Overcoming AIDS: the ‘Next Agenda’
The gender factor

Women are more physically susceptible to HIV infection than men. Data from a number of studies suggest that male-to-female transmission during sex is about twice as likely to occur as female-to-male transmission, if no other sexually transmitted infections are present. Moreover, young women are biologically more susceptible to infection than older women before menopause.

Women’s increased risk is also a reflection of gender inequalities. Gender refers to the societal beliefs, customs and practices that define ‘masculine’ and ‘feminine’ attributes and behaviour. In most societies, the rules governing sexual relationships differ for women and men, with men holding most of the power. This means that for many women, including married women, their male partners' sexual behaviour is the most important HIV-risk factor.

The epidemic also has a disproportionate impact on women. Their socially defined roles as carers, wives, mothers and grandmothers means they bear the greatest part of the AIDS-care burden. When death and illness lead to household or community impoverishment, women and girls are even more affected due to their low social status and lack of equal economic opportunities.

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Women and girls' special vulnerability

Challenging negative gender roles is critical to the global AIDS response. The 2001 UN Declaration of Commitment on HIV/AIDS recognized that gender inequality is fuelling the epidemic. In the Declaration, governments pledged to create multisectoral strategies to reduce girl’s and women’s vulnerabilities. Its 2003–2005 benchmarks include:

- addressing the epidemic’s gender dimensions (article 37);
- accelerating national strategies that promote women’s advancement and their full enjoyment of all human rights; the sharing of responsibility by men and women to ensure safer sexual behaviour and empowering women to make decisions about their sexuality and protect themselves from HIV (article 59);
- eliminating discrimination against women, including violence against women, harmful traditional practices, trafficking and sexual exploitation (articles 61–2);
- reducing mother-to-child HIV transmission by increasing women’s access to antenatal care, information, counselling and testing, other prevention services, and treatment (article 54); and
- reviewing the epidemic’s social and economic impact, especially on women in their role as caregivers (article 68).

Since 2001, a variety of regional, national and international initiatives have emerged. The United Nations Development Fund for Women launched a programme to intensify gender and human rights activities within 10 highly affected countries’ national responses (Barbados, Brazil, Cambodia, India, Kenya, Nigeria, Rwanda, Senegal, Thailand, and Zimbabwe). Among other activities, the programme aims to enhance national capacity to review legislation or policies with implications for the epidemic’s gender dimensions.

“Too often I have listened to women describe how their experiences are not part of the policy discussion. Whether talking about the unequal impact of globalization, the ravages of war and armed conflict, or the reality of living with HIV/AIDS, they feel marginalized and excluded from decision-making and resources that affect their lives. And yet, it is well-known that the most effective policy approaches come from listening to those who have experienced such problems first hand, who can provide needed perspectives, improve understanding and offer creative solutions so that resources may be used creatively”. —Noeleen Heyzer, Executive Director, the United Nations Development Fund for Women

HIV-positive women’s organizations are becoming increasingly visible. Globally, the International Community of Women Living with HIV and AIDS helps positive women’s organizations to share their experiences. One of the organization’s recent initiatives is the Voices and Choices project. It includes participatory research and advocacy for improved policy and practices. In 12 francophone African countries, it also currently researches support, treatment and care provision for HIV-positive women.

A new coalition

In 2003, the Global Coalition on Women and AIDS was launched. It brings together HIV-positive persons, civil society leaders, celebrity activists, nongovernmental organization (NGO) representatives, and UN figures to facilitate collaboration and to support innovative scaling up of efforts that have an impact on women’s and girls’ lives. The Global Coalition will work on: preventing HIV infection among girls and young women; reducing violence against women; protecting girls’ and women’s property and inheritance rights; ensuring women’s and girls’ equal access to treatment and care; supporting community-based care with a special focus on women and girls; promoting women’s access to new prevention technologies and supporting ongoing efforts towards girls’ universal education.
AIDS is an extraordinary kind of a crisis. To stand any chance of effectively responding to the epidemic we have to treat it as both an emergency and a long-term development issue. This means resisting the temptation to accept the inevitability of AIDS as just another of the world’s many problems. The AIDS epidemic is exceptional; it requires an exceptional response that remains flexible, creative, energetic and vigilant.

AIDS is unique in human history in its rapid spread, its extent and the depth of its impact. Since the first AIDS case was diagnosed in 1981, the world has struggled to come to grips with its extraordinary dimensions. Early efforts to mount an effective response were fragmented, piecemeal and vastly under-resourced. Few communities recognized the dangers ahead, and even fewer were able to mount an effective response. Now, more than 20 years later, 20 million people are dead and 37.8 million people (range: 34.6–42.3 million) worldwide are living with HIV. And still, AIDS expands relentlessly, destroying people’s lives and in many cases seriously damaging the fabric of societies.

But experience has shown that the natural course of the epidemic can be changed with the right combination of leadership and comprehensive action. Two decades of tackling AIDS have yielded important successes and have taught crucial lessons about which approaches work best, although a cure remains elusive. We now know that comprehensive approaches to prevention bring the best results. Forthright national leadership, widespread public awareness and intensive prevention efforts have enabled entire nations to reduce HIV transmission. In Africa, Uganda remains the pre-eminent example of sustained success. In Asia, comprehensive action in Thailand averted some five million HIV infections during the 1990s. Cambodia too has managed to curb rapid growth of its epidemic. On every continent we can point to cities, regions or states where concerted efforts have kept the epidemic at bay.

At the same time, we now have antiretroviral medicines that can prolong life and reduce the physical effects of HIV infection. Coordinated national and international action has slashed the prices of these medicines in low- and middle-income countries, and sustained efforts are now under way to make access a reality for people living with HIV across the world who desperately need antiretroviral therapy. Furthermore, the veil of silence and stigma that has crippled efforts to respond to AIDS is finally lifting in many countries. Leaders of governments, businesses and religious and cultural institutions are increasingly coming forward to take action against AIDS. The movement of people living with HIV has become a global force in the vanguard of social
Progress update on the global response to the AIDS epidemic, 2004

The AIDS epidemic: dynamic and diverse

- The epidemic remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission.
- Girls and young women are at greatest risk. As of December 2003, women accounted for nearly 50% of all people living with HIV worldwide, and for 57% in sub-Saharan Africa.
- Young people (15–24 years old) account for half of all new HIV infections worldwide; more than 6000 contract the virus each day.
- The 2001 UN Declaration of Commitment on HIV/AIDS envisions major progress in delivering comprehensive care services by 2005. However, only minimal coverage has been achieved for care and treatment of HIV-related disease. Current prevention efforts in most low- and middle-income countries come nowhere near the scale of the epidemic.
- Achieving the 2005 targets will require urgent, innovative and expanded efforts to strengthen and accelerate the response.

change in responding to the epidemic. The impact of AIDS on development prospects in the worst-affected regions is being increasingly recognized, and action is under way to make necessary fundamental shifts in development practice.

Despite these signs of progress, more sophisticated monitoring and evaluation of the epidemic’s behaviour reveal the scale of the challenge: fewer than one in five people who need prevention services and tools have access to them. Globally, five to six million people need antiretroviral medicines now; yet only 7% in low- and middle-income countries have access to these drugs—fewer than 400 000 people at the end of 2003. Many national leaders are still in denial about the impact of AIDS on their people and societies.

An unprecedented level of financial resources is now available to tackle the disease, but it is still less than half of what is really needed. Even these funds are not being applied in a fully effective, coordinated manner. In some instances, AIDS funding sits idle, blocked in government bank accounts or stalled by rules of international funders.

The result: the AIDS epidemic is now at a true crossroads. If the world’s response to AIDS continues in its well-meaning but haphazard and ineffectual fashion, then the global epidemic will continue to outpace the response. But there is an alternative: to embark boldly upon the ‘Next Agenda’—an agenda for future action that adopts the essential, radical and innovative approaches needed for countries to reverse the course of the epidemic.

A few home truths…

Women now the most affected

In the early days of the epidemic, men vastly outnumbered women among people infected with HIV. Indeed, it initially took the medical establishment some time and a great deal of evidence before it accepted the very idea that HIV was a threat to women. The proportion of females infected by HIV worldwide steadily grew until by 2002 about half of all people infected were women and girls.

In Southern Africa, where almost every family has been touched by AIDS, infected females outnumber males by as much as two to one
in some age groups. Besides being the majority of those infected, women and girls are now bearing the brunt of the epidemic in other ways too: it is they who principally take care of sick people, and they are the most likely to lose jobs, income and schooling. Women may even lose their homes and other assets if they are widowed. To bring the concerns of women and girls into sharp focus, gender sections can be found in each chapter.

**Young people: harsh impact**

The epidemic is also affecting young people disproportionately: 15–24-year-olds account for half of all new HIV infections worldwide; more than 6000 contract the virus every day. This trend is especially alarming because this is the largest youth generation in history. Today’s 15–24-year-olds have never known a world without AIDS, and have no ‘folk memory’ of the shocking early days of the ‘new’ disease. Yet it is today’s young people who will be responsible for sustaining responses to the epidemic—they are tomorrow’s leaders, thinkers and decision-makers, and it is vital that they play an integral part in responding to the epidemic (see ‘Young People’ focus).

**The epidemic’s dimensions and the task ahead**

No other infectious disease in history has been so intensively studied. In the two decades since AIDS was first recognized, an enormous amount has been learned about HIV and the forces that drive the epidemic around the world.
Factors that influence HIV transmission: vulnerability and risk

Given the increases in the number of women infected with HIV, there is a special need to address the specific factors that contribute to women’s vulnerability and risk. These include ensuring adolescent girls have access to information and services, that violence against women is not tolerated, that women can enforce property rights, that they do not miss out on treatment and that prevention options are expanded (for example, through developing a microbicide). However, in seeking to empower women, it is important to recognize that cultural and social expectations for boys and men can be just as much of a trap; they too need to be empowered to recognize and reject pressures to treat women and girls badly.

HIV transmission is not a random event; the spread of the virus is profoundly influenced by the surrounding social, economic and political environment. Wherever people are struggling against adverse conditions, such as poverty, oppression, discrimination and illiteracy, they are especially vulnerable to being infected by HIV. Efforts to prevent the spread of HIV need to focus both on individual risk behaviour, and on the broad structural factors underlying exposure to HIV—so as to help people control the risks they take and thereby protect themselves.

Vulnerability, risk and the impact of AIDS coexist in a vicious circle. Vulnerability can be reduced by providing young people with schooling, supporting protective family environments and extending access to health and support services population-wide. Addressing vulnerability at the structural level includes reforming discriminatory laws and policies, monitoring practices and providing legal protections for people living with HIV.

Challenges in scaling up antiretroviral treatment

Since 2002, the feasibility of providing antiretroviral therapy in resource-poor settings has become almost universally recognized. Governments and donors worldwide are increasingly committed to expanding access as quickly as possible to the many people who need life-prolonging antiretroviral treatment.

Scaling up antiretroviral treatment requires assured long-term political support and funding. Any lapse in support could result in collapsed antiretroviral programmes, with resultant interruptions in treatment giving HIV the opportunity to become drug resistant. Not only would this be an individual tragedy, it would also create a grave social threat, since drug-resistant strains of the virus can spread and render entire treatment programmes useless.

Health staffing is also crucial to the prospects of extending antiretroviral access. Already, Africa has a major shortage of nurses, midwives and doctors, as they leave their native countries for better salaries, working conditions and opportunities in higher-income countries. For example, 70% of doctors trained in South Africa currently live abroad. The gap is partially filled with health professionals from other African countries, which then widens the gap there. The cycle of out-migration leaves the lowest-income countries on the continent in dire need.

It is important to avoid the kind of chaos reported from some countries, where desperate patients buy antiretrovirals without medical advice and often without prescriptions. Treatment literacy should be an integral part of all treatment programmes, and people with HIV can play an important role since they speak with the authority of their own experience. In addition, community members can
be trained to support treatment adherence and can assume some of the duties of health-care workers. This will help make more efficient use of all available resources.

**AIDS-related stigma hampers the response and accelerates transmission**

AIDS-related stigma and discrimination directly hamper the effectiveness of AIDS responses. Stigma and concerns about discrimination constitute a major barrier to people coming forward to have an HIV test, and directly affect the likelihood of protective behaviours. For example, the silence around HIV can prevent the use of condoms or can lead to HIV-positive women breastfeeding their infants for fear of being identified.

Stigma is not only directed towards people living with HIV. In many cases, HIV stigma has attached itself to pre-existing stigmas—to racial and ethnic stereotypes and to discrimination against women and sexual minorities. At the same time, long-standing patterns of racial, ethnic and sexual inequality increase vulnerability to HIV. In many countries stigma and discrimination remain important barriers to understanding how marginalized groups of society are coping with the epidemic.

Data now show that relatively new epidemics in East Asia, Eastern Europe and Central Asia are spreading fast. Despite the overwhelming evidence that AIDS is everywhere, the impulse to say AIDS is only a problem ‘somewhere else’ is still strong. In such a climate, people who are stigmatized and live on the margins of society, such as injecting drug users and men who have sex with men, are often badly served by prevention programmes. In some countries, their care and support needs are systematically ignored.

**Developing a comprehensive approach to HIV prevention**

Current HIV-prevention coverage is extremely low. Only a fraction of people at risk of HIV exposure have meaningful access to basic prevention services, although most countries have developed strategic frameworks for prevention activities. In low- and middle-income countries in 2003, only one in ten pregnant women was offered services for preventing mother-to-child HIV transmission, and an even smaller proportion of adults aged 15–49 years had access to voluntary counselling and testing.

Closing this prevention gap will require major recommitment of resources as well as a commitment to full-scale programming—too many efforts today are still at the ‘demonstration project’ level. It should be stressed that efforts to expand coverage of prevention services should avoid ‘more of the same’. They need to take account of what experience has shown works best. For example, evidence suggests that messages and activities developed at the grassroots level are much more effective than those developed by remote ‘professionals,’ and that to make a difference, prevention messages need to be focused and go beyond simply raising awareness of AIDS.

Full-scale and comprehensive prevention efforts will need to be sensitive to the different contexts of the epidemic. For example, where overall HIV prevalence remains low, the relative importance of measures addressing particularly vulnerable sections of the population—such as sex workers, men who have sex with men, or migrant populations—increases. Where population-wide prevalence is high, efforts still need to be tailored to particular populations, but reducing HIV transmission will depend on achieving and sustaining a broad range of safe behaviours across wide
population sectors, such as all young people. Evidence-informed decisions about effective prevention require knowledge of local epidemics, how they are changing over time, and who is currently at greatest risk of HIV exposure.

The changing nature of the epidemic requires prevention efforts to be constantly renewed. For example, it has become clear that the overwhelming emphasis on more effective treatment in high-income countries since the latter half of the 1990s was to the detriment of renewed prevention efforts. Prevention gains stalled and, in many cases, rises in HIV transmission were experienced for the first time in a decade. Similarly, in Thailand, outstanding success in reducing transmission associated with sex work in the 1990s changed the shape of the epidemic; now, the area of greatest need is within marriages and regular relationships.

**Impact alleviation**

The first signs of the full-scale societal impact of AIDS are becoming apparent in Southern and Eastern Africa, with the exacerbation of food crises, increases in the number of orphans, and relentless weakening of human capacity in both government and private sec-

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**The UN system: active on all fronts**

The United Nations system has remained committed to the effective implementation of the 2001 Declaration of Commitment on HIV/AIDS. The Joint UN response to the AIDS epidemic continues to gather pace, especially with the addition of the World Food Programme (WFP) as the ninth UNAIDS Cosponsor. Twenty-nine individual UN agencies take global leadership roles in their areas of specialization. Among UNAIDS Cosponsors these are: United Nations Office on Drugs and Crime (UNODC) on injecting drug users; United Nations Population Fund (UNFPA) on gender and young people; United Nations Educational, Scientific and Cultural Organization (UNESCO) on education; United Nations Children’s Fund (UNICEF) on orphans and mother-to-child transmission; International Labour Organization (ILO) on HIV and the workplace; United Nations Development Programme (UNDP) on HIV, governance and development; and the World Bank through its Multi-Country AIDS Programme. With the joint World Health Organization and UNAIDS ‘3 by 5’ Treatment Initiative, the WHO has increased its role in the global expansion of access to antiretroviral treatment.

The United Nation’s Secretary-General’s four Special Envoys on HIV/AIDS have increased HIV-related political, donor, civil society and media attention. For example, Nafis Sadik, the Special Envoy for Asia, has boosted Nepal’s human-rights approach to AIDS. In several Caribbean countries, Dr George Alleyne, the Special Envoy for the Caribbean, encouraged legal reforms and steps to reduce AIDS-related stigma and discrimination. Meanwhile, the UN Special Envoy for Eastern Europe and Central Asia, Dr Lars Kalling, is raising awareness of how injecting drug use is a key factor in HIV spread.

In Africa, Stephen Lewis, the Special Envoy for that region, has joined with James T. Morris, Executive Director of WFP and the UN Secretary-General’s Special Envoy for Humanitarian Needs in Southern Africa, to raise awareness about Southern Africa’s deadly combination of AIDS, drought and shrinking human capacity.
AIDS is fundamentally changing the fabric and functioning of societies. One way in which the epidemic creates a vicious circle is by striking hardest at those countries with the weakest capacity to implement responses. In many nations, AIDS is now depleting capacity faster than it can be replenished.

Given the deep and lasting effects of the epidemic, the most-affected countries need to review and adapt policies and investments across a wide range of areas to cope with the coming impact. AIDS calls for a complete rethinking of how skills will be built, retained and sustained. In low-prevalence countries, aggressive prevention efforts are important in order to preserve investments in human and institutional development. A long-term perspective on retaining or rebuilding development capacity needs to be adopted. The immediate pressures of responding to the epidemic and keeping people alive will have immediate returns, but must also be accompanied by forward-looking measures that restore social resilience (see ‘Impact’ chapter).

More commitment needed to help orphans

An issue of particular concern is the neglect of orphaned children. AIDS has killed one or both parents of an estimated 12 million children in sub-Saharan Africa. Yet less than half of the countries with the most acute crisis have national policies in place to provide essential support to children orphaned or made vulnerable by the epidemic. To limit the impact of AIDS on the social and economic life of communities and countries, it is a political imperative that orphaned and vulnerable children be cared for.

Challenges of the ‘Next Agenda’

It will take some extraordinary efforts to make the leap from the current piecemeal approaches to AIDS to the dynamic requirements of the ‘Next Agenda’. The world’s foremost national and international leaders, scientists, policymakers, business and community leaders and the UN system all need to create new concepts and embrace key challenges in order to revolutionize and harmonize the global AIDS response.

Resources and funding

In financing, the ‘Next Agenda’ will require innovations that enhance country capacity to determine resource needs in prevention, care and impact alleviation. It requires countries and the international community to respond with unprecedented commitment and political will. Important progress has been made in raising additional funds, but global spending in 2003 was less than half of what will be needed in 2005, and only one-quarter of the amount needed in 2007 (see ‘Finance’ chapter). National and community-level civil society organizations require support to access and effectively use funds. For their part, donors and the international community need to carefully determine their fair share of contributions to the AIDS response.

Efforts to track resources and to prove they are being used efficiently also need strengthening, since this evidence is key to continuing financial support for programmes.

Building and rebuilding capacity

In addition to mobilizing still more funds, a great deal of work is needed to seriously scale
up country programming capacity, and to clear blockages and bottlenecks in the system to ensure the money gets to where it is needed to support activities. AIDS itself has seriously depleted response capacity, and in many cases its impact has been worst in those communities and nations where capacity was already weakest as a result of decades of inadequate development.

Bold new approaches are required to reinvest in human and community resources, starting with preserving lives to the greatest extent possible, including through the roll-out of antiretroviral therapy. Long- and short-term strategies are needed in equal measure. In the immediate term, most countries possess untapped human capacity reserves (for example, in trained workforces that have retired or moved away from their professions). In the longer term, strategies that reverse the worst effects of ‘brain drain’ need to be devised.

**Harmonization and coordination**

At the national level, all stakeholders need to accept that an effective AIDS response can only be achieved if countries own and drive it within their own borders. International assistance is important, but it only works effectively if it is embedded within a national response. The concepts of national ownership, multisectorality, mainstreaming, harmonization and coherence need to be based on guiding principles called the ‘Three Ones’: one agreed AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordination body, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system.

**Action informed by science**

The threat posed by AIDS is now widely recognized. More resources than ever before have been pledged to respond; and more than ever, evidence is available about what works in response to the epidemic. Unfortunately at times, a willingness to be guided by scientific evidence and to develop consensus on effective approaches is put aside in favour of preconceived prejudices or sectoral interests, to the detriment of a concerted global response to AIDS. Time costs lives and it is vital that the world unites with a common understanding of what is needed to mount a rapid and effective response.

**The exceptionality of AIDS**

AIDS is an exceptional disease with exceptional and wide-ranging impact; it requires an exceptional response. It has the characteristics of both a short-term emergency and of a long-term development crisis. New and hybrid forms of response are needed. International financial institutions need to create mechanisms which alleviate countries’ debt-service payments so they can devote additional resources to their AIDS response. Potential short-term inflationary effects of increased and additional resources applied to the HIV epidemic can be managed, and in any event, pale in comparison with what will be the long-term effects of half-hearted responses to AIDS on the economies of hard-hit countries.

The world has new tools and a new opportunity to beat the scourge of AIDS. This is the moment for a bold new agenda to tackle AIDS; we must not let it pass.