The Joint United Nations Programme on HIV/AIDS (UNAIDS) leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS unites the efforts of 11 UN organizations—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and works closely with global and national partners to maximize results for the AIDS response.

Learn more at unaids.org and connect with us on Facebook and Twitter.
UNAIDS VISION

ZERO NEW HIV INFECTIONS.

ZERO DISCRIMINATION.

ZERO AIDS-RELATED DEATHS.
TARGETS FOR ENDING THE AIDS EPIDEMIC BY 2030

We aim to bring the HIV epidemic under control so that it no longer represents a public health threat to any population or country.

90% reduction in new HIV infections
90% reduction in stigma and discrimination
90% reduction in AIDS-related deaths
Importance of location and population

People living with HIV (children and adults) are not included in this map as they must have universal access to services.
THE GAP REPORT

Key messages

In 2013, an estimated:

- 35 million [33.2 million–37.2 million] people globally were living with HIV
- 2.1 million [1.9 million–2.4 million] people became newly infected with HIV
- 1.5 million [1.4 million–1.7 million] people died from AIDS-related illnesses

UNAIDS report shows that 19 million of the 35 million people living with HIV today do not know that they have the virus

Nearly 90% of people who know their HIV positive status in sub-Saharan Africa are on treatment—ending the AIDS epidemic will require smart scale-up to close the gap

Narrative

- Ensure no one is left behind
  - The narrative of the Gap report is about focusing on location and population (local epidemics and population groups).
  - Ending the AIDS epidemic means putting the right emphasis on the right location for the right population. It’s being at the right place for the right people.
  - Smarter scale-up needed to close the gap between people who know their HIV status and people who don’t. People who can get services and people who can’t. People who are protected and people who are punished.

Ending the AIDS epidemic

- No credible reason to stop the world from ending the AIDS epidemic by 2030.
- We have a fragile five-year window to build on the rapid acceleration of results. The next five years will determine the next 15.
- If scale up is fast by 2020, we will be on track to end the epidemic by 2030, or we risk significantly increasing the time it would take—adding a decade or more.
- By ending the epidemic by 2030 the world will avert 18 million new HIV infections and 11.2 million AIDS-related deaths between 2013 and 2030.
Power of treatment

- Treatment saves lives.
- HIV treatment is reaching people who know their HIV positive status.
  - In sub-Saharan Africa, of the people who know they are HIV positive—nearly 90% are on HIV treatment.
- We are also learning more about game-changing power of treatment in its ability to prevent new HIV infections.
- Research in sub-Saharan Africa suggests that 76% of people on ART have achieved viral suppression—whereby they would be unlikely to transmit HIV to their sexual partners.
- Of the 35 million people living with HIV around the world, some 19 million do not know their HIV status.
- Data show that as people find out their HIV positive status they will seek treatment. Our job is to make that as easy as possible.
- New data analysis demonstrates that for every 10% increase in treatment coverage there is a 1% decline in the percent of new infections among people living with HIV.
- At the end of 2013 there were 12.9 million people on antiretroviral therapy—with 22.1 million people not accessing treatment.
- Based on past scale up, UNAIDS projects that as of July 2014—13 950 296 people were accessing HIV treatment.

What it will take to end the epidemic

- Global commitment and local focus—a true people-centred approach is required.
- There will be no ending AIDS without putting people first, without ensuring that people living with and affected by the epidemic are part of a new movement.
- Without a people-centred approach, we will not go far in the post-2015 era.
- Today 15 countries make up 75% of the global burden of HIV.
- Focus on countries being left behind—for example, six countries—Central African Republic, Democratic Republic of the Congo, Indonesia, Nigeria, Russian Federation and South Sudan—are facing the triple threat of highest burden, lowest ART coverage and an increasing rate of new HIV infections.
Multiple epidemics within each country and region. Inside each country we can see patterns in cities—by location and population.

We can take “know your epidemic – know your response” to the neighbourhood level. Cities increasingly are playing a major role in efficient and effective scale-up.

With knowledge of local epidemics and location services we can take complex city-sized epidemics and develop tailored programmes to reach people faster and with better services.

Better understanding of individual benefit.

Too often people at higher risk of HIV infection face multiple issues—such as being a young woman displaced from home and living with HIV.

Constant innovation and research to focused on serving people being left behind. For example, long acting antiretroviral medicines.

Closing the gap

The amazing return on investment we have seen in the AIDS response is a classic example of “what gets measured gets done.”

We must make sure that all people are counted or they risk being left behind.

There is no space in the world for discrimination and unfair criminalization. Everyone deserves equal access to quality HIV services.

Laws should protect people, and ensure that everyone has equal rights.

Only by closing the growing gap between people moving forward and people being left behind will we end the AIDS epidemic.

Advancing the freedom and equality of all people will require open access to information and services free from stigma and discrimination.

Populations at risk

At the end of 2013, there were an estimated 35 million people living with HIV.

At the end of 2013, 240 000 children were newly infected with HIV.

Even though we have the tools to save lives, more than 39 million people living with HIV have died since the epidemic started.
Globally, adolescent girls and young women face gender-based inequalities, exclusion, discrimination and violence, which put them at increased risk of acquiring HIV.

Adolescent girls and young women are most vulnerable to HIV in sub-Saharan Africa—and account for 1 in 4 new HIV infections.

The prevalence of HIV, sexually transmitted infections, hepatitis B and C and tuberculosis in prison populations has been estimated to be between two and 10 times higher than in the general population.

Globally, there are 230 million international migrants. With heightened vulnerabilities, migrants rarely have access to HIV-related health and social services.

There are still 39 countries, territories and areas with HIV-related restrictions on entry, stay and residence.

Approximately 13% of people who inject drugs are living with HIV. HIV prevalence is estimated to be 28 times higher in people who inject drugs than in the rest of the adult population.

HIV prevalence among sex workers is 12 times higher than for the adult population, largely because of widespread violence, criminalization, stigma and discrimination, lack of funding and programmes.

There are 78 countries that criminalize same-sex sexual practices.

Transgender women are 49 times more likely to acquire HIV than all adults of reproductive age.

There are fewer antiretroviral medicines available which are designed for the specific needs of children—children are one-third less likely to receive treatment than adults.

HIV is the leading cause of death for women of reproductive age worldwide.

No evidence that HIV-positive displaced persons pose a substantial public health threat to a country.

A 2012 survey from South Africa reported that 78% of people with disabilities felt that they carried a low risk of HIV infection, although there was a HIV prevalence of 16.7% among the same group.

There are 4.2 million people aged 50 and older living with HIV.

A large proportion of people aged 50 and older are sexually active and do not think they are at risk of HIV.
Record progress

- **Record-breaking declines in new HIV infections**—2.1 million people became newly infected with HIV in 2013—signalling the lowest levels this century. This is a 13% drop in last three years alone. **And a 38% decline in new HIV infections since 2001.**

- **There were 1.5 million AIDS-related deaths in 2013—lowest levels** since the peak in 2005—a drop of 35%.

- For the first time the number of **new HIV infections among children is below 200 000** in the 21 most affected countries in Africa.

- At the **end of 2013 there were 12.9 million people on antiretroviral therapy.**

**By region**

**Sub-Saharan Africa**

- In 2013, there were **24.7 [23.5 million–26.1 million]** people living with HIV in sub-Saharan Africa.
  - Women account for **58%** of the total number of people living with HIV in sub-Saharan Africa.

- In 2013, there were an estimated **1.5 million [1.3 million – 1.6 million]** new HIV infections.
  - New HIV infections declined by **33%** from 2005 and 2013.
  - Sub-Saharan Africa accounts for almost **70%** of the global total of new HIV infections globally.

- In sub-Saharan Africa, **1.1 million [1.0 million–1.3 million]** people died of AIDS-related causes in 2013.
  - Between 2005 and 2013 the number of AIDS-related deaths in sub-Saharan Africa fell by **39%**.

- Treatment coverage is **37%** among all people living with HIV in sub-Saharan Africa
  - **67%** of men and **57%** of women were not receiving ART in sub-Saharan Africa in 2013.
  - **Three out of four people** on ART live in sub-Saharan Africa.
  - In **Nigeria 80%** of people do not have access to treatment.

- There were **210 000 [180 000–250 000]** new HIV infections among children in sub-Saharan Africa in 2013.
— Since 2009, there has been a 43% decline in new HIV infections among children in the 21 priority countries of the Global Plan in Africa.

Asia and the Pacific

- In 2013, there were 4.8 million [4.1 million–5.5 million] people living with HIV in Asia and the Pacific.

- In 2013, there were an estimated 350 000 [250 000–510 000] new HIV infections in the region.
  - New HIV infections declined by 6% from 2005 to 2013.
  - In Indonesia new HIV infections have risen by 48% since 2005.

- In Asia and the Pacific, 250 000 [210 000–290 000] people died of AIDS-related causes in 2013.
  - Between 2005 and 2013 the number of AIDS-related deaths in the region fell by 27%.
  - India accounts for 51% of all AIDS-related deaths in the region.

- Treatment coverage is 33% [28%–38%] among all people living with HIV in Asia and the Pacific.

- An estimated 2.4 million of adult men and 1.4 million of adult women were not receiving ART in Asia and the Pacific in 2013.
  - In only two countries in Asia and the Pacific, Thailand and Cambodia, are more than 50% of people living with HIV accessing antiretroviral treatment.

- There were 22 000 [18 000–32 000] new HIV infections among children in Asia and the Pacific in 2013.
  - Since 2009, there has been a 15% decline in new HIV infections among children in the region.

Latin America

- In 2013, there were 1.6 million [1.4 million–2.4 million] people living with HIV in Latin America.

- In 2013, there were an estimated 94 000 [71 000–170 000] new HIV infections in the region.
  - New HIV infections declined by 3% from 2005 to 2013.

- In Latin America, 47 000 [39 000–75 000] people died of AIDS-related causes in 2013.
—Between 2005 and 2013 the number of AIDS-related deaths fell by 31%.

- Treatment coverage is 45% [33%–51%] of all people living with HIV in Latin America.
- There were 1800 [<1000–7400] new HIV infections among children in Latin America in 2013.

**Western and central Europe and North America**

- In 2013, there were 2.3 million [2.0 million–3.0 million] people living with HIV in Western and central Europe and North America.
  - The United States accounts for 56% of people living with HIV in this part of the world.
- In 2013, there were an estimated 88 000 [44 000–160 000] new HIV infections in the region.
  - New HIV infections rose by 8% from 2005 to 2013
- In Western and central Europe and North America, 27 000 [23 000–34 000] people died of AIDS-related causes in 2013.
  - Between 2005 and 2013 the number of AIDS-related deaths in the region fell by 2%.
- Treatment coverage is 51% [39%–60%] of all people living with HIV in 2013.
- There were <500 [<200–<500] new HIV infections among children in Western and central Europe and North America in 2013.

**Eastern Europe and central Asia**

- In 2013, there were 1.1 million [980 000–1.3 million] people living with HIV in eastern Europe and central Asia.
- In 2013, there were an estimated 110 000 [86 000–130 000] new HIV infections in the region.
  - New HIV infections rose by 5% from 2005 and 2013 in the region.
- In eastern Europe and central Asia, 53 000 [43 000–69 000] people died of AIDS-related causes in 2013.
  - Between 2005 and 2013 the number of AIDS-related deaths in the region rose by 5%.
- Treatment coverage is 21% [18%–24%] among all people living with HIV in eastern Europe and central Asia.
- There were <1000 [<1000–1200] new HIV infections among children in eastern Europe and central Asia in 2013.
Caribbean

- In 2013, there were **250 000** [230 000–280 000] people living with HIV in the Caribbean.
- In 2013, there were an estimated **12 000** [9400–14 000] new HIV infections in the region.
  - New HIV infections declined by **40%** from 2005 to 2013.
- In the Caribbean, **11 000** [8300–14 000] people died of AIDS-related causes in 2013.
  - Between 2005 and 2013 the number of AIDS-related deaths in the region fell by **half**.
  - **Haiti** accounted for **59%** of all AIDS related deaths in the region in 2013.
- Treatment coverage is **42%** among people 15 years or older living with HIV in the Caribbean—an increase of **31%** since 2011.
- There were **<1000** [<500–<1000] new HIV infections among children in the Caribbean in 2013.

Middle East and North Africa

- In 2013, there were **230 000** [160 000–330 000] people living with HIV in the Middle East and North Africa.
- In 2013, there were an estimated **25 000** [14 000–41 000] new HIV infections in the region.
  - New HIV infections rose by **7%** from 2005 to 2013.
- In the Middle East and North Africa, **15 000** [10 000–21 000] people died of AIDS-related causes in 2013.
  - Between 2005 and 2013 the number of AIDS-related deaths in the region rose by **66%**.
- Treatment coverage is **11%** [8%–16%] among people living with HIV in the Middle East and North Africa.
- There were **2300** [1500–3400] new HIV infections among children in the Middle East and North Africa in 2013.
There is a gap of **19 million people** who do not know they are living with HIV of the 35 million people living with HIV.

There is a gap of **22.1 million people** who are not accessing HIV treatment of the 35 million people living with HIV.

There is a gap of **2.4 million** children who are not accessing HIV treatment of the 3.2 million children under age 15 living with HIV (76% of children are not accessing treatment).

**US$ 3–5 billion** is the gap between resources available and the US$ 22–24 million that is needed.

Most of the **2 to 4 million** people living with HIV who are co-infected with hepatitis B and the **4 to 5 million** with hepatitis C do not know they are co-infected and treatment is expensive.

76% is the education gap—76% of adolescent girls in sub-Saharan Africa do not have comprehensive and correct knowledge about HIV.

**Up to 50 times higher** is the gap between the HIV burden in some prisons and the HIV burden among the general population.

39 **countries** is the gap to close between the number of countries that have HIV-related travel restrictions and countries that do not.

137 is the gap to close between how many countries offer needle exchange programmes and how many do not (only 55 of 192 countries reporting offered needle exchange programmes).

12 **times higher** is the gap between HIV prevalence among sex workers and the general population.

78 **countries** is the gap between the number of countries where adult consensual same-sex sexual conduct is criminalized and countries that do not.

49 **times higher** is the gap in risk between a transgender woman becoming infected with HIV compared to the general adult population.

51.2 **million** people is the gap in the number of people who have been forcibly displaced and people who have not.

23% the gap between men with a disability returning to seek health care because they were treated badly to men with a disability who were not.

0 is the gap between the life expectancy of people aged 50 and older living with HIV who are accessing treatment and people who do not have the virus.
Transgender Migrants

People living with HIV (children and adults) are not included in this map as they must have universal access to services.

Young women

Sex work

People who inject drugs

MSM 50+

Disabled

African-American women

Prisoners

Displaced

Pregnant women

Importance of location and population

Adult HIV transmission rate in low- and middle-income countries with high and low antiretroviral therapy coverage, 2013

Nepal
Uzbekistan
Mauritius
Madagascar
Nigeria
Central African Republic
Bolivia
Sierra Leone
Democratic Republic of Congo
Guinea Bissau
Guinea
Malaysia
Republic of Moldova
South Sudan
Morocco
Sudan
Somalia
Algeria
Belarus
Iran (Islamic Republic of)
Kyrgyzstan
Tajikistan
Indonesia
Azerbaijan
Bangladesh
Armenia
Egypt
Tunisia
Pakistan
Burundi
Cambodia
Thailand
Eritrea
Dominican Republic
Ethiopia
Botswana
Rwanda
Malawi
Gabon
Zambia
Costa Rica
Namibia
Zimbabwe
Lao People's Democratic Republic
Cabo Verde
Trinidad and Tobago
Belize
Swaziland
Mexico
Peru
Burkina Faso
Chile
El Salvador
Brazil
Panama
Argentina
Papua New Guinea
Guyana
Number of people receiving antiretroviral therapy newly added during 2010-2013

- **33%** South Africa
- **7%** India
- **6%** Uganda
- **5%** Zimbabwe
- **5%** Nigeria
- **5%** Mozambique
- **5%** United Republic of Tanzania
- **4%** Zambia
- **4%** Kenya
- **4%** Malawi
- **2%** Malawi
- **2%** Ethiopia
- **2%** Cameroon
- **2%** China
- **2%** Russian Federation
- **2%** Democratic Republic of the Congo
- **2%** Indonesia
- **2%** Indonesia
- **2%** Democratic Republic of the Congo
- **2%** Indonesia
- **26%** Remaining countries

AIDS deaths, globally, 2013

- **14%** Nigeria
- **13%** South Africa
- **8%** India
- **5%** Mozambique
- **5%** United Republic of Tanzania
- **4%** Zimbabwe
- **4%** Uganda
- **4%** Kenya
- **3%** Malawi
- **3%** Ethiopia
- **3%** Cameroon
- **2%** China
- **2%** Russian Federation
- **2%** Democratic Republic of the Congo
- **2%** Indonesia
- **2%** Indonesia
- **26%** Remaining countries
In 2013, there were 35 million [33.2 million–37.2 million] people living with HIV.

— Since the start of the epidemic around 78 million [71 million–87 million] have become infected with HIV and 39 million [35 million–43 million] people have died of AIDS-related illnesses.

New HIV infections

- New HIV infections have fallen by 38% since 2001.
- New HIV infections among children have declined by 58% since 2001.

AIDS-related deaths

- AIDS-related deaths have fallen by 35% since the peak in 2005.
  - In 2013, 1.5 million [1.4 million–1.7 million] people died from AIDS-related causes worldwide compared to 2.4 million [2.2 million–2.6 million] in 2005.

Antiretroviral therapy

- In 2013, around 12.9 million people living with HIV had access to antiretroviral therapy.
  - This represents 37% [35%–39%] of all people living with HIV.
  - 38% [36%–40%] of all adults living with HIV are receiving treatment however just 24% [22%–26%] of all children living with HIV are receiving the lifesaving medicines.
**HIV/TB**

- TB-related deaths in people living with HIV have fallen by 36% since 2004.
  - TB remains the leading cause of death among people living with HIV, with an estimated 320,000 [300,000–340,000] deaths in 2012.
  - In 2013, the percentage of identified HIV positive tuberculosis patients who were started or continued on antiretroviral treatment reached 70% (up from 57% in 2012).

**Investments**

- US$ 19.1 billion was available from all sources for the AIDS response in 2013.
  - The estimated annual need by 2015 is currently between US$ 22–24 billion.
- In 2013, domestic investments from low- and middle-income countries accounted for around half of all HIV related spending.
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<tr>
<td></td>
<td>29.8 million [28.1-31.9 million]</td>
<td>30.7 million [29.0-32.7 million]</td>
<td>31.4 million [29.7-33.3 million]</td>
<td>31.8 million [30.2-33.7 million]</td>
<td>32.1 million [30.5-34.0 million]</td>
<td>32.4 million [30.8-34.3 million]</td>
<td>32.7 million [31.2-34.6 million]</td>
<td>33.1 million [31.5-34.9 million]</td>
<td>33.4 million [31.8-35.2 million]</td>
<td>33.8 million [32.2-35.6 million]</td>
<td>34.2 million [32.5-36.2 million]</td>
<td>34.6 million [32.8-36.6 million]</td>
<td>35.0 million [33.2-37.2 million]</td>
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<td>New HIV Infections (Total)</td>
<td>3.4 mil. [3.3-3.6 million]</td>
<td>3.3 million [3.1-3.5 million]</td>
<td>3.1 million [3.0-3.3 million]</td>
<td>3.0 million [2.8-3.2 million]</td>
<td>2.9 million [2.7-3.1 million]</td>
<td>2.8 million [2.6-3.0 million]</td>
<td>2.7 million [2.5-2.9 million]</td>
<td>2.6 million [2.4-2.8 million]</td>
<td>2.5 million [2.3-2.7 million]</td>
<td>2.4 million [2.2-2.6 million]</td>
<td>2.2 million [2.0-2.5 million]</td>
<td>2.1 million [1.9-2.4 million]</td>
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<tr>
<td>New HIV infections (adults)</td>
<td>2.9 million [2.7-3.0 million]</td>
<td>2.7 million [2.5-2.9 million]</td>
<td>2.6 million [2.4-2.7 million]</td>
<td>2.4 million [2.3-2.6 million]</td>
<td>2.3 million [2.2-2.5 million]</td>
<td>2.2 million [2.1-2.4 million]</td>
<td>2.2 million [2.1-2.4 million]</td>
<td>2.1 million [1.9-2.3 million]</td>
<td>2.1 million [1.9-2.3 million]</td>
<td>2.0 million [1.8-2.2 million]</td>
<td>1.9 million [1.7-2.1 million]</td>
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<td>New infections (children)</td>
<td>580 000 [530 000–640 000]</td>
<td>580 000 [540 000–640 000]</td>
<td>580 000 [540 000–630 000]</td>
<td>570 000 [520 000–620 000]</td>
<td>550 000 [510 000–600 000]</td>
<td>520 000 [480 000–580 000]</td>
<td>490 000 [450 000–540 000]</td>
<td>460 000 [420 000–510 000]</td>
<td>400 000 [370 000–450 000]</td>
<td>360 000 [330 000–400 000]</td>
<td>330 000 [290 000–370 000]</td>
<td>270 000 [240 000–310 000]</td>
<td>240 000 [210 000–280 000]</td>
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<td>AIDS-related deaths</td>
<td>2.0 million [1.8-2.2 million]</td>
<td>2.1 million [2.0-2.4 million]</td>
<td>2.3 million [2.1-2.5 million]</td>
<td>2.4 million [2.2-2.6 million]</td>
<td>2.4 million [2.2-2.6 million]</td>
<td>2.3 million [2.1-2.5 million]</td>
<td>2.2 million [2.0-2.4 million]</td>
<td>2.1 million [1.9-2.3 million]</td>
<td>2.0 million [1.8-2.1 million]</td>
<td>1.9 million [1.7-2.0 million]</td>
<td>1.8 million [1.5-1.8 million]</td>
<td>1.5 million [1.4-1.7 million]</td>
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<td>People accessing treatment</td>
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### 2013 global and regional statistics

<table>
<thead>
<tr>
<th>Region</th>
<th>People living with HIV 2013</th>
<th>New HIV infections 2013</th>
<th>AIDS-related deaths 2013 (total)</th>
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<tbody>
<tr>
<td></td>
<td>total</td>
<td>children</td>
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<tr>
<td><strong>Sub-Saharan Africa</strong></td>
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<td>24.7 million</td>
<td>2.9 million</td>
<td>1.5 million</td>
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<td></td>
<td>[23.5 million–26.1 million]</td>
<td>[2.6 million–3.2 million]</td>
<td>[1.3 million–1.6 million]</td>
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<td><strong>Asia and the Pacific</strong></td>
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<td>4.8 million</td>
<td>210 000</td>
<td>350 000</td>
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<td>[4.1 million–5.5 million]</td>
<td>[190 000–270 000]</td>
<td>[250 000–510 000]</td>
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<td><strong>Latin America</strong></td>
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<tr>
<td></td>
<td>1.6 million</td>
<td>35 000</td>
<td>94 000</td>
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<td>[1.4 million–2.1 million]</td>
<td>[27 000–54 000]</td>
<td>[71 000–170 000]</td>
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<td><strong>Western and Central Europe and North America</strong></td>
<td></td>
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<td>2.3 million</td>
<td>2800</td>
<td>88 000</td>
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<td>[2.0 million–3.0 million]</td>
<td>[2300-3600]</td>
<td>[44 000–160 000]</td>
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<td><strong>Eastern Europe and Central Asia</strong></td>
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<td>1.1 million</td>
<td>14 000</td>
<td>110 000</td>
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<td>[980 000–1.3 million]</td>
<td>[13 000–14 000]</td>
<td>[86 000–130 000]</td>
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<td><strong>Caribbean</strong></td>
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<td>250 000</td>
<td>17 000</td>
<td>12 000</td>
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<tr>
<td></td>
<td>[230 000–280 000]</td>
<td>[14 000–20 000]</td>
<td>[9400–14 000]</td>
</tr>
<tr>
<td><strong>Middle East and North Africa</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>230 000</td>
<td>16 000</td>
<td>25 000</td>
</tr>
<tr>
<td></td>
<td>[160 000–330 000]</td>
<td>[11 000–22 000]</td>
<td>[14 000–41 000]</td>
</tr>
<tr>
<td><strong>Global</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35 million</td>
<td>3.2 million</td>
<td>2.1 million</td>
</tr>
<tr>
<td></td>
<td>[33.2 million–37.2 million]</td>
<td>[2.9 million–3.5 million]</td>
<td>[1.9 million–2.4 million]</td>
</tr>
</tbody>
</table>

*Some numbers may not add up due to rounding*
### Global summary of the AIDS epidemic | 2013

#### Number of people living with HIV

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>31.8 million</td>
<td>[30.1 million – 33.7 million]</td>
</tr>
<tr>
<td>Women</td>
<td>16.0 million</td>
<td>[15.2 million – 16.9 million]</td>
</tr>
<tr>
<td>Children (&lt;15 years)</td>
<td>3.2 million</td>
<td>[2.9 million – 3.5 million]</td>
</tr>
</tbody>
</table>

#### People newly infected with HIV in 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>1.9 million</td>
<td>[1.7 million – 2.1 million]</td>
</tr>
<tr>
<td>Children (&lt;15 years)</td>
<td>240 000</td>
<td>[210 000 – 280 000]</td>
</tr>
</tbody>
</table>

#### AIDS deaths in 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>1.3 million</td>
<td>[1.2 million – 1.5 million]</td>
</tr>
<tr>
<td>Children (&lt;15 years)</td>
<td>190 000</td>
<td>[170 000 – 220 000]</td>
</tr>
<tr>
<td>Category</td>
<td>Estimation</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>People living with HIV</td>
<td>35.0 million [33.2 million – 37.2 million]</td>
<td></td>
</tr>
<tr>
<td>New HIV infections in 2013</td>
<td>2.1 million [1.9 million – 2.4 million]</td>
<td></td>
</tr>
<tr>
<td>Deaths due to AIDS in 2013</td>
<td>1.5 million [1.4 million – 1.7 million]</td>
<td></td>
</tr>
</tbody>
</table>
Regional HIV and AIDS statistics
and features | 2013

<table>
<thead>
<tr>
<th>Region and Region type</th>
<th>Adults and children newly infected with HIV (15–49) [millions]</th>
<th>Adults and children living with HIV (15–49) [millions]</th>
<th>Adult &amp; child deaths due to AIDS (15–49) [thousands]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>24.7 million</td>
<td>2.1 million</td>
<td>1.5 million</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>2.1 million</td>
<td>0.3 million</td>
<td>0.2 million</td>
</tr>
<tr>
<td>Asia and the Pacific</td>
<td>4.8 million</td>
<td>0.6 million</td>
<td>0.5 million</td>
</tr>
<tr>
<td>Latin America</td>
<td>1.6 million</td>
<td>0.4 million</td>
<td>0.3 million</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1.1 million</td>
<td>0.3 million</td>
<td>0.2 million</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>2.3 million</td>
<td>0.9 million</td>
<td>0.7 million</td>
</tr>
<tr>
<td>Western and Central Europe and North America</td>
<td>1.5 million</td>
<td>0.8 million</td>
<td>0.6 million</td>
</tr>
<tr>
<td>TOTAL</td>
<td>35.0 million</td>
<td>2.1 million</td>
<td>2.1 million</td>
</tr>
</tbody>
</table>

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information.
Adults and children estimated to be living with HIV | 2013

Total: 35.0 million [33.2 million – 37.2 million]

- North America and Western and Central Europe: 2.3 million [2.0 million – 3.0 million]
- Caribbean: 250,000 [230,000 – 280,000]
- Latin America: 1.6 million [1.4 million – 2.1 million]
- Middle East & North Africa: 230,000 [160,000 – 330,000]
- Sub-Saharan Africa: 24.7 million [23.5 million – 26.1 million]
- Eastern Europe & Central Asia: 1.1 million [980,000 – 1.3 million]
- Asia and the Pacific: 4.8 million [4.1 million – 5.5 million]
- Caribbean: 250,000 [230,000 – 280,000]
Estimated number of adults and children newly infected with HIV | 2013

- **Middle East & North Africa**: 25,000 [14,000 – 41,000]
- **Sub-Saharan Africa**: 1.5 million [1.3 million – 1.6 million]
- **Eastern Europe & Central Asia**: 110,000 [86,000 – 130,000]
- **Latin America**: 94,000 [71,000 – 170,000]
- **Caribbean**: 12,000 [9,400 – 14,000]
- **Asia and the Pacific**: 350,000 [250,000 – 510,000]
- **North America and Western and Central Europe**: 88,000 [44,000 – 160,000]

**Total**: 2.1 million [1.9 million – 2.4 million]
Estimated adult and child deaths from AIDS | 2013

Total: **1.5 million** [1.4 million – 1.7 million]
### Children (<15 years) estimated to be living with HIV | 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Number</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle East &amp; North Africa</td>
<td>16,000</td>
<td>[11,000 – 22,000]</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>2.9 million</td>
<td>[2.6 million – 3.2 million]</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>14,000</td>
<td>[13,000 – 14,000]</td>
</tr>
<tr>
<td>Caribbean</td>
<td>17,000</td>
<td>[14,000 – 20,000]</td>
</tr>
<tr>
<td>Latin America</td>
<td>35,000</td>
<td>[27,000 – 54,000]</td>
</tr>
<tr>
<td>North America and Western and Central Europe</td>
<td>28,000</td>
<td>[23,000 – 36,000]</td>
</tr>
<tr>
<td>Asia and the Pacific</td>
<td>21,000</td>
<td>[19,000 – 27,000]</td>
</tr>
<tr>
<td>Total</td>
<td>3.2 million</td>
<td>[2.9 million – 3.5 million]</td>
</tr>
</tbody>
</table>

Total: 3.2 million [2.9 million – 3.5 million]
Estimated number of children (<15 years) newly infected with HIV | 2013

Total: 240,000 [210,000 – 280,000]
Estimated deaths in children (<15 years) from AIDS: 2013

- **Middle East & North Africa**: 1300 (<1000 – 2000)
- **Sub-Saharan Africa**: 180,000 (150,000 – 220,000)
- **Eastern Europe & Central Asia**: <500 (<200 – 1000)
- **Latin America**: 1500 (<1000 – 4200)
- **Caribbean**: <1000 (<100 – <1000)
- **North America and Western and Central Europe**: <200 (<100 – <200)
- **Asia and the Pacific**: 14,000 (12,000 – 19,000)

**Total**: 190,000 [170,000 – 220,000]
About 6,000 new HIV infections a day in 2013

- About 68% are in Sub Saharan Africa
- About 700 are in children under 15 years of age
- About 5,200 are in adults aged 15 years and older, of whom:
  - almost 47% are among women
  - about 33% are among young people (15-24)
### 2013 global HIV and AIDS estimates

**Children (<15 years)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living with HIV</td>
<td>3.2 million</td>
</tr>
<tr>
<td><strong>New HIV infections in 2013</strong></td>
<td>240 000</td>
</tr>
<tr>
<td><strong>Deaths due to AIDS in 2013</strong></td>
<td>190 000</td>
</tr>
</tbody>
</table>

Estimates are within brackets to indicate uncertainty.
Overview

Much more attention is needed to prevent and treat HIV during adolescence. New infections among adolescents could be halved by 2020 by scaling up high-impact interventions and working across sectors. The treatment, care and support needs of children living with HIV change as they grow older and begin to take greater responsibility for their own health. But services generally do not keep pace with or cater to their needs. This is particularly true for marginalized adolescents—males who have sex with males, adolescents who inject drugs and sexually exploited adolescents—despite the disproportionately high prevalence of HIV among them. A comprehensive strategy is required to address these diverse needs.

Key messages

- To end the AIDS epidemic among adolescents, all children should be born free of HIV and remain so for the first two decades of life.
- Increased investments in high-impact interventions that target people at higher risk of HIV infection can prevent an estimated 2 million new infections among adolescents between now and 2020.
- Adolescents are the only age group in which AIDS-related deaths have increased.

Innovations

- Adolescent-friendly programmes and innovative responses to HIV allow countries to make rapid, cost-effective gains against the epidemic while bypassing bottlenecks in service delivery. Such innovations save lives, protect health and help to ensure the participation of young people.
- MTV, with the United Nations Children’s Fund (UNICEF) and the United States President’s Emergency Plan for AIDS Relief, provided information to adolescents and young people on how to protect themselves against HIV through Shuga, a video and radio drama series that followed young people in urban and rural settings in Africa. The series aired in six countries with an estimated audience of 45 million young people.
- U-report for HIV prevention in Zambia is capitalizing on mobile phone use among young people in sub-Saharan Africa by using text messages to increase this group’s participation in national HIV responses. U-report
addresses their knowledge gap and increases demand for services, including testing and counselling, by providing confidential, individual and interactive free counselling on HIV and sexually transmitted infections.

Challenges

- Discrimination, poverty, inequalities and harsh laws prevent adolescents from seeking and receiving testing, health care and support.

- Adolescent girls, particularly in sub-Saharan Africa, face higher risks of HIV infection. About 60% of all adolescents living with HIV are girls. Low social status, household poverty, food insecurity, poor quality education and violence all limit opportunities for girls.

- In three countries (Gabon, Sierra Leone and South Africa) in 2012, more than 80% of the new infections among adolescents aged 15-19 years occurred among girls.

- Too many adolescents do not get tested for HIV or receive counselling. Age of consent laws and policies may restrict access in many countries.

Key statistics

- An estimated 2.1 million adolescents were living with HIV in 2012.

- There were 300 000 new infections among adolescents aged 15–19 years in 2012.

- HIV is estimated to be the number two contributor to adolescent mortality globally, and number one in Africa.

- An estimated 71 000 adolescents (10–19 years) died of AIDS-related illnesses in 2005, while in 110 000 adolescents died of -related illnesses in 2012.

Background

Three broad groups of adolescents face major barriers accessing prevention, treatment and care services: adolescent girls, adolescent key populations and adolescents living with HIV. The core vulnerability of these groups lies in structural, socioeconomic and gender inequality, including failures in child protection and social protection. This can be exacerbated where providers lack skills or are unwilling to work with vulnerable adolescents and adolescents at higher risk, which too often results in limiting their access to accurate information and the services they need.
Opportunities for greater success in reducing the impact of HIV on adolescents lie in increasing demand for, access to and uptake of key interventions, while also addressing the social and economic factors that heighten adolescents’ vulnerability to HIV and limit their access to the services they need.

A new commitment to addressing the challenges of the second decade of life is needed, so that all children—infants, young children and adolescents alike—have the opportunity to become healthy, secure and productive adults.

Q&A

1. Why have AIDS-related deaths increased among adolescents?

   It important to note that this is modelled data that, nonetheless, indicates that adolescents are falling behind in the AIDS response. Discrimination, poverty, inequalities and harsh laws often prevent adolescents from seeking and receiving testing, health care and support. Too many adolescents do not get tested for HIV or receive counselling, especially those who are at higher risk of HIV infection and most marginalized—adolescent girls, adolescent males who have sex with males, adolescents who inject drugs and sexually exploited adolescents. For adolescents living with HIV, treatment options for second and third line drugs are often not available. There is also a lack of focus on linkage to quality care, adherence and psychosocial support. Much greater commitment to the adolescent agenda is needed—without it we will not be able to end the AIDS epidemic among adolescents. Finally, improved data are needed on HIV mortality and survival times in the age group 5–14 years.

2. What can be done to ensure that adolescents are protected from HIV?

   First, we need to go to where adolescents are and reach out to them. Then we have to deliver programmes that are engaging and interesting, as well as effective.

   Adolescent-friendly programmes and innovative ways to engage them are critical to attract adolescents to HIV prevention and treatment services. An AIDS-free generation will not be reached through a single intervention, but rather an appropriate combination of high-impact interventions implemented within a supportive and enabling environment. A new analysis featured in the Stocktaking report 2013 shows that it is possible to prevent new HIV infections among 2 million adolescents in low- and middle-income countries by 2020 through targeted programmes and increasing investment for adolescents from approximately US$ 3.8 billion in 2010 to about US$ 5.5 billion by 2014. These investments should focus on high-impact interventions such as condoms, antiretroviral therapy, prevention of mother-to-child transmission, communications for behaviour change and targeted approaches for
marginalized populations and populations at higher risk. This is in addition to investments in other supportive sectors, such as education, social protection and welfare and strengthening health systems.

3. Why are adolescents girls more vulnerable to HIV?

Adolescent girls, particularly in sub-Saharan Africa, face higher risks of HIV infection. Low social status, household poverty, food insecurity, poor quality education and violence all limit opportunities for girls. Power imbalances and higher social status of older men mean that young girls may be preyed upon or exploited by older men who are more likely to be living with HIV than adolescent boys. In three countries (Gabon, Sierra Leone and South Africa) in 2012, more than 80% of new infections among adolescents occurred among girls.

The HIV response needs to take into account addressing violence and gender inequality. For example, evidence shows that experiencing violence during childhood increases the risk of HIV infection. So does violence inflicted by an intimate partner.

4. Does providing sex education to young people encourage engagement in sexual activities or promote promiscuity?

Research clearly shows that information about sex and sexuality does not increase sexual activity or reduce the age of sexual initiation among young people. In fact, it does the opposite. Young people who receive age-appropriate, accurate sexual health information regarding abstinence, condom use, sexual development and other related topics are more likely than those who learn only about abstinence to delay sexual initiation and to use condoms for dual protection when they do have sex.

Age-appropriate sexuality education can increase knowledge and contribute to more responsible sexual behaviour. Several countries show evidence of improved knowledge about HIV prevention.

Among countries with available survey data, some had comprehensive, correct knowledge above 50% among adolescent girls aged 15–19 years. These are Cuba (3% increase in four years), Guyana (19% increase in nine years), Namibia (32% increase in six years), Serbia (8% increase in four years), Swaziland (4% increase in four years) and Viet Nam (9% increase in six years). Kenya, Namibia and Swaziland had comprehensive, correct knowledge above 50% among adolescent boys aged 15–19 years.
Overview

The Millennium Development Goals (MDGs) taught us that a new global framework can set policy priorities, energize alliances and guide the allocation of vast national and international resources. The post-2015 agenda seeks to elaborate a set of sustainable development goals (SDGs). These will be negotiated in a very different global context to when the MDGs were set—the AIDS epidemic has changed dramatically, and the geography of poverty, demography and inequality has undergone major shifts. Reflecting this new reality, the SDGs are highly likely to be universal goals that combine the three dimensions of sustainable development—environmental, social and economic well-being—in a single, integrated global framework.

In addressing and moving beyond the unfinished MDGs, it is imperative that there is a strong commitment to ending the AIDS epidemic by 2030 in the post-2015 agenda. This should be underpinned by three targets to spur progress towards the three zeros: zero new HIV infections, zero discrimination and zero AIDS-related deaths. Ending the AIDS epidemic will not only be a historic achievement in its own right, but can also serve as a catalytic force for global health, human rights and development outcomes.

Key messages

- The post-2015 agenda should include a commitment to ending the AIDS epidemic and three targets: reducing new HIV infections, discrimination and AIDS-related deaths to 10% of 2010 levels.
- Leaving no one behind is contingent upon rights-based action on the social, political and economic determinants of HIV.
- Mechanisms should be strengthened to enable broad participation and ownership in implementing and monitoring the post-2015 agenda.
- Ending the AIDS epidemic will serve as a catalyst for achieving a shared vision of social, economic and environmental justice.

Challenges

- Retaining visibility for AIDS in a crowded, contested and diverse environment.
A number of issues are emerging in post-2015 discussions in intergovernmental bodies. Among them are issues critical for the effectiveness of the future AIDS response, including sexual and reproductive health and rights, men who have sex with men, sex workers and human rights.

It must be communicated that UNAIDS advocates for ending the AIDS epidemic as a public health threat and that increased investment in research for a vaccine and cure will accelerate progress towards ending the AIDS epidemic.

Ending the AIDS epidemic will demand an overhaul of development financing, including establishing/strengthening mechanisms that meet the needs of marginalized groups in all countries and moving beyond overseas development assistance.

**Key statistics**

UNAIDS is advocating for a target framework in the post-2015 development agenda that aims to end the AIDS epidemic by 2030 and get us closer to zero new HIV infections, zero discrimination and zero AIDS-related deaths. The baseline year for all targets is 2010.

- Achieve a 90% reduction in new HIV infections, including among key populations, and eliminating new HIV infections among children towards achieving zero new HIV infections, which would mean a reduction to 200 000–300 000 people newly infected with HIV annually in 2030.
- Achieve a 90% reduction in stigma and discrimination faced by people living with HIV, vulnerable populations and key populations towards achieving zero discrimination.
- Achieve a 90% reduction in AIDS-related deaths towards achieving zero AIDS-related deaths, which would mean a reduction to 200 000–300 000 people dying from AIDS-related causes in 2030.

**Background**

Building on language agreed to at the June 2013 UNAIDS Programme Coordinating Board, the United Nations Economic and Social Council (ECOSOC) provided solid foundations for a strong commitment to AIDS beyond 2015.
The process of setting the development agenda for the post-2015 era is complex and involves several stakeholders. Major initiatives led by the United Nations and Member States are outlined below.

The Open Working Group on Sustainable Development Goals (OWG), established following the 2012 United Nations Conference on Sustainable Development (Rio+20), is tasked with proposing a framework for the SDGs. The OWG will meet several times through July 2014 in preparation for the development of its final report, which will be available by the end of the sixty-eighth session of the General Assembly.

Beyond the OWG, the Rio+20 Outcome Document mandated two additional processes: the Committee of Experts on Sustainable Development Financing (CESDF) and the High-Level Political Forum (HLPF).

The HLPF, a novel leadership forum, replaces the Commission on Sustainable Development and was created to ensure sustainable development remains a top priority for world leaders. The HLPF will convene at the level of Heads of State and Government every four years under the auspices of the General Assembly. The forum will meet every year at the ministerial level under the auspices of ECOSOC—the next of which will be held in New York in July 2014.

CESDF is an intergovernmental committee of 30 experts that was established to oversee broad consultation to assess development financing needs, review existing instruments and evaluate additional initiatives. It has been tasked to produce a report in August 2014 that presents options for an effective sustainable development financing strategy. The Working Group on Financing for Sustainable Development has been set up under the UN System Task Team to support the work of the committee.

A number of high-level meetings and thematic debates were held under the auspices of the General Assembly from March to June 2014 to support consensus-building among Member States on the next development agenda.

The Sustainable Development Solutions Network, commissioned by the UN Secretary-General and headed by Professor Jeffrey Sachs, is mobilizing scientific and technical expertise from academia, civil society and the private sector.

Looking ahead, the President of the General Assembly will host a high-level post-2015 stocktaking event during the General Assembly Debate in September 2014. Following this, the United Nations Secretary-General will develop a synthesis report that is expected to provide a starting point for Member States’ negotiations. By the end of 2014, formal negotiations will begin and are foreseen to intensify in May, June and July 2015, leading up to the September Summit of Heads of State and Government in 2015, where it is expected that the post-2015 development framework will be adopted.
Q&A

1. Are countries on track to meet MDG 6?

Many countries have met the goal of halting and reversing the AIDS epidemic, but the epidemic continues to grow in many places and among specific groups of people—we must complete the unfinished MDG agenda by leaving no one behind.

The new SDG framework presents an opportunity for a more ambitious agenda in which the global community commits to ending the AIDS epidemic by 2030.

2. Why is the post-2015 agenda important?

It will determine the contours of the global health and development architecture and define which national policies and programmes are implemented, as well as the extent to which gains to date are sustained and scaled up.

Global leaders are confronted with the opportunity to build on the MDGs and commit to a transformative and universal agenda with the vision and ambition to ensure a more equitable distribution of power, rights and resources across regions, and within countries and communities.

If the global AIDS response successfully leverages this opportunity, a commitment to ending the AIDS epidemic by 2030 could be secured at the highest political level in the context of a shared vision of social, economic and environmental justice.

3. What is UNAIDS’s position on post-2015?

UNAIDS has developed a draft discussion paper that includes key messages and a target framework on ending the AIDS epidemic. The Joint Programme is advocating for:

- A commitment to ending the AIDS epidemic by 2030.
- Three targets: reducing new HIV infections, discrimination experienced by people living with HIV and key populations, and AIDS-related deaths to 10% of 2010 levels.
- HIV-sensitive indicators across the agenda to ensure policy coherence and joint action to address the social, political, economic and environmental determinants of HIV, poor health, poverty and inequality.
- Strengthened mechanisms to enable broad participation and ownership in implementing and monitoring the post-2015 agenda.
4. Why is UNAIDS advocating for a commitment to ending the AIDS epidemic and what does it mean?

Given unprecedented progress in the AIDS response and remarkable scientific advances, the global community faces a historic opportunity to transform UNAIDS’s three zeros vision into a concrete commitment to ending the AIDS epidemic by 2030.

Evidence gathered by the UNAIDS and Lancet Commission: Defeating AIDS—Advancing Global Health creates optimism that ending the AIDS epidemic is possible in the post-2015 era.

Ending the AIDS epidemic is understood to be the reduction of HIV incidence and AIDS-related deaths to levels that no longer represent a major health threat to any population or country, measured by the achievement of the three targets presented in the statistics section of this brief.

But ending the AIDS epidemic post-2015 can only be achieved if no one is left behind. HIV reflects the profound and multi-faceted relationship between human rights and sustainable development. Leaving no one behind will therefore be contingent upon rights-based action on the social, political and economic determinants of HIV.

5. What is UNAIDS’s position on universal health coverage (UHC)?

AIDS has shown the power of uniting around a common vision to deliver results. The Lancet Commission on Investing in Health proposes outcome-oriented goals—grand convergence on diseases of poverty. Ending the AIDS epidemic by 2030 can be a catalyst of that convergence. UHC does not focus on health outcomes and on the economic and social determinants of health, which are vital for ensuing healthy lives and that no one is left behind. HIV-related indicators for UHC must include those related to all three zeros: no new HIV infections, discrimination and AIDS-related deaths.

Concern that equity measured through wealth quintiles only will miss most vulnerable and marginalized groups that are not always among the poorest. UHC would be a useful target under a goal of “ensuring healthy lives”.

6. What will the post-2015 process involve moving forward?

The Open Working Group’s final report will be available by the end of the sixty-eighth session of the General Assembly. During the General Assembly Debate in September 2014, the President of the United Nations General Assembly will host a high-level post-2015 stocktaking event.

The United Nations Secretary-General will issue a synthesis report on the post-2015 agenda by the end of 2014. This is expected to provide a starting point for Member States’ negotiations in 2015.
It is expected that the post-2015 development framework will be adopted at the Summit of Heads of State and Government in September 2015.

7. What role will the UNAIDS and Lancet Commission play in influencing the post-2015 agenda?

Launched in May 2013, the UNAIDS and Lancet Commission: Defeating AIDS—Advancing Global Health, is co-chaired by Joyce Banda, President of the Republic of Malawi; Nkosazana Dlamini Zuma, Chairperson of the African Union Commission; and Professor Peter Piot, Director of the London School of Hygiene and Tropical Medicine. The Commission was co-convened by Richard Horton, Editor of The Lancet, and Michel Sidibé, Executive Director of UNAIDS.

The Commission was formed to highlight the importance of AIDS in the post-2015 development agenda and to generate high-profile advocacy for ending the AIDS epidemic as a shared priority of the post-2015 era.

The Commission brings together a diverse group of HIV, health and development experts, young people, people living with HIV and affected communities, activists and political leaders. The Commission seeks to contribute to the post-2015 debate through deliberating, for example, what ending the AIDS epidemic means or how future financing mechanisms should meet the needs of marginalized groups in all countries, including middle-income countries.

The Commission aims to:

- Produce evidence in a special report of The Lancet.
- Mobilize commitment to action on the part of individuals, civil society, businesses, institutes and governments, and momentum for a transformation in global health and development through public dialogue and political mobilization.
- Generate greater awareness among key thought-leaders of the contributions of the AIDS response to broader global health outcomes and sustainable development, and of the rationale for a prominent position for HIV in the post-2015 development agenda.

 Commissioners will leverage their networks and individual capacities as thought-leaders in their respective fields to move the AIDS, health and development agendas forward by advocating for the inclusion of the principles and achievements of the AIDS response in the post-2015 development agenda.
Overview

In 2013, there were 3.2 million [2.9 million–3.5 million] children living with HIV below the age of 15 years.

Despite significant progress in stopping new HIV infections among children, the number of children becoming newly infected with HIV remains unacceptably high. Globally, around 240 000 [210 000–280 000] children became infected with HIV in 2013.

The risk of a mother living with HIV passing the virus to her child can be reduced to 5% or less if she has access to effective antiretroviral therapy during pregnancy, delivery and breastfeeding. In 2013, 67% [61–73%] of pregnant women living with HIV had access to the life-saving medicines.

Stopping new HIV infections among children is one of UNAIDS’s top priorities and, in 2011, UNAIDS and partners launched a new Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.

The Global Plan focuses on the 22 countries where 90% of HIV-positive pregnant women live—21 are in Africa, the other is India. The aim of the Global Plan is to reduce the number of new HIV infections among children by 90% by 2015 and to reduce deaths among pregnant women and children due to AIDS-related illnesses by 50% within the same time period.

In 2011, the most recent year for which we have results, only one third of children exposed to HIV were tested for the virus within the recommended two months. Without knowing the HIV status of a child it is impossible to access life-saving treatment. Without treatment, half of all children born with HIV will die by the age of two and the majority will die by the age of five.

The number of children who have access to treatment is extremely low. In 2013 three quarters of children in need of lifesaving antiretroviral medicines did not have access.

Key messages

- We are getting one step closer towards the elimination of new HIV infections among children.

- As a result of scaled-up HIV prevention services there was a 58% decline in the number of new HIV infections among children between 2002 and 2013.
For the first time the total number of children newly infected with HIV dropped below 200,000 in the 21 African priority countries of the *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*.

However, of the 545 children who contract HIV every day only around a third are tested for the virus within the first two months. Without knowing the HIV status of a child it is impossible to start lifesaving treatment.

The number of children on antiretroviral therapy is appallingly low—just 24% [22%-26%] of children in need of treatment have access.

More medicines specifically adapted to the specific needs of children need to be developed.

**Innovations**

Research is underway to improve the palatability and suitability of paediatric formulations. This includes exploring the use of sprinkles that dissolve in the mouth rather than liquids or tablets. Although such products are not yet available they could be interesting options for the future.

**Challenges**

- In 2013, an estimated 67% [61–73%] of pregnant women living with HIV had access to antiretroviral therapy to prevent their children from becoming infected with HIV.

- In 2011 only one third of children exposed to HIV were tested for the virus within the recommended two months. This is largely because it requires complex laboratory technology that is often only available at central laboratories. Also, results can take a long time to come back, which means that families do not always return for the results and never learn of a child’s HIV status.

- HIV treatment for children can be complicated, requiring pills and liquids, some of which are difficult to swallow and can taste unpleasant. The large volume of medicines recommended for children under the age of three is also a challenge.

- Despite the scientific advances made in research and development for new HIV medicines for adults, the options for children lag behind significantly.

- The barriers to access to treatment for children are far-reaching. Clinics are often far from home; stigma and fear prevent carers from bringing their children to the clinics for HIV testing and treatment; treatment is difficult to
administer for children; there is a lack of training and support for families, carers and health-care workers to provide HIV services for young people; and there are not enough HIV medicines developed specifically for a child’s needs.

Key statistics

- In 2013, an estimated 3.2 million [2.9 million–3.5 million] children under the age of 15 years were living with the virus, but just one quarter (24% [22–26%]) had access to the life-saving medicines.
- 3.2 million [2.9 million–3.5 million] children were living with HIV.
- 740 000 children were accessing treatment.
- 240 000 [210 000–280 000] children became newly infected with HIV.
- 200 000 [170 000–220 000] children died of AIDS-related illnesses.
- 545 children became newly infected with HIV every day.
- 530 children died of AIDS-related illnesses every day.

Background

When children have access to treatment they do well and can live normal, healthy and happy lives, just like any other child. However, children living with HIV can face discrimination at home, school and in the community.

Efforts to normalize HIV and ensure that adults and children have accurate information about the virus are essential. Children and families affected by HIV should not be afraid to openly access HIV testing and treatment services for fear of negative reprisals. Through being open about HIV and sharing experiences, the fear around the disease can be dispelled, making people less afraid to seek and access essential HIV services.

Q&A

1. What more can be done to stop new HIV infections among children and ensure they have access to treatment?

   A combination of efforts is needed to prevent new HIV infections among children, ensure that their mothers remain healthy and improve the diagnosis and treatment of HIV for children.

   HIV testing and treatment needs to be available closer to where the children most affected live and health workers need to be trained and supported to identify and treat children living with HIV.
2. What are the official treatment recommendations for children?
Guidelines from the World Health Organization recommend initiating treatment for all children younger than five years of age who are diagnosed with HIV.

3. How important is community support?
Community support systems are invaluable and need to be strengthened to allow them to effectively support children and carers to keep them healthy and ensure that they have access to the HIV services they require.
Overview

Social protection and child protection, care and support must underpin efforts to scale up high-impact interventions through the first two decades of life.

Creating an AIDS-free generation is more than a biomedical endeavour. Economic and social drivers of HIV—such as poverty, food insecurity, drug and alcohol use, social marginalization, gender inequality, violence and sexual exploitation, and lack of access to education, including comprehensive sexuality education—need to be addressed concurrently as part of a multisectoral approach to HIV among children.

Efforts to address the needs of children living with HIV, or in households affected by HIV, through comprehensive protection, care and support interventions have not achieved broad coverage. Much greater collaboration across sectors is required. Economic and psychosocial support is particularly important for the estimated 17.8 million [16.1 million–21.6 million] children who have lost one or both parents to AIDS.

Key messages

- Comprehensive social support for children and families affected by HIV is an essential element of the response to HIV. Children and families affected by HIV are often the most vulnerable and marginalized, faced with poverty and social exclusion.
- HIV-sensitive social protection needs to reach households affected by HIV through inclusive targeting approaches.
- Social protection supports HIV outcomes (prevention, treatment, care and support) through complex pathways that need additional mapping.
- HIV-sensitive social protection should be embedded in a comprehensive and integrated developmental policy framework.
- The social protection, care and support programming of the United Nations Children’s Fund (UNICEF) increasingly seeks to ensure an integrated systems approach to responding to children affected by HIV. This involves strengthening of both community and social protection systems and more effectively linking these programmes with the health sector, and strengthening access to and utilization of key programme interventions.

Innovations

- Social protection programmes, particularly cash transfers, appear to be rapidly expanding, with some estimates suggesting they have doubled in
Africa—from 120 programmes implemented between 2000 and 2009 to about 245 programmes in 2012. That year alone, cash transfers might have reached US$ 10 billion. In Zambia, the inclusion of early childhood development in the Education Sector Plan (2012–2015) seeks to expand access to schooling and improve educational quality and equity, especially for orphans, other vulnerable children and children affected by HIV. In India, mechanisms are being put in place to reduce out-of-pocket expenses for people affected by HIV and support access to primary health care, including through call centres coordinating free and low-cost transport.

**Challenges**

- HIV has broad social and economic consequences for children and their families, but orphans and other vulnerable children, including those living in families affected by HIV, frequently do not receive any type of support. Mitigating the impact of HIV on the estimated
  - 17.8 million [16.1 million–21.6 million] of the world’s children who have lost one or both parents to an AIDS-related illness—85% of whom live in sub-Saharan Africa—is a particularly formidable task. While comprehensive social support for children and families affected by HIV is an essential element of the response to HIV, it is frequently an afterthought in many HIV-specific programmes. Stronger linkages between HIV programming and broader national social protection efforts and community-based services are needed to ensure that more children and families receive the support they need.

**Key statistics**

- Globally, 17.8 million children have lost one or both parents to AIDS, and 85% of whom live in sub-Saharan Africa.
- Estimates put the number of children living in institutional settings globally at more than 2 million.

**Background**

Over the past decade, evidence on the impact of social protection programmes on HIV outcomes, as well as on childhood and adolescent well-being, has expanded considerably. In addition, we know much more about which approaches effectively protect, care and support children and families affected by AIDS and about the pathways between multiple childhood deprivations and subsequent HIV outcomes. Social protection programmes are increasingly HIV sensitive, and their rapid scale-up is reaching an increasing number of vulnerable households affected by HIV.
Social protection, care and support programmes enable the response to more effectively address the underlying drivers of the epidemic, reduce the social and economic barriers to universal access, contribute to reductions in new infections, increase treatment uptake and retention and help mitigate the impact of the epidemic.

While scaling up social protection programmes has seen much growth in cash transfers, these are just one intervention in what should be a wider range of social protection, care and support interventions and approaches. Interventions can include the provision of predictable transfers (cash, food or other resources), programmes that increase access to basic services for the most vulnerable, (including combining transfers with the provision of care and support services) and efforts to ensure that policies, frameworks and the legal environment uphold the rights of the most vulnerable and excluded. They can be contributory or non-contributory, conditional or unconditional. Conditional interventions are provided in exchange for a particular action, such as school attendance, or work in public works programmes; unconditional interventions include national health insurance or old age pensions.

**Q&A**

1. **How is the United Nations (UN) addressing the needs of abandoned children?**

   UNICEF has received many inquiries from families hoping to adopt children from countries other than their own. UNICEF believes that all decisions relating to children, including adoptions, should be made with the best interests of the child as the primary consideration. The Hague Convention on International Adoptions is an important development for both adopting families and adopted children because it promotes ethical and transparent processes, undertaken in the best interests of the child. UNICEF urges national authorities to ensure that, during the transition to full implementation of the Hague Convention, the best interests of each child are protected.

   For children who cannot be raised by their own families, an appropriate alternative family environment should be sought in preference to institutional care, which should be used only as a last resort and as a temporary measure. Intercountry adoption is one of a range of care options that may be open to children, and, for children who cannot be placed in a permanent family setting in their countries of origin, it may indeed be the best solution. In each case, the best interests of the child must be the guiding principle in making a decision regarding adoption.
2. What is the UN’s position on children in orphanages or institutions?

The UN’s position on alternative care, which includes children in institutions, is in line with the global Guidelines on Alternative Care adopted by the General Assembly of the United Nations in December 2009: “To ensure that, while such permanent solutions are being sought, or in cases where they are not possible or are not in the best interests of the child, the most suitable forms of alternative care are identified and provided, under conditions that promote the child’s full and harmonious development.”
Community systems strengthening (CSS) is what is required to strengthen and build capacity of a community system to effectively deliver its community response. CSS is often mistaken for the community response to HIV.

A community system is “community-led structures and mechanisms used by communities through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities.” Community systems can range from informal and small scale to extensive networks of organizations.

- A community system response, or community response in general, is the collective of community-led activities in response to HIV. These activities are not limited to service delivery, but also include advocacy by civil society and community networks for policies, programming and investments that meet the needs of communities.
- Participation of civil society in monitoring and reporting on progress made in delivering HIV responses.
- Work by community systems on addressing inequalities and social drivers, which are barriers to universal access.

CSS is an approach that promotes the development of informed, capable and coordinated communities and community-based organizations, groups and structures.

CSS aims to strengthen the role and effectiveness of key populations, community actors and organizations in the design, delivery, monitoring and evaluation of HIV and related services and activities, advocacy and policy, organizational management and development, capacity strengthening, engagement in decision-making processes, and accountability and transparency.

**Key messages**

- CSS is an integral part of the HIV response—it means helping to build the skills and capacities within local civil society groups to strengthen national responses to HIV.
- UNAIDS stands firmly behind efforts to strengthen the community response—and funding for these activities through domestic investments, the Global Fund to Fight AIDS, Tuberculosis and Malaria or other resources is essential.
CSS is not a subactivity of health systems strengthening—its activities go far beyond the health sector to include factors that impact the fostering of an enabling environment, as well as core funding for civil society organizations and work on policy and advocacy initiatives.

Innovations


Challenges

- Limited understanding of CSS amongst governments, health ministries, many nongovernmental and community organizations and other stakeholders.
- Reluctance by some governments to direct investment towards community advocacy, monitoring and accountability activities as well as community organizations and networks of key affected populations.
- The absence of CSS interventions and activities within national strategic plans, or, where and when they are reflected, adequate costing is absent.

Background

The Global Fund’s New Funding Model has led to changes in the way CSS is reflected in concept note development, including use of “measurement frameworks” with various modules. The CSS module will include four interventions:

- Intervention 1: community-based monitoring for accountability.
- Intervention 2: advocacy for social accountability.
- Intervention 3: social mobilization, building community linkages, collaboration and coordination.
- Intervention 4: institutional capacity-building, planning and leadership development in the community sector.
Overview

Condoms, both male and female, are currently the only effective technology that concurrently and effectively prevents HIV and other sexually transmitted infections (STIs), as well as unintended pregnancies. They are inexpensive, cost-effective, easy to store and transport, their use does not require assistance of medical or health-care personnel, and they can be utilized by anyone who is sexually active.

Correct and consistent use of condoms is an integral component of combination HIV prevention strategies and a core programme area in the UNAIDS Investment Framework. Other options include avoiding sex with or reducing the number of sexual partners, voluntary medical male circumcision, pre-exposure prophylaxis (PrEP) and, in the event that a person is living with the virus, and in order to protect their partner, treatment as prevention. No single HIV prevention option is 100% efficacious and, condom use is also recommended for people who are circumcised and/or using PrEP.

Comprehensive condom programming is a means to ensure that people at risk of STIs, HIV and/or unintended pregnancies are motivated to use male and/or female condoms, have access to quality condoms, have accurate condom information and knowledge and use condoms correctly and consistently.

Key messages

- Condoms are an integral and essential part of comprehensive and sustainable HIV prevention and care programmes; their provision and utilization must be promoted.
- Investments in condom programming have stalled and are too low. Governments, donors and development agencies should increase their funding of male and female condoms, which are essential and life-saving commodities, and of condom programmes.
- Governments of low- and middle-income countries should budget for male and female condoms and allocate adequate national financial resources to procure and programme them. Programming should include capacity strengthening for service provision, awareness campaigns (e.g. the CONDOMIZE! campaign), demand creation to stimulate and sustain their use and monitoring and evaluation systems to improve programme delivery and measure the effectiveness and impact of condom use.
Financial resources are needed to conduct operational, behavioural and social research to inform effective national programmes.

Key statistics

- Male condoms reduce HIV incidence during vaginal sex by 80–95% and 70% in anal sex.
- Female condoms are 94–97% effective in reducing the risk of HIV infection when used correctly and consistently during vaginal sex.
- In studies of serodiscordant couples in East Africa, condom use was found to reduce HIV infections by 78% in both sexes. Similarly, a Cochrane review of data on the effectiveness of condoms found that consistent condom use was associated with an 80% lower rate of HIV acquisition.
- Increased condom use reduced HIV incidence among adults in South African by between 23% to 37% from 2000 to 2008, according to modelled estimates.
- Increased condom use is also associated with a large number of HIV infections averted in key populations, for example in the Avahan project among sex workers in India.

Challenges

- In 2012, only eight male condoms were procured by donors for every adult male aged 15–49 years in sub-Saharan Africa. The recommended number of condoms to be distributed or sold in these countries is 30–40 per male per year. Hence, there are large gaps in condom provision.
- In 2012, the major donors spent US$ 97 million and US$ 18.5 million for the procurement of male and female condoms, respectively. The Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, allocated US$ 14.5 million to condom procurement in 2012, approximately 0.1% of its funding for HIV in that year.
- Female condom availability is still extremely poor. In 2012, approximately 32 million female condoms were donor procured worldwide, compared with 44 million in 2011. For sub-Saharan Africa, those figures translate to one female condom for every eight women of reproductive age.
- Local production in Africa is lacking.
The majority of support for condoms is spent on procurement, with a minimal budget for programming, including demand creation.

**Innovations**

- In July 2012, a new design, the Cupid Female Condom, was prequalified in addition to the FC2 by the Female Health Company. This work is ongoing and other new designs are expected to be reviewed and possibly proceed to the inspection stage of prequalification in 2014.
- In 2013, the Bill & Melinda Gates Foundation launched the Condom Grand Challenges Explorations for the development of the next generation of condoms. Winners spanning several countries were selected from over three thousand proposals. Winners represent a wide range of backgrounds and disciplines, including design professionals, health researchers, polymer engineers, entrepreneurs and public–private coalitions. Hundreds of selected projects received US$ 100 000 each in funding to develop further their ideas for about six months. The second phase will award the best ideas with US$ 1 million to complete the research and development, as well as clinical studies of the new condoms.

**Q&A**

1. **Why are condoms so important?**

   Unprotected sexual intercourse is responsible for 80% of new HIV infections. Correct and consistent condom use can significantly reduce the risk of HIV transmission. Male and female condoms are currently the most efficient and available technologies to prevent transmission of HIV and STIs. Male and female condoms are the only triple protection methods, providing protection against HIV, STIs and unintended pregnancies. Condoms, especially male condoms, are, in most countries, widely available, either free or at low cost, through the public, private or social marketing sectors.

2. **Why is condom programming necessary?**

   Supplying condoms is only one quarter of the equation. To be comprehensive, condom programming must address the various components that go into such an effort: leadership and coordination; supply and commodity security; demand, access and utilization; and support.

   It is critical for governments to create an enabling environment among policymakers and service providers so that users will be made aware of their risks, feel free to demand and access male and female condoms and have the knowledge to use them correctly and consistently.
Condoms are also required in humanitarian settings to protect health and avoid intended pregnancies in catastrophic situations.

3. Where have condoms made a difference?

There are many examples worldwide. Thailand’s efforts to de-stigmatize condoms and its targeted promotion for sex workers and their clients dramatically reduced HIV infections in these populations and helped reduce the spread of the epidemic in the rest of the population. Condoms have also been critical in reducing the number of infections in India and South Africa.

4. Why is access to male condoms alone not enough?

There is no magic bullet for HIV prevention. Only a combination of biomedical, behavioural and structural strategies and interventions, including social and behaviour change, PrEP, post-exposure prophylaxis, condom use, treatment, male circumcision, voluntary HIV testing, prevention of mother-to-child HIV transmission and treatment, and an enabling environment free of stigma and discrimination, will reduce new HIV infections in adults and children. Studies have shown that adding female condoms to programmes that are already promoting and distributing male condoms increases the number of protected sex acts. When male condoms are available, women sometimes have limited access to them, and often women lack the power to negotiate the use of male condoms with their partners. Access to female condoms gives women an alternative to protect themselves and their families.
Overview

There were an estimated 2100 new HIV infections among young people every day in 2012, and, in 2013, in the worst-affected region, sub-Saharan Africa, only 28% of young women and 36% of young men responded correctly when asked five questions on HIV prevention and HIV transmission.

It is clear that few young people receive adequate preparation for their sexual lives. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs), including HIV. Many young people approach adulthood faced with conflicting and confusing messages about sexuality and gender. Multiple studies have demonstrated that life skills based HIV and sexuality education programmes significantly increase participants’ knowledge and understanding of HIV transmission and prevention, and positively impact attitudes and behaviours related to safer sexual practices. Good quality comprehensive sexuality education that also addresses harmful gender norms contributes to overall HIV prevention and improves health, education and social outcomes for children and young people.

Key messages

- For young people, effective sexuality education forms the foundation for HIV prevention. While education alone cannot eliminate the risk of HIV, unintended pregnancy or coerced sex, properly designed and implemented programmes can reduce some of these risks and underlying vulnerabilities.
- Effective sexuality education can provide young people with age-appropriate, culturally relevant and scientifically accurate information. It includes structured opportunities for young people to explore their attitudes and values, and to practice the decision-making and other life skills they will need to be able to make informed choices about their sexual lives.
- Education on gender equality, gender norms and young people’s rights are critical to the success of sexuality education.

Innovations

- In December 2013, ministers of health and education from 20 countries in eastern and southern Africa committed to a bold new set of actions and
targets to scale-up comprehensive sexuality education and sexual and reproductive health services for young people. Coordinated action between health and education sectors is the first step to realizing holistic HIV responses that meet the needs of young people.

- The United Nations Educational, Scientific and Cultural Organization’s (UNESCO) Sexuality Education Review and Assessment Tool was developed and applied in 19 African countries during 2012–2013. This participatory tool links national context with global standards, facilitating strategic discussions with education personnel to identify major gaps and actions to strengthen sexuality education.

- A virtual classroom project implemented between 2012 and 2014 in China, Jamaica, Russian Federation and Zimbabwe uses the Internet, mobile telephony and traditional media (TV and radio) to reach young people with HIV and sexual and reproductive health information and advice. Through a partnership with China’s largest search engine, Baidu, 198 million people now have access to online information on sexual health, and, in Zimbabwe, over 10,000 students in six universities are receiving facts and having questions answered on HIV through an interactive SMS system built in partnership with a local nongovernmental organization.

Challenges

- Political will and leadership is crucial for scaling up access to comprehensive sexuality education.

- Investments in teacher training are crucial to ensure classroom delivery of the best quality education, using appropriate methodologies and supporting critical reflection.

- In and out of school sexuality education should be closely linked to affordable youth-friendly sexual and reproductive health services and commodity provision.

- Policies, laws and practices in some countries continue to hinder the delivery of education and services to young key populations and others due to their age or legal or marital status.

Key statistics

- In sub-Saharan Africa, only 28% of young women and 36% of young men have comprehensive and correct knowledge of HIV, an increase of only three percentage points and five percentage points, respectively, in almost a decade. The United Nations General Assembly Special Session target is 95%.
Background
The United Nations and a number of civil society organizations provide technical tools and resources for use at the global and country level. These include the *International technical guidance on sexuality education* (UNESCO, 2009), UNESCO guidance on scaling-up comprehensive sexuality education, European standards on sexuality education (World Health Organization, 2010) and It's All One Curriculum (Population Council, 2009).

Q&A

1. **Why do young people need to learn about sexuality?**
   With an estimated 2100 new HIV infections every day in 2012, addressing the needs of young people is an important part in the AIDS response. Numerous studies show that with the right information and skills, young people can change their behaviour to reduce the risk of acquiring HIV infection. In a world affected by HIV as well as by other STIs, comprehensive, good quality sexuality education for children and young people can potentially be life saving. Moreover, young people are clear in their demand for more—and better—sexuality education, services and resources to meet their sexual and reproductive health needs.

2. **Why should schools get involved in sexuality education—isn’t this the responsibility of parents?**
   Parents and families play a vital role in shaping their children’s sexual and social identities. However, sometimes parents feel uncomfortable discussing sex and sexuality within the family and look for support in this role.
   Schools have an important role to play in preparing children and young people for their adult roles and responsibilities. Educational institutions provide a practical means of reaching large numbers of young people with education about HIV in ways that are replicable and sustainable. Sexuality education should be comprehensive and be offered within the formal school curriculum.

3. **Can we teach young people about HIV without discussing sex?**
   At a minimum, HIV education needs to include information on the virus, its modes of transmission and prevention methods. HIV education must include accurate, non-judgemental, evidence-informed teaching on sex and relationships, condoms and safer sex, simply because 80% of all new HIV infections, including among young people, are sexually transmitted.
Overview

Many countries and legal jurisdictions have adopted HIV-specific laws or invoked general criminal law to prosecute people who allegedly fail to disclose their HIV status prior to sexual relations (HIV non-disclosure), expose others to HIV (HIV exposure) and/or transmit HIV (HIV transmission). The overly broad application of criminal law to HIV non-disclosure, exposure and transmission raises serious human rights and public health concerns.

Because of these concerns, UNAIDS urges states to: (a) concentrate their efforts on expanding the use of proven and successful evidence-informed and rights-based public health approaches to HIV prevention, treatment and care; and (b) limit any application of criminal law to truly blameworthy cases where it is needed to achieve justice. States should strengthen HIV programmes that enable people to know how to protect themselves from HIV and to avoid transmitting it, and they should help people access the services and commodities they need for HIV prevention, treatment, care and support.

Key messages

- Governments should remove laws and end practices that block an effective AIDS response, including overly broad criminalization of HIV non-disclosure, exposure and transmission. Overly broad criminalization may hinder prevention efforts.

  — UNAIDS urges governments to limit criminalization to cases of intentional transmission (i.e. where a person knows his or her HIV-positive status, acts with the intention to transmit HIV and does in fact transmit it).

  — UNAIDS calls on countries to ensure that the criminal law’s response to HIV non-disclosure, exposure or transmission is informed by the latest available scientific and medical evidence relating to HIV.

- Criminal law should not be applied to cases where there is no significant risk of transmission or where the person: did not know that she or he was HIV-positive; did not understand how HIV is transmitted; disclosed his or her HIV-positive status to the person at risk; did not disclose his or her HIV-positive status because of fear of violence or other serious consequences; took reasonable measures to reduce risk of transmission, such as practising safer
sex through using a condom or other precautions to avoid higher risk acts; or previously agreed on a level of mutually acceptable risk with the other person. In addition, the criminal law should not apply where an individual living with HIV is unable to transmit HIV because of a low viral load, including as a result of HIV treatment. Countries should ensure that the criminal law takes into account strong evidence of treatment’s significant prevention dividend.

- Prosecutorial and police guidelines are a useful tool for limiting overly broad criminalization.

Innovations

- During 2010 and 2011, Guinea, Togo and Senegal reviewed or adopted HIV-related legislation to restrict the use of the criminal law to exceptional cases of intentional transmission of HIV. On 30 May 2014, Iowa became the first of the 34 states and territories of the United States of America with HIV-specific criminal laws to amend it.

- In May 2013, UNAIDS published a new Guidance Note, *Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations*, which provides clear information to countries on how to ensure that any application of criminal law in the context of HIV is based on the best available scientific evidence and achieves justice without jeopardizing public health responses.

- In the past few years, a number of scientific and medical entities and experts have published opinions and consensus statements calling for reconsidering the application of the criminal law in the context of HIV. Such statements and opinions were issued in 2008 in Switzerland by the Swiss *Commission fédérale pour les problèmes liés au sida*, in 2013 in the United Kingdom of Great Britain and Northern Ireland by the British HIV Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA), and in May 2014 in Canada by more than 70 scientific experts working on HIV across the country.

- England and Wales was the first legal jurisdiction to introduce prosecutorial guidelines in 2008 and to develop police guidelines in 2010. In 2012, Scotland also published its prosecutorial guidelines. A number of other jurisdictions are also considering the development of such guidelines.
Challenges

- Misconception, fear and prejudice continue to drive much of the criminal law’s response to HIV, thus leading legislators and courts to ignore scientific evidence about HIV and disregard basic criminal law and justice principles.

Key statistics

- At least 63 countries have laws that specifically criminalize HIV transmission or exposure.
- Some 33 states and territories of the United States have HIV-specific criminal laws that apply to HIV non-disclosure, exposure or transmission.
- The overwhelming majority of known prosecutions and convictions for HIV non-disclosure, exposure and transmission have occurred in 30 jurisdictions (mainly high-income countries).
- Some 22 African countries have laws that specifically criminalize HIV non-disclosure, exposure and transmission, although little information exists on their actual enforcement.

Q&A

1. What is meant by the “criminalization of HIV transmission”?  
   This expression is often used to describe the application of criminal law to cases where individuals fail to disclose their HIV status prior to sexual relations (HIV non-disclosure), expose others to HIV (HIV exposure) and/or transmit HIV (HIV transmission). Although generally used in relation to cases involving sexual acts, the criminal law may also be invoked for cases linked with other modes of HIV transmission, such as injecting drug use, mother-to-child transmission or occupational transmission (e.g. health-care providers who transmit HIV in the workplace).

   In the past decade, criminal cases relating to sexual exposure to, or transmission of, disease have been related almost exclusively to HIV, while other more infectious or similarly life-threatening conditions are often not prosecuted. This has generated concerns that the strict treatment of HIV by the criminal justice system is motivated by public fear and prejudice about HIV and people living with HIV.

2. What are the reasons behind the criminalization of HIV non-disclosure, exposure or transmission?  
   There are two main claims for criminalizing HIV non-disclosure, exposure and transmission: to punish harmful conduct by imposing criminal penalties and to prevent HIV transmission by deterring or changing risk behaviours.
UNAIDS does not believe that the application of criminal law in the context of HIV supports prevention goals. In rare cases of intentional HIV transmission, the application of criminal law may serve justice by imposing punishment for truly blameworthy acts. However, UNAIDS is concerned that the overly broad application of criminal law will negatively affect programmes seeking to widen access to HIV testing, counselling and treatment. In situations apart from intentional transmission, UNAIDS believes criminal prosecution is not warranted.

3. Why is UNAIDS concerned about the overly broad criminalization of HIV non-disclosure, exposure or transmission?

Although the overall number of people prosecuted or convicted may appear small (600 convictions worldwide), these cases often involve miscarriages of justice for the individuals prosecuted and have wider social impact through sensational media coverage that spreads misinformation and stigma about HIV and people living with HIV.

Overly broad criminalization may hinder prevention efforts by making people afraid to learn or disclose their HIV status and/or access HIV-related treatment and by damaging the privileged nature of relations between patients and healthcare practitioners, as medical records could be used as evidence in HIV-related criminal cases.

4. How is UNAIDS and the United Nations family addressing this issue?

UNAIDS has been providing policy advice on this issue since 1996, having to date released guidance with the United Nations Development Programme and the Inter-Parliamentary Union. UNAIDS is working to dissuade governments in several countries from passing overly broad criminal provisions. The UNAIDS Secretariat, with support from the Government of Norway, has conducted a project to inform a more appropriate application of criminal law to HIV non-disclosure, exposure and transmission. The project comprised:

- The development of background and technical papers on current laws and practices, as well as recent medical and scientific developments that are relevant to the criminalization of HIV non-disclosure, exposure and transmission.

- An expert meeting (convened between 31 August and 2 September 2011 in Geneva, Switzerland) that brought together scientists, medical practitioners and legal experts in order to consider the latest scientific and medical facts about HIV that should be taken into account in the context of criminalization and to explore how to best address issues of harm, risk, intent and proof—including alternative responses to criminalization—in the light of this science and medicine.
A high-level policy consultation, jointly convened by the Government of Norway and UNAIDS in Oslo on 14 and 15 February 2012, that gathered policy-makers from around the world to discuss options and recommendations for addressing the criminalization of HIV non-disclosure, exposure and transmission.

Evidence and best practices gathered throughout this project have informed the development of the UNAIDS Guidance Note *Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations*, issued in May 2013.

The report of the Global Commission on HIV and the Law also includes specific recommendations addressing the overly broad criminalization of HIV non-disclosure, exposure and transmission.

5. **Does UNAIDS support legal frameworks that require people to disclose their status?**

UNAIDS does not support a legal obligation to disclose one’s HIV-positive status. Everyone has the right to privacy and should not be required by law to reveal such information. However, all people have the ethical obligation not to harm others. As agreed in the 2006 United Nations Political Declaration on HIV/AIDS, and reiterated in the 2011 United Nations Political Declaration on HIV and AIDS, governments should provide HIV programmes that empower people living with HIV to practice safer sex and/or voluntarily disclose their status in safety, free from fear of violence and stigma and discrimination.
Overview
The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (Global Plan) set ambitious targets for 2015, including:

- Reducing the number of newly acquired HIV infections among children by 90%.
- Reducing the number of women living with HIV dying of pregnancy-related causes by 50%.

The Global Plan also aspires to reduce AIDS-related paediatric deaths by 50%. The indicators are assessed from a baseline of 2009.

Since the launch of the Global Plan, governments have been translating these targets into the expansion of HIV prevention, treatment, care and support services for women and children, acknowledging the necessity of not only averting mother-to-child transmission as a first step, but also assuring that children and mothers living with HIV get the treatment they need to continue to live long and healthy lives.

Key messages

- We believe that children everywhere can be born free from HIV and their mothers remain healthy.
- We believe that countries can galvanize and intensify their efforts to reduce new HIV infections significantly by the end of 2015. Already many countries have accomplished feats that were considered impossible, and show the political resolve of leaders, the commitment of communities, and the dedication of health-care workers.
- Elimination of new HIV infections among children is a political priority for countries.
- More than 90% of new HIV infections among children occur when women are inadequately supported during pregnancy and breastfeeding. With the right care, respect and support for women with HIV, mother-to-child transmissions are almost 100% preventable.
- The Global Plan has the backing of countries, international organizations, civil society and networks of people living with HIV.
Services to prevent mother-to-child transmission are now more widely available.

— In 2013, over two thirds (69%) of all pregnant women living with HIV in the 21 high-burden countries in Africa received efficacious regimens to prevent transmitting the virus to their child during pregnancy and delivery, compared to 34% in 2009. Virtually all the 21 countries have also transitioned into triple antiretroviral medicines for pregnant women, and are phasing out dual antiretroviral prophylaxis (option A).

— Countries such as Botswana, Namibia, South Africa and Swaziland are already providing more efficacious treatment regimens to over 90% of pregnant women living with HIV. Others, such as Côte d’Ivoire, Malawi, Mozambique, Uganda, Zambia and Zimbabwe, are reaching over 75% of pregnant women living with HIV with treatment or prophylaxis. Despite these improvements, coverage of prophylaxis during breastfeeding remains low. Consequently, in 2013 around two thirds of HIV transmission to children was due to breastfeeding. There is an urgent need to make breastfeeding safer for women living with HIV, because without breastfeeding the likelihood that the child will die of other causes increases.

Antiretroviral therapy reduces the risk of HIV transmission and saves children’s lives.

— Between 2009 and 2013, eight of the 21 highest-burden countries in sub-Saharan Africa—Botswana, Ethiopia, Ghana, Malawi, Namibia, Mozambique, South Africa and Zimbabwe—registered declines of 50% or more in the number of new HIV infections among children.

— Worldwide, the number of newly infected children in 2013 was 240 000, which was 40% less than in 2009, and 60% less than when the number of children acquiring HIV infection peaked at 570 000 [520 000–650 000]. Among the 21 highest-burden countries in Africa, there has been a 46% decline in new HIV infections among infants since 2009 (the baseline year for the Global Plan).

— With accelerated efforts, the number of children acquiring HIV infection can probably be reduced even more significantly between now and 2015.

There is a gradual decline in the number of new HIV infections among women.

— Among 21 of the 22 highest-burden countries, there has been a gradual decline in HIV incidence among women 15–49 years old, compared to 2009. However, the number of women in need of prevention of mother-to-child transmission services has only declined from 1.6 million to 1.5 million, as a result of population expansion, the survival benefit of treatment, and the desire of women living with HIV to have children given the success of prevention of mother-to-child transmission programmes.
Despite the progress, transmission rates remain high in many countries.

— The average final mother-to-child transmission rate declined in the 21 high-burden countries in Africa, from 26% in 2009 to 17% in 2013. The risk can be reduced to less than 5% if coverage of prevention of mother-to-child transmission services is increased above 90% and nursing mothers living with HIV receive HIV prophylaxis or treatment during breastfeeding.

— Among countries, Botswana and South Africa record the lowest mother-to-child transmission rates in 2013. However, most countries have registered only minimal changes in the transmission rate in the preceding year, suggesting a stalling of progress that is consistent with the stalling of antiretroviral therapy coverage.

More post-partum women living with HIV are receiving antiretroviral therapy during breastfeeding. In 2013, 67% of pregnant women living with HIV were receiving treatment to prevent mother-to-child HIV transmission during pregnancy, and 61% received treatment during breastfeeding. While encouraging, the results suggest that still nearly 40% of breastfeeding women living with HIV did not receive antiretroviral medicines during breastfeeding, placing their children at heightened risk of transmission.

Children are not benefiting as much as adults are. The WHO 2013 consolidated guidelines on the use of antiretroviral medicines for treating and preventing HIV infection recommend that all children younger than five years living with HIV should receive antiretroviral therapy; for children older than five years, the criteria for initiating antiretroviral therapy are the same as for adults. In 2013, only 24% of children under 15 years living with HIV were receiving antiretroviral therapy, compared to 36% of adults. The health benefits of HIV treatment are magnified. Beginning antiretroviral therapy before the twelfth week of life reduces HIV-related mortality in children living with HIV by 75%. And without treatment, 50% of infants who acquire HIV will die by their second birthday.

Co-trimoxazole prophylaxis is essential for improving survival among HIV-exposed children and children living with HIV. Since 2006, WHO has recommended that it be included an essential part of the HIV care package. However, in 2013, only less than half of HIV-exposed infants in the low- and middle-income countries that reported these data received co-trimoxazole. Stronger efforts are required to increase coverage of this feasible, well-tolerated, cost-effective life-saving intervention for children living with HIV.

Countries are moving to provide more effective regimens.

— Countries are rapidly adopting the 2013 WHO guidelines, which recommend a single, universal triple antiretroviral regimen both to treat pregnant women living with HIV and to prevent mother-to-child transmission of HIV. Substantial
advantages can come from this regimen, which provides treatment for women living with HIV and at the same time prevents mother-to-child transmission of HIV. The regimen is commonly dubbed as option B, and comprises the first-line recommended adult treatment for HIV. It is taken by the woman during pregnancy through breastfeeding, and can be stopped when the risk of transmission to the baby stops (i.e. after the end of breastfeeding).

— In high-fertility regions, women may conceive within a short time, and stopping and starting the antiretroviral medicines becomes complicated. Faced with this challenge, Malawi decided to offer pregnant women treatment for life, rather than to stop and start and stop. This is approach, commonly referred to as option B+, improves outcomes even more. It not only begins treatment with triple therapy for all pregnant women living with HIV as soon as they are tested, but also continues this treatment for life. Important advantages of option B+ include: further simplification of regimen and service delivery and harmonization with treatment programmes, protection against mother-to-child transmission in future pregnancies, and continuing a prevention benefit against sexual transmission of HIV to serodiscordant partners.

- Many women are still in need of family planning to avoid unintended pregnancies but lack access.

— In 17 of the 22 highest-burden countries, 20% or more of women interviewed in household surveys said they would like to delay pregnancy or end childbearing altogether, but were not using contraception. This includes countries such as Uganda (38%) and Ghana (35%).

- Women living with HIV have the right to bear children, free of stigma and discrimination. Access is required to the highest attainable standard of health including health services that are free of sexual and reproductive health and rights violations.

- Simplify the prevention of mother-to-child transmission approach by moving towards a single, more efficacious regimen for all pregnant women living with HIV. This can enhance the lifesaving potential of prevention of mother-to-child transmission programmes by using streamlined testing and treatment to protect more mothers and babies. This action would also effectively phase out single-dose nevirapine.

- Appreciating that communities are central to the success of ending mother-to-child transmission of HIV by ensuring that women and their babies are not lost from services. This means working with women, men and the extended family to ensure attendance at services, adherence to treatment and links to ongoing care and support services.
Innovations

Over the past two years, this effort has been buttressed by rapid innovation in the field of the prevention of mother-to-child transmission of HIV. Chief among them has been improvement in life-long antiretroviral therapy, now possible with one pill a day. This simplified regimen is one of the landmark components of the WHO 2013 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO now recommends that pregnant women be offered lifelong treatment immediately on confirmed HIV diagnosis, as the regimen prevents vertical transmission during pregnancy, labour and delivery, but also during breastfeeding, while enabling women to start treatment before they are severely immune-compromised. Equally significant has been the recommendation that all children five years and under be started on antiretroviral therapy immediately upon confirmed HIV diagnosis, largely due to the rapid deterioration they incur if they do not get treatment.

There is greater awareness of how HIV interacts with the immune system of infants who receive early and aggressive HAART, even though the recent case of a functionally cured baby in Mississippi has relapsed. However, the possibility of a cure has highlighted the need for even earlier diagnosis for infants, including testing and birth.

Key statistics

- In low- and middle-income countries in 2013, an estimated 1.5 million [1.3 million–1.6 million] women living with HIV were pregnant, and 69% received effective antiretroviral medicines to avoid transmission to the child, an increase of 50% since 2009.
- A target of the Global Plan is that 90% of pregnant women living with HIV receive antiretroviral medicines by the end of 2015, and the data show much work still lies ahead. In most affected sub-region, eastern and southern Africa, 73% of all pregnant women living with HIV in the 21 high-burden countries received efficacious regimens to prevent transmitting the virus to their child during pregnancy and delivery, compared to 34% in 2009. However, in all low-and middle-income countries, only 40% of pregnant women living with HIV were tested for HIV.
- Of the 3.2 million children living with HIV, 91% live in sub-Saharan Africa, 7% in Asia and the Pacific, and the remaining 3% in the rest of the world.
- Between 2009 and 2013, eight of the 21 highest-burden countries in Africa registered declines of 50% or more in the number of new HIV infections among children. Another five countries have registered declines of 40–49%, while the remaining countries have registered a decline of less than 40%
Among the 21 Global Plan priority countries in sub-Saharan Africa, the number of children newly infected decreased from 360 000 [320 000–420 000] in 2009 to 199 000 in 2013; a 46% drop. This also marks the first time the number of new paediatric HIV infections fell below 200 000 since the early 1990s.

Without access to antiretroviral prophylaxis, between 33% and 45% of infants born to women living with HIV will become infected with HIV, depending on the duration of breastfeeding.

Globally, 24% of children in 2013 received antiretroviral therapy, compared to 9% in 2009. However, 38% of adults in need received antiretroviral therapy in 2013.

Some 190 000 children under the age of 15 years died from AIDS-related illnesses in 2013, more than 500 children a day.

The estimated number of HIV-positive women who died declined from 550 000 in 2009 to 380 000 in 2013.

The number of women dying of AIDS-related illnesses during pregnancy remains high in some countries. For example in South Africa, 41% of maternal deaths were related to AIDS-related illnesses.

Q&A

1. **What are the barriers that keep women from accessing prevention of mother-to-child transmission services?**

   Stigma, discrimination and human rights abuses: women living with HIV are vulnerable to human rights abuses, particularly when they become pregnant. These can include mandatory testing, with no confidentially and no pre- or post-test counselling; coerced contraception, abortion or sterilization; verbal and other abuse on diagnosis; and disclosure to relatives without permission.

   Insufficient community engagement: full engagement of the community in understanding the issues faced by women with HIV is important to overcome everyday barriers such cost, distance to services, transportation, child care, lack of facilities within local areas, as well as complicated processes that ask women to return several times.

   Gender inequality: addressing gender inequalities, including harmful societal gender norms and stigma that can evoke violence, which hinders the utilization of services.
Insufficient training: training of health workers and community based organizations in human rights-based policies and programmes will enhance prevention of mother-to-child transmission success.

2. **What is the percent of pregnant women who know their HIV status?**

WHO recommends that all pregnant women be offered an HIV test as part of the basic package of services for antenatal care. Testing is the key first step and entry point to services for prevention of mother-to-child transmission of HIV. Still, many women do not know their HIV status. In 2013, only 46 percent of pregnant women received an HIV test in low- and middle-income countries. Even in regions with generalized epidemic such as western and central Africa, only a third of pregnant women received an HIV test in 2013.
Overview

Food and nutrition enhances adherence to HIV and tuberculosis (TB) treatment and increases the effect of the treatment. Through increased adherence to HIV and TB treatment and better treatment outcomes, food support and nutrition decreases the development of drug resistance and reduces the need for more costly second-line therapies. Food and nutritional support, including early infant feeding guidelines, are critical components of the prevention of mother-to-child transmission of HIV. The provision of long-term and predictable supplies of effective food and nutritional support requires planning and coordination of human and financial resources and investment.

Key messages

- Nutrition and food assistance can support treatment uptake, adherence and treatment durability. HIV has profound consequences on nutritional status. HIV infection compounds malnutrition through its effect on metabolism and the ability to ingest and digest food. Good nutrition helps people on treatment to recover from malnutrition, tolerate drugs and manage side-effects. Nutrition and/or food support, therefore, should be an integral part of HIV and TB treatment regimens and broader AIDS responses.

- Evidence exists to support the link between nutritional support and treatment success. Improving nutritional status around the start of treatment is an important factor in reducing early mortality. People living with HIV who start antiretroviral treatment malnourished are two to six times more likely to die in the first six months of treatment than those who have a normal body mass index (BMI).

- Programmes that support food security can help to reduce the likelihood of negative coping strategies, including transactional sex, re-allocation of household labour, including withdrawing children from school, and selling household assets (e.g. livestock, agricultural equipment), which lead to even worse poverty and migration. Protecting and promoting basic consumption, including food, is thus an integration component of the AIDS response.

- The World Food Programme (WFP), UNAIDS and the United States President’s Emergency Plan for AIDS Relief (PEPFAR) recommend a number of interventions: people living with HIV and TB need to be given the tools to manage their own nutritional status. To this end, nutrition assessment
and counselling need to be integrated into the treatment process. The assessment of nutritional status allows identification of problems early, education provides the client with the necessary information about his or her body’s needs and good nutrition practices with counselling helps the client apply what she or he has learned to his or her personal nutritional status.

Innovations

- Linking health systems with food and nutrition programmes is important. WFP’s new partnership with the United Nations Population Fund and the United Nations Children’s Fund for improving nutrition in pregnant and breastfeeding women and adolescent girls combines work in several key areas. Specifically, nutrition in programming for pregnant and breastfeeding women and adolescent girls can be HIV-sensitive and contribute to the HIV response by generating benefits across the following areas:
  - Prevention: supporting prevention of mother-to-child transmission programmes and initiatives targeting adolescent girls.
  - Treatment effectiveness: nutritional recovery and treatment success through nutritional rehabilitation of malnourished people living with HIV under antiretroviral therapy and/or TB treatment, food assistance to their households.
  - Access to broader HIV care and support: food and nutrition support as enablers for access and retention in HIV care and support, including psychosocial support in support groups of people living with HIV, linkages with livelihood programmes, food assistance to affected households.

- With PEPFAR funding, WFP supports an Ethiopian Government initiative for malnourished people living with HIV in some of the country’s poorest regions. In addition to nutrition assessment and counselling, as well as providing cash or food vouchers to people on antiretroviral therapy, the programme, through its economic strengthening component, also trains people on how to set up small businesses so they can get back on their feet economically and stave off malnutrition.

Challenges

- One of the main challenges is the lack of attention to HIV care and support, owing to limited investment in critical enablers and wrap-around services, including food and nutrition.
- Technical assistance to integrate food and nutrition in national strategic plans is often relegated in the list of priority activities. It is difficult to advocate for
food and nutrition to be integrated in national strategic plans when governments do not understand the value of these interventions for treatment success and improved adherence.

**Key statistics**

- In 2013, WFP supported 1.3 million people infected and affected by HIV and TB in 31 countries.
- In 2012, 162 million children less than five years of age were stunted.
- In 2012, 51 million children less than five years of age were wasted (8%) and 17 million (3%) had severe wasting.

**Background**

The HIV epidemic and TB are both distributed in geographic regions already experiencing low dietary quality and quantity, and a high malaria burden, in particular in sub-Saharan Africa. Both HIV and TB infection compound the impact of malnutrition on health by increasing nutritional needs at a time when food intake and nutrient absorption is often reduced. This vicious cycle is made worse by the impact of HIV and TB on household food and nutrition security and depletion of household resources.

**Q&A**

1. **Who may need food and nutritional support?**

   Nutrition assessment and counselling are important for all people living with HIV and TB patients. Additional support with food supplements can be provided for different purposes, in different forms, using different delivery modes, for varying duration, and to different groups, including:

   - People living with HIV who cannot meet their nutrition requirements but who are not yet eligible for treatment or who do not have access to it.
   - Malnourished people living with HIV who have just started treatment.
   - Malnourished TB-DOTS clients.
   - HIV-positive pregnant women and women who are breastfeeding.
   - HIV-exposed infants.
   - Young children living in HIV-affected households.
   - Food insecure, HIV and/or TB-affected households.
2. How can food and nutrition support help overcome barriers to treatment?

People living with HIV and TB patients can face multiple barriers—poverty, food insecurity and stigmatization—to seeking a diagnosis and accessing and adhering to antiretroviral treatment. A well-designed food and nutrition intervention helps overcome these barriers.

As treatment coverage increases, more attention needs to be paid to adherence and prevention of loss to follow-up, which is already emerging as a major, often poorly understood, challenge. Integrated food and nutrition services at both the health sector and community levels are critical to helping overcome barriers to treatment adherence, and should be considered as part of a comprehensive package of care. As enablers of treatment adherence, such services can ensure scarce resources are spent effectively while preventing the development of resistance to treatment.
Overview
UNAIDS and the World Health Organization (WHO) recommend developing and increasing programmes that support couples receiving voluntary HIV testing and counselling together and facilitate mutual disclosure.

Couples HIV testing and counselling (CHTC) with mutual disclosure of HIV status has many advantages, including supporting uptake and adherence to treatment and prevention of mother-to-child transmission of HIV, as well as prevention of HIV transmission in serodiscordant couples.

For couples that are serodiscordant, treatment should be offered to the partner with HIV to prevent transmission, including support for safer conception and to prevent transmission from mother to child.

Key messages
- There are many benefits for couples testing together and sharing their HIV status. Couples and partners should be offered voluntary HIV testing and counselling with support for mutual disclosure. Couples and partners in antenatal care settings should be offered voluntary HIV testing and counselling with support for mutual disclosure. CHTC with support for mutual disclosure should also be offered to people with known HIV status and their partners.
- Treatment for prevention is effective and should be offered as one of the prevention options for serodiscordant couples. People living with HIV in serodiscordant couples and who are on treatment for their own health should be advised that treatment is also recommended to reduce HIV transmission to the uninfected partner. HIV-positive partners in serodiscordant couples should be offered treatment to reduce HIV transmission to uninfected partners, regardless of CD4 count.

Key statistics
- Currently, only about 45% of people living with HIV globally know their HIV status, and up to 50% of HIV-positive people who are in ongoing relationships are in serodiscordant relationships. Of the HIV-positive people
who know their status, many have not disclosed to their partners, nor do they know their partners’ HIV status. Consequently, a significant number of new infections occur within serodiscordant couples.

- CHTC offers couples the opportunity to test, receive their results and mutually disclose their status in an environment where support is provided by a trained counsellor or health worker. A range of HIV prevention, treatment, and support options—depending on the status of each partner—can then be discussed and decided upon together.

- Evidence from the HPTN 052 trial has confirmed the benefit of early treatment for people with a CD4 count >350 cells/µL in preventing transmission to HIV-negative partners. In order to benefit from such opportunities, couples need to test together and receive counselling, information and support to disclose their status to each other and access prevention and treatment services.

Q&A

1. **What difference will these new CHTC recommendations make?**

   Offering CHTC to couples could be an important way to increase access to and coverage of testing, enabling earlier treatment and improving HIV prevention.

   Support to encourage testing of the partners of people living with HIV is an efficient and effective way of identifying people living with HIV who can benefit from treatment, as at least half of the partners of people living with HIV will have HIV themselves. Currently, a significant proportion of people access treatment late, limiting the effectiveness of the treatment. Moreover, in most high HIV-burden countries, a greater proportion of women than men currently test and access treatment. This is attributed to women’s more frequent contact with medical services and the scale-up of provider-initiated counselling and testing for pregnant women. CHTC could increase access to earlier treatment and reach more men.

   It is estimated that as many as half of people living with HIV who are in a long-term sexual relationship have an HIV-negative partner. Recent data suggest that a large proportion of new HIV infections in epidemics where the primary contributor to the scale of the epidemic in the region is heterosexual transmission and the unequal vulnerability and risk of adolescent girls and young women to HIV occur within these serodiscordant relationships. This occurs partly because the majority of people in relationships are unaware of their own or their partner’s HIV status. Thus, many are unknowingly vulnerable to HIV. The vast majority of people who test do so as individuals and do not
share the results with their partners. In general, serodiscordance is poorly understood by the general population and health workers alike. CHTC will allow people in serodiscordant relationships to be aware of this and take preventive measures, including treatment, to prevent HIV transmission. To date, the response to HIV has been largely individualistic and there has been little attention paid to interventions for couples.

CHTC with mutual disclosure has a range of other potential benefits, such as increased uptake and adherence to interventions for prevention of mother-to-child transmission of HIV and increased support for adherence to treatment.

In the few countries that have introduced CHTC in a systematic and well-planned way, such as Rwanda and Thailand, it has been an acceptable and effective way in increasing testing and access to prevention and care.

Increasingly, countries recommend or consider treatment to reduce HIV transmission in serodiscordant couples, including in Africa, in Lesotho, Malawi, Kenya, Uganda, Zambia and Zimbabwe, and widely across Asia and Latin America. For example, in China immediate treatment is offered to all married HIV-positive people in serodiscordant couples.

2. What are the implications of starting treatment earlier than the current WHO CD4 eligibility thresholds?

It is important for every person to consider his or her options before starting lifelong treatment. These include the potential risks and benefits of starting treatment earlier. No results are currently available from randomized controlled trials comparing starting treatment with a CD4 count >500 cells/µL versus delaying treatment initiation until the CD4 count is <500 cells/µL.

Although there is evidence from observational studies showing that earlier treatment initiation has beneficial outcomes, these data must be balanced with concerns regarding toxicity and the potential of developing drug resistance.

Decisions to take treatment should be made by the individuals concerned in consultation with partners, family and medical providers.

3. With limited resources for HIV, should early treatment for prevention in serodiscordant couples be prioritized?

There are equity concerns about offering earlier treatment to serodiscordant couples (i.e. by expanding treatment indications) when in many places large numbers of patients that meet clinical criteria for treatment are currently untreated. When making a global recommendation on a health intervention, there is always the understanding that there will be issues of cost and feasibility
that vary with context. Countries and programmes will often have to make
difficult choices when resources are limited. In situations of limited or inadequate
resources, individuals who require treatment for their own health should always
be given priority.

4. What is the relevance for men who have sex with men, people who inject
drugs or sex workers in the CHTC guidelines?

It is likely that these recommendations will also have a significant effect on
reducing HIV transmission among other populations, including men who have
sex with men, sex workers, people who inject drugs and transgender people,
and therefore apply to all couples/partnerships.
HIV AND DISABILITY
[Source: UNAIDS—Helena Nygren-Krug: nygrenkrugh@unaids.org]

Overview
Over a billion people are living with a disability; four fifths in low- and middle-income countries. Growing HIV prevalence data indicates that people with disabilities are at an equal, if not increased, risk of acquiring HIV in some countries, owing to various socioeconomic and sociocultural barriers. People living with HIV, in turn, are at risk of developing impairments that can lead to disability as a result of opportunistic infections or treatment, owing to toxicity and associated adverse reactions and sometimes poor absorption of antiretroviral medicines.

The UNAIDS 2011–2015 Strategy sets out the UNAIDS’ commitment to advance comprehensive and non-discriminatory health services for all.

Key messages

- Universal access means that no one is excluded from having access to life-saving HIV prevention, treatment, care and support services, but too often, people with disabilities are invisible in national HIV programmes and their specific needs are ignored. People with disabilities must be included in the development of national strategic plans, and budget line allocation must be made for programmes targeting people with disabilities. People with disabilities have a right to participate in developing frameworks, strategies and plans for getting to zero.

- The assumption that people with disabilities are not vulnerable to HIV because they are not sexually active or are less likely to inject drugs is costing lives. Poor access to sexual and reproductive health services, and adequate HIV prevention, testing and treatment services, means that they are less likely to have the knowledge or the means to protect themselves.

- Violence against people with disabilities is a significant public health and human rights issue. Women and girls, in particular, are more vulnerable to sexual violence or abuse.

- Double burden of stigma and discrimination: people with disabilities may face double stigma and discrimination if they are also living with HIV. All countries must ensure they have laws and policies that promote zero tolerance for discrimination against any person on the basis of disability or HIV status.
Challenges

- National HIV programmes and national strategic plans seldom include the context of disability, with many failing to address HIV-related disability altogether. Moreover, people with disabilities are rarely included in consultation processes to develop such programmes and plans, hence the needs of people with disabilities are rarely considered when formulating national HIV policies and programmes.
- There is a lack of comprehensive and systematic data detailing the link between disability and vulnerability to HIV, a problem compounded by the dynamic and inclusive definition of disability as set out in the Convention on the Rights of Persons with Disabilities (CRPD).

Key statistics

- Around 15% of the world’s population lives with some form of disability. This number is increasing owing to a rise in chronic diseases (including HIV), injuries, ageing and violence.
- People with disabilities have a 50% higher chance of having suffered violence in the past year, raising to a threefold increased risk for people with mental health conditions.

Background

The 2011 United Nations Political Declaration on HIV and AIDS welcomed “the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) and recognized the need to take into account the rights of people with disabilities as set forth in that Convention, in particular with regard to health, education, accessibility and information, in the formulation of our global response to HIV and AIDS.” It also noted with concern that “prevention, treatment, care and support programmes have not been adequately targeted or made accessible to people with disabilities.” Moreover, United Nations Member States committed “to address factors that limit treatment uptake … inaccessible transportation to clinical sites, lack of accessibility of information, resources and sites, especially for people with disabilities.”

Q&A

1. What are the implications of the CRPD for the HIV response?

   The CRPD, adopted in 2006, has important implications for protecting the rights of people with disabilities within the context of HIV and creates a detailed framework of protection for people living with HIV as well as people affected by HIV, such as children who have lost parents to an AIDS-related
illness or family members of people living with HIV. Relevant CRPD provisions include the right to health, equality and non-discrimination, accessibility, participation, education, respect for privacy, freedom from violence and abuse, freedom to receive and impart information, and the right to marry and found a family. The principle of reasonable accommodation obliges states to take positive measures to ensure that people with disabilities are able to access public health services of any kind. In the context of HIV, it means designing HIV services tailored for the needs of people with disabilities so that they can access prevention, treatment, care and support.

2. What is UNAIDS’ position on the link between disability and HIV?

People with disabilities often lack access to HIV knowledge and services. They are more likely to be poor and isolated from the community. And they are in greater danger of sexual exploitation. It is, therefore, imperative that people with disabilities are included as participants in developing national HIV programmes and strategic plans and that these are designed and implemented taking into account the needs and concerns of people with disabilities.

3. How is UNAIDS addressing the link between HIV and people with disabilities?

UNAIDS is working to ensure the specific needs of people with disabilities are reflected in national HIV programmes. At the country level, United Nation joint teams on AIDS provide technical support to national counterparts in ensuring mechanisms for inclusion and participation of people with disabilities.

To strengthen this work, and building on an Issues Brief developed in 2012 on integrating disability into HIV programmes launched at the International AIDS Conference in Washington, DC, efforts are under way to develop a UNAIDS Strategy for Integrating the Needs of People with Disabilities into the HIV Response. This is being developed in close consultation with civil society groups, including groups representing people with disabilities and people living with HIV. UNAIDS welcomes input in this process. It is expected it will be finalized by December 2014.
Overview

- The HIV epidemic driven by the sharing of drug injecting equipment is among the fastest growing in the world. People who inject drugs have multiple vulnerabilities to HIV, hepatitis, tuberculosis (TB) and other infectious diseases.
- Sharing of drug injecting equipment can be three times more likely to transmit HIV than unsafe sexual intercourse.
- People who use drugs are highly stigmatized, even by many health care workers.
- People who use drugs are often unable or unwilling to access HIV services for fear of discrimination and harassment.
- People who use drugs often face incarceration for possession of drugs, injecting equipment and/or sex work.
- People who use drugs often experience violence, including sexual violence.

Key messages

- Human rights, gender and public health considerations must be at the centre of drug and criminal justice laws, policies and practices to stop stigma and discrimination against people who use drugs.
- Meaningful involvement of people who use drugs in the HIV response is critical.
- Providing a comprehensive package of HIV services for people who inject drugs can stop the spread of HIV among this population group.
- Greater domestic investments in harm reduction services for people who inject drugs are required to reach the target of reducing HIV infections among people who inject drugs by 50% by 2015.
- Harm reduction interventions are good value for money. There is compelling evidence of the cost-effectiveness for each of the three interventions, needle–syringe programmes, opioid substitution therapy (OST) and antiretroviral therapy (ART), across all regions of the world.
- Stimulant drug use, both non-injecting and injecting, among certain subgroups of key populations has been associated with transmission of HIV.
Innovations

- New guidance available for implementers include training guidelines for law enforcement officials on providing HIV services for people who inject drugs, a policy brief to address the specific needs of women who inject drugs and a practical guide on interventions addressing their needs, and a handbook to starting and managing needle–syringe programmes in prisons and other closed settings.

- For the first time, in June 2014 the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), UNAIDS and the World Bank released joint estimates on the number of people who inject drugs and on HIV prevalence.

- In order to help countries reach the 2011 United Nations Political Declaration on HIV and AIDS target of reducing by 50% the number of new HIV infections by 2015, UNODC is providing technical assistance to 24 high-priority countries to produce strategic information, identify gaps, build capacities and review policies and legislation. UNODC advocates for enabling law enforcement practices and for greater domestic investment for harm reduction.

- The United Nations issued a joint position on the closing of compulsory drug detention and rehabilitation centres in 2012.

Challenges

- Despite the existence of evidence-based and cost-effective harm reduction interventions, coverage remains low worldwide.

- Punitive laws and policies, whether via prohibiting the provision of sterile injecting equipment and opioid substitution therapy, criminalizing drug use and possession of injecting equipment, or denying HIV treatment to people who use drugs, violate their right to health, and, in turn, harm the community.

- Sustainability: international donors account for 92% of investment for harm reduction services. Greater domestic investment is required to sustain HIV responses for people who inject drugs.

Key statistics

- Of the 12.7 million people who inject drugs, 1.7 million are estimated to be living with HIV.

- HIV incidence among people who inject drugs remains high, accounting for more than 40% of new infections in some countries.
Approximately 40% of HIV-positive people who inject drugs live in eastern and south-eastern Europe and 20% live in eastern and South-East Asia.

Only 74 needles and syringes were distributed per person who injects drugs per year—approximately six needles and syringes per month.

Only 8% of people who inject opiates have access to opioid substitution therapy. And only four out of 100 people who use drugs who are living with HIV received ART.

UNAIDS reported in 2013 that domestic funding accounted for only 10% of harm reduction funding in low-income countries, and only between 18% and 36% in lower-middle and upper-middle income countries, respectively.

Background

Providing the comprehensive package of HIV services WHO, UNODC and UNAIDS recommend for people who inject drugs can stop the spread of HIV among this population group. These harm reduction services are:

- Needle–syringe programmes.
- Opioid substitution therapy and other evidence-informed drug dependence treatment.
- HIV testing and counselling.
- ART.
- Prevention and treatment of sexually transmitted infections.
- Condom programmes for people who inject drugs and their sexual partners.
- Targeted information, education and communication for people who inject drugs and their sexual partners.
- Prevention, vaccination, diagnosis and treatment for viral hepatitis.
- Prevention, diagnosis and treatment of TB.

The Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the United Nations Economic and Social Council and the General Assembly of the United Nations endorsed the comprehensive package for people who inject drugs.

The need for a comprehensive HIV response among people who use drugs was also reflected in the commitments made by United Nations Member States at the United Nations General Assembly in 2001, 2006, 2008 and 2011.
Q&A

1. **Should drugs user be punished?**
   
   No. Drug use should be treated as a health issue, not as a criminal one. In fact, criminalizing and punishing people who use drugs can be counterproductive. Community support, social protection, detoxification services and health care, including primary health care and treatment of drug dependence, can be more effective.

2. **Does UNODC support incarceration and compulsory detention centres for people who use drugs?**
   
   No. UNODC believes that the incarceration in prison settings and confinement in compulsory detention centres of people who use drugs worsen their lives. There have been numerous reports of human rights violations of people who use drugs at the hands of the authorities in those settings. Exposure to the prison environment can also facilitate affiliation with older criminals and criminal gangs and organizations. It often leads to an increase in social exclusion, a reduction in social skills and worse health, including by creating a higher-risk environment for the transmission of HIV, hepatitis and TB, both in closed settings and beyond, representing a significant public health risk for the community, as well. It also increases stigma and helps to form a criminal identity. The United Nations issued a joint position on the closing of compulsory drug detention and rehabilitation centres in early 2012.
Overview

The majority of people living with HIV are of working age. HIV has a potentially devastating impact on workers, their families and national economies. HIV-related stigma and discrimination threaten fundamental rights at work.

Working closely with its constituents (governments, employers’ and workers’ organizations (unions), UNAIDS and all relevant partners, including organizations of people living with HIV, the International Labour Organization (ILO) contributes to the AIDS response through the world of work.

The ILO Recommendation concerning HIV and AIDS and the world of work (No. 200) is the first international labour standard focused on the protection of human rights at work. Recommendation No. 200 is being used extensively to develop HIV workplace policies and programmes.

It is also essential to promote social protection as a means to reducing vulnerability to HIV and mitigate its impact on people living with or affected by HIV. ILO has undertaken research and actively provides assistance to countries to enable them to extend the coverage of social protection, including access to health care and income security.

Key messages

- HIV workplace programmes are a useful entry point to reach hard-to-reach key populations, such as men who have sex with men, sex workers and their clients, injecting drug users and transgender people.
- People living with HIV need employment as much as they need treatment.
- Adopting an economic empowerment approach in the HIV response is an effective strategy.
- Employment of people living with HIV contributes significantly towards their adherence to treatment.
- HIV workplace programmes trigger public–private partnerships and contribute to ensuring that no one is left behind.

Innovations

- The Geting to Zero at Work campaign launched by ILO has been joined by over 200 leaders from different walks of life. The campaign aims at
highlighting the contribution of the world of work in getting to zero new HIV infections, zero discrimination and zero AIDS-related deaths.

- Building upon the Getting to Zero at Work campaign, the VCT@WORK initiative, launched by ILO in collaboration with UNAIDS, is a major public–private partnership. This global initiative aims to reach 5 million women and men workers with voluntary HIV testing by 2015. People found to be living with the virus are referred to HIV care, support and, if necessary, treatment.

- A public–private partnership to economically empower HIV vulnerable populations along transport corridors in six southern African countries: ILO is executing a development cooperation project, supported by the Swedish International Development Cooperation Agency, that focuses on key populations, including sexually active young people and adults, sex workers and their clients, women and girls. This follows an economic empowerment approach. The initiative, based on the partnership between government institutions and the private sector, supports vulnerable populations, including people living with HIV, to form business associations and access credit to start and run a viable business.

- ILO is also engaged in a pioneering research to determine the nature and extent of employment-related discrimination that lesbian, gay, bisexual and transgender (LGBT) workers face. Preliminary results indicate the following: the majority of LGBT workers choose to conceal their sexual orientation at work, which causes stress and can have negative consequences on productivity and career progression; transgender workers experience the most severe forms of workplace discrimination including reluctance of employers to accept their new sex, and increased vulnerability to bullying and harassment by their colleagues. In many cases, transgender people are completely excluded from formal employment.

**Challenges**

- Protecting human rights and addressing stigma and discrimination.
- There is a narrow understanding of the relevance of HIV workplace programmes in reaching out to key populations and the vital role of employment/work for people living with HIV.
- Scaling up HIV programmes and social protection coverage for workers in the informal economy, including migrant workers.

**Key statistics**

- An ILO study on the relationship between employment and treatment adherence found that respondents who were employed were 39% more likely to have achieved treatment adherence than those unemployed.
**Q&As**

1. **What are the key principles of ILO Recommendation No. 200?**

   ILO Recommendation No. 200 focuses on preventing HIV and reducing its impact and protecting human rights at work. It emphasizes that prevention of HIV transmission should be a fundamental priority.

   It provides that there should be no discrimination against or stigmatization of workers, in particular job seekers and job applicants, on the grounds of real or perceived HIV status, or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk or more vulnerable to HIV infection.

   In addition, it provides that real or perceived HIV status should not be a cause of termination in employment and that workers, their families and dependents should enjoy protection of their privacy, including confidentiality related to HIV. Workers and job applicants should not be required to undertake an HIV test or disclose their HIV status or the status of any other person.

2. **How is the ILO recommendation being implemented?**

   The ILO is working with its constituents and other key partners to provide technical advisory support for the development and adoption of national laws and regulations, national or sectoral workplace policies and programmes of action, collective agreements, and strategies specific to certain economic sectors or targeting occupations at higher risk, including in the health-care sector.

   ILO Member States are also called upon to monitor developments on their national policy on HIV and the world of work through an appropriate national mechanism in which employers and workers are represented.

3. **What is the progress in implementation of ILO Recommendation No. 200?**

   Over 45 countries have developed or adapted national and sectoral workplace policies and legislation to integrate its key principles; it has also been translated into 22 languages.
Overview

Sex workers include female, male and transgender adults, over the age of 18, who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not self-identify as sex workers. There are many reasons why people sell sex, including: poverty; to financially support children, parents and other family members; lack of employment possibilities; gender inequality; low levels of education; upward social and economic mobility; migration; humanitarian emergencies, post-conflict situations; and harmful cultural practices, such as early child marriage.

The United Nations Secretary-General has called on all countries to honour their commitments to enact or enforce legislation outlawing discrimination against people living with HIV and key populations at higher risk of HIV infection, including sex workers, stating that in countries with legal protection and the protection of human rights for sex workers, many more have access to services.

Currently, 116 countries and territories criminalize some aspect of sex work. The World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Development Programme (UNDP), UNAIDS and the Network of Sex Work Projects (NSWP) call on countries to move towards the decriminalization of sex work.

Key messages

- Unprotected sex in the context of sex work has been identified as a major factor in rapid epidemic growth, particularly in settings of high population mobility and poor provision of health information and services.
- Sex work is work, regardless of the reasons for doing so. Sex workers should have the same rights to safe working environments as all other workers.
- Sex worker community empowerment and mobilization contributes to reducing HIV and sexually transmitted infections (STIs) among sex workers and increasing rates of condom use, service uptake, violence mitigation, economic empowerment and improved outcomes for their children. Full engagement of, and support for, global, regional and national sex work networks and organizations is the cornerstone of an effective response to HIV and sex work.
- Creating a legal and policy environment that gives sex workers equal rights of access to HIV services is good practice from both a public health and a human rights perspective. Realizing these rights gives sex workers dignity.
and enables them to be agents of HIV prevention and information with their clients and the larger community.

**Innovations**

- The revised 2012 UNAIDS *Guidance note on HIV and sex work*, developed jointly by UNAIDS, NSWP and independent experts, provides policy guidance to support national responses.
- *Implementing comprehensive HIV/STI programmes with sex workers*, developed by WHO, UNFPA, UNAIDS, NSWP, World Bank, 2013, provides the best available programming advice for the service delivery level.

**Challenges**

- Less than 2% of global HIV prevention funding for HIV is spent on sex work and few sex worker programmes have been brought to scale—despite the disproportionate HIV risk, the vulnerability sex workers face and the HIV prevalence rates among sex workers being much higher than the general population in most countries, up to 12%.
- Sex workers face multiple risks, including social marginalization, violence and poor health. These factors adversely affect the ability of sex workers to adopt safer sexual practices, including consistent condom use. Sex workers need access to appropriate, affordable and accessible comprehensive HIV/STI prevention and treatment programmes and sexual and reproduction health services free from stigma.
- Sex workers around the world identify stigma, discrimination and violence as three of the greatest challenges they face. Health-care providers, law enforcement officers, the judiciary, clients, managers of sex work establishments and the community have a shared responsibility in ensuring that sex workers have access to the services they need, free from harassment, victimization and incarceration.

**Key statistics**

- HIV prevalence among female sex workers is 12 times higher than HIV prevalence among all other women aged 15–49 years, including in countries with high HIV prevalence rates.
- An estimated 37% of female sex workers in sub-Saharan Africa are living with HIV (pooled prevalence), and as high as 60% and 70% in southern Africa.
- Less than 50% of sex workers report access to basic HIV prevention services.
- Sex workers are 12 times less likely to access antiretroviral therapy.
- Few HIV prevention programmes reach male and transgender sex workers.
Background

There is no such thing as a child sex worker. Any child under the age of 18 selling sex is a victim of commercial sexual exploitation. Adult sex work should not be associated with trafficking and the commercial sexual exploitation of children. Forced or coerced sex is rape, not sex work.

Q&A

1. How is sex work different from human trafficking?

The UNAIDS Guidance note on HIV and sex work affirms that all forms of involvement in trafficking and the involvement of children in sex work contravene United Nations conventions and international human rights law. Human trafficking for the purposes of commercial sexual exploitation, by definition, involves adults or children being retained to provide sexual services against their will, either through direct force or through deception, violating their fundamental rights to self-determination and autonomy over their bodies. Conversely, sex work is a sexual service entered into by adults on a consensual basis, exercising their own agency over their own bodies. Trafficking should never implicitly or explicitly be associated with sex work.

2. Does the United Nations support the decriminalization of sex work?

WHO, UNFPA, UNDP and UNAIDS, the Global Commission on HIV and the Law, the International Guidelines on HIV/AIDS and Human Rights, the report of the UNAIDS Advisory Group on HIV and Sex Work and the report presented to the Human Rights Council by the United Nations Special Rapporteur on the Right to Health call on all countries to work towards the decriminalization of sex work and elimination of the unjust application of noncriminal laws and regulations against sex workers. The United Nations does not support the criminalization of the clients of sex workers.

3. Does the United Nations support prostitution?

The UNAIDS Guidance note on HIV and sex work does not support the term “prostitution,” nor does it refer to people who sell sex as “prostitutes”. The United Nations supports the human right of people to make informed choices about their lives. It also supports the human rights of people not to be trafficked into sex work or held in slave-like conditions and the human right of all children to be free from commercial sexual exploitation.
Overview

Although antiretroviral treatment (ART) can suppress HIV and can delay AIDS-related illness for many years, it cannot clear the virus completely. In addition, continued lifelong treatment comes with related challenges—motivation, adherence, drug resistance, supply chains, costs and health service delivery, among others. Thus, there is a need to continue the work on finding a cure.

Sterilizing cure is a theoretical concept referring to a complete eradication of all viable HIV in the body. Functional cure is similar to remission in cancer care and is described as long-term health in the absence of treatment. It implies that there is no evidence of ongoing viral replication that persists despite not taking antiretroviral treatment.

Key messages

- A cure is possible. Timothy Brown, also known as the Berlin patient, was reported cured in 2008 of HIV infection after a bone marrow transplant from a donor with genetic resistance to HIV infection. He underwent further tests and was confirmed cured in 2010. He is living evidence of a sterilizing cure. In 2010, scientists reported on 14 French patients from the Visconti cohort who started treatment soon after acute infection with HIV and subsequently stopped treatment but remained well with controlled viral loads. The Mississippi baby was started on ART within the first two days of life, but was subsequently lost to follow up, and when they returned to care, off ART, they were found to have no evidence of replicating virus, even in cellular reservoirs. In March 2014, a second baby from California was reported to be possibly functionally cured as a result of antiretroviral medicine treatments that doctors administered just four hours after birth. However, this baby is still on continued ART. The question remains as to when to stop treating this baby.

- The Mississippi child, now close to four years old, and who was thought to be cured in 2013, was reported in July 2014 to have detectable virus. While this is disappointing news, the case remains extraordinary. What was it that allowed this baby to control the virus and remain well, off ART for two years, despite harbouring HIV? What was the stimulus that caused the virus to be reactivated and develop into a “normal” HIV infection with positive antibody tests, falling CD4 count and raised viral load?
New scientific advances are paving the way towards finding a cure. We are learning about different possibilities of eradicating the virus every day. Technology is playing a huge role in these new discoveries, be it in successful simian/human immunodeficiency virus elimination in monkeys, activating latency, exploring gene editing in humans to create HIV-resistant cells and/or eliminating viral reservoirs.

A cure could be foreseen in the next few decades. There is hope and optimism around the possibility of a genuine cure for HIV being developed. The launch of a new strategy to develop a cure, involving scientists, policy-makers, funders and people living with HIV, in July 2012, marked an increased focus on the development of a cure as a potential approach to curbing the HIV epidemic.

**Innovations**

- Very early initiation of antiretroviral therapy, before reservoirs are fully established. The Mississippi baby and the baby from California both were started very early on antiretroviral therapy. The former stayed off treatment for two years, was previously declared functionally cured (in "remission"), has now resumed treatment. The latter is on continued antiretroviral therapy. The Visconti cohort initiated treatment within 10 weeks of infection and were on treatment for an average of three years. They are now off treatment and “in remission” for an average of eight years or so. However, much more research is needed to establish that this method is universally viable and indeed will result in lifelong cures.

- Making cells “resistant” to HIV (gene therapy). More recently, gene therapy has been viewed as having the potential to engineer HIV control by introducing cells resistant to the virus. In 2014, a clinical trial using gene-editing techniques successfully targeted and destroyed a gene in the immune system of 12 people living with HIV, increasing their resistance to the virus. Because of the invasive nature of stem cell treatment, it is not viable for the majority of people living with HIV, as the body is likely to attack the donor cells. However, this is an important advance in the direction of this kind of research, as it is one step towards a more practical and applicable approach than doing a stem cell transplant.

- Eliminating latently infected cells. Many researchers believe the best hope for eradicating HIV infection lies in combining antiretroviral treatment with drugs that flush HIV from its hiding places. The idea is to “wake up” resting infected CD4 cells, whereupon they will start producing new HIV particles. The activated cells should soon die or be destroyed by the immune system, and
the antiretroviral medication should flush the released HIV. On the other hand, it is also important to have the tools to measure whether cells are producing infectious virus in response to interventions designed to flush out HIV from latently infected cells, and what proportion of cells respond to the intervention.

- Broadly neutralising antibodies (bnAbs). Currently also being studied for HIV prevention as passive immunization in HIV negative individuals, bnAbs are also being researched as a therapeutic vaccine for HIV positive people. bnAbs are potent antibodies that block the activity of many different types of HIV and occur naturally in a small number of people with HIV. More recently, bnAbs have been found to effectively control virus replication in humanized mice and has successfully cleared SHIV infection in monkeys.

**Challenges**

- The complexity and tenacity of the virus. Latently infected T-cells, residual viral replication, anatomical reservoirs (such as the brain, gut, lymph and genital tract) that harbour hidden virus, the rapid surge of the virus when treatment is discontinued, the consistent presence of HIV DNA in infected cells are some of the main challenges in the search for a cure. Most T-cells in the body are resting. HIV mostly infects active CD4 T-cells, which produce new virus but then soon die. In contrast, HIV genetic material in resting cells is integrated into the host cell's genome, where it can remain dormant for a long time, but can "wake up" at any point and reignite viral replication.

- Ethical considerations. Human trials are necessary to provide evidence that something works. With HIV being a very complex virus, a multiplicity of factors needs to be considered. There is a need to ensure that study participants are not exposed to harm during these trials. There is a need for realistic expectations among study participants, especially in early “proof of concept studies”. Researcher responsibilities to their study participants need to be established. With multiple unknowns involved in immune and gene therapies, as the safety of delivery vectors is uncertain, studies need to be conducted with utmost precision and care. Appropriate research design, methods and conduct should be agreed upon through engagement with relevant communities, including scientific and regulatory bodies and government stakeholders.

- Sustained investments in HIV cure strategies. Some of the world’s top research institutions are currently engaged in studies to learn more about infected resting cells and the behaviour of HIV. But this field does not receive much funding. Of the US$ 1.54 billion spent by the National Institute of
Allergy and Infectious Diseases (NIAID) on HIV in 2009, only US$ 40 million was spent on HIV cure research. This represents only 3% of the total NIAID HIV budget. Drug companies, in particular, would prefer to market their antiretroviral drugs. In a difficult economic climate, investing in something that might not be successful could simply seem too risky. However, enthusiasm for research on a cure is growing: President Barack Obama recently announced that US$ 100 million of the NIAID budget would be dedicated to cure research, and amfAR have launched a special funding initiative. What is critical to help advance finding a cure is multiple partner engagement (community, regulatory bodies and pharmaceutical companies), and ultimately, finding a strategy that is cheap, scalable and widely available.

Background

The Towards an HIV Cure project is an initiative of the International AIDS Society (IAS), supported by UNAIDS. The mission of the project is to provide leadership in advocating for increased investment in HIV cure research and to facilitate more concerted efforts to accelerate global scientific research.

In the light of the resurgence of interest and optimism on prospects of a cure for HIV, the IAS undertook to guide the development of a Global Scientific Strategy Towards an HIV Cure. An international scientific working group of over 30 leading scientists in the field worked towards the establishment of a consensus on the state-of-the-art HIV cure research, which lays the foundation for the Global Scientific Strategy.

The Global Scientific Strategy Towards an HIV Cure, which identifies seven priority research areas, spanning basic science in virology and immunology, preclinical science and clinical trials, was launched in July 2012 in Washington, DC.
Overview

Closing the global AIDS resource gap by 2015 and reaching an annual global investment of US$ 22–24 billion in low- and middle-income countries is one of the 2015 global AIDS targets outlined in the 2011 United Nations Political Declaration on HIV and AIDS.

Based on the latest data available, domestic and international resources for HIV reached their highest levels in 2013. With funding increases in the last two years, it is likely that low- and middle-income countries can achieve the 2015 financial target. However, substantial additional funding will be needed to achieve resource targets beyond 2015.

Key messages

- At the end of 2013, US$ 19.1 billion\(^1\) was invested in the AIDS response in low- and middle-income countries. This represents an annual increase of 1% compared to 2012. The resources available for HIV remained flat between 2011 and 2013.

- Domestic resources accounted for around half of HIV funding in 2013. Low- and middle-income countries are developing and leading efforts to mobilize resources for the HIV response. However, there is still a persistent dependency on international financing. Domestic resources (excluding private) in low-income countries make up only 15% of HIV funding. Of the 131 low- and middle-income countries\(^2\) for which the latest data was available, 50 looked to international assistance for 75% or more of HIV financing.

Innovations

- Following the country retargeting process, a global investment need is being estimated for the 2015–2030 resource needs.

- Innovative mechanisms are being implemented to boost funding for HIV.

- Countries are raising domestic resources and creating plans to mobilize resources.

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\(^1\) Based on preliminary estimates from UNAIDS in July 2014.

\(^2\) Based on the World Bank classification of countries on income levels, which includes five countries that progressed to the high-income category in 2013.
Challenges

- A difficult international funding climate that could disrupt the scale-up of HIV services.
- Significantly high dependency on international funding among many low- and middle-income countries.
- Domestic investments need to be scaled up in proportion to the estimated resource needs.
- Donors must maintain their fair share of AIDS funding aimed at improving health and social sectors.

Key statistics

- In 2013, an estimated US$ 19.1 billion was available for HIV programmes in low- and middle-income countries, a 1% increase from 2012 levels.
- International financing: only five of the top 20 donor governments contributed more than 5% of their net official development assistance to HIV. Bilateral contributions from the top five donor governments and the Global Fund constituted around 84% of the total international aid.
- Domestic investments: based on the latest data available, among the 43 low- and middle-income countries reporting AIDS spending data, more than two thirds reported an increase in domestic HIV spending. Fifty low- and middle-income countries looked to international assistance for 75% or more of HIV financing in 2013.
- Resource gap: in 2012, 39 of the 99 countries were not on track to reach their resource mobilization targets by 2015. The distribution gap in financial resources across different programme activities remains uneven. For example, there was an estimated gap of 70% in 2012 for prevention activities aimed at populations at higher risk.
Background

- HIV funding in low- and middle-income countries (2002–2013)
- International HIV assistance: donor governments as a share of total donor government disbursements

![Bar chart showing HIV funding in low- and middle-income countries (2002–2013)](chart)

Source: UNAIDS/Kaiser Family Foundation project 2014.

- Fair share: donor share of world gross domestic product compared to donor share of all resources available for HIV (2013)

![Pie chart showing fair share of donor resources compared to total resources available for HIV (2013)](chart)

Source: UNAIDS/Kaiser Family Foundation project 2014.
HIV IN PRISON SETTINGS

Overview

Globally, at any given time there are over 10 million people in prisons, with more than half in pretrial detention. Given the high turnover, each year over 30 million men and women spend time in prisons and other closed settings, of whom over one third are pretrial detainees. Women in prisons are at higher risk than men in prisons. Virtually all will return to their communities, many within a few months to a year.

The prevalence of infectious diseases, such as HIV, sexually transmitted diseases, hepatitis C and tuberculosis (TB) among prison populations tends to be much higher (up to 50 times) than in the community at large. HIV in prisons affects all regions of the world. Most affected are sub-Saharan Africa (reflecting the high prevalence in the general population) and eastern Europe and Asia (reflecting the high proportion of key populations, especially people who use drugs).

Prisons are characterized by higher risks for the transmission of infectious diseases together with lower access to health services. Isolated from public health services, including national AIDS or TB programmes, prisons and other closed settings are often seriously neglected in country responses to address HIV and TB prevention, treatment and care.

Key messages

Four elements are key to preventing and responding to HIV and other infections, such as hepatitis B and C and tuberculosis, in prisons:

- Introducing comprehensive evidence-informed HIV prevention measures.
- Providing equivalent health services to people in prisons to people in the community, including the provision of antiretroviral therapy.
- Improving prison conditions and undertaking other prison reforms.
Challenges

- Prisons and prisoners are highly stigmatized and are often left out of the national efforts of countries towards universal access to HIV prevention, treatment, care and support. Consequently, there is a lack of both international and domestic investments to address HIV effectively in prisons settings.
- Effective policies to prevent HIV, TB and hepatitis inside prisons and other correctional institutions are often hampered by the denial of the existence of the factors that contribute to the spread of HIV, such as unsafe sexual activities, including among men who have sex with men, and drug use.
- Globally there is a lack of data on HIV prevalence and HIV risks in prisons. There is an urgent need for countries to collect the evidence, develop an appropriate response and monitor the situation.

Key statistics

- Every year, 30 million men and women are held in prisons.
- One third of the prison population is in pretrial detention.
- HIV prevalence in prisons can be two to 10 times, in some cases up to 50 times, higher than in the community.
- HIV prevalence among women in prisons is higher than among men in prisons.

Background

All modes of HIV transmission occur in prisons: transmission through unsafe sex, both consensual and coerced, transmission through the sharing of injecting, tattooing and other body piercing equipment, transmission through unsafe medical, dental and gynaecological practices and mother-to-child transmission.

AIDS-related illnesses and TB are the main causes of death in prisons in many countries. Poor prison conditions and poor health management, combined with a high prevalence of HIV, are responsible for the high TB prevalence and case fatality rates.

Other factors contribute to HIV, hepatitis and tuberculosis transmission in prisons: overuse of imprisonment and of pretrial detention for people who use drugs and sex workers, overcrowding, violence, poor medical and social services, denial of risky behaviours occurring in prisons, lack of protection for vulnerable prisoners, stigma, isolation of prison health services from public health services, lack of
training for prison staff, poor ventilation and poor natural light, corruption, poor diet, etc.

The rights of people in prisons, including their right to health, are not always respected. Mandatory testing, forced treatment, segregation of people living with HIV or lack of access to services constitute major obstacles to protecting the health of people in detention and prisons.

Staff working in prisons are also affected by poor prison conditions, especially with regard to TB. Prison staff are also at risk of accidental exposure to blood.

Women in prisons are at higher risk than men in prisons largely because of the reasons for which they are imprisoned—for example, there is a higher proportion of women who inject drugs and sex workers than in male prisons—and because they often are at risk of sexual violence and lack services.

**Q&A**

1. **What are the key elements to address HIV in prisons?**

   There are four elements that are key to preventing and responding to HIV and other infections, such as hepatitis B and C and TB, in prisons:
   
   - Introducing comprehensive, evidence-informed HIV prevention measures.
   - Providing equivalent health services to people in prisons to people in the community, including the provision of antiretroviral therapy.
   - Improving prison conditions and undertaking other prison reforms.
   - Reducing prison populations.

2. **What is the comprehensive package of interventions for people in prisons?**

   The comprehensive package consists of the 15 interventions that are essential for effective HIV prevention and treatment in closed settings. While each of these interventions alone is useful in addressing HIV in prisons, together they form a package and have the greatest impact when delivered as a whole.
   
   - Information, education and communication.
   - Condom programmes.
   - Prevention of sexual violence.
   - Drug dependence treatment, including opioid substitution therapy.
   - Needle–syringe programmes.
   - Prevention of transmission through medical or dental services.
• Prevention of transmission through tattooing, piercing and other forms of skin penetration.
• Post-exposure prophylaxis.
• HIV testing and counselling.
• HIV treatment, care and support.
• Prevention, diagnosis and treatment of tuberculosis.
• Prevention of mother-to-child transmission of HIV.
• Prevention and treatment of sexually transmitted infections.
• Vaccination, diagnosis and treatment of viral hepatitis.
• Protecting staff from occupational hazards.

3. **Who should be responsible for health in prisons?**

Traditionally, in most countries, health care in prison settings falls under the responsibility of the prison authorities. In addition, health programmes in prisons in general, and HIV or TB in particular, work often in isolation from the ministry of health and national programmes. However, to ensure the equivalence of health care, including in terms of quality assurance of monitoring, continuity of care and access to funding mechanisms, health services in prisons should be under the responsibility of the ministry of health. Only a few countries have successfully transferred this responsibility.

4. **What do we mean by “prison settings”?**

The term “prison settings” is used for all places of detention, and the term “prisoner” to describe all people who are held in such places, including adult and juvenile males and females detained in criminal justice and correctional facilities during the investigation of a crime, while awaiting trial, after conviction and before sentencing, and after sentencing.

5. **How could HIV be transmitted in prisons?**

All modes of transmission occurring in the community (blood, sexual and mother-to-child transmission) occur in prisons. HIV is transmitted in prison settings through the sharing of contaminated injection equipment among injecting drug users, unsafe sexual practices, unsafe skin piercing and tattooing practices and blood-to-blood transmission resulting from sharing of razors for shaving, blood sharing/”brotherhood” rituals and the improper sterilization or reuse of medical or dental instruments.
6. Are HIV interventions effective in prisons?

Yes, the effectiveness of HIV interventions in prisons has been documented and published. This includes condom programming, opioid substitution therapy, needle–syringe programmes and provision of antiretroviral treatment.
Overview

Despite tremendous gains in the global AIDS response, a systematic effort to match investment to needs has so far been lacking. In June 2011, United Nations Member States agreed to make at least US$ 22–24 billion available annually by 2015. It is critical that these resources are invested wisely to maximize returns and achieve value for money.

The investment approach is a process that countries can use to maximize the returns of investment in their HIV response; it catalyses a rigorous examination of the HIV response in terms of effectiveness, efficiency and sustainability over the long term (typically more than 10 years).

It is a four-step process (understand, design, deliver, sustain) that can be used to:

- Analyse the epidemic and the response.
- Prioritise and allocate resources towards the interventions/populations/geographic areas that will achieve the greatest impact over the long term.
- Improve the access, delivery, efficiency and quality of HIV prevention, care and treatment services.
- Assess and address the financing (domestic and external) of the HIV response and its sustainability, including domestic financing.

The investment approach is a process that countries are encouraged to use whenever rigorous examination of the HIV response is required. It is a process that should be applied to develop investment cases, develop new national and subnational strategic plans, review and revise/update existing strategic plans, develop operational plans, prepare concept notes of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), develop partnership frameworks and sustainability plans for the United States President’s Emergency Plan for AIDS Relief (PEPFAR), etc.

Key messages

- The AIDS response needs a people-centred investment approach so that returns are maximized—for the response, the returns are clear: zero new HIV infections, zero discrimination and zero AIDS-related deaths.
- A full and early investment in the AIDS response can reap long-lasting dividends.
• Value for money is best obtained when national HIV responses make timely investments in the right places and right populations, use the right strategies, increase efficiency, reduce costs and promote innovation. Countries should match HIV investments with the scale of the epidemic and align those investments with epidemiological trends. Innovation in programme delivery methods, including new service models, is required to avoid stagnation in HIV prevention and treatment strategies.

• Shared responsibility in a framework of global solidarity is essential to reducing new infections and increasing the numbers of people on treatment. The 2011 United Nations Political Declaration on HIV and AIDS recognizes resource mobilization as a shared responsibility. Now more than ever, ending the AIDS epidemic requires a unified approach, of governments, nongovernmental organizations, foundations, corporations and citizens. Most low- and middle-income countries are expected to see strong economic growth in the coming years, providing an opportunity for an increased capacity to devote additional resources to health. Shared responsibility involves redistributing governance space, ensuring that countries own their response and are accountable to their people.

Innovations

• Several countries are applying investment thinking to set priorities among high-impact programmes and strategies, basing their decisions on existing evidence, investment principles and modelling. These exercises are also underpinning the development of road maps for mobilizing more sustainable resources.

• Early adopters of the investment approach have demonstrated not only its feasibility but also how the approach can foster focus (on high-burden geographic areas and populations), optimize the mix and coverage of interventions to maximize impact, promote efficiency and innovative service delivery models and initiate steps towards more sustainable financing and shared responsibility.

Challenges

• Many countries continue to struggle to match investments to their respective epidemics. Sometimes political considerations undermine programme evidence, which highlights the need for geographical prioritization or an increased focusing on key populations. The failure to respond to the evidence results in suboptimal resource allocation. Stakeholders with vested interests
may resist efforts to rethink resource allocation or to expose allocation decisions to rigorous examination.

- Many countries applying the investment approach face key structural constraints. Existing regulatory and legal frameworks impede the adoption of task shifting and task sharing, for example. Many countries are faced with parallel procurement and supply systems supported by international partners. A large number of countries continue to have punitive laws and law enforcement against key populations that act as major obstacles to accessing HIV services. In addition, some countries do not have legal or policy provisions for enabling service delivery by civil society organizations, even though civil society partners are indispensable partners in expanding the coverage of services, especially to key populations.

- Empirical data on the costs of HIV services are a major gap in available evidence in many countries. In many cases, countries have difficulty in generating data on costs and obtaining cost data from international partners or from international programme implementers.

**Key statistics**

- Fifteen countries have begun to reshape their response in accordance with investment principles.

- More than 50 countries plan to apply the investment approach to develop investment cases or strategic plans over the next two years.

**Background**

Recognizing the need to rethink the approach to investments in HIV, UNAIDS joined with partners in 2011 to outline a new investment approach. UNAIDS subsequently developed guidance for countries to develop national HIV investment cases. A toolkit was introduced at the 30th Meeting of the UNAIDS Programme Coordinating Board (see http://www.unaids.org/en/media/unaid/contentassets/documents/pcb/2012/JC2359_investing-for-results_en.pdf).

The investment approach provides countries with new opportunities to explore options for innovative funding and service delivery, to identify specific steps to enhance equity and inclusiveness for key populations, to use available evidence to understand better the health and economic benefits of timely, rights-based, smart HIV investments and to eliminate inefficiency in HIV programmes.

In addition to helping countries with resource allocation and financing decisions, the investment approach can support countries in their dialogue with international partners. Reflecting the momentum of change initiated by the investment approach,
the New Funding Model of the Global Fund requires that countries articulate the strategic investment thinking underpinning their funding requests. The defining elements of the investment approach—linking investments with impact, and using empirical evidence and modelling to identify gaps—provide the platform for countries to develop a concept note and to support the dialogue process that is central to the New Funding Model, as well serve as a starting point for developing partnership frameworks and sustainability plans for PEPFAR.


**Q&A**

1. **What is the investment framework/investment approach?**

   The investment approach advocates for a more targeted and strategic approach to investment in the HIV response that is based on country epidemiology and context. It represents a radical departure from past approaches, and has four clear aims: maximizing the benefits of the HIV response; using country-specific epidemiology to ensure rational resource allocation; encouraging countries to implement the most effective programmes based on local context; and increasing efficiency in HIV prevention, treatment, care and support.

2. **How should countries make the best AIDS investments?**

   The investment framework calls for six basic programme activities to be scaled up to deliver substantial and sustainable progress in the HIV response:

   - Focused interventions for key populations at higher risk (particularly sex workers and their clients, men who have sex with men, and people who inject drugs).
   - Elimination of new HIV infections among children.
   - Behaviour change programmes.
   - Condom promotion and distribution.
   - Treatment, care and support for people living with HIV.
   - Voluntary medical male circumcision in countries with high HIV prevalence and low rates of circumcision.
The basic activities must be supported by a set of overarching critical enablers that will generate demand for services and assure quality, as well as generate synergies with wider health and development sectors for maximum impact. Policy-makers must make use of information on HIV incidence and prevalence, as well as knowledge of the national and local context of the epidemic. Based on this understanding, countries can then prioritize activities and implement a carefully focused and more effective response.
HIV-RELATED RESTRICTIONS ON ENTRY, STAY AND RESIDENCE

[Source: UNAIDS—Jason Sigurdson: sigurdsonj@unaids.org]

Overview
The elimination of HIV-related restrictions on entry, stay and residence is one of the 2015 global AIDS targets outlined in the 2011 United Nations Political Declaration on HIV and AIDS.

As at 1 July 2014:

- 39 countries, territories and areas impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status;
- 138 countries, territories and areas have no HIV-specific restriction on entry, stay and residence.

Key messages

- Every individual should have equal access to freedom of movement regardless of HIV status. HIV travel restrictions are neither an evidence-informed nor rights-based way to prevent HIV transmission.
- Most countries in the world (at least 138) do not have HIV-related restrictions on entry, stay and residence and have found no need for them. The action taken by the United States to remove its long-standing restrictions in 2010, and more recently by Andorra, Armenia, China, Fiji, Mongolia, Namibia, Republic of Korea, Republic of Moldova, Slovakia, Tajikistan, Ukraine and Uzbekistan, is recognition of this reality. Restrictions based on HIV status are discriminatory. UNAIDS opposes restrictions that limit or restrict movement based on HIV-positive status only and/or single out HIV for different treatment. There is no public health reason to justify such differential treatment. All chronic health conditions (e.g. chronic heart or liver disease, diabetes, cancer) should be treated alike by governments.
- There is no evidence that such restrictions protect public health. Restrictions do not have a rational or realistic relation to protecting public health. It is wrong and discriminatory to assume that HIV-positive people will engage in risky behaviour and transmit HIV to others. Partners can also protect themselves by using condoms. Such restrictions fuel stigma against people living with HIV and can create a misleading public impression that HIV is a “foreign” problem that can be controlled through measures such as border
controls. UNAIDS advocates that the rational way to protect public health is to provide access to HIV prevention and treatment information and services to all mobile people—both citizens and non-citizens—coming into and going out of a country.

**Innovations**

- **Business leaders** are encouraging countries to repeal HIV-related entry, stay and residence restrictions on economic grounds. In a globalized world, companies require flexibility to recruit and deploy workers where they are most needed. Over 40 CEOs have signed a pledge to oppose travel restrictions, among them the leaders of Levi Strauss & Co., the Coca-Cola Company, Johnson & Johnson and Virgin Unite.

- **Governments** are expanding access to HIV treatment for “people on the move”. For example, in Thailand migrants who are officially registered can pay a fee for universal health coverage that includes HIV treatment. In addition, Thai and Cambodian authorities have collaborated on a scheme that allows Cambodian migrants living with HIV to return to their home country to obtain a three-month supply of antiretroviral medication.

- In England, since October, 2012, HIV treatment is available free of charge to everyone who needs to access it, regardless of their nationality or residence status.

**Challenges**

- Reaching the goal of eliminating remaining HIV-related restrictions on entry, stay and residence requires expanded and ongoing efforts, particularly in sensitizing senior officials and advancing law and regulatory reform. National coalitions or task forces—bringing together both government officials and civil society, including people living with HIV—have a potentially important role to play in building momentum for elimination of these restrictions. Efforts should engage ministries of health, interior, migration, justice and labour, and parliaments.

- The largest numbers of migrants affected by mandatory HIV testing, restrictions and deportation are those seeking entry, stay and residence in countries of the Middle East and North Africa region. As such, much greater regional action is required in that region, for example through study visits from national officials in Cooperation Council for the Arab States of the Gulf countries to other countries in the Middle East and North Africa that have no restrictions, such as Morocco and Tunisia. Such learning opportunities can
play a potentially important role in helping decision-makers understand that no public health rationale exists for HIV-related restrictions on entry, stay and residence.

Key statistics

- Countries, territories and areas that have no HIV-specific restriction on entry, stay and residence: 138.
- Countries, territories and areas that impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status: 39.
- Countries, territories and areas that deport people once their HIV-positive status is discovered: 18.
- Countries, territories and areas that require that a person be able to show they are HIV negative to be allowed to stay for even short periods (10–90 days): 5.
- Countries, territories and areas that have a complete bar on the entry and stay of people living with HIV: 5.

Background

39 countries, territories, and areas impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status:

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18 countries deport individuals once their HIV-positive status is discovered:

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Q&A

1. **What are HIV-related travel restrictions?**

HIV-related restrictions on entry, stay and residence are laws, regulations and/or policies put in place by states to regulate the entry, stay or residence of people living with HIV. They can apply to the full range of mobility or to only some aspects of mobility, for example entry and stay involving short-term travel and stay (tourism, family visits, business trips, attending conferences) and/or long-term residence (immigration, labour migration, study, refugee asylum and resettlement, family reunification, consular and international postings).

2. **Why do countries have such restrictions?**

Most HIV-related restrictions were put in place in the 1980s when fear, ignorance and prejudice dominated many responses.

3. **Are HIV travel restrictions a violation of human rights?**

There is no human right to enter or remain in a country. However, there are human rights to non-discrimination, equality before the law, freedom of movement and privacy. To abridge these rights for anyone, including people living with HIV, governments have to show just cause and do so in the least restrictive manner possible. Governments have not met these requirements with regard to restrictions on entry, stay and residence based on HIV status. HIV-specific and blanket restrictions violate the human rights of non-discrimination and equality before the law.

The *International guidelines on HIV/AIDS and human rights* state that any restriction on liberty of movement or choice of residence based on suspected or real HIV status alone, including HIV screening of international travellers, is discriminatory. Where they involve mandatory testing and lack of confidentiality, they also violate the rights to liberty and privacy. For instance, many migrants...
are not told they are being tested for HIV, are not informed of the results, are not counselled if informed and are not referred to medical services.

4. What about governments’ desire to avoid economic costs associate with HIV health care?

It is standard practice for states to refuse to allow a person who is, or is likely to become, a “public charge” or pose an “undue burden” on the state’s resources to enter or stay in a country. If a person living with HIV fills these criteria, she or he may be deported or refused entry. However, UNAIDS asks that states not apply a blanket restriction to all people living with HIV; rather they should do an individual assessment of whether the person will in fact become a public charge, weighing the benefits the person brings against any possible costs. They should also ensure that any valid human rights or humanitarian concerns override economic ones, such as need for asylum, family reunification or emergency health needs.

5. What is UNAIDS’ position on HIV-related restrictions on entry, stay and residence?

UNAIDS works towards removing punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV. Restrictions on entry, stay and residence based on positive HIV status are discriminatory, and there is no evidence that they protect public health. While recognizing that control of a country’s borders and matters of immigration fall under the sovereign power of individual states, national laws and regulations should ensure that people living with HIV are not discriminated against in their ability to participate equally in international mobility and in seeking to enter or stay in a country that is not their own. UNAIDS opposes the following type of restriction(s):

- Where HIV is singled out and addressed specifically, apart from other comparable health conditions.
- Where there are blanket restrictions based on HIV status.
- Where exclusion or deportation occurs because of HIV-positive status only.
- Where HIV testing is mandatory, without sufficient information and counselling and results are not provided.
- Where restrictions are implemented over valid human rights and humanitarian concerns.

6. On what basis was Australia recently removed from the list of countries with HIV-related restrictions on entry, stay and residence?

In July 2014, Australia was removed from the UNAIDS list of countries, territories and areas with HIV-related restrictions. Australia’s removal from the
list was subsequent to a review of the country’s immigration health assessment policies and procedures, and a period of close dialogue with the Government on a few remaining issues for clarification. Australia has made important reforms to its migration health assessment requirements and procedures since the conclusion of a parliamentary inquiry on migration and disability in 2010, including an annual increase to the “significant cost threshold”, the elimination of the cost assessment related to health services for humanitarian visa applicants and improvements to increase the transparency of the health assessment process. These reforms were assessed against the criteria outlined by the International Task Team on HIV-related Travel Restrictions, co-chaired by the Government of Norway and UNAIDS, and it was concluded that Australia had met the task team’s standard. UNAIDS has expressed its appreciation to Australia for having made important reforms to its immigration health assessment policies and procedures, which appear to be overall beneficial for people living with HIV, as well as other chronic health conditions and disabilities, who are seeking entry, stay and residence.

7. What is required of people living with HIV or other chronic health conditions under Australia’s immigration health procedures?

Australian migration regulations outline a number of public interest criteria, including three related to health. Apart from a limited number of situations where exemptions or waivers are available, visa applicants must demonstrate that they are free from disease or conditions that could result in a significant cost to the Australian community or prejudice the access of Australian citizens to health care or community services. HIV testing is required of permanent visa applicants 15 years and over, and temporary visa applicants intending to work as, or study to be, a doctor, dentist, nurse or paramedic. (The latter requirement is for the purpose of determining scope of practice, in line with procedures applicable to Australian nationals.) Additionally, HIV testing is required of individuals known to Australian authorities to be HIV-positive, to have an HIV-positive mother, or be under 15 years of age and have been adopted. Applicants who are required to undergo a limited medical examination must answer a question regarding their HIV status. If the individual reports being HIV-positive, the authorities will require that an HIV test be performed. As is the case with other applicants with a chronic health condition, people living with HIV will be individually assessed for significant costs (presently defined as costs exceeding AUS$ 40 000). For those HIV-positive applicants who are assessed as likely to exceed that significant cost threshold during the period of their proposed stay in Australia, unless eligible for a waiver of the health-related cost requirements, their application will fail on cost grounds.
8. Does Australia have special HIV-related requirements for student visa applicants coming from Africa?

No. UNAIDS received written confirmation from the Government of Australia in February 2014 that the Sub-Saharan Africa Student HIV Pilot Program, introduced in 2001, was discontinued in June 2011.
Overview

By the end of 2013, there were 51.2 million people forcibly displaced worldwide. These included 16.7 million refugees, 33.3 million internally displaced people (IDPs) and 1.2 million asylum seekers.

Determinants of HIV incidence among people affected by conflict is complex, and prevalence rates vary according to a number of interacting factors, phases of disaster and context.

Displacement may well drive HIV infection in contexts in which basic necessities, security, the right to work, social cohesion and protection against sexual violence are reduced or lacking. Post-conflict settings characterized by improved economies and road structures, likely represent the most critical period of the HIV risk in the displacement continuum; this, in terms of linking geographically separate epidemics and intensifying transmission.

According to estimates released in 2008, 1.8 million people living with HIV, 5.4% of the global number, were affected by conflict, disaster or displacement in 2006. In the same year, an estimated 930 000 women and 150 000 children aged under 15 years living with HIV were affected by emergencies. Given that the number of displaced people has increased by 12.4 million, or 24.2%, from 2006 to 2013, it is likely that the number of people living with HIV who are affected by conflict, disaster or displacement has also increased.

Ensuring that displaced people have universal access to evidence-informed HIV prevention, treatment, care and support services is key to prevent morbidity and mortality due to HIV. It is an important component of UNAIDS’s priorities and the Office of the United Nations High Commissioner for Refugees’ (UNHCR) protection and assistance activities.

Key messages

- HIV transmission among displaced people can be reduced if the basic tenets of a protection and rights-based approach are followed:
  - The HIV status of an asylum seeker does not bar the person from accessing asylum procedures. The right to be protected against refoulement remains the cornerstone of international refugee law, and HIV status should not be grounds for an exception to this principle.
Public health interests are best served by promoting voluntary counselling and testing in an environment where confidentiality and privacy are maintained. Countries that have reversed the epidemic have used this approach and banned any form of mandatory testing. There is neither a legal nor a public health basis for imposing mandatory HIV testing of refugees and asylum seekers.

People living with HIV are entitled to live their lives in dignity, free from discrimination. Refugees, IDPs and other people of concern to UNHCR who are living with HIV should enjoy nondiscriminatory access to services. Misconceptions about their link to an increased prevalence of HIV may lead to discriminatory practices and should be dispelled.

- Moral, legal, and public health principles and recent evidence provide a clear rationale for ensuring universal access to antiretroviral medicines for refugees.
- Global elimination of mother-to-child transmission is possible only if refugees have access to a variety of services. The implementation framework for the elimination of new HIV infections among children and keeping their mothers alive applies more so in refugee settings.

Innovations

- Newer models of improving uptake of HIV counselling and testing services. UNHCR supports innovative models in refugee camps with limited counselling and testing coverage. UNHCR worked with an independent researcher and implemented and evaluated a clinic-based routine voluntary HIV testing intervention in the Nakivale Refugee Settlement in Uganda. The mean HIV-positive clients identified per week increased from 0.9 to 5.6. Emphasis will continue to be placed on strengthening quality-assured counselling and testing services at multiple entry points in the health system.

- Increasing access to point-of-care diagnostics. Refugee camps are often based in rural settings that lack basic public services for the host and refugee populations. UNHCR has been supporting health facilities with CD4 machines that serve HIV-positive refugees and the immediate host population, thus averting long travel distances and reducing costs. For example, in the Nakivale Refugee Settlement, blood samples had to be taken 72 kilometres to get a CD4 test done at US$ 6 each. The results were collected and brought back to the settlement the following week for clinician evaluation. The introduction of PIMA CD4 machines at two different health centres had a positive effect on the number of clients attending the clinic and aided in timely initiation of antiretroviral therapy (ART).
- Addressing sex work and HIV in refugee settings through a multifunctional team approach. Significantly higher rates of HIV infection have been documented among sex workers and their clients as compared to most other population groups in sub-Saharan Africa. Effectively addressing HIV among sex workers and their clients in refugee settings calls for a multifaceted approach that coordinates a range of diverse responses with an inbuilt monitoring mechanism. UNHCR developed a 10-step practical guide for countries to launch such interventions according to their context. Since 2011, health care, protection and livelihood interventions have been implemented in six refugee camps in Ethiopia, Kenya and Uganda. Over 650 female sex workers have come forward to access services in these locations and 77 sexually exploited children were identified and referred for protection services.

**Challenges**

- Providing HIV related health and other basic services displaced people is a difficult yet critical undertaking. Living conditions for refugees and IDPs are often challenging. Even where services exist, they may have collapsed or experience disruption. When people are fleeing to another area or country, services originally for the host population may become overwhelmed, programmes may have not planned for increased needs and a disruption in preventative, treatment and care services may occur affecting both the host population and the displaced population. Other factors to consider are the level and type of stigmatization and discrimination such populations may face, especially those living with HIV. This may also complicate access to HIV services.

- Some of the barriers to ensuring access to ART for eligible displaced people include rigid protocols in host countries prescribing conditions under which health professionals can provide services. In many instances these conditions are different from those in the country of origin. Another obstacle is the lack of a client database indicating the number of people on ART prior to the crisis, which would facilitate tracing and help ensure continuity of treatment. In addition, due to spontaneous cross-border movement, people living with HIV may cross the border leading to high loss to follow up patients.

**Key statistics**

- By end of 2013, there were 51.2 million people forcibly displaced worldwide. These included 16.7 million refugees, 33.3 million IDPs and 1.2 million
asylum seekers. The three major refugee hosting countries in Africa are also UNAIDS high-impact countries (HICs): Chad, Ethiopia and Kenya.

- Out of the 10 major source countries of refugees, two are UNAIDS HICs: the Democratic Republic of the Congo and Myanmar.
- The proportion of countries in which refugees have equal access to ART increased from 79% to 97% between 2008 and 2013.
- Eighty-seven per cent of UNHCR operations reported the inclusion of refugees in national HIV strategic plans in 2013.
- Sixty-three per cent of UNHCR operations reported having legislation in their countries protecting the rights of HIV-positive asylum seekers in 2013—an increase from 51% in 2008.
- The proportion of countries with legislation protecting refugees from mandatory HIV testing increased from 63% to 68% between 2008 and 2013, though some countries continue to require mandatory testing of asylum seekers.
- Ninety-five per cent of UNHCR operations had ensured that refugees and host country nationals have equal access to services to prevent mother-to-child transmission.

Q&A

1. What is the link between HIV and displacement?

Conflicts and natural disasters often bring with them displacement, increased food insecurity, destruction of livelihoods and resulting poverty, violence, including increased violence against women, girls and children, and disruptions to HIV-related prevention, treatment, care and support services. As such, disasters can increase the vulnerability of affected populations to HIV infection, as well as disrupt care and treatment for people already living with the virus. The negative impact of HIV on the livelihoods of people affected can also increase the severity of disasters, leaving people less able to cope.

2. Is there any research to dispel the myth that refugees spread HIV among host communities?

Between 2004 and 2012, UNHCR conducted behavioural surveillance surveys in 27 separate communities in 10 countries, the largest trial of paired sites of refugees in protracted refugee camps and surrounding nationals. Data showed no consistent difference in levels of risky sexual behaviour, and there was much variation among the different groups.

Prevention strategies should be targeted in a highly integrated manner for both communities. Forced sex among women was reported at similar levels among
refugees and nationals, with intimate partner violence being the most common. These findings should be used to reduce discrimination against refugees.

3. Why should countries include refugees and other displaced people in HIV national strategic plans?

Refugees, IDPs and other people of concern to UNHCR should enjoy the highest attainable standard of physical and mental health. This requires non-discriminatory access to HIV services that are equivalent to those available to surrounding host communities. This would involve including refugees in national HIV national strategic plans. Besides legal obligations, governments have a public health imperative to include refugees, IDPs and other groups, such as economic migrants, in their disease specific strategic plans and funding proposals.

Communicable diseases do not respect borders, and it is effective public health policy to provide prevention and treatment programmes to the entire population residing in the same geographical area.
Overview

A vaccine is a substance that when introduced into the body teaches the body’s immune system to fight off disease. An HIV vaccine elicits an immune response by effectively making the body create antibodies and/or cells against HIV. Currently, no such vaccine for HIV exists. Most vaccines that are widely used are between 70% and 95% effective, yet vaccines are one of the world’s most effective public health tools. They are cost-effective, as a single dose or several doses often provide protection for years. Most vaccines available today took many years in development before they were licensed and made widely available. The history of vaccines shows that when compared to the discovery of a disease’s causative agent, the development of a vaccine has taken from a little more than a decade to as much as close to a hundred years.

Scientists are currently pursuing candidates that would help to prevent HIV infection in HIV-negative people; such vaccines may also help to control the virus in people who receive the preventive vaccine while HIV-negative and later become infected. Scientists are also developing therapeutic vaccines, which would build immune strength and help to control the virus in HIV-positive people.

Key messages

- An HIV vaccine is the best hope for ending the AIDS epidemic. Almost no infectious disease has been eradicated or effectively controlled without a vaccine. Successfully implementing a 60% efficacious vaccine could reduce new HIV infections by 25% in its first decade and by almost half in 25 years, averting up to 22 million infections, according to modelling by the International AIDS Vaccine Initiative (IAVI), AVAC Global Advocacy for HIV Prevention and the Futures Institute.

- An HIV vaccine is possible. The RV144 trial, conducted in Thailand and reported in 2009, showed that a vaccine could lower the rate of HIV infection by 31% and provided important clues as to how a more effective vaccine might work. It was the first to show that a vaccine could reduce the risk of HIV infection in people. The Pox-Protein Public–Private Partnership aims to build on the RV144 findings. It hopes to increase the level and durability of protection by using an extra vaccine boost and different adjuvants. Follow-on studies are starting and ongoing in Thailand; additional large-scale trials are expected to start in 2016 and 2017 in South Africa and Thailand,
respectively. This suite of studies could prepare the first path to licensure of an HIV vaccine.

- Successes in animal models are showing the way. Recent advances in understanding how the virus behaves, and how the immune system responds, have greatly increased the likelihood of finding an effective vaccine. For example, vaccine trials using viral vectors in monkeys have prevented and cleared HIV infection.

Innovations

- A fairly recent innovation, high-throughput screening (HTS), which relies on robotics and high-speed computer technology, has the ability to screen more than 100,000 compounds a day in complex biological systems on a routine basis. Prior to 2009, there were only a handful of broadly neutralizing antibodies (bnAbs) identified. HTS has enabled the discovery of more than a hundred bnAbs.

- bnAbs are potent antibodies that block the activity of many different types of HIV and occur naturally in a small number of people with HIV. bnAbs are being studied to understand how they bind with the virus to block activity and how they emerge in the body (a process called maturation). Scientists are also trying to design a vaccine that teaches the body to create mature, effective bnAbs that block HIV infection.

- Direct and vector-mediated (using a viral vector) approaches have been used to transfer bnAbs to non-human primates. In monkey models, bnAbs have successfully protected animals from SHIV to various degrees and, more recently, cleared SHIV infection. These support the notion that transfer of or the induction of bnAbs in humans could reduce HIV infection rates; however, clinical human studies need to verify this concept.

- Unprecedented public–private and international collaborations have been formed to accelerate progress towards an effective HIV vaccine. We are achieving together what no one organization or country can do alone. UNAIDS is working together with partners such as IAVI, AVAC Global Advocacy for HIV Prevention and other stakeholders. UNAIDS is also an active participant in the annual vaccine funders’ meetings to highlight the importance of continued research, sustained funding and coordinated responses towards HIV vaccine discovery.
**Challenges**

- HIV makes many copies of itself and mutates, making it unrecognizable to the immune system. Mutation leads to different subtypes of the virus. Researchers must make sure that an HIV vaccine cannot revert to a virulent virus. This means that they cannot use some of the scientific strategies used to develop vaccines for other diseases.

- Vaccine development takes time—it can be a slow, iterative process. After 30 years of the HIV epidemic, researchers believe we are closer to a vaccine than we ever have been. The HIV vaccine pipeline is increasingly diverse. More than 30 HIV vaccine clinical trials are under way, testing a variety of candidates and vaccine concepts. However, most are early stage trials (phase I and II) testing for safety and immune responses; there are no ongoing efficacy trials.

- Despite the promising scientific advances, spending on HIV research and development has stayed flat over the past few years. Vaccine discovery funding is heavily dependent on the Government of the United States of America. Continued public and philanthropic funding will be required to advance the development of promising HIV vaccine candidates to a stage where industry can be induced to step in and bring a vaccine to market.

**Background**

To date, there is no vaccine for HIV available. Many HIV vaccine candidates are in various stages of research, development and testing. Clinical trials for an HIV vaccine started in 1987; and since 2009 more than 150 clinical trials have been completed or are ongoing. Since the mid-1990s, more emphasis has been placed on developing vaccines for countries where HIV burden is highest, focusing on subtypes common in Central and South America, Africa and Asia. Many different types of vaccines will need to be tested in different regions of the world before a safe and effective HIV vaccine will be approved and licensed.

**Q&A**

1. **What is in the pipeline for HIV vaccines of the future?**

   There are a range of candidates in early stages of development, and a wide range of basic scientific work (work not focused on product development) ongoing in the HIV vaccine field. For a description of current and emerging research, see www.avac.org/vaccines.
2. Where are HIV vaccine trials taking place?

There are almost 30 clinical trials of experimental vaccines currently under way in nearly 20 countries, enrolling thousands of participants. Visit www.avac.org/pxrd for a table of ongoing and planned AIDS vaccine trials. For a view to where AIDS vaccine and other biomedical HIV prevention research is ongoing, visit www.avac.org/globalmap.

3. Who is participating in HIV vaccine research?

Like other HIV prevention strategies, HIV vaccine trials are conducted among different populations, including men who have sex with men, people who inject drug, sex workers and heterosexual men and women in sub-Saharan Africa.

4. What are DNA vaccines?

DNA vaccines contain copies of individual genes of HIV. Genes are small pieces of DNA (genetic material) that contain instructions or a code to make the virus’s proteins, which are its building blocks. When the DNA vaccine is injected, the genes are picked up by the body’s own cells, which are then able to produce the proteins coded for by the genes. The proteins are meant to generate an immune response against HIV. The selected genes are harmless and cannot make a whole virus, therefore they cannot cause HIV infection.

5. What are vector vaccines?

Vector vaccines use the same basic concept used in DNA vaccines with the addition of a vector, or delivery vehicle, that carries the gene copies contained in the vaccine into the human cell. A vector is a different virus that is unrelated to HIV and will not cause disease in humans. When the HIV gene copies and the vector are mixed together, the genes insert themselves into the vector and combine with its genetic material. By piggybacking on the vector, the HIV gene copies can enter into human cells more efficiently than if they were used alone in the vaccine. Examples of vectors include pox viruses, alpha viruses, adenoviruses and adeno-associated viruses.
Overview

A human rights-based approach to HIV is essential to achieving effective AIDS responses. Governments reaffirmed this in the 2011 United Nations Political Declaration on HIV and AIDS and made specific commitments to address human rights issues, including the elimination of stigma and discrimination against people living with and affected by HIV, reviewing laws impeding effective HIV responses and putting in place specific programmes to increase access to justice. However, efforts and investments to fulfil these commitments have not been sufficient. Today, human rights issues, particularly stigma and discrimination, inequality and violence against women and girls, denial of sexual and reproductive rights, punitive laws and approaches affecting key populations, and mandatory testing remain among the main barriers to effective HIV responses.

In part to galvanize greater action and advocacy on these issues, zero discrimination is one of the three aspirational goals of UNAIDS.

To advance the vision, action is required to change stigmatizing attitudes, improve both the legal and social environments around HIV and ensure that the three components of the legal environment (law—formal and customary; law enforcement—police and judicial practices; and access to justice) are protective, not punitive.

Key messages

- UNAIDS is committed to advancing human rights and gender equality in the AIDS response and considers this as important as, and intricately related to, HIV prevention and treatment efforts. The proportion of Global Fund Fight AIDS, Tuberculosis and Malaria (Global Fund) grants that include activities addressing stigma, discrimination and other human rights issues increased from 13% in round 8 to 62% in round 10. However, analysis has also shown that such activities are not systematically integrated into grant workplans, budgets and the performance framework. Similarly, while most national AIDS plans and strategies mention human rights, stigma and discrimination, they are not translated into comprehensive, appropriately targeted, and funded programmes, according to an analysis of national planning documents.

- UNAIDS is committed to the elimination of HIV-related stigma and discrimination and the promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms for people living
with and vulnerable to HIV. Discriminatory and punitive environments continue to be major barriers to universal access. In 2012, nongovernmental informants in 70% of countries and national governments in 60% reported the existence of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups.

**Innovations**

- From 2010 to 2012, the United Nations Development Programme (UNDP) convened on behalf of the Joint Programme the Global Commission on HIV and the Law, which analysed evidence, convened regional dialogues, expanded consensus and made recommendations on how to make the law work better for HIV. Its findings and recommendations comprise clearly outlined steps that states can take to improve the legal environment and better protect human rights in the context of HIV.

- In 2012, UNAIDS published a Guidance Note, *Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses*. Subsequently, regional workshops were organized in Africa, Asia and Latin America to support the inclusion of these programmes in national strategic plans, Global Fund proposals and other national HIV frameworks. These programmes, which can be tailored to and benefit people living with HIV, other key populations and women, include: legal services; legal literacy (know your rights/laws); law reform to address the key legal and human rights challenges affecting the HIV response; and stigma reduction programmes; training of police/judges on HIV and human rights; training of health-care workers on non-discrimination, informed consent and confidentiality; programmes to reduce harmful gender norms and violence against women.

- In 2014, UNDP developed a practical manual on legal environment assessment for HIV, which can support countries in reviewing, and generating dialogue for improving, the legal environment relating to HIV.

**Challenges**

- Punitive laws that hinder effective responses to HIV remain widespread. Some 78 countries criminalize consensual same-sex sexual relations, and the vast majority of countries, territories and areas criminalize drug use and aspects of sex work.

- Legal environments that perpetuate gender inequality and do not protect against gender-based violence also fuel the HIV epidemic, making women and girls more vulnerable to HIV infection.
Increased polarization around social, sexual and reproductive health issues, shrinking civil society space as well as patchy resources for human rights programmes in the context of HIV are among key challenges that impact progress on zero discrimination.

Key statistics

- Forty countries, territories and areas imposed some form of restriction on the entry, stay and residence of people living with HIV (as of June 2014).
- At least 63 countries have laws that specifically criminalize HIV transmission or exposure.
- About 39% of countries worldwide reported not having laws that prohibit HIV-related discrimination.
- In 17 out of 23 countries where the People Living with HIV Stigma Index research was conducted, less than 30% of people living with HIV who have experienced rights violations reported having sought legal redress.
- Twenty-seven countries are reported to have compulsory detention for people who use drugs, often without due process or minimum standards of detention or treatment.

Q&A

1. In the current, resource-constrained environment, shouldn’t countries be focusing on service delivery rather than human rights?

Promoting and protecting human rights is especially important in the current, resource-constrained environment, and will result in efficiency gains and more sustainable responses by ensuring:

- That those who most need prevention, treatment, care and support services can access and adhere to them. Human rights-based responses, including key human rights programmes and advocacy, will increase countries’ ability to more effectively reach those who are most affected—women, people who use drugs, men who have sex with men, transgender people, sex workers, migrants, prisoners, young people, persons with disabilities—by helping to overcome the barriers, such as stigma, discrimination, criminalization, gender-based violence and social marginalization, that keep people away from information and services.
- Improved service quality. For example, protecting confidentiality and ensuring counselling and informed consent create optimal conditions for the uptake of services, especially for people seeking HIV testing and women seeking prevention of mother-to-child transmission of HIV services.
The empowerment of people to be able to protect their health. For example, protecting the human rights of women living with and affected by HIV can empower them to safely disclose their HIV status, adhere to a treatment regimen, discuss HIV with their children and mobilize to claim their rights.

2. What can states do now to begin to transform commitments to address human rights related to HIV into action and results?

UNAIDS recommends a package of steps that can be taken, which include the following:

- Measure HIV-related stigma in the community, in health-care settings and as experienced by people living with HIV, including implementing the People Living with HIV Stigma Index, and let data inform political and programmatic responses to reduce stigma.
- Ensure the implementation—in sufficient scale and quality—of programmes to address the legal environment in its three aspects, including conducting legal environment assessments, promoting access to justice and training of health-care workers, police and members of the judiciary, etc.
- Establish a working group on HIV and the law comprised of government (ministries of justice and the interior), parliament, the judiciary and civil society to identify the priority legal issues that need to be addressed.
- Ensure that the size of key populations at higher risk has been measured and their vulnerabilities to HIV mapped, and expand programmes that will effectively reach them.
INTELLECTUAL PROPERTY RIGHTS AND ACCESS TO TREATMENT

[Source: UNAIDS—Carlos Passarelli: passarellic@unaids.org, UNDP—Tenu Avafia: tenu.avafia@undp.org]

Overview

The cost of health technologies to diagnose and treat HIV and its coinfections remains one of the key barriers to sustaining and increasing access to treatment programmes. This is influenced by a variety of factors, including intellectual property (IP) enforcement.

The flexibilities contained in the World Trade Organization’s (WTO) Trade-related Intellectual Property Rights (TRIPS) Agreement, as reaffirmed by the 2001 Doha Declaration on the TRIPS Agreement and Public Health, provide important opportunities for WTO Members to reduce prices and expand access to HIV treatment.

Countries revising their laws should incorporate to the fullest extent possible these flexibilities into national legislation and utilize them in order to meet public health objectives. In addition, countries should carefully consider the public health implications when adopting or implementing more extensive IP protection than is required by the TRIPS Agreement.

International organizations should advocate for and support their national partners in the implementation and use of all public health-related TRIPS flexibilities, and in all other actions consistent with the TRIPS Agreement, to promote access to health technologies used to treat HIV and its coinfections.

Key messages

- TRIPS flexibilities should be accompanied by other policy measures that can help countries scale up access to antiretroviral treatment. Low- and middle-income countries should develop mechanisms to strengthen their capacity to negotiate lower prices of medicines. For example, by setting up joint or “pooled” procurement or developing innovative mechanisms to stimulate local production. Competition law remains one of the least discussed flexibilities within the TRIPS Agreement. There remains a great untapped opportunity for low- and middle-income countries to implement robust competition law frameworks and to complement them with strong enforcement mechanisms to promote access to health technologies.
Innovations

Countries should actively pursue new and alternative models for innovation to treat HIV and neglected tropical diseases by:


- Participating in discussions aimed at developing new models of innovation for health technologies to treat HIV, neglected tropical diseases and the increasing prevalence of noncommunicable diseases by exploring alternative proposals to incentivize innovation outside of the patent system and according to public health priorities, such as prize incentives schemes, pooled financing, public–private partnerships and a treaty for international financing of biomedical research and development.

- Supporting and pursuing alternative public health-oriented models to manage licensing for newer HIV drugs, such as the Medicines Patent Pool, which aims to facilitate the development of newer or improved antiretroviral formulations by providing access to the patents needed for their generic production through voluntary licensing.

Challenges

- TRIPS-plus provisions are measures that go beyond the minimum protection requirements for IP protection under the TRIPS Agreement or that restrict the opportunities for countries to use TRIPS flexibilities. They should be avoided as they may constrain policy space available to low- and middle-income countries to implement and use laws or policies to protect public health. These measures often arise as a result of provisions in free trade agreements (FTAs). The production and distribution of spurious/falsely-labelled/falsified/counterfeit (SFLFC) medicines is an illegal activity that can endanger the lives or health or consumers.

- There is growing evidence that, while the number of new chemical entities has fallen significantly in recent years, the number of patents being granted because of insignificant changes in the chemical formulation of existing pharmaceuticals has not led to new medicines but rather to the exclusion of generic competition in many instances. The flexibility to apply high standards of patentability should be used to incentivize real innovation, rather than the pursuit of insignificant changes.
Key statistics

- The large majority of people living with HIV on treatment are on first-line regimens and will eventually need to switch to second- and third-line regimens, some of which are still under patent and consequently are much more expensive.

- On average, the most commonly used second-line antiretroviral medicines are around four times more expensive in low- and middle-income countries than the WHO recommended first-line regimen of tenofovir + emtricitabine + efavirenz.

Background

Responding to a situation where global debates around access to medicines tend to focus on lower-income countries, delegates from 21 middle-income nations from all continents, together with representatives of civil society and international organizations, discussed their specific needs, perspectives and concerns.

It was recognized that this is especially crucial given that by 2020 the vast majority of people with HIV will be living in such countries. Many middle-income nations are now paying a high price for antiretroviral medicines, particularly those used for second- and third-line treatment and even optimized first-line formulations.

There was much analysis and information-sharing about the markets and prices of HIV medicines and their regulatory status in different middle-income nations. The key question of public health-focused management of IP rights was scrutinized in some detail, exploring both voluntary mechanisms, like the Medicines Patent Pool, and the full use of flexibilities contained in the TRIPS Agreement.

The meeting was a valuable step forward, bringing together middle-income countries from around the world with different challenges in achieving long-term access and sustainability of antiretroviral therapy.

On 19 May 2014, the United Nations Development Programme (UNDP) released a new guidebook encouraging low- and middle-income countries to make greater use of competition law and policy to increase access to HIV treatment and other health technologies.

Q&A

1. What TRIPS flexibilities are best to use?

   Both the expansion and sustainability of treatment programmes are at risk unless countries incorporate and use the public health flexibilities in the TRIPS Agreement. Preventative flexibilities are usually the most efficient, since they act as safeguards before a patent is granted and potentially restricts access. These types of flexibilities include strict application of patentability criteria, measures to facilitate
patent application opposition, or excluding new uses of known substances, new indications of known medicines or methods from patentability. Applying such flexibilities prevents low-quality and frivolous patents from hindering access to medicines.

Making full use of available transition periods to comply with the bulk of TRIPS provisions is another important flexibility. On 11 June 2013, the TRIPS Council agreed to extend until 1 July 2021 the deadline for the least developed countries (LDCs) to comply with the TRIPS Agreement.

WTO Members are entitled to implement their patent legislation to meet public health objectives to ensure that only patents of the highest quality are granted, therefore reducing incidents of ever-greening. This practice has been described as “a strategy consisting of acquiring patents on minor, often trivial, modifications of existing pharmaceutical products or processes in order to indirectly extend the period of patent protection over previously patented compounds.”

Remedial flexibilities are those that may be applied after a patent has been granted; the most often discussed remedial flexibilities are compulsory licences or government use orders, when the patent is used without the permission of the holder, against remuneration. There have been several cases since 2002, when low- and middle-income countries have issued compulsory licenses for essential medicines. Compulsory licences are often used to overcome patent protection in many other fields of technology, including by developed countries. The most frequent issuer of compulsory licences for various fields of technology is the United States of America.

2. What impact might contemporary FTA negotiations have on access to treatment?

India and the European Union are currently negotiating an FTA, which would have ramifications on treatment access beyond the negotiating parties. India’s pharmaceutical industry accounts for more than 80% of the medicines to treat HIV in developing countries. India is also the most important source of generic medicines for noncommunicable diseases, including cancer and heart diseases.

Since 2005, when India had to become fully TRIPS compliant, it has provided patents on pharmaceuticals but has included the TRIPS public health flexibilities in its Patent Act.

The proposed European Union and India FTA with TRIPS-plus provisions could have an adverse impact on the Indian generic pharmaceutical industry’s ability to continue to be the major supplier of affordable HIV medications throughout the developing world and could critically damage successful efforts to scale up treatment access, thereby reversing a decade of hard-won success in saving lives.
Overview

Linking sexual and reproductive health and rights (SRHR) and HIV responses is essential; the majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding, and the risk of HIV transmission and acquisition can be further increased due to the presence of certain sexually transmitted infections (STIs). Sexual and reproductive ill health and HIV share interconnected root causes, including gender inequality, harmful sociocultural norms and practices, economic inequality and poverty, limited access to appropriate information, and social marginalization of women, including women living with HIV and from key populations at higher risk.

The benefits of linking SRHR and HIV include: improved access to and uptake of key HIV and sexual and reproductive health (SRH) services; better access of people living with HIV to SRH services tailored to their needs; reduction in HIV-related stigma and discrimination; improved coverage of underserved, vulnerable and key populations, including women and girls; and decreased duplication of efforts and competition for scarce resources; resulting in enhanced programme effectiveness and efficiency.

Key messages

- Girls and young women are among the most vulnerable to HIV and sexual and reproductive ill health.
- Forced and coerced sterilization, faced by some women living with HIV, are gross violation of their sexual and reproductive rights, undermining the effectiveness of the HIV and SRH agenda.
- HIV targets and any post-2015 sustainable development goals will not be achieved without ensuring human rights and universal access to SRH and HIV services.
- Investing in capabilities of youth to engage in public policy, and ensure their access to comprehensive information on sexual and reproductive health and rights and access to SRHR services is needed to prevent HIV among youth and ensure that young people living with HIV access timely treatment and care.
- Stigma and discrimination, including gender-based discrimination as well as gender-based violence, are human rights violations and prevent access to quality health care.
Key data

- HIV is the leading cause of death in women of reproductive age.
- HIV now ranks as the second cause of deaths in adolescents globally.
  Preventing HIV and unintended pregnancies is critical to attaining the goal of eliminating new HIV infections among children by 90% by 2015.
- One in three women worldwide has experienced either physical and/or sexual violence by an intimate partner, or non-partner sexual violence, in her lifetime. Gender-based violence is a contributing risk factor of HIV and a reported consequence; recent studies of women in South Africa and Uganda found that women who had experienced intimate partner violence were 50% more likely to have acquired HIV than women who had not experienced violence.

Q&A

1. What are the key principles governing SRH and HIV linkages?

   There are six key principles upon which linkages, policies and programmes must be built: (a) address structural determinants; (b) focus on human rights and gender equality to promote a coordinated and coherent response; (c) meaningfully involve people living with HIV; (d) foster community participation; (e) reduce stigma and discrimination, including gender-based discrimination and gender-based violence; and (f) recognize the centrality of sexuality.

2. What is the Rapid Assessment Tool for SRH and HIV linkages?

   It is a tool to: assess HIV and SRH bi-directional linkages at the policy, systems and service-delivery levels; identify critical gaps in policies and programmes; and contribute to the development of country-specific action plans to forge and strengthen these linkages. The tool has been used in 50 countries.

3. Is there any guidance available for preventing HIV and unintended pregnancies in the context of the Global Plan?

   Preventing HIV and unintended pregnancies: A strategic framework: in support of the Global Plan towards elimination of new HIV infections in children by 2015 and keeping their mothers alive and the related Job Aid have been developed and are being rapidly rolled out. They offer guidance to:
   - Implement a package of services for preventing HIV and unintended pregnancies within stigma-free integrated SRH and HIV services.
   - Utilize key entry points to integrating services for HIV and SRH.
Strengthen national programme implementation, including to deliver prong one and two interventions.

Carry out five key strategies:

— Strategy 1: link SRH and HIV at the policy, systems and service delivery levels.
— Strategy 2: strengthen community engagement.
— Strategy 3: promote greater involvement of men.
— Strategy 4: engage organizations of people living with HIV.
— Strategy 5: ensure non-discriminatory service provision in stigma-free settings.

The meaningful involvement of women and girls living with HIV is key to each of these strategies and must be ensured at all levels.

4. Why are linkages of SHR services important for people living with HIV?

It allows people living with and affected by HIV to access both HIV and SRH services in the same facility, increasing the opportunities for a continuity of care without being externally referred. It expands the range of clinical services provided beyond HIV treatment and care to include those for STIs, family planning, cervical cancer, infertility, maternal health, gender-based violence and other related services. It reduces the frequency and costs of health-related appointments, such as time off work and transportation.
Overview

A microbicide is a substance used topically to serve as a barrier to infection. These may be developed as creams, vaginal or rectal gels, suppositories or rings and may contain antiretroviral drugs or other antiviral compounds. There are no licensed microbicides available today. Vaginal and rectal microbicides could help address some of HIV prevention’s unmet needs.

Key messages

- Millions of women and men today lack the power to insist that their sexual partners use condoms or other available prevention strategies. Simple, easy-to-use microbicides would help these individuals take control of their own health—and offer people everywhere an additional, needed HIV prevention option.

- While no microbicide is commercially available, clinical trials could lead to licensing of the first products within this decade. To ensure that people can benefit quickly, the foundation for roll-out must be laid now.

Innovations

- Recent research has shown that a microbicide can work. Despite failure in very early research to provide evidence that a microbicide works, results from CAPRISA 004, which assessed the effectiveness and safety of a 1% vaginal gel formulation of tenofovir, released in 2010, provided the first evidence that a vaginal microbicide—specifically, tenofovir gel—can help to prevent HIV in women. Tenofovir gel reduced HIV acquisition by an estimated 39% overall, and by 54% in women with high gel adherence. Tenofovir gel could potentially fill an important HIV prevention gap, especially for women unable to successfully negotiate mutual monogamy or condom use. However, the VOICE trial that tested daily use of the oral pill and topical gel (1% tenofovir) found that neither worked to reduce the risk of HIV infection. However, further analyses found that trial participants were not following the daily regimen as prescribed, as they did not have detectable drug blood levels. In CAPRISA 004, the tenofovir gel was used peri-coitally, that is before and after sex, whereas in the VOICE trial, participants were asked to use the gel every day, regardless of whether or not they had sex.
An antiretroviral-based microbicide could be licensed within this decade. Ongoing microbicide (vaginal and rectal gel) studies are to report on results in 2015. FACTS-001, a phase III safety and efficacy trial of tenofovir vaginal gel in South Africa, is testing the same dosing strategy evaluated in CAPRISA 004. CAPRISA 008 is follow-on research to CAPRISA 004 to collect additional safety data and to explore how tenofovir gel, if approved, can be provided through family planning services. MTN 017, a first-ever expanded safety study (phase II trial) of a rectal microbicide candidate, a reformulated version of tenofovir gel, is being tested for safety, absorption and acceptability among men who have sex with men and transgender women in Peru, South Africa, Thailand and the United States of America.

Two parallel studies on vaginal rings designed to deliver dapivirine are also ongoing, with results expected in 2015 and 2016. ASPIRE (MTN 020) and the Ring Study (IPM 027) are both evaluating the safety and effectiveness of the dapivirine ring at reducing HIV infection risk in different sites in sub-Saharan Africa.

Challenges

- Tenofovir and dapivirine are not licensed anywhere as a topical preparation. Thus, if the trials show benefit, availability will be a problem, as there is no laboratory manufacturing it on a large scale. A number of actions will be needed to get the product approved and licensed by regulatory boards.

- Tenofovir and dapivirine are being studied for vaginal delivery through a gel and a ring. This is a challenge for women who have anal intercourse. Theoretically, a vaginal gel also gets absorbed into rectal tissue, although this is currently being studied. It is not yet known whether tissue levels will be high enough for these products to protect against rectal infection.

- For men who have sex with men and transgender women, results from research into a gel delivered through the rectum are still awaited.

Background

Among women, unprotected sex with an infected male partner remains the primary risk factor for HIV infection, and in many parts of the world heterosexual intercourse is the driving force of the epidemic. Women are twice as likely as their male partners to acquire HIV during sex, due in part to biological factors that make women more vulnerable. While condoms are an effective method to prevent HIV infection during vaginal and anal sex, for a number of reasons many people don’t use them correctly and consistently.
The latest generation of microbicides being tested is based on antiretroviral medicines that penetrate the vaginal tissues and aim to prevent HIV infection from becoming established. They have been formulated for the vagina and have a high osmolality, which may damage the more fragile lining of the rectum. It is therefore important to test their safety and acceptability when used for anal sex. Research must also focus on the development of microbicides designed specifically for rectal use.

Microbicides delivered as vaginal or rectal gels and vaginal rings are a leap forward in female-controlled methods. UNAIDS believes that people should have options that suit their needs. It firmly supports the development of other HIV prevention options, especially for people who lack the power to negotiate safer sex. To this end, UNAIDS sits on the Advisory board of the Tenofovir Gel Implementation Steering Committee.
PRE-EXPOSURE PROPHYLAXIS (PrEP)

[Source: UNAIDS—Rosalind Coleman colemanr@unaids.org, Peter Godfrey-Faussett:godfreyp@unaids.org]

Overview

Pre-exposure prophylaxis (PrEP) is the use of antiretroviral medication as prophylaxis by people who are HIV-negative and at higher risk of being exposed to HIV. Its intended role is as part of a combined HIV prevention strategy. Oral PrEP using tenofovir (alone or combined with emtricitabine) has shown up to 90% effectiveness in preventing HIV infection among men who have sex with men, heterosexual people and people who inject drugs. In these trials, PrEP’s effectiveness was highly dependent on adherence to the regimen of daily oral dosing.


Key messages

- PrEP can be an appropriate choice for people who know that they are not infected with HIV and who are at higher risk of HIV exposure. Being on PrEP is especially important when other methods of protection are not or cannot be used. For example, when negotiation of condoms is not feasible, as well as among people in long-term serodiscordant relationships.
- PrEP can be empowering, especially where there is high HIV incidence and personal vulnerability, as it strengthens a person’s control and choice in HIV prevention. PrEP is emerging as a new element of combination HIV prevention programmes.

Innovations

- Topical PrEP includes vaginal and rectal microbicides. Tenofovir vaginal gel is currently in a phase III safety and efficacy trial in South Africa (FACTS-001). Dapivirine (in a vaginal ring) is currently in two phase III safety and efficacy studies. Long-acting injections of PrEP are under early investigation.
- Strategies for simultaneous PrEP and antiretroviral therapy provision are under investigation for serodiscordant couples and among sex workers.
The IPERGAY study is investigating the effectiveness and pharmacokinetics of PrEP taken by men who have sex with men during periods of high HIV exposure risk only.

**Challenges**

- Adherence to the daily oral regimen and having regular HIV tests are crucial for PrEP to be effective and not induce drug resistance. Ways to enhance the correct and sustained use of PrEP are under investigation.
- The health services of many of the populations where there is high HIV incidence are underfunded.
- The populations for which PrEP could have the highest HIV prevention impact, and be the most cost-effective, are often marginalized or criminalized in many countries. Assuring access to PrEP requires established rights-based relationships between these communities, programme planners and health workers.

**Key statistics**

Four trials have shown daily oral PrEP effective in preventing sexual transmission of HIV. The effect was higher for people who took PrEP consistently:

- **iPrEx**: PrEP reduced the risk of HIV by 44% in gay men and transgender women of black, Asian, Hispanic/Latino and white racial origin. Taking PrEP consistently reduced the risk by more than 90%.
- **Partners PrEP**: PrEP reduced risk of HIV by 73% in heterosexual HIV discordant couples in Kenya and Uganda. Taking PrEP consistently reduced the risk by more than 90%.
- **TDF2**: PrEP reduced the risk of HIV infection by 63% in heterosexual men and women in Botswana.
- **Bangkok tenofovir study**: PrEP reduced the risk of HIV infection by 75% in people who inject drugs in Thailand.

**Background**

The number of new HIV infections per year has decreased globally, but the rate of reduction has been slow and uneven between countries. Efforts to reduce transmission related to sex work, men who have sex with men and people who inject drugs remain insufficient. Suppressing HIV loads in people living with HIV using antiretroviral medication is effective in reducing HIV transmission, but present coverage rates will not be sufficient to stop the HIV epidemic. PrEP is a biomedical contribution to the existing combined prevention strategies of HIV infection.
PrEP uses medicines for which there are millions of patient years’ experience. Tenofovir and emtricitabine are nucleoside reverse transcriptase inhibitors with well-established antiretroviral activity that are frequently used together. The use of these antiretroviral medicines as PrEP is licensed only in the United States of America so far, but licensing applications are now pending in several other countries, including South Africa, and in some countries in Latin America.

Q&A

1. Is PrEP safe?

Tenofovir and emtricitabine are generally well tolerated in antiretroviral therapy (i.e. when used to treat HIV). Using medication as prophylaxis rather than treatment demands very high safety standards. The description of the safety profile of these drugs used as PrEP is improving. Common side-effects include nausea, dizziness and weight loss in the first month. Small declines in renal function and limited diminished bone density have been seen rarely. These will be monitored in ongoing open label demonstration trials. PrEP is not recommended with high doses of non-steroidal anti-inflammatory medication. Otherwise, PrEP is not reported to interact with alcohol or other drugs, nor interfere with the effectiveness of contraceptive medication. Antiretroviral medicines taken by women living with HIV during pregnancy, and by newborns, have been safe, but PrEP has not been formally researched in pregnant or breast-feeding women.

2. Can PrEP cause resistance to these drugs that are so important in treating HIV?

PrEP is only for people who are HIV-negative. There is a real risk of drug-resistant strains of HIV emerging if people infected with HIV take PrEP. (Using less than three antiretroviral drugs to treat HIV can allow drug resistance to develop.) This is why testing HIV-negative before starting PrEP, and at regular intervals while on PrEP, is a vital safety check. Concerns of HIV drug resistance developing, especially where there is poor adherence to PrEP, are so far unproven. Under trial conditions, with regular HIV testing, any drug resistance has been transitory and mainly linked to acute HIV infection that was not detected at entry into the study. Resistance monitoring of PrEP continues.

3. How can adherence to PrEP be improved?

The reasons for low adherence in the PrEP trials were often related to people remaining in the trials for the associated benefits (e.g. access to health-care workers, free travel) while not being motivated to take PrEP. The reluctance to take PrEP was multifactorial, but included uncertainty about side-effects and discomfort with the placebo control concept. Open label extension trials and
demonstration projects will use only active medication (no placebo) and involve people who request to take PrEP.

In addition, topical and/or longer acting preparations currently under investigation will provide more choice if found effective (rectal and vaginal gels or films, vaginal rings with one-month slow release of medication, long-acting injections). As PrEP becomes normalized, and other preparations become available, effective adherence should improve.

4. Could the introduction of PrEP lead to more risk taking, in particular less safe sexual behaviour?

There is a theoretical risk that PrEP will undermine the use of condoms and other safe sex behaviours. During and after the PrEP trials no systematic increase in unsafe sexual behaviour has been reported. The introduction of PrEP should be associated with the promotion of continued use of condoms and lubrication, and other proven HIV prevention behaviours. It should also be made clear that PrEP does not prevent pregnancy or other sexually transmitted infections.

5. Is PrEP appropriate for people who are only at risk of HIV infection for certain periods?

People who periodically and predictably have a higher risk of HIV exposure, for example migrant workers and their partners, might consider taking PrEP only to cover those periods. The effectiveness of PrEP in these situations would depend on the pharmacokinetics of PrEP drugs in that individual: the time and number of PrEP doses required to obtain inhibitive drug levels in the rectum, vagina or plasma and to remain effective until all virus has been cleared. This is actively under research, and the current recommendation remains to maintain daily PrEP dosing.

6. What is the future for PrEP implementation?

PrEP is currently at a threshold. There is sufficient evidence of its effect and safety, and clearly a need for improved HIV prevention strategies. Challenges to its widespread implementation include: raising public demand through information and access; promoting adherence to guidelines for correct and regular use of the product as part of a combined HIV prevention strategy; understanding better the risk profiles of people who might choose PrEP and developing strategies for focusing PrEP delivery for those priority populations; achieving regulated generic manufacturing where feasible; and assuring funding. Fundamentally, PrEP implementation depends on governments obtaining sufficient information and resources for prevention and treatment, which both need to be stepped up in a coordinated way. Given the scale and complexity of the epidemic, we know that no single intervention can end the AIDS epidemic.
Overview

Recent studies have shown that, at the individual and the community level, scaling up antiretroviral treatment (ART) leads to fewer new HIV infections. The HPTN 052 study, released in May 2011, found that ART was 96% effective in preventing sexual transmission of HIV within serodiscordant couples. In February 2013, the Africa Centre for Health and Population Studies published results from its demographic surveillance site demonstrating that, after adjusting for other risk factors, HIV incidence was nearly 40% lower in areas with high ART coverage than in areas with the lowest coverage for the HIV-positive population. The Africa Centre trial, conducted in parts of KwaZulu-Natal, South Africa, provides the best evidence to date that treatment can benefit a community.

Several large studies are currently testing different approaches to the scaling up of ART in order to determine the impact such an increase in coverage might have on the rate of new HIV infections at the population level.

While compelling evidence exists that treatment works for prevention, no single method of preventing HIV is 100% effective. Therefore, to get full benefit, treatment must be used in combination with other HIV prevention options. Treatment also requires that people know their HIV status.

Key messages

- Treatment is highly effective in preventing HIV infections when added to the standard HIV prevention package (safer sex counselling, free condoms and lubricant, and treatment of sexually transmitted infections).

- The option of treatment as a prevention tool should be available widely and equitably, especially to serodiscordant couples. To increase access, treatment must match the scale of the need, and the Treatment 2015 Initiative must be urgently implemented.

- The good news about treatment for prevention gives us hope that reducing the sexual transmission of HIV by 50% by 2015 is within reach—as 80% of all new HIV infections are transmitted sexually, and in many places a quarter or more of all new HIV infections are transmitted within an established couple.
Innovations

- New options to lower the barriers to HIV testing include home self-testing. The World Health Organization (WHO) and UNAIDS support countries in considering the extension of this mode of testing, provided that the quality of the test kits is assured.

- Community and lay health workers, “buddies” and community-supported treatment literacy are some effective remedies to reduce the loss of patients in follow-up care and to improve support so that people living with HIV have better access to treatment and remain in care.

Challenges

- Limited access to HIV testing and treatment.

- System weaknesses, overcrowding, gaps in patient care and discrimination from care providers.

- In high-income and resource-constrained settings, only a small minority of people testing HIV-positive enter into and remain in treatment programmes so that the virus is fully suppressed.

- Treatment requires that people know their HIV status first. In addition, people who have been newly infected (acute infection) have very high viral loads and may not yet have a positive HIV antibody test; however, they have the highest risk of transmitting HIV.

Q&A

1. Can we treat our way out of the HIV epidemic?

   New HIV infections cannot be stopped using one method alone. A prevention revolution that includes all available options to stop the transmission of HIV is required. ART is now firmly part of this package. We expect that increasing the use of ART will reduce the number of new HIV cases, but we do not yet know what the magnitude of that impact will be.

2. What is the difference between medical eligibility and prevention access to treatment?

   Guidelines from WHO on medical eligibility for treatment recommend that treatment should be started when a person living with HIV has a CD4 count lower than 500 cells/µL (regardless of symptoms), tuberculosis or hepatitis B, is in a serodiscordant couple or is pregnant, or is a child under five years old.
3. Should everyone who tests positive for HIV start treatment right away?

Data provided by studies always have to be understood and interpreted, keeping in mind the individual or couple affected by HIV. People living with HIV and their partners should consult a health-care provider or counsellor together to review their preparedness for issues related to medication adherence and side-effects, as well as to consider options such as male and female condoms, having fewer sexual partners, voluntary medical male circumcision and avoiding penetrative sex.

4. What advice is UNAIDS giving to serodiscordant couples?

People with HIV in serodiscordant couples and who are on treatment for their own health should be advised that treatment is also recommended to reduce HIV transmission to the uninfected partner. HIV-positive partners with CD4 counts >500 cells/µL should be offered treatment.

Couples should ensure that they are tested for HIV, preferably together. They should incorporate knowledge of their HIV status in their risk decision-making. People who test positive should seek access to HIV treatment.
Overview

The UNAIDS 2011–2015 Strategy sets out the Joint Programme’s response in advancing comprehensive and non-discriminatory health services and human rights for all in the context of the AIDS response. In particular, it makes “advancing human rights and gender equality” one of three pillars of the response, along with HIV prevention and treatment. It also recognizes that “Social and legal environments that fail to protect against stigma and discrimination or to facilitate access to HIV programmes continue to block universal access.” It further calls on countries to “make greater efforts: to realize and protect HIV-related human rights …; to implement protective legal environments for people living with HIV and populations at higher risk of HIV infection; and to ensure HIV coverage for the most underserved and vulnerable communities.” The reference in the Strategy to populations at higher risk of HIV infection includes lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

The Joint Programme has worked consistently to address the legal and policy challenges hindering the HIV response in accordance with the commitments made by United Nations (UN) Member States in the 2011 UN Political Declaration on HIV and AIDS. The 2011 Political Declaration notes “that many national HIV-prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men …”

Gay men and other men who have sex with men and transgender women are among the populations most affected by HIV worldwide. Currently, 78 of 193 countries criminalize same-sex relations, with some jurisdictions permitting imposition of the death penalty for convictions under such laws. While a number of countries are putting in place protective laws for LGBTI people which prohibit violence and discrimination and make provision of recognition of third genders, there are also some countries that are further criminalizing LGBTI status and in some cases those who support them (e.g. Uganda, Nigeria, Russian Federation). Criminalization and lack of legal protection, along with high levels of stigma, violence and discrimination, constitute significant barriers to the provision and uptake of HIV services.
Key messages

- New infections among gay men, other men who have sex with men and transgender women and men are important components of national epidemics in countries across all regions. Increasing their participation in and access to HIV services to ensure counselling, testing and antiretroviral therapy is an urgent global health and human rights priority.
- Criminalization of LGBTI people and stigma and discrimination based on sexual orientation and gender identity puts entire communities at risk and drives new HIV infections. It keeps people in need of HIV prevention and treatment services out of reach of life-saving interventions and also places at risk the sexual partners, male and female, of gay men, other men who have sex with men and transgender people.
- UNAIDS joins with the UN Secretary-General and the UN High Commissioner for Human Rights calling for decriminalization of LGBTI people, protection from violence and discrimination, and full access to health and other social services.
- The UN Secretary-General has developed a new initiative, Rights up Front, to improve UN preparedness and action to safeguard human rights around the world. The need for early action, and the crucial role of responding early to human rights violations, is at the heart of the initiative.

Challenges

- In countries that criminalize homosexuality, LGBTI people are reluctant to use services for a variety to reasons; for example, they face condemnatory attitudes and discrimination in health services and their sexual orientation may be revealed to their families, communities or to the authorities, resulting in violence, rejection or arrest.
- Funding for HIV prevention services for men who have sex with men and transgender people is especially limited in East Asia, the Caribbean, the Middle East and North Africa, and across sub-Saharan Africa. Overall, international funding vastly outweighs domestic spending on focused prevention services for men who have sex with men.
- Men who have sex with men and transgender people often have limited access to condoms, water-based lubricants, HIV education and support for sexual risk reduction.

Key statistics

- The highest median HIV prevalence among men who have sex with men was reported in western and central Africa (19%) and eastern and southern Africa
(15%), with somewhat lower but still high levels of HIV infection reported among men who have sex with men in Latin America (12%), Asia and the Pacific (11%), western and central Europe and North America (8%) and the Caribbean (7%).

- According to a review of available studies from 15 countries, an estimated 19% of transgender women were living with HIV. HIV infection was found to be 49 times greater in transgender women than for all adults of reproductive age in these countries.³

**Background**

In June 2011, a historic resolution, tabled by South Africa, was adopted by the UN Human Rights Council (HRC). It expressed “grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity.” The resolution called for a report by the UN Office of the High Commissioner for Human Rights to document discriminatory laws and violence against LGBTI people and urged countries to end such practices. The report was released in November 2011.

On 7 March 2012, the HRC held for the UN’s first ever formal panel on sexual orientation and gender identity. The panel featured powerful messages for ending discrimination and violence and for continued dialogue on the issue. The event also revealed regional and ideological divisions on the issue.

An Anti-homosexuality Bill was signed into law in Uganda, an anti-homosexual marriage act was signed into law in Nigeria, and an anti-propaganda law in the Russian Federation in 2013/2014. There are a number of reports documenting the climate of fear and the negative impact these laws have had on the provision and uptake of HIV services, as well as on the safety and well-being of affected communities. These crises have heightened UNAIDS’ efforts to be proactive and adopt a more strategic approach to addressing sexual orientation and gender identity in the context of the HIV response.

**Q&A**

1. **What is UNAIDS’ position on discrimination based on sexual orientation and gender identity in the context of HIV?**

   All forms of discrimination impede access to HIV services. Discrimination based on sexual orientation and gender identity is a human rights violation and must

be stopped. Homophobia and transphobia, where it exists, fuel the HIV epidemic and must be addressed as a key part of national AIDS responses. National dialogues should be initiated with the aim of decriminalizing sex between consenting adults and providing protective laws against discrimination and violence based on actual or assumed sexual orientation and/or gender identity or gender identity.

2. What has UNAIDS done about incidents of discrimination?

UNAIDS works with governments and civil society to support zero discrimination laws and access to HIV services for all. As part of this, UNAIDS engages with governments on law reform and revisions to other legal mechanisms to prohibit discrimination based on a variety of issues, and to ensure antidiscrimination provisions protect all those living with and vulnerable to HIV.

At the country level, UN joint teams on AIDS provide technical support to national counterparts in bringing about positive legal frameworks and mechanisms that protect people from discrimination and violence. UNAIDS also supports countries to develop a protective and safe environment that enables access to essential HIV treatment, prevention, care and support services for men who have sex with men, transgender people and other key populations at higher risk.

3. How are rights violations against men who have sex with men and transgender people linked to HIV—and why is UNAIDS involved?

When men who have sex with men and transgender people are criminalized, discriminated against and live in fear of violence in their own communities and countries, they can be pushed into risky environments and behaviours, including sex work. They are also hard to reach by HIV service providers, leading to unmet needs and continued risk of HIV transmission in communities. Violence, including extreme violence resulting in death, of LGBTI people on the basis of their actual or perceived sexual orientation or gender identity is reported in many countries across the world.

UNAIDS supports, at the country, regional and global levels, increased HIV programming directed towards LGBTI communities through advocacy, technical support and resource mobilization efforts.
Overview

The 2011 United Nations Political Declaration on HIV and AIDS called for shared responsibility as a mechanism to achieve its targets and commitments.

Africa has made significant progress towards these goals by developing a continental road map on shared responsibility and global solidarity. The pillars of this road map include developing more sustainable health financing models, improving access to medicines through local production and regional market integration and promoting more effective and equitable health governance.

Many other countries—especially the burgeoning economies of Brazil, the Russian Federation, India, China and South Africa (BRICS) and other middle-income countries—are demonstrating leadership in their national AIDS responses and sharing the responsibility for the global response.

Key messages

- There is scope for many countries with growing economies to increase their investment in health and the AIDS response and to assume a bigger share of the financial contribution through innovative funding mechanisms in order to reduce dependence on external resources.

- Accountability systems are critical to ensure that AIDS commitments and results are achieved while generating further political commitments.

- Africa can learn from the successful experience of BRICS in leveraging the AIDS response as an engine for innovation, research and development and local manufacturing of essential health commodities.

- The African Union’s (AU) African Union’s Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa is an important catalyst to foster South–South cooperation.

Innovations

- The 2013 AU accountability report on Africa–G8 partnership commitments towards ending the AIDS, tuberculosis (TB) and malaria epidemics represents a first step towards mutual accountability in the AIDS response.

- The African Peer Review Mechanism now includes core indicators on AIDS in order to strengthen accountability and measurement in AU Member States. AIDS Watch Africa, a unique advocacy platform at the level of Heads of
State, has been reinvigorated to review progress and the implementation of the AU road map.

- African innovative initiatives for funding the AIDS response include levies on mobile phones, hotels, flights and financial transactions. Other opportunities that are being explored include health levies on industrial earnings and natural resources, the development of solidarity funds, increasing integration of health programmes and a greater quest for allocative efficiencies through the application of a robust investment approach.

- The Council of Ministers of Health of Central America and the Dominican Republic (COMISCA) is developing a road map for sustainable HIV investment and spending in collaboration with, among others, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS and the United States President’s Emergency Plan for AIDS Relief. In this connection, COMISCA has undertaken comparative analyses on efficiency, resource allocation, sustainability, vulnerability to funding losses and funding gaps.

Challenges

- Political leadership and regional coordination is necessary to encourage the development of a shared responsibility agenda.

- There is a clear link between economic, social and health vulnerability. People with the worst access to quality health care are generally the most economically vulnerable and are also subject to punitive laws.

- The outlook for the development of Africa’s pharmaceutical industry is positive. However, the sector faces complex challenges, such as the high costs of active pharmaceutical ingredients (including those that could be used to produce antiretroviral medicines) and the implementation of good manufacturing, sourcing and procurement policies and harmonized regulatory processes.

Key statistics

- More than 80 countries increased their domestic investments for the AIDS response by more than 50% between 2006 and 2011.


- African countries import more than 80% of their antiretroviral medicines.

- Of the US$ 2.127 billion available for AIDS in 2012 in Latin America, 92% came from domestic public sources.
Background

- Over the past decade, African countries, under the leadership of the AU, have demonstrated strong political commitment to address health, with particular focus on AIDS, TB and malaria. The African Union’s Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa represents a continental drive to accelerate progress to end the epidemics of AIDS, TB and malaria by 2030, in line with the African common position for post-2015.

- The Caribbean Community (CARICOM) is in dialogue with the AU and is in the process of developing its own shared responsibility and global solidarity agenda.

- Latin America is at the forefront globally in terms of shared responsibility and sustainably financing its HIV response. The latest available estimates show that the region contributes one of the world's highest shares of domestic resources to addressing the ongoing HIV epidemic.

- In March 2014, the Council of Arab Ministers of Health endorsed the Arab AIDS Strategy (2014–2020). Guided by the principles of shared responsibility and global solidarity, the new strategy comprises 10 goals aligned with the targets of the 2011 United Nations Political Declaration on HIV and AIDS.

Q&A

1. **What is shared responsibility and global solidarity?**

   Shared responsibility and global solidarity recognizes that all countries are committed to the global HIV response—in their own way. All parts of society must respond to HIV and engage development partners in supporting their vision.

   Together, countries and their partners have a shared responsibility to fill the HIV investment gap and to ensure that resources are invested to achieve maximum results, while upholding human rights and gender equality. However, shared responsibility is not just about investments. It is about collectively tackling barriers to progress, investing resources for the greatest impact, reinforcing inclusive country leadership, strong analysis and use of data, closure of programmatic gaps, and service delivery.

2. **What progress has been made on the shared responsibility agenda?**

   Co-investment and domestic funding have become core components of shared responsibility and global solidarity. In 2013, domestic spending on HIV accounted for around half the global HIV resources. More than 80 countries...
increased their domestic investments for the AIDS response by more than 50% between 2006 and 2011.

Under the leadership of the New Partnership for Africa’s Development, the African Medicines Regulatory Harmonization Programme is working with regional economic communities to support African countries to improve public health by increasing access to good quality, safe and effective medicines through harmonizing medicines regulations and expediting registration of essential medicines. This programme, which is underpinned by the Pharmaceutical Manufacturing Plan for Africa and the African Union road map, is driving innovation and enhancing the continent’s knowledge economy and industrial capacity through incentivizing local production of pharmaceuticals.

In 2013, African Heads of State meeting at a special summit (Abuja+12) committed to review relevant laws and policies to strengthen rights-based protection for all vulnerable and key populations, and to meaningfully engage them as partners in ensuring accountability and the effectiveness of the response for AIDS, TB and malaria in AU Member States. This remains critical to progress towards ending the epidemic.

Pan-African Parliaments have developed a workplan to strengthen advocacy and oversight strategies on AU policy frameworks, including advocacy for the domestication and monitoring of the shared responsibility agenda in Africa.

CARICOM, on behalf of its Member States, is leading the development of a shared responsibility and global solidarity agenda in the Caribbean.

The Arab AIDS Strategy promoted engagement and emerging leadership from countries such as Saudi Arabia and other Gulf Cooperation Council members. The strategy allowed for addressing sensitive issues in the Middle East and North Africa, such as travel restrictions, key populations and HIV in conflict and post-conflict settings.
Overview

Treatment 2015 is a UNAIDS initiative to accelerate progress towards universal access to antiretroviral treatment (ART). Its underlying principle is that no one should be left behind as HIV treatment is brought to scale. Treatment 2015 emphasizes innovation in HIV testing and treatment, service decentralization, investments in demand generation strategies, community leadership and sustainable financing. Treatment 2015 builds on the growing body of scientific evidence of the therapeutic and preventive benefits of ART.

Modelling commissioned by UNAIDS indicates that implementing the Treatment 2015 framework would lay the foundation for ending the AIDS epidemic. HIV treatment needs to be considered as an essential component of the response because it saves lives, prevents new infections, averts HIV-related illness, promotes labour productivity and saves money.

Treatment 2015 calls on countries to develop new HIV treatment targets, with specific pledges to ensure access for people who experience particular barriers in accessing HIV services, including children, men and key populations. The framework has been endorsed by African leaders (under the umbrella of the African Union), the United States President’s Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Health Organization (WHO).

UNAIDS is assisting nationally and regionally led processes to develop new treatment targets for the post-2015 era.

Key messages

- Achieving universal access to HIV treatment is critical to ending the AIDS epidemic. HIV treatment saves lives, prevents new infections and saves money.
- While rapidly scaling up HIV treatment, urgent efforts are needed to improve the effectiveness and impact of treatment services by closing gaps in the HIV treatment continuum.
- Achieving universal access to treatment will require renewed political commitment, strategic focus on treatment services, innovation in service delivery, community engagement and leadership, and sustainable financing.
Innovations

- Multidisease health campaigns and other innovative, proactive initiatives must replace more passive approaches in order to reach more people with testing services.
- Through decentralization, services should be brought closer to the people who need them; community workers can take on certain tasks currently administered by health workers; and new diagnostic and treatment tools need to be rapidly integrated into service delivery.
- Ensuring the availability of affordable antiretroviral medicines will require cost-effective and public health approaches to the management of intellectual property rights, regional/local drug manufacturing capacity and procurement (such as pooled procurement or regional tenders).

Challenges

- Owing to gaps in the HIV treatment continuum, only a minority of people living with HIV have achieved viral suppression.
- Flagging interest in HIV among key donors potentially jeopardizes the long-term financing that will be required to achieve universal access to treatment.
- Children, men and key populations confront unique and substantial obstacles to obtaining life-saving treatment services.

Key statistics

- Only 36% of people living with HIV were receiving it as of December 2012.
- Scaling up ART would result in actual savings of double or more the initial investments.

Background

Launched in 2013, Treatment 2015 calls for renewing efforts to reach the target of 15 million people on HIV treatment by the end of 2015, and for urgent planning for the post-2015 treatment agenda.
Treatment 2015 has three fundamental pillars of an effective global effort to achieve universal access:

- **Demand**: creating demand for HIV treatment, led by people living with HIV, as well as by key populations heavily affected by HIV, and sustained by civil society and the international community.
- **Invest**: mobilizing sustained investment, giving priority to innovation and using available resources as strategically as possible.
- **Deliver**: ensuring that decentralized health and community systems, infrastructure, and enabling laws and policies are in place to deliver treatment to all people living with HIV who are eligible.
Overview

Halving the number of deaths from tuberculosis (TB) in people living with HIV by 2015 is one of the targets in the 2011 United Nations Political Declaration on HIV and AIDS. UNAIDS is committed to working with partners to reach this goal.

The number of TB deaths among people living with HIV has been declining since 2004. Close collaboration between HIV and TB programmes can accelerate this decline further to meet the 2015 target. Modelling has shown that it can be reached and even exceeded by increasing access to collaborative TB/HIV activities.

According to World Health Organization (WHO) estimates, there were 1.1 million new TB cases and 320,000 TB deaths among people living with HIV in 2012.

Key messages

- Tuberculosis remains one of the leading causes of death among people living with HIV globally—despite being preventable and curable.
- UNAIDS, WHO and partners call for integrating TB and HIV services. Collaborative activities include the Three I’s for HIV/TB: intensified TB case-finding, isoniazid preventive therapy (IPT) and infection control.
- To reduce the risk of TB in people living with HIV, it is important to rapidly scale up early treatment and the Three I’s for HIV/TPB. This package of simple, inexpensive, and cost-effective measures must be integrated into maternal and child health, elimination of mother-to-child transmission of HIV, harm reduction and other programmes.

Innovations

- Ten new or repurposed anti-TB drugs are in late phases of clinical development. In 2012, bedaquiline became the first novel TB drug approved in 40 years. In June 2013, WHO issued interim guidance for its use in the treatment of multidrug-resistant TB (MDR-TB).
- Ten vaccines for TB prevention and two immunotherapeutic vaccines are in the pipeline.
Challenges

- Access to collaborative TB/HIV activities is still far too low.
- Funding for TB research and development has plateaued in recent years, falling from US$ 660 million in 2011 to US$ 630 million in 2012—well below the US$ 2 billion annual funding target outlines in the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

Key statistics

- Access to HIV testing, prevention, treatment and care for TB patients is increasing. In 2012, 46% of notified TB patients had a documented HIV test result and, in sub-Saharan Africa, this was as high as 75%.

- In 68 countries, 22 in Africa, at least 75% of TB patients knew their HIV status. However, only 57% of TB patients known to be living with HIV received antiretroviral treatment (ART) in 2012, despite the WHO recommendation that treatment be provided to all as soon as possible, regardless of their CD4 cell count.

- In 2012, 4.1 million people enrolled in HIV care were screened for TB, up from 3.5 million in 2011. Only 31% of people who were eligible and newly enrolled in HIV care in 2012 received IPT.

Background

The WHO policy on collaborative TB/HIV activities emphasizing the importance of integrated TB and HIV services was published in 2012. This policy is a revision of the interim policy, the implementation of which has resulted in almost a million lives saved since countries adopted it in 2005. However, much more needs to be done in order to reduce TB mortality and achieve the global target set for 2015.

During the 2010 International AIDS Conference in Vienna, UNAIDS signed an agreement with the Stop TB Partnership that set out a plan of collaboration towards achieving the goal of halving TB deaths in people living with HIV by 2015.

A report, *Time to act: save a million lives by 2015—prevent and treat tuberculosis among people living with HIV,* jointly developed by the Stop TB Partnership, WHO and UNAIDS to mobilize resources for TB and HIV and advocate for urgent scale-up of action, was launched at the United Nations General Assembly High-Level Meeting on AIDS in June 2011.
Q&A

1. **What is the link between TB and HIV?**

   TB and HIV are inextricably linked. HIV infection greatly increases the risk of developing TB, which is one of the leading causes of illness and death among people living with HIV, despite the fact that it is mostly curable and preventable. An estimated one third of people living with HIV worldwide are also infected with latent TB and are at an increased risk of developing active TB disease.

2. **What is the impact of TB and HIV co-infection?**

   TB is responsible for approximately one in four AIDS-related deaths globally, and up to half AIDS-related deaths in some African settings. People who are HIV-positive and infected with TB are between 21 and 34 times more likely to develop active TB in their lifetime than people who are HIV-negative.

   HIV infection is the most potent risk factor of latent TB infection progressing to active TB disease. Many people living with HIV in developing countries develop TB as the first manifestation of AIDS. The two diseases represent a deadly combination:

   - TB is harder to diagnose in people living with HIV.
   - TB progresses faster in people living with HIV.
   - TB in people living with HIV is almost certain to be rapidly fatal if undiagnosed, if left untreated or if treatment is delayed.
   - TB can occur early in the course of HIV infection.
   - Although TB risk is reduced with effective ART, TB is still much more frequent in people living with HIV on treatment than in someone who is HIV-negative.

3. **Why is more collaborative action on TB and HIV important?**

   HIV is dramatically fuelling the TB epidemic in Africa, where up to 80% of TB patients in some clinics are co-infected with HIV. Similarly, TB seriously undermines the HIV response, claiming a quarter of AIDS-related deaths. For many years, efforts to tackle TB and HIV have been largely separate, despite the overlapping epidemiology.

   Improved collaboration between TB and HIV programmes will lead to much more effective prevention and treatment of TB among people living with HIV and to significant public health gains through client-centred care.
In response to the dual epidemics, WHO recommends 12 collaborative TB/HIV activities as part of core HIV and TB prevention, care and treatment services, including interventions that reduce TB morbidity and mortality in people living with HIV, in addition to the provision of early ART, namely the Three I’s for HIV/TB.

4. How serious is the threat of extensively drug-resistant TB (XDR-TB)?

There are limited data on the risk of people living with HIV contracting MDR-TB, but what we do know is that when they do contract it, treatment is much more complicated and burdensome on the patient, owing to the drug interactions. However, if MDR TB is left untreated, people with HIV will die much more quickly. The emergence of XDR-TB, which is essentially untreatable in many parts of the world, represents a serious threat to the success of the global HIV response. The well-publicized outbreak of XDR-TB in Tugela Ferry in KwaZulu-Natal, South Africa, was largely among people living with HIV, and most died before a diagnosis was made. The importance of good infection control principles being applied in all HIV care settings is emphasized.
Overview

Diverse stakeholders have coalesced around the 90–90–90 targets for the post-2015 era, which are that 90% of all people living with HIV know their HIV status, 90% of all people with diagnosed HIV receive sustained HIV treatment and 90% of all people on HIV treatment achieve durable viral suppression. Laboratory medicine and diagnostic tools will play a pivotal role in reaching these ambitious targets, as there will need to be a dramatic increase in diagnostic testing. The 2013 World Health Organization (WHO) consolidated antiretroviral guidelines call for use of CD4 testing to guide treatment initiation for people living with HIV as well as scaled-up viral load testing to strengthen treatment monitoring and guide clinical decision-making.

Key messages

- Laboratory medicine is a fundamental partner in achieving the 90–90–90 targets.
- Global scale-up of viral load monitoring is essential to the 90–90–90 approach.
- Stakeholders at the global, regional and country levels urgently need to mobilize the political will, financial resources, innovation and capacity-building support to maximize the contribution of CD4 and viral load monitoring to achieve new global treatment targets.

Innovations

- New point-of-care diagnostic technologies for CD4 and viral load testing are emerging, although focused efforts are needed to ensure the affordability and universal availability of these tools to expedite treatment scale-up and improve treatment outcomes.
- Stakeholders are exploring new strategies to scale up CD4 and viral load testing, including task-shifting in clinical settings, same-day testing of newborns (using viral load technologies), use of SMS printers to expedite the return of diagnostic test results, and approaches to simplify diagnostic strategies in remote and resource-limited settings.
Sample transport networks can link large numbers of primary care centres with laboratory hubs at the same time that they reduce diagnostic transport costs.

Challenges

- Laboratory services are badly underfunded.
- Current CD4 and viral load diagnostic tools are inaccessible for many reasons, including long distances between clinical and centralized laboratory sites, which result in long turnaround times and quality concerns.
- Although point-of-care diagnostic tools offer promise, they have not been brought to scale, and their scale-up confronts considerable challenges, including affordability, commodity procurement and supply chain weaknesses, suboptimal use of existing CD4 and viral load machines, training and other human resource requirements, and weaknesses in data collection and management systems.

Key statistics

- Fewer than one in four people living with HIV are estimated to have durable viral suppression.
- In Rwanda, where viral load testing has been scaled up, 83% of people initiating antiretroviral therapy are virally suppressed two years later.
- Less than 20% of people who test HIV-positive in some settings receive a CD4 test result.
- To maximize scaled-up CD4 and viral load monitoring, intensified efforts are needed to close gaps. In Africa, 41–54% of people living with HIV are lost to care between positive HIV test results and linkage to care, and one quarter of all people who start antiretroviral therapy are lost to care within three years.
- Around 11% of CD4 tests in 2013 were delivered at the point of care.
- Mozambique reduced loss-to-follow-up from 57% to 21% when it transitioned for centralized laboratories to point-of-care tools for CD4 monitoring.

Background

Ensuring that every person living with HIV has ready access to affordable viral load testing will be critical to maximizing the therapeutic and preventive benefits of antiretroviral therapy. Sustained viral suppression saves lives, prevents new infections and saves money.
Achieving and sustaining viral suppression demands universal access to viral load testing, which in turn requires optimal use of existing diagnostic tools, development and expedited roll-out of new viral load technologies, prioritized training and capacity-building for the health-care workforce, and civil society engagement to educate and mobilize communities regarding the importance of viral load testing and the fundamental right of every person living with HIV to know her or his viral load.
Overview

Scientific evidence has shown that voluntary medical male circumcision (VMMC) reduces male vulnerability to HIV by approximately 60%. As a one-time, high-impact intervention, VMMC confers lifelong partial benefit to the circumcised man and significantly reduces HIV incidence across populations with high HIV prevalence. VMMC saves lives and money: the intervention not only leads to cost savings from averted HIV infections and resulting lifetime of antiretroviral treatment (ART), but it is also cost-effective. In some high-prevalence settings, if scale-up is rapid, every dollar spent on VMMC has the potential to save US$ 14 in care and treatment costs, according to mathematical models.

The web site www.malecircumcision.org serves as a clearinghouse for authoritative information on the role of male circumcision in HIV prevention. It brings together tools, guidance documents, presentation materials and updates on country progress. On 6 May 2014, the Public Library of Science published a collection called Voluntary Medical Male Circumcision for HIV Prevention, which includes 13 research papers and an overview presenting key findings, best practices, challenges and recommendations from several priority countries that have begun scaling up VMMC services (http://www.ploscollections.org/article/browse/issue/info:doi/10.1371/issue.pcol.v01.i22).

Key messages

- Male circumcision is recognized as an effective HIV prevention strategy in high HIV prevalence settings, but it must be part of a combination prevention package.
  - Compelling evidence from three randomized controlled trials undertaken in Kisumu, Kenya, Rakai District, Uganda, and Orange Farm, South Africa, have shown that medical male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%.
  - Male circumcision provides partial protection against HIV infection. Circumcised men can still become infected and, if HIV-positive, can infect their sexual partners.
- Countries with high HIV prevalence, generalized heterosexual HIV epidemics and low levels of male circumcision should consider urgently scaling up access to male circumcision services.
Fourteen key countries have been offered programme scale-up support to develop policy frameworks and country implementation plans: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe. The majority are now implementing VMMC service delivery.

In 2013, UNAIDS added Central African Republic and South Sudan as countries that may also benefit from male circumcision because of high HIV and low circumcision prevalence, making 16 countries in total.

While many priority countries have had tremendous success in scaling up, much still needs to be done.

As of December 2012 (the latest date for which we have official figures), 3.2 million African men had been circumcised through specific services for VMMC, a cumulative total from 2008. This number more than doubled in 2012, rising from 1.5 million as of December 2011. These estimates have already been released by the United States President’s Emergency Plan for AIDS Relief and the Bill & Melinda Gates Foundation. These are strong successes, but reaching the goal of 20 million circumcisions by 2016 will require significant action. Joint leadership is needed to strengthen demand, integrate with other services, diversify funding, improve monitoring and accountability, and push for additional human resources to deliver VMMC.

Projections show that if VMMC implementation continues at the same pace as in 2013, 12–14 million men will likely have received VMMC by the end of 2016.

Progress has been most pronounced in the provinces prioritized for scale-up in Ethiopia and Kenya. In five countries where VMMC is stated to be a priority (Lesotho, Malawi, Namibia, Rwanda and Zimbabwe), coverage of VMMC for adults is less than 10%.

VMMC is a sound investment.

Scaling up VMMC to 80% coverage of adults from now to 2015 in the 14 countries could avert 3.4 million new infections through to 2025. This would cost US$ 1.5 billion, but would result in US$ 16.5 billion of cost savings in averted treatment costs. This would create fiscal space for other priorities.

Countries must prioritize VMMC to maximize public health benefits.

Men are significantly less likely to get tested for HIV or enrol in and adhere to ART; as a male-oriented service, VMMC presents a rare opportunity for HIV prevention, case finding and initiating positive
encounters with the health system among men who do not otherwise seek services.

— New modelling confirms the 2007 recommendations that intensified programme focus on younger men (i.e. 15–34 years old) is needed to achieve the greatest impact and programme efficiency.

 Male circumcision should always be considered as part of a combination prevention package.

— A combination prevention package includes promotion of safer sex practices (such as reduction in the number of sexual partners), provision of male and female condoms with promotion of their correct and consistent use, provision of HIV testing and counselling services, and treatment for sexually transmitted infections.

— Medical male circumcision should be provided with full adherence to medical ethics and human rights principles, including informed consent, confidentiality and absence of coercion.

 Innovation in circumcision devices will help accelerate scale-up.

— Devices that are simple, less resource intensive, usable by non-physician providers, acceptable to clients and providers and as safe as standard surgical male circumcision will increase access for VMMC to more clients, including those deterred by surgical circumcision. Several devices that would reduce procedure times are being investigated in clinical trials in Rwanda, Kenya, Zimbabwe and Uganda.

— The first adult male circumcision device, PrePex, is now being rolled out as an alternative to surgical VMMC. This device can be safely administered by lower cadres of health-care professionals than those authorized to perform surgery. PrePex, an elastic collar compression adult circumcision device, was prequalified by WHO in 2013. This device requires no sutures or injected local anaesthetic and may be placed and removed by trained mid-level health providers, including nurses. It is hoped that the device will accelerate scale-up by providing men with an alternative and by relieving demands on the limited number of surgeons available in priority countries.
Overview

Addressing gender inequalities is essential to enabling women in all their diversity, including transgender women, and men to access comprehensive HIV prevention, treatment, care and support services. Violation of the rights of adolescent girls, women and men is undermining an effective gender transformative HIV response. Advancing gender equality, and protecting and fulfilling the human rights of people living with, at risk of and affected by, HIV are critical for reaching zero new HIV infections, zero discrimination and zero AIDS-related deaths.

UNAIDS supports accelerated country-level action for a gender transformative HIV response. However, there is still work to be done. About half of all people living with HIV are women or girls, with variation within regions, countries and communities; however, the absolute number of women and girls living with HIV (15 years and older) is still increasing. As globally the number of new infections among women (15 years and older) is declining, the numbers of new infections are stabilizing in the Asia and Pacific region and in the Caribbean, and slightly increasing in eastern Europe and central Asia, as well as in the Middle East and North Africa, with the latter showing nearly similar patterns among women and men.

Significant gaps also persist in actions and funding to provide gender-responsive programmes and services that take into account the challenges and barriers brought on by structural and social realities. There is a need to do more to eradicate harmful gender norms and discriminatory laws and to promote the meaningful participation of women and girls in national and international decision-making processes.

Key messages

- Gender analysis of national HIV epidemics, context and responses is critical for an effective gender transformative HIV response. Differences in vulnerability to and impact of HIV on women and girls, men and boys and transgender people are intrinsically connected to gender inequality and unequal power relations, and stigma and discrimination. Improved understanding of gender dynamics is critical for effectively addressing sociocultural harmful norms and practices, including gender-based violence, and protecting women’s rights.

- Focus on HIV prevention for women and girls is key to halting and reversing the HIV epidemic. Globally, women comprise 52% of the total number of
people living with HIV in low- and middle-income countries. This pattern also true in selected regions, namely the Caribbean, Oceania and sub-Saharan Africa. Worldwide, young women (15–24) are twice as likely to be living with HIV as their male peers.

- Gender-based violence is one of the contributors to HIV vulnerability to be addressed through the HIV response. According to the World Health Organization, one in three women worldwide has experienced physical and/or sexual violence by an intimate partner, or non-partner sexual violence, in her life. Gender-based violence has been established as a contributing risk factor of HIV. A recent South African study found that young women who experienced intimate partner violence were 50% more likely to have acquired HIV than women who had not experienced violence.

- Women and girls must have the knowledge and power to protect themselves against HIV. Women and girls also must be able to demand services that meet their needs and take their rightful equal place as advocates, leaders and decision-makers. Studies in numerous countries reveal that comprehensive sexuality education in school settings can increase condom use and voluntary HIV testing among young women, reduce adolescent pregnancy and reduce stigma against people living with HIV.

**Innovations**

- One of the innovative tools developed by UNAIDS is the Gender Assessment Tool, intended to assist countries assess their HIV epidemic, context and response from a gender perspective, helping them to make their HIV responses transformative and more effective. So far, the UNAIDS Gender Assessment Tool has been implemented in more than 30 countries, increasing country capacity to integrate the gender perspective in national HIV responses.

- Uganda-based civil society organizations Raising Voices and the Center for Domestic Violence Prevention used community-led activism and mobilization to help bring about changes in behaviour and attitudes towards violence against women and girls through their SASA! methodology, designed by Raising Voices. This community-focused violence and HIV prevention programme challenges power imbalances between men and women through a series of sustained activities that support community members through different stages of behaviour change. Participating organizations reported that the partnership gave them vital tools to continue rolling out the methodology in their communities. Grass-roots activists, women and men, also acknowledged that their own attitudes and behaviours towards gender-based violence and HIV were positively transformed.
Challenges

Strategic investments in HIV are not prioritizing the needs of women and girls throughout their lives and need to be integrated and mainstreamed as key elements to halting and reversing the HIV epidemic. Addressing inequalities related to gender differences in accessing prevention, treatment, care and support are critical to enabling increased coverage and uptake of key HIV programmes and services, along with ensuring effective and sustainable HIV responses.

Key statistics

- Worldwide, young women are twice as likely to be living with HIV as are their male peers, while women older than 15 years are more likely to be living with HIV than their male peers in the Caribbean, Oceania and sub-Saharan Africa.
- Globally, women comprise 52% of the total number of people living with HIV in low- and middle income countries. In sub-Saharan Africa, women account for 58% of people living with HIV. Women also constitute a greater proportion of people living with HIV in the Caribbean and Oceania.
- Unequal gender norms undermine effective HIV responses for men as prevailing concepts of masculinity encourage men’s sexual risk-taking and discourage men from seeking health and HIV services. As a result, men in low- and middle-income countries are less likely to access treatment in comparison with women (57% of treatment-eligible men versus 73% of treatment-eligible women received antiretroviral therapy in 2012).

Q&A

1. What is a ‘gender-transformative response’ and why is it important?

A gender-transformative AIDS response seeks to advance social change for gender equality by addressing the harmful gender norms and practices that contribute to the specific vulnerabilities of women, girls, men, boys and transgender people through broad-based societal engagement. It also requires that existing structures, institutions and gender relations be changed into ones based on gender equality.

2. Why focus on women and girls?

Gender inequality and unequal power relations between women and men significantly influence the HIV epidemic. Biological factors that render women and girls more vulnerable to HIV infection are aggravated by harmful sociocultural norms and practices, including gender-based violence and unequal access to resources, resulting, among others, in age-disparate relationships, lack of access to quality sexual and reproductive health services, inadequate
education opportunities, and economic disparity. To end the AIDS epidemic, the HIV response must be tailored to the specific needs of women and girls, and must ensure continued progress in terms of women’s empowerment and gender equality.
Overview
The World Bank offers long-term financial and specialized technical support and knowledge to countries for the effective prevention of new HIV infections, care and treatment for people living with HIV, and alleviation of the social and economic consequences.

The World Bank has assisted 125 countries to understand their HIV epidemics and 100 countries to strengthen their national AIDS plans. It has also funded about 50,000 community AIDS organizations, helping to create effective community responses in more than 50 countries. Since 1989, World Bank financing for HIV has totalled over US$ 5 billion. As of financial year 2014, the World Bank’s active portfolio for HIV stands at US$ 1.5 billion.

Key messages
- The Bank and its partners are committed to scaling up the elimination of new HIV infections among children and keeping their mothers alive.
- Continued support for the Global Fund to Fight AIDS, Tuberculosis and Malaria is critical to extending life-saving HIV prevention, treatment, care and support services.

Key statistics
- In Rwanda, integrated, incentivized HIV service delivery, supported by the World Bank, contributed to a 76% increase in overall health service utilization.
- A regional project supported by the World Bank in West Africa’s transport corridor reduced sexually transmitted infections by 22%.

Q&A
1. What are some of the key lessons learned for the HIV response in the past decade?
   We can be more cost-effective. Today, we know much more about the nature of the epidemic and how to effectively prevent HIV, and at a lower cost. For example, better geographic and population targeting, focusing on key
populations, can significantly increase efficiency and impact. Through its programme efficiency and delivery science programme, the World Bank is supporting governments to implement and scale-up programmes that are proven to be effective at the least cost without compromising quality.

2. **In an environment of limited resources, how do we prioritize investments in HIV?**

The World Bank is conducting in-country studies and providing new analytical models and tools to inform and advise governments and key stakeholders on improving allocations of limited HIV resources for maximum impact, and ensuring financial sustainability of their national AIDS response. These studies can help governments assess the optimal allocations of their resources between their different activities and evaluate the fiscal consequences of their policy.

3. **What is the future of strategic planning for HIV?**

More efficient high-quality, high coverage services are due less to grand strategic plans and more to detailed operational plans, real-time monitoring and constant tactical adaptations—we must move from the age of planning to the science of delivery.
Overview
UNAIDS has made zero discrimination part of its shared vision, on an equal footing with HIV prevention and treatment. On 1 March 2014, people around the world commemorated Zero Discrimination Day for the first time. UNAIDS called for the annual event to promote everyone’s right to live a full life with dignity—no matter what they look like, where they come from or who they love. Furthermore, in recognition of the importance of reducing stigma and eliminating discrimination to achieve universal access and end the HIV epidemic, UNAIDS is releasing a report on the impact of discrimination as a barrier to access and as a factor for inequities in access at the 2014 International AIDS Conference. The symbol for zero discrimination is the butterfly, widely recognized as a symbol of transformation.

Discrimination

- Discrimination is a violation of human rights—it is illegal, dehumanizing and acts as a major barrier to HIV services.
- Discrimination threatens the health, dignity and security of people living with and vulnerable to HIV.
- For the 30 years of the HIV response, people living with and vulnerable to HIV have demanded and received recognition of their right to non-discrimination.
- UNAIDS is calling for zero discrimination; that is, the removal of discrimination based on health and social status in all sectors: health, employment, education, justice and the community.

UNAIDS vision: zero discrimination

- Ending AIDS in a way that leaves no one behind means that we will have to get past discrimination to the groups that are highly marginalized. Thus, getting to zero new HIV infections and zero AIDS-related deaths is intricately tied up with reaching zero discrimination.
- The AIDS response has taught the world tremendous lessons in non-discrimination, inclusion and tolerance,
- We urge all governments to implement laws to protect everyone from discrimination and to implement programmes to reduce discrimination. It takes political and programmatic commitment to end discrimination.
Only by turning discrimination and denial into acceptance and understanding can we ensure that everyone has equal access to health care.

Zero Discrimination Day

- Zero Discrimination Day is an opportunity to celebrate everyone’s right to live a full life with dignity—no matter what they look like, where they come from or who they love.
- Discrimination can happen to everyone, everywhere. And we also know that it happens more to people who are marginalized and discriminated against because of their sexual orientation and gender identity, drug use, engagement with sex work and HIV-positive status.
- We need to stand united in support of anyone who faces discrimination.
- Zero Discrimination Day is a moment to highlight how everyone can become informed and to promote acceptance, compassion and peace.
- Zero Discrimination Day is an opportunity for constructive dialogue with people around the world.
- We believe in change. This is why the symbol for zero discrimination is a butterfly, widely recognized as a sign of transformation.

Key statistics

- Countries with laws that criminalize same-sex sexual relations: 78.
- Countries with the death penalty for same-sex sexual relations: 7.
- Countries, territories and areas with HIV-related travel restrictions: 41.
- Countries, territories and areas that criminalize transmission of HIV: 56.
- Most countries criminalize some or all aspects of sex work.

Background


Ending discrimination of all kinds is a key component of UNAIDS’ vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. Yet today, too many people around the world continue to face unequal treatment because of their race, religion, nationality, ethnic background, sexual orientation or identity, disability, gender or age.
Discrimination can happen anywhere: at work, at school, at home and in the community. Discrimination doesn’t just hurt individuals or groups of people—it hurts everyone. Discrimination in the context of HIV affects some more than others—sex workers, lesbian, gay, bisexual, transgender and intersex people, people who use drugs, people living with HIV.

There are many things that can be done to counter discrimination and encourage acceptance: speaking up when something is wrong; raising awareness; supporting people who have been discriminated against; and promoting the benefits of diversity. It requires a response through targeted programming to reduce stigma and discrimination, including programming for change in societal attitudes and practices.

Within the context of HIV and access to services for those most discriminated against, discrimination can be addressed through training and sensitization of health-care providers, law-makers and law enforcement agents, by supporting service provision through community-led organizations that can make the link between their communities and health systems, by supporting evidence-based dialogue between religious leaders and people living with HIV, by comprehensive sexuality education, by enforcing protective laws instead of punitive laws, and by increasing rights and legal literacy and access to justice.