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

Population Division **

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

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

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 Un

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

Box 1: Condom Promotion Programmes: The case of Thailand

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 Tw 11.e.02 ou

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 199si/2ele e4women betweav. Tm8C

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 prot

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.

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-

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 rso2003iarv46 (

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

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

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 aar shTm(tg5ty.016 now playing a gre 7

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

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COUNTRIES RESTRICTING THE ENTRY OF HIV POSITIVE	

TABLE 2. E

TABLE 3: DISTRIBUTION OF COUNTRIES ACCORDING TO THE IM

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*

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