

A black and white photograph showing the silhouettes of several people standing in a line and holding hands. The background is a light, hazy sky. The silhouettes are dark against the lighter background, creating a strong visual impact.

Fighting AIDS:
a new global resolve

1 Fighting AIDS: a new global resolve

In the past two years, the sense of common purpose in the worldwide struggle against HIV/AIDS has intensified. More than at any other time in the short history of the epidemic, the need to translate local and national examples of success into a global movement has become manifest.

The political momentum to tackle AIDS has grown. Public opinion in many countries has been mobilized by the media, nongovernmental organizations, activists, doctors, economists, and people living with HIV/AIDS. Communities and nations are progressively taking the lead in responding to the epidemic with increased political commitment, resources and institutional initiatives. But this new political resolve is not universal. An unacceptable number of governments and civil society institutions are still in a state of denial about the HIV/AIDS epidemic, and are failing to act to prevent its further spread or alleviate its impact.

By failing to act, governments and civil society are turning their backs on the possibility of success against AIDS. Where the moment of action has been seized, there is mounting evidence of inroads being made against the epidemic. Alongside the familiar achievements of Senegal, Thailand and Uganda, there are new successes on every continent. Despite emerging from genocide and conflict,

Cambodia responded to the threat of HIV in the mid-1990s and has achieved marked declines in both the levels of HIV and the high-risk behaviours associated with its transmission. The infection rate among pregnant women in Cambodia declined by almost a third between 1997 and 2000. The Philippines has acted early to forestall the epidemic, keeping HIV rates low with strong prevention efforts and the mobilization of community and business organizations.

Brazil remains a leading example of the integration of comprehensive care and a renewed commitment to prevention. The numbers of new HIV infections have been kept much lower than forecast less than a decade ago, while the 1996 decision to establish a legal right to free medication has brought treatment and care to more than 100 000 HIV-positive people. As a result, the number of annual AIDS deaths in Brazil in 2000 was a third of that in 1996. The annual cost of medication (including drugs produced under licence by Brazilian manufacturers) is more than outweighed by the resulting health-care and related savings. Similar legislation-led drug-access models are being pursued across Central and South America.

In Africa, Zambia's focus on HIV prevention among youth and its efforts to involve businesses, farmers, schools and religious groups

in the fight against AIDS are proving successful. The proportion of pregnant urban women aged 15–19 who were HIV-positive had fallen from 28.4% in 1993 to less than 14.8% five years later.

Examples of success come both from settings where HIV prevalence is low (and an expanding epidemic has been prevented) and from those where the impact of HIV/AIDS is already substantial. Both environments present challenges. Even where rapid increases in the epidemic are evident, yet population-wide

prevalence is low, it is all too easy to marginalize HIV. For example, in the Russian Federation, the realization that the epidemic is taking hold among young people, and is not just affecting a stereotyped and stigmatized group of ‘drug addicts’ has been an important impetus for strengthening the national response. In heavily affected countries (e.g., in southern Africa), the challenge has been that of building the political conviction that solutions are possible in the face of the overwhelming impact of the epidemic.

Civil society and government commitment

Growing political engagement in the response to AIDS is grounded in two decades of AIDS activism, led by individuals and communities whose lives have been touched by the epidemic. Organizations as diverse as the Gay Men’s Health Crisis in New York, The AIDS Support Organisation in Uganda, the Save Your Generation Association in Ethiopia, Grupo Pela Vidda in Rio de Janeiro, and many hundreds of others like them, are built on the same foundations: an initially small group of people responding to the impact of AIDS by coming together to provide mutual support and take action.

An activist movement responding to AIDS now exists globally. It has many aspects: community groups providing home-based care, treatment activists working through media and the law courts to extend access to HIV drugs, networks such as the International Council of AIDS Service Organizations and its regional bodies, and associations of HIV-positive people nationally and internationally, together with positive women’s networks.

The presence of nongovernmental and community-based organizations was notable at the United Nations General Assembly Special Session on HIV/AIDS in June 2001, providing a sense of urgency and conscience to Member State deliberations. The Global Fund to Fight AIDS, Tuberculosis and Malaria has modelled a new way of working by including on its Board not only nongovernmental organization representatives but also a seat for people who are themselves directly affected. The bedrock of activism, sustained in communities motivated to take action against AIDS, is key in driving political momentum locally, nationally and globally.

From within the United Nations, Secretary-General Kofi Annan has helped catalyse growing global engagement. In April 2001, at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, in Abuja, Nigeria, he issued a global call to action in the fight against AIDS. The personal priority he has given to AIDS has helped energize the United Nations system, as well as engage political and business leaders in the challenge.

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At the Millennium Summit of the United Nations in September 2000, 43 Heads of State and Government, from both countries heavily affected and those less so, referred to AIDS as one of the most pressing problems worldwide. Presidents and prime ministers, particularly those from Africa and the Caribbean, but also those in Asia and Western and Eastern Europe, are displaying a personal commitment to the fight against AIDS. Support for expanded AIDS responses has been voiced by religious leaders and groups of all faiths—from Catholic and Protestant bishops and the Patriarch of All Russia, to associations of Imams and networks of Buddhist monks in South-East Asia.

AIDS is now a prominent issue at international gatherings—North and South. It has been on the agenda of summits and decision-making forums of the G8 and G77 nations, the Organization of American States, the Organization of African Unity, the Commonwealth of Nations, the European Union, the Association of South-East Asian Nations, and the Caribbean Community Secretariat (CARICOM). Both the World Economic Forum and the World Social Forum (in Porto Alegre) have held key sessions on AIDS and its global implications. The UN Security Council held its first-ever debate on AIDS in January 2000—the first time it had examined a health or development issue. Since then, it has held two more public debates on AIDS.

Global priorities are now clear

The new political momentum culminated in June 2001 when the membership of the United Nations met in a Special Session of the General Assembly to agree on a comprehensive and coordinated global response to the AIDS crisis. The members adopted a powerful Declaration of Commitment, and reaffirmed the pledge (made by world leaders in their Millennium Declaration) to halt and begin to reverse the spread of AIDS by 2015.

The UN General Assembly Special Session on HIV/AIDS differed from the hundreds of meetings and summits held on AIDS in the past 20 years in this crucial respect: it was a meeting of all States, acting as governments. As such, it yielded both a common mandate and a basis for political accountability. The Special Session's Declaration of Commitment, adopted unanimously, now serves as a bench-

mark for global action. Its targets and goals include the need to:

- secure more resources to fight AIDS, increasing annual spending to US\$7–10 billion in low- and middle-income countries;
- ensure, by 2005, that a wide range of prevention programmes are available in all countries;
- by 2005, to ensure that at least 90% of young people aged 15–24 have access to information, education and services necessary to develop the life skills needed to reduce their vulnerability to HIV, and 95% by 2010;
- reduce by 25% the rate of HIV infection among young people aged 15–24 in the

- most affected countries by 2005 and globally by 2010;
- reduce by 20% by 2005 and 50% by 2010 the proportion of infants born with HIV;
- by 2003, enact or strengthen anti-discrimination and human rights protections for people living with HIV/AIDS and for vulnerable groups;
- by 2003, develop or strengthen participatory programmes to protect the health of those most affected by HIV/AIDS;
- empower women as an essential part of reducing vulnerability to HIV;
- by 2003, develop national strategies to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including affordability and pricing; and
- make treatment and care for people with HIV/AIDS as fundamental to the AIDS response as is prevention.

Debate at the Special Session on HIV/AIDS revealed continuing differences between States on how to respond to marginalized groups, such as men who have sex with men, injecting drug users and sex workers. Nevertheless, the Declaration expressed unanimous approval of fundamental approaches to tackling the epidemic, based on frank and forthright responses grounded in respect for human rights.

The Declaration of Commitment provides the world with a basis for effective political action and a yardstick of accountability. At international, regional and national gatherings since the Special Session, the Declaration of Commitment has served to define agendas and create a common platform for action.

Within weeks of the Special Session, implementation of the Declaration of Commitment was receiving regional attention—for example, in the Nassau Declaration on Health issued by Heads of Government of the Caribbean Community, and in regional action taken in the Commonwealth of Independent States.

Indicators, developed by the UNAIDS Secretariat and Cosponsors, together with other stakeholders, will keep track of progress on all the key elements of the Declaration of Commitment. The UN Secretary-General will report annually to the General Assembly on progress made in relation to the Declaration.

Meeting targets

Table 1 details the most recent baseline measures for the 25 worst-affected countries in the world, in relation to targets set in the Declaration of Commitment. These measures indicate current levels of HIV among young people, and show that young people's knowledge and awareness of HIV/AIDS will need to increase considerably if the relevant targets are to be met. The measures also reveal that levels of risky behaviour are relatively high (especially among men), while protective behaviour is generally low among men and women—areas in which substantial progress needs to be made.

The targeted reductions in the proportion of infants infected with HIV, as Table 1 reminds, can only be met if women's access to HIV testing increases significantly. Finally, the rate at which orphans attend school highlights another area where progress is required, since that rate is also an indicator of the degree to which orphans are receiving wider forms of support.

Complementing the Declaration of Commitment, a single United Nations system stra-

Table 1

Measuring progress towards the targets established at the United Nations General Assembly prevention and impact indicators in countries with high HIV prevalence*

Country	HIV prevalence among pregnant women (aged 15–24)						Prevention				
	Major urban areas			Outside major urban areas			Knowledge/awareness among young people				
	Year <i>b</i>	Pregnant women (15-19) Median <i>c</i>	Pregnant women (20-24) Median <i>d</i>	Year <i>e</i>	Pregnant women (15-19) Median <i>f</i>	Pregnant women (20-24) Median <i>g</i>	Heard of AIDS Female (15-24) <i>h</i>	Condom use Female (15-24) <i>i</i>	One faithful partner Female (15-24) <i>j</i>	Aware that 'healthy-looking' person can be infected Female (15-24) <i>k</i>	Has no major mis-conceptions Female (15-24) <i>l</i>
Angola		...	...		...	...	70	30	30	43	17
Botswana	2001 [3]	27.1	34.9	2001 [19]	26.6	46.9	95	76	74	79	35
Burkina Faso	1998 [1]	6.2	8.8		...	...	84	...	...	42	...
Burundi	1998 [1]	8.8	15.4	1998 [1]	24	14.3	85	47	71	66	36
Cameroon	2000 [5]	9.5	11.2	2000 [22]	9.3	14.1	90	46	51	54	23
Central African Rep.		...	...		...	...	...	...	...	46	...
Congo	2000 [u]	11	...		...	...	...	...	...	...	...
Côte d'Ivoire	1998 [3]	4.7	12.2	1997 [9]	7.5	12.1	93	53	55	51	21
Ethiopia	2000 [4]	8.9	17.6	2000 [3]	0	4.3	82	37	62	39	...
Haiti	2000 [n]	3.7	3.8	2000 [n]	3.7	3.8	97	52	56	68	...
Kenya	1997 [1]	12.5	16.2		...	...	90	53	75	65	59
Lesotho	1999 [n]	~ 25	~ 41	1999 [n]	~ 25	~ 41	81	58	50	46	22
Liberia		...	...		...	...	63 <i>y</i>	49 <i>a</i>	44 <i>a</i>	31 <i>a</i>	...
Malawi	2001 [3]	13.6	25.7	2001 [16]	10.2	20.3	99	78	80	84	...
Mozambique	2000 [2]	13	14.7	2000 [18]	6.3	13.7	83	...	...	38	...
Namibia	2000 [n]	11.9	20.3	2000 [n]	11.9	20.3	98	87	77	...	...
Nigeria	2000 [n]	3	5.8	2000 [n]	3	5.8	75	15	44	45	...
Rwanda	1999 [4]	8.4	12.8	1999 [6]	4.2	7.6	99	68	75	23	...
Sierra Leone		...	...		...	...	59	30	32	35	21
South Africa	2000 [n]	16.1	29.1	2000 [n]	16.1	29.1	95 <i>y</i>	...	...	< 50 <i>y</i>	...
Swaziland	2000 [u]	22	42.2	2000 [3]	30.1	42.5	97	63	61	81	43
United Rep. of Tanzania	2000 [3]	13.2 <i>z</i>		2000 [9]	16.3 <i>z</i>		96	62	64	65	35
Togo		...	...		...	...	96	63	74	67	27
Zambia	1998 [4]	16.7	26.8	1998 [18]	6	17.5	96	59	78	75	40
Zimbabwe	2000 [u]	27.1	34.8	2000 [r]	28.4	35.3	96	73	73	74	...

* See Annex 2 for key to letters and numbers used after figures.

Special Session on HIV/AIDS in June 2001: baseline measurements of HIV prevalence,

Prevention								Impact	
High-risk sex in past year		Reported condom use at last high-risk sex		Prevention of mother-to-child transmission				Orphans	
Male (15–59) <i>m</i>	Female (15–49) <i>n</i>	Male (15–59) <i>o</i>	Female (15–49) <i>p</i>	Knowledge of MTCT Female <i>q</i>	Know a place to get tested Female <i>r</i>	Number of pregnant women HIV+ <i>s</i>	Antenatal care coverage (15–49) <i>t</i>	Children orphaned by AIDS (0–14) <i>u</i>	Orphans in School ^v Orphan attendance rate as a % of non-orphan attendance rate
...	...	...	...	48	23	40,000	...	104,000	89
...	...	...	...	81	47	22,000	97	69,000	99
28	8	59	42	45	...	47,000	61	268,000	...
...	...	...	...	81	27	40,000	76	237,000	69
55	28	5	3	63	58	74,000	75	210,000	92
...	...	...	...	45	26	20,000	62	107,000	89
70	43	...	12	...	...	11,000	...	78,000	...
87	30	12	1	65	19	60,000	88	420,000	77
21	8	30	13	57	...	220,000	27	989,000	60
55	32	26	14	72	22	...	80	43,000	82
45	20	42	16	85	...	180,000	76	892,000	75
...	...	...	...	62	...	25,000	88	73,000	89
...	...	...	...	...	...	12,000	85	39,000	...
37	9	39	29	77	70	100,000	92	468,000	92
59	...	...	4	...	...	130,000	71	418,000	46
...	...	...	...	...	79	17,000	91	47,000	...
...	...	...	...	40	...	270,000	64	995,000	...
12	7	50	15	88	45	47,000	92	264,000	93
...	...	...	...	37	9	18,000	68	42,000	74
...	...	...	...	...	...	260,000	94	662,000	...
...	...	...	...	72	60	13,000	87	35,000	86
52	29	34	23	74	52	120,000	49	815,000	72
35	16	37	17	73	...	13,000	82	63,000	92
43	29	30	18	88	59	110,000	83	572,000	88
43	16	70	42	84	43	170,000	93	782,000	85

tegic plan was adopted for the first time in 2001, bringing together within the UN not only UNAIDS and its Cosponsors, but HIV/AIDS activities from a total of 29

UN organizations and agencies. A significant achievement in increased transparency and coordination, this plan will guide the UN system over the next five years.

Paradigm shifts

Underpinning the renewed global resolve in tackling AIDS is a series of shifts in fundamental thinking about the epidemic.

Firstly, we now realize that the HIV/AIDS epidemic is at an early stage of development and that its long-term evolution is still unclear. Despite the epidemic's manifest potential for explosive growth within a matter of years, its overall dynamic needs to be considered in a time frame of decades.

Secondly, successful, proven approaches to HIV prevention have been identified, and the need for a particular emphasis on young people has been recognized. In every country where HIV transmission has been reduced, it has been among young people (and with their determination) that the most spectacular reductions have occurred.

Thirdly, community mobilization is the core strategy on which success against HIV has been built. Fostering such mobilization requires eliminating stigma, developing partnerships between social and government actors, and systematically involving communities and individuals infected and affected by HIV/AIDS.

Fourthly, access to comprehensive care and treatment for HIV/AIDS is not an optional luxury in global responses. Access to care is a basic necessity in programming in every

setting—from the wealthiest to the poorest—and needs to encompass the full continuum, including home-based and palliative care, treatment of opportunistic infections and antiretroviral therapy.

Responding to demands for more equitable access to care is integral to creating broad, demand-driven strategies that respond to the desire by households and communities to protect themselves from HIV and its effects. Demand-driven HIV prevention is likely to succeed far more readily than supply-driven approaches.

Fifthly, addressing the economic, political, social and cultural factors that render individuals and communities vulnerable to HIV/AIDS is crucial to a sustainable and expanded international response.

The Millennium Development Goals, arising from the UN Millennium Summit of September 2000, include a commitment to halt and begin to reverse the global spread of AIDS by 2015. They also include the following goals: to halve global poverty; ensure primary-school education for all; promote gender equality and empower women; and reduce child mortality while improving maternal health. This total package is integral to success in alleviating the impact of AIDS.

Finally, lack of capacity to absorb increased resources allocated for HIV/AIDS, while posing

challenges, is no reason to delay the boosting of responses in countries expressing commitment to an expanded response. Assessments of programme readiness carried out by UNAIDS, together with rapid responses to calls for pro-

posals from the new Global Fund to Fight AIDS, Tuberculosis and Malaria, are both demonstrations of immediate and substantial unmet needs in AIDS programming in much of the world.

Building new capacity for success

Partnerships are emerging in response to AIDS, with increased involvement across the whole of government as well as between governments, civil society and the business sector. Trade unions and women's and youth organizations are engaging in AIDS-related activities, often for the first time. Business coalitions on AIDS have spread, especially in Asia and Africa. Globally, businesses have recognized the need for a proactive AIDS agenda, and efforts in this direction are being spearheaded by the Global Business Council on AIDS.

The International Labour Organization (ILO) became UNAIDS' eighth Cosponsor in 2001. It has engineered a new code of conduct designed to protect and support workers with HIV/AIDS and to use workplaces more effectively in the fight against AIDS (see 'Focus: AIDS and the world of work'). Meanwhile, philanthropic foundations, such as the Bill and Melinda Gates Foundation, are making increasingly imaginative and generous contributions—both financial and intellectual—in prevention, in supporting care access, in reducing mother-to-child transmission, and in the search for a vaccine, among others.

Emergency responses, whether to conflict or disaster, are beginning to deal with AIDS more effectively in emergency settings, be they refugee camps or war-torn zones. The World Food Programme is lending its sup-

port to AIDS responses in its field of operations, while the International Federation of Red Cross and Red Crescent Societies has begun to tackle AIDS-related stigma, starting with its workers and volunteers.

The new paradigm in access to care is beginning to take effect, and long-standing global inequities are being challenged. From disputes before the World Trade Organization, to court cases in South Africa, debate in relation to essential medicines has been resolved in favour of lowering trade barriers to access. The principle of preferential pricing for HIV drugs for low- and middle-income countries has been largely accepted in the pharmaceutical industry. Prices have begun to drop and countries' rights to invoke compulsory or voluntary licensing arrangements on patented drugs and medications were affirmed clearly at the World Trade Organization meeting in Doha, Qatar, in late 2001. Generic versions of many anti-retroviral drugs now exist. The World Health Organization has begun a process of quality assessment of HIV medicines (brand-name and generic) and is widely publishing the results in order to promote the rational use of drugs as well as affordable prices.

In Africa, where the gap between needs and resources is greatest, advances are being made in the wealthier countries (such as Botswana, Gabon and Nigeria); in those countries still

with relatively small HIV-positive populations (such as Senegal); and by building outwards from existing capital-city infrastructure (in countries such as Uganda).

Important progress has been made in the prevention of mother-to-child transmission. New guidelines on antiretroviral therapy and infant-feeding for HIV-infected mothers have been developed. Manufacturer Boehringer Ingelheim's offer, in July 2001, of free nevirapine for low- and middle-income countries is gradually being taken up. But this also means that voluntary counselling and testing need to go beyond the 1% of women in sub-Saharan Africa currently being reached. Antenatal care infrastructure has to expand. And safe

infant-feeding by HIV-infected mothers must become an actual choice, rather than a theoretical one. Much work remains to be done, however, in transforming the successes of small pilot projects into large-scale programmes.

As with the epidemic in general, access to HIV treatment also has governance and security dimensions. Even in the poorest countries, in urban areas, in particular, there is already a huge backlog in demand for HIV treatment. If treatment remains inaccessible, or if it is only extended to small elites, social tension might be further inflamed. Already, AIDS 'miracle cures' have given rise to local instability in India, Nigeria, Thailand and elsewhere.

Paying the bill

There has been a sea change in the understanding of the resources that are needed for an effective global response and in how to generate those funds. As agreed at the UN General Assembly, it is now clear that AIDS-related spending needs to rise to US\$7–10 billion to meet the main prevention and care needs of low- and middle-income countries (see 'Meeting the need' chapter).

In creating optimal conditions for national governments to increase their AIDS efforts, more funds need to be liberated through debt relief or debt cancellation. But there is also no escaping the need for the world's high-income countries to step up their support for the world's poorer countries.

The International Conference on Financing for Development, held in Monterrey, Mexico, in March 2002, ended with a strong call to eradicate poverty, achieve sustained economic

growth and promote sustainable development in the context of a fully inclusive and equitable global economic system. Its consensus statement called for substantially increased international development assistance, and pledges of increased funding were made by a number of nations. The Conference recognized the interconnectedness of domestic development, international development resources and foreign direct investment, international trade, international financial and technical cooperation, and external debt. It endorsed innovation in debt relief, as well as debt cancellation, where appropriate.

As was recognized in Conference discussions, the impacts of HIV are intimately connected with this emerging agenda of greater international coherence in financing for development. In the worst affected countries, AIDS has wiped out 50 years of development gains,

measured in terms of improved life expectancy. By the same token, strengthening domestic and international financing capacities and cooperation, ranging from improved gover-

nance, to increased resource flows and more stable economic conditions, are core strategies for reducing HIV-related vulnerability and the impact of the epidemic.

Global challenges

Huge global challenges still shape the context in which the world confronts the epidemic. Failure to control AIDS is an index of inequitable development and poor governance. Income inequality, gender inequality, labour migration, conflict and refugee movement all promote the spread of HIV.

Despite the widely recognized benefits of globalization, more than a billion of the world's 6 billion people still cannot fulfil their basic needs for food, water, sanitation, health care, housing and education. Worldwide, an estimated 1.1 billion people are malnourished. An estimated 1.2 billion people live on less than US\$1 a day. In more than 30 of the poorest national economies (most of them in sub-Saharan Africa), real per capita incomes have been declining since the early 1980s. At the same time, pressures on States to provide basic services and infrastructure have not eased. The HIV/AIDS epidemic, along with other diseases, conflicts and droughts, is worsening matters further.

But the global response to AIDS shows that the negative effects of globalization need not be 'facts of life'. Greater access to high-income countries' markets, debt relief and more development aid will go a long way towards enabling countries to reduce poverty. High-income countries spent more than US\$300 billion in 2001 on agricul-

tural subsidies—roughly equivalent to the combined gross domestic product of all of sub-Saharan Africa. It is clear that AIDS represents a long and devastating tale of exclusion for millions of people, with or without HIV infection.

The expanding AIDS epidemic provides a compelling case for accelerating much-needed global reform in an effort to better support local responses. This can be done by:

- creating stronger international cooperation, guided by the principles of human rights;
- generating more accountability and transparency of international institutions;
- replenishing national capabilities to safeguard the right to health (including the provision of HIV prevention, access to HIV care or the development of a HIV vaccine), and enlisting the help of the business sector in such efforts;
- redressing global poverty (a driving force of the AIDS epidemic) by, among other things, increasing Official Development Assistance to at least 0.7% of gross national product (a level first agreed to by the international community in 1969 and since endorsed repeatedly, including at the 2002 Monterrey International Conference on Financing for Development); and

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- above all, setting new rules of the game to ensure a more equitable distribution of the fruits of globalization.

It is true that the world cannot afford to wait until the perfect conditions exist before acting against AIDS. The fight against AIDS cannot go on hold until human security is achieved and poverty is eliminated. As Graça Machel said in her appeal to leaders at the African Development Forum 2000, “How would you react if you were told that, of your five children, two would die prematurely, but that you still had a chance to stop their deaths? Which parent wouldn’t mobilize all of their finan-

cial, emotional and human resources and act immediately?” At the same time, the growing global response to AIDS needs to be bolstered by stronger human security, equality and justice. In the long run, success in the struggle against the epidemic requires a global community that acts on the basis of human concern and humane values.

There is no blueprint for bringing the epidemic under control. But the past 20 years have seen the development of tools and knowledge that we know can result in success. The world now has a road map for the fight against AIDS. Time will tell how well it is used. 