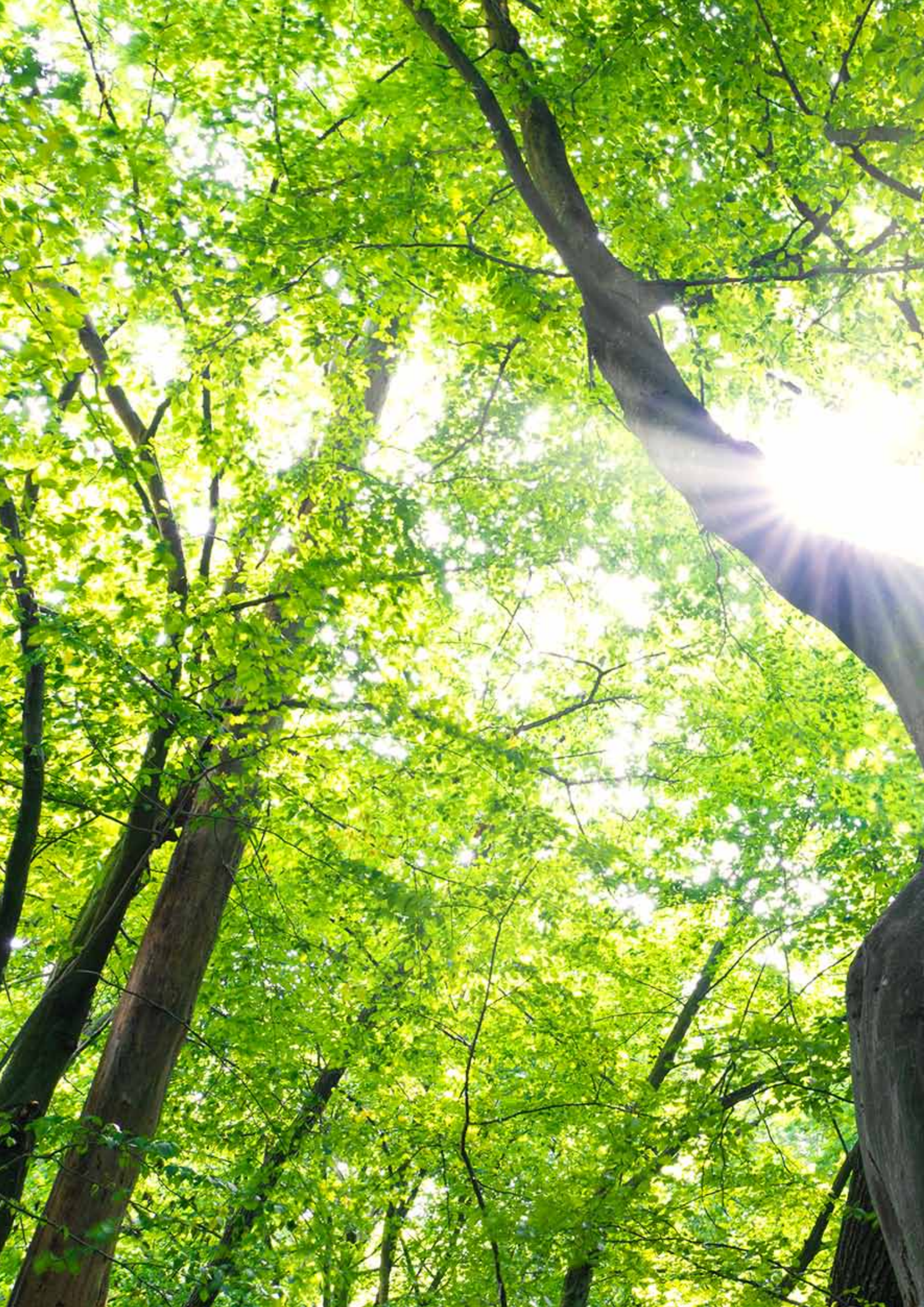
RESULTS



2012

Foreword

The sun finds a way to shine into even the deepest parts of the forest. It is a metaphor for all of us who are working to restore hope and dignity around the world.

In the history of the AIDS response there have been, and still exist, many obstacles to overcome but our path is clear—we work together to get results for all people.

To the millions who have come together with compassion and determination, on this World AIDS Day we say, your blood, sweat and tears are changing the world.

Results are accelerating

There were more than 700 000 fewer new HIV infections globally in 2011 than in 2001. Africa has cut AIDS-related deaths by one third in the past six years.

And as services have been scaled up, uptake has followed. In fact, what had taken a decade before is now being achieved in 24 months. In the past two years there has been a 60% increase in the number of people accessing lifesaving treatment—8 million people are on antiretroviral therapy.

In most parts of the world we have seen a reduction in new HIV infections among young people. We have a special message to you. We can all see by the results that you already are "the change we want to see in the world". We want to know more about your aspirations and dreams. We urge you to continue to engage and lead—and we are counting on you to use your youth as best as you possibly can.

As we enter into the final years of working towards the Millennium Development Goals and the United Nations Political Declaration on HIV/AIDS, much remains to be done to reach our targets.

Treatment has not yet reached 7 million people. We have three years to eliminate all new HIV infections among children. The people who are most affected by HIV still experience marginalization and exclusion.

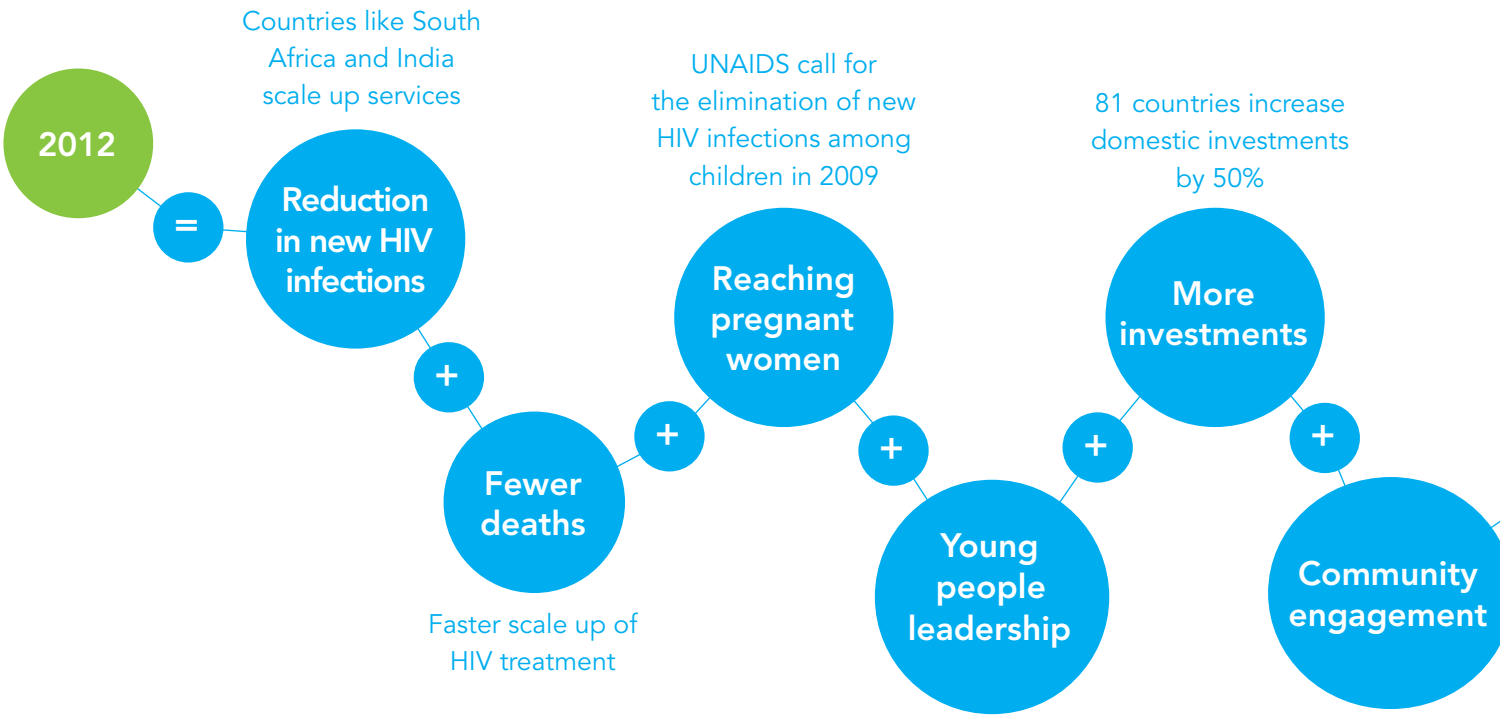
The results we have seen show us that the momentum of our collective political will and follow through can overcome the biggest of obstacles and challenges—even the shortness of time.

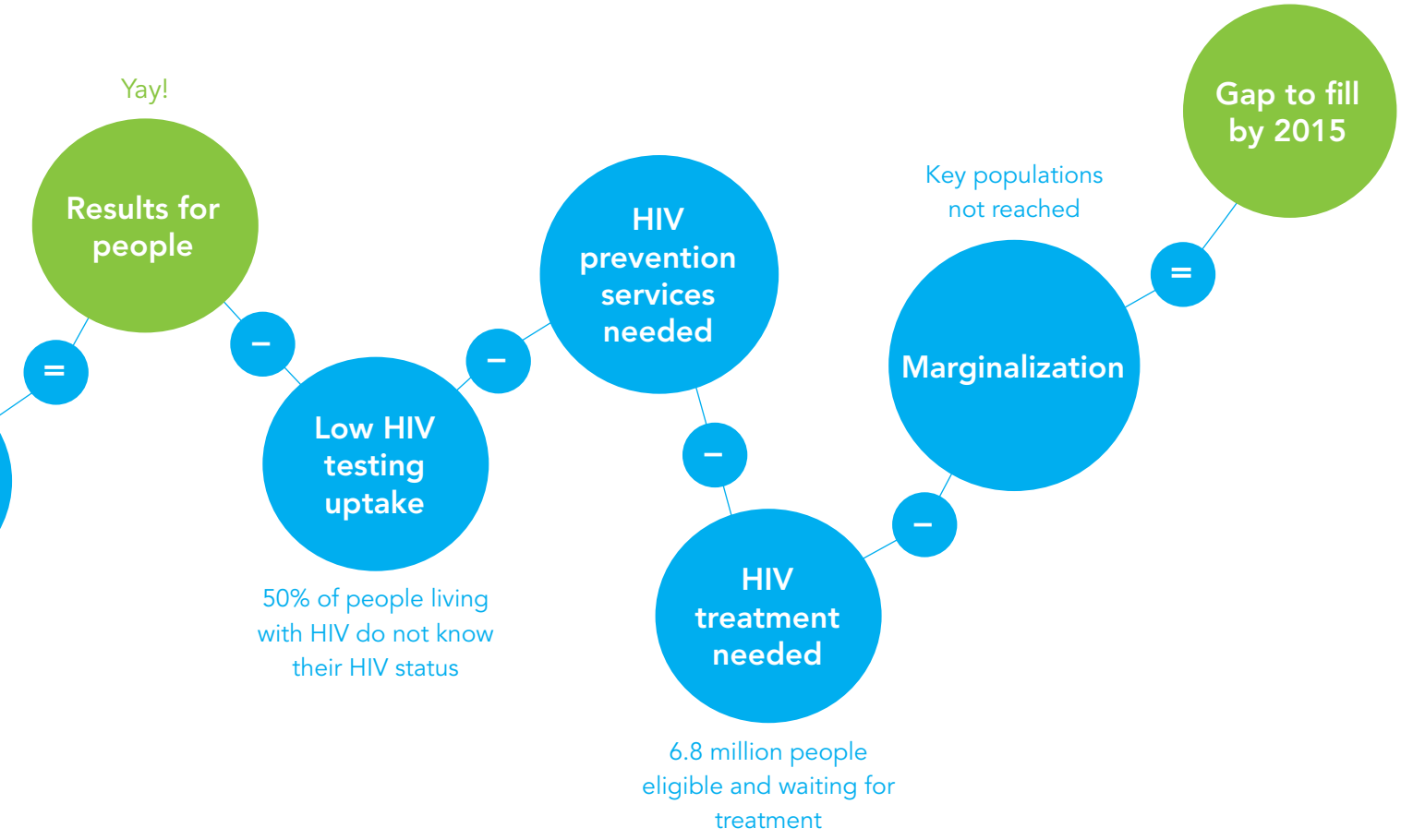
It shows us that with our steadfast determination and compassion—that invisible cord that binds us to other human beings regardless of race, gender, personal status, religion or national borders—we can get results for all people.

Aung San Suu Kyi
UNAIDS Global Advocate
for Zero Discrimination

Michel Sidibé
UNAIDS Executive Director

Keywords


2012
=
Countries like South Africa and India scale up services
Reduction in new HIV infections
+
Fewer deaths
Faster scale up of HIV treatment
+
UNAIDS call for the elimination of new HIV infections among children in 2009
Reaching pregnant women
+
Young people leadership
+
81 countries increase domestic investments by 50%
More investments
+
Community engagement

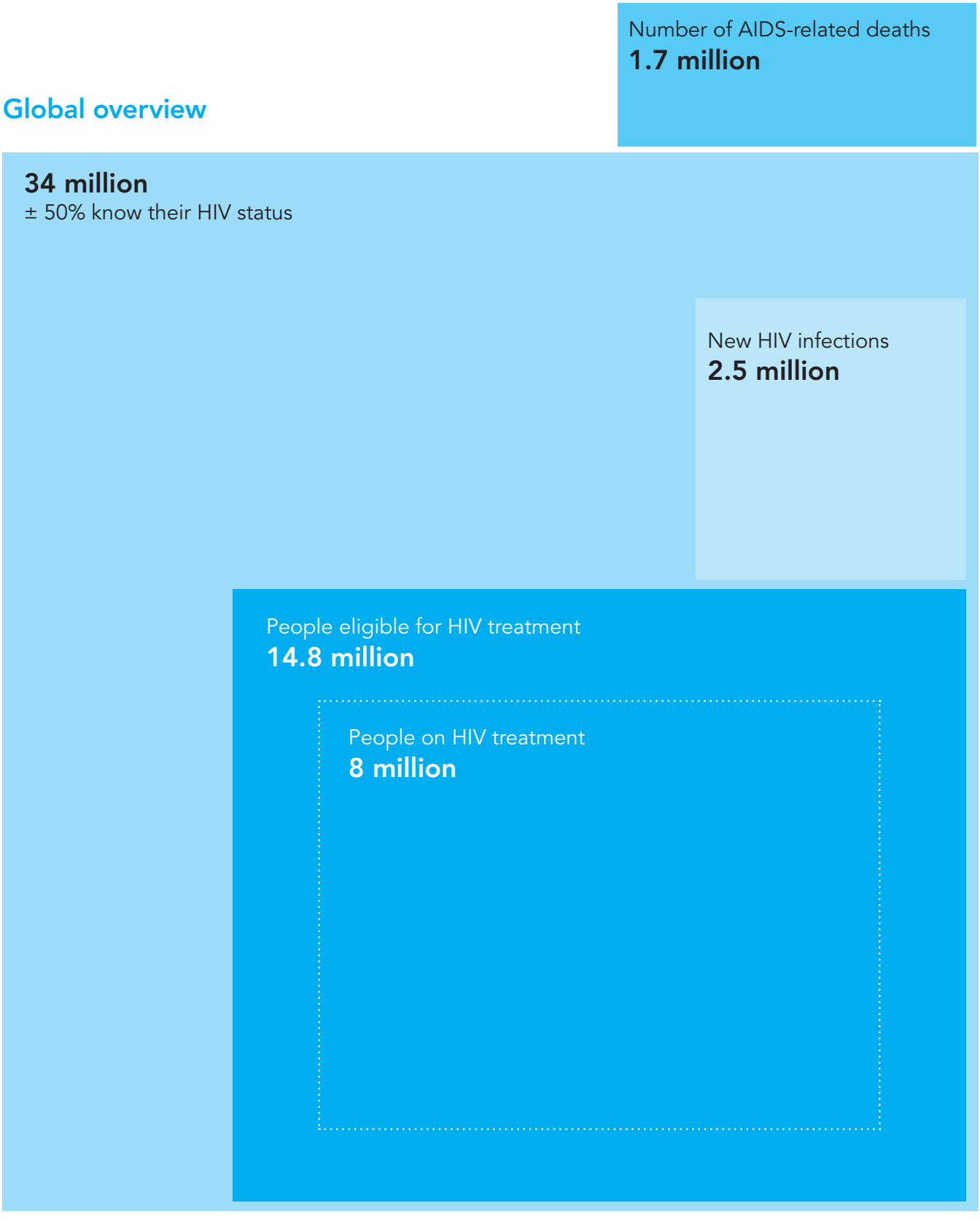

Yay!
Results for people
=
–
Low HIV testing uptake
50% of people living with HIV do not know their HIV status
–
HIV prevention services needed
–
HIV treatment needed
6.8 million people eligible and waiting for treatment
–
Key populations not reached
Marginalization
=
Gap to fill by 2015

At a glance

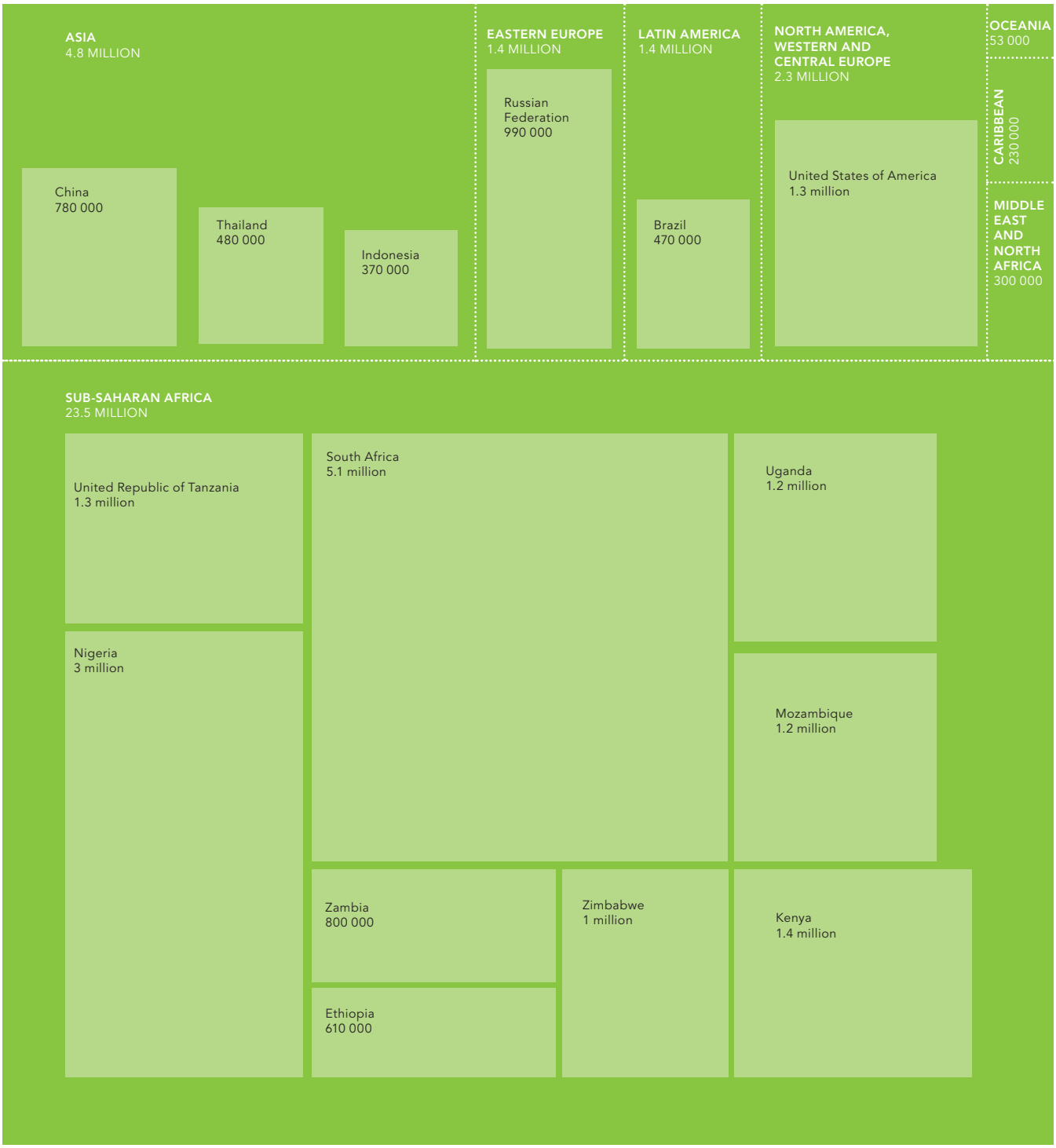
A look at the number of people living with HIV in the world, 2011

Source: UNAIDS 2012 Global Report

Global overview



Regional overview



Tweetable

Countries are making historic gains towards ending #AIDS: 700K fewer new HIV infections across the world in 2011 than in 2001 #Results

Sustained progress in halting new HIV infections

In the last ten years the landscape of national HIV epidemics has changed dramatically, for the better in most countries, especially in sub-Saharan Africa. Countries are making historic gains towards ending the AIDS epidemic: 700 000 fewer new HIV infections across the world in 2011 than in 2001.

Latest data show that a 50% reduction in the rate of new HIV infections (HIV incidence) has been achieved in 25 low- and middle-income countries between 2001 and 2011. More than half of these countries are in sub-Saharan Africa where the majority of the new HIV infections occur. In a further nine countries the rate of new HIV infections fell steeply—by at least one third between 2001 and 2011.

The national declines in HIV incidence in populations shows that sustained investments and increased political leadership for the AIDS response are paying dividends. In particular, countries with a concurrent scale up of HIV prevention and treatment programmes are seeing a drop in new HIV infections to record lows.

Prevention leads to behaviour change; treatment reduces a person's viral load. Both reduce the potential for the virus to be transmitted. The historic slow-down indicates HIV prevention and treatment programmes are successfully reaching the people in need.

In Southern Africa, where most countries have large numbers of people living with HIV or high HIV prevalence, the number of people acquiring HIV has been dramatically reduced. Between 2001 and 2011, in Malawi, the rate of new HIV infections dropped by 73%, in Botswana by 71%, in Namibia by 68%, in Zambia by 58% and in Zimbabwe by 50%. South Africa, the country with the largest number of HIV infections, reduced new HIV infections by 41%. In Swaziland, which has the highest HIV prevalence in the world, new HIV infections dropped by 37%.

In West and Central Africa, Ghana was at the top of the list with a drop of 66% followed by Burkina Faso at 60% and Djibouti at 58%. The Central African

Republic, Gabon, Rwanda and Togo, achieved significant declines of more than 50%. Other countries with significant declines in the region include Burundi, Cameroon, Mali and Sierra Leone where the decline was more than one third. Ethiopia achieved a 90% reduction in the rate of new HIV infections in the last decade. Despite a 25% reduction in sub-Saharan Africa, the region accounted for 72% of all new HIV infections worldwide in 2011.

The region with the sharpest declines in number of new HIV infections is the Caribbean where there has been a drop of more than 42%. In Suriname, the rate of new HIV infections fell by 86% and in the Dominican Republic by 73%. A more than 50% decline was observed in the Bahamas, Barbados, Belize and Haiti. In Jamaica and Trinidad and Tobago, new HIV infections fell by more than one third. In Latin America, the number of new HIV infections has remained stable.

In Asia and Oceania, Nepal drastically reduced new HIV infections by 91% and Cambodia by 88%. Four countries that account for a large number of people living with HIV in the region—India, Myanmar, Papua New Guinea and Thailand—reduced new HIV infections by more than 50%. Malaysia's new infections dropped by 34%. However, the epidemic significantly increased in Bangladesh, Indonesia, Philippines and Sri Lanka.

Despite the encouraging news, national epidemics in many parts of the world continue to expand. There is an opportunity for the redoubling of energy and focus by these countries.

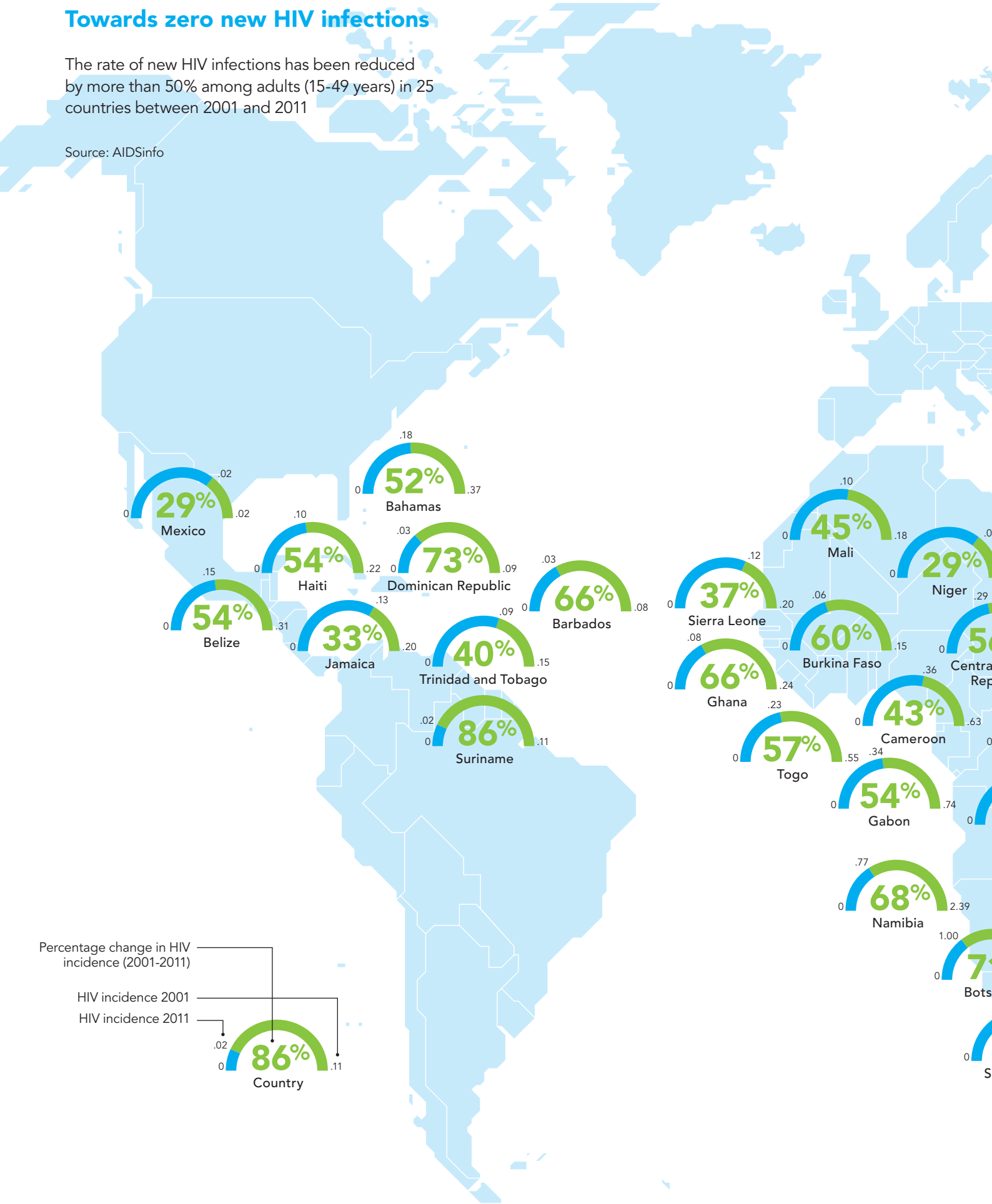
In the Middle East and North Africa, the number of people newly infected with HIV increased by 35% between 2001 and 2011, and the rate of new HIV infections continues to rise in Eastern Europe and Central Asia. In Georgia, Kazakhstan, Kyrgyzstan and the Republic of Moldova the rate of new HIV infections rose by more than 25%. In the Russian Federation the annual number of new infections has dramatically increased in recent years, as reflected in an increase in reported cases of new HIV diagnoses, from less than 40 000 in 2006 to over 60 000 in 2011.

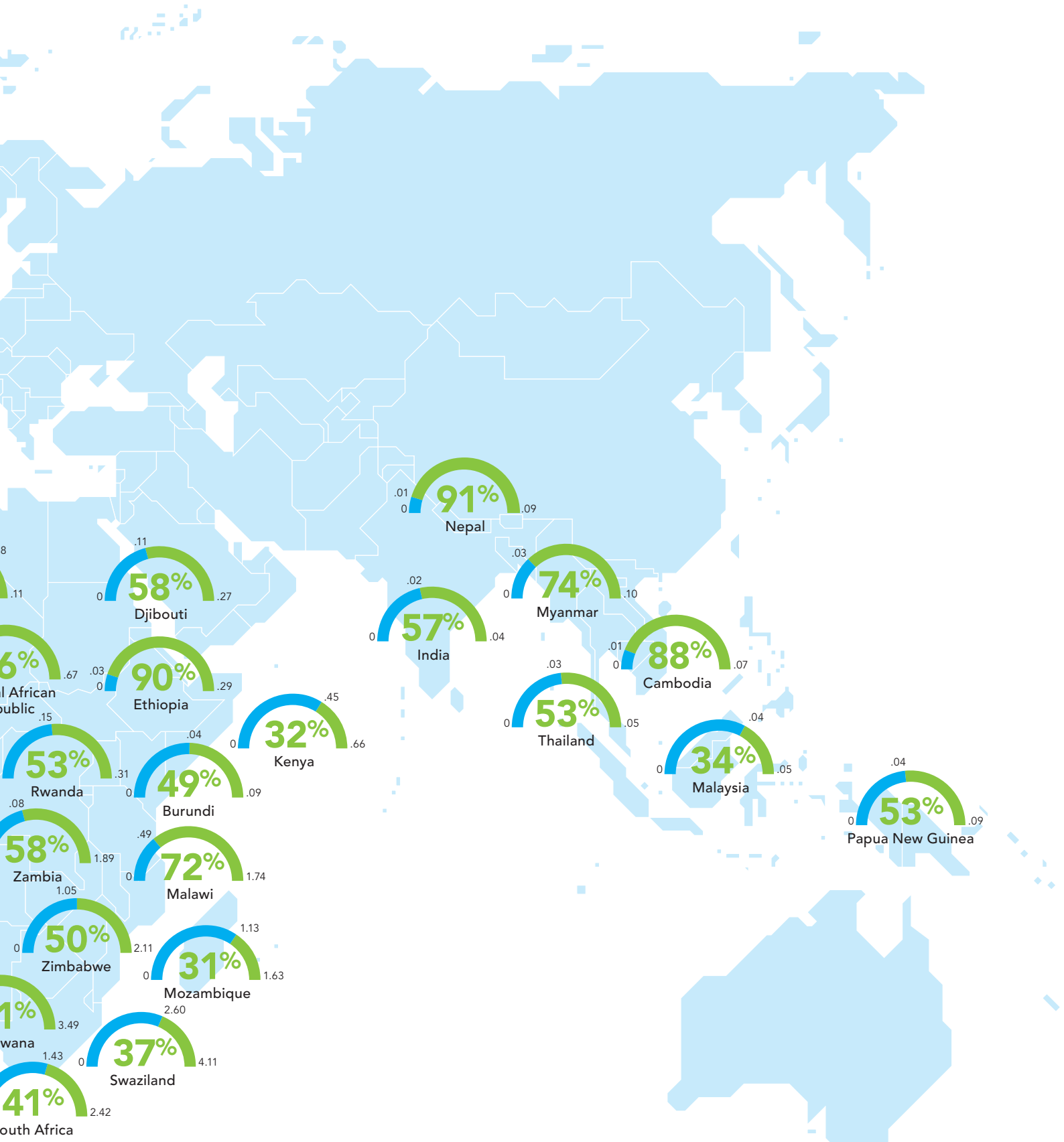
The road from 2.5 million new HIV infections—the number in 2011—to zero new HIV infections is a long one, and there is a significant effort required to accelerate HIV prevention programmes. But the positive national trends for the most part compellingly indicate that with expanded and sustained HIV prevention and treatment programmes—that are evidence-informed and reach people at highest risk and need—rapid declines are possible.

Incidence meter: Towards zero new HIV infections

The rate of new HIV infections has been reduced by more than 50% among adults (15-49 years) in 25 countries between 2001 and 2011

Source: AIDSinfo




.01
0
91%
.09
Nepal
.11
0
58%
.27
Djibouti
.02
0
57%
.04
India
.03
0
74%
.10
Myanmar
.01
0
88%
.07
Cambodia
.03
0
53%
.05
Thailand
.04
0
34%
.05
Malaysia
.04
0
53%
.09
Papua New Guinea
.03
0
90%
.29
Ethiopia
.45
0
32%
.66
Kenya
.04
0
49%
.09
Burundi
.15
53%
.31
Rwanda
.08
58%
1.89
Zambia
.49
0
72%
1.74
Malawi
1.05
0
50%
2.11
Zimbabwe
1.13
0
31%
1.63
Mozambique
2.60
0
37%
4.11
Swaziland
1.43
41%
2.42
.67
.11
.8

What keeps me going is the knowledge that ARVs are affordable and available…The number of people I know who have HIV and are living a normal life, even starting families, really keeps me going.

Person living with HIV, Uganda

Record access to HIV treatment, record drop in AIDS-related deaths

The latest data gathered from countries around the world tell a story of clear success. Sustained investments in access to antiretroviral therapy by donors and national governments have led to record numbers of lives being saved in the past six years. In 2011 more than half a million fewer people died from AIDS-related illnesses than six years earlier. It's a dramatic turning point. In 14 countries, AIDS-related deaths dropped by more than 50% between 2005 and 2011. Numbers can quantify, but alone cannot express the impact of each averted death on the whole community, including its children.

For the first time, a majority of people eligible for HIV treatment in low- and middle-income countries—54%, a record eight million people—were receiving antiretroviral therapy. This means more people than ever who are living with HIV are being helped to live longer, healthier and more productive lives. Lessons learned through the past decade have led to improved collaboration between governments, donors, partners, and a combination of innovation, efficiency and increased domestic investments have seen a return on investment unparalleled in the AIDS response.

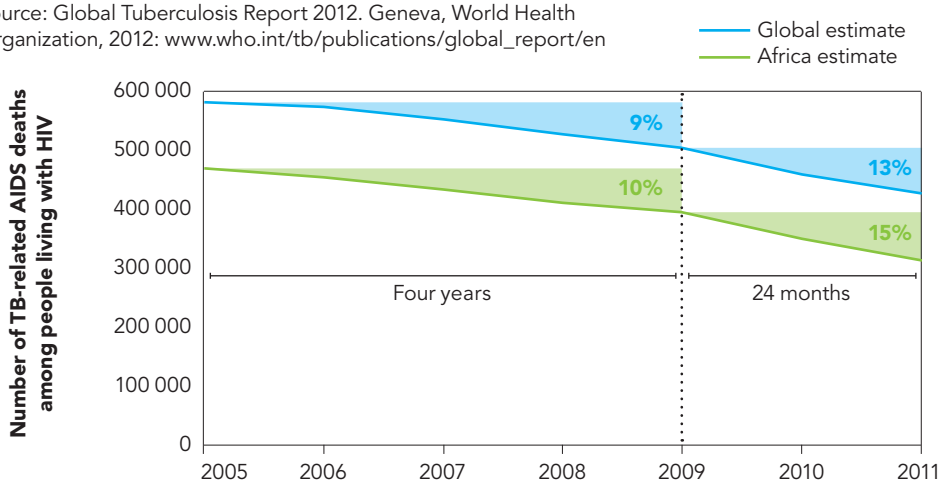
The part of the world most impacted by HIV, sub-Saharan Africa, has cut the number of people dying of AIDS-related causes by 32% between 2005 and 2011. The largest drop in AIDS-related deaths was in some of those countries where HIV has the strongest grip. In South Africa, 100 000 fewer deaths occurred, followed by nearly 90 000 in Zimbabwe, 71 000 in Kenya, 59 000 in Ethiopia and 48 000 in the United Republic of Tanzania.

A number of the region's countries with smaller populations but high HIV prevalence have also made significant gains in averting deaths related to AIDS. Botswana cut AIDS-related deaths by 71%, Rwanda by 68%, Namibia by 60%, Zambia by 56% and Burundi and Côte d'Ivoire by 51%. Benin, Burkina Faso, Eritrea, Guniea, Lesotho, Malawi and Mali all reduced AIDS-related deaths by one third.

The countries of the Caribbean experienced a 48% decline in AIDS-related deaths while in Oceania the drop was 41%. The Dominican Republic had

Declines in TB-related AIDS deaths among people living with HIV, 2005-2011

Source: Global Tuberculosis Report 2012. Geneva, World Health Organization, 2012: www.who.int/tb/publications/global_report/en



61% fewer people dying from AIDS-related causes while Guyana, Haiti, Jamaica and Suriname saw a more than 40% reduction.

In Asia, Cambodia reduced its AIDS-related deaths by 77% and Thailand by 49%. Peru reduced AIDS-related deaths by 55% and Mexico by 27%. Countries like Argentina, Brazil, Chile, Ecuador, El Salvador, Nicaragua, Paraguay and Venezuela provided access to drugs to between 60% and 79% of people eligible for HIV treatment.

Worrisome increases in AIDS-related mortality were observed in Eastern Europe and Central Asia (21%) and the Middle East and North Africa (17%). However, Djibouti showed a decline of 26% in AIDS-related deaths.

Impressive gains were also made in cutting deaths from tuberculosis (TB) in people living with HIV. Between 2004 and 2011, TB-related AIDS deaths fell by 25% worldwide and by 28% in sub-Saharan Africa. In the last 24 months, a 13% decrease in TB-related AIDS deaths was observed in 2011, compared to a 10% decrease over the four-year period between 2004 and 2008.

This accomplishment is due to record numbers of people with HIV/TB co-infection accessing antiretroviral treatment—a 45% increase between 2009 and 2011. India, Kenya, South Africa, Zambia and Zimbabwe accounted for two thirds of all new people with HIV/TB co-infection being treated, but much more needs to be done. No-one should die of TB and HIV.

How have lives been saved?

In just the past two years, HIV treatment access grew by 63% around the world. The massive scale up over the last 24 months enabled tens of thousands of people living with HIV to receive lifesaving antiretroviral therapy for the first time. The increase came at a time when international funding for AIDS remained flat. Countries are better implementing programmes. They have used a combination of innovation, efficiency and increased domestic investments to sustain the rapid growth in access to treatment. The price of

antiretroviral drugs has reduced dramatically from US$ 10 000 per person a decade ago to around US$ 100 annually in some countries.

In sub-Saharan Africa, a record 2.3 million people were added to treatment programmes in the last two years—an increase of 59%. South Africa scaled up its treatment services to reach 1.7 million people—an increase of 75% in the last two years. In Zimbabwe, 260 000 additional people accessed HIV treatment, registering a 118% expansion rate. In Kenya, 200 000 people were added—a 59% increase. Upwards of 100 000 people living with HIV were enrolled in HIV treatment in Malawi, Mozambique, Nigeria, Uganda and Zambia each. Five countries in the region have achieved more than 80% coverage of HIV treatment—Botswana, Namibia, Rwanda, Swaziland and Zambia. Outside of sub-Saharan Africa, China has increased the number of people on HIV treatment by nearly 50% in the last year alone.

Since 1995, antiretroviral therapy has saved 14 million life years in low- and middle-income countries, including nine million in sub-Saharan Africa. Fewer deaths from AIDS-related illnesses has transformed societies: more people, regaining their health, are returning to work and taking care of their families.

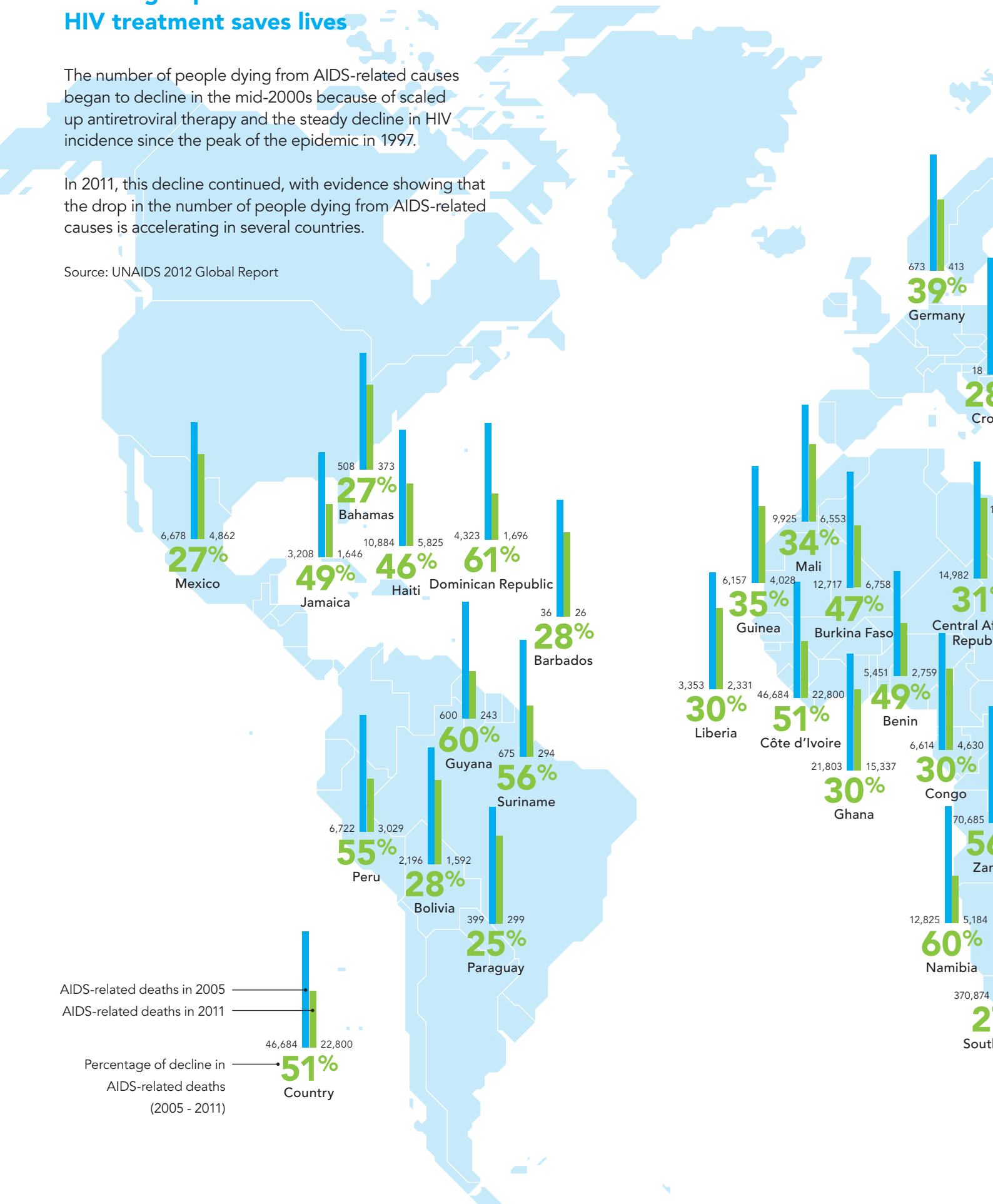
However, the gap between people who can access treatment and people in need is still very large, nearly 46%, and as the demand for treatment as prevention continues to rise and increasingly outstrips availability, this treatment gap is set to grow.

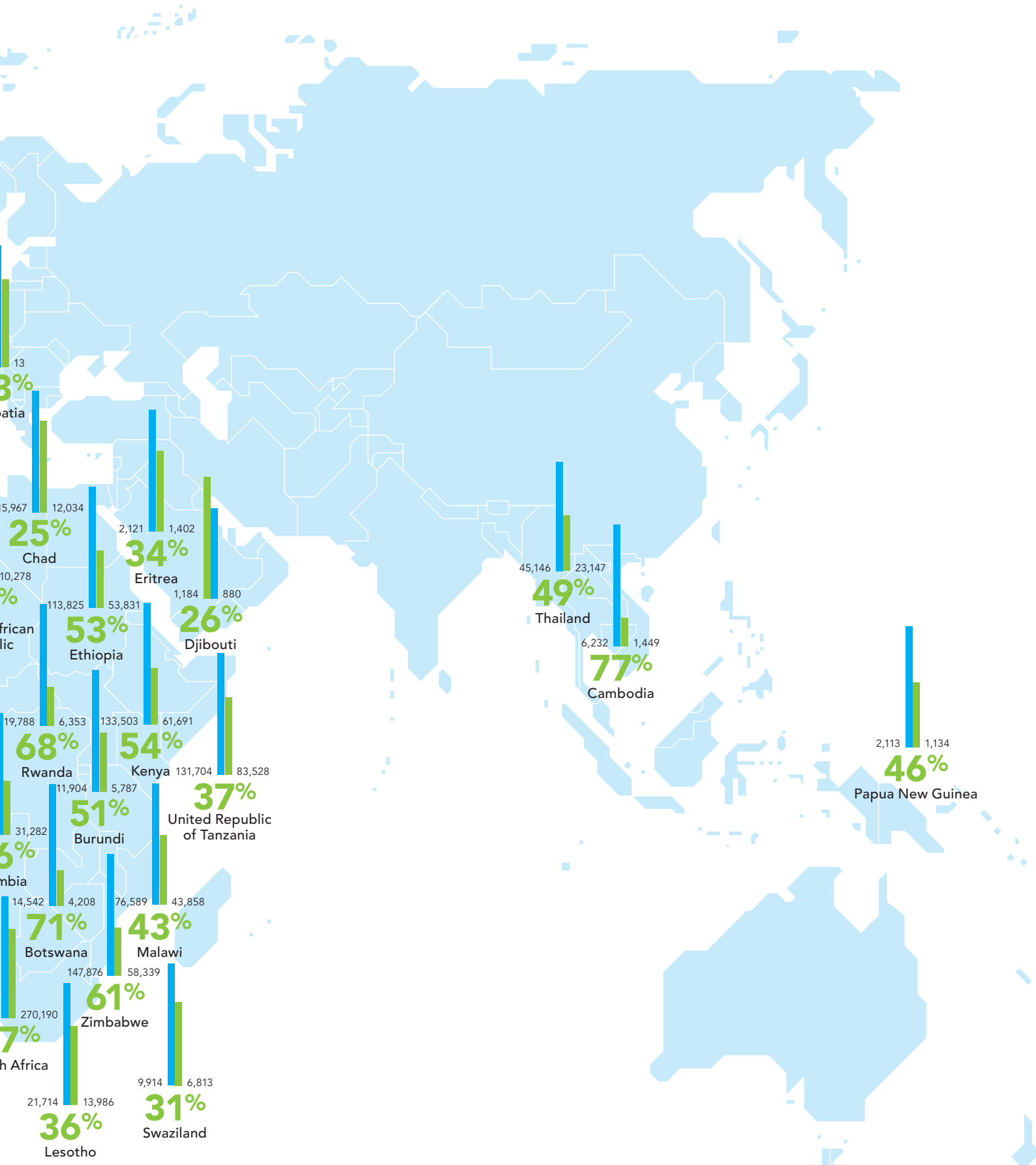
Showing impact: HIV treatment saves lives

The number of people dying from AIDS-related causes began to decline in the mid-2000s because of scaled up antiretroviral therapy and the steady decline in HIV incidence since the peak of the epidemic in 1997.

In 2011, this decline continued, with evidence showing that the drop in the number of people dying from AIDS-related causes is accelerating in several countries.

Source: UNAIDS 2012 Global Report




13
3%
batia
5,967
12,034
25%
Chad
10,278
%
frican
lic
113,825
53,831
53%
Ethiopia
19,788
6,353
68%
Rwanda
31,282
6%
mbia
14,542
4,208
71%
Botswana
270,190
7%
h Africa
21,714
13,986
36%
Lesotho
2,121
1,402
34%
Eritrea
1,184
880
26%
Djibouti
133,503
61,691
54%
Kenya
131,704
83,528
37%
United Republic
of Tanzania
11,904
5,787
51%
Burundi
76,589
43,858
43%
Malawi
147,876
58,339
61%
Zimbabwe
9,914
6,813
31%
Swaziland
45,146
23,147
49%
Thailand
6,232
1,449
77%
Cambodia
2,113
1,134
46%
Papua New Guinea

Tweetable

The aspiration that the world can fully fund the AIDS response is achievable w/ continued shared responsibility & global solidarity #Results

Global solidarity and shared responsibility is sustaining investments in AIDS

Low- and middle-income countries are driving the global increase in HIV investments. The global gap in resources needed by 2015 has now dropped to about 30%. The aspiration that the world can fully fund the AIDS response is achievable with continued shared responsibility and global solidarity.

For the first time ever, domestic investments have surpassed global giving for AIDS, tipping the aid dependency balance. Domestic investments rose from US$ 3.9 billion in 2005 to almost US$ 8.6 billion in 2011. Some 81 countries increased domestic investments for the AIDS response by more than 50% between 2006 and 2011. However, international investments still remain critical and indispensable.

Increased country ownership for domestic investments

South Africa is the country that has made the highest domestic investment in AIDS among all low- and middle-income countries. It alone invested US$ 1.9 billion last year from public sources, resulting in a five-fold increase between 2006 and 2011. This strategic leadership is an example being echoed across the region. Kenya doubled its domestic investments for AIDS between 2008 and 2010, and Togo did the same between 2007 and 2010. This year, Zambia has put a massive injection of funds into its health budget, increasing it by 45%.

Many middle-income countries are increasingly taking responsibility for funding the majority of their AIDS response needs.

Exceptional leadership is coming from the world's fastest-growing emerging economies: Brazil, Russia, India, China and South Africa (BRICS). Together, they contribute to more than half of all domestic spending on AIDS in low- and middle-income countries. Their momentum is unparalleled, having increased domestic public spending by more than 122% between 2006 and 2011.

Brazil and Russia fund almost all of their national AIDS responses from domestic sources. Brazil has for years invested adequately and focussed on

the most vulnerable and marginalized and reaped benefits. Russia on the other hand has not realised the same value for money as its AIDS investment strategy is not optimized to its epidemic patterns. China currently invests more than 80% domestically, and the country has announced it will fully fund its AIDS response in the coming years. India, too, has committed to increase domestic funding to more than 90% in its next phase of the AIDS response. These fast-growing economies have the potential to support others in the region, as well as exert leadership and influence on the AIDS response, both locally and globally.

International investments—fragile status quo

Against the backdrop of continued economic uncertainties in high-income countries, international investments have remained stable at around US$ 8.2 billion in 2011, although the economic downturn has impacted development assistance budgets. The healthy growth in domestic investments is most welcome, and it has indeed become critical to service delivery. However, international assistance remains a crucial lifeline for many countries with low income and high HIV prevalence that have little fiscal space to absorb cuts in development aid. In 26 of 33 countries in sub-Saharan Africa, donor support accounts for more than half of the current AIDS response investments in the region.

The lion's share of international assistance is directed towards supporting HIV treatment, in particular in high burden countries in sub-Saharan Africa. This could render gains in coverage of lifesaving treatments fragile should international assistance drop in the coming years. It is heartening to note many high-income countries have maintained their current levels of funding, in spite of the persistent fragility of their economies. The United States of America continues to be the largest international donor—both bilaterally and through multilateral funding channels—accounting for 48% of all such assistance. As economies recover, international investments must increase, and the donor base has to become more diversified and include the increasing capabilities of emerging economy countries.

Making strategic use of AIDS investments

An important strategy for enhancing value for money is to maximize impact and cost-efficiency by focusing limited resources where the epidemic is most severe and on the populations in the greatest need—the spending pattern differs between regions and countries according to their type of epidemic. In some settings, investing more strategically requires focusing a larger share of prevention spending on the general population. In other countries, the focus needs to be on the key populations that represent the largest percentage of people newly infected. It is estimated that by 2015 the share of investment needs for basic prevention programmes, such as male circumcision, preventing mother-to-child transmission and key populations at higher risk, will have to be increased. For example, today, programmes to reach key populations receive only 4% of investments on basic HIV prevention and treatment programmes globally, but for an optimized HIV response in 2015, this share will need to be about 14%.

Closing the resource gap

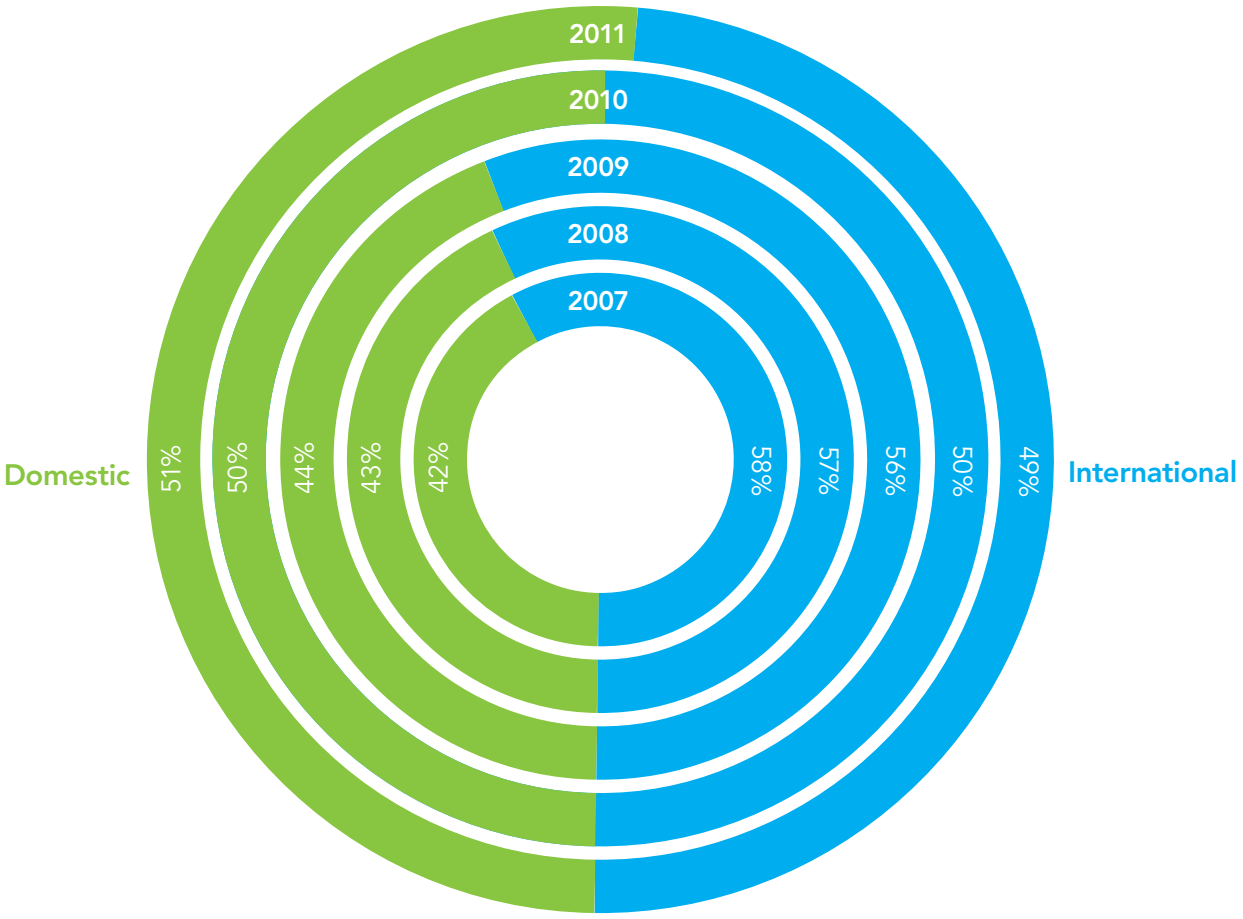
Multiple avenues will need to be pursued if the world is to reach the target of mobilizing US$ 22-24 billion annually for the response. Countries should ensure that HIV spending is focused on effective investments and take steps to further increase their domestic spending for the AIDS response, including developing innovative and sustainable AIDS funding sources. Efforts must be intensified to improve the efficiency of AIDS spending through such means as capturing productivity gains, continuing to reduce the price of antiretroviral medicines, integrating services and improving service delivery. Economic growth in low- and middle-income countries can help expand the fiscal space for HIV investment, and further efforts are needed to cultivate emerging economies as international AIDS donors. In the context of shared responsibility and global solidarity, current international donors must also remain engaged in closing the resource gap for countries in need. Only by applying the investment approach and working within a framework of shared responsibility will countries reach their 2015 goal.

A smaller funding gap to close

There is increasing country ownership and shared responsibility for investments in the AIDS response. Domestic investments now account for the majority of AIDS investments. The gap for investment needs in 2015 is closing, but much more can be done to make investments effective and efficient.

Resources available for HIV in low- and middle- income countries, 2007-2011

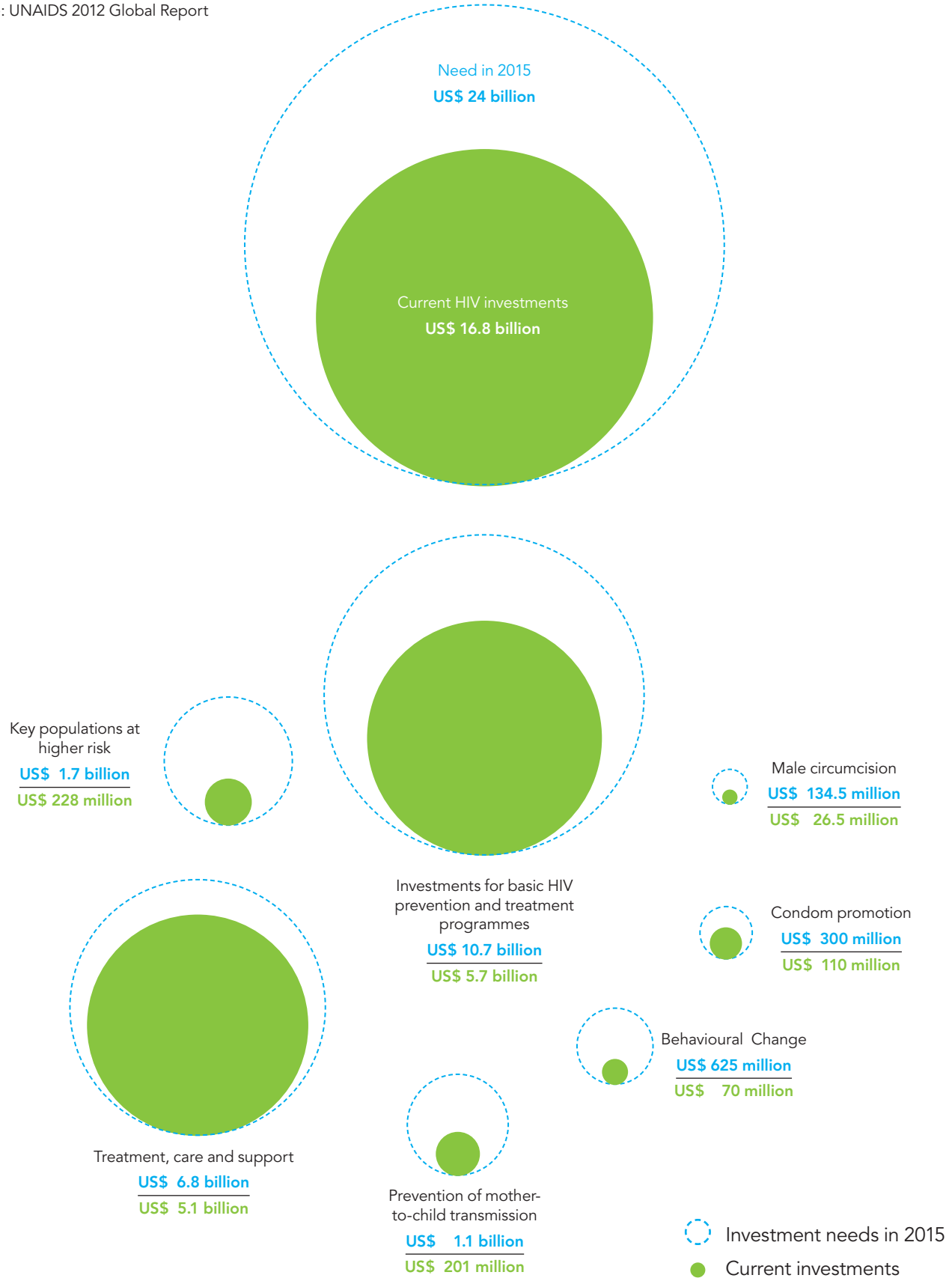
Source: UNAIDS 2012 Global Report



- International investment
- Domestic investment

Resources needed for HIV in low- and middle-income countries in 2015

Source: UNAIDS 2012 Global Report



Having been born with HIV, I have always lived with the virus.
Today it represents taking a couple of pills two times each day…
and it doesn't have to be anything more than that.

Alejandro, Argentina

Declining new HIV infections in children and young people

Rapid declines in new HIV infections among children

New HIV infections in children dropped by 43% from 2003 to 2011. In fact, new HIV infections in children declined by 24% in the last two years alone, which is much sharper than the 19% drop seen in the four year period between 2004 and 2008. Half of all new HIV infections averted—in adults and children—in the 24-month period between 2009 and 2011 were among newborn children. This reduction has been accelerated by the rapid progress made in the last two years in giving more women living with HIV access to prevention and treatment services.

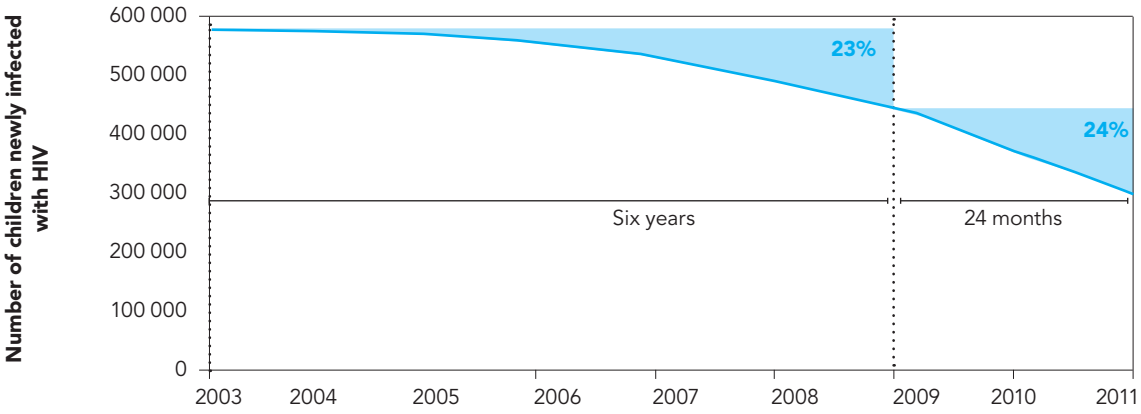
When women living with HIV receive antiretroviral prophylaxis during pregnancy, delivery and breastfeeding, the risk of HIV transmission is reduced to less than 5%.This accelerated progress in cutting new HIV infections has happened as countries move forward in implementing the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.

However, acute geographic inequalities continue. Of the children who acquired HIV in 2011, close to zero live in high-income countries and more than 90% live in sub-Saharan Africa. Encouragingly, the number of children newly infected in the region fell by 24% from 2009 to 2011. Countries with generalized epidemics have the overwhelming majority of children newly infected and they have made major gains during the past decade. In six countries—Burundi, Kenya, Namibia, South Africa, Togo and Zambia—the number of children newly infected fell by between 40% and 59% from 2009 to 2011. In 16 additional countries, declines of between 20% and 39% occurred during the same period.

The number of children acquiring HIV infection has declined significantly in the Caribbean (32%) and Oceania (36%), with a more modest decline in Asia (12%). New infections also dropped in Latin America (24%) and Eastern Europe and Central Asia (13%), regions that had already significantly reduced the numbers of children newly acquiring HIV infection. The Middle East and

New HIV infections among children (0-14 years old) 2003-2011

Source: UNAIDS 2012 Global Report



North Africa is the only region that has yet to see a reduction in the number of children newly infected.

Reaching pregnant women living with HIV

Although reductions in the number of adults acquiring HIV infection are helping to lower children's risk of HIV, recent gains in bringing antiretroviral and infant feeding–based prevention services to scale are primarily responsible for the sharp reductions in the number of children newly infected. From 2009 to 2011, antiretroviral prophylaxis prevented 409 000 children from acquiring HIV infection in low- and middle-income countries.

In low- and middle-income countries, coverage of effective antiretroviral regimens for preventing mother-to-child transmission reached 57% in 2011. Apart from high-income countries, which have long had near-universal coverage for antiretroviral medicines for pregnant women, the Caribbean is the only region approaching similarly high coverage levels at 79%.

In sub-Saharan Africa, the region where 92% of the world's HIV-positive pregnant women live, 59% of them received antiretroviral therapy or prophylaxis during pregnancy and delivery in 2011.

Ensuring a mother living with HIV has access to HIV treatment not only has health benefits for her, but also for her family. Studies indicate that children whose mothers stay alive and healthy have a decreased risk of death regardless of the child's HIV status. Recent estimates suggest that pregnancy-related deaths among women living with HIV have declined from 46 000 in 2005 to an estimated 37 000 in 2010. More effort is needed to ensure that pregnant women tested for HIV during antenatal care are also tested for eligibility for antiretroviral therapy.

Young people—bringing change, shaping the future

The actions of young people are shaping the future of AIDS across the world. Between 2001 and 2011, prevalence of HIV—a proxy indicator of new HIV infections—fell by nearly 27% among young people aged 15-24 globally. The largest progress was seen in South and South-East Asia where HIV prevalence among young men and women fell by 50%. Sub-Saharan Africa and the Caribbean followed with a drop of more than 35% among young men and women. In Latin America, HIV prevalence decreased by nearly 20% among young people. Significantly, the decline was much higher at 33% among young men, the group where the majority of new HIV infections among young people in Latin America occur.

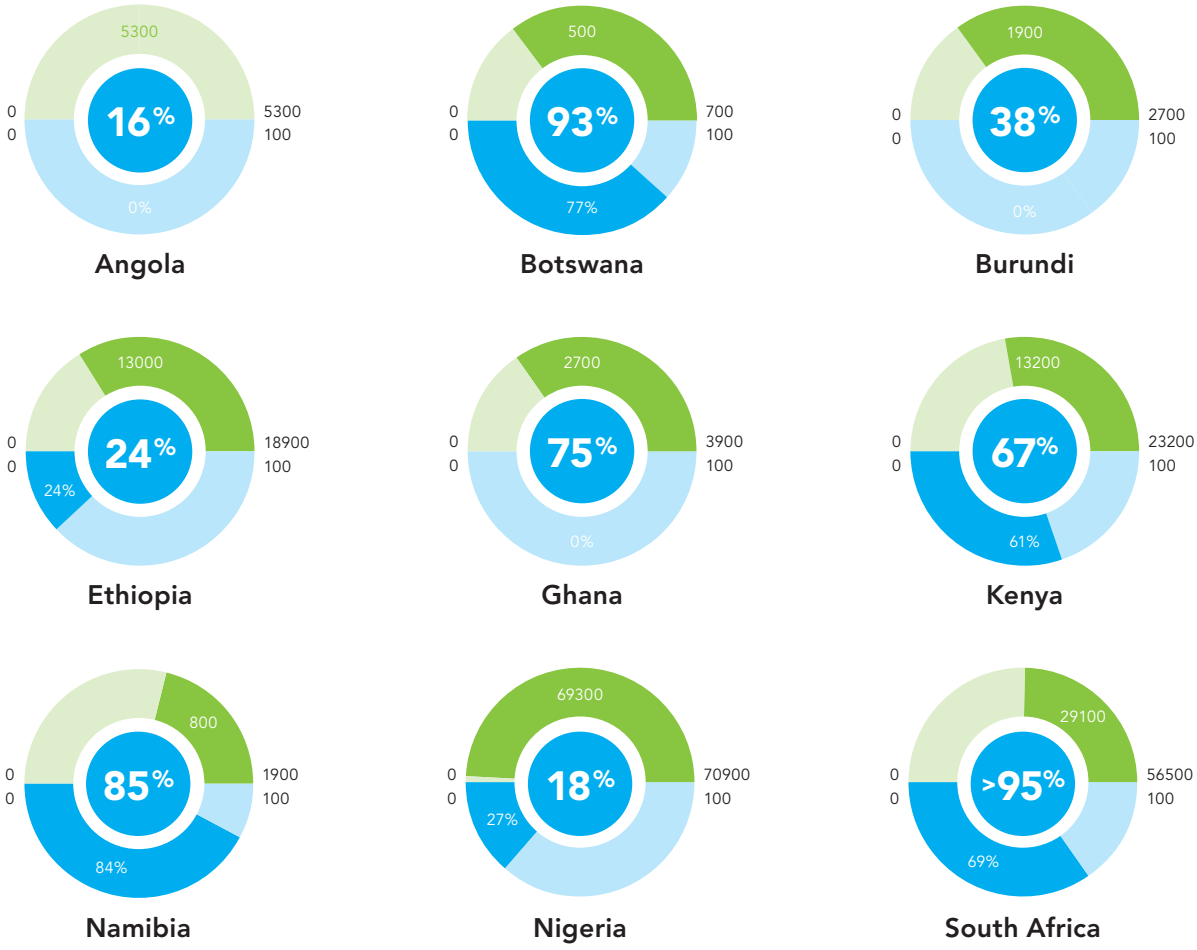
This encouraging trend is reversed in Eastern Europe and Central Asia where there has been a 20% increase in new HIV infections among young people. The majority of young people who are acquiring HIV are those who inject drugs, very few of whom have access to evidence-informed HIV prevention and treatment services.

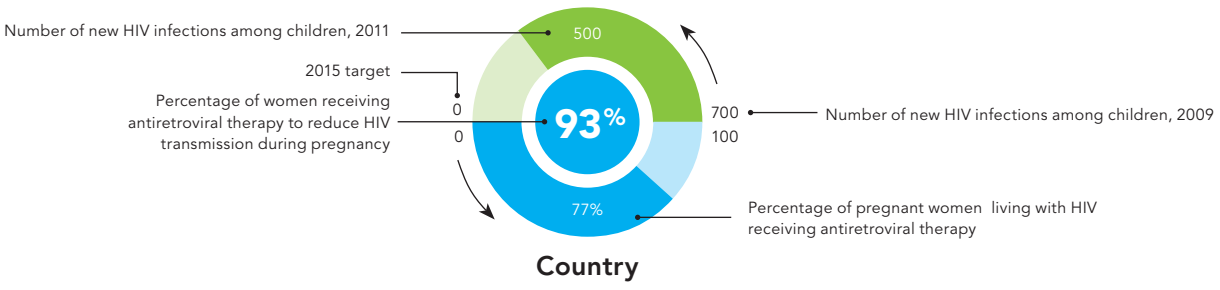
Today, young people account for 40% of all new adult HIV infections. Each day, more than 2400 young people become infected with HIV—and some five million young people are living with HIV. Young people are a fulcrum. They remain at the centre of the epidemic and they have the power, through their leadership, to definitively change the course of the AIDS epidemic. Today, they are already doing so.

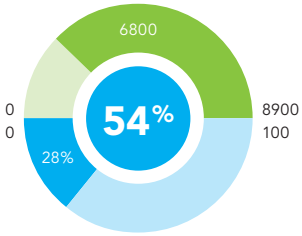
Global plan progress

Much progress has been made in stopping new HIV infections among children in the 21 countries covered by the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. This chart provides a snapshot of progress made against three select indicators—1) the number of children acquiring HIV infections from mother-to-child HIV transmission; 2) the percentage of women receiving antiretroviral drugs (excluding single dose nevirapine) to reduce transmission during pregnancy and 3) the percentage of pregnant women living with HIV eligible for HIV treatment receiving antiretroviral therapy.

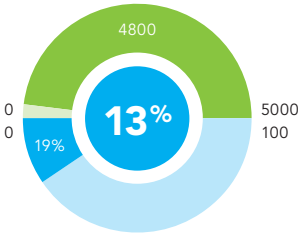
Source: A progress report on the Global Plan, 2012. UNAIDS



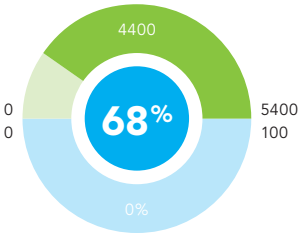




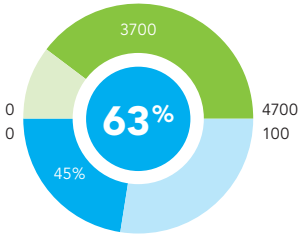
Cameroon



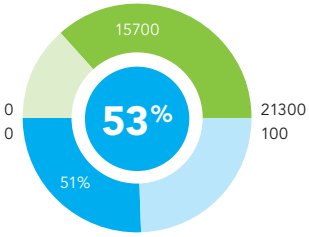
Chad



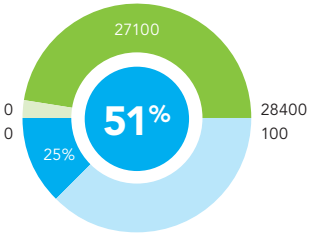
Côte d'Ivoire



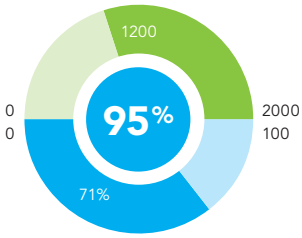
Lesotho



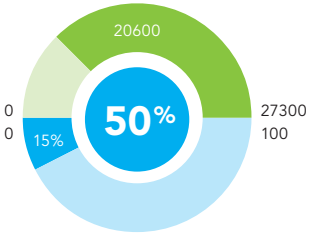
Malawi



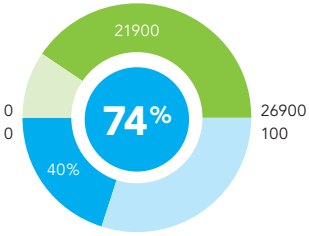
Mozambique



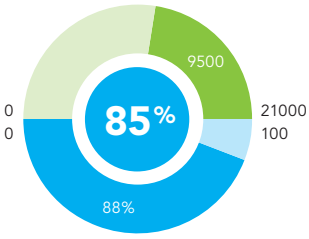
Swaziland



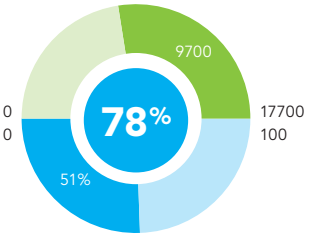
Uganda



United Republic of Tanzania



Zambia



Zimbabwe

I have learned to rise above stigma by standing up for what I believe in. I speak of universal access to comprehensive health care for all—without any form of stigma and discrimination.

Michael, Nigeria

The miles we need to go in 1000 days

A mere thousand days remain before the world has to achieve its 2015 global AIDS targets—reduce sexual transmission of HIV and new HIV infections among people who inject drugs by 50%, eliminate new HIV infections among children, provide antiretroviral treatment to 15 million people and reduce TB-related AIDS deaths by 50%. To enable this to happen, nations committed to investing up to US$ 24 billion annually by 2015.

The destination is clear. Strides forward have to be long, steady and purposeful.

Multiplying the power of HIV treatment

Antiretroviral therapy has emerged as a powerful force for saving lives. Yet despite the unprecedented growth in numbers of people on HIV treatment in the last two years, nearly half of all who are eligible (having a CD4 count of less than 350 per ml, the current threshold) do not have access—that's 6.8 million people in 2011. Half will die within 24 months if they don't start antiretroviral therapy. The number eligible will rise as more of the 34 million people living with HIV become eligible for treatment for their own health.

UNAIDS estimates that an additional four million discordant couples (where one partner is living with HIV) would benefit from access to antiretroviral therapy to protect their partners from HIV. Using antiretroviral therapy as a prophylaxis for people at high risk of HIV infection is also gaining momentum.

HIV treatment is for life and people living with HIV need to take pills every day without fail. There is an urgent need to improve retention rates for people enrolled in HIV treatment as studies show that adherence can fall as people regain good health. Nearly half of the people who began antiretroviral therapy at a treatment centre in Malawi are no longer in care five years later and this proportion is nearly 40% in centres in Kenya. Where communities actively engage in providing care, retention rates are steady. Two-year retention rates in Mozambique climbed to 98% in a programme

where community support strategies were introduced to complement clinical services.

Though treatment prices continue to plummet, second and third line treatment regimens are still very expensive and many countries experience human resource constraints for delivery. Both programme management costs and drug prices can and will have to fall significantly to contain the treatment bottom line.

A number of strategies would help. Programmes can better leverage opportunities to link treatment to other services like couples counselling and testing or opioid substitution therapy. A shift from international to domestic production of drugs and a strong vigilance on trade agreements could spread the risks to sustained delivery of lifesaving medicines in the medium and long-term.

Despite considerable increases in domestic funding, countries continue to rely on overseas development assistance for their HIV response. International funding accounted for more than half of spending in 59 countries and contributed more than 75% of spending in 43 of the 102 low- and middle-income countries.

Knowing your HIV status

Increases in access to treatment can be partly attributed to a growing number of people living with HIV knowing their HIV status. In Ethiopia an estimated 21% of adult men were tested for HIV in 2011 up from approximately 2% in 2005. In Rwanda nearly 39% of adult women were tested for HIV in 2010 compared to about 12% in 2005. In Lesotho an estimated 42% of adult women reported that they had been tested for HIV in 2009 compared to about 6% in 2004. Surveys in 14 countries in sub-Saharan Africa between 2004 and 2011 found significantly more adults had taken an HIV test in the previous year. Multi-disease prevention campaigns in Kenya and Uganda show the potential of innovative community-based HIV testing and counselling approaches. In Kenya around 23% of adult men were tested for HIV between 2008 and 2009 compared to 8% in 2003.

Although the trend towards increased population-based testing rates is encouraging, the available evidence does not conclusively show that HIV testing programmes are reaching the people at highest risk. At the end of 2011 it is estimated that only half of all people living with HIV know their HIV status.

Reaching children and pregnant women living with HIV

While much progress has been made in sub-Saharan Africa in increasing services to prevent mother-to-child transmission of HIV, reported coverage is substantially lower in South and South-East Asia (18%) and in the Middle East and North Africa (7%). It is also difficult to estimate service needs and coverage among women at highest risk of HIV in countries with concentrated epidemics.

The percentage of treatment-eligible pregnant women living with HIV who are receiving antiretroviral therapy was 30% in 2011—lower than the estimated 54% coverage for all adults eligible according to WHO guidelines. Qualitative research is needed to determine why despite improving access to health care, pregnant women are not starting, or being reported to start, antiretroviral therapy.

While the drop in new adult HIV infections is helping to lower children's risk of acquiring HIV, the recent growth of antiretroviral- and infant feeding-based prevention services are primarily responsible for the sharp reductions in the number of children newly infected. From 2009 to 2011, antiretroviral prophylaxis prevented 409 000 children from acquiring HIV infection in low- and middle-income countries. Greater efforts are required to stop primary HIV infection among women and provide reproductive and sexual health services for women living with HIV who do not want to get pregnant. At the same time there are disturbing reports of forced sterilization of women living with HIV in many parts of the world—acts which are a violation of human rights and a gross abuse of authority and trust.

Bringing combination HIV prevention programmes to scale

There were 2.7 million new HIV infections among adults and children in 2011—a long way from the vision of getting to zero. Despite impressive gains, sub-Saharan Africa accounted for 72% of all new HIV infections and new HIV infections are rising in Eastern Europe and Central Asia. HIV prevention gains can be accelerated if all the current HIV prevention options are made available to people at risk in a smart and efficient manner.

Male circumcision: Scaling up voluntary medical male circumcision has the potential to prevent an estimated one in five new HIV infections in Eastern and Southern Africa by 2025. The unit cost is relatively low and is a one-time rather than lifelong expenditure. Nevertheless, countries allocate relatively few resources towards this service—less than 2% of total HIV expenditure in six of the 14 priority countries where data is available.

In Kenya nearly 54% of adults in the Nyanza province have been circumcised and more than 20% in Ethiopia and Swaziland. But in six countries—Malawi, Mozambique, Namibia, Rwanda, Uganda and Zimbabwe—less than 5% of the target number of men had been voluntarily circumcised by end of 2011.

Changing sexual behaviour to avert HIV: Sexual behaviour among men and women has changed to become safer in numerous countries with generalized epidemics including Kenya, Malawi, Mozambique, Namibia, Nigeria and Zambia. In other countries—such as Côte d'Ivoire, Guyana and Rwanda—sexual risk behaviour is increasing, highlighting the need to intensify support for behaviour change efforts.

Age-appropriate sexuality education may increase knowledge and contribute to more responsible sexual behaviour however there are gaps in even basic knowledge about HIV and its transmission. In 26 of 31 countries with generalized epidemics in which nationally representative surveys were recently carried out, less than 50% of young women have comprehensive and correct knowledge about HIV.

Although population-level behaviour change has been shown to reduce the prevalence of HIV infection in several countries with generalized epidemics, linking behaviour change programming to specific HIV outcomes remains challenging.

Increasing consistent, correct, condom use: Condom use is a critical element of combination HIV prevention and one of the most efficient technologies available to reduce the sexual transmission of HIV. Although levels of reported condom use appear to be increasing in several countries with a high HIV prevalence, recent data from nationally representative surveys indicate declines in Benin, Burkina Faso, Côte d'Ivoire and Uganda.

The United Nations Population Fund (UNFPA) estimates that only nine donor-provided male condoms were available for every man aged 15–49 years in sub-Saharan Africa in 2011 and one female condom for every 10 women aged 15–49 years in the region. Less is known about the condoms directly procured by low- and middle-income countries. One estimate suggests more than two billion condoms were directly procured in 2010, far short of the 13 billion estimated for HIV prevention in 2015.

Reaching populations at highest risk: HIV continues to have a disproportionate impact on sex workers, men who have sex with men and people who inject drugs. A recent review of data in 50 countries showed that 12% of female sex workers are living with HIV and the chance of women who engage in sex work being infected is 13.5 times higher than others. Often countries with generalized epidemics—where more than one in 100 adults have HIV—fail to recognize the severity of burden faced by sex workers, nearly one in four of whom in their capital cities are living with HIV.

Similar trends are seen among men who have sex with men. Go to any capital city in the world, men who have sex with men are significantly more likely to have HIV—on average 13 times more than the general population. As global HIV prevalence trends appear to have stabilized there is disturbing evidence suggesting that global HIV prevalence among men who have sex with men may have increased between 2010 and 2012.

People who inject drugs are the worst off: evidence from 49 countries shows that their risk of being infected with HIV is 22 times higher than the general population. In 11 countries the chances are 50 fold higher.

In countries of Eastern Europe up to 40% of new HIV infections occur among people who inject drugs and their sexual partners. In Armenia, in addition to drug use, nearly a quarter of new infections occur among men who have sex with men.

Popular opinion in countries with generalized epidemics is that HIV infection is found evenly across the adult population. Evidence points otherwise. For example, modelling studies conducted in Kenya show that 33 out of every 100 new HIV infections occur among sex workers, their clients, people who inject drugs, men who have sex with men and people in prisons.

About two thirds of countries report having risk reduction programmes for sex workers. New data from surveys conducted in capital cities of 58 countries suggest that median coverage of HIV prevention services is 56%, up very slightly from 2010. Coverage is lower in countries lacking legal protection for sex workers. However where services are provided 85 countries say that nearly nine out of 10 sex workers used a condom the last time they had sex.

Likewise for men who have sex with men—in capital cities the median coverage was 55%. But levels of consistent condom use are insufficient. Although a majority of surveyed men who have sex with men said that they used a condom during their last sexual episode, only 13 countries reported more than 75% consistent condom use, while 58 countries reported between 50%-75% condom use. The number who know their HIV status is also low—fewer than one in three tested for HIV in the past 12 months in South and South-East Asia and in Western and Central Europe, regions where sex between men plays a key role in national HIV epidemics.

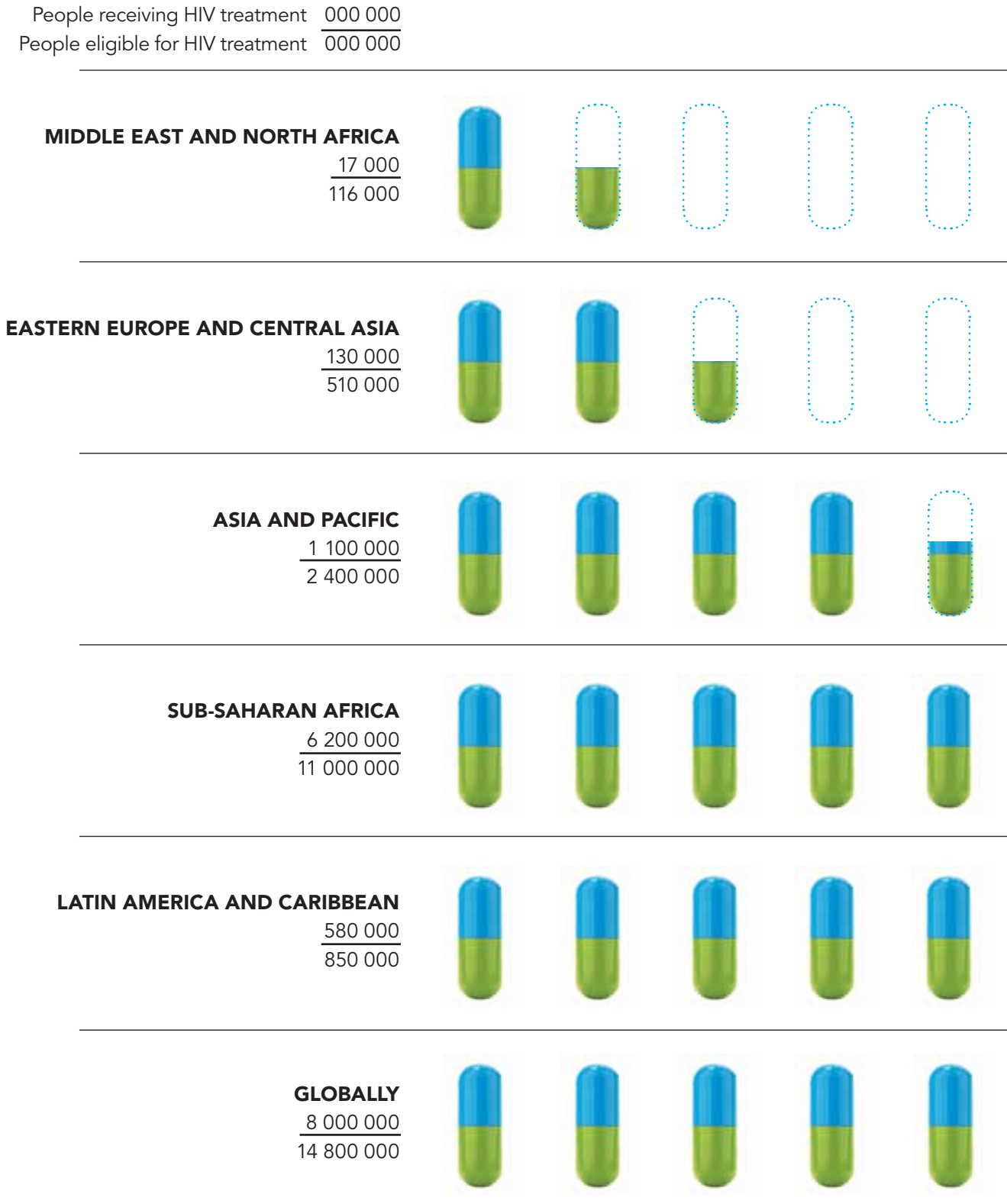
According to country reports, nearly 80% of people who inject drugs reached in surveys in 49 capital cities have access to safe injecting equipment. However a separate 2010 study estimated that, globally, two needle-syringes (range 1–4) were distributed monthly per person who injects drugs—far too little to effectively stop needle sharing and thus the transmission of HIV. Another study estimates that people who inject drugs only use sterile equipment for 5% of injections globally. Studies suggest there is a gender gap in services for drug users whereby women who inject drugs have even poorer access to HIV services.

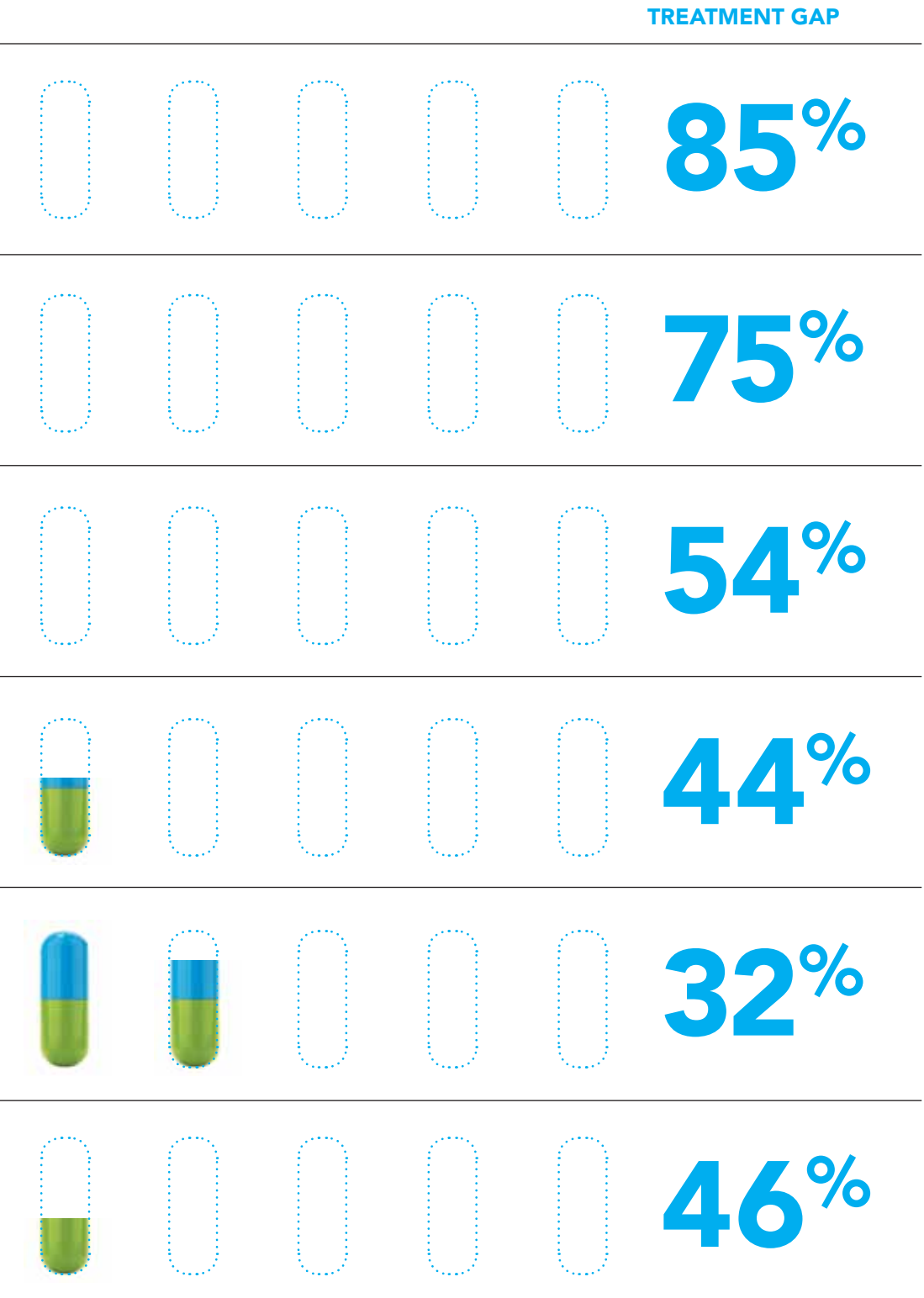
To end the AIDS epidemic, sex workers, men who have sex with men and people who inject drugs cannot remain invisible. They have to be counted in. Getting to zero will require better mapping and effective combination prevention. That means combined behavioural, biomedical and structural strategies, both intensively in specific populations in concentrated epidemics and across the whole population in generalized epidemics.

The treatment gap in low- and middle-income countries

Antiretroviral therapy reached 8 million people by the end of 2011, a twenty-fold increase since 2003. In 2011, for the first time, a majority (54%) of people eligible for antiretroviral therapy in low- and middle-income countries were receiving it. This chart shows the gap in 2011 between the number of people receiving antiretroviral therapy and the number of people eligible for treatment.

Source: UNAIDS 2012 Global Report




TREATMENT GAP
85%
75%
54%
44%
32%
46%

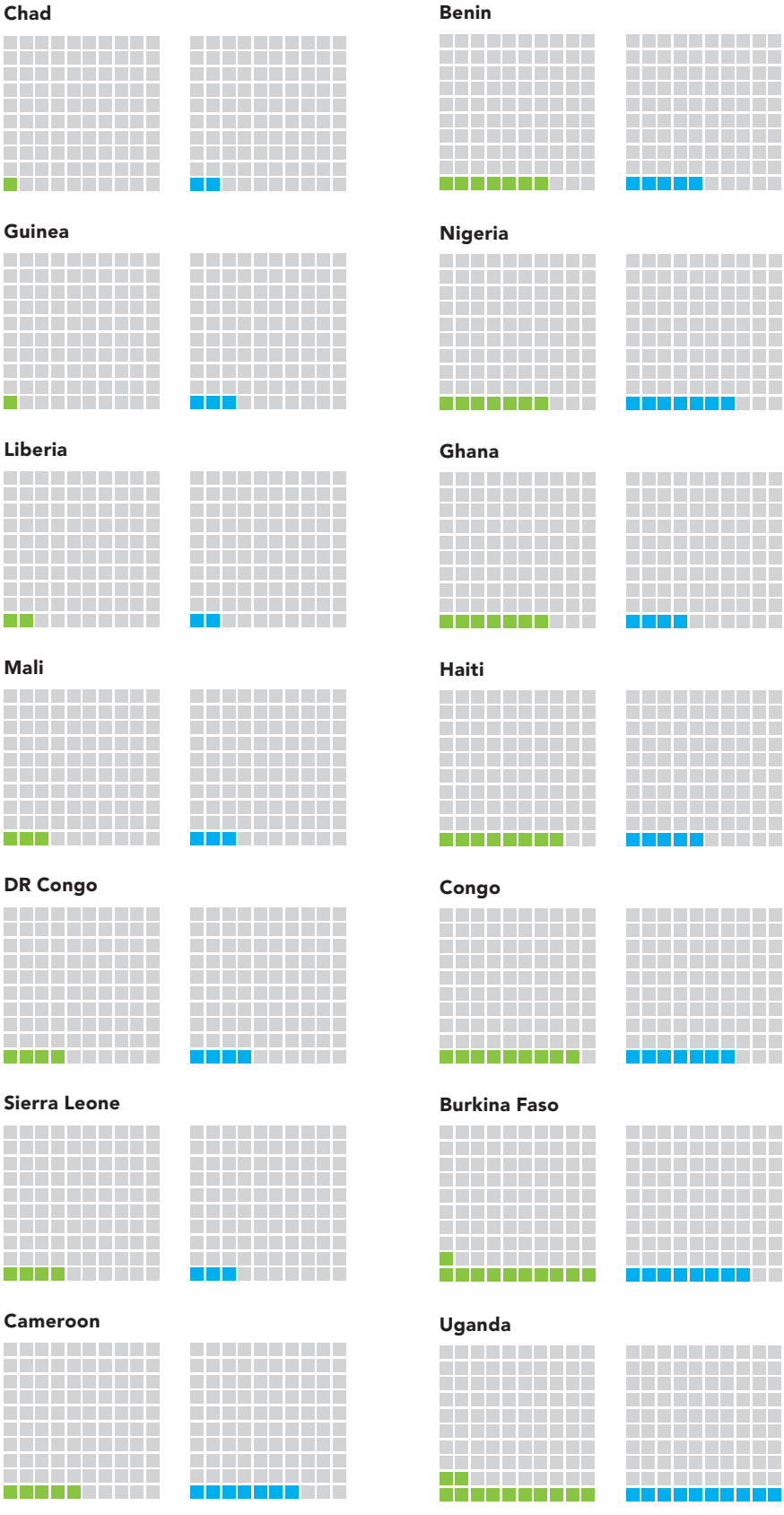
Do you know your HIV status?

Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and received their results.

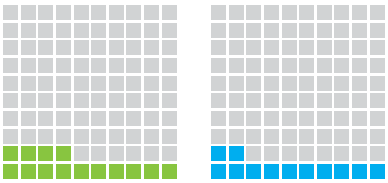
- 1%
- Women
- Men

Source: Demographic and Health Surveys
www.measuredhs.com

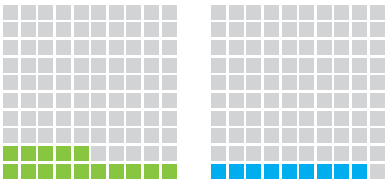
Note: Percentages based on latest available data



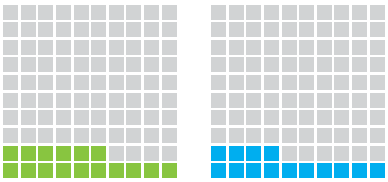
Togo



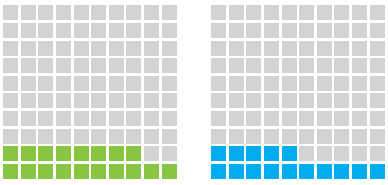
Mozambique



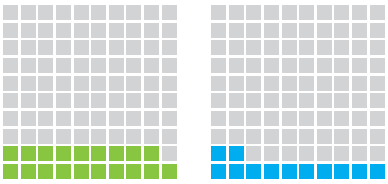
Central African Republic



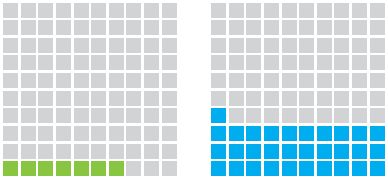
Gambia



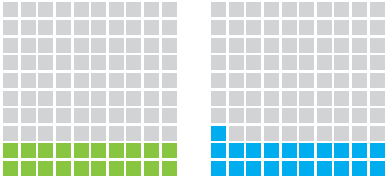
Zambia



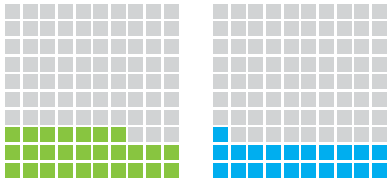
Malawi



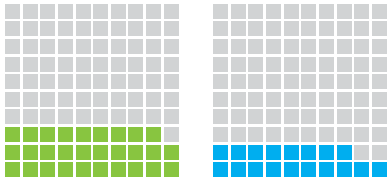
Ethiopia



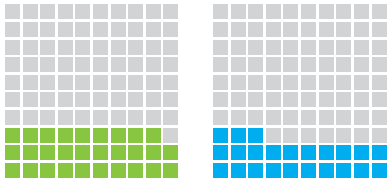
Guyana



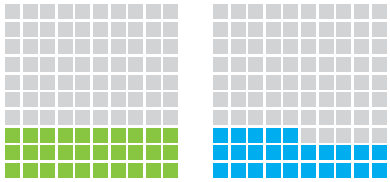
Namibia



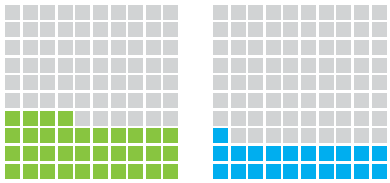
Kenya



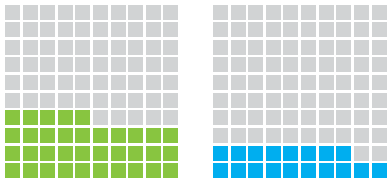
United Republic of Tanzania



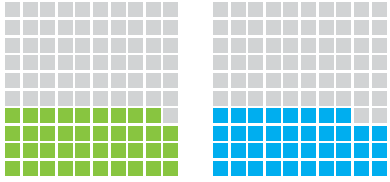
Zimbabwe



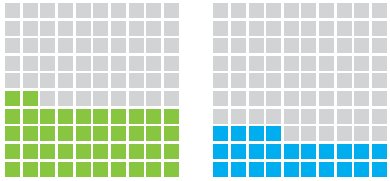
Côte d'Ivoire



Rwanda

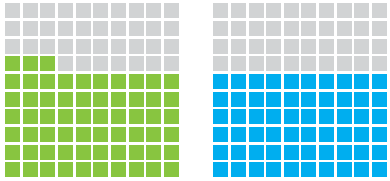


Lesotho



Swaziland

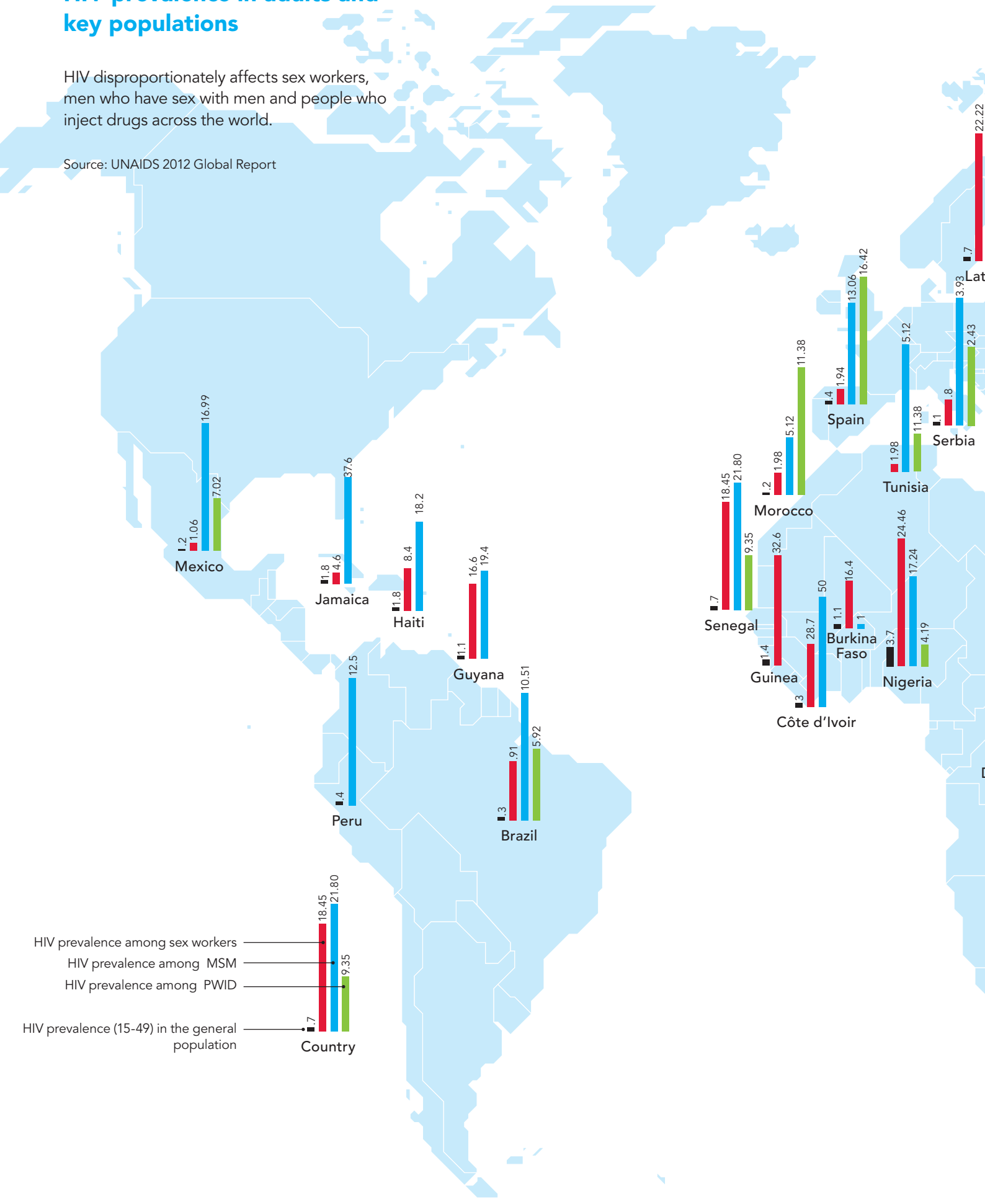
Botswana

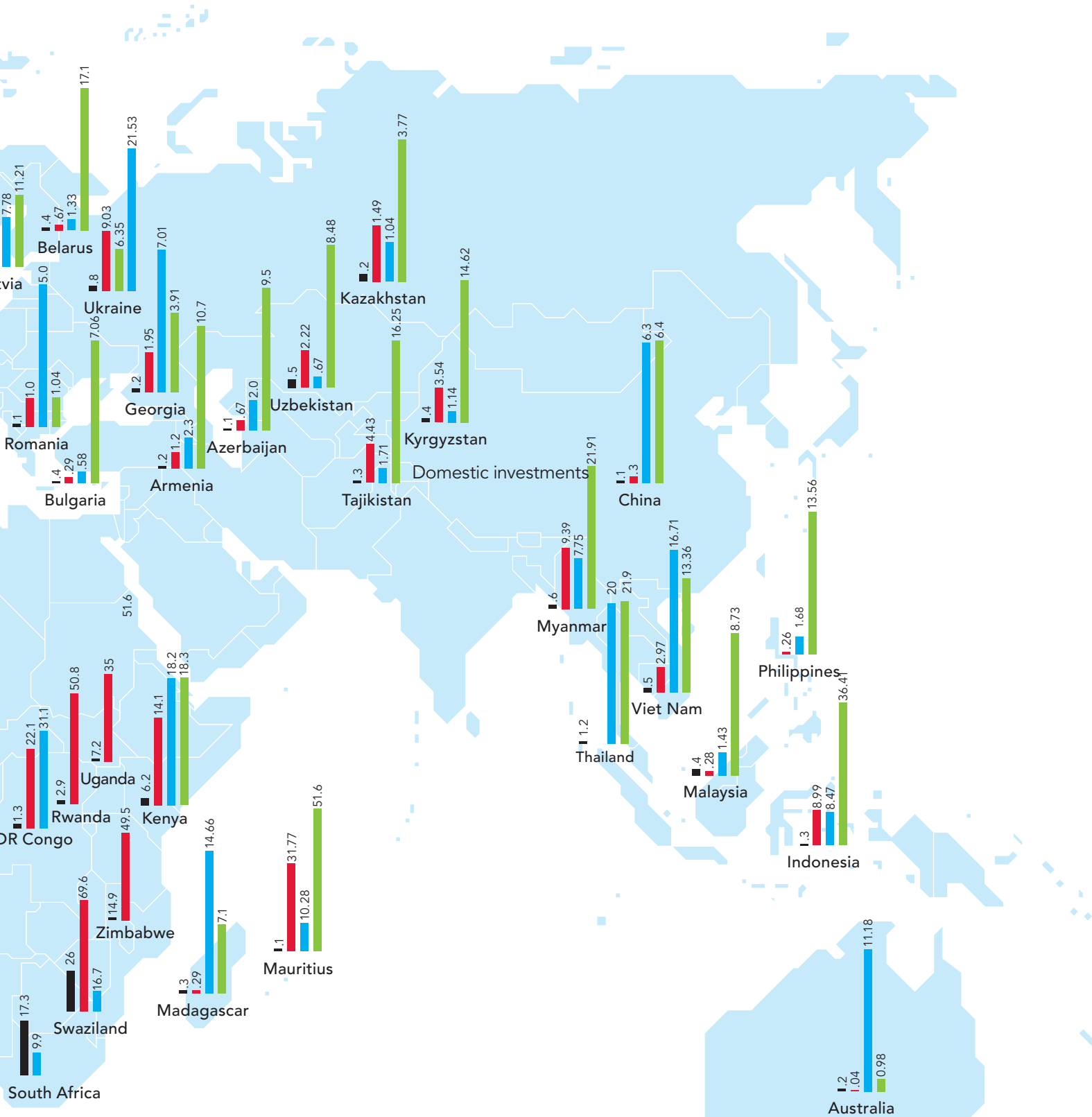


HIV prevalence in adults and key populations

HIV disproportionately affects sex workers, men who have sex with men and people who inject drugs across the world.

Source: UNAIDS 2012 Global Report




Belarus
Ukraine
Georgia
Uzbekistan
Kazakhstan
Romania
Azerbaijan
Armenia
Kyrgyzstan
Tajikistan
Domestic investments
China
Bulgaria
Myanmar
Thailand
Viet Nam
Philippines
Malaysia
Indonesia
Uganda
Rwanda
Kenya
DR Congo
Zimbabwe
Mauritius
Madagascar
Swaziland
South Africa
Australia

2015

20 Avenue Appia
CH-1211 Geneva 27
Switzerland

+41 22 791 36 66

unaids.org

Copyright © 2012 UNAIDS
ISBN 978-92-9253-000