1992–1993 Progress Report

Global Programme on AIDS

World Health Organization
Geneva

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List of Abbreviations

ACHR	Advisory Committee on Health Research (WHO)
ACC	Administrative Coordination Committee of the United Nations
AHRTAG	Appropriate Health Resources and Technologies Action Group
AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Project of USAID
AIDSCOM	AIDS Public Health Communication Project (Washington DC, USA; USAID-funded)
AIDSTECH	AIDS Technical Support Project (North Carolina, USA; USAID-funded)
AMREF	African Medical and Research Foundation
ARFI	AIDS Research Foundation of India
ASAP	AIDS Society for Asia and the Pacific
ASEAN	Association of South-East Asian Nations
ASO	AIDS service organization
BCG	bacille Calmette-Guérin
BTS	blood transfusion service
CBD	community-based distribution
CBO	community-based organization
CDC	Centers for Disease Control and Prevention (Atlanta, USA)
CDD	Diarrhoeal Disease Control (WHO programme)
CI	confidence interval
CIOMS	Council for International Organizations of Medical Sciences
CMV	cytomegalovirus
CONRAD	Contraceptive Research and Development Program
CSM	condom social marketing
DALY	disability adjusted life year
DNA	deoxyribonucleic acid
DSMB	Data and Safety Monitoring Board (WHO)
ECOSOC	Economic and Social Council of the United Nations
EIA	enzyme immunoassay
ELISA	enzyme-linked immunosorbent assay
EPI	Expanded Programme on Immunization (WHO)
FAO	Food and Agriculture Organization of the United Nations
FIOCRUZ	Oswaldo Cruz Foundation (Rio de Janeiro, Brazil)
GBSI	Global Blood Safety Initiative
GMC	GPA Management Committee
GNID	gram-negative intracellular diplococci
GNP+	Global Network of People Living with HIV/AIDS
GPA	Global Programme on AIDS (WHO)
GTZ	Gesellschaft für Technische Zusammenarbeit (Agency for Technical Cooperation, Germany)
GUD	genital ulcer disease
HBV	hepatitis B virus
HIV	human immunodeficiency virus
HIVIG	hyperimmune intravenous immunoglobulin
HTLV	human T-lymphotropic virus (also called human T-cell leukaemia virus)
IAAG	Inter-Agency Advisory Group on AIDS
IAS	International AIDS Society
ICASO	International Council of AIDS Service Organizations
ICW	International Community of Women Living with HIV/AIDS
IDRC	International Development Resource Center
IEC	information, education and communication
IFPMA	International Federation of Pharmaceutical Manufacturers Associations
IFRCRCS	International Federation of Red Cross and Red Crescent Societies

IgA	immunoglobulin A
IgG	immunoglobulin G
ILO	International Labour Office
INSERM	National Institute of Health and Medical Research (France)
IPPF	International Planned Parenthood Federation
KABP	knowledge, attitudes, beliefs and practices
MOU	Memorandum of Understanding
MRC	Medical Research Council (United Kingdom)
MTP	medium-term plan
NACO	Nation AIDS Control Organization (India)
NAP	national AIDS programme
NGO	nongovernmental organization
NIAID	National Institute of Allergy and Infectious Diseases (USA)
NIBSC	National Institute of Biological Standards and Control (Potters Bar, United Kingdom)
NIH	National Institutes of Health (USA)
NNRTI	non-nucleoside reverse transcriptase inhibitors
NORAD	Norwegian Agency for International Development
OAU	Organization of African Unity
ODA	Overseas Development Administration (United Kingdom)
OMT	oral mucosal transudates
PACWA	Pan African Christian Women's Association
PAHO	Pan American Health Organization
PBMCs	peripheral blood mononuclear cells
PCP	Pneumocystis carinii pneumonia
PCR	polymerase chain reaction
PPD	purified protein derivative
PSA	Programme on Substance Abuse (WHO)
PSI	Population Services International
RFA	Request for Applications
RFP	Request for Proposals
RPR	rapid plasma reagin
SAA	Society on AIDS in Africa
SAREC	Swedish Agency for Research Cooperation with Developing Countries
SIDA	Swedish International Development Authority
SIV	simian immunodeficiency virus
SOMARC	Social Marketing for Change (USAID-funded project)
STD	sexually transmitted disease
SWAA	Society for Women and AIDS in Africa
TALC	Teaching Aids at Low Cost (United Kingdom)
TASO	The AIDS Support Organisation (Kampala, Uganda)
TO	Technical Officer
TPHA	Treponema pallidum haemagglutination assay
ULACETS	Latin American Union against STDs
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USFDA	United States Food and Drug Administration
WB	Western blot (assay for detecting antibody to HIV)
YWCA	Young Women's Christian Association
ZDV	zidovudine

Introduction

At the close of the 1992-1993 biennium, the global reach of the HIV/AIDS pandemic was clearer than ever. Although infection rates were beginning to stabilize in some places, elsewhere the virus pursued its epidemic spread. Everywhere, AIDS increasingly claimed the lives of men, women and children, and wreaked destruction on their families, communities and societies.

Yet 1992-1993 were years of intense activity for the Programme as reported in this publication - activity with positive outcomes.

GPA continued to give top priority to building up the national response to AIDS. Efforts to strengthen national AIDS programmes centred increasingly on technical cooperation rather than on financial and operational support. A major achievement was the development of a comprehensive national AIDS programme management course, through which senior management could refine its skills in prioritizing national strategies and interventions and in planning, implementing and evaluating programme activities. GPA also continued to have consultants or multidisciplinary teams stationed in most developing countries to provide on-the-spot technical assistance in key areas, such as condom programming (including social marketing, logistics management, and quality control) and HIV/AIDS surveillance. A further service to national AIDS programmes was the procurement of low-cost condoms and HIV test kits through bulk purchasing.

In the field of prevention, a universal need for national AIDS programmes is to be able to assess the impact of their interventions in a quantified, standardized fashion. GPA field-tested and finalized evaluation methods to this end, and developed prevention indicators in order to permit the systematic assessment of progress.

In the area of care for people with HIV infection and AIDS, where country demands for support were greater than ever, the Programme developed and promoted the concept of a continuum of care. Comprehensive care, including clinical treatment, nursing, counselling and social support, needs to be delivered through an interactive process embracing the hospital, the clinic or the health centre, the community support system and caregivers in the home. During the biennium, GPA made a major contribution to this continuum, in the form of its *AIDS home care handbook*.

As in the previous biennium, GPA conducted and supported research and development to ensure that national AIDS programmes have the best possible tools at their disposal for both prevention and care.

The Programme devoted considerable attention to the conventional sexually transmitted diseases (STDs). A major public health problem in their own right, with 150 to 300 million curable cases a year, STDs also multiply the risk of HIV transmission: an individual with an untreated STD is perhaps 5-10 times more likely to acquire or pass on HIV during sex. The Programme developed simple flow-charts based on syndromic case management. Briefly, this is an approach which enables patients to be examined, diagnosed and treated in one visit without any need for laboratory tests.

Clinical research supported by GPA pointed the way to better care of AIDS patients. For example, finding tuberculosis to be the major killer of Africans with AIDS, GPA launched research on tuberculosis prophylaxis in HIV-positive individuals.

Meanwhile, the Programme accelerated work towards the long-term goal of developing a vaccine to protect individuals from HIV infection and of making it accessible to those in need. By December 1993, 15 candidate vaccines had undergone Phase I testing and some of these had entered Phase II trials. In anticipation of large-scale efficacy trials, GPA supported the establishment of several cohorts of HIV-negative people in sites in Brazil, Rwanda, Thailand and Uganda in order to obtain information on HIV incidence as well as on important social and behavioural issues.

In recognition of women's special vulnerability to HIV, GPA pursued its advocacy of their social and

economic empowerment. It also intensified efforts over the shorter term to develop female-controlled methods of prevention, in particular vaginal microbicides which would allow women to protect themselves without the need for partner consent. During 1993, six pharmaceutical companies discussed microbicide development with GPA, two signed a Memorandum of Understanding for product adaptation, and one began to develop a product for use in developing countries.

To date about 50% of all HIV infections have occurred in teenagers and young adults under 25. GPA published a guide on school education for the prevention of STDs and AIDS in 1993, and has begun work on a prototype curriculum. Studies on peer education for promoting safer sex among young people who do not attend school demonstrated the importance of their direct and active participation in such activities.

GPA continued to invest time and resources in advocacy - through international conferences and meetings, the Executive Director's visits to countries to meet with political leaders and day-to-day contacts with local officials and community groups, the Programme's quarterly newsletter *Global AIDSnews* and its new advocacy book *AIDS: Images of the Epidemic*. The Programme advocated in favour of controversial but effective prevention approaches such as reaching out to drug injectors and ensuring their access to safe injection equipment. It urged compassionate care and support of those living with HIV/AIDS and argued for close collaboration with the communities most affected.

Finally, given the broad range of determinants and repercussions of the pandemic, GPA pursued its search for an equally broad array of allies in the global response to AIDS: government authorities in and outside the field of health, community-based and nongovernmental organizations, groups representing people living with AIDS, women's organizations, the private sector and, not least, the United Nations family of organizations. Six United Nations system organizations, including WHO, began in mid-1993 to seek agreement on forming a novel joint and cosponsored UN programme on HIV/AIDS. As this publication goes to press, all indications are that this unique programme will offer a valuable opportunity for the world to cope with AIDS in a more comprehensive and effective way.

Table of contents

CHAPTER 1

The Global HIV/AIDS Situation

During the course of the 1992-1993 biennium the HIV/AIDS pandemic continued to spread despite the unprecedented efforts to limit the extent and impact of this truly global threat. There is now evidence to suggest that a stabilization in HIV prevalence may be taking place in areas such as the developed continents of Australasia, North America, and western Europe, as well as in the high HIV and AIDS prevalence areas of eastern and central Africa. However, stabilization may mask disproportionate increases in particular modes of HIV transmission, as has been the case with heterosexually transmitted HIV in many developed countries. In addition, in heavily infected countries, such stabilization may merely reflect two neutralizing forces – on the one hand disproportionate increases in new HIV infections among young people, and on the other significant increases in deaths from AIDS among those infected 5-10 years ago. Such phenomena are evidence of the grim transition from epidemic to endemic HIV/AIDS and are one more facet of the ever-changing global challenge of HIV/AIDS.

In addition to the changing profile of the HIV/AIDS pandemic in areas where HIV has long been established, there has been a relentless spread of HIV into populations and areas previously unaffected. In Asia, for example, the geographical distribution of HIV has expanded, largely as a result of its rapid spread among vulnerable population groups. Centred on the long-established opium-growing areas of South-East Asia, very high levels of HIV infection have been detected among injecting drug users (IDUs) as far west as Delhi, India; as far east as Viet Nam; as far south as peninsular Malaysia; and as far north as Yunnan province, China. In India, significant levels of HIV infection are now being reported among female sex workers, not only in cities such as Bombay, but also in rural areas. To the east, HIV infection has also been detected among female sex workers in Cambodia, as well as among Thai fishermen working off both the eastern and western reaches of the Indonesian archipelago. In Thailand, HIV infection is now spreading in the general population. Over 3.5% of military recruits aged 21 were reported to be HIV-infected in many parts of the country following a 1992 round of surveys, with a prevalence rate close to 20% in Chiang Mai, northern Thailand. Among antenatal clinic attenders, HIV prevalence now exceeds 1.4% in more than 20 Thai provinces.

In all parts of the world the ways in which HIV can be transmitted are the same and are well established. Laboratory and epidemiological investigations have continued to show that HIV is transmitted in three ways: mainly through sexual intercourse, but also through blood and from mother to child. Laboratory and epidemiological studies have however shown that HIV is not transmitted by everyday contact, by hugging or kissing, through food or water, or by mosquitos and other biting insects.

HIV transmission as a result of sexual intercourse accounts for about three-quarters of all HIV infections worldwide. Transmission through intercourse between men occurs in most parts of the world, although in the developed countries it has become far less common as a result of the adoption of safer sex practices by homosexual men. The majority of the world's HIV infections have in fact been acquired through sexual intercourse between men and women ("heterosexual" transmission). This mode of transmission continues to grow in importance worldwide, and is on the rise in both the developed and developing world – in sub-Saharan Africa, Asia and much of Latin America heterosexual intercourse is already the predominant mode of transmission. In Brazil, systematic data on HIV prevalence in selected STD clinic attenders (Table 1.1) suggest that HIV has spread beyond the south-eastern states (for details, see Chapter 6). In many states of India, such as Tamil Nadu, Gujarat, Karnataka, and Punjab, prevalence levels in STD patients are now estimated to be above 1%, with far higher levels of infection reported among female sex workers in several large cities. Recent serological data

from sub-Saharan Africa indicate that the pandemic has continued to evolve, particularly in western and southern Africa.

As with certain other STDs, HIV infection can also be transmitted through transfusion of infected blood or blood products. In many parts of the world progress towards a safer supply of blood and blood products is being achieved through the appropriate selection of donors, the screening of donated blood, and through more rational use of blood aimed at decreasing the number of people receiving transfusions. As a result, HIV infection resulting from contaminated blood transfusions has been controlled in the developed countries and is declining elsewhere. Less commonly, HIV is also transmitted through the use of non-sterilized skin-piercing instruments, both in health facilities ("nosocomial" transmission, mostly occurring from patient to patient) and outside the health care setting. A major problem in both the developed and developing world is HIV transmission resulting from the sharing of contaminated injection equipment by drug users.

The transmission of HIV from mother to child ("perinatal" transmission) includes transmission during pregnancy, during delivery and through breast-feeding. Overall, approximately one-third of children born to HIV-infected mothers will be infected with HIV. Much of mother-to-child transmission occurs during pregnancy and delivery, although a

Table 1.1
HIV prevalence among males attending selected STD clinics for syphilis testing – Brazil, early 1993

City	Region	HIV Prevalence: Point estimate (%)	90% Confidence interval
Aracaju	NE	1.25	0-4.0
Belém	N	5.20	2.5-9.5
Belo Horizonte	SE	2.30	1.0-3.5
Brasília	Central	2.88	1.5-6.0
Porto Alegre	S	4.50	3.0-6.0
Rio de Janeiro	S	22.74	19.0-26.5
Salvador (Bahía)	NE	10.35	0-20.0
São Paulo	SE	15.25	10.5-20.0

Source: National STD/AIDS Programme, Brazil.

Table 1.2
The HIV/AIDS situation – end 1993

Region	Estimated cumulative adult HIV infections[1]	Estimated cumulative adult AIDS cases	Reported cumulative AIDS cases	Distribution of adult HIV prevalence by sex men (%)	women (%)
Australasia	> 25 000	5 000	4 671	85	15
North America	> 1 million	400 000	347 890	85	15
Western Europe	> 500 000	125 000	99 712	85	15
Latin America & the Caribbean	1.7 million	300 000	88 088	80	20
Sub-Saharan Africa	> 9 million	1.7 million	301 333	45	55
South and South-East Asia	2 million	> 75 000	4 029	65	35
East Asia and Pacific	> 35 000	> 1 000	926	85	15
Eastern Europe & Central Asia	> 50 000	4 500	3 815	87	13
North Africa & the Middle East	> 75 000	12 000	1 164	80	20
Global Total	**> 14 million**	**> 2.5 million**	**851 628**	**60**	**40**

[1] *Including deaths.*

sizeable proportion of all HIV infections from an infected mother to an uninfected child are believed to occur through breast-feeding. The progression to AIDS in perinatally infected children is rapid, with death occurring usually before the age of 5. As a result of the increase in heterosexual HIV transmission, perinatal transmission is showing a corresponding increase.

As a result of differences in the nature and distribution of the three modes of HIV transmission, identifiable patterns and trends in the male:female distribution of HIV infection have emerged as the pandemic has matured. Initially, in developed countries, men were more exposed to HIV than women, primarily as a result of homosexual intercourse or drug injecting, but the difference in the numbers of men and women infected with HIV has gradually narrowed as heterosexual transmission – especially from injecting drug users to their partners – has become more common. In other parts of the world, where heterosexual transmission predominated from the outset, the difference between the sexes is either narrower or reversed. In sub-Saharan Africa, for example, the number of new infections in women has overtaken those in men, with 6 women becoming newly infected for every 5 men. Also, women tend to become infected at a younger age than men. Worldwide, there are 3 men already infected for every 2 women (see Table 1.2) and before the year 2000 the global number of new infections among women is expected to equal that among men.

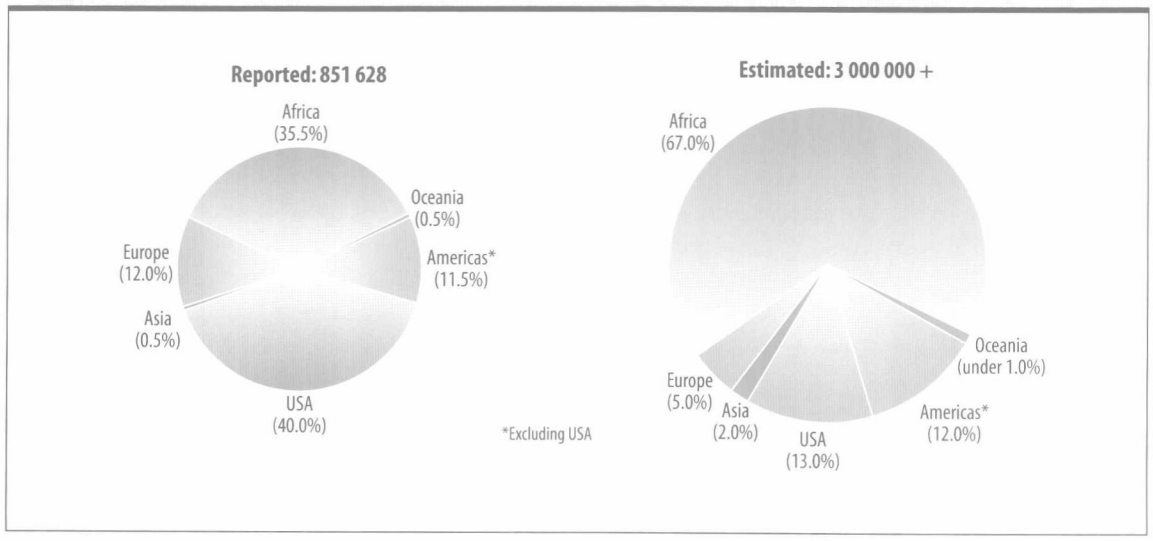
Before the year 2000 the global number of new infections among women is expected to equal that among men.

Two serotypes of HIV are currently recognized, namely HIV-1 and HIV-2. Worldwide, the predominant virus is HIV-1. However, HIV-2 appears to have spread during the 1980s, principally in West Africa, although sporadic infections with this serotype have now been reported from East Africa, as well as from Europe, Asia and Latin America. The modes of transmission of HIV-2 are similar to those for HIV-1, and the two viruses appear to cause clinically indistinguishable AIDS. However, HIV-2 may be less easily transmitted, and the period between initial infection and illness may be longer in the case of HIV-2.

As of 31 December 1993, 851 628 cumulative AIDS cases in adults and children had been reported to GPA by countries – less than 10 years ago, in 1985, the corresponding adult figure was 25 000. Moreover, taking into account under-diagnosis, under-reporting and delays in reporting, GPA estimated at the end of 1993 that a cumulative total of over 3 million AIDS cases had occurred worldwide ranging from over 10 000 in Oceania to over 2 million in Africa – Figure 1.1 shows both the reported and the estimated AIDS cases divided up according to the major geographical regions.

Because of the considerable lag between an initial adult infection with the virus and the onset of AIDS, the number of AIDS cases at any given time cannot be used as a reliable indicator of the true extent of HIV infection in the world. The current number of adult

Figure 1.1
Total number of AIDS cases in adults and children from late 1970s/early 1980s until late 1993



Box 1.1
Estimating and projecting HIV infection levels at the global level

Uncertainties about the size, potential spread, and ultimate dimensions of the HIV/AIDS pandemic have existed since the initial recognition of AIDS in the early 1980s. The major uncertainties include:

- when, and at what level, HIV prevalence will peak in different populations at risk in the various geographical areas
- the rate at which HIV-infected children and adults will ultimately develop AIDS and die.

Despite these uncertainties, a variety of methods and models have been developed for making future projections of the pandemic, and the first step in this is to gauge the current magnitude of the HIV pandemic. Here, the major problem is that HIV infection is largely silent – AIDS cases are the only visible part of the HIV "iceberg". Attempting to estimate the number of HIV infections from the number of AIDS cases has several major disadvantages. To begin with, the number of AIDS cases may itself be seriously underestimated in some countries because of inadequate diagnostic facilities and poor reporting mechanisms. Even if the true number of AIDS cases were known, estimating the number of HIV infections from this number is fraught with difficulty because of the long and variable time between initial HIV infection and the onset of AIDS symptoms. Moreover, because of the long interval between infection and illness, AIDS cases at best reflect the level and distribution of HIV infection 5-10 years earlier. In making estimates of the current magnitude of HIV spread, WHO therefore draws on other sources of information, such as studies of HIV prevalence in specific population groups and areas, the estimated size of such groups, prevalence in neighbouring areas, and trends over time, for example the changes in prevalence from year to year in a given group.

Estimates of adult HIV seroprevalence worldwide are made by WHO using various sources of information and methods. For most developed countries, estimates derived by national experts and/or national AIDS programmes are used. For developing countries where national estimates are not available, GPA makes estimates based on an extensive database which contains information about HIV seroprevalence from published and unpublished reports of HIV serological surveys and studies worldwide. The "AIDS short-term projection model" developed by WHO is then used to obtain global and regional forecasts of future AIDS cases. In this model, the latest available estimate of point prevalence of HIV infection is extrapolated back to the estimated start of extensive spread of HIV in each region, to derive an annual regional incidence of HIV infection. The model assumes that the HIV epidemic follows a characteristic pattern of development.

WHO does not routinely receive reports on the number of children with HIV/AIDS from most countries. Estimates of the numbers of such children are based on the estimated numbers of HIV-infected women, their age, age-specific fertility rates and estimated rates of perinatal HIV transmission.

GPA also monitors and evaluates existing HIV/AIDS computer projection models and has developed guidelines, currently being field-tested, for sector-specific scenario analysis of the demographic impact of HIV infection in Uganda. Once this has been completed the guidelines will be finalized and made available for use in sector-specific analysis by other countries.

AIDS cases reflects at best an insight into the level of HIV infection a decade ago. For a realistic picture of the HIV pandemic, one must estimate the total number of adult HIV infections from the late 1970s/early 1980s until late 1993 (cumulative incidence) and the number of HIV-infected adults (excluding AIDS cases) alive as of late 1993. An account of the methods used by GPA to estimate – and project – HIV infection levels at the global and regional levels is given in Box 1.1. In addition, GPA also initiates and supports country-level activities to monitor HIV infection trends, for example through HIV sentinel surveillance (see Chapter 6).

WHO's estimates of cumulative HIV infections in adults by region are shown in Table 1.2. By late 1993, the cumulative totals of HIV-infected adults were thought to have been 7-8 million men and 5-7 million women. Figures 1.2 and 1.3 show the distribution of cumulative cases and current cases by region. GPA further estimates that, worldwide, close to one million children have been infected with HIV – of these, approximately half are believed to have already developed AIDS. In addition, HIV-infected women have also given birth to almost two million uninfected children, who have already or will become orphans; about 90% of all such children are thought to be in sub-Saharan Africa.

The ultimate long-term dimensions of the HIV/AIDS pandemic cannot be forecast with confidence. However, on the basis of available data on the status of the pandemic and recent trends in its spread, WHO has generated a range of projected new HIV infections during the 1990s. In making projections of the future magnitude of the pandemic, WHO uses the lower limits of its estimated regional ranges of HIV prevalence. The results of HIV/AIDS forecasting by WHO should thus be considered conservative. During this decade, WHO projects that around 10-15 million new HIV infections may be expected in adults, mostly in developing countries. During the same period, WHO

Figure 1.2
Estimated distribution of total adult HIV infections from late 1970s/early 1980s until late 1993

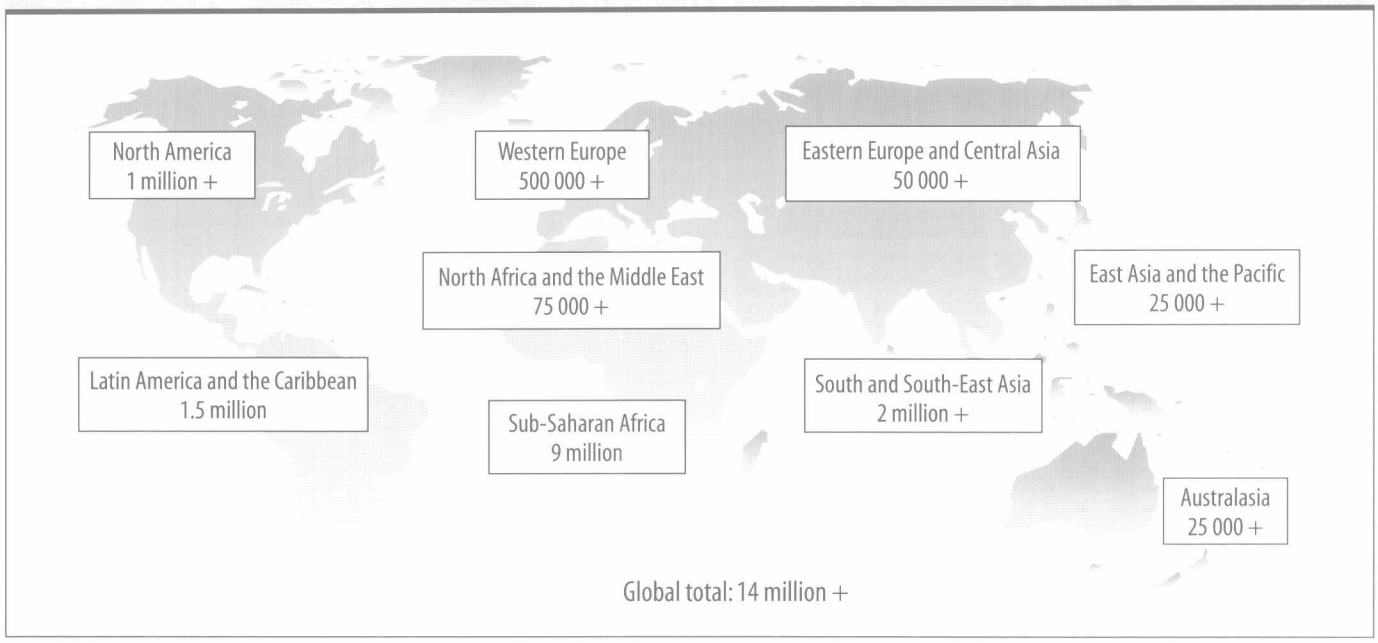
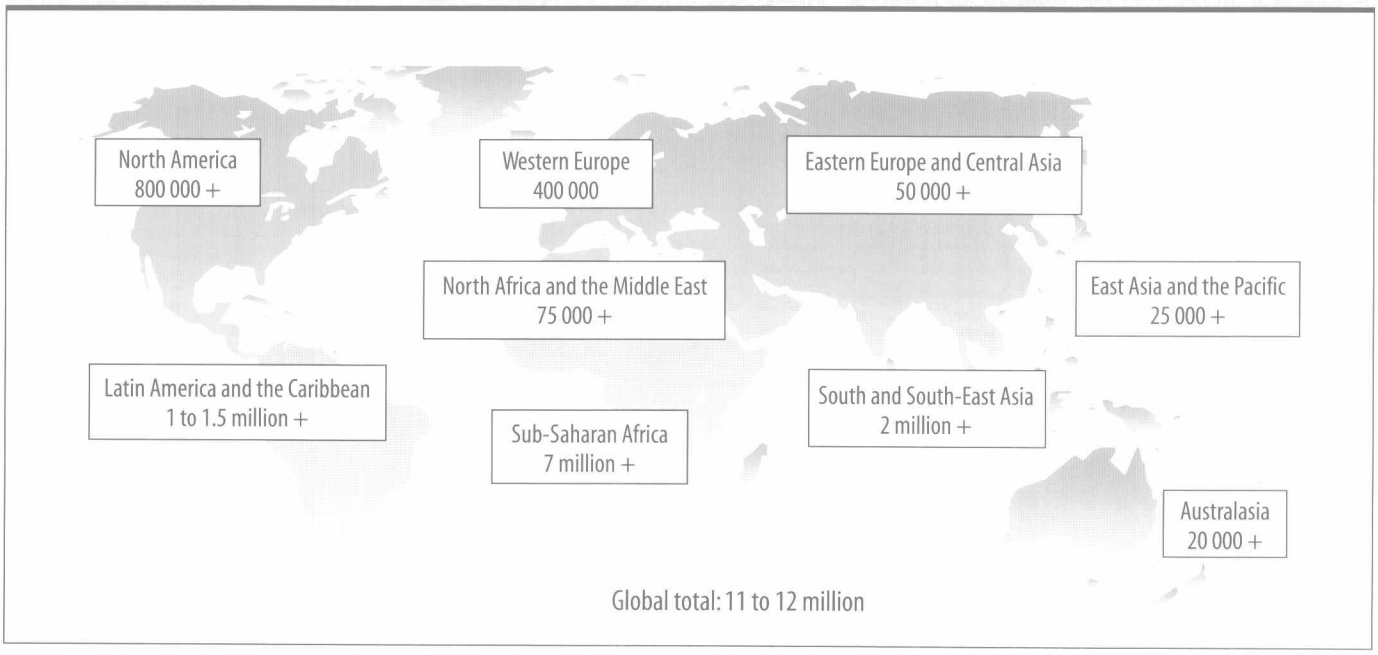


Figure 1.3
Estimated distribution of HIV-infected adults (excluding AIDS cases) alive as of late 1993



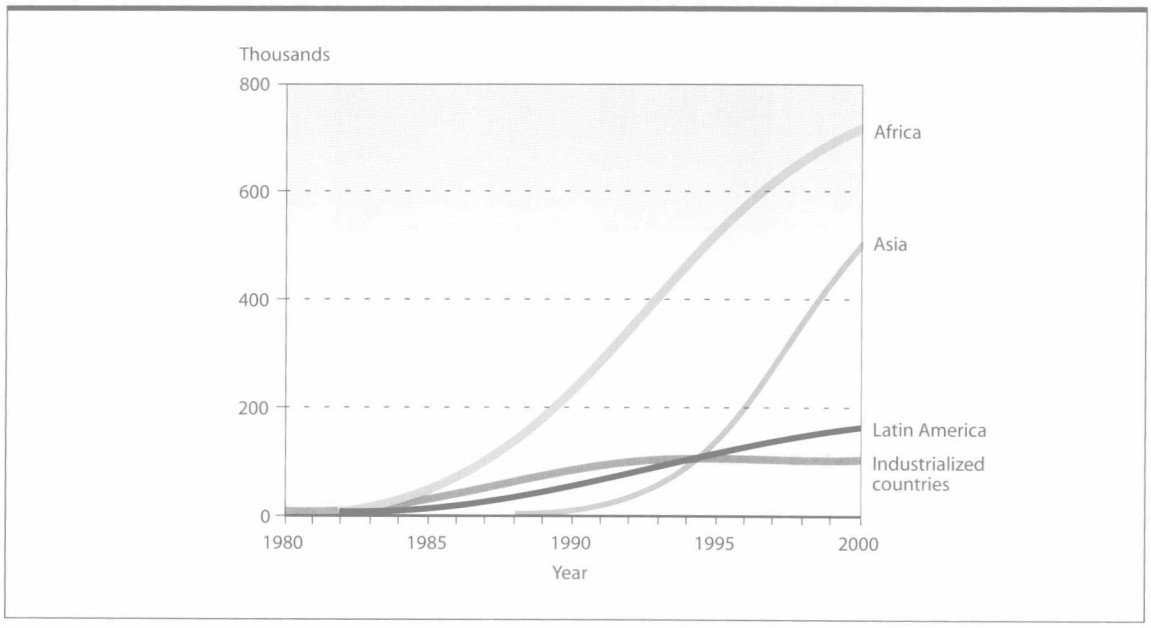
projects that as many as 5-10 million children will be HIV-infected through their mothers, the majority of them in sub-Saharan Africa.

Projections of the number of AIDS cases in infants and children are based on perinatal transmission rates of about 30%. This means that up to 70% of infants born to HIV-infected mothers will not be infected. However, because their infected mothers are likely to die of AIDS within 5 to 10 years of their birth, these uninfected infants will constitute a growing population of orphans. As many as 5-10 million children under 10 years of age will be orphaned by the end of the 1990s as a result of the AIDS-related deaths of their mothers, or both parents. The number of orphans will

Table 1.3
Estimated and projected HIV prevalences in adults by "macro" region

	Mid 1993				2000			
"Macro" region	Estimated HIV prevalence	Estimated AIDS prevalence	Cumulative HIV-related deaths	Estimated population aged 15-49 years (1990)	HIV prevalence	AIDS prevalence	Cumulative HIV-related deaths	Projected population aged 15-49 years
Australasia, Europe & North America	> 1.2 million	> 150 000	> 500 000	646 million	1 million	> 175 000	> 1 million	675 million
Latin America & Caribbean	> 1.4 million	> 110 000	> 250 000	227 million	> 2 million	250 000	1 million	282 million
Africa	> 7 million	> 560 000	> 1.5 million	289 million	> 9 million	> 1 million	5 million	397 million
Asia	2.5 million	< 100 000	< 100 000	1527 million	8 million	> 700 000	1.2 million	1843 million
Global Total	**> 12 million**	**> 900 000**	**> 2.25 million**	**2689 million**	**> 20 million**	**> 2 million**	**> 8 million**	**3197 million**

Figure 1.4
Estimated and projected annual AIDS incidences by "macro" region – 1980-2000



increase further in the early years of the next century as a result of the death of those parents infected with HIV in the 1990s.

For the year 2000, the current WHO projection is that there will be a cumulative total of 30-40 million HIV infections in men, women and children, of which more than 90% will be in the developing countries. The projected cumulative total of adult AIDS cases is close to 10 million. Table 1.3 shows WHO's estimates, by "macro" region, of the number of adults infected with HIV as of mid-1993, and its projections of the number who will be living with HIV infection in the year 2000. Figure 1.4 illustrates estimated and projected annual AIDS incidences in the same regions. By the year 2000, the cumulative number of HIV-related deaths in adults is predicted to rise to more than 8 million from its current total of 2 million.

Throughout the 1990s, the impact of AIDS will be greatest in large urban areas of sub-Saharan Africa, especially in eastern and central Africa, where today, in some cities, as many as a quarter to one-third of all adults aged 15-49 are infected with HIV. In such cities, AIDS deaths in young children and in those aged 15-49 may reduce expected population growth by over 30%, and the adult mortality rate may more than triple. In addition, the current rates and patterns of HIV infection worldwide are setting the scene for the devastating spread of the HIV/AIDS pandemic, particularly throughout Asia – a continent in which over half of the world's population live.

CHAPTER 2

Programme Direction

Advisory bodies

The Global Programme on AIDS receives overall guidance from two advisory bodies: the GPA Management Committee and the Advisory Council on HIV and AIDS (formerly called the Global Commission on AIDS). During the 1992-1993 biennium, both bodies adopted revised terms of reference aimed at reinforcing their complementarity.

GPA Management Committee

The GPA Management Committee, which advises the Director-General on matters relating to the policies, strategies, financing, monitoring and evaluation of GPA, met three times during the biennium. It held two scheduled meeetings (10-12 June 1992[1] and 25-27 May 1993[2]) and one extraordinary meeting (23-25 November 1992[3]). A complete listing of the members of the GPA Management Committee during 1992 and 1993 is presented in Annexes 2 and 3 respectively. In addition, representatives of other Member States and of intergovernmental and nongovernmental organizations (NGOs) attended the meetings as observers.

On financial matters, the GPA Management Committee endorsed the proposed programme budget of US$ 174 million for the 1994-1995 biennium, and expressed concern that the maximum level of income for 1992-1993 was expected to be US$ 10 million less than the US$ 140 million contingency budget prepared for the biennium. A fuller account of the factors affecting the implementation of the 1992-1993 budget is presented later in this chapter.

Following the external review of GPA in 1991, the GPA Management Committee appointed a working group to review the findings and to advise on improving mechanisms for the coordination of AIDS activities at country and global level. On the basis of its report – and that of the External Review Committee – the GPA Management Committee decided in November 1992 to establish a "Task Force on HIV/AIDS Coordination" to facilitate coordination of the response to the HIV/AIDS pandemic. The Task Force has 12 members (see Annex 7) equally divided among four categories – donor governments, developing country governments, United Nations system organizations, and NGOs – and addresses the issue of coordination within and among them.

To improve collaboration within the United Nations system, the GPA Management Committee endorsed the strengthening of the system's primary coordinating body for HIV/AIDS, the Inter-Agency Advisory Group on AIDS (IAAG), and welcomed resolution WHA46.37, adopted by the World Health Assembly in May 1993, calling for a study on the feasibility and practicability of a joint and cosponsored United Nations programme on HIV/AIDS. Further details on these two initiatives may be found below.

Advisory Council on HIV and AIDS

On 1-3 April 1992, the then Global Commission on AIDS held its final meeting.[4] Subsequently – and as recommended by the GPA Management Committee – the Global Commission on AIDS adopted revised terms of reference and changed its name to the Advisory Council on HIV and AIDS. The purpose of the Council is to advise WHO from an independent scientific and technical standpoint on HIV/AIDS policies and strategies, and to make recommendations on approaches to emerging policy issues.

At the first meeting of the Council, which took place on 3-5 February 1993,[5] all training activities initiated by GPA at the global and regional level were reviewed. The Council stressed the importance of countries themselves defining their training needs, planning appropriate programmes to meet these needs, and taking responsibility for funding to the extent possible. The Council also discussed the advisability of maintaining WHO collaborating centres on AIDS. It was recommended that a small number of centres of excellence should be selected or maintained in areas such as

research, training, clinical care and community support.

In November 1993,[6] the Council reviewed all STD activities initiated by GPA since the integration of WHO's STD and AIDS programmes. Several areas were highlighted as particularly important for comprehensive STD management at the country level. These include integration of STD services into primary health care, family planning and antenatal services; diversification of STD services through the training of health workers at various levels of the health system; examination of the feasibility and appropriateness of partner notification; availability of drugs for STD treatment; and careful evaluation of the impact of user fees on STD care-seeking behaviour.

During its meetings the Council returned repeatedly to three vitally important issues:

- HIV testing and counselling
- tuberculosis and HIV infection
- women and AIDS research priorities.

HIV testing and counselling

At its first meeting in February 1993, the Council reviewed the draft statement[7] from a consultation on counselling and testing for HIV infection held in November 1992, and recommended that it be quickly finalized and widely distributed. In brief, the statement opposes mandatory and other forms of testing without informed consent, and provides guidance on the possible uses of voluntary testing and counselling (see Box 2.1). A more detailed explanation of the reasons why mandatory testing works against the public health interest was then prepared by GPA and reviewed by the Council in November 1993. The Council suggested specific changes and underscored the great importance of making the finalized document available rapidly.

There are no benefits either to the individual or for public health arising from testing without informed consent.

Based on a review of current evidence concerning the value of voluntary testing and counselling in preventing HIV transmission through behaviour change, the Council also concluded that voluntary testing and counselling is important for the care and support of HIV-affected people, but for now should not be given high priority as a prevention intervention as its potential impact on behaviour change is uncertain. In response to the Council's suggestions, GPA is also revising its publication *Guidelines for counselling about HIV infection and AIDS* (WHO AIDS Series No. 8).

Tuberculosis and HIV infection

Alarmed by the dramatic increase in tuberculosis as a result of the HIV/AIDS pandemic, the Council called for further research on the efficacy and feasibility of preventive therapy for tuberculosis in individuals with

Box 2.1
Main conclusions of the consultation on testing and counselling for HIV infection

- HIV infection, including AIDS, has important characteristics that affect the usefulness of HIV testing and distinguish it from testing for many other health conditions.
- HIV testing without informed consent should not be carried out,[1] regardless of its rationale, the population group tested, or the term used to designate the testing programme.[2] There are no benefits either to the individual or for public health arising from testing without informed consent that cannot be achieved by less intrusive means, such as voluntary counselling and testing.
- Voluntary testing and counselling can be useful in the care and support of HIV-seropositive individuals, can provide reassurance and support to HIV-seronegative individuals, and can relieve anxiety in both groups.
- Several studies have indicated that voluntary testing and counselling may be effective in preventing HIV transmission among discordant couples when both members of the couple voluntarily participate. For other groups or situations, the findings to date are inconsistent, and more research is needed.
- National AIDS programmes that decide to develop voluntary testing and counselling services where none currently exist should proceed cautiously by initiating and evaluating a trial project. Where such services already exist, their impact should be evaluated.

[1] *Except in the case where all personal identifying data have been removed from a blood sample taken for other purposes, so that the HIV test result cannot possibly be traced back to the donor. This is known as "unlinked anonymous testing".*

[2] *"Routine testing" is sometimes used to mean the testing of individuals for HIV infection without their knowledge, or unless they specifically refuse such testing. Examples are routine testing policies applied by hospitals to patients, and sometimes to people attending antenatal or STD clinics. This term should not be used because it does not specify whether informed consent is properly requested and granted.*