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AIDS POLICY OF THE COMMUNITY AND THE MEMBER STATES IN THE DEVELOPING WORLD

I. INTRODUCTION

Six years after the launch of the Community's special programme on AIDS in the developing countries and in view of the rapid spread of the epidemic - despite efforts undertaken by the countries concerned with the support of the international community - it is now possible for the Commission, together with the Member States, to draw lessons from past experience and define, at Community level, a coordinated approach concerning AIDS in developing countries over the next five years, with the objective of increased effectiveness of EC interventions.

The other Community Institutions (Council, Parliament) as well as joint ACP-EEC bodies (EEC-ACP Council and Joint Assembly) have, since the inception of the EC AIDS Programme in 1987, been regularly associated with it and have been informed of its progress, difficulties and evaluations.
With regard to coordination with Member States, a group of experts was set up in 1987 and has since had nine meetings dealing with a wide range of AIDS-related policy issues and themes.

In this context and in line with the recent resolutions adopted by the Council on the strengthening of coordination between the Community and Member States, this document aims at identifying common policy principles and strategic priorities for AIDS work in developing countries. This should lead to more cost-effective interventions, an improvement of coordination at the international level and better coherence at country level.

The main orientations proposed in the present communication were discussed with Member States experts at a recent meeting on 7 September 1993 and reflect joint learning and experience.

The communication on AIDS policy in developing countries presents the AIDS issue as a cross-cutting factor to take into account, where necessary, in and beyond the health sector. It is fully coherent and consistent with the existing development cooperation policies and with the Communication on the broader issue of health in developing countries to be presented at a later stage.

The communication includes a review on the importance of the epidemic and some projections for the future. A summary is given of the worldwide response and Europe's involvement as well as of the major lessons learned from 6 years experience in the implementation of AIDS activities in the developing world.

It describes general and specific policy principles and strategic priorities for AIDS work by the Community and the Member States. It further stresses the need to increase

efficiency of interventions and draws main conclusions.

This policy will have to be reviewed and refined periodically in order to take further stock of experiences and changes. It is crucial indeed not to confine oneself to top-down guidelines for "afflicted communities". Efficient strategy relies on empowerment of the communities and must enable them to express their needs and priorities in ongoing dialogue with all partners.

II. THE EPIDEMIC, PROJECTIONS FOR THE FUTURE AND THE RESPONSE

The Acquired Immunodeficiency Disease Syndrome (AIDS) was first recognised as a disease in 1981. The Human Immunodeficiency Virus (HIV) was identified as its cause in 1984.

An estimated 13 million people worldwide[1] are currently infected by the virus and as many as 40 to 110 million are expected to be infected by the year 2000[2]. Over 80 % of those infected live in developing countries and this percentage will probably increase.

Life expectancy is predicted to be reduced by about six years by 2010 with assumption of 60 million infected by the year 2000.[3] It is predicted that under-five mortality in Central and East Africa will rise to between 159-189 per 1.000 live births instead of falling, as forecast earlier, to 132 per 1.000.[4] The epidemic affects the adult population disproportionally and more than 1 million children in the developing world have already lost one or both parents to AIDS. As a result the coping mechanisms of communities and societies are stretched.

Only a few years after the start of the epidemic, HIV/AIDS, together with other STDs ranks high among communicable diseases when measured through the use of disability adjusted life years (DALYs) as is stated in the World Development Report of 1993. STDs and HIV/AIDS already rank fifth worldwide and in sub-Saharan Africa, China, India and other Asian countries. They rank fourth in Latin America

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1 Speech of Dr Merson, WHO/GPA, at Berlin Conference June 1993

2 WHO Progress Report 1992 and AIDS Policy Coalition, Harvard, 'AIDS in the World'.

3 World Development Report 1993. Investing in Health. 1993.

4 E.A. Preble : Impact of HIV/AIDS on African children. Social Science and Medicine. 31.6(1990).

and the Caribbean[3]. (See explanation and table in annex 1).

HIV/AIDS dominates therefore public health issues and is a heavy burden on health services in a growing number of countries.

The impact of the disease goes beyond public health concerns because it primarily affects the adult population in its productive and reproductive years and, as such, in its endemic stage, undermines the social and economic structures of the developing countries. Poverty, wars and inequalities aggravate the risk of the spread of HIV/AIDS while the epidemic itself further increases poverty and instability. Sustained efforts to reduce poverty and instability are needed to have lasting benefits where AIDS and health are concerned. Understanding and taking into account the underlying social and economic problems is therefore essential.

A purely technical, or medical, solution such as an effective cure or a vaccine is not expected in the near future. Even once developed, they will probably be neither rapidly affordable by, nor available in, the developing countries.

However, it is demonstrated that resources for effective, and available, AIDS interventions increase the possibilities to minimize the spread and impact of AIDS and avert enormous costs at a later stage - not only the direct costs of health care but also the far greater indirect costs. It is roughly estimated that investing 2.5 billion US$ a year now would save close to 90 billion US$ in direct and indirect costs by the turn of the century.[1,3] This is about 10 to 20 times the amount spent on AIDS prevention in the developing countries last year.

What has been the response to the epidemic till now ? Soon after the epidemic started spreading worldwide it was recognised that its nature and extent required a concerted, worldwide effort. Since 1987, intensive international and bilateral efforts (WHO, other UN agencies and also European Member States) have been aimed at preventing the further spread of HIV and organising an adequate response.

The European Community developed AIDS activities in its development work on the basis of a decision by Parliament and the Council of Ministers[5].

On the initiative of Vice President L. Natali and in collaboration with the ACP countries the EC/ACP AIDS Programme was launched in 1987. A year later, in 1988, the EC AIDS programme was extended to cover all developing

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5 Parliamentary Resolution on AIDS J.O. C88 of 14.4.1986 and Council Resolution J.O. C184 of 23.7.1986.

countries and specifically focused upon prevention. The total financial contribution of the Commission for the period 1987-1992 amounts to 74.8 MECU, not taking into account research funds. The Member States'contributions for the same period amounted to 156.4 MECU, which brings the total effort of Europe of the 12 to 231.2 MECU (see annex 2, table II).

Since 1988 the European Community research programme on life sciences and technologies for developing countries (EC-STD) also has focused on specific aspects of the AIDS epidemic in the developing world.

Increasingly, NGOs are seeking Community finance for AIDS activities in developing countries and the NGO co-financing budgetline is supporting a number of such activities.

While recently the budgets for AIDS channelled through UN agencies stabilised, several EC Member States increased their bilateral aid for AIDS related activities in developing countries.

Increased efforts were made to coordinate activities through regular exchanges and concerted action (Global Management Committee -GMC- meetings organised by the World Health Organisation -WHO-, a GMC Task Force on coordination, a study on UN coordination and six-monthly Member States expert meetings organised by the Commission).

III. MAIN LESSONS LEARNED

AIDS has highlighted individual, gender, social and economic inequalities and injustices and demonstrated the value of human capital as a priority for development.

Specific attention for AIDS was warranted in the beginning because the epidemic and the strategies were new and in need of rapid development. At this stage special attention is further needed for HIV/AIDS because:

a) the infection specifically affects and kills mainly adults in their more productive and reproductive period in life (Cfr table in annex 1)
b) the infected persons can spread the virus over a number of years before they become sick and continue to be infectious until they die
c) innovative approaches are needed to intervene in the absence of medical solutions for prevention or treatment
d) the AIDS factor is a new factor to plan for in cooperation for development, development of a country and several sectors concerned.

Six years of experience worldwide and at community level have made it possible to draw the lessons summarized hereafter.

The need for more investment in AIDS work and the high costs in the future if those human and financial investments are not made timely and effectively is recognised. Despite the efforts made, the need for further investments will expand in the future and also include recurrent costs. Several countries and regions already face serious resource problems in the social sector and to complement the communities' and national efforts, international support will further be needed.

Increasing resources are to go in pair with more targeted and cost-effective interventions put in place timely. A serious international effort is necessary to increase the scale of the interventions to reach a significant impact. Preventive activities for HIV/AIDS are the most cost-effective but in countries where the epidemic is already widespread this is to go along with activities to cope with the epidemic.

Where the implementation of these strategies is concerned, history has demonstrated that medical coercive strategies have opposite effects to those intended and that all interventions should be based on a social learning strategy respecting human rights and dignity. This supposes a right political climate and support by governments and legislators as well as from the communities.

It has been demonstrated that some religious and cultural practices can be incompatible with realistic approaches to STD/HIV prevention but that communities are able to examine these practices and adapt them if supported by their leaders and governments.

Social policy (education, employment, promotion of family life, ...) is playing an increasingly recognised role in the promotion of health of a population and this is also true for

HIV/AIDS where medical solutions are scarce. Interventions such as behaviour modification and condom promotion and marketing are to be organised by medical and by social services. Increasing education of women, decreasing poverty among urban poor and improving living conditions have also the potential for a great impact on the epidemic in the long term.

Concerning public health approaches themselves, the legacy of neglected and ineffective reproductive health services as well as the compartmentalisation of services dealing with adults, and especially women, have added to the inefficiency of the health system in most countries when dealing with major public health problems such as STDs and HIV/AIDS. Even the supply of drugs and condoms still needs improved organisation to have an impact on the STD and HIV epidemics. Furthermore, weak health and educational systems or infrastructure in a lot of countries sometimes lead to investments not being made as rapidly and efficiently as desired.

In the efforts to respond to the epidemic more effectively community based organisations, people living with the virus, the media, the private sector and several other parties have proved to have a crucial role to play next to the more traditional partners and a greater effort will be needed in the future to develop cooperation and co-ownership.

Regarding the scientific learning process it is clear that biomedical research has increased understanding and developed technology rapidly. However, while the efforts to develop vaccins and treatments remain important, attention needs to be refocussed towards increased learning about cost-effective and appropriate policy orientations and management of interventions.

Experience with AIDS and STD interventions show that a strong technical prevention programme is not enough to ensure results. Strong political leadership and support is critical for developing effective policy, translating policy into sustainable programmes, to ensure financial commitment for ongoing programmes, to attract the best qualified people for the task and to avoid complacency and denial.

Some specific lessons for Community interventions are recognised:

- while specific AIDS interventions have been satisfactory, the scale of these interventions has to be increased and more work is needed to integrate AIDS as a cross-cutting theme and factor in development work in general, in several sectors specifically, and in the health sector in particular.
- To further improve the Commission's involvement, personnel need more guidance and training as well as appropriate technical support and flexible procedures.
- While local communities and their organisations are crucial for the work around AIDS, capacities for the European Community to work directly with these organisations at national level need to be enhanced through the development of adequate financial and

administrative procedures.

The lessons drawn from experience allow the Community and the Member States to identify the policy principles for AIDS work in developing countries which follow hereafter.

IV. POLICY PRINCIPLES

The policy principles on which AIDS work is based are developed as follows : the Community and Member States' development policy in general has been based on the principles of mutual interdependency and solidarity[6]. These same principles have brought the EC to adopt a partnership approach and also are at the basis of the Community's AIDS policy.

The AIDS pandemic is a new factor in this interdependence and AIDS activities, programmes and policies form an integral part of the efforts to achieve the stated development objectives, especially those related to poverty alleviation, sustainable economic and social development and the fostering of respect for human rights and fundamental freedoms[7].

The Community and Member States' formal policy on AIDS in development is based on the recognition of the adverse effect of the epidemic on the health status of the population and on development and reaffirms the Community and Member States' strong and continuing commitment to provide assistance that helps developing countries to address the challenges posed by HIV/AIDS.

The specific policy on AIDS in development follows six specific basic principles which lie at the basis of all AIDS work. They are:

- **adaptation to risk environment;**
- **gender sensitivity and specificity;**
- **social learning and human dignity;**
- **empowerment and responsibility;**
- **integration in a wider framework;**
- **adaptation to the stage of the epidemic and rapid response.**

Adaptation to risk environment

Interventions to prevent the spread of the epidemic are to be adapted and focussed at individual behaviours and are also to take into account the social and structural factors at the basis of risk exposure, such as the demographic, cultural and

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[6]Development Policies in the run-up to 2000, Commission Communication to the Council and the European Parliament, September 16, 1992 - page 39.

[7]EC Council of Ministers statement on development cooperation policy in the run-up to 2000, November 18, 1992.

socio-economic factors determining the risk behaviours and responsible for a risk environment. Interventions are to be adapted to, and appropriately concentrated on, the different populations targetted: women, children, youth, people in special risk environments such as truckdrivers, military personnel, clients of commercial sex workers, commercial sex workers themselves, and migrant labour.

Gender sensitivity and specificity

During the first decade of the epidemic, gender specificity has not sufficiently been taken into account and the preventive behavioural messages as well as the methods have not been adapted to the gender specificities.

Analysis of the epidemic and its impact demonstrated that the rate and age of acquisition of the virus, the probability of exposure to unknown risk and the possibility to choose to protect oneself are very different for the two genders.

Therefore all short and long term analysis has to be made, and planning and intervention implementation to be developed, in a gender sensitive and specific way. Because of the specific problems women, more often than men, still face, specific attention needs to go to the political and economic empowerment of women and their legal protection. This must go along with more short term interventions.

Social learning and respect for human dignity

History has demonstrated that interventions based on a coercive, individual oriented strategy have only had counterproductive effects, causing epidemics to go underground and the interventions to be totally unsustainable. Therefore, at the basis of the Community's policy, the strategy adopted should be social learning. This means that individuals at risk and already infected should not be identified and isolated. The strategy will be to find quick and sustainable ways of developing a process of learning, both for idividuals and society, that will minimize the risks of infection, prevent discrimination, and thus respect human rights and dignity.

The normative and legislative role of governments should also be stressed in order to protect communities and individuals against coercive and discriminatory approaches caused by STDs and HIV/AIDS.

Empowerment and responsibility

Most HIV interventions cannot be administered but need high motivation and mobilisation of individuals and communities. These communities have to be empowered to be able to take the responsibility to determine their risks, behaviours and choices. At the same time people, groups and governments in power are to take more responsibility to limit exposure to risk for themselves, their families and communities.

While empowerment is a process to be undertaken by the

individual(s) or communities in need of empowerment, outsiders can facilitate the process through support for specific interventions and removal of barriers. Support of effective policy change (property laws, women's status, ...), support for community based organisations, representation of minority groups and creation of peer groups as well as support through collective action are all ways to strengthen the process.

Integration in a wider framework

Integration in a social policy for health and education as well as across sectors and in development cooperation in general (if structures exist and are sufficiently operational) will support the development of AIDS work in balance with other community and health problems. Integration is also supported by the development of an inclusive national HIV/AIDS policy which involves all major participants. This facilitates co-ownership, policy dialogue, multisectoral approaches and the appropriate tasks being taken up by community based organisations, the private sector, government officials, the media, the people living with the virus and international agencies. Integration, finally, is facilitating greater cost-effectiveness overall.

Adaptation to stage of the epidemic and rapid response

The HIV epidemic spreads in a region over time and is now at different stages in different regions (see figure 1 and annex 3).The response also varies over time but because of denial and slowness of political and administrative response there are often substantial delays in installing HIV interventions before the epidemic becomes widespread. The response should be appropriate to the stage the epidemic is in, while the time lag for an adequate response should be shortened as much as possible. Adapting interventions to the stage of the epidemic will make it possible to organise responses appropriate for different regions and countries (for example, central African countries are already at a stage where prevention and coping have to be addressed together, while several Asian countries still can focus all their attention on minimizing the spread of HIV).

A difference should also be made between short and long term approaches and both should be planned and implemented simultaneously (for example condom provision and education).

The Community and the Member States have developed these common principles and concepts on which to base all AIDS work in the future. They also have formulated strategic priorities for their interventions.

The strategic priorities selected for the Community and the Member States, and commented on below, will be presented to the countries for cooperation and support. This by itself should already enhance coherence and impact.

In view of the scarcity of resources, the Community and the

Member States will support governments and communities to choose the most cost-effective interventions and balanced resource allocations.

V. STRATEGIC PRIORITIES FOR COMMUNITY AND MEMBER STATES INVOLVEMENT IN AIDS WORK IN DEVELOPING COUNTRIES IN THE FUTURE

On the basis of experience and a review of worldwide accepted goals and strategies to reach those goals (see annex 4) strategic priorities for Community and Member States action have been identified. The most important strategic priority will be to minimize the spread of the epidemic. Therefore the following strategies are enumerated in order of priority.

V.1 The first and most important strategic priority will remain to minimize the spread of the epidemic while preventing discrimination and exclusion of those at risk, infected or sick

To reach this objective, HIV/AIDS will have to be tackled through specific interventions and programmes but also by including the AIDS factor across the sectors and in development cooperation in general.
The following orientations will be used in priority to implement this strategy.

V.1.1 Implementation of cost-effective interventions which prevent sexual and perinatal transmission or acquisition of HIV and other sexually transmitted diseases (STDs) through a comprehensive approach which is composed of :

- sexual and reproductive health education specifically adapted to, and accessible for, the groups targeted (youth, women, men and populations in specific high risk situations and environments)
- improvement of management of STDs through better reproductive health services and the provision of drugs for STDs. This approach should focus on the groups most affected and faced with the lowest availablility of services up to now, i.e. women, youth and specifically targetted populations at high risk, such as migrants, displaced people,...
- improvement of use, availability and choice of protective barriers and methods (condoms, virucidal spermicides, partner selection strategies, ...) via reproductive health services and social marketing strategies.

V.1.2 Decrease the poverty-instability-AIDS cycle
The social and economic factors interconnected with AIDS and partially determining the risk environments for populations must be taken into account if one wants to reach a significant improvement in limiting the spread of AIDS and sustaining it. In this context, the Community and the Member States are already jointly making a valuable effort through development cooperation in general. Three activities will supplement and focus these efforts:

- giving increased attention, where poverty alleviation is concerned, to groups and geographic regions especially vulnerable to AIDS (urban poor, displaced people or people living in unstable situations such as refugees, street children, commercial sex workers...);
- reducing the possible influence of development projects on the inadvertent spread of HIV/AIDS. While development projects are supposed to increase the quality of life of the population and therefore reduce the risk of HIV infection, some projects might increase the spread of HIV/AIDS. Therefore the Community will conduct an assessment to see which development projects are more likely to have a negative impact and will then develop tools to be used during the design of different projects. Development projects should also include, where appropriate, an assessment of how HIV will affect their viability (if at all).
- providing assistance to governments in monitoring the measures taken under structural adjustment programmes, or other economic policies, to ensure that the potential economic impact of AIDS is taken into account and that the necessary budgetary allocations are provided to strengthen the countries' capacities to cope.

V.2 **The second strategic priority will be to enable the health sector to cope with the additional burden caused by AIDS and the efforts to contain it.**

This will be done by:

- including AIDS as an important factor in health policy formulation and all health sector reviews, and through articulation of the priorities selected for AIDS, to be implemented by the health sector, with the priorities selected for health sector support;
- organising selective support to enable the health system in a given country to cope with the burden caused by AIDS and the efforts to contain it through selective strengthening of coping efforts such as: * inclusion of protective barriers, diagnostics and drugs for STDs in, for example, the essential drug provision system; * strengthening capacities to ensure comprehensive safe blood provision (HIV and other infections) mainly in countries where prevalence is high and the possible cost-effectiveness highest; * strengthening care and services for the urban poor, women, youth, migrant workers; * increasing capacities for service delivery by the private sector and NGOs concerned with health; * developing financing systems for STDs and reproductive health services in the larger context of health financing systems; * identifying low cost and effective strategies for the care of AIDS patients and the treatment of opportunistic infections; * reducing the costs and human resource utilisation through reduction of the need for hospitalisation and via development of strategies for medical services (public and private) and the use of rationalised treatment protocols and increased home based care facilities.

This support will gradually become part of the support to the health sector through a minimum package for primary and district health care support and be included in budgetary allocations where appropriate. This will be part of the global strategy to be developed by donors aimed at strengthening the health services which are often under-resourced and weakly managed.
During the transition period, while health system reforms are being negotiated and put in place, specific support for STD/AIDS activities in the health system will still be needed in order not to loose time and momentum. Over the years these interventions will become part of the regular health system support.

V.3 **The third strategic priority will be to manage and reduce the consequences of the epidemic on social and economic development.**

In this respect cooperation for development will have to take AIDS into account and the countries and communities supported will have to plan for consequences such as a major increase of orphans, a decrease of productive adults, the need for more training to replace the losses, etc. Countries and communities will need support to deal with these consequences and external support will be necessary for that purpose. This will be achieved through the following priority activities:

- support will be given to governments in assessing the social and economic consequences of HIV/AIDS, initially limited to a few countries to start with
- on the basis of an analysis of the findings assessment tools will be developed to ensure that the HIV/AIDS factor is included, where necessary, in development plans and cooperation programmes
- an attempt will be made to use this methodology to include an analysis of the epidemic in relation to the social and economic life in the country profiles that are to be made, beginning with countries where HIV prevalence is already very high.

V.4 **The fourth strategic priority is to further increase scientific understanding of, and learning on, the HIV/AIDS epidemic, the possible interventions and their use in implementation, monitoring and evaluation of progress.**

The Community, with the Member States, will promote synergistic activities and improve complementarity also in this field through giving priority to the following activities:

- improve the balance between biomedical and programmatic, health policy, socio-economic and operational research for and in developing countries through focus on the latter;
- increase the capacities of national and regional research institutes and training courses in developing countries as well as regional and inter-regional exchange;
- maximize the efficiency of scientific learning through

appropriate resource allocation by decision makers independent from research and commercial groups;
- use the research results to implement findings and methods rapidly where appropriate;
- create adequate instruments and validation of methods for monitoring and evaluation of policy progress, interventions and impact assessment.

The Community and the Member States have made a selection of strategic priorities for which support can be given to countries and communities on the basis of the six principles for interventions laid down in chapter IV.

In view of the scarce resources and the need for the highest possible impact, a further selection will be needed. This selection will have to be made at the country level. It should however be clear that whatever priorities are identified by the countries or the local communities, the Community and the Member States will select those interventions for support that have been evaluated as the most cost-effective.

The Community and the Member States will support the governments and the communities to choose the most cost-effective interventions through supporting studies and development of methods to assess cost-effectiveness and to improve resource allocation, management systems and decision making processes.

To increase cost-effectiveness, it is also important to avoid duplication and to recognize the role of each partner. Therefore the Community and the Member States will facilitate and support the development of national policies and strategies for HIV/AIDS in the framework of which support will be given. The Community and the Member States will also support the full recognition and an appropriate role for local communities, community based organisations and the private sector in the context of the national strategy developed.

VI. COHERENCE AND COORDINATION

In May 1993, the Commission transmitted a communication on procedures for coordination between the Community and the Member States at policy and operational levels[8]. The recommendations to be adopted by the Council on the basis of this Commission proposal will certainly be used to further develop coordination mechanisms regarding AIDS work.

However, it can already be stated now that the AIDS problem is clearly an issue in need of a global approach and more resources in the near future in order to prevent even greater costs. This calls for concerted action rather than activities limited in scope and time. This need for coordination has been recognized very early by the Commission in the field of AIDS, resulting in the constitution, in 1988, of an expert group, gathering Member States and Commission representatives together, and meeting at least once a year. Still, the need for greater focus and enhanced coordination is recognized,

[8]COM (93) 195 final 10/05/1993

particularly in view of the significative financial and technical contribution developed at the European level.

VI.1 At policy level.

VI.1.1 Between Community and Member States.

Concerning AIDS policy, increased policy coherence and complementarity between all parties at the Community level is being strengthened through the recognition of common AIDS policies and priority objectives as proposed in this communication. Policies and strategic issues presented in this communication have been discussed in the Member States' expert group. It is recommended that in the future this group will continue to meet regularly in order to revise the policy formulated and examine its implementation. More specific discussions can be organised in this forum to increase common knowledge and understanding about important themes.

VI.1.2 Between all participating parties: policies and representation at international level and in international bodies.

The Community and Member States will ensure that their policies and priorities regarding HIV/AIDS are clearly represented and articulated in international fora and wide publication of policy orientations, once formally accepted, will be ensured. These policies are part of a wider framework worldwide and are regularly to be discussed in that context in order to facilitate convergence and coordination in the beneficiary countries.

VI.2 At operational level.

IV.2.1 Between Community and Member States.

To implement the strategic priorities agreed upon and developed in this document, the Community and the Member States will pursue maximum focus through active cooperation and increasing complementarity in specific countries and/or regions and concerning specific themes. This will be pursued through :

- continuation and reinforcement of regular information exchange between Member States and Community on planning and programming of interventions in countries and regions through the existing mechanisms such as monthly committee meetings (EDF, ALA, MED) and bilateral meetings
- examining in specific countries, where both the Community and the Member States could play a significant role, ways to enhance cooperation through joint reviews, exchange of information and improved coordination mechanisms. Delegations, technical assistance and Member States representatives in countries will be requested to promote this, for example, through regular meetings and through designation of one party specifically in charge of coordinating the AIDS efforts

- increasing collaboration through joint projects or projects with common purpose.

In selected countries specific concertation will be pursued on some themes, such as socio-economic impact assessment, STD drugs in essential drugs supplies, reproductive health, AIDS assessments of development projects in general and resource allocation methodology development. Results and lessons will be discussed at the Member States expert level.

IV.2.2 Between all participating parties.

This is the prime task of the country itself but the Community will pursue to facilitate the countries' task by improving information exchange about support, policies, strategies and projects and by working more closely with the national coordinators and the UN representatives in charge of coordinating UN support. Discussion at the GMC Task Force of WHO/GPA and in the context of the study on a UN co-sponsored AIDS programme will clarify this further in the future.

V. SPECIFIC INSTRUMENTS AND FINANCIAL RESOURCES

The Community and Member States' work on HIV/AIDS in developing countries includes policy dialogue, thematic work (including AIDS across sectors) and multisectoral work (health, education, social, women, other) as well as funding policy through grants. The financial resources available for this purpose over the period 1987-1992 represented an amount of 231.2 MECU. (See annex 2).

The projections with regard to the spread of the epidemic in the future, as shown in chapter II, call for an increase in the financial and technical response at international level: the Community and Member States are therefore expected to pursue and increase their efforts in this field. The Community contribution for the period 1994-1998 is described in annex 5 and represents a minimum indicative amount of 119 MECU.

This implies the strengthening of cooperation capacities, both at country and at Member States level, to be able to deal with the long term urgency, the complexity and specific nature of AIDS activities, as well as the integration of AIDS work in the framework of global public health policy and of development work in general.

At the level of implementation, more cost-effective interventions will be systematically developed. This requires, as far as Community aid is concerned, maintaining the flexible regulations and guidelines already governing AIDS activities and confirming them for the future. Further work will have to be pursued for more adequate procedures allowing for better and more rapidly available support to local communities and NGOs. This calls for an increase in human resources, both at the level of headquarters and at country level.

VI. CONCLUSIONS

1. The European Community, with the Member States, regularly examined the steps taken and the lessons learned concerning AIDS in developing countries, as was established and requested by the decision of Parliament and the Council of Ministers[9].

2. AIDS is acknowledged to be an essentially cross-cutting, determining factor in economic and social development, and crucial in and beyond the social sector. Already, STDs and HIV/AIDS rank fifth when considering the disability-adjusted life years (DALYs) of 1990. It is expected that by the year 2000 forty million people will be HIV infected. 80 to 90% of those infected live in developing countries and mainly are of (re)productive age. This has profound implications for future progress towards the improvement of living standards and coping mechanisms across the developing world.

3. In seeking to assist developing countries to respond to the challenge of AIDS, support can be provided in a number of interlinked areas. Apart from the more direct preventive and coping activities, policies promoting poverty alleviation, the social and economic well being and status of women, respect for human rights and dignity, and community participation all help to meet the challenge.

4. The major problem related to AIDS is found in the developing countries and the major opportunity to deal with the problem successfully is supporting timely preventive efforts. Investments in tackling the problem in these countries is far too low and often only available at a stage when costs are already high.

5. On the basis of a joint analysis of the lessons learnt during the first six years of experience with AIDS interventions and programmes, a policy framework, priorities for action and ways to enhance efficiency and complementarity are proposed.

6. The Community and the Member States based its general development policy on the principles of mutual dependency and solidarity[6]. Those principles are also important for AIDS policy in developing countries.

7. The specific policy principles on which all AIDS work will be based are described as follows: interventions have to be adapted to risk behaviours, but also to the socio-economic determinants of those behaviours which create specific risk environments; they have to be gender sensitive and specific; they are to based on a non-coercive social learning strategy fostering respect for human rights and dignity; they are not to be administered from above but based on the empowerment of individuals and communities enabling themselves to take responsibility; they are to be integrated in a larger framework and they are to be adapted to the stage of the epidemic and the response is to be mobilised rapidly.

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[9]Parliamentary Resolution on AIDS J.O. C88 of 14.4.1986 and Council Resolution J.O. C184 of 23.7.1986.

8. In designing and implementing assistance in the AIDS field, the Community and the Member States agree on the following strategic priorities :

- To enable governments, communities and individuals to minimize the spread of the epidemic while preventing discrimination and exclusion of those at risk, those infected and those ill by tackling AIDS as a cross-cutting issue as well as an issue for specific intervention.
- To enable the health sector to cope with the additional burden caused by AIDS and the efforts to contain it.
- To assist in reducing the impact of the epidemic on social and economic development.
- To increase the scientific understanding of and learning on the AIDS epidemic.

9. The Community and the Member States also emphasize the wider importance of improvement of the living standards of the poorest populations as well as the status, education and employment of women to minimize the spread of the epidemic, ensure an impact and sustain it.

10. To achieve those priority objectives, the Community and Member States will orientate their support towards the following main activities :

- assisting in implementing comprehensive, cost-effective interventions to minimize sexual and perinatal transmission or acquisition of HIV and other STDs. This should include: improvement of management of STDs through better reproductive health services, mainly for women and young people as well as for populations in high risk environments; improvement of availability and choice of protective barriers (condoms and others) through social marketing and health services; sexual and reproductive health education specifically adapted to young people, women and people in high risk situations; strengthening capacities to ensure comprehensive safe blood provision (HIV and other infections) in countries with high HIV prevalence; strengthened poverty alleviation efforts for specific groups and regions especially vulnerable to AIDS (urban poor, displaced people,...);
- including AIDS as a crucial factor for health policy formulation, health sector reviews and in health interventions where appropriate;
- assessing which development projects are most likely to have a negative impact and developing tools to include an AIDS assessment;
- assisting governments in monitoring the potential socio-economic impact of AIDS and ensure it is taken into account in the planning process, in particular through sufficient budgetary allocations for the sectors concerned;
- in the field of scientific research: improve the balance between biomedical and programmatic, socio-economic research, strengthen the capacities of national and regional research institutes in the developing countries and increase the use of research results to implement findings and methods rapidly, where appropriate.

Support for these activities, and others to be developed, will be implemented gradually and will take into account policies and absorptive capacities of the beneficiary countries as well as the priorities of the communities involved. Special attention will be given to possible complementarities between Commission and Member States interventions as well as with other donors.

11. It is recognised that it is crucial but difficult for national governments and communities to make choices to appropriately allocate scarce resources and the Community and the Member States will support governments and communities to do so by :

- facilitating the development of national policies and strategies;
- supporting increased recognition of the role of communities, community based organisations and the private sector in dealing with AIDS at all levels;
- increasing the capacities of the national structures;
- selective supporting of cost-effective interventions;
- ensuring greater coherence, complementarity and coordination between Community and Member States at policy, strategy and operational level.

12. Use and level of resources. The Community and the Member States note that there is a pressing need for increased investment and activities in the field of AIDS, and while this is recognised by donors, the scarcity of resources in general is also recognised. Therefore the effective use of resources will have to be enhanced through focussing on cost-effective priorities (of which the most important are those to minimize the spread) and through regular monitoring, coordination and exchange of information as well as through decreasing administrative time lags and facilitating procedures. The Community and the Member States recognise nevertheless that even with a more effective use of existing resources there still is a need for further increases in budgetary allocations and human resources, both at headquarters and country level.

13. Policy and operational coordination between Member States and the Community will be strengthened:

- policy coordination will be continued through regular meetings of experts of the Member States and the Commission with the aim of reviewing and refining policy priorities and strategies;
- operational coordination: the Commission and the Member States agree that greater attention should be given to strengthening coordination between those responsible for AIDS activities in the countries through country representation. Specific collaborative mechanisms could be set up at the country level.

This would imply, in a first phase, the selection of some focal countries where extra attention to collaborative efforts will be given. In addition, specific concertation will be launched with Member States on a few significant themes on which a common approach would be further

developed.

14. Coordination with other donors and parties. The Community and Member States will continue to encourage all participating parties to work together and coordinate their assistance for AIDS activities. Special attention will be given to coordination with UN agencies and the World Bank, both at global and country level. The Community and Member States will take care that their policies on AIDS are clearly represented and articulated in international fora and wide publication of policy orientations, once formally accepted, will be ensured. Ongoing representation to enable regular policy and priority discussions will be pursued.

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ANNEX 1

Remark: The use of disability-adjusted life years* (DALYs) in the World Development Report, 1993, is one step in the process of priority setting, combining the approaches and data of economics and epidemiology.
Beyond this approach, data from behavioural and social science as well as management sciences must also be included, together with elements from political science and law, to come to priority setting.

* The global burden of disease (GBD) combines the loss of life from premature death with the loss of life from disability. The GBD is measured in units of disability adjusted life years (DALYs). Disease and injury categories are based on the international classification of diseases.

Table: DISTRIBUTION OF DALY LOSS BY CAUSE FOR 1990 AND BY REGION (per cent)

CAUSE (1)	WORLD	SUB-SAHARAN AFRICA	INDIA	CHINA	ASIA, other	LATIN AMERICA AND CARIBBEAN
POPULATION (millions)	5267	510	850	1134	683	444
COMMUNICABLE DISEASES (2)	45.8	71.3	50.5	25.3	48.5	42.2
* respiratory infections	9.0	10.8	10.9	6.4	11.1	6.2
* perinatal causes	7.3	7.1	9.1	5.2	7.4	9.1
* diarrhea	7.3	10.4	9.6	2.1	8.3	5.7
* vaccine preventable childhood infections	5.0	9.6	6.7	0.9	4.5	1.6
* STDs and HIV	3.8	8.8	2.7	1.7	1.5	6.6
* malaria	2.6	10.8	0.3	< 0.05	1.4	0.4
NON-COMMUNICABLE DISEASES	42.2	19.4	40.4	58.0	40.1	42.8

Worldwide, in sub-Saharan Africa, India, China and other Asian countries, STD/HIV ranks 5th among communicable diseases. In Latin America and the Caribbean it ranks 4th.
Source: Box table 1.3, World Development Report, 1993, Investing in Health.
(1) Injuries are not taken into account in this table.
(2) Only the six major communicable disease groups are mentioned in this table.

ANNEX 2

Table I: External agencies' support to global AIDS strategy*
(Contribution to WHO or to countries, 1986-1991)
(Amounts in million US dollars - current dollars)

CEC + Member States	277.469,-	Million US$ (detailed in table II)
U.S.A.	237.331,-	
Nor/Sw/Fin.	142.987,-	
Canada	70.500,-	
World Bank	55.805,-	
UNDP	41.652,-	
Switzerland	13.850,-	
Japan/Australia	12.743,-	
Other bilateral	10.000,-	
UNICEF/UNFPA	7.481,-	
	869.818,-	Million US$
=	724.848,-	MECU

*Research is not taken into account

Table II: European contribution to the global AIDS strategy (1986-1991) (reported June 1991)
(Amounts in million US$)

AGENCY	TO WHO/GPA	THROUGH WHO/GPA	TO COUNTRY PROGRAMME	TOTAL
UK	37.424	10.372	11.544	59.340
FRANCE	4.349	0,245	34.329	38.678
DENMARK	14.479	2.517	19.900	36.896
GERMANY	4.100	28,06	21.345	25.473
NETHERLAND	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
EEC/COMM.	_	_	89.760	89.760
SUBTOTAL	79.960	13.962	182.504	277.469

Table III: Past financial contribution of the Commission ('87-'92) (Amounts in ECU)

- Lomé II	35.000.000	
- Lomé III	4.030.000	
- Emergency	50.000	
- Co-financing NGO	1.680.222	('87-'91 only)
- Budget line	26.000.000	
- Europe against AIDS	8.040.000	
TOTAL	74.800.222	

Research funds for the same period are estimated at approximately 45 MECU (projects in Europe and developing countries)

ANNEX 3

Adaptation to the stage of the epidemic and rapid response

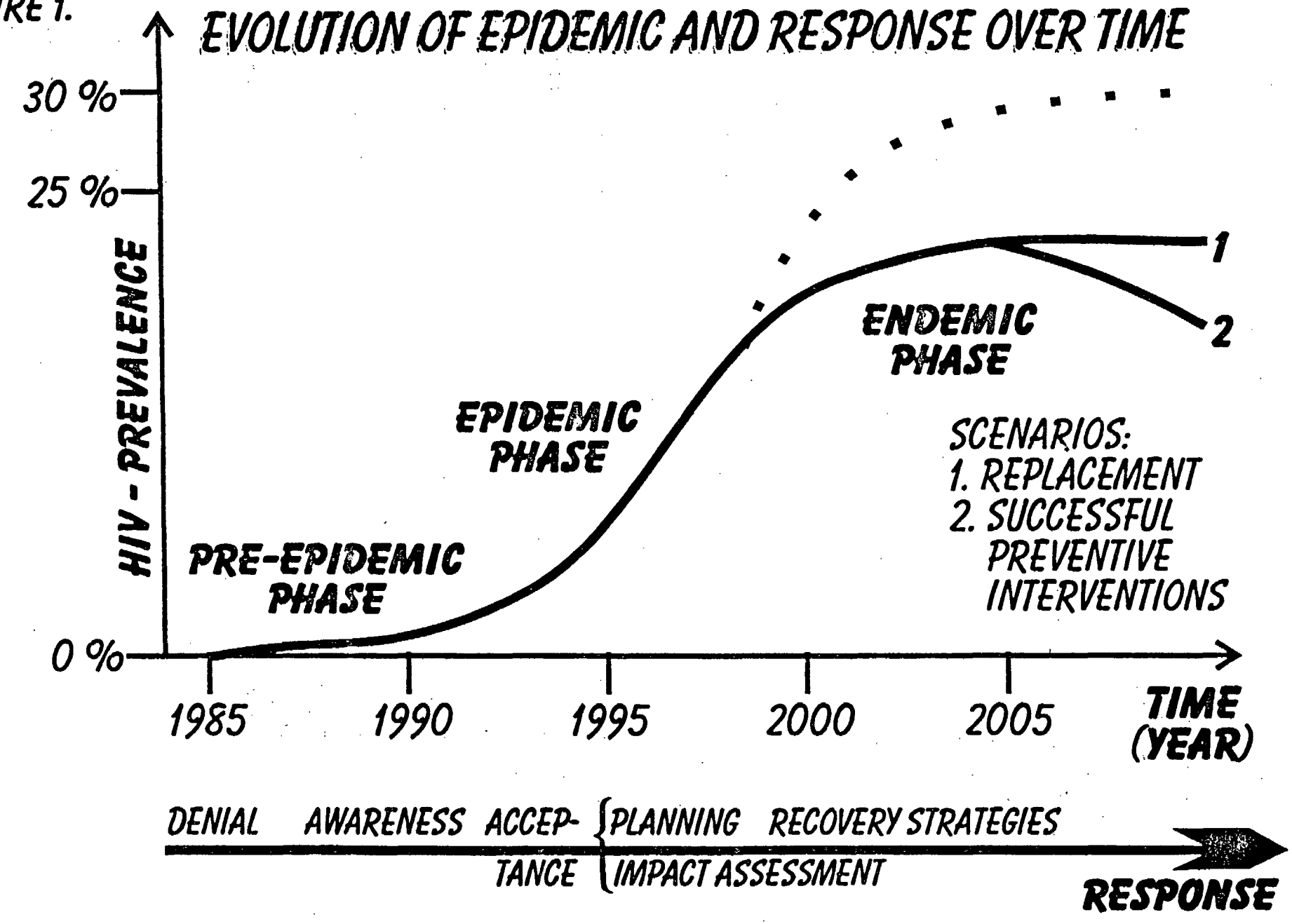
* The first stage recognized is the pre-epidemic stage where the incidence and prevalence of HIV is still relatively low and where mainly groups in risk situations are affected. Infections with other STDs give an estimate of the possible spread and extension and play a role as co-factor, facilitating acquisition and transmission of HIV.

* The second stage is the epidemic stage where the prevalence of HIV in groups in risk situations is above 1 % and the annual incidence increases rapidly even outside the main risk groups. At this stage tuberculosis is also increasing in the HIV positive population and from there into the general population.

* The third stage is the endemic stage where a plateau level is reached with a saturation of the infection among the groups first affected. At that stage the infection rate remains sufficiently high for new infections to replace the sick population after death. (This last stage should not be wrongly interpreted as a result of effective control measures.) Probably instead of a plateau, there will be a decrease if interventions are effective on a wide enough scale.

  The plateau at which the endemic stage levels out depends upon the size of the total population at risk and the impact of preventive measures to increase the not at risk population. When this plateau is reached also depends upon preventive measures and upon other STDs playing a role as co-factor.

FIGURE 1.


EVOLUTION OF EPIDEMIC AND RESPONSE OVER TIME
30 %
25 %
0 %
HIV - PREVALENCE
PRE-EPIDEMIC PHASE
EPIDEMIC PHASE
ENDEMIC PHASE
1
2
SCENARIOS:
1. REPLACEMENT
2. SUCCESSFUL PREVENTIVE INTERVENTIONS
1985
1990
1995
2000
2005
TIME (YEAR)
DENIAL
AWARENESS
ACCEP-TANCE
PLANNING
IMPACT ASSESSMENT
RECOVERY STRATEGIES
RESPONSE

ANNEX 4

GOALS OF AIDS WORK IN DEVELOPING COUNTRIES

The goals are based on generally accepted goals worldwide, as stated in the global strategy developed by WHO / GPA and all major parties and are here only mentioned to see the larger framework.
The paths to reach these goals differ in time and from one risk situation and socio-economic set-up to another but some general rules are recognisable.

The goals are:

1. to minimize the number of new infections
2. to prevent discrimination and exclusion of those at risk for infection, those infected and those ill
3. to enable health systems to cope with the additional burden through selective strengthening and systematic reorganisation, and to provide for patient care and dying with dignity
4. to minimize the impact on social and economic development
5. to reduce the impact of some development projects on the inadvertent spread of the epidemic and mobilize development for the disadvantaged and the marginalised, particularly at risk of HIV.
6. to increase the scientific understanding of the AIDS epidemic and of the possible interventions and to monitor and evaluate the progress.

Strategies to reach these goals in developing countries

Minimize the number of new infections: through reduction of the rate of acquisition and transmission of HIV.

a) Implement cost-effective interventions which prevent sexual and perinatal transmission and acquisition of HIV and other STDs:

1) educate and mobilise on safe and responsible sexual behaviour (reproductive health)
2) improve use, availability and choice of protective barriers and methods (condom barriers, spermicide and partner selection)
3) improve STD management
4) reduce high risk sexual contacts for certain groups such as sex workers and their clients
5) pay specific attention to youth and women of reproductive age
6) minimize perinatal exposure

b) Implement cost-effective interventions which prevent intravenous transmission:

1) increase pool of safe donors
2) screen blood donations
3) rationalise use of blood products
4) reduce need for, and use of, blood products
5) reduce intravenous drug use and use of infected needles

Prevent discrimination and exclusion of those at risk of infection, those infected and those ill:

1) eliminate victimisation and discrimination at school and in the workplace by eliminating unfair dismissal, pre-

employment testing, workplace testing and testing without informed consent
2) ensure maximum confidentiality of results
3) ensure care, treatment and counselling with compassion are available on an equitable basis regardless of serostatus
4) promote non-stigmatisation of marginalised groups
5) develop AIDS charters with statutory force

Enable the health sector to cope with the additional burden through selective strengthening and systematic reorganisation and provide for patient care and dying with dignity

1) enable health services to play an active role in minimizing the spread of the epidemic through strengthening their capacities of contributing to the fulfillment of strategies presented under goal 1
2) identify low cost and effective strategies for the care of AIDS patients and the treatment of opportunistic infections
3) reduce costs by reduction of hospitalisation but ensure in-patient care for major debilitating infections, adverse reactions to drugs and terminal or social care through development of strategies for medical services (public and private)
4) improve patient management, the use of drugs and laboratory services through the use of rationalised treatment protocols
5) examine possibilities to make specific anti-viral drugs accessible at low cost once they become available
6) strengthen overall health systems essential in ensuring effective STD/HIV control; specifically for urban poor, women, marginalised groups and reproductive health, and, where appropriate, in the framework of district health systems
7) provide counselling, legal and social services to communities, patients and their families affected by AIDS
8) identify non-coercive, low cost and effective options for the management of populations with reproductive tract infections and TB related to the AIDS epidemic

Minimize the impact of the epidemic on social and economic development:

1) assess the effect of AIDS on social and economic development at both micro and macro level and develop rapid assessment methodologies
2) develop a comprehensive way of planning for AIDS in development by ensuring that the HIV factor is included in all district and national development plans as well as in the health sector plan
3) develop a human resources planning methodology to establish which sectors are at risk of loosing labour. Increase teaching and assess skill levels and job descriptions
4) introduce appropriate technology in sectors with expected labour scarcity
5) improve flexible credit and funding schemes
6) develop appropriate employment and income generating schemes for affected communities (for example projects for orphans in Zimbabwe, Uganda)
7) develop schemes to support communities to cope with the family and social disruption caused by the epidemic

8) alleviate poverty and instability trough general development programmes

Reduce the impact of some development projects on the inadvertent spread of the epidemic and mobilize development for the disadvantaged and marginalised:

1) assess the impact of development projects on the spread of HIV and plan for it in those projects*
2) development projects should also include, where appropriate, an assessment of how HIV will affect their viability (if at all).

Increase the scientific understanding of the AIDS epidemic, the possible interventions and their use in implementation, monitoring and evaluation of progress:

1) improve the balance between biomedical and programmatic, health policy, socio-economic and operational research for, and in, developing countries
2) focus on anticipatory policy, planning and programme development research
3) link data collection and analysis about epidemic, risk environment and response to interventions
4) increase capacities of national and regional research institutes in developing countries
5) actively promote information dissemination to policy makers, communities (national, regional and international)
6) maximize efficiency through appropriate resource allocation by decision makers independent from research and commercial groups
7) create adequate instruments for monitoring and evaluation of policy progress, intervention and impact
8) validate methods

* Remark : while development projects are to improve quality of life of the population and therefore are assumed to reduce HIV infection, they may assist in spreading HIV inadvertently for example : while a road increases access to markets and social services in remote areas, during construction and once completed it increases movement of populations and could spread HIV and STDs. Therefore it could be planned that construction workers are recruited more often from the area or that the workers coming from outside are to be allowed to move with their families. Increased education and condom availability could also decrease the risk.

FINANCIAL STATEMENT

1. TITLE OF OPERATION

Commission communication concerning the AIDS policy of the Community and the Member States in the developing world.

2. BUDGET HEADING INVOLVED*

B7-5046: Health programmes and the fight against AIDS in developing countries

3. LEGAL BASIS

Parliament resolution on AIDS, OJ No C 88, 14.4.1986
Council resolution, OJ No C 184, 23.7.1986

4. DESCRIPTION OF OPERATION

4.1 General objective

Establishment of a Community framework for AIDS policy and strategies in the developing world.

4.2 Period covered and arrangements for renewal or extension

From 1 January 1994 to 31 December 1998 (a total of five years). Towards the four-year mark, an evaluation will be conducted with a view to reviewing and defining future needs.

5. CLASSIFICATION OF EXPENDITURE

Non-compulsory expenditure
Differentiated appropriations

6. TYPE OF EXPENDITURE

Funding of AIDS projects in the context of the strategies described in the communication. 100% subsidies and subsidies for joint financing with other sources in the public and/or private sector.

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* EDF resources are also being used.

Operations may take the form of technical assistance or studies for the supply of equipment, facilities, works and Part A and B administrative expenses. An A-grade administrator is currently working full-time on the issue.

7. FINANCIAL IMPACT

7.1 Method of calculating total cost of operation

The communication on the establishment of a policy and a framework for AIDS operations will serve as the foundation for the Commission's financial efforts in the future. The table below sets out the forecasts for the budget item in question as included in the 1994 draft budget and extrapolated for subsequent budgets up to 1998.

7.2 Itemised breakdown (as % of total cost of operation)*

	94	95	96	97	98
- Minimizing the spread of the virus (including via the health system)	55	55	50	45	45
- Support for health system (care and financing)	12	12	15	17	17
- Social and economic impact	6	6	6	8	8
- Scientific training	8	8	8	8	8
- Other**	9	9	9	12	12
- Part B running costs	10	10	10	10	10

* Budget and EDF resources combined.

** Including technical assistance of limited duration for monitoring and evaluation.

7.3 Provisional schedule for commitment appropriations (ECU million)*/**

Budget item	1994 draft budget	1995	1996	1997	1998	5-year total
B7-5046	12.5	12.0	13.0	15.0	17.0	69.0

First reading by Parliament. The budget procedure has still to be finalized.

8. FRAUD PREVENTION MEASURES

Every operation is managed and supervised in order to prevent fraud wherever possible. Technical and financial reports are organized at regular intervals together with monitoring and evaluation missions. Internal and external evaluations have so far been satisfactory.

9. ELEMENTS OF COST-EFFECTIVENESS ANALYSIS

9.1.A Specific and quantifiable objectives

- Minimize the spread of the epidemic among the population as a whole and target groups in particular.
- Help the health system tackle the epidemic.
- Assess the social and economic impact of the epidemic and help service providers and communities deal with it.
- Improve scientific training in AIDS and priority projects.

9.1.B Target population

The entire population of the developing world along with the target groups of specific operations. Partners will include AIDS committees, governments, the United Nations, the private sector and NGOs.

* NB: EDF resources are set out in Annex 5 to the communication.

** The explosion of the epidemic probably calls for a review of the Community's effort.

9.1.C Indicators

- The preparation and evaluation on a project-by-project basis of specific direct and indirect indicators enabling the impact of Community action to be quantified.

- Community action will take place in synergy with public health, education and general development operations at international, national or local level.

9.2 Grounds for the operation

The AIDS epidemic is recognized as a priority area for public health and general development in the developing world.

In view of the scale of the problem and the resources needed, worldwide mobilization and intensive coordination are required. The Community approach permits coordination and action all over the developing world.

9.3 Monitoring and evaluation of the operation

- Monitoring and evaluation indicators are laid down for each operation.

- Specific impact studies will also be conducted.

- Cost-effectiveness will be a priority throughout the operation.

- Results and information will be published at regular intervals.

- Management procedures and methods will be systematically evaluated.

- Intermediate and final reports will be prepared for each operation.

The operation will be monitored at regular intervals and an evaluation is planned before the five years are out.

9.4 Coherence with financial programming

The operation is incorporated in the Commission's financial programming for the relevant years and the EDF's forecasts (regional and indicative programmes).

MINIMAL FINANCIAL RESOURCES ESTIMATED FOR 1994 - 1998 FOR ALL DEVELOPING COUNTRIES

Lome IV	Allocated
- Regional	20 MECU
- NIP	30 MECU
- Counterpart funds of structural adjustment (1)	
Budget lines	
- AIDSline	± 69 MECU (2)

(1) Ressources allocated for budgetary support to the health sector in the framework of structural adjustment programmes. This represents a concrete contribution to AIDS activities implemented through the strengthening of the public health system.

(2) This is an extrapolation on the basis of 12 MECU allocated in the budget for 1994.

BUDGET ESTIMATE FOR PAYMENTS (IN % OF COMMITMENTS)

Commitment	'94	'95	'96	'97	'98	'99	2000
1992	20						
1993	30	20					
1994	50	30	20				
1995		50	30	20			
1996			50	30	20		
1997				50	30	20	
1998					50	30	20

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