

HIV/AIDS INFECTION AND NATIONAL AND INTERNATIONAL POLICIES

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I. INTRODUCTION.

The first cases of AIDS were announced back in the early 1980s in the United States of America, Europe and Africa.¹ Society and policy makers first considered AIDS to be a medical curiosity. Very quickly it became a major medical, public health and socioeconomic problem.

The policies advocated over these past 20 years reflect trends in terms of knowledge about the disease and the perception of its effect on people, their families and communities.

The policies devised cover basic and applied research, prevention of the disease, medical care for infected persons and the protection of infected and affected persons, and community, national and international mobilization efforts.

II. HIV/AIDS RESEARCH POLICIES

Several objectives were set for research either in successively or concomitantly. They entailed learning about the disease, its **modes of transmission**, its clinical profile and its causal agent, the diagnostic means and the means required for its treatment and prevention.

In the early years (1981-1983), researchers were especially concerned to identify the disease's modes of contamination to determine their cause. On the one hand, major epidemiological surveys were conducted to that end, mainly in the United States. These studies succeeded in quickly revealing that the disease was transmitted through blood and sexually.^{2, 3} The importance of HIV transmission from mother to child was only revealed much later, towards the end of the 1980s.⁴ This delay was due to the fact that HIV primarily affected males in the Northern countries, where most of these studies were conducted. There were too few groups of HIV-positive pregnant women.

In terms of **identifying the causal agent**, several teams worked together on this subject starting in 1981. Two years later, two teams - one French, headed by Prof. Montanger, and the other American, headed by Prof. Gallo⁵ isolated the same viral agent almost simultaneously; they named it the Acquired Immune Deficiency Syndrome (AIDS), a retroviral type virus.

Once the virus was isolated, research directed its efforts towards perfecting **diagnostic tools** for HIV infection. In 1985, the first HIV diagnostic and screening tests were put on the market.⁶

¹ CDC. Update on Acquired Immune Deficiency Syndrome (AIDS) – United States. MMWR, 1982, 31, 507-514.

² Kingsley, L.A. et al. Risk Factors for Seroconversion to Human Immunodeficiency Virus Among Male Homosexuals. Lancet, 1987, i, 345-448.

³ Guinan, M.E., Epidemiology of AIDS in Women in the United States, 1981 Through 1986. JAMA, 1987, 257, 2039-2042.

⁴ Lapage, P. et al. Postnatal Transmission of HIV from Mother to Child. Lancet, 1987, i, 400.

⁵ Gallo, R.C. et al. Frequent Detection and Isolation of Cytopathic Retroviruses (HTLV-III) from Patients with AIDS and at Risk for AIDS. Science, 1984, 224, 500-503.

⁶ McDougal, J.S. et al. Immunoassay for the Detection and Quantitation of Infectious Human Retrovirus, Lymphadenopathy Associated Virus (LAV), J. Immunol, Methods, 1985, 76, 171-183.

During this period, several studies were also conducted on **antiretroviral treatment research**. In 1986, the first antiretroviral product, azidotymidine (AZT), was used and shown to be effective in controlling the disease among humans.⁷ Since then, research has continued and intensified. By 2001, it had resulted in more than fifteen antiretroviral products being available on the market.

The other focus of research that was developed and continues to be so is the perfection of **treatments and protocols for the treatment of opportunist infections, cancers and other illnesses related to HIV**. This research has had important beneficial effects for patients.

Finally, for more than a dozen years, research has sought an **anti-HIV vaccine**. The findings of such vaccine research have not been very promising to date, however.

III. POLICIES REGARDING PREVENTION OF THE DISEASE

These policies were developed differently in the Northern countries compared to Africa. In the North, policies have focused on blood transfusion safety, on promoting the use of single-use injection material and condoms, on the reduction of sexual behavior at risk for HIV and on the reduction of HIV transmission from mother to child.

3.1. Prevention Policies in European and North American Countries

The HIV epidemic in Northern countries has affected the gay community and drug addicts enormously. When it first emerged, more than 95% of its victims were men. By 2001, 80 to 85% of the people affected were men, which still bears out this preponderance of the gay and drug-addicted population.⁸

a. Policies for Reducing the Sexual Transmission of HIV/AIDS

- **In the gay population**, prevention policies have concentrated on promoting the use of **condoms**. A stigma was immediately attached to the disease: it was thought to attack only gays and drug addicts. As a result, people who contracted AIDS were excluded from society. Very quickly and from the very onset of the epidemic outbreak, the gay population adopted its own preventive measures in its community. In this case, we can say that the gay community's awareness raising activities and commitment guided the setting of national prevention policies advocating the use of condoms in sexual relations at risk for HIV. There were spectacular results, with a reduction in the occurrence of AIDS in this community in the latter half of the 1980s. By 1987 in France, 75% of homosexuals no longer engaged in activities at high risk for HIV.⁹ Precautions were disseminated very rapidly in that community. During that same period, AIDS still did not have any influence on the sexual behavior of drug addicts and heterosexuals.¹⁰ Only 9% of the heterosexual population used condoms (4% as a contraceptive method and 5% to protect themselves against HIV).

- **Prevention policies for drug addicts** were set much more slowly, due in part to the low awareness levels of the community concerned and secondly because of negative judgments about them. This type of prevention policy has focused on the use of single-use needles by drug addicts taking drugs intravenously, but also on

⁷ Yarchoan, R. et al. Administration of 3' -Azido-3' -Deoxythymidine, An Inhibitor of HTLV-III/LAV Replication, to Patients with AIDS or AIDS-related Complex. *Lancet*, 1986, i, 575-580.

⁸ ONUSIDA, Rapport sur l'épidémie mondiale du VIH/SIDA, Décembre 2001.

⁹ Enquête ADRESSE-GPH, 1987.

¹⁰ Moati et al. Social Perception of AIDS in the General Public. A French Study, *Health Policy*.

promoting the use of condoms. The results were also obtained much more slowly and even now, drug addicts continue to contaminate themselves by sharing needles; the level of HIV transmission by heterosexuals is also high in this community.

- **At the general population level**, it has taken much longer to set prevention policies, because AIDS was long thought to be a problem only for high-risk groups - in other words for gays and drug addicts.

b. Reduction Policies for the HIV Transmission Through the Blood.

- **Among the blood transfusion centers**, blood transfusion policies were elaborated as early as 1985, after blood screening began to be applied. They established the systematic screening of blood and blood products. This policy resulted in a drastic reduction in HIV transmitted by blood and its derivatives. In addition, the techniques for preparing blood by-products employed since late 1985 and based on HIV thermosensitivity inactivate the virus. The population of hemophiliacs, who were heavily contaminated before this period - up to 70% in 1985,^{11, 12} has benefited the most from these policies.

- **In all care structures**, the policy advocating single-use injection material was immediately promoted and applied across the board, as were universal protective measures in health care environments.

c. Prevention Policies for Mother-to-Child Transmission of HIV

The risk of mother-to-child transmission of HIV was neglected for years even though the first cases were described as early as 1983 in the United States. The fact that this involved addicted mothers on the edge of society was certainly instrumental in this delay. It was only towards the end of the 1980s that repeated alerts were finally taken into account. The community then realized how drastic the situation was, with more than 25% of cases at risk for mother-to-child transmission of HIV. Before therapeutic schemes were perfected making it possible to reduce such transmission, issues focused on the appropriateness of screening pregnant women, of HIV-positive women becoming pregnant, of obliging families to manage situations with HIV-positive women who risked HIV transmission by more than 25% if they became pregnant, with the related issue of whether a pregnancy should be aborted therapeutically or not, and finally, the issue of whether serologically incompatible couples should have children.

With the development of the clinical trials (ACTG 076)¹³ proving the effectiveness of AZT in reducing mother-to-child transmission, policies generalizing treatments for the reduction of mother-to-child transmission of HIV were applied. These results were substantiated by a study conducted in Thailand using a shorter therapeutic scheme. Today, this policy is widely followed in Northern countries. In France, for example, HIV blood screening is proposed for 90% of pregnant women; it is accepted by 99% of women who want to be pregnant, and 90% of women infected by AIDS accept preventive antiretroviral treatment. Currently, the estimated transmission rate is less than 1%.

¹¹ Allan, J.P. Prevalence of HTLVIII/LAV Antibodies in Patients with Hemophilia and in Their Sexual Partners in France.

¹² CDC, Human Immunodeficiency Virus Infection in the United States; A Review of Current Knowledge. Morbid Mortal Weekly Rep, 1987, 36 (S6), 1-45

¹³ Connor, E.M. et al. Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type with Zidovudine Treatment. N. Engl J. Med., 1994, 331, 1175-1180.

Generally speaking, in Northern countries today, HIV prevention activities seem to be losing momentum. For the year 2001, there were an estimated 30,000 new cases of adults and children who contracted HIV in West Europe and approximately 45,000 in North America.¹⁴ This regression is partly explained by the lower awareness level of young gay men who have rarely seen a peer die, unlike their elders; secondly, by the absence of infection control in the drug addicted population; and finally, by poor efforts to raise awareness in the public at large. It is worth noting, however, that most of the new infections are found in the drug addict population. Nonetheless, it has been demonstrated that prevention campaigns in that community involving education about AIDS, the promotion of condom use, encouragement not to share needles and drug addiction treatment are effective. It is now necessary to reinforce countries' political will to apply truly effective measures that properly target at-risk groups.

3.2. Prevention Policies in Countries of Sub Saharan Africa

In Sub Saharan Africa, the most common mode of contamination is through heterosexual sex. This explains the male/female sex ratio, which is almost 1/1. In 2001, women made up 55% of the total HIV-positive population. In most countries in this zone, preventive actions were initiated long after the epidemic began. The first actions undertaken were to control blood transfusion safety.

a. Reduction Policies for Blood-Transmitted HIV

Most **blood transfusion centers** began to ensure systematic screening for HIV in 1986. This safety measure has gradually been reinforced by the application of other complementary strategies aimed at the maximum reduction of HIV contamination risk. They involve taking blood samples and selecting donors, setting qualifying standards for blood donations, which are determined by selecting donors through a highly detailed questionnaire along with a biological screening of the principal agents causing sexually transmissible diseases and of diseases carried through transfusion (syphilis, hepatitis B and C virus, etc.), and the meticulous preparation of products while eliminating the risk of bacterial contamination. Currently, wherever blood transfusion centers exist, blood transfusion security is relatively good. In most regions of Africa, however, there is still an enormous need to create and strengthen efficient blood transfusion services responding to national needs for blood transfusions and blood products.

b. Reduction Policies for Sexual Transmission of HIV

There is little available data on homosexual transmission of HIV/AIDS in Sub Saharan Africa. This mode of transmission certainly exists, but to a lesser degree compared to heterosexual transmission. **In the general heterosexual population,** the general prevention policy retained has been to reduce the risk of sexual transmission of HIV. Several strategies have been defined: mass information campaigns about AIDS, campaigns targeted more towards certain higher-risk populations (prostitutes, long-distance truck drivers, uniformed personnel, youths, etc.), treatment of other sexually transmitted infections and the promotion of condom use.

This prevention policy has had very mixed results, considering that the HIV+ prevalence rate has continued to rise significantly. In 2001, it was at 8% for the adult population while the incidence was 1% for the same population and there were 3.5 million new infections during the same year.¹⁵

Nonetheless, there were encouraging results in some countries heavily struck by AIDS, such as Uganda. Such results were the fruit of a national, wide-sweeping

¹⁴ UNAIDS, Report on the HIV/AIDS Epidemic, December 2001.

¹⁵ UNAIDS, Report on the HIV/AIDS Epidemic, December 2001.

mobilization plan involving the highest authorities in the country, among others, and covering the entire territory. In Uganda, HIV infections among pregnant women in urban zones dropped from 29.5% in 1992 to 11.25% in 2000. The utilization of condoms during occasional sex also increased. In the District of Masindi it increased from 42% in 1997 to 51% in 2000; in Pallisa District, it increased from 31% to 53% for the same periods. In Kampala, 98% of men used condoms during occasional sex in 2000.¹⁶

Unfortunately, these excellent results are not shared in most African countries, for the policies applied in them are not as voluntarist in spirit. Furthermore, a combination of other reasons explain why results are still found lacking:

- The massive AIDS information campaigns, which use the radio, television, pamphlets and posters as their tools, fail to reach most of the population, which lacks access to these resources for economic and educational reasons. As an example, in Burundi, only 31.6% of the population possesses or listens regularly to the radio; 4.2% of Burundis watch television regularly; 2.9% read newspapers regularly and 60.8% can read and write.¹⁷
- The population's low educational level limits their access to the various potentially useful communication channels.
- Poverty fosters promiscuity and prostitution and also limits the fear of AIDS in populations, where everyday risks of disease and death linked to other causes such as war and hunger are high. This aspect is frequently cited as a major obstacle to prevention.
- The frequency of other sexually transmissible infections propagates HIV infection.

Current AIDS prevention policies in Africa direct efforts along 4 main focal points:

- Information and training by peers in order to successfully pass on knowledge about behavioral changes extended to all categories of the population;
- Strong involvement by the community implicating the highest authorities in every country;
- Reinforced training for the population;
- Linking AIDS control with poverty reduction efforts.

c. Policies in the Reduction of Mother-to-Child Transmission of AIDS.

Mother-to-child transmission of HIV is most prevalent in Africa. Out of 2.7 million children living with HIV/AIDS in the world in 2001, the majority lives in Africa.¹⁸

There are still several obstacles to overcome in implementing a policy for the reduction of mother-to-child transmission in Africa:

- Lack of political conviction in some countries, like that observed in South Africa;
- Little HIV screening for pregnant women: just 11% in Malawi¹⁹ and 14.2% in Burundi;²⁰
- Most women who are tested never come back for the results;
- Finally, among those who are told they are HIV-positive and for whom treatment is indicated, few follow the treatment. In Côte d'Ivoire, less than 50% follow treatment to reduce HIV transmission.²¹

¹⁶ UNAIDS, Report on the HIV/AIDS Epidemic, December 2000.

¹⁷ Enquête nationale socio comportementale sur l'infection par le VIH/SIDA au Burundi, 2001.

¹⁸ UNAIDS, Report on the HIV/AIDS Epidemic, December 2001

¹⁹ ONUSIDA, Le point sur l'épidémie de SIDA, 2001

²⁰ Enquête socio comportementale sur l'infection par le VIH/Sida au Burundi, 2001.

In Africa, policies to prevent HIV transmission from mother to child are still not very efficient. Paradoxically, this could be one of the most viable kinds of prevention and easily carried out if certain conditions were in place: a strong political commitment, reinforcement of counseling and of prenatal monitoring programs among pregnant women...

IV. Medical Coverage Policies.

Medical coverage policies hinge upon 3 points: 1) coverage of opportunist infections and other ailments related to AIDS; 2) antiretroviral treatment; and 3) psycho-social care for people infected and affected by HIV. These policies have varied and been applied at different times in the Northern countries and in Africa.

4.1. Coverage Policies for Patients Infected by HIV in Northern Countries

a. Coverage of opportunist infections (IO) and other ailments related to HIV.

Ever since the epidemic began, coverage of OIs and the other ailments linked to HIV has been provided and constantly improved. New molecules were discovered and new therapeutic schemes were designed to improve the treatment of bacterial, parasitic, fungal and viral infections related to HIV. This coverage before and outside of ARVs, had demonstrated its beneficial effect for patients in terms of reducing morbidity, prolonging life and improving their quality of life. On the other hand, treatment for cancers linked to AIDS, despite some results obtained with certain forms, has not yielded decisive results.

In most Northern countries today, coverage for OIs and other ailments linked to AIDS is considered to be very good and provided for the majority of infected patients.

b. Antiretroviral Treatment Among Patients Infected by HIV

The first antiretroviral products were put on the market as early as 1986. The policy immediately adopted allowed access to treatments for everyone, whatever the cost. Consequently, all patients for whom therapy was recommended received ARV treatment and this has continued until today. Accompanying measures led to better compliance and therapeutic tolerance of this medicine.

The findings of the first therapeutic schemes (mono or double therapy until 1995) raised much hope. Clinicians very quickly realized the limits of these treatments in terms of efficacy and tolerance. The introduction of triple therapy treatment in 1996, with the policy to grant wider access to this multiple therapy, induced a fundamental modification in the prognoses about the infection, considerably prolonging patient's lives, reducing the frequency of pathological events linked to HIV, granting people a quality of life comparable to that of uninfected individuals and reducing the related death rate.

These positive results explain the paradoxical increase in the rate of HIV-positive infections in Northern countries. In 2001, HIV+ prevalence was at 0.3% in Western Europe and 0.6% in North America. These figures can be explained on the one hand by an important reduction in mortality and on the other hand by the persistence of new infections.

4.2. COVERAGE POLICIES FOR AIDS PATIENTS IN AFRICA

a. Coverage of Opportunist Infections and other Ailments Linked to HIV

Specific coverage of OIs in Africa has long remained underdeveloped. It was integrated into basic health care services, which as we know are poorly dispensed

²¹ ONUSIDA, Le point sur l'épidémie de SIDA, 2001

in Africa. From the time national AIDS control programs were set up beginning in 1987, emphasis was placed instead on prevention and very little on coverage. However, one particular aspect of this coverage immediately caught the attention of health authorities - tuberculosis. In fact, tuberculosis constitutes one of the major health risks linked to HIV to the extent that HIV+ patients are at very high risk for contracting tuberculosis and exposing people not infected by AIDS to tuberculosis.²² Tuberculosis control programs have been reinforced in most African countries.²³

As for coverage of the other OIs, in most countries in the region, national AIDS control programs only incorporated this component in the early to mid-1990s. However, results obtained to date remain mediocre. For example, it is estimated that just 15% of patients are properly covered for OIs in Burundi.²⁴ This low performance explains a still high mortality, with 3.5 million deaths in 2001 and a survival span that is still short for AIDS patients in Africa.

b. Antiretroviral Treatment in Africa

When antiretroviral medication first appeared, not one African country had a policy permitting widespread access to ARVs, unlike countries in the North. The exorbitant cost of this medication, the poor financial resources of most countries and the high number of patients in need of such treatment explain the absence of such a policy. However, starting in 1997, NGOs, associations of HIV-infected persons, scientific associations, political associations, etc., began to mobilize internationally to obtain access for everyone to all treatments. The results of this mobilization have guided policies now in the making:

- National policies for facilitating access to ARVs through several measures; removing tax on medication, therapeutic solidarity funds, etc.;
- Community participation and mutual aid societies. In that context, various corps and companies set up mutual aid funds by means of special deductions allowing HIV victims to purchase medication, among other things.
- Certain pharmaceutical corporations' policy to lower medical product prices for poor countries;
- Policies to produce lower-cost generic medication.

All of these policies are in the process of modifying access to ARV treatments in Africa. Nonetheless, even if the number of patients receiving such treatment is increasing, the majority of them will not benefit from them soon in Africa, unless enormous efforts are joined to strengthen care structures, to render them more accessible and attractive and unless the price of these ARVs are adjusted to accommodate most people's pocket books.

c. Psychosocial Coverage.

More than anywhere else, AIDS in Africa poses enormous social and economic problems for people affected and infected by HIV.

- The number of children orphaned by AIDS is skyrocketing. At the end of 1999, there were 13.2 million orphaned children, including 12.1 million in Sub Saharan Africa. These orphans, in addition to the poverty caused by the loss of

²² Nunn, P.P. et al. Impact of Human Immunodeficiency Virus on Tuberculosis in Developing Countries; *Thorax*, 1994, 49, 511-518.

²³ Dolin, P.J. et al. Global Tuberculosis Incidence and Mortality During 1990-2000. *Bull World Health Organ* 1994, 72, 213-220.

²⁴ Plan d'action national de lutte contre le VIH/SIDA au Burundi, 2002-2006.

one or both parents, often risk missing out from school and become more vulnerable to HIV infection themselves.

- Difficulties in gaining access to health care for patients infected with AIDS. Their precarious health status and repeated hospitalizations expose HIV victims to losing their jobs. Additionally, the high cost of medical care digs the families living with AIDS deeper into poverty.

Traditionally in Africa, orphaned children were taken in by the extended family. Today, the high number of orphans requiring care, rising urbanization, ever-growing impoverishment, modernism and its individualistic tendencies, are limiting the number of orphans that can be taken care of. And yet, sustainable solutions can only be obtained organized around families. Social structures can only be imagined as transitory while waiting for a child to be placed in a family or a host facility.

V. POLICIES FOR PEOPLE INFECTED AND AFFECTED BY HIV

Thanks to the mobilization efforts of HIV patients and AIDS control associations, AIDS is one disease that has provoked a transformation in care provider/patient relations, moving towards greater “democratization” of medical coverage. HIV patients have fought to be better informed, to be included in decision-making that concerns them, and to ensure better legal protection for themselves. The policies currently advocated in this area aim at better personal and community protection through the universal attainment of human rights and basic freedoms.

VI. NATIONAL AND INTERNATIONAL SOLIDARITY POLICIES

The rallying together in the fight against HIV infection has yielded one of the handsomest examples of national and international solidarity. This solidarity has been demonstrated among affected communities in the collaboration between AIDS control associations in different countries around the world, at the level of health structures implicated in AIDS control, at national levels and among major global organizations.

6.1. At the national level, the example of Burundi. Burundi can be taken here as the example of a country with a high prevalence of AIDS that has not yet won its battle against the HIV/AIDS epidemic. There are many complex reasons behind this lack of satisfying results or failure. They are political, institutional, sociocultural and economic in nature.

a. At the Political Level, Burundi, like many other African countries, was unable to gauge the full extent and impact of HIV/AIDS. From the very beginning of the epidemic, political spheres did not want to know about it or refused to know about it and blocked any initiative concerning it. One is reminded of 1983, when the first publications declaring the existence of AIDS in Burundi were censored. It was only in 1987, 4 years after the first cases appeared, that the existence of the epidemic was taken into account, with the creation of the NACP. Even though the existence of AIDS was admitted, however, it was not really considered a problem meriting national attention until the end of the 1990s, more than 15 years after the epidemic was recognized in the country. This refusal to acknowledge the disease was reflected in the paucity of funds allocated in the national budget for the NACP, which was less than US\$20,000 in 1997. The government finally demonstrated its commitment for the 2001 fiscal year by advocating a national HIV/AIDS control action plan for 2002-2006 and backing it with 233 million US dollars. Unquestionably, these results, if achieved, will foster actions fighting AIDS, which will in turn facilitate AIDS control.

b. At the Institutional Level, the NCAP was created as a department in the Ministry of Public Health, assigned a Department Director with very low visibility and allotted little financial or human resources. This coordinating structure had weak decision-making powers due to its institutional anchoring and lack of managerial autonomy. An illustration: on the organizational chart, NACP answered to the Health Program Directorate, which was under the umbrella of both the General Directorate for Public Health and the Minister's Cabinet. This institutional position had a negative impact due to the absence of any initiatives taken and little advocacy favoring AIDS control. Last year (2001), this structure was modified and given a higher profile. A National AIDS Control Board (*Conseil National de lutte contre le SIDA -CNLS*) was created with an autonomously managed administration attached to the Ministry of State to the Presidency of the Republic in charge of HIV/AIDS control in Burundi. This structure is assigned to coordinate national policy and build up resources. In light of its design, this AIDS control coordinating office could be an independent, functional pole of excellence leading interventions in different sectors of the country.

c. At the Sociocultural Level, the findings of the last socio-behavioral survey²⁵ underscore some of the cultural barriers hindering AIDS control:

- Fear of people infected with HIV, going so far as to propose extreme measures against them that hinder overt actions (29.4% surveyed suggested that HIV victims be should be isolated, while 30.4% wanted them imprisoned);
- Fear of learning one's true blood condition;
- Unfounded negative beliefs about condom use (10.5% surveyed think condoms transmit HIV) and poor press about them (23.2% think they diminish sexual pleasure);
- Sexual practices at high risk for HIV contamination: precocity of sexual relations (16.9% of youths aged 10-14 have already engaged in sex) and the existence of other immediate deadly risks such as hunger, war and the other endemics that relegate one's perception of danger to the back burner. The end result is the acceptance of instant pleasure, even if it bears the risk of transmitting HIV.

d. At the Economic Level, the extreme poverty situation engulfing most of the population can make certain people more vulnerable. Some prostitutes justify the risk they take by their extreme poverty, like one woman from Bujumbura who basically says, "If a client is already in the house, he tells you to return his money if you want to make love using a condom. You think about it; it's night time, you have children who will demand something to eat the next day; you don't have any money. You don't have a choice; you agree." Recently in the refugee camps of Sierra Leone, Liberia and Guinea, we have also seen young girls who suffer sexual abuse on a regular basis in exchange for a few daily necessities for survival.

Based on all the situations described above, it is absolutely essential that poverty reduction be integrated as a priority program in the AIDS control plan.

e. The NGO Response

²⁵ Enquête socio comportementale sur l'infection par le VIH/SIDA

AIDS control has been a major element for mobilizing communities. In fact, many local NGOs were created for that reason. They have basically contributed to HIV prevention. For several years, their focus has been to provide coverage, especially for home care. Nonetheless, their support remains very modest compared to the immensity of needs.

International NGOs, on the other hand, have barely begun to engage in a few actions having very limited impact. Still, we can highlight the vital support given to tuberculosis control by the *Association des Frères Damien*. For many years it has provided financial support to the National Tuberculosis Control Program in Burundi, rendering screening and treatment accessible and free.

f. Response of Bilateral and Multilateral Organizations

Bilateral cooperation agencies have approved some areas of medical coverage, particularly AIDS prevention. The blood transfusion security component is fully covered by the combined support of the Italian Cooperation, the European Community and WHO. WHO and Belgian Cooperation have collaborated on certain STI coverage actions. UNICEF supports prevention actions in the school environment and just brought its support to a pilot program for the prevention of mother-to-child transmission of HIV. UNDP supports local NGOs through home care actions, HIV prevention in care settings and legal protection. The French Cooperation has been involved in some health care actions. Finally, in the framework of WHO and UNAIDS, the NACP has received managerial support from its inception to date.

All of these actions undertaken by the national and international communities and the private sector are still very limited in scope. Indeed, if one can judge by the results obtained from them, it is obvious that the HIV infection rate is steadily rising (11.3% of the adult population in 2001), that only 15% of patients with opportunist infections receive appropriate care, that less than 3% of patients for whom therapy is indicated receive antiretroviral treatment and that less than 10% of orphaned children receive any assistance. Much more serious and better-coordinated actions must be conducted in order to reverse the HIV/AIDS epidemic in Burundi.

6.2. At the International Level

a. **AIDS Control Associations.** In the Northern countries, associations have acquired extensive expertise in getting communities involved. They have participated in research, prevention actions, in the development of treatments and in providing therapeutic support. Their actions have been instrumental in helping public health policies progress towards taking better consideration of the concerns of the sick and towards a better patient-care provider relationship. However, while their actions are important in the North, their contributions are still limited in the South, because they lack sufficient means.

North-South and South-North cooperation between AIDS control associations has facilitated advocacy for AIDS control in Southern countries. In addition to other outcomes, this has meant spectacular results for improved accessibility to care, including for ARV treatment.

b. **At the Country Level and International Organizations Level,** the political response in 1987 was the creation of the GPA/WHO whose task was to guide and coordinate AIDS control using the resources supplied by multilateral funds allocated for that effort. Given the scale of the actions to be taken, the GPA/WHO was converted into the worldwide AIDS program called UNAIDS to allow a coordinated response to this endemic: "It became apparent that a program joining the United Nations Institutions whose expertise and mandates complement each other, was necessary, in light of the urgency and scope of the epidemic, its deep

socioeconomic and cultural roots, the taboos and hypocrisy surrounding the issue of HIV and its modes of transmission, and the discrimination and violations of Human Rights confronting people infected with AIDS and those who are threatened with becoming infected by it."²⁶ During 2000, a major phase was reached in raising awareness about the disease. The United Nations, which had never made any major resolutions regarding public health, met three (3) times to discuss measures to be taken for AIDS control. The resulting resolutions centered around optimizing health and development policies, the reduction of health care costs and increased efforts in new pharmaceutical products research, in addition to other social aspects related to transmissible diseases.²⁷

Here we can see the emergence of well-intentioned discourse on ways to combat HIV/AIDS. Actions undertaken to date at the global level are generally still too inadequate to hope that they can have any sustainable impact in curbing this epidemic. An analysis of some results should help clarify what actions still need to be taken.

One of the most rewarding successes of HIV prevention has occurred in the heterosexual population of developed countries. Several conditions have combined to contribute to this success: a) the very high educational level of this community; b) their material situations allowing them access to all communications channels; and 3) their great involvement in combating AIDS. Uganda is another good example whereby certain conditions have combined to help curb the epidemic in the past few years. The population has had to cope with heavy trauma, for whole villages have been decimated by the disease. All the powers in the country (political, religious, community, etc.) have become heavily involved, and the community is highly mobilized through AIDS control associations, among others. Finally, all this activity is supported by substantial financial means.

The focal points that could be emphasized in AIDS control are simultaneously medical, socioeconomic and educational in nature.

b. **At the Medical Level**, the AIDS pandemic has pulled back the curtain that attempted to hide the sorry state of health care in Southern countries. If OI and ARV coverage never raised debate in the Northern countries, it is because everything was included in a continuity of care assured by the community and for all pathology. In the South, AIDS appeared to remind everyone that many sick people lacked properly adapted care, even for the inexpensive diseases that are come in the scope of OIs for the purpose of this paper. It has since become clear that clinical coverage of AIDS in the South must be integrated into the system and that general care policies must be reinforced. Fortifying health care depends on the existence of physical facilities and the guarantee that they are regularly equipped and supplied, the existence of sufficient human resources and the quality and attractiveness of the services offered. In this context, the treatment issue is at the heart of debate which, beyond economic considerations, must be ethical and humane. While it is logical that pharmaceuticals should make a profit from medical products, those same industries and the international community must find compensating mechanisms that will make these products, particularly the ARVs, accessible to the principal beneficiaries, thereby addressing the concern for ethics, equity and humanity.

c. **At the Educational Level**, epidemiological data showed that young people were the main victims of HIV contamination. Effective campaigns have since been

²⁶ ONUSIDA, 1999

²⁷ Politique de coopération internationale de la France en matière de lutte contre le VIH/SIDA dans les pays en développement, Ministère des Affaires Etrangères, Juin 2001.

devised to reach youths. It is also known that youths attending school are easily accessible geographically and structurally. First of all, AIDS prevention courses can be integrated easily into the training curriculum; secondly, the better educated one is, the easier it is to comprehend and accept messages. Hence, an effective and long-term method of HIV control is one that also reinforces the education and training of youths.

- d. **At the Socioeconomic Level**, it was also stressed that someone struggling to survive daily is little inclined to prevent a disease not known to kill a person as soon as he or she contracts it. Furthermore, a decent life inspires beneficiaries to preserve and protect themselves against any disease that might compromise that lifestyle. This is true for HIV as well as for other disease whose prevention requires sustained measures. Poverty reduction therefore finds prime of place in the fight against HIV/AIDS.

If organized with that in mind, international support of AIDS control in developing countries would avoid the current exodus from the South to the North. This is occurring now for economic reasons (weakening Southern countries even more, to the extent that educated youths are the first to leave), social security concerns (fleeing conflicts of every kind) and health reasons (to gain better access to health care). A recent trend has developed with many HIV patients fleeing to the North for the sole reason of obtaining adequate health care. For reciprocal considerations, AIDS control is becoming a concern shared worldwide that must retain everyone's attention. Adequate means must be given to fight this disease through its principal priority points. The presence of the HIV virus in a community is a necessary condition and **not enough to curb its propagation**. Only effective controls of all the factors facilitating the epidemic will check the spread of AIDS around the world.

Conclusions

The AIDS pandemic was declared less than twenty years ago. When the epidemic first emerged, several governments affected by it refused to accept that it really existed, thereby retarding the start of the process establishing policies to combat this evil. The spread of HIV infection was the consequence of that delay in decision-making. Furthermore, infected persons were excluded and marginalized from society.

Society quickly came to the realization that the AIDS pandemic, beyond the threat it constituted for community health, also had a major negative impact on the economies of nations and their economic and social development. The policies set at the onset of the epidemic focused essentially on prevention and support services for the sick. These policies have gradually evolved towards a global approach, notably incorporating access to treatments, among other benefits. Today, it is becoming increasingly clear that AIDS control must be achieved through a global strengthening of countries' health and educational systems and in conjunction with poverty reduction - in other words, with countries' socioeconomic development.