ICASO
INTERNATIONAL COUNCIL OF
AIDS SERVICE ORGANIZATIONS

COMMUNITY MONITORING AND EVALUATION

IMPLEMENTATION OF THE UNGASS DECLARATION OF COMMITMENT ON HIV/AIDS

International Council of AIDS Service Organizations (ICASO)

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This report is dedicated to the memory of Steve Harvey, a leader and activist who defended the rights of people living with HIV and those most vulnerable to infection, who was murdered in Jamaica in 2005.

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ABBREVIATIONS

ARV	Antiretroviral
CCM	Country Coordinating Mechanism
ICASO	International Council of AIDS Service Organizations
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental Organization
PLHIV	Persons Living with HIV
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing

EXECUTIVE SUMMARY

In 2005, ICASO undertook a research project to evaluate, through independent in-country monitoring, the extent to which governments and the community sector have implemented the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment. More specifically, the project sought to analyze how communities have been involved in implementing the commitments, and whether the government's monitoring mechanisms have been inclusive of their inputs.

The project was carried out in 14 countries – Cameroon, Canada, El Salvador, Honduras, Indonesia, Ireland, Jamaica, Morocco, Nepal, Nigeria, Peru, Romania, Serbia and Montenegro, and South Africa. This document, which has been prepared by ICASO, summarizes the results of the 14-country project and proposes a set of recommendations for governments and the community sector.

A. Major Cross-Cutting Findings

The following is a summary of the major findings of the study:

- Knowledge and use of the Declaration of Commitment by policy makers and the community sector is generally low.
- Participation by the community sector in the development, implementation and monitoring of national strategies remains very limited in many countries, including participation in the periodic review of progress on the implementation of the Declaration of Commitment.
- Political leadership is still lacking in most countries. There are significant gaps between what the politicians promise and what they deliver.
- There is a huge gap between what exists on paper in terms of anti-discrimination policies and what happens in reality. Stigma and discrimination are commonplace, and they constitute the major obstacle to the successful implementation of prevention, care, treatment and support services.
- Most developing country governments are spending a very small proportion of national budgets on HIV/AIDS.
- There is little connection between the legally guaranteed right to health and actual access to health, especially for the most vulnerable groups.[1]

1. The term "most vulnerable" is used to refer to groups of people that are key to the dynamics of and responses to HIV/AIDS. Examples of these include: People living with HIV and/or AIDS, orphans and vulnerable children, women, youth, sex workers, usersinjection drug users, Men who have sex with men, Migrants, refugees and prisoners.

- There are large gaps in the services being provided to vulnerable groups.
- Little is being done to promote the empowerment of women and to eliminate the stigma associated with sex work.
- The illegal status of sex work and of drug use, combined with the high levels of stigma and repressive law enforcement practices, dramatically limit access by sex workers and drug users to basic health and social services.
- While access to antiretrovirals (ARVs) has improved in the last few years in all of the developing countries surveyed, it is still far from what is needed to save millions of lives.

B. Recommendations

Based on the findings of the country reports on what actions need to be taken to ensure that the goals of the Declaration of Commitment are achieved, the following is a list of the key recommendations:

Knowledge and Use of the Declaration of Commitment:

1. **Greater access to information:** Stakeholders at country level, with support from UNAIDS should ensure that the Declaration of Commitment is available in schools and public libraries. Resources should be utilized to translate into easy to understand and action-oriented language the contents of the Declaration. Community sector organizations should develop a coordinated campaign on the national level to build awareness and understanding of the Declaration of Commitment (and other international tools).

2. **Improve monitoring and evaluation (M&E):** M&E systems should be developed taking into consideration the characteristics of the epidemic in the country, and should include indicators to measure stigma and discrimination, access to services by the most vulnerable, gender inequalities, tuberculosis and HIV co-infection (where relevant), and quality of services, particularly voluntary counselling and testing (VCT), prevention tools and messages, treatment and care.

Leadership and Participation of the Community Sector

1. **Universal access commitment:** Governments should commit to universal access to prevention, care and treatment through a strategic plan of action with interim and final numerical targets at the global and national levels and clear assignments of responsibility for governments, multilateral agencies, donors and the community sector.

2. **Finance the response:** Governments should provide adequate financial resources for the timely implementation of their national AIDS strategies and should follow up with regular monitoring and evaluation of the implementation process.

3. **Strengthen community responses:** Governments and other stakeholders should make a significant investment in the community sector by strengthening the capacity of community sector organizations to fulfill their role in the response to HIV/AIDS. National AIDS strategies must strengthen community-level provision of prevention, treatment, care and support, and incorporate these into comprehensive national health human resource plans.

4. **UNAIDS support:** UNAIDS and its cosponsors should play a stronger role in supporting the community sector at the national level. This includes advocating for appropriate involvement within government structures and national bodies, and supporting the involvement of people living with HIV and members of the community sector in evaluating programmes and policies.

5. **Centrally involved:** Governments should ensure that the response to HIV/AIDS is truly multisectoral, and should take action to improve coordination among the stakeholders. Governments should involve the community sector, including, but not limited to, people living with HIV and representatives of vulnerable groups. They should be centrally involved in the planning and design of national AIDS programs, human resource and health sector development plans, program implementation and service delivery, advocacy, monitoring and evaluation and reporting.

6. **Self-selection:** The community sector representatives must be selected through peer-driven, democratic, transparent processes.

7. **Community shadow reporting:** In addition to their involvement in the government-led reporting processes, the community sector should develop shadow reports related to the implementation of the UNGASS Declaration of Commitment. This process will empower them to demand to be involved in government-led monitoring, evaluation and reporting processes. UNAIDS should provide greater support to the community sector in developing monitoring and evaluation frameworks related to the Declaration.

Human Rights and Vulnerable Groups

1. **Address human rights abuses:** Governments and other stakeholders must recognize that a wide range of human rights abuses both fuel the epidemic and follow in its wake, and that addressing these abuses should be an essential part of donor and government responses to HIV/AIDS.

2. **Address stigma and discrimination:** Governments and other stakeholders should address stigma and discrimination far more aggressively than they have to date. Stigma and discrimination are the major obstacles to achieving universal access to prevention, care, treatment and support services.

3. **Increase understanding of rights:** Governments and other stakeholders should design and implement programs to educate their population about laws and policies concerning their rights and entitlements. Most people do not understand that they have rights and do not know about the legal mechanisms available to protect and enforce those rights.

4. **Enforce supportive legislation:** Government must review and ensure implementation of existing legislation and policies. Where necessary, government should adopt additional legislation and policies and establish effective enforcement mechanisms to support gender equality and non-discrimination with regard to people living with and/or affected by HIV and AIDS, as well as those who are particularly vulnerable to HIV infection, including men who have sex with men (MSM), sex workers, injection drug users, prisoners and migrants.

6. **Remove laws and conditionalities:** Governments and donors should remove laws and conditionalities that restrict or criminalize the use or promotion of HIV commodities and services including, but not limited to, male and female condoms, safe injecting equipment and substitution therapies. Governments should abolish laws and policies that criminalize certain behaviors or jobs, such as same gender sex, drug use or sex work.

7. **Increase funding:** Governments and donors should increase funding for programs to eliminate human rights abuses against people living with, and at high risk of, HIV/AIDS – including sexual and gender-based violence; discrimination; and violations of the right to complete and accurate information about HIV/AIDS prevention, treatment and care.

8. **Prevention needs of women:** In order to address women's inequality and vulnerability, prevention messages should be redefined to make them appropriate to the lives and realities of women and men, girls and boys. Women need prevention methods that they can control – for example, increased access to female condoms. Community sector organizations should advocate more systematically for increased commitment to and development of a microbicide that will be widely and freely distributed.

Access to Services

1. **Impediments to access:** Governments must eliminate policies and practices that impede universal access to prevention, care and treatment, including those that discriminate on the basis of residency or citizenship, age, gender, sexuality, occupation, employment, risk behavior, health status, and race or ethnicity.[2]

2. **Remove user fees:** Governments must ensure that access to a comprehensive package of HIV/AIDS-related services is in no way dependent on the ability to pay. In particular, users' fees should be eliminated wherever these have the potential to limit access to such services.

3. **Strengthen human resources:** Governments should implement policies and strategies to attract, retain and train health care workers, still a formidable challenge for the public health sector. Without addressing the crisis in human resources for health – including poor working conditions, low salaries, concerns about career choices, the lack of incentives and the international poaching of health care workers – health programmes will suffer.

4. **Respond to immediate and future needs:** A comprehensive response must take into account the needs to deliver on the commitment of universal access to prevention, treatment and care interventions that we have today, and with equal urgency to develop better tools – drugs, diagnostics and prevention technologies, notably vaccines and microbicides – for the future.

5. **Access to information:** Stakeholders must take actions to ensure the right to complete, accurate, evidence-based information about HIV/AIDS prevention, care and treatment services, including development and improvement of health literacy among persons living with HIV, particularly in relation to prevention, management and treatment of early HIV-associated conditions. Information about sexuality should be mandatory.

6. **Scale-up voluntary and confidential testing:** Voluntary and confidential HIV counseling and testing programs must be strengthened and scaled up. Governments and other stakeholders must promote the right of each person to know his or her HIV status, to have medically accurate information on HIV and AIDS, and to have HIV testing, counseling and related services readily available and accessible to him or her. HIV testing programs must remain voluntary, not mandatory, and include counseling, informed consent and confidentiality protections.

7. **Services for women:** Community sector organizations should advocate for increased access to quality counseling and support group services that are sensitive to the realities of women affected by HIV and AIDS.

8. **Ensuring use of TRIPS flexibilities:** Resourced-limited governments should commit to employing the flexibilities offered under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to secure access to a sustainable supply of affordable medicines and other essential health technologies. Developed countries should commit to cease pressuring resource-limited countries that seek to utilize these measures. The World Health Organization should develop operational guidance to assist countries in implementing these commitments.

UN BUILDING, NEW YORK

INTRODUCTION

SECTION 1

A. Background

In June 2001, heads of state and other representatives from 189 countries met at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS. This meeting was a historic landmark, reflecting the fact that, in 20 years, the HIV/AIDS pandemic had caused suffering and death worldwide beyond belief, destroying entire communities and reversing development gains. At this meeting, the country representatives unanimously adopted the Declaration of Commitment on HIV/AIDS.

The Declaration of Commitment is an important document because it reflects political will at the highest levels. It is not a binding document, but it states what governments have pledged to do – themselves, with others in international and regional partnerships, and with the support of the community sector – to reverse the epidemic. It sets real targets (with timelines) for accessing prevention, care, treatment and support, empowering women, protecting human rights of people living with HIV (PLHIV) and other vulnerable groups, and increasing resource allocations.

In 2002, in order to measure and monitor progress achieved towards implementing the Declaration of Commitment, UNAIDS developed a set of core indicators. Governments have used these indicators to prepare annual reports to UNAIDS on the progress made in implementing the Declaration. These reports are the basis for the annual overall report that is drafted and presented by the United Nations Secretary-General at the UN General Assembly's annual UNGASS Review meeting. This annual gathering aims to be a comprehensive assessment of national performance against the specific targets laid out in the UNGASS Declaration of Commitment.

For the most part, to date, the official country reports have only provided the perspective of national governments. The community sector involvement in the preparation of these reports has varied from country to country, but generally has been poor.

In 2003, in a four-country pilot project, ICASO undertook a community-led study of the community sector's participation in the implementation and monitoring of the UNGASS Declaration of Commitment. The study confirmed that government leadership, in spite of the adoption of the Declaration, had not been strong enough to reverse the epidemic. In fact, since the adoption of the Declaration of Commitment, the epidemic had worsened, which suggested that governments had not fulfilled the commitments they made when signing the Declaration.

In 2005, ICASO undertook a broader research project to further evaluate, through independent in-country monitoring, the extent to which governments and the community sector have implemented the Declaration of Commitment. More specifically, the project sought to analyze how communities have been involved in implementing the commitments, and whether the government's monitoring mechanisms have been inclusive of their inputs.

The project was carried out in 14 countries – Cameroon, Canada, El Salvador, Honduras, Indonesia, Ireland, Jamaica, Morocco, Nepal, Nigeria, Peru, Romania, Serbia and Montenegro, and South Africa. Organizations and individuals, including PLHIV, were recruited in each country to serve as lead researchers for the study.

The researchers were provided with extensive guidelines on the information to be collected and the format of their reports, as well as a questionnaire that could be adapted at the country level. The researchers were asked to collect and analyze data from various community sector organizations. Data collection, and the preparation of a national report by the in-country researchers, took place over a period of several months.

ICASO provided financial and technical support, and the collection of the data followed a similar methodology among the countries involved in the project. However, the interpretation and analysis of the data was the responsibility of the researcher(s) themselves. Their reports were not edited, commented on or in any way influenced by ICASO. These reports were submitted to UNAIDS as input to their 2005 Global Annual Report and the 2005 United Nations Secretary General Report on the implementation of the UNGASS Declaration of Commitment (which previously only took into account input submitted by the governments). In fact, the Report of the Secretary-General acknowledges that "[t]o obtain the fullest possible picture on progress in the global response since the special session, country reports have been supplemented by information provided by the community sector in more than 30 reports."

This present document, which has been prepared by ICASO, summarizes the results of the 14-country study and proposes a set of recommendations for governments and the community sector. **Section 1** serves as an introduction to the report and concludes with an overview of the Declaration of Commitment.

Section 2 presents the major findings, common themes and cross-cutting issues. This section examines the knowledge and use of the Declaration of Commitment; leadership at all levels and the development and coordination of national strategies; the participation of the community sector; and issues and challenges in several areas, including human rights, vulnerable groups and access to services. Extracts from the country reports have been included in boxes interspersed throughout Section 2. (These extracts are not verbatim; they have been paraphrased.)

Section 3 provides a list of key recommendations based on the findings of the study.

Section 4 provides highlights from each of the 14 country reports.

B. Overview of the Declaration of Commitment

The Declaration of Commitment acknowledges and affirms the key role played by communities, PLHIV and vulnerable groups, NGOs, community organizations and faith-based organizations in the response to HIV/AIDS.

The Declaration of Commitment establishes specific time-bound targets in a number of areas, including prevention; care, support and treatment; human rights; reducing vulnerability; and alleviating the social and economic impact of HIV/AIDS. Some of the key commitments are shown below.

Prevention

- Reduce HIV prevalence among people aged 15-24 in the most affected countries by 25 percent (by 2005).
- Establish prevention targets to reduce HIV incidence among vulnerable groups (by 2003).
- Provide expanded access to essential commodities including male and female condoms, sterile injecting equipment, harm reduction programs for drug users, voluntary and confidential counseling and testing, and early and effective treatment for STIs (by 2005).
- Ensure that 90 percent of people aged 15-24 have access to information and education about HIV/AIDS (by 2005).

Care, Support and Treatment

- Develop strategies to strengthen health care systems (by 2003).
- Develop strategies to provide progressively and in a sustainable manner the highest attainable standard of treatment for HIV, including antiretroviral therapy and treatments for opportunistic infections (by 2003).

Human Rights

- Enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of human rights and fundamental freedoms by, PLHIV and members of vulnerable groups (by 2003).
- Develop (and accelerate the implementation of) national strategies that promote the empowerment of women, including empowering women to have control over their sexuality, and that promote shared responsibility of men and women to ensure safe sex (by 2005).
- Develop (and accelerate the implementation of) national strategies that promote and protect women's full enjoyment of all human rights and that reduce women's vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls (by 2005).

Reducing Vulnerability

- Implement strategies, policies and programs to identify the factors that make individuals particularly vulnerable to HIV infection, and to begin to address these factors (by 2003).
- Develop or strengthen national strategies, policies and programs to promote and protect the health of groups that have high or increasing rates of HIV infection (by 2003).

Alleviating Social and Economic Impact

- Develop (and accelerate the implementation of) national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services (by 2003).

The Declaration of Commitment calls on government leaders to develop and implement multisectoral national strategies and financing plans for combating HIV/AIDS that confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with the community sector and the business sector and the full participation of PLHIV, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; and address risk, vulnerability, prevention, care, treatment and support, and reduction of the impact of the epidemic.

In addition, the Declaration of Commitment calls for civil society involvement in the national periodic reviews of the progress achieved in realizing these commitments, to identify problems and obstacles to achieving progress, and to ensure wide dissemination of the results of these reviews.

In August 2005, the Executive Director of UNAIDS issued a letter to all UN Member States reminding them of their reporting obligations and launching a new document: *Monitoring the Declaration of Commitment on HIV/AIDS Guidelines on Construction of Core Indicators*. The main purpose of these guidelines is to provide national AIDS programs with advice on how to measure the core indicators on HIV/AIDS. The letter also emphasized the importance of fully involving civil society in monitoring UNGASS progress:

"The guidelines…emphasize a participatory and transparent approach throughout the report preparation process…UNAIDS encourages governments to integrate input from a range of civil society organizations into the national report. UNAIDS also strongly recommends that national governments organize a workshop/forum to present and discuss the draft national progress report before submission; where appropriate, the final report should reflect the discussion at this event."

MAJOR FINDINGS, COMMON THEMES AND CROSS-CUTTING ISSUES

SECTION 2

The lack of political leadership and commitment fuels the AIDS epidemic and constitutes a barrier to effectively address it. The lack of leadership and commitment has resulted in inadequate implementation of effective policies and programs; failure to commit sufficient resources; disregard for human rights and dignity; exclusion of, and discrimination against, the most vulnerable; decades of inattention to health workers and health care systems; refusal to base prevention interventions on the evidence of what is effective; and financing and trade policies that undermine access to lifesaving drugs. This section provides a summary of the major findings, common themes and cross-cutting issues covering: knowledge and use of the Declaration of Commitment; leadership, and the development and coordination of national strategies; participation of the community sector; human rights; vulnerability; and access to treatment, prevention and voluntary counseling and testing.

BOX 1

- Most of the stakeholders at the different levels in the civil society are aware of the commitments assumed by the state in UNGASS. There are those who managed to transform them into a tool for their own advocacy. — *Peru*
- The community sector, for the most part, has a basic awareness that the document exists, but only a handful have a working knowledge about the document or actively use the document as a tool in planning or guiding their work. Very few know how to operationalize the Declaration into their ongoing programs and service delivery. The Declaration is most often used as a reference, particularly for (a) making advocacy arguments and referring back to commitments made by the Canadian government; and (b) rationalizing funding proposals, justifying doing the work as important because it is included in the Declaration. — *Canada*
- Most community groups and many government officials (even those working on HIV/AIDS) had never heard about UNGASS or the Declaration of Commitment, and many officials were reluctant to provide information for the shadow report, for fear that it might be published and put their jobs at risk. — *Cameroon*

A. Knowledge and Use of the Declaration of Commitment

There is evidence that suggests that when it was first adopted, the Declaration of Commitment spurred the development of national strategies and structures to address the AIDS epidemic in some countries. Nevertheless, today, knowledge and use of the Declaration of Commitment by policy makers is low in most of the countries surveyed. In these countries, the Declaration usually only surfaces when it is time for governments to prepare their periodic reports to UNAIDS on progress in achieving the commitments in the Declaration.

Knowledge and use of the Declaration of Commitment among community sector organizations varied by country, but was generally poor. In many countries, only a few community sector organizations were aware of the Declaration; these were usually national organizations that were involved with the national AIDS structures.

Use of the Declaration of Commitment as an advocacy tool by community sector organizations was limited, except in Peru and Canada (see box 1).

Participation by community sector organizations in the periodic reviews of progress in implementing the Declaration of Commitment was nil or limited in most of the countries surveyed.

However, there were some notable exceptions. In Morocco, community sector organizations were involved in the preparation of the government report. In fact, representatives from community sector organizations were invited to several meetings organized by the Minister of Health and their inputs were taken into consideration. In Ireland, a dedicated meeting was held to present and discuss the preliminary shadow report findings. It brought together both domestic and international development non-governmental organizations (NGOs), with government departments of health and foreign affairs – one of the first four-party meetings of its kind on the epidemic. In Canada the government contracted with the same NGO that prepared a shadow report to write the "NGO section" of the official report. As a result, this section of the report largely reflected the shadow report's content and perspective. With support from the United Nations Population Fund, the findings and recommendations of the shadow report on El Salvador were presented and discussed at a workshop with other stakeholders.

Most of the countries surveyed did not report on the extent to which the specific time-bound commitments in the Declaration of Commitment had been met. This is perhaps due to the fact that the monitoring and evaluation systems necessary to measure the achievement of the commitments are still not sufficiently developed. However, researchers in one country, Jamaica, reported that the government of Jamaica has generally made very good progress in implementing its commitments, though not always in the time frames established by the Declaration or equally among all target areas.

BOX 2

- Leadership has failed to take the fight seriously. — *Cameroon*
- All the international frameworks and treaties to which South Africa is a signatory will not make a difference if political commitment is not turned into effective and coordinated political action. — *South Africa*
- The government of Cameroon has excellent programs that, if implemented as designed, could greatly reduce the spread of the virus and improve on the lives of those infected. Failure to put in place transparent and participatory monitoring systems, and failure to bring to justice cases of corruption, embezzlement and abuses in the context of HIV/AIDS has greatly dampened the fight against HIV/AIDS in Cameroon. — *Cameroon*
- There is still a huge divide between public policy and public practice that leaves many people infected and affected by HIV/AIDS vulnerable to human rights abuses and HIV infection. — *South Africa*

B. Leadership, and the Development and Coordination of National Strategies

Government leadership on HIV/AIDS is not reflected in levels of funding, or in effectively targeted and coordinated allocation of available resources. Many researchers reported barriers to, or the absence of, "full and active participation" from the community sector and the private sector.

The study found that in most of the countries surveyed political leadership is still lacking. Two exceptions were (a) Serbia and Montenegro where strong political commitment resulted in new and modern legislation during the period 2003-2005, and (b) Morocco, where strong political leadership was demonstrated by the collaboration between the community sector and the Ministry of Health.

All of the countries surveyed have put into place a national strategy and a national coordinating structure for HIV/AIDS.[2] These are two of the three elements of the Three Ones, a set of principles which was promoted by UNAIDS after the Declaration of Commitment was adopted. The third "one," a single, national monitoring and evaluation system for HIV/AIDS, has been established in most of the countries surveyed; in the other countries, a national structure is being developed.

2. In Canada, which is a federal state, there were concerns that no one body has the responsibility for coordinating the entire national strategy.

BOX 3

ROLE OF THE GLOBAL FUND

The Global Fund was cited repeatedly as a positive force in the response to HIV/AIDS, one that has helped toward achieving the goals of the Declaration of Commitment. One obvious reason is that the Fund is providing a great deal of money to fund services including, in particular, the provision of ARVs.

Many interviewed for this study referred to the positive contribution of the Global Fund processes – particularly the creation of Country Coordinated Mechanisms (CCMs). Most proposals to the Global Fund are generated by CCMs, which are required to include representatives of all the stakeholders working on HIV/AIDS in-country. Respondents in some countries credited the CCMs with having been instrumental in bringing civil society and governments together to collaborate on the response to HIV/AIDS. Some of the examples cited by the researchers were as follows:

- In Serbia and Montenegro, the process involved in preparing the Global Fund application boosted cooperation among key stakeholders.
- In Honduras, the only mechanism that brings government and civil society together is the Global Fund's CCM.
- In Morocco, a successful Global Fund grant was a key factor in bringing civil society and government together.
- In South Africa, when the South African National AIDS Council, the country's coordinating body for HIV/AIDS, was also designated as the CCM, representation from civil society increased.

In addition, respondents in some countries credited the Global Fund processes with having established much-needed monitoring and evaluation systems to track progress in the fight against HIV/AIDS. For example, in Romania, the monitoring and evaluation of progress in implementing the national strategy is conducted as part of the reporting requirements associated with the Global Fund grant.

Although most of the national strategies recognize the importance of a multisectoral effort, of protecting human rights, and of addressing the vulnerabilities of some populations – there is a gap between what exists on paper and what exists in the real world, and between what politicians promise and what they deliver (see box 2).

The report from Romania points out that the national strategy cannot be considered a working document as long as there is no financial commitment from the government to support its implementation. In fact, most of the developing countries surveyed reported that their governments are spending a very small proportion of the national budgets on AIDS. The governments of Nepal, Nigeria, Cameroon, Honduras, Indonesia and Jamaica are spending a very small proportion of their national budgets on AIDS. Many countries reportedly face challenges in managing the relationship between government priorities and donor requirements. In the developed countries surveyed, there were concerns that AIDS is no longer a priority.

C. Participation of the Community Sector

The Declaration of Commitment acknowledges the significant contribution of PLHIV and other civil society actors in addressing HIV/AIDS in all its aspects, and recognizes that their full involvement and participation in the design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the epidemic.

The participation by the community sector in the development of national strategies, and within the national coordinating structures, varied considerably among the countries surveyed. Not surprisingly, the extent to which the community sector was involved depended on the nature of the relationship between government and the community sector. In some countries, the lack of participation of the community has been an issue since the early days of the epidemic. It was not possible to tell from this study whether the Declaration of Commitment has had any effect on increasing the participation of the community sector. It should be noted, however, that the researchers in several of the countries found that the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has been instrumental in bringing about more the community sector participation (see box 3).

The participation of the community sector ranged from very limited (in countries such as South Africa and Romania) to extensive (in countries such as Morocco, Jamaica and Canada). In most of the countries reporting very limited participation, there has been some improvement in recent years, albeit small (see box 4).

The researchers in Peru found that while the community sector participation has been very limited, there has been a noticeable improvement since 2003. Researchers in Nepal reported that while the community sector had limited involvement in the development of the national strategy, it had more involvement in a recently-developed annual action plan. This has resulted in issues being incorporated into the action plan that were missing from the national strategy – issues such as access to ARVs and prevention programs for men who have sex with men (MSM).

In those countries reporting some participation by the community sector, the researchers found that in most cases vulnerable groups (such as men who have sex with men, injection drug users, sex workers and prisoners) were not actively involved at the national level. Researchers in several countries pointed out that representation is not the same as participation. For example, researchers reported that:

- although the community sector is represented on National AIDS Coordinating Authorities, impact and true involvement is frustratingly limited; and
- although the NGO sector is represented on a number of decision-making structures in Ireland, their ability to set agendas inside these structures is very limited.

In countries where community participation was limited, the reason most often cited was that the community sector was not seen as true partners with something useful to contribute. In Cameroon, the researchers found that some government officials see community sector organizations as competitors rather than collaborators. They also found that information sharing between government and the community sector was very poor.

BOX 4

- Little opportunity for review of the national plan has taken place; interactions and relations with key community sector organizations are at an all-time low. — *South Africa*
- The National AIDS Program treated community sector organizations as real partners, paying attention to their claims, and not merely as simple interlocutors. — *Morocco*
- Community sector organizations who are not involved with the National AIDS Committee (often due to their distance from Kingston where meetings are held, or to limitations of staff or resources) find their access to information and input limited. — *Jamaica*
- Many NGO representatives feel that their efforts were not recognized and sustained by government partners. — *Romania*
- The Government has a tendency to hand-pick civil society representatives to participate in certain structures or dialogues. — *South Africa*
- The association between community sector and government in Honduras has been characterized by division and difficult-to-handle relationships. — *Honduras*
- Civil society and government generally work well together to address HIV/AIDS from a multisectoral, multi-stakeholder perspective. — *Canada*
- NGOs are feeling that the partnership model is not working. — *Ireland*

D. Issues and Challenges: Human Rights

Although the Declaration of Commitment called on governments to implement measures to eliminate all forms of discrimination against PLHIV and members of the most vulnerable groups within the particular epidemics in their countries, and to ensure that they can enjoy their human rights and fundamental freedoms, the researchers in this study found that little progress has been made. Stigma and discrimination are still commonplace. For PLHIV and members of vulnerable groups, stigma and discrimination constitute a major obstacle to the successful implementation of much-needed prevention, care, treatment and support services. Human rights abuses both fuel the epidemic and follow in its wake. Addressing these abuses immediately should be an essential part of the responses to HIV/AIDS.

In many of the countries surveyed, there are laws guaranteeing the right to health, and there are laws to protect the human rights of PLHIV and members of some vulnerable groups. It was not clear, however, whether the Declaration of Commitment spurred the development of these laws.

BOX 5

- South Africa has a highly developed rhetoric of rights, but very little real effort in translating this into action. There is very little on the ground that supports what is in the constitution. — South Africa
- The breach between the theory of a state with a legal framework of equality, and the daily practice in the access and protection of the rights, is the Achilles heel of the country's response to HIV/AIDS. — Honduras
- Reports of discrimination, especially against PLHIV and MSM, abound, yet only one legal case has been identified that addresses this situation (a case of anti-gay violence is slowly working its way through the courts). Reasons given for this include fear on the part of victims to come forward due to the potential for increased discrimination or violence, disinterested or even abusive law enforcement, and an insensitive media. — Jamaica

BOX 6

- In most cases, it is up to individuals who experiences discrimination to (a) know their rights; (b) recognize that they have been discriminated against; (c) have knowledge of the complaints mechanisms available for redress; and (d) be willing and able to lodge a complaint. — *Canada*
- There is little or no awareness among decision-makers or NGOs about the need for a rights-based policy approach for drug users and sex workers. — *Romania*
- The rights of vulnerable groups have not improved in the last four years, since the signing of the Declaration of Commitment. — *Honduras*

Even in countries with such laws, there is usually little connection between the legally guaranteed right to health and actual access to health, especially for vulnerable groups. There is a huge gap between what exists on paper in terms of anti-discrimination policies and what happens in reality (see box 5). For example:

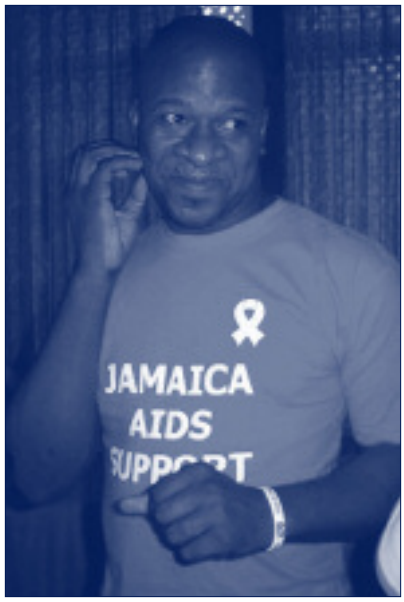
- Enforcement of anti-discrimination legislation is usually inadequate.
- Although discriminatory legislation in Romania concerning MSM was rescinded, discrimination persists when it comes to essential public health services: MSM avoid showing or disclosing their sexual orientation in public or before a physician because of judgmental attitudes.
- In Peru, laws relating to the rights of PLHIV are not respected by the authorities or the general population.
- In El Salvador, despite the existence of equality laws, discrimination towards PLHIV and vulnerable groups occurs because of fear and ignorance in the general population.
- Policies on paper do not always translate into a clear understanding of procedures or proper behavior by health care workers.

Even where governments have committed to providing ARVs to all PLHIV who need them, the lack of funding often prevents governments from delivering on their commitment.

In many of the countries, legal regulations discourage some of the groups that are most vulnerable to HIV infection from accessing prevention and treatment services. For example in Jamaica, same-gender intimacy among men, possession of injecting equipment and sex work are illegal.

The researchers identified several other barriers to the full implementation of human rights laws and policies (see box 6):

- Governments have not done enough to create a culture based on rights.
- Governments fail to educate the population concerning the laws and policies.
- The fight against discrimination is not part of the government's agenda.
- There is no formal system for monitoring the implementation of the laws and policies, especially among vulnerable groups.
- Most people do not understand that they have rights and do not know about the legal mechanisms available to protect those rights.
- Most people do not have the skills to fight for their rights.
- Where governments do take action, it tends to be reactive rather than preventive.



STEVE HARVEY, AIDS ACTIVIST WHO WAS MURDERED IN JAMAICA IN 2005

BOX 7

Examples of **most vulnerable groups** include:

- People living with HIV
- Orphans and vulnerable children
- Women
- Youth
- Sex workers
- Injection drug users
- Men who have sex with men
- Migrants
- Refugees
- Prisoners

In most of the countries surveyed, there are no laws or policies in place to protect the human rights of sex workers and injection drug users. In fact, sex work and drug use are criminalized, and the people engaged in these are routinely prosecuted. This makes it extremely difficult for these groups to access ser-vices. In some countries, this applies to MSM as well. See subsection E on Vulnerable Groups below for further discussion of this.

The researchers reported that in Serbia and Montenegro, Nepal and Jamaica, there are no laws protecting the rights of PLHIV and vulnerable groups. However, in Jamaica, several community sector organizations are working to protect the rights of PLHIV and vulnerable groups, in some instances with the assistance of the government. Two of the national NGOs specifically monitor discrimination against PLHIV, and one of these (along with a human rights NGO) monitors for abuses against MSM.

BOX 8

- Sex workers, drug users, MSM and outreach workers provide numerous examples documenting how officials routinely harass and discriminate against vulnerable groups, compounding their already marginalized status and reinforcing their reluctance to use HIV/AIDS-related health services, including needle exchange. — *Romania*
- The most vulnerable groups face cultural, institutional and legal barriers that limit their access to health and social services, as well as the interventions specifically designed for these groups. — *Romania*
- Canada's strong economic position has not been adequately reflected in the reduction of poverty, isolation, marginalization and overall vulnerability of many populations. Canada has not made enough progress with respect to addressing the determinants of health that make individuals vulnerable to HIV, addiction and violence. — *Canada*
- Unfortunately, most NGOs and international development partners report that stigma and discrimination remain the greatest obstacle to successful prevention and treatment efforts. — *Jamaica*

E. Issues and Challenges: Vulnerable Groups

Despite the fact that the Declaration of Commitment calls for governments to take action to address vulnerability (see box 7) and to provide more services to the most vulnerable the study found that there are still large gaps (see box 8).

Some countries still provide few or no services for vulnerable groups. For example:

- In Romania, no money is allocated by the government to prevention programs targeting vulnerable groups.
- In Nepal, very little has been done by government, the private sector or domestic NGOs for vulnerable groups.
- In Jamaica, there is no legislation that protects the rights of vulnerable groups specifically, so they must seek redress based on the general laws and through the common venues available to any citizen.

In Romania, while community sector organizations have attempted to reach out to vulnerable groups by providing prevention and care services – an activity in line with the national strategy – state actors, in particular law enforcement agents, dissuade persons at risk from taking advantage of these services through repressive practices, such as harassment and persecution.

In a number of other countries, either services are not reaching a large proportion of the vulnerable populations, or specific groups are being left out. For example:

In Jamaica, it was reported that prevention efforts reach only 10 percent of women, MSM, prisoners and sex workers. Refugees and injection drug users are not mentioned in the national strategy. However, in Jamaica, efforts are under way to address the issue of migrant workers, especially as the Caribbean Single Market Economy is implemented and will facilitate greater movement among citizens of member countries.

- In Morocco, there are no programs for migrants, but the Ministry of Health (MoH) is aware of the issue and a specific program for migrants is planned to be included in the National AIDS Program 2006-2010.
- In Ireland, migrants, injection drug users and sex workers are not being targeted sufficiently.

BOX 9

- The country has a far reaching framework for the protection of the human rights of PLHIV, but its implementation is just beginning and there are no protocols for monitoring. — *Peru*
- PLHIV often loose their jobs or are denied healthcare services because of the ignorance and fear surrounding HIV and AIDS. It is estimated that 60 percent of healthcare workers believe that PLHIV should be isolated from other patients. — *Nigeria*
- Reports of discrimination against PLHIV abound, yet only one legal case has been identified. Reasons given for this include fear on the part of the victim to come forward, disinterested and abusive law enforcement and an insensitive media. — *Jamaica*

- One of the major weakness is in implementing policies geared toward protecting and supporting orphans and vulnerable children. While this group is identified repeatedly in the national AIDS strategy, the general consensus among those surveyed indicates that much more needs to be done in this area. In South Africa, more attention needs to be paid to the needs of children, especially those made vulnerable by HIV/AIDS. In Jamaica, educational programmes for children are being implemented by the community sector.

People Living With HIV

None of the researchers identified any legal/formal barriers for PLHIV to access services. In fact, non-discrimination laws and regulations have been put into place in all countries (and all countries are part of different international human rights treaties). This highlights the fact that discrimination against PLHIV is largely the result of cultural and social beliefs.

In Peru, the situation for PLHIV is continually plagued by all types of abuse that in most cases constitutes a violation of their fundamental rights theoretically protected by national laws (see box 9). In El Salvador, even though the labor legislation prohibits the exclusion of PLHIV, still they are subject to discrimination when applying for a job or retaining a job, once it is disclosed they are HIV-positive. In El Salvador too, a person diagnosed with HIV infection automatically loses his/her chances to access bank credit, or housing and life insurance, because these institutions require an HIV test to access services.

Community sector organizations work to protect the rights of PLHIV in varying capacities, and some with the support of their governments. Some organizations monitor for discrimination against PLHIV (or most vulnerable groups). Others provide specific services, such as voluntary counseling and testing (VCT), condom distribution, crisis management, psychosocial support and treatment.

Women

Although the Declaration of Commitment calls for the implementation of strategies to promote the empowerment of women, few steps have been taken in this direction in the countries that were included in this study (see box 10). The researchers revealed that in Romania, Peru, Morocco, Nepal and Serbia and Montenegro the issue of women's empowerment is being addressed not at all or to a very limited degree. In only one developing country in the study – El Salvador – the government has taken some concrete action: the researchers reported that the government has developed a strategy to protect and strengthen the position of women. However, in this same country, women living with HIV have been forced to be sterilized because of their HIV status.

BOX 10

- No one, including civil society, is focusing on the implementation of the UNGASS commitment to protect women. — *Serbia and Montenegro*
- Cultural norms still foster gender inequities that make sexual autonomy, including condom negotiation, difficult, especially for teenage girls who show much higher rates of AIDS diagnosis than boys in the same age range. — *Jamaica*

ETHIOPIAN CULTURAL PERFORMER

BOX 11

- Policy makers and authorities view sex workers as nuisances at best, and as immoral lawbreakers at worst. — *Romania*
- The continued criminalization of sex work has contributed to the stigma, isolation and violation of human rights of sex workers. — *South Africa*
- As with MSM, judgmental attitudes and a lack of interest on the part of some prevention workers pose the biggest social barriers to effective prevention efforts for sex workers. — *Jamaica*

The researchers said that in three countries – Romania, Nepal and Serbia and Montenegro – there are either no services specifically targeting women or the ser-vices are extremely limited. In Romania, there is a national prevention of mother to child transmission (PMTCT) program, but there is no specific program that targets women's vulnerability. In Morocco, a few initiatives have been carried out by different government departments aimed to reduce women's vulnerability to HIV infection.

The researchers in Nigeria reported that harmful marriage practices (such as early-age marriage and female genital mutilation) were violating women's human rights and were contributing to increasing HIV rates in women and girls; and that widespread female circumcision or genital mutilation were putting women at risk of contracting HIV.

In Jamaica, according to an umbrella agency for women's organizations, the government has strengthened legal and policy frameworks within the context of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). The Convention promotes gender equality, women's empowerment and stigma reduction for those infected with, affected by, or at risk of, HIV/AIDS.

Sex Workers

Sex work remains illegal in most of the countries in the study. This illegal status, combined with the high levels of stigma attached to sex work, means that services for sex workers are limited and uneven and that, even where such services exist, it is very difficult for sex workers to access them (see box 11).

'KHOTE'/TRANSGENDER SEX WORKERS AT A TRUCKING DEPOT

The following are examples of the problems identified by researchers:

- There are low levels of condom use among sex workers in Nigeria because of a lack of knowledge about HIV transmission and poor acceptance by male clients.
- In all of Romania, there is only one outreach program for sex workers.
- In Jamaica, legal prohibitions and public shame create a fear of disclosure among sex workers and a high potential for exploitation. In addition, funding constraints imposed by the U.S. Agency for International Development (USAID), which prohibit interventions that reduce the stigma of sex workers, constitute a barrier to effective HIV prevention.

Furthermore, by holding to a policy that criminalizes sex work, governments lose the opportunity to promote the health and labor rights of sex workers.

YOUTH IN ETHIOPIA DURING OUTREACH ACTIVITY

Youth

All of the countries surveyed have prevention programs that specifically target youth. Researchers in Honduras said that investment in HIV prevention among youth and adolescents has been the biggest effort in raising awareness of HIV/AIDS in that country. In other countries, such as Romania, although rural youths were identified as a target group in the prevention strategy, nothing has been undertaken to improve availability of condoms for them.

However, there are significant barriers to youth being able to access services, including the following:

- In some countries, there is little or no information on sexuality, particularly in school curricula.
- Parental consent is required before minors can be tested for HIV or receive prevention and treatment services.
- Although youth are playing a more active role in the response, many of the efforts to reach youth are being led by an older population.
- There is a sense of ignorance among youth; many young people do not identify HIV/AIDS as one of their concerns.

Men Who Have Sex With Men

BOX 12

▸ Important rates of infection and prevalence among MSM are hidden behind the fact that male sex workers and MSM are consolidated into one group. — Peru

The issue of sexual orientation was only partially addressed by the researchers. Some referred to the issue that their national AIDS strategy lumps into one category MSM, transgender, and sex workers (see box 12). Others, like Jamaica, raised the issue that same-gender sexual intimacy is a criminal act in the country, so providing services to the MSM community presents the MoH with a difficult challenge: independent research indicates that MSM is the most vulnerable group in Jamaica but strong homophobia (and legal barriers) makes it difficult to design and provide services to them.

BOX 13

- Drug policies are almost exclusively based on law enforcement driving injection drug users underground, away from HIV education and prevention services. — Romania

In Canada, discrimination in the basis of sexual orientation is prohibited in all jurisdictions of the country. In El Salvador, some MSM reported that they were asked to change their behavior because it goes against "God's principles."

The issue of MSM is not covered in all the country reports. Although in Serbia and Montenegro, only 15 percent of the reported cases were identified as MSM and they are not considered "most at-risk" in the AIDS Strategy, some specific outreach and prevention programs have been implemented (peer education and condom/lubricant distribution) for this group.

For most, stigma associated with acknowledging same-gender sex (particularly among men) leads to lack of self-disclosure and leaves many in this group with non-differentiated messages and services.

Injection Drug Users

Drug use is illegal in all of the countries surveyed. The researchers in most of the countries reported that the illegal status of drug use – when combined with (a) the stigma associated with drug use and (b) repressive law enforcement practices – dramatically limit users' access to basic health and social services (see box 13).

While on the one hand, community sector health programs have attempted to reach out to the most vulnerable by offering prevention and care services – an activity in line with National Strategies – other state actors, in particular law enforcement agents, dissuade persons at risk from taking advantage of these services through repressive practices. For example, in Romania, while the national strategy against drugs acknowledged the positive impact of harm reduction projects – due in great part to the community sector pressure – there are no institutional arrangements for supporting these programs.

In most of the countries surveyed, harm reduction services – including needle exchange, and substitution programs – were either non-existent or extremely limited (particularly outside major centers). For example:

- In Romania, needle exchange programs cover less than 10 percent of injection drug users in Bucharest, and there are no such programs outside the capital. Although clean needles and syringes are available in pharmacies and no prescription is needed, most pharmacists refuse to sell them to injection drug users.
- In Serbia and Montenegro, there is only one NGO doing harm reduction. Needle exchange programs exist in three cities. Pharmacists in smaller towns are not willing to sell needles and syringes.
- Only two provinces in Indonesia offer drug substitution programs.
- In Ireland, services to drug users are over-stretched and based primarily in the capital, Dublin.

F. Issues and Challenges: Accessing Specific Services

Treatment

Access to antiretroviral (ARV) treatment has improved in the last few years in all of the developing countries surveyed, but it is still far from what is needed to save thousands (if not millions) of lives. In some cases, the improvement has been significant. For example:

- In Peru, the greatest advance in the national response to HIV/AIDS has been in the area of access to ARVs. Coverage is around 70 percent of the goal.
- In Serbia and Montenegro, the government ensures access to all who qualify.
- In Jamaica, through resources provided largely by the Global Fund, access to ARVs has been enhanced.

Even where governments have committed to providing ARVs to all PLHIV who need them, the lack of funding often prevents governments from delivering on their commitment. Access is often limited to those living in the capital or urban areas. Repressive policies toward drug users, sex workers, and other vulnerable groups create obstacles to accessing treatment and other services. Inadequate health systems, stigma and discrimination and lack of sufficient drugs to treat opportunistic infections are additional significant barriers to access to treatment (see box 14). For example, although access to ARVs has improved in Honduras, they are only available to 10 percent of PLHIV who need them. Researchers in individual countries identified the following challenges and barriers to universal ARV access:

- ARVs are typically available only at limited health care facilities. The cost of transportation can be prohibitive, especially for people living in rural areas.
- There is insufficient information and counseling on ARVs.
- Medical personnel are not sufficiently trained on ARV management. Often there is no mandatory training or continuous education on HIV/AIDS.
- Stigma and discrimination towards PLHIV and members of vulnerable groups (including in health care facilities themselves) impede access.
- Resources are insufficient to guarantee universal access. Furthermore, the failure to commit to long-term funding means that the sustainability of ARV programs is not assured.
- The infrastructures to support ARV treatment are insufficient.
- The diagnostic tests are expensive; the costs often have to be borne by the patient.
- Diagnostic equipment is not widely available.
- Adolescents need a guardian to accompany them to gain access to ARVs.
- There are difficulties buying, storing and distributing the medicines.
- There are insufficient health care workers to handle the numbers of patients who require treatment.
- Free trade agreements often restrict access by virtue of the "TRIPS-plus[3]" provisions that have been included in the agreements.
- New ARVs are not available, and/or only a limited number of ARVs are available.

BOX 14

- The process for obtaining free drugs deters some who feel shame and stigma when they have to acknowledge their inadequate financial situation. — *Jamaica*
- Currently, very few Nigerians have access to basic HIV/AIDS prevention, care, support and treatment services. Around 500,000 people are estimated to need ARVs, but only 17,000 are receiving treatment from governmental programs. — *Nigeria*

3. This refers to the practice of according greater patent protection for brand-name medicines than what is required in the World Trade Organization's Trade-Related Aspects of Intellectual Property (TRIPS) Agreement.

BOX 15

- Access to HIV prevention services is limited by costs and by the situation of people without legal documentation. Other barriers are illiteracy, inequality related to gender issues, and the stigma surrounding STI's. — *Peru*
- The MoH has developed specific prevention messages for youth, women in general and pregnant women; noticeably absent are any messages targeting MSM or sex workers. — *Jamaica*

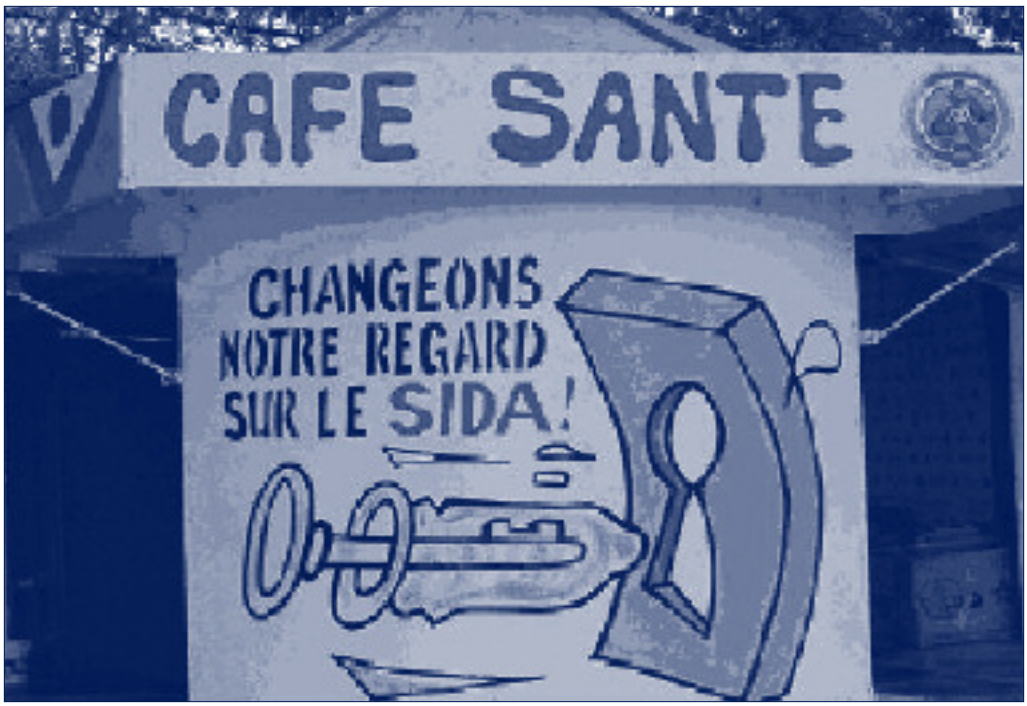
Although a lot of the attention has been focused on ARVs, access to treatments for opportunistic infections remains limited in many countries. In Jamaica, for example, the researchers reported that access to these treatments declined due to financial constraints. Except for a single antibiotic, whose cost is covered by the government, other medications and medical fees are the responsibility of the patient. This results in many people avoiding treatment for opportunistic infections until they become critically ill.

Prevention

Comprehensive and inclusive prevention services are not being designed and implemented in any of the countries monitored. Governments often fail to develop specific services to reach the most at-risk and vulnerable groups and communities. In some cases there are legal barriers to provision of services to precisely those groups that are clearly identified as most vulnerable to new infection (see box 6). In some cases, accurate evidence-based information about HIV/AIDS prevention is not even available. And what is available presents one approach or another, but not a comprehensive package of prevention options. Additionally, there are laws and donor conditionalities that restrict or criminalize the use or promotion of male and female condoms, safe injecting equipment, and substitution therapies (see box 15).

In Indonesia, Honduras, El Salvador, Jamaica, Nigeria, Peru, Romania, Morocco and Nepal, male condoms were available but there are still significant issues to be resolved related to access, quality and cost. Other prevention technologies were far less available. Female condoms in particular were not available at all or if they were available, were either very hard to find or too expensive. In Nepal safe injecting equipments are available in any pharmacy. In South Africa, the Government-initiated branded male condoms aimed to make them more 'socially accepted' (uptake has increased from 33 million to 45 million). Also, the South African government has increased funding for female condoms.

In theory in Canada, all HIV prevention tools are available and accessible, except in prisons, where institutional policies prohibit access to clean needles and in some cases condoms (this is also the case in Morocco). In practice, most vulnerable populations in Canada (youth, Aboriginal communities, refugees, trafficked women, and sex workers) have very inconsistent access to the prevention tools. Even a widespread, proven and accepted practice to screen blood for transfusions is not use in Nigeria, where blood transfusions are responsible for 10 percent of all HIV infections and there is no coordinated national blood supply system.



HEALTH 'SHOP' LET'S GHANGE HOW WE LOOK AT AIDS

Voluntary Counseling and Testing (VCT)

Although VCT is available in all of the countries surveyed, access is often restricted to a few centers in the larger cities. Most researchers report that although the number of testing centers has increased, the degree to which the counseling has increased as well is not known. Most researchers reported that at the policy level testing remains voluntary, but that in many instances the test is done without consent or even knowledge (see box 16).

Fears about confidentiality often deter and discourage people from seeking testing; policies on paper do not always translate into clear understanding of procedures and/or proper behavior by healthcare workers.

In practice, the extent to which HIV testing was accompanied by pre- and post-test counseling varied from country to country. Researchers in Romania reported that HIV testing is seldom accompanied by counseling. In Indonesia, although there was a big effort to train counselors, few are providing counseling. In Serbia and Montenegro, there are only four VCT centers. In most countries, pregnant women undergo mandatory testing, as a component of pre-natal care.

BOX 16

- Patients were tested without their informed consent because it was thought that the patients were not well prepared, and that it would be too painful for the patient to talk about the possibility of being infected with HIV. — *Indonesia*
- The capabilities to develop adequate counseling for the different behaviors and gender identities are still in the very initial stages of development. — Peru

KEY RECOMMENDATIONS

SECTION 3

Based on the findings of the country reports on what actions need to be taken to ensure that the goals of the Declaration of Commitment are achieved, the following is a list of the key recommendations:

Knowledge and Use of the Declaration of Commitment:

1. **Greater access to information:** Part of the effective response by communities, which is a key indicator of a successful national response, is understanding the international tools and instruments that could be used in national and local level interventions that will ultimately have an impact on this epidemic. Stakeholders at country level, with support from UNAIDS should ensure that the Declaration of Commitment is available in schools and public libraries. Resources should be utilized to translate into easy to understand and action-oriented language the contents of the Declaration. Community sector organizations should develop a coordinated campaign on the national level to build awareness and understanding of the Declaration of Commitment (and other international tools).

2. **Improve monitoring and evaluation (M&E):** Most of the countries surveyed did not report on the extent to which the specific time-bound commitments in the Declaration of Commitment had been met. This is perhaps due to the fact that knowledge and use of the Declaration is low in most countries and also that the M&E systems necessary to measure the achievement of the commitments are still not sufficiently developed. M&E systems should be developed taking into consideration the characteristics of the epidemic in the country, and should include indicators to measure stigma and discrimination, access to services by the most vulnerable, gender inequalities, tuberculosis and HIV co-infection (where relevant), and quality of services, particularly voluntary counseling and testing (VCT), prevention tools and messages, treatment and care.

Leadership and Participation of the Community Sector

1. **Universal access commitment:** Governments should commit to universal access to prevention, care and treatment through a strategic plan of action with interim and final numerical targets at the global and national levels and clear assignments of responsibility for governments, multilateral agencies, donors and the community sector.

2. **Finance the response:** Governments should provide adequate financial resources for the timely implementation of their national AIDS strategies and should follow up with regular monitoring and evaluation of the implementation process.

3. **Strengthen community responses:** Governments and other stakeholders should make a significant investment in the community sector by strengthening the capacity of community sector organizations to fulfill their role in the response to HIV/AIDS. National AIDS strategies must strengthen community-level provision of prevention, treatment, care and support, and incorporate these into comprehensive national health human resource plans.

4. **UNAIDS support:** UNAIDS and its cosponsors should play a stronger role in supporting the community sector at the national level. This includes advocating for appropriate involvement within government structures and national bodies, and supporting the involvement of people living with HIV and members of the community sector in evaluating programmes and policies.

5. **Centrally involved:** Governments should ensure that the response to HIV/AIDS is truly multisectoral, and should take action to improve coordination among the stakeholders. Governments should involve the community sector, including, but not limited to, people living with HIV and representatives of vulnerable groups. They should be centrally involved in the planning and design of national AIDS programs, human resource and health sector development plans, program implementation and service delivery, advocacy, monitoring and evaluation and reporting.

6. **Self-selection:** The community sector representatives must be selected through peer-driven, democratic, transparent processes.

7. **Community shadow reporting:** In addition to their involvement in the government-led reporting processes, the community sector should develop shadow reports related to the implementation of the UNGASS Declaration of Commitment. This process will empower them to demand to be involved in government-led monitoring, evaluation and reporting processes. UNAIDS should provide greater support to the community sector in developing monitoring and evaluation frameworks related to the Declaration.

Human Rights and Vulnerable Groups

1. **Address human rights abuses:** Governments and other stakeholders must recognize that a wide range of human rights abuses both fuel the epidemic and follow in its wake, and that addressing these abuses should be an essential part of donor and government responses to HIV/AIDS.

2. **Address stigma and discrimination:** Governments and other stakeholders should address stigma and discrimination far more aggressively than they have to date. Stigma and discrimination are the major obstacles to achieving universal access to prevention, care, treatment and support services.

3. **Increase understanding of rights:** Governments and other stakeholders should design and implement programs to educate their population about laws and policies concerning their rights and entitlements. Most people do not understand that they have rights and do not know about the legal mechanisms available to protect and enforce those rights.

4. **Enforce supportive legislation:** Government must review and ensure implementation of existing legislation and policies. Where necessary, government should adopt additional legislation and policies and establish effective enforcement mechanisms to support gender equality and non-discrimination with regard to people living with and/or affected by HIV and AIDS, as well as those who are particularly vulnerable to HIV infection, including men who have sex with men (MSM), sex workers, injection drug users, prisoners and migrants.

5. **Remove laws and conditionalities:** Governments and donors should remove laws and conditionalities that restrict or criminalize the use or promotion of HIV commodities and services including, but not limited to, male and female condoms, safe injecting equipment and substitution therapies. Governments should abolish laws and policies that criminalize certain behaviors or jobs, such as same gender sex, drug use or sex work.

6. **Increase funding:** Governments and donors should increase funding for programs to eliminate human rights abuses against people living with, and at high risk of, HIV/AIDS – including sexual and gender-based violence; discrimination; and violations of the right to complete and accurate information about HIV/AIDS prevention, treatment and care.

7. **Prevention needs of women:** In order to address women's inequality and vulnerability, prevention messages should be redefined to make them appropriate to the lives and realities of women and men, girls and boys. Women need prevention methods that they can control – for example, increased access to female condoms. Community sector organizations should advocate more systematically for increased commitment to and development of a microbicide that will be widely and freely distributed.

Access to Services

1. **Impediments to access:** Governments must eliminate policies and practices that impede universal access to prevention, care and treatment, including those that discriminate on the basis of residency or citizenship, age, gender, sexuality, occupation, employment, risk behavior, health status, and race or ethnicity.

2. **Remove user fees:** Governments must ensure that access to a comprehensive package of HIV/AIDS-related services is in no way dependent on the ability to pay. In particular, users' fees should be eliminated wherever these have the potential to limit access to such services.

3. **Strengthen human resources:** Governments should implement policies and strategies to attract, retain and train health care workers, still a formidable challenge for the public health sector. Without addressing the crisis in human resources for health – including poor working conditions, low salaries, concerns about career choices, the lack of incentives and the international poaching of health care workers – health programmes will suffer.

4. **Respond to immediate and future needs:** A comprehensive response must take into account the needs to deliver on the commitment of universal access to prevention, treatment and care interventions that we have today, and with equal urgency to develop better tools – drugs, diagnostics and prevention technologies, notably vaccines and microbicides – for the future.

5. **Access to information:** Stakeholders must take actions to ensure the right to complete, accurate, evidence-based information about HIV/AIDS prevention, care and treatment services, including development and improvement of health literacy among persons living with HIV, particularly in relation to prevention, management and treatment of early HIV-associated conditions. Information about sexuality should be mandatory.

6. **Scale-up voluntary and confidential testing:** Voluntary and confidential HIV counseling and testing programs must be strengthened and scaled up. Governments and other stakeholders must promote the right of each person to know his or her HIV status, to have medically accurate information on HIV and AIDS, and to have HIV testing, counseling and related services readily available and accessible to him or her. HIV testing programs must remain voluntary, not mandatory, and include counseling, informed consent and confidentiality protections.

7. **Services for women:** Community sector organizations should advocate for increased access to quality counseling and support group services that are sensitive to the realities of women affected by HIV and AIDS.

8. **Ensuring use of TRIPS flexibilities:** Resourced-limited governments should commit to employing the flexibilities offered under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to secure access to a sustainable supply of affordable medicines and other essential health technologies. Developed countries should commit to cease pressuring resource-limited countries that seek to utilize these measures. The World Health Organization should develop operational guidance to assist countries in implementing these commitments.

HIGHLIGHTS OF THE INDIVIDUAL COUNTRY REPORTS

SECTION 4

Country profiles were prepared by ICASO staff, respecting the language and style used by the country researchers, as this short profiles are based solely on information provided by the researchers in their country reports (except from the demographic indicators that were extracted from the UNAIDS 2006 Report on the global AIDS Epidemic).

Most country profiles have been divided into five sections. There are some country profiles that do not include all the sections because the country reports did not address those specific issues. The general sections of the profiles are: demographic indicators; general response to the epidemic (by the government and by community sector organizations); national HIV/AIDS policy and implementation (access to treatment, care and support; prevention; vulnerable groups; and voluntary counseling and testing); monitoring and evaluation; and lessons learned and recommendations.

COUNTRY PROFILE: CAMEROON

Sourced from report by LUKMEF – Cameroon

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	16.322.000
LIFE EXPECTANCY AT BIRTH FOR MEN	50
LIFE EXPECTANCY AT BIRTH FOR WOMEN	51
NUMBER OF PEOPLE LIVING WITH HIV	510,000 [460,000 – 560,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	290,000 [260,00 – 310,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	5.4%
DEATHS DUE TO AIDS	46,000 [36,00 – 55,000]

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

In Cameroon, the main coordinating structure for the fight against HIV/AIDS is the National AIDS Control Committee (NACC), put in place in 1986. In 2002, the country elaborated a five-year plan for the fight against HIV/AIDS. The plan was divided into the following areas: prevention, treatment and psychological support. In the area of prevention, the government has adopted a decentralized and multi-sectoral approach by delegating some of the NACC responsibilities to the Provincial Technical Groups (PTG), which at the same time created the Local AIDS Control Committees (LACC), which are community response groups put in place by the NACC and made up of members of the Communities.

Although the intention behind the decentralization was to involve communities, in reality this commitment has been poorly sustained. The staff of the PTG is trained only for two days and then promised government funding. The lack of training and financial incentives promised, rather than the commitment to HIV/AIDS, reduces significantly the effectiveness of the projects.

Community Sector

Although groups like women's associations and village development associations exist and are theoretically best suited to do HIV work in the communities, such organizations have never been used to their full capacity. The decentralized structure, in theory, takes into account the involvement of community groups, but in practice their full participation has never been completely ensured.

Besides grassroots organizations, there are around 6,000 NGOs operating in Cameroon that are working alongside government in the fight against AIDS. While NGOs are actively involved in the work to reduce the epidemic, the coordination between NGOs and other structures is not well regulated. Government often sees NGOs not as partners, but as competitors.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

Access to testing and treatment for the rural population remains poor and expensive. Lack of testing and treatment centres in the rural areas coupled with poverty, illiteracy and ignorance about HIV/AIDS, are fuelling the epidemic in rural regions of Cameroon. The fact that testing and treatment are not free in Cameroon has increased the money going into private 'pockets' providing testing and treatment services.

Currently there are just 24 treatment centres in the country located mostly in urban centres. Urban populations unable to access or afford treatment often resort to traditional medicine. In the urban areas, treatment could cost up to US$13, compared to the cost of up to US$50 (including transportation) in the rural areas.

Palliative care is still at a very early stage (only reaching less than 20% of those in need). The principal reason is the lack of skilled personnel. Additionally, the lack of understanding about the importance of this service by policy and decision makers hinders efforts to scale up palliative care

Prevention

Based on data obtain from the key informants, close to 40% of those interviewed use male condoms regularly, while the use of the female condom is extremely limited due to lack of availability.

Vulnerable Groups

Women: The situation of women in Cameroon with regards to their vulnerability to HIV remains a major challenge in the national strategy. Gender considerations, specifically women's economic dependency on men, have not been properly addressed in the last five-year plan. Failure to develop strategies to address the socio-economic factors that make women more vulnerable to HIV infection led to the increased rate of HIV infection among women. In some provinces, the rate is 11.9 percent (compared to a 5.5 percent national average).

4. MONITORING AND EVALUATION

Poor involvement of the local community and their lack of understanding of the bigger picture makes monitoring and evaluation at the local level difficult. Sharing of information and results of programs in Cameroon is completely absent, making learning and replication of good practices in the fight against HIV/AIDS difficult. Additionally, the national AIDS plan fails to set timelines and lacks a transparent, accountable and accessible monitoring strategy.

5. LESSONS LEARNED AND RECOMMENDATIONS

Despite a comprehensive theoretical framework developed by Cameroon's government to fight the HIV pandemic, the practical implementation has faced major setbacks, among which are:

- Un-transparent fund management;
- poor monitoring and reporting system;
- high levels of corruption;
- absence of an HIV resource centre;
- inadequate involvement of the community sector; and
- low budget allocation for HIV/AIDS.

The major problems for the implementation of HIV/AIDS policies are lack of transparency, objectivity and accountability. The government of Cameroon has designed excellent programs that if implemented as designed could greatly reduce the spread of the virus and improve the lives of those infected. Failure to put in place a transparent and participatory monitoring systems, failure to bring to justice cases of corruption, embezzlement and abuses in the context of HIV/AIDS has greatly dampen the results of the fight against AIDS in Cameroon.

At the level of the community sector, lack of a structured coordinating, monitoring and reporting mechanism has rendered the exchange and sharing of good practices and lessons learned difficult, creating, in many cases duplication of efforts and waste of scarce resources to respond efficiently to the epidemic.

To overcome the challenges highlighted, the following recommendations should be considered:

- HIV testing should be free and accessible;
- Wider promotion of generic ARV drugs;
- NGOs and grassroots organizations need to be given an opportunity to equally participate in the provision of essential treatment, care and prevention services;
- With poverty being the root cause of the epidemic in the country, more programs need to be implemented with a focus on poverty alleviation;
- Implement gender sensitive programs; and
- Creation of a national HIV/AIDS monitoring and evaluation, information, and documentation centre that will act like a watchdog over the implementation of the national strategy, and will also facilitate the creation of a more unified response.

COUNTRY PROFILE: CANADA

Sourced from report by AIDS Calgary Awareness Association

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	32,268,000
LIFE EXPECTANCY AT BIRTH FOR MEN	78
LIFE EXPECTANCY AT BIRTH FOR WOMEN	83
NUMBER OF PEOPLE LIVING WITH HIV	60,000 [48,000 – 72,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	9,600 [7,700 – 12,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.3%
DEATHS DUE TO AIDS	< 1,000

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

Overall, there is a lack of political leadership from Canadian leaders with respect to HIV/AIDS, both domestically and internationally. Most references to the epidemic are made in the context of funding announcements. Canada does not have a National AIDS Council; however there are several HIV/AIDS national committees which are proxies for such a council. Canada's current HIV/AIDS Action Plan is defined by two documents that provide an opportunity for all parts of the country and all organizations involved in HIV/AIDS to come together as part of a larger, nation-wide effort. The goals of the Action Plan include: involving PLHIV in the programs and services that affect their lives; prevent HIV infection; ensure access to care, treatment and support; and provide leadership.

Community Sector

The community sector has been instrumental in the development of Canada's Federal Initiative by advocating for adequate funding and for their meaningful involvement in developing the Action Plan. In 1998, when the Canadian Strategy on HIV/AIDS (CSHA) was launched, Health Canada recognized that it could not address the issue on its own. Starting in 2000, civil society was involved in a series of consultations and committees to develop the Action Plan. Community sector groups, for the most part, have a basic awareness of the Declaration, but only a few have a working knowledge or actively use the document as a tool.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

While Canada has the right principles in place to provide access to treatment and care, the difficulty is putting those principles in practice. There are significant inconsistencies in access to treatment based on geography and sub-populations as a result of the marginalization of certain groups. PLHIV in Canada do not always have the information that they need to understand their ARV therapies and their side effects. There are also inequities in access to treatment for specific populations. In urban settings, it is much easier to access information in a confidential way than it is in rural areas. The situation is the worst among the Aboriginal populations as there is no jurisdictional responsibility for ensuring access to treatment for off-reserve Aboriginal people.

Generally, Canada lacks population-specific strategies that provide confidential, culturally and linguistically relevant HIV/AIDS treatment and treatment information for different groups of people living with HIV/AIDS.

Prevention

In theory, all HIV prevention tools (e.g., male and female condoms, lubricants, clean needles, methadone substitution therapy) are available and accessible across Canada, except in prisons where institutional policies prohibit access to clean needles and in some cases condoms. In practice, even outside of prisons, most vulnerable populations (e.g., youth, Aboriginal communities, small rural communities, refugees, trafficked women) have very uneven access to these prevention tools. Prevention initiatives are largely led by community organizations working directly with the vulnerable populations.

Most prevention messages in Canada have targeted MSM and gay men, injection drug users and youth, although there are some worrisome findings about the level of knowledge and risk behaviours amongst Canada's youth.

Limited messages have been targeted to women, sex workers, migrants and mobile populations, and very few prevention initiatives have been implemented for prisoners and transgendered and bisexual people. More Aboriginal, youth-specific services and prevention programs need to be developed and maintained. Rural areas, isolated areas and on-reserve need special attention. More targeted prevention messages that recognize the unique cultures of First Nations, Métis and Inuit youth need to be developed and maintained.

Vulnerable Groups

People living with HIV in Canada still face significant levels of stigma and discrimination, and people who are vulnerable to HIV face policy and systems barriers that put them at greater risk of HIV. Canada's HIV rates continue to rise both amongst isolated vulnerable populations such as injection drug users and men who have sex with men, but also through heterosexual contact and increasingly amongst women. Aboriginals continue to be disproportionately affected by HIV, and HIV amongst people from countries where HIV is endemic is the fastest increasing risk category.

There are significant legal and policy barriers that adversely affect people at risk of or living with HIV/AIDS, creating and exacerbating situations of stigma and discrimination, leading to covert behaviours, risk of violence and HIV infection. Legal and policy sanctions against drug use, sex work, and needle exchange in prisons create situations in which people become more vulnerable to HIV transmission. As of 2005, no Canadian prison system had yet started a needle exchange program. Other policy issues are problematic from human rights perspectives, such denial of immigration for people living with HIV, opt-out HIV testing policies for pregnant women and mandatory collection of blood for recipients of emergency services.

Women: The government of Canada has not developed a strategy specifically to protect and to provide opportunities for empowering women in the context of the AIDS epidemic, although "women at risk" are one of the vulnerable groups named in the Federal Initiative. No strategies specific to empowering women are mentioned in the Federal Initiative or Leading Together. Rather, women are mentioned in a general context along with others groups of people vulnerable to HIV/AIDS. Recently, the Public Health Agency of Canada has been working with the coalition called "Blueprint for Action on Women and HIV/AIDS" in order to discuss the draft Framework on Population Specific Approaches for the Federal Initiative and to identify priority actions for women. This action is vital to bring more attention to the issue of women's vulnerability with regards to HIV/AIDS as women continue to suffer from limited access to care, treatment and prevention services.

Aboriginal populations: There are a limited number of First Nations[4] prevention programs. In particular, aboriginal youth under the age of 15 (together with IDUs) is the group most in need of HIV prevention messages, but are among the least likely to be receiving them.

African-Caribbean populations: The are now efforts underway by the African and Caribbean Council on HIV/AIDS in Ontario to develop a National HIV/AIDS Strategy for Black Canadian, African and Caribbean Communities.

Youth: Recent studies have showed that the overall knowledge of HIV/AIDS among Canadian youth is very low. HIV/AIDS education in Canada's public education sector is hugely inconsistent. In some provinces and territories, HIV/AIDS education begins early in elementary school, while in others HIV/AIDS is only first mentioned much later and the programs include very limited information.

IDUs: Published estimates of national HIV prevalence and incidence indicate that 30 percent or 800-1,600 of the estimated 2,800-5,200 new HIV infections that occurred in Canada (latest figure available is 2002) were among injecting drug users. Current regulations make it a criminal offence to possess, import, export, or traffic not only the drugs themselves but also "anything that contains or has on it a controlled substance and that is used...in introducing the substance into a human body." This means that if a syringe or other equipment used for injecting drugs contains residue of a drug, that equipment is technically a "controlled substance" and the person with the syringe could be found guilty of possession.

Sex workers: No specific mention of sex workers as a vulnerable population is made in the *Federal Initiative*. Sex work is not illegal in Canada. However, the majority of activities surrounding prostitution are illegal under the Canadian Criminal Code and sex workers are criminalized even if they work in private (e.g., their homes).[5]

Prisoners: A number of studies have provided evidence of the extent of injection and other drug use in prisons. Sterile injection equipment should be made available in prisons where prisoners inject drugs. As of 2005, no Canadian prison system had started a needle-exchange program. However, a few systems, including the federal prison system, are studying the issue.

In prisons, sexual activity is considered to be a less significant risk factor for HIV and hepatitis C transmission than sharing of injection equipment. In some provincial prisons, condoms and lubricant are not available, and in many provincial prisons they are not easily and discreetly available. Some jurisdictions such as Ontario, Alberta, and Nova Scotia, among others, continue their policy of making condoms available only through prison health services.

PLHIV: While the law in each province and territory prohibits discrimination based on a person's HIV/AIDS status, there is no explicit reference to HIV/AIDS in the various anti-discrimination statutes. Rather, they refer to "disability" or "handicap." One issue that is a significant focus in Canada is that people living with HIV face numerous barriers with respect to remaining in employment or returning to employment after taking disability or sick leave. There are many issues faced by people living with episodic disabilities, such as HIV, in Canada. While Canada enacted human rights legislation, and included PLHIV under the umbrella of physical disability, enforcement of this legislation remains inadequate. In most cases, it is up to the individuals who experience discrimination to know their rights. This enforcement mechanism presents a problem since in order to access their rights; people must first have access to basic human rights information and rights-based education. Given the nature of HIV/AIDS related stigma, national and community-based organizations have a key role to play in eliminating discrimination by bridging the enforcement gap.

Voluntary counseling and testing (VCT)

Canadians choosing to be tested for HIV have three different testing options depending on the province or territory in which they reside. These options include: nominal/name-based HIV testing; non-nominal/non-identifying HIV testing; and anonymous testing. A barrier to HIV testing for on-reserve Aboriginal people is the lack of confidentiality. Often, community health centres on reserves are run by friends or family members of community members, thus compromising the issue of confidentiality.

4. MONITORING AND EVALUATION

A monitoring plan has not yet been established for Canada's Action Plan. The Federal Initiative states that coordination, planning, evaluation, and reporting will be enhanced to optimize both the federal and pan-Canadian responses to the epidemic and the use of resources. The focus will be on supporting the implementation of Leading Together and the development of issue-specific plan and an evaluation strategy for the Federal Initiative. Integral to this will be mechanisms that enhance the engagement of people living with and vulnerable to HIV/AIDS.

5. LESSONS LEARNED

Canada has not made enough progress with respect to addressing the determinants of health that make individuals vulnerable to HIV, addiction, and violence. People living with HIV in Canada still face significant levels of stigma and discrimination, and people who are vulnerable to HIV face policy and systems barriers that put them at greater risk of HIV. Canada's HIV rates continue to rise both amongst isolated vulnerable populations such as injection drug users and men who have sex with men, but also through heterosexual contact and increasingly amongst women. Aboriginals continue to be disproportionately affected by HIV, and HIV amongst people from countries where HIV is endemic is the fastest increasing risk category. A significant percentage of youth in Canada is complacent about HIV, perhaps due in part to misinformation – some believing for instance, that a cure for HIV/AIDS already exists.

Civil society and government generally work well together to address HIV/AIDS from a multi-sectoral, multi-stakeholder perspective, and Canada's newest incarnation of a national HIV/AIDS strategy, the Federal Initiative, brings new hope that HIV will be addressed from across the federal government and not just by a Ministry of Health. However, Canada still needs to assemble an overarching coordinating body which would champion, implement, and monitor a strategic plan. Civil society would also like to see national leaders speak about HIV/AIDS to the public to help raise awareness and reduce stigma in speeches outside funding announcements.

4. It refers to indigenous peoples of North America located in what is now Canada, and their descendants, who are not Inuit or Métis. Collectively, First Nations, Inuit, and Métis peoples are known as Aboriginal peoples.
5. Canadian HIV/AIDS Legal Network: Sex work, rights: reforming Canadian criminal laws on prostitution, July 2005.

COUNTRY PROFILE: EL SALVADOR

Sourced from report by Asociación Atlacatl Vivo Positivo

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	6,881,000
LIFE EXPECTANCY AT BIRTH FOR MEN	68
LIFE EXPECTANCY AT BIRTH FOR WOMEN	74
NUMBER OF PEOPLE LIVING WITH HIV	36,000 [22,000 -71,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	9,900 [5,300 – 21,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.9% [0.5 – 3.8%]
DEATH DUE TO AIDS	2,500 [1,600 – 3,700]

Source: UNAIDS 2006 Report on the global AIDS Epidemic

1. RESPONSE TO HIV/AIDS

Government

There is a National Council of HIV/AIDS, which is regulated by the AIDS Law. This Law also created in 2004 the National Commission against AIDS (CONASIDA), which works as an advisory body to the Ministry of Health. CONASIDA includes people representing ministries and other governmental institutions, as well as NGOs and the private sector.

Community Sector

There was a greater participation of the different stakeholders in the design of the National Strategic Plan 2005-2010 in comparison to the process in 2001 (for the 2001-2004 Plan). In 2001, only 22 organizations participated actively. Whereas in 2005, 73 organizations participated (government institutions, community sector organizations, associations of PLHIV, and international development agencies).

Access to treatment in El Salvador was initiated thanks to pressure from community sector organizations, who initially sought a dialogue with the government. When the dialogue did not yield any results, they carried out protests. Later on, they sued the government in the Supreme Court, ending with a collective action against the State in the Inter American Commission on Human Rights. After this, the government began recognizing the importance of the participation of the community sector in the program design and implementation.

2. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

Access to ARVs is established in the National Policy for HIV/AIDS. In 2001 (when the government started ARV therapy), ARVs were provided in only four national hospitals. By December 2004, ARVs were provided in 16 hospitals covering a total of 2,000 people (in addition to more than 600 covered by the Social Security system) – which is about 36 percent of those in need of ARVs. ARVs are provided without cost, but other medicines carry a fee that needs to be paid by the patient.

However, the marked influence of Christian groups in the country has motivated people not to take or to abandon ARVs because they are being told to put their lives “in God’s hands”.

Although ARVs are part of the Essential Drug List, their delivery is not timely and continuous, and tests for viral load and CD4/CD8 are not carried out properly. This is mainly due to lack of supplies for conducting diagnostic tests. There is also the issue of over-crowded hospitals and the waiting period to see a doctor.

Prevention

The Integral Assistance Policy includes strategies for primary prevention based on abstinence, faithfulness and the use of condoms (known as ABC), and secondary and tertiary prevention actions that contribute to the reduction of HIV and STI.

The most common preventive tool is male condoms, which are provided for free in the hospitals and by support groups and NGOs. They can also be purchased in supermarkets and pharmacies, though some pharmacists refuse to sell them due to religious beliefs. Although some NGOs in their prevention campaigns inform people about the female condom, it is not available.

Vulnerable Groups

There are regulations and campaigns that reflect the government's commitment to offer quality services, without distinction of race, sexual orientation, or political and/or religious beliefs. However, stigma and discrimination toward PLHIV and other vulnerable groups occurs due to fear, ignorance about AIDS, and the lack of human rights approaches within the AIDS NGOs.

There is no law or policy against homosexuality or sex work. But among the under-aged, sex work is illegal; and the use, possession or trade of drugs is illegal under the anti-drugs law. In El Salvador, the Penal Code prohibits 'improper behaviours' in public spaces, which has been interpreted to mean that sex work in public places is prohibited. There is legal protection to avoid discrimination against PLHIV through the Constitution, Health Code, and Labour legislation.

The legal framework in El Salvador, from the theoretical point of view, protects the rights of PLHIV, without making specific distinction of sexual orientation, work/profession, political affiliation or religious beliefs. But even with the framework protecting rights, no sanction has been imposed against those who violate the law.

Women: Addressing gender inequality is included in the National AIDS Policy, and some concrete strategies have been planned, such as the need to implement programs to reduce violence against women and girls. A study carried out by the Atlacatl Association found that women living with HIV/AIDS are forced to be sterilized or are automatically sterilised when they have had their children, without consent, a clear violation of their human rights.

MSM: Action is needed to reduce the exclusion of the MSM population in El Salvador so they can have real access to all services. MSM, lesbians, gays, bisexuals, and transgendered people are still subject to discrimination in the health care setting. Some MSM reported that they were asked to change their behaviour because it goes against "God's principles".

IDUs: There have not been any studies of services for injection drugs users; perhaps due to the fact that national statistics show a low prevalence amongst this group (one percent of the total reported cases of HIV are due to injection drug use). Even though the commercialization and consumption of drugs in El Salvador are penalized, disposable syringes and needles can be easily purchased in any pharmacy, since they are sold without prescription to be used with legal medications.

PLHIV: The protection of the rights of PLHIV in the workplace is established in the Salvadorian legal framework. However, more work needs to be done in this field, so that the norms established in the legislation are implemented and enforced. Testing without consent and violation of confidentiality are just some of the issues that need to be dealt with. When a person is diagnosed with HIV, automatically he/she loses the right to access bank credits, housing and life insurance as banks and insurance companies request an HIV test or they make their clients sign a document where they authorize them to investigate their medical record.

Voluntary Counseling and Testing (VCT)

There are more than 160 VCT centres – 132 are operated by government, including the Social Security system; eight are operated by NGOs (providing counseling services only); and the rest are run by private laboratories. However, not all 160 provide counseling and testing. In 2004, almost two hundred thousand HIV tests were administered.

4. MONITORING AND EVALUATION

The current M&E systems only track epidemiological data, so it is necessary to make it more inclusive and comprehensive. For example, the current system does not provide specific information by groups (such as MSM, sex workers and prisoners), so they are left out of the prioritizing of strategies.

Recently, the National AIDS Program conducted an internal evaluation of the network of public hospitals where ARV therapy is offered. The evaluation not only looked at the technical aspects of the services provided, but also at the quality and the human aspects of the services. The results of this evaluation formed the basis for internal restructurings of the program.

5. LESSONS LEARNED

The gathering of information for the elaboration of the country report, showed that there is an increasing political will to address the challenges of the epidemic, but this political will has not yet translated into real commitments. This is particularly true in relation to the inclusion of the other sectors of society in the response to HIV/AIDS.

Despite the current gap between theory and practice; laws, policies and programs; and design and implementation, PLHIV and the community sector in general have understood that they can use the existing legal framework to claim their rights.

COUNTRY PROFILE: HONDURAS

Sourced from report by Nelson J. Arambú (lead researcher)

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	7,205.000
LIFE EXPECTANCY AT BIRTH FOR MEN	65
LIFE EXPECTANCY AT BIRTH FOR WOMEN	70
NUMBER OF PEOPLE LIVING WITH HIV	63,000 [35,000-99,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	16,000 [7,500-27,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	1.5% [0.8-2.4%]
DEATH DUE TO AIDS	3,700 [2,000 – 6,200]

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

Recently, the government has intensified its efforts to improve its HIV/AIDS response. The Second Strategic Plan of HIV/AIDS, PENSIDA II, was designed with the participation of different actors and sectors which traditionally were not involved in the national response (51 percent of the participants from the community sector, including vulnerable groups and PLHIV). Although PENSIDA II is a comprehensive document that supports multisectoral participation, there are no direct mechanisms for consultation with, or participation by, the community sector in the development and implementation of programs, or monitoring and evaluating of their results.

The position of the government with respect to the most vulnerable groups – MSM, female sex workers, and IDUs – is not clearly defined. The emphasis with respect to vulnerability has centered on children and youth.

Community Sector

Community sector involvement has been led by a variety of actors and has focused on the prevention and treatment of STI and HIV/AIDS, offering services related to the promotion of sexual and reproductive health, education, VCT, advocacy, and monitoring and fighting violations of human rights. The community sector has focused its efforts on PLHIV, communities of Garífunas[6], sex workers, MSM, children and orphans, young people, and prisoners

The role of the NGOs is very important since it has filled some of the gaps in the government-led interventions. The advocacy that NGOs have undertaken over many years has led to forcing the government to assign greater resources to respond to the problem.

The partnership between the government and the community sector has not yet been developed to the point where communities can be seen as partners that must be involved in the important decision-making process. Instead, the community sector is seen as an implementer of programs in support of the government's work.

The only permanent dialogue between civil society and government is within the national structure of the Global Fund. The Country Coordinating Mechanism (CCM) was formed on the basis of multisectorial participation and has representatives from all the country's political, social and economic sectors: the government, with the support of the United Nations in Honduras, multilateral and bilateral development organizations working on HIV/AIDS, tuberculosis and malaria, community sector organizations, and associations of affected people (HIV/AIDS and tuberculosis).

3. NATIONAL HIV/AIDS POLICY AND ITS IMPLEMENTATION

Access to Treatment, Care and Support

Access to treatment has partially improved: 3,630 people with AIDS were receiving ARVs in 19 Integral Attention Centers between 2002 and 2005. However, obstacles to the implemen-

6. Ethnic group in the Caribbean area, descended from a mix of Amerindian and African people

tation of a treatment program ranged from economic constrains to pure bureaucracy (and overall inefficiency of the system). For example, after three years of the implementation of the Global Fund grant, the government and the community sector have not developed a strategy for universal access to ARVs and still, only 10 percent of those in need are receiving treatment.

One of the most often-mentioned challenges with respect to ARVs is the Central American Free Trade Agreement (CAFTA); which was approved and ratified by the Honduras's Congress in 2005. The agreement, for example, limits purchasing of generic medication from other countries in the region. However, community groups did not play an aggressive role in the process, perhaps due to an insufficient understanding of the possible implications.

Prevention

Basic prevention tools are available, especially male condoms, lubricants, sterilized injection equipment, and disinfectants. However, there is no availability of female condoms. Male condoms are available in health centers, pharmacies, bars, clubs, and some hotels and motels, but the general public knows little about them. Also, the expansion of the program for the prevention of mother to child transmission (PMTCT) has aided prevention efforts. Finally, intense activities to raise awareness of the importance of prevention with significant participation from diverse civil society organizations, among which include religious organizations and the private sector, has also significantly improved prevention efforts in the country. The government's prevention strategies emphasize the use of the male condom as the primary tool for prevention. However, neither lubricants nor female condoms are included in these campaigns.

Vulnerable Groups

The PENSIDA II establishes the promotion and defence of human rights as one area of work. Strategies include increasing the knowledge about the national legal framework related to HIV/AIDS and human rights; strengthening the monitoring mechanisms, as well as strengthening the capacity of civil society to use the mechanisms created for monitoring, denouncing and redressing violations of human rights related to HIV/AIDS. The Special Law on HIV/AIDS and the AIDS Plan includes protection of the rights of vulnerable groups, but does not emphasize protection of the human rights of PLHIV.

Women: No information is available with respect to the government's response to issues concerning women, at least in terms of concrete actions. Women's organizations and feminist groups have led the process, but they are not officially considered national actors on HIV/AIDS. They are not dealing with HIV issues exclusively, and have several projects that focus on raising general awareness of women's issues. The PMTCT program is only focused on the child and not the mother.

MSM: There are no legal barriers to people accessing ARVs, although many MSM have complained about the difficulties to access ARVs and overall treatment. The traditional answer from medical personnel is that they are not the first priority. This same situation is faced by drug users and gang members. According to some complaints from the MSM community, ARV access protocols privilege pregnant women, children and youths, and men who are fathers. MSM and other groups are considered to be less important in order of priority, which is caused by homophobia, social exclusion, religious traditionalism, and the moral values of health personnel. Although in theory the legal framework does not penalize homosexuality, in practice they are discriminated against. This causes these groups to be socially, politically, and culturally excluded. Additionally, there are few projects directly dealing with MSM issues. It was only in 2004, after 10 years of fighting, that three gay and lesbian organizations were granted legal status.

Sex Workers: Sex work is considered a felony. This has an impact on their vulnerability to HIV infection. The response at the government level and among NGOs has focused primarily on prevention and information campaigns on STIs and HIV; these campaigns have placed a clear emphasis on the use of condoms. However, a challenge remains to also ensure that sex workers are empowered to exercise their rights and liberties.

PLHIV: One of the most important positive efforts of the HIV legislation has been the emphasis on the promotion and protection of human rights. However, efforts to improve and implement this legislation are still very weak. In 2005, there was an attempt to pass legislation to make HIV/AIDS tests mandatory in order to access jobs and education. The community sector mobilized and advocated against this attempt and the effort paid off, but this success was a product of a belligerent opposition rather than an open dialogue. Discrimination can be found throughout the educational sector, from access and coverage to mistreatment of students with HIV/AIDS.

Youth: Resources and efforts invested in trying to control and reduce the impact of the epidemic are primarily focused on youths. One of the ongoing discussions is on the way in which youth are (or are not) involved in HIV-prevention initiatives. Youths have had a more active participation role in prevention campaigns.

Voluntary Counseling and Testing (VCT)

The counseling component of the VCT program is a very important one, and in Honduras it has included government, civil society and donors coming together in partnership. The STI-HIV/AIDS Program established a Counseling Network, which is strengthened by means of training and capacity building. These capacity building opportunities also allows for monitoring of staff's efficiency. According to the 2005 HIV/AIDS Programs Progress Report on Counseling, there is an active participation of different stakeholders that deal with counseling and psychological assistance.

VCT services through the public health system are free. The most common difficulty reported by vulnerable groups is the moral questioning by some staff members, especially toward MSM and sex workers.

One issue that needs immediate attention is the fact that an HIV test is mandatory for couples wanting to get married.

4. MONITORING AND EVALUATION

PENSIDA II designed assessment processes to improve monitoring and evaluation mechanisms, tools, and processes. However, the indicators have not been developed for the different phases of implementation of the Plan and the different areas, particularly those related to human rights of PLHIV.

PENSIDA II also called for periodic national assessments with the involvement of civil society (particularly PLHIV), vulnerable groups, and family of PLHIV.

5. LESSONS LEARNED

The information available shows the diversity of actors involved, an impressive amount of data, and many expectations; but at the same time, few voices, limited access to information, and, every day, more HIV cases, more orphaned children, and more young people exposed to HIV infection because of lack of information.

In spite of the importance and repercussions of the UNGASS Declaration of Commitment, there has been limited dissemination of its content. Few people and organizations that work on HIV/AIDS fully grasp the commitments and responsibilities that all those involved need to assume to reduce the incidence and the impact of HIV infection and to improve the quality of life of the most vulnerable groups.

COUNTRY PROFILE: INDONESIA

Sourced from report by PITA Foundation

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	222,781,000
LIFE EXPECTANCY AT BIRTH FOR MEN	65
LIFE EXPECTANCY AT BIRTH FOR WOMEN	68
NUMBER OF PEOPLE LIVING WITH HIV	170,000 [100,000-290,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	29,000 [15,000 – 52,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.1%
DEATHS DUE TO AIDS	5,500 [3,300 – 8,300]

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

With the widening threat of the HIV epidemic, in 1994 the government of Indonesia issued a special regulation to establish the National AIDS Commission and appointed the Coordinating Minister of People's Welfare as the head. According to the policy, every province and district from that point on was to have the Governor and City Mayor as the head of a Provincial AIDS commission.

The National AIDS Commission formulated the first National Strategy on HIV/AIDS in 1994 and developed a National AIDS Program in 1995. In March 2002, the Government held a special Assembly on HIV/AIDS that was directly led by the President. The Assembly covered in detail the state of HIV epidemic in Indonesia, using the UNGASS Declaration as a guide. The latest effort was the implementation of a National Strategy on HIV/AIDS 2003-2007, which outlined a series of comprehensive prevention and treatment programs.

Community Sector

The Government of Indonesia has developed and implemented the National AIDS program using a multi-sectoral approach. The role of the community sector in the multi-sectoral strategy started in 1998. Since then, community sector actors have provided feedback through seminars, forums, workshops, informal meetings and consultations. Although the intention was to create favourable conditions for the meaningful involvement of communities, in reality the process has not been completely satisfactory, as very few NGOs have an effective communication with the government.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

In the most recent National HIV/AIDS strategy (2003-2007), the priority areas included care, treatment and support. Since 2001, ARVs are sold at lower prices as a result of negotiations with Indian pharmaceutical companies. In January 2004, the Indonesian Department of Health participated in the "3 by 5" campaign, committing to subsidize drugs for 5,000 PLHIV across the country by the end of 2004, with a view to increase the target to 10,000 by 2005. The availability of ARVs and its distribution is managed by the government.

Prevention

The National Strategy on HIV/AIDS stated that prevention programs need to start from increasing knowledge and skills concerning the means of transmission and how to prevent infection. The prevention program includes: increasing healthy lifestyles, life skills education, peer support group education, counseling, harm reduction, STI control, blood safety, and prevention of mother to child transmission. Some of the prevention messages, however, are heavily criticized by religious organizations that claim that the messages promote sex.

Many provinces are still not able to implement prevention program because of a lack of funds.

Vulnerable groups

Youth: The government of Indonesia, in cooperation with UNICEF, and through the Department of National Education, established a program on life skills education for high school students. UNESCO has also held a seminar about youth and HIV/AIDS, and is planning to work with the Department of Education to develop HIV/AIDS-related activities for youth.

MSM: There are special services for MSM in most provinces in Indonesia that are managed by NGOs. But many MSM are reluctant to use services available because of the conservative and stigmatizing societal attitudes.

Sex workers: In Bali, services are provided to sex workers. These services include HIV testing, STI screening, and other women's related health issues. In North Jakarta, the outreach programs have been done for sex workers in the forms of seminars, condom campaigns, and skills training.

PLHIV: Indonesia has a law protecting the rights of PLHIV from discriminatory treatment and behaviour. The Anti-Stigma and Discrimination campaign is a national strategy for overcoming unfair treatment of PLHIV and other vulnerable groups. Although anti-discrimination policies exist, in practice mistreatment continues.

Voluntary Counseling and Testing (VCT)

VCT is not widely available in Indonesia, as there are only a few testing sites in the whole country. Lack of trained personnel presents a major problem. Where test centers do operate, they are not promoted and individuals are not aware of their existence. The price of a test also presents a barrier. It is often unclear how much a test costs. There is some surveillance of the vulnerable groups, primarily injection drug users and sex workers, but there are no programs to reach out to transgender population (even though there is evidence that HIV prevalence among this group is high).

4. MONITORING AND EVALUATION

The National Strategy on HIV/AIDS in Indonesia 2003-2007 regulates the monitoring, evaluation and implementation of all national HIV/AIDS programs and policies. HIV surveillance has become the responsibility of the Department of Health.

5. LESSONS LEARNED AND RECOMMENDATIONS

Despite the relative progress with the implementation of HIV/AIDS national policies, the Indonesian government still has to develop an efficient enforcement mechanism. Reaching out to vulnerable groups, especially IDUs and sex workers remains a barrier to achieving universal access to treatment, prevention and care. A more constant and effective inclusion of the community sector and other stakeholders needs to become a reality in order to achieve effective policy implementation.

COUNTRY PROFILE: IRELAND

Sourced from report by Gay HIV Strategies – Gay and Lesbian Equality Network (GLEN) and Health and Development Network (HDN)

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	4,148,000
LIFE EXPECTANCY AT BIRTH FOR MEN	75
LIFE EXPECTANCY AT BIRTH FOR WOMEN	81
NUMBER OF PEOPLE LIVING WITH HIV	5,000 [3,000 – 8,300]
WOMEN AGED 15 AND OVER LIVING WITH HIV	1,800 [920 – 3,200]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.2%
DEATHS DUE TO AIDS	<100

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

The Irish government's response to HIV can be evaluated in three phases. Phase One (1983-89) was slow, with little investment from the government. Phase Two saw effective engagement through the 1990s with the setting up of the National AIDS Steering Committee (NASC), the funding of a variety of agencies, and the development of a national strategy. In phase Three, from 2001, the Irish government has been criticized for not making HIV a high priority and for not reviewing the NASC strategy to meet the new realities of the epidemic. Currently the major obstacle to reviewing progress is that the strategy lacks benchmarks.

Community Sector

NGOs value cross-sector collaboration and there is a strong sense of partnership both among NGOs and also between NGOs and government agencies. However, there is a general consensus among NGOs that they are not valued by the government sector and their representation is merely symbolic.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

Access to a variety of HIV/AIDS-related services is considered poor. A strong urban/rural divide exists in the ability to access services. Young people have especially been affected by poor access to information about HIV/AIDS. Many services are reluctant to provide contraceptives or safer sex commodities to young people under 16, despite the fact that many of them are sexually active. Payment for services and commodities also makes it difficult for many to access them. This especially concerns asylum seeker, refugees and migrants.

Prevention

It has been suggested that prevention measures are difficult to measure because of the absence of benchmarks. In the context of the recommendations of the Education and Prevention Sub Committee it is recognized that many of the prevention recommendations have been carried out, however others still require immediate attention. Simultaneously there needs to be a specific secondary prevention strategy to directly target HIV-positive individuals.

Vulnerable Groups

Youth: HIV prevention among young people is being compromised consistently by the ability of schools to abstain from all or parts of the Social and Personal Health Education (SPHE) program. Faith based exemptions mean that targets cannot be met and poses a challenge for health educators as to whether they should engage with a particular school. It was also noted that even where a safe sex message could be delivered at school it was often seen as a one-time effort rather than ongoing process.

IDUs: Services to drug users have traditionally been based in Dublin as it was once the case when drug use was rare in other parts of the country. This is no longer the case, but service provision does not reflect that. Drug dependency services are confined to methadone maintenance and do not seek to support drug users who choose to continue injecting.

MSM, sex workers, and migrants: There are certain services targeting migrants, sex workers and MSM but they are all provided by local NGOs that are taking the initiative or responding to client needs. Some NGOs have long-term commitments to engage with migrants.

Women: There is no knowledge of national strategies targeting women and young girls to reduce vulnerability to HIV. Some NGOs have capacity building programs and training to encourage women to make decisions regarding their health. The strategy on fertility control for young women should include HIV prevention. Maternal and ante-natal care/HIV prevention has been highly successful.

Voluntary Counseling and Testing (VCT)

In Ireland diagnostic and treatment services are free but operate within similar constraints of geographical access and often have long waiting lists. Drop-in provision and a waiting list of 6-8 weeks are not uncommon.

4. MONITORING AND EVALUATION

In general, the surveillance system is good and the relevant data is made available. Concern were raised, however, about the ability for health providers to fulfill their obligation for data collection because data is not systematically collected at the point of service delivery or it is not being reported back to the Health Protection Surveillance Center. Concern was also expressed about the monitoring of migrants data, as it does not reflect the movement of asylum seekers and refugees.

5. LESSONS LEARNED AND RECOMMENDATIONS

A national sexual health strategy should be developed to incorporate HIV prevention, treatment and care. HIV should be considered in the context of general sexual health promotion. The strategy should include clear outcomes and benchmarks for evaluation.

Awareness of what the government has committed to is also very variable with the majority of NGOs. It suggests that the government should do more to inform people of both its commitments and its successes, where it meets them.

COUNTRY PROFILE: JAMAICA

Sourced from report by Jamaica AIDS Support (JAS)

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	2,651,000
LIFE EXPECTANCY AT BIRTH FOR MEN	70
LIFE EXPECTANCY AT BIRTH FOR WOMEN	74
NUMBER OF PEOPLE LIVING WITH HIV	25,000 [14,000 – 39,00]
WOMEN AGED 15 AND OVER LIVING WITH HIV	6,900 [3,300 – 12,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	1.5%
DEATHS DUE TO AIDS	<500

Source: UNAIDS 2006 Report on the global AIDS Epidemic

1. RESPONSE TO HIV/AIDS

Government

As a department within the Jamaican Ministry of Health, the National AIDS Program coordinates the prevention, treatment and control of HIV/AIDS and other sexually transmitted infections (STI). The program includes the following components: research; STI control and prevention; HIV/STI surveillance; treatment, care and support; capacity building; and monitoring and evaluation. The National AIDS Program developed the Jamaica HIV/AIDS/STI National Strategic Plan for 2002-2006. The plan outlines a comprehensive and multi-sectoral approach to the epidemic and has been divided into four priority areas: 1) policy, advocacy, legal and human rights; 2) multi-sectoral response; 3) prevention; 4) surveillance, monitoring and evaluation.

The National Strategic Plan also includes workplans for the main ministries related to HIV/AIDS such as the Ministry of Education, Youth and Culture; the Ministry of Local Government; and the Ministry of Tourism and Sport. Each workplan contains ministry-specific goals with accompanying activities for implementation.

Community Sector

The National Strategic Plan (2002-2006) was developed with input from a variety of community sector organizations through informal dialogues, meetings and focus groups. Progress reports and review drafts were distributed to some community organizations through email, although this method significantly limited the involvement of those organizations without proper access to the internet. Some considered the process successful in representing their views; others, especially PLHIV, felt that the government misinterpreted their input. In general, few community organizations are aware of the UNGASS DoC and only one organization claimed involvement in any national review of progress toward implementation of the commitments. No organization claimed to have used the document as an advocacy tool. The representatives that are aware of the commitments are routinely involved in assisting the government in its commitment to implementation of the commitments. They run various outreach programs, organize condom distribution, and conduct a range of HIV education activities.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

The HIV/AIDS/STI National Strategic Plan 2002-2006 calls for improved treatment and care of PLHIV. Through resources provided largely through the Global Fund, access to ARVs, support systems to ensure adherence to the drug regimen, nutritional interventions, and palliative care (including home-based and hospice care) were enhanced.

Despite major media campaigns, stigma and discrimination still discourage HIV-positive individuals from accessing treatment. Groups with double stigma, especially MSM and sex workers, find these fears especially paralyzing. Adding to this fear is a legitimate concern about the degree of confidentiality. Policies on paper do not always translate into clear understanding of a proper behaviour by health care workers. Fears about confidentially discourage many Jamaican from seeking testing and treatment until their health deteriorates severely.

Prevention

The National Strategic Plan identifies prevention as one of its five priority areas. The plan lists eight prevention objectives within this priority area including: increase condom use, promote responsible sexual behaviour, increase focus on high risk groups, expand VCT, reduce mother to child transmission, and provide post-exposure prophylaxis. Varying degrees of progress have been made in these areas. In general, civil society reports that the availability of prevention tools is quite variable. Male condoms are widely available. Female condoms, because of the higher cost, are not as accessible although can be found in pharmacies. A variety of educational and behaviour change materials related to prevention of HIV are provided to the public through programs supported by Ministry of Health and community groups.

Vulnerable Groups

Women: The National HIV/AIDS policy calls for more equal gender relations and empowerment of women as a vital component of a successful prevention program. The specific prevention programs focusing on women is prevention of mother to child transmission, infant feeding options, access to voluntary counseling and testing and ARV treatment, and counseling for pregnant women.

MSM: MSM are considered the most vulnerable group in Jamaica because of the homophobic attitudes among general public. This makes it difficult to provide prevention services to them. As a result, only one NGO provides 'safe space' for this group and only two conduct prevention interventions specifically addressing their needs.

IDUs: Intravenous drug use is not common in Jamaica and therefore is not seen to pose a significant threat to the containment of HIV. This results in a lack of any real prevention programs targeting this group. It also leads many prevention/ treatment providers to overlook this potential risk behaviour.

Sex workers: Sex workers in Jamaica, like MSM, suffer from stigma and discrimination. A few agencies, both public and private, offer outreach programs for sex workers at strip clubs, beaches and streets where sex workers solicit clients. There are also programs supporting targeting sew workers who are also using drugs. As with the MSM population, judgmental attitudes and a lack of interest on the part of some prevention workers pose the biggest social barriers to effective prevention efforts.

PLHIV: Shame related to seropositive status discourages many Jamaicans from seeking treatment. This disease is still judged extremely negatively by many. Another very common deterrent to treatment is the fear that one's HIV status will not remain confidential. Stories of inappropriate use of information abound, whether in medical, work or school settings. Access is also often limited due to financial constraints and individuals do not seek treatment until they become critically ill.

Voluntary Counseling and Testing (VCT)

The National HIV/AIDS Policy stipulates expanded VCT as a strategy for achieving two of its four main objectives: prevention and treatment. Currently, there are around 356 testing sites in the country. Counseling is free at government and community sector facilities. Testing may be provided free, by donation, or for a payment of approximately US$3. Although identities of HIV-positive clients should remain confidential, in practice this is not always the case.

4. MONITORING AND EVALUATION

The issue of monitoring and evaluation (M&E) has received considerable attention from the National HIV/STI Control Program, especially in the past two years. During this time, the capacity of the M&E unit has been greatly enhanced. It currently tracks 104 global and/or national indicators that are linked to target outcomes, including: vulnerable groups; policy, advocacy and human rights and stigma and discrimination. Reports are generated by the M&E unit on an annual, biannual or quarterly basis. Various entities contribute data for the reports, including the Surveillance unit, the PMTCT Coordinator, the Ministry of Education, the National AIDS Committee, civil society, and others.

5. LESSONS LEARNED

A set of recommendations has emerged based on this study to various players working in the sphere of HIV/AIDS. At the federal level, the following needs to be taken into consideration to adequately address the issue of the pandemic: focus on decreasing stigma and discrimination; improve the institutional framework; address the issues of poverty, corruption, and crime; increase funding; encourage meaningful cooperation among all actors. The community sector in its own turn will have to improve its advocacy skills for effective implementation of national policies and legal frameworks; strengthen their implementation, monitoring and evaluation capacity; increase participation in and support of the National AIDS Committee, and increase fiscal accountability and transparency of all community sector organizations.

COUNTRY PROFILE: MOROCCO

Sourced from report by Association de lutte contre le sida (ALCS)

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	31,478,000
LIFE EXPECTANCY AT BIRTH FOR MEN	69
LIFE EXPECTANCY AT BIRTH FOR WOMEN	73
NUMBER OF PEOPLE LIVING WITH HIV	19,000 [12,000 –3 8,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	4,000 [2,100 – 8,400]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.1%
DEATHS DUE TO AIDS	1,300

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

The Minister of Health created the National AIDS Program (NAP) in 1988, two years after the first case of AIDS was detected. In 1989, the NAP created a short-term plan for the fight against AIDS. And then, two medium-term plans covered the periods 1991-1994 and 1996-2000. In 2002, Morocco developed a new National Strategic Plan (NSP), initially intended for 2002-2004, but it was prolonged until the end of 2005. Sustained effort and a good consultative and participatory process that lasted more than a year went into developing the NSP. However, even if the process was good, the planning exercise did not yield the results expected: the activities were not planned in detail, those responsible for each activity were not identified, and completion dates for the strategic steps were not set.

The NSP identifies the priorities related to (a) the vulnerability to HIV/AIDS (occasional or permanent sex workers, young people of both sexes, especially those who are not in school, unemployed and living in the streets, migrants and mobile populations, notably seasonal workers, men in uniform, and prisoners), and (b) the impact of AIDS (people living with AIDS and their families). The NAP is responsible for the NSP implementation. It is in charge of planning, coordination, follow-up, and evaluation of the strategies and activities performed. It mobilizes all potential partners and supports the actions of the community sector.

Community Sector

The community sector played a key role in identifying the vulnerable groups, particularly concerning sex workers who were not mentioned in the earlier AIDS plans.

NGOs frequently organize outreach prevention initiatives directed towards the general public. These are complemented by information about AIDS been provided by phone. This approach has proven to reduce the fear of being judged, and the callers receive personalized information, adapted to their level of understanding and needs.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

Morocco has an exemplary policy regarding access to ARV triple-therapy. Access to treatment is one of its greatest successes. But this success is seriously compromised by the intellectual property rules that have been adopted (TRIPS and Free Trade Agreement (FTA) with the United States). In 2005, Morocco began purchasing Indian generic ARVs, thus, the price was reduced (cost of triple therapy is around US$90 per patient per month).

The commitment of the Ministry of Health (MoH), to increase access to treatment, also resulted in an increase in budgetary allocation. Since 1999, the MoH has created a budgetary line exclusively devoted to the purchase of ARV drugs. Initially of approx. US$445,000, this line was increased starting in 2001 by approximately US$55,000 per year over 4 years.

At the moment, ARVs are only available in hospitals, which are responsible for the prescription of treatment and its modifications. Patients go to the hospitals every six months or more often if necessary. However, the MoH is engaged in a decentralization strategy in order to spare patients long, costly, and exhausting journeys.

Prevention

One of the main priorities for the NAP is the reduction in HIV infection for the vulnerable groups identified in the six priority geographical regions. The MoH implemented two main strategies; the first one refers to the first-ever national communication campaign against AIDS by utilizing all media, especially TV and radio, which are the only ways to reach the greatest number of people given the high illiteracy rate in the country. The campaign was both developed and implemented in partnership with the community sector. The second strategy was purchasing and distributing condoms. In a context characterized by strong cultural resistance, the national communication campaign constitutes a politically courageous act. However, its effectiveness has been reduced by lack of financial resources, insufficient duration, and messages not incisive enough.

Vulnerable Groups

Women: The percentage of women of the total AIDS cases rose from 8 percent in 1988 to 38 percent in 2005. This rapid progression of the number of women infected shows their vulnerability to the infection. However, women were not identified as a priority vulnerable group in the National Strategic Plan. To begin with, women are not considered a group as such, because they represent more than 50% of the population. Further, in the Plan, each group must have a specific location. This is the case for teens and school institutions; however it is not possible to assign a specific location to women.

MSM: Homosexuality is more severely punished than sex work. Male homosexuals in Morocco are forced to live their sexuality in a clandestine way in order to avoid the police and a jail sentence. Arrests are often accompanied by verbal and physical violence. Homosexuality is socially condemned. Only sexual intercourse between men and women is regarded as normal or natural. The issue of identifying MSM as a priority group was considered during the elaboration process of the NSP, but due to some opposition, MSM were left out of the list. Despite support from the Ministry of Health, outreach and social workers were arrested and accused of incitement to vice when they were distributing condoms to MSM because it was considered that they were encouraging sexual intercourse with other men.

Illegal immigrants: Initially, Morocco was only a transit country for migrants (wanting to go from Africa to Europe), but as the borders have become increasingly secure, the migrants are now settling in Morocco for a longer time. Migrants are particularly vulnerable to HIV because the national prevention campaigns do not reach them or reaches too few of them because they do not have access to media, they are 'unreachable' and do not understand Arabic. Migrants are afraid of being arrested when entering health services, jeopardizing access to healthcare and follow-up treatments. Secondly, migrants often do not have enough money to pay for care and they are rarely officially recognised as poor, so they cannot claim exemption from payment. Lastly, doctors sometimes refuse to treat them.

IDUs: Neither the government nor community groups promote any policy aimed at reducing risk for injecting drug users. The governmental approach is solely repressive. However, within the framework of the NSP review, a rapid evaluation of HIV infection in relation to injection drug use is being finalized. This study was coordinated by the Mental Sickness and Fight Against Drug-Addiction Service of the MoH, with the support from UNAIDS and the United Nations Office on Drugs and Crime (UNODC). Its objectives were to determine the number of IDU, and estimate the HIV prevalence amongst IDU. This evaluation will serve as a basis for the development of a program for IDU within the future NSP. Funds have already been planned in the second phase of the Global Fund program.

Sex workers: Sex workers are particularly vulnerable. This vulnerability is related to a combination of three main factors: it is legally prohibited (punishable by 6 months of imprisonment and a fine); discrimination and social rejection; and socio-economic vulnerability. The NSP identifies permanent or occasional sex workers, both men and women, as a vulnerable group to which priority should be assigned. This was a very courageous decision of the MoH.

Youth: Even though sexual intercourse is only legal within marriage, sex among youth outside wedlock is common. The vulnerability of young people is mostly linked to lack of knowledge, the absence of adequate information and an erroneous perception of risks. Different studies on college students show that in fact less than two-thirds of men and only one-third of women can identify condoms as a means of protection. Amongst uneducated and lower-educated young people, knowledge of HIV/AIDS is dramatically lower. The current legislation prohibits medical treatment, including HIV testing, of minors without the consent of their parents or guardian, so they either lie about their age or do not seek testing or treatment.

PLHIV: Violations of the rights of PLHIV still exist, even if the NSP expressly underlines the respect of PLHIV's rights. In the workplace, even if trade unions have not yet received any complaints, it seems that some employers require medical

certificates before hiring, which includes an HIV test. There are no specific laws protecting PLHIV from discrimination, and the government has not implemented any national mechanism committed to collect data assessing the respect for the rights of PLHIV.

Voluntary Counseling and Testing (VCT)

The first Counseling and Testing Centre (CTC) in Morocco was opened at the beginning of the 1990's in the Pasteur Institute in Casablanca. The first center managed by a community group took the name "Center for Information, Anonymous and Free Testing" in order to underline its specificities such as the exemption from payment and the guaranteed anonymity. At that time, there was no other possibility of voluntary and confidential testing offered in Morocco. People discovered their HIV status in the hospital, once they had developed AIDS or when they donated blood, which has been screened since 1988. The MoH has since then become aware of the key role of testing in the prevention strategy. The MoH has chosen community groups to manage the VCT centers. HIV testing is also offered in private structures (clinical, hospital, laboratories). In the pre-natal services of public structures, HIV testing is supposed to be offered to every pregnant woman, but in reality it is not.

During the pre-test counseling, different prevention messages are provided for the following patterns of behaviours: unprotected- in particular anal sexual intercourse; commercial sexual intercourse; and drug injections. However, people are free to answer or not the questions asked by the physician. Vulnerable priority groups identified in the NSP receive special attention and some organizations have reserved some days of consultation for the beneficiaries of out-reach prevention programs (sex workers and MSM).

4. MONITORING AND EVALUATION

AIDS cases are compulsorily reported to the NAP. The form is directly sent by the physicians to the NAP. It is anonymous and contains socio-demographic and clinical information as well as the risk factors.

There is not a comprehensive M&E system of the NSP. For example, activities carried out by community groups using external funds (for example from international organizations) are not included in any report and the MoH is not always aware of them.

5. LESSONS LEARNED

The work of community groups complements the work of the Ministry of Health. The partnership between the community groups and the Ministry of Health takes different forms depending on the activities carried out. For example, prevention work for vulnerable groups, such as sex workers, is largely undertaken by the community sector because the scope for action of the Ministry of Health is limited by cultural resistance and legislation. Concerning access to medical care, the approach is completely different, as the community sector helps reinforce the action of the Ministry of Health.

COUNTRY PROFILE: NEPAL

Sourced from report by Blue Diamond Society

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	27,133,000
LIFE EXPECTANCY AT BIRTH FOR MEN	61
LIFE EXPECTANCY AT BIRTH FOR WOMEN	61
NUMBER OF PEOPLE LIVING WITH HIV	75,000 [41,000 –180,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	16,000 [7,500 – 40,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.5%
DEATHS DUE TO AIDS	5,100

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

The 1997-2001 Strategic Plan for HIV/AIDS in Nepal was the first effort to strategize the HIV/AIDS response in the country. In 2002, a comprehensive national strategy was developed covering the period up to 2006. The strategy identified five priority areas: 1) prevention of STIs among vulnerable groups; 2) prevention of new infections among young people; 3) ensuring that care and support services are available and accessible for all people infected with HIV; 4) monitoring and evaluation; 5) establishment of an effective management system.

The strategy, however, has major setbacks as it does not mention anything about the rights of PLHIV and vulnerable groups. Moreover, the three national councils designated as official institutions for HIV/AIDS have not been effective. They are not autonomous institutions, but rather are part of the heavily bureaucratized and allegedly corrupt Ministry of Health.

Community Sector

Most community actors were not aware of the development of the national HIV/AIDS policy and strategic plan until 2005. The information was not made available in a detailed and timely manner. Moreover, the whole process and related documents were written in English, which is not a widely spoken language, and were only translated into Nepali much later.

The National Action Plan 2005/2006 for the first time incorporated the input from the civil society. The participatory process included seminars, discussion forums, workshops, and informal consultations. Despite this, no long-term sustainable partnership between government and civil society has been established.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

The most recent annual action plan has included the provision of ARVs for 1,000 PLHIV by 2006. Currently there are about 350 people receiving ARV treatment through government; however, there may be others getting drugs through other venues. Prisoners have the greatest difficulty to access treatment; most of them die even before they are diagnosed. MSM are also often denied health-care because of the stigma attached to this group.

Community sector groups have been actively involved in persuading the government to provide free ARV treatment, but their attempts are undermined by a shortage of trained doctors, nurses and community health workers for all those in need of treatment and care.

Prevention

Most prevention tools such as condoms, lubricants, clean needles, and others are available and accessible in urban centres, but are almost impossible to access in rural areas. AIDS prevention programs exist but are not suited for the general population as they exclude important messages especially those pertaining to vulnerable groups.

Vulnerable Groups

Women: There are several HIV educational awareness and prevention programs in Nepal run by various organizations to educate women about HIV/AIDS. These programs, however, are very general and do not reflect the unique position of women with regards to HIV/AIDS.

Youth: Various youth awareness programs are conducted by the non-governmental sector to increase HIV awareness and to promote prevention methods. There are many NGOs working with youth to prevent them from further use of drugs. Safe sex messages are also popularized by the media, but the messages are not clear and not very youth-oriented. The Nepalese government committed that by 2005 at least 90 percent of all young men and women will have access to the information about HIV, but so far the promise has fallen far short of its goal.

Children: The government of Nepal has not done anything so far to provide psychosocial support, education, shelter, nutrition or health care to children orphaned or infected by HIV. This issue has been completely ignored, with the exception of a few community organizations that are working with orphaned and HIV+ children.

MSM: There are no policies guaranteeing the provision of prevention services for MSM. The strategic plan has only recently identified MSM as a vulnerable group. Up until now, MSM have been criminalized because of the law referring to this behaviour as 'unnatural'.

PLHIV: There is no legislation in Nepal that protects the rights of PLHIV from discrimination. The anti-discrimination legislation bill is yet to be passed. Despite a number of programs promoting de-stigmatization and fair treatment of people living with HIV, they are still mistreated and are often denied medical services.

Voluntary Counseling and Testing (VCT)

VCT centers are located in various parts of Nepal, but mostly in the large cities. Smaller towns rarely have a VCT centre and therefore community organizations need to refer individuals to urban testing sites. The community sector has been particularly active in providing VCT, especially for vulnerable groups. But because of the lack of governmental support for these initiatives, there is a shortage of testing sites for MSM and sex workers.

4. MONITORING AND EVALUATION

The Nepalese Ministry of Health monitors its national health program, which includes HIV/AIDS, on a quarterly basis. The research process for the reports, however, does not include communities, vulnerable groups, or other sectors which is why the objectivity and accuracy of the reports is questionable.

5. LESSONS LEARNED AND RECOMMENDATIONS

An immediate review and changes are required to the national HIV/AIDS policy of Nepal. The changes should include the following: human rights; empowerment of women, girls and vulnerable groups; prevention; capacity building of the health care system; infrastructure for prevention, care and treatment; and adequate funding. The revamping of the Nepalese HIV/AIDS policy should happen with the participation of women, transgender individuals, PLHIV, and vulnerable groups.

COUNTRY PROFILE: NIGERIA

Sourced from report by the Network of People living with HIV/AIDS in Nigeria (NEPWHAN)

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	131,530,000
LIFE EXPECTANCY AT BIRTH FOR MEN	45
LIFE EXPECTANCY AT BIRTH FOR WOMEN	46
NUMBER OF PEOPLE LIVING WITH HIV	2,900,000 [1,170,000-4,200,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	1,600,000 [810,000 – 2,400,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	3.9%
DEATHS DUE TO AIDS	220,000

Source: UNAIDS 2006 Report on the global AIDS Epidemic

1. RESPONSE TO HIV/AIDS

Government

Nigeria adopted multi-sectoral and multi-dimensional approaches to the fight against HIV/AIDS with the establishment of the National Action Committee on AIDS (NACA).

NACA's main responsibilities are the coordination and monitoring of the implementation of the AIDS plan. So far, there has been some progress, but there are still huge gaps in HIV prevention, treatment, care and support, particularly at community level. The government has responded to HIV/AIDS through the establishment of one national coordinating body (NACA), one national strategic plan framework, and one monitoring and evaluation framework (the 'Three Ones') plus a National Policy on HIV/AIDS.

Community Sector

The two major civil society networks involved in HIV/AIDS in Nigeria are the Civil Society on HIV/AIDS in Nigeria (CiSHAN) and the Network of People Living With HIV/AIDS in Nigeria (NEPWHAN). While CiSHAN is a coalition of NGOs, community-based organizations and faith-based organizations involved in HIV/AIDS intervention, NEPWHAN draws its memberships from support groups, associations, organizations and constituencies of PLHIV in Nigeria. Civil society organizations act as a watch-dog in order to ensure transparency and accountability in the utilization of resources.

CISHAN sustains a common forum for the articulation of the views of civil society into the national response to HIV/AIDS. The coalition also undertakes advocacy and gathers, shares and disseminates relevant information amongst community sector organizations as well as other stakeholders.

NEPWHAN coordinates and strengthens support groups, organizations, associations and constituencies of PLHIV in order to contribute meaningfully to the national response. The goal is to advocate for the rights of PLHIV in Nigeria and seek to put in place comprehensive HIV/AIDS prevention and support services.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

In 2002, the Nigeria Government started an ambitious ARV program to get 10,000 adults and 5,000 children onto ARVs within one year. An initial US$3.5 million-worth of ARVs were imported from India and delivered at a subsidized monthly cost of US$ 7 per person.

In 2003, the program suffered a major setback when it was hit by a shortage of drugs. This meant that some people did not receive treatment for up to three months. Eventually, another US$3.8 million worth of drugs were ordered and the program resumed. However, it has not yet achieved its goal because of poor infrastructure, logistics, and management.

More than ever before, there is momentum to expand access to HIV/AIDS treatments in Nigeria. Despite these efforts, the coverage of the HIV/AIDS programme is limited to, or largely concentrated in, urban cities. There are about 50 treatment sites. The government accounts for 33 sites and NGOs, faith-based organizations and the private sector run 17. About 50,000 people are currently receiving ARVs, while over 500,000 people are in need of ARVs. Of this number, the government is providing ARV to 17,000 people. By the end of

2005, the government started plans for the distribution of ARVs free of charge, eliminating the fee that patients previously had to pay for subsidized drugs. One of the major challenges to access treatment is the fact that they are not available in local communities where they are most needed.

Prevention

Condoms have become nearly universally available in Nigeria because of efforts to increase coverage and subsidize prices. Uptake and use is affected by the people's perceptions of how effective condoms are, perceived effects on sexual satisfaction, and people not wanting to be seen as promiscuous when buying condoms. These are all factors that need to be overcome. A more systematic barrier is the opposition from religious organizations. This is more difficult to break down, but with careful negotiation and consultation, progress is being made, though the country's consumption of condoms is still perceived as low.

A massive campaign was put in place to inform people about sexual health and HIV. Radio campaigns have been extremely successful at increasing knowledge and changing behaviours. One of these focused on encouraging consistent condom use, increasing knowledge and increasing skills for condom negotiation in single men and women between 18 and 34.

Eighty percent of HIV infections in Nigeria are transmitted through heterosexual intercourse. Factors contributing to this include a lack of information about sexual health and HIV, low levels of condom use and high levels of STIs. Blood transfusions are responsible for 10 percent of all HIV infections, as there is no coordinated national blood supply system and blood is not routinely tested for HIV.

Vulnerable Groups

The HIV/AIDS policy identifies the importance of upholding and protecting the rights of all Nigerians including people living with or affected by HIV/AIDS; addresses the vulnerability of certain social groups including women and children to the HIV/AIDS epidemic; and develops appropriate measures to ensure that all these relevant issues are addressed.

Women: Nigeria is a male-dominated society and women are seen as inferior to men. Women's traditional role is perceived to be limited to having children and being responsible for the home. Their low status and lack of access to education increases their vulnerability to HIV infection. Certain social and cultural practices that heighten gender inequity also make them vulnerable to HIV, such as cross-generational sexual relationships, female circumcision, and female genital mutilation.

MSM: No information was available on MSM issues.

Sex workers: Although sex work is illegal in Nigeria, there are over one million female sex workers. HIV infection rates among sex workers have been estimated to be as high as 30 percent in some areas. There are low levels of condom use among sex workers because of a lack of knowledge about HIV transmission and poor acceptance by male clients.

PLHIV: Stigma and discrimination against PLHIV is commonplace in Nigeria. Both Christians and Muslims see immoral behaviours as being the cause of the HIV/AIDS epidemic. This affects attitudes towards PLHIV and HIV prevention strategies and messages. PLHIV often lose their jobs or are denied healthcare services because of the ignorance and fear surrounding HIV and AIDS. There is so much ignorance about HIV/AIDS that 60 percent of healthcare workers think HIV positive patients should be isolated from other patients.

Youth: In Nigeria, estimates show that 60 percent of all new cases of HIV infection occur in young people between the ages of 15 and 25. Recently, a new curriculum was introduced for comprehensive sex education for youth. It focuses on improving young peoples' knowledge and attitudes to sexual health, and reducing sexual risk-taking behaviours. In the past, attempts at providing sex education for young people were hampered by religious and cultural objections. The new curriculum called Family Life Education was developed with consultation from religious and community leaders.

Voluntary Counseling and Testing (VCT)

The introduction of VCT is so far the best tool in tackling the spread of HIV/AIDS. But barriers such as inadequacy of testing sites, human capacity, and the availability of test kits, etc., are hindering the effectiveness of the program.

4. LESSONS LEARNED

Nigeria still faces many challenges in terms of the AIDS epidemic. Poverty, lack of knowledge on prevention, lack of empowerment of women and girls, the vulnerability of youth, with 60 percent of the population under 24, lack of access to voluntary counseling and testing, low ARV therapy coverage and strong stigma and discrimination against people living with and affected by HIV and AIDS constitute the principal difficulties in tackling the epidemic and its resultant effects. These issues need to be dealt with in order for the plans and strategies to be adequately implemented.

COUNTRY PROFILE: PERU

Sourced from report by Via Libre

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	27,968,000
LIFE EXPECTANCY AT BIRTH FOR MEN	69
LIFE EXPECTANCY AT BIRTH FOR WOMEN	73
NUMBER OF PEOPLE LIVING WITH HIV	93,000 [56,000-150,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	26,000 [13,000 – 45,000]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.6%
DEATHS DUE TO AIDS	5,600 [3,400 – 8,500]

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

The National Multi-Sector Health Care Coordinator (CONAMUSA) is a coordinating agency, formed by representatives of the government, bilateral and multilateral development agencies, civil society, and organizations of people directly affected by HIV/AIDS, tuberculosis, and malaria in Peru. CONAMUSA was set up as an association that attempts to promote and create consensus, develop messages and concepts shared among all sectors, repair the gaps between the public and private sectors, and complement and strengthen all that the government is working on in the area of the HIV/AIDS.

The processes leading to the last two national strategic plans were developed with direct input from the Ministry of Health; no other sub-sectors of the health sector or other sectors, such as the Ministries of Education, of Women and Human Development, or of Labour, were included. The participation of the community sector was very limited with a highly reduced list of people summoned to meetings in very short processes.

Community Sector

The unwritten HIV/AIDS agenda of the community sector is still centered on prevention, support and treatment linked to the health sector. Only a few have addressed issues related to stigma and discrimination and vulnerability.

There has been little interaction with other stakeholders that are not working directly in the field of HIV/AIDS in order to strengthen joint actions. There are also no stakeholders from the private sector engaged in HIV/AIDS.

There have been a number of important efforts, mainly by organizations of PLHIV and NGOs, aimed at securing health care and benefits for PLHIV. These efforts have contributed to the fulfillment of human rights, as improvements to access to treatment, for example, have resulted from these efforts.

A proactive community sector, the formation of CONAMUSA, and the processes of the Global Fund has resulted in communities being more included in the national response. It is necessary to continue and reinforce this joint work by institutionalizing participatory processes, expanding the participative processes for electing representatives, widening the agenda to include concerns from a truly multi-sectoral perspective, and ensuring that both national and regional needs are met.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

The greatest advance in the national response against HIV/AIDS has been expanded access to ARVs and to free medications. ARVs are given out in 54 public health care facilities as well as by three NGOs. However, this improvement is only noticed in Lima and Callao, and not in other cities of regions. This situation is just an illustration of some of the difficulties in implementing the ARV Program on a national scale.

Although access to treatment is a significant step forward in the national response and a result of the actions of community sector organizations, international financial support, and the government commitment, there are still serious concerns: (a) universality of access – there still is no proper attempt to address the economic, legal, and cultural barriers; and (b)

sustainability – no one can guarantee political will to sustain the program in the national budget further than the government and authorities in power now.

What is more, information about treatments is not supplied by the government, meaning that some community sector organizations, particularly PLHIV groups, have had to implement projects to address this need.

Some restrictions to access to treatment include PLHIV without family support (either because they do not want to disclose their status for fear of discrimination or they in fact do not have a family network) and PLHIV who do not have a permanent home. In addition, MSM and male and female sex workers, who by their own behaviours do not conform to the 'accepted' standard, are less likely to find support in their own families.

Access also remains limited for other reasons, such as the little amount of information given, the cost of health care and tests. Furthermore, there is the prolonged waiting period for receiving test results, since the analysis of all the tests is done solely by the National Institute of Health. Lastly there is the stigma and discrimination present in the health care facilities themselves.

There are also gaps in the law related to adolescents, where it is necessary for a parent or guardian to accompany them in order to gain access to services, including the provision of ARVs.

Prevention

The national response for the prevention of HIV/AIDS includes different approaches. One is the male condom, which is available in pharmacies and other places, and also distributed through public health care services. The female condom, which is not easily available, costs around US$8.50 (more than half of the Peruvian population lives on less than US$2.00 per day). Lubricants are easily found in the major cities, but are very scarce in rural areas or cities far from the capital. Prevention messages, with two main messages transmitted through the media and school programs and aimed at a general audience: abstinence and the use of condoms.

Access to HIV/AIDS prevention services is limited by costs and by the situation of people without legal documentation. Other barriers are illiteracy, inequality related to gender issues, and the stigma surrounding STIs. Also, health workers need to become actively involved in the fight against the stigma and discrimination, the two main barriers preventing MSM and sex workers from gaining access to prevention services.

Prevention in adolescents, young people, and the population in general also shows serious shortcomings. It must be noted that a few steps have been taken to incorporate explicit content on prevention in school curricula, yet the process is still in the initial stages with the number of trained teachers well below what is needed. The content of the preventive messages do not incorporate the differentiation of risk and are aimed toward an ideal heterosexual relationship from an adult perspective.

Vulnerable Groups

Although the legal framework protects the human rights of PLHIV and other vulnerable groups, there is nearly no surveillance of violations and no compensation measures in cases where rights have been violated. The government has not done enough to create a culture based on rights or to build protocols of surveillance and redress that could make it easier for PLHIV, MSM, sex workers and adolescents to exercise their human rights.

According to the applicable laws, there are no professions or behaviours that are illegal, such as homosexuality, intravenous drug use, or sex work, although the sale and procuring of narcotics is punishable under the law. However, embedded in the character of local governments and the national police force are reproachful attitudes towards sex workers based upon the arguments of maintaining order and good conduct.

PLHIV: There are laws in Peru that recognize the rights of PLHIV. However, PLHIV are confronted by serious difficulties with respect to (a) gaining access to health services and (b) maintaining access once they start to receive them. In spite of the existence of laws that recognize the principles of autonomy, confidentiality, right to work, and protection for workers terminated as a result of discrimination, the situation of PLHIV is continually plagued by all types of abuse that in most cases constitute violations of their fundamental rights theoretically protected by the law. The problems in the workplace for PLHIV have not been an area of concern for the government, but neither has it been part of the agendas of the community sector. Furthermore, information about this is very limited.

Women: Considering that this epidemic is centered on vulnerable groups, particularly MSM, the interventions for women are usually directed towards female sex workers as a vulnerable group. However, this strategy only focuses on STIs and HIV and has not considered empowerment itself. Despite the fact that the proportion of affected women to affected men has increased from one woman to every 14 men in 1990, to one

to every 3.6 men, it has not influenced the design of preventive intervention strategies. The Ministry of Women and Human Development has not developed any activities, or coordinated with the Ministry of Health, or actively participated in CONAMUSA.

MSM: In relation to MSM, important differences in the rates of infection and prevalence are hidden behind this label since it does not distinguish between the population of MSM who are sex workers and those who are not. Nor does it distinguish among the different sexual identities, lumping them all together into a homogenous group for data gathering purposes. This label has many times made the specific needs of those groups invisible as it tries to group together transvestites, MSM who are not sex workers, and adolescent MSM without considering their particularities, and therefore limits the access of these groups to prevention, health care and treatment. This increases their vulnerability and raises questions about whether their rights are being respected.

IDUs: Sterile, disposable syringes are widely used in the public health care services and are available in pharmacies and other stores. However, there are no reported cases of HIV-positive people who use intravenous drugs.

Sex Workers: Since 1997 the National Sanitary Strategy set up a system of Periodic Health Care Units for male and female sex workers for early detection, timely care, and appropriate treatment for STI and HIV/AIDS.

Voluntary Counseling and Testing (VCT)

Since 1997, the law protects voluntary access to ELISA test in the Ministry of Health services, which must be accompanied by pre-test and post-test counseling. However, the voluntary nature of the test is continually questioned when the test becomes a condition for getting a job or even to continue working. Concerning the test for pregnant women, the law states that the test in no longer voluntary but mandatory, but that still it should include counseling. However, in practice it is done in group, which departs from the true nature of counseling and violates the confidentiality of the individual.

4. MONITORING AND EVALUATION

In both 2003 and 2005, the government undertook evaluations of the implementation of the UNGASS Declaration of Commitment. Both evaluations were carried out with limited participation by the community sector. The final version of the 2003 evaluation was never disseminated.

An important weakness is the absence of organized surveillance systems. A series of reports exist but these are nothing more than anecdotal accounts of the situation and do not support the processes of advocacy and the defence of the rights of PLHIV and other vulnerable populations.

With respect to human rights, even though there is a legal framework, its implementation is still at early stages, and there are no protocols for monitoring it.

5. LESSONS LEARNED AND RECOMMENDATIONS

Even though access to treatment is the main advancement made in the last five years, there are still economic, social, and cultural barriers that need to be addressed. In addition, the cost of the tests, problems with maintaining supplies, and the stigma towards, and discrimination against, the vulnerable populations and PLHIV are the main obstacles for scaling up treatment services.

Fighting against discrimination in health care services, in the workplace and in schools is not part of the government agenda, is not included in the plans of the National Sanitary Strategy, and is not on the agenda of any of the other sectors involved.

COUNTRY PROFILE: ROMANIA

Sourced from report by ARAS

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	21,711,000
LIFE EXPECTANCY AT BIRTH FOR MEN	68
LIFE EXPECTANCY AT BIRTH FOR WOMEN	76
NUMBER OF PEOPLE LIVING WITH HIV	7,000 [3,400-22,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	N/A
HIV PREVALENCE RATE (15-49 YEAR OLD)	< 0.1%
DEATHS DUE TO AIDS	N/A

Source: UNAIDS 2006 Report on the global AIDS Epidemic

1. RESPONSE TO HIV/AIDS

Government

In Romania, the main institution responsible for Government policy on HIV/AIDS is the National Multisectorial Commission for the surveillance, control and prevention of HIV/AIDS cases (CNMS). The main policy document developed by the CNMS is the National HIV/AIDS Strategy for 2004-2007. The Strategy comprises three major intervention areas: prevention, access to care and treatment, and efficient surveillance system.

The major constraints in implementing the Strategy are: 1) criminalization of vulnerable groups, particularly drug users and sex workers; 2) the infrastructure of the medical system; 3) lack of horizontal cooperation among various relevant ministries; 4) lack of national funds and adequate surveillance system; 5) general attitude regarding HIV/AIDS.

Community Sector

The community sector participated in the drafting of the National AIDS program primarily through the establishment of associations of and for people living with and affected by HIV/AIDS. In 2000 they were united into what became the National Union of Organizations of the People affected by HIV that was represented in the CNMS.

However, while involvement in the decision-making process does not constitute a problem, the actual support and recognition of the community sector is problematic. In practice, the National Strategy is merely regarded by communities as a symbolic document rather than the actual governmental commitment to involve community actors. This is explained by the lack of financial support and the Romanian government lack of interest in supporting NGOs involved in advocacy and grassroots work for PLHIV.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

One of the main objectives of the National Strategy on HIV/AIDS is to ensure universal, continuous and non-discriminatory access to treatment, care and socio-medical services for people living with HIV/AIDS. All patients are enrolled in ARV treatment according to the National Treatment Guideline developed by the National Commission for Fighting against HIV/AIDS established within the Ministry of Health.

Although there are no formal barriers that limit the ability of PLHIV to obtain ARV treatment and care, many de facto barriers still persist. The biggest obstacles to accessing comprehensive care and treatment services are: 1) limited access to urban treatment centers due to limited number of centers and short working hours; 2) lack of information and counseling on ARV treatment; 3) the attitude of medical and other professionals at hospitals – including stigma and discrimination – and insufficient knowledge on how to work with PLHIV.

Prevention

Having as the main goal to maintain the HIV incidence rate in 2007 at the 2002 level (0.04%), the National Strategy prevention priority focuses on youths and groups at risk (sex workers, injecting drug users, men who have sex with me, Roma[7], prisoners and mobile population). The strategy also includes prevention of vertical transmission and prevention within the medical system and at the workplace.

On paper, the strategy provides the full range of prevention services; however in reality the implementation continues to be selective. In Romania, 80 percent of all services are situated in urban centers with only 4 percent in rural areas. Although condoms are widely available in urban areas, there is no national policy of social marketing of condoms in villages. For example, although rural youths were identified as a target group in the prevention strategy, nothing has been done to improve availability of condoms for them.

Vulnerable Groups

While campaigns for youth and general population were implemented with the support from international donors, there are no targeted campaigns for the most vulnerable groups. The existing policies do refer to the stigma and discrimination of most vulnerable groups, yet cultural, institutional and legal barriers are not effectively addressed by the Romanian government.

Women: There is no specific HIV prevention program targeting women's needs. The only programs that partially address women's needs are prevention of mother to child transmission initiatives. These programs are included in the national AIDS program, but there is no evaluation of the quality and impact of these programs on women.

MSM: The only HIV prevention programs that target MSM were implemented by the community sector. Due to stigma and discrimination towards MSM, most services are hard to access.

IDUs: While there are several needle exchange programs, they are not supported by the government. Although clean syringes and needles are available in pharmacies without prescription, many pharmacists refuse to sell them to drug users. Methadone substitution therapy is almost non-existent. Drug policies are based on law enforcement punishing drug use and thus driving IDUs further away from services. These negative practices result in only 10 percent of all IDUs having access to necessary services and only 2 percent using clean injection equipment.

Sex workers: Romania is one of the countries in Central Europe where sex work is punished by the Criminal Code. At the same time the growing HIV/AIDS epidemic in the region places sex worker at a high risk not only for HIV but also for other diseases. Additionally, a significant percentage of sex workers use drugs. Despite the high vulnerability of sex workers to HIV, there is only one outreach program in the country targeting sex workers, which is supported by the Global Fund.

Voluntary Counseling and Testing (VCT)

According to the Ministry of Health statistics, in 2005 nearly half a million HIV test were provided, which shows an important increase from the number of tests provided in 2000. No information is available regarding the provision of pre and post test counseling. Only two NGOs provide pre and post test counseling in 19 centers. The number of persons being tested from vulnerable groups is very low. In 2005 less than 1000 tests were taken by members of vulnerable groups.

4. MONITORING AND EVALUATION

The Global Fund provided an opportunity for the National Strategy for HIV/AIDS to be translated into national programs. The monitoring arrangements of the Global Fund set out the targets and evaluation reports for the national strategy.

5. LESSONS LEARNED

The 2004-2007 National Strategy for HIV/AIDS was the first document demonstrating Romania's political will to confront the epidemic. However the strategy is largely supported by the Global Fund, without matching financial support from the national bodies. Therefore, in order for the National Strategy to be successful, it will be essential for the Romanian government to provide adequate financial and technical recourses for the timely implementation of the programs and follow-up with regular monitoring and evaluation. A critical component will be building sustainable links with the community sector to be able to incorporate their expertise. Only under these conditions the National Strategy for HIV/AIDS will be something more than just another plan.

7. Roma, or Gypsies, are Europe's largest minority. Europe's Roma population is estimated at 7 to 9 million people. Romania is the country with the highest absolute number of Roma ranging between 1 and 2 million.

COUNTRY PROFILE: SERBIA AND MONTENEGRO

Sourced from report by Yugoslav Youth Information Center

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	10,503,000
LIFE EXPECTANCY AT BIRTH FOR MEN	70
LIFE EXPECTANCY AT BIRTH FOR WOMEN	75
NUMBER OF PEOPLE LIVING WITH HIV	10,000 [6,000 - 17,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	2,000 [1,000 – 3,500]
HIV PREVALENCE RATE (15-49 YEAR OLD)	0.2%
DEATHS DUE TO AIDS	< 100

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

The government established its National HIV/AIDS Commission (NAC) in March 2002. It was re-established in 2004. After a series of debates and consultations, NAC approved the Serbian HIV/AIDS National Strategy 2005-2010, and it was launched in February 2005.

Community sector

HIV/AIDS was one of the first areas where the Government included the community sector as a partner, in joint efforts to combat the epidemic. The partnership was further intensified with the creation of the National AIDS Commission and especially in June 2004, when the NAC approved the National Strategy. In 2003 community sector organizations started to actively work with hard-to-reach populations.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to treatment, Care and Support

The Government ensures – in theory – universal access to ARVs and other drugs for prophylaxis and treatment of opportunistic infections for all PLHIV. The entire cost of ARV treatment is covered by public sources.

Prevention

Most HIV prevention tools are available. Male condoms are available and easy to access at hospitals, and through NGOs, CBOs and pharmacies. Female condoms are only known to a small portion of the population and are hard to find at either pharmacies or hospitals. Clean needles are easily accessible at the pharmacies, but stigma and discrimination against injection drug users often make it difficult for users to access the needles. Methadone substitution therapy is implemented by governmental hospitals and is supported by the Ministry of Health.

Vulnerable Groups

Women: No special HIV prevention programs exist for women and girls.

MSM: There are outreach activities (information sharing, condom and lubricant distribution) for MSM in five cities (Belgrade, Novi Sad, Subotica, Nis and Kragujevac). All activities are run by NGOs in cooperation with the Public Health Institutes.

IDUs: There are harm reduction programs led by NGOs mostly in the larger cities. Outreach workers, including doctors and nurses, are trained to provide injecting users with counseling and orientation. The drop-in centers run by NGOs, offer voluntary counseling and testing for HIV.

Sex workers: The stigma to which sex workers Serbia are exposed, and the illegal status of sex work result in low access to HIV services and a high under-reporting rate.

PLHIV: There is no special focus on human rights of people living with HIV/AIDS. Human rights are implemented without specific reference to PLHIV. Most existing programs for this group are run by NGOs. Government bodies rarely provide any support for PLHIV initiatives.

Voluntary Counseling and Testing (VCT)

The testing centers are organized through collaboration between government and NGOs and are funded by governmental and international agencies. Normally VCT centers are positioned as separate units within health care institutions. All personnel at testing facilities are trained to care for the unique needs of everyone willing to take an HIV test. Services like pre- and post-testing counseling are offered at the sites.

4. MONITORING AND EVALUATION

There have been a number of initiatives in Serbia under the guidance of the United Nations Theme Group on HIV/AIDS and the Global Fund directed towards establishing an efficient M&E mechanism. In November 2004, a national M&E working group was established. In January 2005 the first draft of the indicators were developed and approved by all stakeholders and integrated into the National Strategy Document.

5. CONCLUSIONS, RECOMMENDATIONS, AND LESSONS LEARNED

To improve Serbia's response to the HIV/AIDS epidemic the following needs to be given more attention: 1) support the establishment of a functional National M&E system; 2) initiate the formulation of national policies and standards guaranteeing youth-friendly health, social, and education services; 4) strengthen HIV/AIDS/STI surveillance systems; 5) further inclusion of PLHIV; and 6) raise additional funds for medium- and longer-term projects.

COUNTRY PROFILE: SOUTH AFRICA

Sourced from report by Shaun Mellors, principal researcher

1. DEMOGRAPHIC INDICATORS

TOTAL POPULATION	47,432,000
LIFE EXPECTANCY AT BIRTH FOR MEN	47
LIFE EXPECTANCY AT BIRTH FOR WOMEN	49
NUMBER OF PEOPLE LIVING WITH HIV	5,500,000 [4,900,000-6,1000,000]
WOMEN AGED 15 AND OVER LIVING WITH HIV	3,100,000
HIV PREVALENCE RATE (15-49 YEAR OLD)	18.8%
DEATHS DUE TO AIDS	1,200,000

Source: UNAIDS 2006 Report on the global AIDS Epidemic

2. RESPONSE TO HIV/AIDS

Government

The principal focus of the South African Government's approach to HIV/AIDS is around four key areas of interventions: prevention; treatment, care and support; research, monitoring and surveillance; and legal and human rights. The HIV/AIDS plan takes specific account of the needs of the historically disadvantaged populations and underserved health districts. The South African National AIDS Council (SANAC) was reconstituted in November 2003 by broadening the number of sectors represented. The 2004-2005 national budget also showed major commitment to HIV and AIDS expenditure. Government allocated approximately US$240 million for HIV programs and services. US$62 million was earmarked for the Antiretroviral Rollout Program.

Despite the progress, the effectiveness of the National HIV/AIDS policy is still difficult to measure, due to the absence of an efficient monitoring and evaluation system. There is also very little reference in official documentation and policies to international guidelines and declarations. The main impediments to successful implementation of the national plan are: 1) lack of cooperation between health facilities and communities; 2) lack of integration between services at facility level, especially between HIV and tuberculosis; 3) inadequate coordination at national, provincial and district levels; and 4) lack of financial resources to sustain programs.

Community Sector

The National Integrated Plan (NIP) for HIV/AIDS ensures a multicultural approach and joint delivery of input from all sectors of society. This multi-sectoral strategy ended, however, at the end of 2005 and currently there is no on-going partnership with communities about future directions and targets.

Very little opportunity for review of the National Plan has been given to community representatives. Despite collaborative and focused efforts on their part to contribute, it remains difficult to sustain a meaningful impact. With regards to the development of the 2000-2005 National AIDS Policy, the community sector was invited to submit ideas. However, although this was sufficient as a starting point, it was not enough to ensure ongoing input. It still remains unclear how the community sector is going to participate in the development of 2006-2010 National AIDS Policy.

3. NATIONAL HIV/AIDS POLICY AND IMPLEMENTATION

Access to Treatment, Care and Support

The South African Government is trying to address the expansion of health care system and rapid and effective access to drugs, affordability and human capacity, although they are still faced with major obstacles to successful implementation. The pace of implementation is primarily hampered by the lack of trained doctors, nurses and pharmacists. As a result of the human resources crisis, many sites are unable to take on more patients. This is worsened by the fact that the sites have the technical capacity to commence ARV programs, but are unable to do so due to delay in the accreditation process. Shortage of health care personnel and social workers also worsens the serious problem of access to proper nutrition.

The drug procurement process was finalized in March 2005. The tender is worth over 3.7 billion rand and expires in 2007. It was awarded to seven pharmaceutical companies for the supply of ARVs to public health facilities countrywide. Suppliers and health procurement officials are supposed to meet four times a year to ensure adequate planning to meet the demand for ARVs. Yet despite this, the Joint Civil Society Monitoring Forum[8] (JCSMF) have received a number of reports over the past few months regarding problems with drug availability in various parts of the country,[9] in particular the supply of Efavirenz (marketed by MSD as Stocrin®).

With this in mind, the Treatment Action Campaign (TAC) continues to take the necessary legal steps to ensure that companies such as MSD and Abbott Laboratories grant licenses for the local production and/or importation of generic versions of their patented medicines. The TAC has also demanded that the Minister of Health uses her power under the Patents Act to issue the compulsory licenses required.

Treatment is free at government accredited roll out sites, which are primarily found out public health care facilities. There is sometimes administrative fees attached to initial visits, to allocate a card etc., but these are not attached to ARV therapy (ART) per se. ART is offered at Government treatment sites, NGO/CBO/FBO sites, and private medical facilities. Generic drugs are allowed under the law in South Africa. They are manufactured in the country for internal use, imported into the country and manufactured for export only.

Prevention

The year 2006 was declared "the year of accelerated HIV and AIDS prevention" by the Ministry of Health. The multi-pronged approach towards prevention has been highlighted in the five-year strategic plan for HIV and AIDS and includes: Information, Education and Communication (IEC). The key elements of the IEC strategy are: Living Positively; Circles of Support (increasing support for orphans and other vulnerable children); a Youth Campaign and IEC interventions in the context of High Transmission Areas.

Other preventive approaches include: treatment-related prevention (e.g., treatment of STIs), and interventions to reduce the risk of mother to child transmission. The government also initiated branding procured male condoms (CHOICE) in June 2004 thus increasing the uptake of condoms from 33 million to 45 million. The department has also increase funding for female condoms in 2004/2005, doubling the female condom distribution.

Vulnerable Groups

Women: The latest South African statistics on HIV/AIDS show that women are still disproportionately affected by the disease. Gender inequality persists, making women more vulnerable HIV. Although the National Strategic Plan acknowledges that "the low status of women" is one of the factors underlying the HIV and AIDS epidemic, when it comes to actual substance around addressing women's realities, very little is done.

MSM: Homosexuals are protected within the constitution, and the Constitutional Court recently gave the Government 12 months to finalize the legislation recognizing the rights of the same sex couples to marry.

Sex workers: According to the Sex Work Education and Advocacy Taskforce, an NGO based in Cape Town, South Africa has failed to adequately address the rights of sex workers. Policies that criminalize sex work diminish the opportunity to consider the rights of sex workers. Given the illegality of sex work, initiatives targeted to improve the conditions of this vulnerable group are usually hampered due to persisting stigma and discrimination.

Children: community sector organizations are involved in supporting and protecting children orphaned or infected by HIV/AIDS. In August 2005, several organizations co-hosted a two-day workshop for key civil society stakeholders active in the children's HIV/AIDS sector. The workshop analyzed a series of policies – international and national – that deal with the rights of children. The proper implementation of these policies should become a priority in South Africa since currently children affected by the epidemic are severely neglected.

PLHIV: The Bill of Rights protects all people, and this means that people living with HIV and AIDS have the same rights as any other person – at least on paper. For example, any person living with HIV and AIDS has the right to medical treatment and care; children infected with HIV have the right to attend any school; no employer can require that a job applicant have an

8. Founded by the AIDS Law Project, Health Systems Trust, Centre for Health Policy, Institute for democracy in South Africa, Open Democracy Advice Centre, Treatment Action Campaign, UCT School of Public Health and Family Medicine, Public Service Accountability Monitor and Médecins Sans Frontières
9. In Gauteng, Kwa-Zulu-Natal and Mpumalanga in particular.

HIV test before they are employed; an employee cannot be fired, retrenched or refused a job simply because they are HIV positive; women infected with HIV have the right to make choices about their pregnancy, woman cannot be forced to terminate her pregnancy if she is HIV positive; and any person with HIV has the right to confidentiality.

Insurance companies can currently refuse life insurance to people living with HIV. However, many insurance companies have special policies for people who are HIV positive.

Voluntary Counseling and Testing (VCT)

VCT is regarded as one of the top prevention approaches. The South African Government has doubled the number of health facilities providing VCT from 1,500 in 2002/03 to 3,686 in 2004/2005. The number of people using these facilities has also increased two-fold in 2005.

4. MONITORING AND EVALUATION

Little interaction and opportunity for review of the national plan has taken place, interaction and relations with key civil community sector organizations are at an all time low. However collaborative, energized and focused the efforts from civil society are – and there have been many – it is difficult to sustain and make a meaningful impact if there are constant contradictions, confusion and set backs, even more so if these come from the very core of policy making.

The Joint Civil Society Monitoring Forum says that while government has set in place national indicators, it is unclear if data is being collected according to these indicators. Data is not being made available – therefore it is difficult to assess the clinical impact of the Operational Plan and that of the prevention of mother to child transmission programme.

The Treatment Monitor is an established inter-cluster project within the Health Systems Trust. The aim of the Treatment Monitor is to facilitate and support a set of research activities in South Africa that assist in monitoring access to HIV treatment and care, as well as the impact that HIV has on health services across the country. Ultimately it aims to identify and share information on models of best practice and lessons learnt in order to stimulate and promote the ongoing improvement of effective and efficient HIV treatment and care and health services in general.

5. LESSONS LEARNED

The achievements made to date still fall short of what needs to be done to ensure a comprehensive and efficient response to HIV/AIDS in South Africa. The government still needs to develop and support an integrated AIDS Program that provides unequivocal leadership in the country. The development of necessary references to international guidelines will have to be a vital component of all national policies. Civil society will have to be more proactive at increasing awareness and understanding of the DoC and to develop necessary mechanisms to use the Declaration as an advocacy tool.

CONTACT INFORMATION
IN-COUNTRY RESEARCHERS

ANNEX 1

Country	Lead Organization(s) / Researcher	Contact information
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Canada	AIDS Calgary Awareness Association	#200, 1509 Centre Street South Calgary, Alberta T2G 2E6 Canada Fax: (403) 263-7358 www.aidscalgary.org ldolan@aidscalgary.org
El Salvador	Asociación Atlacatl Vivo Positivo	43 Av. sur y 12 calle Poniente # 606 Colonia Flor Blanca Tel. (503) 22983950 / 22985801 San Salvador, El Salvador srmontealegre@yahoo.com
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Ireland	Gay HIV Strategies – Gay and Lesbian Equality Network (GLEN) and Health and Development Networks	Fumbally Court, Fumbally Lane Dublin 8, Ireland Tel: + 353 1 4732602 www.glen.ie ciaranmckinney@glen.ie
Jamaica	Jamaica AIDS Support (JAS)	4 Upper Musgrave Avenue Kingston 10, Jamaica Tel: 1 876 978-2345 Fax: 1 876 978 7876 info@jamaicaaidssupport.com

Morocco	Association de lutte contre le SIDA (ALCS)	17 Bd Al Massirra El Khadra Mâarif, Casablanca Tel: 022 99 4242/43 Fax: 022 99 4244 www.alcsmaroc.org alcs@menara.ma
Nepal	Blue Diamond Society	Blue Diamond Society GPO Box: 8975, EPC 5119 Kathmandu, Nepal Tel: 977 1 4443350 www.bds.org.np sunil@bds.org.np
Nigeria	Network of People Living with HIV/AIDS in Nigeria (NEPWHAN)	4, Jaba Close, Off Arthur Unegbe Street Area 11 Garki Abuja, Nigeria Tel: 234-9-3145505-7 Fax: 234-9-3145506 www.nepwhan.com patmatem@nepwhan.com
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