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# International response to the HIV/AIDS epidemic: planning for success

Peter Piot<sup>1</sup> & Awa Marie Coll Seck<sup>2</sup>

**Abstract** More assertive political leadership in the global response to AIDS in both poor and rich countries culminated in June 2001 at the UN General Assembly Special Session on AIDS. Delegates made important commitments there, and endorsed a global strategy framework for shifting the dynamics of the epidemic by simultaneously reducing risk, vulnerability and impact. This points the way to achievable progress in the fight against HIV/AIDS. Evidence of success in tackling the spread of AIDS comes from diverse programme areas, including work with sex workers and clients, injecting drug users, and young people. It also comes from diverse countries, including India, the Russian Federation, Senegal, Thailand, the United Republic of Tanzania, and Zambia. Their common feature is the combination of focused approaches with attention to the societywide context within which risk occurs. Similarly, building synergies between prevention and care has underpinned success in Brazil and holds great potential for sub-Saharan Africa, where 90% reductions have been achieved in the prices at which antiretroviral drugs are available. Success also involves overcoming stigma, which undermines community action and blocks access to services. Work against stigma and discrimination has been effectively carried out in both health sector and occupational settings. Accompanying attention to the conditions for success against HIV/AIDS is global consensus on the need for additional resources. The detailed estimate of required AIDS spending in low- and middle-income countries is US\$ 9.2 billion annually, compared to the \$ 2 billion currently spent. Additional spending should be mobilized by the new global fund to fight AIDS, tuberculosis and malaria, but needs to be joined by additional government and private efforts within countries, including from debt relief. Commitment and capacity to scale up HIV prevention and care have never been stronger. The moment must be seized to prevent a global catastrophe.

**Keywords** Acquired immunodeficiency syndrome/prevention and control; HIV infections/prevention and control; International cooperation; United Nations; Intersectoral cooperation; Socioeconomic factors; Social support; Politics; Anti-HIV agents/supply and distribution/economics; Prejudice (*source: MeSH*).

**Mots clés** SIDA/prévention et contrôle; HIV, Infection/prévention et contrôle; Facteur socioéconomique; Coopération internationale; Nations Unies; Coopération intersectorielle; Soutien social; Politique; Agents anti-HIV/ressources et distribution/économie; Préjugé (*source: INSERM*).

**Palabras clave** Síndrome de inmunodeficiencia adquirida/prevencción y control; Infecciones por VIH/prevencción y control; Cooperación internacional; Naciones Unidas; Cooperación intersectorial; Factores socioeconómicos; Apoyo social; Política; Agentes anti VIH/provisión y distribución/economía; Prejuicio (*fuentes: BIREME*).

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Voir page 1111 le résumé en français. En la página 1111 figura un resumen en español.

## Renewed international resolve

The year 2001 has seen a remarkable convergence of political, scientific and economic forces, creating

major new opportunities for a more intensive global response to the AIDS pandemic.

In the political sphere, there has been more concerted and higher-level action than ever before. In April, President Obasanjo of Nigeria hosted a special summit of the Organization of African Unity in Nigeria to focus African leadership on the response to AIDS. It resulted in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, which called the AIDS situation a “state of emergency” facing the continent. Govern-

<sup>1</sup> Executive Director, Joint United Nations Programme on AIDS, 20 avenue Appia, 1211 Geneva 27, Switzerland (email: bartosm@unaids.org). Correspondence should be addressed to this author.

<sup>2</sup> Minister of Health and Prevention, Senegal.

ments committed themselves to allocating at least 15% of their national budgets to the health sector to assist in the fight against HIV/AIDS, tuberculosis and other related infectious diseases (1).

In other regions as well, political action against the HIV/AIDS epidemic was intensified in 2001. Important events include the launch of a Pan-Caribbean Partnership Against HIV/AIDS by CARICOM, a major discussion on AIDS at the Economic and Social Commission of Asia and the Pacific, and attention to AIDS in the declaration and plan of action adopted at the Summit of the Americas in Quebec in April.

Meanwhile, in many of the wealthy countries, efforts in the global response to AIDS were accelerated and became more concerted. The European Union adopted a programme for action against HIV/AIDS, malaria and tuberculosis in the context of poverty reduction. The US and most other "donor" countries significantly increased their budgets to support AIDS control activities in the developing world. The Group of Eight (G8) at its meeting in Genoa reasserted the commitment it had made the previous year at Okinawa to an increased response to communicable diseases.

These events culminated in the Special Session on AIDS held by the United Nations General Assembly at the end of June — the most concerted, high level and comprehensive gathering of nations ever held to discuss AIDS. The Declaration of Commitment (2) unanimously adopted at that session included commitments to: national planning; prevention targets, including 25% reductions in prevalence among young people; urgent provision of the highest attainable standard of treatment for HIV/AIDS; enacting or strengthening human rights protection for people living with HIV/AIDS; reducing vulnerability to HIV infection; national strategies to support children orphaned by AIDS; dealing with the economic and social impact of AIDS; increasing investment in HIV-related research, including work on vaccines and microbicides; incorporating HIV programmes in emergency responses; and, by 2005, reaching an annual HIV/AIDS expenditure target of US\$ 7–10 billion in low- and middle-income countries.

## The basis for success

The increased political momentum and the prospect of significant increases in available resources make the need for clarity about the best methods in tackling the HIV epidemic more crucial than ever. The Global Strategy Framework on HIV/AIDS, approved by the Programme Coordinating Board of UNAIDS in December 2000, distilled the lessons learnt in 20 years of responding to the epidemic (3).

First, political leadership is required at all levels to marshal the necessary commitment and resources for the social mobilization on which the response must be built. Second, responses to the epidemic

need to be conceptualized as multisectoral tasks, and not confined to health sector action. Just as the impact of AIDS is felt across all social and economic sectors, so too the scale and breadth of the response needs to encompass all elements of national planning. Third, national coordination is required and, given the multisectoral nature of the crisis, many of the most effective national responses are those which have been steered from the offices of prime ministers and presidents. Fourth, responses are successful when people living with HIV are centrally involved in the effort. Fifth, successful responses to the epidemic have their roots in communities. Local actors are able to determine the most effective priorities for action when they are properly informed, and they can act accordingly when they are helped to mobilize the necessary resources. When these principles are applied to local responses, and when the political leadership exists to proliferate local responses on a national scale, the epidemic can be reversed.

The Global Strategy Framework also shows how to shift the dynamics of the epidemic by lowering risk, vulnerability and impact simultaneously. Most prevention efforts to date have focused on reducing immediate risks by bringing about behaviour change. But behaviour change has been frustratingly difficult to achieve and sustain, because the risks related to HIV exposure are not always easy to control.

Reducing vulnerability is a way of generating a deeper level of change in social structures in order to increase individuals' control over risks. It might involve making sexual health services accessible, giving marginalized groups protection against discrimination, or using schools as a resource to involve whole communities in AIDS responses. The impact of AIDS makes it harder to reduce vulnerability, because it disrupts social structures and depletes resources. So reducing impact also has to be part of the mix — by supporting orphans, for example, or creating training opportunities, or improving access to care and treatment.

This analysis is grounded in the most effective and sustainable responses to HIV/AIDS in diverse regions and communities. The key lesson learnt is that success is possible. Empirical evidence from Brazil, Cambodia, parts of Thailand, Uganda, the United Republic of Tanzania and urban areas in Zambia shows that incidence can be sustainably reduced by preventive interventions, even after it has risen to high levels across the population.

The common experience of these countries is that risks cannot be reduced in isolation. Where responses have been successful they have built wide community support, given "target" groups the driving role in designing and delivering change, and participated in changing the social environment. The "expanded response" to the epidemic has been criticized as insufficiently prioritized, not focused on outcomes, and lacking in emphasis on sustained behaviour change (4). But the evidence from those national and local responses to the epidemic in which

sustained drops in HIV incidence have been achieved, or in which low incidence has been maintained despite surrounding trends to the contrary, shows that it is precisely when the response to the epidemic is based on a broad social mobilization, accompanied by clear deliverables, that success has been achieved.

## Making prevention possible

To succeed, interventions must be targeted and they must be carried out in the right supportive environment. Close examination of the celebrated example of the “100% condom use” campaign in Thailand shows its success to have depended on its being part of a package: HIV prevention became part of Thailand’s national sense of destiny, from the Prime Minister down. There was a nationwide debate on sexual mores, together with structural solutions such as regulation of the sex industry, intensive education, skills development and peer intervention with sex workers, and efforts targeting clients (5).

Likewise, in the Calcutta red-light district of Sonagachi the establishment of an autonomous, self-sustaining social movement built around the sex industry has succeeded in keeping HIV prevalence low, both among sex workers and within the general population (6). In contrast, in Mumbai, Maharashtra, where many sex workers are bonded labourers, and sustained communitywide interventions have been lacking despite positive results from well-targeted interventions (7), HIV prevalence among sex workers rose steadily between 1987 and 1997 to the current level of over 70% (8). Similar attempts to target miners have shown that to increase the uptake and success of interventions, workers need to understand them in the social context of their work, recreation, families and communities.

Even in epidemics initially driven by the very specific practice of injecting drug use there is a simultaneous need for widely diffused intervention. For example, modelling based on the rapidly growing HIV epidemic in the Russian Federation shows that early implementation of harm reduction interventions for injecting drug users will have a substantial impact on the size and growth rate of the future epidemic. Equally, however, it is important to invest now in programmes that influence young people, given the relatively low age of injecting drug users, and the future spread of the epidemic, which will be mainly heterosexual.

Success requires a combination of prevention methods, then, aimed at behaviour patterns embedded in their social contexts. This applies both to groups especially exposed to risk and to the general population. In programmes for in-school youth, for example, the United Republic of Tanzania is in the process of scaling up its most successful school programmes by using a combination of peer and life skills education, school–parent AIDS committees to bring AIDS awareness into the community, and

guardian programmes to counter the sexual harassment of girls (9). In the Mbeya region, also in Tanzania, falls in HIV incidence came through decade-long planning and donor involvement directed at building local capacity through a comprehensive approach combining services, education and political advocacy (10).

Nowhere is the lesson of combining prevention efforts more crucial than in relation to young people. Young women and young men need to take joint responsibility for reducing the impact of AIDS on their lives. They have proved themselves capable of changing the course of the epidemic if they have the right knowledge and support. In every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred (see Box below).

Underlying the success of combination prevention are processes of social mobilization that enable communities to become autonomous actors in efforts against AIDS. A broad range of social levers must be used to support and empower community action. In some cases these include religious leadership. For example, an important factor in Senegal’s success at keeping HIV prevalence low, contrary to much of the surrounding region, is the active involvement of religious leaders as part of a sustained effort at societywide mobilization (13).

## Building synergies between prevention and care

The Declaration of Commitment adopted by the UN General Assembly recognized that “prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response” (2). Successful prevention and care build a common constituency for action.

### Examples of sustained changes in behaviour that have been led by young people

- In Brazil, the proportion of young men using condoms the first time they had sex rose from 5% in 1986 to 50% in 1999.
- In high-income countries like Switzerland and the USA, the proportion of sexually active teenagers was lower in the 1990s than in the 1980s.
- In a number of Latin American countries, young people have been found to be more likely than older people to use condoms for casual sex.
- In Uganda the proportion of teenage girls who had ever used a condom tripled between 1994 and 1997.
- In Thailand, fewer young men are visiting sex workers and condom use has increased. HIV prevalence measured among 21-year-old army recruits fell from a peak of 4% in 1993 to below 1.5% at the end of the decade (11).
- In Zambia, especially in urban areas, sexual activity has decreased, condom use has increased, and the age at which sexual activity starts has risen. As a result, the proportion of pregnant women under 20 who were HIV-positive had fallen from 27% in 1993 to 17% by 1998 (12).

In the North, where most people with HIV have access to the new classes and combinations of HIV antiretrovirals, mortality dropped sharply in 1996 and 1997. Attention shifted to the complex medical problem of adjusting drug combinations to stay one step ahead of a mutating drug-resistant virus, but progress on prevention fell behind. In nearly every high-income country, the past few years have seen the epidemic make inroads in poorer and more marginalized parts of society. Also, among gay men, once the champions of behaviour change, unsafe sex is on the rise, with a corresponding rise in HIV infection rates.

Meanwhile, in the South, the slogan "prevention is the only cure" began to sound like the hypocritical justification of a morally bankrupt global divide. Inadequate access to the treatments that have transformed AIDS in rich countries is tantamount to robbing poor ones both of a powerful weapon against the epidemic, and of hope in collective action. Antiretrovirals are not magic bullets, but they are an essential component of a comprehensive prevention and care response. They can motivate individuals to be tested for HIV, support the prevention of mother-to-child transmission, and help break down barriers of isolation and despair. All this is in addition to their more direct benefit, of providing therapy with the treatment of opportunistic infections and palliative care.

Brazil provides the leading example of integrating renewed commitment to prevention with comprehensive care. In 1996, that country brought in a law establishing the right to free medication. The numbers of patients using antiretrovirals grew from 25 000 in 1997 to around 90 000 in 2000. The annual cost of antiretroviral supply, which includes drugs produced under licence by Brazilian manufacturers, is now over US\$ 350 million, but the estimated savings from hospitalizations avoided is estimated at some US\$ 420 million (14), with additional cost benefits flowing from healthy and productive life-years gained. In 1994 the World Bank estimated existing trends would result in 1.2 million cumulative HIV infections in Brazil by 2000, but success in curbing the rate of growth in the second half of the 1990s resulted in the number reaching only 540 000 by that time. Following Brazil's example, universal treatment access has been pursued elsewhere in the region, notably Costa Rica, El Salvador and Panama.

Similarly, in Barbados, planning for universal treatment access has been a core element of a major renewal in the national effort against HIV. With an expanding epidemic in a small population, Barbados is becoming a regional exemplar with the strength of its multisectoral AIDS response, led by the Prime Minister and supported by the World Bank.

Accelerating access to care has been systematically pursued as a key priority of UNAIDS, involving the coordinated efforts of the programme's cosponsors, in particular UNICEF, UNFPA, WHO and the World Bank. Effective strategies have

included dialogue with the research-based pharmaceutical industry. This has led to widespread support for preferential drug pricing for developing countries, pricing transparency, price competition (which includes the generic manufacturers), and assistance to countries in planning and financing national plans for accelerated access. As a result, by mid-2001, benchmark prices for combination antiretroviral therapy for developing countries stood at some 5–10% of the prices in high-income settings.

The fruits of this approach are being seen in the increasing number of countries rapidly expanding access to treatment. In sub-Saharan Africa the twin challenges of poverty and large epidemics make quick wins in accelerating access difficult. Nevertheless considerable progress is expected and under way. The President of Gabon, one of the higher-income countries of sub-Saharan Africa, recently created a "therapeutic solidarity fund" which will provide resources for universal treatment access, with expanded capacity through local medical centres, regional hospitals and the central hospital (15). Botswana ranks second after Gabon in per capita income in sub-Saharan Africa, but first in per capita HIV infection, with prevalence estimated at 36% of the adult population. There, a major effort to organize universal access to antiretroviral therapy is being developed with major support from the Bill and Melinda Gates Foundation and the Merck pharmaceutical company.

Elsewhere in Africa, the accelerating access initiative of UNAIDS had resulted in government agreement with pharmaceutical companies on reduced prices for antiretrovirals by September 2001 in Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Mali, Rwanda, Senegal and Uganda, as well as Gabon. While deep discounts have been achieved in these agreements, the country-by-country process is relatively slow. UNAIDS is therefore intensifying its efforts to support regional collaboration to facilitate procurement.

A final area in which quick wins should be possible is the prevention of mother-to-child transmission. Antiretroviral treatment is one part of the strategy, together with primary prevention among women, and the accessibility of safe feeding alternatives. The United Nations General Assembly's commitment to reducing the number of infants infected with HIV by 20% by 2005 and 50% by 2010 necessitates a substantial acceleration in efforts. At present, well over 600 000 infants are infected annually.

## Stigma

HIV-related stigma may well be the greatest obstacle to action against the epidemic, for individuals and communities as well as political, business and religious leaders. An all-out effort against stigma will not only improve the quality of life of people living with HIV and those who are most vulnerable to



infection, but meet one of the necessary conditions of a full-scale response to the epidemic.

Defeating HIV-related discrimination requires health and social services to be sensitive to it and act against it. A key area of action has been within the health sector. For example, in India, the Lawyers Collective in Mumbai has been not only raising awareness among people with HIV of their legal rights as citizens and as patients, but sensitizing doctors and other health care workers to HIV-related legal and ethical issues.

Voluntary counselling and testing (VCT) services are central to tackling stigma because they constitute the entry point for care and treatment, and it is at this point that potential patients are at their most vulnerable to stigma. Guidelines published by UNAIDS and WHO on beneficial HIV disclosure and partner counselling have helped to establish a coherent and ethical framework for this highly sensitive procedure (16). Across the world, VCT services are being expanded, and at the same time becoming more sensitive to discrimination. India's National AIDS Control Organisation is promoting VCT centres; the Chris Hani-Baragwanath Hospital in Soweto is pioneering community outreach and the expansion of VCT services; UNAIDS, particularly with its WHO component, is integrating HIV education and counselling into primary health care in Rwanda. A particular concern in Rwanda is to gear these services to the psychosocial needs of young women who have been the victims of rape.

Protection from discrimination extends well beyond the health and related sectors. For example, the International Labour Organization has recently brought out a new code of practice on HIV and the world of work (17). HIV discrimination at the workplace has been a focus in many countries, including South Africa, where the Employment Equity Act has made it illegal for the majority of Government departments to carry out pre-employment HIV testing. Micro-finance is another area in which great care is needed to combat discrimination rather than perpetuate it: the International Labour Organization is strengthening micro-finance and entrepreneurial skills among women in Malawi, Mozambique, the United Republic of Tanzania and Zimbabwe, integrating AIDS education into the programme.

In addition to the existing agenda for tackling HIV-related vulnerability and the immediate impact of the epidemic, there is a long-term agenda that has as yet barely begun. A very large cohort of orphaned children will cause political as well as social instability in the worst-affected countries. The impact of AIDS on human resources in public and private sector work is considerable. Development capacity, already overstretched, is being stretched even further as AIDS kills gifted, skilled and educated personnel. Depleted human resource capacity in the most affected countries is only now being placed on the development agenda as a significant issue. Programmes and interventions for dealing with it are urgently needed.

## The new resources environment

To meet any of the targets set by the United Nations General Assembly, an order-of-magnitude boost in spending on the response to AIDS is required in most developing countries. Detailed calculations made by UNAIDS and our collaborators on the resource needs of low- and middle-income countries show that by 2005, US\$ 9.2 billion ought to be spent annually on AIDS interventions: US\$ 4.8 billion on prevention and US\$ 4.4 billion on care (18). The proportions vary from region to region: 66% on care in Africa, for instance, but 68% on prevention in Asia.

This level of spending would provide 6 billion condoms, treatment for 22 million sexually transmitted infections, and voluntary counselling and testing for 9 million people. An additional 35 million women would receive testing at prenatal clinics and 900 000 would receive antiretrovirals to prevent mother-to-child transmission. Special prevention programmes would reach almost six million sex workers, 28 million men who have sex with men, and three million injecting drug users.

One source of additional resources will be the new Global AIDS and Health Fund. Since the announcement of such a fund by the Secretary-General of the United Nations, Kofi Annan, in April 2001 at the Abuja AIDS summit, it has garnered wide support from international bodies including the General Assembly Special Session, the Organization of African Unity, and the G8. By mid-year, US\$ 1.5 billion had been pledged to the Fund. The Fund is designed to be international in character, and its transitional arrangements include representation from both developing and industrialized countries, United Nations agencies, foundations, people living with HIV, and business.

The Fund will be an important new resource for national HIV/AIDS strategies, but it cannot be the only one. National budget allocations, funds liberated through debt relief or cancellation, social insurance, and private sector efforts will all be needed. The gap between the US\$ 1.8 billion currently being spent and the US\$ 9.2 billion needed in developing countries must be filled from a variety of sources. With reasonable increases in spending, a third to a half of the required amount could come from government and private spending within the countries concerned. Of this, US\$ 100 million could come from an allocation of 10% of liberated debt relief funds under the Highly Indebted Poor Countries Initiative. Social insurance and the private sector are also valuable sources of funds. Donor support, if official development assistance were increased by up to 10% and foundations also increased allocations, could amount to some US\$ 3 billion annually (18).

Lack of capacity to absorb increases in resources for HIV/AIDS, while posing challenges, is no reason to delay the scaling up of allocations in countries expressing commitment to an expanded response. Mechanisms for monitoring and evaluating implementation, documenting progress towards

meeting goals, and evaluating the cost-effectiveness of chosen strategies must be developed as the activities take shape.

## Conclusion

Commitment to scaling up HIV prevention and care, and the capacity to do so, have never been stronger. A remarkable opportunity exists now for concerted action on all fronts. The required scale of

response will not be reached in the space of one or two years, but this initiative represents a feasible and achievable plan for the current decade. Steadily mounting evidence indicates that failure to act now will mean failure to prevent a global catastrophe. An effective and scaled up response to the HIV epidemic will make life liveable for millions of people worldwide. ■

**Conflicts of interest:** none declared.

## Résumé

### Riposte internationale à l'épidémie de VIH/SIDA : planifier pour réussir

L'engagement politique de plus en plus marqué en ce qui concerne la riposte mondiale face au SIDA aussi bien dans les pays pauvres que dans les pays riches a atteint son point culminant en juin 2001 lors de la session spéciale de l'Assemblée des Nations Unies consacrée au SIDA. Les délégués y ont pris d'importants engagements et ont adopté un cadre stratégique mondial visant à modifier la dynamique de l'épidémie en réduisant simultanément le risque, la vulnérabilité et l'impact. Ces engagements montrent la voie à suivre pour réaliser des progrès tangibles dans la lutte contre le VIH/SIDA. Les succès enregistrés dans la lutte contre la propagation du SIDA viennent de divers secteurs de programme, dont le travail avec les professionnels du sexe et leurs clients, les usagers de drogues injectables et les jeunes. Les données proviennent également de divers pays dont la Fédération de Russie, l'Inde, la République-Unie de Tanzanie, le Sénégal, la Thaïlande et la Zambie. On retrouve dans chaque cas une association d'approches ciblées tenant compte du contexte social de l'existence d'un risque. De même, l'établissement de synergies entre la prévention et les soins a été un facteur de réussite au Brésil et offre de bonnes perspectives en Afrique subsaharienne, où l'on

a obtenu une baisse de 90 % du prix des antirétroviraux disponibles. Les succès enregistrés portent aussi sur le recul de la stigmatisation des malades, qui entravait l'action communautaire et bloquait l'accès aux services. Le travail contre la stigmatisation et la discrimination a été efficacement mené à la fois dans le secteur de la santé et dans les milieux professionnels. Outre l'intérêt accordé aux conditions du succès de la lutte contre le VIH/SIDA, il existe un consensus quant à la nécessité de ressources supplémentaires. L'estimation détaillée des dépenses liées au SIDA qui seraient nécessaires dans les pays à revenu faible et moyen est de US \$9,2 milliards par an, contre les 2 milliards actuellement dépensés. Les fonds nécessaires devraient être mobilisés par le nouveau fonds mondial pour la lutte contre le SIDA, la tuberculose et le paludisme, mais devraient aussi être complétés par des efforts supplémentaires des gouvernements et du secteur privé, grâce notamment à l'allègement de la dette des pays. L'engagement et la capacité à faire passer la prévention et les soins en matière de VIH à la vitesse supérieure n'ont jamais été aussi importants. Il faut saisir cette occasion pour empêcher une catastrophe mondiale.

## Resumen

### Planificación para asegurar el éxito de la respuesta internacional contra la epidemia de VIH/SIDA

El desarrollo de un liderazgo político más enérgico en la respuesta mundial contra el SIDA, tanto en los países pobres como en los ricos, tuvo su culminación, en junio de 2001, en el periodo extraordinario de sesiones de la Asamblea General de las Naciones Unidas sobre el SIDA. Los delegados asistentes suscribieron importantes compromisos y respaldaron un marco estratégico global para imprimir una nueva dinámica a la epidemia reduciendo el riesgo, la vulnerabilidad y el impacto. Se indica así el camino para conseguir avances reales en la lucha contra el VIH/SIDA.

La evidencia disponible sobre la posibilidad real de contener con éxito la propagación del SIDA procede de diversos sectores programáticos, en particular del trabajo realizado con profesionales del sexo y sus clientes, con usuarios de drogas inyectables y con jóvenes. Procede también de diversos países, entre ellos la India, la

Federación de Rusia, Senegal, Tailandia, la República Unida de Tanzania y Zambia. Su común característica es el recurso a métodos focalizados unido a una atenta consideración del contexto social en que se inscribe el riesgo. Análogamente, el fomento de la sinergia entre la prevención y el tratamiento ha apuntalado los éxitos conseguidos en el Brasil, y encierra grandes posibilidades para el África subsahariana, donde se han logrado reducciones del 90% de los precios de venta de los antirretrovíricos. Parte del éxito consiste también en superar la estigmatización, que socava la acción de la comunidad y bloquea el acceso a los servicios. Se han llevado a cabo efectivamente actividades contra la estigmatización y la discriminación tanto en el sector de la salud como en entornos laborales.

Al mismo tiempo hay que prestar atención, como otra de las condiciones para combatir eficazmente el VIH/

SIDA, al logro de un consenso mundial respecto a la necesidad de recursos adicionales. Se estima que la suma requerida para luchar contra el SIDA en los países de ingresos bajos y medios asciende concretamente a US\$ 9200 millones anuales, frente a los 2000 millones dedicados en la actualidad. El nuevo fondo mundial contra el SIDA, la tuberculosis y el paludismo debería contribuir a

reducir esa diferencia, pero se necesita también el concurso de gobiernos y del sector privado en los países, en particular en forma de alivio de la deuda. El compromiso y la capacidad conseguidos para ampliar las actividades de prevención y tratamiento de la infección por el VIH nunca habían sido tan importantes, y hay que aprovechar esta oportunidad para evitar una catástrofe mundial.

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