AIDS at 30

Nations at the crossroads

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AIDS at 30

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PREFACE

Chart a bold path

This report comes at a decisive moment in the international response to the AIDS epidemic. Over the past 30 years, AIDS has united the international community in a way that few other crises have. The disease galvanized grass-roots groups to fight for the human rights of some of the world's most vulnerable people. AIDS generated new levels of solidarity between the north and south. And it has inspired medical innovation.

Now the world has reached a crossroads. The number of people becoming infected and dying is decreasing, but the international resources needed to sustain this progress have declined for the first time in 10 years, despite tremendous unmet needs. We have a long way to go to prevent new HIV infections, end discrimination and scale up treatment, care and support.

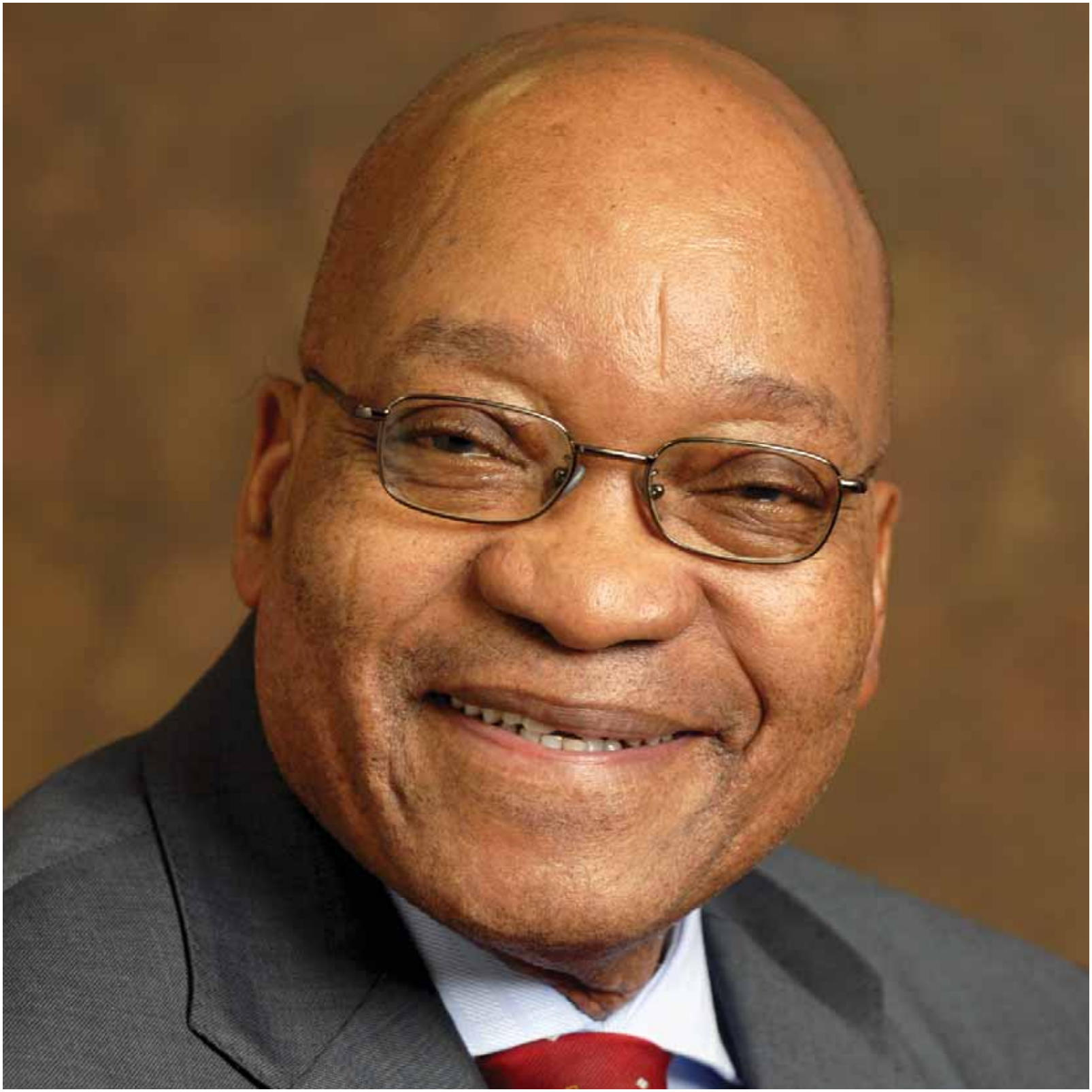
The 2011 General Assembly High Level Meeting on AIDS offers an opportunity to take a hard look at successes and failures over the past three decades, and formulate plans for a future of zero new HIV infections, zero discrimination and zero AIDS-related deaths.

UNAIDS has developed a Strategy for 2011–2015 to support countries in their efforts to combat the disease and help achieve the Millennium Development Goals. The strategy sets out a series of concrete objectives to radically reduce the number of new infections and expand treatment. It also gives priority to human rights and equity.

Governments, civil society, the UN family and other partners must work in a spirit of shared responsibility and mutual accountability to forge strategic partnerships, support national ownership, engage emerging economies, facilitate South-South cooperation, link the AIDS response with broader health and development efforts, and usher in a new approach to financing. This report can help guide us.

At the High Level Meeting and beyond, we must chart a bold path, never forgetting those who died too soon, and always keeping foremost in mind those who will enjoy healthier, longer lives thanks to the commitments we make and the actions we take.

Ban Ki-moon
United Nations Secretary-General



FOREWORD

From fear to unity

It is a great honour for me to offer a foreword to this important report on the progress of the world's nations against AIDS.

My country has been more affected than any other by this epidemic. AIDS has stolen the lives of millions of our brothers and sisters and has orphaned millions of our children.

This epidemic has also transformed South Africa – in some ways for the better. AIDS proved to be an agent of change that helped us overcome our painful past by uniting all ethnicities, classes and communities against our common enemy. Our losses strengthened us to take charge of our own destiny. From tragedy, we have reclaimed hope and forged progress.

Because of South Africans working together, the AIDS epidemic has stabilized, and prevalence has declined among children and young people. We continue to press forward. One year ago we launched an historic, unprecedented scale-up of our national response. By the end of this year, we aim to cut the rate of new HIV infections in half and provide HIV testing to 15 million people. By May we had tested 8.4 million people. It is also our goal to provide lifesaving drugs to 80% of South Africans who need them this year. South Africa has committed hundreds of millions of dollars towards AIDS – more than ever before – and we are funding the bulk of our AIDS response from our own resources.

Looking back over 30 years, the global AIDS epidemic has mirrored our country's transformation, from fear and fragmentation to unity and commitment. I am gratified to see other countries, especially in Africa, bringing civil society and governments together to own, and be accountable for, the response to AIDS.

I believe that the General Assembly High Level Meeting on AIDS will not only celebrate our collective achievements but also open new paths to progress and lead to a more positive future in halting the AIDS epidemic.

Jacob Zuma
President of South Africa

INTRODUCTION

Our ambitious vision

I am grateful to the leaders who have lent their influential voices to this report. It is evident that even after 30 years, HIV has not faded in global significance, but continues to engage the great minds of science, geopolitics, human rights and social change.

At this critical point in the epidemic we must take stock and make important decisions. It has been 30 years since the first reported cases, 15 years since treatment became a reality, 10 years since the United Nations General Assembly Special Session on HIV/AIDS and five years since our commitment to achieve universal access to HIV prevention, treatment, care and support. This report provides evidence of how much we have achieved and weighs that against our vision for the future: zero new HIV infections, zero discrimination and zero AIDS-related deaths.

In these pages you will find scientific analysis, personal insights and the results of extensive national and regional consultations at the front lines of the AIDS response. While perspectives differ, one simple truth emerges: we cannot break the arc of this epidemic – where five people were newly infected for every three starting treatment in 2010 – if we adopt a 'business as usual' approach.

Since the 2006 Political Declaration on HIV/AIDS, the world has changed profoundly in ways that challenge our goal of universal access. But with the right approach, we can make use of these changes to transform and accelerate the AIDS response, and in doing so, move all of the Millennium Development Goals (MDGs) forward.

The economic climate has changed. Persistent financial challenges in many countries are putting unprecedented downward pressure on funding sources, internally and internationally. But with the right approach, this situation can be catalysed to accelerate country ownership of the response and build stronger partnerships between developing countries. It can move us all to do things better, with maximum value for money.

The epidemic has changed. We have made tremendous progress in stabilizing or reducing rates of new infections in nearly 60 countries, but this success only highlights the rampant stigma and discrimination that contributes to rising infection rates among key populations at higher risk and to the vulnerability of women and girls. We can end the discrimination and inequity that blocks access to prevention, treatment, care and support. We can stop the criminalization of people living with, and at risk of, HIV. »

» *Treatment needs have changed.* We have put 6.6 million people on treatment, but nine million are still waiting. The cost of treating everyone eligible is growing exponentially. We have an opportunity to provide better, more cost-effective drugs and smarter service-delivery systems. These are basic tenets of our vision for Treatment 2.0. We can also make sure every pregnant woman living with HIV receives treatment so that we might halve AIDS-related maternal deaths and end new child infections within five years.

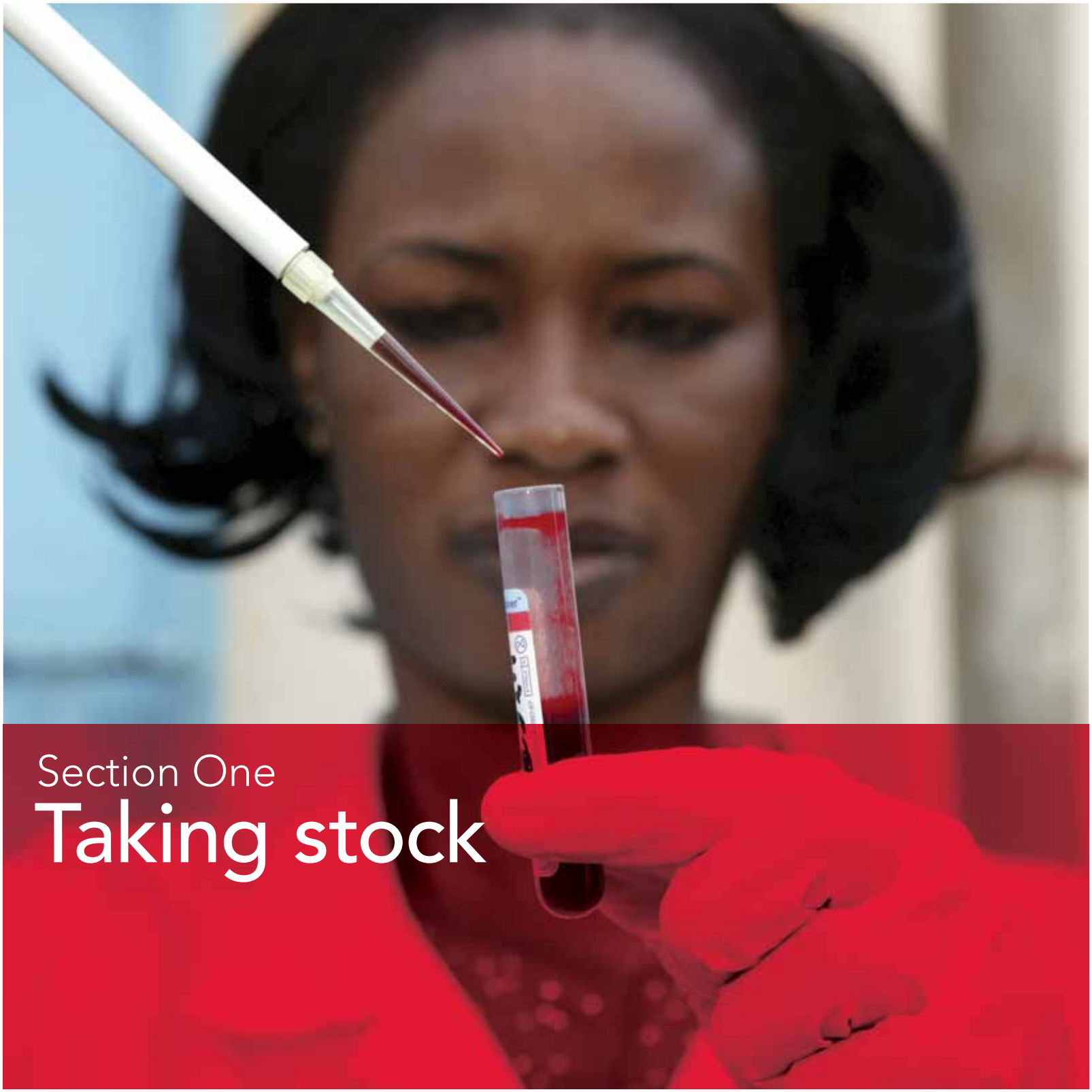
Treatment for prevention will shape the future of the AIDS epidemic. The latest trial showing conclusive evidence that early antiretroviral treatment effectively blocks HIV transmission can transform the prevention landscape. We must embrace treatment for prevention as a game-changing prevention option for the next decade.

The UNAIDS Strategy 2011–2015 details the approaches and the targets that will guide our transformation: spelling out the elements of a sustainable response that builds on strong national ownership, clear accountability, community mobilization, the participation of people living with HIV and shared investment responsibilities. This report has the evidence to hold countries accountable and the expert viewpoints to remind us what is at stake. Together, and in harmony with the Report of the United Nations Secretary-General, they form a solid base for action that will lead us to achieving the MDGs by 2015, and ultimately, reaching our ambitious vision.

Michel Sidibé
UNAIDS Executive Director

96%

Results of the HPTN052 trial announced on 12 May 2011 show that if an HIV-positive person adheres to an effective antiretroviral therapy regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%



Section One

Taking stock

Most severe epidemic in modern times

Thirty years ago, the United States Centers for Disease Control and Prevention (CDC) issued the first official report of what would become known as the HIV epidemic. The initial CDC report gave little clue that the news foretold the most severe epidemic in modern times.

Early signs of the disease were primarily confined to high-income countries, where new cases increased exponentially in the early 1980s. In reality, HIV had been spreading unnoticed for decades, especially in sub-Saharan Africa.

Between 1981 and 2000, the number of people living with HIV rose from less than one million to an estimated 27.5 million [26–29 million]. HIV emerged at different times in diverse regions, but eventually came to affect every part of the world.

From its early years, HIV gave rise to passionate community action to stem the spread of infection and to care for those living with the virus. Yet despite the enormity of the epidemic, the global community largely failed to respond during the epidemic's first two decades. When UNAIDS was established in 1996, total spending on HIV programmes in low- and middle-income countries remained below US$ 300 million. As late as 1998, long after it had become clear that low- and middle-income countries accounted for 95% or more of the global HIV burden, total spending on HIV in resource-limited settings was still less than US$ 500 million.

While an effective response was perhaps most needed in the 1980s, before numbers reached crisis proportions, the ultimate results of governmental inaction became most visible in the 1990s, especially in southern Africa. While less than 1% of adults in South Africa were living with HIV in 1990, 16.1% were living with HIV a decade later. During the same period, adult HIV prevalence rose from less than 1% to 24.5% in Lesotho, and from 3.5% to 26% in Botswana.

Lessons learnt during the epidemic's first two decades

Even as global neglect allowed the epidemic to spin out of control between 1981 and 2000, fundamental lessons were becoming apparent.

The critical importance of leadership

While the world as a whole failed to act at the required scope and scale during the first two decades of the epidemic, a few visionary national leaders stepped forward. Confronting what was then Africa's most severe epidemic, Uganda's President Yoweri Musevini launched a full-scale national mobilization against HIV, enlisting communities to reject stigma, communicate openly about risks and change behaviour norms, and putting in place policies and programmes that would enable Uganda's epidemic to shrink during the 1990s even as others in sub-Saharan Africa rapidly expanded. Leaders in Brazil, Thailand, Senegal and other countries also implemented strong national programmes, collectively averting millions of new infections. »

» Experience in the epidemic's early years underscored a maxim that remains true. Strong and courageous political leadership is central to success in the response to HIV.

The transformative power of communities and people living with HIV

People living with AIDS gathered in Denver (USA) in 1983 to launch a global movement through the Denver Principles. Rejecting notions of passivity, helplessness and dependence, the Denver Principles insisted on respect for the rights of people living with HIV to self-determination, freedom from discrimination, and full and active participation in decision-making on issues that affect their lives. The solidarity and commitment of people living with HIV was reflected in networks and organizations at regional, national and local levels. At the Paris AIDS Summit in 1994, 42 nations formally recognized the principle of the Greater Involvement of People with AIDS.

From the epidemic's earliest years, affected communities responded where governments failed. Community organizations were created to serve people living with HIV, such as New York City's Gay Men's Health Crisis and The AIDS Service Organisation in Uganda. In countries throughout the world, communities of sex workers and people who use drugs mobilized to develop and implement effective, community-centred prevention strategies. Communities pioneered innovative advocacy and protest campaigns, such as those undertaken by national and local chapters of the AIDS Coalition to Unleash Power (ACTUP). In 1998, activists joined to create South Africa's Treatment Action Campaign, building a national movement that would eventually alter the country's response to HIV as well as the course of South Africa's history.

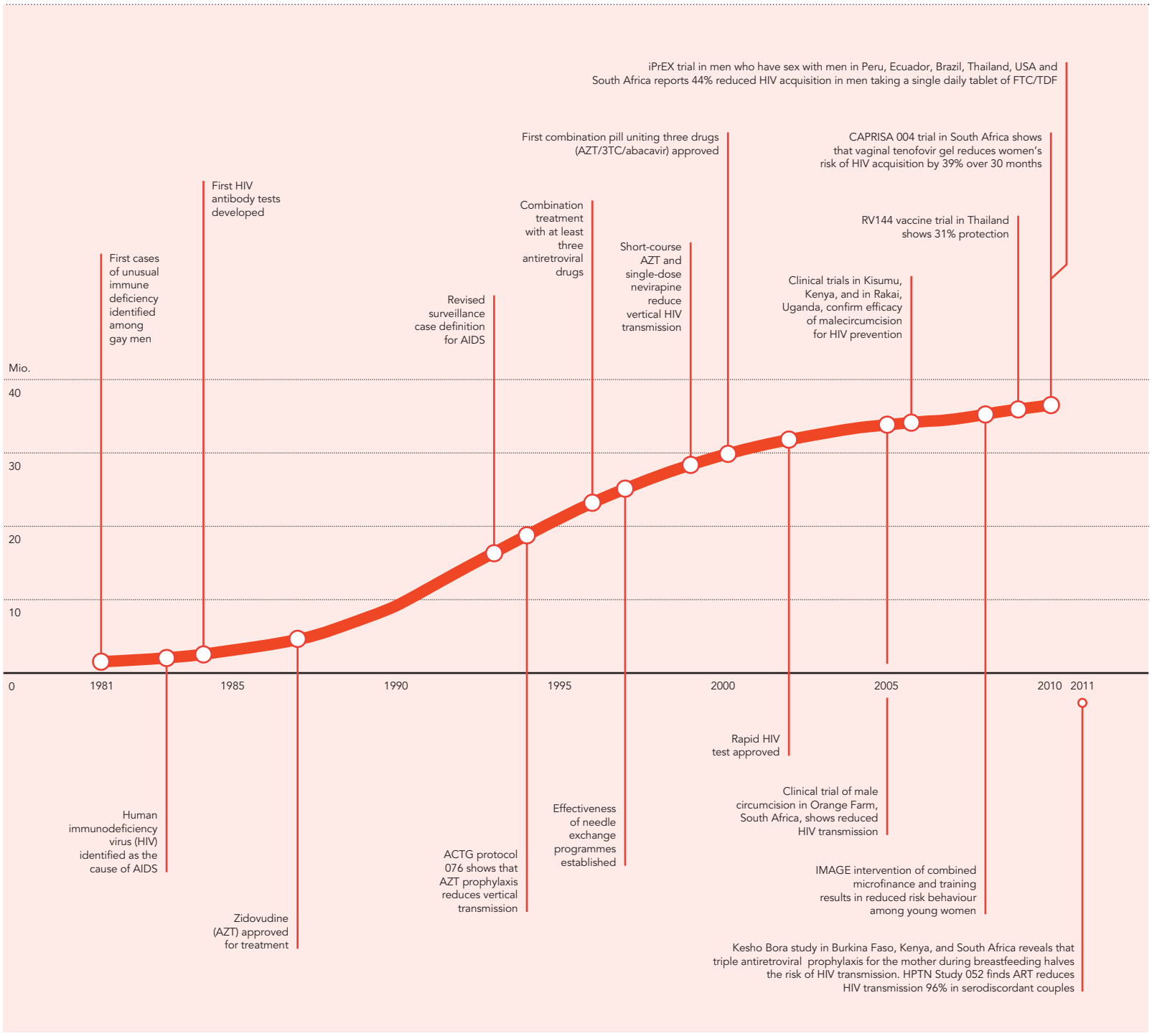
The importance of scientific knowledge

Scientific knowledge about HIV expanded steadily in the years 1981–2000. The virus was identified in 1983, and the first serologic test became available in 1985. In the 1990s, studies demonstrated in developed and low- and middle-income countries the possibility of significantly lowering the risk of vertical transmission.

Advances were also made in treating HIV during the epidemic's early years. After limited results achieved with early antiretroviral compounds, regulatory approval was given in 1996 to a new class of antiretroviral drugs, protease inhibitors, which ushered in the era of highly active antiretroviral therapy. Combination therapy proved to be powerfully effective, swiftly lowering rates of AIDS deaths by two thirds or more in many high-income countries. Due to its high cost, combination antiretroviral therapy was largely unavailable in low- and middle-income countries between 1996 and 2000. An important exception was Brazil, which in 1996 became the first middle-income country to adopt a national policy of free antiretroviral therapy. In addition to treating HIV infection itself, substantial gains were also made in the 1980s and 1990s in developing treatments and preventive regimens for numerous HIV-related opportunistic illnesses, helping prevent or delay illness and death and improving quality of life for people living with HIV.

Yet a defining feature of the first two decades of HIV was the common failure of leaders to put scientific knowledge to use. Even the most basic prevention tool – the male condom – remained largely unavailable in the countries where the epidemic was expanding the fastest. Despite a robust body of evidence documenting the effectiveness of harm-reduction programmes for people who use drugs, relatively few settings implemented these programmes at sufficient scale. Due to the failure to act, rates of HIV infection and AIDS deaths continued to mount. Yet glimmers of hope also emerged in the epidemic's early years. In Australia, for example, quick action to implement harm-reduction »

Number of people living with HIV and scientific breakthroughs, 1981–2011




STOP
H.I.V.
POSITIVE


VERSAL ACCE


CURE AIDS
CONDOM
WORK

» programmes averted what appeared to be an inevitable epidemic among people who inject drugs. In Brazil, aggressive pursuit of a rights-based, evidence-informed approach to address the country's multi-faceted and rapidly growing epidemic brought a measure of control to HIV, averting hundreds of thousands of HIV infections, according to an analysis by the World Bank.

The social dimensions of HIV

From its earliest days, the viral epidemic was accompanied by a social epidemic of comparable severity. Grounded in fear, ignorance, and social disapproval of groups heavily affected by HIV, the epidemic of stigma and discrimination frequently overwhelmed the ability and willingness of communities and countries to respond to HIV. In country after country, people living with HIV often lost their jobs, homes, and access to health care or other public services. Recognizing the role of stigma and discrimination in blocking effective responses, Dr Jonathan Mann, the head of the Global AIDS Programme at the World Health Organization (WHO) during the epidemic's first decade, emphasized the need to protect the human rights of people living with HIV.

In the first two decades of the epidemic, the countries that mounted the most successful responses recognized the need for strong measures to protect and promote the rights of people affected by HIV. Yet many countries remained slow to accept this reality, with many failing to prohibit HIV-related discrimination. Indeed, laws and policies in many parts of the world institutionalized such discriminatory attitudes and practices. Dozens of countries imposed travel or entry restrictions on people living with HIV, many sought to criminalize HIV transmission or exposure, and leaders in different regions depicted people living with HIV as threats from which society needed to be protected.

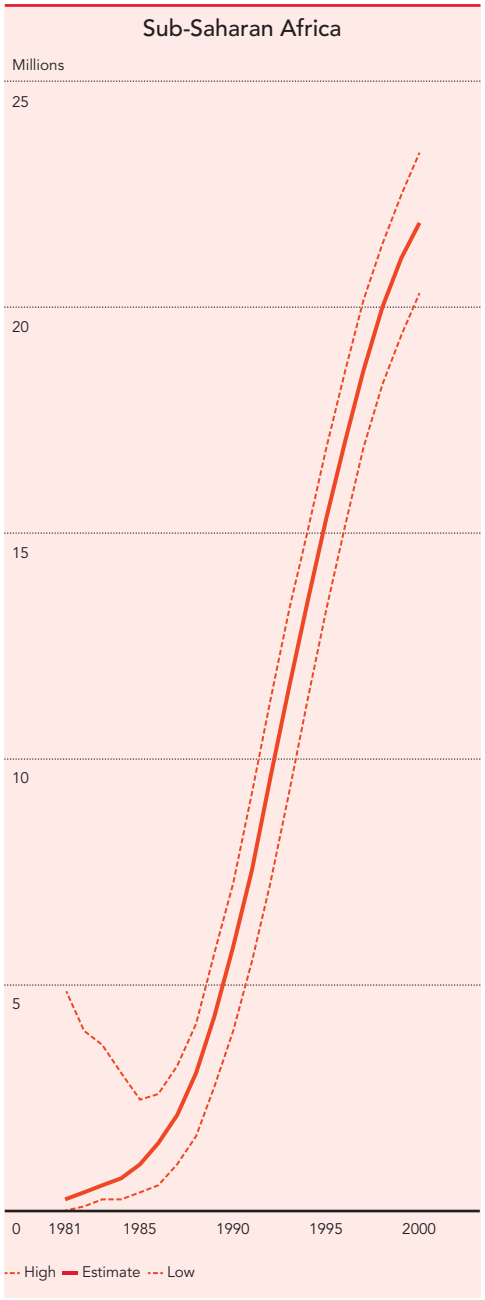
Although HIV is perhaps the most serious global health challenge of our time, it was clear from the earliest days that it was more than just a disease. it was quickly evident that social conditions have a profound effect on vulnerability to HIV; that the epidemic was undermining efforts to address poverty, hunger, and other health and development issues; and that economic conditions, social attitudes, and legal frameworks played a key role in a country's ability to respond effectively. Taking account of the multi-dimensional nature of HIV and of the need for a genuinely multisectoral response, diverse stakeholders in the global health and development fields determined that a new international response to HIV was required. In 1996, UNAIDS was launched. Initially a pioneering collaboration of six United Nations agencies, UNAIDS would eventually expand to 10 cosponsors, supported by a secretariat and with a presence in more than 100 countries. In the 1990s, a growing number of countries also recognised the need for multi-disciplinary action, involving diverse sectors and constituencies in national HIV strategies.

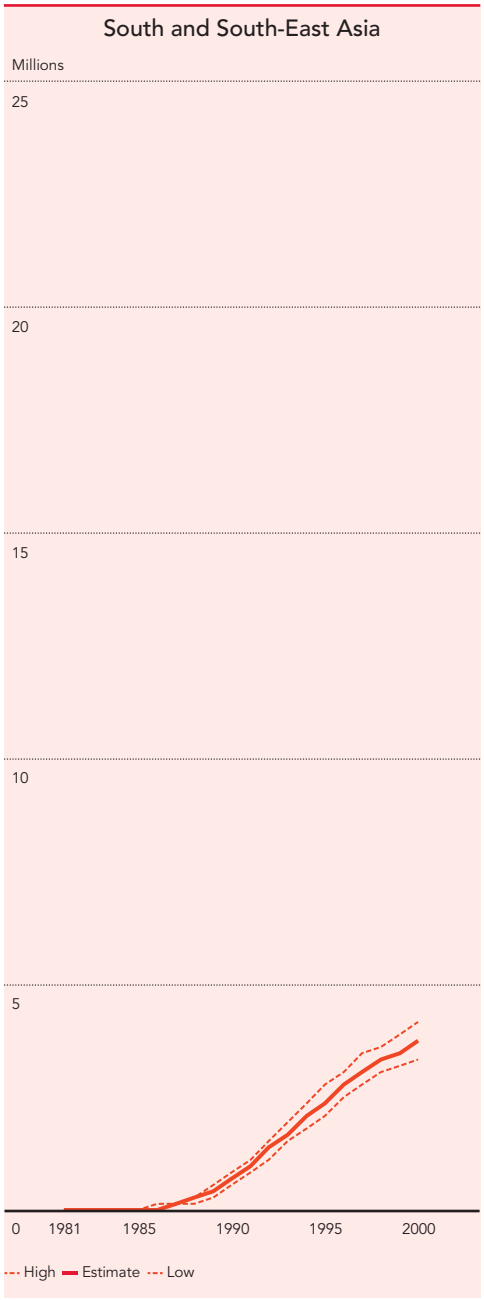
Even as official action remained inadequate, the epidemic wrought considerable social changes in 1981–2000. Especially in countries that began taking the epidemic seriously, human sexuality became a topic of open public discussion, helping establish a foundation for more effective prevention measures. The growing proportion of women and girls among people living with HIV highlighted the harmful consequences of gender inequality. The epidemic's disproportionate impact on key populations focused growing attention on the social marginalization of sex workers, men who have sex with men, and people who use drugs, giving rise to human rights movements that would become more visible in the epidemic's third decade.

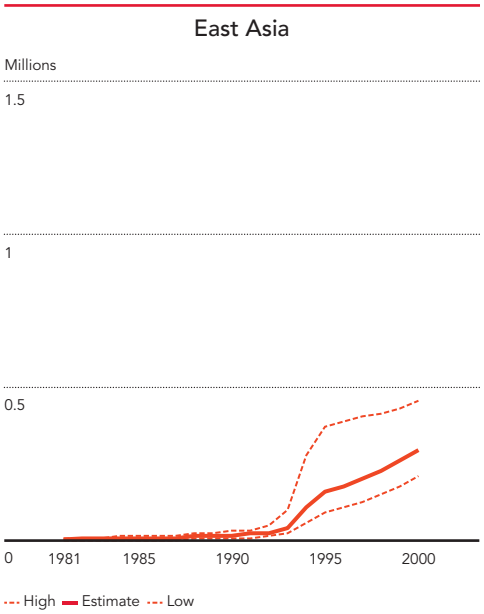
Over the first two decades, governmental inaction allowed the epidemic to become a global crisis, with especially harsh consequences in southern Africa. But the seeds had been sown for an unprecedented global movement that would reap historic results in the early 21st century. «

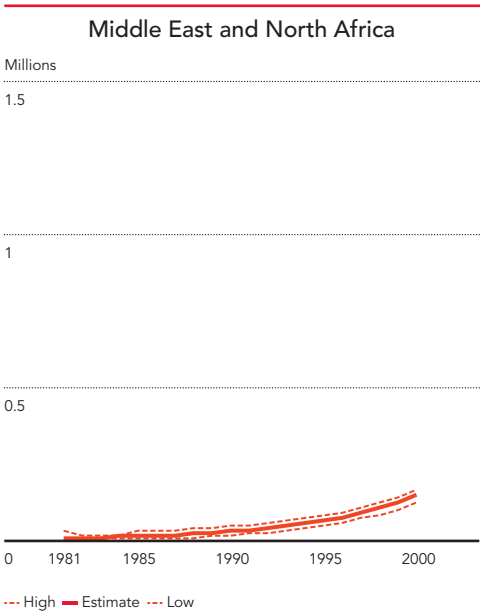
"A defining feature of the first two decades of HIV was the common failure of leaders to put scientific knowledge to use."

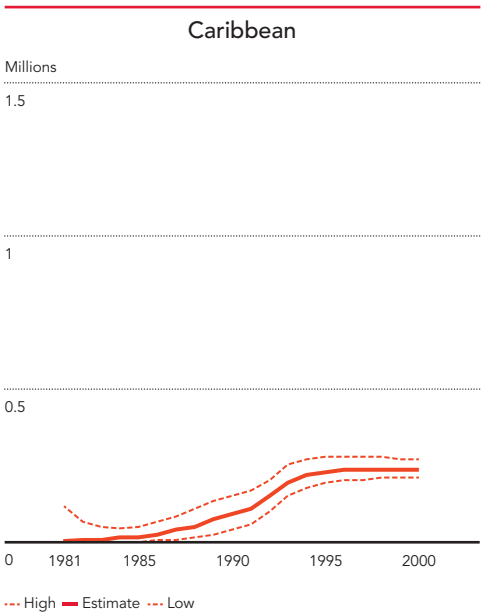
People living with HIV, 1981–2000







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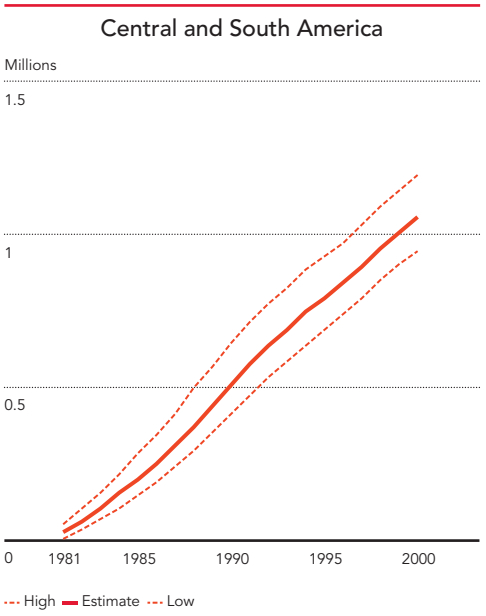
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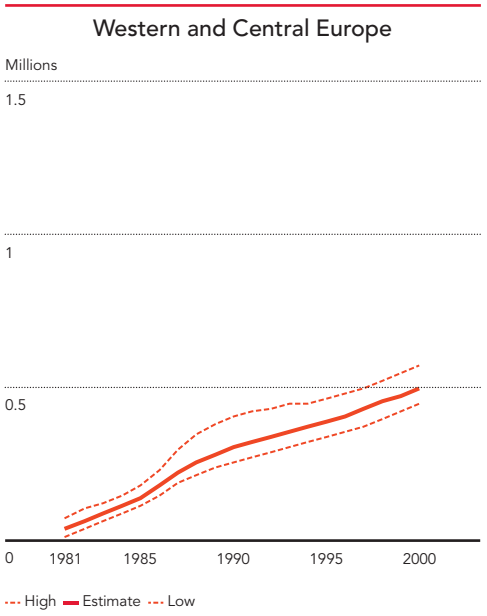
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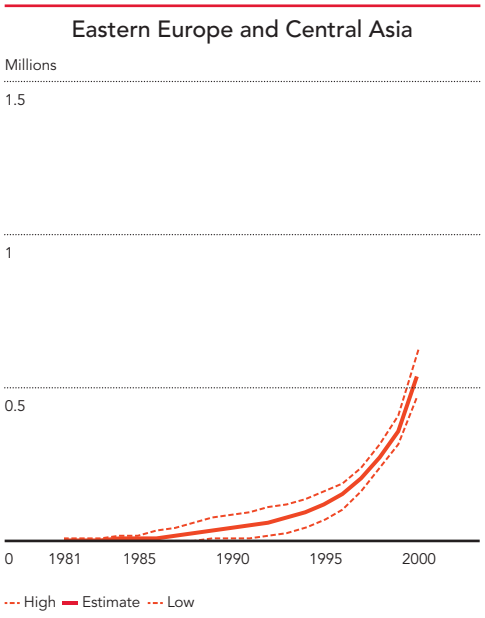
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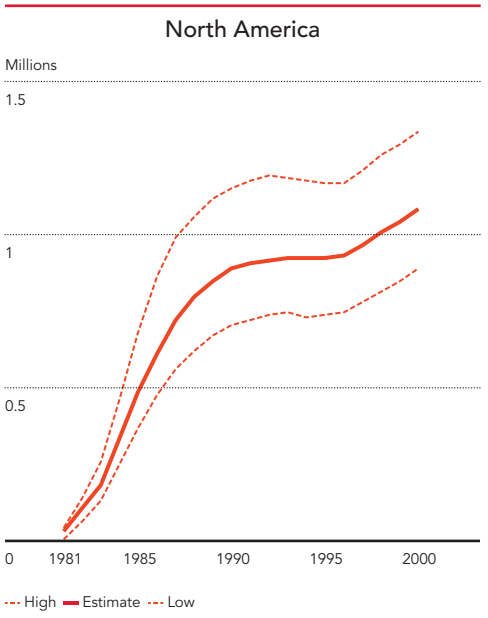
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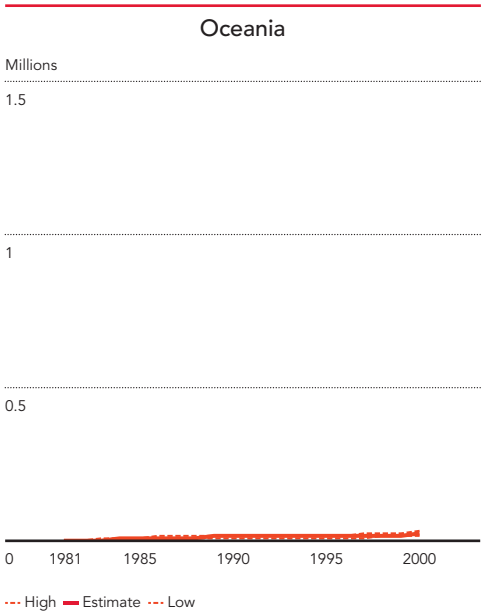
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COMMENTARY

Peter Piot

2001: a turning point in the epidemic

The former UNAIDS Executive Director offers an historical perspective on the AIDS response.

When I became the first Executive Director of UNAIDS in 1995, it was clear to me the response to AIDS was woefully inadequate. Low- and middle-income countries were spending just US$ 250 million a year and only two, Uganda and Thailand, had achieved even modest reductions in new infections. There was no coordination between United Nations agencies, no involvement of civil organizations outside high-income countries, people living with HIV battled stigma and discrimination, and there was no effective treatment.

It would be another five years before I saw signs that the tide was turning. The UN Security Council broke new ground in January 2000 when it discussed a health or social issue. This was a defining moment; finally AIDS was recognized as a threat to global security.

By 2001 we had reached an inflection point. The world was acknowledging AIDS as a global epidemic demanding a response from all of humanity. Two events were pivotal.

The Heads of State and Government of the Caribbean meeting in February 2001 led to the Caribbean Partnership Commitment, and the launch of the Pan-Caribbean Partnership against HIV/AIDS. This became the Caribbean's prime platform on AIDS, galvanizing resources from governments, civil society and the private sector, regional institutions and the international community.

Two months later, the Special Summit of the Organization of African Unity, attended by almost all African leaders, adopted the Abuja Declaration, affirming the AIDS epidemic was a state of emergency for the continent. The AIDS response was finally at the forefront of African leaders' minds.

UN Secretary-General Kofi Annan's call to action listed the following priorities: preventing further spread of the epidemic; reducing vertical transmission; making care and treatment universally accessible; striving for a cure for AIDS and a HIV vaccine; and protecting those made vulnerable by the epidemic, particularly orphans.

These developments paved the way for the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. This signified the first global political commitment at the highest level. It recognized AIDS as one of the big global issues of our time, not just a public health issue.

This was the year when evidence showed the course of an AIDS epidemic could be changed, and when business, religious groups, youth organizations, entertainers and people living with HIV joined the response.

Political engagement reached new heights. The UNGASS Declaration of Commitment on HIV/AIDS gave us a guide for action with measurable targets.

This was when we realized the response to AIDS required resources counted in billions. It led to the Global Fund to Fight AIDS, Tuberculosis and Malaria. By 2002, resources for the response reached US$ 1 billion, and it was recognized that if the epidemic were to be tamed and those infected to receive proper care, the sum needed was 10 times larger.

The year marked the start of a newly mobilized partnership between the UN, governments, the private sector, nongovernment organizations and diverse communities. That shift towards collective responsibility made 2001, and the UNGASS declaration in particular, the tipping point. «

Peter Piot is a former Under-Secretary-General of the United Nations and Executive Director of UNAIDS. He is now the Director of the London School of Hygiene and Tropical Medicine.

182
countries

A total of 182 countries reported in 2010 on their implementation of the Declaration of Commitment

A new chapter in the HIV response

By 2000, demand was growing for action to be taken on HIV. The 2000 International AIDS Conference in Durban, the first held in a developing country, adopted the theme "Breaking the Silence" as delegates demanded concerted global action to bring HIV treatments and proven prevention tools to settings that had long lacked access. As the epidemic's second decade drew to a close, the United Nations Security Council held a special session on HIV, the first for any health issue, citing the epidemic's potential impact on global security and encouraging countries to think of HIV and global health in new ways.

An important chapter in the HIV response was about to begin. In the epidemic's third decade, the response to HIV would be near the top of the global political agenda.

In 2001, Member States gathered for an unprecedented Special Session of the UN General Assembly. For the first time in the epidemic's history, global goals and targets were established for the response, unanimously endorsed by 189 countries. Performance indicators were put in place to monitor global progress towards agreed targets, and countries began submitting reports every two years on the degree to which their commitments had been kept. Between 2006 and 2010, the percentage of countries submitting progress reports on global HIV commitments increased from 64% to 94%. »

Countries that did NOT provide reports on the implementation of the Declaration of Commitment in 2010

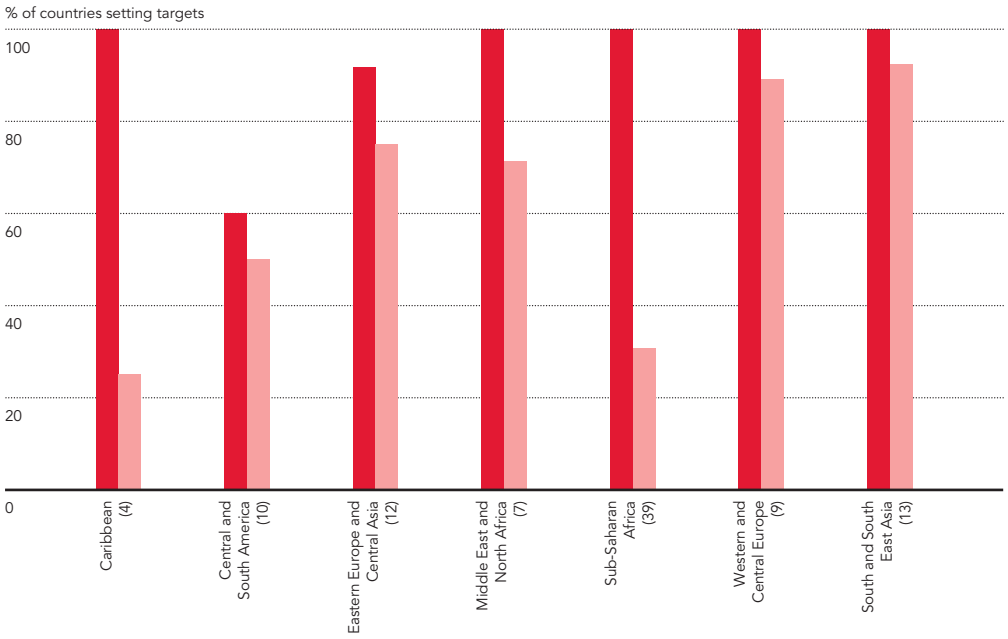
Andorra
Democratic People's Republic of Korea
Republic of Korea
France
Iceland
Iraq
Kiribati
Liechtenstein
San Marino
Turkmenistan

» With the global community finally mobilized to respond to HIV, it was increasingly apparent that fragmented national efforts would no longer suffice. Supported by the UN system and other partners, nearly all countries developed national HIV strategies and action plans. Today, 94% of countries (162 of 172 countries reporting) have national HIV strategic plans, up from 87% in 2006. National strategies have broadened in scope over time, addressing core prevention, treatment, care and support needs. Strategies have also evolved to to take account of the needs of additional populations, including refugees, migrants and prisoners. Gaps in national efforts persist, however, especially in linking national strategies with clear epidemiological and societal information, in fully addressing issues of human rights and gender inequality, and in integrating HIV with wider health and development sectors.

The coordination of national responses also improved during the epidemic's third decade. Two out of three (67%) countries in 2010 reported having a single HIV monitoring and evaluation system, up from 46% in 2006, although country reports cite insufficient coordination of diverse partners as a continuing challenge to national responses.

Although global momentum towards a stronger and more effective response to HIV was clear following the 2001 Special Session, progress in bringing essential HIV services to scale was slow in the early years of the third decade. It became obvious that small-scale projects that reached only a fraction of those in need would never be sufficient to reverse the epidemic. »

Countries setting universal access targets, by region, 2004–2010



Insufficient data available from North America, Oceania, East Asia.

» By the 2001 Special Session, a growing constituency of activists, clinicians and health experts were calling for a global effort to introduce antiretroviral therapy in resource-limited settings. Momentum for a worldwide treatment campaign quickened at the 2002 International AIDS Conference in Barcelona, and a full-fledged global movement was born with the launch in 2003 of the "3 by 5" campaign, which aimed to deliver antiretroviral therapy to three million people in low- and middle-income countries by December 2005.

Essential services

Inspired by the vision of a healthier and more equal world, leaders from around the globe gathered at the UN in 2006 to review progress since the 2001 Special Session. At the 2006 High Level Meeting on HIV/AIDS, UN Member States embraced a transformative new goal of universal access to HIV prevention, treatment, care and support. Global leaders agreed that no one, regardless of where they lived or what community they belonged to, would be left behind in the response to HIV. Global endorsement of the goal of universal access built on earlier calls by the Group of Eight countries and the African Union to deliver essential HIV services to all who needed them.

The goal of universal access galvanized an extraordinary global movement, uniting national governments, international organizations, civil society, people living with HIV, the private sector, and people from all walks of life, in a common effort to deliver essential services to all who needed them. Following the 2006 meeting, 117 countries reviewed obstacles to universal access and established time-bound targets for service coverage and health outcomes. Gaps remain, however, as countries are more likely to have clear targets for antiretroviral therapy than for services for key populations at higher risk.

"Global leaders agreed that no one would be left behind."

In the third decade, we expanded our knowledge of effective strategies to address HIV. Promising new biological prevention tools have emerged since 2001, including adult male circumcision, the first evidence of efficacy of a vaginal microbicide, and pre-exposure antiretroviral prophylaxis among men who have sex with men (MSM). In addition to the biological prevention tools, data has also become available on the effects of structural interventions aimed at behaviour change. In 2010, two studies in sub-Saharan Africa found that conditional cash transfers to young people reduced their risk of becoming HIV-positive or receiving another sexually transmitted infection. In addition, accumulated evidence has identified ways to optimize the effectiveness of long-standing interventions, prompting revisions in 2010 to international guidelines for antiretroviral therapy and preventing vertical transmission.

Energy and commitment

After two decades of official inaction, the global community has responded to the epidemic with unprecedented energy and commitment over the past decade. The results have been profound, for individuals, households, communities, and entire societies.

This chapter highlights progress in several key areas of the response in the past 10 years. These snapshots of progress and continuing challenges are not intended to be an exhaustive review of every aspect of the response, but rather, to illustrate the many ways in which the HIV response has changed the world. «

COMMENTARY

Lula da Silva

Sharing knowledge for the profit of all

The country's former president says Brazil is using its experience and growing economic stature to help other countries in the global AIDS response.

Brazil, a country of which I am proud to have been president, has shown there are no challenges that cannot be overcome. Today, we are a great nation as well as a world leader in the fight against AIDS.

In the 1990s, World Bank projections indicated that in 2000, Brazil would have 1.2 million people living with HIV. With the integrated efforts of government, academia and civil society organizations, both in prevention and treatment, this number is far less, about 600 000 people. Since 1996, all patients needing treatment have had universal, free-of-charge access to 20 antiretroviral drugs, 10 of them locally produced, and today, 200 000 people are on highly active antiretroviral therapy.

The quest of the Ministry of Health for sustainable treatment led me to decree in 2007 the compulsory licensing of an important anti-AIDS drug, Efavirenz. This licensing was a crucial step towards internalizing national production of this drug, for boosting technological development in the health sector, and for resource savings, which, to us elected officials, meant new patients would have access to treatment and new drugs.

The Brazilian response to AIDS also stands out for its early adoption of prevention strategies, focusing primarily on condom use. In 1986, condom use in the first sexual intercourse was only 9%; by 2008, it had reached 60%. Today, our country is the world's largest governmental buyer of condoms and the only country that has a public producer of condoms made of natural latex, extracted in the Amazon region and producing 100 million per year.

As Brazil is affected by a concentrated AIDS epidemic, another important decision was to establish prevention programmes directed to vulnerable populations. In these programmes, the social reality of sex workers, gays and drug users, among others, is taken into consideration, resulting in better prevention responses. We have always adopted a human-rights perspective in HIV prevention – for all health issues for that matter – and in the recent past, the Brazilian government has refused American financial aid because of unacceptable conditions attached with regard to sex workers.

The experience we have acquired is shared with other countries. Brazil has a well-established pharmaceutical industry producing AIDS drugs and is now transferring technology and financial resources to the Government of Mozambique to build its own factory. Whereas Brazil once received financial aid, it now proudly occupies the position of an important international partner. The South-South Cooperation on HIV/AIDS covers more than 19 countries and includes the exchange of technical programmes and the donation of more than 7 000 antiretroviral treatments a year to people in nine countries.

I hope that in a few years, world inequalities will be lessened. I dream of more people having access to integral health care, from information to prevention methods, and to all the needed drugs, and that these be increasingly developed and manufactured in several countries so they become accessible to all. This is a fundamental step to a more just world for all. «

Lula da Silva was the President of Brazil from 2003 to 2011.

Significant rise in HIV investment but efficiencies needed

There was a significant increase in investment in the HIV response in low- and middle-income countries between 2001 and 2009, with total expenditure rising nearly 10-fold, from US$ 1.6 billion to US$ 15.9 billion. The world met the interim funding target of US$ 7-10 billion in 2005 that was outlined in the Declaration of Commitment, but funding has since fallen short of growing needs and questions remain about its efficiency. As the epidemic enters its fourth decade, flattening support potentially jeopardizes the sustainability of financing at recent levels.

Public and private domestic resources accounted for 52% of total spending on HIV programmes in low- and middle-income countries in 2009, but many low-income countries remain heavily dependent on external financing. In 56 countries, international donors supply at least 70% of HIV resources. This pattern potentially encourages the emergence of new global inequities, as millions of people in sub-Saharan Africa now rely on external donors on a daily basis for the drugs and services that keep them alive. Sustainable approaches need to be put in place, with robust and predictable donor commitments and an energetic national response that is fully integrated with other national priorities.

The waning support of international donors must be reversed. Even before the global economic downturn, many donor countries were failing to devote their fair share to the HIV response. Among high-income countries, there was a 139-fold difference in the share of national wealth devoted to HIV assistance in 2009. Some countries that are now emerging as global and regional economic powers may in due course become international donors for the HIV response.

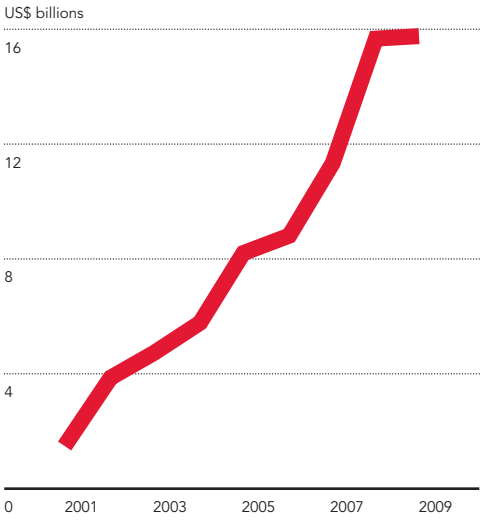
Governments in low- and middle-income countries also need to increase their financial outlays for HIV programmes. The UNAIDS Domestic Investment Priority Index, a formula that accounts for total HIV burden and government resources, shows that eight of 14 countries in West and Central Africa, six of 16 countries in Eastern and Southern Africa, and all but four countries in Asia were allocating inadequate resources to HIV in 2009. To address the epidemic's multi-generational challenge, affected countries will need to devote more resources to the response according to their capacity to pay and their disease burden.

Self-financing responses

Many middle-income countries should be in a position to entirely self-finance their HIV response within the next few years, although this process is likely to take longer in low-income countries in sub-Saharan Africa that are hyperendemic. Inadequate spending by the governments of low- and middle-income countries and by international donors represents a short-sighted failure to invest in the future. HIV spending is a cost-effective investment, returning health and economic dividends for future generations.

In addition to spending too little on HIV, countries are often failing to focus spending where it would have the greatest impact. According to a review of available evidence commissioned by the World Bank, minimal prevention resources in West Africa are being directed to programmes for sex workers and men who have sex with »

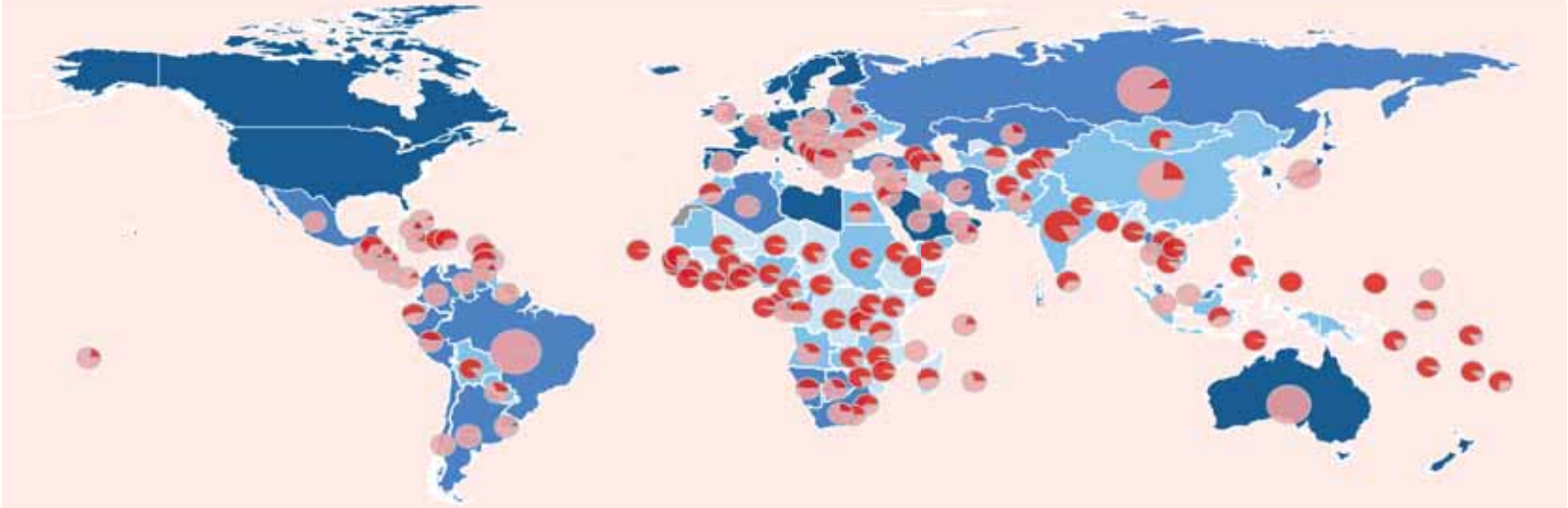
Global resources available for HIV in low- and middle-income countries, 2001–2009



15.9 billion

US$ 15.9 billion was invested in the HIV response in low- and middle-income countries in 2009

HIV funding sources by income level – UNGASS indicator no. 1, last year available (2007–2009)



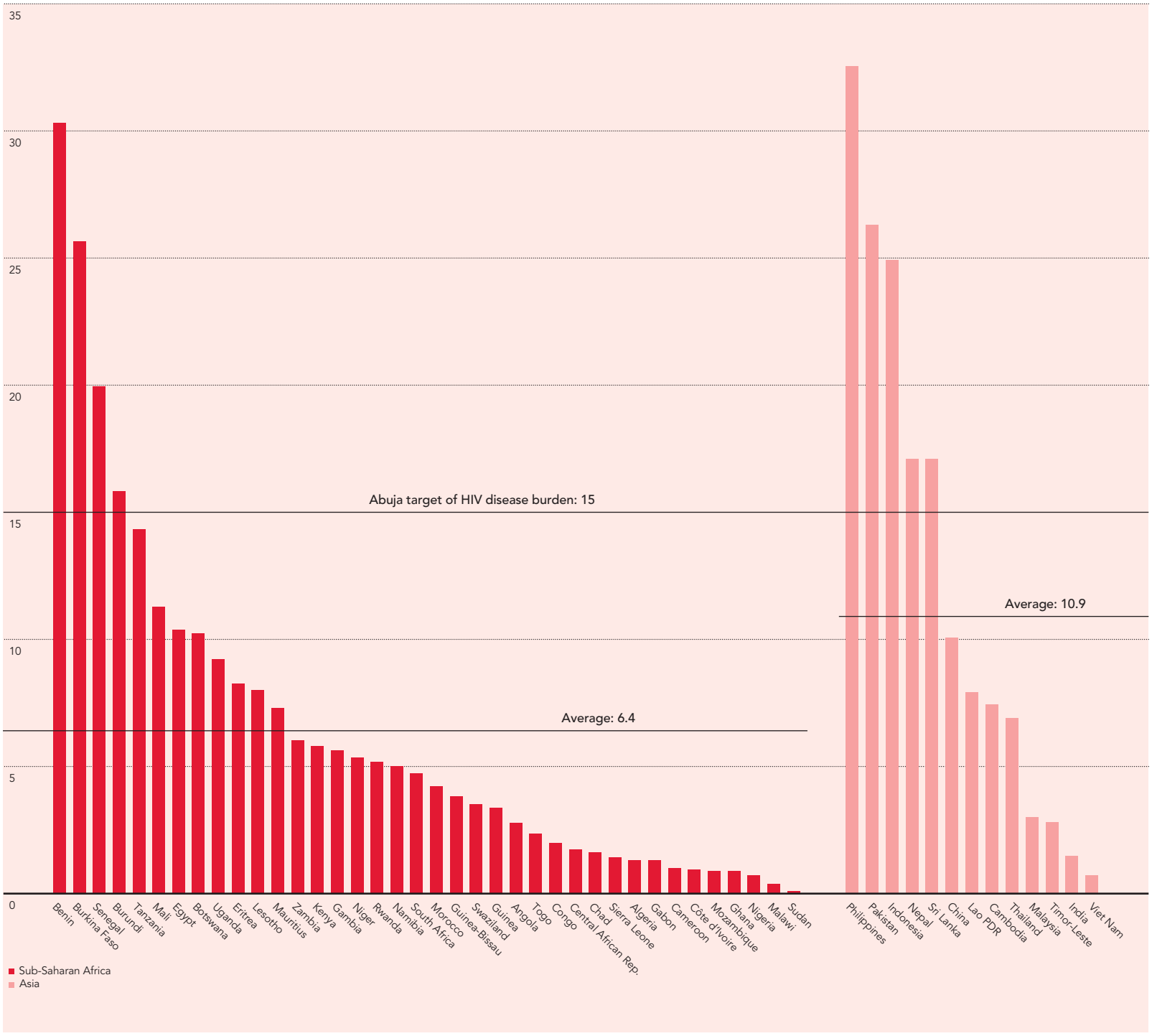
Income level
- Low-income
- Lower-middle-income
- Upper-middle-income
- High-income
- Missing value

Domestic HIV spending
- International
- Public

Note

The boundaries and the names shown and the designations used on these maps do not imply official endorsement or acceptance by the United Nations.

Domestic Investment Priority Index
Selected countries in sub-Saharan Africa and Asia,
2008–2009



» men, even though these key populations have HIV prevalence more than 10 times greater than the general population. In parts of southern Africa, older adults in heterosexual relationships account for a large share of new infections, but few programmes address their specific needs. In Asia, about 90% of the HIV prevention spending focused on young people is not allocated to programmes for young people at higher risk of becoming infected.

Shared responsibility

Building on timely evidence of national epidemics and responses, stronger national planning processes are needed to improve the efficiency and impact of limited funding. In recent years, a growing number of countries has benefited from studies that have estimated new infections by modes of transmission and compared national prevention priorities with epidemiological patterns. These studies, which have quantified the gap between epidemiological patterns and national prevention resource allocations, have prompted several countries to begin to realign their HIV programmes to address actual needs. In addition to improving the strategic focus of prevention efforts, countries and programme implementers also need to improve the efficiency and effectiveness of interventions, investing in enhanced quality control, results-based management, and impact evaluation.

Sustaining the HIV response over the long term will demand shared responsibility, requiring stronger efforts from both domestic and international sources. While working to mobilize sufficient resources, HIV stakeholders will also need to focus on efficiency, capturing economies of scale, improving programme management, and implementing incentives to maximize programmatic impact. «

International assistance for HIV from major donor governments, 2009 (US$ millions)

	2009 disbursements	International assistance for HIV per US$ 1 million GDP
United States	4 434.9	311.1
United Kingdom	779.0	356.8
Germany	397.9	118.7
Netherlands	381.9	480.6
France	338.4	126.5
Denmark	193.3	624.9
Sweden	171.8	423.8
Spain	163.6	111.8
Japan	141.8	28.0
Norway	130.2	339.9
Canada	129.9	97.2
Australia	99.9	100.2
Ireland	81.2	356.7
Italy	9.5	4.5

This includes both bilateral disbursements and contributions to the Global Fund and UNITAID (only for HIV)

Source: UNAIDS/KFF, Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other donor governments in 2009, July 2010

Photo: Justin Sullivan/Getty Images for the Clinton Foundation

COMMENTARY

Bill Clinton

Smart response is a sound investment

The former US President believes increased AIDS funding is essential, but more can be achieved with existing resources.

Much progress has been made in the fight against AIDS, but there is still a long way to go, and we now face a critical juncture. More that 7000 people, including 1000 children, are newly infected with the virus every day and someone dies an AIDS-related death every 20 seconds.

When Nelson Mandela asked me to make AIDS a major focus of my post-Presidency, many people questioned whether widespread care and treatment in the developing world was even possible. Nearly 10 years since founding the Clinton Health Access Initiative, we have proven that we can turn the tide on the AIDS epidemic. I believe that over the next five years, emerging technologies will enable us to achieve the ambitious Treatment 2.0 goals UNAIDS has set for the world.

Unfortunately, funding constraints inspired by the global economic slowdown and government policies make achieving the goal more difficult. While we need more money, we must do more with what we have. Too high a percentage of aid is channelled through organizations with high overheads, rather than national and local governments and nongovernmental organizations that can deliver high-quality services at far lower cost. And stakeholders around the world must focus more on high-impact prevention efforts that reach the most vulnerable populations, including those affected by political bias and social stigma. By doing these things, even with the same level of funding, we can prevent many more infections. For this to be successful, governments and donors must share budgeting and resource data, employ transparent processes that encourage accountability among partners, and agree on spending priorities.

We must also improve the efficiency and effectiveness of individual interventions. In 2010, South Africa was paying twice the international rate for antiretroviral drugs and facing a half-million new patients in the coming two years. With help from the Clinton Health Access Initiative, it used market dynamics to cut its 2011 tender price for these drugs in half, with projected savings of US$ 680 million, reflecting aggressive negotiations with international generic suppliers and leaving South Africa in a strong position to make further improvements in future procurements.

Finally, we will need to maximize the use of medical personnel – our most precious resource – by pushing as many services as possible to the community level. Africa has 10% of the world's population, 25% of its health burden, and 3% of its health-care workers. Shifting tasks from doctors to nurses, and from nurses to community health workers, will strengthen local health-care networks and enable them to reach more people in the most vulnerable populations.

People in rich countries don't die from AIDS anymore, but those in poor countries still do – and that's just not acceptable. A smart, effective response to AIDS is not only the right thing to do; it has proved to be an extraordinarily sound investment with a very high rate of return. We can't turn back now. «

Bill Clinton was the 42nd President of the United States of America, serving from 1993 to 2001.

Grounding the response in human rights and gender equality

The world will be unable to achieve zero new HIV infections and zero AIDS-related deaths without achieving the third zero: eradicating discrimination by effectively addressing the harmful impact of stigma, social and legal exclusion, and gender inequality.

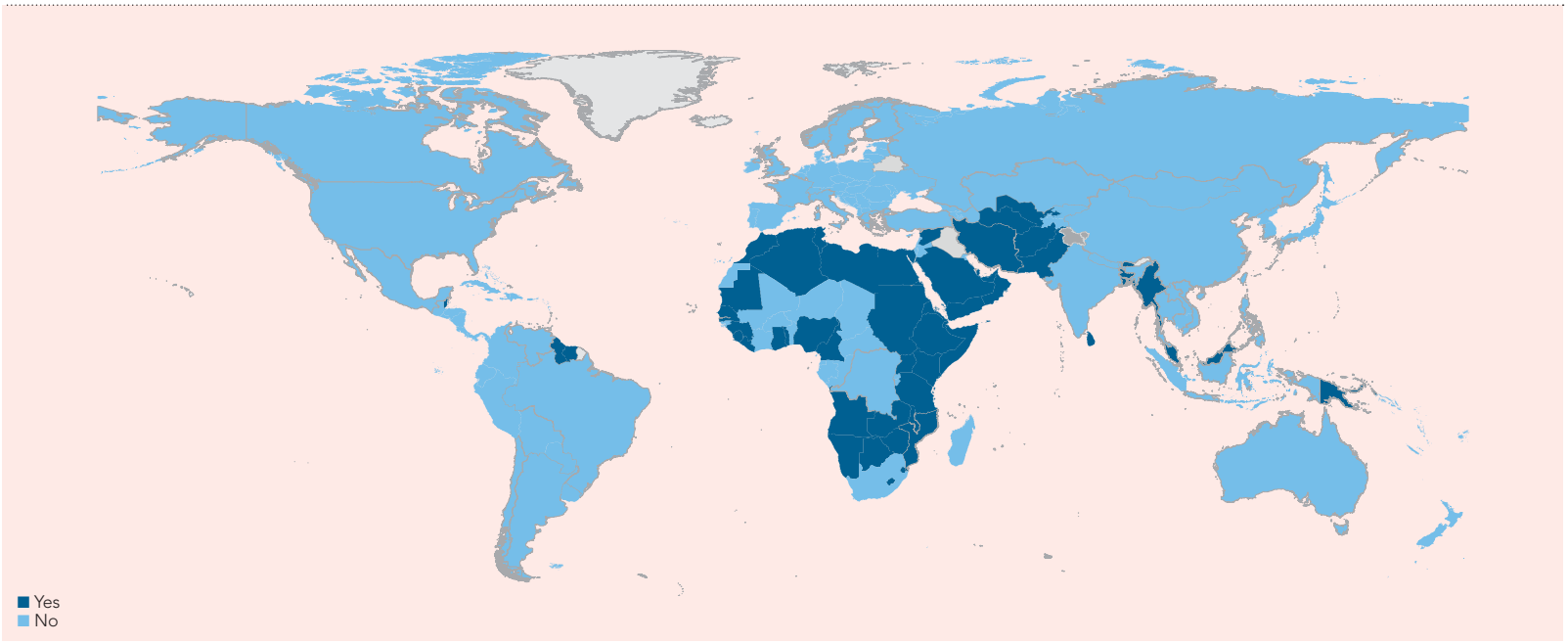
According to research from nine countries under the People Living with HIV Stigma Index, 53% of Rwandans living with HIV have been verbally insulted, 33% of rural Zambians living with HIV have experienced physical violence, and 65% of Rwandans living with HIV have lost a job or income opportunity. Furthermore, women living with HIV from various countries report abuses of their sexual and reproductive health and rights. Nearly 20% of women in Namibia who participated in discussions and interviews with the International Community of Women Living with HIV (ICW), reported that they had been coerced or forced into sterilization. Such deep-seated social ostracism and discriminatory actions discourage people from being tested for HIV or seeking other needed services.

Harmful social gender norms further weaken HIV responses by reinforcing gender inequality and deepening the vulnerability of women and girls. In some countries, more than 60% of women have experienced physical or sexual violence from their most recent spouse or co-resident partner. Among young women in South Africa, experience of intimate partner violence increases the odds of becoming infected with HIV by 11.9%, while gender inequality within a relationship increases the risk by 13.9%, according to a study reported in *The Lancet* in 2010. UNAIDS and its partners are working with countries to ensure responses are centred on women and girls; more than 60 countries have started implementing the UNAIDS Agenda for Women and Girls, engaging more than 400 civil society organizations, including women's groups.

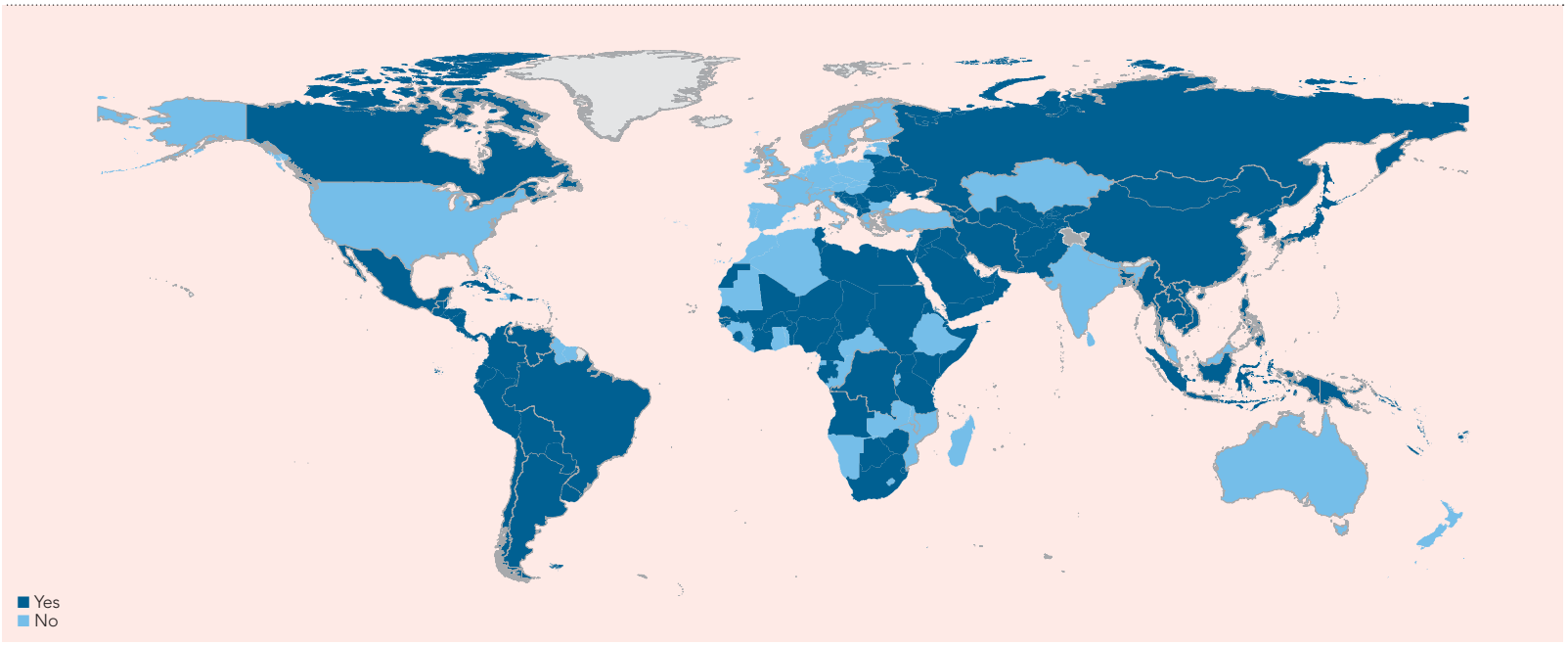
Special attention is needed for young girls, as more girls living with HIV due to mother-to-child transmission are surviving and entering adolescence, in part due to increased availability of antiretroviral treatment. These girls have particular sexual and reproductive health needs which need to be considered. Girls of the same age group are also exposed to intergenerational partnerships and they may experience violence and sexual abuse. In many settings, inadequate access to education reduces young girls' life opportunities and increases their vulnerability.

More countries are recognizing the need to implement programmes to reduce HIV-related stigma, although efforts remain inadequate. According to the UNAIDS Global Report 2010, the proportion of countries reporting programmes to address stigma and discrimination increased from 39% in 2006 to 92% in 2010, although a budget for these programmes was in place in less than half of these countries. Member States at the International Labour Conference adopted the first international labour standard on HIV and AIDS and the world of work in 2010, calling for stronger legal and policy frameworks and anti-stigma initiatives in the workplace. »

Countries criminalizing same-sex sexual activities between consenting adults, 2009



Countries with laws deeming sex work to be illegal, 2009



» Discriminatory laws

In many parts of the world, discrimination against people living with HIV is institutionalized in national legal or policy frameworks. More than 56 countries have laws that specifically criminalize HIV transmission or exposure, with the majority of prosecutions reported in high-income countries. As of April 2011, 47 countries, territories and areas imposed some form of restriction on the entry, stay and residence of people living with HIV. However, in a more positive development, China, Namibia and USA lifted their HIV-related travel restrictions in 2010, while Ecuador and India clarified that no such restrictions were in place. Ukraine removed its restrictions in early 2011.

National laws frequently reflect and exacerbate discrimination against key populations at higher risk. In 116 countries, territories and areas, some aspect of sex work is criminalized. Seventy-nine countries and territories worldwide criminalize consensual same-sex sexual relations, including 85% of countries in Eastern and Southern Africa, 81% in the Middle East and North Africa, and 69% in the Caribbean. Thirty-two countries have laws that allow for the death penalty for drug-related offences, and 27 provide for the compulsory detention of people who use drugs, often without due process or minimum standards of detention or treatment. Such laws, as well as abusive law enforcement and poor access to legal services, deter individuals from seeking needed services, increase their vulnerability to becoming HIV-positive, and intensify their social isolation.

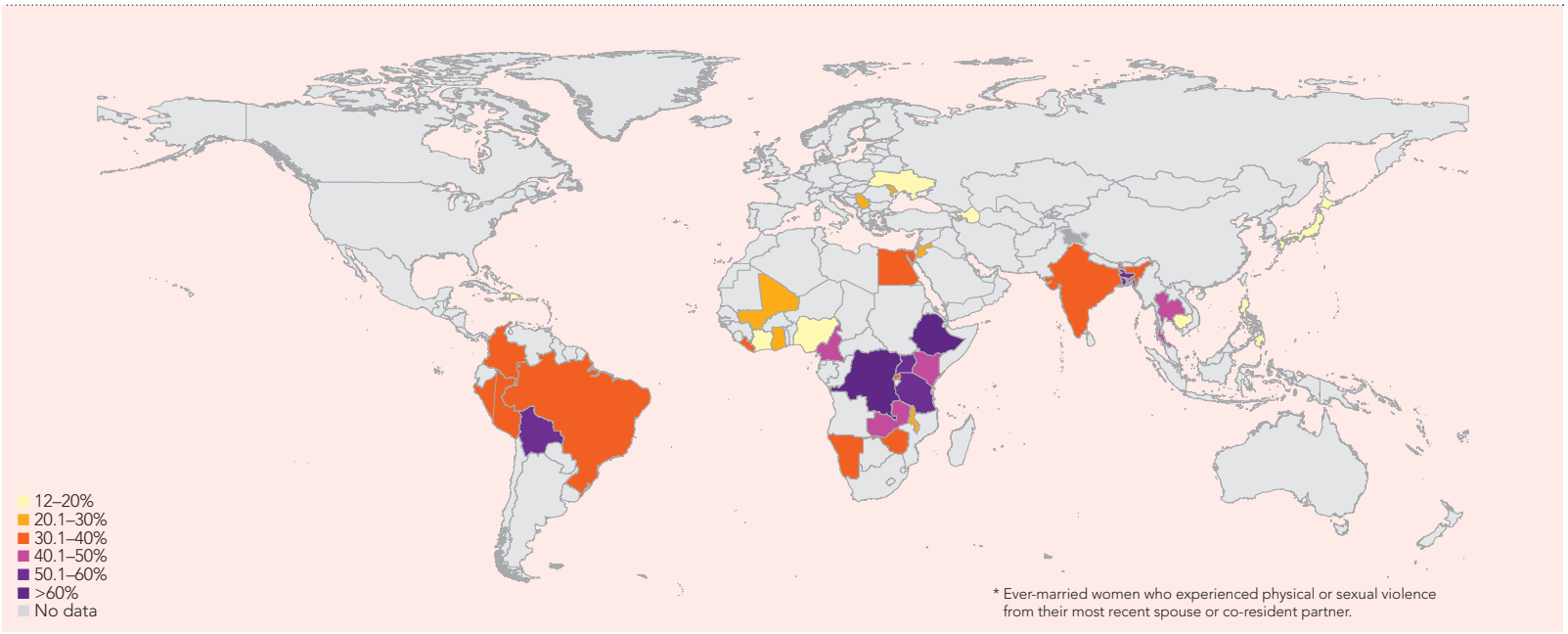
The intersection between social exclusion, inequality and HIV risk underscores the need to address the epidemic's social dimensions. Without courageous action to alleviate the social roots of HIV risk and vulnerability, it will be impossible to reach global HIV goals. «

Experience of stigma and discrimination by people living with HIV (the People Living with HIV Stigma Index), 2010

	% experiencing stigma in family and community		% experiencing abuse or violence		% stigma and discrimination in workplace		% internalized stigma	
Country[1)]	excluded from family events	gossiped about	verbally insulted	physically assaulted/ harassed	employment opportunity refused	loss of job or income	feel ashamed/ have low self-esteem	feel suicidal
Belarus	7	67	42	14	17	28	36	7
China	10	39	30	6	14	na	75	na
El Salvador	10	48	31	7	8	19	na	17
Myanmar	15	45	18	10	15	na	81	25
Paraguay	17	56	26	9	8	12	43	22
Poland	11	55	na	25	11	17	38	19
Rwanda	22	42	53	20	37	65	22	14
United Kingdom	na	63	40	22	na	na	63	25
Zambia (urban)	28	72	52	17	na	36	36	8
Zambia (rural)	27	80	51	33	na	39	38	22

1) These countries represent a cross-regional snapshot of information collected through the People Living with HIV Stigma Index.
na: Not available

Violence against women in 2009*



* Ever-married women who experienced physical or sexual violence from their most recent spouse or co-resident partner.

Countries, territories, and areas imposing some form of restriction on the entry, stay and residence of people based on their HIV-positive status, 2010

Andorra	Jordan	Saudi Arabia
Armenia	Kuwait	Singapore
Aruba	Lebanon	Slovakia
Bahrain	Lithuania	Solomon Islands
Belarus	Malaysia	Sudan
Belize	Marshall Islands	Syrian Arab Republic
Brunei Darussalam	Mauritius	Taiwan, China
Comoros	Nicaragua	Tajikistan
Cuba	Oman	Tonga
Cyprus	Papua New Guinea	Turkmenistan
Democratic People's Republic of Korea	Paraguay	Turks and Caicos Islands
Dominican Republic	Qatar	United Arab Emirates
Egypt	Republic of Korea	Uzbekistan
Fiji	Republic of Moldova	Yemen
Iraq	Russian Federation	
Israel	Samoa	

Countries which have recently lifted their HIV-related travel restrictions, or clarified that no such restrictions are in place

China
Namibia
Ukraine
USA
Ecuador
India

Source: UNAIDS, 2011

COMMENTARY

Angélique Kidjo

Education the key to empowering women

The musician and women and children's rights campaigner demands zero tolerance for gender-based violence.

I have been to camps for displaced people and met women who were raped. Not only did they have to suffer this most violent assault, many became infected with HIV.

It is time to speak out about violence, which in some countries can affect half of all women and girls. Rape and sexual assault is not just committed in war or by strangers. It is often committed by a woman's partner or someone she knows. The threat of violence prevents women from feeling they have the right to say 'no' and this puts them at greater risk of HIV infection.

Many of the women I have talked to who have been raped share horrific stories of violence, stigma and social isolation. These women and their families need our support. They need access to medicine, treatment and other services. They need to know there is someone they can turn to.

Even when there is no physical violence, the threat of violence can leave women feeling powerless. Many women in Africa say their first sexual experience was against their will. We need to break the silence and get the message across loud and clear, this is wrong.

In villages across Africa, women are too scared to talk about or be tested for HIV for fear of having violence inflicted on them or being abandoned.

Many of the women I have talked to are not able to tell their male partner to use a condom. Women need a prevention method they can control, and I am encouraged by the South African trial of a vaginal gel. We need more research into such women-friendly options.

It is unacceptable more women than men live with HIV and that young women are particularly vulnerable.

Before I became a full-time singer, I worked in a hair salon. I was in school and the job helped pay my rent. It was not an easy way to earn a living, but I promised my parents when I left Benin that I would not do sex work to get by.

But for too many girls, sex work seems their only option. If we are to make a difference, we need to support girls and young women to become economically independent. I am inspired by women and communities who are finding local solutions and dealing with problems related to HIV themselves. We need to offer them more support.

I feel very strongly about educating women and girls. Educating girls in Africa gives them the strength and the tools they need to be the mothers of change.

I set up the Batonga Foundation to support both secondary and higher education for girls in Africa. My dream is for every little girl in Africa to have access to an education like I had, an education which allowed me to realize my goals.

When we invest in women and girls, families are stronger and societies more stable. Women and men must come together to be agents for change for our children, so they can grow up in a world free from violence and HIV. «

Angélique Kidjo is a Grammy award-winning musician from Benin, and has been a UNICEF Goodwill Ambassador since 2002.

Dramatic gains in treatment access

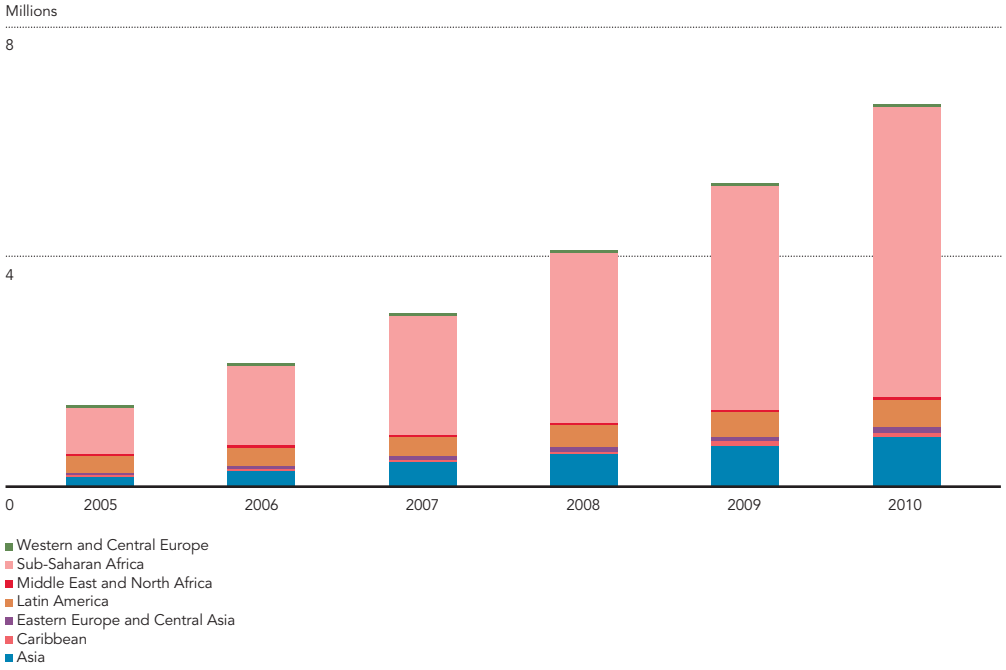
Perhaps the most notable achievement in the HIV response has been the dramatic expansion in access to treatment. This is all the more remarkable given that it has occurred largely in settings where sophisticated therapies for chronic diseases have long been inaccessible.

As of December 2010, an estimated 6.6 million people in low- and middle-income countries were receiving antiretroviral therapy, an increase of 1.4 million from a year earlier. Between 2001 and 2010, the number of people receiving antiretroviral treatment rose nearly 22-fold, a vivid illustration of the power of international solidarity, innovative approaches and people-centred responses.

In several regions, access to treatment has accelerated significantly. In sub-Saharan Africa, for example, the number of people receiving antiretroviral treatment in 2010 increased by 31%; in the Middle East and North Africa, that figure was 21%.

Universal access is achievable. As of December 2009, seven countries had already reached at least 80% of treatment-eligible individuals with antiretroviral treatment. Eighteen countries reported treatment coverage of at least 60%. Countries are responding to the changes in treatment eligibility criteria specified in the 2010 updated guidelines issued by WHO, enrolling individuals with a CD4 count below 350. Under the new recommendations, the total number of »

Number of people on antiretroviral therapy in low- and middle-income countries, 2005–2010



» people eligible for treatment is about 50% higher than under the previous guidelines, which called for treatment to be initiated once a patient's CD4 count fell to 200 or below.

Expanded access to treatment has replaced despair with hope, rejuvenated communities and households, and mitigated the epidemic's immediate and long-term impact. Since its emergence in 1996, highly active antiretroviral therapy has saved an estimated 14.4 million life-years worldwide as of December 2009. Although 54% of life-years saved between 1995 and 2009 were in Western Europe and North America, where antiretroviral therapy has long been available, 3.7 million life-years have been saved in sub-Saharan Africa. The pace of reducing morbidity and mortality in sub-Saharan Africa has accelerated since 2005 as a result of dramatic programme scale-up.

The journey towards these achievements has been long and difficult. During the epidemic's first two decades, small-scale programmes providing symptomatic and palliative care were the only treatment options for most people living with HIV in low- and middle-income countries. Between 2001 and 2010, by contrast, momentum towards equitable access quickened, in large measure due to increased competition among pharmaceutical companies leading to sharp reductions in the prices of antiretroviral drugs in low- and middle-income countries. The global "3 by 5" campaign (antiretroviral treatment for three million people by 2005), which advocated for a public-health approach to treatment scale-up, accelerated global momentum for expanded treatment access. Health systems adapted to the new challenges and benefited from increasing attention, proving false the predictions that health system weaknesses would preclude rapid scale-up.

Journey incomplete

Notwithstanding these great strides, this journey remains incomplete. As of December 2010, about nine million people were eligible for antiretroviral therapy but not receiving it, underscoring the need for an even greater commitment in the quest for universal access. In several regions with low treatment coverage, special efforts are needed. Particular attention is needed to close the access gap for children living with HIV. While an estimated 420 000–460 000 children were receiving antiretroviral therapy at the end of 2010, treatment coverage for children is considerably lower than the overall coverage for people of all ages (28% versus 36% in 2009). »

» Improving treatment outcomes will require better adherence to prescribed regimens. Treatment adherence is a challenge in all settings, in high-income countries and in resource-limited areas. In 2009, nearly one in five people (18%) who started antiretroviral therapy in low- and middle-income countries were no longer in care 12 months later. Experience suggests that changes in clinic practice, as well as community involvement, with increased use of expert patients and other peer-based models, can support treatment adherence, but these strategies are not being adopted in many places.

The sustainability of lifelong treatment remains an important challenge. At present, more than 95% of patients on treatment are on first-generation antiretroviral medicines, the majority of which are off-patent. As drug resistance increases over time, more patients will require second- and third-generation medicines. Most of these more recent medicines will remain under patent protection for years to come, resulting in potentially drastic increases in treatment costs. This can be alleviated to a large extent by making use of the flexibilities of public health-related TRIPS (trade-related aspects of intellectual property rights). In March 2011, UNAIDS, WHO and UNDP issued a policy brief calling on all countries to use TRIPS flexibilities to lower costs and improve access to HIV treatment.

New phase urgently needed

It is a clear a new phase of HIV treatment is urgently needed. The Treatment 2.0 approach offers the prospect of more sustainable, more efficient treatments for HIV. Treatment 2.0 calls for the use of superior pills and diagnostic devices; investment in treatment scale-up to reduce rates of new infections; reduced costs for all components of treatment; improved testing uptake and linkage to care; and strengthened community mobilization to support treatment aims. It is estimated that the Treatment 2.0 model could avert an additional 10 million deaths by 2025.

While antiretroviral therapy is a cornerstone of HIV treatment and care, health outcomes are optimized when services are holistic and centred on each individual's needs. For example, nutritious food is critical to people living with HIV, who are 2–6 times more likely to die soon after initiating therapy if they are malnourished. Assistance to enable people living with HIV to buy food or pay their children's school fees is often needed to keep people enrolled in care, as acute poverty and the financial pressures associated with HIV infection may force some people to make excruciating choices between life-saving treatment and daily subsistence. «

Massive effort pays dividends in South Africa

South Africa has the world's largest HIV epidemic, with almost 17% of all people living with HIV. In recent years the South African government has engaged in a massive effort to bring treatment, care and support to all those in need. In 2009–2010, an ambitious holistic health campaign to screen people for both communicable and noncommunicable disease resulted in 7.6 million people being counselled and tested for HIV, and 4.4 million people screened for tuberculosis (TB). This helped many learn their status and contributed to a rapid increase in the number of people identified for antiretroviral therapy, and for TB treatment and prevention. Between 2009 and 2010 the number of people living with HIV who received isoniazid prophylactic therapy for TB increased from 23 000 to 120 000. The most recent treatment data show the number of people receiving antiretroviral therapy increased by 43% from 2009 to 2010, with at least 1.39 million people receiving treatment for HIV in South Africa.

Coverage of antiretroviral therapy at the end of 2009

(WHO 2010 Guidelines, CD4<350)

0–20%

Bolivia
Bhutan
Burundi
Central African Republic
Colombia
Dem. Rep. of the Congo
Djibouti
Egypt
Gambia
Iran
Kyrgyzstan
Latvia
Lebanon
Liberia
Madagascar
Maldives
Mongolia
Myanmar
Nepal
Pakistan
Republic of Moldova
Russian Federation
Sierra Leone
Somalia
Sri Lanka
Sudan
Tajikistan
Ukraine

21–40%

Algeria
Angola
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Bulgaria
Cameroon
Chad
China
Congo
Côte d'Ivoire
Ecuador
Equatorial Guinea
Eritrea
Fiji
Ghana
Guinea
Guinea-Bissau
Honduras
Hungary
India
Indonesia
Kazakhstan
Lithuania
Malaysia
Mauritania
Mauritius
Morocco
Mozambique
Nicaragua
Niger
Nigeria
Panama
Paraguay
Peru
Philippines
Serbia
South Africa
Togo
Uganda
United Rep. of Tanzania
Uzbekistan
Viet Nam
Zimbabwe

41–60%

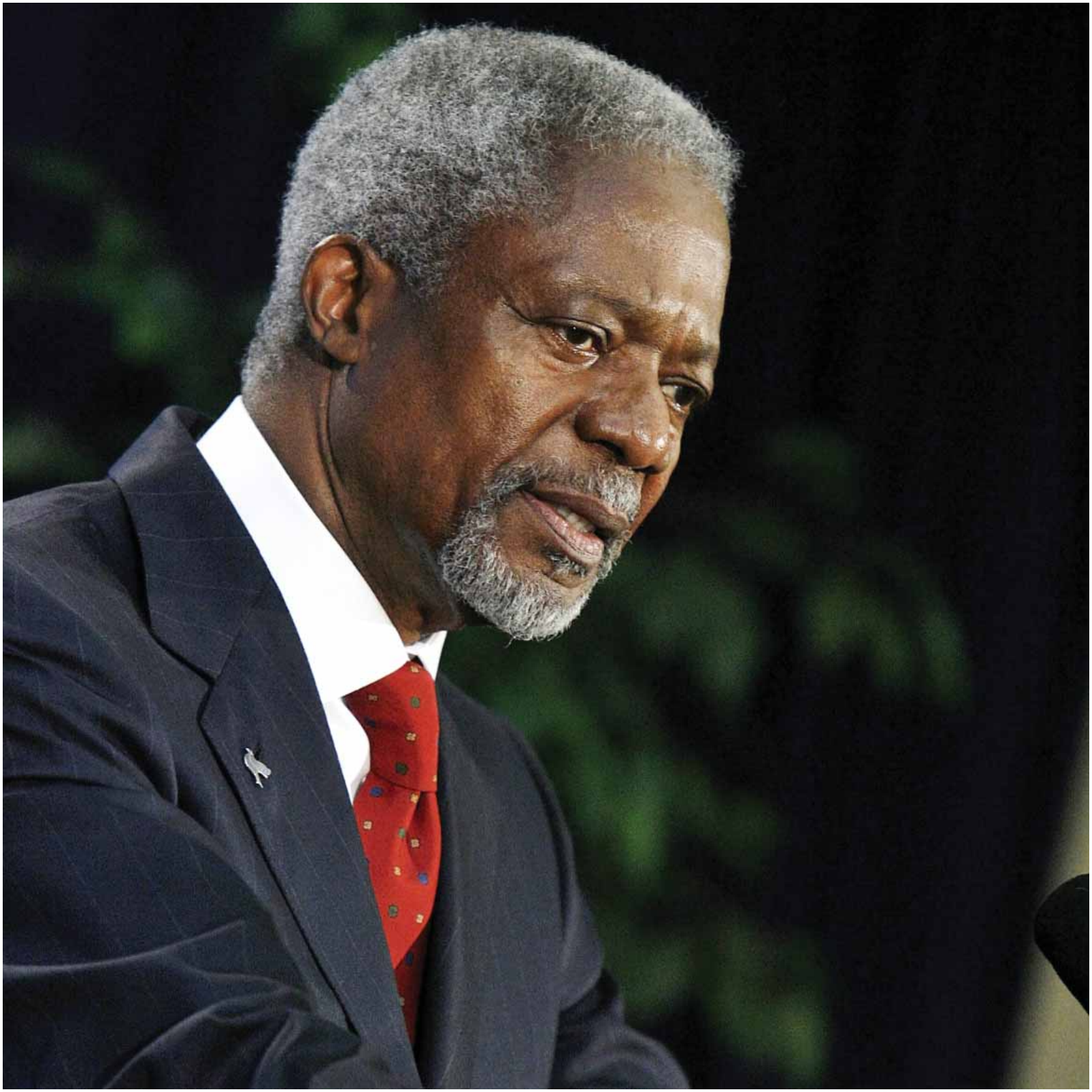
Benin
Brazil
Burkina Faso
Dominican Republic
El Salvador
Ethiopia
Gabon
Guatemala
Haiti
Jamaica
Kenya
Lesotho
Malawi
Mali
Mexico
Papua New Guinea
Senegal
Suriname
Swaziland
Tunisia
Uruguay

61–80%

Argentina
Chile
Costa Rica
Croatia
Georgia
Lao People's Dem. Rep.
Namibia
Slovakia
Thailand
Turkey
Zambia

>80%

Botswana
Cambodia
Cuba
Guyana
Oman
Romania
Rwanda



COMMENTARY

Kofi Annan

Still the greatest challenge of our generation

The former United Nations Secretary-General urges leaders to tackle social barriers and affirm human rights as key planks in the AIDS response.

As Secretary-General of the United Nations, I decided to make the fight against AIDS my personal priority. In 2001, I called on Member States to work together for a global strategy to combat the AIDS epidemic. Since then there has been real progress; new infection rates have fallen by almost 25% since 2001. I also called for what I termed a "war chest" to fund the response. As a result, the Global Fund for AIDS, Tuberculosis and Malaria was established.

But the Millennium Development Goal of halting and starting to reverse the spread of AIDS by 2015 is still a formidable challenge. Thirty years since the start of this terrible epidemic, too many people still get infected and too many die of AIDS-related illness. Discrimination, including the flouting of the most basic human rights, is still widespread for those living with HIV.

Women and girls are particularly at risk. Too many suffer sexual abuse or feel unable to insist on protected sex. AIDS is the number-one cause of death globally for all women of childbearing age. This requires us to put women at the centre of the AIDS response. They must also be empowered to speak up and protect themselves and their children.

We know as well that homosexuals, sex workers, drug users, and people living with HIV suffer from daily discrimination and prejudices, discouraging them from seeking help and treatment.

We all have to step up our efforts to create a world in which everyone, whatever their background, is treated with the respect and dignity they deserve as fellow human beings. There is a clear need for greater prevention, access to better treatments, gender equality and an end to discrimination to stem the tide of the epidemic. We have to view the AIDS response within the wider battle to uphold human rights. Unless we do so, the danger is that we will fail to meet our ambitions.

In 2006, at the United Nations General Assembly High Level Meeting on AIDS, I described AIDS as the greatest challenge of our generation. I called on all heads of state to make the AIDS response their personal priority, to say "AIDS stops with me" and to demonstrate that personal commitment with action. That means leaders have to devise policies and enact legislation that tackle social barriers. They must affirm human rights and recognize that the response to AIDS is inherently linked to other economic and social policies.

Five years on, as the Member States of the United Nations gather again to discuss the response to AIDS, we have the opportunity to review our progress. Clearly, we still face a daunting challenge. The need to reaffirm our personal commitment to play our part in this global effort remains as strong as ever. «

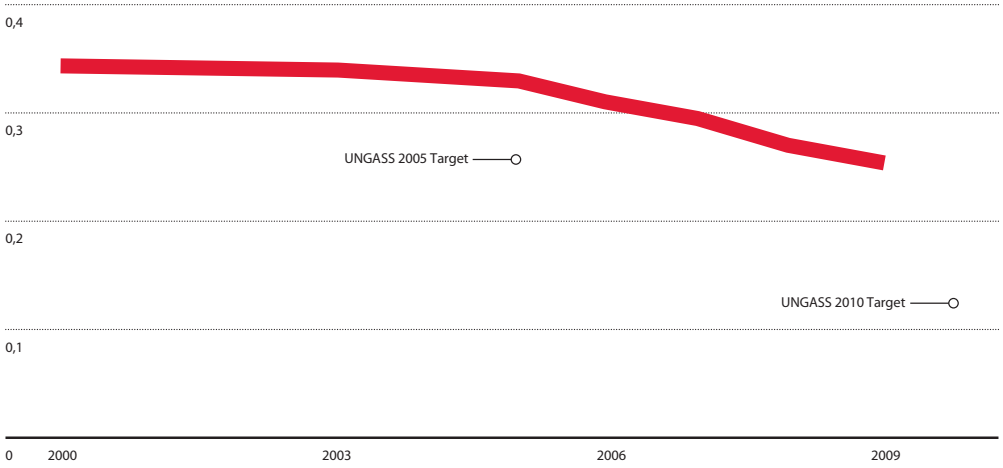
Kofi Annan was the UN Secretary-General from 1997–2006. In April 2001, he issued a five-point Call to Action to address the AIDS epidemic and proposed a Global AIDS and Health Fund to help developing countries confront the crisis.

Eliminating all new child infections

Over the past decade, prevention programmes were launched around the world to halve vertical transmission rates by 2010. Although this ambitious target was not achieved, the progress made demonstrated the feasibility of eventually eliminating all new child infections.

The groundwork for eliminating new infections in children was undertaken in the epidemic's second decade. An initial study (ACTG 076) demonstrated that providing zidovudine to pregnant women and their newborns sharply lowered the odds of transmission. This first study altered practices in antenatal-care settings in high-income countries, rapidly reducing the number of new infections in children, but the complexity and cost of the intervention made it difficult to implement in resource-limited settings. The results of two studies, released in 1999, changed the dynamic for low- and middle-income countries, however, by demonstrating that either a shorter course of zidovudine or a single dose of nevirapine could significantly reduce the risk of mother-to-child transmission. This galvanized global action to implement prevention programmes for HIV-positive pregnant women in resource-limited settings. In 2002, the Interagency Task Team on the Prevention of HIV Transmission in Pregnant Women, Mothers, and their Children defined four key intervention strategies that had to be implemented simultaneously:

Estimated mother-to-child transmission rate and UNGASS target among low- and middle-income countries, 2000–2009



① primary prevention of HIV infection among women of childbearing age
② prevention of unintended pregnancies among women living with HIV
③ prevention of HIV transmission from women living with HIV to their infants
④ appropriate treatment, care and support for mothers living with HIV and for their children and families. »

HIV-positive pregnant women in low- and middle-income countries receiving antiretrovirals in 2009

0–20%

Azerbaijan
Bangladesh
Burundi
Chad
Comoros
Congo
Democratic Rep. Congo
Djibouti
Egypt
Ethiopia
Guinea
Indonesia
Iran
Lao PDR
Lebanon
Liberia
Madagascar
Maldives
Mauritania
Mexico
Mongolia
Nepal
Pakistan
Papua New Guinea
Philippines
Serbia
Sierra Leone
Somalia
Sri Lanka
Sudan
Tajikistan
Tunisia

21–40%

Algeria
Belize
Bolivia
Bulgaria
Burkina Faso
Cameroon
Central African Rep.
Chile
China
Colombia
Costa Rica
Croatia
El Salvador
Equatorial Guinea
Eritrea
Gabon
Georgia
Ghana
Guatemala
Guinea-Bissau
Honduras
Hungary
India
Mali
Morocco
Niger
Nigeria
Senegal
Togo

41–60%

Benin
Cambodia
Côte d'Ivoire
Dominican Republic
Fiji
Haiti
Kyrgyzstan
Malawi
Mauritius
Oman
Panama
Peru
Uganda
Uruguay
Viet Nam
Zimbabwe

61–80%

Cuba
Gambia
Kazakhstan
Kenya
Lesotho
Mozambique
Myanmar
Nicaragua
Paraguay
Rwanda
Slovakia
United Rep. of Tanzania
Zambia

>80%

Argentina
Armenia
Belarus
Bhutan
Botswana
Ecuador
Guyana
Jamaica
Latvia
Lithuania
Malaysia
Namibia
Rep. of Moldova
Romania
Russian Federation
South Africa
Suriname
Swaziland
Thailand
Ukraine
Uzbekistan

Low and middle income countries in which single-dose nevirapine was either never used, or is no longer used to prevent mother-to-child transmission of HIV, as of May 2011

Afghanistan	Guinea	Philippines
Albania	Guinea Bissau	Poland
Algeria	Guyana	Republic of Moldova
Angola	Honduras	Romania
Argentina	Hungary	Russian Federation
Armenia	Indonesia	Rwanda
Bangladesh	Iran (Islamic Republic of)	Saint Kitts and Nevis
Belize	Iraq	Saint Lucia
Bhutan	Jamaica	Saint Vincent and the Grenadines
Bolivia	Jordan	Samoa
Bosnia and Herzegovina	Kazakhstan	Sao Tome and Principe
Botswana	Lao People Democratic Republic	Senegal
Brazil	Latvia	Serbia
Bulgaria	Lebanon	Seychelles
Burkina Faso	Lesotho	Sierra Leone
Burundi	Liberia	Slovakia
Cambodia	Lithuania	Solomon Islands
Cameroon	Madagascar	South Africa
Cape Verde	Malaysia	Sri Lanka
Central African Republic	Maldives	Suriname
Chad	Mali	Swaziland
Chile	Mauritania	Tajikistan
Colombia	Mauritius	Thailand
Comoros	Mexico	Timor-Leste
Congo	Micronesia	Togo
Cook Islands	Montenegro	Tonga
Costa Rica	Morocco	Trinidad and Tobago
Cote d'Ivoire	Namibia	Tunisia
Croatia	Nauru	Turkey
Cuba	Nepal	Turkmenistan
Djibouti	Nicaragua	Tuvalu
Dominica	Niue	Ukraine
Ecuador	North Sudan	Uruguay
El Salvador	Pakistan	Uzbekistan
FYR Macedonia	Palau	Vanuatu
Gabon	Panama	Venezuela
Ghana	Papua New Guinea	Yemen
Grenada	Paraguay	
Guatemala	Peru	

Low- and middle-income countries in which there is some use of single-dose nevirapine to prevent mother-to-child transmission of HIV, as of May 2011

Azerbaijan	Gambia	Niger
Belarus	Georgia	Nigeria
Benin	Haiti	Somalia
China	India	Southern Sudan
Democratic Republic of the Congo	Kenya	Uganda
Dominican Republic	Kiribati	United Republic of Tanzania
Egypt	Kyrgyzstan	Viet Nam
Equatorial Guinea	Malawi	Zambia
Eritrea	Mongolia	Zimbabwe
Ethiopia	Mozambique	
Fiji	Myanmar	

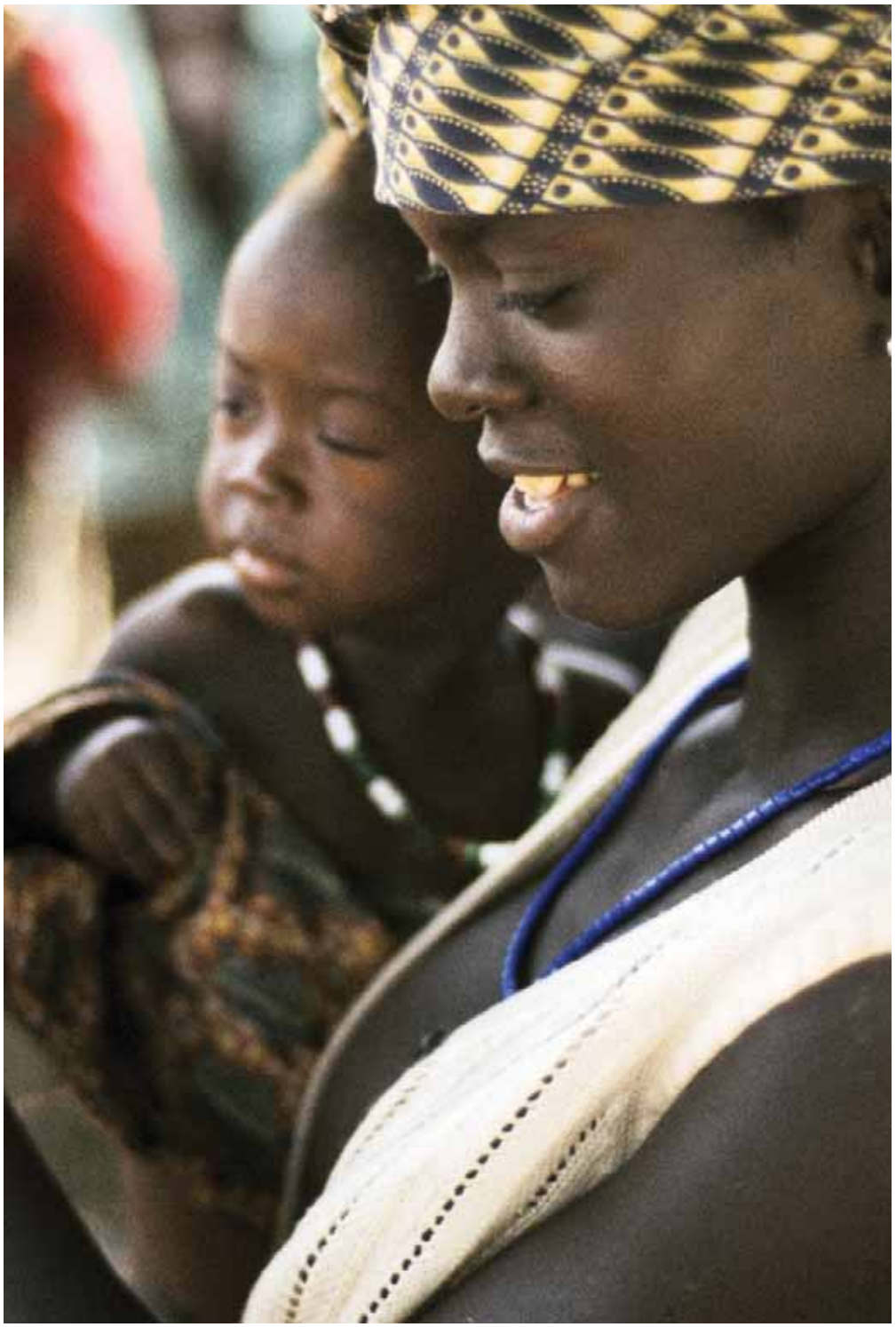
Note: information was not available for the Democratic People's Republic of Korea, the Syrian Arab Republic and the Libyan Arab Jamahiriya
Source: UNAIDS, 2011

In the first half of the third decade of the epidemic, progress in implementing programmes to deliver these affordable approaches was slow. By 2005, five years after affordable means of preventing vertical transmission became available, only 15% of HIV-positive pregnant women in low- and middle-income countries received antiretroviral prophylaxis. The initial delay in implementing programmes, combined with continuing coverage gaps, caused the world to miss the target of halving vertical transmission by 2010. Factors that slowed scale-up of prevention services for newborns included inadequate utilization of antenatal services; inadequate linkage between specialised services for preventing vertical transmission and reproductive health services; interruptions to drug supplies; insufficient engagement of men in prevention efforts; and use of suboptimal regimens.

Since 2005, steady action has rapidly increased the number of HIV-positive pregnant women receiving antiretroviral drugs to prevent mother-to-child transmission (see table, left). While universal access to the prevention of vertical transmission remains a global aspiration, 22 countries had achieved at least 80% coverage of prevention of vertical transmission by December 2009, with global coverage reaching 53%.

Effective regimens

Over time, our knowledge has increased as to which regimens are most effective in preventing vertical transmission. While single-dose nevirapine reduces the risk of transmission by about 50%, combination regimens and antiretroviral treatment for eligible mothers recommended by WHO since 2009 are capable of reducing the risk of transmission by 90% or more. Consequently, single-dose nevirapine is no longer recommended for the prevention of vertical transmission. Several countries, including the high-burden countries of Botswana and Swaziland, have completely phased out the use of single-dose nevirapine. WHO, UNICEF and UNAIDS are working with country partners to accelerate the shift towards state-of-the-art regimens in other countries, particularly those with high numbers of new infections in children.



In the period 2007–2009, the percentage of women who received single-dose nevirapine decreased from 49% to 30%, according to WHO. Preliminary data suggest that this decline continued in 2010. However, many countries report that the majority or a substantial proportion of women still receive only single-dose nevirapine.

The data on coverage of interventions to prevent mother-to-child transmission presented in previous reports did not exclude single-dose nevirapine. In order to show trends in coverage the data in this report maintains comparability to previous reports by also not excluding single-dose nevirapine. WHO, UNAIDS and UNICEF will support countries for improving collection of disaggregated data so that future reports can present coverage with and without single dose nevirapine.

Improvements in programmes to prevent new infections in children have enhanced health outcomes for pregnant women living with HIV. More than 50% of pregnant women who tested positive for HIV in 2010 were assessed for their eligibility to receive antiretroviral therapy for their own health. These gains in reducing vertical transmission have helped to reduce childhood mortality. The number of children newly infected with HIV in 2009 (370 000 [230 000–510 000]) was 26% lower than in 2001. Nevertheless, despite the improvements in preventing new infections, antiretroviral treatment for children remains two thirds the coverage level of adults.

The world possesses the tools to ensure an HIV-free generation by 2015. Recent modelling from data in 25 highly affected countries indicates that to eliminate new child infections by 2015, major progress is needed in all four prongs of effective prevention regimens. To address programmatic barriers and expedite progress, a global task team on the elimination of new child infections was launched in early 2011 to guide efforts worldwide.

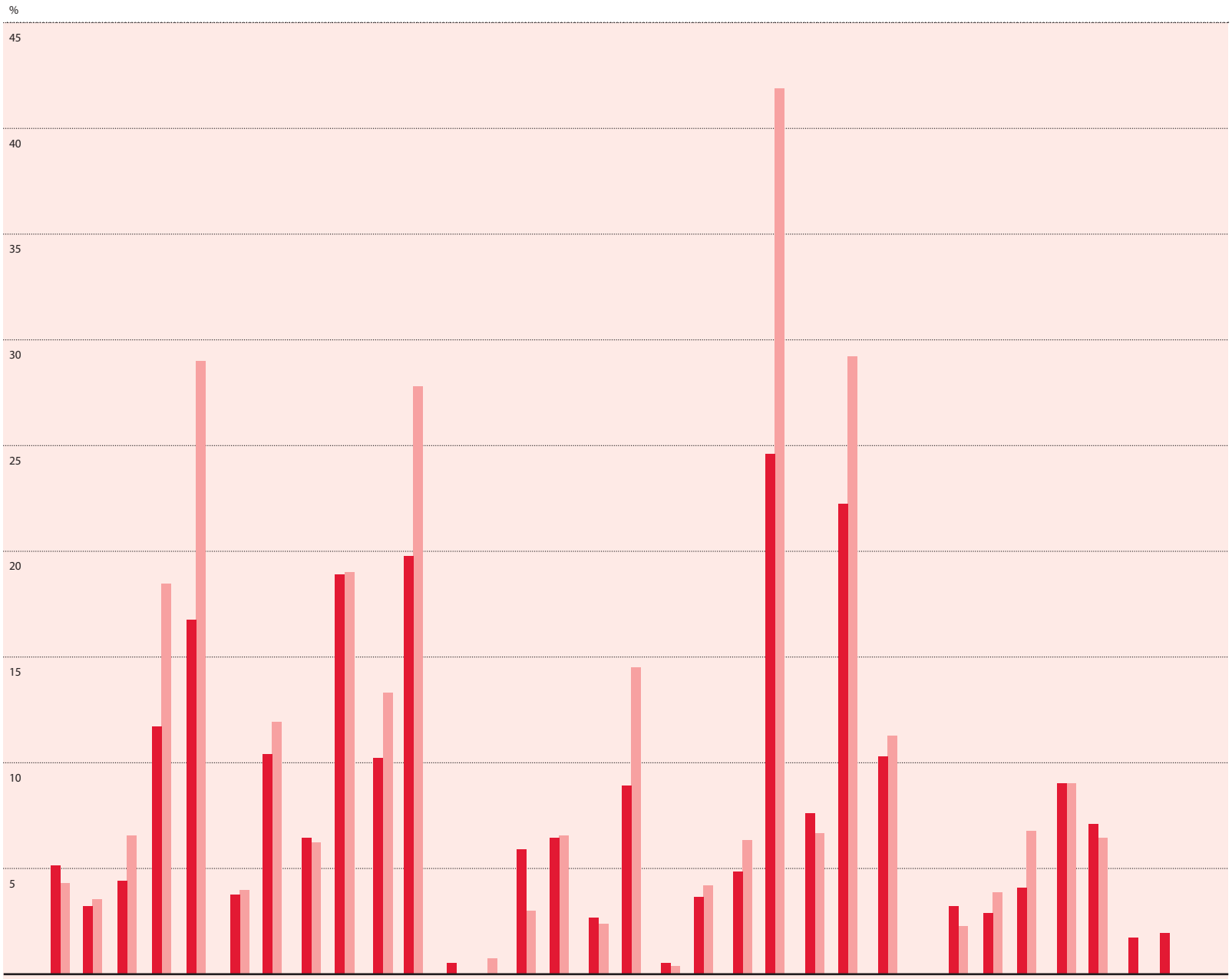
Safe sex message starts to sink in

HIV-related knowledge increased and more people adopted safer sexual behaviours during the third decade of the epidemic, reflecting the impact of scaled-up prevention and awareness efforts. While behavioural trends in general population surveys are favourable in many countries, additional improvements are needed to sharply lower infection rates in future years. In particular, stronger efforts are needed to measure behavioural trends among key populations that are not effectively captured by household surveys in the general population and among displaced people in humanitarian settings.

Although knowledge alone is not sufficient to produce long-lasting changes in sexual behaviours, accurate knowledge of HIV is a critical first step towards risk reduction. The world has fallen far short of reaching the target set out in the 2001 Declaration of Commitment to ensure that at least 95% of those aged 15–24 have access to needed information, education and services. According to the most recent population-based surveys in low- and middle-income countries with available data, only 24% of young women and 36% of young men responded correctly when asked five questions about HIV prevention methods and popular misconceptions about HIV transmission. Young women tend to be less likely than young men to be aware of the prevention benefits of consistent condom use. When prompted, 74% of young males in DHS surveys knew that using a condom helps to prevent HIV infection, while only 49% of young females knew the right answer. Some 78% of young males also knew that having a single, faithful partner lowers the risk of HIV infection, compared to only 59% of young females.

Although the majority of people living with HIV remain undiagnosed, more people than ever are aware of their HIV status. In several high-prevalence countries in sub-Saharan Africa, more people are being tested and receiving their results, although testing rates remain inadequate. In countries with available data on testing, women are consistently more likely to be tested than men, in large measure due to women's exposure to HIV prevention services in antenatal settings. Testing rates vary considerably among countries, with the percentage of adults tested for HIV in the past 12 months ranging from less than 5% in Bolivia, Cameroon, Madagascar and the Philippines, to 42% of women in Lesotho. »

Proportion of males and females tested in the past 12 months who know their results, selected countries, 2000–2009



Source: Demographic and Health Surveys and other national reports

49%

Only 49% of young females know that using a condom helps to prevent HIV infection, compared to 74% of young males

» As HIV-related knowledge has increased, important changes in sexual behaviour have occurred. Signs of favourable changes in sexual behaviour are evident from multiple household surveys conducted between 1995 and 2009 in 15 countries with HIV prevalence above 2%. In these high-prevalence countries, the proportion of males and females reporting more than two sexual partners in the prior year declined in most countries. However, in Uganda, which achieved the earliest successes in promoting safer behaviours, prevalence of higher-risk sex among males increased from 2001 to 2006, and higher-risk sex also increased in South Africa between 2002 and 2009. In these 15 countries, males are more likely than females to report multiple sexual partners.

Rates of condom use remain low. In 14 countries where HIV prevalence exceeds 2% and where nationally representative data are available, more than 70% of men and women who had high-risk sex in the past year report not using a condom the last time they had sex. Trends in condom use in these countries are mixed, with significant increases in condom use among males reported in Cameroon, Lesotho, Malawi, Namibia and Nigeria, as well as among females in Cameroon, Congo, Côte d'Ivoire, Mozambique, Namibia, Nigeria, Tanzania, Uganda and Zambia. However, condom use declined among men in Côte d'Ivoire. Levels of condom use are particularly high in some hyperendemic countries such as South Africa, where 77% of men and 67.5% of women reported using a condom the last time they had sex.

Over the past decade, some of the most important prevention successes have occurred among young people. As a general rule, young people in heavily affected countries are increasingly opting to become sexually active at a later age and to avoid risky sexual behaviour. In 15 countries with HIV prevalence higher than 2%, the proportion of males with an early-age sexual debut declined significantly in seven countries, and in 11 countries for females. However, there are exceptions to the general rule of delayed sexual debut; in Lesotho, for example, the proportion of males having sex before age 15 increased from 13% in 2004 to 22% in 2009, while early initiation of sex among females rose from 6% to 8%. «

More than one sex partner in the past year
Adults 15–49, self-reported, 2003–2009

Country	Year of survey	% Females 15–49	% Males 15–49
Benin	2006	0.7	20.7
Botswana	2008	10.4	22.7
Burkina Faso	2003	0.9	14.7
Cameroon	2004	5.7	30.7
Chad	2004	0.8	17.1
Republic of Congo	2009	6.9	28.6
Côte d'Ivoire	2005	3.6	23.8
Ghana	2008	1.0	11.3
Guinea	2005	2.0	24.7
Guyana	2009	1.3	na
Haiti	2005	1.3	23.0
Kenya	2008	1.2	9.4
Lesotho	2009	6.4	21.1
Liberia	2007	5.8	18.0
Malawi	2004	0.8	9.1
Mali	2006	1.2	15.2
Mozambique	2009	3.0	19.8
Namibia	2006	1.7	11.2
Nigeria	2008	1.0	9.9
Sierra Leone	2008	3.5	15.7
South Africa	2008	3.7	19.3
Swaziland	2007	1.6	13.6
United Republic of Tanzania	2007–08	2.6	17.9
Uganda	2006	1.8	20.5
Ukraine	2007	2.3	12.9
Zambia	2009	0.8	8.7
Zimbabwe	2005–06	0.9	9.0

Source: Demographic and Health Surveys, and other national surveys
na: Data not available

Young people: knowledge of condom use as an HIV prevention method, selected countries, 2003–2010

Country	Year of survey	% Females 15–49	% Males 15–49
Albania	2009	82.2	77.1
Armenia	2005	71.9	64.1
Azerbaijan	2006	40.4	27.4
Benin	2006	87.1	73.3
Bolivia	2008	76.8	64.2
Cambodia	2005	92.0	88.5
Cameroon	2004	82.8	71.2
Cape Verde	2005	93.3	88.2
Chad	2004	57.3	28.7
Congo	2009	82.6	66.3
Côte d'Ivoire	2005	75.3	63.4
Dominican Republic	2007	89.3	84.5
Democratic Republic of Congo	2007	62.8	53.8
Ethiopia	2005	65.7	47.4
Ghana	2008	82.5	74.9
Guinea	2005	81.8	74.3
Guyana	2005	91.4	80.3
Haiti	2005	91.5	84.5
Honduras	2005–06	na	72.3
India	2005–06	74.3	39.2
Kenya	2008	79.1	72.9
Lesotho	2009	78.9	84.6
Liberia	2007	65.9	52.2
Madagascar	2008	69.6	67.2
Madives	2009	na	75.5
Malawi	2010	71.1	73.2
Mali	2006	68.1	58.8
Morocco	2003–04	na	39.5
Mozambique	2009	74.9	74.3
Namibia	2006	86.4	83.4
Nepal	2006	89.6	67.8
Niger	2006	63.1	54.2
Nigeria	2008	69.7	52.0
Philippines	2008	na	54.3
Republic of Moldova	2005	89.5	79.4
Rwanda	2005	88.4	79.5
Samoa	2009	56.3	53.0
Sao Tome and Principe	2008	79.5	75.6
Senegal	2005	71.1	71.1
Sierra Leone	2008	64.2	47.4
Swaziland	2006–07	87.1	88.7
Timor-Leste	2009	37.2	18.2
Uganda	2006	82.0	72.4
Ukraine	2007	92.1	91.4
United Republic of Tanzania	2007–08	79.5	67.6
Zambia	2007	74.1	71.0
Zimbabwe	2005–06	79.0	72.4

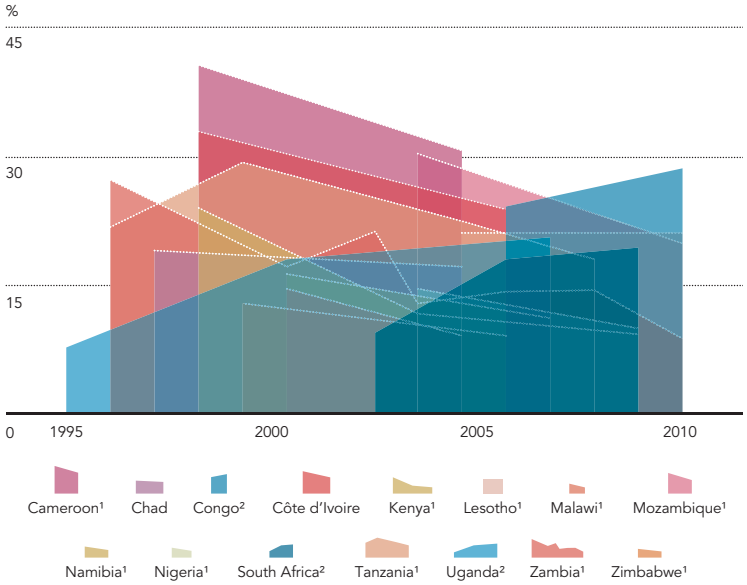
Source: Demographic and Health Surveys
na: Data not available

People (15–49) reporting condom use at last sex if had more than one sex partner in the past year, selected countries, 2001–2009

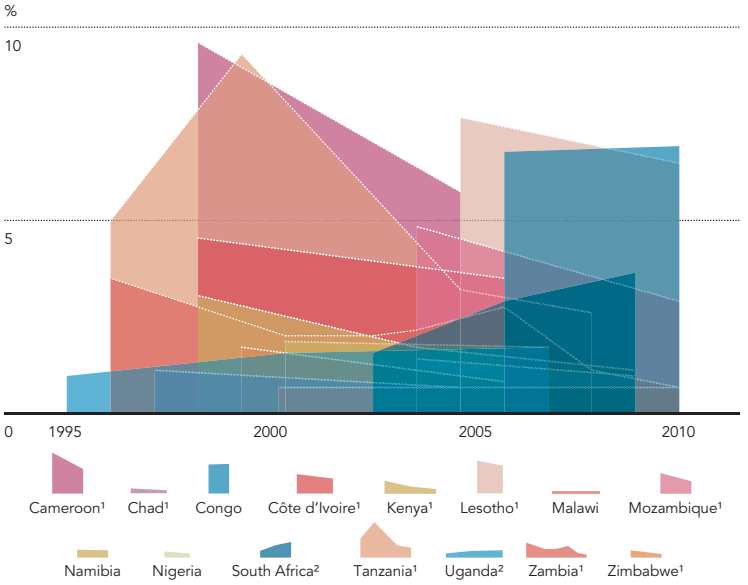
Country	Year of survey	% Females 15–49	% Males 15–49
Armenia	2005	na	58.4
Azerbaijan	2006	0.0	26.0
Benin	2006	20.6	17.4
Bolivia	2008	na	35.2
Burkina Faso	2003	43.7	43.2
Cambodia	2005	7.6	41.1
Cameroon	2004	34.6	37.5
Cape Verde	2005	57.4	69.4
Chad	2004	6.5	15.9
Colombia	2005	30.8	na
(Republic of the) Congo	2009	29.0	27.9
Côte d'Ivoire	2005	40.7	37.6
Democratic Republic of Congo	2007	7.7	16.0
Dominican Republic	2007	34.9	45.0
Ethiopia	2005	na	8.5
Ghana	2008	18.1	26.2
Guinea	2005	19.7	24.4
Guyana	2009	47.9	65.4
Haiti	2005	21.0	34.0
Honduras	2005–06	26.5	na
India	2005–06	11.5	22.7
Kenya	2008	na	37.0
Lesotho	2009	38.5	52.3
Liberia	2007	13.5	22.3
Madagascar	2009	7.6	7.4
Madives	2009	na	75.5
Malawi	2004	15.9	20.0
Mali	2006	8.1	12.2
Marshall Islands	2007	10.6	19.5
Mozambique	2009	24.0	19.9
Namibia	2006	65.7	74.4
Nepal	2006	na	29.6
Nicaragua	2001	19.2	na
Niger	2006	7.6	6.6
Nigeria	2008	22.9	33.1
Peru	2007	31.1	na
Philippines	2008	na	na
Republic of Moldova	2005	22.3	45.1
Rwanda	2005	na	7.7
Sao Tome and Principe	2008–09	28.1	32.9
Senegal	2005	21.0	31.2
Sierra Leone	2008	6.8	15.2
South Africa	2009	67.5	77.1
Swaziland	2007	55.0	55.8
Uganda	2006	24.3	20.4
Ukraine	2007	48.0	46.4
United Republic of Tanzania	2007–08	20.6	22.4
Viet Nam	2005	na	57.90
Zambia	2009	na	19.9
Zimbabwe	2005–06	40.8	36.3

Source: Demographic and Health Surveys, and other national surveys
na: Data not available

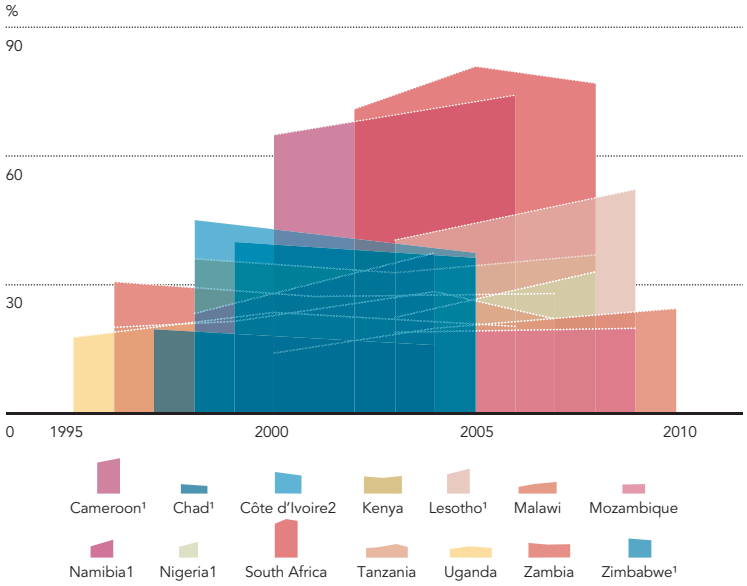
Sex with more than one partner in the past 12 months – males
Countries with HIV prevalence more than 2%, 1995–2010



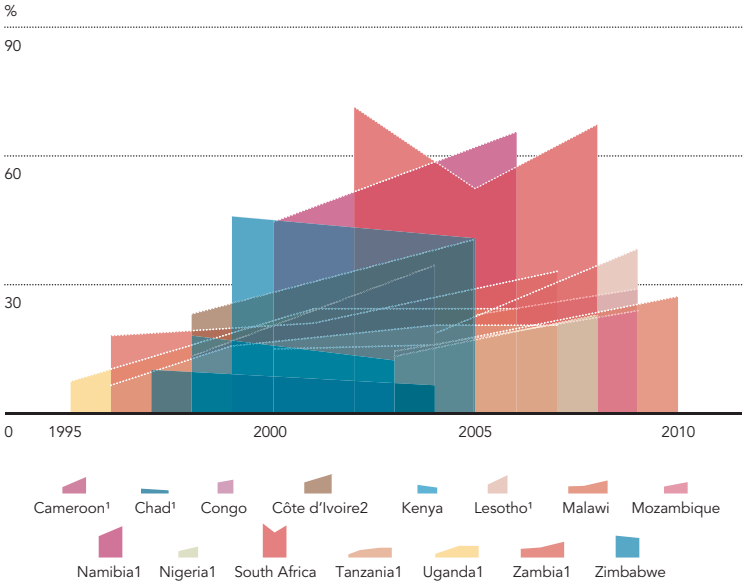
Sex with more than one partner in the past 12 months – females
Countries with HIV prevalence more than 2%, 1995–2010



Used a condom at last higher risk sex – males
Countries with prevalence more than 2%, 1995–2010



Used a condom at last higher risk sex – females
Countries with prevalence more than 2%, 1995–2010



1) identifies a statistically significant decrease in high-risk sex, while
2) indicates a statistically significant increase in high-risk sex.
Source: Demographic and Health Surveys, and other national surveys

Key populations need more attention

The effects of HIV are not evenly distributed, and responses have not been appropriately tailored to those most in need.

Globally, HIV prevalence levels above those reported in the general population have been documented among men who have sex with men (MSM), transgender people, people who inject drugs (IDUs), and sex workers. Elevated HIV prevalence among key populations is especially striking in concentrated epidemics, but is also the case in sub-Saharan Africa, where until recently, data did not exist for IDUs and MSM. Worldwide, these key populations account for a significant share of new HIV infections, including in countries with generalized epidemics.

As measured by national reports on HIV prevalence and service coverage, more countries are acknowledging the role of key populations in national epidemics. According to the most recently available data, the proportion of countries reporting that they conduct systematic surveillance of HIV among key populations increased between 2008 and 2010: for sex workers, from 44% to 50%; for MSM, from 30% to 36%; while among IDUs it remained stable at 28%. Progress in reporting is still modest, and programmatic efforts and budget allocations remain inadequate.

There is ample evidence of the effectiveness of harm reduction among IDUs – a comprehensive package of interventions that prevents HIV transmission at individual and population levels – when implemented to scale. Programmatic gaps, therefore, represent a missed opportunity to slow national epidemics and protect the well-being of marginalized groups.

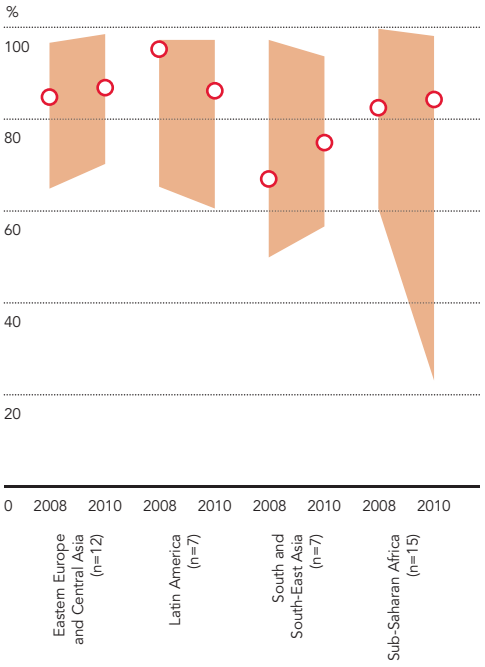
An estimated 20% of the 15.9 million IDUs worldwide are living with HIV. This statistic underscores the world's failure to put the lessons of harm reduction to use. In at least 69 countries where injecting drug use has been documented, no programme to provide even sterile needles and syringes exists. In most countries with needle and syringe programmes, the number of sterile needles distributed per person using drugs is considerably below recommendations for HIV prevention.

Access limited

Access to other essential HIV services for people who use drugs is also limited. For example, opioid substitution therapy is not available in 77 countries in which injecting drug use has been documented, or is illegal; in countries where the service is available, the extent of service coverage is often unclear. Of the 39 countries reporting antiretroviral treatment coverage for IDUs in 2010, 19 reached less than 10% of IDUs eligible for treatment. This is despite cost-effectiveness data showing clear benefits of targeting ART to people who inject drugs in areas with concentrated epidemics, and savings ratios as high as 7:1 for providing drug treatment compared with the social and medical costs of drug use.

Likewise, many countries have focused minimal attention on the HIV-related needs of MSM and transgender people. The epidemic among MSM communities is a worldwide phenomenon, with 63 out of 67 countries reporting in 2009 a higher HIV prevalence among MSM compared with the general population. Yet despite the high »

Proportion of female sex workers reporting the use of a condom at last sex with a client: medians and ranges



Number of reporting countries: n
Median Values
Ranges

Countries NOT reporting on coverage of prevention services among MSM, 2006–2010

Andorra	Eritrea	Luxembourg	San Marino
Afghanistan	Ethiopia	Madagascar	Sao Tome and Principe
Algeria	Fiji	Malawi	Saudi Arabia
Antigua and Barbuda	Finland	Mali	Seychelles
Angola	France	Malta	Sierra Leone
Armenia	Gabon	Marshall Islands	Slovakia
Australia	Gambia	Mauritania	Solomon Islands
Austria	Germany	Mauritius	Somalia
Bahrain	Ghana	Micronesia, Federated States Of	Sudan
Barbados	Greece	Moldova	Suriname
Belize	Grenada	Monaco	Swaziland
Benin	Guinea	Montenegro	Syrian Arab Rep.
Bhutan	Guinea-Bissau	Morocco	Tajikistan
Botswana	Haiti	Mozambique	United Rep. of Tanzania
Brunei Darussalam	Iceland	Namibia	Timor-Leste
Burkina Faso	Iran	Nauru	Togo
Burundi	Iraq	Netherlands	Tonga
Cameroon	Ireland	New Zealand	Trinidad and Tobago
Cape Verde	Israel	Niger	Turkey
Central African Rep.	Italy	Norway	Turkmenistan
Chad	Jordan	Oman	Tuvalu
Colombia	Kenya	Pakistan	Uganda
Comoros	Kiribati	Palau	United Arab Emirates
Democratic Rep. of the Congo	Dem. People's Rep. of Korea	Panama	United States of America
Congo, Rep. of the	Republic of Korea	Portugal	Vanuatu
Croatia	Kuwait	Qatar	Venezuela
Cyprus	Kyrgyzstan	Rwanda	Yemen
Djibouti	Lesotho	Saint Kitts and Nevis	Zambia
Dominica	Liberia	Saint Lucia	Zimbabwe
Ecuador	Libyan Arab Jamahiriya	Saint Vincent and the Grenadines	
Equatorial Guinea	Liechtenstein	Samoa	

20%

One of every five people who inject drugs is living with HIV

» prevalence of HIV among men who have sex with men, most countries have no information on HIV among this group and also lack data on coverage for basic prevention services. Those countries that report coverage data, typically reach fewer than half of the focus population. Moreover, at least 79 countries, territories and areas have laws against male–male sexual contact, including some that authorize the death penalty.

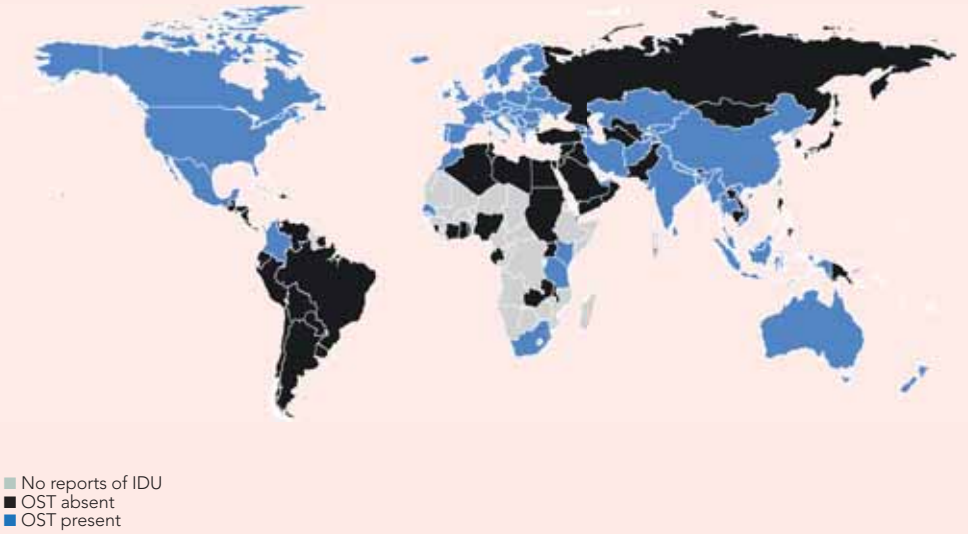
Although a disproportionate risk of HIV among sex workers was documented in most countries in the early stages of the epidemic, the reach of comprehensive prevention programmes for sex workers remains inadequate.

Programmes have impact

Where these programmes are being implemented with appropriate quality and scale, however, they appear to be having an impact. Among 56 countries reporting in both 2008 and 2010, median condom use with the most recent client reached 84%, with a range from about two thirds to nearly 100%. Although programmatic experience among sex workers and their clients is perhaps the most compelling evidence available of the power of focused prevention efforts, these need to be sustained if past gains are not to be lost.

In the relatively few settings where effective prevention measures for key populations at higher risk have been implemented, evidence indicates that community empowerment models are often most effective. Indeed, many of the most effective prevention approaches for key populations – such as the Sonagachi prevention model for sex workers, harm reduction outreach programmes, and community-based prevention efforts in many urban settings for MSM – were developed and delivered by communities themselves. «

Availability of opioid substitution therapy (OST)



Hate crimes add to burden of most vulnerable

Social marginalization and institutionalized discrimination not only increase the HIV-related vulnerability of key populations and undermine national responses, they also often lead to appalling acts of hate and violence against members of these populations.

According to the Global Coalition on Women and AIDS, sex workers often risk harassment, violence or sexual abuse at the hands of uniformed services or intimate partners. In some countries, including Bangladesh, India and Namibia, more than half of sex workers report having been beaten or raped.

People who use drugs are frequently harassed and abused, often by law enforcement officers. According to studies, female drug users are at greatest risk of violence.

Transgender people also are frequently subjected to violence. According to a recent literature review, violence against transgender people often begins early in life, takes various forms, and usually is a lifelong challenge.

Sometimes, members of key populations pay the ultimate price. In 2011, David Kato, a human rights activist who championed the rights of men who have sex with men (MSM) and other sexual minorities, was attacked in his home in Uganda and killed. While his death generated widespread condemnation, violence against MSM and other key populations is a worldwide phenomenon, affecting countries in all regions and spanning all income strata.

COMMENTARY

Sasha Volgina

Treat, don't punish, drug users

Sasha was diagnosed with HIV in 2000 after years of injecting drugs. This is her story.

I wish I had known something about HIV in the late 1990s because when I was diagnosed, all I knew was that HIV was from Africa and I was going to die soon.

I went through rehabilitation and I do not use drugs any more. I would be happy today not to have hepatitis B, C, D and HIV infection, but I have to carry this 'virus baggage' because there was no prevention among drug users then, no counselling, no harm reduction and no substitution therapy.

The overall attitude towards people using drugs has not changed much for the better. There are about two million heroin addicts in my country and more than a third of them are thought to be HIV-positive. In my view, it is possible to stop these 'twin' epidemics and prevent thousands of people from suffering and dying.

Drug users who want to quit should be given a chance to do so. They should get access to a strong rehabilitation and support system. Today's system is not able to cope with the magnitude of the drug addiction epidemic in the country, so many of them remain without a chance: drug overdoses are increasing, and people are committing crimes and going to jail. This vicious circle of punishing people instead of treating them is not in the interest of drug users, society or public health.

Programmes of substitution treatment, using methadone or buprenorphine, can help drug users stop injecting, prevent them from becoming HIV-positive and being exposed to other infections, and withdraw from crime. Those programmes work successfully in developed countries and several countries of Eastern Europe. A study in the British Medical Journal last year found that the introduction of substitution therapy could cut rates of HIV transmission in Russia by up to 55%. Despite all these facts, we are not moving in this direction and harm reduction, including substitution therapy, remains forbidden in Russia. The lives of many are being ruined by the ignorance and incompetence of medical officials, or by the poor judgement of politicians.

I remember the time when we drug users were marked as "socially unproductive" and were not eligible for HIV treatment. We were told, "You have to kick your drug habit before we give you HIV treatment". Now drug users are included in HIV treatment programmes, but without drug addiction rehabilitation and substitution therapy, there is much less chance of these programmes working. Doctors say drug users fail on treatment but it seems the treatment system is failing us.

I saw how AIDS patients were dying when there was no treatment and it was very hard to take. I am getting treatment now; I feel good. The antiretroviral drug treatment is a miracle. It is a great chance for life. Life is a miracle. Recently, I have become a mother and my daughter is also a miracle: it is the best thing that happened in my life. And I strongly believe that all people, including people using drugs, deserve the miracle of life. «

Sasha Volgina is the director of Svecha (Candle), a Russian community-based organization representing people living with HIV.

Male circumcision a critical new HIV prevention tool

Over the past decade, a major tool for HIV prevention has emerged: voluntary medical male circumcision. To date, introduction of this breakthrough strategy has been slow, underscoring the need for urgent action to bring circumcision services to scale.

At the time of the 2001 United Nations General Assembly Special Session, epidemiological patterns suggested that circumcised men might be less likely to become infected by HIV. However, no clinical trials had been performed that would provide definitive scientific evidence that medical circumcision of adult men reduced the odds of female-to-male sexual transmission. Beginning in 2005, a series of randomized controlled trials in sub-Saharan Africa found that circumsising adult men reduced their risk of infection by about 60%.

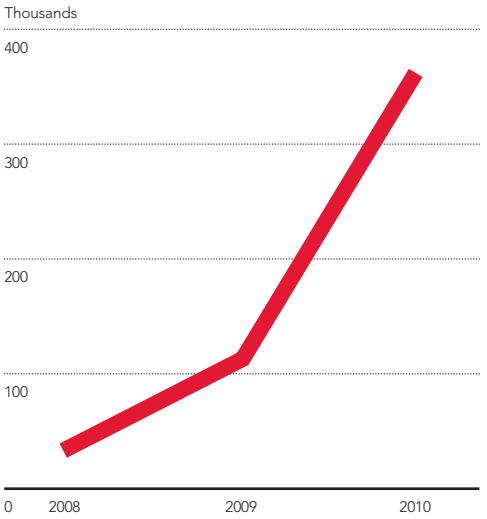
These findings resulted in a major effort to introduce circumcision in settings with both high HIV prevalence and low levels of male circumcision. Male circumcision offers a partial reduction in HIV risk. Its main advantage is that, once performed, the risk reduction is life-long.

The prevalence of circumcision varies considerably in sub-Saharan Africa. Although it is common in many areas, especially in West and Central Africa, most men are not circumcised in the Southern African countries most heavily affected by HIV. In nine countries in Southern Africa and four in Eastern Africa, less than 80% of adult men are circumcised. Outside Eastern and Southern Africa, only in the Central African Republic and Sudan are less than 80% of men circumcised.

Circumcision prevalence varies also within countries, depending on cultural traditions. In Kenya, more than 90% of men are circumcised in all provinces except Nyanza Province, near Lake Victoria, where only 45% of men are circumcised. This pattern matches the distribution of HIV in Kenya, with Nyanza having substantially higher HIV prevalence than other parts of the country.

Supported by international guidelines produced in 2007 by WHO and UNAIDS, 13 countries (Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe) prepared to introduce medical male circumcision, undertaking situation analyses and planning strategies for scale-up. Initial uptake was slow following the release of the guidelines, with slightly more than 100,000 men circumcised in eight* of the 13 priority countries in 2009. There are signs that the pace of scale-up is accelerating, with more »

Annual male circumcisions for HIV prevention in eight countries* in Eastern and Southern Africa, 2008–2010

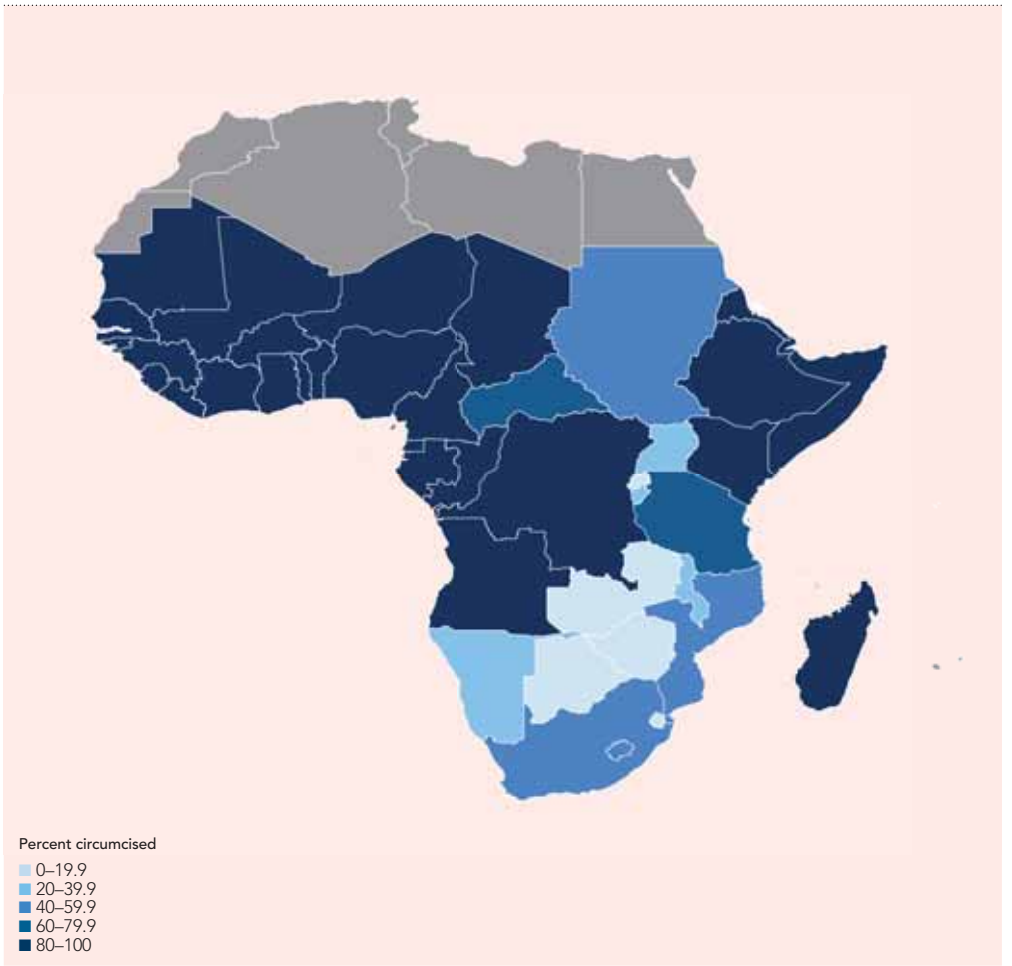


* Kenya, Malawi, Namibia, Rwanda, South Africa, Swaziland, Zambia, Zimbabwe

"Male circumcision offers a partial reduction in HIV risk that, once performed, is life-long."

» than 350,000 men circumcised during 2010 in these eight countries, although tens of millions of men remain uncircumcised. Swiftest progress has occurred in Nyanza Province in Kenya, where a combination of strong political commitment and intensive outreach to community leaders has increased demand and facilitated access to medical circumcision services. A similar uptake has been apparent in South Africa, though most other countries in Eastern and Southern Africa have been slow to adopt or implement new policies for male circumcision. «

Male circumcision prevalence in sub-Saharan Africa, 2010



COMMENTARY

Aaron Motsoaledi

Integrated response vital to success

Aaron Motsoaledi, South Africa's Minister of Health since May 2009, urges a holistic approach that places HIV at the heart of his country's many health challenges.

Systems integration is critical to the AIDS response in South Africa. We have a generalized epidemic, but the highest prevalence of HIV in South Africa is among pregnant women. Because we want to eliminate vertical HIV transmission we have to ensure that HIV and maternal-child health services are integrated.

We also have to treat patients holistically because although HIV is by far the biggest public health crisis in South Africa, it is not the only epidemic we are dealing with.

We have a 73% tuberculosis/HIV coinfection rate and the two diseases must be treated as two sides of the same coin. There is also a clear relationship between HIV and the pandemic of noncommunicable diseases, such as diabetes mellitus and cancer, particularly cervical cancer.

The response to AIDS in our country goes beyond the Ministry of Health and involves multiple sectors. The HIV counselling and testing campaign that got under way in April 2010 has so far counselled nine million South Africans, tested 7.7 million for HIV, screened 4.6 million for tuberculosis and identified 1.4 million HIV-positive people. Screening also includes hypertension and diabetes. This was done at universities in collaboration with the private sector.

We are also working with the South African Business Coalition on HIV/AIDS to conduct workplace testing. The next step is to take HIV counselling and testing to farm workers together with their unions.

Integration must be led from the top in order to leverage support across government departments, the political spectrum and different sectors, but it must also happen at the local level.

We are still learning, and we are far from getting it right, but we know that only by getting communities and community leaders involved can we successfully integrate supply with demand for HIV treatment and prevention services. «

Dr Motsoaledi, a medical doctor by profession, worked in public hospitals and later as a private practitioner in remote and under-served rural areas. He was elected to the national parliament as an MP in 2009 and subsequently appointed Minister of Health by President Zuma.

Service integration crucial to linking HIV to MDGs

The response to HIV is intimately linked with progress towards all the Millennium Development Goals (MDGs), especially the health-related MDGs 4, 5 and 6. Service integration, in particular, is vital to reduce the incidence of HIV, maternal and child mortality and tuberculosis.

Maternal and child mortality

Accelerated progress on HIV is critical to global efforts to reduce HIV-based pregnancy-related deaths (HIV-related deaths of pregnant women or within 42 days following the termination of a pregnancy). Globally, maternal deaths declined by 34% from 1990 to 2008, indicating that the world is unlikely to achieve the global goal of a 75% reduction by 2015. According to recent estimates, HIV is a leading cause of pregnancy-related deaths, accounting for about 11% of all these deaths in 2008. Continuing high death rates among women living with HIV are slowing global progress on maternal health, underscoring the urgent need for family planning, primary HIV prevention for women and for prompt diagnosis and timely initiation of treatment.

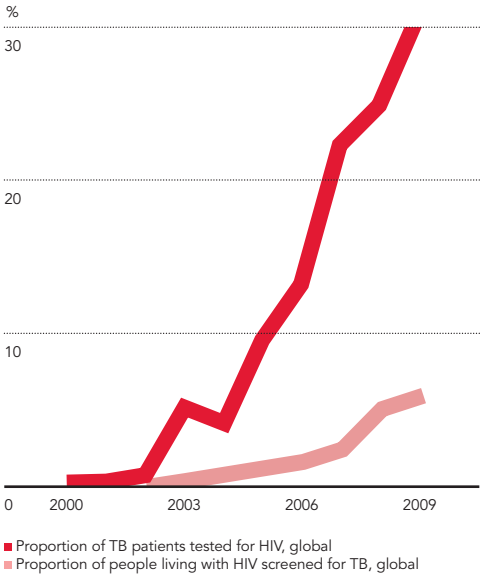
Achieving universal access to HIV prevention and treatment services will also expedite progress in protecting the health and well-being of children. HIV-positive newborns have about a 50% risk of death before age two in the absence of treatment. Recent gains in the HIV response, including a decline in the number of children newly infected with HIV, as well as improving coverage for paediatric treatment, are contributing to global efforts to reduce mortality in children under five. In 2009, HIV accounted for 2.1% (1.2–3.0%) of under-five deaths in low- and middle-income countries, a decline from 2.6% (1.6–3.5%) in 2000.

Further advances in reducing AIDS-related deaths among children are especially critical in sub-Saharan Africa, home to about 90% of all children living with HIV. In sub-Saharan Africa, HIV was responsible for 3.6% (2.0–5.0%) of all deaths in children under five in 2009. Here, too, striking achievements are evident, as the HIV share of all under-five deaths has sharply fallen from the 5.4% (3.3%–7.3%) reported in 2000.

Tuberculosis

Universal access to effective prevention, diagnosis and treatment for HIV-related tuberculosis (TB) could prevent up to one million TB deaths in people living with HIV between now and 2015, but the world is falling far short of this target. Only 28% of TB patients globally knew their HIV status in 2009, and only 5% of people living with HIV were screened for TB. Although early initiation of antiretroviral therapy significantly reduces the risk of death among HIV-positive people with TB, only 37% of these HIV-positive TB patients received HIV therapy in 2009. Better results were reported for cotrimoxazole prophylaxis, as 75% of HIV-positive people with TB received this regimen that reduces the risk of death by 40%. Although HIV infection increases the risk of TB infection progressing to TB disease by several orders of magnitude, only 86 000 people living with HIV (<0.3%) were started on isoniazid preventive therapy in 2009. »

Proportion of TB patients screened for HIV and proportion of people living with HIV screened for TB, 2000–2009



» Focused action in high-burden countries would pay particular dividends in global efforts to reduce AIDS-related deaths. According to data compiled by WHO, 10 countries accounted for more than 69% of all people with HIV-related TB in 2009.

The close links between HIV and other health issues highlight the critical need to take the AIDS response out of isolation and for careful service integration. Particular needs include close collaboration between HIV and TB service systems; integrating HIV prevention into sexual and reproductive health services, as well as providing strong linkages between HIV treatment and programmes to prevent vertical transmission; coordination between HIV services for children with other paediatric health services; and coordination of HIV services with services for other chronic conditions. «

1 million

Universal access to prevention, diagnosis and treatment for HIV-related TB could save 1 million lives by 2015

Ten countries with highest estimated under-five mortality due to HIV, 2009

	Number of under-five deaths due to HIV, 2009	Lower and upper range
Nigeria	33 000	16 000-49 000
South Africa	20 000	12 000-27 000
Mozambique	13 000	6000-18 000
Uganda	11 000	4500-17 000
Kenya	9800	4100-16 000
United Republic of Tanzania	8900	3800-15 000
Malawi	8000	3000-13 000
India	7700	3200-14 000
Zambia	7600	2600-13 000
Zimbabwe	7000	3300-10 000

Ten countries with highest burden of HIV-related TB, 2009

Rank	Country	Best estimate global TB incidence in PLHIV	Lower and upper range	% of Global burden
1	South Africa	280 000	230 000-340 000	21.90
2	India	130 000	54 000-240 000	10.20
3	Nigeria	120 000	95 000-140 000	9.40
4	Zimbabwe	73 000	60 000-87 000	5.70
5	Mozambique	62 000	50 000-74 000	4.80
6	Uganda	54 000	36 000-74 000	4.20
7	Kenya	53 000	43 000-64 000	4.10
8	Ethiopia	40 000	22 000-63 000	3.10
9	United Republic of Tanzania	38 000	26 000-49 000	3.00
10	Zambia	38 000	29 000-48 000	3.00

Source: The WHO Global TB Control Report 2010

COMMENTARY

Chen Zhu

Great strides but challenges remain

Minister of Health says China can be proud, but not complacent.

The HIV epidemic is a global public health and social concern. Curbing its spread requires a large-scale systematic programme. Fully recognizing that HIV and AIDS are not purely a health issue, the Government of China has been pursuing an integrated response. It has implemented a 'four frees, one care' policy (i.e. free access to antiretroviral therapy; prevention of vertical transmission; voluntary counselling and testing, and schooling for children orphaned by AIDS; and care for those living with HIV), and promoted government leadership, multisectoral cooperation, and social participation.

China's integrated HIV response has three key components. First, the Government established the State Council AIDS Working Committee in 2004, comprising representatives from 30 ministries and seven key provinces. Each ministry has explicitly defined responsibilities. Accordingly, all provincial governments, and 88% of prefecture (city) governments, establish their own leadership and coordination bodies. Multisectoral collaborations embrace HIV and AIDS education among women, young people, and migrant workers; preventive interventions, such as methadone maintenance treatment; and care for children affected by the epidemic.

Second, the national HIV programme has been integrated into the reform of China's health-care system, with a considerable increase in funding earmarked for HIV. China is striving to incorporate its response into other aspects of the health system, combining HIV, sexually transmitted infections, and hepatitis C prevention and control; incorporating the prevention of vertical transmission of HIV and congenital syphilis; and addressing HIV and tuberculosis coinfection.

Third, international HIV programmes have been integrated with the national programme to maximize the benefits from international support. As well as learning from other regions, the Chinese government has shared its own best practices and played a more active role in cross-border initiatives.

After more than 10 years of endeavour, China has made remarkable progress in HIV prevention and control. A rapidly growing epidemic has been contained, with decreases in mortality, improvements in the quality of life of people living with HIV and a reduction in social stigma and discrimination. Nonetheless, China still faces challenges: more than 50% of HIV infection is undetected, and transmission among men who have sex with men is increasing rapidly. At the end of 2010, a notice issued by the State Council urged an even stronger response to the epidemic. On top of the 'four frees, one care' policy, the notice articulates 'five scale-ups, six enhancements'. Five scale-ups refers to expanding the coverage of HIV education, surveillance and testing, preventing vertical transmission, and comprehensive interventions and antiretroviral treatment services. Six enhancements includes strengthening organization and leadership, capacity building and blood safety management, as well as medical insurance, care and support, and protecting the rights and interests of people living with HIV.

We can further enhance our HIV response in China. Standing side by side with our international partners, we are confident of making an even greater contribution to the global response and to achieving the Millennium Development Goals. «

A former 'barefoot doctor', Chen Zhu has been the Minister of Health of China since 2007.

Summarizing a decade of progress: substantial gains, but targets missed

Since 2001, the global HIV response has resulted in major gains, including notable reductions in rates of new HIV infections and AIDS-related deaths, as well as unprecedented advances in expanding access to essential services for HIV prevention, treatment, care and support. These important achievements, however, are unevenly distributed, exceedingly fragile, and short of agreed targets.

Between 2001 and 2009, global HIV incidence steadily declined, with the annual rate of new infections falling by nearly 25%. A more complex and varied picture emerges, however, at the regional level. Above-average declines in HIV incidence have occurred in sub-Saharan Africa and in South and South-East Asia, while Latin America and the Caribbean and Oceania regions experienced more modest reductions of less than 25%. Rates of new infections have remained relatively stable in East Asia, Western and Central Europe, and North America. HIV incidence has steadily increased in the Middle East and North Africa, while in Eastern Europe and Central Asia, a decline in new infections was reversed mid-decade, with incidence rising slightly from 2005 to 2009. »

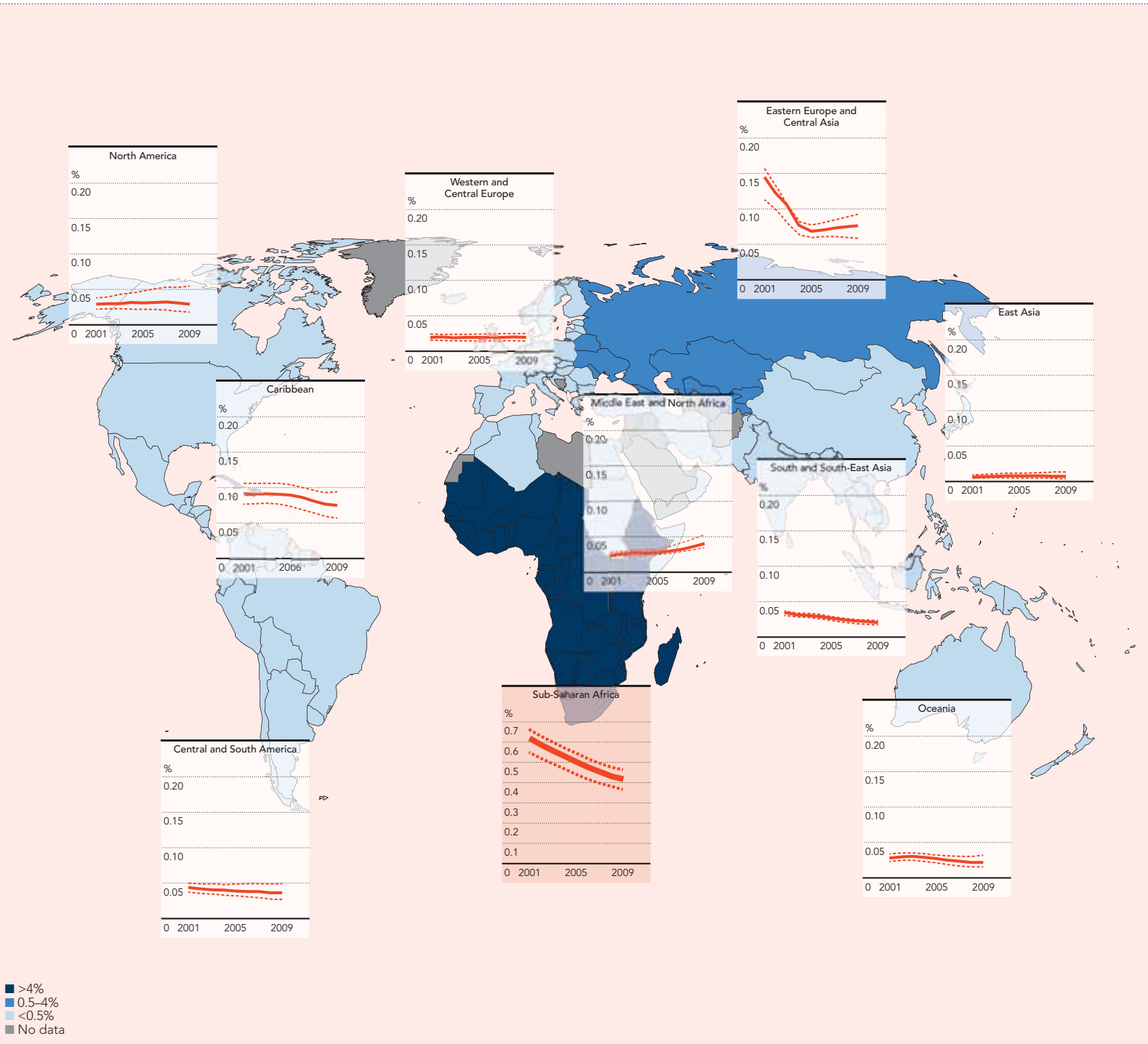
Summary of performance in low- and middle-income countries against programmatic targets, 2001–2010

Component	Agreed targets	Achieved
Young people's comprehensive knowledge of HIV	2010: 95%	34% (2009)[1]
Coverage of antiretroviral drugs for prevention of vertical transmission	2010: 80%	53% (2009)
Reduction in vertical transmission rate	2010: 50%	21% (2009)
Antiretroviral therapy	2005: 3 million 2010: universal access	1.3 million (2005) 6.6 million (2010)
Reduction in HIV prevalence among young people (as a proxy for incidence)*	2010: 25%	24% (2009) in all countries

* Global performance
1) Males 34%, Females 24%

"There is often considerable variation in HIV prevalence and epidemiological patterns within countries. Hotspots of high HIV transmission may extend beyond national borders."

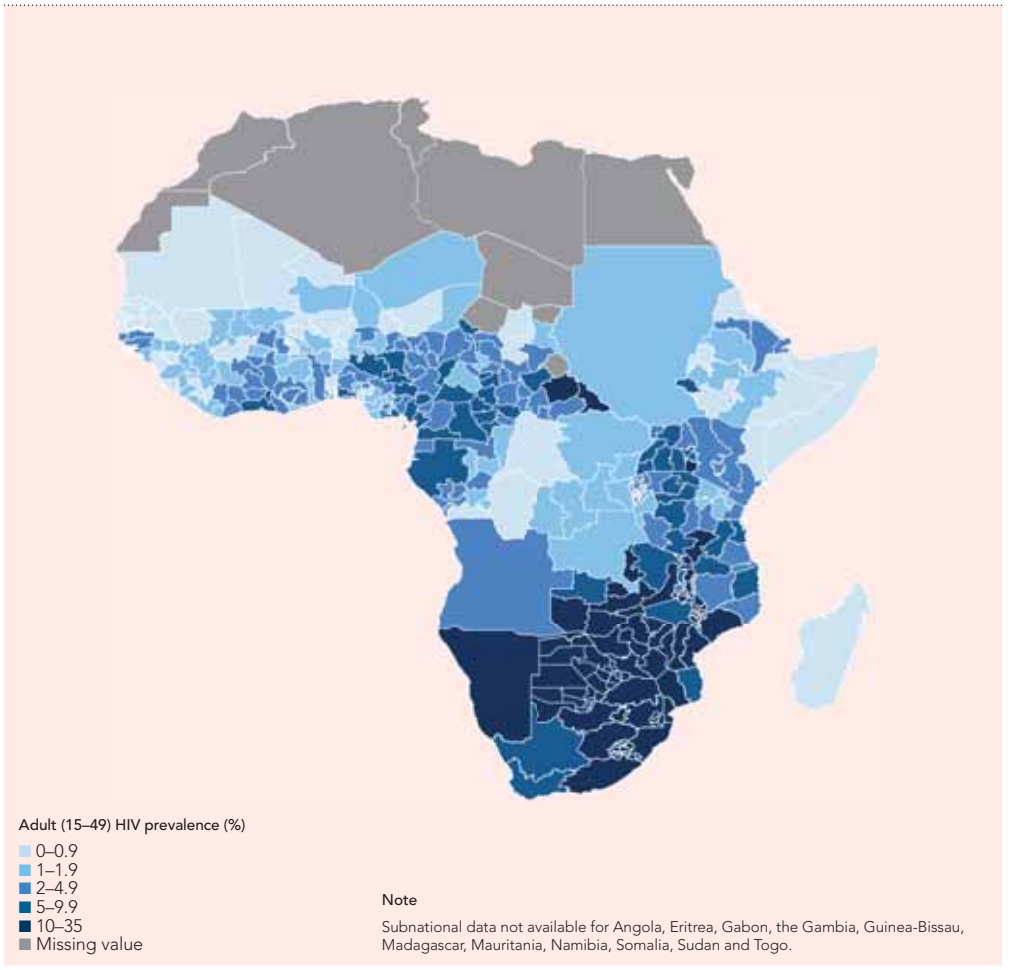
Regional adult HIV prevalence in 2009 and trends in HIV incidence, 2001–2009



» Improved surveillance and other data collection have taken place during 2001–2009. Although it is common to speak of "national" epidemics, there is often considerable variation in HIV prevalence and epidemiological patterns within countries, and epidemic 'hotspots' are apparent. While national HIV prevalence in the Central African Republic, Kenya and the United Republic of Tanzania is below 10%, each of these countries also has hyperendemic regions where more than 10% of adults are living with HIV. Hotspots of high HIV transmission may extend beyond national borders, such as in the western part of the Central African Republic and south-east Cameroon, or in areas bordering Lake Victoria in Kenya, the United Republic of Tanzania and Uganda. These patterns highlight the importance of local strategic focus for national responses and regional cooperation in forging effective strategies to address cross-border patterns.

After low-level responses in the epidemic's first two decades, the most recent decade brought historic achievements. These gains, while unprecedented, are partial at best. The establishment of global and national targets helped drive these successes in the response. In most cases, though, the world failed to achieve these targets, underscoring the need now to build on the previous decade's achievements to ensure long-term success in the response. «

Know your epidemic: subnational estimates of HIV prevalence in sub-Saharan Africa, 2001–2010



Note

Subnational data not available for Angola, Eritrea, Gabon, the Gambia, Guinea-Bissau, Madagascar, Mauritania, Namibia, Somalia, Sudan and Togo.

34 million

The number of people living with HIV was around 34 million worldwide in 2010

Section Two

Regions united

Regions united for universal access

The 2001 United Nations General Assembly Special Session on AIDS started something big. The principles of universal access were based on the explicit recognition of the needs of all people for equitable access to prevention, treatment, care and support, as demonstrated in the resulting Declaration of Commitment:

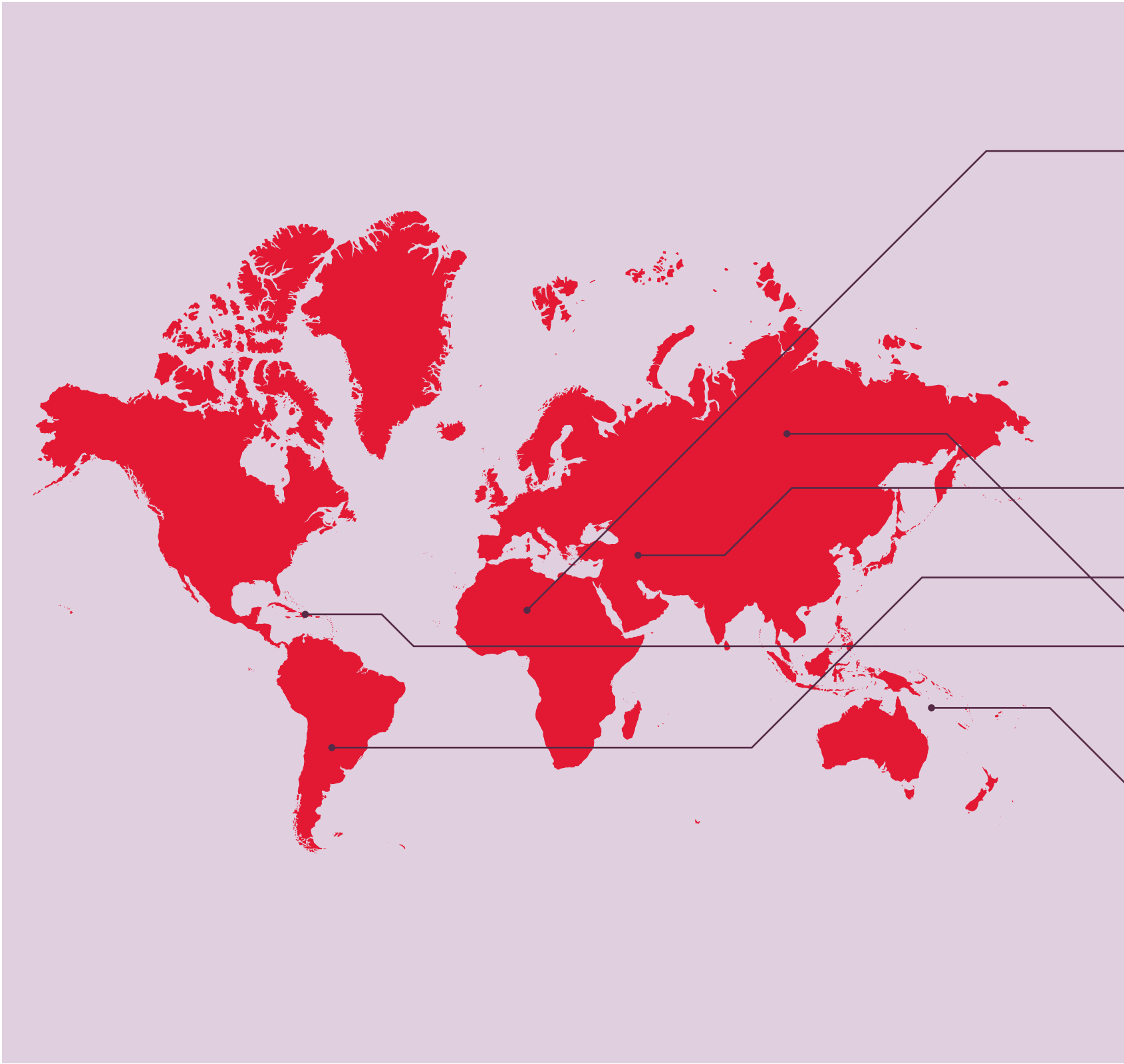
"HIV and AIDS services and products must be accessible, acceptable, affordable, available, of good quality and sustainable to all people in need, regardless of their status and free from any form of stigma or discrimination."

In 2005, the Gleneagles Group of Eight Summit endorsed the notion of universal access and UNAIDS formally launched that ambitious initiative the following year.

Universal access has turned into something more than an initiative: it is now a full-fledged movement, with support from governments, civil society, nongovernmental organizations, including networks of people living with HIV, and multinational systems such as the UN. Targets have been set collaboratively and progress assessments are conducted jointly. Debates and discord continue, but they have become more constructive as everyone works towards the same goals.

Over the past two years, 117 countries have taken stock of their progress towards universal access. Their assessments fed into the six regional consultations summarized in the following pages. These snapshots of AIDS epidemics around the world demonstrate the strengths and weaknesses of various approaches, the issues and opportunities ahead and the priorities and commitments of countries and regions. They are intended to support ongoing work through objective analyses.

Universal access is a process of improving and expanding services so that all people in every part of the world, regardless of their status, can protect themselves from HIV and get the treatment and care they might need. Ultimately the outcome will reflect the vision articulated by UNAIDS in 2010: zero new HIV infections, zero discrimination and zero AIDS-related deaths. «



Africa

African Civil Society Declaration on the Review of Progress towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa, April 2011 / Africa's Common Position to the High Level Meeting of the UN General Assembly Special Session on AIDS, April 2011 / The Windhoek Declaration: Women, Girls Gender Equality and HIV: Progress towards Universal Access, April 2011 / Conference of African Ministers of Health Commitments to Universal Access, Windhoek, April 2011

Eastern and Southern Africa

Eastern and Southern African Civil Society Position Paper on Universal Access to HIV and AIDS Prevention, Treatment, Care and Support, March 2011

West and Central Africa

Regional Consultation of the Civil Society on Universal Access in West and Central Africa: Resolutions, March 2011

Middle east and North Africa

Regional Consensus Statement: Policy Dialogue Towards Achieving Universal Access to HIV Prevention, Treatment, Care and Support in the Middle East and North Africa, June 2010

Latin America

Results of the Regional Latin America Consultation Political Commitment, March 2011

Caribbean

Progress towards Universal Access in the Caribbean Regional Review 10th PANCAP Annual general Meeting, November 2010

Eastern Europe and Central Asia

Statement at the Regional Consultation on Universal Access to prevention, treatment, care and support for HIV in Europe and Central Asia, Kiev Ukraine March 2011 (by Eurasian Harm Reduction Network, East Europe and Central Asia Union of PLWH, International Treatment Preparedness Coalition in Eastern Europe and Central Asia, European AIDS Treatment Group)

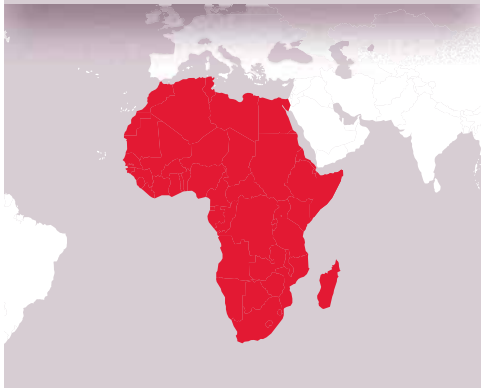
Asia and the Pacific

Resolution of the Asia Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support, March 2011

Greatest public health challenge in history

KEY MESSAGES

- Exceptional measures needed to halve new HIV infections by 2015.
- Women and girls are more affected as HIV mostly transmits through heterosexual contact.
- A rights-based response must be more than a convenient slogan.
- AIDS, health and development must be integrated for maximum impact.
- Eliminate vertical transmission and strengthen maternal and newborn health as a priority.



In graphics depicting the global AIDS epidemic there is always one piece of the pie chart that is biggest, one vertical column that is tallest, one trend line that is steepest: Africa. What has been happening in Africa over the past 30 years is the greatest public health challenge in human history.

Yet some of the most progressive and demanding AIDS policies come out of Africa. The Abuja Declaration, the Maputo Plan of Action, the Kampala Heads of State Summit and, most recently, the African Union Health Ministers' Common Position, all aim to conquer AIDS.

On track to universal access

Coverage of services to prevent new child infections increased from 15% in 2005 to 54% in 2009. The HIV incidence rate declined by more than 25% between 2001 and 2009. Antiretroviral treatment coverage is increasing. Almost all governments on the continent have national AIDS plans, and some of the most heavily affected countries are projected to achieve universal access. Africa's Common Position acknowledges universal access across the continent may take longer than 2015, and urges governments to quickly integrate the AIDS response into "national development instruments" and pursue "evidence-informed and rights-based responses". It spurs the prevention revolution by committing to "halve the number of infections by 2015", mandating legal systems to "eradicate HIV-related stigma and discrimination", and challenging researchers to "accelerate vaccine and microbicide development".

United and determined

Some 22.5 million people now live with HIV in Africa. The majority (60%) are women and girls. HIV prevalence is as high as 25% in some countries, and the rate of people becoming newly infected outpaces treatment access. Of the 16.6 million children globally who have lost one or both parents to an AIDS-related illness, 14.9 million are in Africa.

As international aid falters, many have called for African governments to contribute more of their own resources regardless of their national income. International organizations, donors and governments must resolve the contradiction between need and the capacity to pay if fragile progress is to be strengthened and global commitment to shared responsibility is to be renewed. «

60%

Women and girls comprise 60% of Africans living with HIV

Owning AIDS in East and Southern Africa

Parts of East and Southern Africa have hyper-endemic HIV rates and HIV prevalence remains high with feeble signs of subsiding. For every three people who start treatment, another five are infected. The rates of infection, the loss of productivity, the numbers of orphans and other data make bleak reading.

Yet, there is progress. Treatment coverage in the subregion is accelerating; it is 90% in some places. New infections in children are decreasing, while prevention of mother-to-child transmission is increasing. As antiretroviral drugs become more available, people are living with HIV longer and AIDS-related deaths decline.

Governments are not blind. Political leaders are mobilized and collaborating with civil society. People living with HIV are part of broader development responses, and more services are targeting key populations at higher risk.

Progress will remain fleeting, however, as long as only a fraction of the population knows their HIV status, and the risk of HIV exposure continues through widespread unprotected sex. Governments have the responsibility to provide services and create the enabling environment for change. But ultimately, people must take responsibility for reducing their own risk of infection.

Scaling up the response in West and Central Africa

There has been significant progress in West and Central Africa in recent years, with HIV incidence decreasing in 10 countries and HIV prevalence stabilizing in seven. Access to antiretroviral treatment has increased from 1% in 2001 to 25% in 2009, and the coverage of prevention of vertical transmission services has increased from 4% in 2005 to 23% in 2009. New leaders, including ministers of justice and parliamentarians, have championed human rights, and civil society has been instrumental in moving the agenda forward.

It is clear, however, that this progress is fragile and significant disparities remain among and within countries and localities. Many countries have generalized epidemics but also have very significant concentrations of infections in key populations: prevalence among sex workers is nearly 40% in some countries, and new infections among men who have sex with men are up to 20%. In 2009, West and Central Africa had 6.45 million people living with HIV and 75% of people in need of antiretroviral drugs were not receiving them.

Of particular concern is the service coverage for prevention of new child infections. While significant gains have been made, prevention coverage for pregnant women is well below the average for low- and middle-income countries overall, and Nigeria alone accounts for nearly one third (32%) of the global coverage gap for services to prevent vertical transmission.

A diverse range of factors means AIDS continues to impact heavily on West and Central Africa: political and institutional instability; 50% of States in conflict or post-conflict situations; weak community and health infrastructure; a high dependency on foreign aid; persistent stigma and discrimination of key populations at higher risk and inadequate drug management systems. Until evidence-based interventions are scaled up to make optimal use of resources and innovative financing, including increased domestic funding, the epidemic will persevere.

Gaining ground on 'zero' targets

KEY MESSAGES

- Countries are making progress but time is running out. Programmes must be accelerated, particularly in South Asia.
- Treatment sustainability is facing a double challenge of unmet funding needs and threats to access to affordable drugs.
- Responses must target key affected populations. Communities to own their programmes.
- Young people from key affected populations can lead a prevention revolution.
- Discriminatory laws and practices must be abolished. An enabling environment is critical for progress.
- Countries must honour their commitments to the AIDS response and increase domestic funding.

The Asia Pacific region has made significant progress in controlling HIV's spread. The number of people living with HIV has remained stable for the past five years and estimated new infections are 20% lower than in 2001. Thailand, Cambodia and certain parts of India have turned their epidemics around by providing quality services to their key populations at higher risk. Cambodia is one of eight countries worldwide to have reached universal access to antiretroviral therapy (94% coverage). Significantly fewer children are getting HIV and dying from AIDS than 10 years ago, and two countries report 80% coverage of services to prevent new child infections.

These gains, however, are insufficient and fragile. In 2009, median reported prevention coverage for people who inject drugs was 17%; for men who have sex with men 36.5%; and for female sex workers 41%. Programmes in key affected populations to prevent transmission to intimate sexual partners are severely lacking.

The region demonstrates that sustained access to HIV treatment must go hand-in-hand with sustained access to prevention for key populations at higher risk.

Unlocking progress

There are laws obstructing the rights of people living with HIV and those most vulnerable to HIV infection in 90% of the region, and 16 countries restrict their travel. Sex with a same-sex partner is criminalized in 20 countries, while 29 countries criminalize some aspect of sex work. Eight countries compulsorily detain people who use drugs and 11 apply the death penalty for drug offences. Distributing needles and syringes to drug users is prohibited in seven countries. Such punitive environments damage public health as the marginalized are unlikely to seek services.

According to the latest UNGASS reports, AIDS expenditures in 2009 totalled US$ 1.07 billion. Estimates based on the methodology suggested by the Commission on AIDS in Asia indicate that US$ 3.3 billion is needed for a targeted response across the region. International funding accounted for more than 50% of AIDS spending in most of the region's countries. To reach universal access, a rapid increase in domestic funding is needed, particularly in middle-income countries, which would need to spend less than 0.5% of gross national income to fund their response. »

Sustaining policy momentum

The Resolution of the Asia and Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support adopted in March 2011 urged the governments of Asia and the Pacific to:

- Lead their own prevention revolution by realizing that optimal coverage of key affected populations and their partners is the most effective way to manage HIV.
- Translate Treatment 2.0 into comprehensive action and address gaps in country treatment, care and support programmes.
- Address human rights, legal environment and stigma and discrimination issues that impede progress towards universal access.
- Promote financial sustainability through strengthened national ownership and improved capacity for programme effectiveness.

Inclusive consultation, strong resolution

The Asia and Pacific Regional Consultation on Universal Access brought together more than 250 participants from 27 countries in Bangkok in March 2011. Governments, civil society, United Nations agencies and other development partners were represented.

Civil society and regional governmental bodies played leading roles in the debates, while young leaders from key affected populations demanded a voice in the HIV response.

The consultation delivered a thorough and progressive resolution that prescribed the following actions to achieve the targets of zero new HIV infections, zero discrimination and zero AIDS-related deaths: instigate a prevention revolution focusing on key populations at higher risk; increase efforts to sustain gains in treatment; and redress legal barriers, stigma and discrimination, and funding gaps.

Civil society steps in to lead the response

KEY MESSAGES

- The epidemic is still growing but political mobilization has decreased.
- Civil society plays an essential role.
- More than 50% of infections in 2010 were through shared drug-injecting equipment. Scaling-up harm reduction is a priority.
- Sexual transmission is increasing but sexual education and condom promotion are missing in most countries.
- Effective control of HIV/TB coinfection is essential, notably in prisons.
- Legal and social discrimination of key populations at higher risk fuels the epidemic.
- More cost effective prevention, targeting high-risk groups, and cheaper treatments are needed.

**Seventeen countries in Eastern Europe and Central Asia (EECA) reported spending more than US$** 1.2 billion on HIV and AIDS in 2009, of which US$ 750 million was spent in the Russian Federation. As the region assesses its progress towards universal access, it is reasonable to consider the return on that investment in making prevention, care and treatment services available to everyone.

Some progress has been made: prevention of vertical transmission coverage exceeds 90%; access to antiretroviral drugs is increasing although it remains among the lowest in the world; there has been progress in the legal systems on travel restrictions and harm-reduction in several countries; and public-sector spending on AIDS is rising. The recent Regional Consultation on Universal Access concluded, however, that the region's epidemic "remains serious" and "the burden of HIV is increasing".

Injecting drug users form a key population at higher risk in the sexual transmission of HIV, to their spouses and partners. Transmission also occurs via sex workers, and to a lesser but growing extent, through men who have sex with men (MSM). Prevention and treatment services are increasingly failing to reach them.

High stakes

There are encouraging trends in harm-reduction policy-making, but access to oral substitution services remains limited and often stigmatized. There are reports of harm-reduction services being denied; abuse of confidential drug-user registries; and police harassment and arbitrary arrests. HIV and tuberculosis (TB) coinfections are a particular concern in prisons, where multidrug resistant TB is common. Access to prevention and treatment for prisoners is low. Migrants have limited access to HIV prevention and treatment and lack health insurance coverage.

Investing in cooperation

The region is home to a vigorous community of AIDS policy-makers, researchers and activists. More than 150 high-ranking officials, experts and members of civil society gathered in Kiev for three days in March to assess their region's progress towards universal access and to set targets for 2015.

Cross-border collaboration between national governments remains insufficient and hampers initiatives for migrants. Civil society has assumed leadership and is willing to collaborate with governments, which sometimes adopt a confrontational rather than cooperative approach. »

Priorities for achieving universal access

By 2015:

- Treatment coverage will increase to 100% of identified patients needing antiretroviral drugs.
- Countries where injecting drug use is the main driver will expand coverage to 60%.
- All countries will expand domestic funding for HIV by at least 20% from current levels.
- All countries will eliminate vertical transmission.
- All countries will realign laws and policies that criminalize most at-risk populations with international standards.
- Interstate systems will be established that provide universal access for migrants.
- At least 50% of countries of the region will have legal mechanisms to redress discrimination.

The bottom line

While some countries show progress, and a regional path towards universal access is emerging, most of the region's governments are not accelerating policies and programmes as epidemics worsen. That is particularly worrisome given that external aid will diminish as a result of reduced access to Global Fund grants.

Stronger policies, cost-effectiveness, bolder programming and political leadership are crucial to achieving a favourable return on investments. Investments to date are for the long term. Just how long depends on the pace at which the virus spreads compared with the pace at which governments respond.

50%

Half of HIV infections in Eastern Europe and Central Asia in 2010 were due to drug users sharing needles

Impressive numbers hide disparities

KEY MESSAGES

- Great strides in treatment coverage aided by the production of generic drugs in Brazil.
- Achievements threatened by weak logistics that lead to drug stock-outs.
- Under-served, vulnerable communities need greater protection from inequality.
- Law enforcement agencies must stop hate crimes.
- Regional response funded by substantial domestic resources, but it needs to be better targeted.

At first glance, statistics suggest HIV in Latin America is under control. Prevalence in the general population is stable at 0.4%. More than half the people needing treatment can receive it and universal access to treatment is a reality in Brazil, Costa Rica and Mexico. Costa Rica reported zero cases of vertical transmission in 2009.

But these numbers hide disparities. HIV prevalence is alarmingly high among men who have sex with men (MSM; up to 20.3%), sex workers (up to 19.3%) and transgender people (up to 34%), in some countries. Access to treatment is uneven, with difficulties particularly for key populations at risk, where stigma and discrimination continue to fuel the epidemic.

There is political will: 95% of the region's response to AIDS is funded by domestic resources, but allocations are not sufficiently aligned to the patterns of the epidemic, and funding for treatment far outweighs that for prevention, particularly among at-risk populations.

Early engagement

In 2006, Latin America was one of the first regions to commit to universal access when stakeholders gathered in Brazil to discuss scaling up HIV programmes.

To prepare for the second regional consultation in Mexico City in March 2011, 16 country-based technical reviews assessed progress against the 2006 targets. Findings were mixed: more MSM were getting tested, but young people were being diagnosed too late; generic antiretroviral drug production had increased but stock-outs were frequent; despite Costa Rica's success, there was no measurable improvement in preventing vertical transmission across the region; and data showed greater condom use among sex workers and more people who inject drugs using sterile equipment, but MSM still not being widely reached by prevention programmes promoting safer sex.

Hard truths

Unless every person in Latin America is able to access services without fear of reprisal or violence, access will not be universal. Ingrained social, cultural and economic barriers make women and girls and key populations at higher risk of infection. Initiatives that target men who have sex with men and transgender people must link to broader efforts that promote human rights and protect public health.

On the right path

The region can be proud of its low HIV prevalence in the general population. Over the past 30 years, Latin America has kept infection rates low and services available, although strong efforts are still required to reach those most vulnerable to HIV. The 2006 and 2011 consultations demonstrate the region is responding to the epidemic's toughest challenges, and there is every reason to believe it has set the correct course. «

Making commitments

Latin American leaders have proposed the following reforms to achieve universal access.

1 Leadership Build regional and national leadership capable of functioning "differently and strategically". Build relationships between governments and civil society.
2 Prevention Turn the health and education ministers' declaration, Prevention through Education, Mexico 2008, into action, with new projects for youth, including sexual and reproductive health education and services.
3 Care and treatment Scale up treatment to 100% through price negotiations, expanding local production and distributing antiretroviral drugs. Broaden access to friendly health-care services, including diagnosis, for people most at risk. Integrate people living with HIV into treatment adherence programmes.
4 Human rights Establish regional and national observatories to oversee justice for the marginalized. Document hate crimes and human-rights violations. Create a legal defence paradigm to uphold the human right to sexual health. Engage law enforcement and justice systems to safeguard against stigma and discrimination.
5 Sustainability Identify and develop evidence-based, cost-effective interventions to strengthen health systems and integrate HIV with primary and chronic disease care.
6 Gender equity Include gender equity in national and regional legal frameworks, and in school curricula.

0.4%

HIV prevalence is stable in Latin America at 0.4% overall, but key populations at higher risk need more support

Inclusion, investment the smart way forward

KEY MESSAGES

- Upper middle-income countries must invest more in responding to epidemics.
- Treatment services must target key populations at risk.
- Laws should protect human rights and against arbitrary discrimination.
- The region is on track to be the first to eliminate travel restrictions.
- Silence is no option. The region must assert itself as a key voice in the global response.

With 1% prevalence, the Caribbean has the highest infection rate in the world after sub-Saharan Africa. Prevalence is highest among men who have sex with men (MSM) and sex workers, according to the most recent data. In Jamaica, 33% of MSM are living with HIV. In Suriname, 24% of female sex workers are infected with HIV.

With many Caribbean countries criminalizing sex work and sex between men, universal access will be impossible unless those laws change.

At the recent Regional Consultation on Universal Access in Trinidad and Tobago, leaders agreed those laws had to be repealed and revised. They called for a Pan-Caribbean Human Rights Charter to guarantee the right to health for all, a welcome united front against legalized discrimination. Following the consultation, the Jamaican Prime Minister and the Leader of the Opposition signed a 'Declaration against HIV Stigma and Discrimination'.

Women can lead the way

A review of the Caribbean AIDS epidemic offers good news and bad news. There was a 14% reduction in HIV incidence between 2001 and 2009 – four countries reduced new HIV infections by 25% – and greater access to treatment reduced AIDS-related deaths by 43% over the same period. But 18 000 new infections took place in 2009, an average of 50 daily. Some 7000 women needed treatment to prevent vertical transmission but only 4000 received it. Most alarmingly, AIDS is the leading cause of death among Caribbeans aged 20–59.

In the past decade the Caribbean received more than US$ 1.8 billion in external funding. In 2009 external sources funded 64% of overall AIDS spending. As international development assistance diminishes, national investments must increase.

Regional leaders know they must think creatively and inclusively about new approaches. At the regional consultation in Trinidad and Tobago there was support for more women to assume leadership roles. If young men and women are to be reached, attention should be paid to the role of popular culture, education and links between HIV and sexual and reproductive health. Modernizing societal views on the key populations at higher risk requires innovation from new leaders. It is quite possible women will lead the way.

The right of Caribbean people to make their own history was a resounding message at the consultation. It is up to the region's leaders to determine the role of AIDS in its history. AIDS could continue to decimate legally stigmatized populations, strain national budgets, and hurt industries. Caribbean societies need to make wiser investments and secure the needs and rights of all citizens. «

Health is wealth

A dollar can go only so far; it can be spent wisely or unwisely. Evidence indicates more money should be spent on prevention and treatment for men who have sex with men and female sex workers, though they are less likely to access services due to stigma, discrimination and criminalization. Resolving this conflict requires complex government cooperation: ministries of finance, labour, education, social development and health have equal stakes in ensuring public investments in prevention are strategic and evidence-based.

'Health is wealth' was another key message at the recent regional consultation on universal access. Experts are examining the lessons learnt from successful disease eradication programmes, such as measles and polio, as well as the broad advances in the health systems. Both have contributed to the improvement in the health status and economic development since the independence of the Caribbean islands. Investing in AIDS and linking it with broader development agendas could be a smart investment strategy for public and private financiers. Experts say it is a smart public-health strategy too.

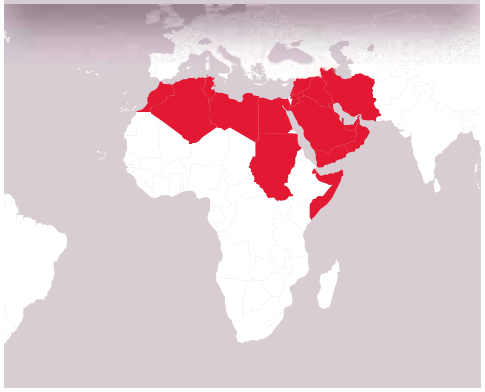
43%

In 2001–2009, greater access to treatment reduced AIDS-related deaths in the Caribbean by 43%

New approaches for a new day

KEY MESSAGES

- The Middle East and North Africa is one of the two regions with the fastest-growing epidemics and where treatment coverage is low.
- Stigma and discrimination are major obstacles to universal access, including quality services
- Responses must be tailored to key affected populations.
- Rights-based programmes must be adopted and focus on young people to lead the prevention revolution.
- Creating an enabling environment is critical for universal access. Countries must abolish discriminatory laws and practices.



Ten years ago, HIV had no place on mainstream political or social agendas in the Middle East and North Africa, but today there is evidence that most countries in the region have changed course. In 2008, only eight countries contributed to multilateral progress reports; in 2010 that number was 20. All countries have developed national AIDS strategies, many using emerging evidence to shape their responses. All countries provide free antiretroviral drugs (ARVs), yet more must be done to improve access to health services.

Stigma and discrimination against key populations at higher risk of infection still hamper progress towards universal access; a majority of countries in the region have laws that criminalize key populations. However, there have been improvements over the past five years. Egypt, Lebanon, Morocco and Tunisia have programmes targeting men who have sex with men, and sex workers. The Islamic Republic of Iran has adopted a combination prevention approach to reduce new HIV infections among people who inject drugs, while Djibouti has integrated migrant and mobile populations in its strategy.

From Dubai to Djibouti – a call for universal access

The consensus statement from the Dubai Consultation in June 2010 was a milestone in the region's response to HIV. Government and civil society representatives confronted controversial social and political issues, and committed to universal access to HIV prevention, treatment, care and support. They demanded an enabling environment that protects the human rights of vulnerable groups, including women and girls and people living with HIV. Participants agreed that people living with HIV and civil society should be better integrated into government policy-making and programming.

The 16 government officials who signed the statement acknowledged that innovative financing initiatives, including domestic funding, were needed. The Global Fund is by far the region's largest donor (US$ 326.4 million over five years), and the percentage of HIV allocations in national budgets is still low overall, yet history shows progress depends on governments increasing domestic spending on the AIDS response.

The Declaration of Commitment and Call for Action endorsed at the Djibouti conference in September 2010 represented another major breakthrough, with participants calling for access to services for all mobile and migrant populations. »

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Youth go online to challenge traditions

A powerful social and political youth movement is coalescing in the region to define its future. The Internet is buzzing with a new generation of college graduates and young professionals who do not abide by state-sanctioned communications.

The major changes in the region are happening through youth-based social networking and go far beyond the political. Young activists have long been using this medium to inform each other about sexually transmitted infections and HIV treatments, locate family planning services, and organize advocacy. They do not limit their social networking to any one topic, because they want full-scale change.

Youth know their online voice goes beyond political borders, and can transcend cultural traditions that allow HIV to spread and jeopordize their human right to health. They are in the vanguard of a social revolution that is challenging conventional wisdom.

As Dr Mohamed ElBaradei and Archbishop Emeritus Desmond Tutu said in a recent editorial: "The young people who overwhelmingly led the popular uprising which tore down Egypt's corrupt and morally bankrupt regime are a global inspiration. Their spirit, and their mastery of new forms of cellphone- and internet-accelerated social movements, are part of the agenda we must harness for an HIV prevention revolution."

The way forward

By endorsing the Dubai consensus statement, AIDS leaders in the Middle East and North Africa committed to integrating services; focusing on women and girls; combating stigma and discrimination; generating knowledge about epidemics and responses; developing innovative funding; fomenting an interministerial government response; building a strong civil society; and engaging in multilateral systems. «

Solidarity for universal access: The IAG consensus

Only history will be able to judge the impact AIDS has on humanity, but one thing is certain: the global response to this epidemic has changed the paradigm of economic and social development by identifying and acting on shared principles that are essential for success: HIV does not stand alone; partnerships are essential. Human rights are fundamental. The most affected communities must be at the centre. Traditional gender norms can be obstacles. Resource allocations and flows need rigorous coordination and mutual accountability. Young people will inherit problems the current generation cannot solve.

A worldwide crisis requires worldwide mobilization, which 182 countries embraced in the United Nations General Assembly 2006 Political Declaration, aptly titled universal access. The premise is simple: when every nation achieves universal access to HIV prevention, treatment, care and support for all its populations, this epidemic will end.

In the past two years, 117 countries took stock of their progress towards universal access and those assessments fed into multiple regional consultations. A multi-stakeholder International Advisory Group (IAG), mandated by the UNAIDS Programme Coordinating Board, reviewed the findings of countries and regions, as well as other global and regional studies and declarations. The IAG found overwhelming and ongoing support for the universal access movement. This diverse group endorsed the recommendations from these aggregate consultations and concluded that five global challenges are pivotal now. This IAG consensus, formalised in Johannesburg, South Africa in April 2011, does not extend to every detail of every response, but its collective perspective highlights where action is critical.

"We need mechanisms to ensure that both public and private services are free of stigma and discrimination or homophobia."
– Dr José A Córdova, Secretary of Health of Mexico, at the Latin America regional consultation.

1. Human rights save lives

No HIV response can be effective unless it combats discrimination and exclusion. Punitive laws and stigma against men who have sex with men, transgender people, people who use drugs, sex workers and migrants, undermine the programmes that are most effective and needed.

Girls and women are routinely denied their human rights. They have less access to education, nutrition, health care and economic opportunity than men. Many societies continue to tolerate or justify violence against girls and women.

Until the human rights of all people are protected, HIV will continue to spread. »

- International human rights legal frameworks should be updated to include sexual rights.
- Regional mechanisms, from charters to legal services, should be used to provide access to justice for those whose rights are violated.
- Parliamentarians, the judiciary, law enforcement, educators, media, and civil and religious leaders should be mobilized to build a culture of tolerance and respect.
- UNAIDS should lead the development and ratification of a set of human rights indicators for national monitoring, accountability and budgeting.
- There must be zero tolerance of violence against girls and women. Homophobia must be fought. There must be zero tolerance of violence against gay and other men who have sex with men, and transgender people.

2. Prevention and treatment: two sides of the same coin

Treatment has transformed AIDS from a death sentence into a challenge for lifelong care, giving hope, restoring productivity, and providing incentives for knowing your HIV status. It has created a new understanding of HIV prevention. Yet the costs of AIDS drugs remain too high and often are subject to narrow commercial interests. Tuberculosis (TB) is the biggest killer of people living with HIV, and viral hepatitis and other coinfections need to be addressed.

Prevention has fallen dangerously behind treatment because the causes of new infections – sexuality, gender inequalities, socioeconomic disparities and drug use – are hard to talk about, and hard to change. Stigma around these issues, and around HIV itself, continues to hinder support for and uptake of services. Well-designed prevention programmes work. Families and communities are central to their success.

- Countries and communities need to own their HIV responses and demand full implementation of proven strategies with ambitious targets.
- Young people must have unfettered access to quality sexuality education and comprehensive sexual and reproductive health services.
- Harm-reduction services need to be available for all people who use drugs.
- Every country should provide and promote access to continuous and comprehensive HIV treatment, as early as possible. Treatment should be integrated with strengthened TB, sexual, reproductive and maternal health-care services.
- All countries should remove barriers to the manufacture, import and export of life-saving generic medications in order to lower the costs of treatment, and use all available mechanisms to achieve simpler, affordable, high-quality antiretroviral therapy.
- National programmes should bring combination prevention to scale. Cultural and religious differences should not deter the provision of life-saving services.

3. Inspiring leaders

Strong leaders have a clear vision and use all ethical, technical and political means to achieve it. They take on difficult topics, seek evidence from stakeholders, and lead by example.

AIDS cuts across health, education, economics, justice, religion, labour and politics worldwide, and in hyperendemic settings it intersects with agriculture, water, sanitation, transport, housing, culture and sport. Because of this diversity, informed leadership is needed not only in government, but also from civil society, affected communities, scientists, trade unions, the media, faith-based organizations and the private sector.

- Countries should invest in new and courageous leaders, especially young people, to drive coordinated partnerships that engage with the communities where AIDS hits hardest.
- Leaders should challenge conventional wisdom and prejudices, promote fairness, and ensure the voices of minorities are heard.
- Programmes should be led by people who understand and use the power of inclusion and solidarity.

4. Investing and resourcing: getting smarter

All current and future investments need to be based on evidence and allocated with the "know your epidemic, know your response" principle. If done correctly, this will deliver high-impact interventions, 'tipping point' strategies, and evidence-informed planning, all designed to yield the maximum return on investment: the end of AIDS.

Long-term responses need to be financed by domestic expenditures where possible, although there will always be a need and a role for international financing. More resources are required to scale up the response. The Global Fund, UNITAID and other innovative financing mechanisms should be fully endowed by current and new donors.

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- UNAIDS should lead the development of a long-term (20 years) global investment and financing strategy, identifying the key elements, and the most cost-effective and efficient ways to fund them.
- Countries need to develop and apply evidence-informed investment criteria and tools to support the most effective and efficient use of resources for programming at community and national levels.
- National AIDS authorities should require all partners, domestic and international, to adhere to these criteria in order to maximize value for money.

5. Shared accountability

Thousands of people and organizations are involved in universal access at all levels. With so many resources on the line and so many millions of lives at stake, stronger systems are needed to monitor and account for how human and financial resources are deployed, and to measure their impact.

- National programmes must include people living with HIV and those most at risk in decision-making. They have the biggest stake in effective HIV programming; they know what is working, what is not, and why.
- Governments should be responsible and accountable for allocating resources where they are most needed, and for monitoring the impact of investments on achieving national targets aligned with global indicators.
- Recognized government authorities, such as parliaments, should exercise their oversight functions by calling for regular reporting from governmental, civil society and international partners in their national responses.
- The United Nations General Assembly should continue to hold biennial reporting on progress towards universal access. Regional economic and political communities should also hold routine reviews of progress until universal access is achieved.

Only global solidarity on these issues will change the trajectory of the epidemic, save lives and lead to zero new HIV infections, zero discrimination and zero AIDS-related deaths. «

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Georgina Theodora Wood, Chief Justice, Ghana

COMMENTARY

Jean Ping

Tide of progress sweeps across Africa

The African Union Commission Chairperson says the continent is ready to shed its needy image to be a land of opportunity.

For too long, Africa has been commonly perceived as the problematic continent, suffering from poverty, poor governance and AIDS, and having value only as a source of raw materials.

But the surprise story of the past decade has been Africa's emergence as the continent of opportunity. It has made significant economic progress and the most robust economies, such as those in Ghana, Botswana and South Africa, are wielding greater global influence. In 2011, Africa is expected to grow by 5.1%, the highest rate outside Asia. The World Bank says Africa has the potential to lead global growth in the next two decades.

That opportunity is being cemented as we break the trajectory of the devastating AIDS epidemic and realize the vision of zero new HIV infections and zero AIDS-related deaths.

Since the turn of the century, we have seen the first signs of decisive progress, with a more than 25% drop in new HIV cases in 22 countries of sub-Saharan Africa. Botswana, Namibia, South Africa and Swaziland have achieved the target of at least 80% coverage of treatment to prevent vertical transmission of HIV, and several others, including Mali and Côte d'Ivoire, are on track, with a five-fold coverage increase in the past two years.

At the African Union Summit in Kampala in July 2010, heads of states and governments extended the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, TB and Malaria Services by 2015. Member States pledged to commit 15% of their domestic national budget to health; Benin, Burkina Faso, Djibouti, Malawi, Rwanda and the United Republic of Tanzania are already consistently allocating an average of total government expenditures to health. The summit also agreed to intensify efforts to prevent vertical transmission of HIV and to improve maternal and child health, and a broad partnership was mobilized to realize these objectives.

The milestones in the fight against AIDS are matched in other social sectors. For instance, Burkina Faso nearly doubled the number of children in primary schools, while providing daily meals for all children and take-home rations for girls. Ghana has already achieved its target to reduce the proportion of under-nourished people, by increasing agricultural productivity through fertilizer subsidies and providing supplements and school-feeding programmes.

Rwanda was ranked first in the world in 2009 with women comprising more than 50% of the representation in the national parliament, while in Angola, Burundi, Lesotho, Mozambique, Namibia, South Africa, Tanzania and Uganda more than a quarter of the representatives in parliament are women.

Today's story of AIDS in Africa is one of optimism about progress, but with a warning to remain vigilant. The African Union has agreed to revitalize AIDS Watch Africa, which will be our continental instrument to lead advocacy efforts and monitor performance.

We are witness to a tide of progress sweeping Africa. The changing global economy has created new opportunities, and innovation, scientific developments, and shared knowledge and best practices on HIV, have been part of the new cycle of opportunity. «

Jean Ping was the Foreign Minister of Gabon from 1999–2008 and President of the UN General Assembly from 2004–2005.

Section Three

To the next level

End new HIV infections

For much of the world, what was once a death sentence is now a chronic illness, but there is still a long way to go. It is time to move beyond the emergency response of the past decade to a programme that is global in scope but meets the needs of each country; that is sustainable, efficient, and effective; that maintains the gains of the past decade and expands existing programmes to the people who are not receiving assistance.

For every three people who newly receive medication in low- and middle-income countries, five more people become infected. In 2009 there were 2.6 million new infections and reducing this number must be at the top of the agenda.

Meeting these two challenges – extending treatment to those eligible need, and controlling the spread of the disease – is a shared responsibility. It is a global challenge, and everybody has something to contribute.

HIV affects some people more than others, and AIDS responses in every sector need to overcome exclusion and stigma that facilitate HIV's spread. National health-care plans need to address particularly key populations at higher risk and recognize that health-care workers are often in the front line of the production and reproduction of stigma. Education and justice systems have to be models of inclusion and non-discriminatory practice. Many countries in almost all regions of the world do not have plans that adequately address the needs of men who have sex with men and people who inject drugs. «

Game changers in the drive towards zero

Major innovations in social, medical and communication technologies continue to help transform the AIDS response. Among the most exciting developments is the convergence between HIV treatment and prevention goals.

On 12 May 2011, the US National Institutes of Health announced the early closure of a clinical trial that tested the effects of early antiretroviral therapy on the risk of transmitting HIV. The trial included more than 1 700 couples in 13 sites worldwide. At the start of the trial, one partner in each couple was HIV-negative, while the other was HIV-positive but was not medically eligible for HIV treatment. The trial was stopped because of an early indication of very good results.

This compelling evidence of the high degree of effectiveness of antiretroviral drugs in reducing the likelihood of HIV transmission has been described by UNAIDS as a 'game changer', and it opens up a new front in HIV prevention.

The challenge is to bring innovation rapidly and effectively to the populations in need – and the priorities range from financing and implementation architectures, to eradicating social stigma, reducing medication toxicity, and making the right to 'know your HIV status' a reality for all.

2.6 million

There were 2.6 million new HIV infections worldwide in 2009

End new HIV infections – continued

Need to do better: tools requiring scale-up

These tools, used in combination, are proven ways to turn the tide of the AIDS epidemic.

- Treatment, care and support for people living with HIV: Closing the treatment gap is a clear and pressing global priority. Fully realizing the potential of antiretroviral therapy to save lives and prevent illness also requires proper attention to co-infections, especially tuberculosis (TB). AIDS programmes do not adequately screen for TB and other treatable infections. TB is the most common cause of death for people with HIV; 25% of all TB deaths are in people with HIV, and there are one million cases of TB in people with HIV a year.
- Preventing vertical transmission: The goal of eliminating new infections in children has inspired an unprecedented coalition of partners united in their determination to overcome development challenges and close this prevention gap.
- Male circumcision: Clinical trials show it reduces the chance of men becoming HIV-positive by about 60%. So far, 400,000 circumcisions have been undertaken since it has been recommended by UNAIDS and WHO for countries with high prevalence and low rates of circumcision.
- Social and behavioural change communication: Underlying the reductions in HIV incidence over the past decade have been changes in behaviour; in particular, fewer partners, condom use with casual partners, and fewer young people becoming sexually active at an early age. Sustaining these behaviours needs constant reinforcement.
- Focused efforts in key populations: Efforts that involve and support sex workers and their clients, men who have sex with men, and people who inject drugs are among the most direct measures to curb HIV incidence, yet they are still far from universal.
- Condom promotion and distribution: Condom use is still far too low. Estimates from 23 countries with high HIV prevalence indicate that while there has been an overall increase in condom use, about three quarters of people had not used a condom the last time they had sex. Female condom programming has advanced but still has great growth potential. Overcoming the barriers to a broader scale-up, namely, their unaffordability and the lack of a secure supply chain, will help give women a powerful prevention tool.
- Testing is underutilized: The right to know your HIV status and the enabling environment to act upon it – whether to access treatment, support behaviour change, or expand options for discordant couples – is far from a reality. Most people still do not know they have HIV until they develop symptoms of AIDS. Levels of testing in high-burden countries vary dramatically, from 4.8% of women in Cameroon to more than 42% in Lesotho. Community approaches that mobilize demand for testing while also bringing down barriers of fear and stigma hold great promise.

Champion a prevention revolution by:

- focusing evidence-informed and rights-based efforts on the populations that account for the largest share of new infections and by intensifying proven interventions in transmission hotspots;
- ensuring protective laws, supportive law enforcement and access to justice;
- scaling up research investments to accelerate the development of vaccines, female-controlled methods, microbicides and other prevention tools.

From the Report of the Secretary-General to the 65th General Assembly of the United Nations: Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths.

Share responsibility to build sustainable outcomes

To move beyond the emergency approach in the AIDS response, more diverse sources of funding are required. As more countries have recognized their national interest in a decisive AIDS response, the need to mobilize additional domestic funding has also been acknowledged. Yet few countries in sub-Saharan Africa, for example, have met the targets they set in Abuja in 2001 for their health budgets. If high-burden countries allocated their domestic investment to the HIV response in proportion to the disease burden and the size of the health budget, the domestic investment in sub-Saharan Africa would almost double, and much of that increase would come from the region's largest economy, South Africa.

The next major shift needed for a more effective AIDS response is country ownership; not only is it central to sustainable AIDS responses, it is also the key path to improved aid effectiveness. National ownership means inclusive multisectoral national leadership at all levels in managing the design and implementation of effective AIDS policy and strategy, and assuring results-based mutual accountability. Countries and donors need to move from short-term aid commitments to longer-term financing that is both predictable and sustainable. Increased incentives are needed to foster greater country partner ownership of national AIDS policies and programmes, together with the aggressive development of technical assistance delivered by providers in the South and through South-South cooperation.

AIDS is not just a medical problem. The response to it should be better integrated into existing health systems, particularly women's health programmes, and into community, justice, education, social protection and welfare systems, so that prevention and treatment are administered more effectively and capacity is built across systems as a whole. «

Forge a revitalized framework for global solidarity to reach universal access to HIV prevention, treatment, care and support by the year 2015 by:

- exercising inclusive and accountable leadership;
- meeting fair-share commitments to reach investment needs;
- strengthening the capacity of national institutions, community systems and human resources for health.

Secretary-General's Report, 2011

COMMENTARY

Edwin Cameron

Liberated from a silent darkness

The South African justice reveals how he overcame fear and shame to reveal his HIV-positive status.

In 1999 I decided to go public about my HIV status. I had kept it secret since I was diagnosed in 1986. Despite all the death and suffering in Africa, the epidemic was characterized by silence, fear, and shame. To speak out seemed essential. But I had to battle my own fear and shame. Doing so was one of the most potent and liberating decisions in my life.

The murder of Gugu Dlamini was pivotal. In late 1998 she was stoned and stabbed to death by neighbours who heard her say on radio she had HIV. This unprotected, impoverished woman spoke out, and died. How could I, protected in my middle-class privileges, keep quiet? In November that year, Simon Nkoli, a brave activist who had publicly stated he had AIDS, also died. I talked at his funeral service about the significance of his openness about AIDS. Yet I was still silent.

I was in tremendous inner conflict. I was a human-rights advocate fighting for justice and equality, repelling ignorance and fear, yet living in fear and silence myself. The imperative was to end this disjuncture. My secret status and public profile had to find union.

The epidemic also needed voices. I knew I could not be the voice of the epidemic in Africa. I was a white man on a black continent, a gay man in the midst of a heterosexual epidemic, a relatively affluent person, living on treatment, in a continent of poverty. But I spoke out so my voice could help end the silence.

Twelve years on, there is much cause for optimism. The medical management of HIV is well understood and treatment works well. Antiretroviral therapy has also redefined the social response to the epidemic. In South Africa we have Dr Aaron Motsoaledi, a committed and informed health minister who embodies the no-nonsense, "stop agonizing and get it done" approach we need.

But the number of daily infections is cause for dismay and sorrow. Changing people's patterns of sexual behaviour is a big task. Here, gender and human rights are central. Women are disempowered in law, they are socially and politically subordinate, and being able to say how and when they are willing to have sex is not a reality for many.

HIV has always been an epidemic of the vulnerable and legally disenfranchised. It emerged among gay men when homosexuality was illegal in most of the United States of America. It still burdens injecting drug users, sex workers, and Africa's poor. People on society's fringes face immense barriers to access medical care, HIV diagnosis and treatment. Above all, stigma remains a defining feature.

People in high office across Africa are still reluctant to talk openly about living with HIV. We have the voices of doctors, social scientists and politicians, but need the voice of every person with or at risk of HIV. When we can all speak freely and fully, in claiming treatment and fairness and non-discrimination in health care and jobs, we will have begun to normalize HIV. «

Edwin Cameron is a Constitutional Court justice and the first senior South African official to state publicly he was living with HIV.

Ensure mutual accountability for universal access

Accountability, measuring and evaluation, and a focus on results (not just spending) must be core components of any plan. The global AIDS response prides itself on tracking epidemiology and treating more people than almost any other disease programme, but a built-in mechanism to measure success and identify areas that are not working is still lacking. It is time for the AIDS community to adopt a systematic approach to measuring effectiveness.

Every programme should be able to answer this basic question: is the money doing what it is supposed to do? The focus must shift from outputs (the number of people covered by services or receiving medication) to outcomes (halting the increase in new cases and helping people who are infected lead healthy, productive lives).

The case for smarter metrics focused on lasting outcomes is nowhere more evident than in HIV treatment. The evidence we have now, and there is not enough of it, suggests that our focus on distributing medication alone is insufficient: a 2007 study in sub-Saharan Africa found that after two years, an average of 40% of patients who had been in HIV treatment programmes had stopped taking their medication. The next frontier is how to keep treatment effective over the long term. Social, economic and educational factors all play significant roles and must be addressed. "Top-down" approaches are valuable for reaching scale, but can easily fall apart on the ground unless there is significant community engagement, and better again, if the projects are developed from within the community.

The smarter-aid approach focuses on identifying, measuring and scaling up programmes that work. One strong example of this is the campaign to reduce vertical HIV transmission, which affected an estimated 400 000 children in 2009. A good prevention programme can reduce the risk of infection from 40% to less than 5%. Using this approach, South Africa, with one of the world's highest AIDS burdens, has drastically reduced the rate of vertical transmission with 90% coverage. In sub-Saharan Africa overall, the percentage of under-five deaths due to HIV has been falling, from 5.4% in 2000 to 3.6% in 2009.

But making it work means more than just handing out drugs. It requires a multifaceted, multidisciplinary approach that integrates cutting-edge science with local involvement. Often the best responses to complex problems come from home-grown solutions, which can address vital aspects of the AIDS response and avoid the perverse incentives and unintended consequences that often undermine the well-intentioned efforts of international aid organizations. «

Commit to forging robust mutual accountability mechanisms to translate commitments into action by:

- setting ambitious national targets with periodic reviews of progress;
- developing a revised framework of core global indicators;
- reporting progress at the 2013 Millennium Development Goals (MDG) special event and subsequent MDG reviews;
- establishing annual peer-based regional reviews, organized by competent regional political bodies;
- ensuring substantive participation in national and regional reviews for delegations of civil society and affected communities, including people living with HIV, people who use drugs, men who have sex with men, people who buy and sell sex, and young people.

Secretary-General's Report, 2011

Break the upward trajectory of costs

The global AIDS response is at a critical tipping point. Significant funding is needed to maintain the gains of the past decade and extend them to the millions more who need help. Today the disease affects more than 34 million people [30.9-36.9 million]. At least nine million of them in low- and middle-income countries are eligible for treatment and are not getting it, according to the World Health Organization.

To meet these challenges requires strengthened commitments, smarter investment and rethinking past approaches. Put simply, more lives have to be saved with more effective and efficient treatments, and more people have to be prevented from contracting HIV. To promote strong and effective prevention, continue existing treatment programmes and provide help to those being neglected, funding must be increased.

Universal access to HIV prevention, treatment, care and support can be achieved by 2015 with a boost in funding. The increase in funding since 2001 has already delivered dividends, but levels are insufficient to turn the tide of the epidemic. Taking into account synergies between programme elements, potential efficiencies in treatment delivery, and the impact of treatment on prevention, a 2011 investment framework proposed by UNAIDS and its partners found a more focused annual investment of at least US$ 22–23 billion would be needed by 2015, US$ 6 billion more than the US$ 16 billion now available. This would be a sound investment in the future: by 2020 the return on this investment would be 12 million more infections averted than would be possible with current funding levels, and 7.4 million more deaths averted.

The strides we have made in the response to AIDS have been the result of a unique collaboration that has brought together new technology and medicines with creative, and sometimes unorthodox, methods for using them. Examples include the insistence on including marginalized groups as part of the solution, not the problem; rejecting the notion that "expensive" health care should not be available to people in poor countries; overcoming traditional pricing practices to make medicines affordable; and developing combination therapies that have given millions of people a new lease on life.

It is now possible to halve the current rates of HIV infection, but that can only happen if we increase the pace of innovation. It is time to focus, streamline and intensify our efforts. We must move beyond traditional boundaries in dealing with disease and how we fund our response to it, as the old dynamics of geopolitical power become increasing multipolar, while distinctions between the rich and the poor expand further.

Already we are seeing many novel strategies that are taking us in the right direction. Among them: directing antiretroviral therapy to the site of infection, so that HIV can be effectively blocked from entering the body (e.g. delivering microbicides to the genital tract); uncovering potentially powerful vaccine candidates as a result of research on antibodies; and making creative structural changes, such as moving from rigid institutional approaches to more inclusive, community- and network-based responses, and helping people take charge of their own health care.

At the same time, we face many new challenges. A case in point is the urgent need to bolster adherence to medication programmes and intensify follow-up and supervision. This requires a multipronged response: point-of-care diagnostics, increasing the use and training of community support workers, and reworking the clinical relationship between physician and patient. «

Deliver more efficient and sustainable programmes by:

- catalysing efficiency-generating innovation in treatment access – the Treatment 2.0 agenda;
- maximizing efficiency in non drug-related costs, including by decentralizing services, task-shifting and building the capacity of community health workers, and strengthening community systems;
- ensuring that synergies are exploited between the HIV response and efforts to achieve the Millennium Development Goals.

Secretary-General's Report, 2011

COMMENTARY

Amadou Toumani Touré

Calling all youth to be leaders

Thirty years into the response to HIV, an estimated 3000 young people are newly infected with HIV every day. This is why I hosted a summit in Bamako, Mali, on 15–17 April 2011, bringing together more than 150 young HIV activists from across the world to rally a youth-led response on HIV. The Call to Action adopted at the summit underlines one of the key elements for discussion at the UN General Assembly Special Session on AIDS in June 2011.

In my opening address to the summit, I called upon youth leaders there and around the world to serve as an example to others: to reduce HIV transmission through information and sensitization campaigns directed to the most vulnerable groups; to eliminate mother-to-child transmission; and to repel all discrimination and stigmatization related to HIV and AIDS. These should be, I told them, their new HIV 'commandments'.

Youth must not carry this burden alone. Nation states have a crucial role to play in the vast mobilization that is needed to tackle this pandemic. Mali, for example, has made considerable progress since 2004. The number of testing centres has increased 10-fold, from 26 to 260. Treatment sites have expanded from nine to 67, and the number of patients receiving antiretroviral therapy has grown from 3300 in 2004 to more than 27 000 today. Mali has conducted a number of sensitization campaigns and adopted a new bill to protect individual rights of infected and affected people. The state budget allocated more than US$ 5 million per year and has also established a national fund for HIV and AIDS.

There does not have to be an 'AIDS fate' in our countries. But we cannot afford to lower our guards. Our vigilance must be permanent. Young people must be given the space to lead. I encourage the youth of the world to redouble their vigour and be leaders in the response to HIV and AIDS. «

Amadou Toumani Touré is the President of Mali.

Social revolution needed for health of women and girls

There are many factors that drive the spread of HIV in women and girls: poverty and economic disparity; lack of education; violence, or the fear of violence; and the lack of sexual and reproductive health services. The combination of these factors makes it difficult for women and girls to access HIV prevention, treatment and care services.

A comprehensive approach must be adopted. AIDS education, testing and care are often not integrated with sexual and reproductive health programmes. In many countries, sexual issues for girls are a taboo subject. This needlessly increases their risk of HIV infection.

Upholding human rights and protecting against stigma and violence are essential to responding more effectively to HIV among women and girls. Access to effective contraception and safe abortion must be recognized as a human right. Legal protections must be in place and enforced to stop violence against women.

Many adolescent girls fear revealing their HIV status to a sexual partner due to concerns about the impact such disclosure may have on maintaining a relationship. Because of the lack of integration of HIV prevention with sexual and reproductive health, service providers are not equipped to identify or care for this "hidden population" of adolescents who fear the stigma and discrimination that disclosing their status will bring.

National AIDS plans and programming must have significant input from women's groups to ensure the interventions are designed and implemented to meet the needs of women and girls living with and at risk of HIV. That means integration with sexual and reproductive health services, ranging from contraception to natal care, abortion and post-abortion care, and comprehensive medical care. «

26%

More than a quarter of all new HIV infections globally are in young women aged 15–24

Young leaders share vision, demand rights

Ensure that the status of women and girls in our societies and our responses to HIV promote their health, human rights, security and dignity by:

- reversing harmful gender norms;
- providing equal rights and equal access to justice and security for women and girls;
- protecting the rights of women and girls living with HIV, including their sexual and reproductive health and human rights;
- strengthening social protection, care and support;
- scaling up programmes to eliminate gender-based violence;
- ensuring national responses meet the HIV-specific needs of women and girls;
- delivering a comprehensive, integrated HIV, TB and sexual and reproductive health package addressing the broader health needs of women and children.

Secretary-General's Report, 2011

HIV is the leading cause of death of women of reproductive age.

The number of girls aged 10–14 living with HIV has grown from about 50 000 in 1999 to more than 300 000 in 2010.

In Southern Africa, young women are up to five times more likely to become infected with HIV than young men.

An estimated 12–18% of all pregnancy-related deaths are due to HIV.

In the past three decades, AIDS has gone from being a global threat to a global movement, a disease of stigma to a path to empowerment, and from a neglected illness to a shared responsibility. We can turn the tide of AIDS, but only if we do it creatively, bravely, and together.

The global youth summit on HIV in Mali in April 2011 appealed for youth empowerment to usher in a new generation of AIDS leadership.

The vision of a world with no new HIV infections, no AIDS-related deaths and no discrimination has been enthusiastically embraced by today's generation of global leaders. But the sobering fact is that most of these leaders will not live to see this vision realized.

This responsibility must pass to a new generation of leaders who are already poised to lead a stronger, more resolute and sustained AIDS response. The same refusal to accept the intolerable, demand for rights to be respected and appeal for mass mobilization for a better world that have been in evidence in 2011 on the streets of Egypt, Tunisia and other locations, are already being heard in the response to resist the ravages of AIDS. «

COMMENTARY

Maged El Sayed El Rabeiy

Harnessing the power of youth

The HIV-positive Egyptian says young people can change the face of the epidemic worldwide.

My journey with HIV began three years ago when I was going to do military service and was diagnosed as HIV-positive. Since I was a child I had known the modes of HIV transmission, and I guessed I would be one of the infected persons, but when guessing became reality, I refused to accept it. At that time I was shocked, as I used to consider HIV a disease of no treatment, a disease of death.

A few months later, I joined The Friends of Life, the only nongovernmental organization in Egypt supporting people living with HIV and providing them with care. I was surprised when I saw others just like me: children, women and young people, all living with HIV. Now my life is changed completely. It is a life with a heavenly mission to help my peers who are suffering, sharing their pain, providing care and support, and preventing others from passing on HIV.

Living with HIV does not limit our humanity. People living with HIV, young people in particular, have the same rights to dignity, health and health care, education, work, housing, and freedom of marriage, assembly and self-expression.

HIV in Egypt is surrounded by the three S words: stigma, silence and shame, due to religious and social norms. All of these lead to increased discrimination against people living with HIV, but they do not limit our human rights. Breaking the silence of society and giving people living with HIV the opportunity to reveal themselves openly can significantly change the face of HIV in Egypt.

Just as young Egyptians changed our country's destiny in January 2011, so can young people worldwide change the face of HIV. We can do it because young people are powerful, energetic and organized. Young people living with HIV can also participate in preventive intervention, as they are the most capable of reaching their peers, raising awareness and correcting misconceptions. Their participation is essential to ensure HIV programmes achieve their target of greater involvement of people living with HIV.

My message for all young people living with HIV is this: we have to join together as one united power, to defend our rights and prevent others from passing on HIV. The battle does not end until we fulfil our vision: zero new HIV infections, zero discrimination and zero AIDS-related deaths. «

Maged El Sayed El Rabeiy is a project coordinator with The Friends Of Life organization in Egypt.

Tutu urges young leaders to keep hope alive

Archbishop Desmond Tutu urged all those involved in the AIDS response to "keep hope alive", as he passed the baton of leadership for HIV prevention to a new generation of leaders in symbolic ceremony on Robben Island on 3 May.

The island off the coast of Cape Town in South Africa was an inspirational setting for Archbishop Tutu, co-chair of the UNAIDS High Level Commission on HIV Prevention, to reinforce to his fellow commissioners and special guests the depth of the AIDS challenge and to urge those touched by the epidemic not to lose hope during the long days of struggle. The site of the former prison where Nelson Mandela and other political prisoners were detained during the apartheid era has become a powerful testimony to the endurance of the human spirit and its ability to bring about change in the face of imposing barriers.

The Archbishop, who is retiring from public life, spoke of the lost years in South Africa's AIDS response, when people were left to perish even though the means to save their lives were in place. He implored the group to focus on the goodness in humanity, adding that "God smiles" when he hears of the work for an HIV-free world. As the voices of the Treatment Action Campaign choir rang out, the 79-year-old cleric called forward an emblematic group of young people from across the world, each member dedicating themselves to the HIV prevention revolution and to mobilize their peers and communities in a renewed, revitalized AIDS response.

These young leaders brought to Robben Island the Bamako Declaration: the Mali call to action for new leadership in the HIV response.

Inspired by the spirit of Robben Island, a series of specific commitments were made during the ceremony to further the prevention response:

- Former National Basketball Association player Earvin 'Magic' Johnson announced his foundation would be a founding partner in a global fellowship programme for young people.
- The Elena Pinchuk ANTIAIDS Foundation in Ukraine announced it would establish a global competition for youth social media projects in HIV prevention.
- The Global Centre for Innovation in Mobile Health, together with Cell-Life of South Africa, pledged to work with UNAIDS and mobile service providers to promote HIV prevention and behaviour change dialogue through the use of mobile phones.
- A new 'stand-with' movement will be created to inspire digitally networked young people to work together against HIV.
- MTV international said it would directly involve young people in its HIV programming efforts.

The delegates wholeheartedly endorsed the involvement of young people every step of the way and were particularly moved by the commitment made by Claire Gasamagera from Rwanda. Born with HIV and the head of her household of four since the age of 17, she has dedicated herself to helping lead the generation that frees the world of HIV.

Gasamagera told the meeting that no one believed she would survive, but here she was, in her 20s and excited to be attending the High Level Commission in the presence of Archbishop Tutu and other world leaders and dignitaries. Gasamagera pledged to use her knowledge, skills, experiences and leadership to ensure that young people living with HIV in her country were empowered and their initiatives supported so that they might take their rightful places at the front line of the HIV response. «

"Keep hope alive and focus on the goodness in humanity."

COMMENTARY

Rachel Arinii Judhistari

Youth demand a say in shaping destiny

This women's rights campaigner says young people are ready to lead the way – not tomorrow, but now!

I am 22 years old. I come from Indonesia, from a religious background, and have experienced what it means to be a young woman in today's world. I have friends who have been raped, married off at a young age, sexually harassed, and suffering from HIV and AIDS. Some of these things happened to me and I was not supported to demand justice.

When I was 15, my teacher gathered us for a special meeting. A male guest in a doctor's coat accompanied by our imam told us that condom campaigns were propaganda to make people lose faith in God and turn us into sinners. None of the girls could ask questions because they said only boys were at risk. This was our sexual education. I was refused by the clinic when I went for HIV testing. They said it was because I was too young and not married. But I know that I am also too young to die of AIDS.

Young people are a diverse and complex group, but one thing we have in common is that we are especially vulnerable to HIV. We have rights, but sadly, young peoples' lives still remain challenged by poverty, inequality and violence. We account for 40% of new HIV infections, but youth HIV programmes do not account for 40% of funding.

We have to do better than this. Who do we hold accountable?

We call on governments, United Nations agencies and decision-makers to promote accurate, timely, gender-sensitive and evidence-based sexuality education for young people. This should recognize the rights of young people to enjoy their sexuality in a safe and pleasurable way, free from coercion, discrimination and violence.

Young people demand youth-friendly sexual and reproductive health services, including HIV counselling, testing, and treatment. These services should be delivered by trained health providers who respect the diversity and right to confidentiality of young people, especially young women and girls.

There are a multitude of youth-led initiatives and networks. They cut across geographical, ideological, political and other boundaries. Young people have a natural ability to reach out to their peers and to others. HIV initiatives should reach out to youth-led networks to connect with young people, better understand their needs, and tap into the unique attributes of young people.

We young people are often called the leaders of tomorrow, but we are the leaders of today, and we demand a seat at the table where decisions that affect us are made. «

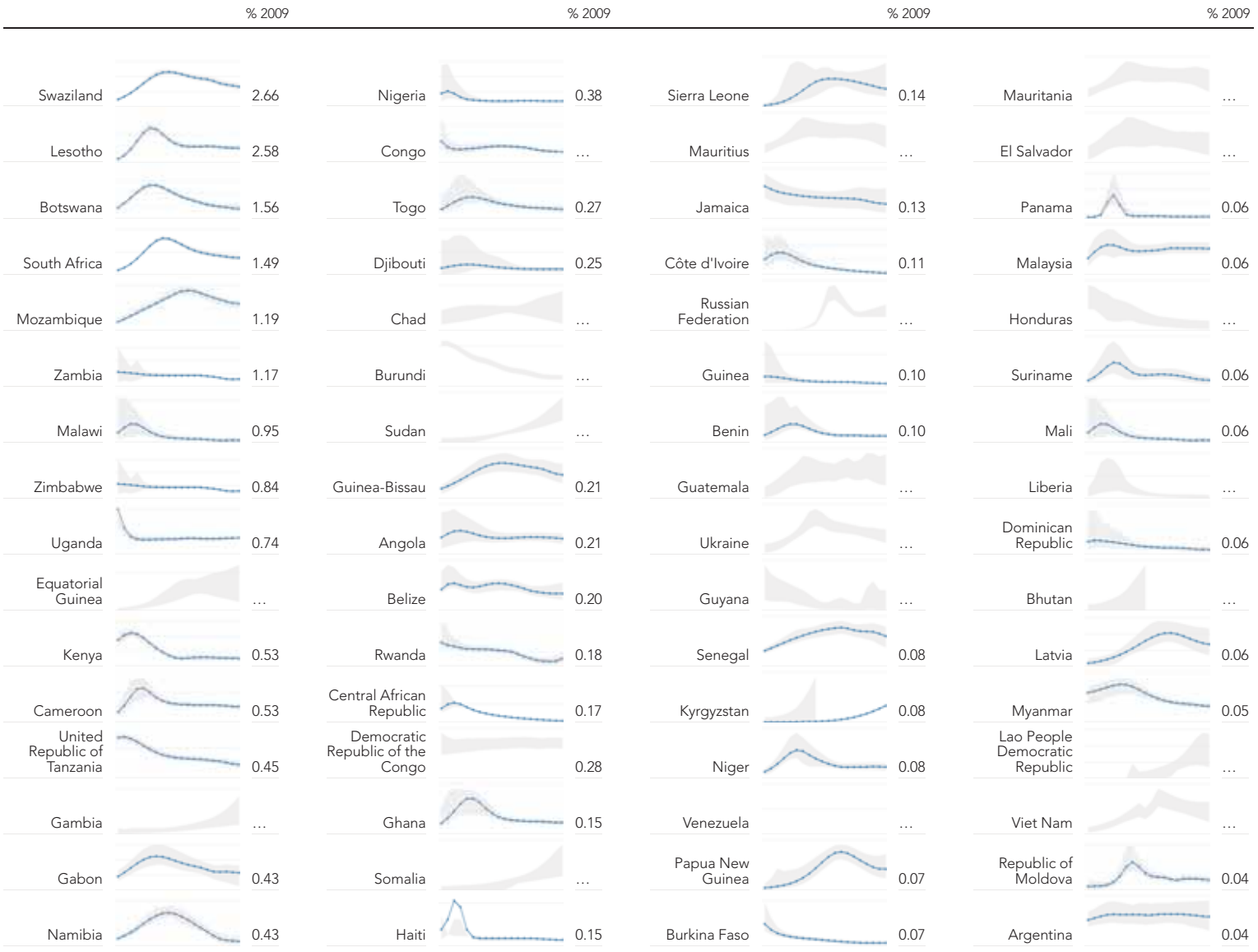
Rachel Arinii Judhistari is the regional focal point for Asia and the Pacific at the Global Youth Coalition on HIV/AIDS, and the founder of the Indonesian Independent Youth Alliance. She is also a programme officer for women's health and rights and advocacy partnerships at ARROW, the Asian-Pacific Resource and Research Centre for Women.

Section Four

Scorecards and sources

HIV incidence

HIV incidence among 15–49 year olds, 1990–2009

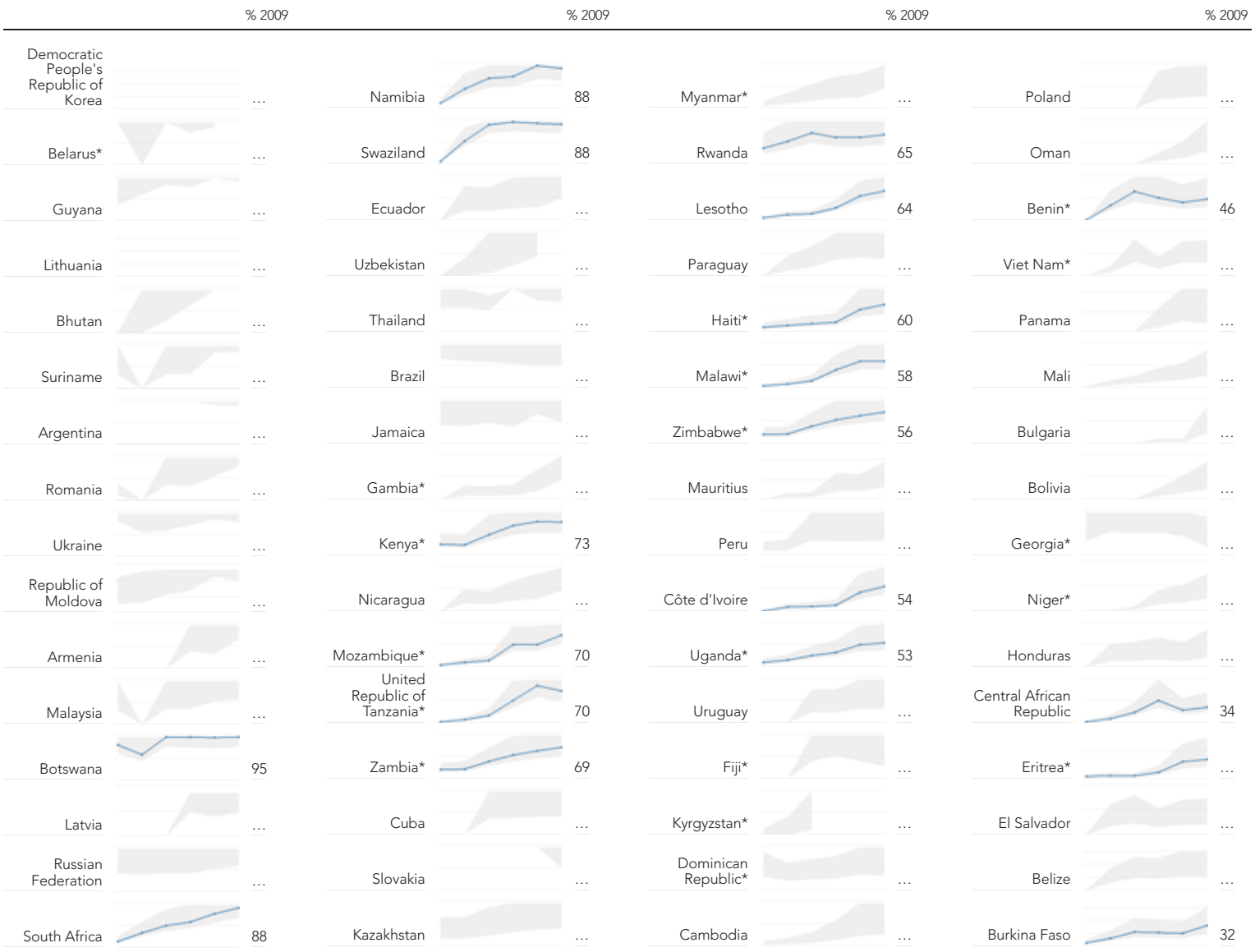


HIV incidence

HIV incidence among 15–49 year olds, 1990–2009

ARVs to prevent new child infections

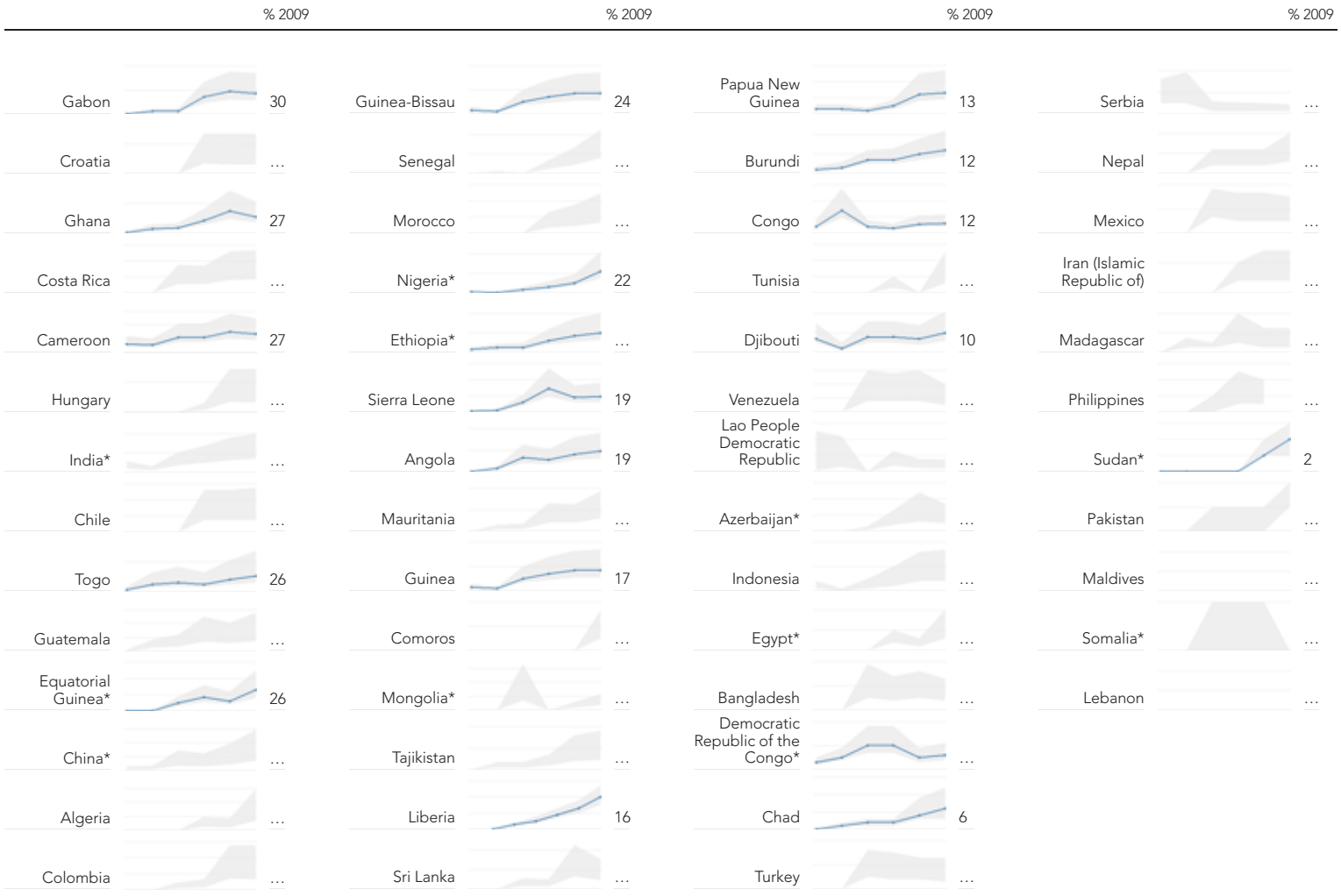
Pregnant women living with HIV who received antiretrovirals to prevent HIV transmission to their children, 2004–2009



* Countries that had not yet phased-out the use of single-dose nevirapine as an intervention to prevent mother-to-child transmission by May 2011.

ARVs to prevent new child infections

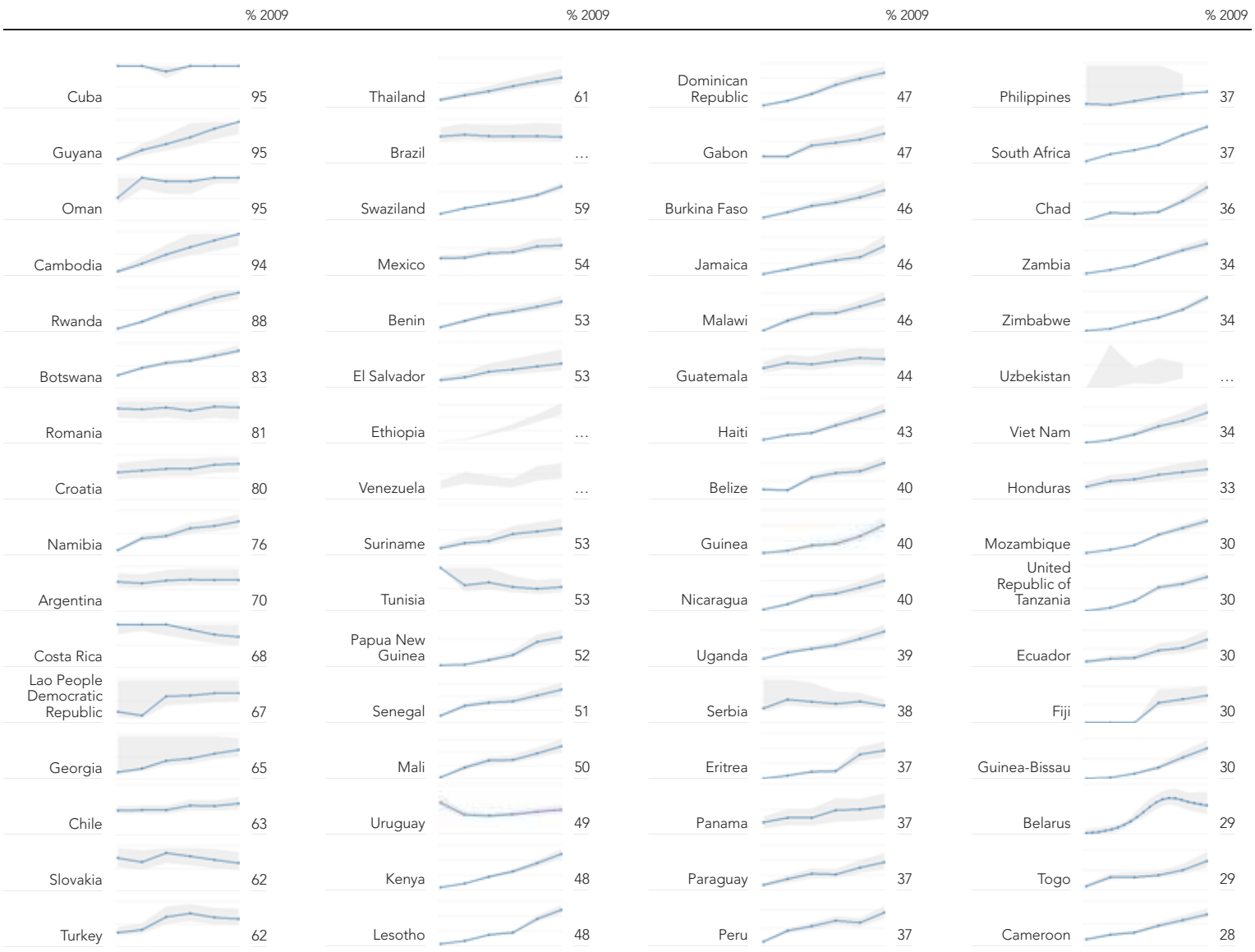
Pregnant women living with HIV who received antiretrovirals to prevent HIV transmission to their children, 2004–2009



* Countries that had not yet phased-out the use of single-dose nevirapine as an intervention to prevent mother-to-child transmission by May 2011.

ART coverage

Coverage of antiretroviral treatment for people with CD4 counts less than 350, 2004-2009



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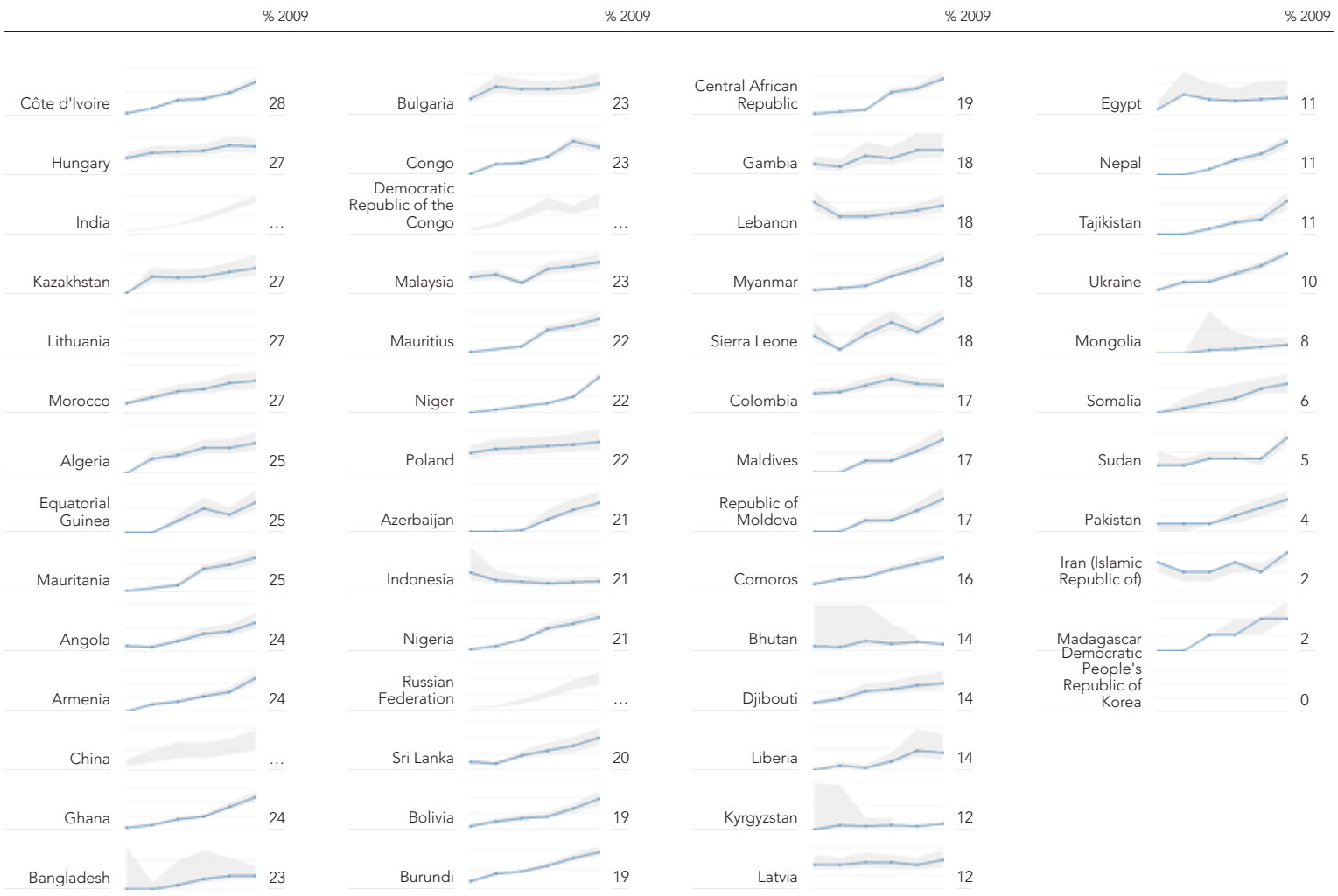
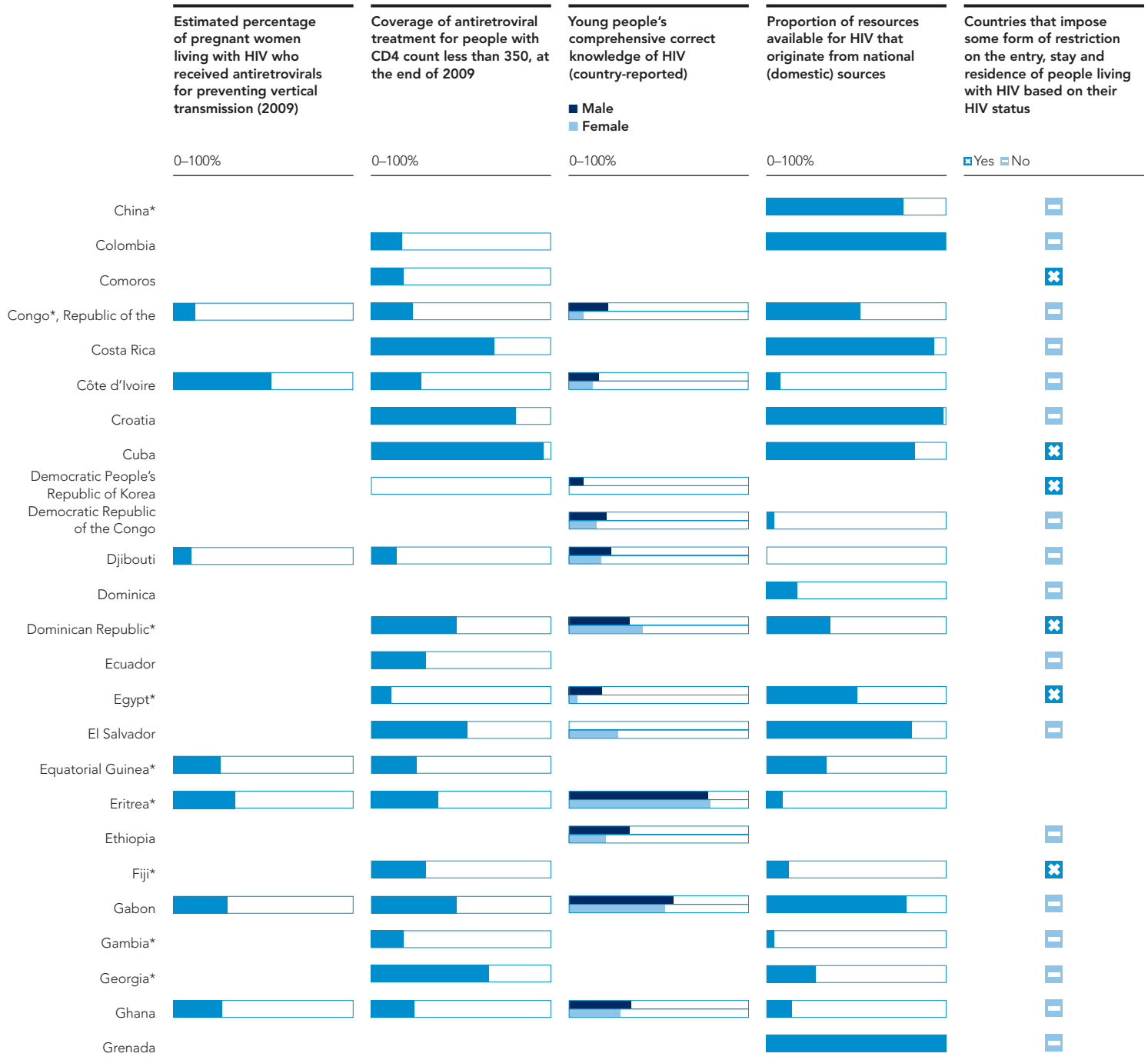


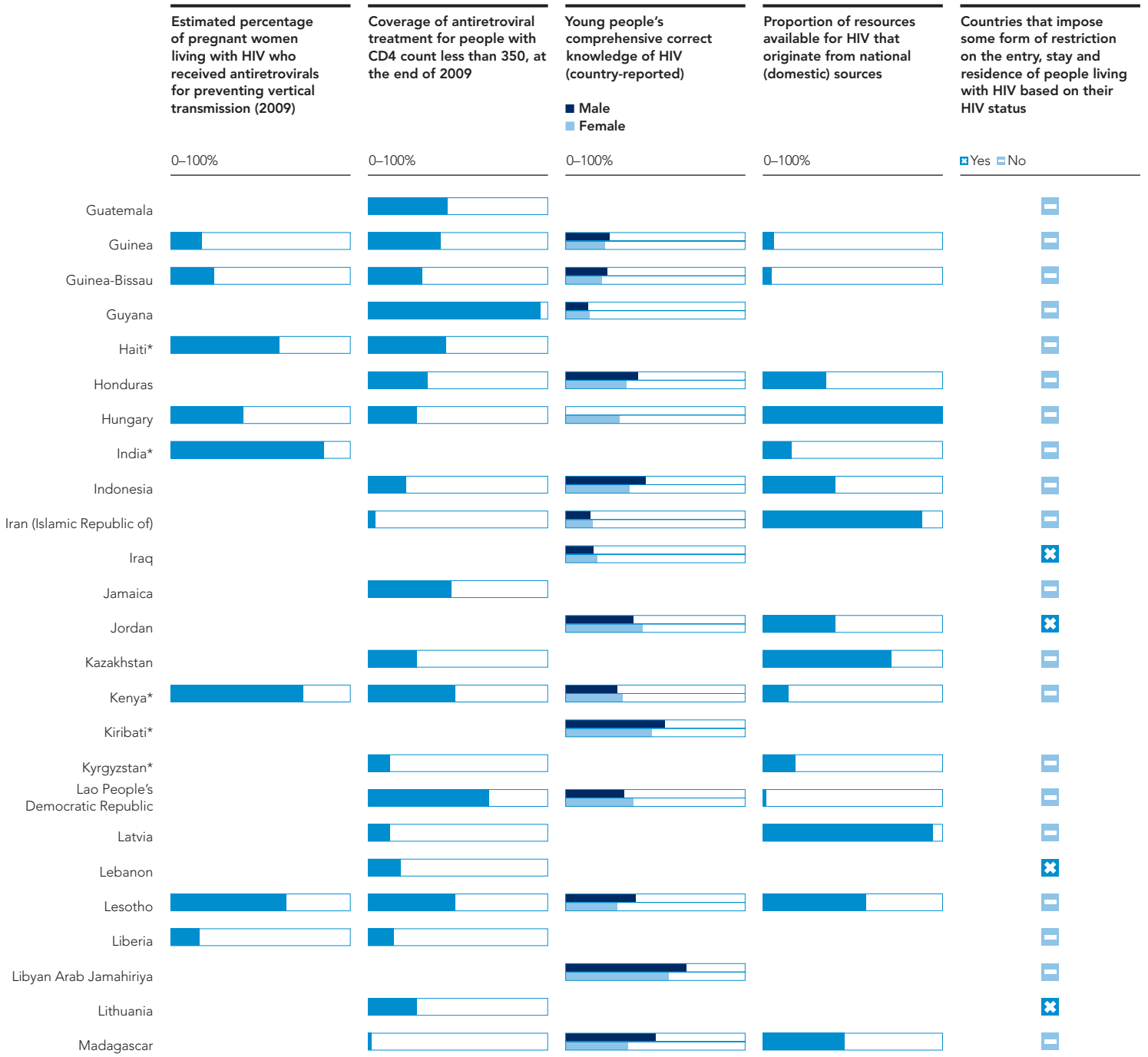
HIV Progress Indicators

* Countries that had not yet phased-out the use of single-dose nevirapine as an intervention to prevent mother-to-child transmission by May 2011.

HIV Progress Indicators – continued

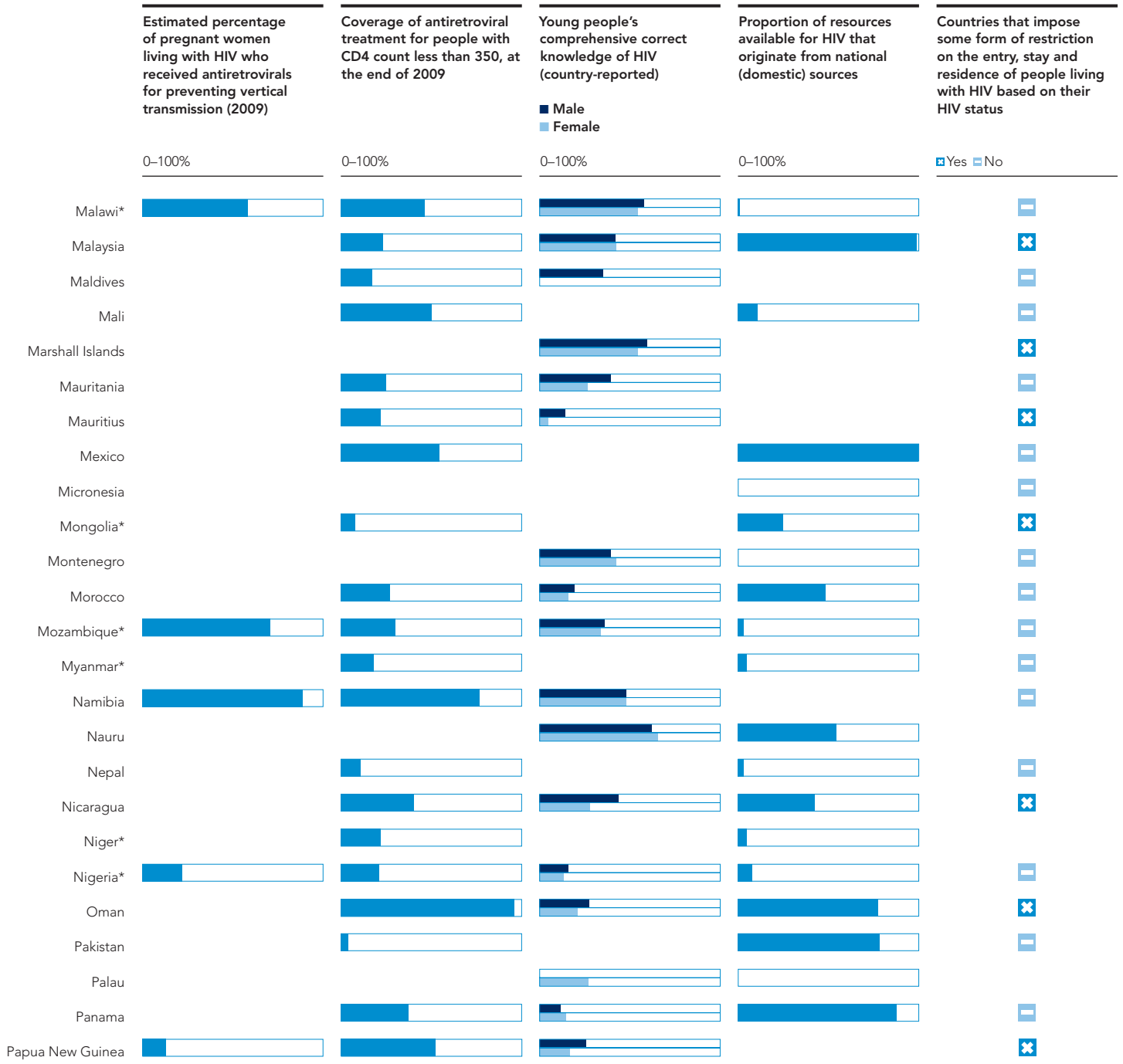


* Countries that had not yet phased-out the use of single-dose nevirapine as an intervention to prevent mother-to-child transmission by May 2011.

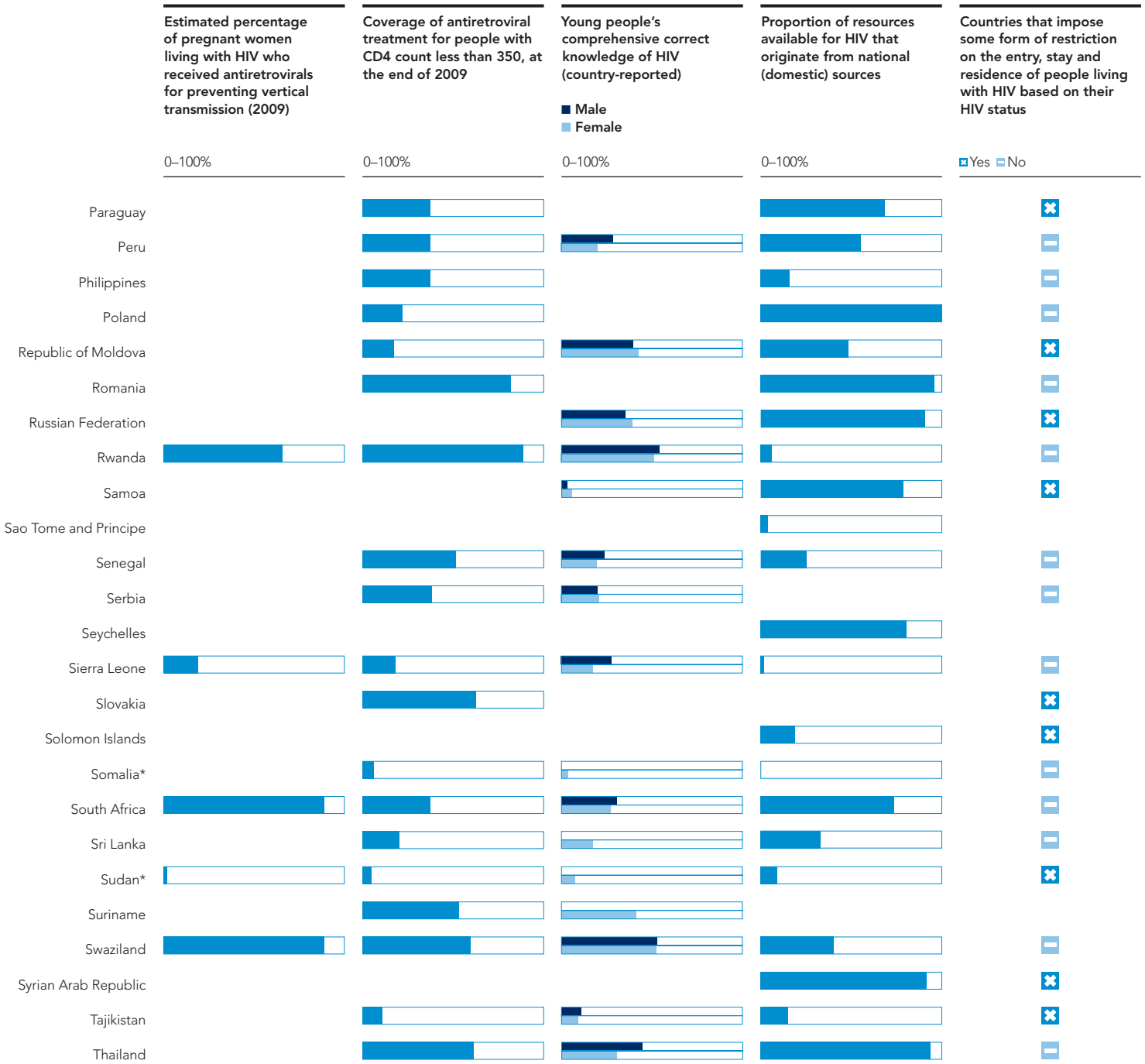


* Countries that had not yet phased-out the use of single-dose nevirapine as an intervention to prevent mother-to-child transmission by May 2011.

HIV Progress Indicators – continued



* Countries that had not yet phased-out the use of single-dose nevirapine as an intervention to prevent mother-to-child transmission by May 2011.



* Countries that had not yet phased-out the use of single-dose nevirapine as an intervention to prevent mother-to-child transmission by May 2011.

HIV Progress Indicators – continued

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