HIV/AIDS

More than 30 years since the disease was first described in 1981, HIV remains a leading cause of ill-health and mortality. While investments in the HIV response have achieved unprecedented results, globally, in 2014, there were 36.9 million people living with HIV, 2.0 million new infections and 1.2 million deaths. Four out of ten people living with HIV are in sub-Saharan Africa, where HIV is a leading cause of death among adults, women of child-bearing age and children.

ACHIEVEMENTS

MDG Target 6A (halting and beginning to reverse the spread of HIV by 2015) has been achieved. By 2014, the number of people newly infected with HIV was about 40% lower than peak incidence in the second half of the 1990s (Figure 5.8). AIDS-related deaths have declined by 32% since the peak in 2004. New HIV infections among children declined from 500,000 in 2000 to 220,000 in 2014, mainly due to increased access to ARVs for HIV-infected pregnant women.

There has also been good progress towards MDG Target 6.B (universal access to treatment) with 14.9 million people living with HIV receiving ART globally by the end of 2014, up from 690,000 in 2000 (Figure 5.9). However, this still only represents 40% of the estimated 36.9 million people living with HIV. In sub-Saharan Africa, the ART coverage rate stands at 10.7 million of a total of 25.8 million people living with HIV.

SUCCESS FACTORS

The strong combination of domestic, donor and public-private financing, based on the UN General Assembly declarations on HIV/AIDS and the establishment of new and innovative funding mechanisms for HIV such as PEPFAR, the Global Fund and UNITAID, along with global and local civil society mobilization, have provided leadership, advocacy, coordination and resources for a worldwide response.

Preventive interventions: Combinations of effective interventions have contributed to reduced HIV transmission, including behaviour change communication to encourage changes in sexual behaviour; programmes targeting key populations such as harm-reduction programmes for PWID, maximizing the prevention benefits of ARVs, including for the prevention of mother-to-child transmission of HIV; and voluntary medical male circumcision in high HIV-prevalence settings.

ART: The development and global scale-up of access to ART has been one of the most successful public health interventions of the MDG era. The drop in the prices of ARVs, owing to global advocacy, greater predictability of demand, economies of scale, increased competition among manufacturers, involvement of generic manufacturers and voluntary licensing have made treatment more affordable.

Increased funding. In 2015, US$ 21.7 billion, four times that in 2000, was invested in the AIDS response in low- and middle-income countries; in 2014, 57% of these investments came from domestic sources. Since 2000, international funding has increased approximately tenfold, rising from nearly US$ 900 million to US$ 8.6 billion in 2014.

Innovative approaches to services delivery: The use of task shifting, decentralization and community involvement helped stretch health-care delivery systems to expand services without compromising quality. This has extended the public health approach into communities.

CHALLENGES

Africa: 10% of people living with HIV are in the African Region, where nearly one in every 20 adults is infected (Figure 5.10). An integrated multisectoral, multifaceted approach will require continued substantial external funding together with increased domestic contributions.

Treatment coverage: The 2015 revision of the WHO guidelines for ART removes the threshold for treatment initiation, recommending treatment for all, which expands the population eligible for treatment and presents an obvious coverage challenge. The main obstacle to higher treatment coverage is lack of access to treatment, but unawareness of HIV status; it is estimated that about half of all people living with HIV are not aware that they are infected.

Vaccines: More than 30 clinical trials of HIV vaccines, testing a variety of candidates and vaccine concepts, are currently under way (Phase I and II), but no effective vaccine is likely to be available in the near future.

Bringing down incidence: Universal access to, and uptake of, male and female condoms is still lacking, especially for young people. Young women are especially vulnerable, due to various factors, including gender inequalities and gender violence. Interrupting HIV transmission among key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, remains a challenge in many countries.

Stigma and discrimination: Legal environments in many countries increase HIV vulnerability, contribute to risk behaviours and inhibit access to HIV services. Many countries retain laws that either criminalize, or sanction the persecution of, people (or their behaviours) who are at higher risk of HIV infection.

Eliminating health-care associated transmission in spite of major reductions in HIV transmission through unsafe injections and blood transfusion; 24% of blood donations in low-income countries are not screened for one or more viruses (HIV, HBV, HCV) using basic quality procedures.

Coinfections and other comorbidities: TB, hepatitis (B and C), and other communicable diseases occur in conjunction with HIV infection. As people living with HIV live longer on ART they experience a broader range of NCDs related to their chronic HIV infection, side-effects of their treatment and ageing, including cardiovascular disease, diabetes, respiratory disorders and cancers, all requiring chronic care.

STRATEGIC PRIORITIES

The SDG target is to end the AIDS epidemic by 2030. UNAIDS has led the development of a global strategy, Fast Track: Ending the AIDS Epidemic by 2030, while more detailed, sectoral strategies such as the WHO Global Health Sector Strategy on HIV 2016–2021 are under development. The global strategy targets a reduction in the annual number of people newly infected with HIV by 80% and the annual number of people dying from AIDS-related causes by 80% (compared with 2010).

The main areas of focus post-2015 include:

- A focus on populations that have been left behind by the HIV response, such as adolescent girls, key populations (sex workers, men who have sex with men, people who inject drugs and transgender people), migrants, children and older people;
- A focus on locations where the greatest HIV transmission is occurring and with the greatest HIV burden, and the use of data to support the impact of programmes;
- An integrated HIV response that expands the contribution towards UHC, including health workforce, procurement systems, injection and blood safety and treatment of coinfections;
- Sustainable programmes with transitioning to domestic funding of essential HIV services.