2012

UNAIDS | **LETTER TO PARTNERS** | Michel Sidibé

With Nobel Peace Prize Laureate Archbishop Desmond Tutu and youth leaders who committed to new HIV prevention efforts at Robben Island in Cape Town, South Africa (2011).

2 April 2012

Dear Friends,

At the recent African Union Conference of Ministers of Economy and Finance I was struck that the traditional lines drawn between ministries of health and finance, between investment and development have been rightly blurred. These artificial divisions no longer reflect world realities. And it is for this reason I am especially pleased that UNAIDS has signed a new agreement with the New Partnership for Africa's Development (NEPAD). Together we will forge a new alliance demonstrating Africa's leadership in the AIDS response. It's one of the many exciting developments and possibilities this year presents us.

The fourth decade of the epidemic has barely begun, yet we can already see how greatly it will differ from the three already past. The pain and the loss are not over, nor is the risk that missteps or a loss of heart could reverse our hard-won gains. But a new word has entered our lexicon. It is on the lips of people living with HIV, activists, health workers, policy makers and world leaders. It signals a new vision and carries with it a new sense of energy, hope and potential. The word could make 2012 a most memorable year if it truly informs and directs our efforts in every sector of society and every region of the world. That word is **zero.**

Getting to zero means working together to create a world with zero new HIV infections, zero discrimination, and zero AIDS-related deaths. Our vision has united diverse partners behind a political commitment and a strategic plan to address the central challenges we face. We have articulated specific, measurable targets for 2015 in the United Nations 2011 Political Declaration on HIV/AIDS, identified the steps required to achieve them and inspired world leaders to speak openly of a prospect that only recently seemed far-fetched. In short, we have built a foundation from which we can now credibly envision an AIDS-free generation.

The challenge is to stay focused despite a gathering storm of new challenges. While expanding access to established prevention strategies and treatment regimens, we must also augment and in some cases supplant them with better ones. After nearly a decade of resource growth, we have entered a period of shrinking and uncertain commitments. The era of emergency relief is ending, and we have yet to develop a more sustainable response to succeed it.

To get to zero—and realize our ambitious goals for 2015—we must find ways to get broader access and better outcomes with available resources.

The future costs that HIV imposes on people, families, communities and countries will be determined by how the AIDS response adapts to emerging challenges and new opportunities. Choices will be shaped by finite resources, evolving global priorities and the types of new alliances forged. Success or failure will be determined by how well HIV prevention programmes are focused, how the next generation of treatment is delivered, and the strength of our collective commitment to human rights, gender equality and greater involvement of people living with HIV.

The global economic crisis has slowed global AIDS funding but has not stopped real results from being delivered or diminished the hope. The global community—all countries of the world and all sectors of society—must recommit to innovation, integration and implementation if we are to reach our shared and achievable goals.

In short, the global AIDS response has reached a new critical juncture, and this year will be pivotal. Destiny is in our hands, and we must mould it while we can.

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By improving collaboration between HIV and TB services almost one million lives around the world have been saved in the past six years.

AN INTEGRATED RESPONSE FOR BETTER RESULTS

If the history of AIDS has taught us anything, it is that epidemics don't occur in a vacuum. HIV has exploited our social and political shortcomings—and it has shown again and again that an effective response must span the health sector and go beyond it to address the laws, attitudes and economic injustices that make infection more likely and more lethal.

The relationship between HIV and the Millennium Development Goals reflects an understanding that the AIDS response is inseparable from broader health and human development efforts. Integration of key services, optimizing synergies and creating linkages are not just ideals but necessities as we enter an era of declining resources.

This World TB Day reminded us that integration is also paying huge returns as we strive to prevent tuberculosis (TB) deaths among people living with HIV. Our current global target—to halve the number of TB deaths by 2015—would be an empty aspiration if HIV programmes had to pursue it alone. But as countries find ways to integrate the responses to these two leading killers, interventions become more efficient and more powerful. I am grateful to our colleagues at Médecins Sans Frontières (MSF), among others, for documenting the remarkable difference that "one-stop service" could make to the million-plus people currently co-infected with TB and HIV and welcome the World Health Organization's (WHO) recently updated HIV-TB policy guidance to further reduce the dual HIV-TB burden.

76%

In Lesotho, some 76% of HIV patients are co-infected with TB.

For example, both infections are common in Lesotho, where some 76% of people living with HIV also have TB. Like many countries, Lesotho has traditionally addressed TB and HIV through separate health programmes that are linked but not integrated. People receiving TB treatment at a rural health centre may have to travel a half day to reach a district hospital with an HIV programme. And the resulting delay in HIV treatment undermines all efforts to manage their TB. Since 2006, MSF has worked with Lesotho's health sector to operate a decentralized, nurse-based HIV/TB programme in a rural health district that includes 14 primary care sites and one district hospital. In these centres, clinicians treat both conditions, trained lay counsellors to help patients manage both treatment regimens, and oversee patients' records to track their general health rather than a fragment of it. "I was grateful I didn't have to travel to the hospital," a patient named Joseph told MSF recently. "I was worried about paying for the transport and taking extra time off work. Seeing the same nurse and counsellor was good as I got to know them and [they] me. I felt they were treating me, and not just the disease."

The integration of care has been more than a convenience. In the MSF programme some 81% of co-infected patients received antiretroviral therapy in the one-stop service sites, versus 24% nationally, and their death rates varied accordingly. Our ultimate hope—and our immediate challenge—is to catalyze similar changes nationwide in every country.

Integrated health systems can provide many services more efficiently, because they leverage existing infrastructure to expand critically needed services. And more people are recognizing how the AIDS response can be an entry point for better results. UNAIDS has recently joined with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the George W. Bush Institute and the Susan G. Komen for the Cure foundation to leverage public and private investments in HIV and cervical cancer for women in low- and middle-income countries. Women with HIV infection have a higher risk of developing cervical cancer. The new "Pink Ribbon Red

Ribbon" initiative will use the HIV platform to expand prevention, screening and treatment for cervical cancer in sub-Saharan Africa and Latin America. By tapping the natural synergies among closely related endeavours, the initiative could reduce deaths from cervical cancer by 25% over five years.

BELIEVE IT. DO IT.

One of my first actions as Executive Director was to call for the end of new HIV infections among children by 2015. Bold? Yes. Achievable? Absolutely.

Momentum has moved countries to join this call—in June 2011 with my Co-Chair Ambassador Eric Goosby, who serves as the US Global AIDS Coordinator, we launched the "Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive".

35%

An estimated 35% of pregnant women in low- and middle-income countries received an HIV test in 2010, up from 7% in 2005.

By focusing on the 22 countries with the highest estimated numbers of pregnant women living with HIV, national plans are underway with renewed vigor and support. Even beyond these high burden countries, progress is being made. I was recently in Benin with President and Chairperson of the African Union Dr Thomas Yayi Boni and together we launched a national plan to prevent new HIV infections among children. Along with the United Nations Children's Fund (UNICEF), WHO, the United Nations Population Fund (UNFPA) and other partners on the ground, Benin will expand services. Between 2004 and 2011, the number of health facilities offering services to pregnant women living with HIV more than doubled from 204 to 450. Despite scale-up, only about half (49%) of pregnant women eligible for HIV services are currently receiving them.

An estimated 35% of pregnant women in low- and middle-income countries received an HIV test in 2010, up from 7% in 2005. Nearly half (48%) of pregnant women living with HIV are receiving effective antiretroviral regimens to prevent new infections among children.

I look to 2012 as a turning point where effective treatment regimens reach more pregnant women living with HIV than ever before. We are reaching out to everyone. Under the leadership of John Megrue, the recently launched "Business Leadership Council for a generation born HIV free" is bringing business acumen and private sector resources to ensure we reach the goal. In the coming months, I will count on your support as UNAIDS launches a Mother's Day campaign called "Believe it. Do it." to bring awareness and action to this issue.

REVOLUTIONIZING PREVENTION EFFORTS

When we called for an HIV revolution, people answered—especially young people. Last year, during a visit to Tanzania, together with United Nations Deputy Secretary-General Dr Asha Rose Migiro, I had a chance to visit the Tanzanian Youth Alliance (TAYOA), a non-profit organization that operates a national AIDS helpline. More than 200 young people support the National AIDS Helpline and other TAYOA programmes, including youth outreach clubs and an information technology project. Medical students volunteer their time to respond to HIV-related queries from young people, who can call the helpline free of charge from landlines or mobile phones. Starting with a single phone line in 2001, the organization now runs eight lines, answering 1000 calls every day. The callers get reliable information confidentially on issues ranging from sexual relationships to condom use, HIV testing, antiretroviral therapy and the prevention of HIV transmission from mother to child.

With United Nations Secretary-General Ban Ki-moon and Rebecca Awiti, mother living with HIV and her HIV-negative triplets in Nairobi, Kenya (2011).

TAYOA's national helpline stems from a unique public-private partnership between the Government of Tanzania, the U.S. Centers for Disease Control and Prevention and six national telecom operators. But it is ultimately a testament to the energy and commitment of young people, who are more interested in driving prevention initiatives than passively receiving advice. "One of the great lessons we have learned in our journey is the need to embrace and cultivate a culture of volunteerism in our society," Peter Masika, TAYOA's country director told me during our visit. "We have learned that when young people are meaningfully engaged, they can take charge and act to improve their own quality of life, and the lives of their friends."

Social media networks now promise to push youth participation in the AIDS response to a whole new level. With the launch of CrowdOutAIDS.org, UNAIDS has recently involved more than 5000 young people around the world in an effort to crowdsource a new youth strategy for UNAIDS in real-time. An independent committee is drafting the document, using collaborative authoring tools to let all participants participate actively in the process. UNAIDS will share its experience of this highly innovative approach of participation in UN policy making and programme development with its partners.

Applying football and life skills at a Grassroot Soccer training session in Cape Town, South Africa. (2011)

It's not just the young people we need to reach. We must work harder to empower people of all ages whose life circumstances place them at increased risk of HIV. As of 2009, only 26% of countries had established HIV prevention goals for reaching sex workers, only 30% had set targets for reaching people who use drugs and just 18% had them for men who have sex with men. Even fewer countries report data on key populations, and HIV prevention services for these groups are often minimal. Other key populations that require heightened prevention support include prisoners, migrants, transgender people and people with disabilities.

As we work to raise awareness and reduce risk-taking behaviour, we must also recognize that behaviour change is no longer our only hope for preventing new infections. While urging people to avoid risk, we can now use technology to help reduce the risk of HIV transmission. For example, we now know that antiretroviral treatment can help prevent sexual transmission of HIV, just as it reduces the risk of HIV transmission from mother-to-child. Research findings reported last year confirmed that consistent use of antiretroviral drugs can reduce—by 96%—the risk that a person living with HIV will pass the virus to a sexual partner. This finding suggests that by dramatically expanding voluntary testing and treatment, we could effectively reduce a whole community's viral load and dramatically slow transmission rates, even where HIV prevalence is high. New research from KwaZulu-Natal in South Africa is already showing results. This realization makes universal access to treatment all the more urgent.

Another largely untapped HIV prevention strategy is voluntary medical male circumcision, which can reduce female-to-male sexual transmission by about 60%. Recent modelling indicates that 80% coverage of voluntary adult medical male circumcision in 14 priority countries would reach 20 million men by 2015. Such a scale-up would cost a total of US$ 1.5 billion and could avert 3.4 million new HIV infections through 2025. It would also result in net savings of US$ 16.5 billion by 2025 due to averted treatment and care costs.

In 2007, WHO and UNAIDS released a joint policy statement recommending voluntary adult medical male circumcision as one component of a comprehensive HIV prevention strategy in regions where male circumcision is rare, HIV prevalence is high and heterosexual contact is the main mode of transmission. In response to the WHO/UNAIDS policy statement, the Government of Kenya launched a voluntary medical male circumcision programme that, by the end of 2010, had enabled 230 000 men to receive safe, medical circumcision procedures. This programme alone expects to circumcise 860 000 men over the next five years—and other high-prevalence countries are emulating it.

In South Africa, I traveled with New York Times health reporter Donald McNeil to the Zola Clinic in Soweto. I was energized by the transformation of the clinic's efforts to stop new HIV infections among children—and was inspired by the two women who run the medical male circumcision programme. Dr. Josephine Darko and Sister Mulashi Biola are beyond forces of nature—pioneers like these will get us to zero. Zola clinic is seeing up to 150 men a day. Dr Darko can barely keep up with demand.

The search continues for a topical microbicide that women can use with or without their partners' support. I recently had the opportunity to visit the Centre for the AIDS Program of Research in South Africa (CAPRISA), a UNAIDS collaborating centre for HIV prevention research, where this groundbreaking work is taking place. Dr Salim Karim leads a fantastic team in this world-class research hub. We need to see more leading research centres like this in Africa.

During a recent visit to the Pacific Island Countries, at an event on International Women's Day hosted by the President of Fiji, it was impressive to see how young women are standing up to gender-based violence and demanding their right to sexual health education.

Fiji and the other Pacific Island Countries, with the exception of Papua New Guinea, continue to have low HIV prevalence. This may lead to a false sense of security that HIV is no longer a threat compared with the rise of non-communicable diseases. The latest data from across the region indicates the increase in new HIV cases is linked to high-levels of migration and tourism, sex work, multiple sexual partners, low-levels of condom use, high prevalence of sexually transmitted diseases and a growing concern over violence against women. If the epidemic is not contained, these countries and territories will lack the resources and the capacity to respond effectively. This region needs the continued support of international donors to sustain the AIDS response.

Getting to zero is ultimately a matter of preventing new HIV infections. I believe we can reach the targets of the Political Declaration on AIDS through transformative politics, policies and practices. By 2015, we can reduce sexual transmission of HIV by half, eliminate new HIV infections among children and halve new HIV infections among people who use drugs.

80%

Recent modelling indicates that 80% coverage of voluntary adult medical male circumcision in 14 priority countries would reach 20 million men by 2015.

STRAIGHT TALK ABOUT HIV TREATMENT

Let me do some plain speaking about the future of HIV treatment access. A decade ago, it was hard to imagine that 6.6 million people would ever receive antiretroviral therapy in low- and middle-income countries. Reaching that milestone has been one of the greatest achievements in the history of public health. Yet 7.6 million people eligible for treatment—including 5 million Africans—still lack access to these lifesaving drugs. And the need is growing even as the rate of new infections declines. We are simply unprepared to meet this challenge. I say this even as an incorrigible optimist.

And it is just not about scaling up access to treatment. It is about making HIV treatment, care and support simple to deliver, long-lasting and efficient. Sadly, research and development into new HIV medicines and point-of-care diagnostics have not kept pace with the growing demands of the AIDS response. Even more worrisome is that investments towards such research and development are slowing down and in some cases simply vanishing. The pipeline for new drugs is much smaller and will soon run dry.

A decade ago, the focus of the treatment access revolution—led by activists and community organizations—was towards pressuring the pharmaceutical industry to share the lifesaving antiretroviral drugs they produced more equitably with the poor and needy. Yes, we succeeded and prices for first-line drugs were reduced from over US$ 10 000 per patient/year in 2000 to around US$ 100 per patient/year in 2011 in the most affected countries.

But today, we need a second phase of the treatment access revolution—this time to work with the pharmaceutical industry to continue the quest for better and smarter HIV medicines and point of care solutions. Existing formulations are losing their edge; we are losing people to treatment follow up due to a lack of rapid diagnostics; and second-line drugs are still too expensive and out of reach. We need new business models that provide incentives and new mechanisms to support research and development of new drugs.

TREATMENT 2.0

Treatment 2.0—an initiative that UNAIDS and WHO launched jointly in June 2010—is our unifying strategy for addressing these needs. Now in its second full year, the initiative is driving innovation and efficiency in key areas, such as cheaper, simpler drugs and diagnostics, and integrated, decentralized HIV service delivery. The initiative has five components, and each will play a vital role as we work this year to meet our objectives for 2015.

Treatment 2.0 Priorities

1. Optimize drug regimens
2. Provide point-of-care and other simplified diagnostic and monitoring tools
3. Reduce costs
4. Adapt service delivery
5. Mobilize communities

Treatment 2.0 Principles

- Simplification
- Innovation
- Efficiency
- Effectiveness and cost-effectiveness
- Accessibility
- Affordability
- Equity
- Decentralization and integration
- Community involvement

Consistent use of antiretroviral drugs can reduce—by 96%—the risk that a person living with HIV will pass the virus to a sexual partner.

WHAT DO WE NEED FOR THE FUTURE OF HIV TREATMENT?

1. A RED PILL, A BLUE PILL AND A GREEN PILL

Currently, most people on HIV treatment have to take at least three medications every day for the rest of their lives. There are too many combinations of first-line treatment available today. Some of these regimens are needed for pregnant women, for people with HIV-TB co-infection, and for paediatric AIDS. It is not just complicated for the person taking the medicines, but also for health care providers, logistics and supply chain management professionals and policy makers. And second-line drugs are even more complex.

We need simple, fixed-dose regimens to improve adherence—a single red pill for first-line treatment, a single blue pill for second-line treatment and a single green pill for third-line treatment. A single-dose first-line regimen already exists, but its uptake is still low.

Drug resistance is another growing challenge. An estimated 25%–30% of people living with HIV in Africa now need second-line antiretrovirals to avoid treatment failure, but only 3% are receiving them. With more friendly and accessible tools to monitor resistance (such as point-of-care viral load tests), people can easily move to another more suitable regimen.

2. MEDICINES—THAT ARE EASIER TO TAKE AND ARE LESS TOXIC, DEVELOPED THROUGH PUBLIC-PRIVATE PARTNERSHIPS

Antiretroviral drugs are effective in reducing viral load, but their side effects are many, and concerns about their long term toxicity and drug resistance limits early initiation of treatment. Thus the "treatment for prevention" dividend cannot be universally extended yet.

All patients, rich or poor, need regimens that are less toxic, minimize drug interactions and prevent resistance. Newer, less toxic medicines are available in rich countries, but their cost is still prohibitive in the countries with the greatest need.

Efforts to reduce dosage of existing drugs and to produce new fixed-dose combinations remain of paramount importance. They bring two benefits—potentially reducing side effects and reducing costs, as basic ingredients account for nearly 60%–80% of drug costs. There are on-going phase III trials of three drugs for dosage reduction and we eagerly await the results.

Research for long-lasting drugs, including injectables is in its infancy. It will take many years before such drugs are made available commercially. What is even more worrisome is that efforts to discover such drugs are waning as pharmaceutical research and development companies seek other more lucrative markets.

As part of the Treatment 2.0 agenda, under WHO's leadership, short-term priorities for drug development were defined last year. Follow-up meetings this year will address medium- and long-term priorities. This agenda requires urgent and broad based-support if we are going to provide people with new, more effective treatment options that are essential to scale-up treatment in the future.

3. SIMPLIFIED POINT-OF-CARE

The impact of HIV treatment is not fully optimized in both developed and developing countries, as large numbers of people living with HIV come to know their HIV status only when their immune systems are already compromised. In many cases, healthcare providers must wait for several days after an HIV diagnosis to get a CD4 count reading to determine a person's eligibility for treatment. Complex viral load tests make it harder for people to know if the medicines they are taking are having the desired impact.

CD4 testing is becoming more widely available and some point-of-care technologies now exist, but there are barriers to effective implementation. We continue to see how better monitoring leads to better care. In Mozambique, the time required for CD4 staging is now one day—down from 28—in clinics that have acquired CD4 point-of-care testing devices. As a result, only half as many patients (33%, down from 64%) are being lost to follow-up before they can start treatment.

However, the pick-up of new-generation devices to easily measure CD4 counts is not yet ubiquitous. We have to join forces to break down barriers for faster scale-up.

4. BETTER PAEDIATRIC FORMULATIONS

The number of children requiring treatment will continue to fall as the global goal of eliminating new HIV infections among children by 2015 becomes a reality. But we cannot forget the 3.4 million children living with HIV today. These children need paediatric formulations that are easy to use and allow for long-term treatment. There are very few options available today for children who develop resistance to first-line treatment.

Investments in paediatric formulations must be considered from a broader perspective. In Uganda, for example, fixed-dose, combination ARVs have replaced costlier and less convenient syrups as a first-line treatment for children. This changeover, accomplished in just two years, has yielded savings of US$ 2 million, while improving patient care.

However there are very few new paediatric formulations in the pipeline. There are almost zero investments in new discoveries. We cannot afford to fail our children.

5. REDUCED COSTS

Yes, we still have a cost problem, especially with second- and third-line drugs. UNAIDS is working on several fronts to address barriers to obtaining low-cost drugs and commodities and has recently published reports highlighting access barriers in the current TRIPS agreement. The reports also outline the positions we must advocate to safeguard TRIPS flexibilities in low- and middle-income countries. These documents have been widely circulated and are available on the UNAIDS website.

6. INTEGRATED SERVICE DELIVERY

No one now denies the need to weave HIV-related services more tightly into primary health care. The challenge is to integrate systems that have long been funded, managed and patronized separately. We have studied successful efforts to decentralize HIV care in three countries and will soon release case studies that examine their experiences. In another forthcoming publication, UNAIDS will describe and catalogue the innovative models that MSF has used to expand HIV services in low-resource settings. In Malawi's Thyolo district, for example, the lag time between diagnosis and treatment dropped from three months to three weeks after hospitals shifted treatment delivery to health centres, where nurses now manage it directly. It is hard to overstate the impact these lessons could have if applied on a large scale.

7. A SECOND TREATMENT REVOLUTION—LED ONCE AGAIN BY COMMUNITIES

Social change is never a top-down phenomenon. The strength of a movement comes from the people who stand up for social justice and insist on reform. When communities lead, leaders follow. Community mobilization pushed the first HIV treatments to market, and it is this force that will ultimately drive the next phase of treatment access. People whose lives, families and communities are at stake must have a hand in demanding, delivering and evaluating HIV services.

We—all of us—must work as one to engage them in every aspect of the response—from developing prevention strategies to promoting treatment adherence, from safeguarding human rights to demanding fair trade policies and drug prices. Last year, UNAIDS sponsored community consultations in Bangkok and Johannesburg to brief NGO constituents and highlight the continuing importance of advocacy.

8. THE HOPE FOR A VACCINE MUST BE KEPT ALIVE

The world must not lose sight of the quest for an effective vaccine against HIV. A preventive vaccine, remains the sustainable solution to ending AIDS.

9. SECURING THE FUTURE—A NEW COMPACT BETWEEN THE HIV COMMUNITY AND INDUSTRY

How can we achieve the above? We need a new engagement between the HIV community and industry. UNAIDS, together with key allies, will convene leaders of the pharmaceutical industry to forge collaboration among themselves to promote innovation, especially by sharing their current knowledge and expertise for production of a new generation of drugs.

UNAIDS will work with regulatory authorities to make access to quality drugs easy, and where needed, to promote public-private efforts to ensure that the next generation of HIV drugs are available as a public good. Similar efforts are also necessary for the development of point-of-care technologies. We risk going into the future with antiquated tools if we do not invest now—in people, in collaboration and in science.

GLOBAL SOLIDARITY

There was no greater show of global solidarity than the adoption of the 2011 Political Declaration on HIV/AIDS at the General Assembly High Level Meeting on AIDS. With more than 30 world leaders participating, Member States agreed that this is the beginning of the end of AIDS. A new Security Council resolution also keeps the AIDS response on the global agenda. Political commitment has never been higher.

Global investments in the AIDS response have increased 50-fold in just 16 years—from US$ 300 million in 1996 to approximately US$ 15 billion today. These investments have brought dramatic returns—a global surge in access to prevention and treatment, and sharp declines in new infections and AIDS-related deaths. We would not be where we are today without the massive commitments of the United States of America through PEPFAR, of small and large donors, domestic investments by countries and the catalytic impact of the Global Fund.

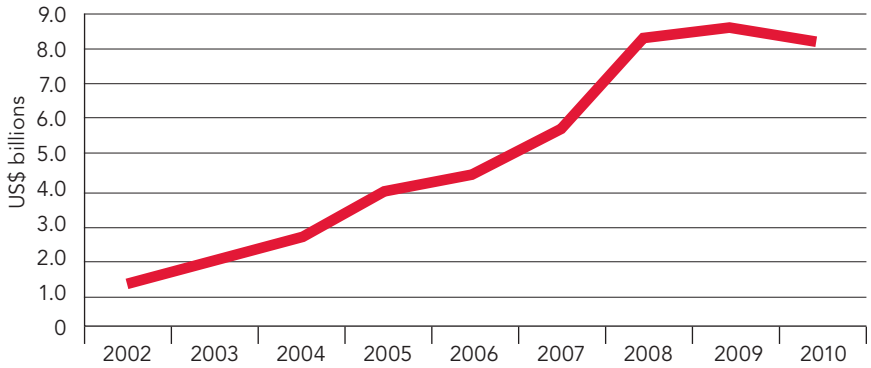
Yet the needs still far exceed available resources, and the surge has stalled. At current rates, it would cost US$ 25 billion a year—a 40% increase over current commitments—to provide universal access to HIV prevention, treatment, care and support. United Nations Member States have collectively pledged to provide nearly that amount (US$ 22 billion to US$ 24 billion) by 2015. But international support has not increased since 2008. And in 2010, it declined for the first time in a decade (from US$ 7.6 billion in 2009 to US$ 6.9 billion in 2010). Last year, the Global Fund was forced to cancel its next round of grants when donors fell short of their funding commitments.

The warning this raises is obvious. Until now, the global response has hinged on the largesse of a relatively small handful of traditional donor countries. Their commitments are unpredictable and undependable in the current economic climate, yet millions of lives depend on them. We must call on wealthy countries to honour their commitments while, at the same time, building a more balanced, sustainable response—one that belongs ultimately to the countries and people whose wellbeing depends on it.

We must also tap local resources and ingenuity, and ensure that every investment is well targeted and managed for maximum impact. UNAIDS is working with countries, particularly in Africa, and the African Development Bank to apply more strategic investment thinking in AIDS responses.

figure 1

Resources available for HIV in sub-Saharan Africa, 2002-2010 (US$ billions)



NEW AFRICAN LEADERSHIP

I started 2012 at the African Union Summit—addressing heads of state at the NEPAD Committee meeting. It was an honour and revelation. Building on the support received by African leaders at the High Level Meeting, political leadership is shifting to support a more sustainable agenda.

Hard work, especially in the past decade, has meant more health systems are in place and the results have swung a massive pendulum. In country after country in Africa and Asia, millions of men and women are back to work—healthy again, they are looking after their children and the elderly. Just a decade earlier, the roles were reversed; it was the elderly and children who were forced to look after people living with HIV, as AIDS decimated families.

Investments in the AIDS response have already boosted the productivity of Africa's factories and farms, reduced the number of orphans needing support, strengthened health systems and improved access to technology. How can affected countries gain more control over the global AIDS response? Here are three of the most acute challenges, and three strategies to help ensure that we meet them.

1. Negotiate a new compact of shared responsibility

The AIDS response in Africa can gain greater sustainability through the pursuit of a more balanced partnership with international partners. Such a balance could be achieved by negotiating long-term, predictable investments from international partners while exercising leadership and commitment by growing African investments and innovative financing.

The international community must not falter in meeting the obligations it has made to the AIDS response. Protecting development assistance, however, will require more visible southern leadership and commitment. Sourcing African-led solutions in the AIDS response in a context of shared responsibility will not only open more space for African ownership, but also further the health gains made in the past decade and contribute to sustainable development solutions such as growing new industries and expanding knowledge-based economies.

Shared responsibility and global solidarity for the AIDS response is based on three premises:

- Countries need to demonstrate political leadership through willingness and ability to articulate a national AIDS, health and development vision and pull partner efforts into alignment.
- Development partners and African governments need to fill the HIV investment gap together—through traditional and innovative means—investing 'fair share' based on capacity.
- Resources should be reallocated according to country needs and priorities—among countries, programmes and populations—for greatest results.

As part of a global compact on shared responsibility, countries could agree on target levels for domestic investment in the AIDS response that are specifically adapted to the projected level of government revenue, including that from innovative domestic sources, and the size of the disease burden caused by AIDS. In return for verifiable progress towards meeting these financing goals within a medium-term period, a consortium of donor organizations could provide an assurance to fund the remaining financing gap in line with an agreed investment envelope that aims to meet the outcome targets specified in the 2011 Political Declaration on HIV/AIDS.

80%

80% of the ARVs consumed in Africa are manufactured in India, where patent laws have long allowed manufacturers to produce older low-cost generic versions of patented pharmaceuticals.

figure 2

Reliance higher for AIDS than health

Source: Country Progress Reports; WHO.

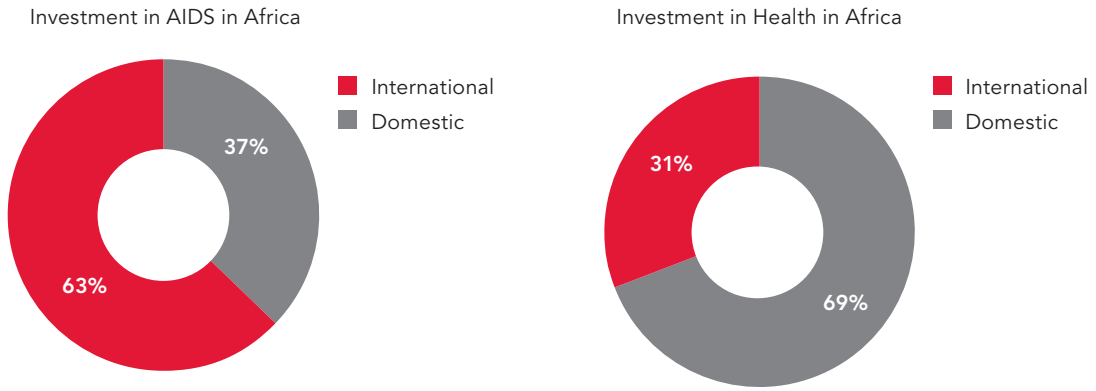
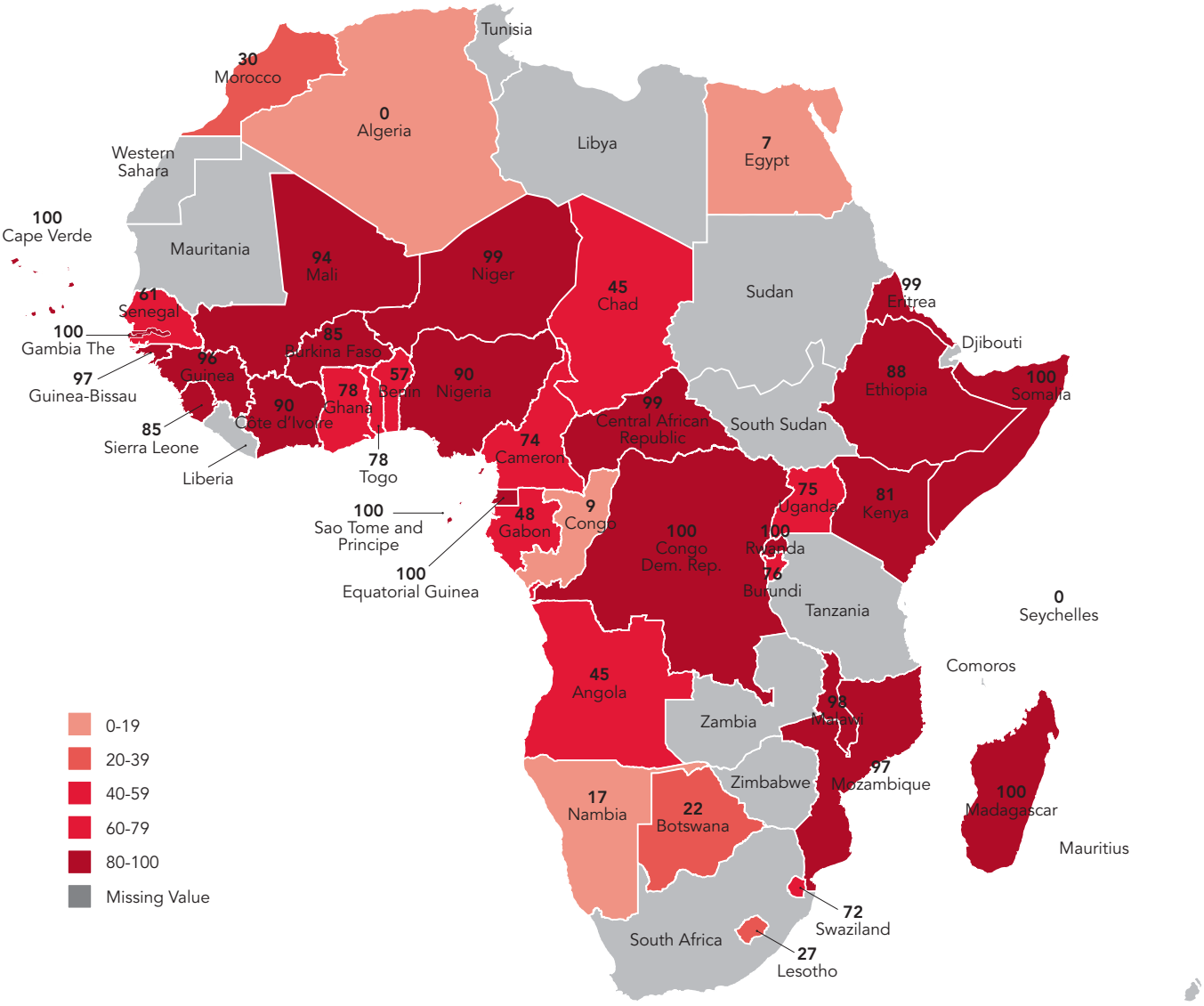


figure 3

Percentage of care and treatment expenditure from international sources

Source: Country Progress Report; Ethiopia's Fourth National Health Accounts, 2007-2008, April 2010.



Assuming that African governments increase their own spending to the extent they are able to and assure efficiency gains, it is highly feasible for the international community to fill the remaining resource gap, even in difficult financial times. The estimated African resource gap peaks at US$ 2.4 billion before falling steadily to reach a point, in 2020, where less overall resources will be needed as compared to those available today.

2. Accelerate access to new medicines, while assuring their quality

In the United States, the development, approval and dissemination of a new medicine typically takes eight years. Africa waits far longer for access to new medications, no matter how urgent the need. By creating an African Drug Regulatory Agency, the countries most affected by HIV could speed the introduction of new, quality-assured medicines to African markets. A regional drug authority could also monitor drug quality, track adverse events and investigate reports of counterfeit drugs—critical services that African patients cannot yet take for granted.

3. Promote African production of essential medicines

Today, 80% of the ARVs consumed in Africa are manufactured in India, where patent laws have long allowed manufacturers to produce older low-cost generic versions of patented pharmaceuticals. That privilege is now ending. African countries could legally meet their own medical needs—and expand their own economies—by manufacturing the same drugs domestically. African governments can foster local competencies by creating a supportive policy environment. And new development partners—such as the emerging economic powers of Brazil, Russia, India, China and South Africa—can transfer the technology needed for domestic production. WHO and UNAIDS have rallied health ministers from these countries (known collectively as BRICS) to speed that technology transfer. Our global success in the AIDS response depends in large measure on the political commitment of Africa's national leaders to take urgent steps to initiate these strategies.

GIVING VOICE TO THE VOICELESS

Globally, governments cite stigma as one of the greatest impediments to accelerated progress in the AIDS response. Stigma and discrimination deny people at risk of HIV infection the tools they need to protect themselves and their communities. They also deny care and treatment to people living with HIV. Some 79 countries and territories criminalize same-sex sexual relations between consenting adults, and more than 100 countries criminalize aspects of sex work. In settings throughout the world, fear and social disapproval increase the vulnerability of mobile populations, prisoners, adolescents who practice high-risk behaviour and people in humanitarian settings. Such discrimination deepens social marginalization, increases the risk of harassment or violence and inhibits communities from mobilizing to address the epidemic.

A 2010 survey of people living with HIV found that more than one-third had experienced loss of employment, denial of health care, social or vocational exclusion or involuntary disclosure. In many countries, people living with HIV are at high risk of losing their homes, employment, property and inheritance due to inadequate protection. In addition, 49 countries, territories and entities impose some form of restriction on the entry, stay and residence of people living with HIV.

Recent progress has been encouraging. Armenia, China, Fiji, Namibia, Ukraine and the United States have repealed their respective HIV-based travel restrictions. And the number of countries reporting anti-discrimination laws in place increased from 56 countries in 2006 to 71 countries in 2010. Yet three in 10 countries worldwide still lack laws prohibiting HIV-related discrimination. More than half of countries reported having laws or policies that indirectly or inadvertently reduce access to HIV services for vulnerable populations. Many of the countries with anti-discrimination laws do not rigorously enforce them.

With our call for Equal Freedom of Movement for People Living with HIV, UNAIDS is pushing for the elimination of HIV-related restrictions on entry, stay and residence—an antiquated practice that has no benefit for public health and undermines dignity and opportunity for people living with HIV. Such restrictions have no place in today's increasingly globalized world. We will work for the end to such restrictions in the 49 countries, territories and areas that continue to have them.

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We will work for the end to HIV-based travel restrictions in the 49 countries, territories and areas that continue to have them.

UNAIDS is speaking out against punitive laws that affect people living with HIV or people at higher risk of exposure. The United Nations Secretary-General Ban Ki-moon and a number of prominent activists and officials from around the world are lending their voice on these issues.

Already this year, 11 United Nations entities have joined UNAIDS in issuing a statement calling for the closure of compulsory drug detention and rehabilitation centres. The existence of such centres—which have been operating in many countries for the last 20 years—raises human rights issues and threatens the health of detainees, including through increased vulnerability to HIV and TB infection. This joint call will enable coordinated and concerted efforts by the UN system at country, regional and global levels to support governments to close compulsory drug detention and rehabilitation centres and replace them with voluntary, rights-based, evidence-informed programmes in the community.

Over the past 18 months UNAIDS has worked with civil society and donor partners to develop a new funding mechanism for a range of donors to provide ongoing, sustainable support to regional and global networks of civil society, key populations and people living with HIV. Through this effort and others, we have taken steps to articulate to donors why resources are still needed for their work, the impact of resource flat-lining and new approaches to the delivery of aid.

UNFPA, the UNAIDS Asia and Pacific Regional Support Team and the Asia Pacific Network of Sex Workers (APNSW), in partnership with the International Labour Organization (ILO), the United Nations Development Programme (UNDP), the United National Office on Drugs and Crime (UNODC), the World Bank and the Network of Sex Work Projects, jointly organized the first Asia Pacific Regional Consultation on HIV and sex work, which resulted in the development of eight draft country-level action plans on HIV and sex work; setting a regional agenda to respond to HIV among sex workers and their clients; strengthening technical capacity of the APNSW Secretariat; and establishing regional and national-level dialogues between governments and sex workers.

UNAIDS offices in Peru and Argentina collaborated with transgender people to produce a video and research regarding their reality. This acted as a catalyst for the creation of REDLA Trans Regional Network, providing a space in the region to give a voice to transgender communities. Subsequently, many national networks have been developed, and today transgender people have a strong voice in the region.

Listening to the experiences of sex workers in Delhi, India. (2011)

The UNAIDS vision:
Zero new HIV infections
Zero discrimination
Zero AIDS-related deaths

In 2010, women represented about 50% of all people living with HIV and 59% of people living with HIV in sub-Saharan Africa. Adolescent girls and young women in sub-Saharan Africa contract HIV at several times the rate of men of the same age. These are symptoms of powerlessness, and we won't get to zero without addressing that underlying cause. To that end, the Joint Programme is working to ensure that the needs of women and girls are addressed in at least half of all national AIDS responses. That means ensuring that strategic actions for women and girls are incorporated into strategic plans, with appropriate budgets for implementation, monitoring and evaluation.

At the same time, we must foster and support social movements that seek to empower women and girls, and we must work at all levels to stop gender-based violence.

UNAIDS EVOLUTION

The positive developments in the global AIDS response have unfolded against a complex backdrop: a global economic crisis, the first-ever reduction in donor contributions to international AIDS funding and the call of the UN Secretary-General to better control costs within the UN system. To deliver more effective support to countries, and to respond to the need for greater efficiency and effectiveness, I initiated an organizational review of the UNAIDS Secretariat with three objectives:

- Align UNAIDS' internal structure to our vision, Strategy and the Political Declaration on AIDS;
- Strengthen staff skills and deployment at headquarters, regional and country levels to achieve results; and
- Lower overall operating costs and demonstrate UNAIDS' value for money.

Never in its history has UNAIDS undergone such a comprehensive and ambitious process of internal review and restructuring. The process was supported by the introduction of groundbreaking new policies that keep UNAIDS at the leading edge of UN reform and programmatic excellence. We are implementing a wide array of changes to the structure of the organization, as well as revising the processes of decision-making, resource allocation and accountability. The new structure will ensure a stronger and more focused UNAIDS that will deliver results faster, smarter and better.

UNAIDS will be increasingly country-focused, with our seven Regional Support Teams empowered to drive strategy implementation within their regions. We are streamlining the structure of UNAIDS headquarters in Geneva to operate with fewer layers and more flexible departments. This will accelerate decision-making, improve flexibility in the use of resources and allow more effective internal communication and coordination.

The number of posts in Geneva will be reduced over time by roughly 100 through the abolition of vacant posts, phasing out of short-term posts, retirements, mobility and reassignment to Regional Support Teams and country offices. Our aim is to deliver greater value for money: these changes are expected to generate total net savings of US$ 40 million by 2014-2015.

During the implementation of this strategic realignment, UNAIDS will maintain our principles of fairness and transparency, as well as provide opportunities for and support to affected staff.

AS WE SHAPE OUR DESTINY, WHAT WILL BE OUR LEGACY?

As we embark on this exciting new era for UNAIDS, we look forward to your continued cooperation and support to achieve our shared vision.

We have several major milestones this year that will bring opportunities to deliver on commitments.

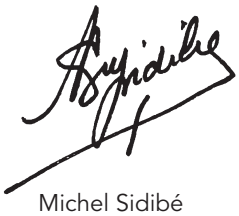
Before we meet for the next African Union Summit, let us have a clear roadmap for African leadership for the AIDS response.

Before we meet in Washington D.C. for the International AIDS Conference, let us ensure that we have reviewed the progress made since the 2011 United Nations High Level Meeting on AIDS and we are on track to reach our goals by 2015.

By World AIDS Day, let us be able to report fewer laws blocking key populations from accessing services. Let us be able to report that more children have been born free from HIV, more people are on treatment and even fewer young people have become infected with HIV.

If 2012 is to be the memorable year we all want for the AIDS response, then I must count on you—our partners in solidarity; our partners for innovation, integration and implementation.

My best wishes,



Michel Sidibé
Executive Director, UNAIDS

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

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