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IMPLEMENTING THE DECLARATION OF COMMITMENT OF HIV/AIDS

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Implementing the Declaration of Commitment on HIV/AIDS

"Politics, policies and partnerships"

As part of the overall follow up process to the UN General Assembly Special Session on HIV/AIDS, a series of regional consultations is being organized to highlight lessons learned thus far, with the aim of considering these issues at an informal high level panel discussion during the 58th General Assembly later this year. This paper seeks to help frame the debate by focusing the discussions on 3 broad areas: (a) the engagement of civil society, especially people living with HIV/AIDS, religious leaders and the private sector; (b) agriculture and food security; and (c) uniformed services, security and stability

Overview

During the last two decades, the HIV/AIDS epidemic has progressed from a serious public health threat to the most serious developmental challenge of our time. In the worst affected regions, the epidemic threatens the survival of entire communities and the stability and future prosperity of whole nations. The current UNAIDS/WHO global estimates exceed even the most gloomy predictions of just a few years ago (Fig 1).

Figure 1

GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC
DECEMBER 2002

Number of people living with HIV/AIDS Total	**42 million**	
	Adults	38.6 million
	Women	*19.2 million*
	Children under 15 years	3.2 million
People newly infected with HIV in 2002 Total	**5 million**	
	Adults	4.2 million
	Women	*2 million*
	Children under 15 years	800 000
AIDS deaths in 2002	**Total**	**3.1 million**
	Adults	2.5 million
	Women	*1.2 million*
	Children under 15 years	610 000

To date an estimated 60 million people have been infected with HIV and over 20 million have died. Even though there are discernible regional differences in the dynamics and severity of the epidemic (figure 2), every region is affected, as is every country in each of these regions. Just as there appears to be no natural cultural, religious, ethnic or national barrier to the pandemic, there is also no natural ceiling to the levels that it may reach nor to the devastation it may wreak. Even as the epidemic continues to ravage sub Saharan Africa, we witness its relentless progress in other parts of the world, most notably Eastern Europe and the populous areas of Asia, where significant economic and social changes are giving rise to conditions and trends that favour the rapid spread of HIV; wide social disparities, limited access to basic services and increased migration.

Figure 2

REGIONAL HIV/AIDS STATISTICS AND FEATURES, END OF 2002

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate (*)	% of HIV-positive adults who are women	Main mode(s) of transmission (#) for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s early '80s	29.4 million	3.5 million	8.8%	58%	Hetero
North Africa & Middle East	late '80s	550 000	83 000	0.3%	55%	Hetero, IDU
South & South-East Asia	late '80s	6.0 million	700 000	0.6%	36%	Hetero, IDU
East Asia & Pacific	late '80s	1.2 million	270 000	0.1%	24%	IDU, hetero, MSM
Latin America	late '70s early '80s	1.5 million	150 000	0.6%	30%	MSM, IDU, hetero
Caribbean	late '70s early '80s	440 000	60 000	2.4%	50%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	1.2 million	250 000	0.6%	27%	IDU
Western Europe	late '70s early '80s	570 000	30 000	0.3%	25%	MSM, IDU
North America	late '70s early '80s	980 000	45 000	0.6%	20%	MSM, IDU, hetero
Australia & New Zealand	late '70s early '80s	15 000	500	0.1%	7%	MSM
TOTAL		**42 million**	**5 million**	**1.2%**	**50%**	

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2002, using 2002 population numbers.

Hetero (heterosexual transmission), IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men).

Current projections suggest that an additional 45 million people will become infected with HIV in 126 low- and middle-income countries (currently with concentrated or generalized epidemics) between 2002 and 2010— unless the world succeeds in mounting a drastically expanded, global prevention effort. More than 40% of those infections would occur in Asia and the Pacific (currently accounts for about 20% of new annual infections).

But these outcomes are not inevitable. Indeed, every goal and target in the Declaration of Commitment on HIV/AIDS is premised on our ability -- and collective resolve -- to limit the future spread and impact of the HIV/AIDS epidemic.

Prevention remains the key strategy in the fight against HIV/AIDS To be truly effective, these efforts must be tailored for specific sectors and groups and be supported by a wide range of players. This will require the involvement of multiple sectors beyond health and multiple players beyond just governments. This broader engagement - the multisectoral response - becomes all the more imperative when one considers the equally urgent and mutually reinforcing actions that must accompany prevention, namely providing treatment, care and support for those infected and affected by HIV/AIDS, mitigating the social and economic impact and reducing the vulnerability of individuals and communities to the epidemic.

Recent events in Southern Africa have exposed the linkages between HIV/AIDS and food security and recent reports have highlighted the interplay between HIV/AIDS and security, reinforcing arguments for the broadening of national responses beyond the traditional areas of health, education and social welfare where most current efforts appear to be focused. It is clear that success will only be achieved when the response matches the epidemic in both its complexity and scale, which makes achieving effective multisectoral action both essential and urgent.

But mounting an effective multisectoral response is neither simple nor easy. To some extent, these difficulties were anticipated in the Declaration of Commitment which prescribes a process whereby a range of policies would be enacted by 2003, in order to develop or expand the programmes necessary to achieve the impact targets set for 2005 and 2010.[1] While such policies appear to exist in most countries, their state of implementation is less than satisfactory. For example, half of the national submissions to the 2002 report of the Secretary-General, cited difficulties in mobilizing and co-ordinating a wide range of players, most often because these players lack the experience of working together, as well as the natural inclination to do so. Considering the implications that this is likely to have on the attainment of the longer term goals, an urgent exploration of factors essential to the achievement of an effective multisectoral response would appear to be warranted.

Key issues

The engagement of civil society

[1] By 2005, reduce the HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25% and by 25 per cent globally, by 2010. By 2005, reduce the proportion of infants born to HIV infected mothers by 20% and by 50% by 2010.

Actions in and by communities have featured prominently in every success recorded against the epidemic thus far. These range from the achievements of the gay community in the early days of the epidemic, to the steadily increasing efforts of organizations representing people living with HIV/AIDS. As evidence linking HIV/AIDS to deeper developmental and societal issues has mounted, the benefits accruing from the engagement of much wider cast of players, including those representing youth, women, organized labour, business and religious leaders, has also become evident. While their engagement has brought new energy and diversity, this convergence of interests has also exposed the deeper structural problems that exist in many societies, a development that has at times accentuated the tension that shapes all NGO - government interactions. This paper will focus on three key groups whose involvement was emphasized in the Declaration of Commitment, people living with HIV/AIDS, the faith-based organizations and the business sector.

This sharpened of focus casts the spotlight on three sets of players whose full engagement is to be crucial for effective national responses. HIV/AIDS related civil society organizations have been persistent and effective in their efforts to get societies and governments to confront difficult issues - sexuality, intravenous drug use, human rights, stigma and discrimination and access to treatment to name just a few, - that are crucial to an effective national response. The particular arguments for engaging **people living with HIV/AIDS** (PLWHA's) more fully, would on the surface appear to be compelling and self evident, given the unique perspective that that they bring. Indeed, this consideration is embodied in the GIPA principle (*Greater Involvement of People with AIDS)* adopted more than a decade ago and endorsed at every major gathering or event since that time. However, people living with HIV/AIDS (PLWA's) remain an under utilized resource in the fight against the epidemic, often as a consequence of societal norms and mores that relegate them to the margins of societies. However in some instances, this may be due to organizations representing people living with HIV/AIDS not deploying HIV positive persons where they could be most visible and effective, for example in positions of leadership.

- What defines an effective NGO - Government relationship and how can this be fostered ?
- What constitutes an enabling national environment that could encourage the emergence and strengthening of civil society organizations active in the area of HIV/AIDS ?
- How may the skills and knowledge that they represent be better utilized within the national response. Are there areas where they are better or less suited to act ? What is required to make GIPA a reality ?
- To whom are civil society organizations accountable ? How does this relate to the responsibilities that member states have under the Declaration of Commitment ?
- What is the role of outside partners and in particular, of the UN ?

Faith based organizations represent the backbone of many communities and often deliver a range of services that respond to the material and spiritual needs of the communities where they are active. The demands for both health services and counselling have increased exponentially as the epidemic has progressed. Many programmes are swamped by the needs of the sick and the dying, as well as those of the young and the old that are left behind. Those programmes are often run by special segments of faith-based organisations and do not necessarily involve the leaders. With some exceptions, religious leaders have been slow to answer the calls for action, activities and advocacy in the field of HIV. There is a need for them to answer to the pandemic and to form coalitions at the national level. Religious leaders can be forceful advocates for the

eradication of stigma; indeed the Ecumenical Alliance states that "stigma and discrimination is a sin and against the will of God." Religious leaders, with their excellent contacts in many governments, need to take on their natural advocacy role. These local actions can only be sustained if there is support and validation at a higher level, aimed at integrating such activities into the core business of these institutions. And this is occurring across religions, faiths and cultures, as reality spurs institutional and attitudinal change, and protecting lives becomes as important as saving souls. Yet there are still parts of the world where the faith based approach to HIV/AIDS, continues to be marked by dogma and discrimination, and where the pursuit of the perfect often drowns out the consideration of what is proven or possible. This leads to the alienation of the HIV positive persons seeking hope in religion and limits the opportunities to work with them even though they represent a precious resource in the fight against HIV/AIDS. And this leads to a third level of possible actions for religious leaders; they need to work on reconciliation, in individuals, between individuals, in communities and between communities, as well as between religious HIV positive people and their religious communities.

- To what extent are faith based organizations involved in the national response ?
- What does it take to get faith based organizations engaged ? How can the leaders be recruited to fight against HIV/AIDS
- Are there areas where they are particularly effective or less effective ?
- Are there particular approaches that have proved successful in breaking down resistance to comprehensive strategies such as A, B, C.

The engagement of the **business sector** is no less important, but the path to successful partnerships has sometimes been complicated by differing perspectives and conflicting value systems. After all, businesses exist to make profits, they survive by being competitive. This tends to be less of a problem once the actual or potential impact of HIV/AIDS on the workforce, productivity and costs is appreciated, particularly in those sectors at greatest risk such as the transportation or tourism industries, or those reliant on migrant workers e.g., commercial farming, mining, construction or the oil industry. Once alerted to these linkages, companies have usually responded, be it through compassion, enlightened self interest, the persuasive power of voluntary codes of conduct or the dictates of legislation.

Whatever the motivation, once engaged business has proven to be a model partner. At the global level, 105 large companies have now joined the Global Business Coalition on HIV/AIDS to concretely address the issues in the workplace and inspire others to follow suit. National business organizations and their members are increasingly becoming an integral part of the national HIV/AIDS response, providing resources and expertise in an effort to extend the reach of services into communities. But some companies have gone much further. In locations as diverse as Côte d' Ivoire, Rwanda, South Africa and India, companies have made efforts to protect their fragile skills base by bolstering in house prevention programmes with treatment programmes that for the first time, include the option of anti-retroviral drugs. This option exists thanks to a complex interplay of factors and players - international trade politics, local and global international activism, generic competition, voluntary discounting by the multinational pharmaceutical industry and the brokering role played by the UN in each of these areas.

As a strong force that is part of and able to influence societies within which they are located, business organizations have certain obligations to their workforce and their customers. Exactly what these obligations may be is usually a matter for discussion between management, workers,

shareholders and at times, government. Yet too many businesses still stand on the sidelines, seeing HIV/AIDS as an issue to be dealt with by governments or NGOs alone. This attitude is sadly also reflected in their human resource planning, which is often discriminatory such as - pre-employment testing or defeatist - where multiple individuals are hired for a single position, in the hope that at least one will survive.

- What is the current engagement of business in the national response ?
- How can the business sector be persuaded to become more involved at the local level ? Are there sound business reasons for doing so ?
- Does the business sector have any particular obligations to the societies within which they are located ?
- What support do they need as their engagement increases and who is best positioned to provide this ?

Thus far this paper has primarily focused on who should be enlisted into the fight against HIV/AIDS, but as recent developments have shown, it is also important where efforts are channelled.

Agriculture, food security and HIV/AIDS

Though AIDS is primarily perceived and dealt with only as an 'urban' issue, a very large number of people living with HIV/AIDS and those affected by it, are in the rural areas of developing countries. Both AIDS and poverty are rampant in rural areas and constitute a key challenge to these economies. The agricultural sector is disproportionately impacted by HIV/AIDS as it is highly labour intensive and has large numbers of mobile or migratory workers. AIDS has killed more than seven million agricultural workers in 25 countries of Africa since 1985 and could kill an additional 16 million (up to 26% of the agricultural labour force) in sub-Saharan Africa by 2020. In many areas, farm household labour is not as abundant and unskilled labour is not as easily replaced, as many assume. The negative effect of HIV/AIDS on this sector impoverishes communities, erodes their capacity through losses in human resources, and disrupts their operations by severing key linkages in the production chain.

The current food crisis in Southern Africa confirms what many have suspected - that AIDS has the ability to make a bad situation – widespread crop failure due to erratic rains and inadequate government policies – much worse. HIV/AIDS represents a massive and often irreversible shock for poor households, stripping away traditional coping mechanisms. As impoverished families try to cope with sickness and death caused by HIV and AIDS, they become incrementally poorer after reducing their meagre assets, sometimes to a crisis point that threatens to dissolve the household unit. Faced with reduced income, fewer people to work and an unrelenting need for food and medicine, household members may be forced to adopt potentially lethal survival strategies such as prostitution.

With three quarters of the world's poor living in rural areas and rapidly rising infections rates in most regions, the current situation in Southern Africa offers a frightening glimpse at what the future may hold for agrarian societies the world over.

HIV/AIDS, security and stability

Uniformed services, including defence and civil defence forces, are a highly vulnerable group to sexually transmitted infections (STIs) mainly due to their work environment, mobility, age and other facilitating factors that expose them to higher risk of HIV infection. Simultaneously, uniformed services also offer a unique opportunity for HIV awareness and training with a large 'captive audience' in a disciplined and highly organized setting.

Among male population groups studied, military and police generally report higher levels of HIV/AIDS infection than the national average in many countries. Military personnel, in particular, are a population group at special risk of exposure to STIs, including HIV/AIDS. In peacetime, STI rates among armed forces are generally 2 to 5 times higher than in civilian populations; in times of conflict the difference can be much higher. Personnel posted abroad are among those most at risk of STI/HIV infection and/or transmission. The practice among uniformed services of posting personnel far from their communities or families for long periods of time, is a significant risk factor that increases the chances of HIV infection. These risks increase dramatically when personnel are sent abroad on peacekeeping missions since they often have more financial resources than local people and usually feel less constrained by the values that they would usually observe at home. The fact that local sex industries flourish around military bases supports these assertions.

In regions where HIV/AIDS has reached epidemic proportions, it threatens to destroy the very fabric of what constitutes a state, including institutions that guarantee safety and personal security as well as those that educate and impart social skills to the younger generation. While such cataclysmic collapse has yet to occur, effects are being felt in many heavily affected countries. The future will look bleak for many fragile democracies if, as a consequence of HIV/AIDS they are forced to contend with large segments of their populations that are young, idle poorly socialized and uneducated, unemployed and unemployable.

The conditions conducive to the rapid spread of HIV/AIDS - rapid economic change, wide social disparities, limited access to basic services and increased migration - exist the world over, including in several large countries - Russia, China, India, Indonesia and Nigeria. While there is often not total unanimity on national HIV estimates, much less on future projections, there can be no doubt regarding the upward trajectory of the epidemic in these and other countries and the potential global implications thereof.

- Have impact assessments been undertaken in these areas ?
- Does the national HIV/AIDS strategic plan include strategies for these sectors ? What is their current state of implementation ?
- Is HIV/AIDS integrated into rural development plans where these exist ?

Conclusions

The preceding sections have attempted to capture the key arguments for broadening the national response to HIV/AIDS, both in terms of the players involved and the sectors engaged. It is by design limited in scope as it will be enriched by the series of consultations now taking place. This paper aims to: stimulate a discussion which taps into the experience of the participants in these consultations; and lead to the identification of key factors that will energise national responses and facilitate full and timely implementation of the Declaration of Commitment.