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NGO Delegation | GLOBAL REPORT on HIV/AIDS

*To the 18th meeting of the
UNAIDS Programme Coordinating Board (PCB)
Geneva, Switzerland ~ 27-28 June 2006*

A quarter of a century into the epidemic, the global AIDS response stands at a crossroads. The important progress made against AIDS since the special session—particularly in terms of greater resources, stronger national policy frameworks, wider access to treatment and prevention services and broad consensus on the principles of effective country-level action—provides a solid foundation on which to build a comprehensive full-scale response. But success will require unprecedented willingness on the part of all actors in the global response to fulfil their potential, embrace new ways of working with each other and be committed to sustaining the response over the long term.

Declaration of Commitment on HIV/AIDS Five years later
Report of the Secretary-General (UNGASS, 2006)

GLOBAL REPORT STRUCTURE

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INTRODUCTION

The nongovernmental organization (NGO) Delegation of the UNAIDS Programme Coordinating Board (PCB) presents to the 18th meeting of the PCB this annual report highlighting the major concerns and recommendations regarding HIV and AIDS. It is requested that the PCB takes note of this report and takes specific steps to manifest the recommendations outlined in each region.

It is our intention to communicate to this high level forum, the identified trends around HIV and AIDS and highlight the main problems and obstacles faced by people living with HIV and their organizations.

Through a call for responses, civil society representatives from the five regions identified key issues around stigma and discrimination, policy towards HIV and needs around partnership and sustainability affecting their work progress.

With the five-year review of the UNGASS Declaration of Commitment on HIV/AIDS in 2006, this is a key year in AIDS policy definition. It represents a challenge but also a unique opportunity to reinvigorate the necessary commitment and support to fight the pandemic.

We believe that a capable and sustainable global response to the AIDS epidemic is not possible without the incorporation of the voices, vision and full participation from those who are directly affected by the pandemic and their representatives from civil society.

Nothing here is particularly new. We are all too familiar with the vast majority of issues, trends, obstacles and shortfalls we report year after year.

Almost all of the progress made each year is quickly subsumed or overcome by increases in infections or infection rates and the number of deaths globally. With rare exception governments the world over miss progress targets and commitments for financial support year after year.

What would be *new* to report is that every leader of every nation had the political will to rally his or her government and people to address the realities of their respective epidemics. Sadly, this is still widely and sorely lacking in many parts of the world.

We all already know the challenges and, for the most part, know how to solve the problems. What persists—and is almost never measured or reported—is the lack of political will of our leaders to honestly face the realities of HIV and AIDS, publicly confront stigma and discrimination, and finance the implementation of what we already know works.

In 2004, more than 3 million lives were tragically and unnecessarily lost. Until we all—nongovernmental organizations, governments, and international institutions alike—truly work together, this will continue to be the case.

Epidemiological situation

Among the 40 million people currently living with HIV globally, nearly 26 million are in sub-Saharan Africa. An estimated 3.2 million people in the region became newly infected in 2005, while 2.4 million died of AIDS. Among young people aged 15–24 years, an estimated 4.6% of women and 1.7% of men were living with HIV in 2005. Women constitute 60% of people living with HIV in Africa.¹

HIV in Africa is primarily transmitted through sex, which is largely heterosexual.² A significant secondary cause of infections is mother to child transmission of the virus during labour or breastfeeding, with a small additional percentage caused by unsafe injection practices.³

According to UNAIDS, Southern Africa remains the epicentre of the global AIDS pandemic. Swaziland, for instance, registers a prevalence rate of 20% in a population of 1.1 million.⁴ For the first time however there are signs that one of the epidemics in the region could be ebbing. New evidence shows a declining trend in national adult HIV prevalence in Zimbabwe, mainly in the urban areas.

East Africa continues to provide the most hopeful indications that serious AIDS epidemics can be reversed. The countrywide drop in HIV prevalence among pregnant women seen in Uganda since the mid-1990s is now being mirrored in urban parts of Kenya, where infection levels are dropping, in some places quite steeply. Nationally, the decline in Kenya was from a peak of 10% in the mid-1990s to 6.1% in 2004.⁵

UNAIDS observes that in both countries, behavioural changes are likely to have contributed to the trend shifts. Elsewhere in East Africa, though, HIV prevalence has either decreased slightly or remained stable in the past several years.

Although the epidemics in West Africa vary in scale and intensity, this sub region historically has been less severely affected than other parts of sub-Saharan Africa, as may be indicated by Benin with a prevalence rate of 2% among the 15–49 year age group in a population of 7.5 million.⁶ National adult HIV prevalence is yet to exceed 10% in any west African country, and there is no consistent evidence of significant changes in prevalence rate among pregnant women in recent years. As efforts continue to curb the spread of HIV, there is some evidence that AIDS treatment sites are ideal venues for the

¹ UNAIDS (2005). Epidemic update for sub-Saharan Africa: December 2005.

² UNAIDS (2003). Access to HIV Prevention: Closing the Gap. Global HIV Prevention Working Group, May 2003.

³ Ibid.

⁴ Swaziland UNGASS Progress Report 2003–2005.

⁵ Kenya UNGASS Progress Report 2003–2005.

⁶ Benin UNGASS Progress Report 2003–2005.

delivery and reinforcement of HIV prevention. Emerging evidence indicates that prevention programmes specifically designed for people living with HIV are effective in reducing the incidence of risk behaviour.⁷

However, progress in expanding treatment and care provision in sub-Saharan Africa in the past year has been uneven. At least one third of people in need of antiretroviral therapy are receiving it in such countries as Botswana and Uganda, while in Cameroon, Côte d'Ivoire, Kenya, Malawi and Zambia between 10% and 20% of people requiring antiretroviral drugs were receiving them in mid-2005.⁸

It is clear that there is extensive unmet need in most of this region. In South Africa, at least 85% who needed antiretroviral drugs were not yet receiving them by mid-2005; the same applied to 90% or more of those in need in countries such as Ethiopia, Ghana, Lesotho, Mozambique, Nigeria, the United Republic of Tanzania and Zimbabwe.⁹

While aiming to reach even more people living with HIV with treatment, it is equally important to continue to address underlying socioeconomic and socio-cultural dynamics that create situations of vulnerability, so that rates of declining infection can be increased or, at a minimum, maintained and so that rates of treatment can be dramatically increased.

Recent trends in prevention, care and treatment

While the prevalence rates in sub-Saharan Africa are grim, the consensus is that an effective response to the epidemic is a comprehensive one, requiring prevention, care and treatment and protection of human rights. These elements are part of a continuum, with prevention enhanced by the availability of treatment, which in turn reduces the stigma of an illness perceived to be a death sentence. Effective prevention also relies on the reduction of vulnerability to infection in high-risk groups like women and youth, including through the protection of human rights.

Several factors explain the trends and limit the effectiveness of efforts to counter the spread and impact of the disease. These include inadequate or misleading HIV information; stigma and discrimination; silence and denial about the disease; poverty and inequality; gender inequities; militarization, war and conflict; and sexually transmitted diseases. High mobility is another primary risk factor for infection, as is seen in the extremely high infection rates among refugees, migrant workers and truck drivers who operate along commercial routes. There are also extremely high rates of infection among sex workers in Africa, particularly those who work commercial transport routes.

In sub-Saharan Africa, women account for nearly 60% of all HIV infections, while young women (aged 15–24) are up to six times more likely to be infected than young men in

⁷United Nations (2006). The Declaration of Commitment on HIV/AIDS Five Years Later, Report of the Secretary-General (Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS, UNGASS 2006). Geneva.

⁸ www.unaids.org/en/Regions_Countries/Regions/SubSaharan Africa.asp

⁹ Ibid.

parts of Africa.¹⁰ These differential rates are largely explained by the gender inequalities due to lack of economic independence, educational opportunities and access to health information and services for women and girls.

The heightened risk of infection among women and girls is exacerbated by increased physiological vulnerability to infection, legal disenfranchisement, diminished educational opportunities, sexual violence, sexual trafficking and intergenerational sex. Poverty is another risk factor for women, forcing many into sex-work, placing them at high risk of contracting HIV and transmitting it to partners.

The encouraging news however, is that there are signs of HIV infection in women in some cases on the continent. For instance, among 11 sub-Saharan African countries for which reliable epidemiological evidence is available for both 2000/01 and 2004/05, 6 reported a decline of 25% or more among pregnant women (aged 15-24) living in capital cities.¹¹

Nevertheless, in much of sub-Saharan Africa, knowledge about HIV transmission routes is still low. Generally, women are less well-informed about HIV than are men; this is also true of rural areas compared with those living in cities and towns. This is the case even in the ten countries where more than one out of ten adults is infected. In 24 countries (including Cameroon, Côte d'Ivoire, Kenya, Nigeria, Senegal and Uganda), two thirds or more of young women (aged 15–24) lacked comprehensive knowledge of HIV transmission (various surveys, 2000–2004). Data from 35 of the 48 countries in Africa show that, on average, young men were 20% more likely to have correct knowledge of HIV than young women. Education levels make a huge difference, too (UNICEF, 2004). For example, young women in Rwanda with secondary or higher education were five times as likely to know the main HIV transmission routes than were young women who with no formal education (Ministère de la santé Rwanda, 2001).¹²

On a more encouraging note, however, the percentage of young people having sex before the age of 15 declined and condom use increased between 2000 and 2005 in nine of 13 sub-Saharan countries studied. Also, condom use among sexually active 15–24-year-olds appears to have increased according to information provided by 11 countries in sub-Saharan Africa. Notable exceptions were Rwanda and Uganda, where condom use by young men actually decreased.¹³

In sub-Saharan Africa as elsewhere, HIV and AIDS has been characterised by pervasive prejudice and stigma. People infected or thought to be so, have routinely experienced social and political isolation and marginalization, are often abandoned and expelled by families and communities, or subjected to intimidation and violence. The prejudice has

¹⁰ United Nations (2006). The Declaration of Commitment on HIV/AIDS Five Years Later, Report of the Secretary-General (Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS, UNGASS 2006). Geneva.

¹¹ Ibid.

¹² UNAIDS (2005). Epidemic update for sub-Saharan Africa: December 2005.

¹³ United Nations (2006). The Declaration of Commitment on HIV/AIDS Five Years Later, Report of the Secretary-General (Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS, UNGASS 2006). Geneva.

fed into and been a direct cause of pervasive human rights violations of people living with HIV, particularly in the form of systemic discrimination and breaches of privacy rights.¹⁴

There are complex and multiple causes for this. UNAIDS reports that stigma is “triggered by many forces, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment, irresponsible media reporting on the epidemic, the fact that AIDS is incurable, social fears about sexuality, fears relating to illness and death and fears about illicit drugs and injecting drug use.”¹⁵

The stigma attached to the disease, and direct negative consequences attached to being HIV-positive, perpetuate a persistent social and often political silence and denial. In high prevalence developing countries, silence and denial are deepened by the fear of being ill without accessible and effective health care. In this atmosphere, people are unlikely to be receptive to prevention messages, and have little incentive to voluntarily test themselves.

It is worth noting that since the “3 by 5” initiative was launched in 2003, the number of people on antiretroviral drugs in low- and middle-income countries more than tripled, to 1.3 million. The number of people receiving antiretrovirals in sub-Saharan Africa increased eightfold over the two-year period covered by the initiative. The initiative definitively demonstrated that administration of antiretroviral drugs is feasible in resource-limited settings, that rates of treatment adherence in developing countries are as good or better, than those reported in high-income countries and that a streamlined public health approach helps to expedite the introduction of complex therapies. However, only 24 countries achieved the target of providing treatment to at least half of those in need. HIV treatment sites are ideal venues for the delivery and reinforcement of HIV prevention, and emerging evidence indicates that prevention programmes specifically designed for people living with HIV are effective in reducing the incidence of risk behaviour.¹⁶

As already observed, however, access to HIV treatment in sub-Saharan Africa is severely limited: Only one third of people in need of antiretroviral therapy are receiving it in such countries as Botswana and Uganda, while in Cameroon, Côte d’Ivoire, Kenya, Malawi and Zambia between 10% and 20% of people requiring antiretroviral drugs were receiving them in mid-2005.¹⁷

In South Africa, at least 85% of those who needed antiretroviral drugs were not yet receiving them by mid-2005; the same applied to 90% or more of those in need in countries such as Ethiopia, Ghana, Lesotho, Mozambique, Nigeria, the United Republic of Tanzania and Zimbabwe.¹⁸ Tragically, these statistics still leave from 66% to 90% of

¹⁴ UNAIDS (2002). “A Conceptual Framework and Basis for Action: HIV/AIDS Stigma and Discrimination,” UNAIDS 02.43E, 2002.

¹⁵ Ibid.

¹⁶ United Nations (2006). The Declaration of Commitment on HIV/AIDS Five Years Later, Report of the Secretary-General (Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS, UNGASS 2006). Geneva.

¹⁷ www.unaids.org/en/Regions/Countries/Regions/SubSaharanAfrica.asp

¹⁸ Ibid

HIV-positive people in need of treatment *now* without access to it—essentially nothing less than a death sentence.

A lack of affordable treatment is not only a tremendous injustice, but an obstacle to an effective response to the pandemic. Treatment is one of the greatest possible incentives for people to test themselves, thereby bringing them into contact with preventive messages and services.

National governments, international partners and communities are failing to adequately provide care and support for the 15 million children orphaned by AIDS and for millions of other children made vulnerable by the epidemic. Although most heavily affected countries in sub-Saharan Africa have national policy frameworks for children made vulnerable by AIDS, less than 1 in 10 of such children are reached by basic support services. Also, diagnosing HIV in children is frequently complicated in resource-limited settings, and the optimal time to initiate treatment is often not apparent. Moreover, there are few formulations of antiretroviral drugs suitable for use in children, and those that are available tend to be much more expensive than adult regimens.¹⁹

These deficiencies are only partially explained by a lack of resources. Despite commitments to the contrary, many nations in Africa have simply failed to prioritize the epidemic as the emergency it is, and leadership and political will, which are cost-free financially but widely and sorely lacking—remain insufficient. This lack of political will to act appropriately is also reflected in the failure of African countries to sufficiently fund comprehensive prevention and treatment.

However, we recognize that an effective response is not the sole responsibility of government, nor is it entirely dependent on resources. All members of society bear some responsibility, including the media, communities, the private sector, religious leaders and private sector workers like health-care workers and educators.

In particular, civil society and PLWH (people living with HIV) organizations play a critical role in driving appropriate AIDS policies and programmes. AIDS advocacy among people living with HIV and human rights groups has always been a fundamental element of the response to HIV. Success depends on the enforcement of legal protections, the effective use of mass media, and the mobilization of communities, people living with HIV and all civil society to ensure that governments and other relevant sectors act accountably and responsibly.

Major issues highlighted in the region

- Although there are now more resources available to respond to AIDS in Africa than there were five years ago, urgent action is needed to reach the millions of African

¹⁹ United Nations (2006). The Declaration of Commitment on HIV/AIDS Five Years Later, Report of the Secretary-General (Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS, UNGASS 2006). Geneva.

people who are still excluded from access to life-saving treatment, prevention, care and support services, it is our belief that comprehensive prevention, treatment, care and support are indivisible: action in one area without equivalent actions in the other areas is unacceptable.

- Corruption and mismanagement of funds by some governments have jeopardised the right of people living with HIV and affected by HIV and AIDS to access prevention, care and support and treatment; structures and systems to monitor the use of funds in a transparent manner need to be instituted; civil society representatives—nominated by civil society and not appointed by governments—need to be involved in every phase of planning and implementation; without such involvement, the continent will be unable to undertake a sustainable response to the challenges of scaling up towards universal access.
- The critical shortage of health-care workers and weak health systems is the key bottleneck to scaling up access to AIDS treatment; while the needs of individual countries must be determined locally, experts estimate that sub-Saharan Africa needs at least 1 million new health workers to meet essential health needs; sustained commitment and creative action are necessary to develop and support the health workforce needed to secure the right to health and achieve universal access to AIDS treatment by 2010, as well as other international health goals; decades into the AIDS epidemic, Africans are faced with the reality that many of their health-care systems are buckling under the pressure of new AIDS treatment programmes; many of the best, brightest and most educated individuals are systematically recruited by institutions based in the global north; developed countries need to address their own health-care worker shortages internally without depleting the urgently needed workforce personnel from developing countries.
- The rights of women and girls continue to be violated with impunity, further deepening their vulnerability to infection and stigma; young people remain on the margins of policy and programme design even as their vulnerability to infection has not yet been addressed; and people living with HIV in many communities remain unable to access basic services due to the stigma and discrimination that they face on a daily basis.
- Burdensome debt repayment obligations and conditionalities by international finance institutions continue to undermine the capacity of most African governments to devote sufficient resources for HIV and AIDS including meeting the 15% Abuja commitment. Only two African countries reached the 15% target of health-care spending within their national budgets and if debt repayments are factored in, not a single African country would have reached the target set in 2001; large portions of budgets are externally funded and subject to unacceptable conditionalities.
- Without a massive and sustained effort to meaningfully involve civil society, the same global difficulties that impeded the attainment of the “3 by 5” campaign will also be encountered in the goal towards universal access in the next four years. Universal

access to prevention, treatment, care and support can only be achieved where goals and targets are set: without goals there can be no progress towards access.

- Despite the pledges made by states in the UNGASS Declaration of Commitment, not one single African country has met the target of “reducing HIV infection among young people by 25% by 2005” nor have any African countries managed to “ensure 90% access to information, education, services and life-skills,” or reduce “by 20% the number of babies infected by HIV”.
- Despite various interventions aimed at prevention, care, support and treatment of HIV, the global pandemic has had and continues to have an increasing devastating impact on the lives of African women and girls.
- In spite of the disproportionate impact of the pandemic on women and girls, governments are yet to recognize the centrality of promoting and protecting women’s and girls’ human rights in all HIV interventions.
- Assault on women’s human rights continues through various forms of violence against women and girls, including, but not limited to: rape, marital rape, domestic violence, trafficking, harmful customary and traditional practices, lack of property rights, violence and torture during conflict, forced marriages and early marriages. These forms of violence continue to take place within homes, at work, in schools, in clinics and hospitals, at police stations and in many other places and they are increasing at an alarming rate, fuelling HIV infections among women and girls.
- In contexts of extreme poverty and inadequate state health services, women and girls, and in particular women living with HIV and orphaned girls—have been forced to become the backbone of their families and communities providing family-based care and community nursing systems; with limited knowledge and skills and without resources, remuneration or other forms of state support, their disproportionate burden of care and support for people living with HIV continues to increase; community healthcare workers need to be state supported and internationally funded.
- Women living in militarized communities and zones of armed conflict face peculiar and heightened risks of HIV infection as a result of violence, sexual crimes and torture—in war and emergency situations or as refugees and internally displaced persons—with extremely limited protection of their human rights.
- Women’s low socioeconomic status, lack of access to and control over empowering and emancipating resources such as land and property increases women’s and girls’ exposure to many dehumanising cultural norms, beliefs and practices that undermine women’s and girls’ emotional, spiritual, physical, and psychological well being, choices and agency, bodily integrity and self esteem and increase their vulnerability to HIV infection.

- Diminishing investments at the national and international level in the education of women and girls has an adverse effect on the ability of women and girls to access HIV and AIDS information, education and services that are critical for: the prevention of new infections, re-infections, for treatment and care knowledge and protection of women's and girls' human rights.

Recommendations

- That world leaders and African Heads of State take all necessary measures to create a national and international community that places top priority on the development of a policy, legislative and administrative environment in which human rights, especially those of women and girls and people living with HIV, are actively promoted, fully enjoyed and protected within and through national, regional and continental responses to violence against women and girls and discrimination of people living with HIV, and through HIV and AIDS policies, programmes and interventions. The leaders should strengthen HIV and AIDS programming by giving pivotal priority to women's and girls' rights.
- National and global efforts be directed towards the expansion of the current prevention paradigm to promote and protect women's and girls' sexual and reproductive rights, legislate and implement interventions that protect against violence against women and girls, legislate and implement property and inheritance rights of women and girls, ensure access to appropriate and evidenced based prevention information, provide antiretroviral prophylaxis to all women and girl survivors of sexual violence and invest in fast tracked development of microbicides, vaccines and other new prevention technologies.
- National and global efforts should ensure that people living with HIV have access to appropriate, free and comprehensive treatment—including but not limited to—nutrition services on HIV and further ensure that women and girls have an equitable share of treatment services.
- Invest significant new resources in a number of impoverished countries to recruit, train, support, and effectively use the number of community and professional health workers needed to achieve universal access to AIDS treatment for all in need by 2010 and universal access to primary health care.
- Launch a substantial community health worker initiative to train, compensate and deploy community members, especially women and people living with HIV, to provide basic care, treatment, prevention services, and referrals. Community health workers should have access to care, including HIV treatment, and be offered a career pathway. Programmes should be integrated into primary health-care systems, and ensure adequate supervision, support and ongoing training.

- Invest in reducing the burden of care on women and girls through programmes that provide enhanced access to palliative care and that compensate women and girls equitably for their contribution.
- Prioritize the strengthening of health services and infrastructure through adequate resources to reduce the burden of care and medical costs of HIV and AIDS on women and girls in Africa.
- Given the limited resources African governments are directing to public health care, in part because of the aid restrictions and conditionality of the World Bank and International Monetary Fund, governments should take back their mandate and responsibility to provide quality, affordable public health care to its citizens.
- Establish an inclusive and participatory process for the development of national targets and indicators, as well as put in place monitoring and evaluation and other accountability mechanisms that address the allocation of responsibilities, timeframes, and access to information by civil society organizations involved in monitoring and reviewing progress.
- Strengthen the existing means of information dissemination to all levels of the society, especially the grass roots communities.
- Stress the monitoring role of all partners including national governments, parliamentarians, civil society including people living with HIV, as well as the private sector in monitoring implementation of the UNGASS Declaration of Commitment on HIV/AIDS, at national levels and request that UNAIDS offices at regional and country levels support this process.
- Encourage the PCB to incorporate actions within its operation workplans (and provided for within its UBW)—actions to support universal access to HIV prevention, treatment, care and support, *ensuring that at least 10 million people have access to HIV treatment—including 7 million Africans—through an acceleration of HIV treatment scale-up efforts by all stakeholders including UNAIDS. To ensure that this target is reached equitably, UNAIDS should work with Member States to develop specific targets for the inclusion of vulnerable populations in national treatment plans, including active injecting drug users, children, men who have sex with men, women and migrant populations.*
- Explore and support innovative means of mobilizing additional domestic resources to secure sustainable and predictable financing for HIV and AIDS (such as the International Finance Facility and the Airline Solidarity Contribution), including reducing military spending in order to increase social spending, and ensuring that National Economic Planning Processes reflect the commitments made in the Declaration of Commitment on HIV/AIDS.

Epidemiological situation

At the end of 2005, 8.3 million people were infected with HIV in the Asia Pacific region, representing 20% of the total number of people living with HIV in the world. Out of this number, half a million people died in 2005 and 1.1 million people became newly infected.

This region makes up 60% of the world's population, of which China (20%), India (15%) and Indonesia (4%) are predicated to be countries with generalized HIV epidemics if effective prevention measures are not scaled up. India, which has an estimated 5.1 million people living with HIV and China, which could have an estimated 10 million people living with HIV by 2010—will overtake Africa with the most compelling problem if the risks are not mitigated. Moreover, the epidemic has yet to emerge as a menace in areas such as the Pacific islands, but holds great threat to the sustainability of the response due to the lack of funding because of the ostensible size and scale of the situation.

HIV is a long-term threat to economic growth and development, and if infection trends continue to rise, it will have an immense impact on the economic growth of the region. A joint UN-Asian Development Bank study estimates economic and financial annual losses could reach US\$ 17.5 billion by 2010.

In all affected countries in the region, the epidemic adds incremental pressure onto the health sector of developing countries (China and South-East Asia), which has had to cope with the SARS outbreak in 2003, and more recently the Avian Flu.

The ambitious “3 by 5” plan of WHO and UNAIDS of treating 3 million people living with HIV by the end of 2005 was not fulfilled; however, significant improvements (with the exception of prevention of mother-to-child transmission services) extending prevention and care for sexually transmitted infections, counselling and testing, and HIV treatment and care, strains health budgets, infrastructures and systems.

As the epidemic moves from localized areas to becoming more generalized, the urgency for prevention is still far from being realized in many populations including young people, women (especially since a significant proportion of new infections occur in women who are married and infected by husbands, and mother to child transmission), injecting drug users, sex workers and their clients, men who have sex with men, and migrant workers.

Stigma and discrimination against people living with HIV remain the greatest obstacles to a successful response 25 years into the epidemic. The confidentiality breaches of people living with HIV's in health-care settings, and the refusal of medical treatment by health-care personnel upon learning the HIV-positive status of individuals, deter many from accessing the services they need.

Intervention and information programmes which mitigate prevention, treatment and care services for marginalized populations continue to be few. Meaningful involvement of people living with HIV is at least equally rare.

Moreover, commitments on paper frequently do not translate into real protection for HIV-positive people. While an estimated one half of countries surveyed in the region has adopted legal frameworks to prevent HIV-related discrimination, only one third has legal measures in place prohibiting it. Furthermore, most countries lack institutionalized human rights monitoring systems capable of routinely detecting and reporting violations to national authorities.

Recommendations

- A better collaboration is needed between WHO, UNAIDS, bilateral donors and funding donors, with clear assignment of responsibilities and detailed national plans for treatment scale-up with the inclusion of governmental commitment and leadership—to move from commitment to action.
- There is a need to improve in-country visibility of WHO and UNAIDS and the limited coordination with civil society. This includes the scale up of resources and technical support required, from organizational development, monitoring and evaluation, to programme implementation of civil society organizations.
- Reform laws that collide with current National AIDS policies, with alignment to access vulnerable populations or they will disable core principles and values of empowerment and participation of the marginalized groups;
- The response to AIDS in Asia and the Pacific should become an international priority with milestone-driven action plans to accelerate intergovernmental cooperation, development and implementation of strategic plans to strengthen the regional response, and mobilization of financial and technical resources.
- Recognize that women are most vulnerable to HIV by incorporating and fully integrating gender equality and equity across all programme areas, and through advocacy and political commitment, financing and resources, human rights, commodities, services and partnerships, with resources made available for continued research and development of new preventive technologies such as microbicides.
- Accountability at all levels—government, civil society and donors—has to be clearly defined, with current mechanisms strengthened or developed, tracking the efficiency of funds.
- Scale up the provision of care, treatment and support to people living with HIV at all levels and to all groups, including antiretroviral treatment as well as treatment for opportunistic infections.

Epidemiological situation

At the end of 2005, 2.1m people were infected with HIV in Latin America and the Caribbean. Among young people in Latin America 15–24 years of age, an estimated 0.4% of women and 0.6% men were living with HIV. In 2005, approximately 110 000 people died of AIDS and almost 250 000 people became infected.

Recent trends in prevention, care and treatment

Access to treatment and care has been provided in some countries in this region but millions of people living with HIV still do not have access to antiretroviral therapy. In some countries, national governments continue to resist launching an effective response to the HIV/AIDS pandemic.

In Argentina and Brazil, the provision of antiretroviral therapy is free of charge and accepted as a responsibility of the government managed by the National AIDS Coordination committees.

In Colombia, antiretroviral treatment is available from the General System of Social Security in Health. The Medication Fund offers antiretroviral therapy at a low cost.

In Cuba, antiretroviral drugs are available free of charge through the AIDS National Coordination committee.

In Panama, the Social Security Office in the Ministry of Health provides antiretroviral treatments free of charge.

In Bolivia, treatment is not available universally. Fifty-two people recently made a petition to the Human Rights Commission to request that the government provide them access to antiretroviral treatment. The Brazilian Government has made a donation to Bolivia, which will allow 100 people to be on treatment pending the arrival of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Another 48 people are receiving treatment through a USAID/Ministry of Health programme. In total 148 people, receive ARVs through these means. In addition, Bolivian organizations such as REDVIHDA recycle antiretroviral drugs from other countries like Argentina, Chile, Colombia, Germany and the USA.

In Peru, antiretroviral drugs are available at a low cost and medications for opportunistic infections are accessed through donations.

Brazil has played an important role within the region by leading other governments and calling on them to initiate a minimum reasonable response to HIV. Brazil has promoted

Horizontal Technical Cooperation and supported active participation and partnership with civil society actors.

Regional networks have played a crucial and significant role by improving capacity of organizations and service providers and by developing a pool of highly qualified local consultants made up of people from vulnerable populations. Regional networks have also played an important role in monitoring and evaluating UNGASS, the Global Fund to Fight AIDS, Tuberculosis and Malaria and initiatives such as “3 by 5” and the “Three Ones”. However, it has not been enough. Regional networks are very concerned about the lack of attention UNAIDS and the international community is paying to HIV issues in this particular region.

To succeed in meeting the target of universal access by 2010, UNAIDS must take a lead in coordinating support here. The lack of attention to this region has been noted as a threat to adequately addressing HIV in the region.

Major issues highlighted in the region

- There is a lack of attention and capacity development for health professionals working in prisons. Prevention, treatment and care for prisoners is inadequate and should be an area of focus for national governments and UNAIDS. Prevention indicators should be reviewed and interventions should be based on social science evidence.
- A lot of people in the region are not registered in country treatment protocols but are receiving treatment through other means. Networks in the regions are concerned that because of this, the epidemic information produced in the region may significantly under represent the severity of the epidemic.
- In efforts to scale up access to antiretroviral drugs, the quality of medications provided need to be monitored to ensure that the highest quality drugs at the lowest possible prices are made available.
- People affected by the epidemic must be included in decision-making at all levels.
- There is an immediate need for political and financial support for regional networks to allow them to carry out current activities and projects.
- Attention must be paid to integrating all prevention, treatment and care initiatives.
- Research should be conducted to identify organizations whose infrastructure would allow them to begin providing and monitoring antiretroviral drug programmes.
- Funding to support programming targeted to vulnerable populations such as injecting drug users, sex workers, prisoners and women should be included in all initiatives.
- There is an urgent need to implement laws and policies to protect the human rights of vulnerable groups: men who have sex with men; drug users and injecting drug users; women and young girls and boys; people living with HIV; prisoners and those in

mental health institutions. Organizations in the region, invite UNAIDS to be their partner in working with vulnerable populations and to play its relevant role.

EUROPE | REGIONAL REPORT

Epidemiological situation

Although Eastern Europe had initially been isolated from the global HIV pandemic by draconian Soviet restrictions on contact with foreigners and harsh social control, there has been a growing epidemic since the mid 1990s. The first outbreaks were reported in 1995 among injecting drug users in Odessa and Nikolayev in southern Ukraine.

They were rapidly followed by other drug-related HIV outbreaks, notably in the Russian territory of Kaliningrad in 1996 and a few months later in other regions of the Russian Federation (Krasnodar, Rostov on Don, Tver) and in neighbouring Belarus and the Republic of Moldova. In 1999, two very large outbreaks were identified, again in the Russian Federation, in the Moscow and Irkutsk regions. Since then, the situation has continued to worsen rapidly, affecting more regions and countries. UNAIDS and WHO recently reported that, with an estimated 1 million HIV-positive individuals at the end of 2001 compared with only 30 000 at the start of 1995, Eastern Europe and Central Asia are the regions of the world with the fastest growing HIV epidemic. By contrast, in Central Europe, epidemics that began in the late 1980s have remained at low levels, apart from specific outbreaks in Romania and Poland, and do not seem to be expanding. To further understand the development and recent trends of the HIV epidemic in Central and Eastern Europe, we analysed HIV surveillance data for the 27 countries of the former communist bloc, including all countries of the former Soviet Union, some of which are in Central Asia.

We also reviewed published and unpublished studies and reports. We then examined the contributions of different vulnerable populations and discussed factors influencing the past increases in rates of HIV infection and the potential for future increases, taking into account the public-health response.

The European region contains a diverse range of HIV epidemics. In the western countries, the HIV epidemic is mature. However in the countries of Eastern Europe (including Russia, Ukraine and Lithuania) the HIV epidemic is exploding. The regions of Eastern Europe and Central Asia (which will be highlighted in this report) have the fastest growing incidence rate of HIV infection in the world. These two contrasting epidemics meet in European countries, with migration and travel threatening to intermingle them both.

In Western Europe, the adult (age 15–49) HIV prevalence rate ranges from 0.2%–0.4%. The total number of people infected range from 450 000—720 000. New cases of HIV numbered from 16 000—120 000 in 2004. Access to treatment is adequate for most

people living with HIV. Evidence demonstrates that Portugal is one of the western European countries with the biggest increase of people living with HIV.

In Eastern Europe and central Asia the adult HIV prevalence already exceeds that of Western Europe with an estimated 1.0% to 1.6% of the adult population (15–49) infected. The total number of individuals living with HIV infection ranges from 920 000—2 100 000. New infections are rapidly increasing with an estimated 110 000—480,000 in 2004 alone. Within these regions diverse epidemics are present. The situation in the Russian Federation is particularly worth mentioning—having a complex epidemic larger than any in all of Europe.

During the past five years, most countries of the former Soviet Union have been severely affected by HIV epidemics that continue to spread as a result of injecting drug use. With an estimated 1 million individuals already infected—mostly from injecting drug users—and high rates of syphilis, the region may soon also face a large-scale epidemic of sexually transmitted HIV infection. Indeed, data indicate that an HIV epidemic, fuelled by heterosexual transmission, is emerging; its expansion will depend on the size of so-called bridge populations that link high-risk groups with the general population. The lack of evidence to indicate increased rates of HIV as a result of homosexual transmission could indicate the social vulnerability of homosexual and bisexual men in the region rather than the true epidemiological picture.

In view of the current levels of HIV prevalence, Eastern Europe will soon be confronted with a major AIDS epidemic. By contrast, rates of HIV in central Europe remain low at present, but behaviours that promote HIV transmission are present in all countries. With current HIV prevalence levels, the East region will soon be confronted with a major AIDS epidemic and thousands of people will need care in countries in which the health-care systems have basically collapsed. It is also likely that HIV will have a strong negative impact on tuberculosis control in this part of the world in which the prevalence of tuberculosis, including that of multidrug-resistant strains, is high and in which both infections—tuberculosis and HIV—are concentrated in the same young, disenfranchised populations. The dramatic situation in the eastern region should not be allowed to lead to complacency in the Centre region.

There is a danger that the label of low prevalence may translate to low priority for HIV prevention. In Romania, there is a large surviving cohort of HIV-infected adolescents who were infected as children and now frequently homeless, who may soon start to engage in behaviours that put them at risk of transmitting HIV to others. Economically motivated migration from affected countries of the eastern region to central and Western Europe is a further cause of concern. Targeted but non-discriminatory prevention programmes and the promotion of voluntary counselling and testing within migrant communities must become urgent priorities.

Recent trends in prevention, care and treatment

Necessary components for an effective response to HIV:

- effective universal and non-discriminatory prevention services and commodities together with universal access to treatment and standards of care for all is mandatory;
- scaled up of prevention efforts for vulnerable populations – injecting drug users, sex workers and street kids;
- re-examination of drug policies and bringing them in line with broader European discourse;
- improvement of therapeutic drug strategies; and
- increased research efforts in relevant areas, particularly in the field of preventive HIV vaccines.

Major issues highlighted in the region

PREVENTION

There is:

- Low sustainability of prevention efforts among groups in vulnerable situations;
- Lack of investment in HIV prevention from some governments;
- A need for a stronger focus on prevention towards women;
- Unfavourable legislation regarding groups in vulnerable situation (criminalization due to drug possession);
- A lack of life-skills-based education at school (or lack of comprehensive sexuality education) and reluctance from key governmental actors to plan it. Prevention campaigns in schools and prisons are developed mostly by nongovernmental organizations without proper financial support from governments; and
- A lack of supplies (notably condoms and sterile needles) and youth-friendly services.

TREATMENT

- Antiretroviral drug prices are very high.
- There is a lack of supplies for treatment of opportunistic infections and co-infections in AIDS centres. Although AIDS treatment is free in some European Union countries, access to it is not equal.
- Undocumented migrants and ethnic minorities have low access to treatment and care facilities.
- The informed consent process is not working; it must be more than just signing a paper.
- There is a lack of residences and other shelters for people facing multiple dependence situations or without family support. Some facilities refuse to accept people living with HIV in elderly care residences and in government institutions.

STIGMA AND DISCRIMINATION

- There is still existence of widespread stigma and discrimination towards people living with HIV; it is worsened when it is faced by people in vulnerable conditions such as injecting drug users, minorities, migrants, prisoners, sex workers, men who have sex with men and women.
- Stigma and discrimination towards people living with HIV, both publicly and by health care professionals, persists. Discriminatory testing is required when accessing and keeping a job.
- Insurance companies refuse to approve loans to people living with HIV.
- There are several reported occurrences of discrimination among health-care services.
- More investment is needed for projects and campaigns targeting stigma and discrimination.

POLITICAL LEVEL

- There has been no concrete implementation of the Dublin Declaration and other international recommendations signed by the various governments.

PROJECT DEVELOPMENT AND SUSTAINABILITY

- There is a lack of financial support for project implementation.
- Some HIV or AIDS nongovernmental organizations have no governmental support even when the projects are considered wide-reaching and highly regarded internationally.
- Partnerships and networks are not easy to establish. True collaboration is far from being the norm.
- Stronger contacts are needed between national nongovernmental organizations and international organizations to allow for a constant update, new partners and project opportunities.

PRISONS

- There is a low existence of voluntary counselling and testing in prisons.
- Prisoners get told that they will be treated like people living with HIV if they are not willing to comply with the tests (Bavarian region in Germany is proud to have a 100% “voluntary” test rates among their prisoners);
- Prisoners very often don’t get counselling when they get the test results. They quite often don’t get information about the severity of the chronic disease they have. If the test result is negative they don’t get any notice at all.
- The existence of men who have sex with men in all prisons is well known. Yet prisoners don’t have free and uncontrolled access to condoms.

Epidemiological situation

The estimated number of people living with HIV in the United States of America (USA) at the end of 2003 exceeded one million for the first time. In Canada, just under 58 000 HIV diagnoses were reported at the end of 2004. Western Europe and North America remain the only regions in the world where most people in need of antiretroviral treatment are able to receive it. As a result, the number of AIDS deaths plummeted in the late 1990s. In recent years, more than half of new HIV transmission has been among African Americans. In 2001, the AIDS case rate among African American adults and adolescents was almost 10 times higher than among their white counterparts, according to the United States Centers for Disease Control and Prevention.

In Canada the number of positive HIV tests continues to increase and more women have tested HIV-positive in recent years. Men who have sex with men continued to represent the highest number and proportion of positive HIV tests. When reviewing the data on positive HIV tests, with ethnicity known, Aboriginal people and those of African or Caribbean origin were overrepresented. According to the 2001 Census, Aboriginal peoples made up 3.3% of the Canadian population yet in 2004, they were 21.4% of positive HIV tests where ethnicity was known. This represented an increase from 1998 when the proportion was 18.6%. For people of African and Caribbean origin, who made up 2.2% of the Canadian population in 2001, they were 12.1% of the positive HIV tests in 2004. Again, this represented an increase from 1998 when the proportion was 5.3%.

With regards to AIDS cases in 2004, women represented a growing proportion of the AIDS diagnoses in Canada and MSM continued to represent the highest number and proportion of AIDS diagnoses. Aboriginal and African/Caribbean people also continued to be overrepresented in the proportion of AIDS diagnoses. While the number of AIDS diagnoses has decreased over the years, the proportion attributed to Aboriginal people and those of African or Caribbean origin have increased. In 2004, Aboriginal peoples represented 14.8% and those of African and Caribbean origin represented 15.5% of AIDS cases where ethnicity was known.

The changing nature of the epidemic in this region needs to be taken into consideration when programming is developed. In both, the USA and Canada, the stigma faced by men who have sex with men among people of African or Caribbean origin and Aboriginal people contributes to the challenge of reaching these populations with prevention and treatment. In the US, where an estimated 30% of new HIV transmission is associated with injection drug use, extensive barriers to harm reduction, including limited access to syringe exchange and opiate substitution therapy, are a major impediment to HIV prevention efforts.

Recent trends in prevention, care and treatment

The main challenge in this region is to intensify efforts and adapt them to the changing patterns of the epidemic.

Prevention in prisons

Prisoners in Canada don't have access to the same range of HIV prevention and treatment services as other people. In particular, there are no sterile syringes in prison, thanks to denial about drug use in prison and unfounded fears of sterile syringe programmes.

There are other problems with HIV services in prisons—for example, growing evidence of interruptions of antiretroviral treatment for prisoners living with HIV; some procedures required for people living with HIV to get specialized care threaten confidentiality of their HIV status; some problems with access to condoms, lubricants and bleach. Special services for women living with HIV in prison are often lacking.

Only two prisons in the United States offer methadone treatment services for heroin users in prison, and there are no sterile syringe programmes. Even condom access in many USA prisons is inadequate, often limited to conjugal visit rooms. Access to basic information about HIV transmission and support for HIV-positive inmates is rare. The privatization of prisons in the USA is a barrier to accountability and transparency in the provision of HIV-related services.

Barriers to access to treatment and care

Health care is a provincial responsibility in Canada. Each jurisdiction takes a different approach to public reimbursement for life-saving medication. Consequently a patchwork of systems results in a wide variability in the services available across the country. Some jurisdictions have substandard levels of support for people living with HIV.

In the USA, many persons are without access to treatment for HIV disease because they are without health insurance, they do not qualify for subsidized programmes, or because of cutbacks in government programmes. As the AIDS epidemic in the USA has continued to have a disproportionately heavy impact in communities living in poverty, the lack of a safety net for HIV services has been disastrous in many parts of the country.

Shortage of health-care professionals

There is a serious shortage of health professionals in many parts of the region. PLWHA particularly, those living in rural areas, have inadequate access to care. Rather than dealing with the shortage through sound training and retention policies, many jurisdictions recruit health professionals from developing countries, which exacerbates the health delivery challenges in countries where HIV/AIDS prevalence is high.

Unscientific prevention policies

Despite agreeing to UNAIDS' own Policy Position Paper on Intensifying HIV prevention which states that the "male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections," the United States continues its institutional focus on abstinence and fidelity ("being faithful")—the A and B of its ABC prevention policy—continuing to cause confusion among prevention implementers in the developing world and may indeed be causing more infections. Requiring PEPFAR recipient countries to spend at least 66% of its prevention funding on A and B sets up artificial constraints which prohibit prevention implementers from utilizing the most effective combined prevention strategies for the various faces of their respective epidemics.

Additionally, its relegation of the use of condoms "if necessary" only for so-called high-risk groups (sex workers, men who have sex with men, etc.) leaves many others at greater risk of infection.

Supervised injection sites

In Canada, the federal government exemption that allows one safe injection site (SIS) to operate on a pilot basis in Vancouver, Canada is scheduled for renewal in September 2006. The city has appealed to Prime Minister Stephen Harper for a renewal, citing uniformly positive research results so far. Additional evaluations are being undertaken, but in general even residents of Vancouver who had initially objected to the site seem to have come around as the facility has helped to reduce overdose deaths and other negative outcomes. While Harper has stated that he would do away with safe-injection sites, his new government has not yet signalled its thinking for the September deadline. In the meantime, several other Canadian cities—including its largest city, Toronto—have studied the feasibility of sites in their communities. If the federal government were to try to stop safe injecting sites, this would be a major retreat from science-based policy in favour of an ideologically driven decision.

Global gag rule on prostitution

The United States' requirement that recipients of its funding make an oath of non-support of prostitution causes recipients to either stop outreach to sex workers or stop receiving funding. Either of these options will have long-term negative effects on preventing further infections.

Funding needed to address the pandemic domestically and internationally

Funding for frontline AIDS organizations in Canada continues to be inadequate despite the fact that the Federal Initiative to address HIV/AIDS was launched in 2005 and funding was doubled. The increases are being rolled out over 5 years and an undetermined

amount of money goes to government bureaucracy rather than front-line work. Federal, provincial and territorial governments should adequately fund front-line services and support to people living with HIV and do so in an open and accountable fashion.

While Canada and the United States purport to be generous supporters of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the WHO “3 by 5” initiative, their overall budget for Official Development Assistance is lower than the levels provided in the 1980s. To align themselves with the other G8 countries they need to set a time frame for meeting the internationally accepted target of contributing 0.7% of GNI to development assistance and provide their fair share to the costs needed to respond to AIDS.

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