



World Vision

G8: Keep your promises on global AIDS

Act Now

WORLD VISION INTERNATIONAL POLICY BRIEFING, G8 Summit, Germany, June 2007



a policy briefing and
call to action

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G-8: Keep your promises on global AIDS

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World Vision calls on the G8 to keep its promises for universal access to prevention, treatment and care for all people living with HIV and AIDS by 2010.

If these promises are not kept, millions more people will be infected; millions more will die; millions more children will be orphaned; and nations will risk economic ruin.

The Gleneagles Communiqué, signed by all the G8 leaders in 2005, states:

18(d) With the aim of an AIDS-free generation in Africa, significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010. Limited health systems capacity is a major constraint to achieving this and we will work with our partners in Africa to address this, including supporting the establishment of reliable and accountable supply chain management and reporting systems. We will also work with them to ensure that all children left orphaned or vulnerable by AIDS or other pandemics are given proper support. We will work to meet the financing needs for HIV/AIDS, including through the replenishment this year of the Global Fund to fight AIDS, TB and Malaria; and actively working with local stakeholders to implement the '3 Ones' principles in all countries.

At the Gleneagles Summit in 2005, the G8 leaders promised to work towards achieving universal access to treatment for HIV and AIDS by 2010. If these promises are not kept, millions more people will be infected by the virus, millions more will die and millions more children will be orphaned. The impact in terms of economic growth and trade will be devastating.

part one

World Vision calls for action by G8 leaders

This paper highlights five critical areas that must be addressed by the G8 leaders if they are to keep their 2005 promises to ensure the achievement of universal access to prevention, treatment and care by 2010. World Vision calls for the G8 leaders to agree to action in five areas:

1) Increase funding to achieve universal access

- Agree upon a comprehensive funding plan for universal access to HIV prevention, treatment, care and support by 2010.
- Agree upon a formula for HIV and AIDS expenditures from each of the G8 nations, based on their proportion of global wealth, and map out how they will raise additional money to fully fund all national HIV and AIDS plans.
- Make long-term funding commitments to the Global Fund including raising additional funds through innovative funding sources.
- Establish a monitoring system to review the implementation of these commitments.

2) Strengthen health systems to achieve universal access

- Provide predictable long-term (10-year) funding to poor countries heavily affected by HIV and AIDS so that their health care systems may be strengthened sustainably.
- Use the G8's influence with the IMF to change macro-fiscal policies so that poor countries may significantly invest public funding in the strengthening of their health systems without being penalised.
- Endorse and support the WHO strategy to "treat, train and retain" health workers.
- Invest in health worker training institutions in countries with widespread shortages of health workers.

3) Enable universal access to care for orphans and vulnerable children

- Make time-bound and measurable commitments to earmark 12 per cent of HIV and AIDS expenditures specifically for affected children.
- Support governments of all highly affected countries to develop and implement national plans of action that protect orphans and vulnerable children and guarantee their human rights.

4) Facilitate affordable treatment to achieve universal access

- Ensure that affordable medicines, including generic combinations, are available, particularly for second-line treatments.
- Ensure that children are considered in national and international efforts to scale up access to treatment.
- Support pharmaceutical companies in developing simple and affordable diagnostic tests, increasing research and development for child-specific needs and producing pediatric fixed-dose combinations.
- Provide support to ensure that women living with HIV and their unborn children and infants have access to appropriate interventions to reduce mother-to-child transmission of HIV.

5) Establish a Permanent G8 Working Group on AIDS

- Create a mechanism that regularly and systematically reviews progress on G8 commitments on AIDS to ensure that they are fulfilled.

part two

global context

The global AIDS pandemic continues to grow dramatically. According to the latest UNAIDS figures,ⁱ an estimated 39.5 million people are living with HIV. In 2006, 2.9 million people died of AIDS-related illnesses, including 380,000 children under 15, and there were 4.3 million new infections, including 2.8 million (65 per cent of the total) in sub-Saharan Africa. There were significant increases in Eastern Europe and Central Asia, where infection rates appear to have risen by more than 50 per cent since 2004. Globally, 15.2 million children under 18 have lost one or both parents to AIDS and millions more have been made vulnerable.ⁱⁱ An estimated 2.3 million children are living with HIV worldwide and only 1 in 10 of those who need anti-retroviral treatment is receiving it.

In Asia there were almost 1 million new HIV infections in 2006, bringing to an estimated 8.6 million the number of people in the region now living with the virus. Access to anti-retroviral treatment is still poor, with only 16 per cent of those in need receiving it in 2006. There were 167,000 new infections in Latin America and the Caribbean in 2006, bringing the total number of people living with HIV in the region to almost 2 million. Of all global AIDS-related deaths in 2006, 72 per cent occurred in sub-Saharan Africa, and the region continues to be home to the largest numbers of people living with HIV. An estimated 1.4 million children in sub-Saharan Africa were orphaned as a result of AIDS in 2006.

It is increasingly the case that AIDS in Africa has a woman's face. Across sub-Saharan Africa, women bear a disproportionate share of the AIDS burden: not only are they more likely than men to be infected with HIV, but in most countries they are also more likely to be the ones caring for people infected with HIV. In South Africa, women aged 15–24 are four times more likely to be HIV-infected than young men; in Ethiopia, prevalence among adult women is double that among adult men.ⁱⁱⁱ Efforts

to prevent mother-to-child transmission of HIV have not been scaled up as rapidly as anti-retroviral treatment, with only 9 per cent of HIV-positive pregnant women having access to appropriate services.

Evidence shows that scaled-up interventions can reverse the spread of AIDS. Provision of anti-retroviral therapy has expanded treatment even in resource-limited settings like Kenya, Malawi, Rwanda, Uganda and Zambia, confirming that AIDS-related illness and death can be reduced in low-and medium-income countries. In Rwanda, for instance, nearly 76 sites were providing anti-retroviral therapy to more than 18,000 people by the end of 2005. Worldwide, it is estimated that between 250,000 and 350,000 deaths were averted in 2005 as a result of increased access to treatment (WHO/UNAIDS). Prevention efforts have led to declines in national prevalence in some sub-Saharan African countries, but the magnitude of the pandemic is such that the number of people living with HIV continues to grow, as does the number of deaths due to AIDS. If this is to be reversed, G8 countries must scale up support and meet their commitments to universal access by 2010.

With increased resources, millions of lives can be saved.

part three

economic impact of breaking G8 promises on universal access

AIDS is turning back the clock on development: it is devastating the social and economic infrastructure of communities and nation states. Economic growth, income and poverty reduction are all impacted by HIV and AIDS. The World Bank estimates that the annual per capita growth (measured by GDP) in half the countries of sub-Saharan Africa is falling by 0.3-1.5 per cent each year as a direct result of AIDS; by 2020 heavily affected countries could lose more than 20 per cent of their GDP.^{iv} It is now expected that the AIDS pandemic will peak in advance of the economic damage it will cause. In southern Africa, where prevalence rates amongst 15-49 year olds are already 20 per cent, the worst is still to come. Alarming, Asia and the Pacific as well as Eastern Europe and Central Asia continue to experience mounting epidemics. If measures to combat the disease are not expanded, development in many economies will be halted.

Research is now showing that HIV and AIDS causes much greater long-term damage to national economies than previously assumed. Because AIDS kills mainly young adults, it weakens the mechanism through which human capital is accumulated and transmitted across generations. The regional average life expectancy for sub-Saharan Africa is 47; without the impact of HIV and AIDS it would be 62 years. When the productive labour force is diminished, economic growth is undermined. In Malawi, HIV and AIDS are impacting the country's most productive citizens, crippling the economy and depriving schools of teachers, hospitals of doctors and nurses and businesses of workers. By undermining human capacity, HIV and AIDS reduce productivity, disrupt organisations and thwart future development. This is why the HIV and AIDS pandemic is the biggest threat to achieving many of the MDGs.

With adequate spending on well-targeted programmes, an astounding two-thirds of the projected 45 million

new infections this decade could be prevented. Likewise, with increased commitment to care and treatment it is possible for those living with HIV and AIDS to live longer, more productive lives, thereby providing love and care for children who would otherwise be orphaned. Yet on present trends, the world will not achieve the MDG of halting and beginning to reverse the spread of HIV and AIDS by 2015.

Case Study:

Fostering HIV prevention and care through the provision of income and dignity for people living with HIV (PLHIV) in Honduras

Honduras has a population of approximately 7 million, 64 per cent of whom live below the threshold of poverty. The country's HIV prevalence is estimated to be 1.8 per cent. In the Villafranca Area Development Programme in Tegucigalpa, World Vision initiated a programme in conjunction with its microfinance agency, FUNED, to strengthen HIV prevention and care by encouraging young women and mothers living with or affected by HIV to develop micro-enterprises. A Community Bank strategy known as Bank Boxes was applied. Each Bank Box is a group of five or more owners of productive micro-enterprises who work together as a solidarity group. A total of 150 families of people living with HIV (PLHIV) grouped in 18 Bank Boxes (a total of 457 people) have benefited from training in micro-credit management, marketing, quality control and storage. The average portfolio after two years is US\$48,445. Although 37 per cent of the women who have benefited were nearly illiterate, the project closed its year without any arrears, reflecting solid partnership from the team and increasing the likelihood of success in the coming years. The solidarity groups create a good opportunity and safe space for dialogue on topics like sexual and reproductive health, HIV prevention, stigma and anti-retroviral adherence. Linkages between HIV prevention and micro-enterprise interventions represent a valuable opportunity to promote a more comprehensive development approach that nurtures increased social inclusion. Prevention at an individual level is more effective when structural issues such as access to income generation opportunities (including access to affordable credit) are addressed.

part four

increasing funding to achieve universal access

The HIV and AIDS Declaration of Commitment, formulated at the UNGASS Conference in 2001, estimated the cost of fighting HIV and AIDS at \$9.2 billion per annum, a sum that was increased to \$12 billion after more careful review. Unfortunately, efforts have fallen far short of the target and the pandemic continues to spread almost unhindered. In 2005 the shortfall amounted to \$4 billion, and in 2006 it reached an appalling \$6 billion (\$8.9 billion available as opposed to the \$14.9 billion required in 2006).

If HIV and AIDS are to be successfully tackled—if the numbers of HIV infections are to be drastically reduced, the number of deaths due to AIDS dramatically minimised and the care of children orphaned and made vulnerable by AIDS improved—then, according to UN experts, \$18 billion will be needed in 2007 and \$22 billion in 2008. Unfortunately, the UN expects that only \$10.1 billion will actually be available in 2007, meaning a shortfall of \$8 billion in 2007. For 2008, we estimate that the funds actually available will reach no more than \$11 billion, leaving a troubling shortfall of \$11 billion.

Reaching the goal of universal access by 2010 will depend on adequate financing of the Global Fund to fight AIDS, TB and Malaria. The Global Fund has played a vital and growing role in supporting the international response to HIV and AIDS, providing 20 per cent of all international funding for AIDS in 2005, and in 2006 funding treatment for one-third of all people in poor countries who are currently accessing treatment.

World Vision calls on G8 leaders to:

- *Agree upon a comprehensive funding plan for universal access to HIV prevention, treatment, care and support by 2010.*
- *Agree upon a formula for HIV and AIDS expenditures from each of the G8 nations, based on their proportion of global wealth, and map out how they will raise additional money to fully fund all national HIV and AIDS plans.*
- *Make long-term funding commitments to the Global Fund including raising additional funds through innovative funding sources, e.g., UNITAID.*
- *Establish a monitoring system to review the implementation of these commitments.*

Case Study:

Facilitating children's access to treatment through community engagement in Burundi

In partnership with the World Food Programme, World Vision implemented a programme in Muyinga, Burundi to facilitate children's access to ARV treatment. The programme integrated treatment with nutrition, prevention efforts, care and support for orphans, vulnerable children and other people living with HIV and AIDS. In this community engagement model, people were prepared to seek treatment, supported to help identify and encourage others in need of treatment and supported to adhere to treatment. Efforts included community sensitisation on HIV and AIDS and overcoming stigma and discrimination to encourage people to disclose their status and seek treatment. The nutrition component of the programme provided food packs and agricultural inputs to households with orphans, vulnerable children and others living with HIV and AIDS. World Vision facilitated vulnerable children's access to rural health centres for treatment by providing transport at regular intervals as well as delivery of drugs to health centres in the district. The prevention component targeted behaviour change among youths and several providers of reproductive health services.

part five

strengthen health systems to achieve universal access

Properly functioning health systems are absolutely critical to achieving the goal of universal access. Yet in most poor countries, access to basic health care is severely threatened by weak and under-funded health systems that are beset by severe understaffing and are limited by restrictive International Monetary Fund policies.

According to the World Health Organization, there is a worldwide shortage of more than 4 million health workers.^v While deficits are large in South-East Asia due to its population size, the biggest shortfalls are evident in sub-Saharan Africa. Health workers face poor working conditions, low pay, inadequate occupational health and safety, badly-resourced medical facilities and a lack of staff. These difficult circumstances are compounded by the risk of contracting HIV as a result of working in an environment where many patients might be HIV-positive or suffering from AIDS. Not surprisingly, many health workers feel so vulnerable, undervalued and unable to cover their living expenses that they seek work elsewhere.

Investing in capacity building and improved working conditions for health workers in poor countries is fundamental to achieving strong health systems and reaching the goal of universal access. The G8 can assist by providing resources to better the conditions for health workers. A predictable long-term funding approach is needed to strengthen health systems sustainably and to implement the “treat, train and retain” strategy of WHO.^{vi}

Most poor countries with a high HIV and AIDS burden already depend on foreign aid. Yet in order to maintain access to these funds they must adhere to the fiscal policies mandated by the IMF, which limit public expenditure to prevent inflation rates from rising. These policies, designed to ensure macro-economic stability,

punish poor countries for making large investments to improve their health systems.^{vii} These restrictions must be changed so that countries may counter the social and economic costs of failing to address HIV and AIDS as aggressively as possible.

World Vision calls on G8 leaders to:

- *Provide predictable long-term (10-year) funding to poor countries heavily affected by HIV and AIDS so that their health care systems may be strengthened sustainably.*
- *Use their influence with the IMF to change macro-fiscal policies so that poor countries may invest significant public funding in the strengthening of their health systems without being penalised.*
- *Endorse and support the WHO strategy to “treat, train and retain” health workers.*
- *Invest in health worker training institutions in countries with widespread shortages of health workers.*

part six

enabling universal access to care for orphans and vulnerable children

UNAIDS estimates that 15.2 million children under the age of 18 worldwide have lost one or both parents to AIDS. In sub-Saharan Africa, where HIV and AIDS are most prevalent, 12 million have been orphaned due to AIDS. This number is expected to rise to 15 million by 2010.

Children orphaned or made vulnerable by HIV and AIDS face significant psychological and material difficulties. Unlike many other causes of parental death, AIDS very often claims both parents and thus significantly impacts children's well-being, particularly their ability to access education and health services. While parents are living with AIDS, the earning power of the household is severely reduced even as demands on household resources increase. Children assume additional household and economic responsibilities that may make them vulnerable to exploitative labour practices and sexual abuse, which in turn increases their risk for HIV infection. The emotional trauma of their parent's illness and possible stigmatisation and discrimination from the community further contribute to their vulnerability.

Policy interventions to support orphans and vulnerable children must aim to provide for not only material, economic and physical needs but also psychosocial needs. These interventions should include:

- Strengthening and supporting the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, material and psychosocial support.
- Mobilising and strengthening community-based responses that promote community care for children who lack support and that engage community leaders in responding to the needs of vulnerable community members.
- Strengthening the capacity of children and young

people to meet their own needs and to access essential services like education, health care, water and sanitation services and birth registration.

- Raising awareness at all levels through advocacy and social mobilisation to create a supportive environment for children and families affected by HIV and AIDS.
- Ensuring that governments develop appropriate policies and services for the most vulnerable children, including legislative frameworks to protect them from human rights abuses.
- Eliminating costs associated with school attendance to ensure that children orphaned and made vulnerable by HIV and AIDS have access to primary education and to help achieve the goal of universal primary education by 2015.

Case Study:

Strengthening community care and support for OVC through Community Care Coalitions in Africa

Community Care Coalitions (CCC) is a model of caring for orphans and such children that aims to strengthen and scale up community care and support for vulnerable children. World Vision is implementing this model across many African countries. In the CCC model, community-based organisations involved in care for orphans and vulnerable children form coalitions so as to better coordinate their care activities, raise local resources and effectively manage child-care and support initiatives. The CCC develops criteria for identifying children in need of care and support. Community-based volunteers then identify vulnerable children using criteria adjusted for local conditions. The volunteers visit children in their homes to provide counselling and other forms of psychosocial support. A recent review of the CCC model in Uganda revealed that communities have become more active in caring for orphans and vulnerable children and that more local resources are being gathered to support the children, who express appreciation for the support they receive from community volunteers. The main strength of the CCC approach is that it builds on and encourages use of local structures and resources for caring for vulnerable children, which are more sustainable than externally driven responses.

The needs of orphans and vulnerable children are most urgent because, according to UNICEF, less than 5 per cent of them are receiving any kind of public support. There are few attempts to track what percentage of HIV and AIDS resources are applied to improving the lives of orphans and vulnerable children. G8 leaders must therefore fulfil the commitments they made in 2005 at Gleneagles, and reaffirmed again last year at St. Petersburg, to provide proper support to all OVC including universal access to treatment, care and prevention by 2010.

Case Study:

Access to treatment in Uttarakannada Area Development Programme (ADP), India

World Vision's Uttarakannada ADP is located in Karnataka state, one of the states with highest HIV prevalence in India. This well functioning ADP covers 600 villages and straddles two districts. HIV prevalence in these districts is 3 per cent. An ADP needs assessment indicated that this prevalence rate was significantly higher than in the rest of the state. A major trucking stop on an interstate route in the middle of the ADP was identified as a risk setting for HIV transmission.

The Karnataka Institute of Medical Sciences (KIMS), one of a number of anti-retroviral treatment (ART) centres established by the national government in response to the 3 by 5 initiative, is 35 kilometres from this ADP. KIMS provides testing, monitoring and free ART for those whose CD4 count falls below 200. In response to the districts' relatively high HIV prevalence, an HIV programme was commenced as part of the on-going ADP efforts. The ADP assists families affected by HIV, including people receiving ART. A PLHIV support group meets monthly. A drop-in centre attached to an ADP sub-centre at the edge of the Siddhi tribal area provides information and voluntary counselling and testing (VCT) and a meeting place for PLHIV. Ten community care counsellors undertake a range of activities including house-to-house visits and school and university visits to train young people in life skills. They also assist in facilitating access to ART by assisting with transport to KIMS, providing childcare while PLHIV are absent and providing financial support for additional expenses such as treatment of opportunistic infections. The HIV programme has relied on trust built up over many years through ADP achievements, which include improved roads, access to water and sanitation, school support and income generation activities.

World Vision calls on G8 leaders to:

- *Make time-bound and measurable commitments to earmark 12 per cent of HIV and AIDS expenditures specifically for affected children.*
- *Support governments of all highly affected countries to develop and implement national plans of action that protect orphans and vulnerable children and guarantee their human rights.*

part seven

facilitating affordable treatment to achieve universal access

Drugs for HIV and AIDS treatment must be made available at affordable prices to stop the deaths of children, parents and caregivers. The accessibility of effective drugs at reasonable prices is a critical component of achieving the G8's promises for universal access to treatment by 2010.

Doha Declaration

World Trade Organization (WTO) members passed the Declaration on TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement and Public Health in November 2001 in Doha, Qatar. This declaration allows developing countries to manufacture generic drugs and override patents held by major pharmaceutical companies in times of national health crises. This marks the first WTO acknowledgement that the prices of drugs manufactured by these large patent-holding companies are hindering access to medicine in developing countries. Under the TRIPS Agreement, governments are required to follow certain procedures when they elect to invoke TRIPS using compulsory licensing. As TRIPS may only be invoked in cases of a public health emergency, the respective governments are expected to simultaneously initiate an expedited procedure for addressing the health emergency. Individual governments themselves define what an emergency is and this is monitored by the Director-General of the WHO.

AIDS treatment for children

Children with HIV and AIDS are dying unnecessarily because they are unable to access ARV treatment. This problem stems mainly from a lack of inexpensive, feasible diagnostic tests for children under 18 months; a dearth in properly trained health personnel; and a lack of affordable, child-friendly ARV drugs. Simplified treatment guidelines coupled with a range of fixed-dose combinations of ARVs that require only one or two

Case Study:

Access to treatment in El Prodigio Area Development Programme (ADP) in the Dominican Republic

HIV prevalence in the Dominican Republic (DR) is between 1.6 and 2 per cent. Prevalence is higher in the eastern region, where many poor agricultural settlements (*bateyes*) tend to be neglected by government services. There, the prevalence fluctuates between 4 and 6 per cent. A donor-funded government programme provides free ARV treatment but has not achieved universal access. World Vision's El Prodigio ADP is located in El Seibo province in eastern DR. One of the poorest provinces, El Seibo has a large mobile population, including groups moving from Haiti into the DR and from the DR into Puerto Rico. PLHIV peer support groups have been established as the principal intervention for supporting ART access through the Synergy Project, a national initiative funded by the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the World Bank. This project provides funding, including training, transportation and small stipends, for four peer supporters.

Activities include VCT, PLHIV peer support and home-based care. Members of a Home-Based Care Network (HBCN) provide counselling, information support and referral to health services, respond to individual needs such as childcare, cleaning and cooking, and accompany pregnant women to access pMTCT services. Currently, 84 PLHIV have disclosed their status and 15 are on ART. The peer supporters visit regularly to provide advice, practical support and friendship and may accompany PLHIV when accessing health services to ensure that they receive proper treatment and are not discriminated against. Although the ad hoc nature of nutrition support is likely to limit the effectiveness of this activity to assist PLHIV in maintaining a sufficient level of nutrition to benefit fully from treatment, the HBCN and peer supporters provide a very strong model of ARV adherence.

pills twice a day have facilitated the treatment of HIV and AIDS in adults, but the development of comparable drugs for children is lagging behind. Although the World Health Organization has developed simplified treatment guidelines that specify which drugs to use for children, developing countries have difficulty in obtaining simple and affordable combinations of the drugs. The global market for pediatric AIDS drug formulations is not attractive for originator or generic companies; very few children in wealthy countries are born with HIV, and in developing countries, where the majority of infected children live, pediatric formulations are not considered a priority.

AIDS treatment for mothers

Failure to prevent mother-to-child transmission is driving the rapidly increasing number of HIV-positive children. Globally, 90 per cent of all HIV-positive children are infected via their mothers.^{viii} Without prevention of mother-to-child transmission (pMTCT) services, about 35 per cent of infants born to HIV-positive mothers will acquire the virus during pregnancy, labour, delivery or breastfeeding.^{ix} Providing a mother with a full range of pMTCT services can reduce this risk of transmission to less than 2 per cent.^x But only 9 per cent of HIV-positive pregnant women currently receive pMTCT drug therapies.^{xi} This is a gross violation of the rights of these women and their children. In May 2006, African Heads of State issued the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa and set clear goals for 2010 including that 80 per cent of pregnant women have access to pMTCT services and facilities.^{xii}

World Vision calls on G8 leaders to:

- *Ensure that affordable medicines, including generic combinations, are available, particularly for second-line treatments.*
- *Ensure that children are considered in national and international efforts to scale up access to treatment.*
- *Support pharmaceutical companies in developing simple and affordable diagnostic tests, increasing research and development for child-specific needs and producing pediatric fixed-dose combinations.*
- *Provide support to ensure that women living with HIV and their unborn children and infants have access to appropriate interventions, including effective treatment, to reduce mother-to-child transmission of HIV.*

part eight

establishing a permanent G8 working group on AIDS

World Vision supports the efforts of the World AIDS Campaign and the Global Unions to establish a built-in mechanism that reviews progress on G8 commitments on AIDS to ensure that they are fulfilled. Ideally this would be through the establishment of a high-level, permanent G8 working group on HIV and AIDS-related issues. Other alternatives include designating AIDS-related issues as a standing item on the G8 agenda or creating a mechanism that outlines policy options, based on monitoring and reporting, to the annual Health Ministerial meeting preceding the G8 Summit, which would in turn provide policy recommendations for the G8 principals to fulfil their previous commitments.

World Vision calls on G8 leaders to:

- *Create a mechanism that regularly and systematically reviews progress on G8 commitments on AIDS to ensure that they are fulfilled.*

summary

World Vision calls on the G8 leaders to keep their promises for universal access to prevention, treatment and care for people living with HIV and AIDS. Much has been done, but much more is required. There is an urgent need for the G8 leaders to *act now to prevent the infection and death of millions more people; the orphaning of millions more children; a rapid rise in poverty (known to be a significant factor in the spread of AIDS); and potential economic ruin for affected nations.*

- i UNAIDS/WHO, 2006 AIDS Epidemic Update
- ii UNICEF 2007 'Children and AIDS: A Stocktaking Report'
- iii UNAIDS/WHO, 2006 AIDS Epidemic Update
- iv Clive Bell, Shantayanan Devarajan and Hans Gersbach, 'The Long-run Economic Costs of AIDS: Theory and an Application to South Africa' World Bank, 2003
- v Working Together for Health, The World Health Report, 2006
- vi Treat, Train, Retain, WHO, August 2006. <http://www.who.int/mediacentre/news/releases/2006/pr37/en/index.html> and <http://www.who.int/hiv/pub/meetingreports/TTRmeetingreport2.pdf>
- vii Blocking Progress: How the Fight against HIV/AIDS is Being Undermined by the World Bank and International Monetary Fund, Action Aid International USA et al, 2004
- viii UNICEF 2002 'A UNICEF Fact Sheet, Mother-to-Child Transmission of HIV'
- ix UNAIDS 2005 'AIDS Epidemic Update: December 2005' Joint United Nations Programme on HIV/AIDS, Geneva
- x UNICEF 2005 'A Call to Action: Children, the Missing Face of AIDS'
- xi UNICEF 2007 'Children and AIDS: A Stocktaking Report'
- xii African Union 2006 Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria (ATM) Abuja Nigeria, 2–4 May, 2006

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and communities world-wide to reach their full potential by tackling the causes of poverty and injustice. As followers of Jesus, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people regardless of religion, race, ethnicity or gender.

Children are often most vulnerable to the effects of poverty. World Vision works with each partner community to ensure that children are able to enjoy improved nutrition, health and education. Where children live in especially difficult circumstances, surviving on the streets, suffering in exploitative labour or exposed to the abuse and trauma of conflict, World Vision works to restore hope and to bring justice.

World Vision recognises that poverty is not inevitable. Our Mission Statement calls us to challenge those unjust structures that constrain the poor in a world of false priorities, gross inequalities and distorted values. World Vision desires that all people be able to reach their God-given potential, and thus works for a world that no longer tolerates poverty.

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