



## Global Fact Sheet: HIV/AIDS

### I. HIV/AIDS Basics

**HIV/AIDS** is one of the most destructive diseases humankind has ever faced. It brings with it profound social, economic and public health consequences. It has become one of the world's most serious health and development challenges. HIV is a leading cause of death worldwide. The first cases were reported in 1981 and since the beginning of the pandemic more than three decades ago; approximately 30 million people have died of AIDS-related illnesses. There are an estimated 35.3 million People Living with HIV (PLHIV).

**HIV** stands for Human Immunodeficiency Virus, and is the virus that causes AIDS. HIV destroys certain blood cells that are crucial to the normal functioning of the immune system, which defends the body against illness.

**AIDS** stands for Acquired Immunodeficiency Syndrome. It occurs when the immune system is weakened by HIV to the point where a person is susceptible to any number of Opportunistic Infections (OIs) or diseases. Having AIDS is defined as presenting with HIV and one or more OIs.

**OPPORTUNISTIC INFECTIONS** (OIs) are illnesses caused by organisms that do not usually cause disease in persons with healthy, functioning immune systems. The most common OIs in PLHIV include:

**Candidiasis** (Thrush) is a fungal infection that usually affects the mouth, throat, lungs or vagina.

**Cryptosporidiosis** (Crypto) is a diarrheal disease caused by a protozoan infection.

**Cryptococcal Meningitis** is a fungal infection of the membranes surrounding the brain and spinal cord.

**Cytomegalovirus** (CMV) is a herpes virus that can cause infections in most organs of the body, though PLHIV are more susceptible to CMV retinitis, which can lead to blindness.

**Herpes Simplex Viruses** (HSV) are a group of viruses that can cause oral and/or genital herpes. These are common infections, but outbreaks for PLHIV can be more frequent and more severe.

**Mycobacterium Avium Complex** (MAC) is a bacterial infection that can cause: recurring fevers, problems with digestion and serious weight loss.

**Pneumocystis Jiroveci Pneumonia** (formally known as Pneumocystis Carinii Pneumonia or PCP) is a fungal infection that can cause fatal pneumonia. This is a fairly common OI in people who have not been tested or treated for HIV.

**Toxoplasmosis** (also referred to as Toxo) is a parasitic disease that can infect many parts of the body but most commonly causes an infection of the brain.

**Tuberculosis** (TB) is a bacterial infection that attacks the lungs and can cause meningitis.

## **HIV Testing**

HIV infection is detected through the test of a sample of blood or oral fluid (oral mucosa). If the blood or oral fluid sample contains HIV antibodies – proteins the body produces in an attempt to fight off the infection – the person is HIV positive (also referred to as HIV infected or seropositive). Several rapid HIV tests are available, including ones developed for use with oral fluid or blood plasma samples. All rapid tests provide results in less than 30 minutes; however, positive results require confirmatory blood tests. Pre- and post-test counselling can help individuals assess their personal risk for infection and develop strategies for coping with their test results. Viral load tests are an important tool in the clinical management of HIV disease. When a person already knows that she or he is infected with HIV, they may also have a viral load test to detect HIV genetic material and estimate the amount of virus in the blood.

## **HIV Transmission**

HIV does not survive well outside the body. Therefore, it cannot be transmitted through casual, everyday contact. Mosquitoes and other insects do not transmit HIV. HIV is primarily spread through unprotected vaginal or anal intercourse with someone who is HIV positive, by sharing contaminated needles, syringes and/or other injecting equipment and, less commonly, through transfusions of infected blood or blood clotting agents (in countries where blood is not screened for HIV antibodies). Babies born to HIV positive women may become infected before birth, during birth or through breast-feeding after birth.

## **HIV Treatment**

Despite significant advances in HIV treatment and prevention, there is still no cure, only treatment.

**ARV** stands for Antiretroviral and refers to a type of drug that works by interfering with the replication of HIV.

**ART** refers to Antiretroviral Therapy.

**HAART** (Highly Active Antiretroviral Therapy) is a modality of ART that involves the use of three or more ARVs in a single regimen. HAART emerged in 1996. This therapy helps to slow the growth of HIV in the body by interfering with the ability of the virus to replicate, which allows the body's immune system to maintain or recover its ability to produce the white blood cells necessary to respond to OIs.

The main classes of ARVs currently available are:

- **Nucleoside Reverse Transcriptase Inhibitors** (NRTIs), which block the replication of HIV by interfering with a protein called Reverse Transcriptase (RT), essential for the reproduction of HIV.
- **Non-Nucleoside Reverse Transcriptase Inhibitors** (NNRTIs), which also block RT, but in a slightly different way than NRTIs.
- **Protease Inhibitors** (PIs), which block the function of a protein called protease, essential for HIV reproduction.
- **Entry Inhibitors**, also known as Fusion Inhibitors, which block HIV from entering target cells.
- **Integrase Inhibitors**, which prevent HIV from integrating its genetic message (RNA reverse transcribed into DNA) into the nucleus of cells.

## II. The HIV Epidemic

### Global Highlights

#### General Facts

In 2013:

- 35.3 million people were living with HIV worldwide, including 3.3 million children.
- The global prevalence rate (the percentage of people aged 15 - 49 who are infected) was 0.8 percent.
- There were 2.3 million new HIV infections, including 260 000 children.
  - Approximately 95 percent are in low- and middle-income countries
  - About 700 infections are in children under 15 years of age
  - An estimated 5,500 new HIV infections are in adults aged 15 years and older, of whom:
    - almost 47 percent are among women
    - about 39 percent are among young people (15-24)
- A total of 1.6 million people died from AIDS-related illnesses.
- Although the testing capacity has increased over time; the majority of people with HIV are still unaware that they are infected.
- In 2010, in resource poor countries, 6.6 million PLHIV were receiving treatment, representing only 47 percent of the people eligible for treatment. In 2012, approximately 9.7 million PLHIV had access to ART in low- and middle-income countries.

Since the beginning of the epidemic:

- More than 75 million people have been infected with HIV.
- Approximately 36 million people have died of AIDS-related illnesses.
- It is estimated that each day 6 300 individuals worldwide are infected with HIV.

Many of the countries hardest hit by HIV also suffer from other serious issues, for example, infectious diseases, poverty and food insecurity.

#### HIV and Tuberculosis

- HIV is the strongest risk factor for the development of tuberculosis (TB). One third of PLHIV are co-infected with latent TB. People co-infected with TB and HIV are 21-34 times more likely to develop active TB disease than people living without HIV.
- In 2011 it was estimated that 79 percent of TB and HIV co-infection occurs in sub-Saharan Africa.

- TB is estimated to cause one in four AIDS-related deaths. In 2011, approximately 430 000 people died of HIV-associated TB. A majority of these deaths occur in Africa, where the mortality rate from HIV-related TB is more than 20 times higher than in other world regions.
- With inexpensive drugs, TB is both preventable and curable. Evidence has shown that early initiation of ART significantly reduces the risk of death amongst HIV-positive people who are co-infected with TB.
- Of the TB patients who were known to be HIV positive in 2011, 48 percent (over 258,000) were enrolled on ART.

### **Vulnerable Communities and Populations at Higher Risk of HIV Infection**

- In 2013, women represented approximately 57 percent of all adults living with HIV worldwide. Women are biologically more susceptible to HIV. In addition to suffering from gender inequalities, discrimination and violence can also increase their vulnerability to infection.
- Young women (aged 15-24) have an especially high risk of acquiring HIV, with infection rates twice as high than in young men. In 2013, about half of all PLHIV were women, and in 2010, young women accounted for 22 percent of all new HIV infections. HIV is the leading cause of death of women of reproductive age and every minute, a young woman is newly infected with HIV.
- Although globally, most new infections are transmitted heterosexually, in some countries HIV continues to disproportionately affect three categories of populations: people who use drugs, men who have sex with men (MSM) and sex workers.
- Several structural factors, including poverty, discrimination and stigma interact to prevent a better access to essential information, prevention and treatment services amongst these vulnerable communities.

### **Mother-to-child Transmission of HIV**

- In 2010, an estimated 32 percent of the 1.49 million pregnant women with HIV needing antiretroviral medicine to prevent MTCT were unaware of their HIV status.
- In June 2011, the United Nations Secretary-General launched the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, which lays out key actions needed at both the global and country level to expedite progress toward these goals. The plan focuses on reaching pregnant women living with HIV and their children – from the time of pregnancy until the mother stops breastfeeding.
- Between 2005 and 2012, the scaling up of Prevention of Mother-to-Child Transmission (PMTCT) services has prevented approximately 800 000 children from HIV infection.

□ Over 90 percent of new infections in infants and young children occur through MTCT.

Without any interventions, between 20 percent and 45 percent of infants may become infected, but this risk can be reduced to less than 2 percent in a non-breastfeeding population by a package of evidence-based interventions. In low- and middle-income countries, coverage of effective antiretroviral regimens PMTCT reached 57 percent in 2011.

□ In 2010, an estimated 35 per cent of the estimated 123 million pregnant women in low- and middle-income countries received an HIV test, up from 26 per cent in 2009, 21 per cent in 2008 and 8 per cent in 2005.

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 was estimated that only half of all people living with HIV were aware of their HIV status.

### **HIV Knowledge**

□ In 2010, in low- and middle-income countries, only 24 percent of young women and 36 percent of young men responded correctly when asked five questions on HIV prevention and HIV transmission.

□ Despite an increase in HIV-related knowledge, globally, less than 30 percent of young women have comprehensive and correct knowledge of HIV.

□ Just 49 percent of young females know that using a condom helps to prevent HIV infection, compared to 74 percent of young males.

□ An aggravating factor in the lack of basic HIV knowledge amongst women is that they account for two-thirds of the world's illiterate adults of which there are 796 million.

### **HIV Response Funding**

The HIV response is funded by various stakeholders, including multilateral institutions, the private sector and low- and middle-income country governments. Donor governments account for most of the funding for HIV in many hard hit countries, mainly through the Global Fund to Fight AIDS, Tuberculosis and Malaria and other channels such as UNITAID. Despite the rise in resources in the last decade to address HIV in low- and middle-income countries, in 2010 UNAIDS estimated an annual resource gap of \$6 billion. In 2012, continued gains were made in mobilizing financial resources for the AIDS response. In 2013, an estimated US\$ 18.9 billion was available for HIV programmes in low- and middle-income countries – a 10 percent increase over 2011. The estimated annual need by 2015 is considered to be between US \$22-24 billion.

## **Regional Highlights**

### ***Sub-Saharan Africa***

- This region continues to be the most affected by HIV. More than two-thirds (70 percent/25 million) of all PLHIV live in sub-Saharan Africa—including 88 percent of the world's HIV-positive children.
- In 2012, an estimated 1.6 million people in the region became newly infected.
- One million fewer people acquired HIV in 2012. A drop of almost 40 percent.
- An estimated 1.2 million adults and children died of AIDS, accounting for 75 percent of the world's AIDS deaths in 2012.
- Almost all of the region's nations have generalized HIV epidemics (i.e. national HIV prevalence rates which are higher than 1 percent).
- Women comprise 59 percent of PLHIV in this region.
- Sub-Saharan Africa is the region with the highest number of pregnant women living with HIV.
- More than 90 percent of children with HIV live in this region, where the epidemic has orphaned more than 14 million children.
- Young women in Sub-Saharan Africa are eight times more likely than men to be living with HIV. In 2010, young women accounted for 71 percent of the young PLHIV in Sub-Saharan Africa.

### ***North Africa and the Middle East***

- In the Middle East and North Africa, the estimated number of people acquiring HIV rose by more than 50 percent.
  - 2001: 21 000 [16 000–30 000]
  - 2012: 32 000 [22 000–47 000]
- Most of the women with HIV in this region are infected by their husbands/partners who engage in high-risk behaviours and are mostly not aware of their status (97 percent in Saudi Arabia, 76 percent in Iran).
- An estimated 17,000 adults and children died of AIDS in 2012.

### ***Asia Pacific***

- Nearly five million people are living with HIV across South/South-East Asia and East Asia.
- In 2012, there were 351 000 new infections and 261 000 people died of AIDS-related causes.
- Sex work is the key driver of HIV in Asia Pacific.
- Thirty-five percent of PLHIV are women and an estimated 50 million women are at risk of acquiring HIV from their male partners.

### ***Latin America***

- In this region, the epidemic is mainly concentrated amongst MSM.
- Twenty-two percent of men who have sex with men reported having sex with both men and women, thus increasing the risk of the spread of HIV infection through heterosexual sex.
- More than 36 percent of adults living with HIV in the Latin American region are women.

### ***Caribbean***

- As of 2012, more than 250 000 people are living with HIV/AIDS.
- Women account for 53 percent of PLHIV in the Caribbean.
- Young women are about two and a half times more likely to be infected with HIV than young men.

### ***Eastern Europe & Central Asia***

- This region is home to an estimated 1.3 million PLHIV.
- The main drivers of the epidemic are injecting drug use and sex work.
- In 2010, half of all HIV infections in the region were due to drug users sharing contaminated needles.
- Ukraine and the Russian Federation have the largest epidemics in the region with Russia having the highest number of PLHIV. They account, together, for 90 percent of the people newly infected in the region.
- HIV prevalence is twice as high amongst young women as amongst young men.
- In 2012 HIV/AIDS claimed 91 000 lives.

### ***North America***

- The estimated rate of new HIV infections for African American women is more than 15 times as high as the rate for Caucasian women.
- Eighty-five percent of African American women living with HIV acquired HIV through heterosexual sex
- As of 2012, fewer than 200 children a year were infected with HIV in the United States.

### III. Trends in the Last Decade

#### Global Trends

- The number of PLHIV has increased from 31.7 million in 2003 to 35.3 million in 2013, as a result of: continuing new infections, people living longer with HIV, and general population growth.
- The global prevalence rate (0.8 percent in 2013) has levelled since 2001.
- The number of people newly infected with HIV has declined in the last decade, contributing to the stabilization of the epidemic. The estimated numbers of children acquiring HIV in low- and middle-income countries have decreased since 2000: from 536 000 in 2000, 535 000 in 2005, 390 000 in 2010 to 320 000 in 2012.
- The number of AIDS-related deaths has also declined in the last decade. In 2012, the number of AIDS-related deaths - 1.6 million - fell down from a peak of 2.2 million in the mid-2000s, due to the more widespread availability of ART, since its introduction in 1996.
- At the end of December 2009, since the advent of Highly Active Antiretroviral Therapy (HAART) in 1996, it is estimated that HAART has saved an estimated 14.4 million life-years worldwide.
- As of April 2011, 47 countries, territories and areas imposed some form of restriction on the entry, stay and residence of people living with HIV. However, in a more positive development, China, Namibia and USA lifted their HIV-related travel restrictions in 2010, while Ecuador and India clarified that no such restrictions were in place.
- A total of 182 countries reported in 2010 on their implementation of the 2001 Declaration of Commitment.
- The number of pregnant women living with HIV has remained relatively stable since 2005.
- In 2012, 62 percent of pregnant women living with HIV in low- and middle-income countries received the medicines they needed to prevent transmission of HIV to their babies.
- In the 22 priority countries of the Global Plan, to eliminate new HIV infections among children by 2015, overall MTCT rates have declined from an estimated 26 per cent in 2009 to 17 per cent in 2012. Countries beyond the scope of the Global Plan are also making significant progress towards Elimination of-Mother-to-child-Transmission (EMTCT). E.g. Cuba, Panama and Thailand and much of Eastern Europe report that as of 2010, they are approaching transmission rates of 2 percent.
- In low- and middle-income countries, the availability and uptake of HIV testing has increased considerably in recent years. Yet, a large proportion of people infected with HIV are still unaware of their HIV status, and despite high levels of testing in some contexts (in antenatal care clinics for example), key populations at higher risk of HIV infection are often not reached.

Maximizing coverage of these populations requires more innovative, appropriate and cost-effective approaches.

□ In 2012, approximately 9.7 million PLHIV in low- and middle-income countries were receiving ART, an increase of 50 percent from 2010.

### **Regional Trends**

□ Caribbean, Latin America, North America and Western Europe: New HIV infections have remained relatively stable since 2001.

□ Eastern Europe and Central Asia: After decreasing in the early 2000s, HIV incidence has been accelerating again since 2008. The number of PLHIV grew up by 250 percent since 2001 in this region.

□ East Asia has seen a 25 percent decrease in new infections during this period.

□ Asia Pacific: the proportion of women with HIV compared to men has stabilized at about 35 percent since 2002.

□ In the Middle East and North Africa, the annual number of people newly infected with HIV was 59 000 in 2010, versus 43 000 in 2001.

## IV. HIV Prevention

There are a number of tools available that can be utilized individually or in combination in order to prevent HIV transmission.

**Condom Use** is one of the least expensive, most cost-effective methods for preventing HIV transmission. Consistent, correct use of condoms significantly reduces the risk of transmission of HIV and other STIs. There are condoms available for use by both men and women. Ongoing Research & Development (R&D) work in the area of female condoms includes product development, HIV research, clinical trial preparation, education and advocacy. In 2010, global investment in R&D related to female condoms totalled US\$3.1 million.

**Socio-Behavioural Interventions** include educational programs designed to encourage individuals to change their behavior in order to reduce their exposure to HIV and risk of infection. Such efforts include encouraging correct and consistent condom use, a reduction in the number of sexual partners, abstinence and the delaying of sexual initiation amongst youth. On a broader scale, social/cultural interventions are used to change norms that contribute to HIV risk and vulnerability, such as gender inequality, homophobia and HIV-related stigma.

**Blood Screening** aims at ensuring that people have access to safe (donated) blood. While screening of all blood donations should be mandatory for HIV and other Transfusion-Transmissible Infections (TTIs), in 39 countries blood donations are not routinely tested for TTIs including HIV, hepatitis B and C and syphilis. In low-income countries, 47 percent of blood donations are tested in laboratories without quality assurance. Blood screening is part of blood transfusion safety, which also includes access to blood that is available at reasonable cost, adequate to meet the patients' needs, transfused only when necessary, and provided as part of a sustainable blood programme within the existing health care system (WHO criteria).

**Mother-to-child Transmission (MTCT)** of HIV can occur before or during delivery, or after delivery via breast milk. The risk of MTCT can be reduced significantly through the use of ARVs by HIV-positive women during pregnancy and delivery, and by their infants following birth, as well as by refraining from breast-feeding. These regimens reduce the risk of MTCT by decreasing viral replication in the mother and through prophylaxis of the infant during and after exposure to the virus. In 2010, funding for operations research related to prevention of vertical transmission from mother-to-child at birth and during breast feeding was US\$59.7 million.

**Male Circumcision** has been shown to reduce the risk of HIV transmission by approximately 60 percent. In March 2007, WHO and UNAIDS recommended that male circumcision be considered an important intervention - as part of a comprehensive prevention package - to reduce the risk of heterosexually acquired HIV infection in men, based on studies conducted in Kenya, Uganda and South Africa. Investment in circumcision operations research grew significantly in 2010. Between 2005 and 2010, global public-sector and philanthropic investment in R&D and operations research in this field totaled US\$59 million.

**Post-Exposure Prophylaxis (PEP)** involves the short-term use of ARVs to prevent infection in people who have recently been exposed to HIV. There are two types of PEP: (1) **occupational PEP** (also known as "oPEP"), taken when someone working in a healthcare setting is potentially exposed to material infected with HIV, and (2) **non-occupational PEP** (also known as "nPEP"), taken when someone is potentially exposed to HIV outside the workplace (e.g., from sexual assault, or during episodes of unprotected sex or sharing contaminated needles). PEP reduces the risk of infection, but is not 100 percent effective.

**Pre-Exposure Prophylaxis (PrEP)** involves taking ARVs before engaging in behaviour(s) that place one at risk for HIV infection (such as unprotected sex or sharing contaminated needles) in order to reduce or prevent the possibility of HIV infection.

□ In 2010, global public-sector and philanthropic investment in PrEP equalled US\$58.27 million. It totalled US\$205 million over the last five years.

**Treatment-as-Prevention (TasP)** refers to the use of ART by PLHIV to lower their viral load and hence the potential to transmit HIV. Recent research has shown that providing HIV treatment to PLHIV significantly reduces the risk of transmission to their negative partners. The recent HPTN052 trial (announced in May 2011) demonstrated showed that if an HIV-positive person adheres to an effective ART regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96 percent. Evidence has also emerged on the fact that ART reduces the incidence of TB. In 2010, R&D invested in the field of HIV prevention effect of ART was US\$19.6 million.

### **Harm Reduction Efforts for Persons Who Use Drugs**

In many countries, injecting drugs is a major driver of the HIV epidemic. Preventing HIV and other harms amongst People Who Use Drugs (PWUD) - and providing them with effective HIV and drug dependence treatment - are essential in the HIV response. Avoiding the rapid spread of HIV amongst PWUD and transmission of the virus to other populations requires combining various harm reduction strategies, such as needle and syringe programmes; opioid substitution therapy; prevention and treatment of sexually transmitted infections; condom distribution; targeted information, education and communication; vaccination and treatment of viral hepatitis; prevention and treatment of TB, HIV testing and counselling and ART.

Scientists are exploring **microbicide** development as a potential HIV prevention method. Microbicides are substances (usually delivered via gels or foams) that, when applied to the vagina, can substantially reduce transmission of one or more sexually transmitted infections (STIs). They work by either destroying the microbes or preventing them from establishing an infection. An HIV microbicide would provide a female-controlled method of prevention. There is also research exploring rectal microbicides.

□ In 2010, total global investment in microbicides R&D was US\$247 million, a 5 percent increase from 2009 that returned it to a level that exceeded its highest previous level equalling US\$244 million in 2008. In 2012, funders invested a total of US \$1.31 billion across R&D (research & development) for six key prevention areas: preventive HIV vaccines, microbicides, PrEP, treatment as prevention, operations research related to voluntary medical male circumcision and prevention of vertical transmission. This is a six percent increase over funding in 2011.

□ There still are no **vaccines** available to prevent HIV or improve the ability of the immune system to defend itself against HIV.

Vaccines are currently being tested by researchers, who reported in 2009, for the first time, that an experimental HIV vaccine modestly reduced the risk of HIV infection, bolstering long-term prospects for vaccine research. Yet, it is likely that a successful vaccine is still a number of years away. In 2012, investments in global preventive HIV vaccine R&D were virtually flat—increasing by just US\$2 million over the previous year to total US\$847 million.

## **HIV Treatment**

### **Treatment Figures**

In 2012, in low- and middle-income countries:

- It is estimated that at the end of 2012, just under 10 million PLHIV had access to ART in low- and middle-income countries.
- Ten countries had achieved universal access to treatment (coverage of at least 80 percent of people eligible for ART).
- In 2012 alone an additional 1.6 million people newly gained access to treatment.
- Since 2002 there has been a 40-fold Increase in access to ART.
- By 2012, approximately 62 percent of pregnant women living with HIV had access to ART.
- Fifteen countries, including Botswana, Guyana and South Africa, were able to provide more than 80 percent of HIV-positive pregnant women, the services and medicines to prevent MTCT of HIV.
- The cost of first line ART in some low- and middle- income countries has been reduced to around US \$140 per person per year as opposed to the mid-1990s where the cost was around US \$10 000.

### **Testing and Counselling**

- Uptake of HIV testing and counselling increased from about 64 million tests in 2009, 72 million tests in 2010, to 118 million in 2012 (in 124 reporting countries).
- Only 28 percent of infants born to mothers with HIV received an HIV test within the first two months of life (in 65 reporting countries).
- In 2010, 35 percent of pregnant women in low- and middle- income countries received HIV testing and counselling, up from 26 percent in 2009.

Lack of knowledge of serostatus (having or not having detectable antibodies against a specific antigen, measured by a blood test) by PLHIV is a major obstacle to realizing the goal of universal access to treatment and prevention. A significant proportion of PLHIV continue to present late for treatment because they are unaware that they are seropositive, including in high-income countries, thus reducing the effectiveness of ART on morbidity, survival and preventing HIV infection. In many circumstances, people informed of their HIV-positive status are not adequately linked with the appropriate services, thus preventing immediate enrolment in care.

## **VI. Focus on Vulnerable Communities**

### **Key Populations at Higher Risk of HIV Infection**

HIV continues to disproportionately affect PWUD, MSM and sex workers, including transgendered people. These communities are targeted with specific interventions. Yet, despite significant progress in improving HIV surveillance amongst them, they continue to face high levels of stigma and discrimination and laws that criminalize their behaviour, thus preventing access to health care and prevention. In 2010, the median percentage of key populations at higher risk of HIV infection receiving HIV testing and counselling was: 23 percent amongst PWUD, 32 percent amongst MSM and 49 percent amongst sex workers.

### **People Who Inject Drugs**

An estimated 20 percent of the 15.9 million people who inject drugs worldwide are living with HIV. This statistic underscores the world's failure to put the lessons of harm reduction to use. In 2013, coverage of harm reduction programmes for PWID remained limited. Amongst 107 reporting countries, only 42 had needle and syringe programmes and 37 offered opioid substitution therapy. In Europe and Central Asia, inequity in the access of PWID to ART continued in 2010. This community represented only 22 percent of those receiving ART.

### **Men who Have Sex with Men**

In 2010, in a subset of 113 low- and middle-income countries, the availability of targeted interventions for MSM regionally was higher in Latin America and the Caribbean, in Europe and Central Asia and in East, South and South-East Asia.

### **Sex Workers**

In 2010, in a subset of 113 low- and middle-income countries, the availability of programmes and policies engaging sex workers was highest in East, South and South-East Asia and was substantially more limited in North Africa and the Middle East.

## **Gender-based Inequality, Discrimination and Violence**

### **Against Females**

In many countries, a number of factors relating to gender inequality contributes to the risk of the spread of HIV infection by further increasing women's vulnerability to HIV and by limiting their capacity to access information and treatment.

These factors include; limited decision-making power; lack of control over financial resources and limited economic opportunities; restricted mobility and child-care responsibilities; denial of property and inheritance rights; and early marriage. In addition, violence against women and girls through physical and/or sexual violence, including by an intimate partner, reduces their ability to protect themselves from HIV infection.

As a consequence of HIV infection, women living with HIV are more likely to experience violations of their sexual and reproductive rights, for example forced sterilizations. Only 46 percent of all countries allocate resources for the specific needs of women and girls in their national response to HIV. In Sub-Saharan Africa, only one female condom is available for every 36 women. Although research is ongoing into a dual purpose prevention (vaginal) ring which aims to provide protection against HIV infection by delivering ARVs as prevention and which will also act as a contraceptive. The rings are currently being manufactured and are soon to undergo testing (March 2014).

**Women who Have Sex with Women (WSW)**, including lesbians, bisexual women, transgendered people – constitute a neglected and invisible minority in policy and programming around HIV, despite evidence showing that this community is at risk. Besides facing stigma, discrimination and even sexual violence, WSW lack access to HIV services and information due to neglect within the HIV policy and programming environment.

**Women who Inject Drugs** are particularly vulnerable to HIV transmission. The overlap of different stigmas from drug use and related risk behaviours make it difficult for them to access their full sexual reproductive health rights.

## Sources

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