Chapter 40

The UN response to the HIV pandemic

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Introduction

It is commonly held that significant conceptual differences within and among international agencies' AIDS policies and strategies hindered an effective response to the epidemic during the 1980s and early 1990s. In fact, one of the reasons for the establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 was the recognition of the need 'to bring the AIDS activities of six UN agencies into a synergistic effort' [1]. Considerable efforts appear to have been made to harmonize policies and coordinate action since then. Two consecutive unified work plans of UNAIDS and its co-sponsoring agencies have been elaborated [2,3], and various processes of regional strategy development involving UN agencies, bilateral agencies, government representatives and non-governmental organizations (NGOs) embarked upon. A new global AIDS strategic framework [4], which supersedes previous global strategies developed by the World Health Organization (WHO) almost a decade earlier, sets 'guiding principles and leadership commitments that together form the basis for a successful response to the epidemic'. According to the UNAIDS Secretariat's own assessment, 'common ground is increasingly replacing the ideological divides that often hampered previous efforts' [4].

However, little analysis of key features of global AIDS policy and the underlying conceptual differences within and between agencies, and of the extent to which policies have indeed converged, has been carried out. In this chapter, we will examine some historical aspects of the AIDS policy debate within the UN family. In particular, we shall first attempt to show that international AIDS policy has evolved, as had public health policies earlier on, from an emphasis on individual risks and targeted behavioural interventions towards addressing the societal-level determinants of the epidemic. We shall, furthermore, show that international AIDS policies and strategies have changed from an early emphasis on disease control to the promotion of community development, only to swing back later to a biomedical model that embraces new disease control elements such as rapid testing and antiretroviral treatment. Conceptual differences and developments within and between programmes and agencies in intervention approaches will be highlighted to describe further the evolution within the UN community of a balanced HIV response addressing vulnerability and stigma issues while at the same time scaling up access to effective therapies within strengthened health systems.

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The views expressed in this chapter are those of the authors and are not necessarily those of the organization they work for, unless specifically stated in the text.

We draw on a large number of WHO, UNAIDS, United Nations Children's Fund (UNICEF) and World Bank policy documents, country strategic plans and our own experiences in policy discussions in both WHO and UNAIDS.

Public health debates before HIV

Disease control versus community empowerment

Most disease control programmes in existence today are ultimately based on principles that guided the successful Smallpox Eradication Programme model, which involves measurable targets of the programme. Secondly, they design a multifaceted strategy to meet these objectives. Lastly, they implement targeted interventions relating to the strategy, or ensure that this is done by appropriate individuals and organizations. Evaluation and monitoring are carried out to determine whether or not the objectives are achieved [5].

If the 1970s saw the eradication of smallpox through the application of a technology-based disease control approach, the decade also heralded the arrival of some revolutionary thinking in public health, which culminated in the Alma-Ata Declaration at the International Conference on Primary Health Care in 1978 [6]. The proponents of this primary healthcare (PHC) approach viewed poor health as due, in large part, to the inequitable distribution of power and wealth. They argued that ill health could not be eradicated by the application of new technologies alone. The solution that they proposed was the vigorous application of a community empowerment approach through full information and participation, to change drastically what they saw as an unacceptable and exploitative situation.

The WHO's historic Alma-Ata Declaration called for international commitment to involve people in the design, choice and delivery of their own healthcare in what was a radical departure from the conventional thinking of that era [6]. The strategic consequences were taken up to the extent possible by many Ministries of Health, the UN agencies, in particular WHO and the United Nations Development Programme (UNDP), and the donor community, in particular the Nordic and Western European countries. As a result, specific units in Ministries of Health were charged with promoting PHC and the establishment of village health committees, supporting training of new multipurpose cadres such as community health workers and strengthening peripheral health units such as dispensaries and PHC centres. At the same time, targeted disease control was promoted as well. A 'selective PHC strategy' was proposed and supported in particular by UNICEF. This strategy viewed Alma-Ata as too idealistic and called for cost-effective interventions to address in the short run the most prevalent and debilitating illnesses with available techniques such as oral rehydration solutions and measles vaccinations [7]. The debate between disciples of the disease control approach and advocates of a more participatory approach to bringing about improvements in health in a broader sense has continued ever since and is well reflected in the structure of WHO and many ministries of health in which divisions responsible for reducing disease burden through targeted technical interventions operate beside divisions devoted to strengthening health systems and primary or community health development.

Not all public health planners and policy-makers have seen the two approaches as fundamentally antithetical, however [8]. Many view multisectoral participation and community involvement as relatively more or less important, depending on the specific health

problem, and as a means to an end rather than an end in itself, as the development of the response to HIV within WHO and UNAIDS has shown.

From health education to health promotion

In the area of health education, the mid-1980s saw this shift in perspective from disease control to community development; from an individual and community health education focus towards a societal-level health promotion articulated in an international consensus statement. The Ottawa Declaration defined 'health promotion' as 'the process of enabling people to increase control over and to improve their health' [9,10]. In the same year as the Ottawa declaration, a review of health education approaches in developing countries contrasted the educational, community development approach supported by WHO with the more target-oriented promotional approach supported by UNICEF [11]. The former encompassed a continuum of initiatives that varied from projects that organized community committees as vehicles for collaboration to projects that worked with communities with no prior agenda other than to empower the people. The latter was best seen in social marketing terms, with people considered to be informed consumers of cheap or free and effective immunization and nutrition services rather than individuals to be educated and empowered [11].

The initial response to AIDS

At the same time as the new health promotion concepts were being developed and applied, one of the most serious threats to human health in the twentieth century emerged. However, precisely because HIV infection was new, the initial response had to emphasize the dissemination of information on the nature of the newly detected infection, its modes of transmission and means of avoiding it, as well as anti-discrimination messages to confront 'denial, hysteria and moral panic' [12]. According to the final report of WHO's Global Programme on AIDS (GPA), 'Especially in the earlier stages of the unfolding pandemic, ... the development and dissemination of scientifically credible and reliable information on HIV was an invaluable tool in GPA's unrelenting and largely successful effort to advocate a strong and clear public health rationale for protecting the human rights and the dignity of persons living with AIDS' [13].

The initial responses of the GPA and its predecessor, the Special Programme on AIDS (SPA), bore many of the hallmarks of a disease control approach to contain the outbreak of a fatal infectious agent, even though a technological 'fix' was nowhere in sight. According to the earliest Global AIDS Strategy, as outlined in SPA's first progress report, AIDS would be controlled by 'attacking every mode of AIDS virus spread, in every country, using every scientific and educational tool' [14]. HT Mahler, the Director General of WHO at the time, announced: 'In the same spirit that WHO has addressed smallpox eradication, WHO will dedicate its energy, commitment and creativity to the even more urgent, difficult and complex task of global AIDS prevention and control' [14].

Evident from the slogan 'AIDS: a worldwide effort will stop it!', Jonathan Mann, the first Executive Director of GPA, and his team expected considerable results from the control programmes that they helped many countries put in place [15,16]. GPA provided rapid assistance to gather information on the spread of HIV and to develop short- and medium-term National AIDS Control Plans. Funds were easily made available to cover the costs of

setting up National AIDS Programme (NAP) infrastructures, surveillance and logistics systems for HIV test kits and condoms, as well as information, education and communication (IEC) programmes. At the same time, the most heavily affected communities in the industrialized countries, for instance gay communities, and healthcare staff and their families in developing countries such as Uganda, had already begun to mobilize themselves, demonstrating what can be considered the earliest community responses to the epidemic [17]

From awareness-raising to behavioural change

Following what GPA's final report calls the emergency stage of the international response to HIV [13] and after, 'well-known and longstanding inadequacies of human resources and infrastructure had hampered a more effective implementation of medium-term plans' [16], the expanding epidemics in Africa, the West and Asia proved that the initial hopes for control had been unrealistic. It was now increasingly recognized that 'technologies' such as value-free information, condoms and drugs to treat sexually transmitted infections (STIs) were valuable, but could not by themselves solve the AIDS problem. AIDS would be around in the foreseeable future. Other important factors fuelling the epidemic needed to be properly understood and effectively dealt with. As the report acknowledges, 'although the early years were spent chasing but never really getting ahead of the virus, there was growth in understanding how to confront it' [13].

A key strategy element that was re-examined during this period was the role of sexual behaviour and how people could be motivated to change it. 'The implementation of effective technologies to prevent HIV-transmission (had) proved to be profoundly complex and difficult; the importance of behavioural factors was underestimated in the early stages of the pandemic' [13]. GPA then systematically assessed behavioural models for their relevance to HIV prevention [18], behavioural scientist posts were created, and in 1991, GPA's Steering Committee on Social and Behavioural Research met for the first time [19]. Growth in the volume of research carried out in this area was subsequently reported upon as one of GPA's achievements [20].

Nevertheless, approaches and strategies implemented in the field continued to vary enormously. In Africa and South Asia, pilot projects using behavioural change approaches among vulnerable populations were successful, although their replication on a large scale was proving difficult [21]. Prevention efforts in low-prevalence regions such as in East Asia, the Pacific, and Central and Eastern Europe mainly took the form of HIV surveillance and the dissemination of infection prevention and control information during the early 1990s [22–24].

The growing emphasis on behavioural change enabled interventions to become more focused. 'Instead of a shotgun approach to selecting targets for change, health educators can now decide in advance on what needs to be considered as a priority area for change and adopt the most appropriate strategies for changing them', one report concluded [18]. 'A shift from a broad thrust to the general public only, to multiple-focused interventions and an increase in involvement of other partners, including NGOs and community groups' was noted in 1990 [23]. Behavioural change interventions began to be directed at sex workers, truckers and other populations at higher risk of HIV exposure on the assumption that for HIV, as for other STIs, the most efficient strategy for reducing the spread was to prevent infections among core transmitters, those with the highest rates of partner change [25].

Vulnerable group behavioural strategies remained controversial, however, both within and outside GPA. These strategies were associated with the risk of overstating the differences between the 'high-risk' and 'mainstream' populations, of focusing exclusively on women as HIV transmitters, of equating unsafe with bad and safe with good behaviours, and of stigmatizing those believed to be in the former behavioural category [26]. Moreover, in some regions, especially in Africa, the opportunity to contain the epidemic by concentrating on inducing behavioural change among high-risk populations had already passed by the early 1990s, as a large proportion of people not belonging to these categories, including many married women, had become infected.

From individual behaviour to societal change

From the early 1990s, it was increasingly recognized that in the absence of a supportive environment, preventing the spread of HIV through the promotion of individual behavioural change was a difficult, if not an impossible, undertaking. As Mann and Tarantola, who guided the development of GPA's original strategy, reflected later on, 'questions inevitably arose about the societal context in which individuals were behaving' and 'as awareness of the economic, political and cultural dimensions of HIV and related behaviours increased, HIV was perceived as resulting from, and therefore defined as, a combination of individual behaviour and societal or contextual forces' [27].

The importance of clear and firm policies protecting marginalized individuals and groups was now frequently stressed. In 1994, Michael Merson, then Director of GPA, pointed out: 'Laws that criminalise homosexuality hinder efforts to reach gay men with information and education. Fear of mandatory testing and detention prevents sex workers and drug users from coming forward for condoms and needles that would protect them' [28].

The revised WHO Global AIDS Strategy of 1993 acknowledged that AIDS was not just a medical or health sector problem, but also a social, cultural and economic one. It emphasized that effective AIDS action could not rely on the technical skills of health cadres alone, and called for the shaping of a multidisciplinary and multisectoral response to the epidemic [29]. Reflecting the greater emphasis on policy development and structural change, the identification of major socio-cultural, economic and political constraints on HIV prevention and the development of strategies to reduce or remove these constraints became distinct elements in GPA's Strategic Plan [30]. It was at this time as well that care was promoted as an essential complement to prevention and, through meeting the medical, social and psychological needs of families affected by HIV, could enhance prevention efforts [31,32].

There was also growing recognition by GPA of the need for national programme planning to achieve greater participation by a broader spectrum of actors. In a move away from the selective disease control programme approach, the integration of national and local HIV programmes into national health systems was discussed [33]. To facilitate this, GPA issued a new set of guidelines on national AIDS planning, including recommendations for national 'consensus-building workshops' involving high-level leaders and decision makers from key sectors, not only health, but also education, social welfare and criminal justice, among others [34]. Almost 60 countries followed these guidelines.

The crucial role that communities have to play in HIV prevention had been strongly endorsed as early as 1992. Building on that, the role that enabling approaches may play in HIV prevention was now discussed in light of the societal-level development approaches

espoused by the UNDP, and also with regard to small-scale initiatives for vulnerable individuals, groups and communities [35]. For instance, a GPA newsletter stressed that: 'The community—be it the neighbourhood, the school or college community, a professional group or the smallest support group composed of family or friends—is a uniquely powerful force in societies everywhere, which needs to be harnessed if we are to bring the AIDS pandemic under control' [36]. An exhaustive review of initiatives employing enabling approaches to prevent HIV was carried out. A series of such pilot projects using enabling approaches to prevent HIV among particularly vulnerable groups was initiated, the experiences of which were reviewed, together with similar projects supported by other agencies, by Tawil and colleagues in 1995 [37].

Clearly, without ever reaching the community development end of the policy continuum, GPA's thinking and action had evolved a great deal from its early disease control focus, in light of its own experiences and those of others. Two critical pillars of the Alma-Ata Declaration—multisectoral participation and community involvement—were now central to its agenda. The thrust of the Ottawa Charter, which had called for greater emphasis on 'enabling public policies', on environments and societies rather than merely on individual lifestyle changes, now seemed to be well reflected in its policies, advocacy and research.

Resistance to GPA's policies and strategies: a paradigm shift

Whether rightly or wrongly, many in the international community did not agree with GPA's agenda, especially as 'the ability to translate the new insights into action had lagged behind' [27]. For instance, with regard to poverty as one of the main contextual issues identified, 'public health had difficulty to go beyond pointing to it as a problem' [27]. Moreover, the clear progress made in the analysis of, and reflected in the discourse on, the societal-level determinants and strategies of AIDS as opposed to individual risk behaviours was blurred by persisting inconsistencies between statements that showed a shift in thinking towards an empowerment perspective versus others that revealed a continued commitment to a selective disease control approach. Interventions for a selective approach were easily at hand, while empowerment as a strategy was much more difficult to translate into an effective and sustained intervention.

Various authors noted and reflected upon the shift of paradigms that was occurring during this period. In 1996, an international development journal dedicated an entire issue to AIDS entitled 'Fighting Back: HIV-AIDS and Development', containing long sections on community responses to HIV and AIDS [38]. In the same year, some argued that the AIDS prevention discourse should change in emphasis from individual and group factors that determine behaviours to include systemic, societal and political influences [39], while others found that such a shift had already begun to take place [40]. Summarizing the discussions about 'responses to AIDS by individuals, communities and societies', during the XI International Conference on AIDS in Vancouver that year, Mane *et al.* confirmed that such a shift in models or paradigms had shaped many of the conference presentations focusing on community empowerment and mobilization [41].

Many health workers coming from a PHC tradition, including the authors of this chapter, saw the opportunity to strengthen further a revival of an updated or redefined Alma-Ata-like approach. The global economic and political climate had changed since the late 1970s and 1980s, but the need for participatory programmes that relate to community health in a

comprehensive and holistic way, complementing prevention efforts and care at the individual and community level, had not. Moreover, for those coming from other disciplines and traditions, including development sciences, economics and law, the shift in approaches simply vindicated their view that AIDS was not—and had never been—primarily a disease, but essentially a social, health and development issue that demanded a multisectoral strategy. The newly established UNAIDS programme was expected to spearhead a renewed effort for global advocacy and mobilization. It reduced the emphasis on individual behavioural change and disease control approaches that had been a major part of the former GPA's agenda.

Towards a shared vision

Following on from WHO's GPA, UNAIDS assumed its global leadership and policy-making role in 1996. Created 'to bring the AIDS activities of six UN agencies into a synergistic effort' [1], some of which had hardly been active in AIDS work before, UNAIDS embraced multiple perspectives, striving to build a shared vision of the epidemic and of the required responses to it. However, even though the complementarity of individual behaviour change promotion and strengthened contextual and societal-level responses to the epidemic was no longer controversial, the underlying differences in the views of those of its co-sponsoring agencies, some of which embraced a selective and target-oriented approach to health and others of which favoured a comprehensive development model, had not entirely disappeared.

UNAIDS' co-sponsors

The United Nations Population Fund (UNFPA) had just gone through its own paradigm shift, following the call by the International Conference on Population and Development (ICPD) in Cairo in 1994 to replace family planning programmes that emphasized demographic-specific targets in terms of contraceptive coverage and fertility reduction by the promotion of a comprehensive reproductive health and rights approach, and women's empowerment [42]. Although the translation of its agenda into actionable measures and the provision of comprehensive services has proved difficult [43,44], the ICPD's emphasis on the link between development and gender inequities helped to stimulate the direction of global AIDS policies, as gender became increasingly recognized as an important link in the continuing spread of the epidemic [42].

Drawing on UNDP's experience in development work as well as that from the outcomes of the Cairo conference, Elizabeth Reid, Head of the UNDP HIV Programme in the 1990s, proposed that where an enabling environment existed, change could occur spontaneously; however, outside agencies could also play a valuable catalysing role by helping create the milieu in which change could occur, by ensuring that the required services and supplies were available, and by facilitating dialogue and building consensus [45]. However, if WHO–GPA's prescriptions had been seen by some as narrow and limited, those of UNDP could be seen as unclear with regard to the choice of concrete strategies and activities, and as unlikely to be effective except in the very long term [46]. The UNAIDS Secretariat, aiming to assert itself in its global leadership role, and in anticipation of being asked for demonstrable results of its work by its board and donors, was not willing to place all its eggs in the long-term basket.

Meanwhile, the World Bank, another of UNAIDS' co-sponsors and an important player, embraced an approach that would go beyond individual risk reduction towards addressing the economic and structural causes of the epidemic, but blend it with a decidedly, albeit sophisticated, target-oriented disease control perspective. A comprehensive policy research document was developed that 'draws on three bodies of knowledge: the epidemiology of HIV, public health insights into diseases control, and especially public economics, which focuses on assessing trade-offs in the allocation of scarce resources' [47]. Following discussions with UNAIDS policy-makers and other AIDS experts, several modifications were made to the original draft of the paper, notably the limitations of individual behavioural change strategies were given more prominence than originally planned. Micro-level approaches aiming 'to influence individual choices directly' needed to be complemented by a second, more indirect approach, 'to change the economic and social conditions that make it difficult or impossible for some people to protect themselves from HIV', the document acknowledged. 'Measures pursued by this approach have many other benefits besides reducing the HIV epidemic and they are already on the agenda of most developing governments. The benefits are sometimes more difficult to quantify because of their broad impact. However, these measures (to alter societal norms, raise the status of women and reduce poverty) are highly complementary to policies that directly affect the costs and benefits of risky behaviour' [47].

Arguments also arose over the meaning and importance of 'information'. While most health educators associate 'information' with the old health information dissemination paradigm—with the 'I' in Information, Education and Communication (IEC)—which, on its own, cannot influence or explain behaviours, the economists of the World Bank and many others saw information as an extrinsic determinant of behaviour constituted by 'all types of knowledge, regardless of how it is acquired or shared' [47]. The document therefore took the unprecedented step of explaining in its text what it meant by the provision of 'information', namely the full range of IEC services: information on the facts of transmission and protection; training in skills and motivation; education, such as in schools; and counselling.

The development of HIV policies within UNICEF showed the variety and apparent inconsistencies of its approaches as well. A comprehensive approach had already been adopted in the early 1990s, balancing 'direct' responses—typically in the health sector, such as protection of blood supply, testing and epidemiological monitoring, safe practices in health facilities, promoting access to condoms, and treatment of STIs—with 'indirect multisectoral interventions to address the social and economic conditions that favour the spread of the epidemic' [40]. As one policy document highlights: 'AIDS is fundamentally a development challenge, intermingling issues of poverty, inequality, culture and sexuality in complex ways' [48]. Other passages of the same document, however, reflected not only UNICEF's health promotion, but also its selective PHC emphasis. For instance, social mobilization that had 'brought unprecedented success of the universal child immunization campaign' is alluded to, and efforts to apply approaches 'that relate most directly to achieving measurable gains in the reduction of HIV' [48] are called for. One critical review of UNICEF policies suggested that it might not have sufficiently internalized the HIV threat and proposed, among other strategies, that its support to countries be redirected to poverty reduction and to improving health and basic social services, including condom and essential drug supplies to treat HIV-related conditions. Greater support and direction to regional and country offices with respect to communication for behaviour change as it related to HIV was also proposed [49]. The recently developed UNICEF Medium-Term HIV Strategy 2002–2005 essentially operationalizes these recommendations [50].

In 1994, the WHO saw most of its GPA staff being reallocated to the UNAIDS Secretariat and therefore had to rebuild its capacity to respond to HIV. Building on its comparative strength in the health sector, WHO opted for a policy of mainstreaming, whereby all its departments involved in health promotion and care, health technologies, disease control and health systems integrated specific HIV-related activities into their own programmes. The organization-wide HIV activities were then coordinated by a small unit that provided technical stimulus, monitoring and liaison with UNAIDS and other partners [51]. In this way, community development and health intervention approaches were embraced and supported, although not necessarily blended with HIV-related interventions, while new ones such as HIV treatment could be highlighted and fostered in the WHO's departments.

Vulnerability and an expanded response to the epidemic

Confronted with diverse views among its co-sponsors, the UNAIDS Secretariat thus adopted a broad approach calling for an 'expanded response' to the epidemic that would 'balance strategies focused on risk reduction to slow transmission with those that focus on social and economic policy to reduce vulnerability' [52,53]. In fact, these notions of an 'expanded response' and 'vulnerability reduction' have been the cornerstone of UNAIDS' policy since its inception. As UNAIDS has interpreted them, both imply a shift in emphasis from individual-level analysis and response to enabling policy change and structural interventions, including the required mobilization of leadership to effect these changes. Both concepts also, incidentally, leave room for different interpretations, depending on whether disease control or community development thinking predominates.

The formulation of the 'vulnerability' concept in AIDS policy preceded the establishment of UNAIDS by several years [54,55]. Its explicit introduction into the set of UNAIDS' global objectives, which were otherwise similar to those defined in previous strategic plans, including those developed by WHO's GPA, was mainly meant as a qualitative improvement, to stress the need to go beyond an individual-level perspective. 'In the context of HIV, vulnerability builds on the notion that both personal and collective factors influence the probability of exposure or risk-generating situations and that this influence may vary over time' [52]. However, it may also be interpreted, depending on one's background and ideology, as expanding the risk concept to those at potential or medium risk, such as ordinary young people in a low- or moderately high-prevalence area, rather than those who are at immediate and highest risk, such as sex workers and drug users.

Similarly, the notion of an expanded response to the epidemic can be interpreted in both qualitative and quantitative terms. In addition to scaling up and improving the quality of classic health interventions aimed at providing care and reducing the immediate risk of transmission, and mobilizing the resources for this scale-up, UNAIDS has used the term to propose more initiatives in the health and, especially, social sectors, that may reduce vulnerability in the medium term. These include legislation to prevent discrimination and marginalization, and income-generation programmes and credit schemes particularly for

women [52]. 'In the longer term, community development, employment and wealth creation, promotion of equality between men and women, literacy programmes, and the protection of human rights should help address the underlying causes and consequences of the epidemic' [52].

During UNAIDS' initial period, internal debates regarding the terminology contained in official documents beyond these two key concepts—vulnerability reduction and expanded response—had revealed some of the underlying differences in perspective among members of the various schools of thought. For instance, 'intervention,' with its disease control and target connotation, had been replaced by 'action', and 'technical collaboration' temporarily reduced to 'collaboration', only to reappear in its original form in later documents, including the UNAIDS strategic plan [52]. Similar arguments arose over UNAIDS' aim to identify, develop, document and disseminate successful international 'best practice' programmes and projects to stimulate similar action elsewhere. Confronted with the view that there could be no one universally best practice when facing multiple heterogeneous epidemics and contextually relevant responses, UNAIDS dropped the 'international' and recognized that local processes rather than internationally prescribed methods and expected outcomes were crucial [1,56]. The recently developed UNAIDS strategic planning guidelines, a tool for planners at government, district and community levels, which superseded GPA's national strategic planning guide, are even more cautious, instead mentioning 'best known practices' in other countries and communities from which planners can learn; however, the potential for confusion remains, as most UNAIDS documentation is published in a 'best practice series' [57].

New challenges

Advances in access to highly effective antiretroviral combination therapy are already having a significant impact on global AIDS policies and strategies. Although the impact of therapy on HIV transmission at the individual and community levels is still to be determined, there is increasing evidence that it is not so much the impact of treatments on transmissibility as their perceived or real influence on vulnerability in terms of a reduction of stigma and fatalism that may make a bigger difference. Communities are more active in mobilizing against the epidemic when they are motivated by opportunities for prevention, care, treatment and support [4]. Furthermore, what during the mid-1990s was still rejected as unproven has now been shown to be effective: namely, strategies in which voluntary counselling and testing is the entry to prevention and care [4,58,59]. Botswana, Senegal, Brazil and Thailand were the first countries to adopt formal national AIDS strategies that emphasized universal access to counselling, testing, care and treatment, with the expectation that both those infected and the non-infected might benefit from breaking the silence surrounding HIV [60]. Other countries are in the process of reformulating their national policies and strategies in a similar manner.

Furthermore, the emergence of easily applicable short courses, including single-dose regimens to prevent mother-to-child transmission (MTCT), has revived the debate between those promoting the universal application of a cost-effective technology and those drawing attention to the prior need to address the contextual factors affecting women's—and their children's—risk and vulnerability, including their access to comprehensive reproductive health services [61].

On both these issues, namely, the development of policies and strategies to address the increasingly diverse epidemics and the emergence of affordable HIV combination treatment and simple technologies to prevent MTCT, UNAIDS and its co-sponsors steered a middle course at the end of the 1990s with both targeted interventions and approaches aimed at vulnerability reduction and overall empowerment.

First, a key objective of the unified budget of UNAIDS and its co-sponsors is to reduce the transmission of HIV through the development of programmes 'focused primarily on young people and vulnerable populations' [2,62]. The 2001 Global Strategy Framework reiterated objectives that refer to the education and protection of young people in general, as well as of particularly vulnerable groups [4]. Programmes address individual, institutional and community behaviours or situations that contribute most significantly to HIV transmission and can be modified through targeted programmes, as well as the most significant social and economic factors contributing to individual and community vulnerability to HIV infection [2,62].

Secondly, with regard to treatment and the reduction of MTCT, for instance, UNAIDS and WHO have reorganized their roles again. For example in WHO, a new HIV department was created in 2000 with the key role of making affordable treatment available as soon as possible. Other departments focus on integrated disease management at community level, and others, such as the Reproductive Health Department, aim to strengthen WHO's role in HIV prevention and care for women and newborns. This WHO focus on both integrated and focused health and medical approaches has allowed UNAIDS to emphasize its comparative advantage in coordinating and monitoring its UN agencies and ensuring a multisectoral response. However, UNAIDS and WHO have both cautioned against a too selective treatment approach, stating that while antiretroviral regimens can make a significant contribution, preventive activities at all levels by all sectors remain of paramount importance [2].

Conclusions

The AIDS policies and strategies of international agencies have evolved in light of their own and others' experiences of responding to the epidemic. Their policies and strategies need simultaneously to draw on infectious disease epidemiology, health system strengthening and community development. To date, too many programmes and interventions remain focused on individually defined risk behaviours and treatments, while programmes in which communities are both agents and targets of intervention remain rare [56,63,64]. Policies and strategies are needed that are both population-specific and comprehensive, that blend disease control and community development elements. Through a combination of behavioural and contextual analyses, vulnerable groups and communities can de defined and assessed, including their capacity to self-mobilize and to adopt new norms and technologies. Specific barriers to normative behavioural change that are relevant to specific communities—whether they are primarily defined by location, religion, ethnic affiliation, occupation or shared interests, including sexual preferences—need to be identified. Armed with these insights, tailor-made enabling policies and economic approaches can then be developed successfully. In the same way, communities need to become HIV care- and treatment-prepared because lifelong drug adherence will change daily life. 'It is at the community level that the outcome of the battle against AIDS will be decided' [4]. The challenge for international and UN agencies is to achieve a sufficiently close collaboration to be able to support such a coherent response.

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Chapter 41

Donor, lender and research agencies' response to the HIV crisis

Chris Simms

Introduction

Although the international donor community (IDC) has long held that governments' failure to confront the HIV pandemic and take clear steps aimed at its prevention and control are key to understanding the severity of today's crisis [1,2], evidence shows that donors themselves did not adequately prioritize and provide effective, timely leadership to tackle the crisis. A significant body of literature, including routine donor evaluations and peer reviews [3,4], raises questions as to the preparedness and capacity of the IDC to respond. Donor aid and the way it was delivered are described as donor-driven, consisting of short-term projects and programmes, lacking community consultation and participation, and evaluated in terms of inputs or disbursements. Furthermore, donor initiatives may have actually reduced access to goods and services aimed at the prevention and treatment of HIV at the individual and community levels. Similarly, review of efforts by the international health research community to deal with such issues as an AIDS vaccine, a 'social vaccine', poor essential health research capacities in developing countries and inequalities in global research spending suggests the response to the pandemic was belated, underfunded and undermined by institutional constraints and the pursuit of Northern agendas over Southern needs.

Level of donor funding targeting HIV

Without a long-term development framework, or even a medium-term instrument such as a Poverty Reduction Strategy (PRS), the IDC had significant influence over priority setting and the development agenda in the 1980s and 1990s. Review of the major health policy movements for the period 1960–2000 shows that strategies of the World Bank ('growth and poverty', poverty alleviation, structural adjustment, 'agenda for reform'), the United Nations (vertical disease control, primary healthcare, 'health systems development') and the European Commission (poverty alleviation, 'rural development', 'integrated development') had 'a heavy influence over policy' that went far beyond financial contributions [5]. Analysis of external aid to the health sector undertaken for the World Bank confirms that overseas development aid (ODA) plays 'a critical role in capital investment, research and strategic planning' in developing countries [6]. In poor countries such as Tanzania, Uganda and Mozambique, where donor contributions constituted 50–70% of public health expenditures, the international donor and lending communities exercised enormous fiscal and policy leverage. For example, as Africa's main development partner and a key member of the

international health community, the World Bank reported that it had a special leadership role in fighting HIV. In its seminal document, *Intensifying Action Against HIV*, it acknowledged this role as well as the need that it be held accountable for its stewardship, stating that 'those who look back at this era will judge our institution in large measure by whether we recognized this wildfire that is raging across Africa for the development threat that it is, and did our utmost to put it out. They will be right to do so' [7]. While ultimate responsibility for confronting HIV rests with governments, some analysts conclude that 'donor priorities and financial stringency, at least as much as issues within recipient countries, brought about the past and present low levels of aid funding, which in turn has contributed to the present pandemic' [8].

To the extent that levels of aid funding are an indicator of donors' priorities, expenditure data show that more than a decade had elapsed before donors and lending institutions began to take the fight against HIV seriously. Review of data from the Organization for Economic Cooperation and Development (OECD) Creditor Reporting System (CRS) shows that the worldwide budget of the 22 wealthy donor countries and one donor region [the European Union (EU)] that constitute the Development Assistance Committee (DAC) of the OECD dedicated specifically to controlling AIDS in least-developed and other low-income countries (category 13040) averaged just US$78 million annually between 1990 and 1998 [9]. Only a handful of countries provided funding every year; others, such as Japan, Austria, Luxembourg, Ireland and Portugal, apparently committed no funds toward AIDS. Analysis of Japan's response to HIV, as the world's largest bilateral aid donor, shows that even during the years 2000–2004, 'it fails to give high priority to HIV, including it as one of many targeted infectious and parasitic diseases' [10].

Analysis of the investments made between 1986 and 1996 by the World Bank, the largest contributor to HIV activities, shows that it had 10 stand-alone HIV projects and 51 projects with an HIV component in 27 countries [11]. Bank lending for HIV during these years amounted to a paltry US$552 million. It also appears that it was inequitably distributed across regions—with Brazil, for example, a relatively rich country with a low prevalence rate of less than 1%, receiving US$160 million compared with US$274 million for all of Africa, where some countries, such as Lesotho [12] and Zambia [13], with adult HIV prevalence rates at 26% and 22%, respectively, were virtually ignored until 2000.

Data from the Joint United Nations Programme on HIV (UNAIDS) show that total ODA per HIV-infected person declined by over 50% between 1988 and 1997, to less than US$10 per HIV-infected person. By 1998, the aid effort in sub-Saharan Africa amounted to just over US$3 per HIV-infected person, according to the CRS data. A striking feature of the period was that 'no discernible attempt was made in the 1990s to increase donor flows once it became clear that existing aid flows were insufficient to slow the disease's advance' [14].

In recent years, levels of spending have improved. A new study by the OECD's DAC and UNAIDS demonstrates a clear trend toward rising aid donations to fight HIV [15]. The latest definitive figures, combining the aid efforts of major bilateral and multilateral donors, show an allocation of US$2.2 billion in 2002 to control and combat the pandemic in the developing world. Bilateral aid rose steadily, from US$822 million in 2000 to US$1.1 billion in 2001, and to US$1.35 billion in 2002—a 64% increase over 3 years. Multilateral aid rose from US$314 million in 2000 to US$460 million in 2002, and total contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria reached US$917 million by the

end of 2002, 60% of which will target HIV. Spending on HIV programmes in low- and middle-income countries increased by 20% over 2002 to US$4.7 billion in 2003; government spending alone was about US$1 billion; in 2004, total external and domestic funding reached US$6 billion.

While the inadequacy of donor allocations to HIV before 2000 is self-evident and acknowledged by most donors, some of the most useful data describing this failure are available from the World Bank's Operations Evaluation Department (OED), whose job it is to provide 'independent evaluation' of Bank activities. Of the situations in Zambia and Lesotho noted earlier, for example, OED details the Bank's failure to prioritize and place HIV on the agenda and its consequences. It reports that while the Bank was 'well aware' of the alarming welfare trends caused by HIV in Zambia, health specialists were not successful in persuading 'Bank management to use its influence to bring HIV/AIDS control to the top of the reform agenda through advocacy and inclusion in the macroeconomic dialogue' [13]. OED states that 'earlier advocacy by the Bank, in collaboration with a highly active donor community, might have resulted in a more vigorous and inclusive multisectoral response to HIV/AIDS by GRZ' (Government of the Republic of Zambia) [13]. In the case of Lesotho, OED reports that 'the Bank did not help Lesotho develop the most basic integrated health information system and survey instruments necessary to monitor HIV, leading to underestimation of prevalence and, consequently, of its impact. HIV was not then at the center of the country dialogue and the Bank's 1994 population sector review did not trigger a shift in Bank strategy in the last half of the 1990s towards more actively combating HIV/AIDS' [12]. Given these findings, OED concludes that Lesotho may have been better off without a Bank presence in the health sector [12].

These findings suggest that the donor and lending communities had yet to see the crisis as a development crisis, but rather as a discrete public health challenge. Reviewing levels of donor aid targeting HIV in 1997, the World Bank, in what it called a 'strategic document', *Confronting AIDS: Public Priorities in a Global Epidemic*, states 'these allocations are remarkably large relative to national spending on the same problem and probably in comparison with international spending on any other disease. Perhaps only the international campaign to eradicate smallpox in the 1970s benefited from such a large preponderance of donor funds' [2].

The impact of structural adjustment policies on access to healthcare

The decline of public health delivery systems in many low-income countries in the 1980s and 1990s was associated with economic crisis and the implementation of structural adjustment programmes (SAPs) by the World Bank, the International Monetary Fund (IMF) and some donor agencies. An OED evaluation of 114 adjustment operations in 53 countries for the period 1980–1993 found large reductions in social spending especially in sub-Saharan Africa, where 'during adjustment', spending declined to 76% of 1981 levels, and 'after adjustment' declined to 68% of 1981 levels [16]. These had a prolonged and detrimental impact on governments' ability to respond to the HIV epidemic because effective prevention and control presume a robust health system.

Just as important as the size of the cuts was the way they were implemented. Without proactive steps taken by the international financial institutions (IFIs) to maintain spending