UNAIDS
PROGRESS
REPORT

1996-1997

Joint United Nations Programme on HIV/AIDS

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LIST OF ABBREVIATIONS

AFRICASO	African Council of AIDS Service Organizations
AFRO	WHO's Regional Office for Africa
AHRN	Asian Harm Reduction Network
AHRTAG	Appropriate Health Resources and Technologies Action Group
APCASO	Asia/Pacific Council of AIDS Service Organizations
APN+	Asia-Pacific Network of People Living with HIV/AIDS
ASEAN	Association of South East Asian Nations
CAREC	Caribbean Epidemiology Centre
CCO	Committee of Cosponsoring Organizations
CIOMS	Council for International Organizations of Medical Sciences
DFID	Department for International Development, UK
EMRO	WHO's Regional Office for the Eastern Mediterranean
ESCAP	Economic and Social Commission for Asia and the Pacific
EURO	WHO's Regional Office for Europe
FAO	Food and Agriculture Organization of the United Nations
FCAA	Funders Concerned About AIDS
FHI	Family Health International
GIPA	Greater Involvement of People Living with HIV/AIDS
GNP+	Global Network of People Living with HIV/AIDS
GPA	WHO's Global Programme on AIDS
GTB	WHO's Global Tuberculosis Programme
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HTCG	The Horizontal Technical Collaboration Group
IAAG	Inter-Agency Working Group on AIDS
IAWG	Inter-Agency Working Group
ICASO	International Council of AIDS Service Organizations
ICW	International Community of Women Living with HIV/AIDS
ILO	International Labour Organization
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
IPU	Inter-Parliamentary Union
LACCASO	Latin American/Caribbean Council of AIDS Service Organizations
MAP	Collegial Network for the Monitoring of the Status and Trends of the HIV/AIDS Pandemic
MERG	Monitoring and Evaluation Reference Group
MTV	Music Television
NAP+	Network of African People Living with HIV/AIDS
NGO	Nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
PAHO/AMRO	Pan American Health Organization/WHO's Regional Office for the Americas
PCB	Programme Coordinating Board
PSI	Population Services International
SAARC	South-Asian Association for Regional Cooperation
SADC	Southern African Development Community
SEAHAP	South-East Asia HIV/AIDS Project
SEARO	WHO's Regional Office for South-East Asia
SWAA	Society for Women and AIDS in Africa

TASO	The AIDS Support Organization
UNDAF	United Nations Development Assistance Framework
UNDAW	United Nations Division for the Advancement of Women
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNV	United Nations Volunteers Programme
USAID	United States Agency for International Development
WHO	World Health Organization
WAI	West African Initiative on HIV/AIDS
WPRO	WHO's Regional Office for the Western Pacific

Introduction

By the early 1990s, it had become clear to an increasing number of United Nations Member States that the HIV epidemic was undermining the efforts of national governments, nongovernmental organizations and their partners to improve the health, economic well-being, and political stability of many countries, particularly in the developing world. As part of the need for an expanded response to a growing problem, there was a need for the United Nations system to better coordinate its efforts to deal with AIDS, and to increase the value of its contribution by speaking with a stronger and more unified voice. It was in this context that UNAIDS was established and became operational in January 1996 as the HIV/AIDS programme of six UN system agencies the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank (SEE PANEL 1).

PANEL 1

UNAIDS MISSION STATEMENT

As the main advocate for global action on HIV/AIDS, UNAIDS will lead, strengthen and support an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

1996-1997 has been a crucial period for the development of the Programme, largely in terms of determining how UNAIDS would operate and in which areas it could be most effective. This period is characterised by a striking paradox in the evolution of the HIV epidemic and the response to it. In November 1997, just prior to World AIDS Day, UNAIDS and WHO announced that analysis of more accurate surveillance data had yielded startling new statistics. The new data revealed that, by the end of 1997, more than 30 million people were estimated to be living with HIV – in addition to 12 million people who already had died from HIV-related causes. It was estimated that 5.8 million adults and children became infected with HIV in 1997 alone – an average of about 16 000 new infections every day. These statistics were rendered all the more alarming by the fact that in western nations many had the perception that the 'AIDS crisis' was over. This misconception was further reinforced by the popular but erroneous belief that the introduction of antiretroviral therapy had somehow solved the problem. The paradox facing the world during the 1996-1997 biennium was that although people the world over acknowledged the HIV epidemic as being more serious than they had previously believed, the response was hampered by a growing sense of complacency.

This paradox constitutes an enormous challenge to efforts to strengthen the global response to AIDS. Over the course of the past two years, UNAIDS has focused on developing its strategic approach, and using lessons learned about how the epidemic spreads, how best to respond to it, and how to harness the collective resources of the United Nations system. To effectively leverage the organizational resources of its Cosponsors in response to the epidemic, UNAIDS uses two equally important and mutually reinforcing strategies. First, it seeks to build worldwide commitment and political support for the response to the epidemic through advocacy based on the most current information and technically sound analysis. Second, it seeks to improve access to and use of the best and most effective practices in responding to the epidemic.

This report highlights the activities, achievements, progress and challenges of the UNAIDS Secretariat, and, to the extent possible, of the Programme's Cosponsors. It reflects the significant improvement in coordination within the United Nations system in response to the epidemic, as well as an expanding collaboration with civil society. These points are covered in sections detailing the current status of the epidemic and the global response; the strategic approach viewed as critical in shaping the response to the epidemic; the United Nations

system response; improving the functioning of the UNAIDS Secretariat; and challenges, opportunities and strategic options. The report aims to offer the reader an overview of key activities conducted during 1996-1997 and their significance, as well as of the work and priorities anticipated in the future.

Current status of the epidemic and the global response

• Overview

Estimates available at the end of 1997 show that infection with the human immunodeficiency virus (HIV), which causes AIDS, is far more prevalent than previously thought – UNAIDS and WHO estimate that over 30 million people were living with HIV infection by the end of 1997 (SEE PANEL 2). Included in the figure of 30 million people are 1.1 million children under the age of 15. The overwhelming majority of HIV-infected people – more than 90% – live in the developing world. Due to limited access to counselling and testing, nine out of ten do not know that they are infected.

Even more alarming than the enormous number of people living with HIV is the fact that the spread of the virus – about 20 years into the pandemic – continues largely unabated in many countries. Altogether, some 5.8 million people are believed to have acquired HIV infection in 1997 alone, including 590 000 children infected at birth or through breastfeeding. Overall, this is equivalent to nearly 16 000 new infections every day of the year.

An estimated 2.3 million people died of AIDS in 1997, about the same number as those who died of malaria. These deaths represent one-fifth of the total 11.7 million AIDS deaths since the beginning of the epidemic in the late 1970s. Of the people who died of AIDS in 1997, 46% were women and 460 000 were children. Because the vast majority of people living with HIV are in the developing world, access to antiretroviral drugs for most is difficult if not impossible, and consequently mortality rates are unlikely to decline.

PANEL 2

ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV/AIDS AS OF END 1997

Although nearly every country is touched by HIV, the virus spreads very differently in different parts of the world and there are important differences in patterns of spread within the various communities and geographic areas of the same country (SEE PANEL 3).

Sub-Saharan Africa remains the region with the fastest-growing epidemic. The African epidemic is also the one that has been most underestimated in previous years. Now thought to have fully two-thirds of the total number of people living with HIV in the world, sub-Saharan Africa as a whole has reached the unprecedented level of 7.4% of all those aged 15 to 49 infected with HIV. Southern Africa remains the part of the continent worst affected by HIV. In some areas of the region, the proportion of the adult population living with HIV has doubled over the last five years and it is not unusual to see infection rates estimated at one in five adults and one in three pregnant women, or even higher.

The epidemic is newer in Asia than in Africa, and only a few countries in the region have developed systems sufficient for monitoring the spread of HIV. For this reason, estimates of HIV in Asia often have to be made on the basis of less information than in other regions. The Government of China reported at the end of 1996 that up to 200 000 people were HIV-infected, a figure estimated to have doubled by the end of 1997. In India, surveillance is uneven, but indications are that between 3 and 5 million people are living with HIV, the largest number within any one country in the world. Rates of HIV infection remain well under 1% in several South-East Asian nations, while other countries in the region such as Cambodia and Myanmar show much higher levels of HIV spread. The reasons for these differences are not entirely clear. Nor is there any assurance that currently low rates will remain so, given the prevalence of risk behaviour, including commercial sex and, in some places, injection of drugs.

PANEL 3

HIV/AIDS: Regional statistics and features, December 1997

Region	Epidemic started	Adults & Children living with HIV/AIDS	Adult prevalence rate (1)	Cumulative number of orphans (2)	% of HIV-positive adults who are women	Main mode(s) of transmission for adults living with HIV/AIDS*
Sub-Saharan Africa	late '70s-early '80s	20.8 million	7.4%	7.8 million	50%	Hetero
North Africa & Middle East	late '80s	210 000	0.13%	14 200	20%	IDU - Hetero
South and South-East Asia	late '80s	6.0 million	0.6%	220 000	25%	Hetero - IDU
East Asia & Pacific	late '80s	430 000	0.05%	1 900	11%	IDU - Hetero - MSM
Latin America	late '70-early '80s	1.3 million	0.5%	91 000	19%	MSM - IDU - Hetero
Caribbean	late '70s-early '80s	310 000	1.9%	48 000	33%	Hetero - MSM
Eastern Europe & Central Asia	early '90s	150 000	0.07%	30	25%	IDU - MSM
Western Europe	late '70s-early '80s	530 000	0.3%	87 000	20%	MSM - IDU
North America	late '70s-early '80s	860 000	0.6%	70 000	20%	MSM - IDU - Hetero
Australia & New Zealand	late '70s-early '80s	12 000	0.1%	300	5%	MSM - IDU
TOTAL		30.6 million	1.0%	8.2 million	41%	

* IDU: transmission through injecting drug use – Hetero : heterosexual transmission – MSM: men who have sex with men

(1) *The proportion of adults alive with HIV infection or AIDS in the adult population (15 to 49 years of age).*

(2) *Orphans are defined as children who lost their mother or both parents to AIDS when they were under age 15.*

Thailand, with probably the best-documented epidemic in the developing world, is continuing to produce evidence of a fall in new infections, especially among sex workers and their clients. These populations accounted for the majority of the 750 000 persons currently infected, representing 2.3% of the adult population. The decrease in new infections is the outcome of concurrent and sustained prevention efforts aimed at increasing condom use among heterosexuals, boosting respect for women, discouraging men from visiting sex workers, and offering young women better educational and other prospects to discourage their entry into commercial sex. Notwithstanding this progress, HIV rates among Thailand's injecting drug users have stabilized at a relatively high level (around 40%), and a survey among men who have sex with men in Northern Thailand reported low AIDS awareness and condom use.

In Latin America, the picture is also heterogeneous. For the most part, HIV is concentrated in neglected populations living on the social and economic margins of society. The epidemic has taken its greatest toll on men who have sex with men and injecting drug users. Systematic data collection is difficult in these groups and information remains rather scarce. Nevertheless, studies on Mexican men who have sex with men show that, on average, as many as 30% of them may be living with HIV. Rates in drug users vary from between 5% and 11% in Mexico to close to 50% in Argentina and Brazil. Rising rates in women show that heterosexual transmission is becoming more prominent. In Brazil, the male/female ratio of AIDS cases has dropped from 16:1 in 1986 to 3:1 today. Although HIV rates in pregnant women are still comparably low in general, they have reached 1% in Honduras and exceeded 3% in localities in Brazil. Rates remain substantially higher in the Caribbean with reports of up to 8% of pregnant women already carrying the virus in a number of localities.

Drug injection is a major factor behind the dramatic surge in HIV infection in several Eastern European nations, accounting for the majority of the 100 000 new infections estimated to have occurred in 1997. In Ukraine, where around 70% of infections have been in drug users over the past three years, it is estimated that approximately 110 000 people are living with HIV at present. Russian officials estimate there are about 350 000 regular drug users in the country, many of whom share injecting equipment. In Belarus, Moldova and Russia, new cases of syphilis rocketed from very low levels in the late 1980s to well above 2 per 1000 population by 1996, with continuously increasing trends.

The growing gap between the developed and the developing world concerns not only the scale of HIV spread, but also mortality from AIDS. In North America, Western Europe, Australia and New Zealand, newly-available antiretroviral drugs are reducing the speed at which HIV-infected people develop AIDS. In Western Europe, evidence suggests that new AIDS cases will have fallen by around 30% in 1997 compared with 1995, before combination antiretroviral treatment became available. The fall is greatest in countries in which infection has been concentrated in homosexual men, in whom HIV rates began dropping 5–10 years earlier, demonstrating that the decline in AIDS cases is often the combined result of better prevention and better treatment. In the United States, newly-published figures indicate that the first-ever annual decrease in new AIDS cases – 6% – occurred in 1996, and an even bigger decrease is expected in 1997. Again, the largest fall – a drop of 11% – was in homosexual men.

AIDS continues to have a significant impact on reducing life expectancy – one of the most accepted indicators for development (SEE PANEL 4).

The gains achieved over the last few decades in much of the developing world will in some places be cancelled out by HIV. By the end of this decade, a number of countries in Southern and Eastern Africa will see a reduction in life expectancy of 10 years or more, compared with 1990. Other well-established indicators for development are the rates

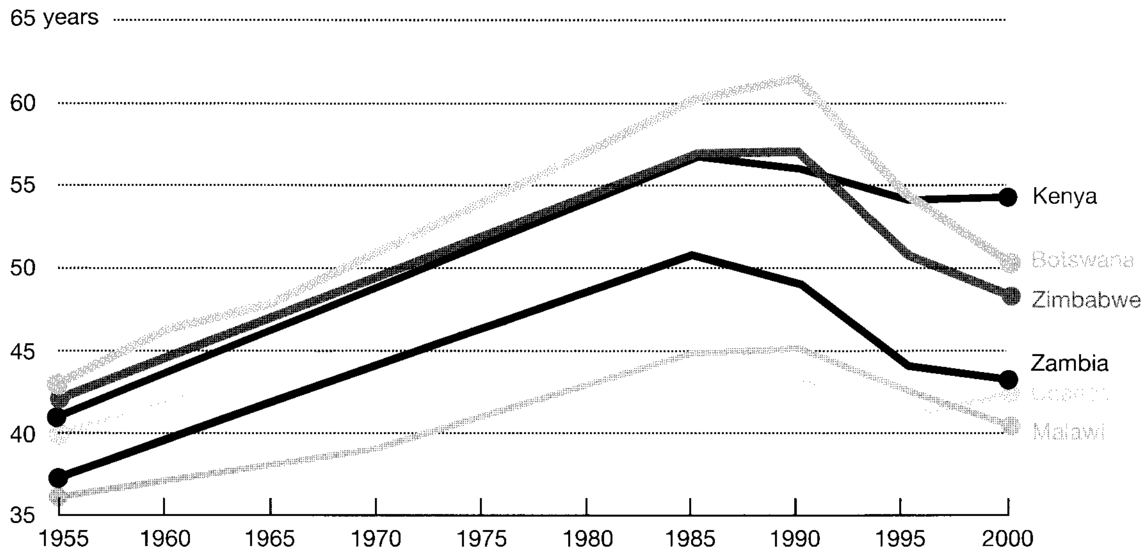
of infant and child survival. HIV continues to erode the substantial gains achieved in this area. Already, in the countries most affected by the epidemic, one-quarter more babies under 12 months old are dying than would be the case if there were no HIV. In these same countries, infant and child mortality rates are expected to rise by up to 100% or more compared with 1990 figures because of AIDS. Since the beginning of the epidemic, it is also estimated that more than 8 million children have lost their mothers to AIDS when they were less than 15 years old; many of them also lost their fathers. This figure is expected to almost double by the year 2000.

In many countries, AIDS is the leading cause of death in adults. In the United States, after introduction of combination therapy to slow down the progression of HIV disease in 1996, AIDS dropped into second place among leading causes of death in people aged 25-44 for the first time since 1992. In heavily-impacted countries in Africa, AIDS accounts for more than one-third of adult deaths, and for women between the ages of 20 and 44, as many as seven out of every 10 deaths. In trading centres in Uganda which are home to large numbers of younger adults, nearly nine out of 10 deaths in 15-to-49-year-olds are HIV-related.

Despite progress made in a limited number of countries in slowing the spread of HIV and a growing sense in many wealthier countries that the major threat of the epidemic is over – following the introduction of highly active antiretroviral therapy – the virus continues its expansion at a staggering rate in most parts of the world.

PANEL 4

PROJECTED LIFE EXPECTANCY AT BIRTH
SELECTED SUB-SAHARAN COUNTRIES



Source: World Population Prospects: the 1996 revision, *United Nations Population Division,* 1996

• New developments in the response to AIDS

The 1996-1997 period witnessed a number of significant developments in the response to the epidemic, as well as important lessons (SEE PANEL 5) learned and reinforced in the area of HIV prevention and AIDS treatment.

PANEL 5

AIDS PROGRAMMES WORK

- *Prevention strategies to promote safer sexual behaviour can significantly reduce HIV transmission rates.*
- *Voluntary counselling and testing can be effective in reducing transmission of HIV.*
- *Mother-to-child transmission of HIV can be reduced significantly by zidovudine (AZT).*
- *Sexual health and life-skills education for young people helps postpone first intercourse and helps decrease the risk of acquiring HIV or other sexually transmitted diseases or pregnancy among those already sexually active.*
- *Male condoms protect against sexual transmission of HIV.*
- *The female condom is acceptable, effective, and can be widely distributed.*
- *Treating sexually transmitted diseases reduces HIV transmission.*
- *Needle exchange, integrated with AIDS education, helps keep HIV rates low in drug users when started early.*
- *New combination antiretroviral therapies significantly reduce morbidity and mortality from AIDS.*

Prevention programmes can lead to a lower rate of HIV transmission

The 1996-1997 biennium marked considerable progress in documenting the success of HIV prevention programmes by demonstrating that behavioural change on a national scale can change the course of the epidemic. With the help of data from behavioural surveys repeated over time and HIV sentinel surveillance in pregnant women, researchers and programme managers in Thailand and Uganda documented a reduction in sexual risk behaviour since the early 1990s and showed how. This change in behaviour has led to a significant decline in HIV prevalence, especially among young people.

In Uganda, over the past five years, there was an overall decline of 40% in HIV prevalence among pregnant women in urban areas. This decline was closely linked to a two-year delay in first sexual intercourse, a large increase in condom use, and a small reduction in the number of non-regular sexual partners.

In Thailand, behavioural surveys indicated that the majority of sexual risk activities were associated with commercial sex. This led to a national policy of '100% condom use', established with the active involvement of brothel owners and sex workers. National mass media and peer education among young people help to reinforce the policy. Researchers have documented a clear reduction in the incidence of HIV, illustrated by the decline in HIV prevalence from 8% in 1992 to less than 3% in 1997, among young military conscripts.

The role of voluntary counselling and testing in preventing HIV infection

A randomized, controlled trial to test the effectiveness and consequences of voluntary counselling and testing for prevention of new HIV infections confirmed that counselling and testing can reduce risk behaviour. These findings come from the Multisite Voluntary Counselling and Testing Study (SEE PANEL 6), conducted from 1995 to 1997 with Muhimbili University College of Health Sciences, Dar es Salaam, Tanzania, Kenya Association of Professional Counsellors and University of Nairobi, Nairobi, Kenya, and Queen's Park Counselling Centre, Port-of-Spain, Trinidad.[1] The study also provided crucial data on the practical aspects of voluntary counselling and testing services in resource-constrained settings.

PANEL 6

THE MULTISITE VOLUNTARY COUNSELLING AND TESTING STUDY*

This study, conducted in 1995-1997 in Kenya, Tanzania and Trinidad, compared voluntary counselling and testing to a health-information control programme. Preliminary results have indicated that:

- *voluntary counselling and testing produced greater reductions in unprotected sexual intercourse with non-primary partners;*
- *voluntary counselling and testing were more effective in reducing unprotected intercourse with commercial sex partners;*
- *voluntary counselling and testing were more effective in reducing unprotected sexual intercourse among couples who had been tested and counselled together;*
- *client-centred counselling methods were effective in helping clients trust that their confidentiality would be respected;*
- *client-centred counselling strengthened the ability of individuals to cope with their HIV diagnosis, and facilitated early referrals to care and support;*
- *there was no evidence that voluntary counselling and testing increased the incidence of negative life events (relationship break-up, discrimination, etc.), although there were indications that women who test HIV-positive may need additional support services; and*
- *prospective clients were willing to pay a minimal fee for voluntary counselling and testing.*

* Preliminary results from the Voluntary Counselling and Testing Efficacy Study. Data presented at the satellite workshop 'Making Counselling and Testing Work: Efficacy and Feasibility of Voluntary Counselling and Testing in Developing Countries'. Tenth International Conference on AIDS and STDs in Africa. December 1997, Abidjan, Côte d'Ivoire.

(1) This study was a collaborative effort with WHO, the Center for AIDS Prevention Studies of the University of California at San Francisco, Family Health International's AIDS Control and Prevention Project, the United States Agency for International Development and the UNAIDS Secretariat.

Use of zidovudine in preventing mother-to-child transmission of HIV

In February 1998, the findings were announced of a trial in Thailand, sponsored by the Thai Ministry of Public Health and the United States Centers for Disease Control and Prevention. It demonstrated that the use of a relatively short zidovudine (AZT) regimen, involving the administration of the drug to HIV-infected pregnant women during the last four weeks of pregnancy and during delivery, reduces mother-to-child transmission of HIV by half among women who do not breastfeed (SEE PANEL 7).

Combined with access to safe alternatives to breastfeeding, zidovudine therefore offers an effective and feasible way to reduce mother-to-child transmission, particularly in developing countries. In light of this study, the UNAIDS Secretariat, in collaboration with UNICEF and WHO, hosted a meeting in March 1998 to plan programme implementation for the prevention of mother-to-child transmission of HIV. Further research needs to explore the efficacy of the shorter regimen among breastfeeding populations.

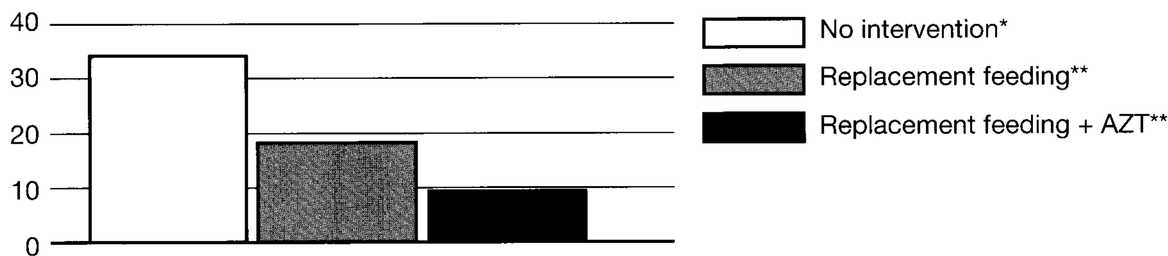
Female condoms bring results in slowing the spread of HIV and other sexually transmitted diseases

In 1997, a study was conducted in Thailand by Prince Songla Hospital, Hat Yai, Khon Kaen University Hospital, Khon Kaen, Siriraj Hospital, Bangkok, Research Institute for Health Sciences, Chiang Mai, and the Ministry of Public Health and sponsored by UNAIDS comparing female and male condom use. This study showed that in the group of women who had both male and female condoms available to them, the average incidence of sexually transmitted diseases decreased by 34%. The number of unprotected sex acts decreased by 25% compared to the group of women who had only the choice of using male condoms. Other studies indicate that the female condom is an acceptable option for women, providing greater opportunities to communicate about safer sex.

To increase the availability of female condoms, UNAIDS successfully negotiated a lower price with its manufacturer, the Female Health Company, for developing country public sectors. More than four million female condoms were purchased as of April 1998 in the developing world and substantial sales were registered in South Africa, Uganda, Zambia and Zimbabwe.

PANEL 7

PERCENTAGE OF CHILDREN INFECTED THROUGH THEIR HIV-POSITIVE MOTHER, WITH AND WITHOUT INTERVENTION



* *Baseline data from sub-Saharan Africa.*

** *Data from a study conducted by the Ministry of Public Health, Thailand, and the United States Centers for Disease Control and Prevention, announced on 18 February 1998.*

Increasing acceptance of harm reduction approaches for HIV prevention among injecting drug users

Initiatives based on a public-health approach to HIV prevention among injecting drug users have long proven effective in reducing the spread of HIV infection among those who inject drugs. Both developing and industrialized countries are now adopting an increasing range of harm reduction measures such as needle exchange programmes and substitution therapy. A recent international review[2] compared rates of change of seroprevalence among drug users in cities with and without needle exchange programmes. On average, HIV prevalence increased by 5.9% per year in the 52 cities without needle exchange programmes, and decreased by 5.8% per year in the 29 cities with needle exchange programmes.

Preventing and treating tuberculosis in people living with HIV/AIDS

In February 1998, WHO organized a consultation with UNAIDS on preventive therapy for tuberculosis in people living with HIV. Given that HIV is a major cause of the large increase over the last decade in the incidence of tuberculosis, participants maintained that preventive therapy is a public health need in populations with a high prevalence of HIV infection. In addition to energetic treatment for active tuberculosis using the DOTS strategy[3], participants recommended that preventive therapy be part of a package of care for people living with HIV/AIDS. Recommendations on appropriate drug regimens and their administration and supervision have also been disseminated.

Augmenting the availability and affordability of essential drugs

In December 1997, WHO revised its essential drug list to include several drugs of special interest to people with HIV infection, including sulfadiazine (to treat toxoplasmosis), acyclovir (to treat herpes), and fluconazole (to treat systemic yeast infections). AZT is now also part of the list, as an important drug for preventing mother-to-child transmission of HIV. Inclusion of these drugs on the WHO essential list usually leads to a reduction in price through bulk purchases, with consequent greater availability of the drugs for people living with HIV and AIDS.

Highly-active antiretroviral treatment (HAART)

In 1996, a new approach to antiretroviral therapy called 'highly-active antiretroviral treatment', or HAART, was developed. This treatment involves the combination of at least two nucleoside reverse transcriptase inhibitors and a protease inhibitor drug. While HAART cannot be considered a cure for HIV infection, in some cases it can halt replication of HIV and resulting damage to the immune system. Consequently, patients receiving HAART develop AIDS more slowly and live longer. However, the usefulness of HAART is limited by the relatively high cost of therapy (approximately US$ 10000 per year, which is prohibitive in most countries); the side effects of the drugs; its difficult treatment schedule; and variable tolerance and response to therapy. In areas where HAART has been introduced on a wide scale, significant decreases in AIDS cases and mortality (down 30% to 50% over a one-year period) and shifts in the pattern of clinical problems encountered by people living with HIV/AIDS have been observed.

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(2) *The Lancet, 21 June 1997;* ***349*** *(9068): 1797–1800*

(3) *(Directly Observed Treatment, Short Course). The components of the DOTS strategy are a recording and reporting system to monitor programme efficiency; case detection and diagnosis; patient management; drug supply and management; and political commitment.*

Including AIDS on the highest political agendas

In an increasing number of countries, senior government officials and legislative bodies addressed AIDS for the first time during the 1996-1997 biennium. AIDS received acknowledgement as a critical issue at major international fora, as well. These included the address by President Nelson Mandela of South Africa, with the support of UNAIDS, to the 1997 World Economic Forum in Davos on the impact of the epidemic on development in Africa. The declaration of the G-8 Summit in 1997 also referred to AIDS, urging that governments take strong action to address the epidemic in their own countries and to assist developing countries and UNAIDS.

On 1 December 1997, the United Nations General Assembly, in conjunction with UNAIDS, organized a special session on the epidemic to commemorate World AIDS Day. High-level representatives, including the Secretary-General of the United Nations, the President of the General Assembly, and United States Secretary of State Madeleine Albright, attended the session. In 1997, discussions and resolutions of other political bodies, such as the Association of South-East Asian Nations, also addressed the epidemic.

During the 1996-1997 period, some countries enacted proactive HIV-related legislation. An example is the Philippines, whose new legislation comprehensively promotes and protects the human rights of people suspected or known to be living with HIV or AIDS, outlaws compulsory testing, guarantees privacy, and expands provision of HIV education and information for children and youth (SEE PANEL 8). In 1998, the Inter-Parliamentary Union adopted a UNAIDS-promoted resolution at its meeting in Namibia. Despite several notable expressions of political commitment to an effective and expanded response to the HIV epidemic, denial of the epidemic's multiple consequences and of the top priority for action continues.

PANEL 8

POLITICAL ADVOCACY IN THE PHILIPPINES

Political leadership in the Philippines has displayed a keen understanding of AIDS and of the impact of a significant epidemic on the Philippines. After meeting with two HIV-infected women in the Presidential Palace on World AIDS Day in 1992, President Ramos formed the Philippine National AIDS Council. At the end of 1996, he declared 1997 as National AIDS Prevention Year in the Philippines, the year in which the Philippines hosted the Fourth International Congress on AIDS in Asia and the Pacific.

During his opening speech to the Congress delegations, President Ramos declared the AIDS Bill pending before the Philippine Congress as urgent, resulting in its enactment in February 1997. The United Nations system assisted the process by providing technical support in the preparation and passing of the Bill.

The AIDS Law institutes a nation-wide HIV/AIDS information and education programme, in schools and workplaces, for departing workers, and for tourists entering and leaving the country. It establishes a comprehensive HIV monitoring system; strengthens the Philippine National AIDS Council; creates a special AIDS service within the Department of Health, outlaws discrimination, bans mandatory testing, strengthens and expands the social support and testing services in the country, and insists on confidentiality for people living with HIV.*

* *A copy of the Law is available via the web site of the Department of Health, Philippines (http://www.doh.gov.ph/aids/index.htm).*

Expanding the response to AIDS: the strategic approach

Notwithstanding the 16 000 new HIV infections that occur every day, the epidemic is not out of control everywhere. Some countries and communities have managed to stabilize HIV rates or achieve a turnaround. Some have made progress on care and support for people infected and affected. A UNAIDS analysis of country responses, and of the corresponding achievements and failures, identifies some correlates of success (SEE PANEL 9).

PANEL 9

SOME IMPORTANT FEATURES OF EFFECTIVE PROGRAMMES

- *Effective programmes are those which receive **political commitment** stretching up from the community to a country's highest level.*
- *To be effective, programmes have to promote **openness** about HIV and its existence, and **dissipate fear and prejudice** against people already living with HIV or AIDS.*
- *It is essential to establish **systems that give information** on where people in the country are infected or threatened and why, and ensure analysis of the factors affecting their vulnerability to HIV. Such mapping is the best basis for programme planning.*
- *Effective programmes are characterized by **focused interventions** with steadily expanding coverage. Initially, action should be focused on locally important vulnerable and at risk populations and on geographic areas where HIV is an emergency. Planning must nevertheless take into account the need to reach many different populations of this kind, including those who will become exposed in the future. Action must also be focused on achieving safer behaviour through multiple, complementary interventions of known effectiveness.*
- *As a complement to focused action, effective programmes must create **general awareness** and knowledge in the rest of the population, especially among **young people**, who represent more than half of all of those infected after infancy. This can be accomplished cost-effectively through mass-media campaigns, peer-outreach education and life-skills programmes.*
- *Effective programmes offer both **prevention and care.** Care services have benefits that extend even beyond the human rights and needs of the sick individual. They help convince others that the threat of HIV is real and make prevention messages more credible.*
- *Because the epidemic and our understanding of it are highly dynamic, programmes have to be **flexible** enough to keep up with the changes. This requires careful monitoring and evaluation of interventions and programmes.*
- *To be successful, programmes need to involve **multisectoral and multilevel partnerships** in and between government and civil society, with AIDS being routinely factored into the individual and joint agendas. Not only do the various partners have a stake in participating, but they have valuable contributions to make to HIV prevention, care and support at levels ranging from the national to the district and community.*

- ***Mainstreaming and resource mobilization*** *are corollaries of the preceding feature. Effective programmes identify opportunities to involve partners with similar goals and objectives, and capitalize on synergies between AIDS and other programmes.*

- *Effective programmes are those which take a* ***long-term approach*** *and build societal resistance to HIV. We must promote safer attitudes and behaviour in society, especially in the younger generation, that will ultimately offer serious resistance to the spread of HIV.*

The initial reaction to the epidemic was to persuade individuals and selected groups to change their behaviour by informing them about AIDS. Over time, it became understood that for behaviour change, individuals need not only information but also decision-making skills, access to tools and services, and supportive peer norms.

By the mid-1980s, it was more generally appreciated that individuals do not always control their own risk situations and that societal behaviour affects the vulnerability of individuals. At the same time, as individuals infected with HIV earlier in the epidemic gradually fell ill and died, the need to provide health care and cushion the epidemic's impact acquired prominence – action that required the involvement of different sectors of society.

More recently, a growing appreciation has emerged that the epidemic is also a development challenge. To the extent that people's vulnerability has social and economic roots, often including marginalization, poverty and women's subordinate status, tackling these conditions makes society, as a whole, less vulnerable to HIV in the long term.

The strategic approach that UNAIDS advocates draws on all of these approaches: focused programmes to promote safer behaviour by those at higher risk of infection; societal action to reduce the vulnerability of those not in control of their HIV risks and to mitigate the impact on those affected by the epidemic; and more active mainstreaming of approaches to dealing with AIDS within broader development efforts (SEE PANEL 10).

PANEL 10

Pathways for expanding the response to HIV/AIDS

- *Expanding coverage of programmes*
- *Focusing action*
- *Expanding partnerships in the design, implementation and evaluation of AIDS-related policies and programmes*
- *Involving all relevant sectors*
- *Increasing resources mobilized in support of prevention and care*
- *Enhancing the sustainability of AIDS programmes over time*

Source: *Expanding the Global Response to HIV/AIDS through Focused Action,* UNAIDS *Best Practice* Collection, 1998.1, pp.12–14

Rather than propose a universal blueprint, the Programme has promoted a set of principles on the basis of which each society can find its own locally relevant path to action:

- Development of a country strategy should begin with a serious analysis of the local HIV/AIDS situation, risk behaviour and vulnerability factors, with the resulting data serving to prioritize and focus initial action.

- Ignoring simplistic solutions, the strategy should build on tried and tested methods of AIDS prevention, care and impact alleviation, even when these may be sensitive issues in some cultures (e.g. condom promotion among sex-work clients), or

require hard political choices (e.g. needle exchange for drug injectors).

- From the outset, an appropriate balance of interventions should address the needs of both people at higher risk and those at potential risk (e.g. young people and married women).
- The strategy should seek to build expanded partnerships between governments and civil society at all levels in order to gear up the response, and to progressively encourage the involvement of all relevant sectors and resource mobilization that taps into a diversity of human and institutional sources (SEE PANEL 11).

PANEL 11

WHY ALL SECTORS OF SOCIETY SHOULD BE INVOLVED IN THE RESPONSE TO THE HIV EPIDEMIC

- *Each sector has a stake in prevention because it stands to suffer the impact of an out-of-control epidemic, for example, an education sector where 30% of the teachers are infected, or a defence sector with infection rates in the military of over 60%.*
- *Each sector has easy access to populations that it can help inform and educate at relatively little extra cost.*
- *Most sectors have the mandate of promoting human development and quality of life, and these efforts are compatible and synergistic with vulnerability reduction, e.g. through the promotion of the basic right to education and participation.*
- *Multisectoral action that draws on the human and budgetary resources of multiple government ministries, nongovernmental organizations, academic institutions, businesses and communities lead to a large-scale expanded response that is sustainable over time.*