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HIV/AIDS

background information for
 international cooperation

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute respiratory tract infection
ART	Antiretroviral Therapy
CABA	Children affected by AIDS
CSW	Commercial sex workers
HAART	Highly Active Antiretroviral Treatment
IDUs	Injecting drug users
IMF	International Monetary Fund
MDG	Millennium development goals
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
PEP	Post Exposure Prophylaxis
PLWHA	People living with HIV or AIDS
SDC	Swiss Agency for Development and Co-operation
STI	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and testing
WHO	The World Health Organisation

Introduction

“He was not comfortable with my presence, sickly looking as I was in those days. In 1992 I lost my teaching job - I had decided to go public about my HIV positive status. After my first radio program declared my sero-status publicly, I was dismissed.” David Sekirevu Mukasa, Uganda, coordinates activities of people living with HIV or AIDS.¹

To be able to really understand HIV/AIDS and its impact on people's lives and the communities they live in, interacting with a person living with HIV or AIDS or those affected by it would be the best introduction. This information brief intends to give some additional background information, which may help the reader to better understand the epidemic and the context in which it develops.

40.3 million people are currently estimated to be HIV-infected.

Virtually unknown 20 years ago, HIV has until now infected more than 60 million people worldwide, 40.3 million people are currently estimated to be HIV-infected. UNAIDS and WHO estimate that, without dramatic increases in HIV-prevention efforts, some 45 million new infections will occur worldwide by 2010. AIDS is now the fourth-biggest killer globally. It has killed more than 25 million people since it was first recognized in 1981 and every day there are 8,400 HIV/AIDS related deaths. The HIV epidemic has cut life expectancy by more than 10 years in several of the most affected nations. In 2005, 5 million people were newly infected with HIV and 3 million people died. Every day, there are about 14,000 new HIV infections worldwide. Of these:

HIV/AIDS is a major threat to development and affects all sectors.

- More than 95% occur in developing countries
- Almost 2,000 are among children under 15
- Almost half occur among women
- More than half are among young people aged 15 to 24

Over the past ten years, the impact of HIV/AIDS has become a devastating obstacle to development. The HIV/AIDS epidemic is today considered a major threat to development and economic growth in affected countries and its impact is felt across all sectors – health, education, agriculture, infrastructure, the corporate sector and many others.

In the most affected regions, the impact is undermining the economic, social and political gains of the last half-century.

HIV/AIDS is a major challenge for international cooperation, as it risks eroding decades of progress in development. Six of eight key areas covered by the Millennium Development Goals – reducing poverty and child mortality, increased access to education, gender equality, improved maternal health and efforts to combat major infectious diseases – are being undermined by high rates of HIV in many low- and middle-income countries.

Particularly in least income countries, the epidemic dramatically impacts on the young and productive generation. HIV/AIDS can decimate the workforce, create large numbers of orphans, exacerbate poverty and inequality and put pressure on health systems. Basic care and treatment of an infected person for a year, even without ART, can cost as much as 2-3 times per capita GDP in the poorest countries. In the most affected regions, the impact is undermining the economic, social and political gains of the last half-century. At the same time poverty, gender inequality, social and political complacency are fuelling the epidemic.

¹ Global Network of People living with HIV/AIDS, <http://www.gnpplus.net/cms/index.php>

Taking into consideration the global extent and the impact of the epidemic on developing and countries in transition, it is crucial for professionals working in the field of international cooperation to have basic knowledge and understanding of HIV/AIDS and related issues. All development experts, from a wide range of sectors, are asked to contribute to fighting the epidemic. Using a “multisectoral approach” within HIV strategies is essential to addressing the wide range of vulnerability factors that fuel risky behaviours as well as the spiral of poverty and illness caused by HIV/AIDS.

Chapter 1: What is HIV/AIDS?

HIV stands for human immunodeficiency virus, the virus that causes AIDS.

HIV stands for human immunodeficiency virus, the virus that causes AIDS. HIV destroys certain blood cells that are crucial to the normal function of the immune system, which normally defends the body against illness. Loss of these cells in people with HIV is a clear predictor of the development of AIDS.

AIDS stands for “Acquired Immunology Deficiency Syndrome”. It occurs when the immune system is weakened by HIV to the point where a person develops a number of diseases, including cancers.

HIV is transmitted via:

- **Sexual transmission** is accounting for 75-85% of HIV infections in adults worldwide.
- **Bloodborne transmission** nowadays accounts for only a small percentage of HIV infections worldwide, due to the introduction of routine screening procedures of blood in many countries. Unsafe medical practise, reuse of needles and medical equipment without sterilisation can spread HIV infection.
- **Injecting drug use**, as the sharing of injection equipment is a highly efficient route of HIV transmission.
- **Mother-to-child** transmission means that an infected mother may infect her child during pregnancy, delivery or breastfeeding.

Heterosexual transmission accounts for more than 70% of all HIV infections worldwide. Certain behaviours that lead to a higher risk of contracting and spreading HIV are common amongst commercial sex workers (CSWs) and their clients, injecting drug users (IDUs), men who have sex with men (MSM), and highly mobile workers. In many cases HIV/AIDS is initially concentrated in groups who engage in high-risk behaviour (concentrated epidemic), and then spills over into the wider population (generalised epidemic).

Exposure	Approximate risk
Vaginal intercourse	0.1%
Anal intercourse	1.0%
Needle-stick injuries	0.3%
Needle-sharing among intravenous drug users	1.0%
Mother-to-child	20-40%
Blood transfusion	100%

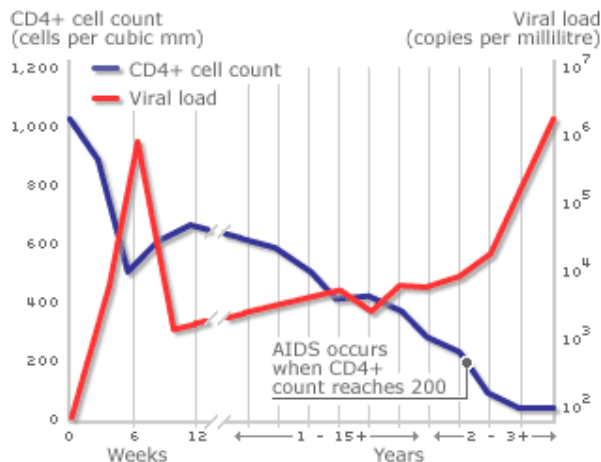
Table 1: Approximate risk of acquiring HIV in an unprotected contact (After Royce et al, N Engl J Med 1997; 337:799).

As HIV does not survive well outside the body, it cannot be transmitted through casual, everyday contact. Mosquitoes and other insects do not transmit HIV.

The HIV virus can be detected by a laboratory test, from about 4 to 12 weeks after infection, when antibodies (the natural defence reaction of the immune system) will be developed. The time between infection and the presence of detectable levels of antibodies is called the "diagnostic window". HIV is most commonly detected through the test in a blood sample (newer methods also use oral fluid). Rapid tests for HIV can show results within minutes. However, the accuracy of rapid tests needs to be demonstrated in the particular community in which they will be introduced. Rapid tests can be especially useful in settings where follow-up is difficult because clients live far away and may not return for results. Any test for HIV should be considered an invasive test, the results of which may have far-reaching implications for the client. It implies that tests need to be done on a voluntary basis and include pre- and post test counselling.

HIV infection can be detected from about 4 weeks after exposure until 12 weeks at the latest.

The graph below shows a typical progression after infection. At first, the immune system (the CD4 cells are white blood cells that are part of the defence system) usually manages to keep the multiplication of the virus down, resulting in a reduced "viral load" (count of viruses in the blood test). Over time, the virus manages to damage the immune system (CD 4 cells drop, virus can multiply) up to the point that the AIDS occurs.



Without treatment, the average interval from HIV infection to development of severe immunodeficiency is about 8 years.

As shown in the graph, an infected person can remain without any symptoms or with very general symptoms similar to those of a flue (as prolonged lymph node swelling, night sweats or continued diarrhoea) for several years. In the absence of treatment, the average interval from HIV infection to development of severe immunodeficiency is about 8 years, but this varies greatly between individuals. Once the immune deficiency causes severe illnesses, we speak of AIDS. At this stage so-called opportunistic diseases can occur. These are illnesses caused by organisms that do not usually cause disease in persons with normal immune systems. They include pneumonia (Pneumocystis Carinii), fungal and viral infections (e.g. Candida fungus, or Herpes-virus), malignant tumours (e.g. Kaposi sarcoma) and lung tuberculosis which is one of the leading causes of death for people living with HIV/AIDS. In developing countries AIDS often breaks out earlier due to malnutrition and additional other illnesses. In the absence of treatment the average sur-

vival of patients with AIDS is 2-4 years in most developed countries and six months or less in developing countries, due to lack of treatment for concurrent opportunistic infections.

HIV can still be transmitted when a person is receiving highly active antiretroviral therapy and/ or has an undetectable virus load. Therefore preventive measures need to be continued also when a patient is under antiretroviral treatment.

Chapter 2: The global epidemic

Sub-Saharan Africa is the worst affected region in the world. Six southern African countries have a prevalence above 20%.

An increasing proportion of **women** are being affected by the epidemic. In 2005, 17.5 million women were living with HIV worldwide —one million more than in 2003. Thirteen and a half million of those women live in Sub-Saharan Africa.

AIDS is today the leading cause of death in **Sub-Saharan Africa**. With about 70% of the total global burden, Sub-Saharan Africa is the worst affected region in the world. The predominant mode of transmission is heterosexual. 12 African countries have a prevalence above 10%. In six southern African countries (Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe) HIV infection levels among pregnant women are 20% or higher. There are great regional variations. Botswana has the highest HIV prevalence, with 38.8% in the general population and higher rates among risk groups and within urban areas. An infection rate at that level implies that without adequate treatment the epidemic would cause death of about one third of the country's population in the coming decade.

HIV/AIDS is a leading cause of death in a number of countries in the Caribbean Basin.

The second most affected region after Sub-Saharan Africa is the **Caribbean**. HIV/AIDS is a leading cause of death in a number of countries in the Caribbean Basin. Of the seven countries three have national HIV prevalence levels of at least 3% (Bahamas, Haiti, and Trinidad and Tobago). The predominant mode of transmission is heterosexual, but intravenous drug use and sex between men are also important routes of transmission.

Eastern Europe and Central Asia have the fastest growing HIV epidemic in the world.

Eastern Europe and Central Asia is currently experiencing the fastest growing HIV epidemic in the world. The most common route of transmission is still among population groups with high risk behaviours such as intravenous drug users and commercial sex workers, but in some countries the epidemic has started to spread from high risk groups to the general population ("bridging effect").

HIV epidemics are emerging rapidly throughout **Asia**, where the predominant mode of transmission is heterosexual. India and China, the world's most populous countries, are experiencing rapid growth of HIV in certain subpopulations and geographic areas. Although national rates of infection in these countries are relatively low, due to the size of their populations, even small increases in infection rates translate into large numbers of people infected with HIV.

In **high income countries** overall infection rates are relatively low. Nevertheless, in Switzerland, where today an estimated 20'000 people are living with HIV, as well as in many other European countries, numbers of new infections have started to increase again. Main reasons are

In high income countries, the “normalisation” of the epidemic poses new challenges.

increased unprotected sex (particularly amongst men having sex with men) and migration from high prevalence countries. One reason for the increased individual risk behaviour is that HIV has become less of a deadly threat due to the availability of anti retroviral treatment (ART). This trend is called “normalisation” and brings new challenges to HIV prevention.

A trend towards growing infection rates is also evident in the **Middle East and North Africa**, underlining the notion that no region in the world has sidestepped the epidemic. As other regions with still relatively low infection rates, it is particularly affected by denial and stigma.

Some countries have proved success of prompt, vigorous and large-scale interventions.

There are success stories in the fight against HIV/AIDS on a national scale among developing countries. Thanks to prompt, vigorous and large-scale implementation of effective intervention programmes, which are enabled by favourable policy environments, strong political leadership and popular support, countries such as Thailand, Uganda and Brazil have been able to control the spread of HIV/AIDS. Thailand, for example, has reduced annual new HIV infections from 140,000 a decade ago to 30,000 in 2001. Worryingly, and similar to the trend in Europe, newest reports speak about increasing infection rates in Thailand.

Chapter 3: HIV prevention

Integrated prevention is a cornerstone of any HIV strategy. It is most effective as part of a comprehensive strategy involving care, treatment, and support. The tools to prevent HIV infection exist, are highly cost-effective and have proven to be effective. The cost of averting an HIV infection is a fraction of the cost needed for treating and care of an AIDS patient. A core set of preventive interventions includes:

- **Promoting behaviour change** through communication programs, peer education, and voluntary counselling and testing (VCT).
- **Increasing condom use** through condom promotion and distribution (male and female condoms).
- Diagnosing and treating **sexually transmitted infections** (STI).
- Ensuring a **safe blood supply**.
- **Preventing mother-to-child transmission** (MTCT) through ARV and providing infant feeding options.
- **Supporting harm reduction** among injecting drug users (IDUs), which includes providing clean injecting equipment, counselling, substitution programs and drug dependency treatment.

Prevention programmes should include targeted interventions, be gender sensitive and address stigma.

Evidence strongly suggests that one of the most efficient methods to reduce the spread of HIV (or any STI) in the general population is to reduce its transmission among **groups with high risk behaviour** (such as IDUs or CSWs). This targeted prevention is more effective when combined with programs to change social norms and reduce stigma. All interventions should be based on a Human Rights approach and be gender and culture sensitive.

Four microbicide candidates are currently tested.

There is now a scientific consensus that an AIDS vaccine is possible.

New prevention approaches that give more control to women and girls are urgently needed. **Microbicides**² offer the best promise of a prevention tool women can control. Four microbicide candidates are now being tested in large-scale clinical trials. They include soaps, acid buffering agents, seaweed derivatives and anti-HIV compounds. There is now a scientific consensus that an **AIDS vaccine** is possible. The number of AIDS vaccine candidates in small-scale human trials has doubled since 2000 and the number of countries and agencies involved has significantly grown. Developing countries, which in 2000 participated only marginally in vaccine research and development, are now helping lead the field. Nevertheless efforts fall still short of the estimated need and global spending on an AIDS vaccine is less than 1% of global spending on all health product research development of a vaccine is likely to take several more years. In addition, typically new vaccines take up to 20 years to reach developing countries after their introduction in industrialized countries.

Health personnel that have been exposed to a potential HIV contamination during a needle stick accident, as well as victims of rape, **should be given access to Post Exposure Prophylaxis (PEP) within 72 hours**. Due to its potentially serious drug side effects its application is controversial in cases where persons have exposed themselves to risk during unprotected sex.

Research results suggest that **male circumcision** reduces the risk of acquiring HIV by 61 per cent. Currently, results are awaited of similar ongoing studies. If they confirm the findings, it will need to be decided whether male circumcision should in the future be developed into a recommended prevention strategy.

Despite its proven effectiveness, access to HIV prevention falls far short from the needs.

Despite the proven effectiveness of HIV prevention and an increased international attention to HIV, efforts still fall short of what is needed and much remains to be done to reach the United Nations Millennium Development Goal of halting and beginning to reverse the spread of HIV by 2015. It is estimated that adequate prevention could avert until the year 2010 up to 29 million of the world wide expected 45 million new infections. Still, only 42% of all people at risk of sexual exposure to HIV are able to obtain a condom. Only 12% of people worldwide who want to be tested for HIV are able to access voluntary counselling and testing services. This is why UNAIDS has recently led an initiative to intensify global prevention efforts and developed a position paper which emphasizes these opportunities³.

Levels of awareness and knowledge about HIV/AIDS still vary widely around the world. According to recent surveys from over 40 countries, more than half of young people most at risk have serious misconceptions about how the virus is transmitted. Many people in all parts of the world have not yet accepted that the risk of contracting HIV applies to them and stigmatisation can be extreme. For instance, more than 90% of adolescents in Haiti believe they have a tiny or non-existent risk of contracting it, while the nation actually has one of the highest preva-

² Microbicide: an agent that destroys microbes. Microbicides, applied to the vaginal/cervical surface, should act as chemical barriers to prevent the spread of sexually transmitted diseases. Several compounds are under investigation to block HIV infection.

³ UNAIDS Position Paper <http://www.unaids.org/en/default.asp>

lence rates outside Sub-Saharan Africa. Nearly 20% of respondents in a survey in the US believed that people who acquired HIV through sex or drug use had got what they deserved. According to UNAIDS, stigmatisation and denial are the “greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating impact”.

Despite huge unmet needs, many successful prevention efforts are under way. As good practice examples some prevention initiatives using mass media are outlined below.

The popular South African soap opera *Soul City* has brought about social policy change at a national level. The series primarily deals with HIV/AIDS but touches on other related issues such as domestic violence. Through its advocacy pressure the series has even contributed to the implementation of the Domestic Violence Act in 1999.

The weekly television soap “AIDS in the City”, produced in Côte d’Ivoire and shown across French West Africa, has shown how the promotion of condoms can be linked directly to their subsequent availability. The series revolves around the life of a family affected by HIV/AIDS and is the key part of a condom social marketing campaign.

To raise awareness on HIV/AIDS and other social and public issues, the “BBC Afghan Education Project (BBC AEP)”, a radio program supported by SDC, combines information with entertainment. It disseminates educational features, drama and soap opera reaching about half of the population.

Chapter 4: Progress in treatment and care

A comprehensive approach includes both treatment and care with psycho-social support.

There is still no cure to an HIV infection. Antiretroviral therapy can, however, make a great difference to those who have access. However, access to drugs is not the only element needed. A comprehensive treatment and care approach includes voluntary counselling and testing, psycho-social support, palliative care, prevention and treatment of opportunistic infections, good nutrition, strengthening of health systems, fair and sustainable financing, and, where possible, access to Highly Active Antiretroviral Treatment (HAART). ARV stands for antiretroviral drugs and refers to a type of drug that slows down the reproduction of HIV. HAART is a modality of antiretroviral treatment that involves the use of three or more ARVs. It strengthens the immune system and thus helps to prevent opportunistic infections. HIV drug treatment is complex and adverse events can take many forms. National treatment options should be followed and close adherence to prescribed therapy is essential, since drug resistance tends to develop when doses are skipped. In industrialized countries, the introduction of HAART has lowered AIDS related death rates by 70%. Community and home-based care can complement traditional hospital-based care and help ease the pressure on the health system.

Treatment and care can be mutually reinforcing.

There is the ethical imperative not to exclude the inhabitants of low income countries from lifesaving therapies and the international community has made its commitment to scale up treatment in developing countries explicit through several global initiatives. Examples of

Prices of drugs significantly dropped, but not all countries have access to low cost or second line drugs.

such global initiatives are WHO's "3 by 5"⁴ or "The Global Response to AIDS: 'Making the Money Work'" in 2005. Treatment and care can be cost-effective and have spill over effects in strengthening commitment to prevention and both treatment and prevention are mutually reinforcing. A study in Uganda found that the introduction of ART led to a 27-fold increase in the number of people accessing testing and counselling services. Countries increasingly succeed in putting structures in place and strengthening systems to provide ART in a context of scarce resources. Brazil has been providing ART in the public health sector since 1996, Thailand since 2000. Experience from developing countries has shown that rates of adherence to HAART are at least as high as in developed countries. Prices of first-line treatments have dropped from over US\$10,000 to as little as US\$150 per patient a year since 2000. However not all countries have access to these generic drugs. Some patients need "second line drugs", which means that they do not react to the drugs usually prescribed. Second line drugs are extremely expensive and little available in developing countries.

The number of people on anti-retroviral therapy has doubled since 2003, but still accounts for only 8% of those in need.

The number of people on ART more than doubled from 400 000 in December 2003 to approximately one million in June 2005. According to the Director-General of WHO "this is the first time that complex therapy for a chronic condition has been introduced at anything approaching this scale in the developing world." 14 low- and middle-income countries have met the target providing ART to at least half of the people in need, and several are moving towards providing universal access. There has been a significant increasing commitment by countries to mobilize own financial resources, including for example Bahamas, Botswana, China and South Africa.

Nevertheless most high-burden countries will need substantial external resources to scale up ART and there are currently still fewer than 8% of people living with HIV/AIDS in developing countries who receive antiretroviral therapy (ART). The estimate of 1 million receiving treatment is far less than the 1.6 million that was set as a milestone by June 2005. It is now clear, that the "three million goal" will not be met this month. Of the world's unmet need for ART, an estimated 76% is in sub-Saharan Africa and 17% in Asia.

Most African countries report that demand for treatment is much higher than their capacity to supply it. Though the majority of countries in eastern Europe and central Asia aim to provide universal access by the end of 2005, this does not include the two countries with the largest unmet treatment need, the Russian Federation and Ukraine. In Latin America and the Caribbean, on average two out of three people who need treatment are receiving it, but several countries are lagging behind. In north Africa and the Middle East, coverage remains low at about 5 per cent.

Recommendations to increase progress in treatment scale-up include:

- Political commitment: So far, of 49 WHO/UNAIDS "focus

⁴ The "3 by 5" initiative aimed at providing antiretroviral treatment to 3 million HIV infected persons in developing countries by the end of the year 2005.

- countries”, 40 have developed implementation plans.
- Standardized approaches and increased capacity: Countries successful in providing ART developed standardized drug regimens and trained non-physician health workers to safely and effectively administer ART.
- Technical support: There is a clear need for better and coordinated technical support.

Some key challenges remaining include:

- **Challenges linked to weak health systems and lack of skilled human resources.**
- Increasing financial and technical support to strengthen health and social systems.
- Integrating treatment and prevention.
- Measuring progress and analyzing barriers to implementation on a continuous basis.
- Ensuring access to treatment and care for marginalized groups, such as injecting drug users and sex workers.
- New medicine formulations for children are urgently needed, and current costs of treatment for children must be reduced.

Chapter 5: The international response

The international response has significantly gained momentum with set targets to be met and a significant increase in resources.

US \$ 18 billion above what is currently pledged is needed for global HIV/AIDS efforts over the next three years.

One important milestone that marked the international response was the Declaration of Commitment on HIV/AIDS adopted at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001. Since then, the international community has set further targets. On is to reduce HIV prevalence among 15-24 year-olds by 25% in the most affected countries by 2005 and globally by 2010. There also have been major new financial resources made available by high income countries. Of the US \$ 3,1 billion that the Global Fund to Fight AIDS, Malaria and TB approved in the first four funding rounds, 56% were allocated to fighting HIV and AIDS. The recent G8 proposal to cancel debt owed to the IMF, the World Bank and the African Development Bank allows eligible countries to reallocate resources from debt payments to HIV/AIDS efforts. The international initiatives are matched by an increasing commitment of affected low-income countries to increase the allocation of own funds. But despite these increased resources, UNAIDS estimates that at least an additional US \$ 18 billion above what is currently pledged is needed for global HIV/AIDS efforts over the next three years. To “make the money work”, a **Global Task Team** was initiated in 2005 to develop a set of recommendations on improving the institutional architecture of the response to HIV and AIDS. They are to simplify and further harmonize procedures and practices to improve the effectiveness of country-led responses and reduce the burden placed on countries. In the same direction, a year before, the **"Three Ones"** principles ⁵ had been endorsed by donor countries to achieve a more effective and efficient use of resources, and to ensure rapid action and results-based management.

⁵ Three Ones

<http://www.unaids.org/Unaid/EN/About+UNAIDS/What+is+UNAIDS/UNAIDS+at+country+level/The+Three+Ones.asp>

An “expanded response” to HIV and AIDS means that factors contributing to risk, vulnerability and impact all need to be addressed.

Today, UNAIDS proposes an “expanded response” to HIV and AIDS. Risk, vulnerability and impact are all areas to be addressed: Risk is determined by individual behaviour and situations; Vulnerability stands for an individual's or community's inability to control their risk (i.e. poverty, illiteracy, gender, living in a rural area, being a refugee); impact is about the long-term changes that HIV/AIDS causes in different sectors. The concept of an expanded response is crucial for understanding where it is possible to make a difference in terms of curbing the epidemic. Each sector has particular comparative advantages in addressing one or several of these three dimensions.

The HIV/AIDS epidemic needs to be addressed by large scale “specific interventions”, interventions in various sectors that have fighting HIV/AIDS as their core business. Examples of HIV/AIDS specific interventions include: HIV/AIDS prevention campaigns, social marketing of condoms, scaling up antiretroviral treatment, support programmes for children affected by HIV or AIDS or education sector programmes on HIV/AIDS education.

In addition, through “Mainstreaming HIV/AIDS” development actors working not specifically in the field of HIV/AIDS can address causes and effects of the epidemic, both through their usual work and within their workplace. Given that today in many countries development work can not continue as in the times before the AIDS epidemic, mainstreaming of HIV/AIDS can provide an opportunity to make development efforts more relevant, effective and sustainable. This implies that the way of work and the objectives pursued may need to change in order to be adapted to the reality of the HIV/AIDS context. While the core business (e.g. agriculture, support to the water sector, small business, etc) remains the focus, it is linked to HIV/AIDS through mainstreaming.

List of relevant reference documents and links

- **SDC AIDS policy 2002-2007**
www.deza.admin.ch/ressources/
- **SDC Toolkit Mainstreaming HIV/AIDS in practice**
http://www.deza.ch/ressources/deza_product_en_1280.pdf
- **The global fund to fight AIDS, Tuberculosis and Malaria**
<http://www.theglobalfund.org/en/>
- **AIDS epidemic update. UNAIDS, 2005**
<http://www.unaids.org/Epi2005/doc/report.html>
- **Swiss platform for HIV/AIDS and international cooperation**
<http://www.aidsfocus.ch>
- **Treatment MAP (following progress of scaling up ART per country)**
www.plusnews.org/aids/treatment.asp
- **UNAIDS, questions and answers**
http://www.unaids.org/en/resources/questions_answers.asp
- **UNAIDS, glossary to HIV and AIDS related terms**
<http://www.unaids.org/en/resources/terminology/glossary+of+hiv+and+aids-related+terms.asp>