



HIV/AIDS

Briefing Paper



AIDS - THE UNDECLARED WAR

“The HIV/AIDS epidemic is taking a devastating toll in terms of human suffering; it is jeopardising economic growth, development prospects and political stability, especially in Sub-Saharan Africa” (UNECE 2000)

There are no words to adequately portray the impact AIDS has had on millions of lives around the world. Only in the last few years has the international community really begun to take action in response to this global epidemic. Conservative estimates for 1999 suggest that 34.3 million people were infected globally by the end of the year, over 5 million people are newly infected each year and more than 6 thousand lives are lost every day to the disease (Brown 2000). 1.3 million children (aged 0-14) contracted HIV in 1999, 3.8 million have died since 1980 and nearly 13 million children have been orphaned as a result of the epidemic. The horrifying situation is most starkly apparent in Sub Sahara Africa (SSA), which accounts for over 70% of people infected globally. 77% of all infected children and 7.8 million of those orphaned by HIV/AIDS are from this region (UNAIDS 2000).

Whilst strategies to combat HIV/AIDS are improving and recent medical advancements in prevention and care have been considerable, there is a long way to go to limit further spread of the disease and help those most crippled by the epidemic. AIDS infects people irrespective of economic background but the epidemic is most keenly felt by those with the least resources to tackle it. One third of the world's population (up to 50% in Africa and Asia) lack access to basic medication, let alone the specialised treatments required for HIV/AIDS (WHO b. 2000). Something little short of miracle is required to cope with the enormous battle ahead and for SSA in particular only a concerted international effort is going to have any kind of impact.

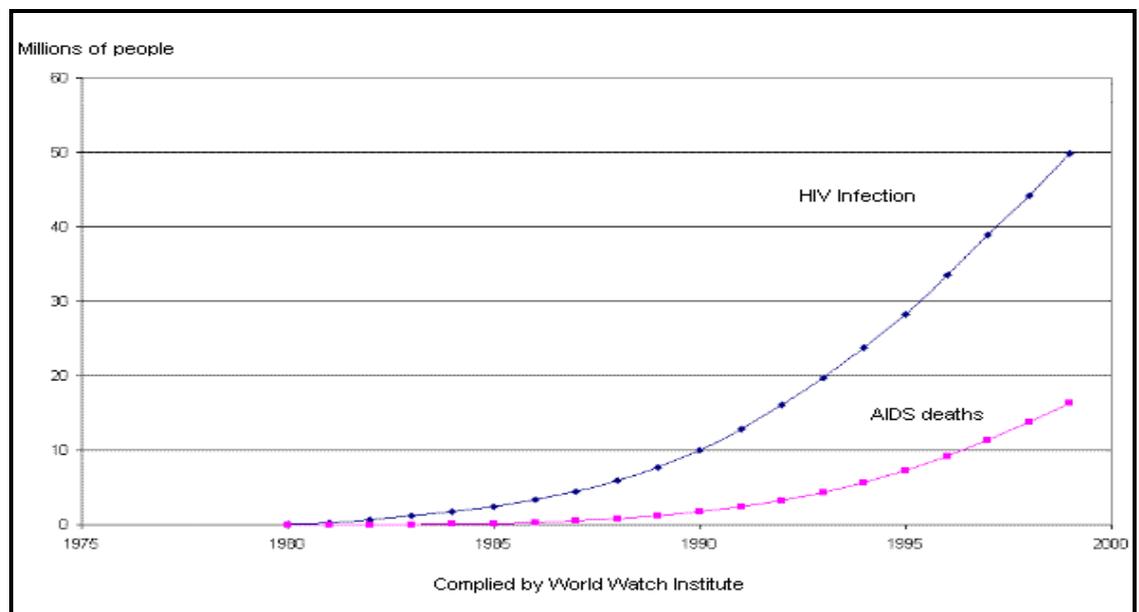


Figure 1. Global estimate of cumulative HIV/AIDS infection & death, 1980-1999 (Brown 2000)

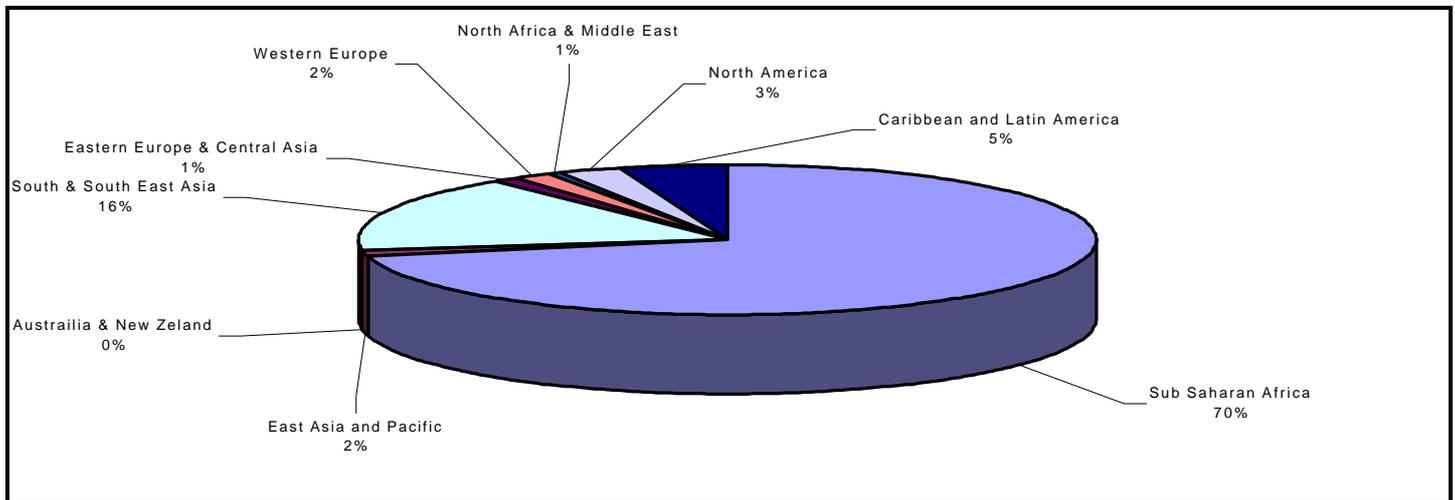
OVERVIEW AND REGIONAL TRENDS

A short paper such as this can only give a broad picture of some of the critical problems relating to Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), however the link between the disease and its impact on development is becoming increasingly clear. The first cases of AIDS are believed to date as far back as the 1930's but only in the 1980's did it reach global proportions (see Figure 1).

AIDS is caused by HIV, a virus which kills or impairs cells in the immune system, destroying

the body's ability to fight infections and cancers. The virus is transmitted horizontally and vertically. **“Horizontal”** transmission occurs during heterosexual intercourse and between men who have sex with men (MSM) when no barrier method (i.e. condom) is used during intercourse with an HIV infected person. It is also transmitted between injecting drug users (IDU) from sharing infected needles. **“Vertical”** transmission occurs between mothers and their children during or after pregnancy. Approximately one in three children (0-2 years) will contract HIV from infected mothers (UNICEF 2000). The most typical mode of transmission varies within regions and countries but the regional trends do highlight something of the scale of the problem, especially for SSA (Table 1, Figure 2).

Figure 2. Proportion of adults & children living with HIV/AIDS in different regions (UNAIDS 2000)



HIV/AIDS has severely undermined the development of many countries, in terms of individual suffering and loss, as well as knock-on effects to families, communities, economies, medical services, businesses, public services and society as a whole (WSSD 1999, DESA, 1998). At a macroeconomic level, the epidemic has impacted national economic growth in a number of countries e.g. Tanzania has experienced a 15 to 25 % fall in GDP as a result of the AIDS epidemic (WB 1997). This is due to a number of reasons. The epidemic absorbs a lot of funds for the provision of basic health care and prevention services e.g. in Rwanda in 1995 an estimated 66% of public health expenditure was for HIV/AIDS patients. Increasingly stretched resources mean that the provision of health care for other patients is also severely reduced. Government revenues and private saving are reduced by these health costs, as well as due to the costs of implementing related regulatory and social security systems (e.g. life insurance). Such costs slow investment in employment creation and capital intensive sectors. The impacts on the work place are also considerable. For example AIDS-related increases in mortality are predicted to reduce workforces globally by 11.5 million people by the year 2020 and some African work forces will fall by as much as 20% of existing levels (UNAIDS b. 2000, BBC 2000). Human resources, especially in key sectors such as teaching and health care, are cut back and rural areas are particularly effected as people are less willing to work in areas with poor access to services (UNAIDS a. 2000).

The quantity and quality of labour has declined for a number of reasons, such as AIDS related increases in absenteeism and mortality, as well as from reduced capacity in education and health care, and human resources training. Certain sectors are more effected than others, e.g. transport, fishing, mining, tourism, agriculture and construction. This is because the work is typically seasonal or involves considerable travel away from home and families, factors associated with higher levels of risky behaviour in individuals (UNAIDS b. 2000). The epidemic is having a devastating effect on agricultural output, e.g. Zimbabwe's maize production has dropped by 61% because of AIDS-related losses in staff. Agriculture is the largest industry in Africa and an important form of subsistence for many developing countries, yet farmers are being forced to switch to less labour intensive crops, which directly impacts on the security of food supply (UNAIDS a. 2000). Military/civilian interaction is also instrumental in spreading HIV/AIDS. Armed forces are highly mobile, and soldiers are known to solicit commercial sex, as well as use rape as a weapon of war. Refugee populations are especially vulnerable to such activities. The risk of HIV infection is estimated at 6 times higher in refugee camps than outside. As a result of their close involvement with infected individuals in areas of conflict peace-keeping forces are also at risk of infection. Several African countries currently face armed conflict, food emergencies, inadequate water supply and sanitation, droughts and floods. HIV/AIDS severely exacerbates the political instability and insecurity in SSA. In 1999, 2 million people were killed by HIV/AIDS in SSA as compared to the 200,000 thousand who die each year from armed conflict, giving rise to the view that *“HIV/AIDS is the greatest undeclared war”* (UNICEF 2000).

Table 1. Regional trends of the epidemic

Region	Details
Central Asia & Eastern Europe	Critical groups: IDU, MSM, sex workers Newly independent states of former Soviet Union show the highest global rate of infection. Infections doubled between 1997 and 1999. Incidences of drug abuse are growing, e.g. between 1-2.5 million Russians are thought to be IDUs. Nearly half of all AIDS cases in Eastern Europe are thought to be attributed to use of infected needles.
Latin America & Caribbean	Critical groups: Heterosexual, MSM, sex workers, IDU, mother-child. HIV/AIDS is present in across a diverse range of people. Urban areas are especially affected e.g. 7% of pregnant women were found infected in some urban areas of Guyana. Critical groups are found in the sex industry and IDUs e.g. a survey in George Town found 46% of sex workers were infected, 33% said they didn't use condoms. Honduras, Guatemala, Belize, Mexico, Colombia and the Caribbean are showing increasing levels of both heterosexual and MSM infection.
Asia & Pacific ^a	Critical groups: Heterosexual, MSM, sex workers, IDU, mother-child. The proportion of infected people relative to the total population is low but absolute numbers are high e.g. In India 3.7 million adults are infected. Young populations (especially aged 20-24) indicate high levels of infection in Asian countries. Around half of those currently infected with HIV will have full blown AIDS by the age of 25, with a high chance of death by 35.
Africa ^b	Critical groups: Heterosexual (although other groups are also infected) Heterosexual transmission is the most common mode of infection (common to developing regions). SSA is the worst affected region & of these countries Botswana has been hardest hit (36% of adults are infected, average life expectancy has fallen from 61 years in 1990 to 47 years in 2000). Other critical countries include: Lesotho, Swaziland, Zimbabwe, Zambia, South Africa, Kenya, Namibia, Malawi, Rwanda, Mozambique.
Western Europe	Critical groups: MSM, IDU Recent trends are positive, e.g. only 3 in 10,000 women in Germany are infected, however there is evidence of growing levels of infection. This may be due to increasing complacency about risky behaviour, such as drug abuse and failure to use condoms, e.g. an estimated 51% drug users in Barcelona are HIV infected.
North America	Critical groups: MSM, IDU The status of the epidemic is similar to Western Europe and other industrialised countries. Whilst IDUs and MSM make up the greatest number of cases, heterosexual transmission is clearly linked e.g. 9 out of 10 cases of heterosexual infection in New York resulted from sexual intercourse with drug users.

Sources: UN AIDS 1999, UNAIDS 2000, DESA 1998

a (South, South East and East Asia, Pacific, Australia New Zealand)

b (SSA, North Africa and Middle East)

At the microeconomic and local level, earnings, savings and disposable income are likely to fall with greater numbers of people facing the financial burden associated to HIV/AIDS care and treatment. Young adults (15-49), especially women, display high rates of infection, from Sexually Transmitted Diseases (STDs) as well as HIV. They often lack the knowledge and resources to protect themselves and others. In the past, the highest number of infected cases were found in men, however, women are showing increased levels of infection. In 1999, women accounted for 49% of new infections and more than 50% of AIDS related deaths. Of the cumulative total of adult deaths (18.8 million) since the beginning of the pandemic more than 51% were women. The infection impacts on women's health, physical and mental well-being, raises the risk of mother to child transmission, affects their ability to be mothers and carers, and limits their educational and employment opportunities (UNCSW 1999). Children also face infection, being orphaned and suffer untold psychological effects because of the abuse, alienation, stigma and discrimination which is frequently borne by individuals associated to the disease. Such pressures mean that children tend to drop out early from school, forcing them to become providers for themselves and their families. Reduced access to education and loss of teachers has a direct impact upon the skills and learning of young people, further diminishing their ability to develop as "healthy" members of society (Simms 2000). The family structure is effected as the need for extended families to support infected individuals and orphaned children is enhanced. However, these traditional structures are weakening in many developing and transitional countries due to urbanisation and migratory changes. The elderly are also likely to bear an increasing burden as a result e.g. care of infected people, orphaned children, and remaining in the work place for longer period. Marginalised people e.g. the poor, minorities, migrants, Indigenous People, IDUs, sex workers, people with disabilities, MSM, prisoners, all have to cope with an increasing incidence of HIV/AIDS. Limited economic, political and social influence, as well as lack of access to basic services reduces an individual's ability to combat the disease.

Numerous direct and indirect causal factors have been linked to the spread of HIV and increased risk of infection. These include lack of information, severely limited access to care and preventative methods, "risky" attitudes toward sexual behaviour, low status of women, drug and alcohol abuse, other STDs, economic changes and political instability. Some of the critical issues include:

1. Access to medication, prevention and care

Access to care is crucial for those infected with HIV/AIDS to fight off the threat of “opportunistic” diseases e.g. tuberculosis and pneumonia, and in terms of receiving palliative care. On average it takes 10 years for HIV to reach fully blown AIDS and patients need long term care and support. Whilst many in developed countries receive adequate care, people in developing countries are less fortunate and have difficulty obtaining even basic health care provision. Some economic policies can restrict access to treatments by imposing tariffs and customs duties on critical products. Locally produced, generic medicines may be more widely accessible and can be cheaper than patented products, however the quality, distribution and administration of such medicines is not guaranteed. A shortage of medication, facilities, transport infrastructure and skilled staff, as well as adequate counselling and support infrastructure is common in SSA and rural areas of developing countries and few in these areas can afford to pay for the palliative and immunostimulant treatments necessary.

In terms of prevention there are over 100 medicines currently in development, including 30 anti-virals, 12 vaccines, over 15 anti-infectives, and around 6 gene therapies. An HIV vaccine might seem like a panacea to preventing further infection. However, it is estimated that it will take roughly ten years until such a vaccine would be readily marketable. Tens of millions of people will continue to require on-going treatment and the search for a cure must continue. Continued innovation and investment in research is therefore vital. Thus appropriate incentives and mechanisms for promoting innovation and access to products will also require further development and enhancement.

Other preventative methods, such as female condoms, have been shown to be effective and empowering for women but they are an expensive alternative to the male version and poorly distributed. Contraceptive microbicides show potential but need further research to ensure their safety and affordability. Hence at present male condoms, fidelity or abstinence remain the main ways to prevent sexual transmission. Provision of clean needles, drug prevention and rehabilitation programmes can help reduce the risk of IDU transmission but these approaches, like the use of contraceptives, can be controversial and require sufficient resources to administer effectively.

2. Culture, environment, human rights and behaviour

Stigma and discrimination, early marriage, domestic and sexual violence, exploitation of sex workers (male as well as female), transmission of other STDs, alcohol and drug abuse are among the socio-cultural factors linked to the spread of HIV/AIDS (ICPD 1994, UNCSW 1999). Young women are especially vulnerable to HIV infection (and other STDs) because of biological, cultural and economic factors. Women are more vulnerable to HIV infection through the genital tract and they are sexually mature and active at younger age. The low social status of women in many societies encourages discrimination, domestic and sexual violence, coercion and psychological abuse, so that they are less able to negotiate safe sexual practices. Studies of the impacts of sexual abuse at an early age suggest that this can also lead to risky sexual behaviour and low self esteem in women in the longer term. In general women have less access to information and education and are therefore less able to make an informed response to the disease. Women face immediate income needs and hence some are forced to resort to offering sex in order to pay for schooling and families. These factors, compounded by cultural norms, such as polygamy, increase the threat of HIV/AIDS to women (UNAIDS a. 2000). AIDS/HIV poses many complex questions with regards to sexual behaviour from an ethical, moral and religious standpoint. Humanitarian and faith communities all over the world are having to help fight against rising prejudice and discrimination, as well as cope with ever greater numbers of people who need their moral and spiritual support and guidance.

Biological diversity, indigenous rights and traditional medicinal knowledge are closely linked to access to care and prevention. Traditional healers are the principle carers in many developing countries, especially for communities in rural areas. Where their medicinal knowledge, access to biological resources or cultural and spiritual rights are undermined it impinges directly on the community’s ability to combat diseases, including HIV/AIDS. Many important pharmaceutical species (flora and fauna) which may have anti-viral or immunostimulant properties or could treat opportunistic diseases are currently endangered. These species are being threatened by unsustainable uses, ecosystem degradation and climate change. There is still insufficient data to assess the full extent of this threat in many regions (ELCI 2000). Furthermore, for Indigenous Peoples who might want to protect traditional medicinal knowledge through formalising their Intellectual Property Rights, the cost and complexity involved in applying for patents is often prohibitive (VSO 2000).

3. Lack of knowledge and mis-information

Present estimates of the epidemic are thought to vastly underestimate the true scale of the problem making it difficult to

obtain an accurate picture of the status of the epidemic. Hence a vast number of people remain unaware of their infection. It is estimated that only 5% of those infected in SSA are actually aware they are HIV positive (UNAIDS 2000 b). Many countries have limited facilities for diagnosis and screen testing. The social stigma attached to HIV/AIDS and the lack of symptoms during the initial stages of infection mean that many people fail to come forward for testing. Poor access to information and education has enhanced the social stigma attached to infected people which arises mainly from misconceptions and mis-information relating to the disease. Infected people can mis-apply treatments through lack of support for self-medication. Also many remain unaware of how to take basic precautions or reduce risky behaviour to prevent infection e.g. a recent survey in SSA found 25% of women were unsure how to protect themselves from HIV infection. Some recent surveys in SSA uncovered the (incorrect) view that condom use reduces male virility. Other surveys also revealed people who held the view that circumcision gave total protection against HIV infection when in reality it only slightly reduces risk. Similar incorrect assumptions can be made regarding those close to HIV/AIDS carriers e.g. children of infected parents are often thought to be carriers as well. Such perceptions exacerbate discrimination, marginalisation and denial of the epidemic in society, thereby reducing the likelihood that those infected will change risky behavioural patterns.

4. Resource short-fall

The need for far greater and targeted financial support is paramount if these critical issues are to be effectively tackled. Many developing countries fall far short of meeting this need. And whilst Overseas Development Assistance (ODA) targeted for HIV/AIDS programs in developing countries has risen in last few years, it has yet to bring significant improvements in access to care and prevention awareness in the poorest countries. 28 out of the 32 heavily indebted poor countries are in SSA, which together owe over US \$2.2 trillion in debt. Africa as a whole currently spends four times more on debt repayments than it does on health and education (UNAIDS b. 2000).

BREAKING THE TREND

The World Health Organisation (WHO) definition of “health” refers to complete physical, mental, spiritual and social well-being, and not merely the absence of disease or infirmity (ICPD 1994). WHO talks of equity as a prerequisite to achieving the right of good health. Hence, although prevention and treatment are core elements to tackling the disease, it has been argued that greater gains will be made by taking a rights-based approach to tackling HIV/AIDS (UNAIDS a. 2000). This strategy reflects not only the right to good health but also to information and education, freedom of expression and association, liberty and security, privacy and confidentiality, and against inhuman and degrading treatment. This describes a broader more sustainable strategy geared towards improvements in equitable information provision, social reform, infrastructure development and resource mobilisation.

1. Enhancing knowledge, information, education

Information alone is not enough to change behaviour. It requires effective analysis, communication, participation and accountability to build knowledge and skills. Furthering our understanding of the disease will need to include multi-disciplinary assessment of social, economic cultural, behavioural linkages, as well as assessment of policy. Disaggregated data, e.g. by gender, age or income, is crucial to help identify demographic / behavioural trends. Assessment and collation of examples of good practice is also vital, e.g. programmes which combine traditional medicinal practice alongside modern medicine, or development of species inventories for traditional medicinal species to help prioritise threatened species and identify the critical habitats which support them. Experimental and clinical evaluation of traditional medicinal plants with antiviral, immuno-stimulant and treatment properties is also required, including assessment of their safety and efficacy (ELCI 2000).

Information resources for education and training programs should incorporate broad issues such as reproductive and health issues, human rights, abuse, discrimination, biological and cultural aspects. This information needs targeting toward critical groups. For example, young people, of an appropriate age, can be targeted not only at school but more widely, such as in sports and social clubs. The media e.g. radio, television, theatre, music and the press can also have a powerful impact (UNICEF 2000). Support for parents, carers, policy makers and teachers is vital for community-based outreach to develop awareness amongst peers in schools, families, places of work and recreation (ICPD 1994).

2. Access to health care services, medication and reproductive rights

The right of universal access to “appropriate and affordable” health care services should aim to enhance the ability to choose “safe, effective, affordable and acceptable” methods for family planning, prevention of HIV/AIDS and other STDs, and ensure that services provide a level of care which is affordable, convenient and good quality. Developing countries clearly need enhanced health care services, including access to voluntary diagnosis and counselling, information and education, referral to alternative services (family planning, confidential diagnosis and treatment), as well as increased research, promotion, supply and distribution of condoms, pharmaceuticals, vaccines and safe blood transfusion. This all requires the mobilisation of considerable resources (see 4. below) and skills-sharing within and between countries (UNPFA 1998). The use of community care plans is increasing, which involves greater support for extended families and community groups e.g. income and employment generation projects, psychological support and financial assistance, in order to build community capacity to combat the disease (Simms 2000, UNCHR 1999). A tiered pricing system for anti-HIV therapies could better reflect the purchasing power parities of different countries to make medicines more affordable. However for the poorest no price is really affordable. Mobilisation of external resources are therefore key to help countries obtain and appropriately administer these products (Mukherjee 2000). To enable the rapid adoption and implementation of effective technology, barriers to technology transfer need to be identified. Recently five major drug manufacturers, the WB and UNAIDS met to discuss how to accelerate access and quality of drug provision. Clearly such collaborations should also consider how to accelerating field trials and create incentives for enhancing production and access to medication.

3. Changing Social attitudes and behaviour

“Equal relationships requires mutual respect and willingness to accept responsibility for consequences of sexual behaviour” (UNGASS 1999).

If building gender equality and equity is seen as key in the fight against AIDS then changes are necessary in both male and female knowledge, attitudes and behaviour. Women need to develop greater self esteem and knowledge in order to take more responsibility for their sexual and reproductive health, free from coercion, discrimination, and violence. Men need to take greater responsibility for their own conduct and recognise the importance of women’s health and well-being (WCW 1995). To promote gender equality, programmes should highlight the importance of women’s health needs and support female involvement in planning, implementation, evaluation and decision making within health provision. Enhancing public acknowledgement and pro-active response to the epidemic will require considerable cultural sensitivity to reflect the diversity of circumstances and needs. Open discussion, moral and spiritual support for infected and affected people and awareness raising about the disease can help change attitudes and reduce prejudice and discrimination. Publicity campaigns, such as in Brazil, Thailand and Uganda, have shown that a direct link between campaigns, behavioural change and reduced infection. For example an information campaign by the Brazilian Government increased condom use in adults from 5% in 1986 to 50% in 1999. Religious bodies can play a key role in helping to “break the silence” on HIV/AIDS. Many places of worship (churches, mosques, synagogues, temples, hospitals with religious affiliations) have initiatives which deal with HIV/AIDS at a local level e.g. fund raising campaigns, assisting home-based care (UNAIDS a. 2000).

In terms of biological resources, conservation programmes which aim to protect ecosystems are crucial for maintaining known and potential medicinal species. Pharmaceutical companies can incorporate respect for indigenous IPR through royalty and benefit-sharing agreements which may help compensate for use of indigenous knowledge. “Formally” trained practitioners should recognise traditional health practitioners as equals and partnerships encouraged, e.g. through the exchange of information and research which helps to enhance the sustainable conservation, use and management of medicinal plants and their associated ecosystems (ELCI 2000).

4. Resource mobilisation and distribution

Improved access, capacity, cost-effectiveness and quality of programmes will require considerable investment. James Wolfensohn, president of the World Bank, recently pledged the maximum available funds to create and implement HIV/AIDS programmes (DFID 2000). One estimate for the global cost of basic health care provision in 2005 was given as \$18.5 billion, 7% of which would be for HIV/AIDS related initiatives (WSSD 1995). However, more recent UNAIDS figures estimate a total cost between \$2-3 billion a year for HIV/AIDS programmes in Africa alone. UNICEF estimates that \$2-4 billion will be required to control the epidemic in young people globally (aged 10-15). Increased financial support is needed for research and monitoring, as well as to provide economic support for those infected and affected by HIV/AIDS. Also global and national funds need enhancement to facilitate the transfer and procurement of drugs. Most funds are expected to come from domestic sources but it is unrealistic to ask many of the developing country govern-

ments to meet these costs alone. International initiatives such as the Poverty Reduction Strategy Papers (World Bank) have incorporated facilities targeted to HIV/AIDS programmes in countries such as Nigeria, Mauritania and Burkina Faso (UN CSW 1999). It has also been suggested that domestic resources could be enhanced through debt relief from aid agencies, releasing funds for HIV/AIDS related strategies (UNAIDS b. 2000).

Table 2. Institutional roles and responsibilities

	Examples of recommended roles and responsibilities
Government	<ul style="list-style-type: none"> * Cross departmental response: enhanced coordination between departments e.g. labour, defense, education, health, industry, social security. A national AIDS Commission can assist coordination and monitoring of departmental activities. * Promotion of reproductive rights and responsible conduct: Set up procedures to enable people to report violations of rights and strengthen/enforce laws, e.g. prohibition of child pornography and support gender sensitive strategies that include women at all levels via legislation, policy, projects etc. * Promote community participation: decentralisation of public health programs, setting up partnerships with focus groups e.g. local NGOs, women's groups, trade unions, cooperatives, religious groups. Decentralisation requires training and education at more local levels for health care workers, teachers, parents and guardians, and other community representatives. * Resource mobilisation: Investment in prevention (e.g. reproductive health services and drug prevention and rehabilitation), diagnosis and care (e.g. counselling, medication) is crucial. Rising insurance premiums may not be affordable by employers, thus governments need to encourage policies in the insurance sector which are both affordable and realistic. * Strengthen broad-based health care provision: Regulate access to health care by establishing standards for diagnosis, drug delivery, patient care & counselling for patients and families. Review international agreements (including trade) that limit access. Create incentives toward better provision e.g. tax credits to pharmaceutical companies to encourage investment in research where companies are subject to generic competition.
NGOs	<ul style="list-style-type: none"> * Rights based approach: NGOs, women and community groups, faith communities etc. can encourage a more equitable approach through greater community inter-action e.g. creation of "inter-faith alliances", life-skills training for HIV/AIDS in schools, for organisational members. They can also put pressure on the authorities responsible to provide culturally sensitive and relevant care. * Direct assistance: NGOs can help implement programs, through sharing lessons learnt on the ground, assisting exchange of ideas, education and training for community-based prevention and care programs, e.g. through training workshops, conferences, volunteer placements in critical areas. * Protection of Indigenous/traditional knowledge and biological resources: For example, traditional healers associations can help protect traditional knowledge and conserve biological resources within their native ecosystems, as well as raise community awareness in order to reduce the stigma and risky behaviour associated to infection.
Private sector	<ul style="list-style-type: none"> * Long term business plans: Work place prevention, care and social investment programs will help save health care costs and enhance labour force productivity, e.g. health education workshops. * Enhancing traditional rights: Royalty and benefit sharing agreements, partnerships with traditional healers to help protect medicinal species and improve availability and supply of medicinal species through conservation and sustainable harvesting practices. * Safety nets & workers rights: Pre-employment and on-the job screening can lead to unethical and discriminatory practice, thus the rights of workers need to be incorporated in programs e.g. confidential / voluntary testing, equitable insurance and work-related policies. * Business coalitions: collectively pool resources and response to epidemic, share information on prevention and care, raise awareness in the workplace, e.g. Global Business Council on HIV/AIDS and also national business coalitions in Botswana, Brasil, South Africa and Thailand's have involved trade unions and governments for prompt and effective action against HIV/AIDS. * Awareness raising: Use of Multi-Media e.g. radio, theater, television, press, music etc to reduce stigma, inform people and encourage open debate.
International institutions	<ul style="list-style-type: none"> * Resource mobilisation: Enhance funding into research for potential species with HIV/AIDS medicinal properties e.g. Commonwealth Fund for Technical Cooperation. * Advocacy: Encourage governments, society and other international institutions to set HIV/AIDS as a central development issue and intensify international response, support debt relief and resource mobilisation and expand partnerships, awareness and response. * Access to services and treatment: Support policies to reduce public sector prices for vaccines and drugs, e.g. UNAIDS "Access to drugs" initiatives in Cote d'Ivoire and Uganda support rational drug selection and use, generic competition and development of national drug management policy. Also International AIDS Vaccine Initiative gives research and technological support for Africa and other developing states. Private sector investment in development of vaccines may be enhanced by procurement of existing vaccines for other diseases, signalling international willingness to pay for AIDS vaccines development. Standardise principles of trade in medicinal plants e.g. TRAFFIC (Trade Record Analysis of Flora and Fauna in Commerce) guidelines to trade in wildlife (legal and affordable) and clarification of the relevant articles in TRIPS. * Social and cultural rights: Strengthening of UN goal to eliminate discrimination and violence against women, and provide assistance to victims of any forms of violence in the home, workplace and during armed conflicts. Redefine and monitor IPR to better promote the customary rights of traditional healers e.g. HARITAF International Working Group on AIDS * Research and information: Identification of additional needs, e.g. countries in transition. To design, manage and disseminate best practice, technological developments, status reports. Raise the profile of traditional medicine by publishing research findings and information on efficacy and safety.

Sources: VSO 2000, WB 1999, UNICPD 1994, WSSD 1995, UNCSW 1999, Economist 2000, ELCI 2000

THE WAY FORWARD: A UNITED RESPONSE

In the four years since UNAIDS was set up, it has made remarkable steps in linking a wide range of actors together, such as setting up the “International Partnership against AIDS in Africa”. Largely due to UNAIDS’ activities, HIV/AIDS is now on the agenda of many international fora e.g. the World Education Forum, South Summit (Havana), G8 2000 meeting in Japan. At the 13th International AIDS meeting in Durban (July 2000), the UN Security Council made a resolution recognising HIV/AIDS as an issue of security, linking HIV/AIDS to areas of conflict. Furthermore the UN Economic Commission for Africa decided to focus on AIDS for the African Development Forum in October 2000 (Addis Ababa, Ethiopia) and called it “*AIDS: the Greatest Leadership Challenge*”. These links and on-going discussions need to be maintained and enhanced as what is urgently needed now is action. UNAIDS advocates localised and national level responses, targeted toward critical groups (UNAIDS 2000). Such an approach requires the multi-sectoral involvement of government, pharmaceutical and private sector, academia, women’s groups, NGOs, educational institutions, legal and media sectors, as well as those infected with and affected by the disease (Table 2.).

UNAIDS’ “*Report: on the global HIV/AIDS epidemic*” takes the international view a step further by linking the HIV/AIDS agenda to broader principles of poverty elimination, human rights and sustainable development. Many of the recommendations in UNAIDS’ report are focused around International Development Targets agreed upon at various international summits¹. This includes the specific target of reducing young people’s (aged 15-25) vulnerability to HIV/AIDS infection by increasing access to preventative methods (such as condoms, voluntary testing, counselling and follow up) to at least 90% by 2005 and 95% by 2010. In addition the target was set to reduce the rate of HIV infection in young people in “most effected” countries by 25% by 2005 and globally by 2015 (UNGASS 1999). It is clear there have been some advancements in meeting these targets. However, strategies need to be continually assessed and reviewed to ensure that they are progressing in the right direction. Table 3 summarises some examples of suggested indicators which could be used to monitor progress.

Certain key areas need to be considered in the future:

- * How can WHO, along with other institutions, enhance access to treatment and future vaccines, and create further incentives to stimulate investment in vaccination and medicinal development;
- * How can UNAIDS enhance its collaborative initiatives, toward mobilisation of sufficient resources and increasing access to prevention and care, as well as supportive action at the local level;
- * How to operationalise a wider assessment of potentially important medicinal species, ensuring the better protection of associated ecosystems, as well as the rights and knowledge of local and Indigenous Peoples;
- * How to ensure on-going and in-depth assessment of infection in critical groups (women, children, drug users, refugees) to monitor progress and behavioural changes;
- * How governments can increase the scope of national legislation and policy to better incorporate human rights and HIV/AIDS priorities.

With aspects of health, education, equity, poverty elimination and human rights agreed as international goals, any attempt to tackle the HIV/AIDS epidemic will need to put these aspirations at its core in the struggle to give an adequate level of support for all those living with and affected by the disease. AIDS is already impacting on millions of lives, but the full death toll and impact of the disease is only likely to reveal itself over the next five to ten years. The epidemic poses a very real and immediate global challenge and what is needed now is a concerted and coordinated international response.

GLOSSARY

AIDS: Acquired Immune Deficiency Syndrome
 Anti-retrovirals: drugs which attack the AIDS virus
 IDU injecting drug users
 HIV: Human Immuno-deficiency Virus
 MSM : Men who have sex with men
 STI: Sexually Transmitted Infection

Table 3. Examples of indicators to monitor progress in combating HIV/AIDS

	Examples of Indicators
Education	Enrolment: Primary & Secondary school enrolment ratio (gross and net values) Teaching capacity: Total % of teachers HIV/AIDS infected Knowledge: Child & adult literacy rate; % population aware of two or more methods to prevent transmission
Environment	Strategy: Inclusion of strategies for HIV/AIDS prevention and care as part of NSSD Basic resources: % of population with access to clean water and basic sanitation Biological resources: Number of endangered medicinal species; % area of critical ecosystems protected and sustainably managed
Poverty	Strategy: Inclusion of HIV/AIDS strategies in Poverty Reduction Strategy Papers Employment: Proportion of adults (aged 15-49) infected with HIV/AIDS Income disparity: GNP of poorest 20% of population; ratio of poorest to richest 20% infected with HIV/AIDS; cost of medication relative to income
Health	Primary care services: Ratio of health care workers to population (per thousand); % of population with access to reproductive health care services; Prevention: Contraceptive prevalence rate in sex workers/youth/IDUs/ refugees / women; Resource mobilisation: % GNP for HIV/AIDS program; % ODA for HIV/AIDS program; Monitoring: % of total population tested, % of health care centres with adequate facilities for diagnosis
Youth	Sexual behaviour: Age of first sexual encounter (disaggregated data sets); % of infected cases aged 16-18 years (key age group to assess behavioural trends) Orphans: % orphans due to HIV/AIDS deaths; % orphans in institutional, extended family or foster care Mortality: % HIV/AIDS deaths for children under 5;
Gender	Strategy: Implementation of the Declaration on the Elimination of Violence Against Women & the Beijing Platform for Action Employment: % of women in higher levels of employment (e.g. management); ratio of female to male wage Health: % women (aged 15-49) infected with HIV/AIDS; HIV prevalence in pregnant women Education: Ratio of girls to boys in primary education
Conflict	Policy: Implementation of the Declaration of Principles of Tolerance and Follow-up Plan of Action (1995); UN Convention on Human Rights; UN Declaration on a Culture of Peace Humanitarian assistance: Implementation of initiatives in areas of conflict e.g. "days of tranquillity" to carry out immunization and medicinal distribution campaigns; "corridors of peace" to deliver humanitarian supplies; "sanctuaries of peace" designation for health and medical institutions, e.g. hospitals and clinics.

Sources: ICPD 1994, WCHR 1997, CEDAW 1980, WSSD 1995, UN GA 1999, UNDSO 1998

FOOTNOTES

- Other relevant agreements include: universal primary education in all countries by 2015; death rates of infants and children under the age of 5 years reduced by two thirds from 1990 to 2015; access, through primary health care systems, to reproductive health services for all individuals of appropriate age, no later than 2015; the number of people living in extreme poverty in developing countries should be reduced by at least 50% between 1990 & 2015; national strategies for sustainable development to be implemented by 2005, to reverse the trend of environmental resource loss and degradation at global and national levels by 2015 (UNCED 1992, ICPD 1994, WCW 1995, WSSD 1995).

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