INTRODUCTION: WHY DON'T HIV/AIDS POLICIES WORK?

TIM ALLEN*

LSE, London, UK

This 'policy arena' offers some responses to the above question and indicates ways forward. The authors originally presented their papers at a workshop held at the London School of Economics in March 2004. James Putzel draws on evidence from Uganda, Senegal and Malawi to interrogate problems that have arisen with the national AIDS commissions favoured by the World Bank; Tim Allen and Suzette Heald compare and contrast responses to the pandemic in Uganda and Botswana; Heather Zhang describes the situation in China; Ken Shadlen looks at issues involved in securing access to drugs, and Tony Barnett comments on how HIV/AIDS data should inform action. Here, I do not attempt to summarise the various arguments they make, but provide a brief critical overview of global HIV/AIDS policy. In so doing I point forward to many of the issues that are addressed in more detail in the pages that follow.

The HIV/AIDS pandemic has raised policy dilemmas of a magnitude that are yet to be fully recognized or understood. There seems to be remarkably little appreciation of the scale of the problem in India or (as Zhang demonstrates) in China. Even in those parts of Africa where HIV/AIDS has already become the main cause of adult mortality, governmental responses sometimes lack a sense of urgency or purpose. In South Africa the national government has infamously remained in denial about the situation, and until recently has done almost nothing. Yet before too much blame is apportioned to South African politicians, it is important to note that in neighbouring Botswana the government acted, but with no apparent effect (a point addressed by Allen and Heald). Given the continuing rise in rates of infection and mortality, it would be fair to conclude that HIV/AIDS public health policies have been seriously inadequate.

It is important to note at the outset that the failures in HIV/AIDS policy have been selective. Certain measures have proved to be very effective, but they have mostly been implemented among relatively affluent people or among people living in affluent countries. For recipients of these policies, the risk of infection by HIV/AIDS has been largely contained or reduced, and for most of those infected it has become a condition of chronic morbidity, rather than imminent mortality. For various reasons the application of these policies to poor countries has been very limited, and AIDS-related mortality has become a telling and shocking indicator of economic deprivation.

*Correspondence to: T. Allen, Development Studies Institute, London School of Economics, London WC2 2AE, UK. E-mail: t.allen@lse.ac.uk

The relatively successful strategies adopted for dealing with HIV/AIDS in affluent countries have been a response to effective lobbying by influential groups and individuals. Pressures have been brought to bear both to promote behavioural change and make progress in the provision of therapies. Amongst other things, the former has involved various forms of health education, including disturbing advertisements. Particularly in the 1980s HIV/AIDS awareness campaigns engendered a fear of infection (as well as a fear of those infected). Use of condoms was heavily promoted, and 'risk groups' were targeted—notably homosexual men, sex workers and drug addicts (who were sometimes provided with free syringes). Such efforts to inform and persuade were combined with a degree of constraint and enforcement. Places where homosexual men would gather to have sexual intercourse were often closely monitored (sometimes informally by gay activists) or closed down (such as the bath houses in California). There was also the threat of legal action against those who deliberately infected others, and social pressures to reduce high-risk behaviours were actively encouraged both by governments and diverse kinds of nongovernmental activists.

At the same time, public concerns about the virus created incentives and secured funding for biomedical therapies to move quickly beyond palliative care for the afflicted. Although a cure or vaccine proved elusive, testing procedures improved and it became possible to prevent transmission through blood transfusions. In addition, early breakthroughs in the development of antiretroviral drugs suggested a potentially effective mode of treatment. The first of these was being marketed in 1986, and by the mid 1990s, combinations of antiretrovirals and other drugs were prolonging the lives of HIV positive people—sometimes indefinitely, and could also be used to reduce the risk of transmission from mothers to their children.

Some of the reasons why these responses to HIV/AIDS were not replicated in poor countries are obvious. Until recently, the costs of providing for antiretroviral treatment were far too high to even contemplate (a point elaborated in the paper by Ken Shadlen), and in any case, until mortality rates started to rise dramatically, HIV/AIDS tended to be viewed as a problem mainly affecting rich countries. Moreover, facilities with which to run the kinds of behavioural change schemes introduced in rich countries were largely absent. Many countries do not have basic primary health care facilities, and initially HIV seemed to pale into insignificance when compared with many other diseases, such as malaria and tuberculosis. As a result, few governments in poor countries were placed under much domestic pressure to do anything.

Particularly in the 1980s, it was mostly international medical agencies, such as the WHO, which took a lead in encouraging poor countries to introduce HIV/AIDS programmes. However, many of the programmes that were started with development assistance funding did not prove to be very effective. In the absence of affordable biomedical therapy, strategies concentrated on health education and behavioural change. Often these were targeted at specific risk groups, something that was an integral part of programmes in rich countries, but which was not necessarily optimal where modes of transmission were so different, and where overall rates of HIV infection in populations were so high. More generally, international aid agencies were not in a position to transform gender relations and were rarely able to change sexual behaviour. Also the introduction of condoms (which was often presented as a kind of 'magic bullet' solution) has been found to be highly controversial and very difficult. Amongst other problems, condoms are often closely connected with longstanding and unpopular contraception campaigns, and there may be religious and moral reasons for their rejection. In some

instances they are even believed to be a direct cause of ill health, something which is hardly surprising when it is considered that their promotion has often coincided with high excess mortality. Even if these kinds of hurdles are overcome, there remain huge logistical and financial constraints. In countries in which basic public facilities are acutely limited, it has simply proved impossible to provide a regular supply of condoms to all sexually active people, let alone to make sure that they are correctly used.

It is possible that in some locations things would have been different if funding for programmes had been adequate. However, the efforts of international agencies and others concerned about HIV/AIDS in poor countries took place against declining interest in the pandemic in rich countries, where the relative success in containing the disease tended to reduce concerns about the situation in other parts of the world. Until recently, international funding for HIV/AIDS control programmes has been very limited, in spite of much rhetoric to the contrary from prominent figures and a formal commitment to funding the Millennium Development Goals (which include the target of halting and beginning to reverse the spread of HIV/AIDS by 2015). Organizations like UNAIDS continue to complain that the resources available are hopelessly inadequate. However, with the MDG deadlines looming, this might be about to change, as finances are suddenly moved from other pressing concerns. Many informed observers are now worried that too much is about to be spent too quickly, overloading fragile health-care systems, and exacerbating the acute problems that have already arisen in delivering integrated HIV/AIDS programmes in poor countries (several of which are discussed by Putzel).¹

Serious questions can be raised about the accuracy of HIV/AIDS prevalence data (Allen and Heald, Zhang, and Barnett all comment on this issue). Nevertheless, few would deny that overall the situation in the most seriously affected regions is bleak. It is therefore scarcely surprising that much has been read into 'success stories'. These include parts of Latin America, where similar kinds of pressures have been placed on governments from concerned parties as in Western Europe and North America, and it has been possible to implement somewhat similar programmes. In Brazil, for example, there has been some success in reducing HIV prevalence among injecting drug users, in increasing reported use of condoms and (as Ken Shadlen notes) in providing antiretrovirals to HIV/AIDS patients. Other countries have managed to contain the pandemic with more authoritarian methods. Cuba and Thailand are examples—although both are in many respects exceptional cases and cannot be readily emulated. In Africa, 'success stories' are largely absent. The one, much cited, exception is Uganda. Others are Senegal and, somewhat paradoxically, Botswana—because of the mass-access ARV programme that has been introduced there. They are all examined in the papers that follow.

At the moment it is hard to see how the global HIV/AIDS pandemic is going to be brought under control. However, it is likely that future government policy making will be shaped by the following factors.

- (i) The degree to which the pandemic slows and begins to decline.

In the early 1990s there was speculation that the first signs of declining incidence and prevalence in southwest Uganda might indicate that the pandemic had reached a 'natural' peak (i.e. that the disease had become less virulent and that the decline in incidence rates were therefore not the result of public health interventions, but would

¹The point about the sudden, short-term, concentration of funds on HIV/AIDS programmes was made to me by several staff members of the World Bank, UNICEF, DFID and the London School of Hygiene and Tropical Medicine while taping interviews for the Open University on global public health issues in July 2004.

have happened anyway). It was hoped that this would also be the case elsewhere—i.e. that rates of infection would decline, irrespective of public health interventions. However, that proved not to be so, and rates have risen far higher than those seen in Uganda, particularly in southern Africa. Nevertheless, the pandemic can probably be expected to reach a ‘natural’ peak at some point, because that is what happens to all diseases. It will doubtless occur at different rates in different places (for example, there are indications that rates of infection are now levelling off and perhaps even dropping slightly among some populations in South Africa).²

- (ii) The degree to which HIV/AIDS impacts on the economic growth and political stability of affected countries.

Notwithstanding the economic hardships that have been observed in many families affected by HIV/AIDS-related morbidity and mortality, it remains a matter of debate how much this will affect a country’s overall economic performance. Until recently it was common for economists to argue that the economic benefits of low population growth will counter the effects of HIV–AIDS related mortality. More recently it has become ‘politically incorrect’ for such a view to be aired in public, nevertheless it remains quite widespread, particularly with respect to certain countries. It is probable that the overall economic impact of HIV/AIDS will be highly variable from one place to another. Where its impact is severe, it is likely to cause political instability and perhaps put pressure on governments to act more decisively in order to survive. Political pressures are also likely to emerge as a consequence of the demographic impact of the pandemic. As Tony Barnett observes in the postscript to this collection, in highly affected countries there will be (and in some cases already are) unprecedented population profiles, including extraordinary dependency ratios (i.e. the number of dependents per adult of productive age). The political implications of such processes can be expected to be far reaching.

- (iii) The degree to which the pandemic is seen as a threat to the social, economic and political interests of rich countries.

Towards the end of the 1990s the US government began to describe HIV/AIDS as a national security issue, and concerns have been expressed in the UK about the number of people of African origin who are being treated for HIV/AIDS at British hospitals. Such considerations may lead to greater efforts to disengage from HIV/AIDS affected regions, but this is unlikely to be a tenable strategy over time, especially as the pandemic continues to spread in Asia. It is perhaps more likely that the growing threat of the pandemic on affluent populations will result in pressures being placed on their governments to engage more adequately in global public health issues.

- (iv) The degree to which bio-medical responses become more effective.

A cure for HIV/AIDS remains a long way off, and the vaccines currently being developed are expected to provide only limited protection at best. However, new antiretroviral treatments may improve the quality of life of those infected and may become easier to deliver than those currently available. It may also become possible to provide some form of mass antiretroviral treatment that requires less infrastructure than the current drugs on offer, and which will be less likely to become ineffective due to the emergence of resistant strains of the virus. A key aspect in the emergence of effective bio-medical responses will be the degree to which the costs of the drugs and of their delivery to patients are born by international donors. At present many

²Personal communication with Cathy Campbell, LSE.

developing countries do not have the necessary infrastructure and could not afford to set up and fund delivery programmes, even if the drugs themselves are provided free of charge.

- (v) The degree that concerns about human rights are set aside.

It is certainly true that there are many things that are not known about HIV/AIDS, but it is in fact known how to control it, and not just in rich countries. Enforced testing, enforced use of condoms, segregation of those who are positive, and perhaps enforced compliance with antiretroviral regimes: these are strategies which would have an effect. They also involve what might be regarded as infringements of civil liberties, and it seems likely that they could only be implemented in parts of the world by military force. Such authoritarian measures have already been introduced in certain places. Enforcement was an important aspect of the programme in Thailand, and in Cuba all HIV positive people were compelled to live in segregated sanatoriums from 1986 until a partial easing of restrictions in the mid 1990s. These strategies provoked considerable criticism, but it cannot be denied that they did help contain HIV/AIDS epidemics. Elsewhere, the human rights of those who are HIV positive are privileged over those who are not. It is very understandable why this is the case, but in public health terms it is potentially counterproductive. Moreover, if the rates of infection occurring in southern Africa were occurring in a rich country, such as the UK or Canada, it would be surprising if extreme measures were not introduced. The extraordinary responses to the SARS virus in 2002–03 make that very clear. As rates of HIV infection and AIDS-related mortality continue to rise, it is inevitable that at least some of those governments with a capacity to act aggressively will do so. More generally, increased use of mass testing procedures is inevitable.

ACKNOWLEDGEMENTS

This collection could not have been produced in such a timely way without the contributions of the numerous people who have reviewed the papers so quickly and thoughtfully. Most have to remain anonymous, but I would like to specifically mention Tim Dyson, Cathy Campbell, Deborah James, and Melissa Parker. I would also like to thank Tony Barnett for his many helpful suggestions.