

HIGH-INCOME COUNTRIES

AIDS mortality continues to drop, thanks to the widespread availability of antiretroviral treatment.

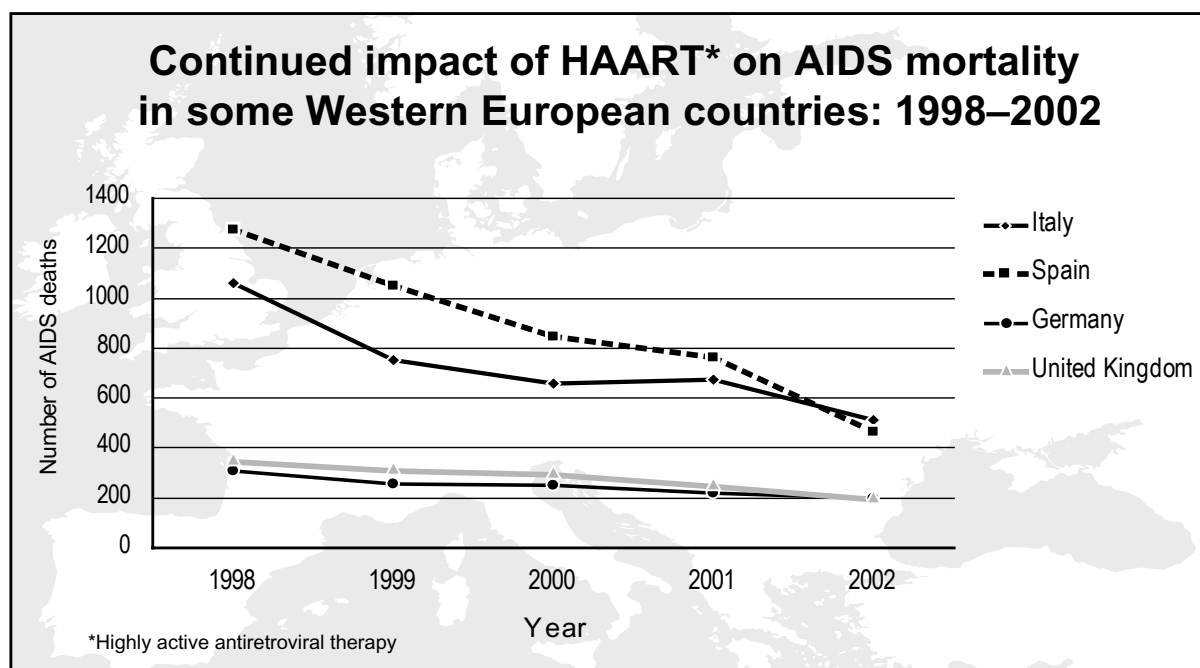
The total number of people living with HIV continues to rise in high-income countries, largely due to widespread access to antiretroviral treatment. It is estimated that 1.6 million people are living with HIV in these countries—a figure that includes the 80,000 who were newly infected in 2003. AIDS claimed approximately 18,000 lives in the past year. As Figure 10 illustrates, the number of annual AIDS deaths has continued to slow in high-income countries, including those in Western Europe, due to the widespread availability of antiretroviral treatment.

There is mounting evidence that prevention activities in several high-income countries are not keeping pace with the changes occurring

in the spread of HIV. Such shortcomings are most evident where HIV is lodged also among marginalized sections of populations, including immigrants and refugees.

In the United States of America, around half of the approximately 40,000 new infections annually are occurring among African-Americans (12% of the country's population), with African-American women accounting for an increasing proportion of new infections. (Overall, an estimated one-third of new infections is occurring through heterosexual contact.) Many of the women do not engage in high-risk behaviour, but are contracting HIV through unsafe sex with their male partners—a significant share of whom also have sex with men

Figure 10



Source: HIV/AIDS surveillance in Europe (2002). End-of-year report. Data compiled by the European Centre for the Epidemiological Monitoring of AIDS.

or inject drugs. Analysing data from 11 States, a recent US Centers for Disease Control and Prevention study found that 34% of HIV-positive African-American men said they had sex with both women and men. However, only a small proportion of HIV-positive African-American women reported knowing that their partners also had sex with men. The secrecy surrounding such overlapping risk behaviour seems rooted mainly in the stigma that remains attached to homosexuality. The costs are steep: AIDS is now the leading cause of death for African-American women aged 25–34. According to the Centres for Disease Control, some 90% of young urban HIV-positive African-American men who have sex with other men are unaware of their seropositive status. Overall, it is estimated that fully one-quarter of the 850,000–950,000 people living with HIV/AIDS in the USA are unaware that they are HIV-positive.

Sex between men remains an important aspect of the epidemic in most high-income countries. In Germany, Greece and the Netherlands, it is the most common mode of HIV transmission, while in the United States of America (in 2002) and in Australia (in 2001) it accounted for 42% and 86% of new HIV diagnoses, respectively. Yet, the resurgence of other sexually transmitted infections in Australia, Japan, Western Europe and the United States of America points to a revival of high-risk sexual behaviour—especially among

for example. In England and Wales, diagnoses of gonorrhoea at sexually transmitted infection clinics rose by 102% in 1995–2000, with the steepest increases occurring among older teenagers (aged 16–19), while Australia has reported its highest incidence rates for gonorrhoea among adults aged 15–39 since 1997. Reported gonorrhoea cases have increased also in the Netherlands, Sweden and Switzerland. This would seem to indicate that current prevention activities are registering poorly among the younger generation.

Japan is seeing a steady increase in the number of reported HIV infections. The number of new HIV cases reported annually has doubled since the 1990s to more than 600 in 2001 and 2002. This rise has been accompanied by an increase in other sexually transmitted infections over the same period, with the rate of Chlamydia rising by over 50% among women since 1995. There is also evidence of more widespread sexual activity among Japanese youth (reflected in the increase in the percentage of young people who have had sex by the time they turn 19 years of age).

In Western European countries that report HIV cases, heterosexual intercourse may now be the most common mode of HIV transmission. However, a large share of the increase in new HIV infections reported there in 2002 has been attributed to the significant number of persons believed to have been infected elsewhere, in a

Continuing a trend of recent years, there is more evidence of increasing rates of other sexually transmitted infections—perhaps presaging new increases in HIV incidence.

young people, including men who have sex with men. The prevention programmes that had achieved notable success in limiting HIV transmission in the 1990s, especially among men who have sex with men, appear to have been shifted to the back burner in many high-income countries.

France, Ireland, the Netherlands and the United Kingdom have reported outbreaks of syphilis in men who have sex with men, with new syphilis cases reported among men who have sex with men in the Netherlands increasing by 182% in 2002,

country with high HIV prevalence. Most of those cases have been recorded in the United Kingdom (where the number of HIV diagnoses reported in 2002 was double that in 1998) and in Germany (where new HIV diagnoses last year rose for the first time since 1997). In the United Kingdom, 70% of heterosexually-transmitted HIV cases were among people who had acquired HIV while living in countries with generalized epidemics. HIV infections apparently acquired elsewhere in the world also accounted for a significant share of new diagnoses in the Netherlands, Norway and

Sweden. It is vital that prevention, treatment and care programmes be adapted to reach all persons affected by HIV/AIDS, particularly those whose language, culture or immigrant status might limit their access to services.

The role of injecting drug use in the HIV epidemic varies among the high-income countries. In the United States of America and Canada, about 25% of newly acquired HIV infections have been attributed to injecting drug use, whereas, in Australia, injecting drug use accounts for less than 10% of new HIV diagnoses. In Europe,

just over 10% of newly diagnosed HIV cases in 2002 were caused by injecting drug use, although, in Portugal, this mode of transmission caused almost half the total HIV infections in 2002. (However, the country is seeing a significant increase in sexually transmitted HIV infections, both heterosexual and between men.) These patterns underscore the need for prevention (and treatment) programmes that reach injecting drug users—including those in prisons and those who belong to marginalized minorities. In Canada, for example, aboriginal persons are overrepresented among injecting drug users.

DEFUSING STIGMA AND DISCRIMINATION

Stigma and discrimination both stymie efforts to control the global epidemic and create an ideal climate for further growth. Together, they constitute one of the greatest barriers to preventing further infections, providing adequate care, support and treatment, and alleviating the epidemic's impact.

Stigma and discrimination undermine prevention by making people afraid to find out whether or not they are infected, and discourage people from adopting preventive measures—such as insisting on condom use during sex—that might be interpreted as an acknowledgement that they are HIV-infected.

Stigma and discrimination also create a false sense of security that undermines prevention efforts. Often stigma and discrimination build on existing prejudices and patterns of social exclusion. By associating HIV/AIDS with groups of persons perceived as 'outsiders', people harbour the illusion that they themselves are not at risk of becoming infected. As a result, they may help to perpetuate risky behaviour (such as unsafe sex) because they believe that behaving differently would raise suspicion about their HIV status.

Fear of discrimination is preventing people from seeking treatment for AIDS. People can be deterred from using voluntary counselling and testing services, a linchpin in prevention, treat-

ment and care programmes. Those living with HIV can therefore be left isolated, and deprived of the care and support that could lessen the epidemic's impact.

Even when seeking care and support, people infected with HIV can experience the harsh repercussions of stigma and discrimination. Those seeking care or counselling may be rejected by the very services that should help them, as recent studies illustrate.

A survey conducted in 2002 among some 1,000 physicians, nurses and midwives in four Nigerian states, for example, returned disturbing findings. One in 10 doctors and nurses admitted having refused to care for an HIV/AIDS patient, or had denied HIV/AIDS patients admission to a hospital. Almost 40% thought a person's appearance betrayed his or her HIV-positive status, and 20% felt that people living with HIV/AIDS had behaved immorally and deserved their fate. A lack of knowledge about the virus (often flanked by denigrating attitudes towards people living with HIV) seemed to be one factor fuelling the discrimination. Another was the fear among doctors and nurses about exposure to possible infection as a result of lack of protective equipment. Also at play, it appears, was the frustration at not having medicines for treating HIV/AIDS patients, who therefore were seen as 'doomed' to die. Studies in

Out in the cold

My foster son, Michael, aged 8, was born HIV-positive and diagnosed with AIDS at the age of 8 months. I took him into our family home, in a small village in the south-west of England. At first, relations with the local school were wonderful and Michael thrived there. Only the head teacher and Michael's personal class assistant knew of his illness. Then someone broke confidentiality and told a parent that Michael had AIDS. That parent, of course, told all the others. This caused such panic and hostility that we were forced to move out of the area. The risk is to Michael and us, his family. Mob rule is dangerous. Ignorance about HIV means that people are frightened. And frightened people do not behave rationally. We could well be driven out of our home yet again.

'Debbie' speaking to the National AIDS Trust, UK, 2002

What fuels stigma and discrimination?

Stigma devalues and discredits people, generating shame and insecurity. In the context of AIDS, it can fuel the urge to scapegoat, blame and punish certain people (or groups) in order to detract from the fact that everyone is at risk. Stigma taps into existing prejudices and patterns of exclusion and further marginalizes people who might already be more vulnerable to HIV/AIDS. It stems from the association of HIV/AIDS with sex, disease and death, and with behaviours that may be illegal, forbidden or taboo, such as pre- and extramarital sex, sex work, sex between men, and injecting drug use.

Stigma is harmful, both in itself (since it can lead to feelings of shame, guilt and isolation of people living with HIV), and because it prompts people to act in ways that directly harm others and deny them services or entitlements—actions that take the form of HIV-related discrimination. Such unjust treatment can be tantamount to a violation of human rights.

other regions show that such attitudes and actions are commonplace. In the Philippines, a recent survey among persons living with HIV/AIDS found that almost 50% of respondents had experienced discrimination at the hands of health-care workers, while, in Thailand, 11% of respondents said they had been denied medicine because of their seropositive status, and 9% had experienced delays in treatment. Some 70% of people living with HIV/AIDS in India said they had faced discrimination, most commonly within families and in health-care settings, according to recent International Labour Organization (ILO) research. Such experiences have prompted efforts to promote the greater involvement of people living with HIV/AIDS in India—where several NGOs and networks of HIV-positive people are working to reduce discrimination in local hospitals.

Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status. When surveyed recently, 29% of persons living with HIV/AIDS in India, 38% in Indonesia, and over 40% in Thailand said their HIV-positive status had been revealed to someone else without their consent. In many cases, test results were shared with persons other than the spouse or family members; one in nine respondents in a Thai survey said their status had been disclosed to government officials. These kinds of violations of the right to privacy undermine HIV/AIDS programmes by deterring people from finding out their serostatus and thus threaten public health as individuals unknowingly transmit HIV to others.

Given the close links between HIV/AIDS-related stigma, discrimination and human rights

Learning the hard way

The depth of stigma and discrimination should not be underestimated. In Kerala, India, two orphaned children were banished from their school in 2003, and then refused admission to other schools. The reason? They were HIV-positive. In response, they and their grandfather, in Gandhian tradition, staged a hunger strike in front of the Chief Minister's office, insisting on their right to education. The Chief Minister relented and ordered that a state school admit them. However, following a parent-teacher association meeting, the school's students then replied with a boycott of their own, protesting that decision. Bowing to pressure, the government then ordered that the children be schooled at home, effectively barring them from social interaction with other children.

The President of India, the Indian Health Minister, local AIDS authorities and AIDS activists have been appealing to, and working with, the community to dispel the fears and misconceptions that reign in this populous country. Yet, by the end of 2003, almost six months after the debacle began, the children were still forced to receive school lessons and write exams at home. Despite appeals from high-ranking officials, the community has held firm and kept the two orphans at bay.

violations, multiple interventions are needed. Action must be taken both to prevent stigma and to challenge discrimination when it occurs, as well as to monitor and redress human rights violations. Clearly, everyone—from political and social leaders to community members and entertainers—has a role to play in fighting stigma and discrimination.

More and more initiatives are now successfully tackling the denial, ignorance and fear that fuel the cycle of stigma, discrimination and human rights abuses. Some of the most powerful efforts to curb HIV/AIDS-related stigma and discrimination are driven by the involvement of people living with, or affected by, HIV/AIDS. Around the world, they have built organizations, campaigns and even mass movements that mobilize action against the epidemic and that pressure their countries' leaders to tackle the epidemic with resolve. Examples abound—from programmes for leadership training in Zambia, to media and advocacy activities in newspapers and TV programmes, organized by the Belarus 'Positive Movement'. The community-centred approach taken in Zambia, for example, prompted chiefs

Egypt's HIV/AIDS hotline is helping pierce the secrecy and ignorance that surround sexuality and HIV/AIDS. The project offers accurate information on HIV/AIDS and provides anonymous counselling. Staff handle some 5,000 calls a year, two-thirds of them from people aged 18–35, and 20% of them from women. Calls come in from all of Egypt, and even from other Arabic-speaking countries. It helps to get the message out early, too. Kami, an HIV-positive Muppet, features in the South African TV programme *Talkalani Sesame*, in which she broaches HIV/AIDS issues with her friends. The aim is to expose the audience—mainly young children aged 3–6—to AIDS-related stigma and discrimination, and to the ways in which people can challenge or cope with it.

While some companies still prefer to shift the HIV/AIDS burden elsewhere—by demanding pre-employment HIV screening, reducing or removing medical benefits for HIV-positive workers or even firing them—an increasing number of businesses are now implementing workplace prevention and care programmes. Some, such as Volkswagen in Brazil, provide workers with

Who cares?

Greater access to effective care, prevention and treatment is vital to breaking the cycle of stigma, discrimination and human rights abuses.

Where treatment is unavailable, there may be little incentive for individuals to discover their HIV status—all the more so if the likely outcome is rejection and discrimination if they are found to be HIV-positive. Increased access to treatment is one of the most powerful incentives for individuals to learn their HIV status. And the prospect of a longer, more productive life for individuals encourages communities to reassess the way they relate to people living with HIV, creating a sense of hope and reducing the anxieties that can trigger stigma.

The World Health Organization (WHO) and UNAIDS are spearheading a bold initiative to roll out antiretroviral treatment to 3 million people, in areas of most need, by the end of 2005. In addition, a growing number of countries are setting up national comprehensive prevention and care programmes. These initiatives can help lift the pall of suspicion and secrecy that accompanies the epidemic.

in the district of Lundazi to lead by example and take an HIV test, successfully mobilizing community members into following their lead. And they went further, decreeing against widow inheritances and other practices that discriminate against women and girls, leaving them more vulnerable to infection.

antiretroviral and other AIDS-related treatment. The company's AIDS Care programme, which has been running for several years, includes prevention education, provision of free condoms, counselling and support, as well as access to antiretroviral therapy and clinical tests to monitor treatment. Adopted, too, have been anti-discrimi-

Living up to promises

As part of their Declaration of Commitment on HIV/AIDS, drawn up at the United Nations General Assembly Special Session on HIV/AIDS in June 2001, Member States agreed to:

... by 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic (paragraph 58).

nation measures that include guaranteeing the right to confidentiality for workers living with HIV/AIDS, and prohibiting mandatory testing and firing of workers with HIV. Within a few years, the company was reporting a steep drop in hospitalizations and a considerable reduction in treatment and care costs. Such workplace programmes can successfully challenge HIV-related stigma and discrimination.

Meanwhile, the Philippines' HIV/AIDS Control and Prevention Act remains an example of how legislation with strong provisions for protecting people living with HIV/AIDS can serve as a useful instrument for combating HIV-related discrimination. Such legislative and supportive policy environments can help empower communities to tackle stigma, discrimination and human rights violations more effectively.

HIV/AIDS-related stigma and discrimination will only be reduced if it is challenged simultaneously on several fronts:

- inside communities, where media-based efforts can be directed at public opinion to improve the environment of people living with HIV/AIDS;
- in settings such as workplaces, hospitals and clinics, places of worship and education establishments, where equitable policies and educational programmes can counter stigma, discrimination and human rights violations; and
- in the courts, where people can invoke legal rights and duties in order to promote and protect the human rights of people living with HIV/AIDS.

Pitting the law against stigma and discrimination

The law can be a powerful tool against stigma and discrimination. For example, Venezuela's *Acción Ciudadana Contra el Sida* (Citizens' Action against AIDS), has, since the late 1980s, been fighting human rights violations against persons living with HIV/AIDS. It provides free legal advice, acts in cases and handles legal appeals regarding discrimination in employment, medical practice, and social services. The organization has helped extend the scope of a treatment-and-care programme set up within the country's social security system, and it was instrumental in obtaining antiretroviral and other treatment, confidential care and pensions for four military claimants in a landmark case against the Ministry of Defence. The latter ruling set a precedent for the rights to work, privacy, non-discrimination, dignity and 'psychological and economic attention', as well as health care for all military personnel. In July 1999, the Supreme Court ordered the Ministry of Health to provide antiretroviral therapy, treatment for opportunistic infections and diagnostic testing free of charge to all Venezuelan residents living with HIV/AIDS.

MAPS

Global estimates for adults and children, end 2003

Adults and children estimated to be living with HIV/AIDS, end 2003

Estimated number of adults and children newly infected with HIV during 2003

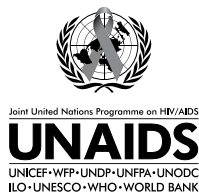
Estimated adult and child deaths due to HIV/AIDS during 2003

GLOBAL ESTIMATES FOR ADULTS AND CHILDREN, END 2003



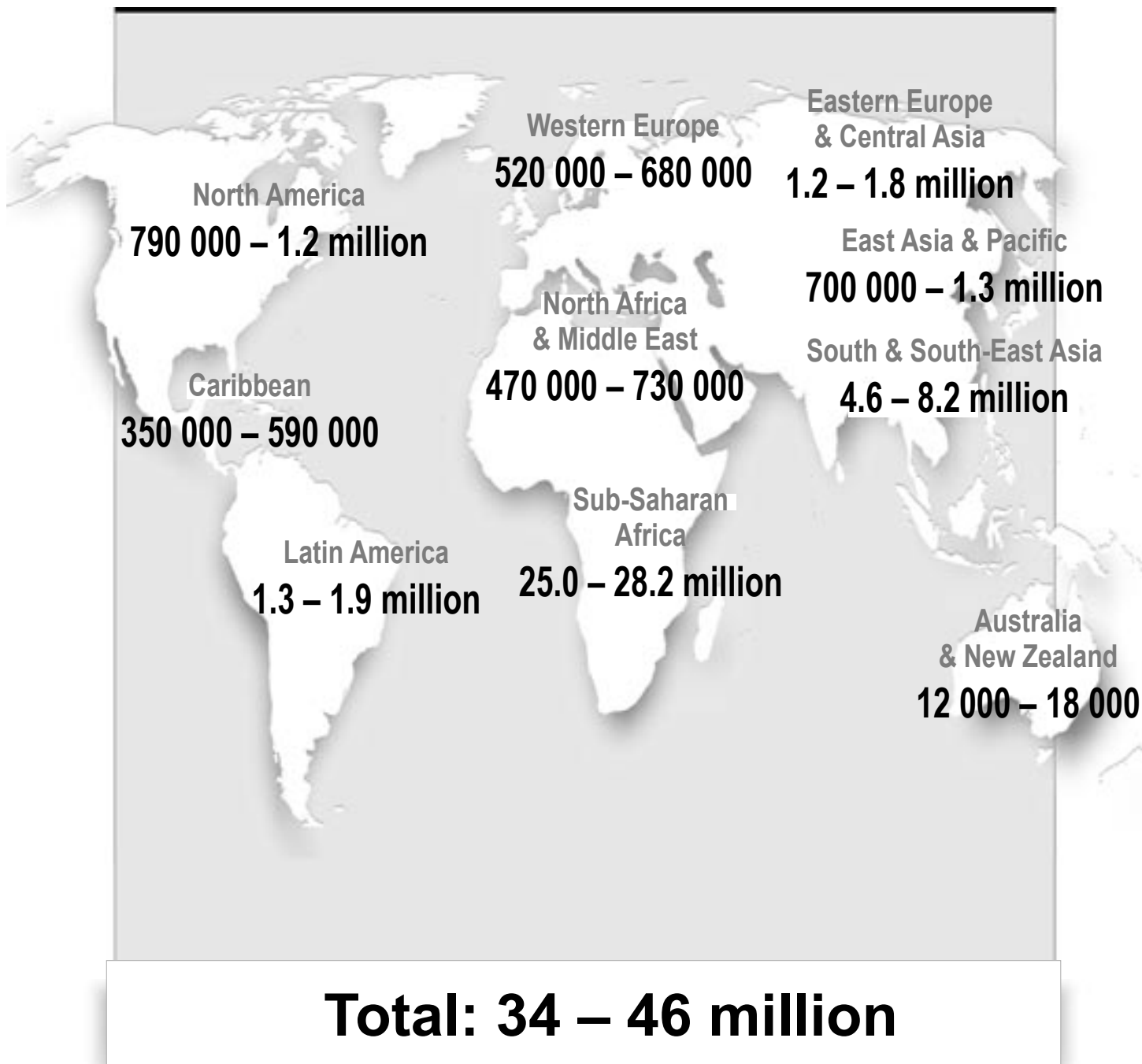
People living with HIV/AIDS	40 million (34 – 46 million)
New HIV infections in 2003	5 million (4.2 – 5.8 million)
Deaths due to HIV/AIDS in 2003	3 million (2.5 – 3.5 million)

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. These ranges are more precise than those of previous years, and work is under way to increase even further the precision of the estimates that will be published mid-2004.



AIDS epidemic update: December 2003

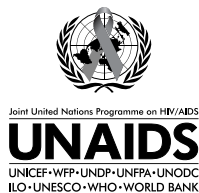
ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV/AIDS, END 2003



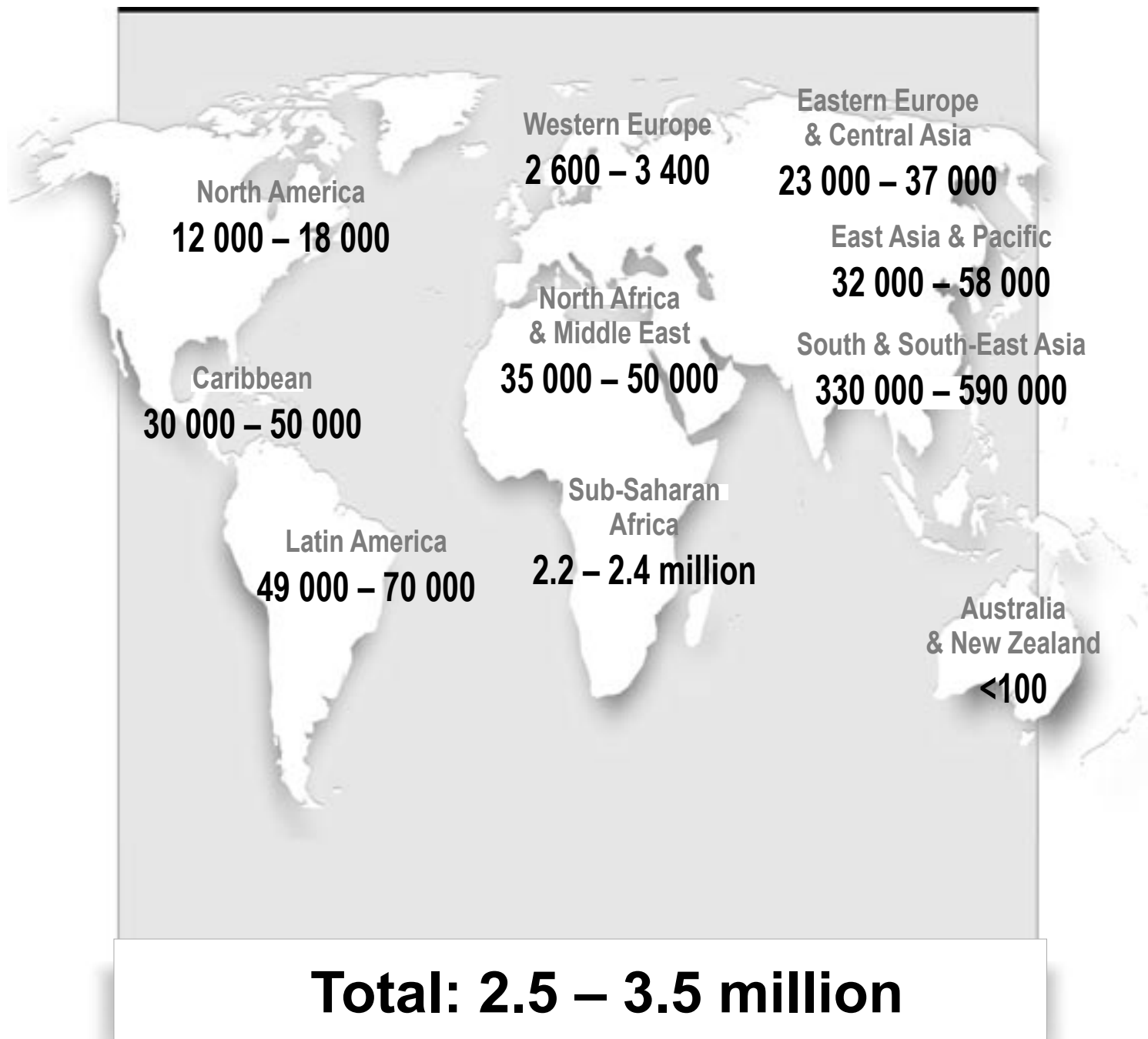
ESTIMATED NUMBER OF ADULTS AND CHILDREN NEWLY INFECTED WITH HIV DURING 2003



Total: 4.2 – 5.8 million



ESTIMATED ADULT AND CHILD DEATHS DUE TO HIV/AIDS DURING 2003



NOTES

NOTES

Explanatory note about UNAIDS/WHO estimates

The UNAIDS/WHO estimates in this document are based on the most recent available data on the spread of HIV in countries around the world. They are provisional. UNAIDS and WHO, together with experts from national AIDS programmes and research institutions, regularly review and update the estimates as improved knowledge about the epidemic becomes available, while also drawing on advances made in the methods for deriving estimates. Because of these and future advances, the current estimates cannot be compared directly with estimates from previous years, nor with those that may be published subsequently.

The estimates and data provided in the graphs and tables are given in rounded numbers. However, unrounded numbers were used in the calculation of rates and regional totals, so there may be small discrepancies between the global totals and the sum of the regional figures.

UNAIDS and WHO will continue to work with countries, partner organizations and experts to improve data collection. These efforts will ensure that the best possible estimates are available to assist governments, nongovernmental organizations and others in gauging the status of the epidemic and monitoring the effectiveness of their considerable prevention and care efforts.

The annual *AIDS epidemic update* reports on the latest developments in the global HIV/AIDS epidemic. With maps and regional summaries, the 2003 edition provides the most recent estimates of the epidemic's scope and human toll, explores new trends in the epidemic's evolution, and features a special section examining stigma and discrimination.

These are some of the most painful symptoms of HIV/AIDS.

**I'm not
allowed to
talk to you**

You disgust me

I trusted you

**You brought shame
on our family**

You deserve it

**How could
you do this
to me?**

**Help us fight fear,
shame, ignorance
and injustice worldwide.**

Live and let live.