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GLOBAL STRATEGY FOR THE PREVENTION AND CONTROL OF AIDS: 1992 UPDATE

The global strategy for the prevention and control of AIDS was originally developed in 1986 and endorsed by the World Health Assembly in May 1987 (WHA40.26), and it has served as the global policy framework for AIDS prevention and care activities for the past five years. At its meeting in April 1991, the Management Committee of the Global Programme on AIDS endorsed the proposal to take a fresh look at the strategy with a view to updating it, given the changing nature of the pandemic and the knowledge gained during the past five years. Accordingly, in consultation with other organizations and bodies of the United Nations system, and with contributions from the Global Commission on AIDS, a proposed update of the global strategy was drafted. The Management Committee reviewed and endorsed the draft at its meeting in November 1991.

The Executive Board, at its eighty-ninth session in January 1992, reviewed and endorsed the global strategy for the prevention and control of AIDS. In its resolution EB89.R19, the Board recommends endorsement of the strategy by the Forty-fifth World Health Assembly.

CONTENTS

EXECUTIVE SUMMARY

The global strategy for the prevention and control of the acquired immunodeficiency syndrome (AIDS) was initially drawn up by WHO in 1985-1986 and unanimously approved by the Fortieth World Health Assembly (May 1987), the Venice Summit of the Heads of State and Government (June 1987), and the United Nations General Assembly (October 1987). It has since served as the main policy framework for the global response to the pandemic, which WHO directs and coordinates in keeping with its mandate from the General Assembly.

The basic premises of the strategy remain as valid today as when they were first stated, but the pandemic has evolved dramatically since then, and valuable lessons have been learned about how to combat it. Taking these developments into account, the 1992 update of the global strategy proposes ways of meeting the new priorities of the evolving pandemic. These are:

- an increased emphasis on the adequate and equitable provision of health care, as the huge numbers of people already infected with the human immunodeficiency virus (HIV) progress from asymptomatic infection to AIDS;
- expanded and more effective treatment for other sexually transmitted diseases, which are now known to increase the risk of HIV transmission;
- a reduction of the special vulnerability to HIV infection of women and their offspring through an improvement of women's health, education, legal status and economic prospects;
- the creation of a more supportive social environment for AIDS prevention through the removal of legal and other barriers to frank messages about sexual transmission and to people's ability to act on such information;
- immediate planning in anticipation of the socioeconomic impact of the pandemic;
- a greater focus on communicating effectively the compelling public health rationale for overcoming stigmatization and discrimination.

The three main objectives of the strategy remain:

- to prevent infection with HIV
- to reduce the personal and social impact of HIV infection
- to mobilize and unify national and international efforts against AIDS.

Preventing HIV infection

Prevention is indisputably the most important objective of the global strategy, since it is the only way to avert all the human, social and economic costs of HIV infection, which is lifelong and, in the absence of curative drugs, believed to be ultimately fatal. A universally effective and affordable preventive vaccine is unlikely to be available before the year 2000.

AIDS is essentially a sexually transmitted disease, which like some other such diseases can also be spread through blood and from an infected woman to her unborn or newborn child. Sexual behaviour is thus the prime focus of action for interrupting transmission. Action for the prevention of sexual transmission of HIV must have three components: (i) frank information and education aimed at all men and women, not just at individuals whose risk of infection is particularly high because they have multiple casual sex partners; (ii) health and social services, especially for the purpose of detecting and treating other sexually transmitted diseases; and (iii) a supportive environment, characterized by the presence of protective social norms (e.g. mutual fidelity, appropriate condom use), the absence of legal and other barriers to frank information, and the absence of stigmatization and discrimination directed against people known or suspected to have HIV/AIDS. More broadly, a supportive environment is one unmarred by poverty. Poverty makes whole communities

vulnerable to AIDS by forcing men to leave their families in search of work, by leaving people hopeless enough to turn to the solace of drugs, and by making prostitution a survival strategy for women and children. AIDS then completes the vicious circle by making the community even poorer.

In theory, sexual transmission requires the active participation of both partners and hence should be preventable by either one. However, such social and economic realities as poverty, a lower level of education, and subordinate social status may leave some individuals with little power or freedom to refuse intercourse or insist on the use of a condom. Women in particular tend to be at higher risk of acquiring HIV infection through sex engaged in for economic survival or imposed by men in or outside marriage. The global strategy thus calls for the social and economic empowerment of women, while acknowledging the importance of shorter-term goals such as support to women's groups, the development of effective preventive technologies (e.g. vaginally applied virucides, female condoms) that can be controlled by women, and the encouragement of safer sexual behaviour by men. Similarly, recognizing the vulnerability of young people, the global strategy lays special emphasis on providing clear information about HIV transmission to pre-adolescent and adolescent girls and boys, and enabling them to learn and practise the related prevention skills.

Preventing parenteral HIV transmission in the health care setting rests on careful attention to infection control procedures, including the proper sterilization of equipment used for skin-piercing, surgical and other invasive procedures. The global strategy calls for efforts to train all laboratory personnel and health care workers in standard procedures based on "universal precautions" (the concept that all blood is potentially infectious) and to provide them with the necessary supplies and equipment. As for HIV transmission through infected blood and blood products, preventive interventions need to be selected carefully in each country depending on their cost-effectiveness, the availability of resources, and the relative importance of this mode of transmission. Approaches of proven efficacy include recruiting voluntary, non-remunerated donors, screening donated blood for HIV, rendering blood products safe for use, and educating the prescribers of blood in order to reduce unnecessary transfusions.

Preventing the bloodborne transmission of HIV among drug injectors needs to go hand-in-hand with efforts to prevent sexual transmission among them. Goals include reducing the demand for psychoactive drugs, reducing the use of drugs by injection, and reducing the use of shared or contaminated injection equipment. As in the case of sexual transmission, action to prevent bloodborne transmission must embrace information and education, health and social services, and a supportive environment.

The best strategy for preventing perinatal transmission is to prevent the sexual transmission of HIV to women of reproductive age. Secondary prevention, in the absence of a "perinatal" vaccine, depends on the avoidance of childbearing by women who know or suspect that they are infected. Counselling, contraception and other fertility regulation services need to be available to women facing these difficult decisions.

Reducing the personal and social impact of HIV infection and AIDS

WHO estimates that 10-12 million adults and children have been infected with HIV since the start of the pandemic, and projects that this cumulative figure will reach 30-40 million by the year 2000. As these infected people develop HIV-related illness and ultimately AIDS (a progression that takes on average 10 years from initial infection), the credibility of AIDS prevention and control programmes will increasingly be judged by the quality of the care they offer.

Hospital, ambulatory and home care, of a quality at least equal to that provided for other diseases, must at a minimum include pain relief and treatment for common opportunistic infections, including antibiotics for the parallel epidemic of tuberculosis among HIV-infected persons. In addition, infected individuals need understanding and compassion if they are to maximize their remaining health potential and refrain from infecting others. Families and friends, the prime support of infected persons, must in turn receive assistance in fulfilling this function, including a supply of essential drugs.

Because AIDS incapacitates people at ages when they are most needed for the support of the young and the elderly, the impact on families with one or more HIV-infected members is enormous, and aggravated by the frequent stigmatization of people with HIV/AIDS. The global strategy calls for direct action, as well as research, to lessen this impact and in particular to reduce the burden on women, who often carry the primary

responsibility for providing AIDS care. It stresses the need to plan immediately for the care of the 10-15 million children who will be orphaned by maternal AIDS by the year 2000.

The impact of AIDS on society at large is equally damaging. Among the direct and indirect economic costs are spiralling health care costs, decimation of the workforce, loss of investments in skilled labour and educated professionals, and loss of consumers and purchasing power. In the developing countries, the pandemic may well cause social disintegration and political turmoil.

Mobilizing and unifying national and international efforts

As recognition has grown that the AIDS pandemic is not just a health issue but a threat to development with far-reaching socioeconomic ramifications, more and more partners have been drawn into the global effort to bring it under control. Their actions need to be unified to ensure a coherent response to the challenges of AIDS, old and new.

One enduring challenge is official denial of the existence of HIV infection by national authorities, and complacency about its current and expected magnitude, attitudes reflected in the general public. The global strategy outlines various approaches to overcoming such obduracy. Another challenge is discrimination against people with HIV/AIDS, an irrational response which often stems from the stigma attached to sexually transmitted diseases and a mistaken belief that HIV can be transmitted through casual social contact, interferes with the supportive environment needed for prevention programmes, and hampers the enlisting of HIV-infected persons as allies in prevention. Non-discrimination is thus vital, not only for the sake of human rights but because of its strong public health rationale.

At country level, the global strategy calls for a broad-based multisectoral response by the various government departments and ministries (health, industry, agriculture, tourism, planning, finance, education, information, labour, justice, etc.), parliament, the private sector, charitable, religious and other voluntary organizations, and the media. It lays special emphasis on the critical role of nongovernmental organizations in promoting safer sexual practices, providing support for people with HIV/AIDS, and combating complacency and stigmatization.

At international level, the strategy calls for solidarity in the generation and sharing of both knowledge and resources. International coordination of HIV/AIDS research is needed in order to promote the sharing of experience and information, accelerate the development of strategies and technologies appropriate for use in developing countries, and ensure that the latter have affordable access to the results of biomedical and other research. At the same time, solidarity and support on a global scale is called for to help generate resources for prevention and care, and to alleviate the pandemic's impact on health and other sectors in developing countries. By the year 2000 these countries will account for 90% of all HIV infections; they cannot shoulder the burden alone. Their efforts will have to be complemented by those of wealthier nations and the private sector. It will take an unprecedented mobilization of global resources to help the developing countries break out of the vicious circle of poverty-AIDS-poverty and to give the world a better chance of bringing the pandemic under control.

A call to action

The global strategy establishes a policy framework for national and international efforts to prevent HIV infection, provide care for the millions of men, women and children already affected and otherwise reduce the pandemic's impact on individuals and society, and mobilize ethical, sustainable and concerted action against the pandemic. Its principles are valid for **all** partners in the global effort against AIDS - developed and developing countries, governmental and nongovernmental groups, scientists and the lay public, organizations and individuals. But the strategy will be useful only to the extent that it is **used as a basis for immediate action.** There are already more than 10 million HIV-infected people, and over 5000 persons are infected every day. In the hardest-hit areas, whole families and villages are dying out. Countries are losing their most productive people - men and women in the prime of life who were the mainstays of agriculture, industry, commerce, education, health, not to mention the sole supporters of the very young and the elderly. And those parts of the world which have been spared such dire consequences thus far are living on borrowed time. By the time the first cases of HIV infection or AIDS are identified in a population, the virus has often spread far and wide.

The challenge for governments everywhere is to give national AIDS programmes their immediate support and sustained political commitment under the leadership of the head of state. A national plan of action needs to be drawn up or revised to ensure that it is consistent with the global AIDS strategy and spells out the measures to be taken by every sector affected by the pandemic. A multisectoral committee with real decision-making power needs to coordinate the national AIDS programme, which should be led by men and women of broad vision. The partnership of the private and nongovernmental sectors must be assured. There remains the challenge of human and financial resources. The existing gap between the resources available and those needed is bound to widen as the pandemic evolves. To narrow this gap, resources must be identified from within national budgets, while the international donor community responds to meet the remaining needs. All countries have a stake in global solidarity: given the interdependence of nations, no country can be completely safe from AIDS until every country is.

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I. INTRODUCTION

1. The global strategy for the prevention and control of the acquired immunodeficiency syndrome (AIDS), initially drawn up in 1985-1986 and endorsed in 1987 by all nations of the world, has served as the main policy framework for the global response to the pandemic which is directed and coordinated by WHO in accordance with its mandate from the United Nations General Assembly. The strategy's basic premises remain as valid today as when they were first stated, but the pandemic has evolved dramatically since then, and valuable lessons have been learned about how to combat it. The 1992 update of the global strategy takes these developments into account.

2. The three main objectives of AIDS prevention and control remain to prevent infection with the human immunodeficiency virus (HIV); to reduce the personal and social impact of HIV infection; and to mobilize and unify national and international efforts against AIDS.

3. The first objective is indisputably the most important. Prevention is the only way to avert all the human, social and economic costs of HIV infection, which is lifelong and, in the absence of curative drugs, likely to be ultimately fatal. The second objective calls for support and care for those who have been infected with HIV, whether they are still healthy or have developed illnesses associated with their infection, including AIDS. The support and care of HIV-infected persons is not only humane, it is vital for the success of prevention and control programmes. The second objective likewise aims at reducing the social and economic impact of AIDS on the friends and families of HIV-infected persons and on society as a whole. The third objective, calling for mobilization and unification of all efforts, arises directly from the special characteristics of the infection itself and from the global nature of the pandemic and its socioeconomic repercussions. Given the interdependence of nations, no country can be completely safe from AIDS unless every country is.

4. The global strategy for the prevention and control of AIDS lays down guiding principles based firmly upon knowledge of HIV infection and its epidemiology, as well as upon practical experience with programmes for the control of HIV/AIDS and other infectious diseases. Many are derived from consensus statements made by international meetings of experts convened since 1987 by the WHO Global Programme on AIDS, often in coordination with other international agencies and bodies. Statements from international consultations issued by WHO cover topics such as HIV transmission and breast-feeding, AIDS control in prisons, HIV/AIDS in the workplace, HIV and prostitution, screening of travellers and others, and HIV transmission in the health-care setting.

5. The guiding principles of the global strategy apply to all national and international action aimed at AIDS prevention and control, and are valid for all partners in the global effort against the pandemic. In particular, the global strategy provides the necessary framework within which each national AIDS programme can set its own objectives and select and implement the strategies and interventions best suited to its particular situation.

II. THE GLOBAL AIDS SITUATION

6. AIDS has in the space of just one decade turned into a pandemic affecting millions of men, women and children on all continents. Although the first reported cases were among homosexual men in a few industrialized countries, it soon became clear that this was an epidemic of much greater scope.

7. In the world as a whole, heterosexual intercourse has rapidly become the dominant mode of transmission of the virus. As a result, the developing countries already hold as many newly infected women as men, and the developed countries are approaching equal incidence in men and women. Perinatal transmission, i.e. transmission of HIV from an infected mother to her unborn or newborn baby, is showing a corresponding increase. Homosexual transmission, on the other hand, has remained significant in North America, Australasia and northern Europe, although even in these areas heterosexual transmission is showing the fastest rate of increase. Transmission through contaminated blood transfusions has been virtually eliminated in industrialized countries; in developing countries, steps are being taken to prevent transfusion-related infections, although much remains to be done and the costs are high. Bloodborne transmission through needle sharing outside the health care setting is on the rise in a number of groups of drug injectors in the developed and developing world.

8. WHO estimates that as at early 1992 at least 10-12 million adults and children worldwide have become infected with HIV since the start of the pandemic. Among them, some two million have gone on to develop AIDS - the late stage of HIV infection, which occurs 10 years on average after initial infection with the virus. By the year 2000 WHO estimates that cumulative totals of 30-40 million men, women and children will have been infected, and 12-18 million will have developed AIDS.

9. Nearly 90% of the projected HIV infections and AIDS cases for this decade will occur in the developing countries. In sub-Saharan Africa, where over 6 million adults are already infected, the situation is critical. As many as one-third of pregnant women attending some urban antenatal clinics are HIV-infected, and seropositivity rates this high are being seen outside cities as well. As a result, WHO now projects that 5-10 million HIV-infected children will have been born by the year 2000. By the mid-1990s the projected increase in AIDS deaths in children will begin to cancel out the reduction in mortality achieved by child survival programmes over the past two decades. In those African countries where the prevalence of HIV infection is already high, life expectancy at birth will actually drop by 5%-10% instead of rising by 20% by the year 2000, as was projected in the absence of AIDS. In Asia, which holds more than half the world's population, the dramatic rise in seroprevalence between 1987 and 1991 in South and South-East Asia may well parallel that seen in sub-Saharan Africa in the early 1980s, and by the mid to late 1990s more Asians than Africans will be infected each year. As of early 1992, Latin America and the Caribbean were estimated to have over one million HIV-infected adults.

10. The brunt of the AIDS pandemic is thus increasingly being borne by the developing countries. In parts of sub-Saharan Africa the pandemic's overall social and economic impact is already enormous and is bound to become more devastating still. The health and social support infrastructure is inadequate to handle the clinical burden of HIV-related disease, which includes an upsurge in tuberculosis. In some cities, up to three-quarters of all hospital beds are already occupied by AIDS patients, and the case-load will continue to rise as today's HIV-infected persons progress from asymptomatic infection to illness. The deaths of millions of young and middle-aged adults, who include members of social, economic and political élites as well as professional health workers and teachers, could lead in some societies to economic disruption and even political turmoil. Through the deaths of young men and women, innumerable children and elderly people are already being left without support. In sub-Saharan Africa alone, 10-15 million children will be orphaned by the year 2000 as their mothers, or both parents, die of AIDS. A similar scenario can be expected in Asia, Latin America and other parts of the developing world in the first decade of the twenty-first century.

III. THE OBSTACLES AHEAD

11. Despite the continued growth of the pandemic, information from many national AIDS programmes yields an encouraging picture of progress in mounting a global response to it. More and more, people are being informed about how they can protect themselves and others from infection, the supply of condoms is being strengthened, donated blood is increasingly being screened for HIV, and resources and staff for HIV/AIDS prevention and care are being expanded.

12. But the same factors that fuelled the pandemic in the first place are still impeding prevention and control efforts. These include ignorance about the nature of the disease, denial of the relevance of AIDS to the individual or to society, and complacency or paralysis in the face of the pandemic's magnitude. These are aggravated by the continued stigmatization of HIV-infected persons and those perceived as being at risk of infection; the subordinate social and economic status of women; traditional and cultural practices that facilitate transmission; and reluctance to discuss sexual matters frankly. As a result there is still insufficient high-level political support for the prevention and control efforts needed, and the human and financial resources available are grossly inadequate in amount and distribution. As daunting as these obstacles may appear, they must be tackled urgently and with determination for they cut across each and every objective of the global strategy. The ultimate success of AIDS prevention and control will depend on how effectively they are overcome.

IV. THE GLOBAL STRATEGY FOR THE PREVENTION AND CONTROL OF AIDS

Prevent HIV infection

13. AIDS is essentially a sexually transmitted disease (STD) and, like some such diseases, can also be spread through blood and from an infected woman to her unborn or newborn child. Methods of proven efficacy exist to reduce transmission through all three routes. It is these approaches, outlined below, that must be applied now, even as biomedical researchers intensify their efforts to develop vaccines, since a universally effective and affordable preventive vaccine is unlikely to be available before the year 2000.

Prevent sexual transmission of HIV

14. HIV is spread primarily through sexual intercourse. This makes sexual behaviour the prime focus of action for interrupting transmission. The first 10 years of experience with the AIDS pandemic show that this objective has been achieved in some settings through the promotion of safer sexual behaviour, although much remains to be learned from sociobehavioural and epidemiological research about the most effective interventions in different cultural settings.

15. Action to influence sexual behaviour must have three components: information and education, backed up by health and social services, and a supportive environment.

16. **Information and education** about how to avoid acquiring or transmitting HIV must be directed to individuals who have multiple casual sex partners and are hence at the highest risk of infection. However, because most people's sexual behaviour is private, and some is secret or even taboo, it is never possible to know about all those who are or will be at particularly high risk so as to target messages only at them. Moreover, individuals who are exposed to HIV through the sexual behaviour of their spouse or regular partner likewise need information. For these reasons, **all** men and women should be informed and educated about AIDS, including how HIV is and is not transmitted, how they can protect themselves and their partners from infection, and where they can go for condoms and support services (e.g. counselling, voluntary and confidential HIV testing, and treatment for other sexually transmitted infections). Women need to know that male-to-female transmission occurs more readily than the reverse during vaginal intercourse; similarly, the "receptive" partner in anal or oral sex is at higher risk. Given the early age at which many young people become sexually active, there should be special emphasis on informing and educating the younger generation. Pre-adolescent and adolescent girls and boys, whether they are in school or not, must have clear and appropriate information and must learn and practise the related prevention skills if they are to protect themselves against infection.

17. Experience shows that people are more open to discussing a nominally taboo subject when they understand its importance for their health. Programmes for the encouragement of safer sexual practices therefore need to be forthright and clear. They should convey the message that only sexual abstinence or mutual lifelong fidelity between uninfected partners wholly eliminates the risk of HIV infection and other sexually transmitted diseases. Otherwise, intercourse (i.e. anal, vaginal or oral penetration) exposes both partners to risk, especially when it is "unprotected" by a condom. People who have multiple casual partners, as well as those who are unsure of the infection status of their regular partner, need to be informed that they can reduce the risk of HIV infection by avoiding penetrative sex or by using latex condoms consistently and correctly for intercourse. As well as preventing HIV and other sexually transmitted diseases, condoms are important for contraception and can usefully serve both purposes.

18. Preventive interventions are more likely to succeed if they fit into existing sociocultural patterns and traditions. Parents, teachers, and traditional, religious and other community leaders thus have an important role to play in reinforcing traditional health-promoting values and practices. Similarly, because communities are the driving force for the modification of social norms, any local practices through which people may be exposing themselves to HIV infection need to be discussed with community leaders and custodians of tradition so that they can encourage norms that are more consonant with AIDS prevention. Experience also points to the importance of peer education, in which a person who enjoys the trust of his or her peers brings prevention messages and skills to them, rather than an educator from outside the group. Peer education is especially important in programmes developed for prostitutes, men who have sexual relations with men, injecting drug users, and other, often socially excluded, groups. However, it is also applicable in other contexts, such as the workplace. Individuals who are themselves at risk are effective peer educators, and people with HIV infection or AIDS are particularly credible bearers of prevention messages.

19. **Health and social services** are the second key element in the prevention of sexual transmission. They are indispensable for the detection and treatment of sexually transmitted diseases since such diseases, if left untreated, greatly increase the risk of HIV transmission. Early diagnosis and treatment with appropriate drugs must be made available through trained health personnel, and the voluntary use of STD services must be encouraged in every possible way. At the same time, research must be pursued to find better ways of diagnosing sexually transmitted diseases in women, who often have no symptoms of infection and hence are unaware of the need to seek care.

20. Health and social services can likewise provide AIDS education, counselling, and voluntary HIV testing. Although mass information campaigns and group education help some people to modify their sexual practices, others need a more personal form of communication and support in order to achieve sustained behaviour change that will protect themselves and break the potential chain of transmission. It is important to provide a personal and fully confidential realm in which people engaging in risk behaviours, people seeking voluntary HIV testing, HIV-infected persons and their families, and small groups, can find information, understanding and support for behaviour change. Traditional medical practitioners can be a valuable resource for this kind of support.

21. Every contact with the health services should be looked on as a potential opportunity for informing people about HIV. For example, people seeking health care for other sexually transmitted diseases, in addition to being at high risk of acquiring HIV infection, are particularly receptive at such times to education about risk reduction. The other key opportunities for information and education that should not be missed are visits to maternal and child health/family planning clinics by women of childbearing age, who are often vulnerable to HIV infection as a result of their lower social status.

22. **A supportive environment** is vital to the success of programmes to prevent the sexual transmission of HIV. Experience has shown that individuals are more likely to adopt safer sexual practices when these are perceived as the norms prevailing in their peer group or community. It is thus crucial to encourage the adoption, readoption or retention of protective social norms, such as mutual fidelity, moral responsibility for not endangering others, and the appropriate use of condoms. A supportive social environment for preventive programmes also means one in which there are no legal or other barriers to the dissemination of frank and informative messages about sexual health (e.g. laws prohibiting the promotion of condoms), and likewise no barriers that would hinder people from receiving and acting on prevention messages (e.g. the enforcement of laws against mutually voluntary sexual activity between adult males).

23. Finally, public support must be firmly marshalled behind rational and humane AIDS prevention and control programmes that do not stigmatize or discriminate against persons known or suspected to have HIV infection or AIDS. Compulsory screening and detention is not only incompatible with human rights and dignity, it actually jeopardizes public health and welfare for at least three reasons. First, it results in evasive behaviour on the part of those who know or suspect they are HIV-infected, and hence makes it harder for health officials to monitor the HIV/AIDS situation and convey information to the very people who are at greatest risk of acquiring and transmitting infection. Second, it deprives AIDS prevention programmes of valuable allies, who could be engaging in peer education. Third, any attempt to isolate and confine infected persons, which can never be completely effective, gives the general public a false sense of security.

24. A supportive economic environment is also crucial for prevention. Clearly, poverty places severe limitations on the resources and infrastructure of AIDS prevention programmes. More broadly, poverty makes whole communities vulnerable to AIDS by forcing men to leave their families in search of work, by leaving people hopeless enough to turn to the solace of drugs, or by making prostitution a survival strategy for women and children. AIDS then completes the vicious circle by making the community even poorer.

25. In theory, sexual transmission requires the active participation of both partners and hence should be preventable by either one. However, such social and economic realities as poverty, lesser education and subordinate social status may leave some individuals with little power or freedom to refuse intercourse or insist on the use of a condom. Women in particular tend to be at higher risk of acquiring HIV infection through sex engaged in for economic survival or imposed by men in or outside marriage. Over the longer term, preventing women's infection with HIV will require their individual and social empowerment and an improvement in their own economic and social status so that they have a greater say in their own and their partners' sexual decision-making, as well as the ability to generate income without risk of infection.

26. In the meantime, all possible support needs to be given to women's groups and national machinery for the advancement of women so that all women, regardless of their level of literacy, can be informed about the risks of HIV infection and helped to protect themselves. The critical importance of using every contact with the health services as an opportunity for information and support to women has already been mentioned. At the same time, efforts are needed to encourage men to protect their partners and babies from AIDS by practising safer sexual behaviour. In parallel, research must be pursued to develop effective preventive technologies that can be controlled by women, such as vaginally applied virucides or female condoms.

Prevent bloodborne transmission of HIV

27. Bloodborne transmission of HIV can occur whenever HIV-infected blood from one person enters the bloodstream of another person, as when donated blood or blood products are transfused or organs transplanted into a recipient, when surgical or other equipment used for injections and invasive procedures is reused without adequate sterilization in the health-care setting, or when drug users share unsterilized injection equipment.

28. **HIV transmission through blood transfusions** can be prevented by the rational use of safe blood and blood products. The risk of becoming infected through a single contaminated blood transfusion is over 90%, and transmission through this route is responsible for some 3%-5% of HIV infections worldwide. Interventions and activities to limit this kind of spread need to be selected carefully in each country, depending on their cost-effectiveness, the availability of resources, and the relative importance of this as compared with other routes of transmission, bearing in mind that blood safety programmes help prevent other bloodborne diseases, such as hepatitis. Prevention of HIV transmission through this route involves recruiting voluntary, non-remunerated regular blood donors to ensure a safe blood supply; providing donors with pre-test counselling and referrals for continued counselling as required; screening donated blood for HIV prior to transfusion; training the staff of blood transfusion services in correct procedures, including techniques for rendering blood products safe for use; and educating the prescribers of blood and blood products in order to reduce unnecessary transfusions. Ensuring blood safety is a fairly expensive intervention, but heavy investments have already been made in it in a large number of developing countries and these should be sustained. In parallel, practical guidelines for limiting recourse to transfusions need to be established, and further simple, cheap and reliable HIV tests need to be developed to facilitate the screening of donated blood.

29. **Drug injectors** acquire and transmit HIV by sharing unsterilized needles and other injection equipment, as well as through sexual intercourse. Given the many health risks and social consequences of drug injecting, of which HIV infection is only one, a major goal should be to reduce the demand for psychoactive drugs, although a more immediate goal would be to reduce the use of drugs by injection. Some countries have backed up their educational campaigns by making clean needles available, and this has reduced needle sharing without any measurable increase in drug use. In countries where such an approach is not possible, the emphasis should be on teaching drug injectors how to clean their equipment and secure a stable supply of disinfectant solutions such as bleach. Interventions to help drug injectors prevent sexual transmission among themselves and from them to others must be implemented concurrently. As with the prevention of sexual transmission, the prevention of bloodborne transmission among drug users calls for further research to determine more effective interventions for encouraging behaviour change.

30. Programmes aimed at reducing bloodborne and sexual transmission of HIV among drug users will not be successful if they consist only of information and education. Equally vital are the other two components of prevention: health and social services; and a supportive social and economic environment that maximizes the availability of drug treatment programmes for those who wish to stop using drugs, encourages health-promoting norms among drug users, and minimizes legal repression, stigmatization and social exclusion.

31. **The prevention of HIV transmission in the health-care setting** is based on careful attention to infection control procedures, including the proper sterilization of equipment used for skin-piercing, surgical and other invasive procedures. The guiding concept is that of "universal precautions", i.e. laboratory personnel and health care workers handling blood or carrying out skin-piercing, surgical and other invasive procedures must work on the assumption that **all** blood is potentially infectious, rather than attempt to identify "high-risk" patients and handle their specimens accordingly. This will require the training of all health workers, including traditional practitioners and birth attendants, in standard procedures based on "universal precautions", and the prioritized allocation of the necessary protective supplies and equipment, e.g. sterilization devices for dentistry and gloves for midwifery and surgery.

Prevent perinatal transmission of HIV

32. Most HIV infections in women of childbearing age are transmitted sexually; hence the prevention of sexual transmission of HIV to women is by far the best strategy for preventing transmission from mother to child.

33. Secondary prevention of perinatal transmission currently depends on the avoidance of childbearing by HIV-infected women. Most seropositive women are unaware of their infection status. For a woman who suspects or knows that she is HIV-infected, the decision whether or not to bear a child is a complex and painful one involving a range of considerations. Among other things, she must weigh the risk of the child's death from AIDS (some 20%-30% of infants born to HIV-infected women are infected, and 80% of them die by the age of 5 years) against the overall prospects for child survival; consider the consequences of certain orphanhood for the child even if uninfected; and balance these against the enormous psychological, social and frequently economic costs of childlessness. Voluntary counselling, contraception and other fertility regulation services should be available to women everywhere as part of the health services and supportive environment needed for prevention of perinatal transmission. Health and social support should likewise be provided for women who decide to have a baby despite the risks. Research is needed to evaluate the impact of current counselling methods for couples and women of childbearing age, and to determine how to improve this impact through alternative methods, for example using religious leaders and traditional health practitioners.

34. Over the longer term, biomedical research needs to pursue the development of "perinatal vaccines" and other means, such as drugs, of preventing HIV infection in the unborn and newborn babies of HIV-infected women.

Reduce the personal and social impact of HIV infection and AIDS

35. As the number of already infected people developing HIV-related illness rises in the coming years, the credibility of AIDS prevention and control programmes will in part be judged on how well they offer care, including relief of physical and psychological suffering. The impact of ill-health on the family, community and society will also demand increasing attention.

Care, including counselling and clinical management

36. At community level, the distinction between prevention activities and care activities disappears altogether. Care for people infected with HIV or ill with AIDS becomes inseparable from education about how the virus is and is not transmitted - for example, to encourage families and communities to care for HIV-infected members rather than abandon them from fear of contagion. Infected persons are more likely to take precautions against infecting their sexual partners if they receive supportive counselling and clinical care. With proper care and support HIV-infected persons can lead useful and productive lives for years, provided their dignity is safeguarded.

37. For all these reasons, the world must strive to ensure that humane care - of a quality at least equal to that provided for other diseases - is everywhere available for HIV-infected adults and children. Services should be appropriate, accessible and continuous. They must in addition be acceptable, i.e., responsive to the needs of patients as perceived by them. At the minimum, clinical care should include pain relief and treatment for common opportunistic infections; this requires adequately trained health-care providers and a reliable supply of essential drugs, including antibiotics for the parallel epidemic of tuberculosis among HIV-infected persons. However, care means more than just medical management. If they are to maximize their remaining health potential and refrain from infecting others, HIV-infected persons need understanding and compassion. Counselling is therefore an equally vital part of care. In addition, families and friends are the prime support of infected persons and must in turn receive the support of the community to fulfil this role.

38. HIV-infected persons have repeated episodes of illness and impairment requiring clinical management, including occasional hospitalization. To the greatest extent possible, they should be cared for at home or on an outpatient basis. In order to provide comprehensive care of this kind, which requires training and support for relatives and other home-care providers, communities must have as their base a primary health care centre or similar outpatient facility. The community health centre should in turn be linked to a hospital where efficient nursing care and the assistance of resident or visiting specialists are available. Effective communication and referral systems between the home, the community health centre and the hospital are indispensable. Equally vital is a supply of essential drugs for at least symptomatic treatment, including pain relief, without which families cannot reasonably be asked to provide home care.

39. Care for people with HIV/AIDS will thus require massive financial, logistic and organizational support, especially in the developing countries. It will also require the best efforts of social, behavioural and biomedical scientists. While available drugs for HIV-related illness must be supplied and distributed where needed, along with clear guidelines on their use, new safe and effective drugs against HIV itself and related diseases need to be developed. Research should also be undertaken into affordable and sustainable ways of providing basic clinical care, including evaluation of different models of care along the home-hospital continuum. Social research is called for on determinants of the coping mechanisms of infected persons, and on approaches to counselling within peer groups and at the community level.

Social and economic support for patients and their families

40. AIDS especially threatens the developing countries and poor and marginal groups within the industrialized countries, aggravating their poverty and exclusion. Moreover, it incapacitates people at ages when they are most needed for the support of the young and the elderly. The adverse impact on families with one or more HIV-infected members is thus enormous and compounded by the frequent stigmatization of persons with HIV/AIDS.

41. The pandemic imposes a double burden on women. Already more vulnerable to HIV infection because of their subordinate status, women are likewise affected by the AIDS pandemic in their role as providers of care in the family and community. In addition to their other demanding tasks in and outside the household, women are thus expected to take care of husbands, children and other family members with HIV-related illness. Those who are not the main financial support of their families are forced to assume this responsibility too as their partners sicken and die of AIDS. In the case of women who are themselves suffering from HIV-related disease, the burden is heavier still. It remains to be elucidated to what extent the demands of AIDS care-giving threaten the health and economic situation of the family as a whole.

42. Immediate action and research are called for to reduce the impact of AIDS on affected individuals and their families. In countries where social security and health insurance schemes exist, the coverage afforded to people with HIV/AIDS should be at least equal to that provided for people with other diseases. In all countries, industrialized and developing, communities are frequently a mainstay of infected persons and their families, and every effort should be made to strengthen the potential forces for health within them - including community and religious leaders, teachers, and social and health workers. In addition to reinforcing traditional community mechanisms for coping with illness, new mechanisms must be identified in both the formal and the informal health sectors. Women's cooperatives, groups working with socially excluded populations, and nongovernmental organizations are an integral part of the community effort and need maximum reinforcement. Support is particularly vital for local AIDS organizations engaged in prevention and care activities; these often have HIV-infected people on their staff, giving them unparalleled insight and motivation in their work. Ways

need to be found of replicating on a national scale the success of such organizations and other community-based groups in providing social, psychological and economic support to people with HIV/AIDS and their families.

43. As nuclear and extended families are hit by AIDS, traditional approaches to care of orphans will need to be supplemented by community-based foster care homes, day-care centres, and a bigger parenting role for schools. Other options include village associations/cooperatives which parents join in preparation for the orphanhood of their children, and the use of religious and other charitable institutions to protect orphans' property and create a protective climate for widows and orphans. Experience has shown that orphaned siblings are more likely to thrive if kept together, and that children orphaned by AIDS should not be singled out in a way that separates them from other orphans or the rest of the community. Planning for community support of orphans must go hand in hand with persistent efforts to overcome the irrational fear of infection, the stigmatization of infected persons, and the laws and practices that permit the exploitation of their survivors.

Reducing the socioeconomic impact of AIDS on society

44. The socioeconomic impact of AIDS on society at large is already enormous in many countries and is bound to grow significantly in the years ahead. Among the direct and indirect economic costs are vastly increased spending on health care; drain on health care resources, including hospitals, drugs and staff; decimation of the workforce (loss of production and productivity in all sectors of the economy, including women's labour in and outside the home); loss of investment in the training of skilled labour and educated professionals; loss of consumers and purchasing power; and loss of tourist revenues. In the developing countries, social disintegration and possibly political turmoil may well occur. AIDS orphans will swell the ranks of street children, already estimated at 100 million, increasing the numbers of young people vulnerable to infection with HIV.

45. The pandemic thus threatens the very fabric of society. It is vital to plan now to forestall these developments. All sectors of the economy, private as well as public, and all nations everywhere must be involved in the effort since all have a stake in bringing the pandemic under control. To ensure that planning proceeds on a solid foundation of fact, further research is essential. The economic impact of AIDS on the individual sectors - agriculture, industry, education, tourism, etc. - needs to be quantified, and an assessment is required of the social and health impact of such factors as the deaths of millions of women who have hitherto carried the prime responsibility for the health and welfare of their families. Research should focus on the pandemic's interrelations with overall development as well as on its impact on the health care system, including formal and informal patterns of care.

Mobilize and unify national and international efforts

46. Historically, global AIDS control has gone through four phases: silence, discovery, mobilization and consolidation.

47. The first period, starting in the mid-1970s, was the time of the "silent pandemic", during which HIV spread unnoticed to almost all continents. With the description of AIDS in 1981, the silence ended and the second period commenced, the period of discovery during which the modes of transmission were defined and the human immunodeficiency virus was discovered. The resulting ability to diagnose infection led to the discovery of the large numbers of persons already infected and to awareness of the long latency period between infection and manifest disease.

48. Immediately after the First International Conference on AIDS, in 1985, a group of scientists and health professionals met under the auspices of WHO and set the stage for the third period - the global mobilization against AIDS. To appreciate the significance of this global mobilization, one must recall that this was a time of uncertainty, ignorance and hesitancy on the part of both the AIDS-affected countries and the international donor community. The situation called for urgent and concerted action. WHO, with its constitutional responsibility to direct and coordinate international health work, took up the challenge and drafted the global strategy for the prevention and control of AIDS, which served as the basis for initial global action against AIDS.

49. The global strategy was reviewed, revised and discussed widely in 1986. It was then unanimously approved and adopted as the foundation for global action by the Fortieth World Health Assembly (May 1987), the Venice Summit of the Heads of State and Government (June 1987), the United Nations General Assembly (October 1987) and the World Summit of Ministers of Health on Programmes for AIDS Prevention (London, January 1988). The human and financial resources required to begin implementing this strategy were mobilized, and the chaotic anxiety of 1985 yielded to the structured, purposeful and increasingly powerful work of national and international AIDS prevention and control.

50. A new period - the consolidation phase - begins in 1992. By now, the vast majority of countries have started to implement national AIDS programmes, in many cases with financial support from bilateral assistance agencies, intergovernmental organizations, and private and other nongovernmental sources. As the far-reaching impact of the pandemic becomes clear, more and more partners are drawn into the global effort. Their actions need to be unified to ensure a coherent response to the old and new challenges of AIDS, as outlined below.

Advocacy to overcome denial and complacency about the pandemic

51. Official denial of the existence of HIV infection in a country, and complacency about its current and expected magnitude, are among the commonest and most formidable obstacles to AIDS control programmes. Yet such programmes cannot be effective unless they enjoy political support at the highest level. Although a great deal remains to be learned about the most effective ways of overcoming government denial and complacency, methods that have been shown to work include epidemiological and social-behavioural research to document the existence within a country of sexual practices and of other factors (e.g. a high rate of other sexually transmitted diseases) conducive to the spread of HIV; visits by government leaders to more severely affected countries; seroprevalence surveys to document HIV infection rates in population samples; projections of the future growth of HIV infections and AIDS cases in the country; and estimates of the pandemic's social and economic consequences.

52. Denial and complacency on the part of the general public are likewise formidable obstacles, for they prevent individuals from acknowledging that they or those dear to them might be directly at risk, or even indirectly affected by the pandemic's impact. In some countries, the public acknowledgment by national celebrities that they or members of their family have AIDS has helped to overcome denial. The media also have a key role to play in raising public awareness of the risk of HIV infection, offering repeated information about how to reduce this risk and where to go for further help, and ensuring the visibility of AIDS prevention and care measures.

Advocacy to counter stigmatization and discrimination

53. To combat AIDS effectively, societies must function on sound public health principles and not succumb to scapegoating, stigmatizing or discriminating against HIV-infected persons in the vain hope of curtailing the pandemic. In the case of HIV/AIDS, these irrational reactions often stem from ignorance about routes of transmission, fear of AIDS as a fatal disease, and the stigma attached to an infection that is for the most part spread sexually. It is vital to combat these reactions through international as well as national pressure.

54. All sectors of society, including the media, have a responsibility to explain in plain terms, understandable by all, that there exists no risk of acquiring HIV infection - or any other sexually transmitted disease - through casual contact, and that hence there is no public health rationale to justify isolation, quarantine or other discriminatory measures based solely on a person's HIV infection status. Non-discrimination is not only a human rights imperative but also a technically sound strategy for ensuring that infected persons are not driven underground, where they are inaccessible to education programmes and unavailable as credible bearers of AIDS prevention messages for their peers. Any attempt to isolate, detect and confine infected persons is dangerous for still another reason: it can never be 100% effective, yet it creates the illusion that all infected persons are out of reach and that precautions against sexual transmission of HIV are no longer necessary.

Broad multisectoral commitment

55. AIDS is not only a health problem but also a social, economic and development issue. It must therefore be tackled by all those who have an interest in keeping or bringing it under control. These include the health

sector, priority productive sectors dependent on human resources (industry, agriculture, mining, tourism), other social sectors (planning, finance, education, information, labour, justice, social services), parliaments, the private sector, charitable, religious and other voluntary organizations, and the media. Coordination of this broad-based multidisciplinary, multisectoral response is the responsibility of governments, in collaboration with the international organizations.

Nongovernmental and community-based organizations

56. Nongovernmental organizations, including voluntary, community-based associations, can play a vital role in promoting safer sexual practices and providing support for persons affected by HIV/AIDS. Their particular strength lies in their access to individuals and communities and in their credibility, without which behaviour change and its maintenance are so much harder to achieve. Associations of persons with HIV or AIDS have a unique credibility in this regard. Nongovernmental organizations are also well placed to combat complacency, denial, stigmatization and discrimination. Those that have their roots in the community are more likely to be responsive to community needs, to be flexible, and to be aware of religious and cultural sensitivities - qualities that complement the strengths of government bodies. It is therefore essential that all relevant parties, governmental, intergovernmental, and nongovernmental, forge partnerships to ensure the genuine involvement of community-oriented organizations that are already working on AIDS or that have the potential to do so. This involvement must include participation in the design, implementation, and review of programmes and activities at local, national, regional and global levels. To be successful, such working relationships need to be based on mutual respect between independent partners. At country level, special emphasis needs to be placed on enabling community-based groups to improve their managerial and technical competence in the areas of prevention, care and advocacy.

International coordination of research

57. International coordination of HIV/AIDS research is vital to create a research environment conducive to the sharing of information and experience, which will help speed scientific progress; to accelerate the development of strategies and technologies appropriate for use in developing countries, including training and the transfer of technology; and to ensure that the fruits of biomedical and other research are made available, at affordable cost, to developing countries.

58. Most clinical, epidemiological, and sociobehavioural research to date has been carried out in the industrialized countries, where men predominate among people with HIV/AIDS and hence among research subjects. There are accordingly large gaps in knowledge about women and AIDS. It is essential to determine, for example, whether HIV-related disease in women has the same progression and is characterized by the same opportunistic infections as in men. More broadly, research needs to focus on the double impact of the AIDS pandemic on women, as infected persons and providers of care, and on the complex links between women's personal vulnerability to infection and their social status. As with all studies on AIDS, women need to be actively involved as researchers alongside men.

Meeting global financial needs

59. The stupendous growth in the external financial resources needed globally for AIDS prevention and care is due to the increasing number of countries affected by the pandemic, the increasing prevalence of infection within each country, the increasing burden of ill-health among HIV-infected persons as they progress towards AIDS, and the indirect costs to key sectors of the economy.

60. If AIDS were confined to the industrialized nations, the financial implications would be grave enough. However, the main burden of the pandemic is shifting ever more clearly to the developing countries, which by the year 2000 will account for 90% of all HIV infections - and in time will have 90% and more of all AIDS cases. To the need for expanded prevention programmes will thus be added the extra demand on health care systems that are already strained to breaking-point and the innumerable costs to society as a whole.

61. Although developing countries have shown resourcefulness in meeting many of their needs to date, they need to summon greater political will in ensuring that the national resources committed to AIDS are commensurate with the urgency of the situation. However, even with an ideal shift of resources from other sectors, such as military expenditure, the developing countries - burdened by heavy debt, political instability,

war, famine and endemic diseases, and hence all the more vulnerable to AIDS - cannot possibly shoulder alone all the AIDS-related funding needs that will arise in the coming decade. Solidarity and support on a global scale is called for on the part of the wealthier nations, whether aid is provided directly or through international agencies. In view of the impact of the pandemic on the entire health care system of developing countries, such support needs to be additional to that already provided to the health sector. The health costs of the pandemic are, however, only a fraction of the total real costs. It is vital for donors to step up their overall development assistance, not only to alleviate the pandemic's impact on all sectors of the economy, but also to reduce the poverty that makes countries vulnerable to the further spread of HIV. The private sector, at both international and national levels, also needs to be mobilized to provide resources, in view of the pandemic's impact on the workforce and on economic development. It will take an unprecedented mobilization of resources to help the developing countries break out of the vicious circle of poverty-AIDS-poverty and to give the world a better chance of bringing the pandemic under control.

V. THE NEW AIDS CHALLENGE

62. The global strategy for the prevention and control of AIDS establishes a policy framework for national and international efforts to prevent HIV infection, to provide care for the millions of men, women and children already affected and otherwise reduce the pandemic's impact on individuals and society, and to mobilize ethical, sustainable and concerted action against the pandemic. Based on current scientific understanding of AIDS and its causal virus, HIV, the global strategy draws on years of practical experience with programmes for the control of HIV/AIDS to propose ways of meeting the new challenges of the evolving pandemic. These are:

- increased emphasis on care;
- better treatment for other sexually transmitted diseases;
- greater focus on HIV prevention through an improvement of women's health, educational, legal and social status;
- a more supportive social environment for prevention programmes;
- provision for the socioeconomic impact of the pandemic;
- greater emphasis on explaining the public health dangers of stigmatization and discrimination.

63. The principles embodied in the global strategy are valid for **all** partners in the global effort against AIDS - developed and developing countries, government authorities and nongovernmental groups, scientists and the lay public, organizations and individuals. But the global strategy will be useful only to the extent that it is **used as a basis for immediate action**. The challenge for governments everywhere is to give national AIDS programmes their immediate support and sustained political commitment under the leadership of the head of state. A national plan of action needs to be drawn up or revised to ensure that it is consistent with the global strategy and spells out the measures to be taken by each and every sector affected by the pandemic. A multisectoral committee with real decision-making power needs to coordinate the national AIDS programme, which should be led by men and women of broad vision. The partnership of the private and nongovernmental sectors must be assured.

64. There remains the challenge of human and financial resources. The existing gap between the resources available and those needed is bound to widen as the pandemic evolves. To narrow this gap, resources must be identified from within national budgets, while the international donor community responds to meet the remaining needs.

65. For the sake of our common survival, we must act with courage and urgency. With every passing day, HIV claims thousands of lives. The only possible answer to the new AIDS challenge lies in global solidarity.

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