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NATIONAL RESPONSES TO HIV/AIDS: A REVIEW OF PROGRESS *

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A. INTRODUCTION

The unprecedented magnitude and scope of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic calls for unprecedented global, regional and national responses. The urgency of a concerted response was recognized in the Millennium Declaration[1], which noted the resolve of Governments to halt and reverse the spread of the epidemic by 2015. From a slow policy response in the early 1980s when the emerging HIV/AIDS epidemic was limited to high-risk groups in a few countries, national HIV/AIDS policies have now become nearly universal. Although Governments in both developed and developing countries had begun to outline policies concerning HIV/AIDS by the mid 1980s, these policies often varied widely across countries. Policies were also frequently fragmented and generally had a narrow health sector focus. This contrasts sharply with the current situation. Most Governments have now devised comprehensive policies and programmes to tackle the epidemic. For example, the Declaration of Commitment on HIV/AIDS[2/] adopted by the United Nations Special Session on HIV/AIDS was an important landmark in the fight against the HIV/AIDS epidemic, as it committed Governments to address the epidemic with renewed vigour and established specific targets and target dates for achieving major policy and programmatic changes.

Policies and programmes are increasingly addressing HIV/AIDS as a development challenge, requiring a multidimensional national response. Governments are formulating more comprehensive policies to address the HIV/AIDS epidemic, and are implementing programmes designed to tackle the epidemic in a more aggressive manner. Nevertheless, in many countries, HIV/AIDS policies and programmes have not yet produced significant changes in the scope and size of the epidemic.

The present paper reviews these national responses to the AIDS epidemic. The paper examines the progress that Governments have made and the constraints they have faced in formulating and implementing policies in three main areas. The paper focuses on policies with respect to: (a) the evolution of Government concern; (b) HIV/AIDS prevention; and (c) care, support and treatment of those infected and affected by HIV/AIDS. The paper also reviews progress with respect to developing multisectoral strategies, establishing HIV/AIDS coordination bodies and establishing partnerships in the fight against HIV/AIDS.

For purposes of the present review, information on national HIV/AIDS policies is drawn from the Population Policy Databank maintained by the Population Division. The databank includes information garnered from various sources, including responses to the United Nations Inquiries among Governments on Population and Development, official Government statements and publications, and information from intergovernmental and non-governmental sources. In addition, information for the present discussion has also been taken from the Government statements presented at the United Nations Special Session on HIV/AIDS.

Information contained in the Population Policy Databank provides valuable baseline information on Government policies and programmes that have been formulated and implemented to deal with HIV/AIDS epidemic. Included is information on whether Governments have established programmes to screen high risk groups for HIV; whether they have outlined policies to screen the blood supply; whether they are instituting Information, Education and Communication (IEC) programmes on HIV/AIDS; and whether they have instituted condom promotion policies and programmes to prevent HIV transmission. The databank also includes information on Government support for needle-exchange programmes and progress in drawing up legislation in support of AIDS programmes. These data allow a broad assessment of progress in policymaking concerning HIV/AIDS.

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[1]/ General Assembly resolution A/RES/55/2; paragraph 19.

[2 /] General Assembly resolution S-26/2, annex.

B. DEMOGRAPHIC IMPACT OF THE EPIDEMIC

The HIV/AIDS epidemic has continued to grow in most major areas of the world despite significant change in the policy environment in the past two decades.

Sub-Saharan Africa is the area of the world that is most severely affected by HIV/AIDS. In 2002 approximately 3.5 million new infections and 2.4 million deaths due to AIDS occurred in sub-Saharan Africa. As of December 2002, Botswana, Lesotho, Swaziland and Zimbabwe all in Southern Africa, had the highest HIV-prevalence in the world; more than 33 percent of adults aged 15 to 49 years were infected.

HIV prevalence is increasing most rapidly in Eastern Europe and Central Asia (UNAIDS, 2002). Some 250,000 new infections occurred in the region in 2002, bringing to 1.2 million the number of people living with HIV/AIDS in the region. The Russian Federation and Ukraine are the most severely affected countries in the region. The majority of infections in Russia and Ukraine are linked to injecting drug use although heterosexual transmission has increased recently (Malinowska-Sempruch and others, 2003). Many other countries in the region are now experiencing rapidly emerging epidemics. These include Azerbaijan, Estonia, Georgia, Latvia, Kazakhstan, Kyrgyzstan, Latvia and Tajikistan.

The HIV/AIDS epidemic in Asia and the Pacific has grown significantly since the beginning of the 21st century. Almost one million people were infected in Asia and the Pacific in 2002, bringing the number of people living with the virus in the region to an estimated 7.2 million - - a 10 per cent increase since 2001. Official estimates put the number of people living with HIV in China at one million in mid-2002 and it is estimated that the number of infected people in China could reach 10 to 20 million by 2010 (UNAIDS, 2002). Some four million people are estimated to have been living with HIV in India at the end of 2001.

Latin America and the Caribbean encompasses a wide spectrum; countries with few AIDS cases, as well as countries whose epidemics are similar to those in parts of sub-Saharan Africa. For example, twelve countries in Latin America and the Caribbean have an estimated HIV prevalence of one per cent or more among pregnant women (UNAIDS 2002). Adult HIV prevalence is estimated at about four per cent in the Bahamas and over six per cent in Haiti (UNAIDS, 2002).

Available data on HIV/AIDS in Northern Africa and Western Asia suggest that although the epidemic has hitherto been muted in these regions, significant outbreaks of HIV are occurring among injecting drug users in the region, notably in Northern Africa and in the Islamic Republic of Iran. The prevalence of high-risk behaviours such as needle sharing among injecting drug users, and unprotected extramarital sex render the region highly vulnerable to a much larger epidemic (UNAIDS, 2002).

Based on these trends it is projected that globally, there will be 278 million more deaths between 2000 and 2050, than would have occurred in the absence of AIDS (United Nations, 2003). The demographic impact of AIDS is expected to be particularly dramatic in the seven countries with the highest HIV prevalence levels. The death toll in these countries, (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) during 2000-2005 will be more than twice as high as it would have been in the absence of AIDS. In Botswana and Zimbabwe, where one out of every three adults is HIV-positive, the situation is particularly dire. Life expectancy at birth in Botswana dropped from 65 years in 1990-1995 to 56 years in 1995-2000 and is expected to fall further to under 40 years, during the 2000-2005 period. This is about 28 years lower than life expectancy would have been in the absence of AIDS.

Other regions are also projected to experience sizeable increases in AIDS cases. In the five most affected Asian countries, the population in 2015 will be one per cent lower than it would have been without HIV/AIDS. Because of the large populations of China and India, the impact of the disease in terms of the estimated number of excess deaths is substantial. Over 3 million excess deaths will occur in Asia in 2000-2005 because of AIDS. India alone is expected to experience over 2 million

excess deaths during this period due to the AIDS epidemic. In the Russian Federation and the United States of America, excess deaths in 2000-2005 are expected to be 0.3 million and 0.4 million, respectively.

Although the HIV/AIDS epidemic has grown to levels unexpected just a few years ago, Government policies and programmes to address the epidemic have evolved and have become more universal. Policies and programmes however vary in comprehensiveness and effectiveness across countries.

C. NATIONAL RESPONSES TO HIV/AIDS

In 2001, concern over HIV/AIDS topped the population policy agenda in both more developed regions and less developed regions. Within the context of the internationally agreed upon principles and goals adopted by the United Nations General Assembly, countries have exhibited considerable variation in their responses to the epidemic. These differences reflect a complex set of demographic, economic, cultural, political, social and institutional factors.

1. Evolution Of Government Concern

The United Nations Population Division began tracking Government concern with HIV/AIDS in the *Sixth United Nations Population Inquiry among Governments,* as assessed in 1987 (United Nations, 1990). At the time about one-quarter of the world's countries reported major concerns with the relatively small number of AIDS cases. Of 108 countries responding to the question, fifty per cent (54 countries) indicated that HIV/AIDS was a major concern; 26 per cent indicated it was a minor concern and 15 per cent indicated that AIDS was of no concern. It is estimated that by the mid 1980s there were fewer than five million people living with HIV/AIDS worldwide, and even in Africa, the worst affected region, just around 750,000 new infections occurred in 1985 (UNAIDS, 2000). Government concerns about the HIV/AIDS epidemic have since evolved from a period when there was widespread denial of the problem by many Governments, through a phase when many Governments viewed HIV/AIDS to be a problem only outside their national borders, to the current phase where most Governments express major concern about the epidemic's actual or potential threat to their own countries.

Based on information in the United Nations Population Policy Databank, 71 per cent of countries were expressing major concerns about HIV/AIDS by 1996. By 2001, this percentage had climbed to 79 per cent of Governments. In 1996 and 2001, a larger proportion of developing than developed countries considered HIV/AIDS to be a major concern. As of mid 2003 84 per cent of countries reported that HIV/AIDS was a major concern (table 2). However, some two-dozen Governments continue to express minor concern about the epidemic, including Austria, Belgium and Norway where HIV/AIDS prevalence is low. Algeria, Croatia, Lebanon, Nicaragua, Paraguay and Uzbekistan, also express minor concern, despite being in regions where the prevalence of HIV/AIDS is increasing.

Although concern about the HIV/AIDS epidemic is now near universal, national concerns vary with respect to the nature and degree of concern. In some countries concern is over the current or immediate impact of the epidemic, while in others there is more concern about the potential future impact. The strength of these concerns depends to some extent on the perceived prevalence of HIV/AIDS. Most Governments of African countries with the highest HIV-prevalence, for example, address the epidemic as an urgent concern. For example, Botswana, Cote d'Ivoire and the Sudan have highlighted the immediate impact of the epidemic on their countries. In contrast, low prevalence countries such as Denmark and Finland have articulated concerns about the epidemic's impact in other countries. Small island States have been concerned about the future threat. In a statement to the United Nations Special Session on HIV/AIDS, the Minister of Health for Vanuatu, for example, noted his Government's deep concern about the epidemic, adding that "Vanuatu in several respects is vulnerable to becoming affected by this deadly disease"(United Nations, 2001). The current near-universal concern over HIV/AIDS is markedly different from the situation prevailing one or two decades earlier.

2. *HIV/AIDS Prevention Activities*

By 2001, many Governments had already instituted policies and taken key preventive measures in a number of areas of HIV/AIDS prevention. As shown in table 3, based on responses to the *Eighth Inquiry Among Governments on Population and Development*, Governments were most likely to have devised policies concerning IEC campaigns, blood screening and condom promotion. Policies on screening high-risk groups, legal provisions and needle exchange were less common and are not addressed in this paper. Instead, policy progress with respect to IEC campaigns, blood screening and condom use are addressed. The discussion is ordered according to the most prevalent kind of policy intervention.

In the early years of the HIV/AIDS epidemic, a number of Governments became concerned about what they perceived to be an external threat that could be contained by restricting the immigration of those known to be infected with HIV. By the mid 1990s some 50 countries had enacted restrictive policies against the immigration of persons with HIV (Health Canada, 1996). Based on responses to the *Eighth Inquiry Among Governments on Population and Development*, of the 90 countries replying to those questions, 15 Governments restricted the entry of permanent immigrants or migrant workers infected with HIV/AIDS. However, a number of Governments also implemented policies to restrict the flow of students, refugees and asylum seekers, return migrants and tourists – see table 1. The most restrictive immigration policies were those of receiving countries in the more developed regions. According to a 1996 United States Law[3], for example, a visa cannot be granted for a visit to the United States for HIV-positive persons. HIV infection also remains a statutory basis for exclusion from permanent residence.

The implementation of restrictive immigration policies in response to a perceived public health threat is not a recent development. Such policies date back to the nineteenth century when immigrant groups were associated with poor health conditions and stigmatised as the source of a variety of physical and societal ills (Markel and Stern, 2002). Restrictive immigration policies in the particular context of HIV/AIDS have similarly been motivated by fear, anger, a wish to differentiate between "us" and "them", and by a view of migrants as vectors of disease (Klein, 2001, p. 1).

With the worldwide spread of the HIV epidemic, Governments have increasingly come to recognize that restrictions on immigrant flows are inadequate to protect them from the HIV/AIDS epidemic. The presence of groups of high risk groups and HIV-infected persons in virtually all countries has led most Governments to become increasingly concerned about the prevalence of HIV within their countries. Activities in the areas of information, education and communication (IEC), blood safety and condom promotion have therefore become the foundation of HIV/AIDS prevention activities in most countries as restrictive immigration policies have come under criticism (see, for example, Canadian HIV/AIDS Legal Network, 2003).

[3] Section 212, (8 U.S.C. 1182) of the United States Immigration and Nationality Act (Inadmissible Aliens)

a. Information, Education and Communication (IEC)[4]

In all countries, better individual knowledge of HIV/AIDS and how to prevent it complements and enhances the effectiveness of other Government policies and programmes. In recognition of this, Governments have sought to improve public knowledge by promoting IEC programmes and have used various channels, including news and other print media, theatre, radio, direct mailings and other public service messages. In some countries Governments have allowed non-governmental organisations, networks of people living with AIDS, religious institutions and international and bilateral donors to become involved in various aspects of IEC with respect to AIDS.

IEC programmes have clearly contributed to increased awareness and knowledge of HIV/AIDS, particularly in urban areas. Key messages on HIV prevention have reached individuals at risk, as evidenced by survey data. Demographic and Health Surveys conducted in a number of developing countries show that in most countries, at least 75 per cent of both male and females had heard about HIV/AIDS. In some countries—Brazil, Colombia, the Comoros, the Dominican Republic, Ghana, Haiti, Kenya, Malawi, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe—virtually the entire adult population was aware of AIDS. Surveys also show that in most countries at least 8 in 10 men knew of at least one sexually transmitted infection (STI) and similar levels of knowledge were reported for women in Brazil, Kenya, Uganda, Zambia and Zimbabwe. Radio is by far the most often cited source of knowledge about AIDS. About half of the female respondents and more than seven in ten male respondents have heard about AIDS on the radio.

Much remains to be done to improve the effectiveness of Government strategies with respect to HIV/AIDS as gaps exist in knowledge levels across subgroups of the population. Poorly educated persons, for example, tend to know less about HIV/AIDS and are more vulnerable to infection. Furthermore, even when they have information about HIV/AIDS, they are less likely to feel they have the power to avert its impact. Table 4, which summarizes information from Demographic and Health Surveys on women's perception of their ability to prevent HIV/AIDS, highlights the importance of education in the prevention of HIV. In virtually all countries, education appears to give women a better sense of control over their fate.

In a few countries, most women were not even aware of the existence of sexually transmitted infections (STIs), which are known to increase susceptibility to HIV infection. The dependent status of women in many countries and their limited power to negotiate for safer sex may account for part of this gap. There are also large rural-urban differences in knowledge, suggesting that Government policies may have been differentially implemented, or that they may be inappropriately targeted for some population groups.

Schools and teachers were not important sources of AIDS information in most countries surveyed. These sources were mentioned by fewer than 10 per cent of respondents in most countries. Only in Brazil did at least half the young women cite this source of information. Radio, however, appears to be a primary source of information on HIV/AIDS in most countries. Whether the importance of radio lies in the fact that there are a large number of radio listeners, or whether it is the approach of radio programming is unclear. However, the consistency of the results suggests a need for promoting radio broadcasting and ensuring that its messages are consistent with those of internationally acknowledged prevention strategies.

[4] This section draws on the findings of an earlier United Nations Study: "HIV/AIDS Awareness and Behaviour". Sales No. E. 02.XIII.8, United Nations, New York, 2002.

b. Blood safety

By 2001 eighty-two countries had instituted measures to screen national blood supplies for the HIV virus (table 3). Fifty-one developing countries reported that they had implemented blood screening, with 14 of those from Africa. The gravity of the challenge posed by contaminated blood supplies was stressed by the Secretary General of the United Nations when he noted that of the 191 World Health Organization member States, only 43 per cent systematically screen donors' blood for Hepatitis B and C and HIV, and 29 per cent have national policies and plans to ensure blood safety and that blood safety must be a key element of national health systems (United Nations, Press Release, SG/SM/7331,OBV/135, 17 March, 2000).

Activities to ensure the safety of the national blood supply have increased considerably since 2001. A number of countries that previously indicated that they had instituted measures to protect their national blood supply from HIV have expanded these procedures to cover a larger share of the blood supply. Nearly all donated blood is now screened for HIV and hepatitis B in Indonesia, Maldives, Nepal, Sri Lanka and Thailand. The Pan American Health Organization (PAHO) has launched a Regional Blood Safety Initiative, to improve the quality of blood for transfusion in the Americas and to emphasize the promotion of voluntary blood donation. In developed countries, procedures that were hitherto relatively safe have become even safer. In the United States, for example, the Food and Drug Administration (FDA) has intensified its oversight of blood banks and blood collection procedures.

Existing blood policies differ in coverage and comprehensiveness across countries. For example, Botswana is strengthening blood-screening and supporting blood donation programmes among low risk groups. Uganda outlined a more comprehensive policy, including the appropriate use of blood and blood products throughout the country, recruitment of non-remunerated blood donors/volunteers from the schools and community, and carrying out community education on the procedures for blood donation, testing and transfusion. Zimbabwe encourages blood banking enabling patients awaiting non-emergency surgery to "bank" their own blood for use during surgery. The policy also aims to: ensure safety of blood and blood products before transfusion; maintain blood donation as a voluntary and non-remunerated service; promote preventive health care to reduce the risk of anemia and thus reduce the need for blood transfusion; screen all blood for HIV before transfusion using procedures and policies which meet both national and international standards. In India, testing of all blood used in the blood banks is mandatory while a Supreme Court directive has banned the operation of unlicensed blood banks. Professional blood donors are also to be phased out under the Supreme Court order.

Notwithstanding the progress of recent years, contaminated blood transfusion remains one of the greatest preventable sources of HIV infection in health care settings (Measure: Carolina Population Center, 1998). Fifteen years after the development of a screening test for HIV, reducing transmission of HIV and other infectious diseases by blood transfusion remains a serious public health challenge, especially in developing countries (Centers for Disease Control, 2003). In a number of provinces, mostly in central China, poor rural farmers sell blood and plasma to commercial blood processing companies to supplement their incomes. This has led to many HIV infections among both sellers and recipients of blood and blood products. The infection risk among sellers is a result of the practice of re-injecting red blood cells from pooled plasma into donors in order to reduce anemia among them and to allow them to sell plasma much more frequently (UNAIDS, 2002).

The proportion of transfused blood that is tested and the accuracy of testing procedures vary across countries. A 1998-1999 survey of national blood transfusion services showed that only 20 per cent of countries reported that they had all aspects of a well-organized blood transfusion service in place. A regional workshop of the Directors of National Blood transfusion Services from 18 African countries (Takpo, 2000) noted major weaknesses in efforts to protect the blood supply. The report noted that most countries still have hospital based and fragmented blood transfusion services that are not coordinated at the national level and that often blood policies that do exist are not fully implemented. Among 46 African

countries, only 13 have implemented a national policy on transfusions and 25 per cent of blood transfused in the region, is not tested for HIV.

Indeed, many countries that report programmes to screen blood for HIV only screen blood units that come through national blood banks or those that are donated voluntarily. Yet, because of blood shortages in many countries, there is heavy reliance on donations from paid donors or from family members of patients who are transfused on emergency basis. It is estimated that there were about six million donations of blood from paid donors and 13.5 million donations from replacement donors in 1998-1999. Sixty to seventy per cent of donations in the developing world come from family or replacement donors (Global Database on Blood Safety, 2001 p. 5). Transfusion of blood from such sources carries a high risk of transmission of HIV and other viruses.

c. Condom-use

Condom-use policies and programmes are nearly universal, although the specifics of such policies and how widely they are implemented vary across countries.

Policies and activities aimed at promoting condom use as a method of HIV prevention have noticeably increased in Africa. Most countries in Africa have some aspect of condom promotion included in their HIV prevention priorities (Harvard AIDS Institute, 2001). Table 5 indicates that Governments are most likely to become involved in service delivery, suggesting that many countries acknowledge the limitations of current services to reach the target population. Cote d'Ivoire, has articulated one of the more specific policies in Africa with regard to condom promotion among adolescents. The policy sets a target of systematically increasing condom use in this group by 35 to 50 per cent between 2000 and 2004. In Botswana, whose HIV prevalence rate in 2003 is the highest in Africa, the policy is more comprehensive but less specific with respect to access to condoms among adolescents. It seeks to increase the supply of condoms, increase access to condoms through multiple channels, promote peer sexual and reproductive health education and promote safer sex in all sexually active age groups, especially among adolescents and men. Nigeria articulated a 100 per cent condom use in "all casual sex" (Federal Ministry of Health, 1997).

Governments in other regions have also, articulated clear policies with regard to condom promotion. There are aggressive condom promotion policies in Thailand, which in 1992 became the first country to institute a 100 per cent use policy in commercial sex establishments. This policy is credited with helping to stem a rapidly expanding AIDS epidemic (see Box 1). Subsequently, a 100 per cent condom use policy has been adopted in a number of countries, especially in Asia. In the Russian Federation, where progress in addressing the epidemic has been slow, improvements in condom accessibility have been reported in recent years. For example, after a period of limited demand for condoms in the early 1990s, an increase in demand is now being met through the use of vending machines to distribute condoms in nightclubs, casinos, clubs, restaurants, cinemas, and airports in Moscow (Savchenko, 1999).

Box 1: Condom Promotion Programmes: The case of Thailand

In Thailand, Government determination to enforce a 100 per cent condom use in brothels and ensure wide access to HIV prevention campaigns through schools, the mass media, and the workplace have been major contributors to lowering HIV infection rates.

During the late 1980s, Thailand experienced an epidemic of HIV among sex workers and injecting drug users. In 1988, infection rates among injecting drug users rose from zero to 30 per cent during a six-month period. The national HIV surveillance system revealed that in the northern city of Chiang Mai, 44 per cent of sex workers were infected with HIV.

In response to fears that the HIV epidemic would spread to the general population, a national HIV prevention programme was launched in 1991 with high-level political commitment at both national and regional levels. Each key Government ministry developed its own AIDS plan and budget and Government funding for HIV/AIDS was stepped up. The Government forged partnerships with NGOs, the business community, people living with AIDS, religious leaders, and community leaders, engaging them in dialogue and resource mobilization for HIV prevention and care programmes.

The Government took the pragmatic step of working with brothel owners to enforce 100 per cent condom use in all commercial sex establishments. Under the scheme, condoms are distributed free to brothels, and sex workers are told to insist on condom use by all clients. Government efforts to police the scheme have included STI contact tracing and the use of Government inspectors posing as would-be-clients in brothels. Commercial sex establishments that fail to comply can be shut down.

The HIV prevention programme also included a mass media campaign, workplace AIDS programmes, life-skills training for teenagers, peer education, and anti-discrimination campaigns. The media campaign urged respect for women and discouraged men from visiting brothels. Improved educational and vocational opportunities were made available for young women to deter them from becoming the sex workers.

The campaign has led to an increase in condom use, fewer visits to sex workers, and a reduction in HIV infection rates. Thai men are now far less likely to visit sex workers and more likely to use condoms. Condom use has also increased in the general population.

The scheme has been highly successful. Reported condom use in brothels increased from only 14 per cent of sex acts in 1989 to over 90 per cent by 1994. Over the same period, the number of new STI cases among men treated at Government clinics plummeted by over 90 per cent. Regular surveys among young male recruits in the Thai army reveal that HIV infection rates among 21-year-old military conscripts peaked at 4 per cent in 1993 before falling steadily to below 1.5 per cent in 1997. By 1995, fewer recruits were visiting sex workers (down from almost 60 per cent of recruits in 1991 to about 25 per cent by 1995) and condom use had increased. These changes in sexual behaviour were paralleled by a decline in HIV infections and other STIs. Through its successful efforts to prevent high-risk sexual behaviour and promote safe sex, the Government has demonstrated that it is possible to reverse the course of the epidemic nationwide within a relatively short period.

Source: Excerpts from: World Health Organization (2000). *Health: A Key to Prosperity: Success Stories in Developing countries.* Accessed at http://www.who.int/inf-new, Accessed 30 July, 2003.

In Colombia, the right to have access to condoms was recognized very early in the epidemic by Government decree. According to the decree, "condom use shall be considered as a measure for the prevention of HIV infection. Consequently, pharmacies, supermarkets, and the like, as well as establishments offering facilities for carrying out sexual practices, shall guarantee that their customers have access to condoms" (Colombia Ministry of Public Health, 1991). In India, condom use is recognised as an essential element of policy. The policy states that the "promotion of condom use as a measure of prevention from HIV infection will be the most important component of the prevention strategy". India's policy specifically addresses the moral dilemma that many countries have faced with respect to providing access to condoms. The policy notes that "Government feels that there should be no moral, ethical or religious inhibition towards propagating the use of condoms amongst sexually active people especially those who practise high risk behaviour" (India - National AIDS Control Organization, 1998).

Although many national policies on condom use and AIDS have not explicitly addressed the use of the female condom, a few countries have specifically incorporated their use in national AIDS policies and strategies. Brazil, for example, has recently endorsed the inclusion of the female condom as part of a comprehensive prevention strategy that includes training, counselling, outreach, education and promotion for women and men. In June 2002, four million female condoms were procured for the National AIDS Programme (Female Health Company, 2001). Thailand included the female condom in HIV prevention activities in 2000. In Africa, a number of countries including Ghana, Lesotho, South Africa, Swaziland and Zimbabwe all articulate the need to expand access to female condoms as part of their national HIV/AIDS strategies.

In spite of recent progress, a number of Governments still hesitate to actively promote condom-use, especially outside marriage. Policies often avoid addressing condom use among adolescents because of moral, religious or other reasons. Many adolescents therefore do not have access to information and services concerning the use of condoms in HIV/AIDS prevention. Many condom promotion programmes choose family planning and reproductive health as the themes under which to promote condom use, thus avoiding the controversies associated with a pro-condom policy. Although policies and programmes that de-emphasize the importance of condom-promotion in HIV prevention have been criticised, Uganda's programme, which is based on the principles of Abstinence, Being faithful and using Condoms (ABC), in that order of importance, has been hailed as a success in Africa (Cory C., 2003). It is estimated that the ABC policy has contributed significantly to changes in sexual practices in Uganda. The percentage of women reporting multiple sexual partners, for example, decreased from about 18 per cent in 1990 to three per cent in 2000 and similar though smaller changes were reported among males (see Box 2).

Despite remarkable improvements in the policy environment with respect to condom promotion there have also been some constraints. Programmes have often had to deal with inadequate supply. In Africa, the current levels of donor support for condoms averages out to about three condoms per year for each adult male (United Nations Population Fund, 2002). In China, where the AIDS epidemic is growing rapidly, it is estimated that in 2001, national productive capacity and imports of condoms were far below the required levels. In many parts of Africa also, limited condom availability is a major issue. The distribution of condoms to local health departments is sometimes inefficient, leading to large overstocks in some areas and shortages in others (Wilson, 2001). NGO-sponsored condom social marketing programmes that seek to meet the needs of lower income segments of the population are common in many countries and they continue to be the source of most condoms in many countries. In India, for example, there are at least seven condom social marketing projects, each focussing on a different area of the country and on a different brand (World Health Organization, 2001b). While condom-marketing programmes provide poorer segments of the population with access to condoms at a lower cost, ensuring adequate supplies is dependent on the vicissitudes of donor funding.

Box 2: HIV/AIDS Prevention: Uganda's success story

Uganda has been hailed repeatedly for its remarkable success in reducing the prevalence of HIV/AIDS through an innovative prevention programme. Uganda has transformed itself from being the epicentre of an emerging global AIDS pandemic in the early 1990s to the first country in Africa to document a decline in HIV prevalence. A steady drop in HIV prevalence among 15–19-year-old pregnant women suggest that recent HIV infections are on the decline in several parts of the country.

The Government of Uganda recognized in the very early phases of the epidemic that HIV/AIDS required a strong multisectoral response, as it posed major threats to the socio-economic development of the country. The Uganda AIDS Commission was established in 1992 and charged with formulating and developing a national multi-sectoral approach. Numerous NGOs, the private sector, church groups, and community activists were all involved in the fight against the epidemic. The national response to HIV/AIDS has also been characterised by a policy of openness, and the challenge has been placed at the highest level of Government. Success in reducing the prevalence of HIV is also the result of a broad-based national effort that has received strong political commitment, highlighted by the personal involvement of the country's President.

A crucial aspect of Uganda's HIV/AIDS programme is its emphasis on prevention through abstinence, being faithful within unions and, failing that, using condoms (ABC). The ABC programme is considered to be responsible for major changes in sexual behaviour, especially among younger men and women. Condom use by single women aged 15–24 has almost doubled between 1995 and 2000/2001, and more women in that age group delayed sexual intercourse or abstained entirely. Young women aged 15-17 were less likely to have ever been sexually active in 2000 than in 1988 (34per cent, compared with 50 per cent); among 18-19-year-olds, the proportion dropped from 81per cent to 77 per cent. Delays in sexual debut, a reduction in the number of sexual partners and increases in condom use all played a part in Uganda's success.

Although the ABC approach has been hailed as a major contributor to the success of HIV prevention in Uganda, other aspects of the prevention strategy are also important. From the outset, the Government involved religious and traditional leaders, community groups, NGOs, and all sectors of society, forging a consensus around the need to contain the escalating spread of HIV and provide care and support for those affected. The Government also embarked on AIDS awareness campaigns, voluntary counseling and testing and treatment of STDs.

A key message from Uganda's experience is that no single approach works. Instead, Governments must assume a strong leadership role and tackle HIV/AIDS prevention in a comprehensive and aggressive manner.

Sources: Cohen, Susan (2002). Flexible But Comprehensive: Developing Country HIV Prevention Efforts Show Promise. *The Guttmacher Report on Public Policy,* October 2002. Accessed at: http://www.agi-usa.org/pubs/journals/gr050401.html ; Sengendo, J. and E. Sekatawa (1999). *A Cultural approach to HIV prevention and care: Uganda's experience.* Studies and Reports. Special Series, Issue No. 1. UNESCO, Paris; World Health Organization (2000). *Health: A Key to Prosperity: Success Stories in developing countries*. Accessed at http://www.who.int/inf-new, July 30, 2003.

A critical measure of the success of Government policies with respect to condom promotion is the state of the public's knowledge of condoms for HIV prevention. Surveys carried out in a number of developing countries show that knowledge of the condom, as a means to prevent HIV transmission, is poor even among educated persons. Table 5 shows, for selected countries, the proportion of women, by education status, who do not know that condoms protect against HIV infection. Among women who have secondary or higher education, ignorance about the protective effect of condoms rises from 12 per cent in Brazil (1996) to 95 per cent in Indonesia (1994). Seventy per cent or more of women who have attained secondary or higher education in Bangladesh, Ghana, India, Indonesia, Jordan, Malawi, Nigeria and Turkey, and report not knowing that condoms help protect against HIV/AIDS. Bangladesh, India, Indonesia and Nigeria, four of the most populous countries with growing HIV epidemics, have low levels of knowledge of condoms for preventing HIV among both educated and uneducated women. Even in Uganda where significant progress has been made in reversing the course of the AIDS epidemic, 51 per cent of women with secondary education do not know that condoms protect against HIV transmission.

Lack of knowledge about condoms is especially high among uneducated women, suggesting that policies and programmes may need to be better targeted at this group. There are only three countries - - Brazil, Cambodia and the Dominican Republic - - where at least 50 per cent of women who are uneducated know about condoms for HIV/AIDS prevention. Brazil and Cambodia have explicit policies to promote condom use for HIV prevention. In Cambodia, for example, a programme to promote condom-use allows for the distribution of condoms through a wide variety of sources – both public and private.

It should be noted that the prevalence of condom use is very low even in developed countries. The highest proportions of married women currently using condoms among developed countries, as assessed in 2001 (United Nations, 2002b) were found in Sweden (25 per cent) and Spain (24 per cent). In the United States, the proportion was as low as 13 per cent. Whereas this may reflect a perception that the risk of contracting HIV is lower in developed, relative to developing regions, it may also indicate a more general reluctance to use condoms, as well as a policy and programme gap that needs to be addressed. It also suggests that in the more developed regions, more work needs to be done to convey the message that other methods of contraception do not protect against HIV.

An important issue that has not been actively investigated is whether low levels of condom use for HIV protection, despite years of condom promotion by Governments, reflects the desire of couples and individuals in many developing countries to attain their fertility desires. In this connection, a United Nations study (United Nations, 2001a) has noted the dominance of fertility desires over fears of HIV transmission. The study noted that while globally, at least three fourths of respondents know about mother-to-child transmission, in some countries, many women who know they are HIV-positive still wish to become pregnant. For people who have not yet attained their desired fertility, condoms may be viewed as a barrier to conception.

2. Providing Care, Support and Treatment

Lack of treatment of HIV infection and the resultant high viral loads among those infected increases the risk of cross-infection and also results in a more rapid progression from HIV to full blown AIDS. Improving access to treatment and care, including medication, is essential to the response to the global HIV/AIDS pandemic and to ensuring respect for the human rights of those affected (United Nations, 2003). In addition, treatment of HIV positive pregnant women and their newborn offspring offers infants protection from mother to child transmission (MCT) of HIV. The care, support and treatment of HIV-infected persons are now recognized as both a human right, and as important components of strategies to slow the spread of the epidemic. Care, support and treatment encompass not only the provision of medical therapies to reduce viral loads in infected persons but also social care, including protection from discrimination and stigmatisation.

The present section reviews Government responses with respect to addressing the treatment and legal needs of those infected and affected by HIV/AIDS.

a. Access to antiretroviral drugs

Governments have increasingly recognized the importance of providing access to treatment for those infected with HIV. Since 1996 anti-retroviral treatment has significantly reduced AIDS-related death rates in high-income countries (United Nations, 2003) but progress in addressing the treatment issues has been much slower. Currently, fewer than five per cent of those who require treatment in developing countries have access to antiretroviral drugs - with an estimated 230,000 people currently receiving ARV therapy in the developing world. The situation is particularly serious in Africa (UNAIDS, 2002)

Nevertheless, developing countries have begun to address HIV/AIDS treatment in a more aggressive manner. In 19 countries, including Barbados, Benin, Burkina Faso, Burundi, Cameroon, Chile, Republic of the Congo, Côte d'Ivoire, Gabon, Honduras, Jamaica, Mali, Morocco, Romania, Rwanda, Senegal, Trinidad and Tobago, Uganda and Ukraine, care plans of action have been or are being developed and used as a framework for dialogue with the pharmaceutical companies. This dialogue has led to pharmaceutical companies offering significant price reductions in these countries (UNAIDS, 2001).

The most impressive growth in treatment coverage since 2001 has been in Latin America and the Caribbean. A World Health Organization (2002) survey of coverage of selected HIV/AIDS related services showed that 11 out of 24 countries in the region have enacted policies or programmes that guarantee access to antiretroviral therapy for those infected with HIV. By 2002, Argentina, Costa Rica, Cuba and Uruguay were providing access to free antiretroviral therapy through the public health sector. The Government of Jamaica has also developed an aggressive care, support and treatment strategy. The Strategy seeks to build capacity at all levels for improved comprehensive HIV/AIDS care; to increase access to anti-retroviral medication; and to strengthen advocacy and resource mobilization efforts that will ensure universal access to anti-retroviral medication (United Nations, 2003). In 2001 Brazil, in a landmark decision, began manufacturing locally, the generic version of the protease inhibitor, Nelfinavir, which is a treatment for HIV/AIDS. Brazil's decision was in line with its policy to make HIV/AIDS drugs available free of charge and as part of its comprehensive health care programme and the success of its approach to HIV/AIDS care, support and treatment has been acclaimed as a success story (see Box 3).

In Africa, a number of countries have entered into negotiations with drug manufacturers to reduce drug prices. Some Governments have also entered into agreements with bilateral and international donors to provide antiretroviral treatment on a pilot basis. In Ghana, Kenya and Rwanda, for example, the United States Agency for International Development (USAID) has begun to provide ARV at selected sites (United States Department of State, 2002). Botswana, with an HIV prevalence of 38 per cent, has become the first African country to adopt a policy of providing antiretroviral therapy to all citizens needing it (UNAIDS, 2002).

Cost factors severely limit the ability of Governments of developing countries to provide care to those infected with HIV. As nearly all AIDS treatment in developing countries and most programs funded by the GFTAM are pilot programs often conducted by nongovernmental organizations, suggests that truly national responses are yet to evolve. Such pilot programs are important, but cannot provide the solution for entire countries. Programmes ultimately must build capacity into the mainstream health care infrastructure (Clinton, 2003).

Box 3: Effective approaches to treatment: The case of Brazil

Brazil has received international acclaim for its successful approach to addressing the HIV/AIDS epidemic. In awarding Brazil the 2003 Gates Award for Global Health, it was noted that Brazil had shown with perseverance, creativity, and compassion, that it was possible for a hard-hit country to turn back its AIDS epidemic. Brazil was also noted for "breaking the logjam" in the debate over AIDS treatment by demonstrating that treating people with AIDS in a developing country was possible in the context of a comprehensive AIDS programme.

Brazil was the first developing country to adopt an official policy, in 1996, of providing antiretroviral drugs at no cost to its citizens. In 2001, the Government decided that it would break a patent on an AIDS drug if the producer did not cut prices by 40 per cent. Since then the Government has greatly reduced treatment costs by negotiating lower prices with drug companies and by manufacturing generic AIDS drugs. The Government estimates that since 1996, its treatment program has reduced AIDS mortality rates by nearly 50 per cent and opportunistic infections by 60-80 per cent. It also estimates that its treatment programme prevented nearly 360,000 hospital admissions between 1997 and 2001, resulting in savings of more than $1 billion.

Brazil's treatment programme is linked to a comprehensive multisectoral HIV prevention programme. HIV counseling and testing, condom marketing, education campaigns, and drug treatment programs are key aspects of the programme. Brazil was the first country to include the distribution of female condoms as part of its HIV/AIDS prevention strategy. The Government also runs needle exchange programmes targeted at reducing the spread of HIV among intravenous drug users.

Although the high costs of providing antiretroviral therapy for those infected with HIV has prevented many countries from making such treatment widely available, Brazil's experience has shown that the cost of providing antiretroviral drugs can be offset by reducing the number of HIV patients who become sick.

Sources: *Brazilian National AIDS Programme Receives 2003 Gates Award for Global Health.* Accessed July 30 2003 at: http://www.gatesfoundation.org/globalhealth/announcements/announce-030528.htm; Kaiser Family Foundation (2003). *Brazil Becomes Developing World Model for HIV/AIDS Treatment, Prevention Strategy.* Accessed 30 July 2003 at www.kaisernetwork.org/daily_reports/rep_index.cfm?dr_id=18176

b. Legal rights of Persons Living with HIV and AIDS

In many countries, people infected and affected by HIV, as well as those presumed to be infected, continue to be discriminated against in law, policy and practice (United Nations High Commission on Human Rights, 2001). The High Commission on Human Rights has thus urged States to "ensure that their laws, policies and practices respect human rights in the context of HIV/AIDS, prohibit HIV/AIDS-related discrimination, promote effective programmes for the prevention of HIV/AIDS, including through education and awareness-raising campaigns and improved access to high-quality goods and services for preventing transmission of the virus, and promote effective programmes for the care and support of persons infected and affected by HIV, including through improved and equitable access to safe and effective medication for the treatment of HIV infection and HIV/AIDS-related illnesses" (paragraph 5). The human rights needs of those infected and affected by HIV/AIDS encompass both legal protection from discriminatory practices as well as the removal of barriers to adequate health care.

Data from the United Nations Population Policy databank indicate that by 2001, only 59 Governments reported that they had enacted legislation in reference to HIV/AIDS (see table 3). Subsequently, there has been improvement in the legal environment in regard to HIV/AIDS. Examples of legislation in reference to HIV/AIDS abound, as many countries introduce and pass legislation addressing a wide range of issues, including access to treatment and discrimination against persons living with HIV and AIDS. For example, Canada, Denmark, Finland, Jamaica, the Netherlands, Nicaragua, Tunisia and the United Kingdom have reported significant progress in adopting legislation to address the human rights of HIV infected and affected persons. Botswana, Mozambique, South Africa, Swaziland and Zimbabwe, all high HIV-prevalence countries in Southern Africa, have all introduced legislation with respect to HIV/AIDS. In Mozambique, pre-employment testing for HIV is prohibited and HIV infected persons are guaranteed the right to confidentiality with regard to their HIV status in the workplace. Furthermore, in the event of occupational exposure to HIV, they are guaranteed medical assistance as well as adequate medication, which must be provided and paid for by the employer (Canadian HIV/AIDS Policy and Law Review, 2003). In Kenya an amendment of an Industrial Property Act opened the way for the importation of cheaper generic HIV/AIDS drugs from countries such as Brazil and India (Doctors Without Borders, 2002). Progress has also been reported in China, which has been slow to respond to the AIDS epidemic. One city, Suzhou, passed a law in 2002 protecting the rights of people living with AIDS and guarantees them equal access to employment, education and health care. This law is the first of its kind in China (Human Rights watch, 2002). In Cambodia an AIDS Law that outlaws discrimination based on HIV status was passed in 2002.

Despite progress, a global review of HIV/AIDS related stigma and discrimination (Canadian HIV/AIDS Legal Network, 2002) suggests that, "there is much more to be gravely concerned about". The report notes, among other constraints, that many societies have not implemented adequate protections for persons living with HIV and AIDS from discriminatory practices related to health care, employment, housing, education, travel and migration and other areas of activity. In some parts of Western Asia and Northern Africa, breaking the silence and overcoming stigma and denial remain key issues. Several national HIV/AIDS programmes are still couched within the framework of medical and health sector approaches (UNDP news release, 27 September 2002).

Where HIV/AIDS prevention policies have been articulated or legislated, they have sometimes served to institutionalise discrimination against persons living with AIDS. For example, a number of countries have legalized practices such as mandatory HIV testing, compulsory participation in prevention programmess, quarantine, isolation, or forced hospitalisation of people with HIV/AIDS. In China, several provincial and local laws and regulations are contradictory to the national guidelines on treatment and care of HIV/AIDS patients issued by the Ministry of Health (UNAIDS Theme Group on China, 2002). In 2003, Zambia announced a policy to curtail the enlistment in the army of HIV positive persons and to put HIV positive persons already in the army in positions with lower responsibility. A review of legislation on HIV/AIDS from 121 countries found that only 17 percent had developed specific legislation to protect

people with HIV/AIDS from discrimination in employment, education, sports, housing, public services, and other social activities.

3. Developing multisectoral strategies

Countries have increasingly incorporated HIV/AIDS into multisectoral national strategic plans. By the end of 2002, 102 countries had developed national strategic plans for HIV/AIDS (United Nations, 2003. In Nepal a new national five-year development plan incorporates HIV/AIDS not only as a health-sector issue, but also as a major development challenge. Romania has received financial support through the Global Fund for AIDS, Tuberculosis and Malaria (GFTAM), for a multisectoral, multi-level co-ordinated set of interventions (GFTAM, 2003). Seventy-one per cent of African countries had either adopted multisectoral strategies, or were in the midst of doing so by 2002 (UNAIDS 2003). In Burkina Faso, a National Strategic Plan 2001-2005 against HIV/AIDS was formulated and a National HIV/AIDS Commission (CNLS), to coordinate the responses of all Government sectors was set up in 2001. Many other countries have also moved away from considering HIV/AIDS as a purely medical issue to a larger development issue that requires the involvement of all sectors.

Progress in developing a multisectoral AIDS strategy has been slow in some countries. For example, only two out of 12 countries reporting from Eastern Europe have integrated HIV/AIDS into development planning (United Nations, 2002). Many countries have reported difficulty in engaging sectors other than health in addressing the epidemic (UNAIDS, 2002). In China, where AIDS threatens to produce the largest numbers of infected and affected persons in the world, weak political commitment and leadership, insufficient openness in dealing with the epidemic, lack of effective policies, lack of an enabling policy environment and poor governance present major constraints in dealing with the epidemic. Furthermore, China's five-year plan for 2001-2005 continues to present HIV/AIDS as a medical issue, without taking into account the epidemic's multisectoral nature and its broader development underpinnings (UNAIDS Theme Group on China, 2002).

4. Establishing HIV/AIDS coordination bodies

With multiple actors addressing the HIV/AIDS epidemic, many countries have recognized the value of establishing national bodies to coordinate policy development and programme implementation.

In 2001, 131 out of 193 countries (68 per cent) of Governments indicated that they had established a governmental AIDS coordination body[5]. A number of these bodies were established early in the HIV/AIDS epidemic and were situated within Ministries of Health where they had little implementation authority and operated with poorly defined mandates. Many more countries have now established governmental bodies that are more specifically charged with coordinating national HIV/AIDS programmes. All countries receiving funds through the World Bank's Multi country HIV/AIDS program MAP1 or MAP2 projects or from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, are required to have a high-level HIV/AIDS coordinating body, with broad representation of key stakeholders from all sectors, including people living with HIV/AIDS. As a result, close to 80 per cent of Governments have now established AIDS coordination bodies, many of which are situated within the office of the Head of State, where they are more likely to receive higher executive attention and recognition.

The establishment of National AIDS Secretariats that are separate from the health sector are more common in the developing than in developed countries. In the latter group, Governments are more likely to charge already existing bodies or new offices within the health sector with the coordination of the AIDS epidemic. The success of HIV/AIDS coordination efforts may be more dependent on the strength of commitment to fight the epidemic than on the establishment of a national coordination agency. In the Bahamas, for example, programmes to tackle the AIDS epidemic have been effectively directed from within the Ministry of Health, in part because of the strength of support from the Prime Minister's office

[5] Population Division Databank on Population Policies

(UNAIDS, 2003). Most developing countries however have created HIV/AIDS coordination bodies that are autonomous and that respond directly to the Head of State.

Although developing countries encounter the largest constraints as they try to strengthen their leadership capacities with respect to HIV/AIDS, challenges also exist for developed countries with advanced health sectors. Canada has reported that its efforts to develop a coordinated national approach are still under way because the increased prevalence of HIV in vulnerable populations present major policy challenges. The Government noted that "HIV/AIDS is just one of the social and health challenges facing those living in environments and with histories that predispose them to infection and illness and that responsibility for addressing broad systemic and historical determinants of health, which cut across multiple jurisdictions and mandates, is fragmented"(Government of Canada, 2002). The challenges of dealing with HIV/AIDS when multiple constraints exist in the health sector are undoubtedly more daunting in developing countries than they are in developed countries.

5. Establishing Partnerships

Governments have increasingly recognized that the AIDS epidemic cannot be effectively addressed without the active partnerships of civil society, those living with HIV/AIDS, community based groups, non-governmental organisations and the private sector. Despite their often-precarious funding, NGOs and community-based groups have come to play a major role in the national response to the AIDS epidemic in many countries, especially in the developing world. In many countries, NGOs were providing basic prevention, education and care for those infected with HIV/AIDS before Governments acknowledged that HIV/AIDS was a national concern. NGOs are also instrumental in providing services that Governments were unable or reluctant to provide (Barnett and others, 2001). In Brazil and Guatemala, the Government has specifically contracted with NGOs to provide services ranging from condom distribution to advocacy with local health officials (Barnett and others, 2001). In India, the National HIV/AIDS Policy and National Blood Policy were prepared after long consultations with various stakeholders, including NGOs, people living with HIV/AIDS, and civil society. The Government of Bangladesh (Government of Bangladesh, 2001) has involved NGOs in the Ministry of Health and Family Welfare's broad range of activities, including policy formulation, delivery of essential services and HIV/AIDS prevention. Thailand's successful response to the HIV/AIDS epidemic has also included non-governmental organizations, community-based organizations (CBOs) and self-help groups. In Africa, active NGO participation in the policy responses is found in many countries, including the Gambia, Ghana, Guinea, Mali, Senegal and South Africa. In South Africa, some 17 non-governmental sectors are involved in battling AIDS, including such sectors as the media, faith based groups, persons living with AIDS, traditional healers and men's and women's groups.

Although discussion of NGO involvement in the fight against AIDS has tended to focus on developing countries because of the intensity of the epidemic in that region, NGOs are playing a key role in the more developed regions as well. In developed countries, however, many key NGOS operate more independently of Government, serving as pressure groups to draw attention to specific aspects of the epidemic. The Coalition for HIV/AIDS Non-governmental Organisations in Europe (CHANGE) for example, has often highlighted the need to maintain the anti AIDS fight within the European Union (see www.aides.org/europe). This independence may reflect the greater financial viability of NGOs in the developed world.

Despite substantial achievements, the formation of partnerships in addressing the AIDS epidemic remains weak in some countries. China and the Russian Federation, for example, have not adequately involved civil society and affected communities in their response to the epidemic (UNAIDS, 2003). For many Governments, the involvement of multiple interest groups in the policy formulation and implementation process is a recent phenomenon and managing this process is itself challenging. Stover and Johnston (1999) noted that although everyone recognizes the need to involve all sectors of Government and society in AIDS programmes, the best mechanisms for achieving widespread

involvement are not apparent. The relationship between Governments, NGOS and other community groups is thus sometimes unclear or fragmented.

The record with respect to Government partnership with NGOs in both developing and developed countries clearly indicates an "outdooring" of concern about HIV/AIDS beyond the narrow confines of Government actors. Silence about the epidemic is gradually fading and giving way to more overt expressions of concern.

D. SUMMARY AND CONCLUSIONS

The HIV/AIDS epidemic has grown to levels unexpected just a few years ago. At the same time Government policies and programmes to address the epidemic have also evolved and become more universal. Virtually all countries now recognize HIV/AIDS as a major concern. Policies and programmes are increasingly addressing HIV/AIDS as a development challenge that requires a multidimensional national response.

The Declaration of Commitment on HIV/AIDS adopted at the special session of the General Assembly on HIV/AIDS acknowledged that prevention of HIV infection must be the mainstay of responses to the epidemic. The scope, effectiveness and comprehensiveness of HIV/AIDS prevention policies and programmes vary across countries.

Policies and programmes on blood safety are becoming more common, but implementation bottlenecks remain, especially in developing countries. Virtually all Governments are promoting IEC policies and programmes. Key messages on HIV prevention have reached those at risk, as evidenced by incipient changes in their sexual behaviour. At the same time, there is considerable scope for improving policy intervention, as behaviour for the most part, remains unchanged and risky.

HIV/AIDS prevention campaigns have significantly raised awareness and knowledge of the risks of infection. Many Governments have successfully implemented condom promotion policies although access to condoms remains limited in some countries. Condom promotion policies and programmes may need to be reinforced, as the use of condoms may be at odds with what couples perceive as acceptable strategies to protect themselves within their own social and family environment. In countries where large families are the norm, the promotion of safer sexual behaviour comes up against the desire for more children.

Governments are also increasingly articulating policies with respect to HIV/AIDS treatment. A number of countries are implementing policies to produce and distribute antiretroviral treatment, but constraints exist.

A key constraint in Governments' efforts to respond to the AIDS epidemic is the wide range of areas in which policies and programmes are needed. Developing countries especially face difficult choices in striking the right balance between prevention, treatment, and care, all of which are necessary to deal comprehensively with the epidemic. Yet some countries have demonstrated considerable success in a number of areas. These include Thailand and Uganda for their successes in slowing the spread of the epidemic, Cambodia for expanding access to condoms, and Brazil for its aggressive approach to treatment and control.

Governments have increasingly recognized that the AIDS epidemic can be best addressed with the active partnerships of civil society, those living with HIV/AIDS, community based groups, non-governmental organisations and the private sector. Despite their often-precarious funding, NGOs and community-based groups have come to play a major role in the national response to the AIDS epidemic in many countries. With their considerable experience in implementing activities to modify sexual behaviour through family planning programmes, NGOs are well placed to advance Government programmes with respect to HIV/AIDS.

For many countries, cost is a major constraint in implementing policies to address the AIDS epidemic. This constraint is particularly acute with respect to treatment. It is expected that US$4.7 billion will be spent to address the AIDS epidemic in 2003 in low and middle-income countries, falling far short of the more than US$10.5 billion that will be needed annually by 2005 to effectively fight the epidemic in these countries.

Despite challenges, Governments' recognition of the severity of the AIDS epidemic indicates that many are now playing a greater leadership role and are willing to request assistance through a growing number of bilateral and international donors to assist them in the fight against AIDS. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) had, by March 2003, approved almost 70 billion dollars in grants to countries to fight HIV/AIDS. Many others countries have received assistance through the World Bank's Multi sectoral AIDS Projects (MAP). In Botswana, the worst affected country, the Bill & Melinda Gates Foundation and the drug conglomerate Merck & Co. have both pledged $50 million in assistance. Merck is also offering an unlimited supply of antiretroviral medicines. These and other funding sources have infused significant resources in support of Governments' policy and programme development efforts. The examples of leaders such as Brazil, Thailand and Uganda have also demonstrated to Governments in different world regions that a successful response to the epidemic is possible.

The concerted effort of many nations to recognize and address the HIV/AIDS epidemic is further evidence that "never, since the nightmare began, has there been such a moment of common purpose. Never have we felt such a need to combine leadership, partnership, and solidarity." (Address of the Secretary General of the United Nations to the Special Session on HIV/AIDS, New York, June 2001).

ANNEX

ASSESSING POLICY PROGRESS: MEASUREMENT ISSUES

Various attempts have been made to review national progress in addressing policy goals with respect to HIV/AIDS. However, this exercise is complicated by conceptual and data limitations.

Many indicators of progress with respect to policy formulation and implementation are difficult to measure and often require subjective judgement. For example, "leadership" and "political commitment" are often identified as key components of successful of HIV/AIDS programmes but are difficult to quantify. Paterson (2001) notes that there is no common understanding of the meaning of political commitment. Because of varying emphases in national responses to the AIDS epidemic it is also difficult to assess progress across countries using the same criteria. For example, in those developed countries where intravenous drug use has been the most important mode of HIV transmission, Governments have put particular emphasis on prevention programmes in those areas. In many developing countries, however, preventing sexual transmission is often the main focus.

Attempts are underway to gather and improve available data on the indicators to measure progress in formulating and implementing HIV/AIDS policies. However, complete and accurate data are still lacking in many countries. Therefore, various approaches have been adopted to assess progress. One approach reviews national policies on HIV/AIDS by examining the organisational structure that has been put in place for their implementation (Harvard AIDS Institute, 2002). Another approach has attempted to review progress specifically within the health sector by measuring how access to specific services for the prevention and treatment of HIV and care for people living with AIDS has changed (The World Health Organization, 2002). In an approach comparing the policies of selected countries, Forster-Rothbart and others (2002) examined the sequence and components of policy interventions in four countries - - Brazil, Senegal, Thailand and Uganda, comparing each to other countries in the same geographic region and highlighting successful policy initiatives. Each of these analyses has shown that countries have varied in their approaches and in their success in articulating and implementing HIV/AIDS policies.

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TABLE 1. GOVERNMENT POLICIES ON THE MIGRATION OF PEOPLE WITH HIV/AIDS

Major region/area	*Total*	COUNTRIES RESTRICTING THE ENTRY OF HIV POSITIVE PERSONS WHO WISH TO ENTER AS: *Immigrants*	*Migrant Workers*	*Students*	*Refugees/ Asylum seekers*	*Return migrants*	*Tourists*
			(NUMBER OF COUNTRIES)				
World	90	15	15	12	8	5	8
More developed regions	34	5	5	6	3	2	2
Less developed regions	56	10	10	6	5	3	6
Africa	16	0	0	0	0	0	0
Asia	23	8	8	5	3	2	6
Europe	29	3	3	4	2	2	1
Latin America and the Caribbean	16	2	2	1	2	1	0
Northern America	2	2	2	2	1	0	1
Oceania	4	0	0	0	0	0	0
			(PERCENTAGE OF COUNTRIES)				
World		19	18	15	10	6	10
More developed regions		16	16	19	10	6	6
Less developed regions		20	20	12	10	6	12
Africa		0	0	0	0	0	0
Asia		42	40	26	18	11	30
Europe		11	11	15	7	7	4
Latin America and the Caribbean		13	13	7	13	7	0
Northern America		100	100	100	50	0	50
Oceania		0	0	0	0	0	0

Source: Results of the Eighth Inquiry among Governments on Population and Development (United Nations publication, Sales No. E.01.XIII.2.

TABLE 2. EVOLUTION OF GOVERNMENT CONCERN ABOUT HIV/AIDS; 1996-2003:[1] THE WORLD AND MAJOR AREAS

Year	Number of countries				Percentage			
	Major concern	*Minor concern*	*Not a concern*	*Total*	*Major concern*	*Minor concern*	*Not a concern*	*Total*
				World				
1996	89	34	2	125	71	27	2	100
2001	79	21	0	100	79	21	0	100
2003	140	26	1	167	84	16	0	100
				More developed regions				
1996	21	12	0	33	64	36	0	100
2001	24	10	0	34	71	29	0	100
2003	27	12	0	39	69	31	0	100
				Less developed regions				
1996	68	22	2	92	74	24	2	100
2001	55	11	0	66	83	17	0	100
2003	113	14	1	128	88	11	1	100
				Least developed countries				
1996	26	8	0	34	76	24	0	100
2001	17	2	0	19	89	11	0	100
2003	42	1	0	43	98	2	0	100
				Africa				
1996	34	7	0	41	83	17	0	100
2001	22	3	0	25	88	12	0	100
2003	45	1	0	46	98	2	0	100
				Asia				
1996	17	7	2	26	65	27	8	100
2001	20	5	0	25	80	20	0	100
2003	29	3	0	32	91	9	0	100
				Europe				
1996	17	11	0	28	61	39	0	100
2001	20	10	0	30	67	33	0	100
2003	26	6	0	32	81	19	0	100
				Latin America and the Caribbean				
1996	16	8	0	24	67	8	0	100
2001	13	2	0	15	87	13	0	100
2003	25	4	0	29	86	14	0	100
				Northern America				
1996	2	0	0	2	100	0	0	100
2001	2	0	0	2	100	0	0	100
2003	2	0	0	2	100	0	0	100
				Oceania				
1996	3	1	0	4	75	25	0	100
2001	2	1	0	3	67	33	0	100
2003	7	1	0	8	88	13	0	100

Source: National Population Policies, 2001 (United Nations publication, Sales No. E.02.XIII.12), and the Population Policy Databank.

[1] Figures for 2003 are preliminary

TABLE 3: DISTRIBUTION OF COUNTRIES ACCORDING TO THE IMPLEMENTATION OF POLICIES TO PREVENT HIV TRANSMISSION: THE WORLD AND MAJOR AREAS, 2001

	NUMBER OF COUNTRIES REPORTING POLICIES WITH RESPECT TO:					
Region/Area	*IEC programmes*	*Blood screening*	*Promoting condom use*	*Screening high risk groups*	*Legal provisions*	*Needle exchange*
World	83	82	81	65	59	45
More developed regions	31	30	31	23	26	25
Less developed regions	51	51	49	41	23	20
Africa	15	14	14	11	7	7
Asia	20	21	20	17	15	8
Europe	28	27	28	22	22	23
Latin America and the Caribbean	15	15	14	11	11	5
Northern America	2	2	2	2	2	1
Oceania	3	3	3	2	2	1

Source: Results of the Eighth Inquiry among Governments on Population and Development (Sales No. E.01.XIII.2, United Nations publication, 2001).

TABLE 4. WOMEN'S PERCEPTION OF THEIR ABILITY TO PREVENT HIV/AIDS: SELECTED COUNTRIES

	Percentage of women who do not know any way to avoid HIV/AIDS			
		Education Level		
Country	*Year of survey*	*No education*	*Primary*	*Secondary and higher*
Bangladesh	1996/97	53.9	51.0	32.8
Mozambique	1997	42.4	40.7	13.5
Haiti	2000	35.7	26.8	10.6
Indonesia	1997	28.6	20.3	16.1
Indonesia	1994	28.1	24.0	18.7
India	1999	26.2	20.4	13.4
Côte d'Ivoire	1994	21.9	8.6	5.1
Zimbabwe	1994	19.9	11.4	4.4
Central African Republic	1994/1995	18.7	13.0	4.6
Chad	1996/1997	17.4	13.8	5.0
Guatemala	1995	16.8	14.9	3.7
Gabon	2000	16.3	11.3	3.7
Bangladesh	2000	15.8	14.2	9.8
Bolivia	1998	15.5	11.2	3.9
Uganda	1995	14.7	8.8	1.6
Madagascar	1997	14.0	7.9	5.9
Zambia	1996	13.8	9.4	4.3
United Republic of Tanzania	1996	13.3	11.6	8.0
Peru	1996	12.8	11.8	4.6
Togo	1998	12.7	7.6	2.6
Comoros	1996	12.5	7.5	3.7
Kenya	1998	11.7	10.3	3.7
Colombia	1995	11.7	5.8	1.2
Zimbabwe	1999	11.3	7.5	2.9
Viet Nam	1997	11.3	5.8	2.6
Mali	1996	10.0	5.9	1.9
Ghana	1998	9.9	6.2	2.9
Guinea	1999	9.9	6.4	3.1
Bolivia	1994	9.8	10.2	5.5
Burkina Faso	1998/1999	9.6	8.3	2.9
Nepal	1996	9.5	10.5	4.2
Nicaragua	1997/1998	9.4	7.4	3.0
Dominican Republic	1996	8.9	5.9	1.7
Niger	1998	8.7	4.5	2.2
Benin	1996	8.1	7.0	4.6
Ethiopia	2000	7.8	3.8	0.3
Eritrea	1995	7.7	2.3	0.3
Nigeria	1999	7.7	5.4	5.1
Malawi	2000	6.6	4.0	0.2
Peru	2000	6.6	7.0	1.5
Cameroon	1998	6.0	5.8	2.4
Colombia	2000	5.6	3.7	0.7
Senegal	1997	5.4	3.0	0.6
Brazil	1996	4.3	2.9	0.8
Turkey	1998	3.7	4.1	1.8
Jordan	1997	3.6	2.4	1.0
Cambodia	2000	3.0	2.2	0.9
Côte d'Ivoire	1998/1999	1.2	0.8	0.2
Kazakhstan	1999	0.0	9.6	2.8

Source: Demographic and Health Surveys (Calverton, Maryland; Macro International Inc.).

TABLE: 5: PRIORITIES WITH RESPECT TO CONDOM PROMOTION, AS CONTAINED IN NATIONAL AIDS STRATEGIES OF AFRICAN COUNTRIES

Country	*Service Delivery*	*Strengthen Institutions*	*Research*	*Develop Policy*
Angola	✓	✓	-	-
Benin	✓	✓	✓	-
Botswana	✓	✓	✓	✓
Burundi	✓	✓	-	-
Cameroon	✓	✓	✓	✓
Central African Republic	✓	-	✓	-
Chad	✓	-	-	-
Comoros	✓	✓	✓	✓
Côte d'Ivoire	✓	✓	✓	-
Democratic Republic of the Congo	✓	-	✓	-
Eritrea	✓	✓	-	-
Ethiopia	✓	-	-	-
Ghana	✓	✓	-	-
Kenya	✓	✓	✓	✓
Malawi	✓	✓	✓	-
Mozambique	✓	✓	✓	✓
Namibia	✓	-	✓	-
Nigeria	✓	✓	-	-
Senegal	✓	✓	-	✓
Sierra Leone	✓	-	-	-
South Africa	✓	✓	-	✓
Uganda	✓	✓	✓	-
United Republic of Tanzania	✓	✓	✓	-
Zimbabwe	✓	✓	-	-
Number of Countries	24	18	13	7

Source: Harvard AIDS Institute (2001): *African Priorities for HIV and AIDS: A Summary Document from the* National AIDS Plans of Several Sub–Saharan Countries

TABLE 6. KNOWLEDGE OF CONDOMS FOR HIV/AIDS PREVENTION BY EDUCATION STATUS

Ranking of countries by the percentage of women who do not indicate condom use as a method to avoid HIV/AIDS, by education

Women with secondary education		*Women with no education*	
Percent who do not know about condoms for preventing HIV		*Percent who do not know about condoms for preventing HIV*	
Brazil, 1996	11.7	Dominican Republic, 1996	34.7
Cambodia, 2000	12.9	Cambodia, 2000	43.4
Dominican Republic, 1996	13.3	Brazil, 1996	49.3
Côte d'Ivoire, 1998/99	17.4	Malawi, 2000	53.8
Gabon, 2000	19.0	Colombia, 1995	58.7
Colombia, 1995	20.3	Zimbabwe, 1999	59.0
United Republic of Tanzania, 1999	21.9	Nicaragua, 1997/98	61.6
Zimbabwe, 1999	24.1	Colombia, 2000	61.8
Burkina Faso, 1998/99	24.3	United Republic of Tanzania, 1999	65.5
Brazil, 1991	27.9	Zimbabwe, 1994	66.5
Ethiopia, 2000	28.3	Gabon, 2000	70.0
Côte d'Ivoire, 1994	28.4	Côte d'Ivoire, 1998/99	72.5
Central African Republic, 1994/95	30.0	Comoros, 1996	77.4
Togo, 1998	30.4	Nepal, 1996	77.9
Mozambique, 1997	30.4	United Republic of Tanzania, 1996	78.6
Colombia, 2000	31.6	Zambia, 1996	79.7
Mali, 1995/1996	31.6	Brazil, 1991	80.4
Benin, 1996	31.6	Haiti, 2000	81.1
Malawi, 2000	31.8	Senegal, 1997	81.9
Zimbabwe, 1994	32.4	Kenya, 1998	82.1
Eritrea, 1995	33.3	Togo, 1998	82.4
Comoros, 1996	33.4	Burkina Faso, 1998/99	82.5
Haiti, 2000	35.2	Kazakhstan, 1999	82.7
Senegal, 1997	35.5	Mali, 1995/1996	83.8
Nicaragua, 1997/98	35.8	Eritrea, 1995	83.9
Guinea, 1999	36.0	Guinea, 1999	83.9
Cameroon, 1998	36.5	Central African Republic, 1994/95	84.1
United Republic of Tanzania, 1996	37.5	Côte d'Ivoire, 1994	84.4
Burkina Faso, 1992/93	41.0	Benin, 1996	84.9
Niger, 1998	41.2	Niger, 1998	85.7
Bolivia, 1998	45.4	Vietnam, 1997	87.4
Zambia, 1996	45.5	Bolivia, 1998	87.9
Guatemala, 1995	48.4	Burkina Faso, 1992/93	89.4
Chad, 1996/97	48.9	Ghana, 1998	89.9
Kenya, 1998	50.5	Guatemala, 1995	90.2
Uganda, 1995	51.2	Ethiopia, 2000	90.3
Madagascar, 1997	51.5	Peru, 2000	90.7
Peru, 1996	53.1	Uganda, 1995	91.6
Nepal, 1996	54.1	Cameroon, 1998	92.9
Peru, 2000	55.3	Mozambique, 1997	93.5
Bolivia, 1994	59.0	Bangladesh, 1999/2000	93.6
Kazakhstan, 1999	63.0	Bolivia, 1994	93.7
Vietnam, 1997	63.3	India, 1998/1999	94.1
Senegal, 1992/93	68.6	Chad, 1996/97	94.2
Ghana, 1998	70.0	Turkey, 1998	94.6
India, 1998/1999	71.9	Madagascar, 1997	94.9
Turkey, 1998	73.0	Malawi, 1992	95.0
Malawi, 1992	73.8	Peru, 1996	95.2
Nigeria, 1999	77.6	Nigeria, 1999	96.0
Bangladesh, 1999/2000	78.6	Indonesia, 1997	98.6
Bangladesh, 1996/97	89.6	Bangladesh, 1996/97	98.9
Indonesia, 1997	93.7	Senegal, 1992/93	99.0
Indonesia, 1994	95.1	Indonesia, 1994	99.6
Jordan, 1997	99.6	Jordan, 1997	100.0

Source: *Demographic and Health Surveys* (Calverton, Maryland: Macro International, Inc.)