Angola	240,000	[97,000 - 600,000]	220,000	[86,000 - 550,000]	220,000	[88,000 - 540,000]
Benin	68,000	[38,000 - 120,000]	65,000	[36,000 - 110,000]	62,000	[35,000 - 110,000]
Botswana *	350,000	[330,000 - 380,000]	350,000	[330,000 - 380,000]	330,000	[310,000 - 340,000]
Burkina Faso *	300,000	[190,000 - 470,000]	280,000	[180,000 - 440,000]	270,000	[170,000 - 420,000]
Burundi	250,000	[170,000 - 370,000]	240,000	[160,000 - 360,000]	220,000	[150,000 - 320,000]
Cameroon *	560,000	[390,000 - 810,000]	530,000	[370,000 - 770,000]	520,000	[360,000 - 740,000]
Central African Republic	260,000	[160,000 - 410,000]	250,000	[150,000 - 400,000]	240,000	[150,000 - 380,000]
Chad	200,000	[130,000 - 300,000]	190,000	[120,000 - 290,000]	180,000	[120,000 - 270,000]
Comoros	…	…	…	…	…	…
Congo, Republic of	90,000	[39,000 - 200,000]	90,000	[39,000 - 200,000]	80,000	[34,000 - 180,000]
Côte d'Ivoire	570,000	[390,000 - 820,000]	510,000	[350,000 - 740,000]	530,000	[370,000 - 750,000]
Dem. Republic of Congo **	1,100,000	[450,000 - 2,600,000]	1,100,000	[430,000 - 2,500,000]	1,000,000	[410,000 - 2,400,000]
Djibouti	9,100	[2,300 - 24,000]	8,100	[2,400 - 23,000]	8,400	[2,100 - 21,000]
Equatorial Guinea	…	…	…	…	…	…
Eritrea	60,000	[21,000 - 170,000]	61,000	[22,000 - 160,000]	55,000	[19,000 - 150,000]
Ethiopia	1,500,000	[950,000 - 2,300,000]	1,300,000	[820,000 - 2,000,000]	1,400,000	[890,000 - 2,100,000]
Gabon	48,000	[24,000 - 91,000]	39,000	[19,000 - 78,000]	45,000	[23,000 - 86,000]
Gambia	6,800	[1,800 - 24,000]	6,700	[1,800 - 24,000]	6,300	[1,700 - 23,000]
Ghana *	350,000	[210,000 - 560,000]	330,000	[200,000 - 540,000]	320,000	[200,000 - 520,000]
Guinea *	140,000	[51,000 - 360,000]	110,000	[40,000 - 310,000]	130,000	[48,000 - 330,000]
Guinea-Bissau	…	…	…	…	…	…
Kenya	1,200,000	[820,000 - 1,700,000]	1,300,000	[890,000 - 1,800,000]	1,100,000	[760,000 - 1,600,000]
Lesotho *	320,000	[290,000 - 360,000]	320,000	[290,000 - 360,000]	300,000	[270,000 - 330,000]
Liberia	100,000	[47,000 - 220,000]	86,000	[37,000 - 190,000]	96,000	[44,000 - 200,000]
Madagascar	140,000	[68,000 - 250,000]	100,000	[50,000 - 180,000]	130,000	[66,000 - 220,000]
Malawi *	900,000	[700,000 - 1,100,000]	850,000	[660,000 - 1,100,000]	810,000	[650,000 - 1,000,000]
Mali	140,000	[44,000 - 420,000]	130,000	[40,000 - 390,000]	120,000	[40,000 - 380,000]
Mauritania	9,500	[4,500 - 17,000]	6,300	[3,000 - 11,000]	8,900	[4,400 - 15,000]
Mauritius	…	…	…	…	…	…
Mozambique	1,300,000	[980,000 - 1,700,000]	1,200,000	[930,000 - 1,600,000]	1,200,000	[910,000 - 1,500,000]
Namibia	210,000	[180,000 - 250,000]	200,000	[170,000 - 230,000]	200,000	[170,000 - 230,000]
Niger	70,000	[36,000 - 130,000]	56,000	[28,000 - 110,000]	64,000	[34,000 - 120,000]
Nigeria	3,600,000	[2,400,000 - 5,400,000]	3,400,000	[2,200,000 - 5,000,000]	3,300,000	[2,200,000 - 4,900,000]
Rwanda *	250,000	[170,000 - 380,000]	240,000	[160,000 - 360,000]	230,000	[150,000 - 350,000]
Senegal *	44,000	[22,000 - 89,000]	40,000	[20,000 - 81,000]	41,000	[21,000 - 83,000]
Sierra Leone	…	…	…	…	…	…
Somalia	…	…	…	…	…	…
South Africa *	5,300,000	[4,500,000 - 6,200,000]	5,000,000	[4,200,000 - 5,900,000]	5,100,000	[4,300,000 - 5,900,000]
Swaziland **	220,000	[210,000 - 230,000]	210,000	[190,000 - 220,000]	200,000	[190,000 - 210,000]
Togo	110,000	[67,000 - 170,000]	100,000	[65,000 - 160,000]	96,000	[61,000 - 150,000]
Uganda *	530,000	[350,000 - 880,000]	620,000	[420,000 - 980,000]	450,000	[300,000 - 730,000]
United Rep. of Tanzania *	1,600,000	[1,200,000 - 2,300,000]	1,600,000	[1,100,000 - 2,200,000]	1,500,000	[1,100,000 - 2,000,000]
Zambia	920,000	[730,000 - 1,100,000]	890,000	[710,000 - 1,100,000]	830,000	[680,000 - 1,000,000]
Zimbabwe	1,800,000	[1,500,000 - 2,000,000]	1,700,000	[1,500,000 - 2,000,000]	1,600,000	[1,400,000 - 1,900,000]
East Asia	**900,000**	**[450,000 - 1,500,000]**	**680,000**	**[340,000 - 1,100,000]**	**900,000**	**[450,000 - 1,500,000]**
China	840,000	[430,000 - 1,500,000]	660,000	[320,000 - 1,100,000]	830,000	[430,000 - 1,400,000]
Hong Kong SAR	2,600	[1,300 - 4,400]	2,700	[1,300 - 4,400]	2,600	[1,300 - 4,300]
Dem. Peo. Rep. of Korea	…	…	…	…	…	…
Japan	12,000	[5,700 - 19,000]	12,000	[5,800 - 20,000]	12,000	[5,700 - 19,000]
Mongolia	<500	[<1,000]	<200	[<400]	<500	[<1,000]
Republic of Korea	8,300	[2,700 - 16,000]	5,600	[1,800 - 11,000]	8,300	[2,700 - 16,000]
Oceania	**32,000**	**[21,000 - 46,000]**	**24,000**	**[16,000 - 35,000]**	**31,000**	**[21,000 - 45,000]**
Australia	14,000	[6,800 - 22,000]	12,000	[6,000 - 20,000]	14,000	[6,600 - 22,000]
Fiji	600	[200 - 1,300]	<500	[<1,000]	600	[200 - 1,200]
New Zealand	1,400	[480 - 2,800]	1,200	[420 - 2,400]	1,400	[500 - 2,800]
Papua New Guinea	16,000	[7,800 - 28,000]	10,000	[4,900 - 17,000]	16,000	[7,700 - 26,000]

1. Estimated number of people living with HIV

Country	Adults and Children end 2003		Adults and Children end 2001		Adults (15-49) end 2003	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
South & South-East Asia	**6,500,000**	**[4,100,000 - 9,600,000]**	**5,900,000**	**[3,700,000 - 8,700,000]**	**6,300,000**	**[4,000,000 - 9,300,000]**
Afghanistan	…	…	…	…	…	…
Bangladesh **	…	[2,500 - 15,000]	…	[2,200 - 13,000]	…	[2,400 - 15,000]
Bhutan	…	…	…	…	…	…
Brunei Darussalam	<200	[<400]	<200	[<400]	<200	[<400]
Cambodia	170,000	[100,000 - 290,000]	170,000	[100,000 - 270,000]	170,000	[99,000 - 280,000]
India	5,100,000	[2,500,000 - 8,500,000]	3,970,000	[2,100,000 - 7,100,000]	5,000,000	[2,500,000 - 8,200,000]
Indonesia	110,000	[53,000 - 180,000]	58,000	[28,000 - 95,000]	110,000	[53,000 - 180,000]
Iran (Islamic Republic of)	31,000	[10,000 - 61,000]	18,000	[6,000 - 36,000]	31,000	[10,000 - 60,000]
Lao People's Dem. Rep.	1,700	[600 - 3,600]	800	[300 - 1,600]	1,700	[550 - 3,300]
Malaysia	52,000	[25,000 - 86,000]	42,000	[20,000 - 70,000]	51,000	[25,000 - 84,000]
Maldives	…	…	…	…	…	…
Myanmar **	330,000	[170,000 - 620,000]	280,000	[150,000 - 510,000]	320,000	[170,000 - 610,000]
Nepal	61,000	[29,000 - 110,000]	45,000	[22,000 - 78,000]	60,000	[29,000 - 98,000]
Pakistan	74,000	[24,000 - 150,000]	63,000	[21,000 - 130,000]	73,000	[24,000 - 140,000]
Philippines	9,000	[3,000 - 18,000]	4,400	[1,400 - 8,700]	8,900	[2,900 - 18,000]
Singapore	4,100	[1,300 - 8,000]	3,400	[1,100 - 6,700]	4,100	[1,300 - 8,000]
Sri Lanka	3,500	[1,200 - 6,900]	2,200	[700 - 4,300]	3,500	[1,100 - 6,800]
Thailand	570,000	[310,000 - 1,000,000]	630,000	[360,000 - 1,100,000]	560,000	[310,000 - 1,000,000]
Vietnam	220,000	[110,000 - 360,000]	150,000	[75,000 - 250,000]	200,000	[100,000 - 350,000]
Eastern Europe & Central Asia	**1,300,000**	**[860,000 - 1,900,000]**	**890,000**	**[570,000 - 1,300,000]**	**1,300,000**	**[850,000 - 1,900,000]**
Armenia	2,600	[1,200 - 4,300]	2,000	[990 - 3,400]	2,500	[1,200 - 4,100]
Azerbaijan	1,400	[500 - 2,800]	…	…	1,400	[500 - 2,800]
Belarus	…	[12,000 - 42,000]	…	[10,000 - 39,000]	…	[12,000 - 40,000]
Bosnia and Herzegovina	900	[300 - 1,800]	…	…	900	[300 - 1,800]
Bulgaria	<500	[<1,000]	…	…	<500	[<1,000]
Croatia	<200	[<400]	…	…	<200	[<400]
Czech Republic	2,500	[800 - 4,900]	2,100	[750 - 4,700]	2,500	[820 - 4,900]
Estonia	7,800	[2,600 - 15,000]	5,100	[1,700 - 10,000]	7,700	[2,500 - 15,000]
Georgia	3,000	[2,000 - 12,000]	1,500	[660 - 4,000]	3,000	[2,000 - 12,000]
Hungary	2,800	[900 - 5,500]	…	…	2,800	[900 - 5,500]
Kazakhstan	16,500	[5,800 - 35,000]	10,400	[5,000 - 30,000]	16,400	[5,700 - 34,000]
Kyrgyz Republic	3,900	[1,500 - 8,000]	1,500	[700 - 4,000]	3,900	[1,500 - 8,000]
Latvia	7,600	[3,700 - 12,000]	6,000	[2,900 - 9,800]	7,500	[3,700 - 12,000]
Lithuania	1,300	[400 - 2,600]	1,100	[400 - 2,200]	1,300	[400 - 2,600]
Poland	14,000	[6,900 - 23,000]	…	…	14,000	[6,900 - 23,000]
Republic of Moldova	5,500	[2,700 - 9,000]	…	…	5,500	[2,700 - 9,000]
Romania	6,500	[4,800 - 8,900]	4,000	[4,000 - 4,000]	2,500	[800 - 4,900]
Russian Federation	860,000	[420,000 - 1,400,000]	530,000	[260,000 - 870,000]	860,000	[420,000 - 1,400,000]
Slovak Republic	<200	[<400]	…	…	<200	[<400]
Tajikistan	<200	[<400]	…	…	<200	[<400]
Turkmenistan	<200	[<400]	…	…	<200	[<400]
Ukraine	360,000	[180,000 - 590,000]	300,000	[150,000 - 490,000]	360,000	[170,000 - 580,000]
Uzbekistan	11,000	[4,900 - 30,000]	3,000	[1,900 - 12,000]	11,000	[4,900 - 29,000]
Western Europe	**580,000**	**[460,000 - 730,000]**	**540,000**	**[430,000 - 690,000]**	**570,000**	**[450,000 - 720,000]**
Albania	…	…	…	…	…	…
Austria	10,000	[5,000 - 16,000]	10,000	[4,900 - 16,000]	10,000	[4,900 - 16,000]
Belgium	10,000	[5,300 - 17,000]	8,400	[4,300 - 14,000]	10,000	[4,900 - 16,000]
Denmark	5,000	[2,500 - 8,200]	4,600	[2,300 - 7,600]	5,000	[2,500 - 8,200]
Finland	1,500	[500 - 3,000]	1,200	[400 - 2,400]	1,500	[500 - 3,000]
France	120,000	[60,000 - 200,000]	110,000	[56,000 - 190,000]	120,000	[59,000 - 200,000]
Germany	43,000	[21,000 - 71,000]	41,000	[20,000 - 68,000]	43,000	[21,000 - 71,000]
Greece	9,100	[4,500 - 15,000]	8,900	[4,400 - 14,000]	9,000	[4,400 - 15,000]
Iceland	<500	[<1,000]	<500	[<1,000]	<200	[<400]
Ireland	2,800	[1,100 - 5,300]	2,400	[800 - 4,900]	2,600	[900 - 5,100]
Italy	140,000	[67,000 - 220,000]	130,000	[65,000 - 210,000]	140,000	[66,000 - 220,000]
Luxembourg	<500	[<1,000]	<500	[<1,000]	<500	[<1,000]
Malta	<500	[<1,000]	<500	[<1,000]	<500	[<1,000]
Netherlands	19,000	[9,500 - 31,000]	17,000	[8,500 - 28,000]	19,000	[9,300 - 31,000]
Norway	2,100	[700 - 4,000]	1,900	[600 - 3,600]	2,000	[700 - 3,900]
Portugal	22,000	[11,000 - 36,000]	21,000	[11,000 - 35,000]	22,000	[11,000 - 35,000]
Serbia and Montenegro	10,000	[3,400 - 20,000]	10,000	[3,400 - 20,000]	10,000	[3,300 - 20,000]
Slovenia	<500	[<1,000]	<500	[<1,000]	<500	[<1,000]
Spain	140,000	[67,000 - 220,000]	130,000	[65,000 - 210,000]	130,000	[66,000 - 220,000]
Sweden	3,600	[1,200 - 6,900]	3,400	[1,100 - 6,600]	3,500	[1,200 - 6,900]
Switzerland	13,000	[6,500 - 21,000]	12,000	[6,000 - 20,000]	13,000	[6,400 - 21,000]
Macedonia, FYR	<200	[<400]	<200	[<400]	<200	[<400]
United Kingdom	51,000	[25,000 - 82,000]	43,000	[21,000 - 69,000]	47,000	[24,000 - 81,000]

Country	Adults and Children end 2003		Adults and Children end 2001		Adults (15-49) end 2003	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
North Africa & Middle East	**480,000**	**[200,000 - 1,400,000]**	**340,000**	**[130,000 - 910,000]**	**460,000**	**[190,000 - 1,300,000]**
Algeria	9,100	[3,000 - 18,000]	6,800	[2,200 - 14,000]	9,000	[3,000 - 18,000]
Bahrain	<600	[200 - 1,100]	<500	[<1,000]	<600	[200 - 1,100]
Cyprus	…	…	…	…	…	…
Egypt, Arab Republic of	12,000	[5,000 - 31,000]	11,000	[3,600 - 22,000]	12,000	[5,000 - 30,000]
Iraq	<500	[<1,000]	…	…	<500	[<1,000]
Israel	3,000	[1,500 - 4,900]	…	…	3,000	[1,500 - 4,900]
Jordan	600	[<1,000]	600	[<1,000]	<500	[<1,000]
Kuwait	…	…	…	…	…	…
Lebanon	2,800	[700 - 4,100]	2,000	[400 - 2,500]	2,800	[700 - 4,000]
Libyan Arab Jamahiriya	10,000	[3,300 - 20,000]	…	…	10,000	[3,300 - 20,000]
Morocco	15,000	[5,000 - 30,000]	…	…	15,000	[5,000 - 30,000]
Oman	1,300	[500 - 3,000]	1,000	[300 - 2,100]	1,300	[500 - 2,900]
Qatar	…	…	…	…	…	…
Saudi Arabia	…	…	…	…	…	…
Sudan	400,000	[120,000 - 1,300,000]	320,000	[110,000 - 890,000]	380,000	[120,000 - 1,200,000]
Syrian Arab Republic	<500	[300 - 2,100]	…	…	<500	[300 - 2,100]
Tunisia	1,000	[400 - 2,400]	600	[200 - 1,200]	1,000	[400 - 2,300]
Turkey	…	…	…	…	…	…
United Arab Emirates	…	…	…	…	…	…
Yemen, the Republic of	12,000	[4,000 - 24,000]	…	…	12,000	[4,000 - 24,000]
North America	**1,000,000**	**[520,000 - 1,600,000]**	**950,000**	**[490,000 - 1,500,000]**	**990,000**	**[510,000 - 1,600,000]**
Canada	56,000	[26,000 - 86,000]	49,000	[24,000 - 79,000]	55,000	[25,000 - 85,000]
United States of America	950,000	[470,000 - 1,600,000]	900,000	[450,000 - 1,500,000]	940,000	[460,000 - 1,500,000]
Caribbean	**430,000**	**[270,000 - 760,000]**	**400,000**	**[270,000 - 650,000]**	**410,000**	**[260,000 - 720,000]**
Bahamas	5,600	[3,200 - 8,700]	5,200	[3,300 - 8,300]	5,200	[3,100 - 8,400]
Barbados	2,500	[700 - 9,200]	2,500	[800 - 7,300]	2,500	[700 - 9,100]
Cuba	3,300	[1,100 - 6,600]	3,200	[1,100 - 6,500]	3,300	[1,100 - 6,400]
Dominican Republic	88,000	[48,000 - 160,000]	90,000	[52,000 - 150,000]	85,000	[47,000 - 150,000]
Haiti	280,000	[120,000 - 600,000]	260,000	[130,000 - 500,000]	260,000	[120,000 - 560,000]
Jamaica	22,000	[11,000 - 41,000]	15,000	[7,700 - 28,000]	21,000	[11,000 - 40,000]
Trinidad and Tobago	29,000	[11,000 - 74,000]	26,000	[11,000 - 59,000]	28,000	[10,000 - 72,000]
Latin America	**1,600,000**	**[1,200,000 - 2,100,000]**	**1,400,000**	**[1,100,000 - 1,800,000]**	**1,600,000**	**[1,200,000 - 2,000,000]**
Argentina	130,000	[61,000 - 210,000]	120,000	[59,000 - 200,000]	120,000	[61,000 - 200,000]
Belize	3,600	[1,200 - 10,000]	2,900	[1,100 - 7,200]	3,500	[1,200 - 9,800]
Bolivia	4,900	[1,600 - 11,000]	4,200	[1,300 - 9,000]	4,800	[1,600 - 9,400]
Brazil	660,000	[320,000 - 1,100,000]	630,000	[310,000 - 1,000,000]	650,000	[320,000 - 1,100,000]
Chile	26,000	[13,000 - 44,000]	25,000	[12,000 - 42,000]	26,000	[13,000 - 43,000]
Colombia	190,000	[90,000 - 310,000]	130,000	[61,000 - 210,000]	180,000	[90,000 - 300,000]
Costa Rica	12,000	[6,000 - 21,000]	11,000	[5,500 - 19,000]	12,000	[6,000 - 20,000]
Ecuador	21,000	[10,000 - 38,000]	20,000	[9,700 - 36,000]	20,000	[10,000 - 34,000]
El Salvador	29,000	[14,000 - 50,000]	24,000	[12,000 - 43,000]	28,000	[14,000 - 46,000]
Guatemala	78,000	[38,000 - 130,000]	69,000	[34,000 - 110,000]	74,000	[36,000 - 120,000]
Guyana *	11,000	[3,500 - 35,000]	11,000	[4,300 - 30,000]	11,000	[3,300 - 33,000]
Honduras	63,000	[35,000 - 110,000]	51,000	[29,000 - 90,000]	59,000	[33,000 - 100,000]
Mexico	160,000	[78,000 - 260,000]	150,000	[74,000 - 250,000]	160,000	[78,000 - 260,000]
Nicaragua	6,400	[3,100 - 12,000]	5,800	[2,700 - 10,000]	6,200	[3,000 - 10,000]
Panama	16,000	[7,700 - 26,000]	11,000	[5,500 - 19,000]	15,000	[7,500 - 25,000]
Paraguay	15,000	[7,300 - 25,000]	10,000	[5,000 - 17,000]	15,000	[7,300 - 24,000]
Peru	82,000	[40,000 - 140,000]	53,000	[26,000 - 88,000]	80,000	[39,000 - 130,000]
Suriname	5,200	[1,400 - 18,000]	4,100	[1,300 - 13,000]	5,000	[1,400 - 18,000]
Uruguay	6,000	[2,800 - 9,700]	5,600	[2,700 - 9,500]	5,800	[2,800 - 9,400]
Venezuela, R.B. de	110,000	[47,000 - 170,000]	73,000	[35,000 - 120,000]	100,000	[47,000 - 160,000]
Global Total	**37,800,000**	**[34,600,000 - 42,300,000]**	**34,900,000**	**[32,000,000 - 39,000,000]**	**35,700,000**	**[32,700,000 - 39,800,000]**

1. Estimated number of people living with HIV (continued)

Country	Adults (15-49) end 2001		Adult (15-49) rate (%) end 2003		Adult (15-49) rate (%) end 2001		Women (15-49) end 2003	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
Global Total	**32,900,000**	**[30,200,000 - 36,700,000]**	**1.1**	**[1.0 - 1.2]**	**1.0**	**[0.9 - 1.1]**	**17,000,000**	**[15,800,000 - 18,800,000]**
Sub-Saharan Africa	**22,000,000**	**[20,400,000 - 24,500,000]**	**7.5**	**[6.9 - 8.3]**	**7.6**	**[7.0 - 8.5]**	**13,100,000**	**[12,200,000 - 14,600,000]**
Angola	200,000	[78,000 - 490,000]	3.9	[1.6 - 9.4]	3.7	[1.5 - 9.1]	130,000	[50,000 - 300,000]
Benin	59,000	[34,000 - 100,000]	1.9	[1.1 - 3.3]	1.9	[1.1 - 3.4]	35,000	[20,000 - 62,000]
Botswana *	330,000	[320,000 - 340,000]	37.3	[35.5 - 39.1]	38.0	[36.3 - 39.7]	190,000	[180,000 - 190,000]
Burkina Faso *	250,000	[160,000 - 390,000]	4.2	[2.7 - 6.5]	4.2	[2.7 - 6.5]	150,000	[98,000 - 240,000]
Burundi	220,000	[150,000 - 310,000]	6.0	[4.1 - 8.8]	6.2	[4.3 - 9.0]	130,000	[85,000 - 180,000]
Cameroon *	500,000	[350,000 - 700,000]	6.9	[4.8 - 9.8]	7.0	[4.9 - 9.9]	290,000	[200,000 - 420,000]
Central African Republic	230,000	[140,000 - 360,000]	13.5	[8.3 - 21.2]	13.5	[8.3 - 21.2]	130,000	[83,000 - 210,000]
Chad	170,000	[110,000 - 260,000]	4.8	[3.1 - 7.2]	4.9	[3.2 - 7.4]	100,000	[66,000 - 150,000]
Comoros	…	…	…	…	…	…	…	…
Congo, Republic of	80,000	[35,000 - 170,000]	4.9	[2.1 - 11.0]	5.3	[2.3 - 11.5]	45,000	[19,000 - 100,000]
Côte d'Ivoire	480,000	[330,000 - 680,000]	7.0	[4.9 - 10.0]	6.7	[4.7 - 9.6]	300,000	[210,000 - 420,000]
Dem. Republic of Congo **	950,000	[390,000 - 2,200,000]	4.2	[1.7 - 9.9]	4.2	[1.7 - 10.0]	570,000	[230,000 - 1,300,000]
Djibouti	7,500	[2,200 - 21,000]	2.9	[0.7 - 7.5]	2.8	[0.8 - 7.9]	4,700	[1,200 - 12,000]
Equatorial Guinea	…	…	…	…	…	…	…	…
Eritrea	55,000	[20,000 - 150,000]	2.7	[0.9 - 7.3]	2.8	[1.0 - 7.6]	31,000	[11,000 - 85,000]
Ethiopia	1,200,000	[760,000 - 1,900,000]	4.4	[2.8 - 6.7]	4.1	[2.6 - 6.3]	770,000	[500,000 - 1,200,000]
Gabon	37,000	[18,000 - 73,000]	8.1	[4.1 - 15.3]	6.9	[3.3 - 13.7]	26,000	[13,000 - 48,000]
Gambia	6,300	[1,700 - 22,000]	1.2	[0.3 - 4.2]	1.2	[0.3 - 4.3]	3,600	[970 - 13,000]
Ghana *	310,000	[190,000 - 500,000]	3.1	[1.9 - 5.0]	3.1	[1.9 - 5.1]	180,000	[110,000 - 300,000]
Guinea *	100,000	[37,000 - 280,000]	3.2	[1.2 - 8.2]	2.8	[1.0 - 7.5]	72,000	[27,000 - 190,000]
Guinea-Bissau	…	…	…	…	…	…	…	…
Kenya	1,200,000	[830,000 - 1,600,000]	6.7	[4.7 - 9.6]	8.0	[5.8 - 11.1]	720,000	[500,000 - 1,000,000]
Lesotho *	300,000	[270,000 - 330,000]	28.9	[26.3 - 31.7]	29.6	[27.0 - 32.3]	170,000	[150,000 - 190,000]
Liberia	80,000	[35,000 - 180,000]	5.9	[2.7 - 12.4]	5.1	[2.2 - 11.3]	54,000	[25,000 - 110,000]
Madagascar	98,000	[48,000 - 160,000]	1.7	[0.8 - 2.7]	1.3	[0.6 - 2.1]	76,000	[37,000 - 120,000]
Malawi *	770,000	[610,000 - 960,000]	14.2	[11.3 - 17.7]	14.3	[11.4 - 17.9]	460,000	[370,000 - 570,000]
Mali	120,000	[37,000 - 350,000]	1.9	[0.6 - 5.9]	1.9	[0.6 - 5.8]	71,000	[23,000 - 210,000]
Mauritania	5,900	[2,900 - 9,700]	0.6	[0.3 - 1.1]	0.5	[0.2 - 0.7]	5,100	[2,500 - 8,300]
Mauritius	…	…	…	…	…	…	…	…
Mozambique	1,100,000	[870,000 - 1,500,000]	12.2	[9.4 - 15.7]	12.1	[9.4 - 15.6]	670,000	[520,000 - 860,000]
Namibia	190,000	[160,000 - 220,000]	21.3	[18.2 - 24.7]	21.3	[18.2 - 24.7]	110,000	[94,000 - 130,000]
Niger	51,000	[26,000 - 98,000]	1.2	[0.7 - 2.3]	1.1	[0.5 - 2.0]	36,000	[19,000 - 68,000]
Nigeria	3,100,000	[2,100,000 - 4,600,000]	5.4	[3.6 - 8.0]	5.5	[3.7 - 8.1]	1,900,000	[1,200,000 - 2,700,000]
Rwanda *	220,000	[140,000 - 320,000]	5.1	[3.4 - 7.6]	5.1	[3.4 - 7.6]	130,000	[86,000 - 200,000]
Senegal *	38,000	[19,000 - 76,000]	0.8	[0.4 - 1.7]	0.8	[0.4 - 1.6]	23,000	[12,000 - 47,000]
Sierra Leone	…	…	…	…	…	…	…	…
Somalia	…	…	…	…	…	…	…	…
South Africa *	4,800,000	[4,100,000 - 5,600,000]	21.5	[18.5 - 24.9]	20.9	[17.8 - 24.3]	2,900,000	[2,500,000 - 3,300,000]
Swaziland **	190,000	[180,000 - 200,000]	38.8	[37.2 - 40.4]	38.2	[36.5 - 39.8]	110,000	[110,000 - 120,000]
Togo	94,000	[61,000 - 140,000]	4.1	[2.7 - 6.4]	4.3	[2.8 - 6.6]	54,000	[35,000 - 84,000]
Uganda *	520,000	[370,000 - 810,000]	4.1	[2.8 - 6.6]	5.1	[3.5 - 7.9]	270,000	[170,000 - 410,000]
United Rep. of Tanzania *	1,400,000	[1,100,000 - 2,000,000]	8.8	[6.4 - 11.9]	9.0	[6.6 - 12.2]	840,000	[610,000 - 1,100,000]
Zambia	800,000	[660,000 - 970,000]	16.5	[13.5 - 20.0]	16.7	[13.6 - 20.2]	470,000	[380,000 - 570,000]
Zimbabwe	1,600,000	[1,400,000 - 1,800,000]	24.6	[21.7 - 27.8]	24.9	[22.0 - 28.1]	930,000	[820,000 - 1,000,000]
East Asia	**670,000**	**[340,000 - 1,100,000]**	**0.1**	**[0.1 - 0.2]**	**0.1**	**[0.1 - 0.2]**	**200,000**	**[100,000 - 320,000]**
China	650,000	[320,000 - 1,100,000]	0.1	[0.1 - 0.2]	0.1	[0.0 - 0.2]	190,000	[95,000 - 320,000]
Hong Kong SAR	2,600	[1,300 - 4,300]	0.1	[<0.2]	0.1	[<0.2]	900	[400 - 1,400]
Dem. Peo. Rep. of Korea	…	…	…	…	…	…	…	…
Japan	12,000	[5,800 - 19,000]	<0.1	[<0.2]	<0.1	[<0.2]	2,900	[1,400 - 4,800]
Mongolia	<200	[<400]	<0.1	[<0.2]	<0.1	[<0.2]	<200	[<400]
Republic of Korea	5,600	[1,800 - 11,000]	<0.1	[<0.2]	<0.1	[<0.2]	900	[300 - 1,800]
Oceania	**24,000**	**[16,000 - 34,000]**	**0.2**	**[0.1 - 0.3]**	**0.2**	**[0.1 - 0.3]**	**6,100**	**[3,600 - 9,200]**
Australia	12,000	[5,900 - 20,000]	0.1	[0.1 - 0.2]	0.1	[0.1 - 0.2]	1,000	[500 - 1,600]
Fiji	500	[200 - 900]	0.1	[0.0 - 0.2]	0.1	[0.0 - 0.2]	<200	[<400]
New Zealand	1,200	[400 - 2,400]	0.1	[<0.2]	0.1	[<0.2]	<200	[<400]
Papua New Guinea	10,000	[4,900 - 16,000]	0.6	[0.3 - 1.0]	0.4	[0.2 - 0.7]	4,800	[2,400 - 7,900]

1. Estimated number of people living with HIV (continued)

Country	Adults (15-49) end 2001		Adult (15-49) rate (%) end 2003		Adult (15-49) rate (%) end 2001		Women (15-49) end 2003	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
South & South-East Asia	**5,800,000**	**[3,700,000 - 8,400,000]**	**0.6**	**[0.4 - 0.9]**	**0.6**	**[0.4 - 0.9]**	**1,800,000**	**[1,200,000 - 2,700,000]**
Afghanistan	…	…	…	…	…	…	…	…
Bangladesh **	…	[2,200 - 13,000]	…	[<0.2]	…	[<0.2]	…	[400 - 2,500]
Bhutan	…	…	…	…	…	…	…	…
Brunei Darussalam	<200	[<400]	<0.1	[<0.2]	<0.1	[<0.2]	<200	[<400]
Cambodia	160,000	[100,000 - 260,000]	2.6	[1.5 - 4.4]	2.7	[1.7 - 4.3]	51,000	[31,000 - 86,000]
India	3,800,000	[2,100,000 - 6,900,000]	0.9	[0.5 - 1.5]	0.8	[0.4 - 1.3]	1,900,000	[710,000 - 2,400,000]
Indonesia	57,000	[28,000 - 94,000]	0.1	[0.0 - 0.2]	0.1	[<0.2]	15,000	[7,100 - 24,000]
Iran (Islamic Republic of)	18,000	[6,000 - 36,000]	0.1	[0.0 - 0.2]	0.1	[<0.2]	3,800	[1,200 - 7,400]
Lao People's Dem. Rep.	800	[300 - 1,500]	0.1	[<0.2]	<0.1	<0.2	<500	[<1,000]
Malaysia	41,000	[20,000 - 68,000]	0.4	[0.2 - 0.7]	0.4	[0.2 - 0.6]	8,500	[4,100 - 14,000]
Maldives	…	…	…	…	…	…	…	…
Myanmar **	270,000	[140,000 - 500,000]	1.2	[0.6 - 2.2]	1.0	[0.6 - 1.9]	97,000	[51,000 - 180,000]
Nepal	44,000	[22,000 - 72,000]	0.5	[0.3 - 0.9]	0.4	[0.2 - 0.6]	16,000	[7,200 - 24,000]
Pakistan	62,000	[20,000 - 120,000]	0.1	[0.0 - 0.2]	0.1	[0.0 - 0.2]	8,900	[3,000 - 18,000]
Philippines	4,300	[1,400 - 8,500]	<0.1	[<0.2]	<0.1	[<0.2]	2,000	[700 - 4,000]
Singapore	3,400	[1,100 - 6,600]	0.2	[0.1 - 0.5]	0.2	[0.1 - 0.4]	1,000	[300 - 2,000]
Sri Lanka	2,200	[700 - 4,300]	<0.1	[<0.2]	<0.1	[<0.2]	600	[200 - 1,200]
Thailand	620,000	[360,000 - 1,100,000]	1.5	[0.8 - 2.8]	1.7	[1.0 - 2.9]	200,000	[110,000 - 370,000]
Vietnam	150,000	[75,000 - 250,000]	0.4	[0.2 - 0.8]	0.3	[0.2 - 0.6]	65,000	[31,000 - 110,000]
Eastern Europe & Central Asia	**880,000**	**[570,000 - 1,300,000]**	**0.6**	**[0.4 - 0.9]**	**0.4**	**[0.3 - 0.6]**	**440,000**	**[280,000 - 650,000]**
Armenia	2,000	[1,000 - 3,300]	0.1	[0.1 - 0.2]	0.1	[0.0 - 0.2]	900	[400 - 1,400]
Azerbaijan	…	…	<0.1	[<0.2]	…	…	…	…
Belarus	…	[10,000 - 38,000]	…	[0.2 - 0.8]	…	[0.2 - 0.7]	…	[3,100 - 14,000]
Bosnia and Herzegovina	…	…	<0.1	[<0.2]	…	…	…	…
Bulgaria	…	…	<0.1	[<0.2]	…	…	…	…
Croatia	…	…	<0.1	[<0.2]	…	…	…	…
Czech Republic	2,100	[750 - 4,700]	0.1	[<0.2]	<0.1	[<0.2]	800	[300 - 1,700]
Estonia	5,000	[1,700 - 9,900]	1.1	[0.4 - 2.1]	0.7	[0.2 - 1.3]	2,600	[900 - 5,200]
Georgia	1,500	[700 - 3,900]	0.1	[0.1 - 0.4]	<0.1	[<0.2]	1,000	[700 - 4,000]
Hungary	…	…	0.1	[0.0 - 0.2]	…	…	…	…
Kazakhstan	10,300	[5,000 - 30,000]	0.2	[0.1 - 0.3]	0.1	[<0.2]	5,500	[2,000 - 12,000]
Kyrgyz Republic	1,500	[700 - 4,000]	0.1	[<0.2]	<0.1	[<0.2]	<800	[<1,500]
Latvia	5,900	[2,900 - 9,700]	0.6	[0.3 - 1.0]	0.5	[0.2 - 0.8]	2,500	[1,200 - 4,100]
Lithuania	1,100	[400 - 2,200]	0.1	[<0.2]	0.1	[<0.2]	<500	[<1,000]
Poland	…	…	0.1	[0.1 - 0.2]	…	…	…	…
Republic of Moldova	…	…	0.2	[0.1 - 0.3]	…	…	…	…
Romania	…	…	<0.1	[<0.2]	…	…	…	…
Russian Federation	530,000	[260,000 - 870,000]	1.1	[0.6 - 1.9]	0.7	[0.3 - 1.2]	290,000	[140,000 - 480,000]
Slovak Republic	…	…	<0.1	[<0.2]	…	…	…	…
Tajikistan	…	…	<0.1	[<0.2]	…	…	…	…
Turkmenistan	…	…	<0.1	[<0.2]	…	…	…	…
Ukraine	300,000	[150,000 - 490,000]	1.4	[0.7 - 2.3]	1.2	[0.6 - 1.9]	120,000	[59,000 - 200,000]
Uzbekistan	3,000	[1,900 - 11,000]	0.1	[0.0 - 0.2]	<0.1	<0.2	3,700	[1,700 - 9,900]
Western Europe	**540,000**	**[420,000 - 680,000]**	**0.3**	**[0.2 - 0.4]**	**0.3**	**[0.2 - 0.4]**	**150,000**	**[110,000 - 190,000]**
Albania	…	…	…	…	…	…	…	…
Austria	9,900	[4,900 - 16,000]	0.3	[0.1 - 0.4]	0.2	[0.1 - 0.4]	2,200	[1,100 - 3,600]
Belgium	8,100	[4,000 - 13,000]	0.2	[0.1 - 0.3]	0.2	[0.1 - 0.3]	3,500	[1,700 - 5,700]
Denmark	4,600	[2,300 - 7,500]	0.2	[0.1 - 0.3]	0.2	[0.1 - 0.3]	900	[400 - 1,500]
Finland	1,200	[400 - 2,400]	0.1	[<0.2]	0.1	[<0.2]	<500	[<1,000]
France	110,000	[55,000 - 180,000]	0.4	[0.2 - 0.7]	0.4	[0.2 - 0.6]	32,000	[16,000 - 52,000]
Germany	41,000	[20,000 - 67,000]	0.1	[0.1 - 0.2]	0.1	[0.1 - 0.2]	9,500	[4,700 - 16,000]
Greece	8,800	[4,300 - 14,000]	0.2	[0.1 - 0.3]	0.2	[0.1 - 0.3]	1,800	[900 - 3,000]
Iceland	<200	[<400]	0.2	[0.1 - 0.3]	0.2	[0.1 - 0.3]	<200	[<400]
Ireland	2,200	[700 - 4,300]	0.1	[0.0 - 0.3]	0.1	[0.0 - 0.2]	800	[300 - 1,500]
Italy	130,000	[64,000 - 210,000]	0.5	[0.2 - 0.8]	0.5	[0.2 - 0.8]	45,000	[22,000 - 74,000]
Luxembourg	<500	[<1,000]	0.2	[0.1 - 0.4]	0.2	[0.1 - 0.3]	…	…
Malta	<500	[<1,000]	0.2	[0.1 - 0.3]	0.1	[0.0 - 0.2]	…	…
Netherlands	17,000	[8,300 - 28,000]	0.2	[0.1 - 0.4]	0.2	[0.1 - 0.3]	3,800	[1,900 - 6,200]
Norway	1,800	[600 - 3,500]	0.1	[0.0 - 0.2]	0.1	[0.0 - 0.2]	<500	[<1,000]
Portugal	21,000	[10,000 - 34,000]	0.4	[0.2 - 0.7]	0.4	[0.2 - 0.7]	4,300	[2,100 - 7,100]
Serbia and Montenegro	10,000	[3,300 - 20,000]	0.2	[0.1 - 0.4]	0.2	[0.1 - 0.4]	2,000	[700 - 3,900]
Slovenia	<500	[<1,000]	<0.1	[<0.2]	<0.1	[<0.2]	…	…
Spain	130,000	[64,000 - 210,000]	0.7	[0.3 - 1.1]	0.6	[0.3 - 1.0]	27,000	[13,000 - 44,000]
Sweden	3,300	[1,100 - 6,500]	0.1	[0.0 - 0.2]	0.1	[0.0 - 0.2]	900	[300 - 1,800]
Switzerland	12,000	[5,900 - 20,000]	0.4	[0.2 - 0.6]	0.4	[0.2 - 0.6]	3,900	[1,900 - 6,400]
Macedonia, FYR	<200	[<400]	<0.1	[<0.2]	<0.1	[<0.2]	…	…
United Kingdom	39,000	[20,000 - 68,000]	0.2	[0.1 - 0.3]	0.2	[0.1 - 0.3]	14,000	[7,100 - 24,000]

1. Estimated number of people living with HIV (continued)

Country	Adults (15-49) end 2001		Adult (15-49) rate (%) end 2003		Adult (15-49) rate (%) end 2001		Women (15-49) end 2003	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
North Africa & Middle East	**320,000**	**[130,000 - 860,000]**	**0.2**	**[0.1 - 0.6]**	**0.2**	**[0.1 - 0.5]**	**220,000**	**[70,000 - 690,000]**
Algeria	6,800	[2,200 - 13,000]	0.1	[<0.2]	<0.1	[<0.2]	1,400	[500 - 2,700]
Bahrain	<500	[<1,000]	0.2	[0.1 - 0.3]	0.1	[0.0 - 0.2]	<500	[<1,000]
Cyprus	…	…	…	…	…	…	…	…
Egypt, Arab Republic of	11,000	[3,600 - 21,000]	<0.1	[<0.2]	<0.1	[<0.2]	1,600	[500 - 3,200]
Iraq	…	…	<0.1	[<0.2]	…	…	…	…
Israel	…	…	0.1	[0.1 - 0.2]	…	…	…	…
Jordan	<500	[<1,000]	<0.1	[<0.2]	<0.1	[<0.2]	…	…
Kuwait	…	…	…	…	…	…	…	…
Lebanon	2,000	[400 - 2,400]	0.1	[0.0 - 0.2]	0.1	[<0.2]	<500	[<1,000]
Libyan Arab Jamahiriya	…	…	0.3	[0.1 - 0.6]	…	…	…	…
Morocco	…	…	0.1	[0.0 - 0.2]	…	…	…	…
Oman	1,000	[300 - 2,000]	0.1	[0.0 - 0.2]	0.1	[0.0 - 0.2]	<500	[<1,000]
Qatar	…	…	…	…	…	…	…	…
Saudi Arabia	…	…	…	…	…	…	…	…
Sudan	300,000	[100,000 - 840,000]	2.3	[0.7 - 7.2]	1.9	[0.7 - 5.2]	220,000	[66,000 - 690,000]
Syrian Arab Republic	…	…	<0.1	[<0.2]	…	…	<200	[<1,000]
Tunisia	500	[200 - 1,100]	<0.1	[<0.2]	<0.1	[<0.2]	<500	[<1,000]
Turkey	…	…	…	…	…	…	…	…
United Arab Emirates	…	…	…	…	…	…	…	…
Yemen, the Republic of	…	…	0.1	[0.0 - 0.2]	…	…	…	…
North America	**940,000**	**[480,000 - 1,500,000]**	**0.6**	**[0.3 - 1.0]**	**0.6**	**[0.3 - 1.0]**	**250,000**	**[130,000 - 400,000]**
Canada	48,000	[24,000 - 79,000]	0.3	[0.2 - 0.5]	0.3	[0.2 - 0.5]	13,000	[6,400 - 21,000]
United States of America	890,000	[440,000 - 1,500,000]	0.6	[0.3 - 1.1]	0.6	[0.3 - 1.0]	240,000	[120,000 - 390,000]
Caribbean	**380,000**	**[260,000 - 610,000]**	**2.3**	**[1.4 - 4.1]**	**2.2**	**[1.5 - 3.5]**	**200,000**	**[120,000 - 370,000]**
Bahamas	4,900	[3,200 - 8,000]	3.0	[1.8 - 4.9]	3.0	[1.9 - 4.8]	2,500	[1,500 - 4,200]
Barbados	2,500	[800 - 7,300]	1.5	[0.4 - 5.4]	1.5	[0.5 - 4.4]	800	[200 - 3,100]
Cuba	3,200	[1,100 - 6,300]	0.1	[<0.2]	0.1	[<0.2]	1,100	[400 - 2,100]
Dominican Republic	87,000	[51,000 - 150,000]	1.7	[0.9 - 3.0]	1.8	[1.1 - 3.1]	23,000	[13,000 - 41,000]
Haiti	240,000	[130,000 - 460,000]	5.6	[2.5 - 11.9]	5.5	[2.8 - 10.4]	150,000	[66,000 - 320,000]
Jamaica	14,000	[7,500 - 27,000]	1.2	[0.6 - 2.2]	0.8	[0.4 - 1.6]	10,000	[5,500 - 20,000]
Trinidad and Tobago	26,000	[11,000 - 57,000]	3.2	[1.2 - 8.3]	3.0	[1.3 - 6.8]	14,000	[5,200 - 36,000]
Latin America	**1,400,000**	**[1,000,000 - 1,800,000]**	**0.6**	**[0.5 - 0.8]**	**0.5**	**[0.4 - 0.7]**	**560,000**	**[420,000 - 730,000]**
Argentina	120,000	[59,000 - 200,000]	0.7	[0.3 - 1.1]	0.7	[0.3 - 1.1]	24,000	[12,000 - 39,000]
Belize	2,800	[1,100 - 6,900]	2.4	[0.8 - 6.9]	2.1	[0.8 - 5.2]	1,300	[400 - 3,600]
Bolivia	4,000	[1,300 - 7,900]	0.1	[0.0 - 0.2]	0.1	[0.0 - 0.2]	1,300	[400 - 2,500]
Brazil	620,000	[300,000 - 1,000,000]	0.7	[0.3 - 1.1]	0.6	[0.3 - 1.1]	240,000	[120,000 - 400,000]
Chile	25,000	[12,000 - 41,000]	0.3	[0.2 - 0.5]	0.3	[0.2 - 0.5]	8,700	[4,300 - 14,000]
Colombia	120,000	[61,000 - 200,000]	0.7	[0.4 - 1.2]	0.5	[0.3 - 0.8]	62,000	[30,000 - 100,000]
Costa Rica	11,000	[5,400 - 18,000]	0.6	[0.3 - 1.0]	0.6	[0.3 - 0.9]	4,000	[2,000 - 6,600]
Ecuador	19,000	[9,500 - 32,000]	0.3	[0.1 - 0.5]	0.3	[0.1 - 0.5]	6,800	[3,400 - 11,000]
El Salvador	24,000	[12,000 - 39,000]	0.7	[0.3 - 1.1]	0.6	[0.3 - 1.0]	9,600	[4,700 - 16,000]
Guatemala	65,000	[32,000 - 110,000]	1.1	[0.6 - 1.8]	1.1	[0.5 - 1.7]	31,000	[15,000 - 51,000]
Guyana *	11,000	[4,000 - 28,000]	2.5	[0.8 - 7.7]	2.5	[0.9 - 6.4]	6,100	[1,900 - 19,000]
Honduras	48,000	[27,000 - 84,000]	1.8	[1.0 - 3.2]	1.6	[0.9 - 2.8]	33,000	[19,000 - 59,000]
Mexico	150,000	[74,000 - 250,000]	0.3	[0.1 - 0.4]	0.3	[0.1 - 0.4]	53,000	[26,000 - 87,000]
Nicaragua	5,500	[2,700 - 9,100]	0.2	[0.1 - 0.3]	0.2	[0.1 - 0.3]	2,100	[1,000 - 3,400]
Panama	11,000	[5,400 - 18,000]	0.9	[0.5 - 1.5]	0.7	[0.3 - 1.1]	6,200	[3,100 - 10,000]
Paraguay	10,000	[5,000 - 17,000]	0.5	[0.2 - 0.8]	0.4	[0.2 - 0.6]	3,900	[1,900 - 6,400]
Peru	51,000	[25,000 - 84,000]	0.5	[0.3 - 0.9]	0.4	[0.2 - 0.6]	27,000	[13,000 - 44,000]
Suriname	4,000	[1,300 - 12,000]	1.7	[0.5 - 5.8]	1.3	[0.4 - 4.1]	1,700	[500 - 6,100]
Uruguay	5,500	[2,700 - 9,100]	0.3	[0.2 - 0.5]	0.3	[0.2 - 0.5]	1,900	[900 - 3,200]
Venezuela, R.B. de	71,000	[35,000 - 120,000]	0.7	[0.4 - 1.2]	0.6	[0.3 - 0.9]	32,000	[16,000 - 53,000]
Global Total	**32,900,000**	**[30,200,000 - 36,700,000]**	**1.1**	**[1.0 - 1.2]**	**1.0**	**[0.9 - 1.1]**	**17,000,000**	**[15,800,000 - 18,800,000]**

1. Estimated number of people living with HIV (continued)

Country	Women (15-49) end 2001		Children (0-14) end 2003		Children (0-14) end 2001	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
Global Total	**15,700,000**	**[14,600,000 - 17,400,000]**	**2,100,000**	**[1,900,000 - 2,500,000]**	**2,000,000**	**[1,800,000 - 2,300,000]**
Sub-Saharan Africa	**12,500,000**	**[11,600,000 - 13,900,000]**	**1,900,000**	**[1,700,000 - 2,200,000]**	**1,800,000**	**[1,600,000 - 2,100,000]**
Angola	110,000	[44,000 - 280,000]	23,000	[8,600 - 61,000]	20,000	[7,500 - 54,000]
Benin	34,000	[19,000 - 59,000]	5,700	[2,900 - 11,000]	5,100	[2,600 - 10,000]
Botswana *	190,000	[180,000 - 190,000]	25,000	[17,000 - 36,000]	22,000	[15,000 - 33,000]
Burkina Faso *	140,000	[91,000 - 220,000]	31,000	[18,000 - 56,000]	31,000	[18,000 - 56,000]
Burundi	120,000	[84,000 - 180,000]	27,000	[16,000 - 45,000]	26,000	[15,000 - 44,000]
Cameroon *	280,000	[200,000 - 400,000]	43,000	[26,000 - 72,000]	39,000	[23,000 - 64,000]
Central African Republic	130,000	[80,000 - 200,000]	21,000	[11,000 - 38,000]	19,000	[10,000 - 35,000]
Chad	97,000	[64,000 - 150,000]	18,000	[10,000 - 32,000]	16,000	[9,400 - 29,000]
Comoros	…	…	…	…	…	…
Congo, Republic of	45,000	[20,000 - 99,000]	10,000	[4,200 - 26,000]	11,000	[4,400 - 26,000]
Côte d'Ivoire	270,000	[190,000 - 380,000]	40,000	[24,000 - 67,000]	38,000	[23,000 - 64,000]
Dem. Republic of Congo **	540,000	[220,000 - 1,300,000]	110,000	[42,000 - 280,000]	100,000	[40,000 - 270,000]
Djibouti	4,200	[1,200 - 12,000]	680	[210 - 2,400]	570	[200 - 2,300]
Equatorial Guinea	…	…	…	…	…	…
Eritrea	31,000	[11,000 - 84,000]	5,600	[1,900 - 17,000]	5,400	[1,800 - 16,000]
Ethiopia	670,000	[430,000 - 1,000,000]	120,000	[69,000 - 220,000]	110,000	[60,000 - 190,000]
Gabon	21,000	[10,000 - 41,000]	2,500	[1,200 - 5,300]	2,000	[900 - 4,400]
Gambia	3,500	[1,000 - 12,000]	500	[100 - 1,900]	<500	[<1,600]
Ghana *	170,000	[110,000 - 280,000]	24,000	[9,600 - 36,000]	22,000	[12,000 - 41,000]
Guinea *	59,000	[21,000 - 160,000]	9,200	[3,300 - 26,000]	7,300	[2,500 - 22,000]
Guinea-Bissau	…	…	…	…	…	…
Kenya	750,000	[540,000 - 1,000,000]	100,000	[61,000 - 170,000]	100,000	[63,000 - 170,000]
Lesotho *	170,000	[150,000 - 180,000]	22,000	[15,000 - 32,000]	20,000	[13,000 - 29,000]
Liberia	45,000	[20,000 - 99,000]	8,000	[3,400 - 19,000]	6,400	[2,600 - 16,000]
Madagascar	55,000	[27,000 - 91,000]	8,600	[2,500 - 30,000]	6,000	[1,600 - 22,000]
Malawi *	440,000	[350,000 - 540,000]	83,000	[54,000 - 130,000]	77,000	[50,000 - 120,000]
Mali	65,000	[21,000 - 200,000]	13,000	[3,900 - 42,000]	12,000	[3,500 - 38,000]
Mauritania	3,300	[1,600 - 5,500]	…	…	…	…
Mauritius	…	…	…	…	…	…
Mozambique	640,000	[490,000 - 820,000]	99,000	[63,000 - 160,000]	87,000	[55,000 - 140,000]
Namibia	100,000	[90,000 - 120,000]	15,000	[10,000 - 22,000]	12,000	[8,200 - 18,000]
Niger	29,000	[15,000 - 56,000]	5,900	[2,800 - 12,000]	4,500	[2,100 - 9,700]
Nigeria	1,800,000	[1,200,000 - 2,600,000]	290,000	[170,000 - 500,000]	260,000	[150,000 - 450,000]
Rwanda *	120,000	[81,000 - 180,000]	22,000	[12,000 - 37,000]	20,000	[12,000 - 35,000]
Senegal *	21,000	[10,000 - 43,000]	3,100	[1,400 - 6,800]	2,700	[1,200 - 5,900]
Sierra Leone	…	…	…	…	…	…
Somalia	…	…	…	…	…	…
South Africa *	2,700,000	[2,300,000 - 3,200,000]	230,000	[150,000 - 340,000]	190,000	[130,000 - 280,000]
Swaziland **	110,000	[100,000 - 110,000]	16,000	[11,000 - 23,000]	14,000	[9,400 - 20,000]
Togo	53,000	[34,000 - 82,000]	9,300	[5,200 - 17,000]	8,700	[4,900 - 15,000]
Uganda *	310,000	[210,000 - 460,000]	84,000	[46,000 - 150,000]	97,000	[54,000 - 160,000]
United Rep. of Tanzania *	820,000	[600,000 - 1,100,000]	140,000	[85,000 - 230,000]	130,000	[83,000 - 220,000]
Zambia	450,000	[370,000 - 550,000]	85,000	[56,000 - 130,000]	84,000	[55,000 - 130,000]
Zimbabwe	900,000	[790,000 - 1,000,000]	120,000	[84,000 - 180,000]	120,000	[83,000 - 180,000]
East Asia	**140,000**	**[69,000 - 220,000]**	**7,700**	**[2,700 - 22,000]**	**5,300**	**[1,800 - 16,000]**
China	130,000	[65,000 - 220,000]	…	…	…	…
Hong Kong SAR	800	[400 - 1,300]	…	…	…	…
Dem. Peo. Rep. of Korea	…	…	…	…	…	…
Japan	2,700	[1,300 - 4,500]	…	…	…	…
Mongolia	<200	[<400]	…	…	…	…
Republic of Korea	600	[200 - 1,100]	…	…	…	…
Oceania	**4,000**	**[2,400 - 5,900]**	**600**	**[<2,000]**	**400**	**[<1,200]**
Australia	800	[400 - 1,300]	…	…	…	…
Fiji	<200	[<400]	…	…	…	…
New Zealand	<200	[<400]	…	…	…	…
Papua New Guinea	2,900	[1,400 - 4,800]	…	…	…	…

1. Estimated number of people living with HIV (continued)

Country	Women (15-49) end 2001		Children (0-14) end 2003		Children (0-14) end 2001	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
South & South-East Asia	**1,600,000**	**[1,000,000 - 2,300,000]**	**160,000**	**[91,000 - 300,000]**	**130,000**	**[77,000 - 260,000]**
Afghanistan	…	…	…	…	…	…
Bangladesh **	…	[300 - 2,100]	…	…	…	…
Bhutan	…	…	…	…	…	…
Brunei Darussalam	<200	[<400]	…	…	…	…
Cambodia	48,000	[30,000 - 77,000]	7,300	[3,800 - 14,000]	6,400	[3,500 - 12,000]
India	1,500,000	[570,000 - 1,900,000]	120,000	[55,000 - 260,000]	100,000	[45,000 - 220,000]
Indonesia	6,900	[3,400 - 11,000]	…	…	…	…
Iran (Islamic Republic of)	1,900	[600 - 3,800]	…	…	…	…
Lao People's Dem. Rep.	<200	[<400]	…	…	…	…
Malaysia	6,300	[3,100 - 10,000]	…	…	…	…
Maldives	…	…	…	…	…	…
Myanmar **	78,000	[42,000 - 140,000]	7,600	[3,600 - 16,000]	5,700	[2,800 - 12,000]
Nepal	9,100	[4,500 - 15,000]	…	…	…	…
Pakistan	4,300	[1,400 - 8,500]	…	…	…	…
Philippines	900	[300 - 1,800]	…	…	…	…
Singapore	800	[300 - 1,500]	…	…	…	…
Sri Lanka	<500	[<1,000]	…	…	…	…
Thailand	200,000	[110,000 - 340,000]	12,000	[5,700 - 24,000]	12,000	[6,200 - 23,000]
Vietnam	41,000	[21,000 - 69,000]	…	…	…	…
Eastern Europe & Central Asia	**280,000**	**[180,000 - 410,000]**	**8,100**	**[6,600 - 12,000]**	**7,000**	**[5,800 - 9,700]**
Armenia	700	[300 - 1,100]	…	…	…	…
Azerbaijan	…	…	…	…	…	…
Belarus	…	[2,800 - 12,000]	…	…	…	…
Bosnia and Herzegovina	…	…	…	…	…	…
Bulgaria	…	…	…	…	…	…
Croatia	…	…	…	…	…	…
Czech Republic	750	[300 - 1,600]	…	…	…	…
Estonia	1,600	[500 - 3,200]	…	…	…	…
Georgia	<600	[200 - 1,300]	…	…	…	…
Hungary	…	…	…	…	…	…
Kazakhstan	3,500	[1,000 - 7,000]	…	…	…	…
Kyrgyz Republic	<500	[<1,000]	…	…	…	…
Latvia	1,900	[900 - 3,100]	…	…	…	…
Lithuania	<500	[<1,000]	…	…	…	…
Poland	…	…	…	…	…	…
Republic of Moldova	…	…	…	…	…	…
Romania	…	…	…	…	…	…
Russian Federation	170,000	[85,000 - 280,000]	…	…	…	…
Slovak Republic	…	…	…	…	…	…
Tajikistan	…	…	…	…	…	…
Turkmenistan	…	…	…	…	…	…
Ukraine	96,000	[47,000 - 160,000]	…	…	…	…
Uzbekistan	1,000	[600 - 3,600]	…	…	…	…
Western Europe	**130,000**	**[100,000 - 170,000]**	**6,200**	**[4,900 - 7,900]**	**5,800**	**[4,600 - 7,400]**
Albania	…	…	…	…	…	…
Austria	2,200	[1,100 - 3,600]	…	…	…	…
Belgium	2,900	[1,400 - 4,800]	…	…	…	…
Denmark	800	[400 - 1,300]	…	…	…	…
Finland	<500	[<1,000]	…	…	…	…
France	30,000	[15,000 - 49,000]	…	…	…	…
Germany	8,100	[4,000 - 13,000]	…	…	…	…
Greece	1,800	[900 - 3,000]	…	…	…	…
Iceland	<200	[<400]	…	…	…	…
Ireland	700	[200 - 1,300]	…	…	…	…
Italy	42,000	[21,000 - 69,000]	…	…	…	…
Luxembourg	…	…	…	…	…	…
Malta	…	…	…	…	…	…
Netherlands	3,300	[1,600 - 5,400]	…	…	…	…
Norway	<500	[<1,000]	…	…	…	…
Portugal	4,200	[2,100 - 6,900]	…	…	…	…
Serbia and Montenegro	2,000	[700 - 3,900]	…	…	…	…
Slovenia	…	…	…	…	…	…
Spain	26,000	[13,000 - 43,000]	…	…	…	…
Sweden	900	[300 - 1,700]	…	…	…	…
Switzerland	3,600	[1,800 - 5,900]	…	…	…	…
Macedonia, FYR	…	…	…	…	…	…
United Kingdom	11,000	[5,500 - 19,000]	…	…	…	…

1. Estimated number of people living with HIV (continued)

Country	Women (15-49) end 2001		Children (0-14) end 2003		Children (0-14) end 2001	
	Estimate	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
North Africa & Middle East	**170,000**	**[62,000 - 480,000]**	**21,000**	**[6,300 - 72,000]**	**16,000**	**[5,400 - 48,000]**
Algeria	800	[300 - 1,600]	…	…	…	…
Bahrain	<200	[<400]	…	…	…	…
Cyprus	…	…	…	…	…	…
Egypt, Arab Republic of	1,200	[400 - 2,300]	…	…	…	…
Iraq	…	…	…	…	…	…
Israel	…	…	…	…	…	…
Jordan	…	…	…	…	…	…
Kuwait	…	…	…	…	…	…
Lebanon	<500	[<1,000]	…	…	…	…
Libyan Arab Jamahiriya	…	…	…	…	…	…
Morocco	…	…	…	…	…	…
Oman	<200	[<400]	…	…	…	…
Qatar	…	…	…	…	…	…
Saudi Arabia	…	…	…	…	…	…
Sudan	170,000	[59,000 - 470,000]	21,000	[6,000 - 72,000]	16,000	[5,200 - 48,000]
Syrian Arab Republic	…	…	…	…	…	…
Tunisia	<200	[<400]	…	…	…	…
Turkey	…	…	…	…	…	…
United Arab Emirates	…	…	…	…	…	…
Yemen, the Republic of	…	…	…	…	…	…
North America	**190,000**	**[100,000 - 310,000]**	**11,000**	**[5,600 - 17,300]**	**11,000**	**[5,500 - 17,200]**
Canada	12,000	[5,900 - 20,000]	…	…	…	…
United States of America	180,000	[88,000 - 300,000]	…	…	…	…
Caribbean	**180,000**	**[120,000 - 310,000]**	**22,000**	**[11,000 - 48,000]**	**22,000**	**[12,000 - 42,000]**
Bahamas	2,500	[1,600 - 4,000]	<200	[<400]	<200	[<400]
Barbados	800	[300 - 2,400]	<200	[<400]	<200	[<400]
Cuba	1,000	[300 - 2,000]	…	…	…	…
Dominican Republic	23,000	[13,000 - 39,000]	2,200	[1,100 - 4,400]	2,100	[1,100 - 4,100]
Haiti	140,000	[71,000 - 260,000]	19,000	[7,900 - 45,000]	18,000	[8,700 - 39,000]
Jamaica	7,200	[3,700 - 14,000]	<500	[<1,000]	<500	[<1,000]
Trinidad and Tobago	13,000	[5,600 - 28,000]	700	[300 - 2,100]	600	[300 - 1,500]
Latin America	**480,000**	**[360,000 - 640,000]**	**25,000**	**[20,000 - 41,000]**	**24,000**	**[19,000 - 40,000]**
Argentina	23,000	[11,000 - 37,000]	…	…	…	…
Belize	1,000	[400 - 2,500]	<200	[<400]	<200	[<400]
Bolivia	1,100	[300 - 2,100]	…	…	…	…
Brazil	230,000	[110,000 - 380,000]	…	…	…	…
Chile	8,000	[3,900 - 13,000]	…	…	…	…
Colombia	40,000	[20,000 - 65,000]	…	…	…	…
Costa Rica	3,500	[1,700 - 5,700]	…	…	…	…
Ecuador	6,200	[3,000 - 10,000]	…	…	…	…
El Salvador	7,700	[3,800 - 13,000]	…	…	…	…
Guatemala	27,000	[13,000 - 45,000]	…	…	…	…
Guyana *	6,100	[2,300 - 16,000]	600	[200 - 2,000]	700	[200 - 1,900]
Honduras	27,000	[15,000 - 47,000]	3,900	[2,000 - 7,800]	3,200	[1,600 - 6,200]
Mexico	49,000	[24,000 - 80,000]	…	…	…	…
Nicaragua	1,800	[900 - 2,900]	…	…	…	…
Panama	4,100	[2,000 - 6,700]	…	…	…	…
Paraguay	2,700	[1,300 - 4,400]	…	…	…	…
Peru	16,000	[8,000 - 27,000]	…	…	…	…
Suriname	1,300	[400 - 3,900]	<200	[<800]	<200	[<800]
Uruguay	1,800	[900 - 2,900]	…	…	…	…
Venezuela, R.B. de	23,000	[11,000 - 37,000]	…	…	…	…
Global Total	**15,700,000**	**[14,600,000 - 17,400,000]**	**2,100,000**	**[1,900,000 - 2,500,000]**	**2,000,000**	**[1,800,000 - 2,300,000]**

	2. AIDS Deaths				3. Orphans due to AIDS			
	Deaths in adults and children end 2003		Deaths in adults and children end 2001		Orphans (0-17), currently living 2003		Orphans (0-17), living in 2001	
Country	***Estimate***	***[low estimate - high estimate]***	***Estimate***	***[low estimate - high estimate]***	***Estimate***	***[low estimate - high estimate]***	***Estimate***	***[low estimate - high estimate]***
Global Total	**2,900,000**	**[2,600,000 - 3,300,000]**	**2,500,000**	**[2,300,000 - 2,800,000]**	**15,000,000**	**[13,000,000 - 18,000,000]**	**11,500,000**	**[10,000,000 - 14,000,000]**
Sub-Saharan Africa	**2,200,000**	**[2,000,000 - 2,500,000]**	**1,900,000**	**[1,700,000 - 2,200,000]**	**12,100,000**	**[11,000,000 - 13,400,000]**	**9,600,000**	**[8,800,000 - 10,700,000]**
Angola	21,000	[9,600 - 45,000]	18,000	[8,500 - 40,000]	110,000	[74,000 - 160,000]	87,000	[58,000 - 120,000]
Benin	5,800	[3,400 - 10,000]	4,900	[2,800 - 8,600]	34,000	[23,000 - 48,000]	25,000	[17,000 - 36,000]
Botswana *	33,000	[25,000 - 43,000]	28,000	[21,000 - 37,000]	120,000	[84,000 - 180,000]	95,000	[63,000 - 140,000]
Burkina Faso *	29,000	[18,000 - 47,000]	30,000	[19,000 - 48,000]	260,000	[180,000 - 370,000]	240,000	[160,000 - 340,000]
Burundi	25,000	[16,000 - 39,000]	25,000	[16,000 - 38,000]	200,000	[130,000 - 280,000]	170,000	[120,000 - 250,000]
Cameroon *	49,000	[32,000 - 74,000]	41,000	[26,000 - 63,000]	240,000	[160,000 - 340,000]	170,000	[110,000 - 240,000]
Central African Republic	23,000	[13,000 - 40,000]	20,000	[12,000 - 35,000]	110,000	[77,000 - 160,000]	90,000	[60,000 - 130,000]
Chad	18,000	[11,000 - 28,000]	16,000	[9,900 - 25,000]	96,000	[64,000 - 140,000]	73,000	[49,000 - 100,000]
Comoros	…	…	…	…	…	…	…	…
Congo, Republic of	9,700	[4,900 - 20,000]	10,000	[5,100 - 20,000]	97,000	[65,000 - 140,000]	87,000	[59,000 - 120,000]
Côte d'Ivoire	47,000	[30,000 - 72,000]	43,000	[28,000 - 66,000]	310,000	[200,000 - 440,000]	270,000	[180,000 - 390,000]
Dem. Republic of Congo **	100,000	[50,000 - 220,000]	100,000	[48,000 - 210,000]	770,000	[520,000 - 1,100,000]	680,000	[450,000 - 970,000]
Djibouti	690	[320 - 1,900]	550	[300 - 1,800]	5,000	[3,400 - 7,200]	4,100	[2,700 - 5,800]
Equatorial Guinea	…	…	…	…	…	…	…	…
Eritrea	6,300	[2,900 - 14,000]	5,800	[2,700 - 13,000]	39,000	[26,000 - 55,000]	28,000	[19,000 - 41,000]
Ethiopia	120,000	[74,000 - 190,000]	100,000	[58,000 - 180,000]	720,000	[480,000 - 1,000,000]	560,000	[370,000 - 790,000]
Gabon	3,000	[1,500 - 5,700]	2,200	[1,100 - 4,500]	14,000	[9,300 - 20,000]	10,000	[6,900 - 15,000]
Gambia	600	[200 - 1,500]	<500	[<1,200]	2,000	[1,500 - 3,200]	1,500	[990 - 2,100]
Ghana *	30,000	[18,000 - 49,000]	26,000	[16,000 - 42,000]	170,000	[120,000 - 250,000]	140,000	[91,000 - 190,000]
Guinea *	9,000	[4,000 - 20,000]	6,900	[3,000 - 16,000]	35,000	[23,000 - 50,000]	25,000	[17,000 - 35,000]
Guinea-Bissau	…	…	…	…	…	…	…	…
Kenya	150,000	[89,000 - 200,000]	140,000	[87,000 - 190,000]	650,000	[430,000 - 930,000]	500,000	[340,000 - 720,000]
Lesotho *	29,000	[22,000 - 39,000]	24,000	[18,000 - 33,000]	100,000	[68,000 - 150,000]	68,000	[46,000 - 97,000]
Liberia	7,200	[3,500 - 15,000]	5,900	[2,800 - 12,000]	36,000	[24,000 - 52,000]	28,000	[19,000 - 40,000]
Madagascar	7,500	[3,200 - 16,000]	4,900	[2,100 - 11,000]	30,000	[20,000 - 42,000]	18,000	[12,000 - 25,000]
Malawi *	84,000	[58,000 - 120,000]	75,000	[52,000 - 110,000]	500,000	[330,000 - 710,000]	390,000	[260,000 - 560,000]
Mali	12,000	[5,100 - 29,000]	11,000	[4,500 - 26,000]	75,000	[50,000 - 110,000]	59,000	[40,000 - 85,000]
Mauritania	<500	[<1,000]	<500	[<1,000]	2,000	[1,100 - 2,300]	1,000	[700 - 1,400]
Mauritius	…	…	…	…	…	…	…	…
Mozambique	110,000	[74,000 - 160,000]	89,000	[60,000 - 130,000]	470,000	[310,000 - 670,000]	330,000	[220,000 - 470,000]
Namibia	16,000	[11,000 - 22,000]	11,000	[7,900 - 16,000]	57,000	[38,000 - 81,000]	33,000	[22,000 - 48,000]
Niger	4,800	[2,300 - 9,800]	3,600	[1,700 - 7,600]	24,000	[16,000 - 35,000]	16,000	[11,000 - 23,000]
Nigeria	310,000	[200,000 - 490,000]	260,000	[160,000 - 410,000]	1,800,000	[1,200,000 - 2,600,000]	1,300,000	[890,000 - 1,900,000]
Rwanda *	22,000	[14,000 - 36,000]	21,000	[14,000 - 34,000]	160,000	[110,000 - 240,000]	160,000	[110,000 - 230,000]
Senegal *	3,500	[1,900 - 6,500]	2,800	[1,500 - 5,300]	17,000	[12,000 - 25,000]	12,000	[8,200 - 18,000]
Sierra Leone	…	…	…	…	…	…	…	…
Somalia	…	…	…	…	…	…	…	…
South Africa *	370,000	[270,000 - 520,000]	270,000	[190,000 - 390,000]	1,100,000	[710,000 - 1,500,000]	660,000	[440,000 - 940,000]
Swaziland **	17,000	[13,000 - 23,000]	13,000	[9,900 - 18,000]	65,000	[43,000 - 93,000]	44,000	[30,000 - 63,000]
Togo	10,000	[6,400 - 16,000]	8,900	[5,600 - 14,000]	54,000	[36,000 - 77,000]	37,000	[25,000 - 53,000]
Uganda *	78,000	[54,000 - 120,000]	94,000	[66,000 - 140,000]	940,000	[630,000 - 1,400,000]	910,000	[610,000 - 1,300,000]
United Rep. of Tanzania *	160,000	[110,000 - 230,000]	150,000	[98,000 - 220,000]	980,000	[660,000 - 1,400,000]	790,000	[530,000 - 1,100,000]
Zambia	89,000	[63,000 - 130,000]	88,000	[62,000 - 120,000]	630,000	[420,000 - 910,000]	570,000	[380,000 - 810,000]
Zimbabwe	170,000	[130,000 - 230,000]	160,000	[120,000 - 220,000]	980,000	[660,000 - 1,400,000]	830,000	[560,000 - 1,200,000]
East Asia	**44,000**	**[22,000 - 75,000]**	**31,000**	**[15,000 - 52,000]**				
China	44,000	[21,000 - 75,000]	30,000	[15,000 - 51,000]	…	…	…	…
Hong Kong SAR	<200	[<400]	<200	[<400]	…	…	…	…
Dem. Peo. Rep. of Korea	…	…	…	…	…	…	…	…
Japan	<500	[<1,000]	<500	[<1,000]	…	…	…	…
Mongolia	<200	[<400]	<200	[<400]	…	…	…	…
Republic of Korea	<200	[<400]	<200	[<400]	…	…	…	…
Oceania	**700**	**[<1,300]**	**400**	**[<800]**				
Australia	<200	[<400]	<200	[<400]	…	…	…	…
Fiji	<200	[<400]	<200	[<400]	…	…	…	…
New Zealand	<200	[<400]	<200	[<400]	…	…	…	…
Papua New Guinea	600	[200 - 1,200]	<500	[<1,000]	…	…	…	…

	2. AIDS Deaths				3. Orphans due to AIDS			
	Deaths in adults and children end 2003		Deaths in adults and children end 2001		Orphans (0-17), currently living 2003		Orphans (0-17), living in 2001	
Country	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
South & South-East Asia	**460,000**	**[290,000 - 700,000]**	**390,000**	**[240,000 - 590,000]**				
Afghanistan	…	…	…	…	…	…	…	…
Bangladesh **	…	[<400]	…	[<400]	…	…	…	…
Bhutan	…	…	…	…	…	…	…	…
Brunei Darussalam	<200	[<400]	<200	[<400]	…	…	…	…
Cambodia	15,000	[9,100 - 25,000]	13,000	[7,800 - 21,000]	…	…	…	…
India	…	…	…	…	…	…	…	…
Indonesia	2,400	[1,100 - 4,100]	600	[300 - 1,000]	…	…	…	…
Iran (Islamic Republic of)	800	[300 - 1,600]	<500	[<1,000]	…	…	…	…
Lao People's Dem. Rep.	<200	[<400]	<200	[<400]	…	…	…	…
Malaysia	2,000	[1,000 - 3,600]	1,500	[700 - 2,900]	…	…	…	…
Maldives	…	…	…	…	…	…	…	…
Myanmar **	20,000	[11,000 - 35,000]	14,000	[7,800 - 26,000]	…	…	…	…
Nepal	3,100	[1,000 - 6,400]	2,000	[900 - 4,200]	…	…	…	…
Pakistan	4,900	[1,600 - 11,000]	3,900	[1,300 - 8,500]	…	…	…	…
Philippines	<500	[<1,000]	<200	[<400]	…	…	…	…
Singapore	<200	[<400]	<200	[<400]	…	…	…	…
Sri Lanka	<200	[<400]	<200	[<400]	…	…	…	…
Thailand	58,000	[34,000 - 97,000]	58,000	[34,000 - 96,000]	…	…	…	…
Vietnam	9,000	[4,500 - 16,000]	5,000	[3,000 - 9,100]	…	…	…	…
Eastern Europe & Central Asia	**49,000**	**[32,000 - 71,000]**	**31,000**	**[21,000 - 45,000]**				
Armenia	<200	[<400]	<200	[<400]	…	…	…	…
Azerbaijan	…	…	…	…	…	…	…	…
Belarus	…	[900 - 3,300]	…	[800 - 3,000]	…	…	…	…
Bosnia and Herzegovina	…	…	…	…	…	…	…	…
Bulgaria	…	…	…	…	…	…	…	…
Croatia	…	…	…	…	…	…	…	…
Czech Republic	…	…	…	…	…	…	…	…
Estonia	<200	[<400]	<200	[<400]	…	…	…	…
Georgia	<200	[<400]	<200	[<400]	…	…	…	…
Hungary	…	…	…	…	…	…	…	…
Kazakhstan	<200	[<400]	<200	[<400]	…	…	…	…
Kyrgyz Republic	<200	[<400]	<200	[<400]	…	…	…	…
Latvia	<500	[<1,000]	<200	[<400]	…	…	…	…
Lithuania	<200	[<400]	<200	[<400]	…	…	…	…
Poland	…	…	…	…	…	…	…	…
Republic of Moldova	…	…	…	…	…	…	…	…
Romania	…	…	…	…	…	…	…	…
Russian Federation	…	…	…	…	…	…	…	…
Slovak Republic	…	…	…	…	…	…	…	…
Tajikistan	…	…	…	…	…	…	…	…
Turkmenistan	…	…	…	…	…	…	…	…
Ukraine	20,000	[9,600 - 33,000]	14,000	[7,000 - 24,000]	…	…	…	…
Uzbekistan	<500	[<1,000]	<200	[<400]	…	…	…	…
Western Europe	**6,000**	**[<8000]**	**6,000**	**[<8000]**				
Albania	…	…	…	…	…	…	…	…
Austria	<100	[<200]	<100	[<200]	…	…	…	…
Belgium	<100	[<200]	<100	[<200]	…	…	…	…
Denmark	<100	[<200]	<100	[<200]	…	…	…	…
Finland	<100	[<200]	<100	[<200]	…	…	…	…
France	<1,000	[<2,000]	<1,000	[<2,000]	…	…	…	…
Germany	<1,000	[<2,000]	<1,000	[<2,000]	…	…	…	…
Greece	<100	[<200]	<100	[<200]	…	…	…	…
Iceland	<100	[<200]	<100	[<200]	…	…	…	…
Ireland	<100	[<200]	<100	[<200]	…	…	…	…
Italy	<1000	[<2,000]	<1000	[<2,000]	…	…	…	…
Luxembourg	<100	[<200]	<100	[<200]	…	…	…	…
Malta	<100	[<200]	<100	[<200]	…	…	…	…
Netherlands	<100	[<200]	<100	[<200]	…	…	…	…
Norway	<100	[<200]	<100	[<200]	…	…	…	…
Portugal	<1000	[<2,000]	<1000	[<2,000]	…	…	…	…
Serbia and Montenegro	<100	[<200]	<100	[<200]	…	…	…	…
Slovenia	<100	[<200]	<100	[<200]	…	…	…	…
Spain	<1000	[<2,000]	<1000	[<2,000]	…	…	…	…
Sweden	<100	[<200]	<100	[<200]	…	…	…	…
Switzerland	<200	[<400]	<200	[<400]	…	…	…	…
Macedonia, FYR	<100	[<200]	<100	[<200]	…	…	…	…
United Kingdom	<500	[<1,000]	<500	[<1,000]	…	…	…	…

4. HIV prevalence rate **5. HIV prevalence rate (%) in groups** **6. Knowledge and**

	2. AIDS Deaths				3. Orphans due to AIDS			
	Deaths in adults and children end 2003		Deaths in adults and children end 2001		Orphans (0-17), currently living 2003		Orphans (0-17), living in 2001	
Country	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*	*Estimate*	*[low estimate - high estimate]*
North Africa & Middle East	**24,000**	**[9,900 - 62,000]**	**17,000**	**[7,500 - 40,000]**				
Algeria	<500	[<1,000]	<500	[<1,000]	…	…	…	…
Bahrain	<200	[<400]	<200	[<400]	…	…	…	…
Cyprus	…	…	…	…	…	…	…	…
Egypt, Arab Republic of	700	[200 - 1,600]	<500	[<1,000]	…	…	…	…
Iraq	…	…	…	…	…	…	…	…
Israel	…	…	…	…	…	…	…	…
Jordan	<200	[<400]	<200	[<400]	…	…	…	…
Kuwait	…	…	…	…	…	…	…	…
Lebanon	<200	[<400]	<200	[<400]	…	…	…	…
Libyan Arab Jamahiriya	…	…	…	…	…	…	…	…
Morocco	…	…	…	…	…	…	…	…
Oman	<200	[<400]	<200	[<400]	…	…	…	…
Qatar	…	…	…	…	…	…	…	…
Saudi Arabia	…	…	…	…	…	…	…	…
Sudan	23,000	[8,700 - 61,000]	16,000	[6,800 - 39,000]	…	…	…	…
Syrian Arab Republic	<200	[<400]	…	…	…	…	…	…
Tunisia	<200	[<400]	<200	[<400]	…	…	…	…
Turkey	…	…	…	…	…	…	…	…
United Arab Emirates	…	…	…	…	…	…	…	…
Yemen, the Republic of	…	…	…	…	…	…	…	…
North America	**16,000**	**[8,300 - 25,000]**	**16,000**	**[8,300 - 25,000]**				
Canada	1,500	[740 - 2,500]	1,500	[740 - 2,500]	…	…	…	…
United States of America	14,000	[6,900 - 23,000]	14,000	[6,900 - 23,000]	…	…	…	…
Caribbean	**35,000**	**[23,000 - 59,000]**	**32,000**	**[22,000 - 50,000]**				
Bahamas	<200	[<400]	<200	[<400]	…	…	…	…
Barbados	<200	[<400]	<200	[<400]	…	…	…	…
Cuba	<200	[<400]	<200	[<400]	…	…	…	…
Dominican Republic	7,900	[4,700 - 13,000]	7,000	[4,200 - 12,000]	…	…	…	…
Haiti	24,000	[12,000 - 47,000]	22,000	[13,000 - 40,000]	…	…	…	…
Jamaica	900	[500 - 1,600]	<500	[<1,000]	…	…	…	…
Trinidad and Tobago	1,900	[900 - 4,100]	1,500	[800 - 2,900]	…	…	…	…
Latin America	**84,000**	**[65,000 - 110,000]**	**63,000**	**[50,000 - 81,000]**				
Argentina	1,500 ***	[1,400 - 3,000] ***	1,500 ***	[1,400 - 3,000] ***	…	…	…	…
Belize	<200	[<400]	<200	[<400]	…	…	…	…
Bolivia	<500	[<1,000]	<500	[<1,000]	…	…	…	…
Brazil	15,000 ***	[14,000 - 22,000] ***	14,600 ***	[13,000 - 20,000] ***	…	…	…	…
Chile	1,400	[700 - 2,500]	800	[400 - 1,500]	…	…	…	…
Colombia	3,600 ***	[2,200 - 6,000] ***	3,300 ***	[2,000 - 5,800] ***	…	…	…	…
Costa Rica	900	[400 - 1,600]	800	[400 - 1,400]	…	…	…	…
Ecuador	1,700	[800 - 3,600]	1,600	[700 - 3,200]	…	…	…	…
El Salvador	2,200	[1,000 - 4,100]	2,000	[1,000 - 3,800]	…	…	…	…
Guatemala	5,800	[2,900 - 10,000]	4,900	[2,400 - 8,400]	…	…	…	…
Guyana *	1,100	[500 - 2,600]	1,300	[600 - 2,700]	…	…	…	…
Honduras	4,100	[2,300 - 7,200]	3,100	[1,700 - 5,500]	…	…	…	…
Mexico	5,000 ***	[4,500 - 10,000] ***	4,200 ***	[4,000 - 9,000] ***	…	…	…	…
Nicaragua	<500	[<1,000]	<500	[<1,000]	…	…	…	…
Panama	<500	[<1,000]	<200	[<400]	…	…	…	…
Paraguay	600	[300 - 1,000]	<500	[<1,000]	…	…	…	…
Peru	4,200	[2,100 - 7,300]	3,700	[1,800 - 6,400]	…	…	…	…
Suriname	<500	[<1,000]	<500	[<1,000]	…	…	…	…
Uruguay	<500	[<1,000]	<500	[<1,000]	…	…	…	…
Venezuela, R.B. de	4,100	[1,900 - 8,000]	2,600	[1,200 - 5,300]	…	…	…	…
Global Total	**2,900,000**	**[2,600,000 - 3,300,000]**	**2,500,000**	**[2,300,000 - 2,800,000]**				

	4. HIV prevalence rate (%) in young (15-24 yrs) pregnant women in capital city		5. HIV prevalence rate (%) in groups with high-risk behaviour in capital city						6. Knowledge and behaviour indicators	
			Injecting Drug Users		Sex Workers		Men who have sex with men		Know that a healthy-looking person can have the AIDS virus (%) (15-24)	
Country	***Year***	***Median***	***Year***	***Median***	***Year***	***Median***	***Year***	***Median***	***Female***	***Male***
Global Total										
Sub-Saharan Africa										
Angola	…	…	…	…	2002	33.3	…	…	…	…
Benin	2002	2.3	…	…	2001	60.5	…	…	56	69
Botswana *	2003	32.9	…	…	…	…	…	…	81	76
Burkina Faso *	2002	2.3	…	…	…	…	…	…	42 v	64 v
Burundi	2002	13.6	…	…	…	…	…	…	66	…
Cameroon *	2002	7.0	…	…	…	…	…	…	57	63
Central African Republic	2002	14.0	…	…	…	…	…	…	46	…
Chad	2003	4.8	…	…	…	…	…	…	28	…
Comoros	…	…	…	…	…	…	…	…	55	…
Congo, Republic of	…	…	…	…	…	…	…	…	…	…
Côte d'Ivoire	2002	5.2	…	…	…	…	…	…	64	67
Dem. Republic of Congo **	…	…	…	…	…	…	…	…	…	…
Djibouti	…	…	…	…	…	…	…	…	…	…
Equatorial Guinea	…	…	…	…	…	…	…	…	46	…
Eritrea	…	…	…	…	…	…	…	…	79	…
Ethiopia	2003	11.7	…	…	…	…	…	…	39	54
Gabon	…	…	…	…	…	…	…	…	72	81
Gambia	…	…	…	…	…	…	…	…	53	…
Ghana *	2003	3.9	…	…	…	…	…	…	71	77
Guinea *	…	…	…	…	2001	39.7	…	…	60	56
Guinea-Bissau	…	…	…	…	…	…	…	…	31	…
Kenya	…	…	…	…	2000	25.5	…	…	74	80
Lesotho *	2003	27.8	…	…	…	…	…	…	46	…
Liberia	…	…	…	…	…	…	…	…	…	…
Madagascar	…	…	…	…	2001	0.2	…	…	27	…
Malawi *	2003	18.0	…	…	…	…	…	…	84	89
Mali	2003	2.2	…	…	2000	21.0	…	…	46	59
Mauritania	…	…	…	…	…	…	…	…	30	39
Mauritius	…	…	…	…	…	…	…	…	…	…
Mozambique	2002	14.7	…	…	…	…	…	…	62	71
Namibia	…	…	…	…	…	…	…	…	82	87
Niger	…	…	…	…	…	…	…	…	37	41
Nigeria	2003	4.2	…	…	…	…	…	…	45	51
Rwanda *	2002	11.6	…	…	…	…	…	…	64	69
Senegal *	2002	1.1	…	…	2002	14.2	…	…	46	…
Sierra Leone	…	…	…	…	…	…	…	…	35	…
Somalia	…	…	…	…	…	…	…	…	13	…
South Africa *	2002	24.0	…	…	…	…	…	…	54	…
Swaziland **	2002	39.0	…	…	…	…	…	…	81	…
Togo	2003	9.1	…	…	…	…	…	…	66	73
Uganda *	2001	10.0	…	…	…	…	…	…	76	83
United Rep. of Tanzania *	2002	7.0	…	…	…	…	…	…	65	68
Zambia	2002	22.1	…	…	…	…	…	…	74	73
Zimbabwe	…	…	…	…	…	…	…	…	74	83
East Asia										
China	…	…	2000	0.0	2000	0.2	…	…	…	…
Hong Kong SAR	…	…	…	…	…	…	…	…	…	…
Dem. Peo. Rep. of Korea	…	…	…	…	…	…	…	…	…	…
Japan	…	…	…	…	…	…	2000	2.9	…	…
Mongolia	…	…	…	…	…	…	…	…	57	…
Republic of Korea	…	…	…	…	…	…	…	…	…	…
Oceania										
Australia	…	…	…	…	…	…	…	…	…	…
Fiji	…	…	…	…	…	…	…	…	…	…
New Zealand	…	…	…	…	…	…	…	…	…	…
Papua New Guinea	…	…	…	…	2000	16.0	…	…	…	…

Country	(%) in young (15-24 yrs) pregnant women in capital city		with high-risk behaviour in capital city						behaviour indicators Know that a healthy-looking person can have the AIDS virus (%) (15-24)	
			Injecting Drug Users		Sex Workers		Men who have sex with men			
	Year	*Median*	*Year*	*Median*	*Year*	*Median*	*Year*	*Median*	*Female*	*Male*
South & South-East Asia										
Afghanistan	…	…	…	…	…	…	…	…	…	…
Bangladesh **	…	…	1999	2.5	2000	20.0	1999	0.3	…	…
Bhutan	…	…	…	…	…	…	…	…	…	…
Brunei Darussalam	…	…	…	…	…	…	…	…	…	…
Cambodia	…	…	…	…	2002	18.5	…	…	62	…
India	…	…	2002	7.2	…	…	…	…	…	…
Indonesia	…	…	…	…	2001	0.0	…	…	32	…
Iran (Islamic Republic of)	…	…	…	…	…	…	…	…	…	…
Lao People's Dem. Rep.	…	…	…	…	2001	1.1	…	…	…	…
Malaysia	…	…	…	…	…	…	…	…	…	…
Maldives	…	…	…	…	…	…	…	…	…	…
Myanmar **	…	…	2000	37.1	2000	26.0	…	…	…	…
Nepal	…	…	2000	50.0	2002	17.0	…	…	…	…
Pakistan	…	…	…	…	…	…	…	…	…	…
Philippines	…	…	…	…	…	…	…	…	67	…
Singapore	…	…	…	…	…	…	…	…	…	…
Sri Lanka	…	…	…	…	…	…	…	…	…	…
Thailand	…	…	2002	53.7	2002	2.6	…	…	…	…
Vietnam	…	…	2001	22.3	2001	11.5	…	…	63	…
Eastern Europe & Central Asia										
Armenia	…	…	…	…	1999	7.5	…	…	53	48
Azerbaijan	…	…	…	…	…	…	…	…	35	…
Belarus	…	…	…	…	…	…	…	…	…	…
Bosnia and Herzegovina	…	…	…	…	…	…	…	…	74	…
Bulgaria	…	…	…	…	…	…	…	…	…	…
Croatia	…	…	…	…	…	…	…	…	…	…
Czech Republic	…	…	…	…	…	…	…	…	…	…
Estonia	…	…	…	…	…	…	…	…	…	…
Georgia	…	…	…	…	…	…	…	…	…	…
Hungary	…	…	2000	2.2	…	…	…	…	…	…
Kazakhstan	…	…	2002	0.0	…	…	…	…	63 x	73 x
Kyrgyz Republic	…	…	…	…	…	…	…	…	…	…
Latvia	…	…	2002	17.3	…	…	…	…	…	…
Lithuania	…	…	…	…	2001	0.5	…	…	…	…
Poland	…	…	…	…	…	…	…	…	…	…
Republic of Moldova	…	…	…	…	…	…	…	…	79	…
Romania	…	…	…	…	…	…	…	…	70	77
Russian Federation	…	…	…	…	2002	3.0	…	…	…	…
Slovak Republic	…	…	…	…	…	…	…	…	…	…
Tajikistan	…	…	…	…	…	…	…	…	8	…
Turkmenistan	…	…	…	…	…	…	…	…	42	…
Ukraine	…	…	…	…	…	…	…	…	78	…
Uzbekistan	…	…	…	…	…	…	…	…	41	…
Western Europe										
Albania	…	…	…	…	…	…	…	…	40	…
Austria	…	…	…	…	…	…	…	…	…	…
Belgium	…	…	…	…	…	…	…	…	…	…
Denmark	…	…	…	…	…	…	…	…	…	…
Finland	…	…	…	…	…	…	…	…	…	…
France	…	…	…	…	…	…	…	…	…	…
Germany	…	…	…	…	…	…	…	…	…	…
Greece	…	…	…	…	…	…	…	…	…	…
Iceland	…	…	…	…	…	…	…	…	…	…
Ireland	…	…	…	…	…	…	…	…	…	…
Italy	…	…	…	…	…	…	…	…	…	…
Luxembourg	…	…	…	…	…	…	…	…	…	…
Malta	…	…	…	…	…	…	…	…	…	…
Netherlands	…	…	…	…	…	…	…	…	…	…
Norway	…	…	…	…	…	…	…	…	…	…
Portugal	…	…	…	…	…	…	…	…	…	…
Serbia and Montenegro	…	…	…	…	…	…	…	…	…	…
Slovenia	…	…	…	…	…	…	1999	1.7	…	…
Spain	…	…	…	…	…	…	…	…	…	…
Sweden	…	…	…	…	…	…	…	…	…	…
Switzerland	…	…	…	…	…	…	…	…	…	…
Macedonia, FYR	…	…	…	…	…	…	…	…	…	…
United Kingdom	…	…	…	…	…	…	…	…	…	…

6. Knowledge and behaviour indicators

	4. HIV prevalence rate (%) in young (15-24 yrs) pregnant women in capital city		5. HIV prevalence rate (%) in groups with high-risk behaviour in capital city						6. Knowledge and behaviour indicators	
			Injecting Drug Users		Sex Workers		Men who have sex with men		Know that a healthy-looking person can have the AIDS virus (%) (15-24)	
Country	***Year***	***Median***	***Year***	***Median***	***Year***	***Median***	***Year***	***Median***	***Female***	***Male***
North Africa & Middle East										
Algeria	…	…	…	…	…	…	…	…	…	…
Bahrain	…	…	…	…	…	…	…	…	…	…
Cyprus	…	…	…	…	…	…	…	…	…	…
Egypt, Arab Republic of	…	…	…	…	…	…	…	…	…	…
Iraq	…	…	…	…	…	…	…	…	…	…
Israel	…	…	…	…	…	…	…	…	…	…
Jordan	…	…	…	…	…	…	…	…	…	…
Kuwait	…	…	…	…	…	…	…	…	…	…
Lebanon	…	…	…	…	…	…	…	…	…	…
Libyan Arab Jamahiriya	…	…	…	…	…	…	…	…	…	…
Morocco	…	…	…	…	…	…	…	…	…	…
Oman	…	…	…	…	…	…	…	…	…	…
Qatar	…	…	…	…	…	…	…	…	…	…
Saudi Arabia	…	…	…	…	…	…	…	…	…	…
Sudan	…	…	…	…	…	…	…	…	…	…
Syrian Arab Republic	…	…	…	…	…	…	…	…	…	…
Tunisia	…	…	…	…	…	…	…	…	…	…
Turkey	…	…	…	…	…	…	…	…	…	…
United Arab Emirates	…	…	…	…	…	…	…	…	…	…
Yemen, the Republic of	…	…	…	…	…	…	…	…	…	…
North America										
Canada	…	…	…	…	…	…	…	…	…	…
United States of America	…	…	…	…	…	…	…	…	…	…
Caribbean										
Bahamas	…	…	…	…	…	…	…	…	…	…
Barbados	…	…	…	…	…	…	…	…	…	…
Cuba	…	…	…	…	…	…	…	…	91	…
Dominican Republic	…	…	…	…	1999	3.5	…	…	92	91
Haiti	…	…	…	…	…	…	…	…	68	78
Jamaica	…	…	…	…	…	…	…	…	…	…
Trinidad and Tobago	…	…	…	…	…	…	…	…	95	…
Latin America										
Argentina	…	…	2001	44.3	…	…	2001	24.3	…	…
Belize	…	…	…	…	…	…	…	…	…	…
Bolivia	…	…	…	…	…	…	…	…	64	74
Brazil	…	…	…	…	…	…	…	…	…	…
Chile	…	…	…	…	…	…	…	…	…	…
Colombia	…	…	…	…	…	…	…	…	82	…
Costa Rica	…	…	…	…	…	…	…	…	…	…
Ecuador	…	…	…	…	2002	14.0	…	…	58 w	…
El Salvador	…	…	…	…	2002	4.0	2002	17.7	68	…
Guatemala	…	…	…	…	2002	3.3	2002	11.5	…	…
Guyana *	…	…	…	…	…	…	…	…	84	…
Honduras	…	…	…	…	2002	8.1	2002	8.2	81	90
Mexico	…	…	…	…	1999	0.3	…	…	…	…
Nicaragua	…	…	…	…	2002	0.0	2002	9.3	73 z	…
Panama	…	…	…	…	2002	1.8	2002	10.6	…	…
Paraguay	…	…	…	…	…	…	…	…	…	…
Peru	…	…	…	…	…	…	2002	22.0	72	…
Suriname	…	…	…	…	…	…	…	…	70	…
Uruguay	…	…	…	…	…	…	…	…	…	…
Venezuela, R.B. de	…	…	…	…	…	…	…	…	78	…
Global Total										

6. Knowledge and behaviour indicators

Country	Can identify two prevention methods and reject three misconceptions (%) (15-24)		Had sex before age 15 (%) (15-19)		Reported higher risk sex in the last year (%) (15-24)		Used a condom the last time they had higher risk sex, of those who had high risk sex in the last year (%) (15-24)		Year
	Female	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	
Global Total									
Sub-Saharan Africa									
Angola	…	…	…	…	…	…	…	…	…
Benin	8	14	16	24	36	90	19	34	2001 d
Botswana *	40	33	…	…	…	…	75 x	88 x	2001 b
Burkina Faso *	…	…	12	8	19	82	41	55	1999 d
Burundi	24	…	…	…	…	…	…	…	2000 c
Cameroon *	16 c,x	…	26	18	41	86	16	31	1998 d
Central African Republic	5	…	…	…	…	…	…	…	2000 c
Chad	5	…	…	…	…	…	…	…	2000 c
Comoros	10	…	…	…	…	…	…	…	2000 c
Congo, Republic of	…	…	…	…	…	…	…	…	…
Côte d'Ivoire	16 c,x	…	22	14	51	91	25	56	1998 d
Dem. Republic of Congo **	…	…	…	…	…	…	…	…	…
Djibouti	…	…	…	…	…	…	…	…	…
Equatorial Guinea	4	…	…	…	…	…	…	…	2000 c
Eritrea	…	…	9	…	…	…	…	…	2002 d
Ethiopia	…	…	14	5	7	64	17	30	2000 d
Gabon	24	22	24	48	53	75	33	48	2000 d
Gambia	15	…	…	…	…	…	…	…	2000 c
Ghana *	…	…	7	4	…	…	…	…	1998 d
Guinea *	…	…	27	20	23	92	17	32	1999 d
Guinea-Bissau	8	…	…	…	…	…	…	…	2000 c
Kenya	26 c,x	…	15	32	39	92	14	43	1998 d
Lesotho *	18	…	…	…	…	…	…	…	2000 c
Liberia	…	…	32	12	…	…	…	…	1999 d
Madagascar	…	…	…	…	…	…	…	…	2000 c
Malawi *	34	41	17	29	17	71	32	38	2000 d
Mali	9	15	26	11	18	85	14	30	2001 d
Mauritania	…	…	13	2	…	…	…	…	2000 d
Mauritius	…	…	…	…	…	…	…	…	…
Mozambique	…	…	…	…	…	…	…	…	2001 e
Namibia	31	41	10	31	80	85	48	69	2000 d
Niger	5 c,x	…	28	10	4	56	7	30	1998 d
Nigeria	…	…	16	8	…	…	…	…	1999 d
Rwanda *	23	20	3	…	10	42	23	55	2000 d
Senegal *	…	…	…	…	…	…	…	…	2000 c
Sierra Leone	16	…	…	…	…	…	…	…	2000 c
Somalia	0	…	…	…	…	…	…	…	2000 c
South Africa *	20	…	9	…	…	…	20	…	1998 d
Swaziland **	27	…	…	…	…	…	…	…	2000 c
Togo	20 c,x	…	20	…	51	89	22	41	1998 d
Uganda *	28	40	14	16	22	59	44	62	2000 d
United Rep. of Tanzania *	26	29	15	24	40	87	21	31	1999 d
Zambia	31	33	18	27	19	50	33	42	2001 d
Zimbabwe	…	…	3	6	20	82	42	69	1999 d
East Asia									
China	…	…	…	…	…	…	…	…	…
Hong Kong SAR	…	…	…	…	…	…	…	…	…
Dem. Peo. Rep. of Korea	…	…	…	…	…	…	…	…	…
Japan	…	…	…	…	…	…	…	…	…
Mongolia	32	…	…	…	…	…	…	…	2000 c
Republic of Korea	…	…	…	…	…	…	…	…	…
Oceania									
Australia	…	…	…	…	…	…	…	…	…
Fiji	…	…	…	…	…	…	…	…	…
New Zealand	…	…	…	…	…	…	…	…	…
Papua New Guinea	…	…	…	…	…	…	…	…	…

Country	Can identify two prevention methods and reject three misconceptions (%) (15-24)		Had sex before age 15 (%) (15-19)		Reported higher risk sex in the last year (%) (15-24)		Used a condom the last time they had higher risk sex, of those who had high risk sex in the last year (%) (15-24)		
	Female	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Year*
South & South-East Asia									
Afghanistan	…	…	…	…	…	…	…	…	…
Bangladesh **	…	…	…	…	…	…	…	…	…
Bhutan	…	…	…	…	…	…	…	…	…
Brunei Darussalam	…	…	…	…	…	…	…	…	…
Cambodia	37	…	1	…	1	…	…	…	2000 d
India	21 x	17 x	…	…	2	12	51	59	2001 a
Indonesia	7	…	…	…	…	…	…	…	2000 c
Iran (Islamic Republic of)	…	…	…	…	…	…	…	…	…
Lao People's Dem. Rep.	…	…	…	…	…	…	…	…	…
Malaysia	…	…	…	…	…	…	…	…	…
Maldives	…	…	…	…	…	…	…	…	…
Myanmar **	…	…	…	…	…	…	…	…	…
Nepal	…	…	9	20	…	…	…	…	2001 d
Pakistan	…	…	…	…	…	…	…	…	…
Philippines	…	…	1 d,v	…	…	…	…	…	2000 c
Singapore	…	…	…	…	…	…	…	…	…
Sri Lanka	…	…	…	…	…	…	…	…	…
Thailand	…	…	…	…	…	…	…	…	…
Vietnam	25	…	…	…	…	…	…	…	2000 c
Eastern Europe & Central Asia									
Armenia	7	8	1	1	0	69	0	44	2000 d
Azerbaijan	2	…	1 f,y	…	…	…	…	…	2000 c
Belarus	…	…	…	…	…	…	…	…	…
Bosnia and Herzegovina	…	…	…	…	…	…	…	…	2000 c
Bulgaria	…	…	…	…	…	…	…	…	…
Croatia	…	…	…	…	…	…	…	…	…
Czech Republic	…	…	…	…	…	…	…	…	…
Estonia	…	…	…	…	…	…	…	…	…
Georgia	…	…	3	…	…	…	…	…	1999 f
Hungary	…	…	…	…	…	…	…	…	…
Kazakhstan	…	…	1	6	27	78	32	65	1999 d
Kyrgyz Republic	…	…	…	…	…	…	…	…	…
Latvia	…	…	…	…	…	…	…	…	…
Lithuania	…	…	…	…	…	…	…	…	…
Poland	…	…	…	…	…	…	…	…	…
Republic of Moldova	19	…	…	…	…	…	…	…	2000 c
Romania	…	…	3	12	…	…	…	…	1999 f
Russian Federation	…	…	…	…	…	…	…	…	…
Slovak Republic	…	…	…	…	…	…	…	…	…
Tajikistan	…	…	…	…	…	…	…	…	2000 c
Turkmenistan	…	…	0	…	…	…	…	…	2000 d
Ukraine	…	…	…	…	…	…	…	…	2000 c
Uzbekistan	3	…	…	…	…	…	…	…	2000 c
Western Europe									
Albania	0	…	…	…	…	…	…	…	2000 c
Austria	…	…	…	…	…	…	…	…	…
Belgium	…	…	…	…	…	…	…	…	…
Denmark	…	…	…	…	…	…	…	…	…
Finland	…	…	…	…	…	…	…	…	…
France	…	…	…	…	…	…	…	…	…
Germany	…	…	…	…	…	…	…	…	…
Greece	…	…	…	…	…	…	…	…	…
Iceland	…	…	…	…	…	…	…	…	…
Ireland	…	…	…	…	…	…	…	…	…
Italy	…	…	…	…	…	…	…	…	…
Luxembourg	…	…	…	…	…	…	…	…	…
Malta	…	…	…	…	…	…	…	…	…
Netherlands	…	…	…	…	…	…	…	…	…
Norway	…	…	…	…	…	…	…	…	…
Portugal	…	…	…	…	…	…	…	…	…
Serbia and Montenegro	…	…	…	…	…	…	…	…	…
Slovenia	…	…	…	…	…	…	…	…	…
Spain	…	…	…	…	…	…	…	…	…
Sweden	…	…	…	…	…	…	…	…	…
Switzerland	…	…	…	…	…	…	…	…	…
Macedonia, FYR	…	…	…	…	…	…	…	…	…
United Kingdom	…	…	…	…	…	…	…	…	…

1. Estimated number of people living with HIV

	6. Knowledge and behaviour indicators								
	Can identify two prevention methods and reject three misconceptions (%) (15-24)		Had sex before age 15 (%) (15-19)		Reported higher risk sex in the last year (%) (15-24)		Used a condom the last time they had higher risk sex, of those who had high risk sex in the last year (%) (15-24)		
Country	***Female***	***Male***	***Female***	***Male***	***Female***	***Male***	***Female***	***Male***	***Year***
North Africa & Middle East									
Algeria	…	…	…	…	…	…	…	…	…
Bahrain	…	…	…	…	…	…	…	…	…
Cyprus	…	…	…	…	…	…	…	…	…
Egypt, Arab Republic of	…	…	…	…	…	…	…	…	…
Iraq	…	…	…	…	…	…	…	…	…
Israel	…	…	…	…	…	…	…	…	…
Jordan	…	…	…	…	…	…	…	…	…
Kuwait	…	…	…	…	…	…	…	…	…
Lebanon	…	…	…	…	…	…	…	…	…
Libyan Arab Jamahiriya	…	…	…	…	…	…	…	…	…
Morocco	…	…	…	…	…	…	…	…	…
Oman	…	…	…	…	…	…	…	…	…
Qatar	…	…	…	…	…	…	…	…	…
Saudi Arabia	…	…	…	…	…	…	…	…	…
Sudan	…	…	…	…	…	…	…	…	…
Syrian Arab Republic	…	…	…	…	…	…	…	…	…
Tunisia	…	…	…	…	…	…	…	…	…
Turkey	…	…	…	0	…	…	…	…	1998 d
United Arab Emirates	…	…	…	…	…	…	…	…	…
Yemen, the Republic of	…	…	…	…	…	…	…	…	…
North America									
Canada	…	…	…	…	…	…	…	…	…
United States of America	…	…	…	…	…	…	…	…	…
Caribbean									
Bahamas	…	…	…	…	…	…	…	…	…
Barbados	…	…	…	…	…	…	…	…	…
Cuba	52	…	…	…	…	…	…	…	2000 c
Dominican Republic	…	…	13	18	16	49	…	…	2002 d
Haiti	14	24	12	28	59	93	19	30	2000 d
Jamaica	…	…	…	…	…	…	…	…	…
Trinidad and Tobago	33	…	…	…	…	…	…	…	2000 c
Latin America									
Argentina	…	…	…	…	…	…	…	…	…
Belize	…	…	…	…	…	…	…	…	…
Bolivia	22 c,x	…	5	15	…	…	…	…	1998 d
Brazil	…	…	…	…	…	…	…	…	…
Chile	…	…	…	…	…	…	…	…	…
Colombia	…	…	10	…	49	…	29	…	2000 d
Costa Rica	…	…	…	…	…	…	…	…	…
Ecuador	…	…	7	…	…	…	…	…	2001 f
El Salvador	…	…	…	…	…	…	…	…	1998 f
Guatemala	…	…	7	15	…	…	…	…	2002 f
Guyana *	36	…	…	…	…	…	…	…	2000 c
Honduras	…	…	13	19	…	…	…	…	2001 f
Mexico	…	…	…	…	…	…	…	…	…
Nicaragua	…	…	11	…	10	…	17	…	2001 d
Panama	…	…	…	…	…	…	…	…	…
Paraguay	…	…	…	…	…	…	…	…	…
Peru	…	…	5	…	29	…	19	…	2000 d
Suriname	27	…	…	…	…	…	…	…	2000 c
Uruguay	…	…	…	…	…	…	…	…	…
Venezuela, R.B. de	…	…	…	…	…	…	…	…	2000 c
Global Total									

… Where sufficient data from the last six years were not available, no estimates have been made.
* A population-based survey with HIV prevalence measurement will be conducted in the near future.
** New surveillance has been conducted recently but the results were not available for inclusion in the estimation process.
*** Estimates and ranges have been informed by data from vital registration systems.
a. Behavioural Surveillance Surveys (FHI[U31]).
b. Botswana AIDS Impact Survey ([U32]2001).
c. Multi-Indicator Cluster Survey (UNICEF[U33]).
d. Demographic and Health Survey.
e. Survey of Youth and Adolescent Reproductive Health and Sexual Behaviours in Mozambique (INJAD, 2001[U34]).
f. Reproductive Health Survey (CDC[U35]).
v. Survey year is 1998.
w. Survey year is 1999.
x. Survey year is 2000.
y. Survey year is 2001.
z. Survey year is 2002.
Source: UNAIDS, 2004 Report on the Global AIDS Epidemic, UNAIDS, Geneva.

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