

Back to basics: HIV/AIDS belongs with sexual and reproductive health

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Abstract The Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994 offers a comprehensive framework for achieving sexual and reproductive health and rights, including the prevention and treatment of HIV/AIDS, and for advancing other development goals. The United Nations Millennium Development Goals now incorporate a target of universal access to sexual and reproductive health within the goal of improving maternal health, but combating HIV remains a separate project with malaria and tuberculosis. We present a brief history of key decisions made by WHO, other United Nations' agencies, the United Nations Millennium Project and major donors that have led to the separation of HIV/AIDS from its logical programmatic base in sexual and reproductive health and rights. This fragmentation does a disservice to the achievement of both sets of goals and objectives. In urging a return to the original ICPD construct as a framework for action, we call for renewed leadership commitment, investment in health systems to deliver comprehensive sexual and reproductive health services, including HIV/AIDS prevention and treatment, comprehensive youth programmes, streamlined country strategies and donor support. All investments in research, policies and programmes should build systematically on the natural synergies inherent in the ICPD model to maximize their effectiveness and efficiency and to strengthen the capacity of health systems to deliver universally accessible sexual and reproductive health information and services.

Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

Introduction

The Programme of Action that was agreed upon at the 1994 International Conference on Population and Development (ICPD) presaged in its 16 chapters the eight Millennium Development Goals (MDGs): poverty eradication, universal primary education, gender equality, child health, maternal health, the control of HIV/AIDS and other diseases, environmental sustainability and partnerships.¹⁻⁴ The negotiators of the path-breaking ICPD agreement understood the interrelationships among these issues and the central importance of women's empowerment, health and human rights.⁵ In particular, they knew that achieving universal access to sexual and reproductive health and protecting reproductive rights is necessary to achieve all the other goals, including the eradication of HIV/AIDS.^{6,7}

The Programme of Action defined prevention, diagnosis and treatment of HIV/AIDS and other sexually transmitted infections (STIs) as one of the core elements of sexual and reproductive health services. As this brief history will show, however, HIV was diverted from sexual and reproductive health – and even from other STIs – into a separate and often competing programme and funding stream. Now, 15 years later, the *Bulletin of the World Health Organization* has invited papers on “bridging the gaps that exist” between sexual and reproductive health and HIV.⁸ How did HIV/AIDS get separated from its base? What went wrong and how can it be fixed?

The ICPD consensus

When 179 Member States of the United Nations signed on to the Programme of Action of ICPD in Cairo, they agreed

that countries should strive to make reproductive health care available to all persons as soon as possible, but no later than 2015 (para.7.6).¹ All primary health care and family planning facilities – directly or through referrals – were to deliver an array of essential information and services relating to family planning; abortion, where not against the law, and management of abortion-related complications in all cases; prenatal, delivery, postpartum and newborn care; and the prevention and treatment of infertility and reproductive tract and STIs, including HIV/AIDS. Information, counselling and condom distribution for HIV prevention were to be incorporated into all reproductive and sexual health services (paras 7.31–7.33). Policies and programmes were also to provide sexual and reproductive health information, education and services to adolescents; to combat sexual violence and discrimination; and to promote gender equality and human rights.

The ICPD consensus was reinforced at the Fourth World Conference on Women held in Beijing the following year.⁹ Echoing the ICPD statement on reproductive rights (para. 7.3), a paragraph was added stating that the human rights of women include their right to have control over and decide freely and responsibly on matters relating to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (para.96). Further support for the ICPD consensus was provided at the 1999 five-year review of implementation of the Programme of Action by a Special Session of the United Nations General Assembly (ICPD+5), which reiterated the goal of universal access and set benchmark indicators to measure progress (unmet need for family planning, access to skilled birth attendants and

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emergency obstetric care, and young people's knowledge of how to prevent HIV infection).^{10,11}

In 2004, the United Nations "ICPD at Ten" review and appraisal, which included six regional meetings, reaffirmed yet again the essential goals and principles of the Programme of Action, although reviewers noted that many countries were likely to fall short of the agreed goals by 2015.¹² In a separate action, world leaders from 85 countries (and hundreds of other notables) signed a statement of support for ICPD's "vision of human development, social justice, economic progress and environmental preservation" and called on the international community, national governments and private philanthropic organizations to prioritize and fund the ICPD Programme of Action.¹³ The anniversary year was also marked by the adoption at the 57th World Health Assembly of a comprehensive global *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*.¹⁴ Based on ICPD priorities, the global strategy urged more rapid progress in improving pregnancy, childbirth and newborn care; promoting family planning; preventing unsafe abortion; controlling STIs, including HIV; and reducing inequities related to gender, adolescence, poverty and access to health services. In 2005, the United Nations General Assembly review of the MDGs renewed international commitment to achieving universal access to reproductive health by 2015 as part of the global strategy for eradicating poverty, improving maternal and child health, promoting gender equality and combating HIV/AIDS.¹⁵

It would seem from these events that the ICPD agenda was firmly established in the hearts and minds of international and national policy-makers. Or was it? Some thought otherwise. In 2006, the editor of the *Lancet* marked the launch of a series of articles (and a "campaign") on sexual and reproductive health by noting that the issue had been "utterly marginalized from the global discourse about health and wellbeing"¹⁶ – quite apart from its displacement by HIV/AIDS in the competition for donor funding.¹⁷ Importantly, what was intended as a comprehensive health and development programme was being

delivered piecemeal, thus greatly undermining its potential.

Separation from its base

In the 15 years following ICPD, key organizational and funding decisions by United Nations agencies (including WHO) and by major donors were to undermine the integrity of the ICPD sexual and reproductive health and rights concept and agenda. The location of HIV/AIDS in the larger scheme of things was especially marked by disputes and contradictions. Inconsistencies within WHO appeared long before ICPD, however. In 1948, the prevention and control of venereal diseases was declared a priority programme by WHO's first Executive Board. Four decades later, in the year following the second International Conference on AIDS in Paris in June 1986, WHO produced a strategic plan of work and established what was later to be called the Global Programme on AIDS. The first *Global strategy for the prevention and control of AIDS* adopted by the World Health Assembly in 1987 did not explicitly address other STIs, however, nor did it reflect WHO's ongoing work in this area, which meant that a crucial opportunity for joint planning was missed at the start.

WHO's work on STIs did become formally integrated into the Global Programme on AIDS in 1991 as a discrete unit reporting to its director, a logical coupling that would last in one form or another for more than a decade. Although the Global Programme was disbanded in 1995 (to be replaced by the United Nations Joint Programme on AIDS, as discussed later), a small Office of HIV/AIDS and Sexually Transmitted Diseases was created within WHO to mainstream these activities within the Organization and to liaise with external partners. In 1998 the Office was reconstituted as the WHO Initiative on HIV/AIDS and STIs. But the joint initiative did not last long. In 2002, STIs (but not HIV) were moved into the Department of Reproductive Health and Research in the Family and Community Health cluster. HIV/AIDS – which had become a separate department in the same cluster – was sent off the following year to the newly formed Cluster on HIV/AIDS, Tuberculosis and Malaria, where it remains to this day. What happened?

To answer this question, we must go back to 1994: the year of ICPD. The

WHO Executive Board – under pressure from bilateral donors, AIDS activists and United Nations agencies who were unhappy with the way the Global Programme on AIDS was functioning at WHO – endorsed a plan for a new Joint United Nations Programme on AIDS co-sponsored by WHO, United Nations Children's Fund, United Nations Development Programme, United Nations Educational, Scientific and Cultural Organization, United Nations Population Fund and The World Bank.^{18,19} Four more United Nations sponsors signed on later. The Joint United Nations Programme on HIV/AIDS (UNAIDS) opened its doors on 1 January 1996, 15 months after the world's governments had signed on to the ICPD agenda. Its mission was to coordinate the tracking of the AIDS epidemic across agencies, to serve as a major source of globally relevant policy on AIDS and to promote a range of multisectoral approaches and interventions.

The ICPD Programme of Action would seem to have offered the new Joint Programme on AIDS an ideal framework for making the economic, social, educational, health systems and technological investments needed for HIV prevention and health-care services. The timing was certainly perfect. But AIDS advocates and researchers had long been committed to a different agenda and UNAIDS was to go its separate way. The *Global strategy framework on HIV/AIDS* issued by UNAIDS in 2001 took a predominantly epidemiological approach to the prevention and management of HIV with a focus on "high-risk" groups such as sex workers, injecting drug users and men who have sex with men.²⁰ Although the strategy document claimed that successful responses to the epidemic must have their "roots in communities", nothing was mentioned about strengthening primary health systems and incorporating HIV prevention, counselling, testing and treatment into the full array of community-based sexual and reproductive health services as agreed at ICPD. In a 290-page history of the first ten years of UNAIDS, ICPD is mentioned only once (in connection with the missed ICPD+5 targets relating to young people's knowledge of HIV prevention methods), and the words "reproductive health" do not appear in the index at all.¹⁸

The gap widens

The global launch of the MDGs introduced yet another deviation of HIV from sexual and reproductive health. An outcome of the United Nations Millennium Declaration adopted by 189 Member States in 2000,² the MDGs offered a framework for measuring progress towards interrelated social, economic and environmental goals that broadly reflected the ICPD commitments. There was a crucial omission, however: the ICPD goal of universal access to sexual and reproductive health.^{6,7} Rather, MDG 5 – improving maternal health – was to be measured by reductions in maternal mortality, primarily through improving women's access to skilled assistance at childbirth. Combating HIV/AIDS was placed in MDG 6 along with malaria and other infectious diseases, as though HIV were transmitted by mosquitoes or waterborne parasites rather than by human sexual and reproductive behaviour. It was not until 2007 that a target of universal access to reproductive health by 2015 was added to MDG 5 in response to intense work by a consortium of "pro-ICPD" agencies and nongovernmental organizations. This was good news for its advocates, of course, but it did not solve the segregation problem. Sexual and reproductive health was in one MDG, HIV/AIDS in another.

The decoupling of HIV from the sexual and reproductive health agenda was to become further institutionalized in the Global Fund to Fight AIDS, Tuberculosis and Malaria, which held its first organizational meeting in January 2002.¹⁸ Providing a channel for donor contributions to countries, the Global Fund took a vertical approach to disease control rather than a horizontal approach to building health-system capacities. Most of its HIV/AIDS money went into treatment. HIV prevention in the general population of married women and the provision of comprehensive sexuality education and health services to adolescents appeared not to have any priority.²¹ Once again the editor of the *Lancet* had cause to lament. "From the very beginning of the global response to the AIDS pandemic," he wrote in 2008, "prevention has been marginalized. Treatment has dominated. This systematic imbalance in clinical and public-health programmes is largely responsible for the fact that around 2.5 million people become newly infected with HIV each year."²²

Multiplication of global strategies

Meanwhile, UNAIDS and WHO had been producing separate global strategies for dealing with reproductive health, STIs and HIV/AIDS. Each recommended its own in-country strategic plans, priority-setting exercises and monitoring systems, to the undoubted confusion of government ministries and health-care providers around the world. In 2003, WHO launched a *Global health-sector strategy for HIV/AIDS, 2003–2007*, originating from the Department of HIV/AIDS,²³ despite the fact that UNAIDS had produced its own *Global strategy framework on HIV/AIDS* in 2001.²⁰ In 2004, WHO's global *Reproductive health strategy* urged immediate action on key dimensions of sexual and reproductive health and rights that included the prevention and treatment of STIs/HIV.¹⁴ A fourth WHO initiative appeared in 2007 with the publication of the *Global strategy for the prevention and control of sexually transmitted infections, 2006–2015*,²⁴ accompanied by a companion strategy for the *Global elimination of congenital syphilis*.²⁵ Both of these documents called (rather plaintively, it would seem) for "strengthening the linkages" between the prevention and treatment of other STIs and HIV. But who was listening? In 2008, a WHO/United Nations Population Fund technical consultation on national-level monitoring of the new MDG target for achieving universal access to reproductive health (that included monitoring the linkages between sexual and reproductive health and HIV) had eight participants from WHO's Department of Reproductive Health and Research, which was coordinating the Inter-Agency Working Group on strengthening linkages between the two lines of work, and none from the Department of HIV/AIDS or UNAIDS.²⁶

UNAIDS had also launched its "three ones" campaign in which countries were to have one HIV/AIDS framework, one AIDS coordinating authority and one country-level monitoring and evaluation system.¹⁸ Intended to reduce the confusion of competing plans, personnel, approaches and lines of authority, the "three ones" have a stand-alone quality. There is little room for the idea of national strategies for HIV prevention and care that are developed and implemented within the framework

of ICPD, the WHO global *Reproductive health strategy*, and national strategies for achieving the MDGs. Nor is there much room in current segregated service delivery structures for adding HIV prevention, care and support to the full spectrum of sexual and reproductive health services – and vice versa – even though integration would be cost-effective and help to break the chain of sexual and reproductive ill health at crucial information and service delivery points in people's lives.

Bringing the elements back together

What can be done to restore the conceptual and organizational integrity of current approaches to sexual and reproductive health? Assuming that major organizational restructuring is not likely in most instances for now, we propose five principles for priority setting that could be adopted by international agencies, donors, national governments and nongovernmental organizations. Applying these principles could make a significant difference in programmatic decision-making, even where there is little intra-organizational collaboration or integration.

First, renew or encourage new institutional commitments to achieving the Programme of Action of ICPD. At the heart of the ICPD consensus – and now a target of the MDGs – is universal access to sexual and reproductive health and the protection of human rights. In April 2009, government representatives to the United Nations Commission on Population and Development issued a strong call for full implementation of the Programme of Action of ICPD and emphasized the essential contribution of several key actions to achieving internationally agreed development goals and the MDGs.²⁷ Although every organization has its own mandate, leadership can assign higher priority to key actions relating to sexual and reproductive health and rights, including HIV/AIDS. An example is a statement by Michel Sidibé, Executive Director of UNAIDS, appointed in December 2008: "First, give women and girls the power to protect themselves from HIV... This requires investment in universal access to comprehensive sexual and reproductive health services... [and also] universal access to sexuality education. Such

education provides full and accurate information; it promotes gender equality and respect for human rights. This will help young people develop the skills for mutual consent in sex and marriage and put an end to violence and sexual coercion.”²⁸ Each organization can also re-orient its programme of work in more powerful and explicit ways to address the ICPD goals.

Second, invest in health systems capacity building with priority attention to universally accessible comprehensive sexual and reproductive health services, especially at the primary level.²⁹ The Global Fund, for example, has taken important steps in this direction recently by allowing countries to apply for health system support and funding of reproductive health services. The new multi-donor, multi-country International Health Partnership promotes health system strengthening with outcome indicators that include advances in sexual and reproductive health.³⁰

Third, prioritize prevention programmes in schools, communities and health systems that provide information and counselling on the positive aspects of sexual and reproductive health as well as on how to avoid STIs/HIV, unwanted pregnancies, sexual coercion and gender-based violence, including special efforts to reach young people and marginalized groups. Countries as diverse as Brazil, Cameroon, Nigeria, Pakistan and Peru

are moving in this direction, with increasing numbers of creative efforts to stop sexual coercion and violence against women and girls.³¹

Fourth, assist countries to incorporate sexual and reproductive health and rights fully into their national, district and local-level HIV/AIDS control programmes and, conversely, to incorporate HIV prevention and treatment into all aspects of sexual and reproductive health information and services. Over time, it is essential for countries to work towards unified policies and strategies rather than maintaining separate programmes, and to harmonize their planning with the achievement of the MDGs.

Fifth, bilateral and multilateral donors have wide scope to amend their HIV/AIDS policies and budgets to invest in sexual and reproductive health and rights. Several European governments have recently revised their policies, recognizing that HIV/AIDS is a sexual and reproductive health issue,^{32–35} and renewed commitments from the United States of America will provide additional leadership from bilateral donors. Implementation remains a challenge, however, including fostering close working relationships and collaboration between previously separate staff and lines of work and achieving better balance between budgets for HIV/AIDS and the other components of sexual and reproductive health and rights.

Given the costs entailed in building global health capacity and the economic distortions of the current economic crisis, it is incumbent on all institutions to identify and promote the powerful synergies among policy and programme interventions to maximize the effectiveness and efficiency of health investments. Appeals for “collaboration” or “bridging the gaps” or “strengthening linkages” between HIV/AIDS and sexual and reproductive health and rights are far from sufficient.^{8,36} What is needed is a reaffirmation of – and a greatly increased investment in – the conceptually and structurally coordinated ICPD approach to sexual and reproductive health and rights by United Nations agencies, donors, governments and nongovernmental organizations. Only then will the full range of the MDGs, including the goal of reversing the spread of HIV/AIDS, be achieved. ■

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Résumé

Un retour aux sources s’impose : le VIH/sida relève de la santé sexuelle et génésique

Le programme d’action de la Conférence internationale sur la population et le développement (CIPD), qui s’est tenue au Caire en 1994, offre un cadre global pour la réalisation de la santé sexuelle et génésique et des droits connexes, y compris la prévention et le traitement du VIH/sida, et pour la progression vers d’autres objectifs en matière de développement. Parmi les objectifs du Millénaire pour le développement, celui portant sur l’amélioration de la santé maternelle intègre maintenant une cible consistant en l’accès universel à la santé sexuelle et génésique, mais la lutte contre le VIH continue de relever, avec le combat contre le paludisme et contre la tuberculose, d’un projet séparé. Nous présentons ici un bref historique des grandes décisions prises par l’OMS, les autres agences des Nations Unies, le Projet du Millénaire des Nations Unies et les principaux donateurs, qui ont conduit à la séparation du VIH/sida de son ancrage programmatique logique : la santé sexuelle et génésique et les droits

connexes. Cette séparation dessert la réalisation des deux séries de cibles et d’objectifs. En préconisant le retour à l’organisation originale du cadre d’action de la CIPD, nous appelons à un renouvellement de l’engagement des dirigeants, à des investissements dans les systèmes de santé pour qu’ils délivrent des services de santé sexuelle et génésique complets incluant la prévention et le traitement du VIH/sida, à la proposition de programmes complets à l’intention de la jeunesse, à la rationalisation des stratégies nationales et à un soutien des donneurs. Tous les investissements consentis en faveur de la recherche, des politiques et des programmes doivent systématiquement tirer parti des synergies naturelles dans le modèle de la CIPD pour produire une efficacité maximale et pour renforcer la capacité des systèmes de santé à délivrer des informations et des services en matière de santé sexuelle et génésique universellement accessibles.

Resumen

Vuelta a los orígenes: el VIH/sida forma parte natural de la salud sexual y reproductiva

El Programa de Acción de la Conferencia Internacional sobre la Población y el Desarrollo (CIPD) celebrada en El Cairo en 1994 ofrece un marco integral para alcanzar la meta de la salud sexual y reproductiva y los derechos conexos, en particular la prevención y el tratamiento de la infección por VIH/sida, así como para avanzar hacia otros objetivos de desarrollo. Los Objetivos de Desarrollo del Milenio de las Naciones Unidas incorporan hoy la meta del acceso universal a la salud sexual y reproductiva dentro del objetivo de mejora de la salud materna, pero la lucha contra el VIH sigue formando parte de un proyecto independiente junto con la malaria y la tuberculosis. Se presenta aquí sucintamente la historia de algunas decisiones clave, tomadas por la OMS, otros organismos de las Naciones Unidas, el Proyecto del Milenio de las Naciones Unidas y algunos donantes importantes, que han llevado a aislar la infección por VIH/sida de la base programática que lógicamente le corresponde en el

terreno de la salud sexual y reproductiva y los derechos conexos. Tal fragmentación es una traba para el logro de esos objetivos y metas. Instando a retomar el concepto original de la CIPD como un marco para la acción, propugnamos la renovación del compromiso de liderazgo, la realización de inversiones en sistemas de salud orientadas a proporcionar servicios integrales de salud sexual y reproductiva, incluidos la prevención y el tratamiento de la infección por VIH/sida, la aplicación de programas integrales dirigidos a los jóvenes, la racionalización de las estrategias de los países y el apoyo de los donantes. Todas las inversiones en investigación, políticas y programas deben aprovechar sistemáticamente las sinergias naturales inherentes al modelo de la CIPD para optimizar su eficacia y eficiencia y fortalecer la capacidad de los sistemas de salud para proporcionar información y servicios de salud sexual y reproductiva universales.

ملخص

العودة إلى الأساسيات: الإيدز والعدوى بفيروسه ينتمي إلى الصحة الجنسية والإنجابية

والأغراض المتوخاة. وإذ يحث الباحثون على العودة إلى الهيكلية الأصلية لبرنامج العمل للمؤتمر الدولي حول السكان والتنمية واعتباره إطاراً للعمل؛ فإنهم يدعون لتجديد الالتزام لدى القيادات، والاستثمار في النظم الصحية لإيلاء خدمات شاملة في الصحة الجنسية والإنجابية، والتي تشمل الوقاية من مرض الإيدز والعدوى بفيروسه ومعالجته، والبرامج الشاملة للشباب، وتعميم استراتيجيات البلدان ودعم الجهات المانحة. وينبغي أن تبنى جميع الاستثمارات في البحوث والسياسات والبرامج بناءً منهجياً على التأزر الطبيعي المتأصل ضمن نموذج برنامج العمل للمؤتمر الدولي حول السكان والتنمية للحصول على أكبر قدر من الفعالية والكفاءة ولتعزيز قدرات النظم الصحية على إيلاء خدمات ومعلومات متاحة وإتاحة شاملة في مجال الصحة الجنسية والإنجابية.

يقدم برنامج العمل للمؤتمر الدولي حول السكان والتنمية الذي عقد في القاهرة عام 1994 إطاراً شاملاً لإحقاق الحقوق وبلوغ الصحة الجنسية والإنجابية، والتي تشمل الوقاية من الإيدز والعدوى بفيروسه ومعالجته والتقدم صوب المرامي الإنمائية الأخرى. وتضم المرامي الإنمائية للألفية التي تبنتها الأمم المتحدة في الوقت الراهن هدف الإتاحة الشاملة للصحة الجنسية والإنجابية ضمن مرمى تحسين صحة الأمومة، إلا أن مكافحة الإيدز لاتزال مشروعاً منفصلاً مع الملاريا والسل. ويقدم الباحثون في هذه الورقة عرضاً تاريخياً موجزاً للقرارات التي اتخذتها منظمة الصحة العالمية ووكالات الأمم المتحدة الأخرى ومشروع الأمم المتحدة للألفية، والجهات المانحة الكبرى، التي قادت فصل الإيدز عن قاعدته البراغمية المنطقية ضمن الحقوق والصحة الجنسية والإنجابية. فقد أدى هذا التجزيء إلى إعاقة بلوغ مجموعتي المرامي

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