MDG6

SIX THINGS YOU NEED TO KNOW ABOUT THE AIDS RESPONSE TODAY
THE HIV RELATED TARGETS OF GOAL 6 INCLUDE:

A. HAVE HALTED BY 2015 AND BEGUN TO REVERSE THE SPREAD OF HIV/AIDS
B. ACHIEVE, BY 2010, UNIVERSAL ACCESS TO TREATMENT FOR HIV/AIDS FOR ALL THOSE WHO NEED IT

INDICATORS TO MEASURE PROGRESS

- HIV PREVALENCE AMONG POPULATION AGED 15-24 YEARS
- CONDOM USE AT LAST HIGH-RISK SEX
- PROPORTION OF POPULATION AGED 15-24 YEARS WITH COMPREHENSIVE CORRECT KNOWLEDGE OF HIV/AIDS
- RATIO OF SCHOOL ATTENDANCE OF ORPHANS TO SCHOOL ATTENDANCE OF NON-ORPHANS AGED 10-14 YEARS
- PROPORTION OF POPULATION WITH ADVANCED HIV INFECTION WITH ACCESS TO ANTIRETROVIRAL DRUGS
There is a lot to be hopeful for as we approach the milestone of reaching the Millennium Development Goals by 2015. Much has been achieved—fewer people are dying of AIDS-related illnesses and the rate of new HIV infections has fallen by more than 17% since 2001. Recent breakthroughs in HIV prevention research—such as a woman initiated and controlled microbicide gel combined with the increasing scale up of male circumcision—hold promise for both women and men to protect themselves from HIV. However this progress has not been sufficient enough to break the trajectory of the AIDS epidemic, and current strategies for HIV prevention, treatment, care and support will not take us to our ultimate goals.

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

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

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

World public opinion is strongly behind a re-energized AIDS response. A first time public global opinion poll conducted by UNAIDS shows that the majority believe that the AIDS epidemic can be pushed back by 2015. But the general public is also calling on the world to do better. We must not fail the 33.4 million people living with HIV at this defining moment of the AIDS response.

Michel Sidibé
Executive Director
1. New HIV infections are falling.

As new HIV infections are steadily declining around most of the world, 22 of the most affected countries in sub-Saharan Africa have reduced HIV incidence by more than 25%. Leading the drop or stabilization of new HIV infections are countries with some of the largest epidemics—Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe.

However, eastern Europe and Central Asia remains the only region where new HIV infections are on the rise. There has also been a resurgence of HIV infections among men who have sex with men in several high income countries.

Globally, the rate of new infections is still high, outstripping advances made in providing life saving treatment to people living with HIV. There are five people newly infected with HIV for every two people newly put on treatment.

Each day there are 7400 new HIV infections. About 40% are among young people between the ages of 15-24. Women continue to be disproportionately affected by HIV in sub-Saharan Africa, representing nearly 60% of all people living with HIV in the region. The proportion of women to men living with HIV in Asia rose from 19% in 2000 to 35% in 2008. Many were infected in the context of marriage.

**COUNTRIES WITH REDUCTIONS IN HIV INCIDENCE OF MORE THAN 25% IN SUB-SAHARAN AFRICA**

- Botswana
- Burkina Faso
- Central African Republic
- Congo
- Côte d’Ivoire
- Gabon
- Eritrea
- Ethiopia
- Guinea
- Guinea-Bissau
- Malawi
- Mali
- Mozambique
- Namibia
- Rwanda
- Sierra Leone
- South Africa
- Swaziland
- Togo
- United Republic of Tanzania
- Zambia
- Zimbabwe
2. More than 5 million people are on HIV treatment.

The number of people accessing antiretroviral treatment has increased 12-fold in just six years. More than 5 million people are on treatment today. As a result, more people living with HIV are leading healthier and productive lives.

AIDS-related mortality has reduced significantly since the widespread availability of treatment in the past few years. There were 200,000 fewer AIDS-related deaths in 2008 than in 2004.

However, two out of three people requiring treatment do not have access to it. In addition, tuberculosis remains one of the leading causes of death among people living with HIV globally—despite being preventable and curable. Recent data from WHO estimate that there were 1.4 million TB cases among people living with HIV and over 500,000 deaths in 2008.
TREATMENT 2.0

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

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

Condom use among men has doubled in the past five years. Meanwhile, tradition is giving space to pragmatism as communities embrace male circumcision, which has the potential of reducing risk of acquiring HIV infection among men by nearly 60%.

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

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

An effective vaccine is years if not decades away, but for the first time an HIV vaccine trial candidate showed some efficacy in human beings.

And investments in prevention are deficient. Fewer than one in five sex workers receive adequate HIV prevention services. Less than 1% of global prevention funding for HIV is spent on sex work despite the disproportionate HIV risk and vulnerability sex workers face.

Today, nearly 10% of global HIV infections are due to unsafe injecting drug use. People who inject drugs often have little or no access to HIV prevention and treatment services. Only two needle–syringes were distributed per person who injects drugs per month and only eight persons who inject drugs had received opioid substitution therapy (OST) per 100 people who inject drugs.

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

<table>
<thead>
<tr>
<th>Percent</th>
<th>Low</th>
<th>Concentrated</th>
<th>Generalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm reduction programs for Injecting drug users</td>
<td>8.00</td>
<td>7.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Programs for men having sex with men</td>
<td>4.00</td>
<td>3.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Programs for sex workers and their clients</td>
<td>2.00</td>
<td>1.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
Around 430 000 children are born with HIV each year. New UN estimates show that there were 42 000 deaths due to HIV among pregnant women in 2008. About half of these deaths were estimated to be maternal. Each one of them is preventable.

There has been significant progress in making prevention of mother-to-child transmission of HIV services available to pregnant women across the world. Countries such as Botswana have achieved virtual elimination and record numbers of women have accessed such services in South Africa. HIV transmission from mother to child has for long been a rarity in high-income countries.

The prevention of mother-to-child transmission supports attainment of several MDGs.
5. Criminalization is challenging the AIDS response.

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

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

More than 80 countries across the world criminalize same-sex behavior. There is no place for homophobia in the world. Criminalization of HIV transmission, men who have sex with men, people who use drugs and sex workers hampers their full participation in accessing services for HIV prevention and treatment.

Every individual should have equal access to freedom of movement—regardless of HIV status. There are 51 countries, territories, and areas that impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status. HIV travel restrictions are neither an evidence-informed or rights-based way to prevent HIV transmission.
Investments in AIDS are showing results. To sustain these results it is imperative that resource availability is predictable. Countries cannot respond effectively to the epidemic on a fiscal year basis. Thanks to the movement to reach country driven universal access goals, demand for access to HIV prevention, treatment, care and support services has increased manifold in recent years. In coming years, this is expected to further increase. Meeting this need is a shared responsibility—of development partners and national governments.

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

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

Some 50% of global resource needs for low- and middle-income countries are in 68 countries where the national need is less than 0.5% of the gross national income. These countries can meet a substantial proportion of their resource needs from domestic resources. Doing so will free up international investments for countries most in need.

In 2009 only US$ 15.9 billion was available for the global AIDS response, US$ 10 billion short of the estimated need. At this turning point flat-lining or reductions in investments will hurt the AIDS response.

AIDS programmes can be made sustainable and affordable—by increasing the efficiency and the effectiveness of the HIV programmes. This means doing it better: knowing what to do and investing resources in the right direction. This will help lower global resource needs in the long run.
Can governments meet the resource needs of the AIDS response from government revenue?

<table>
<thead>
<tr>
<th>Country</th>
<th>Adult HIV Prevalence</th>
<th>Domestic Spending on AIDS as a per cent of government revenue</th>
<th>Size of the economy</th>
<th>Gap in resource need after governments increase domestic investments to optimal levels (in millions of US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Republic of Tanzania</td>
<td>5%</td>
<td>United Republic of Tanzania US$ 562</td>
<td>United Republic of Tanzania US$ 562</td>
<td>United Republic of Tanzania US$ 562</td>
</tr>
<tr>
<td>Malawi</td>
<td>2%</td>
<td>Malawi US$ 264</td>
<td>Malawi US$ 264</td>
<td>Malawi US$ 264</td>
</tr>
<tr>
<td>Mozambique</td>
<td>4%</td>
<td>Mozambique US$ 920</td>
<td>Mozambique US$ 920</td>
<td>Mozambique US$ 920</td>
</tr>
<tr>
<td>D.R. Congo</td>
<td>6%</td>
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<td>D.R. Congo US$ 1195</td>
<td>D.R. Congo US$ 1195</td>
</tr>
<tr>
<td>Nigeria</td>
<td>7%</td>
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<td>Nigeria US$ 393</td>
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</tr>
<tr>
<td>Zimbabwe</td>
<td>20%</td>
<td>Zimbabwe US$ 422</td>
<td>Zimbabwe US$ 422</td>
<td>Zimbabwe US$ 422</td>
</tr>
<tr>
<td>South Africa</td>
<td>25%</td>
<td>South Africa US$ 320</td>
<td>South Africa US$ 320</td>
<td>South Africa US$ 320</td>
</tr>
</tbody>
</table>

Optimal levels of government investments in relation to adult HIV prevalence.