The following provides the full template of the narrative part of the Country Progress Report and detailed instructions for completion of the different sections included in it. It is highly recommended that the UNGASS indicator data are submitted through the Country Response Information System (CRIS) to enhance the completeness and quality of the data and to facilitate trend analysis. A data file (CRIS or the Excel template included on the Guidelines CD-ROM) is required to be sent at the same time as the file containing the narrative Country Progress Report.

UNGASS COUNTRY PROGRESS REPORT

[Country Name]

Reporting period: January 2006–December 2007

Submission date: [fill in the date of the formal submission of the country report to UNAIDS by e-mail]

I. Table of Contents

[Instructions: Fill in]

II. Status at a glance

[Instructions: This section should provide the reader with a brief summary of
(a) the inclusiveness of the stakeholders in the report writing process;
(b) the status of the epidemic;
(c) the policy and programmatic response; and
(d) UNGASS indicator data in an overview table]

III. Overview of the AIDS epidemic

[Instructions: This section should cover the detailed status of the HIV prevalence in the country during the period January 2006–December 2007 based on sentinel surveillance and specific studies (if any) for the UNGASS impact indicators. The source of information for all data provided should be included.]

IV. National response to the AIDS epidemic

[Instructions: This section should reflect the change made in national commitment and programme implementation broken down by prevention, care, treatment and support, knowledge and behaviour change, and impact alleviation during the period January 2006–December 2007.

Countries should specifically address the linkages between the existing policy environment, implementation of HIV programmes, verifiable behaviour change and HIV prevalence as supported by the UNGASS indicator data. Where relevant, these data should also be presented and analysed by sex and age groups (15–19, 20–24, 25–49). Countries should also

use the National Composite Policy Index data (see Appendix 7) to describe progress made in policy/strategy development and implementation, and include a trend analysis on the key NCPI data since 2003, where available. Countries are encouraged to report on additional data to support their analysis and interpretation of the UNGASS data.]

V. Best practices

[Instructions: This section should cover detailed examples of what is considered a best practice in-country in one or more of the key areas (such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity-building; infrastructure development. The purpose of this section is to share lessons learned with other countries.]

VI. Major challenges and remedial actions

[Instructions: This section should focus on:
(a) progress made on key challenges reported in the 2005 UNGASS Country Progress Report, if any;
(b) challenges faced throughout the reporting period (2006-2007) that hindered the national response, in general, and the progress towards achieving the UNGASS targets, in particular; and,
(c) concrete remedial actions that are planned to ensure achievement of agreed UNGASS targets.]

VII. Support from the country's development partners

[Instructions: This section should focus on (a) key support received from and (b) actions that need to be taken by development partners to ensure achievement of the UNGASS targets.]

VIII. Monitoring and evaluation environment

[Instructions: This section should provide (a) an overview of the current monitoring and evaluation (M&E) system; (b) challenges faced in the implementation of a comprehensive M&E system; and (c) remedial actions planned to overcome the challenges, and (d) highlight, where relevant, the need for M&E technical assistance and capacity-building. Countries should base this section on the National Composite Policy Index.]

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

Please email your complete UNGASS Country Progress Report **before January 31 2008** *to UNAIDS Evaluation Department at:* **ungassindicators@unaids.org**.

If the Country Response Information System (CRIS) is not used for submission of indicator data, please submit reports by January 15 2008 to allow time for the manual entry of data into the Global Response Information Database in Geneva.

Printed copies may be posted to:

Dr. Paul De Lay, Director, Evaluation Department
UNAIDS 20 Avenue Appia
CH-1211 Geneva 27 Switzerland

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (please specify)	Yes	No

2) With inputs from

Ministries:		
Education	Yes	No
Health	Yes	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify)	Yes	No
Civil society organizations	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bilaterals	Yes	No
International NGOs	Yes	No
Others (please specify)	Yes	No

3) Was the report discussed in a large forum? Yes No

4) Are the survey results stored centrally? Yes No

5) Are data available for public consultation? Yes No

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: _____

Date: _____

Signature: _____

Address: _____

Email _____ Telephone: _____

Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS
2008 reporting

NATIONAL

Indicators	Data Collection Frequency	Measurement Tool
National Indicators		
National Commitment and Action		
1. Domestic and international AIDS spending by categories and financing sources	Ad hoc based on country request and financing, by calendar or fiscal year	National AIDS Spending Assessments, National Health Accounts or financial resource flow surveys
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	Every 2 years	Desk review and key informant interviews
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Annual	Programme monitoring
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Annual	Programme monitoring and estimates
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Annual	Programme monitoring and estimates
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Annual	Programme monitoring
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Every 4–5 years	Population-based survey
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Every 2 years	Behavioural surveys
9. Percentage of most-at-risk populations reached with HIV prevention programmes	Every 2 years	Behavioural surveys
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	Every 4–5 years	Population-based survey
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Every 2 years	School-based survey
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*	Every 4–5 years	Population-based survey
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Every 4–5 years	Population-based survey
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Every 2 years	Behavioural surveys
15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	Every 4–5 years	Population-based survey

NATIONAL

16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Every 4–5 years	Population-based survey
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*	Every 4–5 years	Population-based survey
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Every 2 years	Behavioural surveys
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Every 2 years	Behavioural surveys
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Every 2 years	Behavioural surveys
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Every 2 years	Behavioural surveys

Impact

22. Percentage of young women and men aged 15–24 who are HIV infected*	Annual	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	Annual	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Every two years	Programme monitoring
25. Percentage of infants born to HIV-infected mothers who are infected	(Modelled at UNAIDS Headquarters, based on programme coverage)	Treatment protocols and efficacy studies

GLOBAL

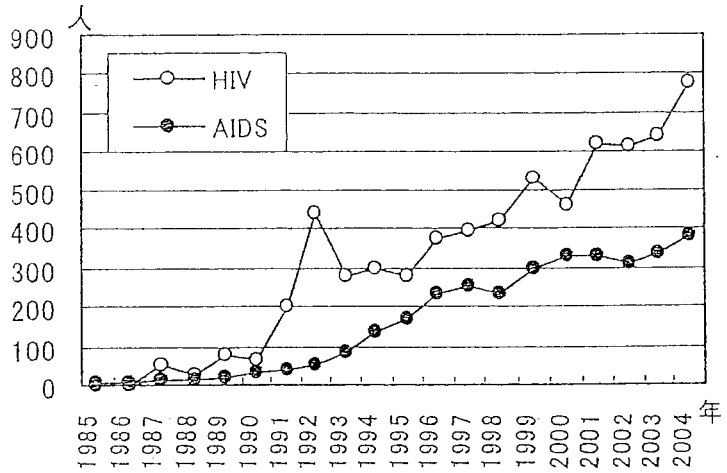
Global Indicators

1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries	Annual	Donor reports
2. Amount of public funds for research and development of preventive HIV vaccines and microbicides	Annual	Donor reports
3. Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programmes	Annual	Desk review
4. Percentage of international organizations that have workplace HIV policies and programmes	Annual	Desk review

* Millennium Development Goals indicator

REPORT TO UNAIDS HIV/AIDS TRENDS IN JAPAN
DECEMBER 2005

Ⅰ. Status at a glance



わが国の HIV 感染者、AIDS 患者の発生動向は増加が続き、性的接触によるものを中心として拡大しつつあると言える。特に、男性の同性間性的接触による感染は HIV 感染者の 60.0%を占め、AIDS 患者も増加傾向にあることから、予防啓発の普及と検査による早期発見・早期治療の機会拡大が必要である。（2004 エイズ発生動向年報　抜粋（厚生労働省エイズ動向委員会）http://api-net.jfap.or.jp/(日本語のみ)）

Ⅱ. Overview of the AIDS epidemic

1）HIV 感染者の報告数は、1996(平成 8)年以降増加が続き、2004(平成 16)年は 780 件で過去最高の報告数となった。日本国籍例は 680 件、外国国籍例は 100 件であった。2004(平成 16)年の HIV 感染者報告例の感染経路は、同性間性的接触が 468 件(60.0%)、異性間性的接触が 200 件(25.6%)で、性感染によるものが合計 668 件(85.6%)を占めた。

HIV 感染者では日本国籍男性の増加が顕著で、2004(平成 16)年の報告数は昨年を大きく上回り過去最高(636 件)となった。日本国籍女性は 44 件と昨年(32 件)に比べて増加した。

日本国籍例では、男性同性間性的接触が昨年に比べて大きく増加し、過去最高の報告数(449 件)となった。また、男性異性間性的接触は 122 件で前年(108 件)に比べて増加した。

日本国籍女性の異性間性的接触による HIV 感染者は 1999(平成 11)年まで増加し、その後横ばいの状態にある。また、日本国籍の異性間性的接触による HIV 感染者の性別構成を年齢階級別にみると、15-19 歳、20-24 歳では他の年齢層とは対照的に女性が過半数を超えている。

2) AIDS 患者の報告数は 385 件で、前年に続き増加し、過去最高となった。日本国籍例は 309 件(80.3%)で過去最高、外国国籍例も 76 件と増加した。

2004(平成 16)年の AIDS 患者報告例の内、異性間性的接触による感染は 135 件

(35.1%)、同性間性的接触による感染は 141 件(36.6%)で、性感染が 71.7%を占めた。また、感染経路不明は 95 件(24.7%)で増加しつつある。推定感染地域は 268 件(69.6%)が国内での感染例であった。

日本国籍男性例は 290 件(75.3%)で昨年(252 件)に比べて増加し、この内異性間性的接触 99 件(34.1%)、同性間性的接触 126 件(43.4%)、感染経路不明例は 54 件(18.6%)であった。

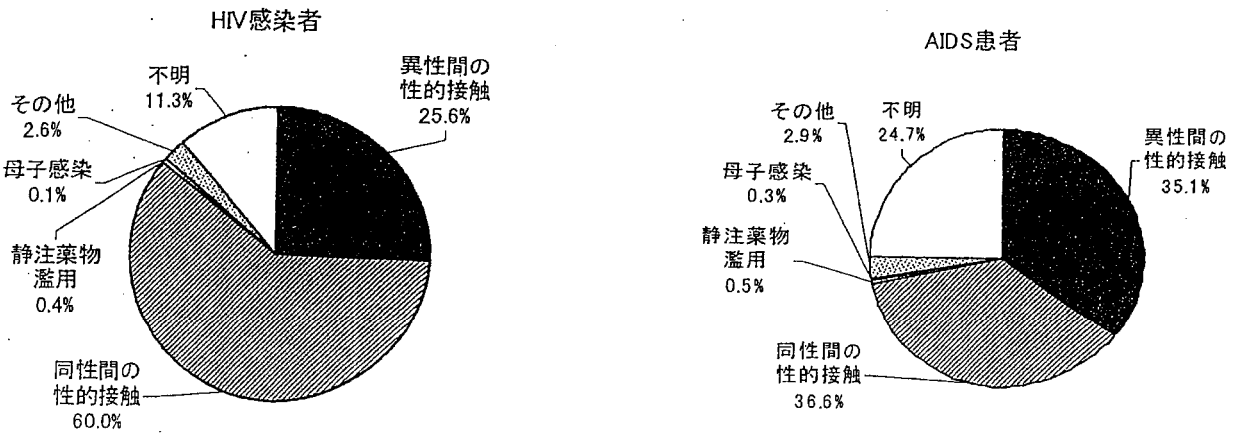
3) 外国国籍例は HIV 感染者、AIDS 患者ともに報告数は横ばいの状況にあるが、2004(平成 16)年の外国国籍報告例は、HIV 感染者では 100 件(12.8%)、AIDS 患者では 76 件(19.7%)を占める。出身地域としては、HIV 感染者、AIDS 患者ともに東南アジア、ラテンアメリカ、サハラ以南アフリカの順に多い。

4) 感染経路は、HIV 感染者、AIDS 患者ともに性的接触による感染が大半であり、静注薬物濫用や母子感染によるものはいずれも 1%以下にとどまっている。

5) 報告地(ブロック)は、東京都、関東甲信越(東京都を除く)が依然多く、2004(平成 16)年報告例では HIV 感染者の 457 件(58.6%)、AIDS 患者の 240 件(62.3%)を占めている。

HIV 感染者はすべてのブロックで増加した。都道府県別では、HIV 感染者は、大阪府で増加が続き、東京都、大阪府、愛知県からは、過去最高レベルの報告が続いている。AIDS 患者は北陸以外の全てのブロックで増加した。(2004 エイズ発生動向年報　抜粋（厚生労働省エイズ動向委員会）注：本年報において、AIDS 患者とは「AIDS を発症して初めて HIV に感染していることがわかった事例」と定義)

図 1. 2004(平成 16)年に報告された HIV 感染者及び AIDS 患者の感染経路別内訳



Ⅲ. National response to the AIDS epidemic

・行政、ＮＧＯ、患者団体、学識経験者等からなるエイズ予防指針見直し検討会（報告書平成 17 年 6 月 13 日）等を開催し、エイズ予防指針（平成 11 年）を平成 17 年度に改訂、

平成18年4月1日より施行する予定。

・厚生労働大臣を座長とする省内局長級会議である「エイズストップ作戦本部」を開催

・エイズに係る関係省庁課長級連絡会議を開催

参考）改正エイズ予防指針の概要（平成18年4月1日施行）

現状

わが国におけるHIV・エイズの発生動向

○ **新規感染者・患者の報告件数は依然と上昇**
- 平成16年においては、初めて年間1,000件を超過し、累積でも10,000件を突破した。また新規感染者の増加率も上昇傾向にある。

○ **最近の感染事例等の分析**
- 2000年以降、特に地方大都市においても増加
- この5年間は20歳代以下が全体の約35%、30歳代が約40%を占め、比較的若い世代を中心に感染拡大が進んでいる。
- 感染経路別では、性交渉による感染がほとんどを占め、特に男性同性間の性的接触が全体の約60%を占めている。

現状の問題点

○ **全体の約1/3が診断時にエイズを発症している**
- 早期発見、早期治療の機会を逸している例が多い

○ **若い世代や同性愛者における対応が不十分**
- 施策対象が不明確、明確化不足。

○ **一部の医療機関へ感染者・患者が集中**
- 診療の質の格差が存在。病院間の連携不足

○ **国と地方公共団体との役割分担が不明確**
- 互いの比較優位性を充分踏まえずに施策を実施

○ **各種施策の実施状況等の評価が不十分**

見直しにおける基本的な方向

○ **疾患概念の変化に対応した施策の展開**
※「不治の特別な病」→「コントロール可能な一般的な病」へ

○ **国と地方公共団体との役割分担の明確化**
※ 国::リーダーシップ・技術的支援
地方公共団体:普及啓発、検査、医療提供など施策の中心

○ **施策の重点化・計画化**
※① 普及啓発及び教育 ② 検査相談体制の充実 ③ 医療提供体制の再構築

今後の主な具体的施策

普及啓発及び教育

《国が中心となる施策:一般的な普及啓発》
- HIV/エイズに係る基本的な情報・正しい知識の提供
  →各種イベント、エイズ予防情報ネット、政府広報、ポスターコンクール等
  →多角的な普及啓発事業の創設(公共広告機構と連携した普及啓発活動)

《地方自治体が中心となる施策:個別施策層に対する普及啓発》
- 青少年、同性愛者への対応
  →青少年エイズ対策事業/同性愛者等予防啓発事業

検査・相談体制の充実

《国が中心となる施策:検査相談に関する情報提供》
- 検査手法の開発、検査相談手法マニュアル作成
- HIV検査普及週間(毎年6/1～7)の創設
- 検査相談に係る情報提供体制の再構築

《地方自治体が中心となる施策:検査・相談体制の充実強化》
- 利便性の高い検査体制の構築(平日夜間・休日・迅速検査等)
- 年間計画の策定、公表等による計画的な検査実施

医療提供体制の再構築

《国が中心となる施策:グランドデザイン策定、新たな手法の開発》
- 中核拠点病院制度の創設
- 病診連携のあり方の検討→エイズ医療提供病診連携モデル事業の創設

《地方自治体が中心となる施策:都道府県内における総合的な診療体制の確保》
- 中核拠点病院の選定を始めとした都道府県内における医療体制の確保
- 連絡協議会の設置等による各病院間の連携支援

施策の実施を支える新たな手法

○ 普及啓発等施策の実施におけるNGO等との連携強化(連携支援の核→エイズ予防財団)
○ 関係省庁間連絡会議の定期的な開催による総合的なエイズ対策の推進
○ 政策評価を踏まえた都道府県等に対する重点支援
→重点的に連絡調整すべき都道府県等の選定

V. Support required from country's development partners

・「個別施策層を対象とする各種施策を実施する際には、ＮＧＯ等と連携することが効果的である。また、ＮＧＯ等の情報を、地方公共団体に提供できる体制を整備することが望まれる。」（改正エイズ予防指針）としており、財団法人エイズ予防財団が実施しているNGO等の人材育成、活動支援等の機能を更に充実することを予定している。

VI. Monitoring and evaluation environment

・エイズの発生動向、検査・相談実施件数、献血におけるＨＩＶ陽性率等については、エイズ動向委員会を年４回開催し、年１回報告書にとりまとめている。

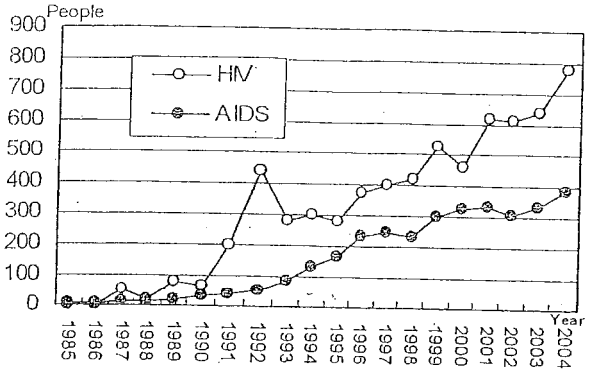
・「国は、国や都道府県等が実施する施策の実施状況等をモニタリングし、進捗状況を定期的に情報提供し、必要な検討を行うとともに、感染者・患者の数が全国水準より高いなどの地域に対しては、所要の技術的助言等を行うことが求められる。」（平成17年度改訂　エイズ予防指針）としており、平成18年度より、厚生労働科学研究等により、国や地方公共団体が実施する主要な施策の実施状況等をモニタリングするとともに、厚生科学審議会等の場において、定期的に報告していくことを予定している。又、新規ＨＩＶ感染者・エイズ患者の報告数が全国水準より高いなどの都道府県等を「重点的に連携するべき地方公共団体」に選定し、定期的に助言・連携を行う予定にしている。

REPORT TO UNAIDS

HIV/AIDS TRENDS IN JAPAN

DECEMBER 2005

I. Status at a glance



The numbers of HIV-infected patients and AIDS patients reported in Japan have continued to increase. The main route of infection is sexual contact, in particular, those between males constituting 60.0% of all HIV-infected patients. The means to improve detection and providing swift treatment becomes more necessary as the number grows. This is improved through further dissemination of information on prevention and testing. (Extract from 2004 Annual Report on AIDS Trends (Committee on AIDS Trends, Ministry of Health, Labour and Welfare) http://api-net.jfap.or.jp/ (Japanese only))

II. Overview of the AIDS epidemic

1) The number of reported cases of HIV-infected patients has continued to increase since 1996, and, in 2004, it recorded its highest with 780 cases. This number consists of 680 Japanese nationals and 100 foreign nationals.

668 (85.6%) cases of infection were through sexual contact, out of which 468 (60.0% of all cases) were those between individuals of the same sex.

The increase in Japanese males infected with HIV is most prominent; the number of cases reported in 2004 (636 cases) greatly exceeding last year's figure. There were 44 cases of Japanese females being infected, up by 12 cases from the previous year.

The number of Japanese nationals being infected(449) was highest reported to date due to the significant increase in infections through sexual contact between males. Also, there were 122 cases of Japanese males infected through sexual contact with individuals of the opposite sex, up from 108 cases the previous year.

The number of Japanese females infected with HIV through sexual contact with individuals of the opposite sex increased until 1999 but remained flat since. Looking at a gender breakdown by age group of Japanese nationals infected with HIV through sexual contact with individuals of the opposite sex, females make up the majority in the 15-19 years and 20-24 years groups, which is in contrast with other age groups.

2) The total number of AIDS patients reported in 2004 was 385, continuing to increase from previous years and recorded its highest level to date. There were 309 (80.3%) Japanese nationals, which is a record figure, and the number of foreign nationals also increased to 76.

Of the reported AIDS patients in 2004, 71.7% of the patiends were infected through sexual transmission, with 135 (35.1% of all cases) infected through sexual contact with individuals of the opposite sex and 141 (36.6% of all cases) with individuals of the same sex. Cases with unknown infection routes totaled 95 (24.7%) and are on the increase. The assumed location of infection was within Japan for 268 cases (69.6%).

The number of Japanese male AIDS patients was 290 (75.3%), up from the previous year (252), with 99 (34.1%) infected through sexual contact with individuals of the opposite sex, 126 (43.4%) with individuals of the same sex, and 54 (18.6%) through unknown infection routes.

3) The trend of foreign nationals reported with HIV infection or suffering from AIDS has been constant. In 2004, there were 100 cases (12.8%) of foreign nationals infected with HIV and 76 (19.7%) reported to be diagnosed with AIDS. The origins of people infected with HIV and AIDS patients in Japan are from Southeast Asia, Latin America and Sub-Saharan Africa, in order of most frequently reported.

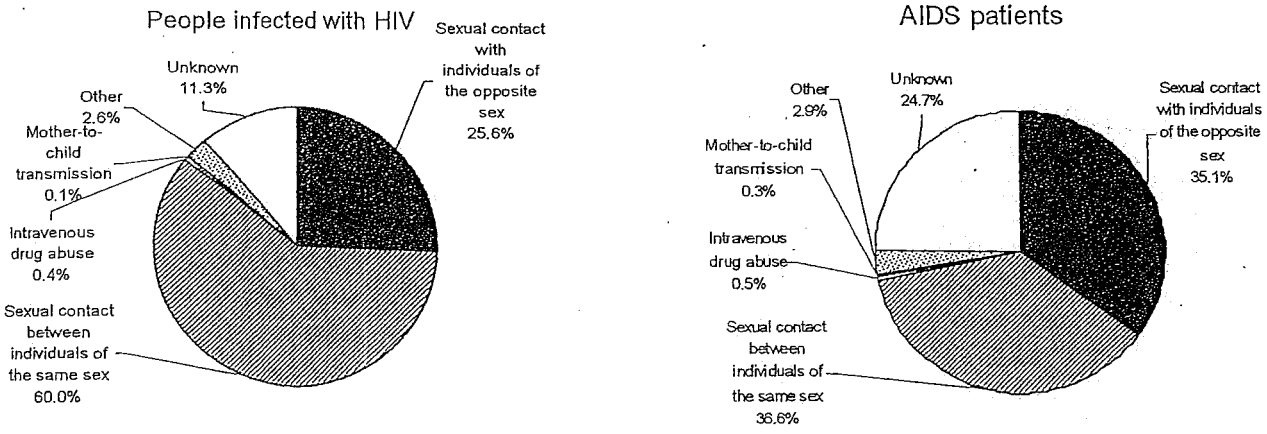
4) The major cause of infection for both HIV and AIDS were from sexual contact, with intravenous drug abuse and mother-to-child transmission both being less than 1%.

5) Looking at regional trends, Tokyo and Kanto Koshinetsu (excluding Tokyo) remain high, making up 457 (58.6%) HIV reports and 240 (62.3%) AIDS reports in 2004.

The number of people infected with HIV increased in all regional blocks. By prefecture, patients infected with HIV continued to increase in Osaka, and record levels were reported in Tokyo, Osaka and Aichi. AIDS patients increased in all blocks except Hokuriku. (Extract from 2004 Annual Report on AIDS Occurrence Trends (Committee on AIDS Trends, Ministry of Health, Labour and Welfare)

Note: This Annual Report defines AIDS patients as cases in which HIV infection is first discovered due to exhibiting AIDS symptoms)

Figure 1: Breakdown of infection routes of HIV and AIDS patients reported in 2004



III. National response to the AIDS epidemic

- The AIDS Prevention Review Commission (report dated June 13, 2005) meetings participated by government officials, NGOs, patient groups and academic experts. – At the Commission meeting in 2005, AIDS Prevention Guidelines (1999) was revised and will go into effect on April 1, 2006.
- Held "Stop AIDS Strategic Headquarters" meetings, headed by the Minister of Health, Labour and Welfare and attended by director general level of the Ministry.
- Held section chief level meetings between relevant government ministries

IV. Major challenges faced and actions needed to achieve the goals/targets

Major challenges faced and actions needed are described in the chart below.

Current State

HIV and AIDS Trends in Japan

- ○ Reports on new infections and patients continue to increase
  - The total number of reports broke the 1,000 mark for the first time in 2004, bringing the cumulative total to over 10,000. The rate of new infection is also on the upward trend.
- ○ Analysis of recent infection trends
  - There are increases paticularly in regional cities since 2000.
  - For the past 5 years, people infected under the age of 30 accounts for 35% of total infections and 40% consists of people in their 30s, showing that the disease is mainly spreading among younger generations.
  - A major cause of infection is through sexual intercourse, with infections of males through sexual contact with individuals of the same sex making up approximately 60%

Current Problems

- ○ Approximately 1/3 of the total exhibit AIDS symptoms when diagnosed
  - Lack of opportunities for early discovery and treatment in many cases
- ○ There is a lack of responses by younger generations and homosexual
  - Measures are unclear or not clear enough.
- ○ Infected people and patients are concentrated in certain medical institutions
  - There are discrepancies in the quality of care. Lack of cooperation between hospitals
- ○ The division of responsibility between national and local governments is unclear
  - Measures are being implemented without considering the comparative advantages of each other
- ○ Evaluation of the implementation of measures is insufficient

Basic principles for improvement

- ○ Adopting measures in line with changes in disease concept
  - * "Special incurable disease" --> "common controllable disease"
- ○ Clarify division of responsibilities between national and local governments
  - National: Leadership, technical support
  - Local governments: Mainly implementing measures such as information dissemination and and education, testing and provision of medical care
- ○ Prioritization and planning of measures
  - * (1) Information dissemination and education (2) Improved testing and consultation system (3) Rebuilding of provision of medical care

Concrete measures for the future

Information dissemination and Education

[Responsible, mainly, on national level: general education]
- Provision of basic information and correct knowledge on HIV/AIDS
  - → AIDS prevention information network, government bulletin, poster competition, etc.
  - →Creation of diverse educational projects (Educational activities linked with the Japan Ad Council)

[Responsible, mainly, on local level: education on specific topics]
- Responses for youths and homosexuals
  - → Youth AIDS prevention projects / seminar on prevention for homosexuals, etc.

Improved testing and consultation system

[Responsible, mainly, on national level: provision of information on testing and consultation]
- Development of testing methods as well as testing and consultation manual
- HIV Testing Week (June 1-7 every year)
- Rebuilding information network on testing and consultations

[Responsible, mainly, on local level: improvement of the testing and consultation system]
- Establishment of "convenient" testing system (open on weekday nights and weekends, rapid testing, etc.)
- Systematic testing through annual planning

Rebuilding of system for providing medical care

[Responsible, mainly, on national level: formulation of a "grand design", development of new techniques]
- Designation of core hospitals
- Consideration of the collaboration between hospitals and clinics
  - → establishment of a collaboration model for hospitals and clinics providing medical care for AIDS

[Responsible, mainly, on local level: securing a comprehensive treatment system within each prefecture]
- Securing medical system within each prefecture starting with the selection of core hospitals
- Assist collaboration between hospitals by establishing liaison councils, etc.

New methods supporting the implementation of measures

- ○ Improved collaboration with NGOs in information dissemination and educational measures (core of collaboration assistance → Foundation for AIDS Prevention)
- ○ Holding of periodic meetings between government ministries to promote comprehensive AIDS measures
- ○ Priority assistance for prefectures based on policy evaluation
  - → Selection of priority prefectures for coordination

V. Support required from country's development partners

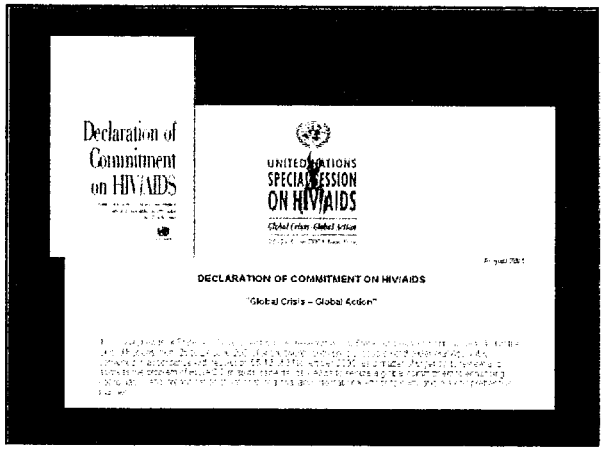
- "Working with NGOs is effective when implementing various measures at individual levels. It is also desirable that a system be created in which information from NGOs can be provided to local governments." (Revised AIDS Prevention Guidelines 2005) Following this guideline, the government plans to further improve the function of the Japanese Foundation for AIDS Prevention of its support to NGOs in their human resource development and in their activity implementation.

VI. Monitoring and evaluation environment

- The Committee on AIDS Trends holds meetings four times each year and issues a report once every year on topics such as trends on the occurrence of AIDS, on numbers of tests/consultations and on HIV-positive cases in blood donations.
- "It is necessary that the government monitors the measures implemented by and coordinated?? between the central government and local governments, provides information on their progress and reviews them when appropriate. The government is also required to provide necessary technical support to regions such as those with a higher proportion of infections or patients than the national average." (2005 Revised AIDS Prevention Guidelines) Based on this understanding, the Ministry of Health, Labour and Welfare plans, from 2006, to monitor the implementation of key measures by relevant national and local governments through health science researches, and to report periodically at such occasions as the Health Sciences Council. Prefectures where cases of HIV and AIDS reports are higher than the national average shall be designated as "local governments requiring priority assistance", and the Ministry of Health, Labour and Welfare plans to periodically provide them with advice and assistance.

国連エイズ政治宣言と国内の課題

樽井 正義



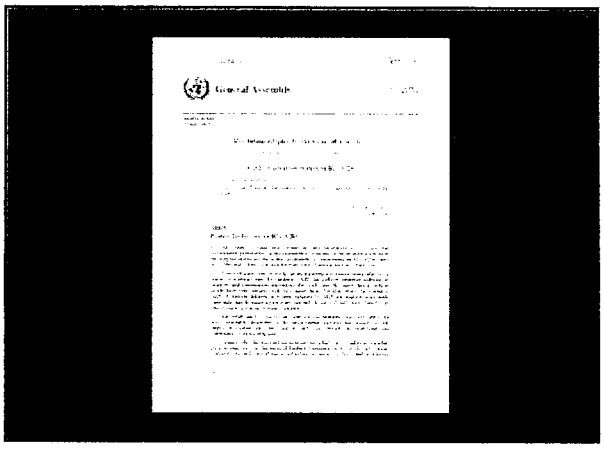
国連政治宣言 1

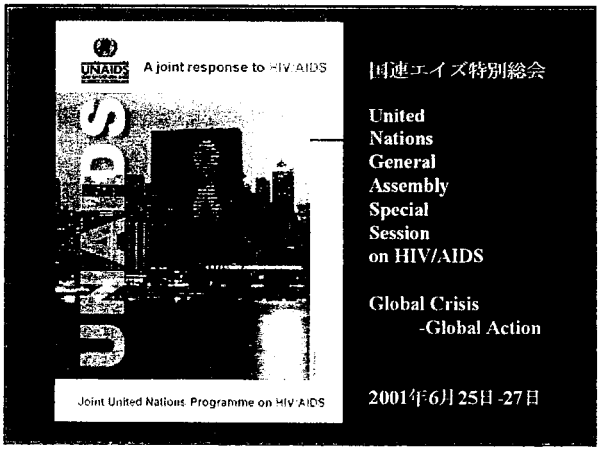
国連エイズ対策レビュー総会

High Level Meeting on AIDS

UNGASS Review

2006年5月31日-6月2日





国連エイズ特別総会

United Nations General Assembly Special Session on HIV/AIDS

Global Crisis -Global Action

2001年6月25日-27日

国連政治宣言 2

- 普遍的アクセス（Universal Access）
  予防・治療・ケア・支援　2010年までに
- 意欲的な国家目標の設定　2006年までに
- 政府主導　三つの統一（Three Ones）
  政策・施策調整・モニタリング評価
- 陽性者・個別施策層（vulnerable）を含む
  全面的で能動的な市民社会の参画
- 開発援助　2010年までにGNP比0.5%
  2015年までに　0.7%

国内の課題 1

・三つの統一

政策　改正予防指針 (06年4月) 厚労大臣告示

実施　関連省庁間連絡会議

評価　施策評価検討会(06年9月)

省庁間の連携・市民社会との連携の強化

NGOの国連プロセスへの参画

・市民社会レポートの作成

・国際NGOとの連携

・政府代表団・宣言案等への提言

・厚労省・外務省との対話フォーラムの開催

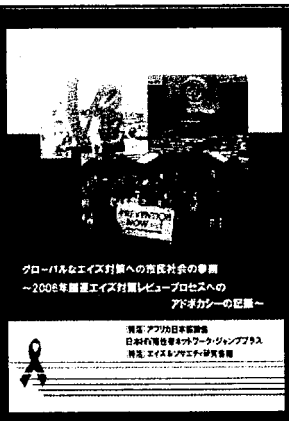
・政府代表団への顧問推薦（自費参加）
総会議長リストによる参加

国内の課題 2

・普遍的アクセスに向けた
具体的な目標の設定

予防　若者・MSM
とくにMSMへの具体策・数値目標
検査・相談制度の改善

治療　拠点病院と診療所の連携
拠点病院間・地域間の格差是正



AJF
JaNP+
JASA 2006

国内の課題 3

・陽性者・個別施策層を含む
市民社会と行政との連携強化

政策立案・施策調整・評価のパートナー

NGO/CBOへの施策・事業への公的資金