

OUTLOOK

THE A TO Z OF
UNIVERSAL
ACCESS

WHERE DOES
THE MONEY FOR
AIDS GO?

THAT WAS THEN.
THIS IS NOW!

IN MY WORDS:
HIV PREVENTION,
4 PEOPLE, 4 STORIES

THE LAST
WORD FROM
MICHEL SIDIBÉ

A DAY
IN THE LIFE

PRUDENCE MABELE SHARES HER STORY

The Harsh Divide

AIDS Treatment in Africa

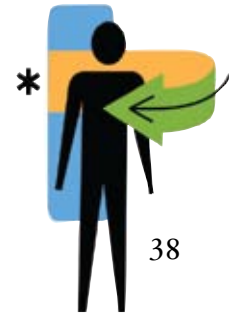


© Gideon Mendel, 2003



Thobani Ncapayi, from Khayelitsha, Cape Town, is HIV-positive and receiving treatment. "Now I feel like everybody else. I am not thinking all the time about HIV. I do not bury my dreams", he says.

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“PEOPLE LIVING WITH HIV SHOULD NOT BE DISCRIMINATED AGAINST, INCLUDING THROUGH RESTRICTIONS ON THEIR ABILITY TO TRAVEL BETWEEN COUNTRIES. THAT THEY ARE SHOULD FILL US ALL WITH SHAME.

...I CALL ON ALL GOVERNMENTS TO REVIEW THEIR LEGAL FRAMEWORKS TO ENSURE COMPLIANCE WITH THE HUMAN RIGHTS PRINCIPLES ON WHICH A SOUND AIDS RESPONSE IS BASED. THIS IS NOT SOLELY A MEDICAL OR SCIENTIFIC CHALLENGE. IT IS A MORAL CHALLENGE, TOO. LET US FIND THE WISDOM AND COURAGE FOR BOLD ACTION ON ALL THESE FRONTS. THAT IS THE ONLY WAY TO ADDRESS THIS CHALLENGE IN ALL ITS COMPLEXITY AND BREADTH.”

UNITED NATIONS SECRETARY-GENERAL BAN KI-MOON

>

THE UNITED STATES RECENTLY JOINED A GROWING NUMBER OF COUNTRIES IN REMOVING HIV-RELATED TRAVEL RESTRICTIONS.

UNAIDS ESTIMATES THAT NEARLY 60 COUNTRIES IMPOSE SOME FORM OF TRAVEL RESTRICTIONS ON PEOPLE LIVING WITH HIV. THE INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS STATE THAT ANY RESTRICTION ON LIBERTY OF MOVEMENT OR CHOICE OF RESIDENCE BASED ON SUSPECTED OR REAL HIV STATUS ALONE, INCLUDING HIV SCREENING OF INTERNATIONAL TRAVELLERS, IS DISCRIMINATORY.

>

What We Are Thinking

TOWARDS UNIVERSAL ACCESS

South Africa, home to the largest number of people living with HIV, will launch on World AIDS Day 2009 a major mobilization campaign towards achieving its universal access goals. President Zuma has committed the government to achieving 80% coverage for antiretroviral therapy and to cutting new HIV infections by half. This reinvigorated commitment has the potential to reshape the face of the epidemic. Many other countries are also reviewing their national responses to AIDS, fine-tuning their strategies for scaling up access to HIV prevention, treatment, care and support. (Read excerpts of President Zuma's speech on page 11.)

EACH SMALL STEP COUNTS

Human rights and dignity for the voiceless have gained the upper hand in many places. The Supreme Court of Indonesia has ruled that drug users need treatment, not jail. The Delhi High Court in India restored dignity to men who have sex with men by reading down a 150-year-old law that criminalized consensual adult sexual behaviour. El Salvador promulgated a ministerial decree banning discrimination based on sexual orientation. The United States of America has removed restrictions on people living with HIV entering the country. And sex workers in Kolkata, India, are running more than a dozen non-formal education centres and two boarding homes for children of sex workers to continue their education.

EACH BOLD IDEA COUNTS

UNAIDS believes that the virtual elimination of mother-to-child transmission of HIV can be achieved by 2015. In Botswana, Namibia and Swaziland, more than 90% of all HIV-infected pregnant women already receive antiretroviral prophylaxis for preventing their babies from being born with the virus. Universal access targets for antiretroviral therapy are being met in many countries, including Zambia. The integration of tuberculosis and HIV services in South Africa has helped to save the lives of many people and has reduced the tuberculosis burden.

The demand for AIDS treatment should become an opportunity for Africa to reform its pharmaceutical practices. A single African drug agency has the potential to guarantee quality medicines, integrate the African market for drugs and invite private sector investment in the continent. And it can be a model for wider development that will contribute to an AIDS+MDG movement in Africa.

The Thailand vaccine trial has shown that a vaccine against HIV will be available one day. When that day comes, it must be financed as a public good, accessible by all.

AIDS IS COMING OUT OF ISOLATION

For all its uniqueness, AIDS cannot be left in a silo. Recent evidence shows that HIV may have a significant impact on maternal mortality. Research models estimate that about 50 000 maternal deaths were associated with HIV in 2008. The two programmes, maternal child health and HIV, must work in synergy to achieve their common goal—saving mothers and babies. We must link our progress in AIDS to the other Millennium Development Goals and pursue a bold strategy that will take us to 2015 and beyond.

In This Issue

In this first issue *UNAIDS Outlook Report* explores new ideas and ways to use the data collected in the *AIDS Epidemic Update* companion report.

It's clear that the HIV epidemic the world faces today is not the same as when it was at its peak in 1996. The number of people living with HIV has continued to grow, albeit less rapidly. The way we respond today needs to keep pace with and overtake the epidemic if we are to see a real change in people's lives, aspirations and futures.

Here are some key statistics for the year 2008:

NEW INFECTIONS PER DAY

Children	1200	↓
Young people	2500	↓
Adults	3700	↓

NEW HIV INFECTIONS

Children	430,000	↓
Young people	920,000	↓
Adults	1,340,000	↓

PEOPLE LIVING WITH HIV

Children	2,100,000	↑
Young people	5,000,000	↑
Adults	26,300,000	↑

AIDS-RELATED DEATHS

Children	280,000	↓
Adults	1,700,000	↑

RESOURCES AVAILABLE (US\$)

Multilateral ODA	2.1 billion	↑
Bilateral ODA	5.7 billion	↑
Domestic	7.2 billion	↑
Philanthropic	0.7 billion	↑

DID YOU KNOW?

Facts from the 2009 AIDS Epidemic Update



1 CAMBODIA

The age difference between spouses in Cambodia correlates positively with a woman's increased risk of HIV infection.

2 KENYA

In 2007, HIV prevalence among uncircumcised men in Kenya was more than three times higher than among men who were circumcised.

3 RUSSIA

In the Russian Federation studies indicate that more than 30% of sex workers have injected drugs.

4 PAPUA NEW GUINEA

Between 2007 and 2008, the number of people over the age of 15 who received HIV testing and counseling in Papua New Guinea went up approximately fourfold.

5 EGYPT

In Egypt, 6.2% of reported AIDS cases are due to receipt of blood products, while 12% come from renal dialysis.

6 CHILE

A five-clinic survey of female sex workers in Santiago, Chile, detected no HIV infections. Sex workers reported always using condoms with clients; however, consistent condom use with steady partners was rare.

7 USA

In the United States, the rate of new HIV infections among men who have sex with men has steadily increased since the early 1990s, rising by more than 50% in 1996–2009.

8 NETHERLANDS

The Netherlands reported no new HIV infections due to mother-to-child transmission in 2007.

9 CHINA

In China, estimated HIV prevalence among injecting drug users ranges from 6.7% to 13.4%.

EPI DEMIC OVER VIEW

The number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million (31.1 million–35.8 million). The continuing rise in the population of people living with HIV reflects the combined effects of continued high rates of new HIV infections and the beneficial impact of antiretroviral therapy. Globally, the spread of HIV appears to have peaked in 1996, when 3.5 million (3.2 million–3.8 million) new HIV infections occurred. In 2008, the estimated number of new HIV infections was 2.7 million (2.4 million–3.0 million).

The epidemic appears to have stabilized in most regions, although prevalence continues to increase in Eastern Europe and Central Asia, due to a high rate of new HIV infections. Sub-Saharan Africa remains the most heavily affected region, accounting for 71% of all new HIV infections in 2008. The resurgence of the epidemic among men who have sex with men in high-income countries is increasingly well-documented. Differences are apparent in all regions, with some national epidemics continuing to expand even as the overall regional HIV incidence stabilizes. AIDS-related deaths appear to have peaked in 2004. The estimated number of AIDS-related deaths in 2008 is 2 million (1.7 million–2.4 million).

An estimated 430 000 new HIV infections (240 000–610 000) occurred among children under the age of 15 in 2008. Most of these new infections are believed to stem from transmission *in utero*, during delivery or post-partum as a result of breastfeeding.

SUB-SAHARAN AFRICA

The epidemic continues to have an enormous impact on households, communities, businesses, public services and national economies in the region. However, the rapid scaling-up of antiretroviral therapy in sub-Saharan Africa is generating consider-

able public health gains. Yet sub-Saharan Africa's epidemic continues to outpace the response. Preserving the long-term viability of treatment programmes and mitigating the epidemic's impact in the region requires immediate steps to elevate the priority given to HIV prevention and to match prevention strategies with actual needs.

ASIA

Asia is home to 60% of the world's population and is second only to sub-Saharan Africa in terms of the number of people living with HIV. Asia's epidemic has long been concentrated in specific populations, namely injecting drug users, sex workers and their clients, and men who have sex with men. However, the epidemic in many parts of Asia is steadily expanding into lower-risk populations through transmission to the sexual partners of those most at risk. In China, where the epidemic was previously driven by transmission during injecting drug use, heterosexual transmission has become the predominant mode of HIV transmission.

EASTERN EUROPE AND CENTRAL ASIA

Eastern Europe and Central Asia is the only region where HIV prevalence clearly remains on the rise. Injecting drug use remains the primary route of transmission in the region. In many countries, drug users frequently engage in sex work, magnifying the risk of transmission. With increasing transmission among the sexual partners of drug users, many countries in the region are experiencing a transition from an epidemic that is heavily concentrated among drug users to one that is increasingly characterized by significant sexual transmission.

CARIBBEAN

The Caribbean has been more heavily affected by HIV than any region outside sub-Saharan Africa, with the second highest level of adult HIV prevalence. AIDS-related illnesses were the fourth leading cause of

The following are excerpts from the 2009 AIDS Epidemic Update, which reports on the latest developments in the global AIDS epidemic. With maps and regional summaries, the 2009 edition provides the most recent estimates of the epidemic's scope and human toll and explores new trends in the epidemic's evolution.

death among Caribbean women in 2004 and the fifth leading cause of death among Caribbean men. Heterosexual transmission, often tied to sex work, is the primary source of HIV transmission, although emerging evidence indicates that substantial transmission is also occurring among men who have sex with men.

LATIN AMERICA

With a regional HIV prevalence of 0.6%, Latin America is primarily home to low-level and concentrated epidemics. Men who have sex with men account for the largest share of infections in Latin America, although there is a notable burden of infection among injecting drug users, sex workers and the clients of sex workers. But only a small fraction of HIV prevention spending in the region supports prevention programmes specifically focused on these populations. The HIV burden appears to be growing among women in Central America.

MIDDLE EAST AND NORTH AFRICA

Epidemics in the Middle East and North Africa are typically concentrated among injecting drug users, men who have sex with men, and sex workers and their clients. Exceptions to this general pattern are Djibouti and southern Sudan, where transmission is also occurring in the general population.

NORTH AMERICA AND WESTERN AND CENTRAL EUROPE

Progress in reducing the number of new HIV infections has stalled in North America and Western and Central Europe. Between 2000 and 2007, the rate of newly reported cases of HIV infection in Europe nearly doubled. In 2008, the Centers for Disease Control and Prevention (USA) estimated that annual HIV incidence has remained relatively stable in the USA since the early 1990s, although the annual number of new HIV infections in 2006 was approximately 40% greater than previously estimated.

THAT WAS THEN. THIS IS NOW!

NEW DATA FROM THE 2009 AIDS EPIDEMIC UPDATE SHOWS US THAT WE HAVE TO BECOME SMARTER ABOUT HIV PREVENTION IF WE WANT TO MAKE A REAL DIFFERENCE.

With an estimated 2.7 million new HIV infections worldwide and five new people becoming infected for every two put on antiretroviral treatment, it's becoming increasingly clear that major programmes that worked in preventing new infections at the beginning of the epidemic may not have the same effect now.

As the HIV epidemic is evolving, so must the response. One way countries are adapting is by using data to follow the source of new infections, or 'modes of transmission', and then basing HIV

prevention programmes on the evidence they find. This model is also proving helpful in detecting dissonance between where the infections are occurring, for developing strategies to stop new infections and for resource allocation.

The national AIDS authorities of Kenya, Lesotho, Swaziland, Uganda and Zambia have just done this; their findings were recently published in a series entitled *HIV prevention response and main modes of transmission*.

This has helped to answer key questions, such as where should HIV preven-

tion programmes be focused? And what should HIV programming consist of?

Experience from various countries clearly indicates that HIV prevention programmes work when we do the following:

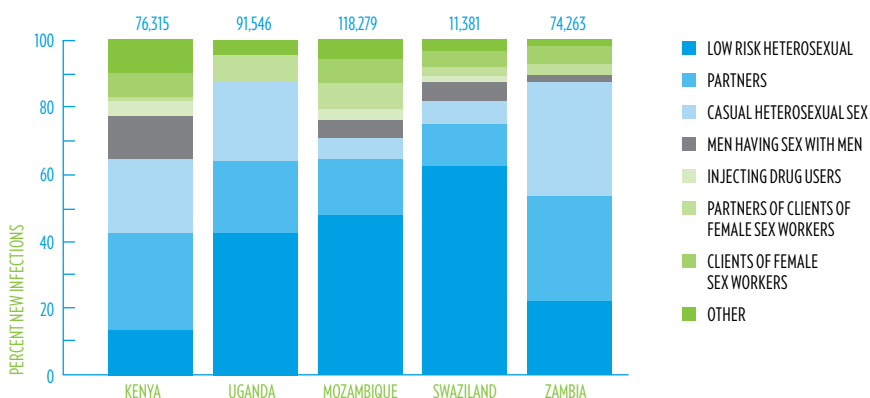
- Better understand populations at higher risk;
- Address contextual factors;
- Saturate high-burden areas as a priority;
- Increase investments for HIV prevention and sustain them over time.

BETTER UNDERSTANDING OF POPULATIONS AT HIGHER RISK

In some countries with generalized and hyperendemic epidemics, HIV has spread to the general population. Even in such situations, a better understanding of the risk dynamics is necessary for the formulation of prevention messages that make a difference.

Take, for example, a small country like Lesotho, where there are nearly 60 new infections each day. Adult HIV prevalence in Lesotho is more than 23%, and both men and women start having sex at an early age. From a simple reading of these data one might think that HIV prevention programmes must try to reach all men and women in Lesotho. However, researchers found that those with a single partner accounted for more than one third of all new infections, while nearly two thirds occurred due to multiple partner behaviours. Additionally, the 2004 demographic and health surveys study showed that a third of all couples in the country include one partner living with HIV. However, few behaviour and social change com-

Chart 1. Incidence by modes of transmission



Source: results from know your epidemic project in southern and east Africa. Reports available at <http://www.unaidsrsta.org/hiv-prevention-modes-of-transmission>.

munications programmes were targeted explicitly towards adults, married couples and people in long-term steady relationships. A similar conclusion was also drawn by researchers in Swaziland.

In fact, Swaziland felt that it had to redefine its definition of 'populations at higher risk' and customize them to their own epidemic pattern. For example, they identified mobile populations as a group needing attention, as men and women who were away from home for longer periods and slept more nights away from home have higher HIV prevalence. Other groups identified for HIV prevention programmes were people in longer-term steady relationships and married couples who have multiple and concurrent partners, HIV-discordant couples and concordant positive couples and people living with HIV.

In Kenya most new infections occur in people who engage in casual sex with multiple partners and among their monogamous partners. However, the study highlighted the continued need to reach sex workers, men who have sex with men, prisoners and injecting drug users, who together account for nearly 31% of all new infections. Similar conclusions were also drawn in Mozambique, where about 27% of new infections occurred among sex workers, men who have sex with men and injecting drug users.

On the other hand, the epidemic in Asia is fuelled by unprotected paid sex, the sharing of contaminated injecting equipment by injecting drug users and unprotected sex among men who have sex with men. Men who buy sex constitute the largest infected population group—and most of them are either married or will get married. This puts a significant number of women, often perceived as 'low-risk' because they only have sex with their husbands or long-term partners, at risk of HIV infection. The numbers can be staggering, as Asian countries have huge populations.

TIP: LOOK DEEPER AT YOUR EPIDEMIC—MAKE SURE THAT PREVENTION MESSAGING IS NOT DILUTED BY LABELLING ALL AT EQUAL RISK OR LOW RISK.

ADDRESS CONTEXTUAL FACTORS

Studies show that despite the evidence of the risk factors of the epidemic, there are few programmes that address the social and structural factors adequately in HIV prevention programmes.

The modes of transmission study in Swaziland showed that its HIV epidemic is maintained by underlying cultural and socioeconomic factors, such as power differentials in intimate relationships,

THAT WAS *Then* & THIS IS *Now*

THEN

IN AFRICA, MULTIPLE PARTNERS

SUGAR DADDIES IN AFRICA. OLDER MEN HAVING SEX WITH YOUNG WOMEN

TREATMENT TOO EXPENSIVE TO BECOME WIDESPREAD

THE ASIA EPIDEMIC WILL BECOME AS GENERALIZED AS IN AFRICA

IN ASIA, CONCENTRATED AMONG POPULATIONS AT HIGHER RISK—MEN WHO HAVE SEX WITH MEN, INJECTING DRUG USERS AND SEX WORKERS AND THEIR CLIENTS

IN LATIN AMERICA, FOCUS MAINLY ON INJECTING DRUG USE, SEX WORKERS AND THEIR CLIENTS

IN MIDDLE EAST AND NORTH AFRICA, NO RISK GROUPS

IN WESTERN EUROPE AND NORTH AMERICA, HIV AMONG MEN WHO HAVE SEX WITH MEN AND INJECTING DRUG USERS IS ON THE DECLINE

NOW

MULTIPLE AND CONCURRENT PARTNERS

MORE EVIDENCE OF YOUNG MEN WITH YOUNG WOMEN, AND OLDER WOMEN AND YOUNGER MEN

4 MILLION PEOPLE ON TREATMENT AROUND THE WORLD, INCLUDING A GREATER UNDERSTANDING OF PAEDIATRIC FORMULATIONS

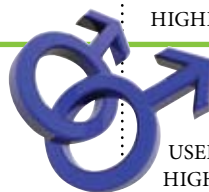
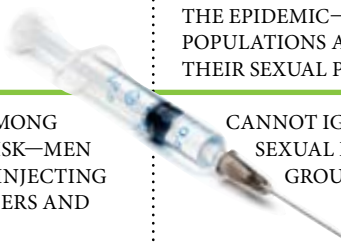
A REGIONAL UNDERSTANDING OF THE EPIDEMIC—CONCENTRATED IN POPULATIONS AT HIGHER RISK AND THEIR SEXUAL PARTNERS

CANNOT IGNORE LONG-TERM SEXUAL PARTNERS OF RISK GROUPS

INCREASING ATTENTION ON MEN WHO HAVE SEX WITH MEN—GROUP AT HIGHER RISK

RISK GROUPS BECOMING VISIBLE: AMONG MEN WHO HAVE SEX WITH MEN, INJECTING DRUG USERS, STREET CHILDREN AND HIGHER-RISK MEN

INCREASING INCIDENCE AMONG MEN WHO HAVE SEX WITH MEN AND AMONG RACIAL AND ETHNIC MINORITIES



sexual entitlements, cultural expectations of men and women and income inequality. Men and women continue to have long-term multiple concurrent sexual partnerships in which sexual acts are often unprotected.

In Lesotho, age-disparate relationships are common and contribute to the very high HIV prevalence in females. This practice is not properly addressed by policies to change the social norms that are currently permissive towards such relationships. Similar findings were also seen in Kenya, Mozambique, Swaziland and Zambia.

Violence against women and girls is another issue that needs to be addressed as part of HIV prevention programmes. A multicountry study conducted by the World Health Organization found that between 1% and 21% of women reported sexual abuse before age 15 across the

world. A recent UNICEF study in Swaziland showed that one in four women faced sexual violence as a child and two out of three 18–24-year-old women had experienced sexual violence. The study also showed that boyfriends and husbands were the most frequent abusers.

Prevention experts in all these countries concluded that current HIV prevention strategies that focus primarily on individual behaviour rather than on the social norms that make risky behaviour acceptable are not adequate to effectively reduce HIV transmission.

TIP: THINK SOCIAL CHANGE.

SATURATE HIGH-BURDEN AREAS AS A PRIORITY

HIV prevalence figures must be read in conjunction with national demographics. A UNAIDS study that looked at the extent of HIV in urban

areas found that 29% of the total HIV epidemic in the eastern and southern Africa region was concentrated in 15 major cities. Together, this is nearly 15% of the global epidemic. But there are few dedicated urban-focused programmes in Africa.

This was also confirmed in the modes of transmission study in Lesotho, which found that even though adult HIV prevalence is above 15% in all districts, 59% of people living with HIV reside in the three western most populous districts. This means precious resources could go further and achieve more if HIV prevention programmes were scaled up in the three most heavily affected districts.

TIP: FOCUS ON THE GEOGRAPHICAL AREAS WHERE MOST NEW INFECTIONS ARE LIKELY TO OCCUR.

INCREASE RESOURCE ALLOCATION FOR HIV PREVENTION

Another way of looking at why prevention programmes are failing is to look deeper into the investments being made. The trend is worrying. Spending on HIV prevention programmes is low in most parts of the world and is falling in many instances. And what is available is not reaching those most in need.

In Uganda, only one third of the resources invested in the AIDS response went towards prevention, while more than half went towards care and treatment. In Swaziland, the HIV prevention budget was only 17% of the total funding available, while in Lesotho it was a mere 10%.

In Kenya and Lesotho, HIV prevention spending has fallen in recent years. Since 2005 the amount of total funding available at the national level for prevention activities in Kenya has fallen to less than 25% of the total AIDS funding.

We have to eliminate mother-to-child transmission of HIV. Rightfully, major investments from within the HIV prevention budget go towards preventing babies from being born with HIV. In Kenya, approximately half of the prevention resources go towards counselling and testing and the prevention of mother-to-child transmission of HIV.

In many countries, funding aimed at groups at higher risk, such as sex workers and their clients, men who have sex with men and injecting drug users, are negligible or non-existent in proportion to their contribution to new infections. Most of the prevention funding goes towards raising awareness, with less for supporting contextual factors.

TIP: INVESTMENTS IN HIV PREVENTION HAVE TO SIGNIFICANTLY INCREASE IF A SERIOUS ATTEMPT AT STEMMING NEW INFECTIONS IS TO BE MADE.

WHAT NEXT? RESHAPING HIV PREVENTION PROGRAMMES

Many countries are beginning to use findings from modes of transmission studies to look ahead and plan better. The National AIDS Commission of Lesotho has used the data from the review to revise its national strategic plan. The plan was recasted and a set of scenarios was developed to help prioritize and make cost-effective investments. The data also helped to inform the development of a number of sector-specific policies and a behaviour change communication strategy.

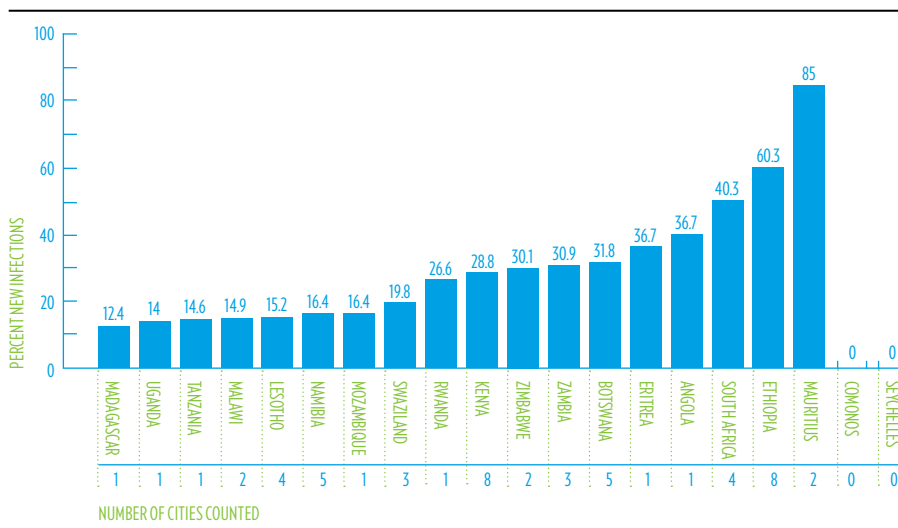
In Uganda, the results of a similar study were widely disseminated, including through the mass media. This helped to increase understanding of the risk faced by different population groups. The Uganda study's finding that signifi-

cant HIV transmission occurred among married couples has paved the way for a campaign to promote HIV testing and counselling among couples. The Uganda National AIDS Commission used the findings to inform the development of prevention policy guidelines and the Ministry of Health agreed to focus on addressing couples as part of its prevention activities in health settings.

Responding to an evaluation of the impact of these studies, a respondent from Uganda said "There now appears to be consensus that there is a problem of new HIV infections among married and cohabiting [couples] and something has to be done to address this. Before the modes of transmission analysis there was a sense of denial, especially from the faith-based organizations..."

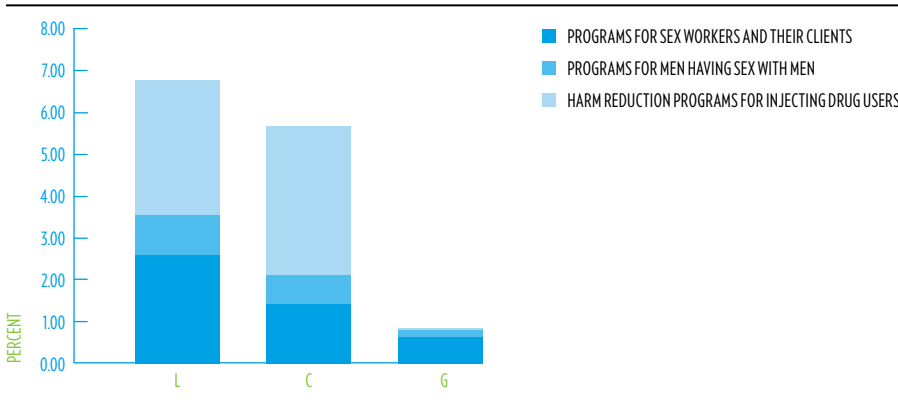
In Kenya, the modes of transmission studies influenced the decision to develop a new national strategic plan. "The fact that policy-makers decided to overhaul the current national strategy was a strong sign

Chart 2. Role of major cities in national HIV epidemics in eastern and southern Africa



Source: Van Renterghem, UNAIDS 2009.

Chart 3. Percentage of spending on programmes directed at populations at higher risk of HIV, as a percentage of total prevention spending, by type of epidemic



Source: Izazola J et al, Journal of AIDS 2009.

of how seriously they took the findings.”

The government has also committed substantial resources, including from domestic sources, to help the National AIDS Commission better coordinate the AIDS response and to scale up the prevention response. “The study also brought greater attention to resource allocation and distribution and an ef-

Many countries are beginning to use findings from modes of transmission studies to look ahead and plan better.

fective national debate on this is taking place and has influenced decisions to be made that made the costing of the national response a key issue”.

HIV prevention needs strong leadership. A leadership that is bold enough to question the status quo and the continuing practice of harmful social norms and practices. Leadership that is able to galvanize communities to take collective responsibility for HIV prevention and to sustain these efforts over time with adequate investments.

Thailand learnt it the hard way. With visionary leadership and implementation of evidence-informed public health strategies in the 1990s, Thailand managed to arrest an epidemic that threatened to spiral out of control. When investment and focus for HIV prevention wavered in the wake of the Asian economic crisis, the epidemic bounced back.

TIP: HIV PREVENTION IS FOR LIFE. THERE ARE NO SHORT CUTS.

Uganda is showing similar patterns. Thanks to early leadership efforts, HIV prevalence declined from a peak of 18% in 1992 to 6.1% in 2002, but today there are signs that this decline may have ended. HIV prevalence has stabilized between 6.1% and 6.5% in some antenatal clinic sites and is rising in others. This has been accompanied by a deterioration in behavioural indicators, especially an increase in multiple concurrent partnerships.

But countries can learn from Thailand, which reinvested and prioritized its HIV prevention efforts and has succeeded in reducing HIV incidence in recent years. ●



In a landmark speech to the National Council of Provinces in October 2009, President Jacob Zuma presented his vision to stop the AIDS epidemic in South Africa. In his speech, the President called for an end to denialism and launched a major movement to cut new HIV infections by half and to reach at least 80% access to antiretroviral therapy by 2011.

Below are some excerpts from President Zuma’s speech:



Indeed, if we do not respond with urgency and resolve, we may well find our vision of a thriving nation slipping from our grasp.

...It is necessary to go into the hospitals, clinics and hospices of our country to see the effects of HIV and AIDS on those who should be in the prime of their lives. It is necessary to go into people’s homes to see how families struggle with the triple burden of poverty, disease and stigma. Let me emphasize that although we have a comprehensive strategy to tackle HIV and AIDS that has been acknowledged internationally, and though we have the largest antiretroviral programme in the world, we are not yet winning this battle. We must come to terms with this reality as South Africans.

...If we are to stop the progress of this disease through our society, we will need to pursue extraordinary measures. We will need to mobilize all South Africans to take responsibility for their health and well-being and that of their partners, their families and their communities.

...There should be no shame; no discrimination; no recriminations. We must break the stigma surrounding AIDS.

...Let World AIDS Day, on the 1st of December 2009, mark the beginning of a massive mobilization campaign that reaches all South Africans, and that spurs them into action to safeguard their health and the health of the nation. The important factor is that our people must be armed with information. Knowledge will help us to confront denialism and the stigma attached to the epidemic...we must not lose sight of the key targets that we set ourselves in our national strategic plan. These include the reduction of the rate of new infections by 50%, and the extension of the antiretroviral programme to 80% of those who need it, both by 2011. Prevention remains a critical part of our strategy. We need a massive change in behaviour and attitude especially amongst the youth. We must all work together to achieve this goal.

...The renewed energy in the fight against AIDS and in mobilizing towards World AIDS Day must start now, by all sectors of our society. Working together, we cannot fail. Whatever challenges we face, we will overcome. Whatever setbacks we endure, we will prevail. Because by working together we can and will build a thriving nation.



The full speech can be accessed online at: <http://www.thepresidency.gov.za>.

Anatomy of a Bad Law

Note to readers: the comments are the reactions of the Executive Secretary upon receiving this advice from the legal ministry. She is sharing her thoughts and frustrations with her colleagues. Her reactions reflect some of the legal obstacles that impede access to universal access to HIV prevention, treatment, care and support. What additional changes would you make?

Somewhere in the world

Memo

To: Executive Secretary, National AIDS Authority
From: Permanent Secretary, Legal Affairs, Ministry of Law and Justice
CC: Readers of Outlook
Date: December 1, 2009
Re: DRAFT AIDS bill

We would like to acknowledge receipt of the draft AIDS bill. While the Law Ministry is aware of the gravity of the AIDS epidemic, it is concerned that a number of the provisions are in contravention of existing laws. These laws are important to protect our society from various vices. In our view, dilution of these laws would hamper the ability of enforcement agencies to maintain law and order in the country. For example:

Penal Code

Section 234—Public Nuisance: "A person is guilty of nuisance when he/she does any act, or is guilty of an illegal omission, and such act or omission causes any common injury, danger or annoyance to the public, or to the people in general who dwell or occupy property in the vicinity, or must necessarily cause injury, obstruction, danger or annoyance to any persons who had rights to use. Whoever causes nuisance shall be punishable with imprisonment, or a fine, or both."

This provision provides protection against the misuse of public places by individuals. For example, the misuse of public parks and spaces by women and men of disrepute is curbed to a large extent.

Section 420—Unnatural Offences: "Any person who (a) has carnal knowledge of any person against the order of nature; (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature, commits an offence and is liable to imprisonment for life. Any person who attempts to commit any of the offences specified in section 420 commits a felony and is liable to imprisonment for seven years."

As you are aware, homosexuality is against our societal values. This provision, though rarely used, is an important moral deterrent. Given the alarming increase in paedophilia, we must take steps to increase the enforcement of this law, rather than modify it.

Section 345—Prostitution: "Any person who carries on prostitution, and the person with whom such prostitution is carried out, in any premises...which are within a distance of two hundred metres of any

We need to better define annoyance and do more work with law enforcement officials. The law is abused to harass sex workers and men who have sex with men.

Says who? Look at our literature and history...

Men who have sex with men and paedophilia are not the same. There are other laws to address exploitation of children, which is a crime..

Why are we trying to regulate adult sexual behaviour?

Since when is 'looking gay' in public a misuse of public space?



We need substitution therapy drugs on essential medicines list, not banned substances list.

Don't mix trafficking and sex work. Trafficking is a crime and has a specific definition.

I would rather have a rigorous implementation of community-led prevention and treatment services

place of public religious worship, educational institution, hostel, hospital, nursing home or such other public place of any kind...may be punishable with imprisonment for a term which may extend to 3 months.)
We are bound by international conventions and human rights considerations to **stop trafficking** of women and girls. The eradication of prostitution is an important political objective of the government. It is already recognized that sex workers are sources of HIV infection. Hence the rigorous application of this law will reduce prostitution and greatly advance the goals of your ministry.

And their 'source' of infection?

Look at the neighboring country. They decriminalized sex work and now HIV infections are down.

Narcotics Act of 1985

Section 24—Consumption of narcotic substances: "Where the narcotic drug or psychotropic substance possessed or consumed is cocaine, morphine, diacetyl-morphine or any other narcotic drug or any psychotropic substance as may be specified in this behalf by the Government, by notification in the Official Gazette, with imprisonment for a term which may extend to one year or with a fine or with both."

Section 34—Punishment for illegal possession in a small quantity for personal use, consumption of any narcotic drug or psychotropic substance or consumption of such drug or substance: "Whoever, in contravention of any provision of this Act, or any rule or order made or permit issued there under, possesses in a small quantity any narcotic drug or psychotropic substance, which is proved to have been intended for his personal consumption and not for sale or distribution, or consumes any narcotic drug or psychotropic substance, be punishable by five years in prison."

The above two articles were included to specifically stop young people from taking drugs and falling prey to addiction.

Section 35—Detention of drug users and peddlers: "Detain and search any person whom he has reason to believe to have committed an offence punishable under Chapter III, and, if such person has any narcotic drug or psychotropic substance in his possession and such possession appears to him to be unlawful, arrest him and any other person in his company. For the purposes of this section, the expression "public place" includes any public conveyance, hotel, shop, or other place intended for use by, or accessible to, the public."

This provision is of great importance to help law enforcement agencies catch and punish offenders, especially those who are selling drugs.

Public Health Act 2007

Section 14—Disclosure of HIV status: "Any person who has been tested positive for HIV is bound to disclose his/her HIV status to his/her spouse or regular sexual partner as soon as possible provided the period does not exceed six (6) full weeks, starting from the date he/she was notified of his/her status. The testing centres shall provide all the necessary psychosocial support to facilitate the disclosure of the HIV test results and help the couple to accept and adapt to the reality of the infection. The testing centre shall be required to make the disclosure in the event of the expiration of six weeks, provided all efforts are made to enable the partners to have full understanding of the infection."

Amended by your request to amend this law and all provisions mentioned.

There are other ways for reducing demand for sex work or drug use. Let us not use fear of criminal penalties. It is driving them underground.

Listen to the Supreme Court of Indonesia: drug users need treatment, not jail sentences

Our outreach workers will be at risk of arrest any time. How come we do not see major drug traffickers getting put away?

Most people take steps to protect their loved ones. What is needed is an environment where people can take the test, not fear the test. Partner notification must be voluntary.

It's mostly women who are tested first. This will lead to more stigma and discrimination of women.



UNAIDS' NINE PRIORITY AREAS:

WE CAN REDUCE SEXUAL TRANSMISSION OF HIV

WE CAN PREVENT MOTHERS FROM DYING AND BABIES FROM BECOMING INFECTED WITH HIV

WE CAN ENSURE THAT PEOPLE LIVING WITH HIV RECEIVE TREATMENT

WE CAN PREVENT PEOPLE LIVING WITH HIV FROM DYING OF TUBERCULOSIS

WE CAN PROTECT DRUG USERS FROM BECOMING INFECTED WITH HIV

WE CAN REMOVE PUNITIVE LAWS, POLICIES, PRACTICES, STIGMA AND DISCRIMINATION THAT BLOCK EFFECTIVE RESPONSES TO AIDS

WE CAN STOP VIOLENCE AGAINST WOMEN AND GIRLS

WE CAN EMPOWER YOUNG PEOPLE TO PROTECT THEMSELVES FROM HIV

WE CAN ENHANCE SOCIAL PROTECTION FOR PEOPLE AFFECTED BY HIV



BEING THE CHANGE | *The next generation*

A change is happening among young people across the world, especially in parts of sub-Saharan Africa. Young people are waiting longer to become sexually active, they have fewer multiple partners and there's an increased use of condoms among those with multiple partners. As a result, HIV prevalence among young people is dropping in many countries.



CHANGING WITH THE TIMES

Let us imagine Precious¹, a young woman in Mbabane, Swaziland. She has heard a lot about HIV. In her school. At church. And in hushed tones at funerals. She knows she has to protect herself, but fears she will let herself get carried away when she is with her boyfriend, Prince. Prince says he is faithful to her and gives her lots of gifts. Her risk of acquiring HIV infection is far different from that of Kathleen, who is of the same age and has a boyfriend and lives in a suburb of Dublin, Ireland.

Iqbal, a young man in Dhaka, Bangladesh, who goes to school has a much reduced risk of acquiring HIV infection than Damien, his peer in Port Moresby, Papua New Guinea. And in Kathmandu, Nepal, Siddharth, a young injecting drug user, has a much higher risk than Gautam, a boy of his own age who does not use drugs. Sixteen-year-old Eduardo in São Paulo, Brazil, is recognizing that he is gay and is beginning a conversation with his parents about it. Each of them faces life in a different way. Their risks are different. Their vulnerabilities are different.

Why is it then that most HIV prevention programmes for young people treat each one of them as the same?

The risk of young people acquiring HIV depends on their gender, age and the region they come from. Therefore decisions about prevention programmes for young people, as with other populations, should be informed by evidence.

Unfortunately, in countries with generalized and hyperendemic epidemics, HIV prevention programmes for young people are not rigorous enough to address the root causes of increasing risk and vulnerability of our imaginary young people, Precious, Prince and Damien.

On the other hand, in countries with low or concentrated epidemics, HIV prevention programmes are aimed at all young people, taking up resources that would have been better served if focused on young people like Siddharth and Eduardo.

A provincial AIDS programme manager in a low-prevalence country once remarked to a visiting donor delegation that was pushing for focus on populations at higher risk “they may be your targeted population, but young people are our precious population.”

A typical programme reaching a young person costs US\$ 9 per year. The choices we have to make are about finding cost-effective ways of reaching young people and choosing

appropriate programmatic elements that take into account a better appreciation of their risk of HIV infection.

WHEN BEING FEMALE IS A RISK FACTOR

In several parts of the world the risk of becoming infected by HIV is disproportionate for girls and young women. HIV prevalence among young women is higher than among men in many Caribbean and Oceanic countries. Teenage girls in Kenya are three times more likely to be infected with HIV than boys of their age. This worsens as they approach adulthood, with nearly five and a half times more women than men of the same age infected.

The real issue is not being female. The higher risk continues because of the failure globally to address the root causes of their vulnerability, engaging on issues such as intergenerational sex, transactional sex, concurrent sexual partnerships and violence.

COUNTERING THE COUGAR AND SUGAR DADDY FACTOR

A high rate of intergenerational sexual partnerships is seen in many countries where young women and men want or need money and goods and older men and women have the resources to meet these needs and desires.

A qualitative study on multiple concurrent partnerships in Lesotho showed that, among other things, money and a desire

Young people now account for 40% of all new infections, down from 45% in previous years.

for material goods were viewed as the central factors in all age-discrepant relationships. One of the participants said, “As schoolgirls, we like the guys who have cars and these days you will find that it is the older guys who have cars. The older guys, these ones who are more like adults, those are the ones that you will feel like they have really charmed you.” In South Africa in 2008 more than a quarter of all young women had sexual partners five or more years older than themselves.

Sometimes young people are seeking basic necessities, such as food and clothes. Other times they are acutely aware of what they don't have compared with their peers. As intergenerational sex is a societal issue it cannot be tackled by mere provision of information about abstinence, being faithful or safer sex. What are needed are social sanctions against the adults who practise it. And parents need to support their children when they stand up against this practice. Having multiple and concurrent partners is also reported among young people in many countries. The factors promoting concurrency among young people are many and full of complexities.

It would be too simplistic to characterize

all sexual activity as transactional or age-disparate. Sexual activity begins relatively early for girls and boys in many countries with generalized HIV epidemics. A study in Swaziland reports that protective traditional values have disappeared due to peer pressure and modernization. On the other hand, sexual norms in many cultures promote the practice of multiple partnerships.

Some harmful sexual behaviours are not just tolerated but promoted. A popular Sesotho saying goes “men are pumpkins. They will spread to other yards.” Various studies have shown that engaging men and boys, who often perpetuate negative sexual norms, is essential for sustainable social change.

But are HIV prevention programmes addressing these factors? Sadly not. A review of HIV prevention programmes in sub-Saharan Africa shows that few programmes directly address the issues of concurrency, multiple partners or age-disparate sex. Most focus on creating awareness.

RISKY BUSINESS

The story in countries with low or concentrated epidemics is similar, with HIV prevention programmes for young people rarely addressing the root causes of HIV risk and vulnerability.

However, a greater travesty is that the programmes are reaching the wrong set of young people. According to the Asia Commission on AIDS, roughly 95% of HIV infections

among young people in Asia are among adolescents at higher risk. Yet more than 90% of resources for young people as a group are spent on low-risk youth, who account for less than 5% of infections. In Eastern Europe and Central Asia, a large number of new HIV infections occur among young people. A third of the street youth in Saint Petersburg, Russian Federation, were found to be infected with HIV.

There is an urgent need to change direction to reach the adolescents and young people at higher risk, such as injecting drug users, young men who have sex with men, and young women who sell sex and their young male clients. They are largely invisible and unreached by prevention services. And their reproductive and sexual health needs “are seldom addressed by traditional youth outreach programmes run in schools and youth network groups,” said

Fatiha Serour, Director, Commonwealth Youth Programme (CYP). “On the other hand, programmes reaching adults at higher risk often fail to grasp these special needs of adolescents and young people.”

Take the story of Srey Mon. She worked long hours of hard work for low pay in a small cafe in Phnom Penh, Cambodia.

New HIV infections among young people are dropping in many countries, notably in sub-Saharan Africa.

But her employer was very tough with her. Frustrated, she moved to another town and began selling sex. She did not have access to HIV prevention services as she worked alone. Eventually she got infected with HIV and died of an AIDS-related disease at the age of 24.

Javier goes to high school in La Paz, Bolivia. In the eyes of the law, he is not yet an adult. In his classroom, they talk of HIV. However, his classmates and parents do not know that he is gay. As a result, he is unable to seek HIV prevention services, and is afraid of stigma.

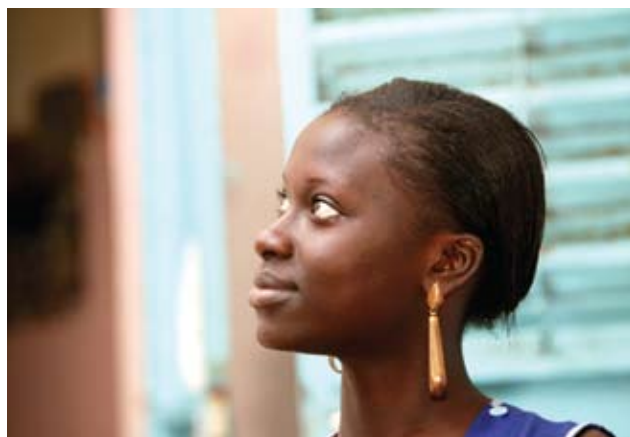
Srey Mon and Javier are not alone. There are thousands more like them who are not being reached early enough to protect them from HIV. However, policy-makers are taking notice in many countries and are adjusting their programmes to better suit young people at higher risk.

WE CAN EMPOWER YOUNG PEOPLE TO PROTECT THEMSELVES FROM HIV

To do this we have to be smart in our approaches. In generalized and hyperendemic epidemics, programmes for young people must promote comprehensive services that include knowledge about HIV, sexuality education and discussion on harmful sexual norms and practices. In other scenarios, programmes must focus on young people at higher risk as a priority, instead of homogenizing programmes for all young people.

Yes, all young people are precious, but let's provide them with programmes that are meaningful to their life contexts. ●

¹ The names in this article are fictitious, but the stories are real.



Prudence Mabele

Thirty-eight-year-old Prudence Mabele of South Africa has been living with HIV for 19 years. She is the founder and executive director of the Positive Women's Network (PWN), a nongovernmental organization she created in 1996 that provides support and information to women living with HIV in South Africa. The organization's work spans from the promotion of gender equality and equity, to education on sexual and reproductive health, to women's rights.

6:00 A.M. WAKE-UP

I get up early because I like to take my time. I watch Morning Live (a South African news and current affairs programme) to stay up to date with what's going on in my country, get inspiration and ideas, and learn about the issues that can influence my day-to-day work. A few weeks ago there was a discussion about female genital mutilation that prompted me to include this topic in our activities and discussions with PWN workers. Morning Live can sometimes make or break my day!

7:45 BREAKFAST

I love the feeling of making my own breakfast in the morning, usually a bowl of freshly cooked oatmeal and a cup of tea. After breakfast I take my treatment. I take it twice a day: at 8 a.m. and 8 p.m.

8:30 DRIVE

I drive to work in my own car, and that usually takes 25 minutes—Johannesburg's crazy traffic allowing.

9:00 WORK

I start my work by answering e-mails and making phone calls. I don't always

spend the whole day at the office. Some days I attend meetings and give presentations. Last week I was interviewed by the host of a popular South African national radio channel. I spoke a bit about myself, living with HIV, and PWN. After my interview, the host was inundated with phone calls from listeners asking all sorts of questions about HIV. This made me realize that there are many people who need information about HIV but don't know where to go or are afraid to ask someone in-person.

12:00 LUNCH

I usually take lunch down at one of the cafes near the office. There are lots of places offering freshly cooked food like homemade curries and sandwiches.

1:00 OUTREACH

I work often outside of the office to go out to the communities with the outreach coordinators and speak to women about HIV prevention, gender-based violence, women's rights and health issues.

3:00 EDUCATE

When I am out in the community, the reasons why I do what I do are so clear. I decided to create PWN to

educate positive women and give them the means to empower themselves, take control over their own lives, and support other women living with HIV. Through PWN, we provide emotional support and education, and we empower women to be agents of change in their own communities.

5:45 EXERCISE

Exercising is important for me, both physically and mentally. I try to work-out for an hour when I can at the gym that's near work.

7:00 DINNER

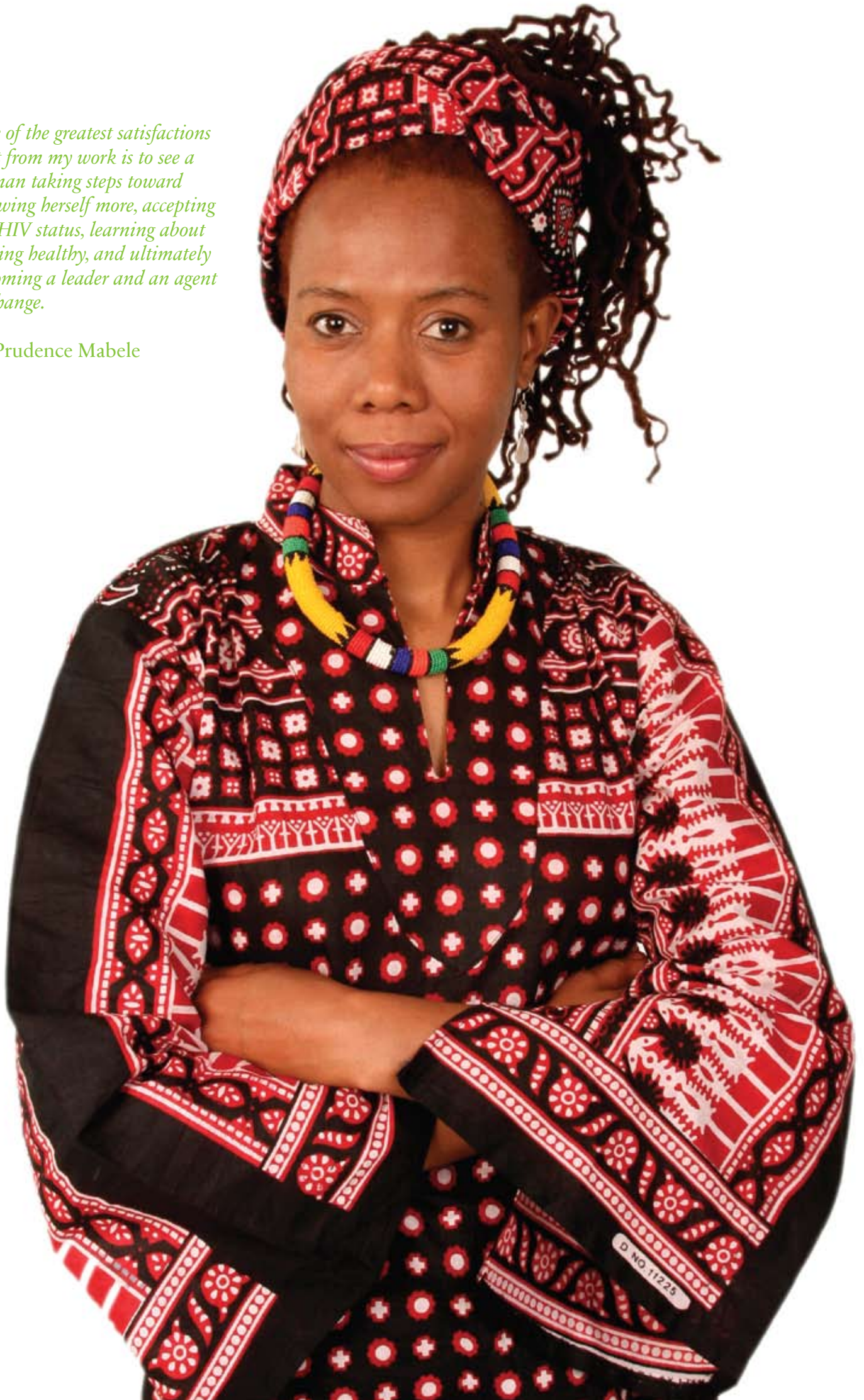
After settling in following a long day's work, I have dinner with friends, sometimes my sister stops by, and then I take my medicines at 8:00. I like to eat healthy food, and I often have fish, vegetables and rice. I love samp with beans, a staple South African meal. I watch a bit of television and then work for an hour or so. Yes, I'm a workaholic!

11:00 REST

In bed: recharging my batteries for another day.

*One of the greatest satisfactions
I get from my work is to see a
woman taking steps toward
knowing herself more, accepting
her HIV status, learning about
staying healthy, and ultimately
becoming a leader and an agent
of change.*

— Prudence Mabele





What's in her bag

1 UMBRELLA

Always good to have in case of rain.

2 KEYCHAIN

Supporting Rainbow Nation New South Africa and local craftspeople who design and create ribbons for PWN and other organizations.

3 SUNGLASSES

Blocking out the hot South African sun—and looking good too!

4 READING GLASSES

For the fine print.

5 CONDOMS

Male and female condoms: safer sex and HIV prevention awareness are instrumental to PWN's outreach and part of a combination prevention strategy.

6 WRITING INSTRUMENTS

Pens and highlighter in a nifty pouch.

7 WEEKDAY PILL BOX

Holds treatment regime taken twice daily.

8 BREAST CANCER LEAFLET

My friend recently died of breast cancer. I have taken the issue to heart and am including breast cancer awareness education in PWN's activities.

9 PASSPORT

Don't leave home without it, because you never know where you might need to go.

10 BUSINESS CARD

Who I am and what I do.

11 INTERNET KEY

I am workaholic, and this vital little tool lets me work on the go wherever I am.

12 CELL PHONE

So I can stay in touch.

13 MP3 PLAYER

Favourite album at the moment is Miriam Makeba's *Mama Africa*.

14 CAR KEYS

Getting me from here to there.

4 things you need to know about Prudence

1 First black woman in South Africa to disclose her HIV status—diagnosed in 1990 and went public in 1992. She did it because she was tired of the silence and stigma surrounding HIV, and she wanted to set a precedent and encourage other HIV-positive women to do the same, to discuss their status with their loved ones, not to be ashamed and to seek treatment and lead fulfilling lives.

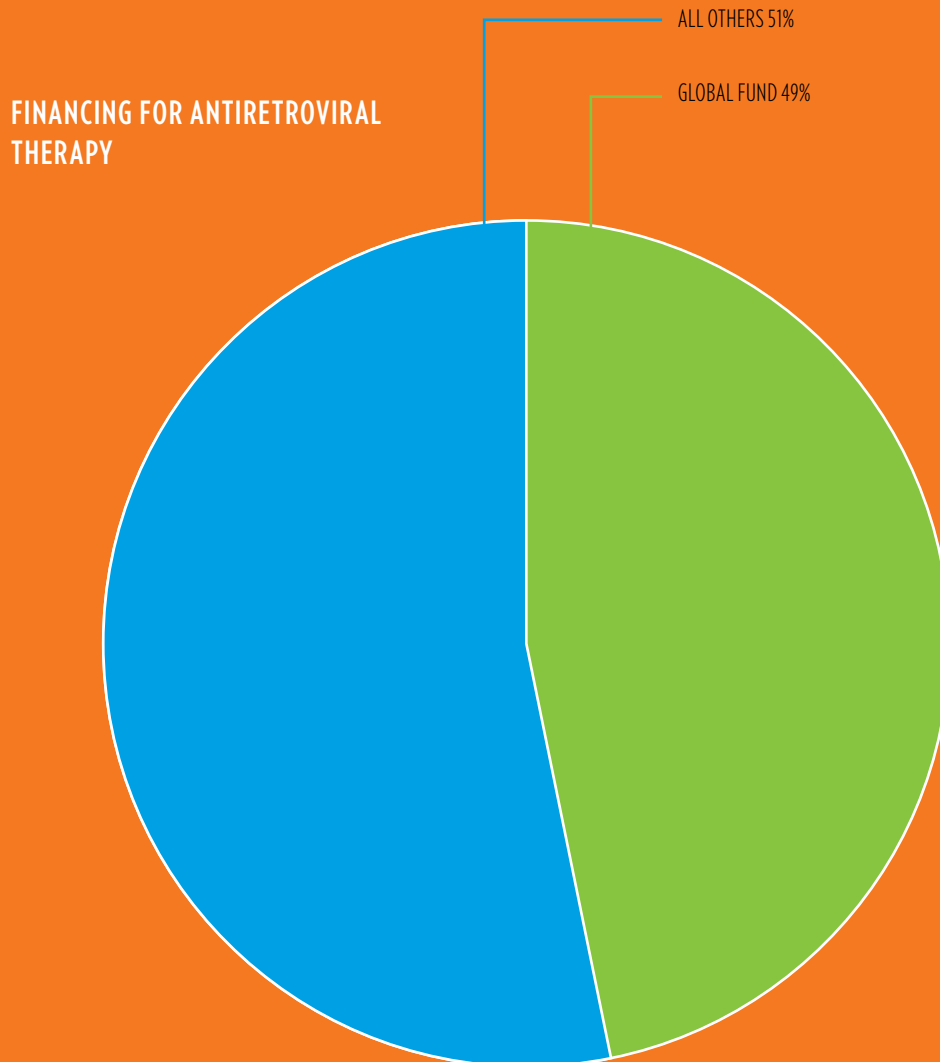
2 She loves jazz, especially South African and American. Hugh Masekela, Jonas Gwangwa, Jimmy Dlodlu and Gloria Bosman—the list is endless.

3 She defines her style as “Afrocentric”, with lots of ethnic jewellery. Her grandmother designed her own clothes and she instilled in her her love of fashion. She supports South African designers such as David Tlale, J.J. Schoeman and Bongiwe Walaza.

4 Next year she plans on starting her MBA to start her own business and further her work around helping people in communities and rural areas.



TREATMENT CASE STUDY: THE GLOBAL FUND

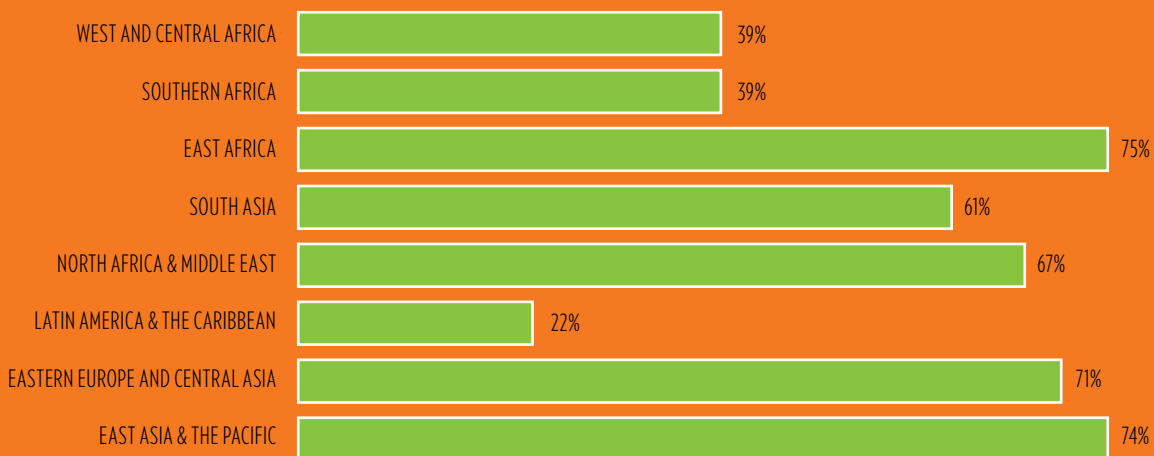


UNAIDS works closely with several funding partners, including the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

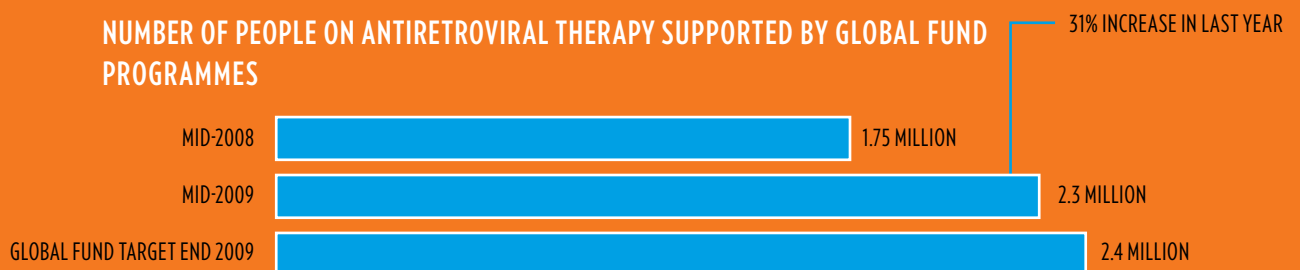
For example, UNAIDS provides technical assistance to countries seeking Global Fund grants to help to reach their universal access goals. With this help, countries are getting results and are making the case for a fully-funded Global Fund.

The Global Fund has increased access to antiretroviral therapy. At the end of 2008, four million people were estimated to be receiving treatment in low- and middle-income countries—half of these treatments were financed by the Global Fund. This was confirmed when WHO, UNAIDS and UNICEF reported in September 2009 that an additional one million people began antiretroviral therapy globally in 2008.

PERCENTAGE ON ANTIRETROVIRAL THERAPY SUPPORTED BY GLOBAL FUND PROGRAMMES



NUMBER OF PEOPLE ON ANTIRETROVIRAL THERAPY SUPPORTED BY GLOBAL FUND PROGRAMMES



The Global Fund was responsible for about 600 000 people commencing treatment in 2008 and by the end of 2008 was financing around half of the four million people estimated to be on antiretroviral therapy in low- and middle-income countries.



WHERE DOES THE MONEY FOR AIDS GO?

CONTINUED INTERNATIONAL INVESTMENTS FOR AIDS NEEDED

International assistance to the global AIDS response has helped countries to scale up access to HIV prevention, treatment, care and support programmes in most parts of the world. This international assistance has been instrumental in catalysing and sustaining the AIDS response in many countries.

The funding cycle patterns of donors to some extent insulated HIV investments in 2009. However, it is critical that investment decisions being

made today are based on future needs. Many developed countries are beginning to emerge from the economic crisis and it is increasingly important to meet the investment of US\$ 25 billion required to reach the 2010 country targets for universal access.

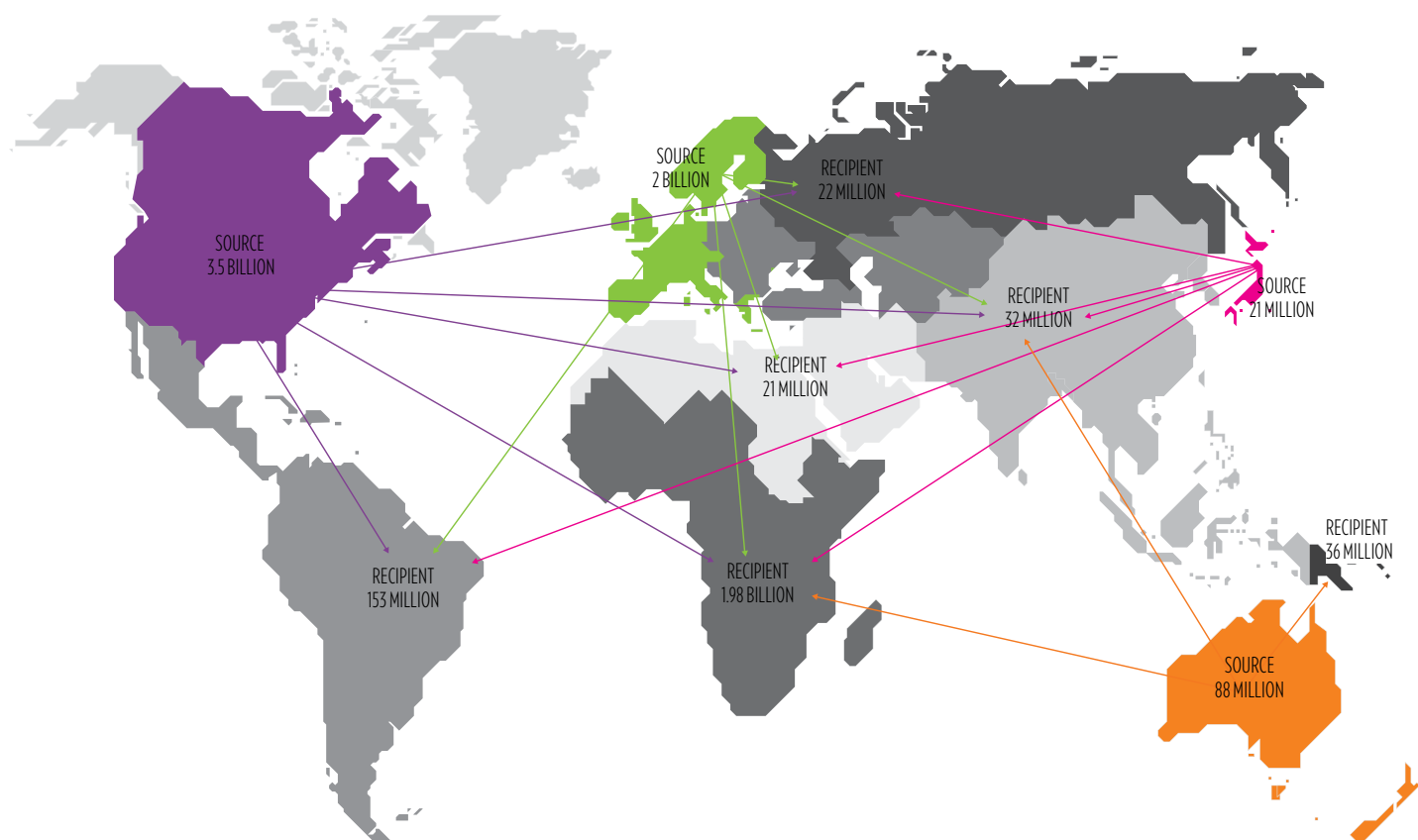
“The economic crisis should not become an excuse to stop investing in the AIDS response” said Michel Sidibé, Executive Director of UNAIDS. “We cannot afford to let the economic crisis paralyse us. Not when the AIDS response is showing results.”

INVESTING IN THE AIDS RESPONSE

In 2008, investments for AIDS reached a record high of US\$ 15.6 billion. This represented a 39% increase from 2007. Out of this, around US\$ 8.2 billion came in the form of international assistance. The share of international assistance is around 55% of the global resources available.

The biggest contribution was made by the Government of the United States of America, whose contribution of US\$ 3.5 billion accounted for 61% of bilateral official development assistance

Map 1. Bilateral ODA flows for AIDS control, 2008 (US\$)



UNAIDS analysis based on data from the Kaiser Family Foundation and OECD/DAC CRS.

in 2008. Some of the other larger donors included the United Kingdom, France, the Netherlands and Germany, which together contributed US\$ 2.5 billion. Even though their total contribution may be small as a percentage of the total, countries such as Ireland, Luxembourg, the Netherlands, Norway and Sweden disbursed between US\$ 280 and US\$ 582 per US\$ 1 million of GDP, far higher than many richer countries.

Philanthropic organizations too have contributed consistently to the AIDS response. Their contributions have increased consistently over the past decade, totalling more than US\$ 600 million in 2008, representing 7% of total resources available in 2008. An estimated 85% came from USA-based organizations and the rest from European not-for-profit organizations. About a half of all philanthropic contributions came from the Bill & Melinda Gates Foundation. The majority of the resources went towards supporting research, while other resources went on HIV prevention and treatment. But the forecast for 2010 is not good, especially for smaller organizations, whose revenues have dipped in the wake of the financial crisis.

THE MAJORITY OF INTERNATIONAL ASSISTANCE FOR AIDS WAS DIRECTED TOWARDS COUNTRIES IN SUB-SAHARAN AFRICA

Out of the ten top recipients of international assistance for AIDS, nine were in sub-Saharan Africa. Together, they accounted for nearly 57% of all investments from the major donors in 2008.

In terms of absolute value, the top five recipients were South Africa (US\$ 729 million), Nigeria (US\$ 432 million),

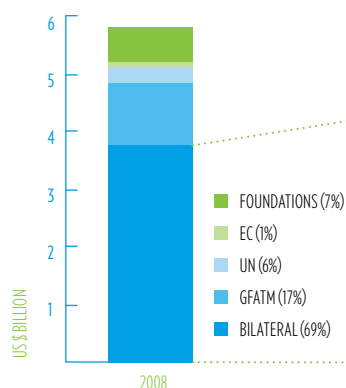
Mozambique (US\$ 368 million), Zambia (US\$ 361 million) and Ethiopia (US\$ 357 million).

The amount of official development assistance received per capita was higher in Guyana (US\$ 70 per capita), Namibia (US\$ 52 per capita), and Botswana (US\$ 34 per capita).

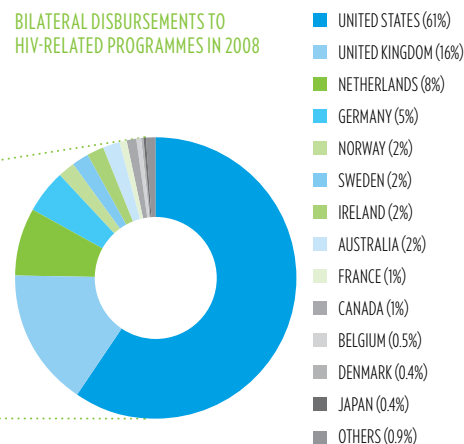
On the other hand, South Africa, which ranked first in terms of the absolute value of official development assistance received, was the recipient of US\$ 15 per capita, while Nigeria, which

International assistance to HIV-related programmes by source and bilateral disbursements, 2008

INTERNATIONAL ASSISTANCE TO HIV AND AIDS IN 2008



BILATERAL DISBURSEMENTS TO HIV-RELATED PROGRAMMES IN 2008



Source: UNAIDS analysis, 2009, based on data from OECD/DAC, Funders Concerned About Aids (FCAA) and, for the philanthropic sector, European HIV/AIDS Funders Group (EFG).

2008 international disbursements

COUNTRY	BILATERALS	MULTILATERAL	TOTAL*
UNITED STATES	87.5%	12.5%	3,953.5
UNITED KINGDOM	91.2	8.8	976.3
FRANCE	12.4	87.6	538.7
NETHERLANDS	86.1	13.9	500.8
GERMANY	60.139.9	477.7	
SWEDEN	50.9	49.1	171.5
NORWAY	64.6	35.4	159.8
CANADA	42.7	57.3	137.6
JAPAN	15.5	84.5	135.8
ITALY	7.0	93.0	123.6
IRELAND	79.8	20.2	112.5
AUSTRALIA	78.1	21.9	109.2
SPAIN	18.681.4	102.4	
DENMARK	46.0	54.0	48.2
BELGIUM	72.6	27.4	35.4
LUXEMBOURG	38.5	61.5	15.2
AUSTRIA	29.1	70.9	7.5
SWITZERLAND	36.8	63.2	6.5
GREECE	86.4	13.6	6.1
FINLAND	55.0	45.0	5.3
NEW ZEALAND	61.8	38.2	5.1
PORTUGAL	1.7	98.3	2.0

*US dollars in millions.
Source: OECD/DAC, *Measuring Aid to HIV/AIDS Control*, April 2009.

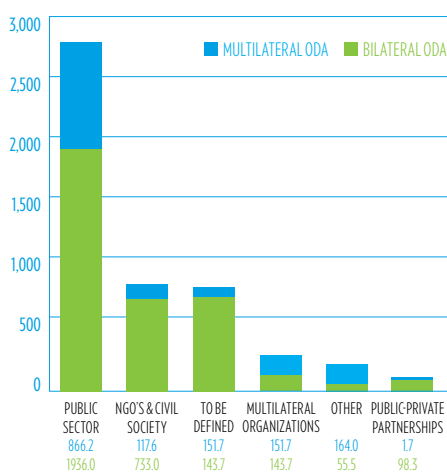
ranked second in terms of absolute value, received only US\$ 2.9 per capita.

Domestic investments for AIDS have increased over the past decade, but most countries still depend on international assistance to finance their programmes. In countries such as Ghana, Haiti, Indonesia, Mozambique and Rwanda, more than 70% of AIDS-related expenditures in 2006 came from international sources.

If international funding were to be reduced and not matched by an increase in domestic funding, it is likely that the AIDS response in over 100 countries would be in jeopardy.

The public sector is the major recipient of international assistance.

Allocation of official development assistance for HIV to implementing bodies, 2007



Source: UNAIDS analysis based on OECD/DAC CRS online database (last visited 25 May 2009).

An estimated 55% of the resources available in 2007 were channelled to government-led initiatives. Civil society organizations, on the other hand, received only about 17%, while 6% went to multilateral organizations and 2% to public-private partnerships.

THE ROLE OF MULTILATERAL ORGANIZATIONS IN AID DELIVERY

Most multilateral organizations traditionally disburse resources received from governments, foundations and individual donations from the general public. Many countries favour channelling a major proportion of their resources through these channels.

For example, Austria, Finland, France, Italy, Japan, Portugal and Switzerland disbursed more than 80% of their international assistance to multilateral organizations. The major multilateral organizations receiving these investments are the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID. In 2007, contributions disbursed to the Global Fund exceeded US\$ 1 billion for the first time, reaching US\$ 1.72 billion in 2008. However, multilateral organizations only represent 25% of all international investments for AIDS.

However, most importantly, more than 70 countries receive more than 75% of the international assistance for AIDS from multilateral organizations. Another 30 countries receive between 50% and 75% in a similar way. The Global Fund has disbursed around US\$ 1.03 billion to 136 low- and middle-income countries. UNITAID has provided US\$ 265 million for the AIDS response, generated out of a special airline ticket tax levied by around 20 countries in 2007.

By mid-2009, nearly 2.3 million people living with HIV were receiving antiretroviral therapy from programmes supported by the Global Fund. UNITAID support is currently providing treatment for more than 170 000 children, with a goal of reaching nearly 400 000 children by the end of 2010. Thanks to UNITAID and its partners, 11 paediatric formulations are now available in developing countries, and the price of quality AIDS medicines for children has fallen by 60% since 2006.

The UN system's assistance to the AIDS response is largely in the area of technical support. However, it also provides support to implementation. For example, the World Food Programme was one of the first agencies to provide food to expand access to antiretroviral

therapy in resource-poor settings. Providing nutrition and food security are critical components of care and support for many people living with HIV, particularly in sub-Saharan Africa.

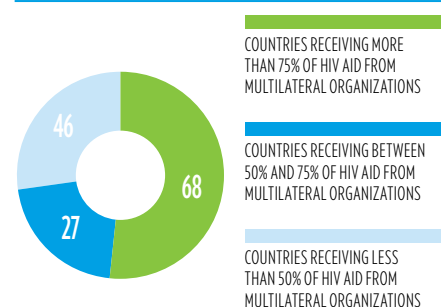
The World Food Programme implements AIDS programmes in over 50 countries, addressing treatment, care and support, and impact mitigation for people affected by the epidemic. In Lesotho, for example, nearly one third of people on antiretroviral therapy, along with their family members, receive nutritional support from the food body. "HIV has robbed families of bread-winners and added financial burden to poor households" says Bhim Udas, Country Director of the World Food Programme in Lesotho. "The pervasive food insecurity in Lesotho makes it difficult for people on antiretroviral therapy to meet their nutritional requirements".

INCREASING AID EFFECTIVENESS—DOING MORE WITH LESS

Most of the international assistance to AIDS is channelled through bilateral channels, from one government to another. An estimated 69% of funding came as bilateral assistance from countries that are members of the Development Assistance Committee of the Organisation for Economic Co-operation and Development. Another 23% was disbursed through multilateral agencies. Private funding from the philanthropic sector accounted for 7% of the international assistance.

This increase in resources and a corresponding increase in the number of actors at the country level often overwhelms national efforts to coordinate an inclusive and multisectoral response based on national priorities. The result is vertical and piecemeal actions against AIDS that are often duplicative and rarely sustainable. This poses significant challenges to the

Source of international assistance to countries



UNAIDS analysis based on OECD/DAC CRS online database (last visited 25 May 2009).

recipient country, which often has to juggle with the requirements of multiple donors.

“Our ability to keep up with this is going to be especially challenging in this economic downturn. We’d be foolish not to open up a strategy to try and bring in other bilateral and multilateral resources. We need to be smarter about how we think as funders. We can’t just go in with parallel systems of intervention. It is probably the biggest issue on my plate, thinking about how to deal with that expanding need, and how to continue the medical, clinical and ethical commitment we’ve made to the patients already on drugs. We’re looking for efficiencies by moving to a more country-based delivery system. We also need an aggressive new dialog with our global partners, who have resources that can converge on this” said Eric Goosby, Global AIDS Coordinator and Ambassador-at-Large, in an interview to the Science Insider Magazine.

In this context it is important that countries have a framework to

accountability mechanisms for each partner. The 2009 national strategic plan forms the basis for overall mobilization of resources from donors.

IMPLICATIONS FOR THE FUTURE

The economic crisis in 2009 has affected the AIDS response in many ways. Although it is unclear whether a lack of resources or faulty planning was responsible, many countries experienced funding cuts for treatment and prevention services.

To a large extent a rapid response mechanism set in place by UNAIDS, its Cosponsors and partners helped to avert stock-outs and shortages; however, the scaling up of programmes has been interrupted in many countries. As we look ahead to 2010, it is important to ensure that the more than 4 million on treatment continue to receive their medicines without interruption.

The global landscape is changing. The G8 has given way to the G20. This is an opportunity for many emerging economies to redefine their role in the

At the same time as domestic investments increase in developed and emerging economies, as well as middle-income countries, it is important that systems are in place to ensure that civil society organizations continue to receive funding for their activities.

Many governments are reluctant to fund civil society organizations or invest in programmes reaching marginalized populations. International organizations are often their only source of funding.

“It is widely accepted that civil society is an important actor in the sphere of HIV prevention. But funding from international organizations to civil society for HIV prevention among injectors is coming to an end soon. Given the lack of the government’s support for harm reduction programmes for injecting drug users, we are extremely worried about how to keep our programmes running” says Pavel Aksenov, Executive Director of the Russian Harm Reduction Network.

Fully funding multilateral agencies, including the Global Fund, is critical in 2010. These channels represent a key lifeline to HIV prevention and treatment programmes in over 137 countries around the world. The nearly 50:50 split between domestic and international investments in the AIDS response will be put under strain in 2010.

Although there are signs of economic recovery in many of the main donor countries, they are not uniform. Will this change the pattern of investments? Who will bridge the gap? These questions are not easy to answer, but we must look at options. The 0.7% target on international aid and the Abuja target of 15% for health must not be buried, even in these tough economic times.

Universal access targets can be reached if governments commit 0.5% of their GDP to international aid and maintain the current proportion of investments for AIDS. It is important that the landmark commitment by the USA to provide US\$ 48 billion between 2009 and 2013 is fully met. As the largest single donor, any cut in its share is likely to have a direct impact on the lives of millions.

The considerations for the many economic stimulus package and bail-out plans approved by governments hold true for AIDS, health and development—helping people. The AIDS response needs a stimulus package now, as this can push forward the gains and in time make them irreversible. ●

PRINCIPLES FOR THE COORDINATION OF NATIONAL AIDS RESPONSES.

THREE ONES PRINCIPLES AIM TO ACHIEVE THE MOST EFFECTIVE AND EFFICIENT USE OF RESOURCES, AND TO ENSURE RAPID ACTION AND RESULTS-BASED MANAGEMENT:

ONE AGREED AIDS ACTION FRAMEWORK THAT PROVIDES THE BASIS FOR COORDINATING THE WORK OF ALL PARTNERS.

ONE NATIONAL AIDS COORDINATING AUTHORITY, WITH A BROAD-BASED MULTISECTORAL MANDATE.

ONE AGREED COUNTRY-LEVEL MONITORING AND EVALUATION SYSTEM.

optimally utilize the resources towards one common goal. The ‘Three Ones’ principles of UNAIDS have served as a good model in many countries to increase aid effectiveness. Take, for example, Malawi. The country has developed a strategic management framework, revised in 2009, which provides a common understanding of the expected results, outputs, impacts, performance measurement and reporting mechanisms to be followed by all key stakeholders involved in the AIDS response in Malawi. A number of donors have for many years pooled their funds in support of Malawi’s national AIDS strategy and have signed a memorandum of understanding that outlines the responsibilities and

global response to AIDS. More than 16% of all international assistance available for AIDS went to G20 members. The lion’s share was taken by three countries: South Africa, India and China.

The Global Fund investments in China and India total more than US\$ 461 million, representing 6% of the investments for AIDS in 2008. Increasing domestic expenditures on AIDS in these countries will significantly free resources for other countries. Brazil is a good example. The majority of the resources for its AIDS response are funded domestically. While South Africa, India and China are ranked 1, 7 and 12, respectively, in top aid recipients for the AIDS response, Brazil stands at number 56.

Ideas Lab



INDIA

SEX WORKERS JOIN FLOOD RELIEF ACTIVITIES

Ashodaya Samithi, an association of sex workers in Mysore, India, made a donation to the Government of Karnataka of 50 000 rupees, which their organization had collected in support of flood relief efforts. Such efforts contribute to breaking down the stigma faced by sex workers. The Chief Minister expressed how deeply touched he was by the charitable donation, saying that a donation of this size meant more to him than a donation 10 000 times larger from wealthy sources.

UNITED STATES

PEER-TO-PEER SOCIAL NETWORKS REACH OUT

People living with HIV in seven US cities referred peers from their social, sexual or drug-using networks for HIV testing and appropriate medical care and prevention services in an efficient high-yield strategy. This peer-driven approach meant that key populations at higher risk of HIV exposure, often difficult to reach with other more conventional strategies, accessed HIV counselling, testing and referral services in much higher numbers and with significantly higher undiagnosed HIV infection levels than through any other strategy.

MALAWI

ENSURING TREATMENT EQUITY

Malawi has a policy for equity in access to antiretroviral therapy that includes monitoring the age, sex and socioeconomic status of people undergoing HIV testing and accessing HIV treatment services. In its free treatment first-come, first-served programme, equity analysis helps identify inequities that are unnecessary, avoidable and unfair. Programmes have been changed and integrated to reduce the costs of transport, food and missed work.



INTERNATIONAL

AIDSSPACE.ORG

A new online social network brings people, ideas and information into one place. AIDSSpace is an online community for connecting people, sharing knowledge and accessing services for the 33.4 million people living with HIV and the millions who are part of the AIDS response. Through AIDSSpace you can: meet and connect with others to learn from their work, exchange ideas and discover new networks; post and share key policies, case studies, best practices, multimedia materials, conference posters, reports and other essential resources; find and post jobs. Sign up today at www.aidspace.org.

UNITED STATES

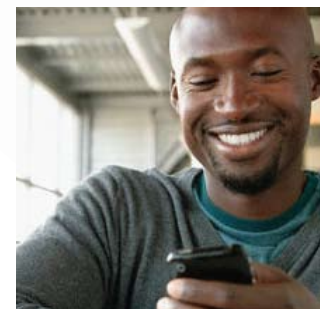
SYRINGE EXCHANGE

HIV incidence among injecting drug users in the United States has declined to under one person for every 100 people in a year thanks to harm reduction. The Congress passed a bill that lifted a 20-year ban on federal funding for needle exchange, which may encourage more equitable service coverage across the country, reduce the stigma faced by drug users and facilitate a move towards integration of services for drug users into the regular health system.

CHINA

PROGRESS ON TREATMENT

Opioid substitution therapy, the most cost-effective treatment available for heroin dependence, is now available in 66 countries and territories, including low- and middle-income countries such as China, Indonesia and Iran. Prison access to opioid substitution treatment has increased from five countries in 1996 to 29 in 2008—a good start, but much remains to be done to improve coverage worldwide both in prisons and in the community.



SOUTH AFRICA

SMS FOR HIV TESTING AND COUNSELLING

Project Masiluleke uses mobile technology to encourage South Africans to get tested for HIV. It sends one million “Please call me” text messages each day throughout South Africa. This encourages people to get tested and treated for HIV. The SMS messages are written in local languages and are used to direct users to the National AIDS Helpline. Once people call, the hotline representatives provide information on HIV testing services and locations. Knowing one’s HIV status is critical in a country where nearly 20% of the population is living with HIV, but fewer than 3% know their status. The initial results of the project indicated a tripling of calls to the hotline during the first three weeks. The project’s sponsors include Nokia and South Africa’s National AIDS Helpline.





BRAZIL

RAINFOREST CONDOMS

A condom factory in Xapuri, Brazil, is helping to prevent the spread of HIV and at the same time may also be helping to save the rainforest. This unique factory uses natural latex collected by local rubber tappers and aims to supply the Brazilian government with 100 million condoms a year. The factory is a joint venture between the local state of Acre, the Ministry of the Environment, and the Ministry of Health.

ROMANIA

MONITORING ARV STOCK-OUTS

In wake of the economic crisis, 22 associations of people living with HIV in Romania joined together to form a federation that has established an alert system to warn of potential stock-outs. Whenever a shortage of drugs occurs, members inform each other and the Ministry of Health. This enables policy-makers to take quick action. The federation has extended the partnership to associations of patients living with other chronic diseases, which monitor the situation for a wide range of conditions.



ZAMBIA

NEW TREATMENT COMBINATIONS FOR CHILDREN

In Zambia, antiretroviral therapy and once-daily co-trimoxazole prophylaxis reduced mortality among HIV-infected children by sixfold. This yielded results comparable with high-income settings. However, even with these impressive medical outcomes, mortality within the first months of therapy remains high for HIV-infected children in sub-Saharan Africa.

UNITED STATES

INJECTABLE ANTIRETROVIRAL DRUGS?

Researchers are studying nanosuspensions of antiretroviral drugs to see if they would be suitable as long-acting formulations that could maintain good drug blood levels without pills, just as injectable contraceptives can do—a hope for the future!



INTERNATIONAL

ANTIRETROVIRAL TREATMENT FOR HIV PREVENTION

A new paradigm puts treatment and prevention in the same continuum. Antiretroviral medicines are already preventing transmission of HIV to babies and now new approaches are being trialled to include their use as a potential pre-exposure prophylaxis and as a topical microbicide.



SOUTH AFRICA

DIAGNOSING HIV AMONG INFANTS AND YOUNG CHILDREN

Use of simplified assays on dried blood spots now offers a feasible, cost-effective means of diagnosing HIV in infants and young children. Early diagnosis and early antiretroviral therapy were found to reduce infant mortality by 76% and to slow HIV-related disease progression by 75% in two medical centres in South Africa.

FAST FACT

MORE THAN
29%

OF PREGNANT WOMEN ACCESSING PUBLIC HEALTH SERVICES TESTED POSITIVE IN SOUTH AFRICA

UGANDA

REDUCING MORTALITY BY COMBINING PROPHYLAXIS AND ANTIRETROVIRAL THERAPY TREATMENT

In a prospective cohort study in Uganda, a combination of antiretroviral drugs and co-trimoxazole reduced mortality by 95% compared with no intervention. These results were achieved even though no routine clinic visits were scheduled after initial enrolment, and home visits were provided by trained lay providers. Provision of antiretroviral therapy to adults has also been associated with the added benefit of lowering mortality rates in HIV-negative children in the family and a reduction in the rate of orphanhood.



Children born of hope in Viet Nam*

Hand in hand with her five-year-old son at 7 a.m., Ngan hurries out of her small home in Thanh Xuan, the area in Hanoi where she lives. She is on her way to do some early morning grocery shopping before taking her son to his kindergarten, just like the many other mothers you can see when a new day starts in the city.

But Ngan's story is different: she is HIV-positive and is now 22 weeks into her second pregnancy.

**UNAIDS is committed to supporting countries to virtually eliminate mother-to-child transmission by 2015.*

Ngan still remembers the shock of her HIV-positive result at a routine antenatal check-up during her first pregnancy five years ago. The following months, when she dealt with her own emotions and fears, were tough. At the same time, Ngan faced discrimination from the community and even her own family. The anxiety of transmitting the virus to her baby was with her day and night.

Thanks to the early discovery of Ngan's HIV status, she received antiretroviral therapy during the first quarter of her pregnancy. Huy, Ngan's son, was born a healthy boy free of HIV in October 2004.



Ngan is expecting her second baby. She visits the Tay Ho Day Care Centre for an antenatal check to make sure that everything is okay with the baby she carries. Her doctor tells her that she is in good health and that the baby is now 450 grams.

HIV-positive women in Viet Nam's provinces who want to become mothers are still concerned about where to get comprehensive care for both mother and child before, during and after delivery. Better equipped obstetric facilities with staff knowledgeable on HIV and prevention of mother-to-child-transmission are much needed at the provincial level.

Ngan considers herself lucky—the virus was not transmitted to her son from her, because she had access to prevention of mother-to-child services. Without these services, the chances of passing HIV to the baby are 30–40%. With the provision of comprehensive prevention services, the transmission rate can be reduced to less than 2%.





As the sun sets over Hanoi, Ngan has already picked up Huy from the kindergarten, and they make their way home on the bustling streets of the city.

Helping each other out after a long day, Ngan and her husband Quang cook together in their small house in the Thanh Xuan district of Hanoi.

Father and son play together after dinner, but the evening is not ending yet for husband and wife. Ngan is an active member of the White Dove Club, a self-help group of people living with HIV covering the southern district of Thanh Xuan. Every night Ngan visits locations frequented by injecting drug users in the area.

The White Dove Club team collects used syringes and needles and distributes clean ones to the people who inject drugs. Her husband Quang, a former drug user, drives Ngan around while their son stays at home with his grandparents.

Ngan and Quang have regained the acceptance of their neighbours because people appreciate that they lead a healthy life. Ngan's parents-in-law, whose other two sons died from drug use, are proud of their eldest son for the support and care he shows his family.



PREVENTING MOTHER-TO-CHILD TRANSMISSION TIMELINE

1994

AZT found to reduce mother-to-child transmission.

1998

Inter-Agency Task Team on PMTCT initiated to provide leadership and guidance to countries.

1999

Single dose of nevirapine found to be effective for PMTCT.

2000

United Nations Millennium Declaration commits Member States to eight time-bound targets, including MDG 6 to combat HIV.

2001

Declaration of Commitment is signed by 189 Member States at the first UN General Assembly Special Session on HIV/AIDS. Target is set to reduce by 50% the proportion of infants infected with HIV by 2010.

2002

UNAIDS, in collaboration with its Cosponsors, develop core indicators to measure progress against the goals set in the Declaration of Commitment.

2006

Political Declaration on HIV/AIDS, renewal of commitments made in 2001 as well as MDGs.

WHO releases guidelines that discourage use of single-dose nevirapine and that promote more efficacious antiretroviral prophylaxis for PMTCT.

Guidance on the global scale-up of PMTCT of HIV released.

2007

An estimated 34% of HIV-positive pregnant women received antiretroviral drugs to prevent HIV transmission.

2008

An estimated 45% of HIV-positive pregnant women received antiretroviral drugs to prevent HIV transmission.

2009

UNAIDS Executive Director calls for virtual elimination of mother-to-child transmission by 2015.

What does HIV prevention mean to you?

What HIV prevention measures do you use or have you used in the past?

How has HIV prevention changed your life?

IN MY WORDS: Four people from different parts of the world reflect on what HIV prevention means to them.

Alexei Voronin*

Twenty-seven-year-old Alexei Voronin lives in the small town of Volkhov in the suburbs of Saint Petersburg, Russian Federation. Alexei is HIV-positive and a former injecting drug user. He's been married for two years. His wife doesn't have HIV.

I started doing drugs when I was a teenager. At that time the only important thing was getting money and finding drugs. I didn't think of any prevention measures to protect myself from HIV when I was sharing a syringe with my HIV-positive elder brother.

In 2006, after feeling very ill, my mother took me to a special hospital for infectious diseases. There I met a psychologist from the organization Humanitarian Action, who changed my life. I felt that I would like

to live again, to stop doing drugs, to study. I wanted to start again from scratch.

I think today about how unconcerned I was about HIV prevention and I can't believe it myself. I feel bad about all those years that I lost. Now I work as an outreach worker for a harm reduction programme at Humanitarian Action. My job is to motivate drug users to visit our bus, where they can exchange used syringes for sterile ones. They can also see a psychologist and have a blood test.

I always try to motivate those guys from the streets to have a look at something different from their everyday routine. I ask them about their sex life and whether they use condoms to prevent HIV and sexually transmitted infections. When they say that they don't have money for condoms I offer immediately a pack of condoms and explain what a condom can save them from. Sometimes I share my experience with them

and say that I didn't use any prevention measures and got into big trouble. They ask "what kind of trouble?" I don't reveal my HIV status, but I tell them about serious health problems that can't be cured.

For a long time I didn't believe I could have a proper family life after all that I had been through. When I met Elena I felt that she was the girl of my life, but I was scared to death to tell her about my HIV status. But she accepted it and we got married two years ago. The last thing I would like to do is to infect my wife with HIV, so we don't have unprotected sex. We also don't talk of having children yet, but that will be a huge challenge for both of us.

** The names in this article are fictitious, but the stories are real.*

FAST FACT

AN ESTIMATED

3.7

MILLION PEOPLE IN EASTERN EUROPE AND CENTRAL ASIA CURRENTLY INJECT DRUGS.

When they say that they don't have money for condoms I offer immediately a pack of condoms and explain what a condom can save them from.



Ms Minh

Born in 1977 in Hanoi, Ms Minh was a sex worker and drug user between 1998 and 2005. She is now a peer educator on harm reduction for sex workers. She is married for the second time to an ex-injecting drug user and is without children.

In 1996 I was working as a waitress to earn enough money for myself and my husband, who was in jail at that time. At some point, I started using drugs, and as I needed more and more money, I decided to start selling sex.

For a long time I was totally unaware of HIV and did not believe there was such a virus, and neither did my sex worker friends. No one informed us about it. We all thought it was something made up to threaten us so that we would give up drugs and sex work. Most of my friends and I had unprotected sex with our customers and shared needles when using drugs. I was ignorant about HIV until I was admitted to a rehabilitation centre in 2003, where Hanh, my best sex worker friend, had already been admitted two months earlier.

Hanh told me in tears that she tested positive for HIV and had to stay in a separate house. I was struck by that fact and started attending training courses on HIV at the centre, knowing how lucky I was not to have had contracted HIV yet. After leaving the centre I went back to sex work. I knew I had to use condoms and not share needles to protect myself from HIV. But the fact was that I could not always use condoms at work. When you feel in need of drugs you only care about how to get money, and if a customer didn't want to use a condom I would easily give in to that.

I knew I had to use condoms and not share needles to protect myself from HIV.

It continued in that way until 2005, when I was determined to stop using drugs and became a peer educator, thanks to the help of my family. I think sex workers today are much luckier than us before thanks to the strong HIV response in Viet Nam. In the role of a peer educator, I give advice to the sex workers living in my area on how to prevent sexually transmitted infections and HIV. Every three months our self-help group organizes HIV testing for the sex workers in this area at our meeting venue so that they don't worry about facing stigma and discrimination in public health-care settings.

When my friend Hanh and I reflect about our past, we both agree that if we had known that unprotected sex and drug use were so devastating we would not have dared to put ourselves in such a big risk in the first place.

In the role of peer educator, I give advice to the sex workers living in my area on how to prevent sexually transmitted infections and HIV.



Jovanna Baby

Jovanna Baby is a 46-year-old Brazilian and the founder of the Brazilian Transvestites and Transsexual Association. She is currently living in Piauí, bringing her knowledge on HIV and human rights to remote zones in the Northeast Region of Brazil.

I have been a transvestite since I was 13 years old. I was born in Bahia, but in 1980, at the age of 14, I moved to Rio de Janeiro. I had to leave, run away from my parents' home in order to be able to live my own gender identity and sexuality.

I worked as a sex worker for 20 years and I have always been very careful with my health and personal hygiene. The use of condoms has always been a constant practice in my sexual relations, either professional or sentimental. My safe sexual behaviour has helped me a great deal. I always use condoms, always. I love my life.

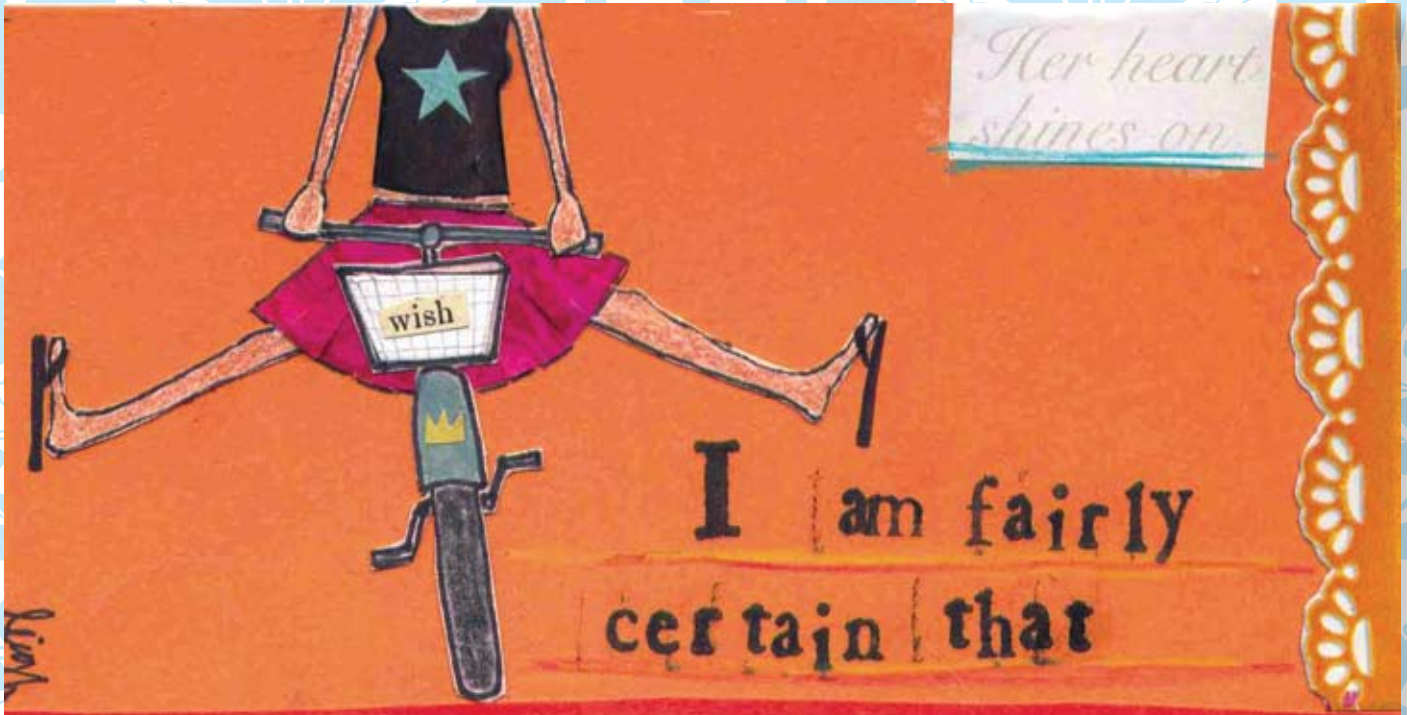
Prevention is like a 'watch dog,' this is my motto. I take care of myself and I only have

FAST FACT

HIV PREVALENCE EXCEEDS

10%

IN 12 OF 14 COUNTRIES IN LATIN AMERICA AMONGST MEN WHO HAVE SEX WITH MEN



*Her heart
shines on.*

**I am fairly
certain that**

contribute your unique gift
to the world.

**Given a Cape and
a nice tiara, I could
save the world.**





safe sex, only! It has been one of the greatest contributions to my self-esteem. Being able to affirm that I am an HIV-negative person, even having worked most of my life in the sex trade, is a reward for me.

Prevention is important for us transvestites in order to enable us to have a more dignified life. We know that prejudice is very strong in Brazil, and it is even worse when it comes to people living with HIV, especially if you are a transvestite.

That is why I decided to help my fellow sex workers and other transvestites by orientating them on the use of condoms as a continuous practice they should adopt in their lives. This sort of behaviour helped them to stay in good health as well as get higher earnings at a time when AIDS was scarily growing and those sex workers who protected themselves from infection were far preferred by potential clients. It was due to those spontaneous attitudes towards my colleagues that I decided to organize a transvestite and transsexual movement in Rio de Janeiro. We then founded a national association and a lot has been achieved, with more to come.

Prevention brought me a great deal of knowledge, not only on HIV but also on my rights as a human being. It made me aware of my inviolable rights as a citizen.



Chengetai Ndlovu

Chengetai is a 28-year-old young woman from Zimbabwe. She's been married for five years and is a mother of two children, aged 5 and 9. She came to South Africa six years ago and works as an accountant for a small South African accountancy firm.

I must have been 16 years old when I first heard about HIV prevention. It was still not publicly embraced because sex was not openly discussed in public. There were a few calls to young people to act responsibly. When we were visited by members of the government blood transfusion services, who were requesting us to donate blood, they informed us about sexually transmitted infections and HIV and asked us to abstain from sex.

I am aware that HIV is predominantly spread through sex. I have lost friends and relatives because of HIV, and I still wonder if we will be able to convince each one of us to control our sexual activities and practise safe sex.

For me, the first prevention measure is to never indulge in something that I know is a risk to my health. I love myself and I want to see many more years to come. The fear of HIV scares me enough to keep me safe and I do not take the warnings for granted. The many lives that are affected by the epidemic are enough testimony to make me realize about the seriousness of the disease.

The case for prevention becomes decisive in light of the absence of a cure for AIDS. In my assessment, HIV prevention remains the single most important intervention any society can easily implement with guaranteed success. ●

INFO INDEX

2015

Deadline set to achieve the Millennium Development Goals

33.4

Millions of adults and children who are living with HIV worldwide

4

Millions of people in low- and middle-income countries who were receiving antiretroviral therapy at the close of 2008

71%

of all new HIV infections occurred in sub-Saharan Africa in 2008

\$25

Billions (US\$) required for the global AIDS response in low- and middle-income countries to achieve universal access, based on country-defined targets for 2010

430

Number in thousands of new HIV infections occurring among children under the age of 15 in 2008

60%

Number of female sex workers who do not consistently use condoms with their clients in China

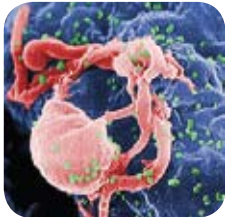
Source is the UNAIDS Epidemic Update and UNAIDS paper entitled What countries need—investments needed for 2010 targets.

A to Z of universal access

UNIVERSAL ACCESS IS A GLOBAL COMMITMENT TO SCALE UP ACCESS TO HIV TREATMENT, PREVENTION, CARE AND SUPPORT. ESTABLISHED IN THE 2006 UN POLITICAL DECLARATION, THE MOVEMENT IS LED BY COUNTRIES WORLDWIDE WITH SUPPORT FROM UNAIDS AND OTHER DEVELOPMENT PARTNERS, INCLUDING CIVIL SOCIETY.

ANTIRETROVIRAL THERAPY

More than 4 million people in low- and middle-income countries were receiving antiretroviral therapy at the close of 2008, representing a 36% increase in one year and a tenfold increase over five years. However, at least 5 million people living with HIV still do not have access to life-prolonging treatment and care. The roll-out of antiretroviral therapy will also significantly reduce the burden of tuberculosis in high-prevalence countries.



BEHAVIOUR AND SOCIAL CHANGE

Transmission of HIV is mediated directly by human behaviour, so changing the behaviours of individuals and communities that enable HIV transmission is the ultimate goal required for HIV prevention.

CONDOMS

Consistent male and female condom use significantly reduces the risk of HIV transmission. Condoms are a key component of combination prevention strategies that individuals can choose to reduce their risks of sexual exposure to HIV.

DISCRIMINATORY LAWS

Discriminatory laws fuel social judgement and further alienate those already most marginalized in society, including sex workers, people who inject drugs, men who have sex with men and people living with HIV. Reforming laws that are based on deeply-rooted discriminatory social attitudes will result in legislation that is a powerful and positive tool in the response to AIDS.

EVIDENCE-INFORMED

HIV prevention actions must be evidence-informed, based on what is known and proven to be effective. Prevention programmes must be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural contexts in which they are implemented.

FINANCING

Based on the country-defined targets for 2010, it is estimated that an investment of US\$ 25.1 billion will be required for the global AIDS response in low- and middle-income countries to achieve universal access. The impact of the global financial crisis threatens to roll-back the hard-won progress made in the global response to AIDS. However, it also represents an opportunity for countries and international organizations to pursue much needed reforms, to refocus on results.

GIPA

GIPA, or the 'greater involvement of people living with HIV/AIDS', is a principle that aims to realize the rights and responsibilities of people living with HIV, including their right to participation in decision-making processes that affect their lives. People living with HIV are active partners in the universal access movement and are promoting the concept of 'positive health, dignity and prevention' in a number of ways, including taking the leadership in creating stronger links and increasing collaboration between the health sector and civil society organizations already providing HIV prevention, treatment and care services.

HIV TESTING AND COUNSELLING

Efforts should be made to encourage people to know their HIV status through access to confidential counselling and testing. In all types of HIV testing the principles of confidentiality and consent should be maintained and counselling should be provided. Such efforts are not only necessary to improve the health of individuals, they are also necessary to achieve universal access to prevention, treatment, care and support and to mount effective responses against HIV.

INTENSIFYING COMBINATION PREVENTION

There is no single magic bullet for HIV prevention. Countries and communities need to use a mix of behavioural, biomedical and structural HIV prevention actions to suit their actual epidemic and the needs of those at higher risk. Combination HIV prevention means providing services and programmes for individuals, such as promoting the knowledge and skills necessary to undertake safe behaviours. Combination HIV prevention needs investment in structural interventions, including legal reforms to outlaw discrimination against people living with HIV and the enforcement of laws that prohibit sexual and gender-based violence.

JOINT UN PROGRAMME

Contributing to achieving global commitments to universal access to comprehensive programmes for HIV prevention, treatment, care and support is the number one priority for the Joint UN Programme on HIV/AIDS (UNAIDS). To that end, UNAIDS brings together the efforts and resources of the UNAIDS Secretariat and ten UN system organizations.



KNOW YOUR EPIDEMIC & RESPONSE

Knowing your epidemic and response enables countries to 'match and prioritize your response' by identifying, selecting and funding those HIV prevention measures that are most appropriate and effective for the country in relation to its specific epidemic scenario(s) and settings.

LEADERSHIP

Leadership is the catalyst for change in a community no matter its size: the global stage, the village gathering or national government. Without strong commitment, and action that follows words, universal access cannot be achieved.

MOTHERS AND BABIES

UNAIDS calls for the virtual elimination of mother-to-child HIV transmission by 2015. An estimated 370 000 children are born with HIV in sub-Saharan Africa every year and only 45% of HIV-positive pregnant women are receiving antiretroviral therapy prophylaxis in low- and middle-income countries. Evidence shows that timely administration of antiretroviral drugs to HIV-positive pregnant women significantly reduces the risk of HIV transmission to their babies. In many developed countries mother-to-child transmission of HIV has been virtually eliminated.



NATIONAL HIV RESPONSES

Effective national HIV responses adopt the 'Three Ones' principles: one agreed AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system. Their full implementation helps to achieve the most effective and efficient use of resources and to scale up universal access services.

ORPHANS

More than 15 million children under the age of 18 have lost one or both parents to AIDS. Vulnerable to poverty, they may be in need of support packages that could include food, education or family or community support.

POPULATIONS AT HIGHER RISK

Risk is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex and injecting drug use with contaminated needles and syringes. The populations at higher risk vary from country to country. But most commonly these populations include sex workers, injecting drug users and men who have sex with men.



QUALITY CARE AND SUPPORT SERVICES

Quality care and support services for people living with or affected by HIV help to reduce the negative social and economic impacts of the disease and bring hope to whole communities. However, most people around the world do not yet have access to such services. Reaching out to these people is a global priority.

RIGHTS

It has long been recognized that the response to HIV must be both evidence-informed and rights-based. Effective HIV responses are those that empower individuals and groups to claim their human rights, including the right to education, information, liberty, privacy, and health. Responses should also be founded on the principles of non-discrimination and equality.

STRENGTHENING HEALTH SYSTEMS

Strengthened health systems and human resources are crucial to achieving the goal of universal access to HIV



prevention, treatment, care and support. AIDS is part of the global health agenda, just as the global health agenda is part of the AIDS response: neither can work in isolation.

TECHNICAL SUPPORT

Technical support has helped to remove obstacles to achieving universal access in many countries. It contributes to greater efficiency, effectiveness and the impact of national AIDS responses and it builds in-country capacities and systems for sustainable responses to AIDS.

UNIVERSAL ACCESS

Universal access is a global commitment to scale up access to HIV treatment, prevention, care and support. The movement, enshrined in the 2006 UN Political Declaration, is led by countries worldwide with support from UNAIDS, development partners and civil society.

VACCINES

A ready-to-use vaccine is many years away. Results from the Thai Phase III vaccine trial show a modest 31% efficacy in preventing new HIV infections. This result has instilled new hope for scientists in the HIV vaccine research field. In the absence of a vaccine, HIV prevention efforts must be sustained and scaled up.

WOMEN AND GIRLS

Women and girls account for half of all people living with HIV. In sub-Saharan Africa, women account for approximately 60% of estimated HIV infections. Ensuring women's empowerment and gender equality, including reversing the underlying socioeconomic factors contributing to women and girls' HIV risk, are critical for the success of the AIDS response and achievement of the MDGs.



XDR-TB

Tuberculosis, including extensively drug-resistant tuberculosis (XDR-TB) and multidrug-resistant tuberculosis (MDR-TB), remains one of the leading causes of death among people living with HIV, despite being preventable and curable. To appropriately respond to both epidemics and avoid more widespread drug resistance, care and prevention for both diseases should be priority concerns of all tuberculosis and HIV programmes.



YOUNG PEOPLE

In 2008, 40% of new HIV infections were among young people aged 15 to 24. Over 95% of all new HIV infections in the Asia region occur among young populations at higher risk. However, over 90% of resources for young people as a group are spent on low-risk youth, who represent less than 5% of infections. Comprehensive evidence-informed responses are required to address the specific needs of young people at higher risk. The engagement of this group in developing the policies, programmes and processes that directly affect and benefit them is a prerequisite.

ZEROING IN ON SEXUAL VIOLENCE

Sexual violence increases women and girls' vulnerability to HIV. Women and girls who survive sexual violence need access to comprehensive health and counselling services and, where necessary, services for HIV prevention, treatment, care and support.

THE LAST WORD

Michel Sidibé became the Executive Director of UNAIDS in January 2009. A native of Mali, he leads the United Nations efforts in supporting countries in the global AIDS response.

You are just about to complete your first year as Executive Director of UNAIDS. How does it feel?

If possible, I am even more humbled and honoured now than when I was appointed. Every day I am seeing real change and the perseverance of the human spirit in difficult times. And this has renewed my commitment to push myself, the organization, and the world for even more results. I also want to thank the excellent UNAIDS team, which has taught me and inspired me.

What issues have you encountered?

Let me touch on just a few. The priority areas developed for the Outcome Framework are a direct manifestation of what I have seen this year. Universal access has remained the top priority for UNAIDS.

The global economic crisis has been a big issue. I have seen how it is affecting families, businesses communities and countries across the world. I am glad to see that countries have continued to invest in strengthening safety nets and protecting the poor.

On my first country visit, which was to South Africa, I saw that TB, despite being curable, remains one of the most common causes of death among people living with HIV. We have seen bad laws repealed and seen how punitive laws continue to discriminate.

I've called for the virtual elimination of vertical transmission. I believe we can reach the year 2015 with virtually no more babies born with HIV. I am also excited about the future of HIV prevention research. I believe we have seen a new injection of hope.

Other thoughts are high on my list, including issues such as violence against women, HIV prevention, treatment, social protection, the need for a new African drug agency, young people and people at higher risk, such as men who have sex with men, injecting drug users and sex workers.



What can each of us do for World AIDS Day?

The theme of this year is Universal Access and Human Rights. For me, that means doing everything we can to support countries to reach their universal access goals for HIV prevention, treatment, care and support—all the while protecting and promoting human rights.

On World AIDS Day we can remember the brothers and sisters we have lost and renew our courage and commitment to get results. And I want to say that everyone can join AIDSspace.org, to find ways to get involved every day, not just on World AIDS Day.

We would like to finish with a few lighter questions...

Where did you live as a child?

In the most populous neighbourhood of Bamako, Mali.

How do you relax?

Cooking for family and friends.

What is your favourite food?

Feijoada (Brazilian black beans).

Who is your hero in history?

Kwame Nkrumah, ex-president of Ghana, who first spoke of his vision for a unified Africa.

What is your favourite piece of music?

Last Tango in Paris by Gato Barbieri, The Cat by the Jimmy Smith Quartet and the album In the Heart of the Moon by Toumani Diabaté and Ali Farka Toure.

What is your happiest memory?

Helping to deliver my first daughter.

What is your favourite film?

The Magnificent Seven, with Steve McQueen.

What motivates you?

The faces of children in need.

What human quality do you most admire?

Tolerance.

What do you most value in your friends?

Loyalty and honesty.

If you could be granted one wish in life, what would you ask for?

Peace and love for the world.

What do you want to be when you grow up?

Television host, to help foster public debate.

Where is your favourite place?

Timbuktu at sunset.

What is your motto?

Just do it!



AIDS



care



MALE CIRCUMCISION IS NOW RECOGNIZED AS PART OF A COMBINATION HIV PREVENTION STRATEGY.

Only 45% of HIV-positive pregnant women receive treatment to prevent the transmission of the virus to their children.



HIV

67%

OF ALL HIV-POSITIVE PEOPLE LIVE IN SUB-SAHARAN AFRICA.



PARTNERSHIP



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