

Reducing HIV/AIDS risk, impact and vulnerability

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Around the world, the initial assumption upon which many early community-based human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) prevention programmes were based was that self-awareness of risk behaviours and knowledge about modes of prevention would suffice to stop the spread of the virus. By the mid-1980s, recognition of the risk behaviours associated with infection had begun to shape the response to the expanding epidemic. This approach met with some success among politically organized communities such as white gay men in Australia, North America, and Western Europe. This was not the case, however, in communities marked by lack of access to information and services, in an adverse social environment and with fragile or nonexistent community organization mechanisms.

The late 1980s witnessed a dramatic rise in the spread of HIV: the pandemic began to affect disproportionately women and men in developing countries as well as the marginalized and poor in high-income countries. This massive epidemic shift called for a new understanding of the root causes of the pandemic and a realization of the magnitude and diversity of efforts needed to bring it under control.

A strategy for a global mobilization against AIDS was proposed by WHO, resulting in January 1987 in the launching of one of its largest initiatives, soon to be called the Global Programme on AIDS (1). By the early 1990s, however, it had become clear that what was being done in the areas of HIV prevention and care, even if replicated many-fold, would not suffice to curb the spread of HIV and mitigate its impact. The global pandemic was simply spinning out of control. While the public health approach to the reduction of risk needed to be strengthened, replicated, adapted to local and evolving needs and resources, and sustained over time, it became

clear that this approach was necessary but not sufficient. It was recognized that HIV transmission was associated with specific risk-taking behaviours, but that these behaviours were influenced by personal and societal factors that determined people's vulnerability to infection. To be effective, risk-reduction programmes had to be designed and implemented in synergy with other programmes which, in the short and long term, increased the capacity and autonomy of those people particularly vulnerable to HIV infection. This "risk-and-vulnerability" paradigm, aimed at shedding light on the root-causes of the pandemic, commended a broad social response far beyond the capacity of the health sector (2). To uproot the pandemic would involve attention to civil, political, economic, social and cultural determinants of vulnerability to HIV/AIDS, best understood under universal human rights principles.

Building on a health and human rights movement that had originally been centred on women's health, rights and dignity, Jonathan Mann spearheaded a new understanding of the pandemic which recast the HIV/AIDS paradigm within a human rights framework: "the continuing challenges of HIV/AIDS have brought public health to the threshold of a new era, based on the inextricable connection between health and human rights. For human rights provides public health with an explicit response to its central dilemma: how to address directly the societal forces which determine, more than anything else, vulnerability to preventable disease, disability and premature death" (3, 4).

In 1994, in Paris, a Summit of Heads of Governments recognized that a meaningful response to HIV/AIDS necessitated expanded efforts in prevention and care, along with social changes aimed at lowering people's vulnerability to infection (5). Unfortunately, the call for this enhanced global response did not succeed in generating the needed international resources. The Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 constructed its global strategy around the principles of combined risk-reduction and vulnerability

reduction approaches, upholding the central role of human rights in the public health response to the pandemic (6).

Today, almost two decades after the emergence of the HIV/AIDS pandemic, two important facets have led to two new and diverging definitions of the response to the HIV/AIDS epidemics, applicable separately to high- or low-income countries. In high-income countries, progress achieved in developing and using highly active antiretroviral therapies has brought biomedical tools into the focus of attention and hope. In such countries, the biomedical paradigm, as characterized by Wolffers in his article in this issue of the *Bulletin* (pp. 267–273), shines in all its splendour. Access to multi-regimen therapies, adherence to treatment, resistance of HIV to new drugs, and resumption of active economic and social life overshadow the continuing spread of HIV among young populations, the upsurge of unsafe behaviours in vulnerable populations, and the need for sustained prevention programmes. In contrast, in developing countries, access to effective prevention and treatment of some of the commonest opportunistic infections associated with HIV infection remains very limited. Highly active antiretroviral drugs and the biomedical services needed to ensure safe and effective therapy are generally unavailable. The devastating impact of HIV/AIDS has set back the hard-earned health, social and economic progress that had been achieved by many countries over decades of investments and efforts. AIDS has become a development issue in the severely affected countries (7).

The relevancy of Wolffers' development paradigm to developing countries hard hit by HIV/AIDS underscores the reality of the impact of AIDS and also, tragically, the current unavailability of a biomedical solution for most of the world's population.

The rich and the poor have become further divided by a common HIV/AIDS pandemic. The world's expanded response must concurrently address prevention and care needs, the reduction of the individual

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and collective impact of HIV/AIDS, and the roots of our vulnerability. The paradigm of HIV/AIDS as a combined biomedical *and* developmental global issue must shape an expanded response which, as UN Secretary-General Kofi Annan puts it, will be “a response that makes humanity live up to its name” (8). ■

References

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