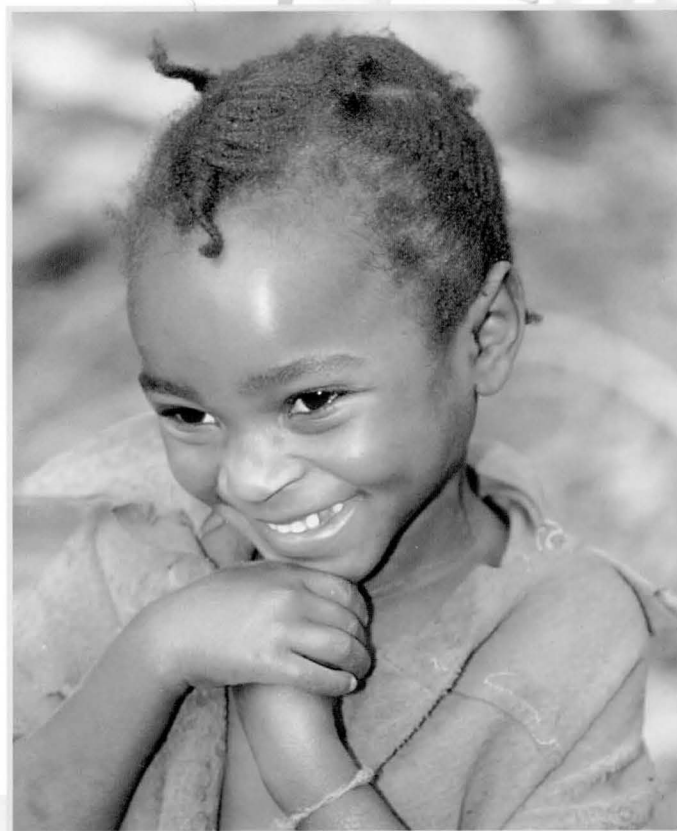


A

ction:

The EC's response to HIV/AIDS

in developing countries



s u m m e r 1 9 9 4

*Second,
updated edition*



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CREDITS

Written and edited by Rex Winsbury
Design and production by edit

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CONTACT ADDRESSES

Commission of European Communities
Directorate General for Development
Health/AIDS Unit (VIII/8)
200, rue de la Loi, B-1049 Brussels, Belgium
Tel: (32.2) 296.37.01
Fax: (32.2) 296.36.97

AIDS Task Force

Technical Assistance Programme
10, rue de Genève, Box 7, B-1140 Brussels, Belgium
Tel: (32.2) 245.43.90
Fax: (32.2) 215.67.47



FOREWORD
BY COMMISSIONER
MANUEL MARIN



HIV is one of the major public health issues of the end of this century. Despite major efforts undertaken by developing countries over the past eight years, with the support of the international community, the epidemic continues to spread rapidly, especially in developing countries.

Aware of the seriousness of the problem in developing countries, the European Union had in 1987 already launched an important programme to support national strategies aiming to reduce the spread of the epidemic and to mitigate its social impact. Interventions developed at both Community and bilateral levels since then make the Europe of the twelve the most important donor in the fight against HIV/AIDS today.

However, the facts must be recognised - our efforts are still not enough. This is why at the beginning of 1994 the Commission took the initiative of submitting to Ministers for Development Cooperation of the Member States a communication which aimed to mobilise the highest possible level of political support. Its objective was to increase European commitment to confront all aspects of the pandemic.

This appeal was well received by Development Ministers. During their meeting of May 6, 1994 they adopted a Resolution defining a European strategy and priorities for the next five years. The message is clear: the European Union and its Member States will increase both their financial and technical commitment to improving interventions and action in the field. The aims are prevention and care, mitigation of the social consequences and strengthening of research.

This new edition of the brochure explains future strategy, derived from the lessons of past experience. I hope that it will give readers a measure of Europe's determination to do more and act fast and in the most efficient manner to counter this immense threat to social and economic stability.



INTRODUCTION

Figure 1 Burden of disease attributable to premature mortality and disability by demographic region, 1990

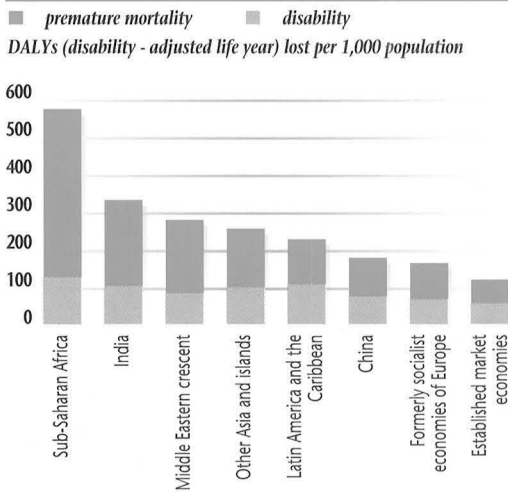
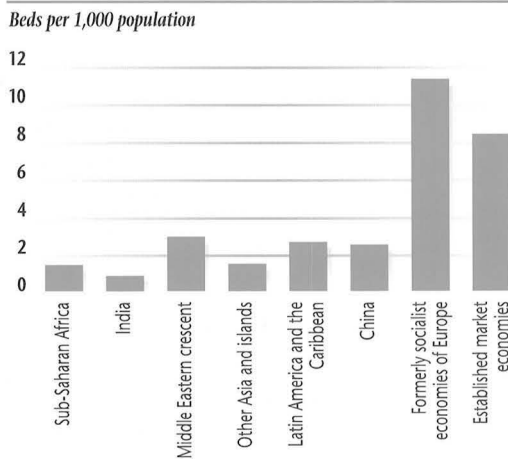


Figure 2 Hospital capacity by demographic region, about 1990



In the two years since the first edition of this brochure was published, the global response to the HIV/AIDS epidemic – and with it, the response of the European Community – has broadened and deepened. As a major contributor to the world's campaign to contain the epidemic the Community has, through its specialists and policy makers, been both an integral part of these broader global developments in policy and practice, and in the vanguard of them. This brochure explains what the European Commission has done and is doing, why, on what principles, how much it costs, and describes the programmes and countries that have benefited from EC support.

With the fading of any remaining hope that a vaccine or cure for HIV/AIDS can be found speedily, or at a price that the average citizen of the hardest hit countries can afford, attention – and funds – have shifted to the health care systems and social attitudes that, on the one hand, can exacerbate the spread of HIV and, on the other hand, can act to prevent it.

The rallying cry is now more modest and more pragmatic than it was in those earlier days of emergency reaction and well-intentioned over-optimism. Rather than cure, prevent or eliminate, the goal now is to minimise the global spread of HIV/AIDS, by whatever practical means are available. What the HIV/AIDS epidemic has done, is to focus attention on the distressing disparities in disease burden and health care capacity between richer and poorer countries; and to place HIV/AIDS within the context of poverty and deprivation of human rights. Thus what began as a targeted response to a specific virus, HIV, has transmuted into a gathering global response to profound contemporary issues of inequality, both personal and international.

THE HAVES AND THE HAVE-NOTS

The 1993 World Development Report issued by the World Bank bore the title *Investing in Health* – itself a recognition that good health is both a basic human right and a necessary condition of economic prosperity. This report showed how wide these disparities are between the haves and the have-nots.

The disease burden on sub-Saharan Africa, for example, is about four times heavier than on the richer countries labelled 'established market economies' (see Figure 1). The disease burden on India is over twice as heavy. But the hospital capacity of these regions is, by comparison, tiny. Figure 2 shows that sub-Saharan Africa and India, for example, have six to 12 times fewer hospital beds than the West for every 1,000 people. The number of doctors for every 1,000 people in these regions is six to 20 times fewer.

Yet it is precisely on the areas of highest disease burden and lowest capacity to cope that the HIV/AIDS epidemic is inflicting and will inflict its worst impact. It is fair to say that the countries called by the World Bank 'established market economies', notably the USA and Western Europe, have scaled back their initial forecasts for the spread of HIV within their populations.

But in the poorer developing countries, the picture is tragically different. HIV is transmitted predominantly by heterosexual contacts, with mother-



Table 1 Evolution of the HIV/AIDS epidemic

Region	HIV incidence (millions)		HIV prevalence (millions)		AIDS-related deaths (millions)	
	1990	2000 ^a	1990	2000 ^a	1990	2000 ^a
Demographically developing group ^b	1.6	2.5	7.4	25	0.3	1.7
Sub-Saharan Africa	1.1	1.0	5.8	12	0.3	0.9
Asia ^c	0.3	1.3	0.4	9	**	0.6
EME and FSE ^d	0.1	**	1.4	1	0.1	0.1
Total	1.7	2.5	8.8	26	0.4	1.8

** Less than 0.05 million.

Note: Incidence refers to new infections in a given year; prevalence refers to the total number of persons infected.

a. Conservative estimates.

b. The countries of the demographic regions sub-Saharan Africa, India, China, Other Asia and islands, Latin America and the Caribbean, and Middle Eastern crescent.

c. India, China, and the demographic region Other Asia and islands.

d. EME, established market economies; FSE, formerly socialist economies of Europe.

Source: World Health Organization data.

to-child transmission and contaminated blood adding to the toll. The World Bank table reproduced here as Table 1 shows in broad-brush form the expected progression of the HIV epidemic, with the incidence of HIV (that is, new infections each year) worsening markedly in the poorer countries of Africa, Asia and South America – but particularly in Asia – while tending to improve in the USA and Europe. Predicted HIV/AIDS-related deaths show an even more alarming trend.

Thus in a frighteningly short time-span of under two decades, HIV/AIDS and other STDs (sexually transmitted diseases) have risen up the league table to become the fourth biggest cause of lost human endeavour in sub-Saharan Africa, and the second biggest cause in Latin America and the Caribbean – see Table 2.

CURRENT THEMES

So the 'new recognition' that has gathered strength over the past two years can be divided into four themes:

1. HIV/AIDS are part of a 'devil's brew' of diseases which afflicts poorer parts of the world, and which interact with each other and with personal behaviour and personal status (or lack of it). Notably, these are tuberculosis, malaria, STDs generally and HIV. So the impact of HIV cannot be measured solely by so-called 'AIDS deaths' and, conversely, HIV prevention may best be carried out by attention to other ingredients in this 'devil's brew'.

2. To contain the HIV epidemic there has to be a functioning health care and education system, where all too often health and education systems have broken down or fallen into neglect. The supply of uncontaminated blood; proper treatment of STDs; adequate supply of essential drugs, contraceptives and condoms; re-creation of primary health care facilities; education of women and young people – all these have to be elevated to a bigger and better planned part of national health and education budgets and of external aid.

3. There is a causal link between HIV infection and being marginalised in society. The most vulnerable are those with fewest rights. Thus the rural and urban poor, women, people in prison, refugees from war, migrant workers, street children, and still in many countries homosexuals, are examples of groups at high risk because they are either powerless or rejected.

4. For the general population, mere information about HIV/AIDS, now almost universal throughout the world, appears not to be enough to change sexual behaviour quickly or radically enough to stem the spread of HIV. So there needs to be fresh thinking about human behaviour and its determinants.

This then is the global backdrop against which to view and assess the creative contribution of the European Community. That contribution is the subject of the following pages.

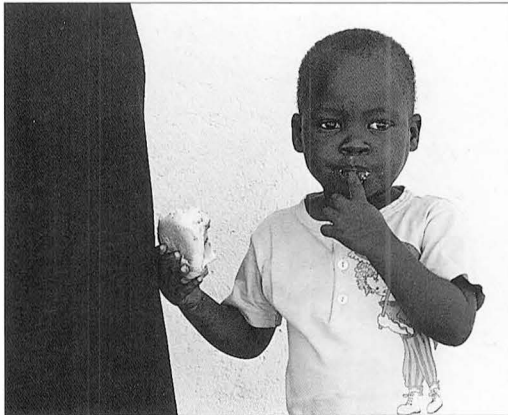
Table 2 Distribution of DALY loss by cause and demographic region, 1990 (per cent)

Region	World	Sub-Saharan Africa	Latin America and the Caribbean
Population (millions)	5,267	510	444
Communicable diseases	45.8	71.3	42.2
Tuberculosis	3.4	4.7	2.5
STDs and HIV	3.8	8.8	6.6
Diarrhea	7.3	10.4	5.7
Vaccine-preventable childhood infections	5.0	9.6	1.6
Malaria	2.6	10.8	0.4
Worm infections	1.8	1.8	2.5
Respiratory infections	9.0	10.8	6.2
Maternal causes	2.2	2.7	1.7
Perinatal causes	7.3	7.1	9.1
Other	3.5	4.6	5.8
Non communicable diseases	42.2	19.4	42.8
Cancer	5.8	1.5	5.2
Nutritional deficiencies	3.9	2.8	4.6
Neuropsychiatric disease	6.8	3.3	8.0
Cerebrovascular disease	3.2	1.5	2.6
Ischemic heart disease	3.1	0.4	2.7
Pulmonary obstruction	1.3	0.2	0.7
Other	18.0	9.7	19.1
Injuries	11.9	9.3	15.0
Motor vehicle	2.3	1.3	5.7
Intentional	3.7	4.2	4.3
Other	5.9	3.9	5.0
Total	100.0	100.0	100.0
Millions of DALYs			
Equivalent infant deaths (millions)	42.0	9.0	3.2
DALYs per 1,000 population	259	575	233

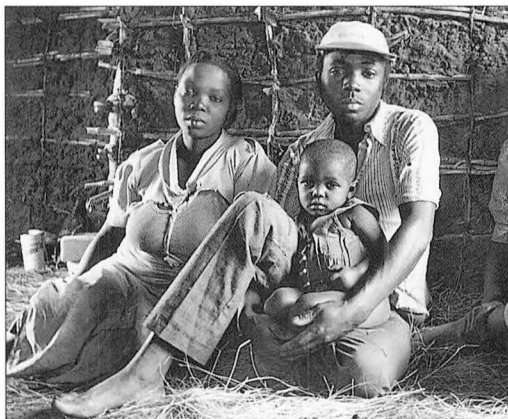
Note: DALY, disability-adjusted life year; STD, sexually transmitted disease; HIV, human immunodeficiency virus.

Source: World Bank data.

HOW THE EUROPEAN COMMISSION SETS ABOUT ITS TASK



Timothy Nunn/Panos Pictures



WHO Photo/Louise Cubb

The full meaning of the European Community's contribution can only be understood through a brief excursion into history. In 1986, the international community reacted to the new and then little known HIV/AIDS epidemic by setting up, under the World Health Organisation (WHO), a Global Programme on AIDS (GPA). The GPA began work in February 1987. But what should the EC do?

On the one hand, it had no tradition of direct intervention in specific health programmes aimed at the control of specific diseases. On the other hand, there was a desperate need. The late Lorenzo Natali, vice-president of the European Commission, hardly hesitated. In a landmark memorandum sent to all ACP (African, Caribbean and Pacific) states who had signed the Second Lomé Convention on European aid to developing countries, he invited them to take part immediately in an EC/ACP AIDS control programme.

"Rapid action using quick and flexible procedures is necessary in view of the priority and complexity of the AIDS problem", he wrote. "The programme is intended as an identifiable EC contribution to the international effort on AIDS control led and co-ordinated by the WHO".

Almost all ACP countries responded to this initiative, which was unique in the history of the EC – a unique response to a unique situation. But how exactly should the EC carry out its new mandate? At that time it had little in-house expertise in health matters. A unique situation demanded a unique solution. So, for the sake of speed and because it was a venture into the unknown, the EC's AIDS Task Force was set up. It was able to get going quickly, recruit the technical staff it needed swiftly, and build up almost from scratch a body of knowledge about action on HIV/AIDS. It answers to the EC's Directorate General for Development, known as DG VIII. The main task of the AIDS Task Force is to prepare, supervise and follow up projects for the Commission.

THE ACTIVITY NOW

But this was never meant to be a permanent solution. And so in May 1993, with the dimensions of the HIV/AIDS problem much better known than in 1987, the 'quick fix' was replaced by a permanent organisation which built on and incorporated what went before. A new Health and AIDS Unit was set up within the formal structure of the Commission. This symbolised the long-term commitment of the European Community to what was now, evidently, a long-term need. Along with the rest of the international community, the EC was moving out of the emergency phase and into a long-term structural approach to the problem.

Against the background of the 1993 Maastricht Treaty and its new concern for health within the European Union, the European Community accepted that its obligation to the health of the rest of the world must also be, and must be seen to be, permanent. At the same time, the financial commitment increased, both in scale and in timescale (see pages 8 and 9). The EC's Health and AIDS Unit consists of only five professionals – essentially doctors and economists. But it is backed up by the technical expertise of the AIDS Task Force.



WHO Photo/Louise Gubb

Mother-to-child transmission has been a particular concern of the EC

WHAT THE HEALTH AND AIDS UNIT DOES

So what are the responsibilities of the Commission's new Health and AIDS Unit, known as DG VIII/8? In a nutshell, the main role of this unit is to give technical support to departments within the Commission that deal with particular regions of the world, and to Commission Delegations abroad, with the preparation, appraisal and monitoring of health projects and programmes in developing countries. This also means that the unit takes part in the analysis of health policies in developing countries, in the preparation of schemes to help the reorganisation of health services, and in institutional strengthening in those countries.

The objective of including the management of the HIV/AIDS programme in this new EC unit is to integrate HIV/AIDS issues more and more into other health and development activities supported by the European Community in the same developing countries. Specific responsibilities and activities of the unit in the field of HIV/AIDS include:

- development of, and monitoring the implementation of, policy guidelines
- programming of interventions
- supervising the preparation and implementation of HIV/AIDS interventions, using the technical assistance of the AIDS Task Force
- co-ordination, both internally between different departments of the Commission dealing with HIV/AIDS and externally, with other interested parties (see page 7).

This then is the newly re-fashioned instrument of the EC. What is it used for? That is the story of the following pages.



EC/ATF

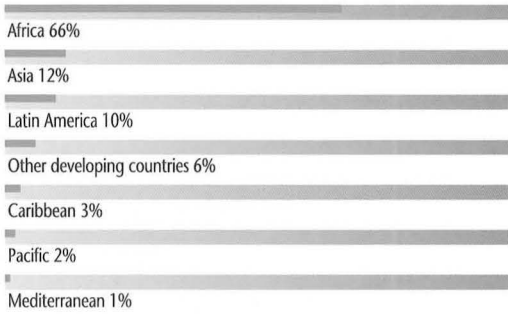
EC/ATF stand at ninth international AIDS conference, Berlin



WHO Photo/Armando Waak

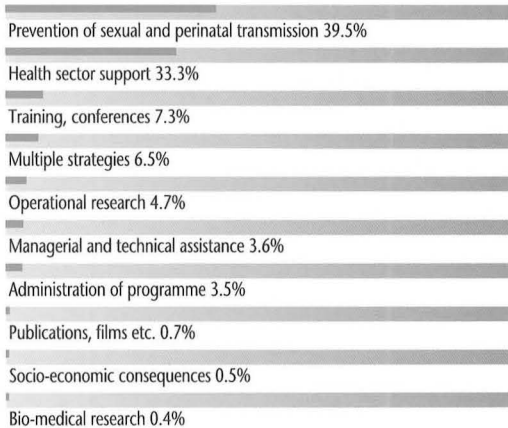
SCALE OF INTERVENTION

Table 3 Regional distribution of EC funds committed to HIV/AIDS activities in developing countries



This does not include cofinancing through European NGOs nor research activities by DG XII directorate for research

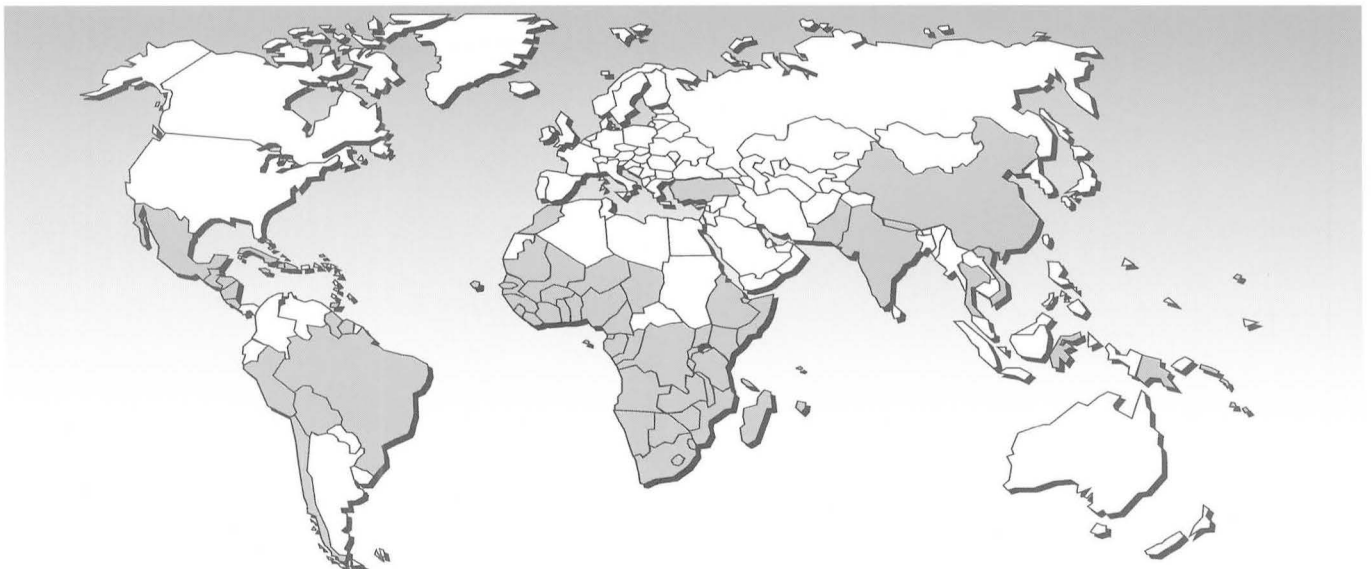
Table 4 Distribution of EC funds committed to HIV/AIDS activities by type of intervention or strategy



The scale of EC intervention is determined by one idea: that nothing less than total commitment to the global HIV/AIDS programme is good enough. So the list of countries that have benefited from EC support, financial and technical, is a long one: from Angola, Antigua and Argentina at one end of the alphabet to Vietnam, Zambia and Zimbabwe at the other. Many countries have seen more than one project. The total number of countries to which EC support has been given, is now well over 80.

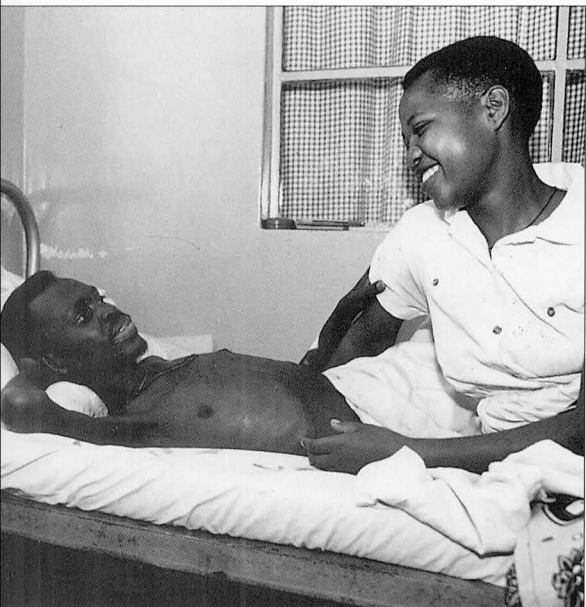
The total number of projects realised, allowing for their different start dates and the different stages of implementation, from proposal to financial approval, implementation and completion, has now topped 220. A few have for various reasons been suspended before completion. Of this total, over 160 are specific to one country and the rest are regional projects or projects that apply to all developing countries. The first chart (Table 3) shows the regional breakdown, but in terms of the amount of money committed by the EC. The variety of the projects is also striking. The second chart (Table 4) illustrates this great variety, again in terms of the amount of money committed to different activities. The number and variety of these projects demands advanced management skills.

Because the larger part of the funds for the EC's HIV/AIDS programme has been voted under the Lomé Conventions, and because African states make up the larger proportion of signatories to those conventions – but also because, so far, Africa has the largest number of HIV infections and the least resources to cope – Africa in the beginning tended to get the larger share of attention and projects. Indeed, Africa will continue to be a prime focus of activity. But it is notable that as the developing countries of Asia, Latin America and elsewhere have begun to identify their needs and problems, so the proportion of EC projects aimed at those regions has risen. Now, of the total of over 220 projects at their various stages of implementation, the continent of Africa (north and sub-Saharan) accounts for just about a half, with the other half directed elsewhere.



Countries with HIV/AIDS programmes for developing countries: Angola, Antigua & Barbuda, Bahamas, Barbados, Belize, Benin, Bolivia, Botswana, Brazil, Burkina Faso, Burundi, Cameroon, Cape Verde, Chile, China, Comoros, Congo, Costa Rica, Ivory Coast, Djibouti, Dominica, Dominican Republic, Ethiopia, Gabon, Gambia, Ghana, Grenada, Guatemala, Guinea Bissau, Equatorial Guinea, Guyana, Haiti, Honduras, India, Indonesia, Jamaica, Kenya, Kiribati, Lesotho, Liberia, Madagascar, Malawi, Mali, Morocco, Mauritania, Mauritius, Mexico, Mozambique, Namibia, Nepal, Netherlands Antilles, Nicaragua, Niger, Nigeria, Pakistan, Papua New Guinea, Peru, RCA, Rwanda, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Solomon Islands, Somalia, South Africa, St Lucia, St Christopher & Nevis, St Vincent & Grenadines, Surinam, Swaziland, Tanzania, Chad, Thailand, Togo, Trinidad & Tobago, Turks & Caicos, Turkey, Uganda, Vanuatu, Vietnam, Zaire, Zambia, Zimbabwe

PARTNERSHIP & COLLABORATION



WHO Photo/Louise Gubb

A woman cares for her husband, who has AIDS

The primary objective of the European Community is to support national strategies. It is the country, its government and its communities that are the focal point, and the aim of the EC's extensive exercise in collaboration is to avoid duplication, identify shortcomings, and spread the benefits of experience and research.

There is internal collaboration within the EC and within Europe and its institutions; there is external collaboration with United Nations agencies, the World Bank, NGOs, and other donors and organisations involved in HIV/AIDS work; and there is collaboration with the various agencies that carry out the EC's interventions. Internal co-operation means:

- between the many directorates of the Commission whose work touches on HIV/AIDS
- agreement with the Council and the European Parliament on policies
- between the Commission and the European Union Member States.

For example, there are regular six-monthly meetings with experts from Europe's Member States, at which the aim is to establish a coherent strategy for Europe as a whole in its support and funding of HIV/AIDS activities in developing countries.

External co-operation means regular meetings with the WHO, which has responsibility for leadership in global strategy and co-ordination. The Commission and several Member States are on the Management Committee of the WHO's Global Programme on AIDS (GPA). But it also means collaboration at local and regional as well as international levels with all UN agencies involved (WHO, UNDP, UNICEF, World Bank etc.).

THE NGO ALLIANCE

Nor is collaboration confined to government and inter-government institutions. Recently the EC has helped to create an NGO Alliance. The aim of this Alliance, which has its own international secretariat, is to strengthen the capacity of indigenous NGOs in developing countries to carry out HIV/AIDS activities, and to channel the support of donors towards these NGOs. This innovative form of collaboration should help to meet three problems experienced by indigenous NGOs.

- how can small, far-off organisations get funding?
- where can they get technical support?
- how best should they get involved in HIV/AIDS work?

PROJECT PARTNERS

The European Commission could not get all its HIV/AIDS projects completed on its own. Its primary partners are usually governments. But to get things done, it often enters into a partnership, under contract, with agencies working in the field. It is these agencies that actually carry out the projects. Among the many partners are universities, NGOs, and medical and educational institutes. Table 5 shows the pattern of collaboration with these 'primary partners'.

Table 5 Distribution of funds for HIV/AIDS activities by main partner

National authorities	54%
Scientific institution, European	21%
NGO, European	15%
Scientific institution, local	6%
NGO, local	3%
Other	1%



FINANCE

Table 6 Global Health expenditure, 1990

Demographic region	Percentage of world population	Total health expenditure (billions of dollars)	Health expenditure as percentage of world total
Established market economies	15	1,483	87
Formerly socialist economies			
of Europe	7	49	3
Latin America	8	47	3
Middle Eastern crescent	10	39	2
Other Asia and islands	13	42	2
India	16	18	1
China	22	13	1
Sub-Saharan Africa	10	12	1
Demographically developing countries	78	170	10
World	100	1,702	100

Table 7 Annual drug expenditures per capita, selected countries, 1990

Country	Expenditure (dollars)	Country	Expenditure (dollars)
Japan	412	Brazil	16
Germany	222	Philippines	11
United States	191	Ghana	10
Canada	124	China	7
United Kingdom	97	Pakistan	7
Norway	89	Indonesia	5
Costa Rica	37	Kenya	4
Chile	30	India	3
Mexico	28	Bangladesh	2
Turkey	21	Mozambique	2
Morocco	17		

Table 8 Official development assistance for health by demographic region, 1990

Region	Health aid received (millions of dollars)	Health aid per capita (dollars)	Health aid as a percentage of health expenditure
Sub-Saharan Africa	1,251	2.45	10.4
Other Asia and islands	594	0.87	1.4
Latin America and the Caribbean	591	1.33	1.3
Middle Eastern crescent	453	1.31	1.3
India	286	0.34	1.6
China	77	0.07	0.6

The EC's spending on HIV/AIDS must be viewed against the background of the enormous world disparities in health expenditure. World Bank figures (Table 6) show that the established market economies with only 15 per cent of the world's population spend 87 per cent of the world's public health expenditure. Put another way, per capita health expenditures in the richer countries average about \$1,860 a year. In Africa it is \$24, in India it is \$21, in China it is \$11.

The same disparities – only worse – stand out from the figures for annual drug expenditures (Table 7). Japan spends twice as much as anyone else per person. Germany and the USA spend around \$200 per person. But Ghana, China, Pakistan, Indonesia, Kenya, India, Bangladesh and Mozambique all spend \$10 or less a year.

So over the years the world has developed an elaborate system of financial aid to its poorer countries. The amount is not large on a world scale – about \$4.7 billion in 1990, according to researchers. Most of it is public money, and it flows through a variety of channels to reach at least some of those who need it.

But a further factor is that financial aid itself is not evenly spread across the developing world. Sub-Saharan Africa receives far more than any other area (Table 8) both absolutely and per capita. As a result, external assistance provides over 10 per cent of Africa's total health expenditure. While Africa's need is great, in the struggle against HIV/AIDS the priorities of the future may not be exactly the same.

EUROPE'S CONTRIBUTION

This then is the context in which to judge the financial contribution of Europe to the global HIV/AIDS programme. The raw statistics show that over the period 1986 to 1991 Europe as a whole (that is, member countries of the European Union plus the Commission itself) spent slightly more than the USA, and about twice as much as Norway, Sweden and Finland, who collectively were the next largest donors. What Table 9 shows dramatically is that the global strategy against HIV/AIDS is heavily dependent on a comparatively few sources – the USA, and Europe broadly defined.

The scale of the Europe Community's own effort then emerges clearly from the analysis of Europe's financial commitment. Again, looking at the period 1986 to 1991, Table 10 shows that the Community devoted nearly \$90 million to supporting international HIV/AIDS activity, compared to the largest individual EU country, the UK, with about \$60 million, followed by France with a little under \$40 million.

Thus the Europe of the twelve emerges as the largest AIDS funder. Without in any way detracting from the enormous effort made by the USA, this shows the catalytic role that the EC has developed, from scratch, over a short period of years.

It is also interesting to see where this money comes from. Table 11 shows the breakdown, for a slightly different period, 1987 to 1995, between EC budget funds, regional funds and funds from the National



Indicative Programmes allocated under the various Lomé Conventions. The total sum that the EC has made available comes to about 149 million ECU (about \$170 million).

These figures do not include the substantial amounts that the Commission is devoting to support for the health sector in developing countries carrying out National, Regional and Structural Adjustment Programmes (SAPs). Some 295 million ECU was allocated for health programmes under the Lomé Conventions for the period 1990-93 for ACP countries alone. If health support within SAPs is also included, it means that about 580 million ECU of Lomé resources has been allocated to the health sector over the past four years. Also, there is a special extra budget for financial help to South Africa's health and AIDS effort. The Commission's NGO co-financing fund can also be used for health and HIV/AIDS activity.

The period 1992 to 1994 shows an actual increase in total funding. For example, the EC 'budget line' shows a build-up from 6 million ECU in 1992 to 12.5 million ECU in 1994.

It is interesting to note that, within the total amounts to be spent by the EC, there will probably be some shift of emphasis. Support for social and economic impact will take a somewhat larger share. Direct effort to minimise the spread of HIV will continue to take by far the largest share of funds, but proportionately less, reflecting shifts of policy and approach to the epidemic.

But perhaps the most important message that has been conveyed to the countries most afflicted by HIV/AIDS is that the EC's forward commitment is not fixed in concrete – it will be reviewed in the light of needs.

Table 9 External agencies' support to global AIDS strategy

Contributors to WHO or to countries, 1986-91 Millions US dollars

EC and Member States	281.291
USA	237.331
Norway/Sweden/Finland	143.069
Canada	70.500
World Bank	55.805
UNDP	41.652
Switzerland	13.850
Japan/Australia	11.743
Other bilateral	10.000
UNICEF/UNFPA	7.496
Total	872.737

Table 10 European contribution to the global AIDS strategy

1986-91 reported June 1991 Amount in millions US\$

<i>Region</i>	<i>To WHO/GPA</i>	<i>Through WHO/GPA</i>	<i>To country programme</i>	<i>Total</i>
UK	37.424	10.372	11.544	59.340
France	4.349	0.245	34.329	38.923
Denmark	14.479	2.517	19.900	36.896
Germany	4.100	2.806	21.345	28.251
Netherlands	17.858	1.045	3.829	22.732
Italy	1.749		1.796	3.545
Belgium	0.987	0.057		1.044
Spain			0.800	0.800
EC/Community			89.760	89.760
Total	80.946	17.042	183.303	281.291

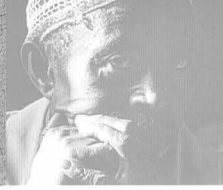
Table 11 EC funds available and allocated for HIV/AIDS activities in developing countries (ECU)

	<i>Budgetline 88-95</i>	<i>Regional funds all ACP 87-95</i>	<i>NIP 91-95 (only started 1991)</i>
Available	60,023,000	59,000,000	30,000,000
Allocated	38,531,977	45,571,791	12,810,000

not including research funds from DG XII and NGO co-financing funds



WHO Photo/Gérard Diez



GOALS, POLICIES AND METHODOLOGIES

Learning the lessons of its first seven years of activity (see box, right), the European Community has drawn up a statement of goals, policies and strategies that underpin its HIV/AIDS work and relate it to the wider context of health, education and human rights in which HIV/AIDS is now seen to belong. This complex statement would not have been possible in the early days of emergency reaction to a new epidemic. But as the epidemic matures and spreads, and hard choices have to be made, it is important to establish a sound theoretical grasp of what the activity, and the expenditure, is for.

A. THE GOALS

There are six goals, and they are simple to state if hard to achieve:

1. to minimise the number of new infections
2. to prevent discrimination against, and exclusion of, those already ill, or infected by HIV, or at risk of infection
3. to enable health systems to cope with the additional burden created by HIV/AIDS through selective strengthening of capacity and systematic reorganisation; and to provide AIDS patients with care and enable them to die with dignity
4. to minimise the effect on social and economic development
5. to reduce the impact of some types of development projects on the spread of HIV and, conversely, to mobilise development effort on behalf of disadvantaged and marginalised people who are particularly at risk of HIV infection
6. to increase scientific understanding of HIV/AIDS and of the possible interventions, and to monitor and evaluate progress.

B. THE POLICIES

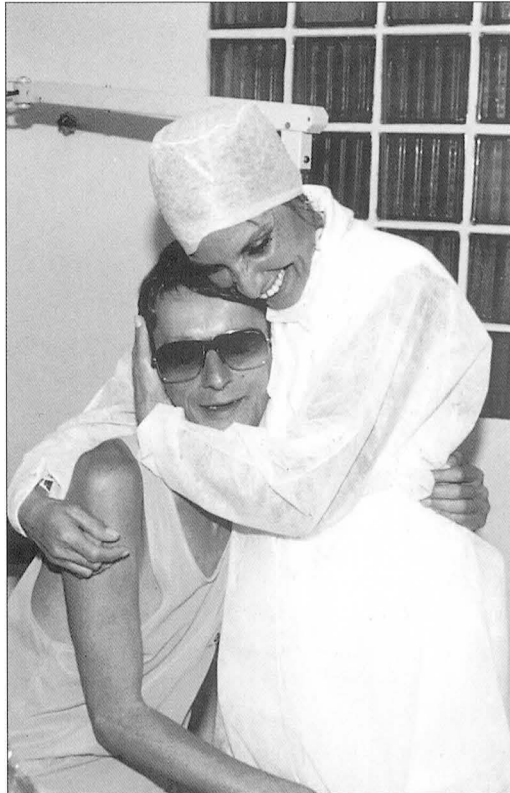
To achieve these six goals means following a set of policy principles, again six in number. These also derive from the general development policy of the EU and its Member States, which stresses the concepts of mutual dependency and solidarity, leading to an approach based on the notion of partnership. The six policy principles are:

1. adaptation to risk environments
2. gender sensitivity and specificity (see also page 12)
3. social learning and respect for human rights and dignity
4. empowerment and responsibility
5. integration into a wider framework
6. timing.

Each of these needs explanation to make its purpose clear:

Adaptation to risk environments

Interventions should focus not only on the behaviour of individuals that puts them at risk, but also on the social and structural determinants of exposure to risk. This is particularly important when dealing with specific target groups such as women, children, young people, people in high-risk situations.



WHO Photo/Armando Waak

*Dentist and patient in a
health clinic for persons
with AIDS*



THE LESSONS LEARNT

The EC's current policy and philosophy on HIV/AIDS has been illuminated by the lessons learnt from past experience. What are the main lessons?

1. The HIV epidemic has stabilised in many industrialised countries, but continues to spread in most developing countries.
2. The majority of HIV-infections therefore occur in developing countries. This is because of their greater vulnerability and risk, in turn caused by social and economic weaknesses and deficiencies in health and education systems.
3. Conversely, attempts to control the level of HIV have worked better in industrialised countries, partly because these attempts were better suited to those countries, and partly because their social, economic, educational and health systems were better able to cope.
4. Where it is widespread, the HIV epidemic has an impact right across the public health system and beyond. Therefore, all sectors of society have to take account of the HIV/AIDS factor, and help to counter it.
5. Coercive approaches to HIV control are counter-productive. They merely drive the epidemic, and its carriers, underground where they cannot be reached. Empowerment of individuals and communities, and respect for human rights and human dignity, are cornerstones of HIV prevention.
6. The formal health sector has undervalued non-medical approaches to HIV control, through social policies and social solutions. Moreover, responses to reproductive health have been compartmentalised, for example between family planning clinics, STD clinics, HIV programmes, ante-natal clinics. This structural weakness must be remedied.
7. The epidemic has emphasised the importance of human capital, and the need to invest in it.
8. The future demands a new mix which combines, on the one hand, focused HIV/AIDS interventions aimed at particular people or services; and on the other hand, a change in health, education, social and developmental policies to broaden and integrate HIV/AIDS strategy.

Gender sensitivity

Analysis, planning and intervention must all show special sensitivity and specificity to gender. Long-term objectives such as the political and economic empowerment, formal education and legal protection of women must go hand-in-hand with short-term interventions focused on specific groups of women and men (see also next page).

Social learning and respect for human rights

History has shown that measures based on coercion of individuals are counter-productive. They drive epidemics underground and make interventions unsustainable. So it is no use just trying to identify the individuals at risk or infected by HIV, and then isolating them from their social environment. Instead, there has to be a process of social learning, the aim of which is to enable individuals and society to avoid the risk of infection wherever possible, and to prevent discrimination against those already infected through respect for their human rights and dignity.

Empowerment and responsibility

Most HIV/AIDS activity cannot be just administered. It needs the motivation and support of individuals and communities. They in turn have to have the power to take responsibility for their own behaviour, risks and choices. Similarly, governments and others in positions of power have to take responsibility for limiting the risks run by those over whom they have authority.

Integration into a wider framework

HIV/AIDS work must be integrated with other community activities, other health and education problems and other medical care strategies, at least where there are organisations and activities in these other areas. Integration also requires a national HIV/AIDS policy which includes all major participants, a multi-sectoral approach that involves all the main departments of state, and open policy dialogue between public and private sectors.

Timing

The HIV epidemic takes time to spread over a region, and is at different stages in different regions of the world. So responses to HIV/AIDS also vary over time. But denial, and political and administrative delays, have often meant that HIV prevention campaigns, needed before the epidemic becomes widespread, have come too late. So the timelag should be shortened, and every response should come at an appropriate stage in the progress of the epidemic.

continued on page 13



Betty Press/Panos Pictures

Handing out HIV/AIDS literature in a shanty town



Sean Sprague/Panos Pictures

A volunteer social worker visits a pregnant woman with HIV

THE SPECIAL NEEDS OF WOMEN

It is valuable to single out one particular lesson learnt from the EC's experience in HIV/AIDS control. That is the special needs of women. Women are affected by HIV/AIDS in many ways – as direct victims of infection; as members of families impoverished by the HIV/AIDS-related deaths of bread-winners; as carers, both within the family and in the community; and as educators, both at home and in schools.

At the same time, women are often powerless to protect themselves. They may not be able to negotiate safe sex; through financial necessity they may be forced into multiple sexual relations; the burden of AIDS care almost inevitably falls upon them; and they may be the victims of sexual violence and practices, such as female circumcision, 'dry sex' or rape, which can exacerbate their risk of infection.

Some cultural practices involving women also increase the risk of HIV: for example, the custom in parts of Africa that a woman whose husband has died should 'marry' her dead husband's brother – even if her husband had died of HIV/AIDS.

The statistics show the disturbing vulnerability of women to HIV infection. Women, it seems, acquire the infection more easily than men. They are often exposed to risk without knowing it. They become infected at an earlier age and, once infected, they receive less care than men.

Once infected, women also run the risk of infecting about one-third of their children. Finally, women are in charge of the early education of almost all children and so play a key part in inculcating a healthy attitude to sexuality in the next generation.

So short-term interventions that focus specifically on women, such as research into female condoms and viral spermicides, are certainly important but are not enough. Longer term work, for example on the legal status of women (or lack of it) and on relations between the sexes, are central to the problem, as are education for women and the creation of employment opportunities.

All HIV/AIDS interventions and research must be gender-sensitive. All too often in the past the messages have, unwittingly, been biased against women simply because they did not take account of the realities of a woman's situation. For example, a woman may rate the risk of being beaten if she tries to insist on using condoms as more threatening than the risk of contracting HIV if she does not use them, and so on.

Thus the needs of women form an ever-present dimension to almost all HIV/AIDS work, and demand informed sensitivity to what those needs and constraints are.



C. THE METHODOLOGIES

These goals and policies lead logically to certain methodologies for carrying out HIV/AIDS work. These are basically four in number:

1. establish strategic priorities for interventions
2. making choices
3. establish greater coherence and co-ordination
4. mobilise all the resources available to the European Community.

These again need explanation to make them clear:

Strategic priorities

Given the goals outlined above, the priorities chosen for EC activity are to:

- minimise both the spread of the epidemic and discrimination against those infected, by such means as improving STD and reproductive health services, decreasing the poverty/AIDS cycle, improving sexual education for children, and developing national AIDS charters that define the legal and ethical principles of HIV/AIDS work
- strengthen the health sector to enable it to cope
- measure the social and economic impact, so as to assist national planning
- reduce the (inadvertent) impact of some development projects and economic policies on the progress of the epidemic, and develop tools for assessing this impact during the investment planning stage
- promote better scientific understanding, both biomedical and socio-economic
- provide technical assistance and training.

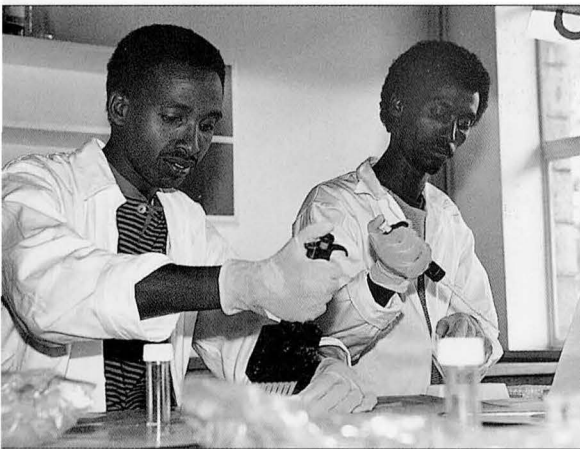
Making choices

There have to be ways of making choices about allocating scarce resources. For example:

- there must be clear coherence with national and regional development plans, achieved through policy dialogue
- there must be co-operation with local communities, and with community-based and private sector organisations: this recognises the increasingly important role of NGOs in HIV/AIDS prevention.
- the country or organisation receiving aid must be able to use it: weak health and education systems in some countries have meant that activity was late or funds used too slowly
- interventions must be cost-effective, as far as that can be measured
- The European Union and Commission must strengthen their own capacity to co-operate with others.

Coherence and co-ordination

- EC policy must be consistent, as between the Community and Member States
- the Community's HIV/AIDS policy must be an integral part of the Community's health policy, and be consistent with other policies in such areas as family planning, education and health, employment, the environment, alleviation of poverty, structural adjustment, and



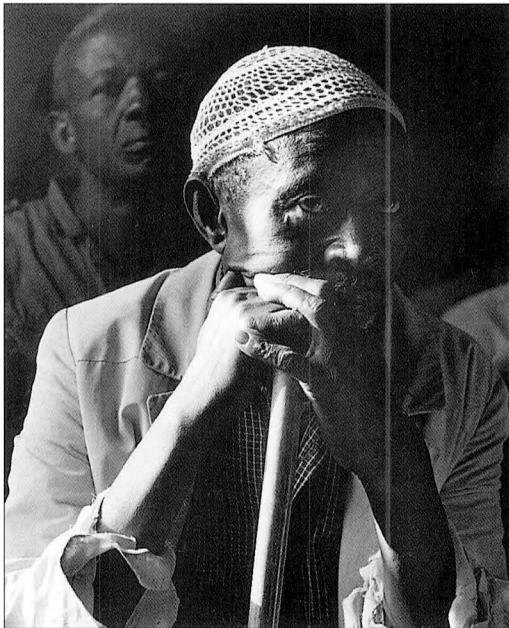
WHO Photo/Louise Gubb

Laboratory technicians being trained in testing blood



WHO Photo/Armando Waak

A home for people with AIDS



WHO Photo/Louise Cubb

*A community leader
at a meeting*

human rights, both within Europe and in developing countries

- EC policy must be explained to, and be consistent with the policies of, other international organisations such as the WHO/GPA, the UNDP and the World Bank
- in each developing country where there is EC-supported activity, the EC must co-ordinate with other donors and UN agencies, under the leadership of the country's government and with the support of the WHO.

Mobilisation of resources

This is dealt with under organisation (pages 4 and 5) and finance (pages 8 and 9).

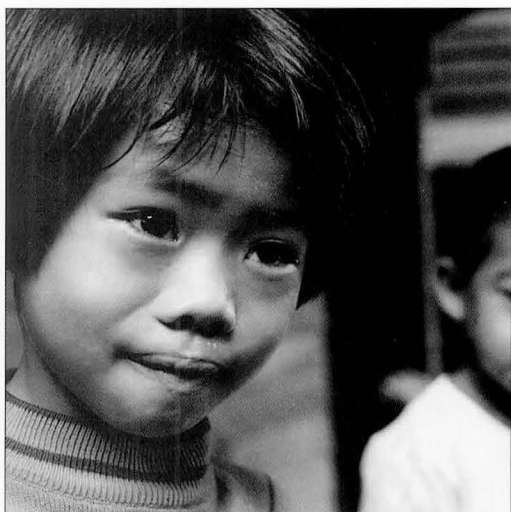
The following pages examine how these policies have been applied in practice.



WHO Photo/E. Mandelmann

*A street theatre
troupe performs a
play about AIDS*

CRITERIA FOR EC SUPPORT



WHO Photo/Gérard Diez

How does the EC, through its Health and AIDS Unit and its AIDS Task Force, develop interventions or programmes, and evaluate proposals put to it? What are its criteria for EC financial support? Clearly, proposals must conform to the general principles of the EC. But then a number of practical considerations come into play.

1. Criteria about methodology

Interventions and proposals must be:

- consistent with the national HIV/AIDS policies of the country in question and with the activities of other organisations there
- technically feasible and cost-effective
- likely to be sustainable, that is, continue after EC support ends
- measurable in their progress and outcome by indicators and evaluation methods
- defined by a detailed work-plan.

2. Criteria about the competence of the agency carrying out the project

As explained earlier, the EC normally works through an agency, under contract. In ACP countries, the basic contract is between the agency and the government of the relevant country. Elsewhere, the contract is with the EC with the general approval of the country concerned. In either case, the EC must be satisfied about the technical and managerial competence of the contracting agency. So it needs to know:

- the main activities and experience of the agency in developing countries, in the health, education and social sectors
- previous experience and work carried out over the past three years in developing countries, in implementation of HIV/AIDS-related activities relevant to the proposal
- previous work experience in the country where the proposed project is to take place
- the availability and qualifications of technical and support staff
- the capability of head-office staff to provide back-up and monitoring of the project
- the experience of the agency in planning, implementing and evaluating similar projects
- whether the agency can encompass all the methodological, technical, social and ethical aspects of the project.

3. Criteria about the financial integrity of the agency

Here, the EC is looking for:

- financial resources which are adequate to back up the amount of EC support asked for
- transparent, rigorous and sound financial management
- previous experience in financial management of, and accounting for, projects carried out with donor funding
- the financial capacity to carry out project-related activities for at least four months before EC funding arrives
- the ability to provide a bank guarantee (this requirement may be waived in some circumstances).

4. Criteria about legal status

The EC needs to know that the contracting agency is:

- registered in one of the member states of the European Community, or in the country where the project will take place
- legally able to sign a contract with the EC



THE MANY FACETS OF EC ACTIVITY

The HIV/AIDS-related activities of the European Commission on behalf of the European Community form a two-dimensional matrix. One dimension of the matrix shows the division between international projects, regional projects, and national projects. The second dimension of the matrix consists of different themes or types of intervention, such as safe blood, STDs, mother-to-child transmission, education, training, health services, health policy, socio-economic impact. The following case studies start with international and regional activities, followed by examples of national programmes. The educational theme is developed in the national case studies. The international and regional dimensions include, for example:

- exchange of information and experience through conferences, seminars and training courses
- development of methodologies for assessing socio-economic impact, planning and management of STD programmes, and mother-to-child transmission (see Rwanda, below)
- operational research on health interventions and education
- development of laboratory techniques, strategies and management methodologies

Often, the same project has international, regional, national and thematic dimensions. The following pages give some examples, among many possible examples, to illustrate the many facets of EC activity.

THE RATE AND CAUSES OF MOTHER- TO-CHILD TRANSMISSION

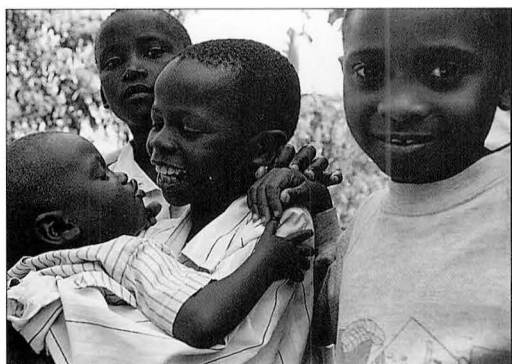
Rwanda, at least until its recent political troubles, was the scene of important EC-initiated and supported research into mother-to-child transmission of the HIV virus – research with wide international implications. This project, spanning the years 1988 to 1994, aimed to:

- study the natural history of pediatric HIV infection
- calculate the rate of transmission in developing countries
- establish the factors acting for or against such transmission

To widen the impact of this study and to establish better methodology, the Commission set up an international group of experts to sort out the problems that had bedevilled research into mother-to-child transmission. The Rwanda study showed that:

- the rate of perinatal transmission was 25 per cent
- HIV-positive mothers were more prone to illness and death
- advanced immunosuppression in the mother was an important risk factor for HIV transmission
- HIV-infected infants tended to develop more slowly
- breast-feeding is a risk factor in transmission after birth.

The expert group corroborated these findings, and established that the median rate of transmission reported in other studies also carried out in developing countries was 24.7 per cent – almost exactly the same. But disturbingly, this international group also found that the median rate of mother-to-child transmission in industrialised countries was markedly lower, at 19.4 per cent.



Betty Press/ Panos Pictures

*Children whose parents
died of AIDS*



TRAINING & MANAGEMENT

The European Commission has made its mark on the training of health professionals in the management and planning of HIV/AIDS/STD programmes. Since 1989 it has initiated and supported, in collaboration with other donors and institutes, intensive STD management courses in English, French and Spanish, based on group discussion, inter-active problem solving and practical learning.

The course numbers are small – about 30 – to enable this interactive approach to teaching to take place. Many of the participants are HIV/AIDS/STD Control Programme managers at national, regional or district level, but they are joined by others from the private sector working in this field.

Inherent in the courses is a particular philosophy, that STDs are part of public health and should be integrated with the existing primary health care system. There is also a basic aim, which is to create a pool of qualified and trained people, by a continuous programme of education. The English-language and French-language courses are held every other year, the former in London or Antwerp, the latter in Dakar. The Spanish-language courses, held in the Dominican Republic, have proved so popular that they are held every year.

The same teaching model and course content is applied to all the three language courses, though with adaptation to the circumstances of each region. The documents are translated into each language.

The course content covers:

- programme management and planning
- costing of STD control strategies
- monitoring and evaluation of STD control programmes
- clinical features and diagnostic methods of STDs
- standard treatment regimes
- surveillance
- epidemiology
- sexual behaviour and its determinants
- health promotion
- interventions for high risk groups
- STD control programmes at primary health care level
- identification of priority areas for operational research.

By the end of the course, the participants will have learnt:

- how to identify priorities and plans for the control of STDs in their countries
- how to develop strategies for STD control which will reduce morbidity and mortality due to STDs
- how to implement STD control programmes through the existing health infrastructure
- how to evaluate the efficacy of an STD control programme.

These courses are in addition to training courses organised within countries, for example the STD training for health workers in Zambia in 1989, in Mozambique since the same year, and in Thailand starting in 1994, in conjunction with ministries of health.



T. Numi/Panos Pictures



SAFE BLOOD

**REDUCING HIV
INFECTION BY
MAKING THE BLOOD
SUPPLY SAFE**

The EC has devoted great effort to safer blood supplies as a means of reducing HIV transmission in Africa. The best known project is in Uganda (see opposite page). But the EC has supported a total of 37 safe blood projects in countries ranging from Cameroon and Guyana to Mexico and Zimbabwe.

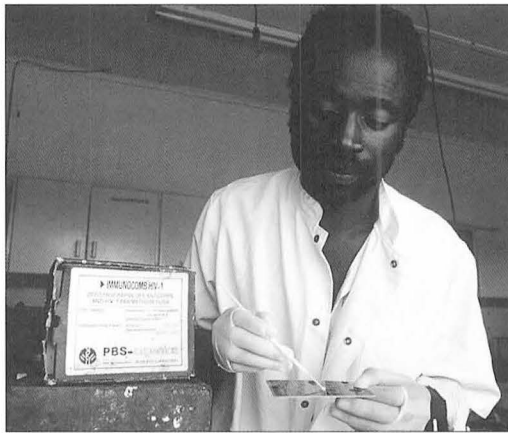
In industrialised countries, HIV infection through contaminated blood is now virtually nil, thanks to appropriate selection of blood donors and screening of blood before use. In developing countries, except where new measures have been taken, between 5 and 10 per cent of infections have been due to transfusion of infected blood.

Transfusion of HIV-infected blood is particularly frightening. It almost always leads to HIV infection of the recipient. This raises acute problems of medical and political responsibility for ensuring a supply of safe blood, not least because people in need of transfusions cannot protect themselves and depend on others making choices for them.

Simple screening of blood is not enough. A safe blood policy must also include these elements:

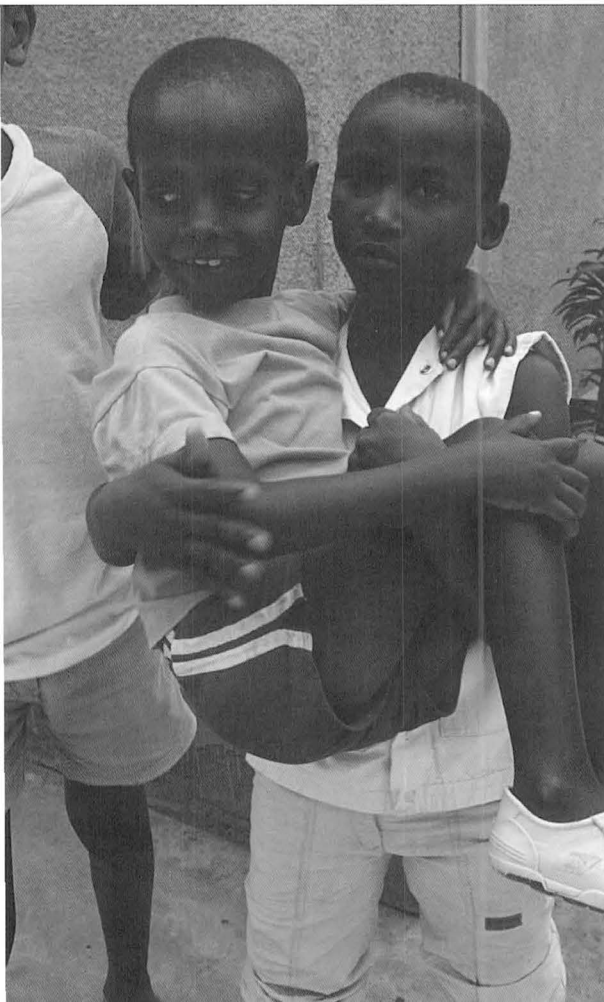
- blood donors need to be selected carefully, and actively retained
- blood donors should be voluntary, not paid, to avoid (for example) infected professional donors selling their blood under different names in different places. An important plank of EC policy is, wherever possible, not to rely on the patient's family to provide blood when the patient is already in crisis and in hospital, since this often leads to the use of paid blood donors with no known history
- blood and blood substitutes must be more judiciously used
- prevention or earlier detection of some diseases reduces the need for blood transfusions and therefore the risk of HIV infection
- screening of blood for other diseases as well as HIV (for example, hepatitis and syphilis) is a basic requirement
- sophisticated testing laboratories are of little use if collection of blood is badly organised: for example, if it produces either too little blood for testing or too much highly infected blood because donors have been badly selected or if it fails to produce enough blood for a reserve supply so that untested blood still has to be used for emergency operations.

A workshop about safe blood was held in 1991, along with a publication on the subject which is being updated.



Ron Gilling/Panos Pictures

*Laboratory worker testing
blood for HIV*



Betty Press/Panos Pictures



SAFE BLOOD EXAMPLE UGANDA

SAFE BLOOD FOR A HIGHLY INFECTED COUNTRY

Uganda provides the classic example of EC support for a safe blood supply. In 1986 the National Revolutionary Movement under President Museveni came to power, ending 12 years of civil strife. By then, the Nakasero blood bank in Kampala, which in 1972 had been providing 10,000 units of blood a year to local hospitals, was in ruins. There were no more than 2,000 blood donations a year for the whole of Uganda, and many of these were not tested for HIV or hepatitis. It was a tragedy. But the staff were still there. So the European Commission sent out a technical adviser, and a temporary laboratory was set up while the Nakasero building was rebuilt and re-equipped. Voluntary unpaid blood donors were recruited to provide blood before patients needed it.

This has since been taken further by the setting up of blood donor clubs, whose members give blood regularly and are drawn from proven low-risk groups, such as church congregations, who have a rate of HIV as low as 0.1 per cent. This compares to recent figures for donors from schools of 2.2 per cent, and 12 per cent for blood donors provided by relatives (see Table 12 for decline in HIV frequency in all these groups).

Within 20 months the Nakasero project was a success. The seven hospitals in the Kampala area were receiving 10,000 safe blood units a year from a renovated Nakasero blood bank with a retrained staff of 60. This prompted a larger ambition, now achieved, to create a national Uganda Blood Transfusion Service (UBTS) to supply all 88 hospitals in the country via four regional blood banks.

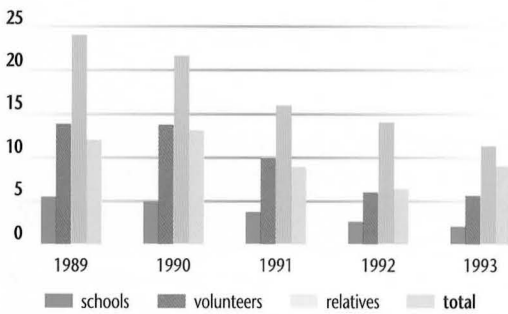
Attention was also given to better use of blood, through guidelines and training for medical personnel in hospitals, and to methods of cost recovery.

The project has had important side benefits. Many thousands of people, mostly between 15 and 25 years of age, have attended talks given by blood donor recruiters. So knowledge about HIV/AIDS has been spread among a prime target group.

The laboratory itself has built up enough capacity to provide testing for many thousands of people who are not blood donors. Meanwhile, the UBTS has virtually achieved its target of 40,000 units of blood a year and can now pay its staff properly. The EC technical adviser remarked as recently as 1992 that:

“the success of this project is due, more than any other reason, to the extraordinary spirit of co-operation of the staff. For four years they have worked efficiently and for long hours with remuneration below subsistence level.”

**Table 12 HIV frequency of NBB blood donors
% positive for HIV antibodies 1989-93**



P. Tweedie/Panos Pictures

Triplets whose father died of AIDS: with a local health worker



STDs

AN INTEGRATED POLICY FOR STDs AND REPRODUCTIVE HEALTH

The European Commission has made a name for itself in placing HIV within the broader context of sexually transmitted diseases (STDs). It has taken a lead in developing an integrated policy for sexual and reproductive health.

The health sector in developing countries has not traditionally paid much attention to STDs. Now, research has demonstrated the biomedical and socio-economic burden they create and STDs are recognised as a serious risk factor for HIV transmission.

The concept of Reproductive Tract Infections (RTIs) has also been gaining ground. It embraces both STDs and other infections of the reproductive tract that are not sexually transmitted. It leads to the idea of a unified medical service for RTIs, and to a more holistic approach that includes education and sexual and reproductive behaviour (see Figure 3).

The EC has initiated and sponsored work on these questions at international and regional level, and in several countries. Four African countries are used here as examples.

Figure 3 Impact of reproductive tract infections (RTI), including STDs and HIV (Ref L. Fransen et al)

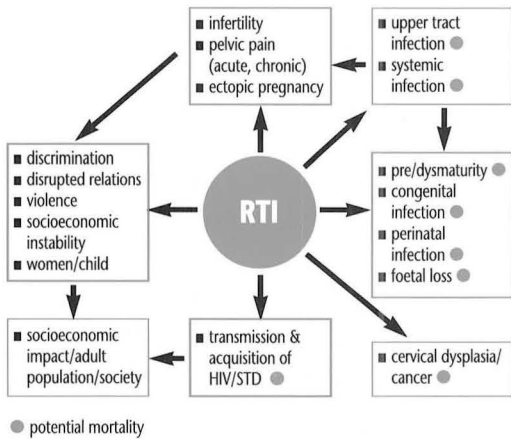
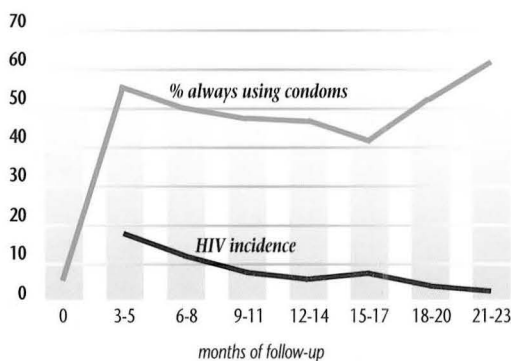


Figure 4 Increase in condom use and decrease of HIV incidence during an intervention among female sex workers in Kinshasa, Zaire (Ref M. Laga et al)



At the beginning of the Kenya project, only a fraction of antenatal attenders eventually received treatment. By the end, all attenders were tested, most positives were treated, and the cost of preventing one case of congenital syphilis had come down from US\$ 730 to US\$ 57.

1. ZAIRE: STD SERVICES AND CONDOM PROMOTION AMONG SEX WORKERS IN KINSHASA

In 1988 the Commission defined and began a project in Kinshasa, in which 1,200 commercial sex workers were provided with STD services and condoms. After two years, the proportion of women using condoms went from zero to 60 per cent (see Figure 4). At the same time, the annual incidence of HIV went down from 18 per cent to 3 per cent, and four other STDs also declined. Unfortunately, these efforts then had to be terminated because of the political turmoil which engulfed Zaire.

2. TANZANIA: LARGE SCALE INTERVENTION STUDY

A larger scale and longer term STD intervention study has been in progress in the Mwanza region of Tanzania (see opposite page). Much interim information has been gathered, so increasing expertise in STD control in Africa.

3. MOZAMBIQUE: INTEGRATION WITH PRIMARY HEALTH CARE

The Commission has been supporting STD control in and outside Maputo, in the context of Mozambique's HIV/AIDS programme and of primary health care planning (see page 22).

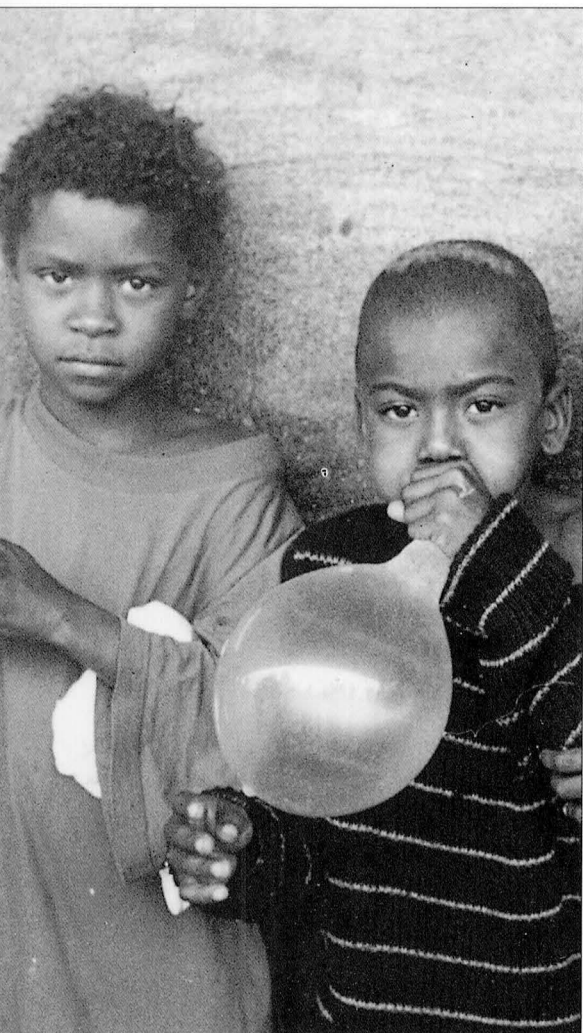
4. KENYA: CONTROL OF CONGENITAL SYPHILIS

A project was set up to screen and treat maternal syphilis, as part of the national HIV/STD programme. The project was also a learning process for other activities. It had been estimated that 30,000 pregnant women a year were infected by syphilis. The main conclusion was that most benefit would come from reorganisation of management and of health services.



STD EXAMPLE TANZANIA

NATIONAL AND REGIONAL ACTION ON STDs



WHO Photo/Armando Waak

Tanzania provides a classic example of EC policy on HIV and sexually transmitted diseases. On the one hand, the Commission has a project in the Mwanza district of north-west Tanzania to quantify the effect of STD treatment on the incidence of STDs and HIV. On the other hand, it has supported the STD part of the national AIDS programme, and is trying to apply nationally the lessons of Mwanza.

1. THE NATIONAL PROGRAMME

The Commission is supporting a technical adviser to the national programme, with two specific tasks. One is education to prevent sexual transmission. The other is to develop management of STDs nationwide. The Commission is also supporting the supply of drugs, training of medical personnel, and improvement of STD treatment.

2. THE MWANZA PROJECT

This five-year project began in mid-1991. In developing countries there is little experience of STD programmes, through public or private health systems, and of their impact on STDs and HIV. So there is too little information about:

- how big a risk factor are STDs for transmission of HIV
- what is the prevalence of STDs
- how effective an attack on STDs would be in countering HIV.

So the primary objectives have been to:

- implement a programme for detecting and treating STDs throughout Mwanza
- determine whether this is effective in reducing the spread of STDs and HIV.

The secondary objectives have been to:

- calculate STD and HIV prevalence
- calculate costs of STD management.

Early findings show HIV prevalence for rural villages, roadside settlements and Mwanza town of 2.5, 8.3 and 11.6 per cent, respectively, with a peak of 20 per cent for young women in the town, and a prevalence of syphilis of between 7 and 12.4 per cent, depending on sex and social stratum, showing that syphilis is a serious public health problem.

A special effort has been made for commercial sex workers in Mwanza town, using a community nurse. This consists of regular medical check-ups, health education, and promotion and supply of condoms. Health workers have been trained to manage STDs on the basis of symptoms and examination, without laboratory tests (which are not available), in six health centres and satellite dispensaries, and supplied with drugs.

This programme will be extended to all health centres in the region. Because it is implemented through the existing health system, it should be feasible to extend it to all Tanzania and perhaps to other African countries.



STD EXAMPLE MOZAMBIQUE

INTEGRATION OF HEALTH INTERVENTIONS

Mozambique has become a model internationally, both for the syndromic approach to STDs and for the horizontal integration of health interventions. The country was not, until recently, a promising setting for STD/HIV/AIDS control. The long-lasting civil war displaced more than a third of the total population of about 16 million people. Some 1.5 million people sought refuge in neighbouring countries. Of the rest, some 60 per cent lived in the poorest and most violent conditions imaginable. War and displacement caused the break-up of families and social structures, fuelled promiscuity and commercial sex, and so increased the risk of STD and HIV infection. Nearly half the health centres in the country were destroyed. Only in late 1993 was peace signed, bringing yet more movement of people as refugees return home.

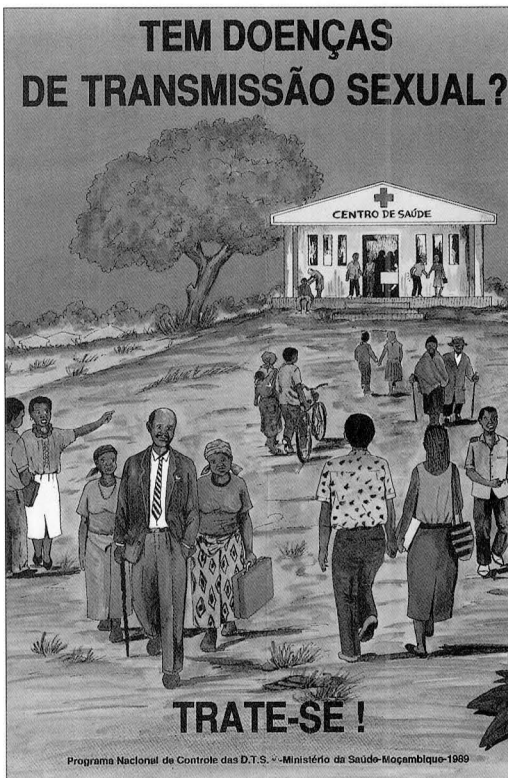
A national AIDS programme was begun in 1987 and, as part of it, the European Commission was asked to support an STD control programme. Before the HIV epidemic, STDs had not received much attention. But from the beginning STD control has been a major component of HIV/AIDS control, and they in turn have been integrated into the national health service of Mozambique.

The pilot phase began in 1988, in the capital city Maputo, with the aim of strengthening the management of STDs and improving the diagnosis, treatment and counselling of STD patients. Support was given both at the reference level, at Maputo's central hospital, and at the application level, in the primary health centres. Among the results were:

- the creation of a panel of experts on STDs
- the writing of guidelines for the diagnosis and treatment of STDs, suited to each level of intervention
- more rational use of health services
- decentralisation of treatment to health centres, with limited referral to the centre of excellence
- analysis of the costs per case treated.

In the second phase, in 1991, the project was extended to Maputo province, and in the third phase (1992) to six provinces. Here the main support was to clinical management and laboratories.

With the signing of peace in October 1993, a new and urgent situation arose. The demobilisation of armies and the return of refugees brought a fresh risk of HIV and STD transmission. So the EC response was urgent action to reinforce the national STD/HIV control programme, and to strengthen district health facilities and provide intensive education and information activities where population movements were expected.



EC/ATF



*Logo of Mozambique's
National STD Control
Programme*



NATIONAL ACTIVITIES CHILE

USING EXISTING STRUCTURES

The European Commission has established projects in several countries of South America, including Chile and Brazil, and is seeking new ways to organise its efforts across the whole of Central and South America. It wants to pursue a common strategy, perhaps working through one single organisation which will act as its implementing agency for the whole of the region.

Central and South America offer a different set of choices compared to, say, Africa, and often have more existing resources and structures which can be used for HIV/AIDS work. The two projects in Chile illustrate this. Both are being carried out by local NGOs.

PROJECT 1. HEALTH EDUCATION FOR URBAN CHILDREN

This is aimed at children and young people in poor urban areas around Santiago, and has been running since the middle of 1991. Apart from the burden of poverty, these children often fail to complete their schooling or go absent from school, suffer high unemployment, and have bleak prospects for the future. Drugs, and teenage pregnancies, are common. Through their sexual activities, they are at high risk of infection by STDs and HIV.

The task was to work out a way to educate these young people and help them to prevent infection. It cannot be done through schools. So the principle adopted was to seek the participation of the target group themselves, that is the children and young people under 21. This acknowledged their right to express themselves.

Also, the local community got involved in the planning, and a secondary benefit of working with these children is that work done with them is transferred by them to the surrounding community.

The pilot stage was to check the literature, run focus groups, do in-depth interviews, and use these as a basis for workshops with young people to create educational materials. These are based on games and role playing. Then came large-scale distribution.

This approach has proved to be effective for 15 to 21 year olds, and is now being extended to 12 to 15 year olds, since by 15 some attitudes are already established, so it is important to get the message across early.

PROJECT 2. EDUCATIONAL MATERIALS FOR WOMEN

This is a more recent project and is again being carried out by a local NGO. The target group is women, in particular prostitutes, and the focus is on STDs. The aim is to set up a national programme under the name Conasida, to design and produce educational materials about how to prevent STDs.



*This mural in Chile says
'SIDA te compromete' – AIDS
concerns you*



NATIONAL ACTIVITIES SOUTH PACIFIC

REGIONAL EDUCATION FOR YOUNG PEOPLE

This project illustrates the EC's concern to make young people aware of the dangers of HIV/AIDS, in time for them to take preventive action, through regional activity based on peer group education. The absolute number of known AIDS and HIV cases in the Pacific island region is small. But it is increasing, among a population of some 6 million people in 22 countries spread out over 30 million square kilometres, of which 98 per cent is ocean.

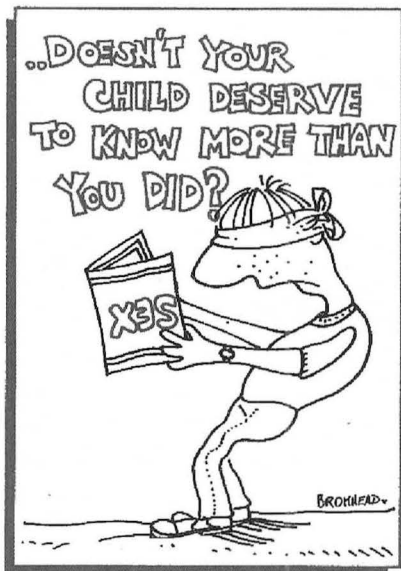
Changing family structures, a mobile population of fishermen, sailors and students who travel extensively, growth in tourism from abroad, a proven incidence of STDs but weak STD health services, and a very young population with 60 per cent under the age of 25 – all these factors make these small island communities vulnerable to the spread of HIV.

In 1990 the South Pacific Commission (SPC) set up an Education and Communication project on AIDS and STDs among its 22 member states. Its activities include a documentation centre, an information exchange, surveillance, and help for local HIV/AIDS education initiatives. The SPC asked for EC support.

An EC mission concluded that the most important priority was to develop targeted educational activities, and that the key priority group to be reached was young people. The SPC already had experience in working with young people through its youth and adult education programme. So the decision was taken to set up an STD and AIDS education office based at the Regional Media Centre at Suva, Fiji. This has technical facilities and staff for printing, video editing, film processing and audio production.

An education officer will work from this office and provide support to the SPC's STD/AIDS education work throughout the region. But rather than concentrate on use of the mass media, as had been the original intention of the SPC, the aim of the four-year project will be to develop peer group education schemes in which young volunteers are trained to carry out educational activities among other young people. The theory behind this is that targeted activity using interpersonal education from young people themselves has more impact on behaviour (see also page 27).

As there is little experience of peer group education methods in the Pacific area, the project will develop pilot schemes for three Pacific countries, building on existing strengths and activities. After evaluation of these pilot schemes, the experience and the educational materials will be disseminated throughout the whole region.



EC/ATF

*Leaflet produced by South
Pacific Commission*



NATIONAL ACTIVITIES BENIN

A MEDIUM FOR SCHOOLS

Benin has been the setting for an EC-funded AIDS education project among school children which is being extended to other countries such as Cameroon, the Comores and Morocco, with other countries to follow. Thus it has become a regional rather than a national project, and illustrates the Commission's principle of replicability.

The objective was to develop a means for educating, every year, all pupils in the first year of secondary school, around the age of 14, about HIV, and through them to reach their extended families and peers with the same message. In part, the project is aimed at the denial and scepticism that still abounds in many places – the problem of credibility. Great care was taken to:

- win the approval of parents beforehand, to avoid offending local traditions
- make the message comprehensible to children. In Benin, they are educated in French rather than in an African language, but tests showed that their grasp of French was limited.

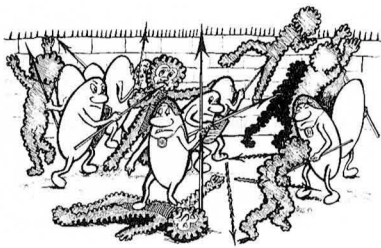
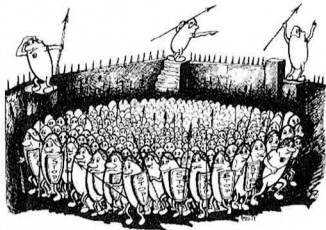
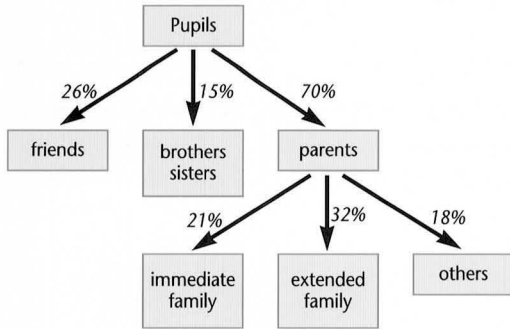
So the 16-page colour brochure produced under the title *AIDS: the killer disease*, and which has proved to be the model for many other countries, uses language and terms that the children can understand. It is legible, and uses a simple personal style using 'I' and 'You'. Photos are used to shock the readers and to convince them of the reality and seriousness of AIDS. There are personal testimonies, and the message is repeated from different points of view. There is no need for the teacher to intervene – the brochures are self-explanatory, and they are cheap and affordable for Africa.

Many thousands of copies have been distributed to schools. Also, the children in Benin then take the brochures home and distribute them, as the diagram shows, among friends, family and neighbours. Six weeks after first distribution, each brochure had reached an average of five people.

The one problem with the brochures is that they are no use to people who are illiterate. So there is a new approach for those who cannot read, a compilation of photos about the reality of HIV/AIDS, with a short text on the back that can be read by a person who knows how to read, to provide and invite verbal comments to and from the people they are shown to, for example commercial sex workers.

For the difficult-to-reach rural areas, where there is also high illiteracy, local radio programmes are being designed in local languages, based on the same content as the schools brochure.

Figure 5 Circulation of HIV/AIDS brochures (Ref R. Verbeke et al)



*In the schools brochure,
drawings like these are used
to great effect*



NATIONAL ACTIVITIES THAILAND

CULTURALLY APPROPRIATE MODELS

Because the HIV epidemic is spreading quickly in Thailand, and because the government has responded vigorously to it – but also because prostitution is widespread – the EC has allocated support for no less than 16 projects in that country. The emphasis is on training public and private health staff to improve prevention and control of STDs, and on education about STDs/HIV/AIDS for groups at risk, particularly rural young people.

PROJECT 1.

This is a schools-based community outreach programme carried out through the department of teacher training in the Thai Ministry of Education. Each of Thailand's 33 teacher training colleges has a Drug Prevention Education Centre, which have played a successful role in anti-drug campaigns since 1977. This project expands the scope of these Centres to include HIV/AIDS.

Teachers are trained to become principal trainers of student volunteers and out-of-school youths who in turn become informal peer-group educators and take the message out to the villages. The project is an ambitious one, with the aim of eventually covering about 6,400 villages in 73 provinces of the country.

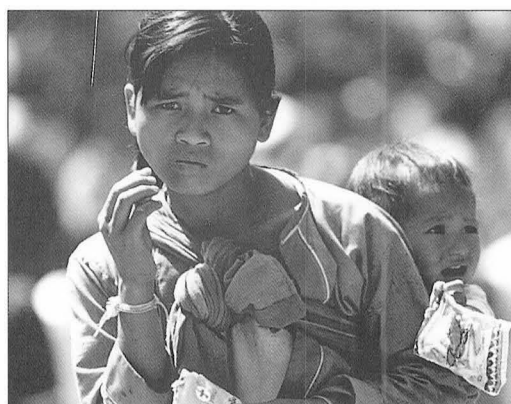
The goal is to reduce and control the spread of HIV/AIDS and STDs by changing risk behaviour, use of condoms, sticking to one partner, and sterile needle exchanges. Special attention is being given to the inter-dependency relationship between the commercial sex industry and its clients. There is a parallel study looking at the extent of commercial sex services, the social and behavioural factors promoting HIV transmission, and the knowledge and care capabilities of rural communities in dealing with HIV/AIDS.

PROJECT 2.

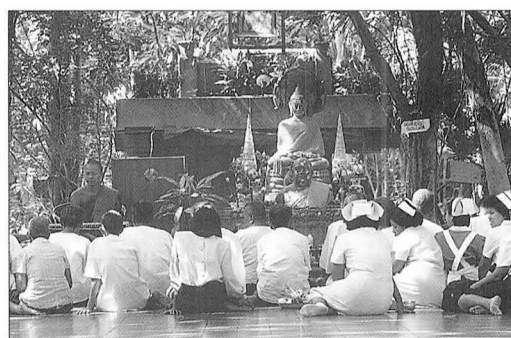
This HIV/AIDS education and prevention effort is carried out through an NGO in Thailand, with the ministries of education and public health. It concentrates on one hard-hit area, the province of Chiang Rai, which has one of the country's highest rates of HIV infection and STD prevalence.

The goal is to decrease the rate of increase of STDs/HIV/AIDS within two districts of the province, by improving the awareness of young people in these rural areas and their motivation to educate each other and to take more responsible and better informed decisions about sexual behaviour. The message is got across using the village education classes organised by the Ministry of Education.

The organisers hope to build a replicable, culturally appropriate educational model that can be integrated into the HIV/AIDS prevention activities of the two government ministries throughout northern Thailand, and possibly all over the country. Other countries of South-East Asia may also benefit from Thailand's experience in Chiang Rai.



WHO Photo/Gérard Diez



WHO Photo/Gérard Diez

Buddhist monks provide training in meditation for AIDS counsellors



NATIONAL ACTIVITIES MALAWI

SELF-HELP THROUGH PEER GROUP EDUCATION

This is a national project that emphasises peer group education among bar girls, lorry drivers, commercial sex workers and STD patients. It provides a classic example of how the EC promotes information, education and communication (known as IEC) as a way of minimising the spread of HIV and STDs. It also provides a classic example of peer group education.

Some HIV/AIDS work can be criticised for concentrating only on knowledge, and not changing behaviour. The peer group approach overcomes this by emphasising self-help, and participation by the target communities in setting objectives for themselves. It is based on the idea that people are more prepared to listen to someone like themselves than to an outsider.

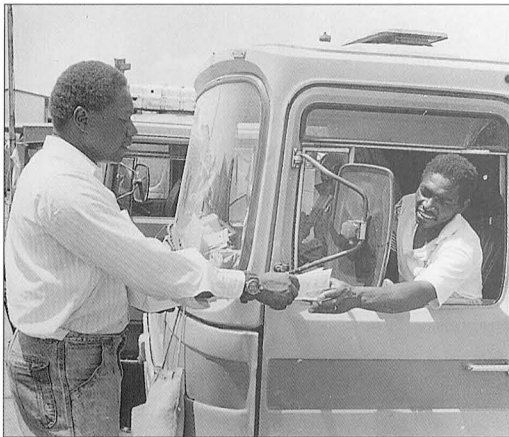
Also, external health workers could not give the constant reinforcement and education that people living inside these communities can provide. Peer education goes beyond giving facts and seeks to empower people to take action. It provides the skills and confidence to help vulnerable groups make decisions about sexual behaviour and negotiate with their partners about safer sex. It means identifying key people who can be trained to work among their peers, to mobilise and inform them.

IEC is therefore an important part of Malawi's HIV/AIDS programme, and early studies showed how important it was to target particular groups. Research among bar girls done in 1986 and 1987 found that 42 per cent and 80 per cent of the samples were HIV-positive. A 1989 study found that over 62 per cent of a sample of patients at STD clinics were HIV-positive. So the EC backed an IEC project for three years from 1990 (then extended for another three years) aimed at bar girls, long-distance lorry drivers, and STD patients.

The 'peer group education' approach has provided the basis for most of this project, which was designed to do more than set up a small-scale pilot. The ambition is to scale it up to a national activity which is sustainable in the long term. This is in line with the EC's policy of sustainable intervention. So the aim has been to promote and maintain risk-reducing behaviour among:

- bar girls
- long-distance lorry drivers
- STD patients
- the general public.

In the first phase, over 1,400 bar girls were trained as peer group leaders and educators. Each of them was probably in contact with 10 other bar girls, giving a coverage of over 14,000 of Malawi's estimated 17,000 bar girls. Even allowing for some drop-out rate, this is impressive. Some truck drivers were also trained as peer group educators.



EC/ATF Dr John Hubley

*Giving condoms to
truck drivers*



EC/ATF Dr John Hubley

*A peer group leader
demonstrates the
use of a condom*



NATIONAL ACTIVITIES

CHINA

BUILDING SELF-RELIANCE

The recent agreement between the EC and the government of China is an example of helping a country to build up its own capacities through training.

China is opening up to the rest of the world, leading to movement of people and therefore the risk of spread of HIV. But so far there are few known cases of HIV in China compared to its large population – perhaps between 5,000 and 10,000, according to a recent survey.

But China recognises that the time to intervene is now. However, intervention cannot be narrowly focused on HIV/AIDS. So the chosen route has been to upgrade China's own capacities in STD management and control, including HIV/AIDS, by a three-year training programme. Four courses are being developed:

1. management of STD programmes
2. clinical and preventive aspects
3. laboratory aspects
4. epidemiology and prevention.

A study tour of Europe is being organised for Chinese health professionals, and 18 fellowships have been arranged, at six months each, for Chinese doctors to study STD programmes at various European medical institutes.

This is a notable example of using aid to help a country to help itself – a route particularly suited to the Chinese social tradition of self-reliance.



WHO Photo

NATIONAL ACTIVITIES SOUTH AFRICA

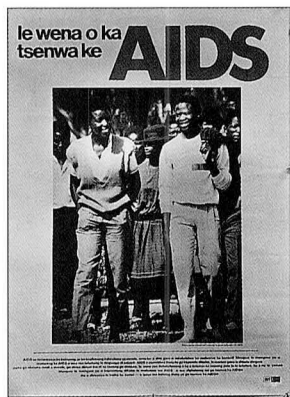
TOWARDS A NATIONAL STRATEGY

There is a special EC fund to help South Africa, part of which is used for HIV/AIDS activities. Due to apartheid, South Africa was for long isolated. But no country can be isolated from the HIV epidemic. There are reckoned to be between 200,000 and 300,000 HIV-infected people in South Africa, with a doubling time of 12 months.

But health policy and funding is highly fragmented, and expenditure is heavily skewed towards whites. So the European Commission has been providing financial help for human rights, health, education and agricultural projects in South Africa, implemented through NGOs.

In the HIV/AIDS field, the Commission has given financial support to two initiatives to create a more co-ordinated approach. One is NACOSA, the National AIDS Convention of South Africa. This has been set up to provide a high-level platform for South Africans from across all political, racial and economic divides, to build a multi-sectoral national strategy.

The other initiative is an NGO co-ordination group of about 70 organisations active in HIV/AIDS. This is more of an information exchange and lobbying group. So thanks to EC (and other) support, South Africa as it enters its new democratic era has the framework for creating a national HIV/AIDS strategy. The text of the AIDS and HIV Charter drawn up in South Africa is on the next page.



Ron Gilling/Panos Pictures

AIDS & HIV CHARTER



PREAMBLE In the light of

- the existing discrimination against persons with AIDS or HIV and their partners, families and care givers
- the danger that the growth of the epidemic in South Africa will lead to an increase in unfair and irrational treatment of those affected by AIDS and HIV
- the desirability of greater awareness and knowledge of AIDS and HIV among all South Africans, and
- the need for concerted action by all South Africans to stop the spread of HIV.

This charter sets out those basic rights which all citizens enjoy or should enjoy and which should not be denied to persons affected by HIV or AIDS, as well as certain duties.

1. Liberty, autonomy, security of the person and freedom of movement

- 1.1 Persons with HIV or AIDS have the same rights to liberty and autonomy, security of the person and to freedom of movement as the rest of the population.
- 1.2 No restriction should be placed on the free movement of persons within and between states on the ground of HIV or AIDS.
- 1.3 Segregation, isolation or quarantine of persons in prisons, schools, hospitals or elsewhere merely on the grounds of AIDS or HIV is unacceptable.
- 1.4 Persons with HIV or AIDS are entitled to autonomy in decisions regarding marriage and child bearing although counselling about the consequences of their decisions should be provided.

2. Confidentiality and privacy

- 2.1 Persons with HIV or AIDS have the right to confidentiality and privacy concerning their health and HIV status.
- 2.2 Information regarding a person's HIV status must not be disclosed without that person's consent, and, after death, except when required by law, without the consent of his or her family or partner, except in cases of clear threat to and disregard of an identifiable individual's life interests.

3. Testing

- 3.1 HIV antibody testing must occur only with free and informed consent, except in the case of unlinked, anonymous epidemiological screening programmes.
- 3.2 Anonymous and confidential HIV antibody testing with pre and post test counselling should be available to all.
- 3.3 Persons who test HIV positive should have access to continuing support and health services.

4. Education on AIDS and HIV

- 4.1 All persons have the right to proper education and full information about HIV and AIDS, as well as the right to full access to and information about prevention methods.
- 4.2 Public education with the specific objective of eliminating discrimination against persons with HIV or AIDS should be provided.

5. Employment

- 5.1 HIV should not be a basis for pre-employment testing or a ground for refusing to employ any person.
- 5.2 HIV or AIDS do not, by themselves, justify termination of employment or demotion, transfer or discrimination in employment.
- 5.3 The mere fact that an employee is HIV positive or has AIDS does not have to be disclosed to the employer
- 5.4 There is no warrant for requiring existing employees to undergo testing for HIV.

- 5.5 Information and education on HIV and AIDS, as well as access to counselling and referral, should be provided in the workplace after appropriate consultation with representative employee groups.

6. Health and support services

- 6.1 Persons with HIV or AIDS have rights to housing, food, social security, medical assistance and welfare equal to all members of our society.
- 6.2 Reasonable accommodation in public services and facilities should be provided for those affected by HIV or AIDS.
- 6.3 The source of a person's infection should not be a ground for discrimination in the provision of health services, facilities or medication.
- 6.4 HIV or AIDS should not provide the basis for discrimination by medical aid funds and services.

7. Media

- 7.1 Persons with HIV or AIDS have the right to fair treatment by the media and to observance of their rights to privacy and confidentiality.
- 7.2 The public has the right to informed and balanced coverage of the presentation of information and education on HIV and AIDS.

8. Insurance

- 8.1 Persons with HIV or AIDS, and those suspected to be 'at risk' of having HIV or AIDS, should be protected from arbitrary discrimination in insurance.

9. Gender and sexual partners

- 9.1 All persons have the right to insist that they or their sexual partners take appropriate precautionary measures to prevent transmission of HIV.
- 9.2 The specially vulnerable position of women in this regard should be recognised and addressed, as should the specially vulnerable position of youth and children.

10. Prisoners

- 10.1 Prisoners with HIV should enjoy standards of care and treatment equal to those of other prisoners.
- 10.2 Prisoners with AIDS should have access to special care which is equivalent to that enjoyed by other prisoners with serious illness.
- 10.3 Prisoners should have the same access to education, information and preventive measures as the general population.

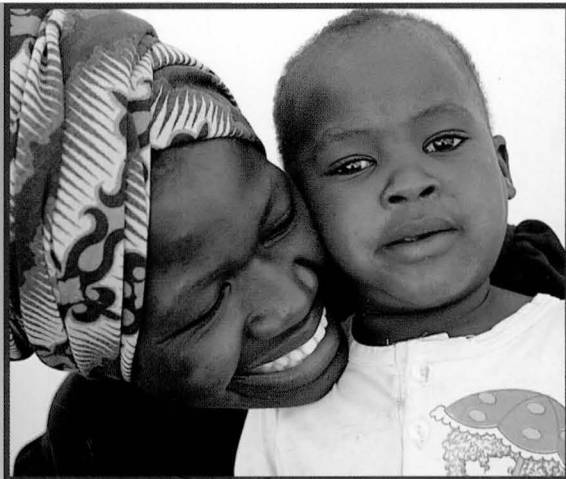
11. Equal protection of the law and access to public benefits

- 11.1 Persons with AIDS or HIV should have equal access to public benefits and opportunities, and HIV testing should not be required as a precondition for eligibility to such advantages.
- 11.2 Public measures should be adopted to protect people with HIV or AIDS from discrimination in employment, housing, education, child care and custody and the provision of medical, social and welfare services.

12. Duties of persons with HIV or AIDS

Persons with HIV or AIDS have the duty to respect the rights, health and physical integrity of others and to take appropriate steps to ensure this where necessary.

**Published by the AIDS Consortium
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University of the Witwatersrand
South Africa**



FRONT COVER
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colour photo, little girl
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colour photo, single woman
WHO Photo/Louise Gubb
top
WHO Photo/G rard Diez
bottom
Sean Sprague/Panos Pictures
hands
Sean Sprague/Panos Pictures

BACK COVER
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Commission of European Communities
Rue de la Loi 200
B-1049 Brussels
Belgium
Tel: + 32 2 235 11 11
Telex: COMEU B 21877