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**20<sup>th</sup> Meeting of the UNAIDS Programme Coordinating Board**  
Geneva, Switzerland  
25-27 June 2007

Provisional agenda item 1.6:

**Report by the NGO representatives**

**Document prepared by the NGO delegation to the Programme Coordinating Board**

**Additional documents for this item:** none

**Action required at this meeting – the Programme Coordinating Board is requested to:**

- i. Request UNAIDS and Co-sponsors, as a matter of priority, to work at the national level to assist governments to bring PMTCT guidelines in line with the WHO Revised Guidelines; and pay particular attention to the provision of sustained treatment to HIV positive mothers.
- ii. Request that all AIDS data collected to be disaggregated by age group and sex, with a further disaggregation between children and adolescents, to assist in effective programming, measurement and evaluation;
- iii. Request the donor community to significantly increase investment in basic TB control programs as the key to preventing the further development and spread of drug-resistant TB and dedicate considerable additional resources to fill the long-term global financing gaps for TB and HIV;
- iv. Monitor and evaluate the Three Pillar approach in consultation with sex workers and ensure that all three priorities, including creating an enabling environment that respects sex worker's rights and promotes and supports their empowerment, are given equal attention and resources.
- v. Agree that a theme of discussion at the next PCB be further development of joint initiatives to work towards combating homophobia, discrimination and criminalization of same sex behaviour, that are hampering HIV efforts in many countries, looking at areas of good practice.
- vi. Request the UNAIDS Secretariat and WHO to assess in 3-5 countries the costs of testing and treatment of HIV and HCV as well as provide guidelines for treatment regimens.
- vii. Request UNAIDS and donors to support, and governments to incorporate policies and resource programs that address the intersection between violence against women and HIV and AIDS as a component of their National AIDS Programs.
- viii. Request UNAIDS and Co-sponsors, as a matter of priority, to work at the national level to assist governments to scale up harm reduction approaches, including needle exchange and substitution therapy, especially in countries with IDU-driven epidemics, paying particular attention to removal of legislative and policy barriers to effective implementation harm reduction services.
- ix. Request UNAIDS, Co-sponsors and governments to commit to significantly increase prevention programs, for both at risk populations and for populations that not in traditional risk groups, such as married women and adolescent girls.

**Cost implications for decisions:**

- vi. US\$ 60,000 (based on costs of three gender assessments)

*“ UNAIDS has pointed to a rapidly expanding HIV epidemic, the possibility of ten million new infections by 2010...we know who the risk groups are, the epidemiology has been projected, we have internal and external migration, we have gender inequality...the question is will there be nine million new HIV infections in China in the next four years? Will we allow that to happen? Will the global community allow that to happen? It could take place relatively unnoticed. Ten million people would be less than one percent HIV prevalence; it could take place because there is a culture of impunity for human rights violations in the world. It could take place because statistics dull us of the pain and suffering of dying of AIDS”*

Mark Heywood, South Africa AIDS Law Project,  
2006 Toronto AIDS Conference

1. On March 20, 2007 the UN Secretary General Ban Ki Moon launched a progress report on the Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS<sup>1</sup>. The report was released without much fanfare, and despite its best intentions to demonstrate progress, the assessment presents a sobering picture of how, notwithstanding global commitments and some progress, at the current pace we will fail to provide universal access to prevention, treatment and care to all those who need it. The slow progress towards this goal is starkly illustrated by the figures for 2006:

- i. 90% of people with HIV do not know their status;
- ii. 4.3 million new infections, with the vast majority in Africa;
- iii. 79% of pregnant HIV positive women are not receiving PMTCT;
- iv. 530,000 children infected;
- v. 72% of those who need treatment do not have access to it;
- vi. 2.9 million deaths due to AIDS, 72% of these in Africa;
- vii. 81% of IDUs have no access to harm reduction; and,
- viii. 42% of those who need them have access to condoms

2. These statistics must not, to quote activist Mark Heywood, *dull us to the pain and suffering of dying of AIDS*, rather we must use them to continue to strengthen our resolve. Our relentless advocacy for greater leadership and accountability is more important than ever. The purpose of this report is to draw attention to some of the most pressing issues from a civil society perspective from Latin America, the Caribbean, North America, Europe, Asia, the Pacific, Africa and the Middle East. This report draws from ideas and recommendations that civil society groups<sup>2</sup> have advanced in the past year and we look forward to their consideration and incorporation into the work of UNAIDS.

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<sup>1</sup> UN General Assembly, Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: Focus on progress over the past 12 months, A/61/816

<sup>2</sup> Advocates for Youth, African Civil Society Coalition, AMFAR, Canadian HIV/AIDS Legal Network, CARE International, CHANGE, Human Rights Watch, Interagency Coalition for AIDS and Development, International Women's Health Coalition, International Gay and Lesbian Human Rights Commission, Network of Sex Worker's Projects, OSI Public Health Program, RedBol, International Treatment Preparedness Coalition (ITPC), GMHC, Russian Harm Reduction Network, Harm Reduction Coalition, Rwanda Women's Organization, Asia Pacific Network of People Living with AIDS, GYCA, International Treatment Preparedness Coalition in Eastern Europe (ITPCru.org), Eastern European and Central Asian Union of Organisations of PLHIV (ECUO), Central and Eastern European Harm Reduction Network (CEEHRN), AIDS Action Europe, European AIDS Treatment Group (EATG)

### **Universal Access: More prevention and more treatment**

3. The universal access process at the national level has highlighted once again the need to establish treatment targets that are appropriate; that are realistic; and that have been agreed to by both government and civil society. In some cases this process is made increasingly difficult by the lack of baseline data, conflicting or inaccurate estimates. For example, in the case of India, WHO and National AIDS Control Organization (NACO) estimates are quite far apart. In 2005 WHO estimated that 783,000 people require antiretroviral treatment against the NACO estimates of only 380,000 people.

4. The political declaration agreed to at the High-Level Meeting of the UN General Assembly in June 2006, includes country commitments to develop ambitious targets for universal access. According to recent UNAIDS and WHO reports, by the end of 2006, 90 countries had provided target data on the outcome indicators proposed by UNAIDS in its operational guidance on target-setting for such access. Of these 90 countries, 81 had set treatment targets and 84 had set outcome targets for at least one prevention intervention, in most cases this was PMTCT. Although countries committed themselves to setting targets by the end of 2006, many targets are still awaiting formal endorsement by national authorities, and some low-prevalence countries have only just begun the target-setting process. In addition, the necessary alignment and integration of target-setting with national planning processes means that a number of countries will continue this process during the course of 2007.

5. Only a comprehensive response that integrates prevention, treatment and care will reverse the pandemic. Efforts to intensify prevention are clearly falling short when globally last year there were 4.3 million new infections. About six times more people contracted HIV globally than those who started antiretroviral treatment. Furthermore, only an estimated one-fifth of individuals at risk of HIV infection have access to prevention; 12% of high-risk individuals have access to HIV counseling and testing; 24% of high-risk individuals have access to HIV/AIDS education; 42% of people in need have access to condoms; and 19% of injecting drug users have access to harm reduction programs.<sup>3</sup> An overwhelming majority of these infections occurred in Africa, which accounts for almost two thirds of all persons globally infected with HIV.

6. Civil society activists have repeatedly called for an integrated approach to prevention, treatment and care. To scale up treatment and prevention programs and services in all regions, donor commitments to HIV/AIDS funding need to be fulfilled and sustained; infrastructure needs to be strengthened; and human rights issues including stigma, discrimination, and gender inequality will need to be confronted with greater commitment. In sub-Saharan Africa, a critical shortage of health care workers and weak health systems is a major challenge in scaling up access to prevention, treatment and care.

7. Civil society organizations, in evaluating the national target setting process, have expressed concern that prevention is falling off the agenda and when incorporated it is often only in the context of PMTCT. Investment in comprehensive prevention must:

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<sup>3</sup> UNAIDS 2006 Epidemic update

- i. Be scaled up and include confidential and voluntary HIV counseling and testing;
- ii. Include access and supply to male and female condoms as well as cervical barrier methods, microbicides, and vaccines as they become available;
- iii. Include evidence based comprehensive sexuality education;
- iv. Incorporate programs and policies to promote gender equality;
- v. Incorporate clean needles and harm reduction;
- vi. Include post-exposure prophylaxis.

8. We welcome the recently released guidance on prevention and look forward to hearing how UNAIDS plans to develop support and commitment at the country level for its integration into AIDS policies and programs.

9. Recent closure of one of the large-scale efficacy trials on microbicides reminds us of the continued need to conduct well-designed trials and highlights the urgency of finding an effective microbicide as soon as possible. Civil society organizations and activists in the field agree that work on finding a microbicide should be undertaken alongside greater investments and attention to existing prevention tools that we know work. We note that despite the availability of treatment options there is still an appallingly low level of access services for prevention of mother to child transmission. Similarly, there is still a global shortage of condoms, in particular female condoms. However, declining support for condoms among some policy makers, misinformation about and stigmatization of condoms, social and cultural norms coupled with ideological opposition to condom promotion and use, and donor agendas are putting people at further risk. For example, states' refusal to distribute condoms to prisoners in most developing countries leaves huge numbers of people vulnerable to HIV. Male and female condoms remain the only technology available to protect against the sexual transmission of HIV. In addition, condoms help prevent other sexually transmitted infections and can prevent unwanted pregnancies and the complications that arise from them.

### **Prevention for Youth**

10. Each day, 6,000 young people are infected with HIV, most of them young women. Moreover, over half of the 4.3 million people infected each year are under 25 years old. Poverty, unemployment, a lack of education and access to sexual and reproductive health services, sexual violence, and gender inequality increase the vulnerability of young people to HIV infection. Globally 15 million children and adolescents have been orphaned by AIDS and are now heads of households. Although world leaders committed that by 2005, 90% of young people would know how to protect themselves from infection, currently in the hardest hit countries, less than half of youth can correctly identify modes of HIV transmission.

11. Governments committed in the 2006 Political Declaration to address the rising rates of HIV infection among youth and to implement comprehensive, evidence-based prevention strategies including the use of condoms and youth-specific HIV education. Despite this, few countries have taken up this commitment in the target setting process at the national level. It is urgent to improve young people's access to youth friendly and affordable sexual and reproductive rights services and counseling; guaranteeing their rights to privacy and confidentiality; including the full range of reproductive health commodities. The increasing rates of infection among youth, and young women in particular, also point to the urgent need for comprehensive sexuality education for youth in and out of school.

## **Stagnation in AIDS Treatment Scale Up Puts Millions of Lives at Risk**

12. One year after the end of the World Health Organization's "3 by 5" campaign to deliver AIDS treatment to 3 million people in low and middle-income countries we are still over 1 million people short of the 3 by 5 goal. In "Missing the Target", the International Treatment Preparedness Coalition (ITPC) reports that while there have been "important areas of progress, the AIDS treatment delivery effort is at risk of stagnating. More people are on treatment, but the pace of scale up remains far too slow." In Eastern Europe and Central Asia 15% are accessing treatment compared to 6% in North Africa and the Middle East, the region with the lowest estimated coverage. In many countries, many people in need of treatment are not able to receive it, particularly in rural areas and in marginalized populations. In sub-Saharan Africa, less than one quarter of the estimated 4.6 million people in need of antiretroviral therapy are receiving it. Even with this critical situation no clear global targets have been set for the scale up of AIDS treatment and services.

13. The new AIDS treatment access numbers released by the World Health Organization (WHO) are a grave warning about the state of AIDS treatment scale up. In 2006, treatment access grew by 700,000 to an estimated total of 2,015,000 people, leaving many millions more in urgent need of antiretroviral therapy. At this rate of expansion the world will fall five million people short of the internationally declared and reaffirmed Universal Access target of 9.8 million on treatment by 2010

14. In 2006, five million people remained without access to ART, and WHO – the lead United Nations agency on AIDS treatment - is not sufficiently funded to maintain a strong focus on AIDS treatment scale-up. The G8 countries have not adequately honored their 2005 Gleneagles commitments to universal access to treatment, prevention and care. Without the funds they have promised to provide, hundreds of thousands of avoidable deaths are inevitable. Only 26 of over 100 countries have developed costed national plans for key HIV/AIDS interventions – a more than 75% failure rate to complete the first agreed upon milestone. This lack of national leadership and commitment is the key barrier to saving millions of lives.

15. The development of a robust plan to access second line treatment options is absolutely critical at this time to sustain progress made on treatment access. In most countries, there are no existing policies for the provision and roll out of second line treatment. In Latin America medicines are still not locally made in sufficient quantity, second-line treatments are costly, and bilateral free trade agreements are eroding countries' abilities use the WTO provisions that allow countries to produce low-cost versions of patent-protected medicines<sup>4</sup>. Together, rising HIV infections and high costs of medicines threaten the sustainability of present treatment coverage levels. The reduction in cost to provide first line ART has led to increased access, but as more people on treatment develop resistance, new treatment options will need to be made available. Plans to reduce the second line treatment costs in some low and middle income countries by pharmaceuticals is a step in the right direction, however UNAIDS and WHO need to lead the way in working with the international community to expand access to second line treatment.

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<sup>4</sup> [http://data.unaids.org/Topics/UniversalAccess/UniversalAccess\\_Bulletin\\_30Jan2006\\_en.pdf](http://data.unaids.org/Topics/UniversalAccess/UniversalAccess_Bulletin_30Jan2006_en.pdf)

16. Treatment activists have mobilized around the drug patent disputes in India and Thailand that threaten treatment programs. The August 30, 2003 decision of the WTO General Council concerning paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health makes it clear that countries have the right to issue compulsory licenses to override patent rights in order to meet their public health needs. Many statements, including the June 2006 UN General Assembly Political Declaration on HIV/AIDS, encourage countries to avail themselves to the full benefits of the TRIPS “flexibilities”, however, when they do so, they face criticism and retaliation. We support and commend the Thai government’s decision to issue a compulsory license for a very important drug needed to treat patients who are in need for second line medicines, and call on pharmaceutical companies to cease threatening countries trying to provide affordable and sustainable treatment to their citizens.

### **Gender Inequality, PMTCT, and Male Circumcision**

17. HIV infection rates are increasing among women and girls in every region in the world. In Latin America, from 2003 to 2006 the percentage of women infected with the HIV virus rose by ten percent. In Ukraine 42% of those infected with HIV are women. Women, especially young women and girls, are vulnerable because of denial and neglect of their rights, gender inequality, social, cultural and economic factors, pervasive violence, and biology. Gender inequality both drives and sustains HIV/AIDS. While over the last few years there has been a greater recognition of the multiple ways in which the AIDS epidemic is affecting women and girls, the response has not matched the accelerating rates of infection and risk among women and girls. Quite simply, there is both a resistance to move away from traditional epidemiological and health-based approaches that ignore the social, cultural, economic and human rights factors that contribute to the feminization of the epidemic.

18. In Asia Pacific, it is estimated that between 2001 to 2004, the number of HIV positive women in the region increased by 16% to 2.4 million – almost one-third of the total number in the region, with rates reaching 39% in Thailand and 46% in Cambodia. The highest risk factor for HIV infection among women in the region is marriage; examples are India and Thailand, with 90% and 80% respectively, of HIV positive women infected by their husbands.

19. Globally, one in three of all women will face some form of gender-based violence in her lifetime. Studies in countries where HIV prevalence is high show that HIV risk may be up to three times greater for women who have experienced violence, than for those who have not. In numerous studies, women report that violence and fear of violence are factors in deciding about disclosure of their HIV status and about seeking testing and other services. Women also say that violence and fear of it influence their ability to negotiate risk reduction with their sexual partners. Many countries refuse to recognize the crime of marital rape. Despite this, the international community has yet to respond effectively and consistently on this evidence. The recently launched campaign by international women’s groups, Women Won’t Wait, represents a positive step in drawing attention to the intersection between violence against women and HIV/AIDS. The campaign calls on the international community to design specific actions that address violence against women for each type of HIV/AIDS program, and allocate the necessary resources to this work. Among some of the issues that require further attention are:

- i. Monitoring of access to treatment by age, sex, and continuity of care.
- ii. The interconnectedness of poverty and AIDS, and their disproportionate impact on women and girls, and in particular links between HIV prevention and economic asset promotion programs.
- iii. The examination of the disproportionate burden of care that women and girls, old and young, take on, in the absence of social safety nets, caring for sick relatives and securing a livelihood as earning family members become sick and die;
- iv. The intersection of age and gender – particularly in looking at how both older and younger women may be at risk and may be excluded from services, care, support and the development of new prevention technologies and clinical trials;
- v. Women's access to SRH, confidential VCT and protection from violence, stigma, and discrimination that may result from disclosure of status;
- vi. The level and extent of resources being allocated and monitoring of HIV/AIDS resources for health services and education that protect and empower women and girls; and,
- vii. Women's sexuality in the context of how they are able to exercise their sexual rights and be in a position to negotiate when they have sex, how often and how they can protect themselves from sexually transmitted infections (STIs) and HIV. This should also include the recognition that women who have sex with women may also be at risk

20. Close to 90% of women in need of PMTCT services are not receiving them. PMTCT is highly effective, and simple to administer. However, notwithstanding the expertise, knowledge, the numerous political commitments, the calls to action and the consequences of inaction, as demonstrated by the increasing rates of children with HIV, progress on PMTCT is nothing short of failure. A recent report by WHO estimates that in 2005, merely 220,000 of the more than 2 million pregnant women estimated to be living with HIV received antiretroviral prophylaxis for PMTCT, an estimated coverage rate of 11% (This coverage rate varies from below 1% to 54% in sub-Saharan Africa). Furthermore, even when countries have established PMTCT targets and programs, these have not been scaled up and efforts have been further hampered by lack of HIV testing available to pregnant women.<sup>5</sup>

21. Male circumcision could represent a positive step towards greater prevention efforts, however, public health messages must emphasize that male circumcision does not provide complete protection against HIV for men and we do not know whether it protects women. Service providers need to continue to promote safer sexual behavior and effective use of all prevention tools. Sensitivity to the cultural and religious context surrounding male circumcision is also important and circumcision must be completely voluntary. Condom promotion and other behavior change efforts need to be undertaken in tandem with MC services. Trained personnel and limited resources must not be diverted from equally pressing priorities. These include sexual and reproductive health services, which remain underfunded and out of reach for many women and girls. In addition, more research is needed to ascertain impacts on the sexual partners of circumcised men. Civil Society Organizations (CSOs) are particularly concerned that studies have not fully assessed the impact of male circumcision on HIV transmission to the female and/or male sexual partners, through vaginal or non-vaginal intercourse.

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<sup>5</sup> WHO progress report page 9



## **Providing pediatric treatment**

22. Globally, pediatric treatment for HIV infected children is seriously lacking with only one in ten children in need of antiretroviral treatment having access to treatment. Nigeria has approximately 100,000 children in need of treatment but only 3% were estimated to be receiving it by September 2006. Only 4% of children born to HIV-infected mothers receive prophylactic treatment to prevent opportunistic infections that can be fatal and WHO reports that 380,000 children died last year in developing countries, of preventable AIDS related illnesses. It is encouraging that countries are taking steps to integrate HIV treatment for children into adult treatment sites. Prices for pediatric treatment remain a challenge in scaling up efforts.

23. Prevention strategies need to focus on adolescents and young people who are most at risk. Globally, a higher number of young women are being infected than men and evidence suggests that declining HIV prevalence in some countries has resulted from the adoption of safer sexual behaviour by young people. However, when it comes to prevention for young people, some of most effective approaches for preventing HIV/AIDS transmission are not being used. Despite evidence that it is not effective, some governments continue to push abstinence only programs. Recent evaluations of abstinence only programs have demonstrated that they have no impact on behavior such as the age of first intercourse. Such programs typically, and contrary to the evidence, discuss methods of contraception and include information on condoms, only with respect to failure rates. In sub-Saharan Africa, a majority of young adults lack adequate knowledge of HIV transmission, so the emphasis on “abstinence-only” approaches and promotion of inaccurate information about the effectiveness of condoms is placing young people at risk. Evidence-based programs that respect individual rights and provide young people with comprehensive sexuality education with an emphasis on gender equality are what are really needed.

## **Co-infection of HIV and TB**

24. Globally there are two billion people infected with the tuberculosis bacillus (TB)<sup>6</sup> and at least 13 million co-infected with TB and HIV. While standard TB is curable even in people living with HIV, WHO reports that in 2005, only 7% of TB patients were tested for HIV worldwide, and countries with a generalized HIV epidemic reported that only 13% of all TB patients were tested for HIV. Globally, 86% of the estimated number of HIV-positive TB patients are not tested for HIV during their treatment for TB.<sup>7</sup> To a great extent CSOs see the crisis with XDR-TB as one generated by the continued failure to deliver basic quality integrated TB and HIV services. Consequently, civil society actors have called for an end to the counter-productive separation of TB and HIV programming. The recent efforts by UNAIDS Executive Director Dr Peter Piot, by signing the ‘Call to Stop TB’ and emphasizing UNAIDS’ commitment to tackling TB as one of the most important causes of illness and death amongst people living with HIV, is an important step towards ending the existing division, and develop closer collaboration between, HIV and AIDS services.

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<sup>6</sup> <http://www.who.int/mediacentre/factsheets/fs104/en/index.html>

<sup>7</sup> WHO report page 21

### **Co-infection of HIV and Chronic Hepatitis C (HCV)**

25. Intravenous drug use fuels at least 70% of HIV transmission in some countries<sup>1</sup> and in these circumstances the risk of Hepatitis co-infection is very high, but is rarely reported and detected in time. WHO estimates that 2.5-4.9% of China's population is HCV positive<sup>1</sup>. Treatment of HCV is very expensive and inaccessible to most patients. More importantly the most prevalent treatment for the co-infection of HIV and HCV is extremely challenging and hepatotoxic. There is an urgent need to make a wider variety of ARVs available to lower the levels of liver toxicity and reduce occurrences of cirrhosis and death.

26. Worldwide, few countries offer free testing of hepatitis in HIV testing facilities, and even fewer offer free treatment of hepatitis where there is a co-infection of HIV. Even where testing and treatment are available, they are mostly offered in urban areas and are often inaccessible and unaffordable due to the costs associated with travel, testing and/or treatment.

### **Safeguarding sex worker's rights**

27. Sex worker advocates state an enabling environment and empowerment of sex workers to demand and enforce good working conditions, access to safe sex materials and information, and addressing violence against sex workers are the most effective ways of addressing HIV/AIDS risk and ensuring effective prevention programming for sex workers and their clients. At a UNFPA global consultation on sex work held in Brazil in July 2006, sex workers and public health experts called for better conditions for people in the sex industry, highlighting the impact that violence, police repression, the violation of sex workers rights and criminalization in general have on HIV prevention efforts. We welcome the recent efforts to provide guidance and a unified approach to the UNAIDS Cosponsoring agencies to the reduction of HIV vulnerabilities in the context of sex work by the UNAIDS secretariat. However, many sex worker health and rights advocates are concerned with the "3 Pillars" framework and feel that it may shift needed attention away from established and thoughtful HIV prevention strategies, such as peer education and sex worker empowerment. Sex workers networks report that at the national level, resources are going to keeping people out and getting people out of sex work, not to improving working conditions for sex workers and supporting peer education. There have also been increased brothel raids, which have been linked to human rights violations and worsened conditions for sex workers caught up in raids. There is no evidence that raids prevent either trafficking or HIV, and all the evidence points to negotiating and better working conditions lowering rates of HIV and enabling sex workers to help others who want out to leave their jobs. Further dialogue and collaboration between UNAIDS co-sponsors and sex workers will be required in the near future to ensure that the proposed "3 pillars" approach safeguards and promotes sex worker's rights.

## **Homophobia continues to hamper HIV efforts**

28. Criminalizing homosexuality hampers efforts to fight HIV, by driving gay and bisexual people underground and making them afraid to discuss their sexual behavior and seek HIV services. Homophobia and criminalization of homosexuality continues to be a significant obstacle to prevention, treatment, care and support. Countries such as Cape Verde and South Africa have repealed their sodomy laws and government officials in Kenya, Malawi, and Mauritius have begun discussions about the harmfulness of such laws. However, despite these positive steps to repeal laws that criminalize same-sex conduct between adults, a resurgence of intolerance and homophobia coupled with lack of action on removing laws that violate the human rights of same sex practicing individuals, men and women, is posing a grave threat to the AIDS response in many countries.

29. The International Gay and Lesbian Human Rights Commission reports that throughout Africa HIV is decimating same-sex practicing communities, “...with a speed and breadth reminiscent of the impact of the epidemic on gay men in New York, San Francisco and other North American cities in the 1980s”, and that AIDS programs are failing to respond to the needs of same-sex practicing communities.<sup>8</sup> They also called for greater attention to lesbians, an issue that the International Community of Women Living with AIDS (ICW) raised in 1992. ICW has also called for research into woman-to-woman transmission and recognition of and support of lesbians living with HIV/AIDS.

30. It is deeply worrying that in 2006 there was a resurgence of attempts to criminalize same sex behaviour, such as the introduction of a bill in Nigeria that would imprison anyone who speaks out or forms a group supporting gay and lesbian people’s rights. Recently, Poland has proposed legislation banning all discussion of homosexuality in schools, directly affecting attempts by civil society to effectively carry out information campaigns on HIV/AIDS prevention.

31. Activists in Jamaica and Human Rights Watch have called for a stop to anti gay violence and murder of gay activists and for authorities to investigate and prosecute perpetrators of this violence. Efforts to repeal laws that criminalize same sex consensual conduct in keeping with international human rights law need to be strengthened while working to end arrests, harassment and persecution of people on the basis of sexual orientation. Without this, these laws will continue to contribute to HIV vulnerability for same sex practicing people by driving them underground, maintaining their marginalization.

## **Injecting Drug Users (IDUs)**

32. The lack of political will to deal with marginalized communities remains a major barrier in delivering prevention, particularly in regions where the epidemic is concentrated among IDUs. Globally the IDU population is estimated to be 13.2 million. One in three new infections outside of Africa affects injecting drug users. Syringe sharing and sexual transmission from HIV positive drug users to their partners accounts for over one-third of HIV cases in the United States. In Eastern Europe and Central Asia, where nearly 83% of HIV cases are attributed to injecting drug use, former or current IDUs

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<sup>8</sup> Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa. IGLHRC, 2007

represented only 24% of the people on antiretroviral treatment at the end of 2004. Overall, IDUs continue to have poor and inequitable access to antiretroviral treatment, particularly in Eastern Europe.

33. Prevention strategies for IDUs need to be comprehensive and include information, skills and support to reduce risk for both drug related and sexual transmission. Risk factors for HIV infection among IDUs differ significantly by gender and these gender differences need to be better understood in order to inform effective HIV prevention programs. For example, in some cases female IDUs are more vulnerable to HIV than their male counterparts and are more likely to have a history of sexual violence. Studies have shown that it is important to also understand the role of gender and provide specific programs to female IDUs.

34. Numerous research studies and government evaluations demonstrate that syringe exchange programs help drug users significantly reduce risk of HIV infection. Despite these acknowledgements and irrefutable evidence some governments restrict funding to domestic and international needle exchange programs remains. These bans have a negative impact, for example in the USA, by restricting access and coverage of syringe exchange for the estimated one million people who inject drugs. In Eastern Europe, there is very low coverage of harm reduction programs. Few governments are adopting proven strategies such as substitution therapy for drug addiction or the provision of clean needles. In many countries substitution therapy remains illegal, which hinders prevention. For example, in the Russian Federation, where the epidemic is concentrated among IDUs, the use drug substitution therapy is not permitted and the availability of clean needles is hindered by current policies. In other countries of the Eastern European sub-region, opiod substitution therapy is in pilot stage when what are urgently needed are wide-scale national programmes.

35. There are some signs of progress and models of good practice in this area. In June 2006, Vietnam adopted a new Law on Prevention and Control of HIV/AIDS. According to the Canadian Legal AIDS network, the law is exceptional in that it explicitly legalizes harm reduction interventions: "*harm reduction interventions in prevention of HIV transmission include ...communication and mobilization, promotion of the use of condom and clean needle and syringes, treatment of opiod addiction by substitution and other harm reduction measures to support safe behaviors to prevent HIV infection and transmission.*"

36. A comprehensive harm reduction approach focusing on facilitating safer injecting, needle exchange and substitution therapies is supported both by UNAIDS best practice recommendations and peer reviewed scientific studies. Additionally, these harm reduction programs should be gender sensitive and provide services for services for female IDUs. Unfortunately, harm reduction programs for people who inject drugs and consequently, their partners, are not universally available and, where they exist, programs are under threat of being closed down for financial or political reasons despite a strong level of support from communities that often include police and local authorities.