

HIV/AIDS
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**INDIAN NETWORK
FOR PEOPLE LIVING
WITH HIV / AIDS**

NACO

**i make sure that nobody
gets HIV from me.**

**i am HIV +ve
i am responsible**

"i am HIV positive-i am responsible" is a positive response from people living with HIV.

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THE GOVERNANCE FACTOR

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WHY GOVERNANCE

Does governance—good or bad—have anything to do with the HIV/AIDS epidemic? At first, it may seem far-fetched to imply a relationship between the two. But experts and political scientists say the two are intricately related. Simply put, they say that good governance is invaluable in controlling the spread of HIV/AIDS; conversely, bad governance allows infection and death rates to spiral out of control.

Donor nations and organizations are increasingly linking good governance to the release of funds for combating HIV. Partly, this can be viewed as an effort to ensure proper utilization of funds and to have them benefit the cause and persons for which they are intended. But beyond that, the principles of good governance are an important tool with which to analyse political and social processes.

THE LINK BETWEEN GOVERNANCE AND HIV/AIDS

The Commission on Global Governance (1995) described governance as "...the sum of the many ways individuals and institutions, public or private, manage their common affairs". Good governance is then synonymous with good management of common affairs.

Good governance is important because of the widespread devastation that HIV/AIDS is capable of causing. A badly managed epidemic can devastate societies, depress growth, and dramatically lower life expectancy. Many African

countries have been pinpointed as examples of bad governance. The other side of the coin is that countries such as Uganda and Thailand have demonstrated that the tide can be stemmed or turned with strategic vision and purposeful action.

A UNDP official, Lee-Nah Hsu, proposed the following "winning formula":

Development + Good Governance System = Low and Stable HIV Prevalence

It's not difficult to find examples to validate this hypothesis, even though it doesn't take into account social and cultural differences.

A government, by addressing the income and economic development aspects of its citizens' lives, is dealing with background HIV vulnerabilities that push the citizens to take risks which they would not have taken if the environment had been more propitious for their livelihood.

For instance, rural migrant workers, whose skills are farm based, may have little choice but to take up sex work after they arrive in a city. If alternative employment or skills training is provided to them, they need not come to the city at all. Providing this employment or training would reduce the workers' vulnerability to HIV/AIDS and would constitute good governance.

WHAT IS GOOD GOVERNANCE?

The UNDP says good governance is "...participatory, transparent and accountable. It is also effective and equitable.

In many places, there are compulsory medical checkups. Or when the entire staff goes for regular medical checkups, they conduct HIV tests without their consent. An employee cannot be dismissed at the whim and fancy of the management. The law requires disciplinary proceedings. So, they make up false charges.



— JAYNA KOTHARI
a lawyer with the
Alternative Law Forum in
Bangalore



And it promotes the rule of law. Good governance ensures that political, social, and economic priorities are based on broad consensus in society and that the voices of the poorest and the most vulnerable are heard in decision-making over the allocation of development resources.”

Good governance goes beyond just good government, for it connotes a good understanding by the citizens of all the functions of the government and their involvement in the management of its institutions in ways that are clear, fair, and consistent, and promote human rights and well-being. Good governance applies at all levels of society.

On the other hand, weak governance almost always projects the image of corruption. Corruption thrives on the absence of transparency and accountability. In turn, it hampers the other elements of good governance—rule of law, equity, responsiveness, effectiveness, and vision.

THE ELEMENTS OF GOOD GOVERNANCE

Participation: All men and women should have a voice in decision-making,



From the 'Begin a Dialog' ad campaign to promote the Compass Project's counselling service in San Francisco

either directly or through legitimate intermediate institutions that represent their interests. Such participation is built on freedom of association and speech, as well as the capacities to participate constructively.

RULE OF LAW: Legal frameworks should be fair and enforced impartially, particularly the laws on human rights.

TRANSPARENCY: Transparency is built on the free flow of information. Processes and institutions are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.

RESPONSIVENESS: Institutions and processes try to serve all stakeholders.

CONSENSUS ORIENTATION: Good governance mediates differing interests to reach a broad consensus on what is in the best interest of the group and, where possible, on policies and procedures.

EQUITY: All men and women have opportunities to improve or maintain their well-being.

EFFECTIVENESS AND EFFICIENCY: Processes and institutions produce results that meet needs, while making the best use of resources.

ACCOUNTABILITY: Decision makers in government, the private sector, and civil society organizations are accountable to the public as well as to institutional stakeholders.

This accountability differs, depending on the organization and whether the decision is internal or external to the organization.

STRATEGIC VISION: Leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding

of the historical, cultural, and social complexities in which that perspective is grounded.

**GOOD GOVERNANCE
IN ACTION**

Some countries have incorporated good governance measures to create effective programmes that have been successful in stemming the spread of HIV/AIDS. Some of those that are repeatedly mentioned are Uganda, Thailand, and Senegal. In each of these countries, national HIV/AIDS programmes share a package of common features that are universally regarded as best practices:

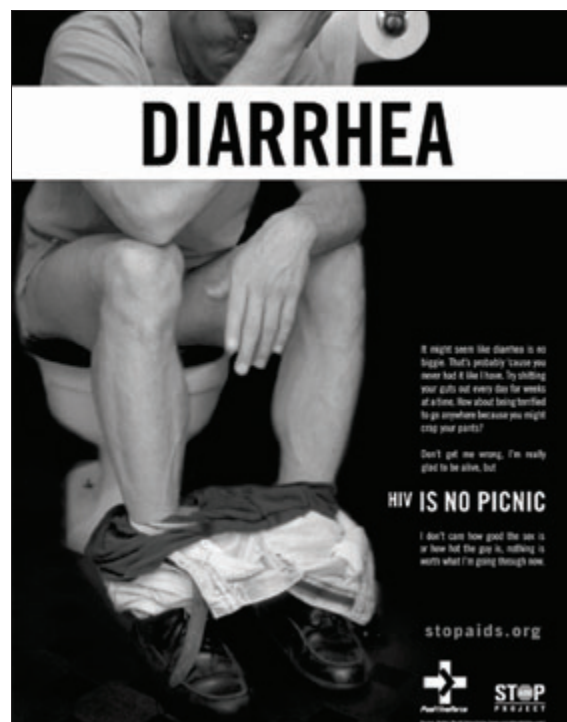
- Strong political commitment at the highest level to dealing with the epidemic (this ensures policies and funding to address the epidemic);
- Multi-sector approaches to prevention and care and, at the government level, involvement by multiple ministries;
- Multi-level responses (at the national, provincial, district, and community levels);
- Effective monitoring of the epidemic and risk behaviours, and dissemination of the findings both to improve policies and programmes and to sustain awareness;
- A combination of efforts aimed at the general population and focused on groups at high risk, at the same time;
- Implementation on a large scale; and
- Integrated prevention and care.

SUCCESS STORY: UGANDA

One of the poorest countries in the world, Uganda is also one of the most severely affected by the HIV/AIDS epidemic. HIV prevalence among

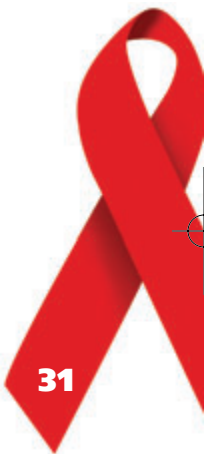
adults here is about 8%. Uganda was lucky in that its government and its people recognized the epidemic fairly early, because of which prevention efforts, including a national budget for the HIV/AIDS programme, were started on a national level.

Uganda adopted a multi-sectoral approach. The Uganda AIDS Commission was set up in the President’s office in 1986, and HIV/AIDS control programmes were established in several government



From the 'HIV is No Picnic' campaign, Stop AIDS Project, San Francisco

ministries, including the Ministry of Health. Persons at different levels of society, such as political, community, and religious leaders, were involved. The Islamic Medical Association of Uganda has supported community education on HIV/AIDS throughout the country, including the distribution of condoms. Radio messages on HIV/AIDS were broadcast widely. Condom social marketing services, backed by USAID, were implemented countrywide. HIV voluntary counselling and testing were made avail-



able extensively and outside the formal healthcare service.

From 1989, the epidemic was tracked at six sites in major cities. By the mid-1990s, all these urban sentinel sites showed a significant decline in HIV infection. Prevalence among pregnant women aged 15-19 dropped from 22% in 1990 to 10% in 1996, after reaching a peak of 28% in 1991.

In 1989 and 1995, Uganda conducted two large population-based surveys (in the urban areas of Kampala and Jinja), which permit comparisons in the status of HIV infection in the country. The findings were as follows:

■ The proportion of 15-year-old girls and boys reporting they had

never had sex rose from 20% to 50%; and

■ The number of men, across age groups, who said they had ever used a condom rose from 15% to 55%; the number of women rose from 6% to 39%.

However, where Uganda is still lagging behind is in its rural areas, where the number of new infections is still high, even among the younger age groups. Considering that more than 86% of Uganda's 21-million population lives in rural areas, this is where Uganda needs to look next on an urgent basis.

SUCCESS STORY: THAILAND

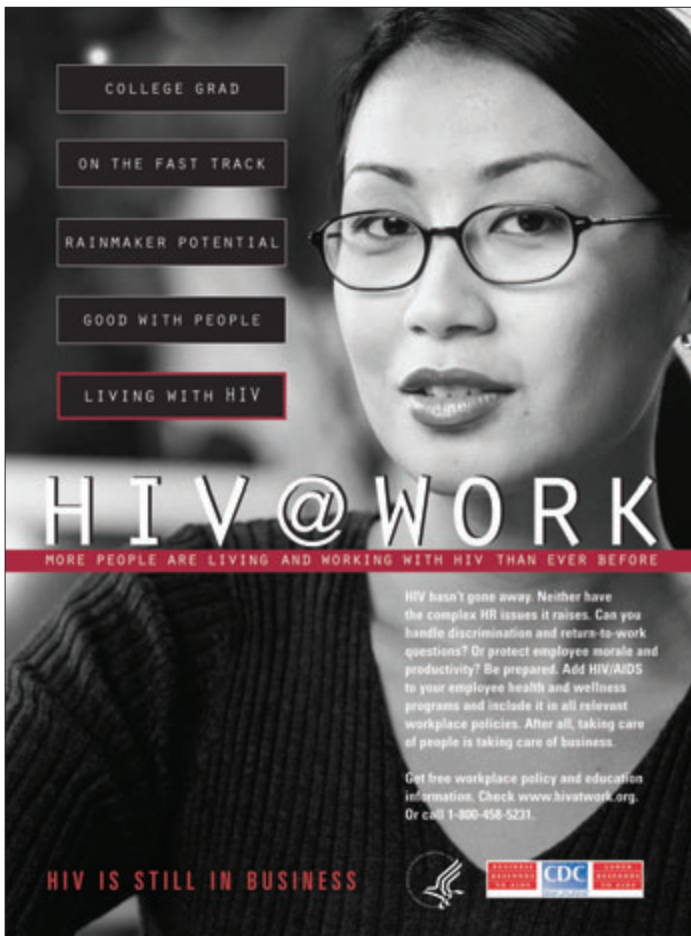
Behavioural changes have reduced the annual number of new HIV infections in Thailand from 143,000 in 1991 to 29,000 in 2000. HIV prevalence among adults is about 1.9% here.

It was only in 1988 that the rapid growth of HIV infections among injecting drug users alerted the Thai government to the emerging problem. In 1991, an intensive and extensive prevention programme was put into place. Some of the guiding principles for the programme's implementation were:

■ Focusing on populations with high-risk behaviour, such as sex workers and injecting drug users, is important, but the general population and young people are also critical;

■ It is necessary to reach the population both extensively (on a broad level) and intensively (through many channels at the same time);

■ Knowledge and awareness are important, but not sufficient; life-skills training (decision-making and negotiation, for example), condom promotion, and



Print ads for use in office newsletters and bulletins to increase awareness

long-term approaches such as changing social norms are also necessary; and

- Socioeconomic interventions are necessary to reduce vulnerability to HIV infection, as, for example, by increasing the opportunity for girls to continue their schooling and to receive vocational training so that they are less likely to become sex workers.

THE PROGRAMME INCLUDED SEVERAL ELEMENTS:

- The Prime Minister chaired the National AIDS Programme, his office actively participated in policy discussion, led the public education effort, and monitored the programme;

- The National AIDS Plan was integrated into the five-year National Development Plan;

- The government HIV/AIDS

budget increased drastically;

- Each key ministry had its own HIV/AIDS plan and budget;

- Provincial governors led the HIV/AIDS programme in their respective provinces; and

- The business community, PLWHA, religious leaders, and other community leaders became very involved in contributing to policy dialogue, resource mobilization, and local implementation.

One of the most striking effects was in the number of visits to sex workers, the behaviour most closely associated with HIV infection in Thai studies. The proportion of urban men aged 20-24 who visited sex workers fell to 17% in 1993 from over 35% in 1990; that of urban men aged 25-29 dropped from 19% to 9%. The 1997 survey found that consistent condom use among sex workers increased from over 50% in 1990 to almost 90% in 1996. ●

GIPA: A Model for Participation

GIPA, or Greater Involvement of PLWHA, recognizes the principle that efficient control of HIV/AIDS cannot be achieved without the meaningful involvement of PLWHA. After all, it is the PLWHA who are experiencing first-hand the full ramifications of HIV infection.

The need for a greater involvement of PLWHA in HIV/AIDS control and information programmes was first voiced publicly in 1983. However, it was only at the 1994 Paris AIDS Summit that the acronym, GIPA, came into being. Since then, the principles have been adopted by UNAIDS and find prominent place in all international declarations relating to HIV/AIDS.

In India, UNDP undertook a pilot GIPA project in cooperation with the New Delhi NGO, Sahara, in 2001. The National AIDS Control Organization (NACO) commenced a partnership with the Indian Network of People Living with HIV/AIDS (INP+) in 2003 and INP+ was given the responsibility for finalizing the first national strategy for GIPA.

PLWHA are taking up a larger role in building networks, voluntary counselling and testing, and in facilitating the rollout of anti-retroviral therapy.

What are the GIPA Principles?

- To support the greater involvement of PLWHA with the aim of stimulating a supportive political, legal, and social environment;

- To involve PLWHA fully in decision-making, formulation, and implementation of public policies;

- To protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS, through legal and social environments;

- To make available necessary resources to better combat the pandemic, including adequate support for PLWHA, NGOs, and CBOs working with vulnerable and marginalized populations; and

- To strengthen national and international mechanisms connected to human rights and ethics related to HIV/AIDS.

