



## Scientific Facts on

## AIDS

status & challenges of the epidemic

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### Level 2 - Details on AIDS

1.	<b>Introduction: global targets on HIV/AIDS.....</b>	<b>3</b>
2.	<b>What are the worldwide trends in the HIV/AIDS epidemic?.....</b>	<b>3</b>
2.1	How many people are affected worldwide?.....	3
2.2	How has the epidemic evolved in heavily affected regions?.....	4
2.3	How has the epidemic evolved in less affected regions?.....	4
3.	<b>How has HIV prevention and treatment evolved since 2001?.....</b>	<b>5</b>
3.1	Has HIV Prevention improved?.....	5
3.2	Do those in need have access to treatment and care?.....	6
4.	<b>Are human rights and vulnerable populations sufficiently protected?.....</b>	<b>7</b>
4.1	Is AIDS sufficiently grounded in human rights?.....	7
4.2	What has been done to reduce vulnerability to HIV infection?.....	8
5.	<b>What has been done in terms of funding and research?.....</b>	<b>8</b>
5.1	What has been achieved in terms of HIV/AIDS funding?.....	8
5.2	What research efforts have been made?.....	9
6.	<b>What strategies are recommended by UNAIDS to halt and reverse the epidemic?.....</b>	<b>9</b>
6.1	Recommendation #1: Sustain and increase commitment and leadership.....	10
6.2	Recommendation #2: Sustain and increase financing.....	10
6.3	Recommendation #3: Aggressively address AIDS-related stigma and discrimination.....	10
7.	<b>What should be done to improve prevention and access to treatment?.....</b>	<b>11</b>
7.1	How can AIDS prevention be strengthened?.....	11
7.2	How can treatment access be expanded?.....	11
7.3	How can human resources and systems be strengthened?.....	11
7.4	How can HIV prevention and treatment become more available and affordable?.....	12
7.5	What are the main needs in the field of research and development?.....	12
7.6	How can the broader social impact of AIDS be countered?.....	12
8.	<b>Conclusion on progress made in the fight against AIDS.....</b>	<b>13</b>

This Digest is a faithful summary of the leading scientific consensus report  
produced in 2006 by the Joint United Nations Programme on HIV/AIDS (UNAIDS):  
*"Report on the global AIDS epidemic"*

The full Digest is available at: <https://www.greenfacts.org/en/aids/>



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- Each question is answered in Level 1 with a short summary.
- These answers are developed in more detail in Level 2.
- Level 3 consists of the Source document, the internationally recognised scientific consensus report which is faithfully summarised in Level 2 and further in Level 1.

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## 1. Introduction: global targets on HIV/AIDS

In 2001, leaders from 189 UN Member States recognized that AIDS was one of the most urgent issues of national and international development. They signed the Declaration of Commitment on HIV/AIDS to help reach the Millennium Development Goal of stopping and beginning to reverse the epidemic by 2015. They also agreed to meet detailed targets, for instance in terms of funding, provision of information to young people, and access to treatment.

Global targets adopted for 2005:

- Total annual HIV expenditure should amount to US\$ 7 - 10 billion.
- 90% of young people aged 15 – 24 should be able to correctly identify ways of preventing HIV transmission and reject major misconceptions about HIV transmission.
- 80% of HIV-positive pregnant women should receive antiretroviral treatment.
- 50% of people with advanced HIV infection should receive antiretroviral treatment.
- The share of young males and females, aged 15 – 24, who are HIV-infected should be reduced by 25% in the most affected countries
- The share of infected infants born in 2005 to HIV-positive mothers should be reduced by 20%.

Only the annual global expenditure target was fully achieved in 2005 with US\$8.3 billion spent on HIV.

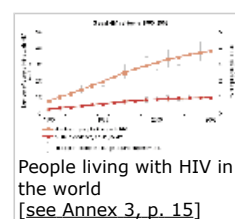
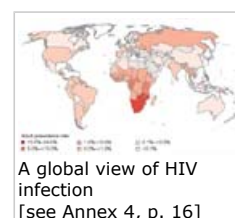
2005 targets & achievements  
[see Annex 2, p. 14]

## 2. What are the worldwide trends in the HIV/AIDS epidemic?

### 2.1 How many people are affected worldwide?

At the end of 2005, about 38.6 (32\* [see Annex 1, p. 14] ) million people were living with HIV worldwide. That year, 4.1 (2.9\* [see Annex 1, p. 14] ) million became newly infected and 2.8 (2.2\* [see Annex 1, p. 14] ) million died because of AIDS. Thus, in absolute terms, the number of people living with AIDS continues to rise because the world population is growing and because antiretroviral drugs help people with HIV live longer.

In relative terms, however, the proportion of people among the world population who become infected with HIV each year (HIV incidence) is stabilizing and the proportion of adults living with HIV (HIV prevalence) is levelling off at about 1%. In several countries, changes in behaviour and prevention programmes have contributed to lowering the share of newly infected people.



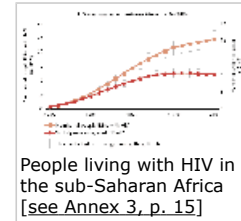
*Note: The 2007 Epidemic Update published by UNAIDS/WHO provides better estimates of the number of people living with AIDS. Better data collecting and estimation methods led to revised figures : the total estimated number of people living with AIDS at the end of 2007 is 33.2 millions, with 2.5 million new infections and 2.1 million deaths (see the 2007 UNAIDS report [see [http://data.unaids.org/pub/EPISlides/2007/2007\\_epiupdate\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf)]). This decrease from previous numbers does not represent a trend in the epidemic, which is still progressing, but a refinement in the data. For example, the new estimate puts the number of people that were living with AIDS in 2005 at around 32 million. The new estimates*

*show the same general trend in the epidemic than previous ones: a leveling off of the increase in prevalence since the late 90's, but with a continuing increase in the number of people living with AIDS.*

## 2.2 How has the epidemic evolved in heavily affected regions?

Current trends in the HIV/AIDS epidemic vary across different countries and regions:

*Note: numbers given in the following regional estimates are based on estimates made in 2005, which were revised in 2007. See the 2007 UNAIDS report [see [http://data.unaids.org/pub/EPISlides/2007/2007\\_epiupdate\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf)] for the latest estimates.*



**Sub-Saharan Africa** is the region most affected by AIDS though there are great variations between countries. In this region, a total of 24.5 million people were living with HIV in 2005 and some 6.1% of adults were carrying the virus.

The situation is particularly serious in Southern African countries where the share of people living with HIV has reached exceptionally high levels but seems to be levelling off in most countries. The AIDS epidemic in South Africa is one of the worst in the world with an estimated total of 5.5 million people living with HIV in 2005 and an increasing share of its adult population being infected (18.8% in 2005 \* [see Annex 8, p. 19]). In some neighbouring countries, the percentage of the adult population living with HIV is even higher, reaching 33.4% in Swaziland. (2007 UNAIDS update: the epidemic in the South African area now seems to have leveled off, but the region is still the most severely affected.)

On a positive note, the share of people living with HIV is falling in Kenya, Zimbabwe and in urban areas of Burkina Faso, because more people are using condoms, they have fewer sexual partners and are older when they first have sex. In Africa, about one in six people in need of antiretroviral treatment are now receiving it.

**The Caribbean** is the second-most affected region in the world with some 1.6% of the adult population living with HIV in 2005. AIDS is the leading cause of death among adults, although the infection levels have decreased in urban areas of Haiti and in the Bahamas, and remained stable in neighbouring Dominican Republic and Barbados.

## 2.3 How has the epidemic evolved in less affected regions?

For all the following world regions, the average share of the adult population living with HIV is lower than the world average of 1%.

In **Eastern Europe and central Asia**, the epidemics are still spreading, with some 220 000 people newly infected in 2005, bringing to about 1.5 million the number of people living with HIV – a twenty-fold increase in less than a decade. Most of these people are living in Ukraine and the Russian Federation, which has the biggest AIDS epidemic in Europe.

In **Latin America**, the biggest epidemics affect countries with the largest populations, such as Brazil which was home to one third of the 1.6 million people living with HIV in Latin America in 2005. However, the most intense epidemics are occurring in the smaller countries of Belize and Honduras. Access to treatment has improved greatly in parts of Latin America, but some countries are too poor to afford the drugs.

Overall, in **North America, Western and Central Europe**, some 65 000 people were newly infected with HIV in 2005, bringing to 2 million the number of people living with HIV. AIDS deaths in 2005 were comparatively few as a consequence of widespread access to antiretroviral therapy. In the United States of America and in some countries of Europe, the epidemic seems to be increasing again among men who have sex with men, which is also a largely hidden problem in Latin America and in Asia.

In **Asia**, some 8.3 million people were living with HIV in 2005. The share of infected people is decreasing in Cambodia, Thailand, and in parts of India, but is increasing in countries such as China, Indonesia, Viet Nam, and Papua New Guinea. There are also signs of HIV outbreaks in Bangladesh and Pakistan. In Asia, about one in six people in need of antiretroviral treatment are now receiving it.

Across **Oceania**, HIV infection levels remain low, although Australia's long-established AIDS epidemic is not disappearing.

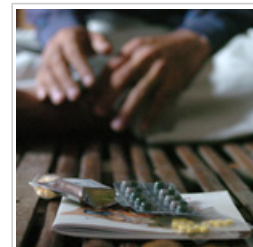
In **the Middle East and North Africa**, the proportion of adults infected with HIV is very low, except in Sudan. However, the epidemics seem to be growing in several countries – including in Algeria, Iran, Libya and Morocco. About one in 20 people in need of antiretroviral treatment are now receiving it in this region.

### 3. How has HIV prevention and treatment evolved since 2001?

Overall, governments are now tackling AIDS much more actively.

Indeed, within world regions, many countries are building international partnerships to coordinate the fight against HIV/AIDS so as to get as close as possible to offering HIV treatment to all those who need it by 2010.

Most countries now have a national plan to deal with AIDS and a single organization to coordinate efforts, and about half of them also have a plan to measure the progress made. However, systems to put these plans into effect and the involvement from civil society and from people living with HIV are still uneven.



HIV positive man and antiretroviral medicines, Cambodia  
Credit: UNAIDS/O. O'Hanlon

#### 3.1 Has HIV Prevention improved?

Prevention programmes involve a series of services that aim to prevent HIV transmission through sexual intercourse, from mother to child, through injecting drug use, and through blood transfusions.

Such prevention services include for instance access to HIV counselling and testing, prevention education for young people, provision of condoms to those who are sexually active, programmes to reduce HIV-related stigma and discrimination, and treatment of other sexually transmitted diseases.

While in some countries HIV prevention services are much more widely available now than in 2001, they only reach a small minority of those in need, and a number of target groups are not being reached.

Programmes aimed at changing behaviour have succeeded in **reducing the frequency of risky sexual behaviours**. Countries that have lowered HIV incidence have benefited from

the emergence of new sexual behaviour patterns – fewer commercial sex transactions in Cambodia and Thailand, delayed sexual debut in Zimbabwe, increasing emphasis on monogamy in Uganda and an increase in condom use overall.

Most countries, however, have missed the target of ensuring that 90% of **young people** have access to critical HIV prevention services by 2005. In fact, less than 50% of young people in the 18 countries surveyed were well informed about AIDS prevention and transmission.

The global **supply of condoms** by the public sector covers less than half the present need and three times more funding is required for this purpose.

More than 340 million people contract a curable **sexually transmitted infection** each year and women are especially vulnerable. Despite the fact that untreated sexually transmitted infections greatly increase the risk of HIV transmission, diagnosis and treatment of sexually transmitted infections and HIV are not very coordinated.

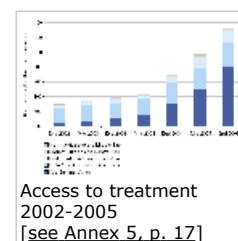
Though prevention strategies are cost-effective, there are disturbing signs that some countries are **reducing their HIV prevention budgets**.

**Unsafe medical injections and contaminated blood** transfusions are still cause for concern, and sound infection control practices should be promoted in health-care settings.

### 3.2 Do those in need have access to treatment and care?

A combination of antiretroviral treatments is effective in preventing or delaying AIDS-related illness and death. However, such lifelong therapies are complex and expensive to deliver, which raises concerns regarding access to treatment in resource-limited settings.

In recent years there has been a worldwide revolution in improving access to treatment.



The 2001 Declaration of Commitment on HIV/AIDS embraced equitable access to care and treatment as fundamental to an effective global HIV response.

In 2003, UNAIDS and WHO launched the "3 by 5" initiative which was a global target to provide three million people living with HIV/AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment (ART) by the end of 2005.

In low- and middle- income countries, the number of sites providing antiretroviral drugs increased from roughly 500 in 2004 to more than 5000 by the end of 2005 and, between 2001 and 2005, the number of people on antiretroviral therapy increased from 240 000 to approximately 1.3 million. This major increase still falls short of the "3 by 5" 3 million target.

As a result of recent unprecedented action across the world to increase access to HIV treatment, some 250 000 to 350 000 lives were saved in 2005.

Twenty-one countries met the 2005 target of providing treatment to at least half of those who need it. Globally, however, antiretroviral drugs still reach only one in five of those who need them.

The expansion of treatment access is hindered, because many individuals cannot afford the treatment-related expenses, or live far from treatment centres. In addition, the needs of

certain vulnerable populations, such as sex workers, men who have sex with men, injecting drug users, prisoners, and refugees have been inadequately addressed

To expand delivery of antiretroviral drugs in resource-limited settings, WHO recommended simplified and standardized treatment programmes involving first-line treatment therapy, along with second-line therapy for those whose first-line treatment fails. However, as many second-line antiretroviral drugs remain too costly for use in many countries, lower prices will probably be needed in order to sustain and expand treatment access.

Making progress towards universal access to treatment requires efforts to:

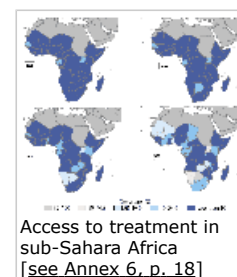
- increase the use of voluntary HIV counselling and testing services so that more HIV cases can be diagnosed;
- reduce HIV stigma and discrimination against people living with HIV or those perceived to be at risk;
- train more health-care workers and make better use of local medical assistants and other community health workers already available.
- avoid shortages of drugs to make sure that people who need them can receive antiretroviral treatment without delay or interruptions; and
- integrate HIV care with other health services, for instance with tuberculosis diagnosis and treatment and reproductive health care. This can lead to higher-quality care and to more people taking antiretroviral drugs.

## 4. Are human rights and vulnerable populations sufficiently protected?

### 4.1 Is AIDS sufficiently grounded in human rights?

Despite some improvements between 2003 and 2005, the fight against AIDS in many countries is still insufficiently based on human rights. This relates for instance to the rights of all population groups to prevention and treatment as well as the non-discrimination of people living with HIV and vulnerable communities.

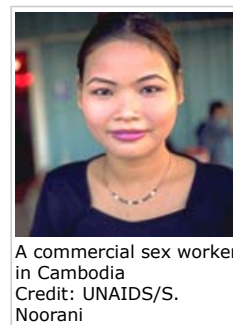
- Eighteen out of 21 countries reported improved policies, laws and regulations to promote and protect human rights.
- Sixty percent of countries surveyed have laws and regulations to protect people living with HIV from discrimination. However, in many cases these laws are not fully enforced, often because there is no money set aside for it.
- Half of the countries studied acknowledge the existence of policies that make HIV prevention and care measures less accessible and effective, for instance, making consensual sex between males illegal, prohibiting condom and needle access for prisoners, or not providing prevention and treatment services to non-residents.





## 4.2 What has been done to reduce vulnerability to HIV infection?

In recent years, more money has been available for HIV prevention. However, many countries have mainly spent this money on prevention programmes which focused on the general public rather than on high risk population groups, which would be more cost-effective and more likely to have an impact on the epidemic. Vulnerable population groups include for instance, sex workers, men who have sex with men, injecting drug users, and prisoners.



Studies in Uganda show **that children who drop out of school** are three times more likely to be HIV-positive in their twenties than children who complete basic education. Many countries in sub-Saharan Africa have lowered or cancelled school fees for vulnerable children but not all countries have set aside money to help children stay in school.

To make **injecting drug users** less vulnerable, some countries offer syringe exchange programmes and drug substitution treatment. Iran, for instance, ordered that illegal drug users no longer be treated as criminals but as patients. However, overall, fewer than 20% of people who inject drugs receive HIV prevention services.

Only ten out of the 24 countries that reported information on **sex workers** managed to offer prevention services to at least half of this population group.

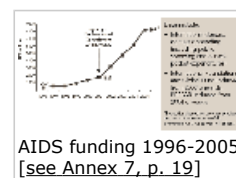
Although in many countries the prevalence of HIV is rising among **men who have sex with men**, public health authorities are not spending enough money on preventing HIV in this population group.

Wars and disasters often force large numbers of people from their homes, disrupt health-care services and expose people to severe health risks, including the risk of HIV infection. Countries are increasingly including HIV into their action plans for emergency situations and all UN-sanctioned peacekeeping operations have full- or part-time HIV advisers.

## 5. What has been done in terms of funding and research?

### 5.1 What has been achieved in terms of HIV/AIDS funding?

The Global target related to HIV/AIDS funding is one of the few targets set for 2005 that has been met and the amount of money available to fight AIDS has increased significantly since 2001. In 2005, US\$ 8.3 billion were spent to tackle AIDS in low- and middle-income countries.



The 2001 Declaration of Commitment on HIV/AIDS resulted in the launch, in December 2002, of the "Global Fund to Fight AIDS, Tuberculosis and Malaria" which has so far approved 350 grants to 128 countries, and distributes 20% of all the international money available for HIV. The World Bank and the United States President's Emergency Program for AIDS Relief are other major contributors.

However, more efforts are needed.



Indeed, despite the huge increase in funding over the years, the money raised to fight AIDS is still insufficient. For instance, it is expected that, in 2007, US\$ 10 billion will be available while US\$ 18.1 billion will be needed.

To plan the long-term fight against AIDS, funding needs to be managed in a better way so that countries can plan ahead knowing how much money they will receive each year. For instance, all governments and donors should say in advance how much money they will give and there must be systems in place to check that the promised money is actually given.

## 5.2 What research efforts have been made?

HIV vaccines and microbicides would benefit people in all countries, from the richest to the poorest.

Funding for research into the development of **preventive vaccines** nearly doubled from US\$ 327 million in 2000 to nearly US\$ 630 million in 2005.

Since 2001, research and development into safe and effective **vaginal microbicides** has gathered momentum with research money reaching an estimated US\$ 163 million in 2005. Such microbicides could help prevent HIV transmission by killing the microbes in the vagina. Large-scale human trials are already under way to test how effective these drugs and other methods, such as the use of a female diaphragm and adult male circumcision, are in preventing HIV.

In almost three-quarters of countries, any research involving humans has to be approved by an ethics committee to make sure that trials are carried out in an acceptable manner. However, people living with HIV and the people caring for them, are usually insufficiently involved in reviewing the way research is carried out.

## 6. What strategies are recommended by UNAIDS to halt and reverse the epidemic?

AIDS is exceptional and the response to AIDS must be equally exceptional. Over the last 25 years nearly 65 million people were infected with HIV and about 25 million have died of AIDS-related illnesses. Today, nearly 40 million people are living with HIV and the vast majority of them do not know that they are infected.

*Note: numbers are based on estimates made in 2005, which were revised in 2007. See the 2007 UNAIDS report [see [http://data.unaids.org/pub/EPISlides/2007/2007\\_epiupdate\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf)] for the latest estimates.*



HIV positive mother and child, Ukraine  
Credit: UNAIDS/WHO/V

However, the considerable efforts made since 2001 are insufficient and progress is uneven within and between countries and regions. To be able to slow, stop and reverse the epidemic, countries need to plan the long-term fight against AIDS rather than simply deal with crises.

UNAIDS makes a series of recommendations.

## 6.1 Recommendation #1: Sustain and increase commitment and leadership

AIDS is a matter of extreme national importance and therefore governments and heads of state need to be active and outspoken about their commitment to implement strategies that involve multiple sectors.

Countries need to include programmes to fight AIDS into their general development plans with the full and active participation of civil society and the private sector, ensuring full accountability of all partners and transparent reporting on progress made in the country or region.

## 6.2 Recommendation #2: Sustain and increase financing

Although the overall spending on AIDS has increased greatly, the money available today may be just one-third of what will be required to deal with the growing epidemic in a few years' time.

National governments and international donors should give significantly more money for AIDS through the Global Fund and other mechanisms. Governments, especially in middle-income countries, should continue efforts to provide an important part of the money spent in their nation from their national budgets. The money raised must be used as efficiently and effectively as possible so that it works for people in need, by coordinating national efforts around one agreed AIDS action framework, one national coordinating authority and one agreed country-level monitoring and evaluation system.

Innovative approaches, such as new international financing mechanisms, are needed to ensure that money for AIDS will be available in the future for a much stronger response to the epidemic.

## 6.3 Recommendation #3: Aggressively address AIDS-related stigma and discrimination

To stop the AIDS pandemic, it is essential to change the social norms, attitudes and behaviours that contribute to its expansion. Action against AIDS-related stigma and discrimination must be supported by top leadership and at every level of society, and must address women's empowerment, homophobia, attitudes towards sex workers and injecting drug users, and social norms that affect sexual behaviour—including those that contribute to the low status and powerlessness of women and girls.

Therefore, it is essential to pass, publicize, and enforce **laws and policies** that protect women and girls against discrimination and sexual violence and to prevent discrimination against people perceived to be at a higher risk of having HIV, such as sex workers, injecting drug users and men who have sex with men. In addition, women need to be adequately represented in policy and decision-making on AIDS.

To reduce HIV-related stigma, it is also essential that barriers to universal access to **education** such as school fees, compulsory school uniforms or textbook charges be addressed or removed.

## 7. What should be done to improve prevention and access to treatment?

To get as close as possible to the goal of offering treatment to all those who need it by 2010, a series of key areas require commitment and action: prevention, access to treatment, human resources, treatment and prevention products, research, and social impact.

### 7.1 How can AIDS prevention be strengthened?

It is critical to renew the emphasis on HIV prevention and to strengthen it in order to prevent millions of new infections each year.

Access to clear, factual HIV prevention information and to HIV testing should be a right. Each person should know his or her HIV status and have access to AIDS information, counselling and related services.

HIV prevention services and education should target vulnerable groups, including sex workers, injecting drug users, men who have sex with men, and prisoners. Other population groups that should benefit from a better access to adequate prevention services include HIV-infected pregnant women who are at risk of transmitting the disease to their children (in the womb, during childbirth, or through breastfeeding) and young people who account for 40% of all new infections.



Community Self Help programme, Kenya  
Credit: UNAIDS/G. Pirozzi

### 7.2 How can treatment access be expanded?

Ensuring that access to HIV treatment continues to grow rapidly will require a series of efforts:

- Access to confidential and voluntary HIV testing should be broadened so that more people know whether they are infected or not;
- Additional sites where treatment can be provided, which are so far largely concentrated in urban areas, should be established, and all population groups affected, including children, must be assured equal access to treatment;
- Access to drugs that prevent common HIV-related infections should be expanded;
- HIV-related stigma and discrimination should be reduced;
- More medical workers should be trained to deal with HIV and AIDS, and the drug supply should be improved;
- The public should be made aware of available treatment services, their benefits and how to use them.

### 7.3 How can human resources and systems be strengthened?

The shortage of skilled workers in many developing countries leads to poor surveillance, planning and administration; bottlenecks in the distribution of funds; failures in the implementation, monitoring and evaluation of activities; and inadequate provision of services.

Eliminating these obstacles will require:

- rapid recruitment and training of additional health-care workers and improving incentives that encourage them to work in their own countries instead of migrating to industrialized countries,
- increasing public financing for training in countries facing severe human resource shortages,

- encouraging the provision of HIV prevention, treatment, care, and support by locals where not enough trained health professionals are available,
- better integration of AIDS services into other primary health care programmes (such as programmes addressing mother and child health, sexual and reproductive health, and diagnosis and treatment of tuberculosis, malaria and sexually transmitted diseases).

## **7.4 How can HIV prevention and treatment become more available and affordable?**

Ensuring that HIV prevention and treatment products such as condoms and antiretroviral drugs are available and affordable will require a series of measures:

- National governments should remove taxes on medicines, condoms and other products that are used for the prevention, treatment, care and support of AIDS, and should also remove laws or regulations that might hinder access to these products.
- Governments should allow medicines into the market as soon as they are approved by the WHO in order to speed up access to new treatment.
- Governments should ensure that the few drugs available to treat and prevent HIV in children reach at least 80% of those in need by 2010.
- Many vitally needed medicines are covered by patents that can limit their use and make them expensive. While drug companies need a sufficient incentive to invest in research and development, AIDS medications must be produced as cheaply and widely as possible to meet the needs of developing countries. Where necessary, countries should make use of the flexibilities in the agreements on intellectual property to ensure they have sustainable supplies of affordable medicines and health technologies, including through local production.

## **7.5 What are the main needs in the field of research and development?**

It is vital to promote technological innovation to develop microbicides, new generations of drugs, and a preventive vaccine.

Therefore, substantially more money must be allocated to research, especially by the pharmaceutical and biomedical industries. In addition, partnerships between the public sector and private companies should be developed to promote faster development of new drugs for children with HIV. Stakeholders should also be involved in the planning and conduct of clinical trials for HIV prevention so as to avoid the controversies these trials often generate. Finally, systems and agreements that guarantee wide and equitable access to treatment products for HIV and HIV-related diseases must be put into place by governments, civil society, and the private sector.

## **7.6 How can the broader social impact of AIDS be countered?**

AIDS exacerbates every other challenge to human development, such as food security and conflict avoidance. Therefore, efforts to reduce the impacts of AIDS must focus at the same time on preventing new infections, caring for those already infected and mitigating the economic, institutional and social impacts of AIDS.

- Efforts to reduce the impact of AIDS should focus first of all on the individuals and families affected, for instance by providing access to therapy, nutritional assistance, and treatment for HIV-related infections and other health problems.

- Children who have lost one or both parents to AIDS need to receive special attention,
- Social protection measures should be taken to preserve livelihoods of people affected by AIDS, including welfare programmes, child and orphan support, and public works to provide employment.
- Refugees or displaced persons are vulnerable populations that should be included in prevention, care and treatment planning in the countries that host them.
- The Chinese AIDS program could serve as a model in supporting families and societies affected by AIDS, since it offers free antiretroviral drugs, voluntary counselling and testing, drugs to prevent mother-to-child transmission, schooling for orphaned children, and care and economic assistance to affected households.

## 8. Conclusion on progress made in the fight against AIDS

In 2001, leaders from 189 UN Member States unanimously recognized that AIDS is among the greatest development crises in human history and agreed to act nationally and internationally to stop the epidemic. They signed the Declaration of Commitment on HIV/AIDS to help reach the Millennium Development Goal of stopping and beginning to reverse the epidemic by 2015. They also agreed to meet detailed targets, for instance in terms of funding, provision of information to young people, and access to treatment.

2005 targets & achievements  
[see Annex 2, p. 14]

A review of all the efforts made between 2001 and 2005 revealed that:

- **There have been great improvements in the fight against AIDS, but progress varies greatly between countries and regions.** In some countries, there is much better access to treatment but prevention programmes are not adequate. In others, the proportion of people living with HIV is falling, but progress towards greater access to treatment is slow. Only some countries have reached the key targets that had been set for 2005.
- **In most countries, a strong foundation now exists on which to build an effective HIV response, with increasing political commitment and partner coordination at country level.** The amount of government money available to fight HIV has increased significantly. There is now much better access to treatment, testing and counselling. More young people are given information on HIV and AIDS at school and blood collected for blood transfusions is now routinely screened for HIV in most countries.
- **There are still significant weaknesses in the fight against HIV.**
  - HIV prevention programmes do not reach enough of those at greatest risk. In 2005 for instance, less than 50% of young people were well-informed about HIV while only 9% of men who have sex with men and fewer than 20% of injecting drug users received any type of HIV prevention service. Only 9% of infected pregnant women were given antiretroviral drugs.
  - The 15 million children orphaned by AIDS and millions of other children made vulnerable by the epidemic do not receive proper care and support.
  - There is stigma and discrimination against people living with HIV.
  - Half of the countries have policies that interfere with HIV-prevention and care programmes.
- **The global AIDS response must become substantially stronger, more strategic and better coordinated in order to achieve the 2010 targets.**

Today, the world possesses the means to begin to reverse the epidemic, but success will require unprecedented willingness on the part of all actors in the global response, including to sustain efforts over the long term.

## Annex

### Annex 1:

#### 2007 UNAIDS estimates

According to more precise, revised estimates from the 2007 Epidemic Update by UNAIDS. (see the 2007 UNAIDS report [see [http://data.unaids.org/pub/EPISlides/2007/2007\\_epiupdate\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf)])

Source & © UNAIDS/WHO AIDS Epidemic Update: December 2007 [see [http://data.unaids.org/pub/EPISlides/2007/2007\\_epiupdate\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf)]

### Annex 2:

**Figure 1. 2005 Country progress towards 2001 Declaration of Commitment on HIV/AIDS global targets**  
(low- and middle-income countries)

2005 Country progress towards 2001 Declaration of Commitment on HIV/AIDS global targets (low- and middle-income countries)	
GLOBAL RESULTS 2005	GLOBAL TARGETS 2005
<b>Total annual expenditure</b>	
US\$ 8 297 000 000 Estimated range: US\$ 7.5 billion–US\$ 8.5 billion	US\$ 7.0–US\$ 10.0 billion - Global target achieved
<b>Percentage of youth aged 15–24 who correctly identify ways of preventing HIV transmission and who reject major misconceptions about HIV transmission:</b>	
<b>MALE:</b> 33% (Country range: 7%–50% coverage), (n=16) <b>FEMALE:</b> 20% (Country range: 8%–44% coverage), (n=17)	90% coverage - No country achieved this
<b>Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis</b>	
9% (Country range: 1%–59% coverage), (n=41)	80% coverage - No country achieved this
<b>Percentage of people with advanced HIV infection receiving antiretroviral therapy</b>	
20% (Country range: 1%–100% coverage), (n=116) 1 300 000 people on treatment	50% coverage - 21 countries achieved this 3 million people on treatment - Global target not achieved
<b>Percentage of young males and females, aged 15–24, who are HIV infected</b>	
<b>MALES:</b> 1.4% (Measure of uncertainty: 1.1%–1.8%), (n=54) <b>FEMALES:</b> 3.8% (Measure of uncertainty: 3.0%–4.7%), (n=54) No comparable global data on this age cohort is available from 2001. Progress towards target can only be measured in individual countries.	25% reduction in most affected countries - 6 of the most affected countries achieved this
<b>Estimated percentage of infants born to HIV-infected mothers who are infected in 2005</b>	
26% of infants born to HIV-infected mothers were also infected (n=33 most affected countries) In 2001, approximately 30% of infants were infected. There has been an estimated 10% reduction in HIV transmission between 2001 and 2005.	20% reduction - 11 of the most affected countries achieved this

Figure 1 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 3.80

Source: UNAIDS Report on the global AIDS epidemic: Executive summary, [see [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR-ExecutiveSummary\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf)] (2006), p.5

### Annex 3:

**Figure 2. Estimated number of people living with HIV, and adult HIV prevalence, [share of the adult population with HIV] globally and in sub-Saharan Africa, 1985–2005<sup>1</sup>**

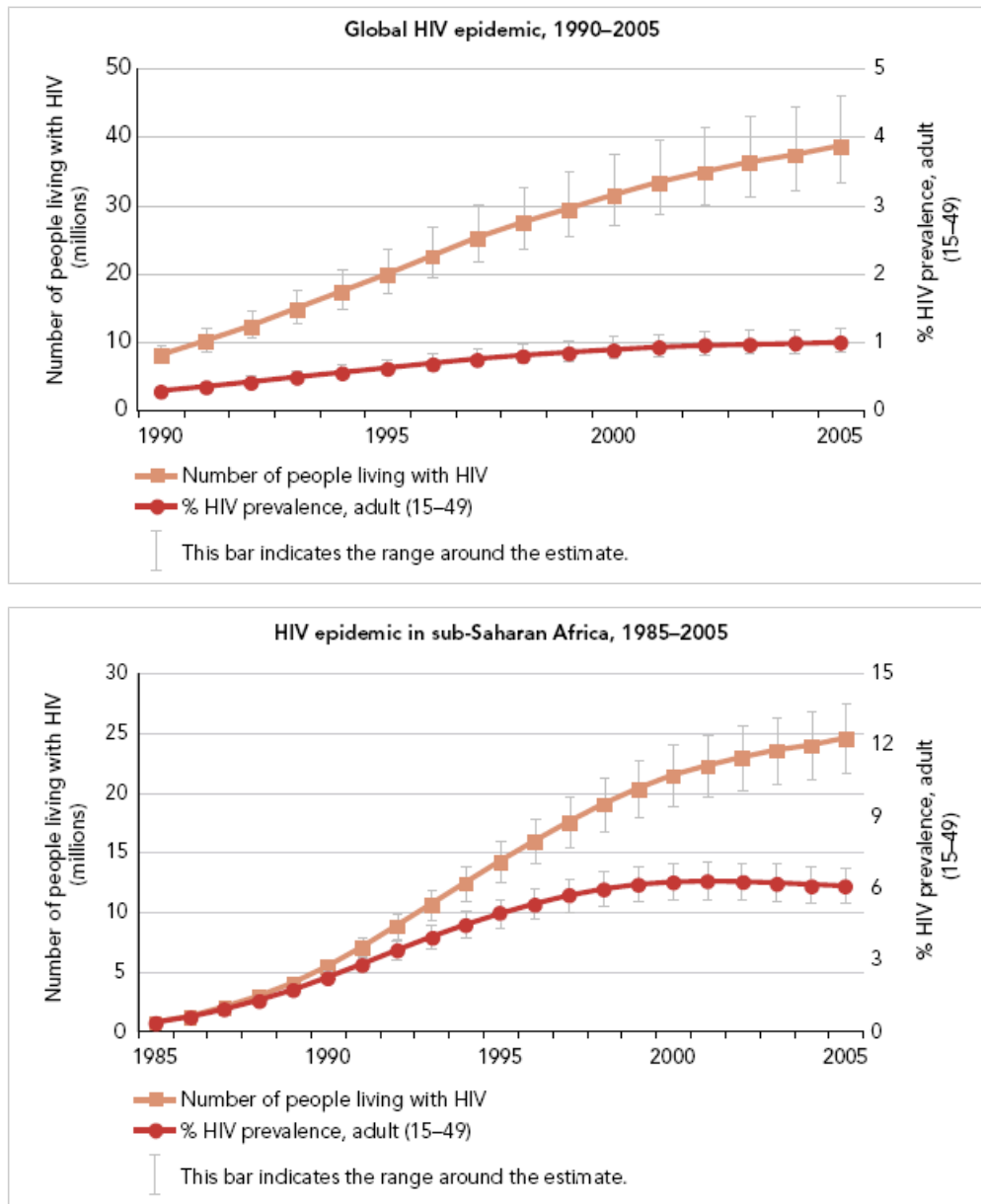


Figure 2 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 2

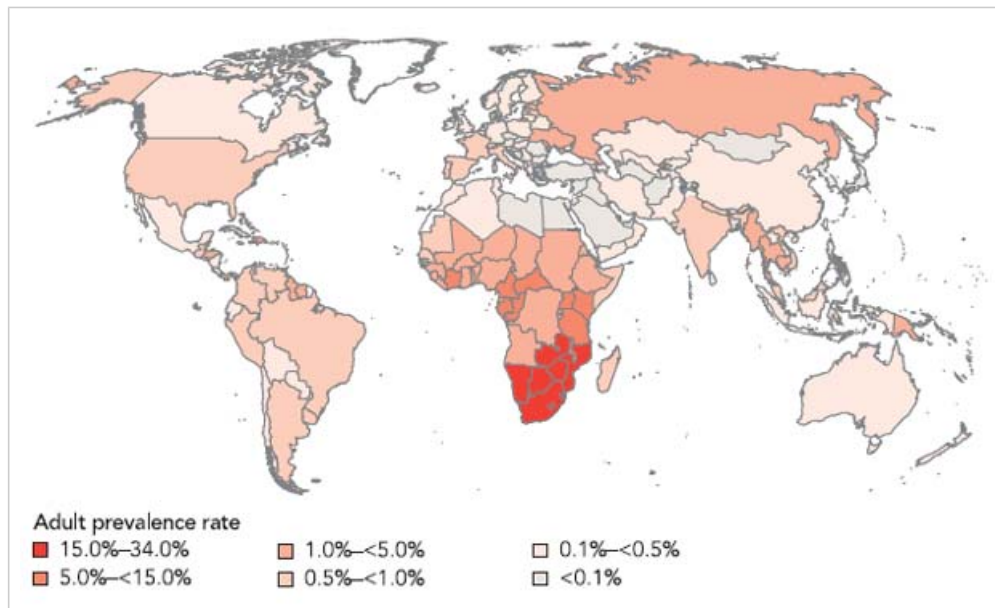
<sup>1</sup> Even though HIV prevalence rates have stabilized in sub-Saharan Africa, the actual number of people infected continues to grow because of population growth. Applying the same prevalence rate to a growing population will result in increasing numbers of people living with HIV.

Source: UNAIDS Report on the global AIDS epidemic: Executive summary, [see [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR-ExecutiveSummary\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf)] (2006), p.7



## Annex 4:

### Figure 2.4. A global view of HIV infection



Source: UNAIDS Overview of the global aids epidemic, [see [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR\\_CH02\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH02_en.pdf)] (2006), Chapter 2, p.14

## Annex 5:

**Figure 3. Number of people on antiretroviral therapy in low- and middle-income countries, 2002–2005**

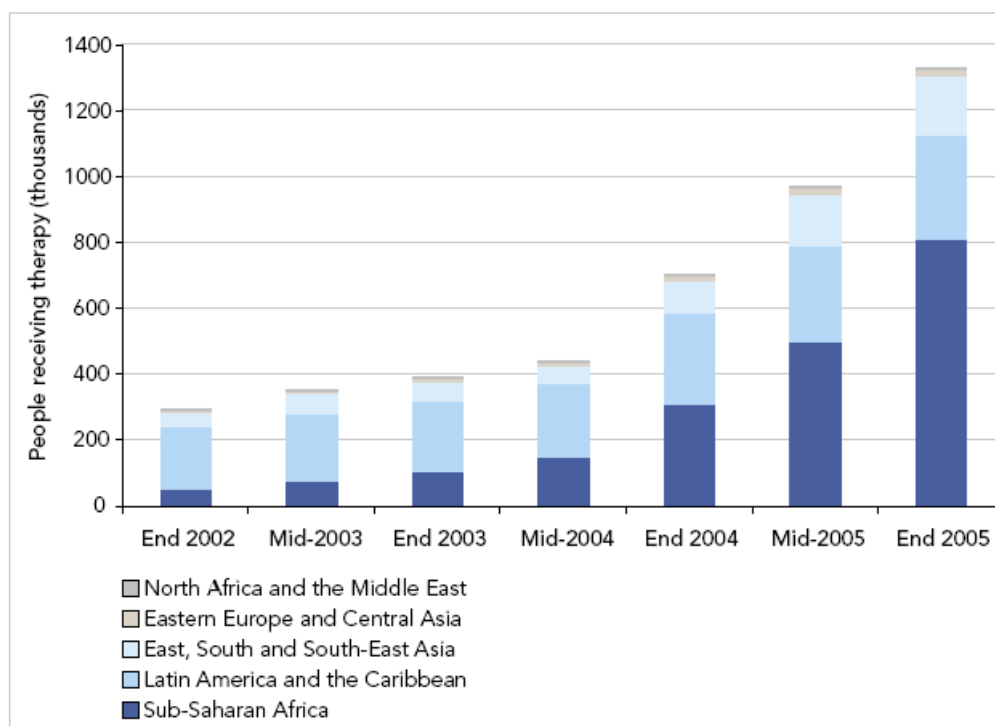


Figure 3 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 7

Source: UNAIDS Report on the global AIDS epidemic: Executive summary, [see [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR-ExecutiveSummary\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf)] (2006), p. 12

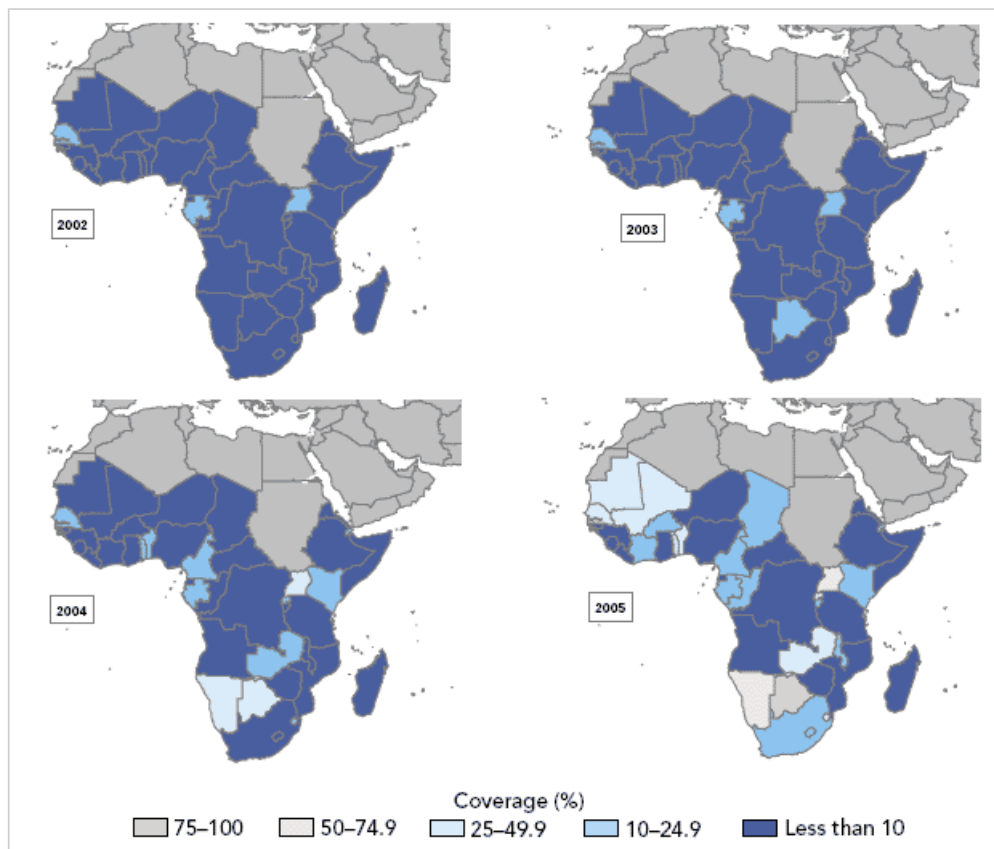
**Annex 6:****Figure 4. People in sub-Saharan Africa on antiretroviral treatment as percentage of those in need, 2002–2005**

Figure 4 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 7.

Source: UNAIDS Report on the global AIDS epidemic: Executive summary, [see [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR-ExecutiveSummary\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf)] (2006), p.14

## Annex 7:

### Figure 5. Estimated total annual resources available for AIDS, 1996–2005

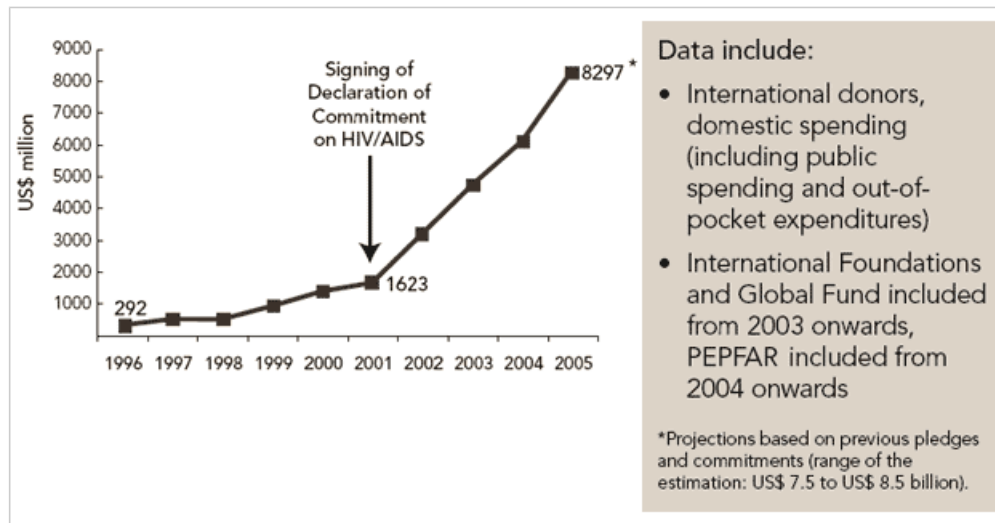


Figure 5 extracted from 2006 Report on the global AIDS epidemic (UNAIDS, 2006), chapter 3.

Source: UNAIDS Report on the global AIDS epidemic: Executive summary, [see [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR-ExecutiveSummary\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf)] (2006), p. 18

## Annex 8:

### Footnote

The estimates of national HIV prevalence (the percentage of adults living with HIV nationally) vary because data are collected from different sources, for example from prevalence among women attending antenatal clinics and from household surveys. These different sources tend to give different results. Estimates based on antenatal clinics tend to be higher than those based on household HIV surveys.

Source & © UNAIDS Report on the global AIDS epidemic: Executive summary, [see [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR-ExecutiveSummary\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf)] (2006), p. 7

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