

Note to the Chef de Cabinet

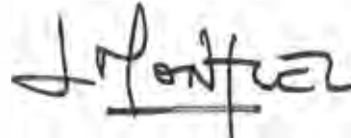
Clearance of the annual HIV/AIDS Report of the Secretary-General to the General Assembly

As requested by the General Assembly's 2011 Political Declaration on HIV/AIDS, the Secretary-General is required to submit a report annually to apprise them of progress in implementation of the Declaration.

The 2013 report shows that scientific breakthroughs, concerted global action and bold progress made by individual countries have set us on course to halting AIDS. The number of new HIV infections and AIDS-related deaths continue to decline globally as access to life-saving therapy and services are reaching more people than ever. The Report cautions that gains of recent years should be used as inspiration to see this through the end, not as an excuse to diminish global commitment. AIDS is not over, and the epidemic continues to expand in many parts of the world. Renewed commitment and solidarity is essential if we are to reach the 2015 targets.

Please find attached for your clearance the revised final draft report, submitted by UNAIDS and reviewed by the Development Unit and the Strategic Planning Unit.

Thank you.



Lenni Montiel
2 April 2013

cc: Mr. Orr

13-02872

HEA/08/001

HEA/04/001

Sixty-eighth session

Implementation of the 2001 Declaration of Commitment on HIV/AIDS and the 2011 Political Declaration on HIV and AIDS.

Accelerating the AIDS response: Achieving the targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS

Report of the Secretary-General

SUMMARY

We have an unprecedented opportunity to lay the groundwork for the eventual end of the AIDS epidemic. Extraordinary scientific breakthroughs, concerted global action and bold progress made by individual countries have set us on course to bring the AIDS epidemic completely under control. Indeed, we have made significant progress towards achievement of the ambitious targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS.

The number of new HIV infections and AIDS-related deaths continue to decline globally as access to life-saving prevention and treatment services are reaching more people than ever. Across 25 low- and middle-income countries, the rate of new HIV infections has been reduced by more than a 50% — more than half in sub-Saharan Africa, the region most affected by HIV. Most significantly, half of the global reductions in new infections in the last two years have been among new-born children, paving the way for an AIDS free generation.

In the 24 months to December 2011, the numbers of people accessing treatment increased by 63% globally, and there were more than half a million fewer AIDS-related deaths in 2011 than in 2005.

The largest reductions in AIDS-related deaths are taking place in countries where HIV has the strongest grip. In 2011, South Africa had 100 000 fewer deaths than in 2005, Zimbabwe nearly 90 000 fewer, Kenya 71 000 and Ethiopia 60 000. In sub-Saharan Africa, the number of AIDS-related deaths has reduced by one third in the last six years, and the number of people on antiretroviral treatment has increased by 59% in the last two years alone.

Low- and middle-income countries have invested an unprecedented proportion of their own domestic resources in the AIDS response. African leaders have used AIDS as an entry-point to enhance their leadership and ownership of the international agenda for health and development. Asian ministers have united to address the HIV-related needs of women and girls.

The progress of the global AIDS response is impressive, however, the AIDS epidemic is far from over. AIDS remains the leading cause of death among women aged 15-49 worldwide. It is the leading cause of life years lost in Southern and Eastern Africa, the third-leading cause of death in Eastern Europe, and the sixth-leading cause of death worldwide. As of December 2011, more than 17 million children had lost one or both parents to AIDS.

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To build on recent gains – and address the devastating human and developmental challenges still posed by the epidemic, the international community must fulfil the commitments of the 2011 UN Political Declaration on HIV and AIDS. This requires proactively revising and adapting approaches to seize new opportunities as they emerge. In order to bring the AIDS epidemic completely under control, the concept shared responsibility and global solidarity must be advanced. Investments in the AIDS response by low- and middle-income countries, as well as by international donors must continue to grow to close the funding gap. HIV programmes must become more strategic, focus investments on interventions that have the greatest impact and that address the needs of populations most in need. Synergies between HIV programmes and broader development initiatives, such as social protection programmes, must be maximized to address the social, legal and economic conditions that increase vulnerability to HIV.

Introduction

1. The 2011 Political Declaration on HIV and AIDS renewed global solidarity and established a set of 10 concrete and time-bound targets to be met by 2015.

2. This report describes progress to date in meeting these targets. It draws primarily from comprehensive reports on progress in their national AIDS response submitted by 186 countries in 2012. With 96% of the 193 United Nations Member States reporting in 2012, the Global AIDS Response Progress Reporting system has among the highest response rates of any international health and development monitoring mechanism – a vivid reflection of the breadth and depth of global commitment to the response to AIDS. While focusing on achievements in the global AIDS response, this report also aims to inform and strengthen the broader development agenda, including the September 2013 General Assembly Special Event to review progress against the full range of Millennium Development Goals.

3. UN Member States still face considerable challenges in their efforts to address HIV. Seven million people who are currently eligible for treatment do not have access to life-saving HIV treatment, with access lowest among children. New HIV infections are still rising in Eastern Europe and Central Asia, and the Middle East and North Africa. Women and girls continue to be disproportionately affected; key populations that have the highest HIV prevalence lack equitable access to services; and, legal and policy barriers continue to undermine effective responses to the epidemic in many parts of the world. Persistent global economic challenges impede efforts to mobilize essential investments to close the funding gap in global response to the AIDS epidemic, and the widening economic gap between rich and poor across the world undermines efforts to mount an inclusive, optimally effective response.

4. These challenges are real but overcoming them is possible. The history of the AIDS response has consistently demonstrated that global solidarity, evidence-based action and the active involvement of people most affected by the epidemic can overcome barriers to progress. But it also requires quickly scaling up programmes that deliver the greatest impact, putting sound policy frameworks in place that optimize programme effectiveness, and promoting synergies between HIV and other development initiatives.

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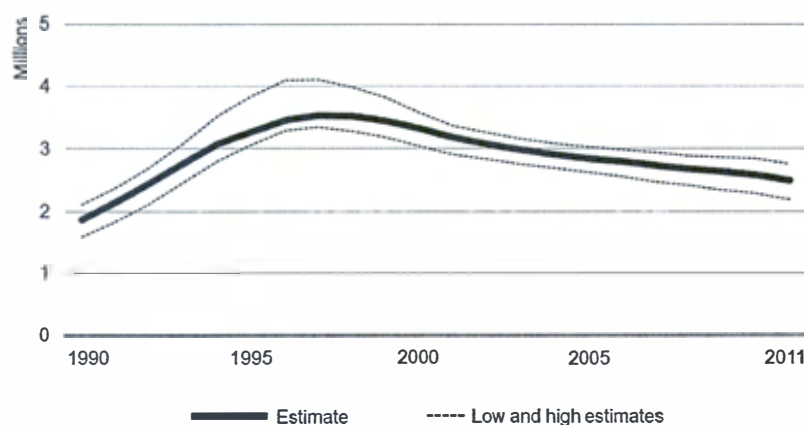
I. The status of the epidemic

5. Globally, an estimated 34 million [31.4 million – 35.9 million] people were living with HIV at the end of 2011. Sub-Saharan Africa, with nearly 1 in 20 adults living with HIV, remains the region most heavily affected by the epidemic, accounting for 69 per cent of all infections worldwide. Outside sub-Saharan Africa, the Caribbean and Eastern Europe and Central Asia have the highest adult HIV prevalence (1 per cent). National and sub-national epidemics are often complex, rapidly evolving and multi-faceted, and epidemiological patterns frequently differ substantially between and within countries.

6. An estimated 2.5 million people (adults and children) were newly infected with HIV in 2011 [2.2 million – 2.8 million], 20 per cent lower than in 2001. Significant declines occurred in the most affected regions – the Caribbean (42 per cent decline) and sub-Saharan Africa (25 per cent decline). The decline in new HIV infections have been especially sharp among children in recent years, with 330 000 children newly infected in 2011 [280 000 – 390 000], 24 per cent lower than the 430 000 who were infected in 2009 [370 000 – 490 000].

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Fig. 1. Number of people newly infected with HIV globally, 1990-2011



Source: UNAIDS

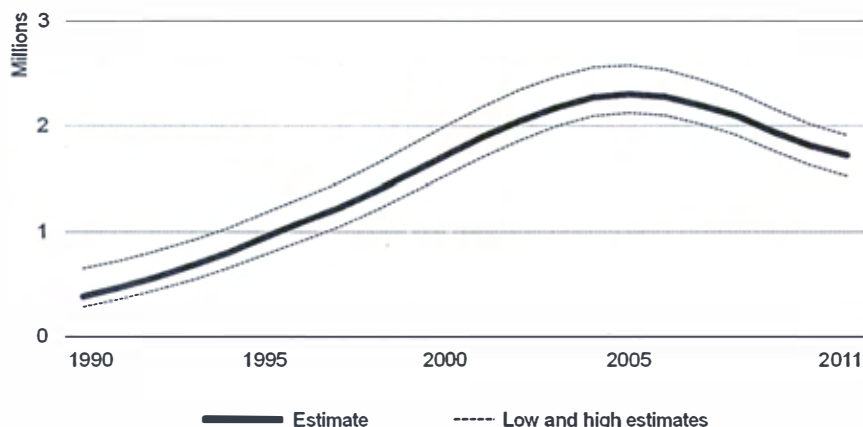
7. Trends in new HIV infections are not uniformly positive in all parts of the world. New infections are on the rise in Eastern Europe and Central Asia and in the Middle East and North Africa. And while many countries in Asia have successfully reduced new HIV infections, the numbers are rising in other countries in the same region.

8. Access to HIV treatment has expanded dramatically, reaching more than 8 million people in low- and middle-income countries in 2011, or 54 per cent of all who were eligible under current treatment guidelines. Treatment coverage is considerably higher in some regions – such as Latin America (68 per cent), the Caribbean (67 per cent), Oceania (69 per cent), and sub-Saharan

Africa (56 per cent) – than in Eastern Europe and Central Asia (25 per cent) and the Middle East and North Africa (15 per cent).

9. In 2011, 1.7 million [1.5 million – 1.9 million] people died from AIDS-related causes – a 24 per cent decline from 2005. However, AIDS-related mortality has increased in several regions, including Eastern Europe and Central Asia (21 per cent) and the Middle East and North Africa (17 per cent). Since 2004, TB-related deaths among people living with HIV have fallen by 25 per cent globally and by 28 per cent in sub-Saharan Africa.

Fig. 2. Adult and child deaths due to AIDS, 1990-2011



Source: UNAIDS

10. Young people aged 15 to 24 account for 14 per cent of all people living with HIV and 34 per cent of new infections. HIV prevalence among young people has fallen by over 50% since the mid-1990s in the Caribbean and in Eastern Africa. However, the global decline in HIV prevalence among young people has been approximately 13%.

11. In 2011, women accounted for 49 per cent of all adults living with HIV worldwide. In two regions, more than half of adults living with HIV are women: sub-Saharan Africa (58 per cent) and the Caribbean (52 per cent). In other regions, the percentage of women among adults living with HIV ranges from 25 per cent (in Western and Central Europe and North America) to 34 per cent (in Asia and the Pacific). Globally, one young woman is newly infected every minute, and young women in sub-Saharan Africa are more than twice as likely as young men their own age to be living with HIV.

12. The epidemic's impact is substantially greater in certain populations. According to surveys, female sex workers are on average 13.5 times more likely than other women to be living with HIV. Prevalence is 22 times higher among people who inject drugs than for the population as a whole. Among men who have sex with men, prevalence is 19 times higher.

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II. Key targets for 2015: progress to date and challenges to overcome

13. The following information describes progress towards the 2015 targets in the 2011 Political Declaration on HIV and AIDS. These 10 targets are part of the global community's broader commitment to ensure universal access to prevention, treatment, care and support by 2015.

A. Reduce sexual transmission by 50 per cent

14. In many countries, changes in sexual behaviours are associated with declines in new HIV infections. In several countries with generalized HIV epidemics, fewer young people are having sex before age 15, fewer have multiple sexual partners and rates of condom use have increased. Favourable trends are not apparent in all countries. Risky sexual behaviours among young people reportedly are increasing in a number of sub-Saharan African countries. Although comprehensive sexuality education empowers young people to make informed decisions about their sexual behaviours, 20 per cent of high-burden countries report that HIV education has not yet been integrated into primary school curricula.

15. Efforts to prevent sexual transmission of HIV continue to be undermined by acute problems in condom access in low- and middle-income countries, where demand has risen to an estimated 10 billion condoms each year. Only 3.4 billion male condoms and 43.3 million female condoms were procured by nine international donors for distribution in low- and middle-income countries in 2011. As most low- and middle-income countries depend on external support for condom procurement, it is unlikely that national investments covered this gap in 2011.

16. Progress in scaling up voluntary medical male circumcision remains slow, although the pace has accelerated in several countries. In six countries with high HIV prevalence and low prevalence of male circumcision, less than 5 per cent of the target number of men had been circumcised by the end of 2011. Some countries – such as Botswana, Kenya, Namibia and Swaziland – have prioritised programming and increased expenditure for voluntary medical male circumcision.

Table 1. Percentage of the 2015 national targets on male circumcision met by 2011

<5%		
Malawi		
Mozambique		
Namibia		
Rwanda		
Uganda		
Zimbabwe		
5–20%		
Botswana		
South Africa		
UR Tanzania		
Zambia		
>20%		
Ethiopia		
Kenya		
Swaziland		

Source: UNAIDS

17. Although 73 per cent of countries reported having implemented HIV prevention programmes for sex workers, surveys in 58 capitals indicate that only 56 per cent of sex workers are reached by prevention services.

18. HIV prevention programmes for men who have sex with men remain inadequate, with coverage of 55 per cent. Condom use also remains low. A majority of men who have sex with men surveyed in 69 countries said that they used a condom during their last episode of sexual intercourse, but in 56 of those countries fewer than 75% did so.

19. Currently, programmes to reach sex workers and men who have sex with men account for less than 4 per cent of HIV expenditure on basic programmes. UNAIDS advises that the share of expenditure allocated to these populations, in countries where most applicable, should rise to 7 per cent by 2015 in order to maximize the impact.

20. Despite these and other challenges, there is progress towards the goal of reducing sexual transmission of HIV by 50 per cent by 2015. In 2012 and early 2013, strong evidence emerged from South Africa and China of the benefits of HIV treatment for prevention at the population level. In rural KwaZulu-Natal in South Africa, uninfected individuals living in a community with high rates of treatment (30–40 per cent of all infected individuals receiving treatment) were 38 per cent less likely to acquire HIV than their peers living in a community where treatment coverage was low (<10 per cent of all infected individuals receiving treatment). Among serodiscordant couples [1] in China, rates of transmission were 26 per cent lower among couples in which the HIV-positive partner had received treatment compared to couples in which the positive partner was not on treatment. Capturing the full prevention potential of treatment will require improving testing programmes, linking those who test positive to on-going health care, initiating treatment at the right time, and ensuring patient retention in clinical settings. Major clinical trials are currently underway to address some of the questions surrounding treatment as prevention, including when to initiate therapy, optimal regimens to reduce the risk of

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[1] A serodiscordant couple is a couple in which one partner is HIV-positive and one partner is HIV-negative. See WHO Guidance on couples HIV testing and counseling including ARV therapy for treatment and prevention in serodiscordant couples. Recommendations for a public health approach, April 2012

transmission, and how best to focus treatment programmes to maximize their impact on preventing HIV transmission.

21. Social support programmes that address children and young people's economic vulnerability have been shown to reduce new HIV infections, and an increasing number of countries are pursuing these programmes. In 2012, results from a large-scale national programme in Kenya found that an unconditional cash transfer to very poor households and households with vulnerable children reduced early sexual debut by 30 per cent and also reduced instances of unprotected sex.

22. New HIV prevention tools are on the horizon. Research on pre-exposure antiretroviral prophylaxis (PrEP) in North America, Latin America, ~~sub-Saharan Africa and the Asia Pacific~~ regions has found that it is efficacious when used correctly, and it offers new hope for woman-controlled HIV prevention. Demonstration projects are under way in these regions focusing on men who have sex with men, sex workers, HIV discordant couples and high risk young women, to develop effective and efficient strategies for offering oral PrEP in the context of combination prevention. In addition, clinical trials are currently evaluating additional microbicide candidates, long-acting products, and dual product methods (including antiretrovirals and contraceptives) which may overcome the problems of adherence that have plagued three of the recent large, multi-country clinical trials of PrEP.

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23. Reaching the goal of reducing sexual transmission of HIV by half requires strategic combinations of biomedical, behavioural and structural approaches matched carefully to national and local needs. These programmatic combinations must be supported by concerted efforts to promote gender equality, remove punitive legal frameworks, eliminate stigma and discrimination, protect human rights and enhance social protection. Six major clinical trials are underway on five continents to evaluate various prevention packages that combine multiple interventions to determine what works best to prevent new ~~infections and improve health~~ outcomes for people living with HIV.

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B. Reduce transmission among people who inject drugs by 50 per cent

24. We have known for years how to prevent transmission among people who inject drugs. Harm reduction is a well-defined, evidence-based approach of essential interventions, including access to sterile needles and syringes, opioid substitution therapy, counselling and testing, HIV treatment and other health services tailored to the needs of people who inject drugs. Countries that have implemented harm reduction programmes at sufficient scale have seen sharp reductions in HIV incidence associated with drug use, with some, such as Australia and the United Kingdom, approaching the elimination of drug-related HIV transmission.

25. Although a number of countries have taken steps in recent years to expand access to harm reduction programmes, service coverage remains grossly inadequate. In 2010, only two needle-syringes were distributed monthly for every person who injected drugs. It is estimated that sterile syringes are used in only 5 per cent of drug injection episodes worldwide. Out of 70 countries having needle and syringe programmes, only eight are implementing such programmes in prisons, and those that exist tend to be small-scale.

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26. Other HIV prevention services that are recommended by the United Nations among people who inject drugs are still limited in their coverage and intensity. In 32 low- and middle-income countries, only 2.4 per cent of people who inject drugs had access to opioid substitution therapy in 2010. Only an estimated 40 per cent of people who inject drugs used a condom the last time they had sex. In countries with epidemics driven in large measure by drug-related transmission, HIV treatment coverage is disproportionately low among people who inject drugs. The same is true for treatment of hepatitis B and C, which is another critical health concern for people who inject drugs.

27. Women who inject drugs are at greatest risk. They are more vulnerable to violence from intimate partners, police and also clients, if the women are sex workers. HIV-positive women who inject drugs and become pregnant are substantially less likely than other women living with HIV to access services to prevent mother-to-child transmission.

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28. To make essential harm reduction services available and protect people who inject drugs from HIV infection, countries need to enable legislative and policy frameworks that uphold human rights, avoid punitive approaches such as compulsory treatment, and provide support for harm reduction programmes to operate. Several countries – including India, Indonesia, Papua New Guinea and Thailand – have implemented commendable programmes to ensure that law enforcement practices do not impede service access for key populations. The 2016 United Nations General Assembly Special Session on the world drug problem provides an opportunity to link HIV prevention with a broader legal and policy framework pertaining to the use of illicit drugs.

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29. International donors account for 92 per cent of all HIV spending on HIV prevention and treatment programmes among people who inject drugs, indicating that few countries have stepped forward to prioritize essential health services for this population. Although injecting drug use is still the leading mode of HIV transmission in Eastern Europe and Central Asia, domestic funding provides only 15 per cent of HIV prevention resources for people who inject drugs in that region.

C. Eliminate new HIV infections in children and substantially reduce AIDS-related maternal deaths

30. One of the greatest recent successes of the global AIDS response has been turning the tide against new HIV infections among children. The global community has embarked on an historic undertaking to achieve a 90 per cent reduction in the number of children newly infected between 2009 and 2015, but more focused progress is needed in key countries to reach this target.

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31. Launched at the UN High Level Meeting on HIV/AIDS in 2011, the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive calls for four key actions: (1) strengthening primary HIV prevention services for reproductive-age women and their partners; (2) meeting the unmet need for family planning among women living with HIV; (3) providing timely HIV testing, counselling and antiretroviral therapy to pregnant women living with HIV to prevent transmission to their children; and (4) delivering HIV care, treatment and support for women living with HIV, children living with HIV and their families. Developing appropriate systems and structures to provide essential support for HIV-positive,

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pregnant women and their families in all settings is critical to implementation of this four-pronged approach.

Table 2. Percentage decrease between 2009 and 2011 in the number of children (0–14 years old) acquiring HIV in countries with generalized epidemics



Source: UNAIDS.

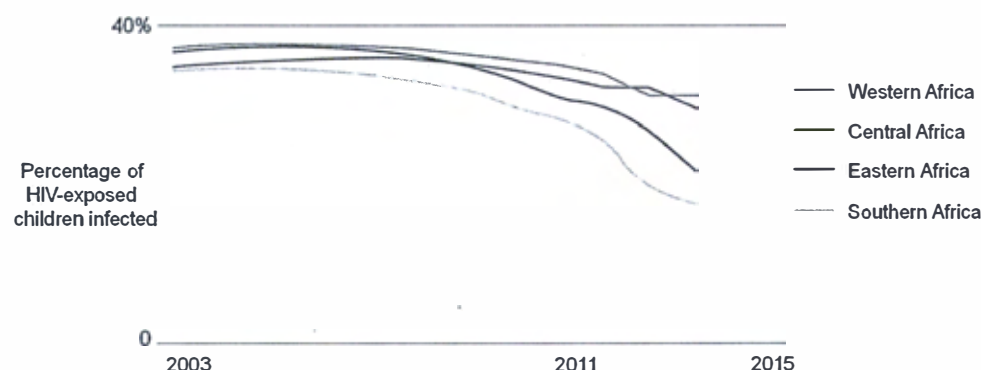
Note: As the analysis above uses 2009 as a baseline year, it does not capture important progress made in many countries (e.g., Botswana) in reducing the number of new infections among children before 2009.

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31. Rapid progress has been achieved in scaling up the use of antiretroviral prophylaxis to prevent new HIV infections among children. In 2011, 57 [51 – 64] per cent of pregnant women living with HIV worldwide, and 59 [53 – 66] per cent in sub-Saharan Africa, received effective antiretroviral regimens to prevent mother-to-child transmission of HIV. Coverage is substantially lower in South and South-East Asia (18 [13 – 23] per cent) and the Middle East and North Africa (7 [6 – 9] per cent). There is evidence that the proportion of pairs of women living with HIV and infants provided with prophylaxis during breastfeeding has increased since 2009, although many countries have yet to implement rigorous measures to monitor antiretroviral coverage among breastfeeding women. Programmes to prevent mother-to-child transmission have expanded in humanitarian contexts, but only 39 per cent of operations have achieved 100 per cent coverage.

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Fig. 3. Trends in mother-to-child transmission rates by sub-region in sub-Saharan Africa, 2000–2011



Source: UNAIDS

33. Efforts to eliminate new HIV infections among children by 2015 are being impeded by insufficient progress on other priorities in the Global Plan. The number of new HIV infections remains high among women of reproductive-age in the 22 priority countries; with the exception of a few countries, progress in reducing unmet need for family planning has been limited. The transition towards more effective antiretroviral regimens has been far too slow in some settings.

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34. Delivering life-preserving treatment to women living with HIV benefits both the women and their children, as children whose mothers die have an increased risk of death regardless of the child's HIV status. Interest is growing in many countries in providing lifelong treatment to HIV-positive pregnant women, using a simplified, once-a-day regimen (Option B+).

35. Provision of TB prevention, screening, treatment and infection control are essential to eliminating new HIV infections among children and keeping mothers alive. Pregnant women living with HIV have a 10-fold higher risk of developing TB than other pregnant women. TB also more than doubles the risk of mother-to-child HIV transmission. In addition, programmes should strengthen the diagnosis of paediatric TB and increase access to treatment for children in need.

36. It is deplorable that children's access to HIV treatment still lags far behind adults. Children under two years old living with HIV require immediate access to HIV treatment, but only 28 per cent of children born to HIV-positive pregnant women were screened for HIV within two months of birth in 2010. In 2011, only 28 [25 – 31] per cent of children 0-14 years old who were eligible for antiretroviral therapy under current guidelines were receiving it. To enhance HIV treatment access for children, countries must implement well-designed systems for tracking mother-and-infant pairs and for linking infants to early diagnostic services. Standardization of paediatric antiretroviral formulations is urgently needed.

37. Despite these challenges, recent progress indicates that the goal of eliminating new HIV infections among children and keeping their mothers alive can be reached by 2015. This will require improved programmatic performance, addressing systemic factors that slow progress, and accelerating efforts to bring national programmes into line with international recommendations. Programmes for women and children need to respect women's autonomy, build on the involvement and leadership of women living with HIV, and take active steps to engage men and boys.

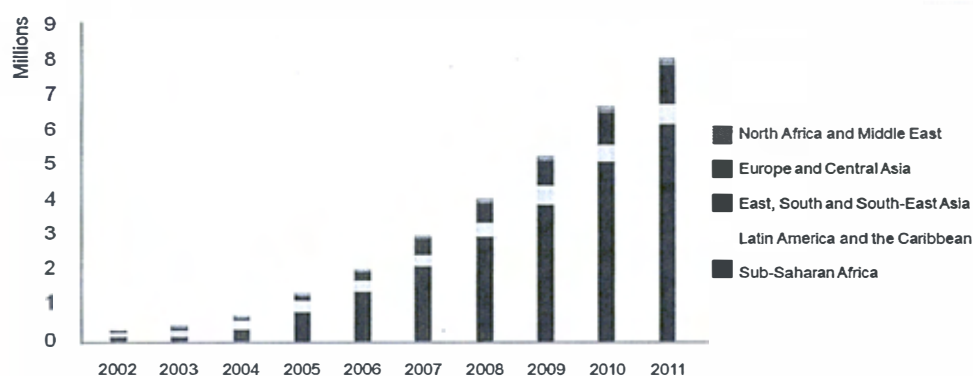
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D. Reach 15 million people living with HIV with antiretroviral treatment

38. The expansion of HIV treatment access in low- and middle-income countries in recent years is one of the most extraordinary achievements in the history of global health. Antiretroviral therapy reduces morbidity and mortality and also prevents new HIV infections. Since 1995, antiretroviral therapy has added 14 million life-years in low- and middle-income countries, including 9 million in sub-Saharan Africa.

39. The number of low- and middle-income countries achieving more than 80 per cent coverage with HIV treatment rose from 7 in 2009 to 10 in 2011, while the number of countries with coverage less than 20 per cent dropped from 28 to 10. However, improvements in HIV treatment access have not been universally shared. Persistently below-average treatment coverage in West and Central Africa, Eastern Europe and Central Asia, and the Middle East and North Africa underscores the need to intensify efforts to expand treatment access in regions where coverage lags. Men in low- and middle-income countries have much lower treatment coverage (47 per cent) than women (68 per cent), in part due to differences in health-seeking behaviours.

Fig. 4. Number of people receiving antiretroviral therapy in low- and middle-income countries, by region, 2002–2011



Source: UNAIDS

40. The percentage of adults being tested for HIV in the past 12 months is rising, according to surveys between 2004 and 2011 in 14 countries in sub-Saharan Africa. The accelerating uptake of HIV testing and counselling services has been aided by technological and systems

improvements, including simplified rapid tests, provider-initiated testing in health care settings, roll-out of home-based testing strategies, decentralization of service delivery, increased integration of HIV testing with other health services and increased use of lay workers to perform rapid tests. Community-based campaigns that focus on education and diagnostic services for multiple diseases have proven effective in expanding access to testing services. Despite these gains, however, many people continue to be diagnosed late in the course of infection, preventing timely initiation of treatment.

41. As scale-up continues, treatment programmes are becoming more efficient, reducing unit costs, improving health outcomes and enabling limited health budgets to reach more individuals. Simplified drug regimens and the development of point-of-care diagnostic tools have contributed to recent efficiency gains. To ensure that individuals receive the most effective regimens, countries are now working to phase out the antiretroviral drug stavudine due to its long-term toxicity and side effects.

42. To maximize the health benefits of antiretroviral therapy, gaps throughout the treatment continuum must be closed. Diagnosis must occur early in the course of infection, systems should be in place to link individuals who test positive to immediate medical care, on-going monitoring should ensure timely initiation of therapy, and adherence support services should be tailored to individual needs. Particular efforts are needed to address treatment access barriers experienced by adolescents, sex workers, men who have sex with men, transgender people, people who inject drugs, migrants, individuals in humanitarian settings, people living in prisons and other groups with diminished health care access.

43. In some countries in sub-Saharan Africa, one-third or more of all people who start treatment are no longer receiving after five years. Countries are trying innovative measures to improve patient retention. In Mozambique, one successful programme saw two-year retention of people in clinic-based treatment programmes rise from 70 per cent to 98 per cent.

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44. While the cost of treatment has continued to decline, further cost reductions are essential to accelerate uptake and sustain access to lifelong treatment. Cost reductions are especially critical for second- and third-line antiretroviral drugs, which remain substantially more expensive than first-line drugs but will become increasingly important in future years as resistance to first-line regimens increases. As countries enhance their capacity to monitor patients' viral load, demand for second- and third-line regimens is certain to increase. Reducing drug costs further will require effective use of flexibilities available under international intellectual property provisions, preserving the availability of generic alternatives to branded drugs, and increasing the capacity of low- and middle-income countries, and in particular in Africa, to develop and manufacture essential medicines. All parties involved in negotiating new Free Trade Agreements should avoid proposing or agreeing to provisions that could diminish the ability of low- and middle-income countries to obtain a reliable supply of affordable medicines.

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E. Reduce tuberculosis deaths among people living with HIV by 50 per cent

45. HIV-associated TB deaths have fallen, as national implementation of collaborative HIV/TB activities saved an estimated 1.3 million lives from 2005 to 2011. However, TB remains the leading cause of death for people living with HIV, accounting for one in four such deaths in 2011.

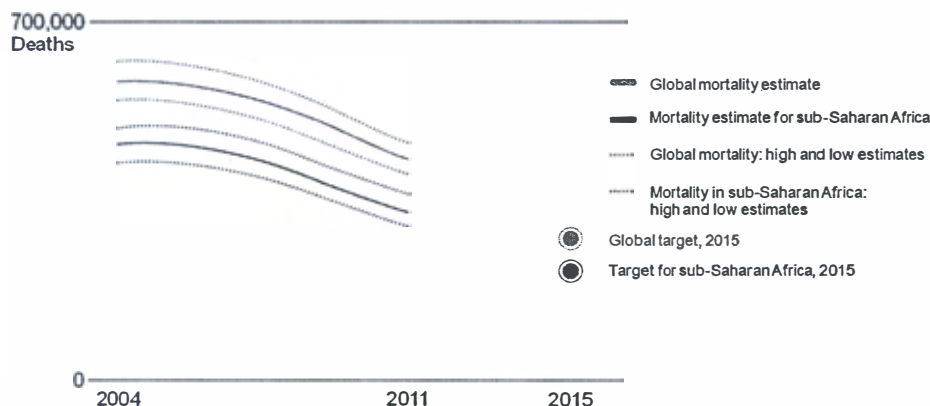
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Fig. 5. Estimated number of TB-related deaths among people living with HIV, 2004–2011



Source: UNAIDS

46. Countries have adhered to the recommended “Three I’s for HIV/TB” approach: intensified case-finding, isoniazid preventive therapy for HIV-positive individuals who do not have active TB, and effective infection control. HIV treatment scale-up **has** also led to declines in HIV-associated TB mortality, as antiretroviral therapy **significantly** reduces the risk of TB illness among people living with HIV.

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47. Considerable progress has been made in reaching TB patients with HIV testing services. In 2011, 69 per cent of all people with TB in sub-Saharan Africa were tested for HIV, while global testing rates among people with TB were much lower (40 per cent). Among people living with HIV, 3.2 million were screened for TB in 2011, with 446 000 people living with HIV receiving isoniazid preventive therapy. Experience shows that focused efforts can increase access to essential services. In South Africa, TB screening among people living with HIV rose nearly two-fold in 2011, while the number of people living with HIV receiving preventive TB therapy increased almost three-fold.

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48. Early diagnosis of TB has also played a vital role in reducing TB-related deaths among people living with HIV. The World Health Organization (WHO) now recommends a new rapid molecular diagnostic test, Xpert MTB/RIF, to initially diagnose TB in people living with HIV.

49. It is recommended that all TB patients living with HIV should start HIV treatment as soon as possible regardless of their CD4 count. However, in 2011, only 48 per cent of people with both TB and a documented HIV-positive test result received HIV treatment. In Eastern Europe and Central Asia, where new HIV infections are increasing, a rise in multi-drug resistant TB underscores the need to strengthen testing and treatment programmes and ensure an integrated response to the linked epidemics of HIV and TB. Many co-infected individuals, including those living in prisons, have difficulty completing prescribed therapy. This highlights the critical need for adherence support interventions.

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50. Ensuring women's access to essential TB services and HIV treatment is essential to accelerate progress. In Africa, women are about 20 per cent more likely than men to die of TB.

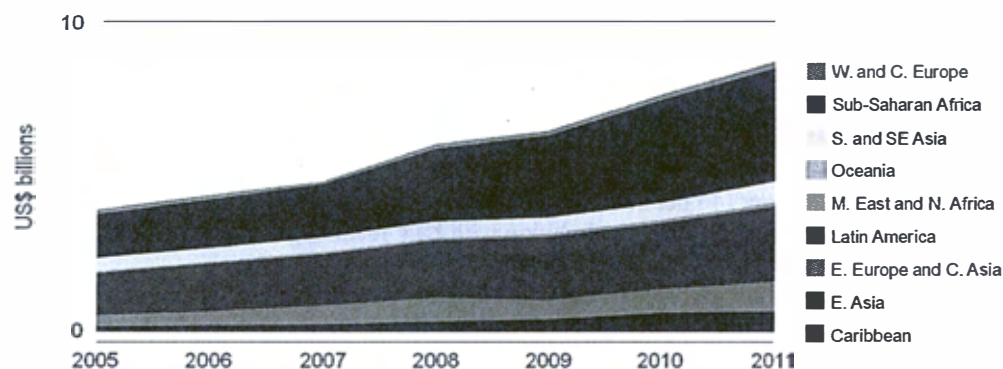
51. In March 2013, African leaders of the SADC region joined global partners to launch an accelerated action on TB and HIV in the next 1000 days and UNAIDS called for "Zero tolerance for parallel systems for TB and HIV". In order to rapidly reduce the number of TB deaths among people living with HIV, services for TB and HIV should be integrated, where possible, and provided at the same site to ensure patient-centred services. HIV treatment should be scaled up using decentralized service networks. Food, nutrition support and other interventions shown to improve TB outcomes should be integrated into programmes for people with TB/HIV co-infection. Collaborative TB/HIV activities should also be integrated into services such as maternal and child health programmes, programmes to prevent mother-to-child HIV transmission, harm reduction and drug treatment programmes and prison health services.

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F. Close the global AIDS resource gap

52. Total annual resources of US\$ 22-24 billion will be needed by 2015 to help lay the foundation for the epidemic's end. UNAIDS recommends that all partners pursue an investment approach, focusing funding on high-impact strategies that respond to documented needs.

Fig. 6. Domestic public and private resources available for HIV in low- and middle-income countries in current billions of US dollars, 2005–2011



Source: UNAIDS

53. In 2011, US\$ 16.8 billion was invested in HIV-related activities worldwide – more than US\$ 5 billion short of the minimum that will be needed in 2015. For the first time, low- and middle-income countries accounted for the majority of HIV expenditures in 2011, contributing US\$ 8.6 billion, more than double what they invested in 2005. However, there is substantial room for progress, as most African countries have yet to reach the Abuja Declaration's target of allocating at least 15 per cent of their national budget to health programmes. Taking projected economic growth into account, UNAIDS projects that African countries alone could mobilize an additional US\$ 5 billion for the AIDS response by 2015 by achieving their Abuja targets and by bringing national HIV investments in line with the epidemic's proportion of the national health burden.

54. Despite the increase in domestic investments, international donors must continue to play a pivotal role in financing the response. Twenty-three members of the Organisation for Economic Co-operation and Development increased their HIV-related disbursements by 10 per cent in 2011. In 2012, the U.S. President's Emergency Fund for AIDS Relief (PEPFAR) programme released a blueprint for strategic action to achieve progress towards an AIDS-free generation. In 2013, the Global Fund to Fight AIDS, Tuberculosis and Malaria launched a new funding model that will prioritize assistance to the most heavily affected countries and focus funding on interventions that will have the greatest health impact.

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55. In 2012, UNAIDS worked with 49 countries to assess national HIV spending, with the aim of bringing spending patterns into line with investment principles. Cambodia, for example, has embarked on a new approach known as "Cambodia 3.0," which seeks to "do more and better with less" by boosting priority interventions, adopting innovative strategies (such as community-based service delivery) to increase programmatic reach and effectiveness, and using strategic information to improve the quality, efficiency and effectiveness of interventions.

56. Inequities in financing must be addressed at the same time that resource mobilization efforts are intensified. Programmes for key populations at higher risk remain badly under-financed and overwhelmingly dependent on international financing. Of HIV-related spending specific to women, 71 per cent focuses on prevention of new infections in children, leaving few resources for women-focused primary HIV prevention, programmes to prevent gender-based violence or initiatives to alleviate women's disproportionate care-giving responsibilities.

57. Closing the resource gap is a shared responsibility of the entire global community. In order to close to this gap, low- and middle-income countries are encouraged to continue to increase their domestic investments, international donors should maintain their commitment to global solidarity, and innovative financing mechanisms should be aggressively pursued. A critical moment will occur in September 2013, when public and private donors convene to replenish funding for the Global Fund (2014-2016). In addition, greater efforts are needed to improve the efficiency and effectiveness of programmes; address demand-side barriers, such as food and livelihood insecurity, that prevent people from accessing and adhering to health services; and rationalize and eliminate parallel administrative and reporting systems.

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G. Meet the specific needs of women and girls, and eliminate gender inequalities and gender-based abuse and violence

58. Inequitable gender norms exacerbate women's vulnerability by limiting their access to education and employment, undermining their capacity to reduce their risk of sexual HIV transmission, and exposing them to the risk of violence or social ostracism. Women are also placed at higher risk of HIV infection through sexual partnerships with men who have sex with men, people who inject drugs, or sex work clients. One study estimates that 50 million women in Asia are at risk of becoming infected by their intimate partners. Gender norms also harm men, encouraging high-risk behaviour and deterring them from seeking essential health services. Prevailing gender norms also increase the vulnerability of transgender people and impede their access to HIV services and safe and secure livelihoods.

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59. Consistent with the Secretary-General's Five-Year Action Agenda, the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV calls for focused

efforts to help countries address the needs and rights of women and girls in the context of HIV. The UNAIDS agenda has fostered political commitment and accelerated action, with 60 per cent of countries having used the agenda to strengthen gender equality within AIDS responses.

60. ~~Regrettably, insufficient~~ attention is being given to gender inequality and its impact on women's HIV-related needs. In 2011, only one-third of countries had brought female condom programming to scale, only one-third reported integrating HIV and sexual and reproductive health services, and only 1 in 10 effectively engaged men and boys in the response.

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61. Prevalence of intimate-partner violence in the past 12 month ranges from 5 per cent to 69 per cent among countries surveyed. Together for Girls is an international coalition of UN agencies, government partners and private sector partners working to support national surveys, evidence-based action, global advocacy and public awareness to address the epidemic of sexual violence against women and girls.

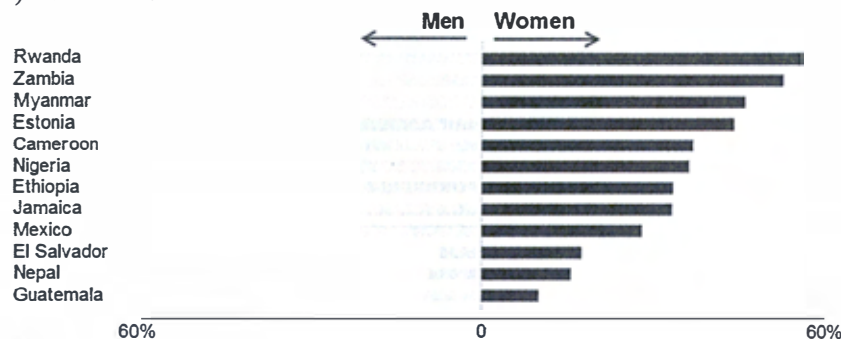
H. Eliminate stigma and discrimination against people living with and affected by HIV

62. More than three decades after the cases of AIDS were first reported, stigma and discrimination against people living with or affected by HIV continues to undermine an effective response. Data collected through the People Living with HIV Stigma Index indicate that large percentages of people living with HIV have experienced physical or verbal abuse, social ostracism and emotional distress. According to studies in nine countries, the percentage of people living with HIV who reported experiencing discrimination in the workplace ranged from 8 per cent in Estonia to 54 per cent in Malaysia.

63. Women living with HIV often experience higher levels of stigma and discrimination. According to national surveys, they are more likely than their male counterparts to be verbally insulted or physically assaulted, to lose employment, and to feel shame. Involuntary sterilization of women living with HIV has been reported in numerous countries.

Fig. 7. Percentage of men and women living with HIV experiencing verbal and physical violence in countries with available sex-disaggregated data

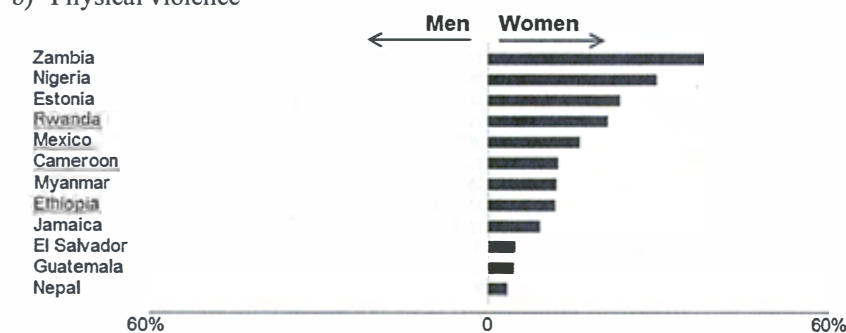
a) Verbal violence



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b) Physical violence



Source: UNAIDS

64. The Secretary-General's Five-Year Action Agenda calls for a policy framework that protects against human rights violations and advances a responsibility to protect populations. Too few countries have implemented HIV policy frameworks that support a human rights approach. In 2012, nearly 4 in 10 countries worldwide reported having no specific legal provisions to prevent or address HIV-related discrimination. The proportion of countries having HIV-related legal services in place rose from 45 per cent in 2008 to 55 per cent in 2012, but a large percentage of countries have failed to take steps to enforce these rights.

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65. At least 60 per cent of countries reported laws, regulations and policies that present obstacles to effective prevention, treatment, care and support for key populations. In addition, 43 per cent of countries with refugees have no legislation protecting the rights of asylum seekers living with HIV. About 60 countries have adopted laws specifically criminalizing HIV transmission, more than 40 per cent of UN Member States criminalize same-sex relations, and most countries have laws deeming some aspect of sex work to be illegal. According to an international review, punitive approaches to drug use – including criminalization of individuals who are dependent on drugs, compulsory drug detention or prohibitions of programmatic components of harm reduction – are widespread and undermine access to HIV services.

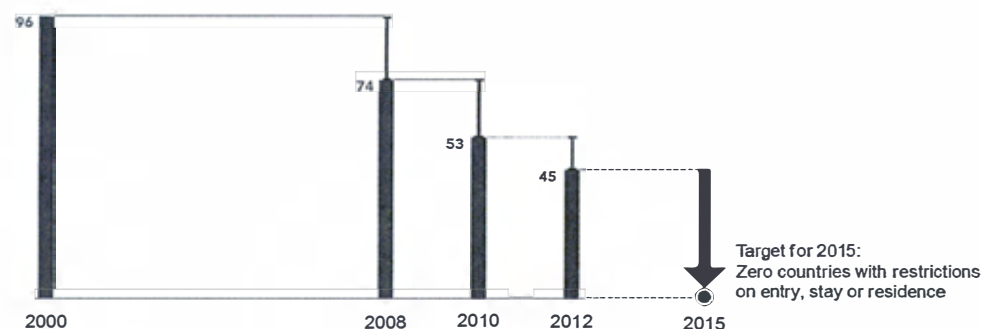
The Global Commission on HIV and the Law has recommended that countries explicitly prohibit HIV-related discrimination; avoid criminalizing HIV exposure, non-disclosure or transmission; enact specific protections for women and girls; use legal measures to ensure treatment access; and remove punitive or discriminatory laws and policies regarding key populations and vulnerable groups. All partners must strengthen efforts to ensure the implementation of these recommendations, which are critical to manage, control and eliminate the spread of HIV.

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I. Eliminate HIV-related restrictions on entry, stay and residence

66. There is a clear international trend away from HIV-related restrictions on entry, stay and residence, with the overwhelming majority of countries and territories having rejected such discriminatory measures. From 2000 to 2012, the number of countries, territories and areas with HIV-related travel restrictions fell by more than half, from 96 to 45. Since 2010, nine countries (Armenia, China, Fiji, Mongolia, Namibia, the Republic of Korea, the Republic of Moldova, Ukraine and USA) repealed their national restrictions.

Fig. 8. Number of countries with restrictions on entry, stay and residence for people living with HIV, 2000–2012 and 2015 target



Source: UNAIDS

67. Restrictions on entry, stay and residence cannot be justified by public health considerations, yet such measures persist and continue to impose severe burdens on people living with HIV and their households. Five countries maintain a blanket ban on entry by people living with HIV. Another five countries require proof of HIV-negative status for individuals wishing to stay for short periods (10-90 days), and 20 countries authorize the deportation of HIV positive people.

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68. In addition to the direct harm to people living with HIV, there is also growing recognition of the economic costs of travel restrictions in an era when businesses need the ability to send human resources – as it is done with capital and commodities resources – where they are most needed. In 2012, some 40 corporate chief executives, representing nearly 2 million employees worldwide, urged the repeal of all HIV-related restrictions on entry, stay and residence.

J. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response

69. The Political Declaration on HIV and AIDS called for concerted efforts to link the AIDS response more closely with the broader development and human rights agenda. The emphasis on an integrated response recognizes the many ways in which halting and reversing the epidemic depends on progress across the array of Millennium Development Goals and the broader development agenda, as well as the ways in which progress on AIDS advances progress towards other global health aims. An approach that integrally links HIV and other health and development efforts also supports sustainability, in keeping with the Secretary-General's Five-Year Action Agenda.

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70. The world has much to learn from the response to AIDS. The remarkable results we have achieved demonstrate the power of a people-centred response. The AIDS response has pioneered innovative approaches to global health governance through principles of inclusion, accountability, shared responsibility and global solidarity. By building on our progress to establish a strong foundation for the eventual end of AIDS, we will show the world what can be achieved through empowered and mobilized communities and a unified international effort. Our success will inspire renewed resolve to tackle other difficult health and development challenges.

71. The AIDS response is helping strengthen national health systems. A comprehensive review of health data in countries that receive PEPFAR support found that AIDS programming increases life expectancy, reduces TB incidence and mortality, and bolsters national health infrastructure. Numerous countries have taken steps to integrate HIV and TB service delivery, and services to prevent HIV in children have been integrated into maternal and child health services in all high-burden countries. Lessons learned from the AIDS response are now informing clinical management of diabetes in Ethiopia, and South Africa has launched an integrated testing campaign focused on HIV, high blood pressure and diabetes. The George W. Bush Institute, PEPFAR, Susan G. Komen for the Cure and UNAIDS jointly launched a new initiative to expand HIV, cervical and breast cancer screening and treatment for women in sub-Saharan Africa and Latin America.

72. HIV-focused interventions are being integrated into broader social protection systems. According to a recent study by the World Bank, social protection investments that address economic and social vulnerabilities of those in greatest need are effectively reaching households with orphans and vulnerable children and high rates of dependence.

73. HIV has also been broadly integrated in humanitarian operations. In 2012, a multidisciplinary group of experts issued guidance to inform research and practice on the alignment of HIV prevention services and gender-based violence in conflict and post-conflict settings.

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74. Concerted efforts are needed to seize additional opportunities for integration. HIV services must be integrated more comprehensively with sexual and reproductive health services. The HIV context needs to be taken into account in policies and programmes to prevent gender-based violence. HIV-specific clinical services must also link with efforts to address non-communicable diseases, which are on the rise in low- and middle-income countries. The AIDS response can also inform, and benefit from, the international push towards universal health coverage.

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III. Focusing on accountability for results: Accelerating progress towards the 2015 targets

75. With the 2015 deadline for global targets rapidly approaching, all stakeholders in the response must bring renewed focus on accountability for results. To accelerate progress and increase accountability and transparency, the biennial Global AIDS Progress Reports will become an annual undertaking beginning in 2013. Annual reporting will allow more timely assessment of progress and shortcomings and underscore the urgency of immediate action to achieve results.

76. Throughout the world, leaders and communities have embraced their own accountability in the response. Citing the 2015 targets in the Political Declaration on HIV and AIDS, health ministers of the Association of Southeast Asian Nations joined together in 2012 to pledge focused and specialized action across the region to reduce HIV among women and girls.

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77. The African Union (AU) roadmap on shared responsibility and global solidarity for AIDS, malaria and TB reflects the commitment and determination of African leaders to make strategic investments in a sustainable response that delivers results. The AU roadmap has three key pillars: (1) More diversified, balanced and sustainable financing models; (2) Access to medicines, including through local production and regulatory harmonization; and (3) Leadership, governance and oversight for sustainability.

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78. To achieve the 2015 targets, the research advances of recent years will need to be translated into effective programmes. It is essential to avoid the historic lag between the emergence of new health tools and their effective introduction in resource-limited settings. With the knowledge base on HIV rapidly evolving, programme planners and implementers will need to remain abreast of research developments and adapt their approaches as new learning becomes available. Strategic information needs to be used more effectively to focus programmes where they are most needed. A greater commitment to timely programme monitoring is also critical to enable programmes to build on successes and address bottlenecks as they emerge.

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79. Renewed commitment and solidarity is essential if we are to reach the 2015 targets. The gains of recent years should be used as inspiration to see this through the end, not as an excuse to diminish global commitment to one of the most serious health challenges of our times. AIDS is not over, and the epidemic continues to expand in many parts of the world. As an unfinished Millennium Development Goal, the AIDS response must have a place of prominence in the post-2015 development agenda. Towards this end, UNAIDS and the Lancet medical journal have established a new commission, From AIDS to Sustainable Health.

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IV. Conclusions and recommendations

80. To seize the historic opportunity to lay the groundwork for an AIDS-free generation, the following recommendations require immediate implementation:

(a) **Concrete steps are immediately needed to close the AIDS resource gap.**

Low- and middle-income countries, international donors, UN agencies, civil society and other partners should join together in a common effort to mobilize at least US\$ 22-24 billion annually for HIV-related activities. Emulating the actions of China, South Africa and other countries that have increased domestic investments, all low- and middle-income countries should reassess national spending priorities. International donors should sustain and increase their investments in HIV-related programmes, with particular efforts made by high-income countries whose contributions do to match their share of the global economy. Urgent attention is needed to ensure the robust replenishment of the Global Fund, which will remain a critical funding source for the AIDS response in future years.

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(b) **Allocation of scarce AIDS resources must become more strategic.** With the assistance of technical partners, all countries should assess and revise investment priorities to maximize impact and promote a sustainable response. Focused resources should accelerate scale-up of basic programmatic activities. Basic programmatic activities should be complemented by strategic investments in critical enabling policies and programmes to build demand and minimize disincentives for services as well as by synergistic development interventions that reduce vulnerability and mitigate the social and economic impact of AIDS on vulnerable families (e.g., social protection and education).

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(c) **With the support of technical partners, all countries should undertake strategic exercises to identify and capture synergies within their health and**

social protection systems. HIV and TB services must be fully integrated; services to eliminate mother-to-child transmission must be further integrated into antenatal service ~~delivery~~; ~~services should be closely linked with sexual and reproductive health services~~; and HIV should be integrated with, and inform, delivery of treatment, care and support for non-communicable diseases. All countries should strive towards universal health coverage, ensuring that the needs of people living with HIV are addressed. Intensified action is also needed to scale up cash transfer and other social protection ~~programmes, particularly for children orphaned and made vulnerable by HIV; without the socialization, education and nurturing that parents provide, children may fall through the cracks, putting them at further risk of exposure to HIV.~~

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- (d) **All stakeholders should work together to eliminate inequities in access to HIV-related services.** Focused resources are needed to address the HIV-related needs of women above and beyond current programmes and to eliminate new infections among children, and urgent efforts are needed to reach men with testing, counselling, treatment and care. As a component of the strategic reassessment of HIV-related investments, countries should increase resources available for evidence-informed, rights-based programmes to address the needs of men who have sex with men, people who inject drugs, sex workers and their clients, and other vulnerable populations, including their intimate partners. Countries should review their legal and policy frameworks to remove punitive laws and other measures that impede access to essential services and to ensure that specific measures are in place to prohibit discrimination and ensure access to legal services for key populations and people living with HIV.
- (e) **New people-centred approaches to the cultivation and mobilization of leadership are needed. Emerging regional leadership on AIDS must be supported and encouraged, with a particular focus on regional efforts to promote greater accountability in the response.** Emerging economies should step forward to help lead the global response. Powerful new communications and mobilization tools, such as social media, should be leveraged to reach current and future generations of young people.
- (f) **The post-2015 international development agenda should take forward the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.** AIDS will remain a major global challenge well beyond 2015. The global development agenda after 2015 should clearly reflect the role of an effective AIDS response as an essential pillar of future health and development efforts.

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we have reached a critical point in the worldwide effort to halt the global AIDS epidemic. We are less than three years away from the deadline for achieving the visionary targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS

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we now have an unprecedented opportunity to lay the groundwork for the beginning of the end of the AIDS epidemic.

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Globally, life-saving HIV services are reaching more people than ever, t

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continues to decline,

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reaches more people than ever before. M

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reduction in the rate of new HIV infections has been achieved across 25 low- and middle-income countries

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The area where perhaps most progress is being made is in reducing new HIV infections in children. Half of the global reductions in new HIV infections in the last two years have been among new-born children.

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Antiretroviral therapy has emerged as a powerful force for saving lives.

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In addition to welcome results in HIV prevention, sub-Saharan Africa has reduced

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In regions most affected by the epidemic,

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