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VIMUN



VIENNA INTERNATIONAL MODEL UNITED NATIONS
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Preparation Paper

Commission on Population and Development (CPD)

"The Effect of HIV/AIDS on Population in Sub-Saharan Africa"

Dear Delegates and Observers,

Our team of the Vienna International Model United Nations (VIMUN) 2009 welcomes you to the Commission of Population and Development on the topic of "The Effect of HIV/AIDS on Population in Sub-Saharan Africa". HIV/AIDS seems to be an overwhelming issue, but we decided to set a regional and thematic focus so that our debates during the conference can be more detailed, coherent and comprehensive.

The discussion in the CPD will concentrate on the following aspects of the HIV/AIDS epidemic (details to be found in the agenda):

- Women and HIV/AIDS
- Mother to Child Transmission (MTCT)
- AIDS orphans
- Stigma and Discrimination

The basic question is: How can further spread of HIV be prevented? How can the life of a person living with HIV/AIDS be made more liveable? What sort of success can the UN expect? These and similar questions should be discussed in our committee.

This paper will give you a brief introduction into our topic.

Please do not forget to inform yourself about the specific position of the country you are representing at the VIMUN sessions. We also want to draw your attention to the helpful links for your research at the end of the paper.

We hope to see well prepared and ambitious delegates willing to write a high-quality resolution. For further questions feel free to contact us cpd.vimun@afa.at

See you at the VIMUN 2009!

Chairperson – Anna Strauss

I am 21 years old and currently studying Political Science in Vienna but next year I will continue my studies at Uppsala, Sweden. This is my first time chairing at the VIMUN but I have participated at the last two ones.

Co-Chairperson – Sarita Vollnhofer

I want to take the opportunity to briefly introduce myself. After completing my bachelor studies in Business which included a stay abroad in South Africa I started to work for the international humanitarian organization CARE. Alongside my work I study International Development and African Studies at the University of Vienna. I am very much interested in the various aspects of international development and aid and therefore already looking forward to co-chairing the CPD at the VIMUN 2009!

Usher – Christopher Lehner

I am 23 years old and a student of Political Science in Vienna. The focus of my studies is on international relations and hope to work in this sector in the future. I have never participated at a MUN but I am looking forward to fruitful discussion in our committee.

1. The Commission on Population and Development (CPD)

A Population Commission was established by the Economic and Social Council in its resolution 3 (III) of 3 October 1946. In its resolution 49/128 of 19 December 1994, the General Assembly decided that the Commission should be renamed the Commission on Population and Development. In the same resolution, the Assembly decided that it, the Council and the Commission should constitute a three-tiered intergovernmental mechanism that would play the primary role in the follow-up to the implementation of the Programme of Action of the International Conference on Population and Development, and that the Commission, as a functional commission assisting the Council, would monitor, review and assess the implementation of the Programme of Action at the national, regional and international levels and advise the Council thereon.

Under its terms of reference the Commission is to assist the Council by:

1. Arranging for studies and advising the Council on:

- (a) Population issues and trends;
- (b) Integrating population and development strategies;
- (c) Population and related development policies and programs;
- (d) Provision of population assistance, upon request, to developing countries and, on a temporary basis, to countries with economies in transition; and
- (e) Any other population and development questions on which either the principal or the subsidiary organs of the United Nations or the specialized agencies may seek advice.

2. Monitoring, reviewing and assessing the implementation of the Program of Action of the International Conference on Population and Development at the national, regional and global levels, identifying reasons for success and failure, and advising the Council thereon;

3. Providing appropriate recommendations to the Council on the basis of an integrated consideration of the reports and issues related to the implementation of the Program of Action. The Commission is composed of 47 Member States elected by the Economic and Social Council for a period of four years on the basis of geographic distribution. Representatives should have a relevant background in population and development.

2. Goals, United Nations Declarations and Resolutions on AIDS

Through a series of goals, resolutions and declarations adopted by member nations of the United Nations, the world has a set of commitments, actions and goals to stop and reverse the spread of HIV and scale up towards universal access to HIV prevention, treatment, care and support services.

• Political Declaration on HIV/AIDS (2006)

In 2006 a Political Declaration on HIV/AIDS was adopted unanimously by UN Member States at the close of the United Nations General Assembly 2006 High Level Meeting on AIDS. It provides a strong mandate to help move the AIDS response forward, with scaling up towards universal access to HIV prevention, treatment, care and support. It also reaffirms the 2001 Declaration of Commitment and the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of AIDS by 2015.

• Declaration of Commitment on HIV/AIDS (2001)

In 2001 Heads of State and Government Representatives of 189 nations gathered at the first-ever Special Session of the United Nations General Assembly on HIV/AIDS. They unanimously adopted the Declaration of Commitment on HIV/AIDS, acknowledging that the AIDS epidemic constitutes a "global emergency and one of the most formidable challenges to human life and dignity." The Declaration of Commitment covers ten priorities, from prevention to treatment to funding.

• Millennium Development Goals (MDGs) (2000)

In September 2000, building upon a decade of major United Nations conferences and summits, the largest gathering of world leaders at United Nations Headquarters in New York adopted the United Nations Millennium Declaration. The Declaration, endorsed by 189 countries, committed their nations to a new global partnership to reduce extreme poverty and set out a series of targets to be reached by 2015 - that have become known as the Millennium Development Goals (MDGs).

The eight MDGs – which range from halving extreme poverty to halting the spread of HIV and providing universal primary education have galvanized unprecedented efforts to meet the needs of the world's poorest.

MDG1: Eradicate Extreme Poverty and Hunger
MDG2: Achieve Universal Primary Education
MDG3: Promote Gender Equality and Empower Women
MDG4: Reduce Child Mortality
MDG5: Improve Maternal Health
MDG6: Combat HIV/AIDS, Malaria and other Diseases
MDG7: Ensure Environmental Sustainability
MDG8: Develop a Global Partnership for Development

The targets of Goal 6 “Combat HIV/AIDS, Malaria and other diseases” include:

Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

6.1 HIV prevalence among population aged 15-24 years
6.2 Condom use at last high-risk sex
6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs

- **UN Security Council Resolution 1308 (2000)**

In January 2000 the UN Security Council made history when for the first time it debated a health issue - AIDS. By subsequently adopting Resolution 1308, it highlighted the possible growing impact of AIDS on social instability and emergency situations and potential damaging impact of HIV on the health of international peacekeeping personnel.

3. Expenses for HIV/AIDS

International and domestic funding for AIDS has grown from 'millions' to 'billions' in the last decade. By the end of 2007, AIDS funding is estimated to stand at just under \$10 billion - an almost forty fold increase since 1996, when just \$260 million was available.

The increase has been largely due to a series of new international funding initiatives and mechanisms, notably the Global Fund for AIDS, tuberculosis and malaria, the World Bank's Global AIDS Programme and the US President's Emergency Plan for AIDS Relief (PEPFAR). Domestic spending on AIDS in low and middle-income countries has also continued to increase to currently represent around one third of all money going into the global AIDS effort.

As investment grows, the importance of “making the money work” is critical. Many developing countries are experiencing serious difficulties as they rapidly expand their delivery of AIDS treatment and HIV prevention services to communities. UNAIDS places particular emphasis on “making the money work” - supporting countries' efforts to tap into new sources of financing and ensure that this financing is used most efficiently and effectively to reach the people who need it most. Better coordination is key to ‘Making the Money work’.

4. Seven Principal outcomes of UNAIDS for the years 2008 and 2009

The seven Principal Outcomes in the 2008–2009 Unified Budget and Workplan reflect overarching priorities in the global effort to move towards universal access to HIV prevention, treatment, care and support.

Principal Outcome 1: Strengthened leadership and resource mobilization for a broadbased AIDS response at all levels, including governments, civil society, including people living with HIV, and other non-state partners. UNAIDS will continue to catalyse a more robust and sustainable global response and to mobilize sufficient resources for scaling up support in countries. UNAIDS will intensify its work to improve political commitment, leadership, and the coordination and harmonization of national responses; and to increase the capacity of nongovernmental organizations and people living with HIV to participate as full and equal partners in the AIDS response.

Principal Outcome 2: Improved planning, financing, technical assistance and coordination at all levels for a sustainable multisectoral AIDS programmatic response, addressing the impact of the epidemic and integrated with national development efforts.

UNAIDS will support countries in development of target-driven national strategies and action plans, helping integrate the AIDS response into broader development efforts. Specific initiatives will focus on ensuring that national responses address the needs of populations at greatest risk.

Principal Outcome 3: Strengthened evidence base and accountability of the AIDS response through greater availability and use of strategic information, including monitoring and evaluation, surveillance, and resource tracking.

UNAIDS will assist countries in building HIV information systems to enable them to “know their epidemic.” UNAIDS will improve analytic capacity at all levels and work to enhance evaluation efforts to promote greater accountability in the AIDS response.

Principal Outcome 4: Enhanced human resource and systems capacities at all levels of government, civil society and other non-state partners to implement comprehensive HIV/AIDS responses, including improved availability and access to affordable HIV commodities.

To accelerate progress towards universal access to HIV prevention, treatment, care and support, UNAIDS will assist countries and key partners in strengthening capacity for scaling up. Focus areas for capacity building include national procurement and supply management, optimizing strategic use of global trade rules to expand access to essential commodities, and strengthening human capacity in health systems and other sectors.

Principal Outcome 5: Strengthened human rights-based and gender-responsive policies and approaches to reduce stigma and discrimination.

Coordinated action will focus on addressing the drivers of the epidemic. UNAIDS will work to strengthen national legal frameworks, promote gender equality, and build the capacity and engagement of diverse partners in addressing the human rights and gender dimensions of the epidemic.

Principal Outcome 6: Increased coverage and sustainability of programmes for those engaging in injecting drug use, sex between men and sex work.

UNAIDS will help countries reach populations at heightened risk with essential HIV prevention, treatment, care and support services. The active involvement of most-affected populations in the development and implementation of national strategies and programmes will be promoted.

Principal Outcome 7: Increased coverage and sustainability of programmes addressing the vulnerability of, and impact on women and girls, young people, children, emergency-affected populations and uniformed personnel.

UNAIDS will promote programmatic scale-up and policy development to reduce the vulnerability of women and girls, young people, children, emergency-affected populations and uniformed personnel.

Principal Outcomes Proposed Budget for 2008–2009 in USD (UNAIDS)

1. Leadership and Resource Mobilization	205 047 374
2. Planning, financing, technical assistance and coordination	106 761 487
3. Strengthened evidence base and accountability	30 520 600
4. Human resources and systems capacities	45 615 495
5. Human rights, gender, stigma and discrimination	27 467 935
6. Most at-risk populations	16 090 000
7. Women and girls, young people, children and populations of humanitarian concern	32 317 109
Contingency	5 000 000
Total	468 820 000

5. The AIDS epidemic today – worldwide

- An estimated 33 million people [30.3 – 36.1 million] were living with HIV in 2007. There were 2.7 million [2.2 – 3.2 million] new HIV infections and 2 million [1.8 – 2.3 million] AIDS-related deaths in 2008.
- The rate of new HIV infections has fallen in several countries, but globally these favorable trends are at least partially offset by increases in new infections in other countries.

- Globally, women account for half of all HIV infections - this percentage has remained stable for the past several years.
- The global percentage of adults living with HIV has leveled off since 2000. In virtually all regions outside sub-Saharan Africa, HIV disproportionately affects people who inject drugs, men who have sex with men and sex workers.

Sub-Saharan Africa

Latest epidemiological trends

- Sub-Saharan Africa remains the region most heavily affected by HIV worldwide, accounting for two thirds (67%) of all people living with HIV and for three quarters (75%) of AIDS deaths in 2007.
- An estimated 1.9 million [1.6–2.1 million] people were newly infected with HIV in sub-Saharan Africa in 2007, bringing to 22 million [20.5–23.6 million] the number of people living with HIV.
- Sub-Saharan Africa's epidemics vary significantly from country to country - with most appearing to have stabilized, although often at very high levels, particularly in **southern Africa**.
- The nine countries in **southern Africa** continue to bear a disproportionate share of the global AIDS burden - 35% of HIV infections and 38% of AIDS deaths in 2007 happened there.
- The HIV epidemics in **Malawi**, **South Africa** and **Zambia** also appear to have stabilized. Although **South Africa's**, with an estimated 5.7 million people living with HIV, continues to be the largest epidemic in the world.
- In **Mozambique**, the epidemic continues to grow - in some of its provinces in the central and southern zones of the country, adult HIV prevalence has reached or exceeded 20%, while infections continue to increase among young people (ages 15-21).
- Most of the comparatively smaller HIV epidemics in West Africa are stable or are declining - as is the case for **Burkina Faso**, **Côte d'Ivoire**, **Mali**, and **Nigeria**.
- HIV prevalence in the comparatively smaller epidemics in East Africa has either stabilized or is receding. After dropping dramatically in the 1990s, **Uganda's** adult HIV prevalence appears to have stabilized at 5.4%. However, there are signs of a possible resurgence in sexual risk-taking that could cause the epidemic to grow again.
- Reductions in HIV prevalence are especially striking in **Zimbabwe**, where HIV prevalence in pregnant women attending antenatal clinics fell from 26% in 2002 to 18% in 2006. In **Botswana**, a drop in HIV prevalence among pregnant 15-19-year-olds from 25% in 2001 to 18% in 2006 suggests that the rate of new infections could be slowing.

6. Women and HIV/AIDS

Women often experience the impact of HIV more severely than men.

The effects of gender inequality leave women and girls more at risk of exposure to HIV. Less access to education and economic opportunity results in women being more dependent on men in their relationships, and many who have no means of support must resort to bartering or selling sex to support themselves and their children. Where women can't own property and lack legal protections, their dependence within their families is even greater.

Women and girls are also at increased risk for HIV infection biologically. In unprotected heterosexual intercourse women are twice as likely as men to acquire HIV from an infected partner. Economic and social dependence on men often limits women's power to refuse sex or to negotiate the use of condoms.

The impact of the HIV epidemic falls more heavily on women, who assume the bulk of care giving when their male partners, children, and parents fall ill. Women with HIV and women whose partners die of AIDS often suffer discrimination and abandonment. In a study in India, almost 90% of the HIV-positive women interviewed were infected by their husbands, but they were often blamed for their husbands' illnesses. In some contexts, their lower status in the family and community make it less likely that they have access to health care including antiretroviral treatment (ART).

Girls are at even greater risk of exposure to HIV. Their age leaves them less able to reject sexual advances than adults. Girls are more likely to be taken out of school than boys, either to care for the family or because there is not enough money to support all the children's education.

Women who are marginalized from society, such as sex workers and injecting drug users, are at greater risk of becoming infected with HIV. Moreover, the impact of HIV is more severe for them because they have even less access to community support systems.

Reducing the impact of HIV requires that the needs and issues of women be addressed globally, nationally, and on the community level. Reversing the underlying socioeconomic factors contributing to women's HIV risk - gender inequality, poverty, lack of economic and educational opportunity, lack of legal and human rights protections – is critical for success.

Addressing women's needs for HIV prevention, treatment and care is vital for curbing the epidemic.

7. Mother to Child Transmission (MTCT) of HIV/AIDS

Prevention of HIV transmission from mother to baby while in the womb or during birth or infant feeding requires a comprehensive package of services that includes preventing primary HIV infection in women, preventing unintended pregnancies in women living with HIV, preventing transmission from pregnant women living with HIV to their infants, and providing care, treatment and support for women living with HIV and their families.

Health systems need to be strengthened so that interventions to prevent mother to child transmission of HIV infection, including the use of antiretroviral drugs, can be safely and effectively implemented. Moreover, HIV testing in pregnancy has a number of benefits in terms of prevention and care for mother and child, although to avoid or minimize negative consequences testing must be voluntary and confidential and accompanied by quality counseling.

Timely administration of antiretroviral drugs to the HIV-diagnosed pregnant woman and her newborn significantly reduces the risk of mother-to-child HIV transmission. Positive mothers should also be provided with access to ART for the protection of their own health.

Combination regimes appear to be most effective but were until recently regarded as too costly for widespread use in low- and middle-income countries. In recent years, projects to prevent mother-to-child transmission in resource-limited settings have primarily focused on provision of single-dose intrapartum and neonatal nevirapine, which cuts the risk of HIV transmission by more than 40%. While the benefits of single-dose nevirapine outweigh the risk of resistance in these settings, development of affordable regimens with superior resistance profiles is an urgent global priority.

8. Protecting and Supporting AIDS Orphans

Worldwide, it is estimated that more than 15 million children under 18 have been orphaned as a result of AIDS. Around 11.4 million of these children live in sub-Saharan Africa. In countries badly affected by the epidemic such as Zambia and Botswana, it is estimated that 20 percent of children under 17 are orphans - most of whom have lost one or both parents to AIDS.

Children whose parents are living with HIV often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before they are orphaned. Eventually, they suffer the death of their parent(s) and the emotional trauma that results. They may then have to adjust to a new situation, with little or no support, and may suffer exploitation and abuse.

The loss of a parent to AIDS can have serious consequences for a child's access to basic necessities such as shelter, food, clothing, health and education. Orphans are more likely than non-orphans to live in large, female-headed households where more people are dependent on fewer income earners. This lack of income puts extra pressure on AIDS orphans to contribute financially to the household, in some cases driving them to the streets to work, beg or seek food. Often there are no adult family members remaining which leads to child headed households. In those cases orphans are not only completely on their own but also responsible for their younger siblings.

Children grieving for dying or dead parents are often stigmatized by society through association with AIDS. The distress and social isolation experienced by these children, both before and after the death of their

parent(s), is strongly exacerbated by the shame, fear, and rejection that often surrounds people affected by HIV and AIDS. Because of this stigma, children may be denied access to schooling and health care. Once a parent dies children may also be denied their inheritance and property. Often children who have lost their parents to AIDS are assumed to be HIV positive themselves, adding to the likelihood that they will face stigma and discrimination.

9. Reducing HIV/AIDS Stigma and Discrimination

UNAIDS defines HIV-related stigma and discrimination as: "...a 'process of devaluation' of people either living with or associated with HIV and AIDS...Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status." It is important to note that even if a person feels stigma towards another, s/he can decide to not act in a way that is unfair or discriminatory.

In many countries and communities, the stigma associated with HIV and the resulting discrimination can be as devastating as the illness itself: abandonment by spouse and/or family, social ostracism, job and property loss, school expulsion, denial of medical services, lack of care and support, and violence. These consequences, or fear of them, mean that people are less likely to come in for HIV testing, disclose their HIV status to others, adopt HIV preventive behavior, or access treatment, care and support. If they do, they could lose everything.

Globally, stigma and discrimination are associated with lower uptake of HIV preventive services, including under- or non-participation in HIV information meetings and counseling and reduced participation in programs to prevent mother-to-child transmission. Stigmatizing attitudes are associated with denial of risk and a lower likelihood of adopting preventive behaviors. Both the fear of stigma and stigmatizing beliefs – which perpetuate the notion that HIV only happens to others – keep people from HIV testing in numerous contexts.

Stigma and discrimination disproportionately affect women and girls. Women tend to experience greater stigma and discrimination than men, are more likely to experience its harshest and most damaging forms, and have fewer resources for coping with it. Violence is a severe consequence of stigma faced principally by women. Both women and girls report increased violence at the hands of their partners for requesting condom use, accessing voluntary testing and counseling, refusing sex within or outside marriage or for testing HIV-positive. Stigma and discrimination are daily realities for people living with HIV and for people belonging to groups particularly vulnerable to HIV infection. Such groups include sex workers, men who have sex with men, people who inject drugs, prisoners and people with tuberculosis. Members of these groups are already stigmatized and are more likely to face more discrimination than others when diagnosed with HIV, including being refused services. The layered stigma that people in these groups experience further heightens the challenge of meeting their needs with respect to HIV. Members of these groups often avoid, or delay, seeking needed services for fear of being "found out", humiliated, and/or treated differently by health workers, and, in some instances, prosecuted and imprisoned.

Useful links

<http://www.un.org/popin/icpd/conference/offeng/poa.html> (Program of Action of the CPD – see 7.27-7.33)

http://www.un.org/esa/population/publications/AIDS_Wallchart_web_2007/Population%20and%20HIV-AIDS%202007.htm

<http://www.unaids.org/en/CountryResponses/Regions/SubSaharanAfrica.asp>

<http://www.unaids.org/en/PolicyAndPractice/Prevention/PMTCT/default.asp> (Mother to Child transmission)

<http://www.unicef.org/aids/> (Children and HIV/AIDS)

<http://www.iasociety.org/> (International AIDS Society)

<http://www.avert.org/>

<http://www.unaids.org/en/KnowledgeCentre/Resources/Publications/default.asp> (UNAIDS publications to various HIV/AIDS related issues)