XIII. RELEVANCE OF POPULATION ASPECTS FOR THE ACHIEVEMENT OF MILLENNIUM DEVELOPMENT GOALS 6 AND 3: COMBATTING THE SPREAD OF HIV/AIDS

Aurorita Mendoza
Prevention and Vulnerability Adviser
UNAIDS Geneva

A. OVERVIEW OF THE AIDS EPIDEMIC

Four years have passed since the world's population awoke to the promise of a new millennium. Since then, 179 Governments have formally committed themselves to three international landmark agreements that set forth clear priorities for some of the world's most serious development challenges. These were:

- Key actions of the further implementation of the Programme of Action of the International Conference on Population and Development in 1999
- The Millennium Declaration, including the Millennium Development Goals (MDG) in 2000 and;
- The UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001.

The respective goals of these global commitments are the embodiment of shared objectives and highlight the linkages among critical underlying social issues, notably, the need to ensure equitable access to social services, the need to attain gender equality and to ensure human rights. This paper emphasizes how, in the context of the AIDS epidemic, these commitments are clearly complementary and mutually reinforcing.

The global AIDS epidemic continues to expand, afflict an increasing number of countries and making inroads into regions previously unaffected by the virus. At the close of 2003, an estimated 37.8 million people were living with HIV while an estimated 4.8 million were newly infected. During that same year, roughly 2.9 people lost their lives because of AIDS-related causes, and an estimated 12 million children had been orphaned as a result of the epidemic in sub-Saharan Africa alone.

Despite improving access to life-saving anti-retroviral treatment and a renewed commitment to education and prevention, no region remains unaffected. In countries where prevalence levels remain stable they are mostly the result of new infections being counterbalanced by the deaths of those infected. Prevalence levels are rising in many countries, including industrialized nations where the use of anti-retroviral therapy has become widespread. The idea that AIDS is akin to any other chronic disease, which can be managed by lifelong treatment, may have contributed to increased transmission in countries that had hoped to reduce transmission rates with expanded treatment.

1. W*omen increasingly affected by the epidemic*

Notwithstanding the existence of effective preventive strategies, the numbers of those infected with HIV continue to mount, with the sharpest increases being recorded among women, especially the young. Whereas as the start of the epidemic prevalence was higher among men, since 1985 the percentage of women among adults aged 15 to 49 living with HIV has risen from 35 per cent globally to almost 50 per cent. In addition to being more physiologically vulnerable to HIV infection, women in many societies are now at higher risk of being infected because of other factors, including gender discrimination, poverty, sexual exploitation, and the inability to negotiate condom use with partners. Where heterosexual

sex is the dominant mode of transmission, the impact on women, especially the young, remains disproportionately high. In global terms, women aged 15 to 24 are 1.6 times more likely to be living with HIV than young men in the same age group.

Sub-Saharan Africa

In Africa, approximately 23 million adults aged 15 to 49 are currently infected with HIV. Of those, an estimated 57 per cent are women. Among those aged 15 to 24, almost three quarters are women. In some countries, prevalence is especially high. Antenatal testing in the Pretoria, South Africa, has shown that more than 20 per cent of pregnant women aged 15 to 24 carry the virus. In neighbouring Botswana and Swaziland the numbers are even higher. Among pregnant women aged 15 to 24 in their respective capital cities, prevalence ranges between 30 per cent and 40 per cent (UNAIDS, 2004)

Several social factors are driving these trends. Exploitative intergenerational and transactional sex increases the vulnerability of women. Young African women tend to have considerably older male partners than themselves, partners who are more likely than young men to be infected with HIV. The age difference between partners reflects power differences and makes it more difficult for young women to negotiate condom use. Across Southern Africa, as in other regions, the spatial mobility of men and rural-to-urban migration are contributing factors to the spread of the disease. Numerous studies have documented that, when couples are separated, men are more likely to engage in sex with casual partners.

Conflict and violence also play a role. Surveys among military personnel show higher HIV prevalence within this population than among the general population. Furthermore, war often causes a breakdown of social norms and concomitant increases in rape and other serious sexual assaults. Domestic violence and the sexual abuse that often goes with it, are further contributing factor for the spread of HIV. Thus, a survey of 1,366 women attending antenatal clinics in Soweto, South Africa, found significantly higher levels of HIV infection among women who had been abused by their male partners. The same survey revealed that abusive men are more likely to be HIV-positive than non-abusers. (UNAIDS and others, 2004b).

Asia and the Pacific

With its huge population and pockets of extreme poverty, the Asia Pacific region could, within the next ten years, become the region with the highest number of HIV-infected persons, with China and India, the world's two most populous countries, facing a potential AIDS catastrophe. Today, 7 million people in Asia are living with HIV with more than a quarter of those infected being women.

Studies suggest that the epidemic in Asia, although concentrated primarily among injecting drug users and female sex workers, is now spreading to the general population. In South-Central and South-Eastern Asia, more than a quarter of HIV-infected adults and 40 per cent of those between the ages of 15 and 24 years are women. In China, the gap between levels of HIV-infection in men and women is narrowing rapidly.

Eastern Europe and Central Asia

Social and economic upheaval following the collapse of the Soviet Union has fueled the rapid spread of HIV in much of Eastern Europe and Central Asia. Declining socio-economic conditions, increased poverty and inequity are driving many to engage in high-risk behaviours such as injecting drug use and unsafe sex. While relatively rare in 1995, by the end of 2003 the number of people infected with HIV had reached 1.3 million with a quarter of a million infected in 2003 alone.

The most affected States are the Baltic nations of Estonia, Latvia and Lithuania, the Russian Federation and the Ukraine. In Belarus, Kazakhstan and Moldova, health authorities have also recorded a number of serious outbreaks. Overall, 33 per cent of infections occurred among women with 28 per cent of those occurring in young women. As with Africa and Asia, trends indicate that the number of women being infected is rising relative to men. In the Russian Federation, the proportion of women among those newly-infected with HIV rose from 24 per cent in 2001 to 33 per cent in 2002.

Latin America and the Caribbean

An estimated 2 million people are now living with HIV in Latin America and the Caribbean. Of those, an estimated 36 per cent in Latin America and 49 per cent in the Caribbean are women. In the Caribbean, the main mode of transmission is heterosexual. Young women aged 15 to 24 are 2.5 per cent more likely to be infected than young men of the same age. Throughout the region, factors contributing to the spread of the disease include high spatial mobility of the population and major socio-economic disparities within populations.

Middle East and North Africa

With the exception of Sudan, HIV prevalence in the countries of North Africa and Western Asia is still low. However, prevalence is increasing among injecting drug users in Bahrain, Iran and the Libyan Arab Jamahiriya, and to a lesser extent in Algeria, Egypt, Kuwait, Morocco, Oman and Tunisia. The potential of HIV to spread to the general population remains high. A study in Iran, for instance, revealed that half of the injecting drug users surveyed were married, and fully a third reported having casual relationships outside marriage, thus exposing their partners to an increased risk of HIV infection. In the region, women aged 15 to 24 years are already more than twice as likely to be living with HIV as men in the same age group, particularly those living in the conflict area of southern Sudan. Owing to cultural norms that limit the frank discussion of sexuality and reproductive health, many countries have failed to develop prevention programmes or public awareness campaigns aimed at diffusing the stigma associated with drug use, sex work and sex between men.

B. Achieving the ICPD Programme of Action and the UNGASS Goals

In 1999, the grim reality of the impact of AIDS was reflected in the key actions for the further implementation of the ICPD Programme of Action. This document highlighted the importance of reproductive health, the central role it plays in HIV prevention and care, and how it should be given the highest priority when it comes to national responses to the epidemic. Despite political commitment to the development and expansion of reproductive health programmes, women in many countries still do not have access to comprehensive services of good quality in the area of reproductive health. Access of young women to those services is particularly limited, partly because issues related to adolescent sexuality, cultural traditions, and parental rights still remain fraught with cultural and political sensitivities.

The extent to which the goals of the key actions for the further implementation of the Programme of Action are realized at the country level will have a major impact on the attainment of key targets of the UNGASS 2001 Declaration of Commitment, especially those related to women and young people. It should be noted that the key actions include two targets on HIV, which were reiterated in the UNGASS Declaration of Commitment. By the 2005, the first “hard” target of the UNGASS Declaration of Commitment will come due. These targets envisage that quantifiable progress be made in reducing HIV infection rates, specifically among young people and newborns. The 2005 UNGASS targets include the following:

- To reduce by 25 per cent HIV prevalence among young men and women (aged 15-24) in the most affected countries.
- To ensure that at least 90 per cent of young men and women have access to HIV information, education and life skills services.
- To reduce the proportion of infants infected with HIV by 20 per cent.
- To ensure financing of at least $USD 7 billion to $USD 10 billion for HIV/AIDS programmes in low and middle-income countries.

1. *Policy support for education and services for STI prevention (provision 67)*

Although the HIV epidemic is well into its third decade, basic education related to the disease remains fundamental to prevent or slow its transmission. A full and accurate understanding of HIV transmission and prevention is the first step towards reducing risk. It is therefore critical to develop comprehensive, multi-sectoral national HIV strategies for the provision of such education and to establish official national bodies to coordinate activities. By 2003, virtually all of the most affected countries had policy frameworks and multi-sectoral strategies in place. However, their response continues to remain concentrated in the health sector, with limited collaboration among the full range of ministries targeted for engagement. Policy areas that require further strengthening include:

• **Reduction of HIV discrimination:** Thirty-eight per cent of countries surveyed, including almost half of those in sub-Saharan Africa, have yet to adopt legislation to prevent discrimination against people living with HIV.

• **Actions to benefit vulnerable populations:** Only 36 per cent of countries surveyed possess legal measures that prohibit discrimination against populations vulnerable to HIV infection. Fewer than 10 per cent of surveyed countries with significant HIV transmission among injecting drug users participate in harm reduction programmes. Only 6 per cent of men who have sex with men in sub-Saharan Africa and only 16 per cent of an estimated 2.2 million sex workers in South-eastern Asia have access to prevention services.

• **Prevention and care for cross-border migration:** Although under certain circumstances, international migration may increase vulnerability to HIV infection, less than half of all countries have adopted strategies to promote HIV-prevention awareness among migrant populations.

• **Promotion of gender equality:** Although numerous and well-documented inequities contribute to the vulnerability of women to HIV infection, nearly one third of the countries surveyed lack policies that ensure equal access to men and women to critical prevention and care services.

• **Access to medication:** Four out of every five countries surveyed reported having policies to ensure improved access to HIV-related drugs. In Asia and the Pacific however, where 7 million people are now living with HIV, this proportion was lowest: fully one third of the countries responding had failed to adopt policies to promote access to HIV-related drugs or antiretrovirals.

• **Mitigation of the epidemic's social and economic impact:** More than 40 per cent of those countries with generalized epidemics (i.e. with prevalence rates above 1 per cent) have yet to evaluate the socio-economic impact of AIDS. Lack of information on this aspect of the disease impedes efforts to mitigate its effects on society (UNAIDS, 2003).

Effective prevention requires policies that help reduce the vulnerability of key populations, so that prevention is facilitated. An indispensable component is the preservation of the dignity and self-respect of people living with HIV. To that end, UNAIDS is advocating the establishment of legislation to

prevent discrimination against people living with HIV. Also critical to prevention is widespread access to accurate HIV testing. Unfortunately, in too many countries access to testing is poor and uptake low—primarily owing to fear of stigma and discrimination. In order to prevent both, UNAIDS promotes expanded access to testing that maintains confidentiality; provides counseling after testing and is based on informed consent.

2. *Integration of prevention and care for STIs and HIV into primary care services related to reproductive and sexual health*

For most women, contact with the health care system only occurs when they seek reproductive health care, either for family planning or antenatal care. In developing countries an estimated 500 million women of reproductive age rely on modern contraceptive methods. During pregnancy, the majority will visit at least once an antenatal clinic, with a significant number following up with an additional visit for post-natal care. While the opportunity to reach this population with HIV prevention information and services is enormous, this opportunity goes largely unrealized despite the availability of infrastructure and reproductive health workers that could provide information on HIV prevention. Indeed, these healthcare providers may be the people professionally most qualified to inform clients of the risks inherent in unsafe sex.

In developing countries, many married women are at increased risk of infection simply by virtue of having a spouse. Indeed, married women in the world's poorest countries are often more vulnerable than their single counterparts because they are unable to negotiate whether to have sex, under what conditions, and whether to use condoms. The POLICY project of USAID found that fewer than one in 10 pregnant women in highly affected countries was offered HIV counselling and testing, antiretroviral therapy, or breastfeeding counselling (UNAIDS and others, 2004a). Adequate resources are key to increasing the ability of healthcare providers to offer three key HIV prevention services:

- HIV counselling and testing and condom promotion in a setting where many women, including adolescents women in particular, are already comfortable;
- prevention, diagnosis and treatment of sexually transmitted infections (STIs) that would otherwise increase the risk of HIV transmission; and
- assistance to HIV-positive women for the prevention of unwanted pregnancies, thus reducing the chances of transmission to infants.

Controlling STIs is an important first-step in controlling HIV

Trials in Uganda and the United Republic of Tanzania indicate that treating sexually transmitted infections may be effective in reducing HIV transmission in areas of low or slowly increasing prevalence. Because untreated sexually transmitted infections (STIs) dramatically increase the risk of HIV transmission, STI control remains fundamental to the prevention of HIV. When it comes to STI prevention and care, however, limited information shows that only one in four countries in sub-Saharan Africa report that at least 50 per cent of STI patients are appropriately diagnosed, counselled and treated.

With the clinical and programmatic guidance of WHO and UNFPA, a number of countries are now benefiting from affordable STI diagnostic and treatment approaches. Male and female condoms are the most effective prevention tools for the sexual transmission of HIV. Scientific data overwhelmingly confirm that male latex and female polyurethane condoms are highly effective when it comes to preventing STIs—including HIV.

Despite the fact that condom distribution has increased substantially over the last decade, not enough condoms are available in many regions where HIV runs rampant, there is a 40 per cent shortfall in

low and middle-income countries according to UNFPA. Unfortunately, international funding for the procurement of condoms has declined in recent years.

The effective promotion of female condoms is hampered by the fact that they cost more than male condoms, which puts them beyond the reach of people in poor countries. Evidence from countries that have successfully introduced the female condom shows that provider training, peer-led education, consistent supply, and private and public sector distribution are essential ingredients. A second-generation female condom that will cost one-third less than the current version has entered Phase II and Phase III trials in South Africa.

3. *Scaling up education and treatment programmes aimed at preventing mother-to-child transmission of HIV*

In 2003, an estimated 630,000 infants worldwide were infected with HIV, the vast majority during pregnancy, labour and delivery or as a result of breastfeeding (UNAIDS, 2004). That same year, 490 000 children died of AIDS-related causes. Up to 60 per cent of newborns infected with HIV die before their second birthday. Overall, most will succumb to AIDS-related illnesses before they reach five years of age. In industrialized nations, mother-to-child transmission is rare owing to the widespread availability of antiretroviral prophylaxis, Caesarean delivery and alternatives to breastfeeding. This is not the case in developing countries with high HIV prevalence.

In the UNGASS Declaration of Commitment, the world pledged to reduce the proportion of infants infected by HIV by 20 per cent by 2005 and 50 per cent by 2010. Achieving these goals will require an immediate and dramatic scaling up of activities. These include expanding primary HIV prevention services for women of childbearing age, and universal offer of HIV testing to pregnant women, comprehensive reproductive health services and antiretroviral prophylaxis to prevent mother-to-child transmission.

However, service coverage remains woefully inadequate in many HIV-affected countries. Apart from Botswana, where 34 per cent of pregnant women were able to access services, by the end of 2003 coverage remained extremely low (less than 1 per cent) in the countries hardest hit by the epidemic. According to estimates from 70 countries, in 2003 the proportion of pregnant women covered by services to prevent mother-to-child transmission was 2 per cent in the Western Pacific, 5 per cent in sub-Saharan Africa, and 34 per cent in the Americas.

The role of the private sector in providing the needed treatment is critical. Since 2000, nevirapine has been offered to low-income countries participating in mother-to-child prevention programmes. HIV rapid diagnosis assays to test 450 000 pregnant women have also been provided. Donations of both products have gone to 48 programmes in 24 countries. In many of these countries however, deficiencies in infrastructure continue to hamper delivery.

4. *Access of at least 90 per cent, and by 2010, 95 per cent, of men and women aged 15 to 24 to information, education and services necessary to reduce their vulnerability*

While some countries have taken innovative steps to promote HIV-awareness and prevention among young people, efforts still fall far short of the 2005 goal. In sub-Saharan Africa, only 8 per cent of out-of-school youth have had some education on prevention. A global study found that 44 out of 107 countries did not include AIDS education in their school curricula.

Research has shown that changing the beliefs of adults, particularly men, is critical to enhancing the efficacy of interventions targeted to youth and trying to effect behavioural change. Many adults,

including political leaders, have trouble accepting the sexuality of young people. A variety of gender factors make young people particularly vulnerable to HIV infection and they need to be considered in developing prevention initiatives (UNAIDS, 2004). These factors are:

- **Early sexual debut:** Many young people become sexually active in their teens and a significant proportion before their 15th birthday. Studies show that adolescents who begin sexual activity early are more likely to have sex with several partners and with partners that have been exposed to HIV. They are also less likely to use condoms.

- **Gender disparities:** Where the primary mode of HIV transmission is heterosexual, young women are disproportionately affected. The higher biological vulnerability of women is one explanation, but power imbalances based on gender, sexual networking and inter-generational sex are also contributing factors.

- **Coerced sexual relationships:** From an early age many women experience rape and forced sex. Violent or forced sex can increase the risk of HIV infection because forced vaginal penetration commonly causes abrasions and cuts that enable the virus to cross the vaginal wall with greater ease.

- **Injecting drug use:** Evidence from studies undertaken in Central Asia and Eastern Europe suggests that the numbers of injecting drug users are climbing even as the age at initiation declines. This trend is seen as a response to rapid social and political change, declining standards of living and increases in heroin availability.

In a UNAIDS survey undertaken in 2000, less than 30 per cent of women aged 15 to 24 had full understanding of how to prevent HIV infection. Only 15 of the 30 countries surveyed were making any effort to integrate a life skills approach into their educational programmes, even though education providing the skills as well as the sexual and reproductive health knowledge needed to reduce risky sexual behaviour has been shown to be effective in reducing the spread of the disease.

A rigorous examination of various interventions focusing on young people showed that high quality and sustained skills-based HIV education in schools and via the media was effective in increasing HIV prevention knowledge and skills. Increasing the access of young people to reproductive health services remains an elusive goal, despite ample evidence of the effectiveness of this approach.

5. *Increased investment and research into the development of cheaper and simpler diagnostic tests, female-controlled prophylactic methods such as microbicides, and single dose treatments and vaccines*

Public sector spending on HIV vaccine research and development amounted to an estimated $US 430 to 470 million in 2001, with the US National Institutes of Health accounting for 57 to 63 per cent of global spending. The Government of the United States had also invested $US 62 million in microbicide research and development, a figure that rose to $US 214 million in 2003 (UNAIDS, 2004).

Major public partners currently funding clinical trials in low and middle-income countries also include the Medical Research Council of the United Kingdom, the Agence nationale de recherches sur le Sida in France and the European and Developing Countries Clinical Trials Partnership. Of the 40 potential microbicides being developed in 2004, only one was being developed by a major pharmaceutical company. In 2003, almost $US 79 million was earmarked for microbicide research, with over half committed by the United States and the remainder by philanthropic organizations, bi-lateral and multilateral agencies.

According to the International AIDS Vaccine Initiative (IAVI), public sector investment on research is set to expand. However, IAVI forecasts that investment by drug and biotechnology firms will decline as research and development costs rise, the US economy continues to flounder and companies encounter more difficulties raising venture capital.

6. *Promotion of adolescent sexual and reproductive health in consultation with young people*

Today's generation of young people (those aged 15 to 24) is the largest in human history. Therefore, giving young people the tools to prevent infection is a crucial and effective strategy, as it has proven to be in a number of settings. There is no age restriction for leadership. Young people are assets whose voices need to be heard and whose talents need to be cultivated so that they can be instruments for change. In addition, adults and young people need to work together to construct new ways of approaching adolescent sexuality, education and issues of gender, violence and harmful traditional practices that increase vulnerability to HIV.

The participation of young people in decision-making must be seriously supported by policy makers. Their growing representation in international fora, emerging from the International AIDS Conferences in 2002 and 2004, has laid the foundation for a youth-led alliance of young people.

7. *United Nations support to government efforts (provision 74)*

The Joint United Nations Programme on HIV/AIDS, UNAIDS, is the main advocate of global action. It leads, strengthens and supports an expanded response aimed at preventing HIV transmission, providing care and support, reducing the vulnerability of individuals and communities, and alleviating the impact of the epidemic. UNAIDS supports a more effective global response to AIDS by providing:

- Leadership and advocacy for effective action;
- Strategic information to guide efforts against HIV/AIDS worldwide;
- Civil society engagement and partnership development;
- Mobilization of resources to support an effective response, and
- Monitoring and evaluation of country and global responses.

With the increased resources for HIV programmes, ensuring a harmonized response from all stakeholders is a challenge. Working through its co-sponsors and partners at all levels, UNAIDS assists countries to have a common framework for programme planning, implementation and monitoring. It works with a vast network of partners from all sectors towards a common vision and provides technical and material support to country efforts.

C. Links Between ICPD and the Millennium Development Goals

AIDS has made patent the risks associated from gender discrimination and the vulnerability of women stemming from unequal access to treatment and care and related to the unequal burden of responsibility that women shoulder when it comes to caring for affected spouses, relatives and orphaned children. Prevailing attitudes usually mean that women have lower priority in terms of health care and often face expulsion, ostracism or even violence if they disclose their HIV status, while discriminatory inheritance rights mean that women often carry an undue burden of care with fewer resources, less money and less education than men. Within this context, the ICPD Programme of Action and, especially, the key actions for its further implementation would, if realized, make important contribution to the attainment of gender equality, one of the MDGs.

1 .*Gender equality and the fight against AIDS*

The MDG goal of gender equality is critical in the fight against HIV/AIDS for a variety of reasons. The economic, social and biological factors that undermine women's capacities to protect themselves must be addressed in order to achieve the MDGs. The HIV epidemic cannot be curbed unless women are given their rightful social and economic status. Not only are women more vulnerable to HIV infection but, in many contexts, women are more likely to bear the responsibility for caring for the sick, whether as spouses, parents or children of those infected. Daughters may drop out of school to tend to ailing parents and look after younger siblings. Widows are more likely than widowers to continue caring for their children and mothers are more likely to take in orphans. Older women are more likely than older men to shoulder the burden of care for their sick children and become surrogate parents to their bereaved grandchildren. When their parents or spouses die from AIDS-related illnesses, women are often left without land, housing or other assets. Furthermore, they may be prevented by law or custom from using family assets for the benefit of their dependants, thus being unable to apply for agricultural loans or credit. These developments make affected women even more vulnerable to sexual exploitation, violence and, consequently, to the risk of HIV infection.

2. *The Global Coalition on Women and AIDS*

In recognition of the special challenges facing women, UNAIDS has launched the Global Coalition on Women and AIDS. Made up of international organizations, non-governmental organizations, donors and other stakeholders, the new initiative was launched in London in February 2004 and is dedicated to actions in seven areas:

- Preventing HIV infection among girls and young women
- Reducing violence against women
- Protecting the property and inheritance rights of women and girls
- Ensuring equal access by women and girls to care and treatment
- Supporting improved community-based care, with a special focus on women and girls
- Promoting access to new prevention options for women, including female condoms and microbicides
- Supporting ongoing efforts towards universal education for girls

While the achievement of gender equality is an MDG goal for 2015, these are actions that can be taken immediately.

The Global Coalition on Women and AIDS is an informal grouping of partners and organizations working to mitigate the impact of AIDS on women and girls worldwide. It is a growing global and inclusive movement seeking to support, energize and drive AIDS-related programmes and projects to improve the daily life of women and girls. The Coalition seeks to build global and national advocacy to highlight the effects of HIV and AIDS on women and girls and stimulate concrete and effective action.

The prevention of HIV among the most vulnerable, their equitable access to essential social services, and the realization of equal gender relations and roles are interlinked issues. There is no doubt that the realization of the ICPD Programme of Action and the key actions for its further implementation would contribute to the realization of the MDG targets for HIV reduction and gender equality.

REFERENCES

UNAIDS (2003). Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003 Geneva: UNAIDS/03.44E.

_____ (2004). 2004 Report on the Global AIDS Epidemic: Fourth Global Report. Geneva: UNAIDS/04.16E.

_____, UNFPA, IPPF and The Alan Guttmacher Institute (2004a). The Role of Reproductive Health Providers in Preventing HIV. Available at http://www.guttmacher.org/pubs/ib2004no5.pdf.

UNAIDS, UNFPA and UNIFEM (2004b). Women and HIV/AIDS: Confronting the Crisis. Available at http://www.unfpa.org/hiv/women/report/index.htm.

United Nations (1994). Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (A/CONF.171/13/Rev.1).

_____ (1999). General Assembly Resolution S21/2 of 2 July 1999. In Official Records of the General Assembly. Twenty-first special session, Supplement No. 3. A/S-21/5/Rev.1.

_____ (2001). Declaration of Commitment on HIV/AIDS, General Assembly resolution S-26/2, Annex.