MDG6

SIX THINGS YOU NEED TO KNOW ABOUT THE AIDS RESPONSE TODAY

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MDG 6:
COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

THE HIV RELATED TARGETS OF GOAL 6 INCLUDE:

A. HAVE HALTED BY 2015 AND BEGUN TO REVERSE THE SPREAD OF HIV/AIDS

B. ACHIEVE, BY 2010, UNIVERSAL ACCESS TO TREATMENT FOR HIV/AIDS FOR ALL THOSE WHO NEED IT

INDICATORS TO MEASURE PROGRESS

- HIV PREVALENCE AMONG POPULATION AGED 15-24 YEARS
- CONDOM USE AT LAST HIGH-RISK SEX
- PROPORTION OF POPULATION AGED 15-24 YEARS WITH COMPREHENSIVE CORRECT KNOWLEDGE OF HIV/AIDS
- RATIO OF SCHOOL ATTENDANCE OF ORPHANS TO SCHOOL ATTENDANCE OF NON-ORPHANS AGED 10-14 YEARS
- PROPORTION OF POPULATION WITH ADVANCED HIV INFECTION WITH ACCESS TO ANTIRETROVIRAL DRUGS

LEVERAGING THE AIDS RESPONSE FOR MILLENNIUM DEVELOPMENT GOALS

There is a lot to be hopeful for as we approach the milestone of reaching the Millennium Development Goals (MDGs) by 2015. Much has been achieved – fewer people are dying from AIDS-related illnesses and the rate of new HIV infections has fallen by nearly 20% in the past 10 years. Recent breakthroughs in HIV-prevention research – such as woman-initiated and -controlled microbicide gel combined with the increasing scale-up of male circumcision – hold promise for both women and men to protect themselves from HIV. The AIDS epidemic is beginning to change course, but these gains are fragile. Current strategies for HIV prevention, treatment, care and support will not take us to our ultimate goals.

But I remain an incorrigible optimist. We can achieve UNAIDS' vision of 'Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths.' Getting to zero will mean reshaping the AIDS response.

This requires sustained leadership, innovation and predictable financing. As the AIDS response reaches the tipping point, we must redouble efforts to achieve universal access to HIV prevention, treatment, care and support.

We must also take AIDS out of isolation, leveraging investments in the global AIDS response to support progress across all other MDGs, including supporting the United Nations Secretary-General's Global Strategy for Women's and Children's Health. The AIDS response should be the bridge that connects other movements: maternal and child health, sexual and reproductive health, gender equality, sexual violence, and even the response to women's cancer. We must move beyond the false notion that health priorities steal from each other.

World public opinion is strongly behind a re-energized AIDS response. A first-time public global opinion poll conducted by UNAIDS shows that the majority believe that the AIDS epidemic can be pushed back by 2015. But the general public is also calling on the world to do better. We must not fail the 33.3 million people living with HIV at this defining moment of the AIDS response.

Michel Sidibé
Executive Director

1. New HIV infections are falling.

From 2001 to 2009, the rate of new HIV infections stabilized or decreased by more than 25% in at least 56 countries around the world, including 34 countries in sub-Saharan Africa. Of the five countries with the largest epidemics in the region, four countries – Ethiopia, South Africa, Zambia and Zimbabwe – have reduced rates of new HIV infections by more than 25%, while Nigeria's epidemic has stabilized.

However, in seven countries, mostly in eastern Europe and central Asia, new HIV infection rates have increased by 25%. There has also been a resurgence of HIV infections among men who have sex with men in several high-income countries.

Globally, the rate of new infections is still high, outstripping advances made in providing life-saving treatment to people living with HIV. There are two new HIV infections for every one person starting HIV treatment.

Each day there are more than 7000 new HIV infections; about 40% are in young people between the ages of 15 and 24 years. Women continue to be disproportionately affected by HIV in sub-Saharan Africa, with 13 women in the region becoming infected with HIV for every 10 men. The proportion of women to men living with HIV in Asia rose from 21% in 2000 to 35% in 2009 and many were infected in the context of marriage.

COUNTRIES WITH REDUCTIONS IN HIV INCIDENCE OF MORE THAN 25%

- Belize
- Botswana
- Burkina Faso
- Cambodia
- Central African Republic
- Congo
- Côte d'Ivoire
- Dominican Republic
- Eritrea
- Ethiopia
- Gabon
- Guinea
- Guinea-Bissau
- India
- Jamaica
- Latvia
- Malawi
- Mali
- Mozambique
- Myanmar
- Namibia
- Nepal
- Papua New Guinea
- Rwanda
- Sierra Leone
- South Africa
- Suriname
- Swaziland
- Thailand
- Togo
- United Republic of Tanzania
- Zambia
- Zimbabwe

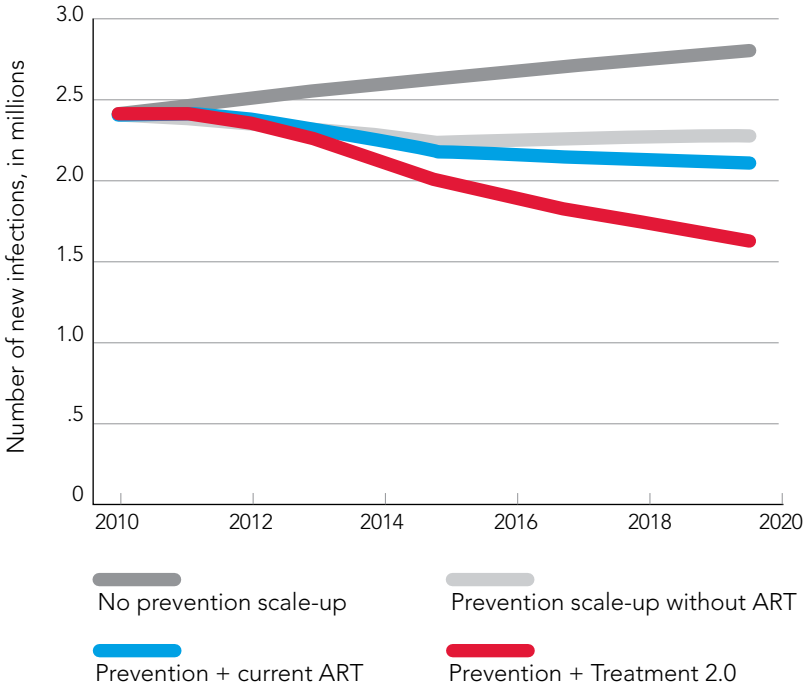
2. More than 5 million people are on HIV treatment.

The number of people accessing antiretroviral treatment has increased by seven and a half times over the past 5 years. More than 5 million people are on treatment today. As a result, more people living with HIV are leading healthier and productive lives.

AIDS-related mortality has reduced significantly since the widespread availability of treatment in the past few years. There were 300 000 fewer AIDS-related deaths in 2009 than in 2004.

However, two of three people requiring treatment do not have access to it. In addition, tuberculosis (TB) remains one of the leading causes of death among people living with HIV globally, despite being preventable and curable. Recent data from the World Health Organization estimate that there were 1.1 million cases of TB among people living with HIV and about 380 000 TB-related deaths in 2009.

INCIDENCE OF NEW INFECTIONS IN FOUR DIFFERENT SCENARIOS



TREATMENT 2.0

Current treatment strategies are not robust enough to reach the 10 million people in need today. Therefore, UNAIDS has called for Treatment 2.0, a new approach that uses a combination of efforts to help reduce treatment costs, make treatment regimens simpler and smarter, reduce the burden on health systems, and improve the quality of life for people living with HIV and their families.

HIV treatment is also an effective HIV-prevention option and can provide a prevention dividend. Moving towards a next generation of treatment (Treatment 2.0) could avert an additional 10 million deaths by 2025 and could also reduce new HIV infections by up to 1 million annually if countries provide treatment to all people in need.

3. HIV prevention works.

Condom use and availability have increased significantly. Eleven countries – from Burkina Faso, to India and Peru – report more than 75% condom use at last higher-risk sex. Data from 78 countries show that condom use among men who have sex with men was more than 50% in 54 countries. Meanwhile, tradition is giving space to pragmatism as communities embrace male circumcision, which has the potential to reduce the risk of acquiring HIV infection among men by nearly 60%.

Young people are leading the prevention revolution by choosing to have sex later, having fewer multiple partners, and increasing use of condoms; in fact, new infections among young people have declined by more than 25% in 15 countries.

For the first time, results from a South African study show that a gel containing an antiretroviral drug tenofovir, when used as a vaginal microbicide, was found to be 39% effective in reducing a woman's risk of becoming infected with HIV during sex, giving women a prevention option that they can initiate and control.

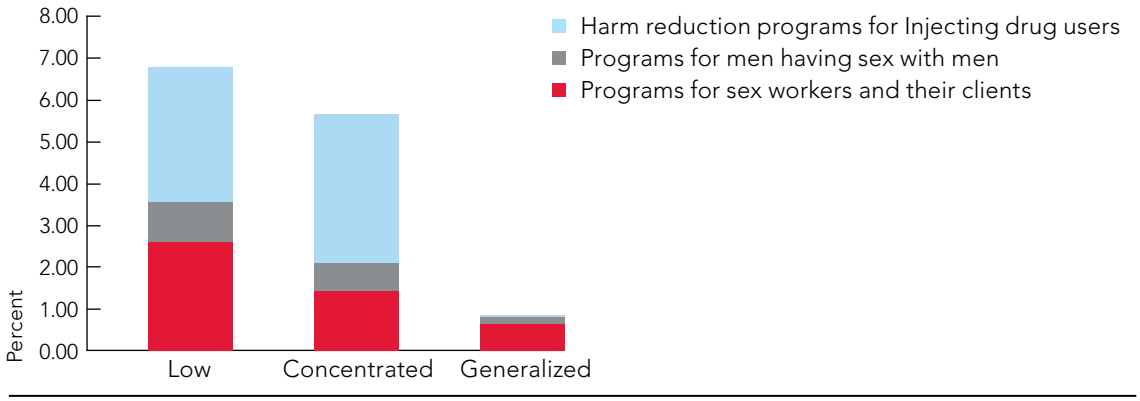
Recent research shows that when men who have sex with men took a daily pill with an antiretroviral drug combination including tenofovir, in conjunction with the use of condoms, their risk of HIV infection dropped by an average of 43.8%.

An effective vaccine is years if not decades away, but for the first time an HIV vaccine trial candidate has shown some efficacy in humans.

Investments in prevention, however, are insufficient. Fewer than one in five sex workers receive adequate HIV-prevention services. Less than 1% of global prevention funding for HIV is spent on sex work, despite the disproportionately high HIV risk and vulnerability that sex workers face.

Today, about 10% of global HIV infections are due to unsafe injecting drug use. Access to HIV-prevention services for people who inject drugs has reached 32% – far short of what is needed to protect drug users from HIV worldwide.

PERCENTAGE OF SPENDING ON PROGRAMMES DIRECTED AT POPULATIONS AT HIGHER RISK OF HIV, AS A PERCENTAGE OF TOTAL PREVENTION SPENDING, BY TYPE OF EPIDEMIC



4. Virtual elimination of mother-to-child transmission is possible by 2015.

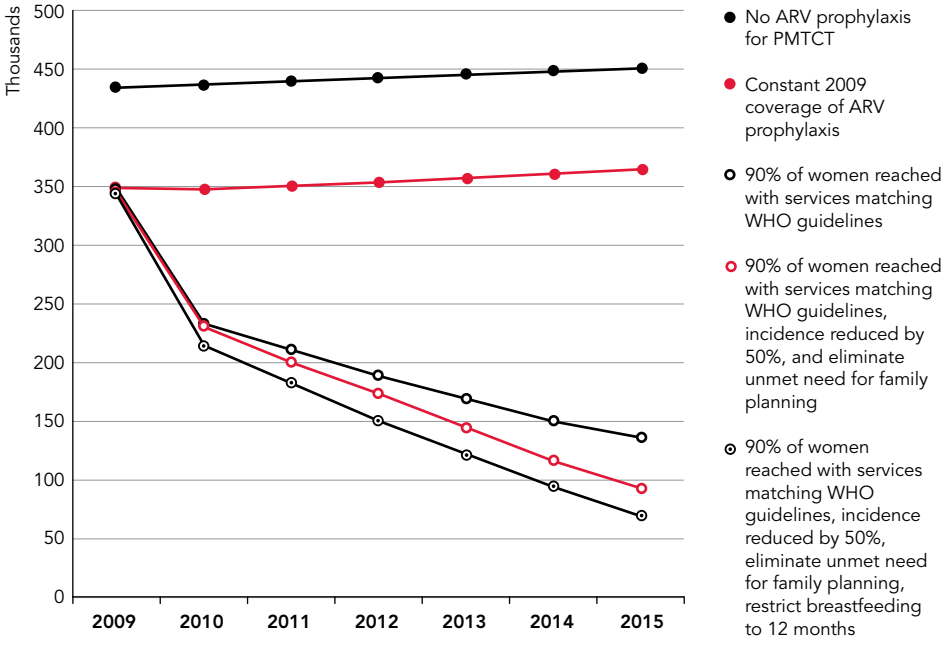
Around 370 000 children were newly infected with HIV in 2009, down by 24% since 2004. Significant gains have been made in sub-Saharan Africa, where new HIV infections among children have fallen 32% in the last five years.

There has also been significant progress in making prevention of mother-to-child transmission of HIV services available to pregnant women across the world. South Africa has achieved almost 90% coverage of treatment. HIV transmission from mother to child has, for a long time, been a rarity in high-income countries. Despite this progress, HIV continues to weigh heavily on maternal and child mortality in some countries.

The prevention of mother-to-child transmission supports attainment of several MDGs.

THE VIRTUAL ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IS POSSIBLE

Estimated New HIV infections among children 0-14: Different scenarios for 25 countries



Source: Mahy M, Stover J, Kiragu K, et al. What will it take to achieve virtual elimination of mother-to-child transmission of HIV? An assessment of current progress and future needs. Sex Trans Infect (Suppl) 2010.

5. Laws are challenging the AIDS response.

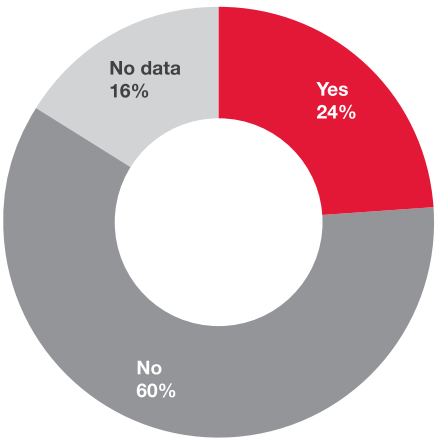
The law can be a powerful tool in addressing HIV. Legal resources must work for – not against – the HIV response. Law enforcement and health services can work together to achieve common results, with dignity.

Available evidence shows that most people living with HIV who know their status take steps to prevent transmitting to others. Criminalization of HIV transmission must be limited to the rarest of circumstances.

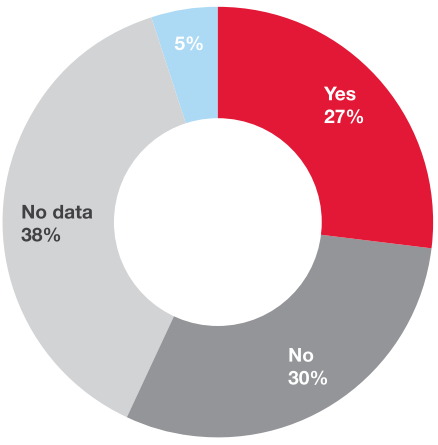
About 80 countries across the world criminalize same-sex behaviour. There is no place for homophobia in the world. Protective versus punitive law can ensure that everyone has access to HIV prevention and treatment. AIDS-sensitive and just law enforcement enables AIDS workers to reach people who use drugs, sex workers and men who have sex with men. Access to justice means that people affected by HIV can challenge discrimination against them and live with dignity.

Every individual should have equal access to freedom of movement, regardless of their HIV status. Forty-nine countries, territories and areas impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status. HIV-based travel restrictions are neither an evidence-informed nor a rights-based way to prevent HIV transmission.

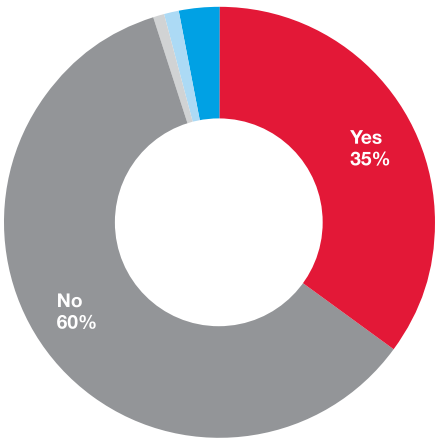
PERCENTAGE OF COUNTRIES, TERRITORIES AND AREAS THAT HAVE HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE



PERCENTAGE OF COUNTRIES, TERRITORIES AND AREAS THAT HAVE LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE



PERCENTAGE OF COUNTRIES, TERRITORIES AND AREAS THAT HAVE LAWS THAT CRIMINALIZE SAME-SEX ACTIVITIES BETWEEN CONSENTING ADULTS



6. Investing for AIDS is a shared responsibility.

Investments in AIDS are showing results. To sustain these results, it is imperative that resource availability is predictable. Countries cannot respond effectively to the epidemic on a fiscal year basis. Thanks to the movement to reach country-driven universal access goals, demand for access to HIV prevention, treatment, care and support services has increased manifold in recent years. In coming years, this is expected to increase further. Meeting this need is a shared responsibility of development partners and national governments.

UNAIDS recommends that national governments allocate between 0.5% and 3% of government revenue on HIV, depending upon the HIV prevalence of the country. Domestic investments for AIDS have increased over the past decade, but for a majority of the countries severely affected by AIDS, domestic investments alone will not meet all of their resource needs.

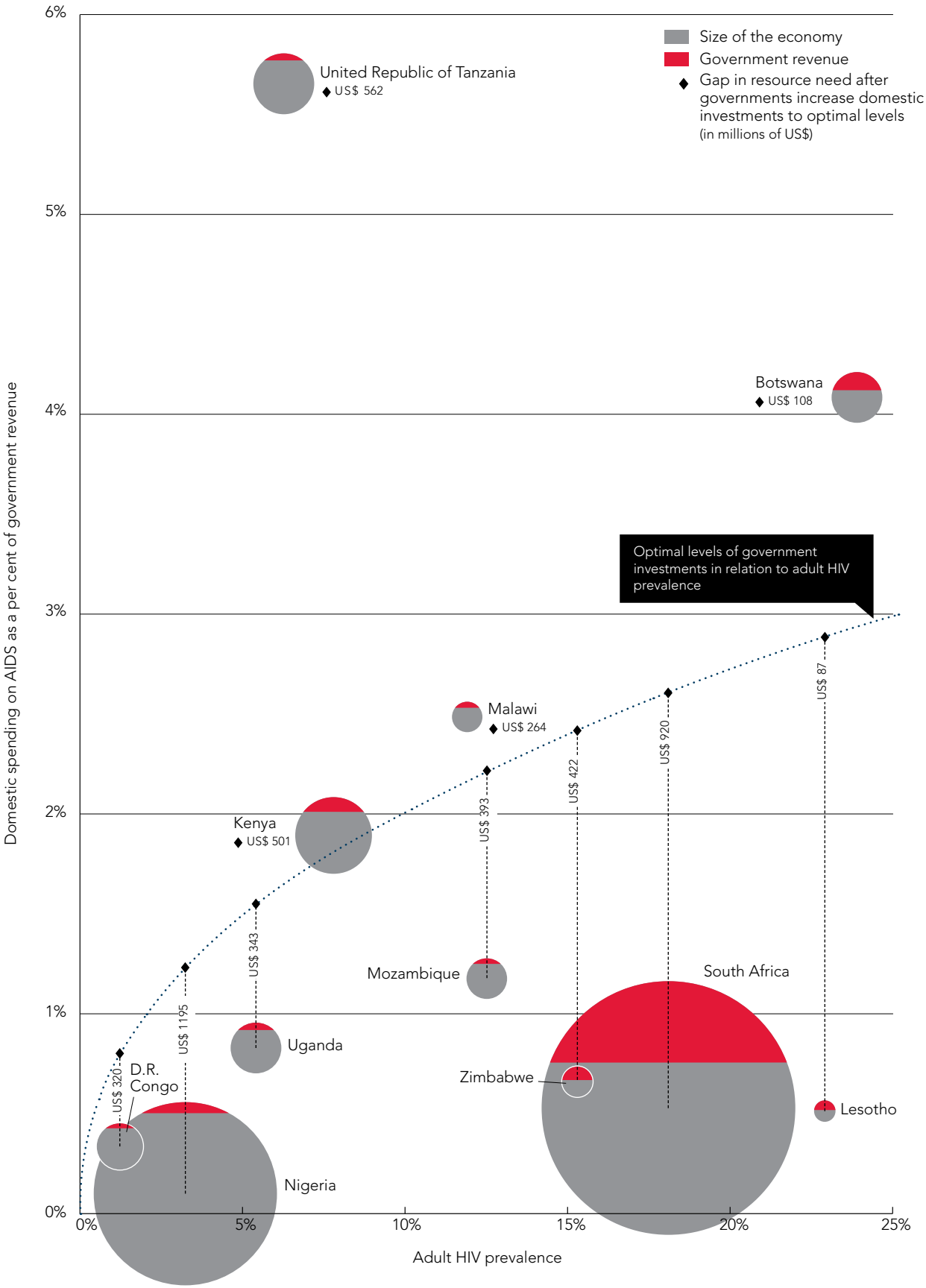
The majority of HIV treatment programmes in low- and middle-income countries are funded by external sources – mainly The Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States Government.

Many wealthier developing countries can meet their resource needs from domestic sources alone. Doing so will free up international investments for countries most in need. Half of global resource needs for low- and middle-income countries are in 68 countries where the national need is less than 0.5% of the gross national income. These countries can meet a substantial proportion of their resource needs from domestic resources.

In 2009 only US$ 15.6 billion was available for the global AIDS response, US$ 10 billion short of the estimated need. At this turning point, flat-lining or reductions in investments will hurt the AIDS response.

AIDS programmes can be made sustainable and affordable by increasing the efficiency and the effectiveness of the HIV programmes. This means doing it better: knowing what to do, and directing resources in the right direction. This will bring down unit costs and lower the global resource needs in the long run.

CAN GOVERNMENTS MEET THE RESOURCE NEEDS OF THE AIDS RESPONSE FROM GOVERNMENT REVENUE?



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