

The United Nations and the Challenge of Hiv/Aid in Sub-Saharan Africa

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Abstract

In response to one of its principal functions – that of confronting problems that challenge humanity, the United Nations Organization had in January 1996, launched the Joint Programme on AIDS (UNAIDS) to help countries fight the epidemic. Recent evidence from clinical trials has affirmed the powerful effect antiretroviral drugs have on the disease as part of effective strategies for HIV prevention, other than cure for AIDS. The study applied the dependency theory to evaluate the role of UNAIDS in fighting the scourge in Sub-Saharan Africa from 1999 – 2010. Our findings show that the region depends on the United Nations for programme sustenance. Similarly, the world incidence of HIV infection has stabilized and begun to decline in many countries with generalized epidemics, with the exception of Sub-Saharan Africa, where its socio-economic and political effects is most devastating, due to the negative disposition of the governments and her citizenry, coupled with inadequate intervention facilities and the poor supervisory machinery of the UNAIDS. Based on our findings, appropriate policy recommendations are proffered.

Keywords: United Nations Joint Programme on HIV/AIDS, Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome, Antiretroviral Therapy, Sub-Saharan Africa.

Introduction

The AIDS epidemic may be the worst devastating health challenge in human history. The disease continues to ravage nations, families and communities around the world. The Acquired Immunodeficiency Syndrome (AIDS) is a term that was barely known a couple of decades ago. Noticed in 1981 in the United States of America (USA), its existence was initially taken as a joke. AIDS is caused by the Human Immunodeficiency Virus (HIV), which is mainly spread through blood contact with an infected person. Viruses are extremely small particles, which can only be seen under the electron microscope. Unlike bacteria, virus can only survive and multiply within a living cell at the expense of this cell (UNESCO/UNAIDS, 2001:1-2). The most common routes of transmission are: unprotected sexual intercourse with an HIV-positive partner; transfusions of HIV-infected blood or blood products; tissue or organ transplants; use of contaminated needles, syringes, or other skin-piercing equipment; and mother-to-child transmission (MTCT) during pregnancy; birth, or breast feeding (WHO, 2009:4-5; Idris, 2010:22; Cook, 2010:138; UNAIDS, 2010).

Human body is protected by the White Blood Cells (WBC), which fights diseases seeking to attack the body. The HIV, once it finds its way into the body, attacks the WBC. At this time, the victim looks and feels healthy, but could spread the disease. A protracted struggle between HIV and the WBC makes the latter weak, thus removing the protective system against further attacks of various diseases. The consequence is that signs and symptoms of AIDS begin to show which eventually will result into the death of the victim (UNAIDS, 2010:27). HIV is not transmitted through: mosquito bites, hand-shake, sharing of toilet/baths, playing games together, or sitting close to an infected person. HIV is extremely fragile, but cannot survive long outside the blood's fluids or tissue. It cannot penetrate unbroken skin. There are two main types of the virus: HIV-1, which is responsible for the worldwide pandemic of AIDS, and HIV-2, which can also cause AIDS and occurs principally in West Africa (ILO, 2001:4-5).

Headquartered in Geneva, Switzerland, the United Nations Joint Programme on AIDS (UNAIDS) was formed in 1994 by a resolution of the United Nations Economic and Social Council and launched in January 1996. UNAIDS is a member of the United Nations Development Group. UNAIDS is the main advocate for accelerated, comprehensive and coordinated global action on the HIV scourge, and seeks to prevent it from becoming a severe pandemic. UNAIDS has five goals:

- Leadership and advocacy for effective action on the epidemic;
- Strategic information and technical support to guide efforts against AIDS;
- Tracking, monitoring and evaluation of the epidemic;
- Civil society engagement and the development of strategic partnerships;
- Mobilization of resources to support an effective response on the HIV/AIDS epidemic (UNAIDS, 2000).

UNAIDS is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the Cosponsors, and five representatives of Nongovernmental Organizations (NGOs), including bodies of people living with HIV/AIDS. UNAIDS has 7 Regional Offices and 80 country offices around the world. The staff of UNAIDS make up its main resource. UNAIDS brings together the efforts and resources of 10 UN System organizations in the response to HIV. The 10 UNAIDS cosponsors are:

- The Office of the UN High Commissioner for Refugees (UNHCR);
- UN Children's Fund (UNICEF);
- World Food Programme (WFP);
- UN Development Programme (UNDP);
- United Nations Population Fund (UNFPA);
- UN Office on Drugs and Crime (UNODC);
- International Labour Organization (ILO);
- UN Educational, Scientific and Cultural Organization (UNESCO);
- World Health Organization (WHO); and
- World Bank (WHO et al, 2011:223).

Therefore, the mission of UNAIDS is to lead, strengthen and support an expanded response to HIV and AIDS, which includes preventing transmission of HIV, providing care and support to those already living with the virus, reducing the vulnerability of

individuals and communities to HIV and alleviating the impact of the epidemic worldwide. In June 2001, the UN General Assembly set up the Global AIDS and Health Fund (UN, 2005:3; UNAIDS, 1996)

Statement of the Problem

Researches has shown that HIV/AIDS is overwhelming scientific enquiries worldwide, despite concerted efforts to stem the tide (see Ambooka, 2012:3-5; Nina, 2012:843). Poverty, illiteracy, sexual indiscipline, especially the promotion and use of condom, broken homes, military conflict, gender inequality, poor access to lifesaving treatment enhances the spread of HIV (Ying et al, 2012: USCDCP, 2011:1-5; Frye et al, 2010; El-Bassel et al, 2005; Rothman et al, 2011). The unfolding tragedy in the decline of global funding to AIDS Response programmes in Africa poses serious threat in combating the scourge. AIDS is consuming business profits and affecting governance and public service, where the country loses hard to replace political leaders and civil servants (Lamprey et al, 2006:10-11). The Highly Active Antiretroviral Therapy (HAART) is largely unavailable to most infected people in low-income countries (WHO, 2011:90-91). Treatment for children with HIV poses special challenges, as the antibody tests in use cannot detect the virus in children under the age of 18 months. AIDS victims face stigma and discrimination, thereby discouraging early testing by potential carriers.

Objectives of the Study

The general objective of this study is to evaluate the role of UNAIDS in SSA, while the specific objectives are to:

- (i) examine the socio-economic and political implications of HIV/AIDS in Sub-Saharan Africa;
- (ii) investigate the factors fueling the spread of HIV/AIDS in Sub-Saharan Africa, despite the intervention measures of the United Nations; and
- (iii) suggest appropriate policy measures to assist the United Nations Joint Programme on AIDS in checkmating the continued spread of the deadly disease, especially in Sub-Saharan Africa.

Significance of the Study

Studies have been executed globally that could provide evidence-based findings to inform strategic planning and implementation of HIV response programmes. Due to the technical nature of these researches, they are restrictively distributed within the medical fields. Therefore, one of the major challenges facing the United Nations is monitoring, evaluation and reporting of HIV/AIDS researches and the impacts across the world. Theoretically, this study will assist in providing information for facilitating further research on the status of the epidemic. On the empirical level, the research will:

- support decision-making as it affects HIV/AIDS Response Programmes in Sub-Saharan Africa.
- determine the effects of the Response on the target groups.

Theoretical Framework

The study adopts dependency theory. The foundations of this theory emerged in the 1950s from the research of the Economic Commission for Latin America and the Caribbean (ECLAC). One of the foremost authors is Raul Prebisch. The principal points

of the Prebisch model are that in order to create conditions of development within a country, it is necessary to:

- promote a more effective governmental role in terms of national development;
- allow the entrance of external capital, following priorities already established in the development plans;
- develop a more effective coverage of social services from the government, especially to vulnerable groups; and
- develop national strategies according to the model of import substitution.

Apart from Prebisch, we have other authors of the dependency theory, among which are A.G. Frank, 1976, 1979; O. Sunkel, 1969; C. Furtado, 1964; Dos Santos, 1970; A. Emmanuel, 1972; Samir Amin, 1972, 1975, 1976; B.N. Ghosh, 2001). According to the dependency theorists, the whole world is divided between two sets of countries – developed countries (DCs) and less developed countries (LDCs). The former are in the centre (Western Europe, Britain and the United States of America) and the latter are in the periphery (backward countries of Asia, Africa and Latin America). The theorists maintain that the cause of underdevelopment in the periphery is their links with the developed countries. According to them, real development will only materialize when the LDCs sever its ties with the DCs. However, the theorists are unanimous that the LDCs depends on the DCs technologically, finance etc for development activities in their countries.

The major theses with regard to Third World countries as expounded in the dependency school are the following:

- The development of Third World nations necessitates their subordination to the core;
- The peripheral nations experience their greatest economic development when their ties to the core are weakest;
- Regions that are highly underdeveloped and still operate on traditional and feudal system are those that had in the past maintained close ties with the core nations (Frank, 1969, Nath, 1990).

In applying the theory to the present study, it is instructive to note that the peripheral countries in Sub-Saharan Africa are heavily dependent on the international body – the United Nations Joint Programme on AIDS, including other industrialized nations, like United States in funding of AIDS-related programmes. In fighting AIDS, World Bank and the DCs are the major donors to the Global AIDS and Health Fund. For example, the two largest donors – United States and United Kingdom gave US\$200 million each in the first year (see Jones, 2004:171-172). Out of the total expenditure on AIDS globally in 1996, which amounted to US\$300 and US\$15.6 billion in 2008, 92.3 percent came from the DCs. LDCs use excessively capital-intensive machineries imported from the DCs in the management of AIDS scourge in their countries. The same apply to the antiretroviral drugs that are manufactured from the developed countries, without which, management of the scourge in LDCs would have been a mirage.

The Case of Sub-Saharan Africa

Sub-Saharan Africa (SSA), which is the main focus of this study, has forty-three (43) independent countries in the continent of Africa (see figure 1).

Figure 1: Map of Africa showing SSA Countries in colours

The number of children orphaned by AIDS is increasing on daily basis. AIDS has exacted a devastating toll on population and health over the years, thereby reversing the hard-won gains in child survival and life expectancy in SSA, and in a growing number of countries and communities worldwide (Davis and Weller, 1999; Lamptey, et al, 2006:4 -

7). In SSA, 10 countries have concentrated epidemic status, 32 with generalized level, while only Sao Tome and Principe has low level of HIV (see WHO et al, 2011:212-216). SSA depends on foreign aid for the sustenance of HIV/AIDS response project. For instance, between 2002 and 2010, the Global Fund approved USD12 billion to countries in SSA, of which USD7.2 billion had been disbursed at of December 2010 (Guardian News, April 15, 2010). AIDS is affecting agricultural production in Africa. A survey in Zambia, for example, showed that chronically ill heads of households in rural areas reduced the area of land they cultivated by more than half; reducing crop production and food availability (ILO, 2009). Despite the various UNAIDS efforts to discouraging risky moral behaviour worldwide, many citizens in the region have multiple sexual partners (see CAREC, 2007:55; Souteyrand, 2010; Baral, 2007; WHO, 2011; Rochelle, 2012; Morris and Kretzschamar, 1997; Halperin and Epstein, 2004; Epstein, 2010; Lurie and Rosental, 2010; Tanser, 2011; Guthrie de Bruyn and Farquhar, 2007; Chen et al, 2007, Williams, 2009, Smith, 2009; Beyrer, 2010; Rispel, 2011; Dahoma, 2011; WHO et al, 2011:176-178 & 185).

Some countries in the region now face HIV and TB epidemics simultaneously. Thus, AIDS promotes opportunistic infections, including TB. In heavily affected countries, HIV is believed to be stretching health care providers, infrastructures, and budgets beyond capacity. It robs employees from the labour force, providers and caregivers from families, and teachers from communities (Bekele, 2011; Kinghorn et al, 2001: 55-84). Countries in SSA are not utilizing donations to the AIDS Response prudently. For instance, a high ranking Nigerians are providing cover for a 'grand grants grafts' in the country. The Global Fund withdrew USD13.91 million HIV/AIDS grant to Mali, due to reported cases of mismanagement. The Fund stopped funding the Uganda AIDS programme, after it was revealed that an official of the Ministry of Health had fraudulently taken USD280,000 donated by the United Nations funding body. The USA Presidential Initiatives on AIDS (PEPFAR) channels its grants to the 22 focus countries in SSA, but there are disturbing reports on the use of funds by national AIDS administrators. International donors have threatened to stop funding the HIV/AIDS Response Projects in SSA due to poor accountability. In December 2010, UNAIDS, World Bank and PEPFAR rolled out assistance from the war ravaged Democratic Republic of Congo (UNAIDS Audit Report, 2010).

The Highly Active Antiretroviral Therapy (HAART) is largely unavailable to most infected people in low-income countries (WHO, 2011:90-91). Based on 2008 data from the Global Database on Blood Safety, an estimated 92 million units of blood are donated worldwide yearly. However, the availability and safety of blood supplies for transfusion remain issues of concern in multiple settings, especially in low-income countries (WHO et al, 2011:64, 67). AIDS victims face stigma and discrimination. Institutional deficiency and insufficient political commitment seem to pose serious constraint on UNAIDS efforts in combating the disease. Human clinical trials always raise ethical and legal issues, especially when it involves a fatal infectious agent like HIV. For instance, clinical trials in Cambodia, Nigeria, and Cameroon to evaluate the effectiveness of tenofovir in preventing human infection were halted in 2004 and 2005 because of pressure from activist groups about ethical concerns (UNAIDS, 2005). It appears that AIDS has no remedy.

Global Perspectives on the HIV/AIDS Epidemic

By the end of 1999, the year which the epidemic was believed to have peaked, there were an estimated 19.0 million adults and children living with HIV/AIDS in the world, and about 1.07 million deaths within the year (see WHO et al, 2011:1-2). The disease has reached epidemic proportions in both the developed and developing countries (ECDC, 2010:590; WHO et al, 2011:49). Globally, at the end of 2010, an estimated 34 million people were living with HIV; including 3.4 million children less than 15 years (WHO et al, 2011:49). In SSA, where most of the people newly infected with HIV live, an estimated 1.9 million people became infected in 2010 (see WHO et al, 2011:49 in Table 1). This was 16% fewer than the estimated 2.2 million people newly infected with HIV in 2001 and 27% fewer than the annual number of people newly infected between 1996 and 1998, when the incidence of HIV in Sub-Saharan Africa peaked overall (WHO et al, 2011:11).

Table 1: Regional HIV/AIDS Estimates as at 31st December 2010

Region	Adults & children living with HIV	Adults & children newly infected with HIV	Prevalence of HIV among adults (%)	Adults & children dying from AIDS-related causes	Prevalence of HIV among men 15-24 yrs old (%)	Prevalence of HIV among women 15-24 yrs old (%)
Sub-Saharan Africa	22.9m	1.9m	5.0	1.2m	1.4	3.3
Middle-East & North Africa	470,000	59,000	0.2	35,000	0.1	0.2
South & South-East Asia	4m	270,000	0.3	250,000	0.1	0.1
East Asia	790,000	88,000	0.1	56,000	<0.1	<0.1
Oceanic	54,000	3,300	0.3	1,600	0.1	0.2
Latin America	1.5m	100,000	0.4	67,000	0.2	0.2
The Caribbean	200,000	12,000	0.9	9,000	0.2	0.5
Eastern Europe & Central Asia	1.5m	160,000	0.9	90,000	0.6	0.5
Western & Central Europe	840,000	30,000	0.2	9,900	0.1	0.1
North America	1.3m	58,000	0.6	20,000	0.3	0.2
World Estimates	34million	2.7million	0.8	1.8million	0.3	0.6

Source: Global HIV/AIDS Response Report 2011, P.49.

The annual number of people dying from AIDS-related causes worldwide is steadily decreasing from a peak of 3.1 million in 2005 to an estimated 1.8 million in 2010 (see UNAIDS/WHO, 2005:3 and WHO et al, 2011:49). The number of AIDS-related deaths began to decline in 2005 – 2006 in Sub-Saharan Africa, South and South-East Asia and the Caribbean and has continued subsequently. However, not all regions and countries fit

the overall trends. The annual number of people newly infected with HIV has risen in the Middle-East and North Africa from an estimated 43,000 in 2001 to 59 000 in 2010. After slowing drastically in the early 2000s, the incidence of HIV infection in Eastern Europe and Central Asia has been accelerating again since 2008. The trends in AIDS-related deaths also differ. In Eastern Europe and Central Asia, the number of people dying from AIDS-related causes increased more than 10-fold between 2001 and 2010. In the same period, the number of AIDS-related deaths increased by 60% in the Middle East and North Africa, and more than doubled in East Asia (WHO et al, 2011:49).

Sub-Saharan Africa continues to account for the global majority of the people living with HIV and Tuberculosis (TB), with an estimated 82% in 2010. HIV is the strongest risk factor for developing active TB disease (WHO, 2011:123). The region contains 12% of the world's population, but bears a disproportionate share of the HIV burden globally. In mid-2010, about 68% of all people living with HIV resided in SSA (WHO et al, 2011:24). The estimated 1.9 million people who became newly infected with HIV in 2010 in the region represented 70% of all the people who acquired HIV infection globally. However, the number of people newly infected in this region is decreasing. About 16% fewer people acquired HIV infection in 2010 than in 2001, when about 2.2 million people were newly infected with the virus (see WHO et al, 2011). In 2010, women comprised 59% of the people living with HIV in the region, close to the same proportion as a decade ago.

The epidemics in SSA vary considerably, with Southern Africa most severely affected, with an estimated 11.1 million people living with HIV in this sub-region in 2009; 31% more than the 8.6 million people living with the virus a decade ago. In Zimbabwe, the annual HIV incidence is estimated to have peaked in 1991 (at 5.5%) and slowed to 1% in 2010 (Hargrove, 2011). Increased awareness of AIDS deaths and the country's economic decay appeared to have been the primary factors driving the changes in sexual behaviour, which occasioned the reduction. One third (34%) of all people living with HIV globally in 2009 resided in the 10 countries in Southern Africa – Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, as did about 40% of all women living with HIV (see UNAIDS, 2010; Halperin, 2011). South Africa's HIV epidemic remains the largest in the world, with an estimated 5.6 million people living with the virus in 2009 (DoH, 2010; Shisana, 2010:205; see also UNAIDS, 2010, 2011:152).

Comparatively, Angola's younger epidemic still appears to be growing (Hallett, 2010). The epidemic in Eastern Africa began declining about a decade ago and has since stabilized in many countries. The HIV incidence slowed in the United Republic of Tanzania to about 3.4 per 1000 person – years between 2004 and 2008 (Hallett, 2010). The national HIV prevalence in Kenya fell from about 14% in the mid-1990s to 6% in 2006 and has stayed there since then, while in Uganda it has been stable at between 6% and 7% since 2001. In Rwanda, it stayed at about 3% between 2005 and 2009. Much smaller proportions of the population are living with HIV in Western and Central Africa, where the adult HIV prevalence was estimated to be 2% or less in 12 countries in 2009 – Benin, Burkina Faso, DR Congo, Gambia, Ghana, Guinea, Liberia, Mali, Mauritania, Niger, Senegal and Sierra Leone (FRK, 2010:4-5; UNAIDS, 2010:7).

The national HIV prevalence in 2009 was highest in Cameroon at 5.3%, Central African Republic, 4.7%, Cote d'Ivoire, 3.4%, Gabon, 5.2% and Nigeria, 3.6%. Nigeria

continues to have the second largest number of people living with HIV in Sub-Saharan Africa (WHO et al, 2011:25; see also UNAIDS, 2010). There has been strong progress in reducing the HIV incidence among children than 15 years in Sub-Saharan Africa. The estimated 350 000 children who were newly infected with HIV in 2010 in the region were 30% fewer than the 500 000 who acquired HIV infection in 2001. However, fewer children are dying from AIDS-related causes; from an estimated 320 000 in 2005 to 230 000 in 2010. South Africa is one of the few countries in the world in which child and maternal mortality increase.

Management of HIV/AIDS

The clinical objective of Antiretroviral Therapy (ART) are to suppress the replication of the virus and restore immune function of the body; limit the likelihood of viral resistance to ART drugs; and reduce HIV-related morbidity and mortality. Since the introduction of antiretroviral in 1996, drug therapy has transformed HIV from a progressive terminal illness to a manageable chronic disease. Drugs slow or reverse the progression of AIDS, although they cannot cure it. The current ART drugs, which fall into three main classes – work by blocking enzymes that are important for the replication and functioning of HIV in the body (Lamptey et al, 2006:15-16). A newer class of antiretroviral – entry inhibitors; works differently. In effect, it fights HIV after it has infected the human body immune system. Entry inhibitors offer hope to people who have developed resistance to current HIV medications. Combining drugs from different classes is the most effective therapy for thwarting AIDS, because the virus can develop resistance to drugs used individually. A similar multi-drug approach is used to treat the underlying ailments, like Tuberculosis (TB) and cancer (Grant et al, (2010). UNAIDS links member countries to sources of supply of the drugs at highly subsidized prices.

Recent studies have shown that low-cost regimens can prevent some of the opportunistic infections that commonly occur with HIV, including TB and Pneumocystis Carinii Pneumonia (PCP), and other major causes of illness, such as nontyphoid salmonella infections and cerebral toxoplasmosis. Preventive therapy for TB would be especially effective in SSA, where TB is a major cause of death in HIV-positive individuals. According to findings, using cotrimoxazole to treat PCP patients who have HIV can significantly reduce hospitalizations and mortality from other bacterial opportunistic infections. Fungal infections, a major cause of illness and death in HIV-positive individuals, respond to preventive therapy with fluconazole (Colebunders et al, 2005 in Lamptey et al, 2006). These simple preventive therapies could reduce illness in people living with HIV. Their relatively low cost means they could reach a much wider population than more expensive antiretroviral drugs. However, Lamptey et al (2006) and WHO (2009) warns that more researches are needed to determine who should apply the drugs; for how long and how the therapies affect drug resistance in the long run.

The liver is a major target of the aging process in HIV infected patients and this has been attributed to multiple health complications arising from the disease itself. According to Pouti (2010:24), Vachon (2010:23) and Idoko (2010), the End Stage Liver Disease (ESLD) in HIV-positive individual could be monitored through fibroscan and biopsy. The management of ESLD tries to change the course of cirrhosis, treat underlying diseases, treat HIV in co-infected patients, reduce portal pressure, and ameliorating systemic hyper dynamic circulatory state, using antibiotics and abumin. At this stage, the

patient needs to be closely monitored and cared for. According to Searle (2010) and Decroo (2009), the broad goal of clinical care (including drug therapy) is to improve the quality of life of people living with HIV by improving access to comprehensive prevention and care programs. Evidence from both developed and developing countries has shown that ART can dramatically prolong the lives of persons living with HIV, enabling them to remain productive members of their community, support their families, and raise children.

Palliative care is an important component of comprehensive care for people living with HIV, who usually experience pain, diarrhea, nausea, cough, shortness of breath, fatigue, fever and confusion, as well as damaging psychosocial stress associated with stigma and end-of-life issues. The WHO (2009) recommends that preventing these symptoms through palliative care and enhanced diets prevents pain and unnecessary visits to health care facilities and allows people with AIDS to remain as active as possible in their community. Lamptey et al (2006) recommends traditional and local remedies. Home-based care providers or family members can enhance the quality of life of people living with AIDS. Strategies for preventing mother-to-child transmission include primary prevention of HIV in girls and women; counseling and testing in pregnant women; family planning services to reduce pregnancy in infected mothers; preventive ART drug therapy; follow up care and treatment for mother and infant; nutritional counseling and breast-milk substitutes, if appropriate.

Recommendations

The following recommendations are made towards effective administration of the United Nations Joint Programme on HIV/AIDS in Sub-Saharan Africa:

1. Many young ladies in SSA are driven into prostitution and other risky behaviours for their daily survival, due to the high level of poverty in most of the countries, thereby becoming more vulnerable to sexually transmitted diseases, including HIV/AIDS. UNAIDS should encourage countries to introduce poverty reduction programmes, which will also go a long way in reducing the high rate of unemployment in the region.
2. UNAIDS should intensify more efforts in the provision of HIV/AIDS testing and management facilities in the region, due to the growing number of people who are need.
3. Regional Directors should ensure that country programme managers render annual performance evaluation reports promptly to them for onward transmission to UNAIDS Headquarters for effective planning purposes.
4. UNAIDS should introduce manpower training and development on periodic basis in order to afford these category of medical personnel the opportunity of being abreast with current trends in the management of the complex disease.
5. Sanctioning of governments and organizations for the mismanagement of HIV/AIDS funds should continue. However, UNAIDS should enhance its supervisory machinery, especially at the regional offices, so that countries and NGOs engaged in the management of the epidemic are not even afforded the opportunity to misuse the funds in the first place.

6. UNAIDS, in collaboration with the United Nations General Assembly should encourage countries to intensify domestic scientific efforts in the fight against HIV/AIDS, thereby reducing their current over reliance on the developed countries for programme sustenance.
7. UNAIDS should encourage countries to intensify more efforts in the area of public enlightenment of her citizenry on the dangers of attrition (treatment interruption), unnecessary stigma and discrimination against HIV/AIDS-positive persons and the continued spread of the disease in SSA, which is the hardest-hit region in the world.

Conclusion

For the estimated 22.9 million people in SSA alone living with HIV as at 2010, out of the world total of over 34 million, after three decades into a very complex disease, the gains are still fragile. Based on the current data, over 7 000 persons are infected with HIV and about 5 000 others die of AIDS daily in the world, with approximately 56% occurring in SSA. Many countries in the region may fail to achieve MDG 6: “Zero Discrimination, Zero New Infections and Zero AIDS Deaths” by 2015, the new target set by the UN after the collapse of the 2010 deadline to achieve a 50% decline in HIV prevalence. There are several factors fueling the spread of HIV/AIDS, but in SSA, it is largely recognized as a disease of poverty, ignorance and sexual promiscuity, hitting hardest where people are marginalized or experiencing economic deprivation. A hard look at the societal structures, beliefs and value system that present obstacles to HIV/AIDS effective programme management in SSA is necessary. In a world that has had to learn to live with an evolving and seemingly unquenchable pandemic over three decades, poses serious challenges.

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