Expanding the global response to HIV/AIDS through focused action

Reducing risk and vulnerability: definitions, rationale and pathways

UNAIDS Best Practice Collection
KEY MATERIAL

Expanding the global response to HIV/AIDS through focused action

Reducing risk and vulnerability: definitions, rationale and pathways

The contribution of Daniel Tarantola from the François-Xavier Bagnoud Center for Health and Human Rights to the preparation of this document is gratefully acknowledged.

UNAIDS/98.1

©Joint United Nations Programme on HIV/AIDS, 1998. All rights reserved. This publication may be freely reviewed, quoted, reproduced or translated, in part or in full, provided the source is acknowledged. It may not be sold or used in conjunction with commercial purposes without prior written approval from UNAIDS (contact: UNAIDS Information Centre – 20, avenue Appia – 1211 Geneva 27 – Switzerland or e-mail: unaids@unaids.org).

1. INTRODUCTION

More than a decade and a half since the beginning of the HIV/AIDS epidemic and over a decade after the inception of the Global AIDS Strategy [1], a dual gap continues to grow relentlessly—between the rapid spread of the HIV epidemic and the limited prevention efforts; and between the rising needs for care, support, and impact-alleviation, and the insufficient response to these needs[2].

By the end of 1997, over 30 million people were living with HIV/AIDS, including 12.1 million women, 17.4 million men and 1.1 million children. In 1997, 5.2 million adult women and men and about 600,000 children newly acquired HIV infection. The mortality due to AIDS-related illnesses in 1997 alone amounted to 20% of the total AIDS-related mortality since the beginning of the epidemic. Globally, these infections are distributed almost equally among women and men. The developing world accounted for most of all new HIV infections in 1997.

As the HIV pandemic pursues its course largely unabated, it has become fragmented and now consists of multiple, concurrent epidemics. Its impact is particularly severe on the developing world and on marginalized populations in industrialized countries.

The rate at which new HIV infections are growing and the pace at which HIV infection progresses to AIDS have begun to slow down in certain populations in some parts of the world. This is happening at the same time as safer behaviour is being adopted and prevention and care services are expanding, and particularly in richer countries owing to the availability of some retroviral therapies.

Yet, enough knowledge and experience have been gained from prevention and care efforts to demonstrate that the rate of transmission of HIV can be reduced and the onset of AIDS-related complications can be delayed significantly if well designed and sustainable programmes are undertaken. The response to the epidemic has not taken full advantage of this accumulated knowledge. There are too few partnerships among those participating in this response. Coordinated, 'scaled-up' action is lacking. And the involvement of civil society in the design and implementation of HIV/AIDS programmes is limited.

There is abundant evidence globally that well-designed prevention programmes can reduce the incidence of HIV. In societies where services and programmes were already well-equipped before the epidemic of HIV/AIDS, the creation of new initiatives and the re-orientation of others led to a gradual decline in the incidence of HIV in the mid-1990s. A similar trend is being observed in certain sections of the population even in resource-constrained settings, at least partly as a result of rigorous prevention efforts.

Continuing initiatives tend to focus on responding to immediate needs for prevention, but for most of the affected populations, these responses are inadequate. Even more significantly, they have not focused adequately on strategies for providing HIV/AIDS care and social support and for alleviating the impact; they have also shied away from addressing the root causes of the epidemic in societies and communities.

HIV and AIDS still unequally affect certain individuals and communities as a result of inadequate services and societal constraints. We acknowledge today that HIV and AIDS will be part of our lives for some time to come, even if sometime in the future we may have an affordable and highly effective vaccine and are able to ensure coverage, and despite antiretroviral therapies showing some impact in parts of the world.

To contain the HIV/AIDS epidemic and mitigate its impact we need to expand the response considerably. This expansion has two elements. First, there must be the simultaneous enhancement and improvement in the quality, scope and coverage of continuing prevention, care, support and impact-alleviation efforts, which target individuals and populations seen to be at particular risk. Secondly, there must be combined with actions directed towards societal factors that lower people's vulnerability to HIV/AIDS. This paper proposes a conceptual framework for an expanded response to HIV/AIDS and suggests the dimensions along which this response needs to proceed.

2. RISK AND RISK REDUCTION

In the context of HIV, risk is defined as the probability that a person may acquire HIV infection. Certain behaviours create, enhance and perpetuate such risk, for example unprotected sex with a partner whose HIV status is unknown, multiple unprotected sexual partnerships, lack of adherence to infection-control guidelines in the health-care setting, repeated blood transfusion, especially of untested blood, and injecting drug use with shared needles and syringes.

> Prevention, care, support and impact-alleviation activities, guided by research findings, are inseparable elements of a meaningful response to HIV/AIDS. The success of prevention depends in part on strengthening the capacities of communities, and of the health, economic, educational, social welfare, political and other systems to meet the needs of those who live with HIV and AIDS and those affected by HIV/AIDS.

Risk arises from individuals engaging in risk-taking behaviour for a variety of reasons. They may, for instance, lack information on HIV, they may be unable to negotiate safer sex, they may think that HIV/AIDS affects a different social strata than their own, or they may not have access to condoms. A strong premise influencing programme planning so far has been that risk can be reduced substantially if knowledge, attitudes and skills of individuals are influenced to permit adoption of safer behaviour.

> A man having unprotected sex with multiple partners may provide an example of conscious risk-taking behaviour. The spouse/partner of this man may herself be faithful to him and unaware of his multiple partnerships or unable to demand that he takes appropriate measures for protecting the partner against HIV infection. Both partners however, engage in risk-taking behaviour when they have unprotected sex with each other.

The initial response to HIV has aimed mainly at reduction in risk-taking behaviour through targeting individuals and groups. Examples of such targeted interventions include the provision of information and education, the promotion of condoms, the prevention and early treatment of sexually transmitted diseases, needle and syringe exchange among drug-injecting populations, and programmes to enhance women's and young people's capacity to demand their own protection when the balance of power between them and their sexual partners is not in their favour. These strategies have also aimed at increasing the safety of medical procedures, including blood transfusion, in the health-care setting.

> The control of communicable diseases has traditionally relied on:
> - influencing individual decisions to adopt protective behaviours and practices;
> - biomedical or physical interventions to reduce the risk of the transmission of infectious agents; and,
> - in some cases, legal action or even coercion.
>
> This is how smallpox was eradicated, several vaccine-preventable diseases were brought under control and food-borne diseases were prevented.
>
> For several years into the HIV epidemic, rational notions of risk have influenced programme planners. The complexities of risk-taking behaviour, however, may be ignored by assuming that behaviour is always rational. Personal intimacy and interpersonal relations have a major impact on behaviour. An injecting drug user may 'choose' to share needles as it is an expression of solidarity with the drug-using support system; sharing may strengthen group identity and support as well as ensure shelter and the next 'fix'. A sex worker who protects herself with clients may have unprotected sex with her steady partner as an expression of love and confidence.

It is now clear that, in combination, these measures have resulted in a decline in the HIV/AIDS epidemic in some populations, and that they need to be strengthened. However, the impact of such measures will vary depending on the quality of messages, the scope and diversity of the strategies used, the ability to target audiences, the existence and quality of accessible services, and the societal context within which such efforts take place.

> From a public health perspective, societal factors are considered when assessing and predicting the risks that expose an individual to a particular disease. Public health interventions, however, have largely focused on the individual, falling short of addressing societal issues that may be at the root of ill health.

The approach to HIV/AIDS, however, has broadened over the recent years to focus not only on individual risk-taking behaviour, but also on the immediate environmental and societal factors that influence such behaviour, and the influence exercised by families and communities on individual behaviour. In many societies, important decisions, such as those related to child-bearing, often involve the family, rather than only the individual or the couple, with the influence of elders being particularly strong. More significantly, there is a growing realization of the key role that power relationships and social inequities play in influencing risk. Overarching the concept of risk and risk-taking behaviour is thus the broader paradigm of **vulnerability** and vulnerability reduction. Individual risk is seen, through this perspective, as influenced by societal factors that increase and perpetuate the vulnerability of certain individuals and sections of society more than others. This recognition merits an approach to HIV/AIDS that goes beyond the immediate risk-taking act and the immediate environmental factors affecting it, to addressing underlying factors that create an overall climate in which such risk-taking behaviours are encouraged, maintained and prove difficult to change [3]. In expanding the response, the individual, familial and community aspects need to be addressed more comprehensively and in a complementary fashion.

> A community is defined here as an association of people sharing a common interest or objective, rather than a geographical community alone. People, thus, belong to a wide variety of communities, for instance neighbourhood, sports club, local women's club, or religious groups. Gate-keepers and opinion leaders, e.g. political or religious leaders, influence the information coming into the community and community decisions.

3. VULNERABILITY AND VULNERABILITY REDUCTION

From a health perspective, vulnerability results from societal factors that affect adversely one's ability to exert control over one's own health.

> A person who may not be highly vulnerable to HIV today may become so tomorrow as a result of, for example, the loss of employment causing stress, forced displacement and consequent disintegration of social support systems.
> The effect may not be the same for all. For instance, for a member of a large, extended family in rural India, the loss of employment may not necessarily lead to the above consequences to the same extent as a person in more industrialized and urban contexts. Thus, the concept of vulnerability takes into account personal and external factors, a temporal dimension, and a complex interaction between these factors that may differ across cultures and within societies.

In the context of HIV/AIDS, vulnerability is influenced by the interaction of a range of factors including (i) personal factors; (ii) factors pertaining to the quality and coverage of services and programmes aimed at prevention, care, social support and impact-alleviation; and (iii) societal factors. In combination, these factors may create or exacerbate individual vulnerability, and as a result, collective vulnerability to HIV/AIDS; others may have a positive effect on reducing vulnerability. Analysing vulnerability to HIV/AIDS implies not only identifying these factors, but also understanding how these factors interact with each other, and how they differ across contexts and cultures.

> Personal factors include, for example, sexual history (number of partners, number of unprotected sexual acts, and nature of sexual act), availability of knowledge and skills required to protect oneself and others and, in relation to care and social support, knowledge about treatment and social support programmes as well as skills to access and take advantage of them. Membership of specific social networks may also influence this vulnerability.
>
> Factors related to services and programmes that influence vulnerability may include, for example, the cultural inappropriateness of HIV/AIDS programmes, the inaccessibility of such services due to distance, cost and other factors, and the lack of capacity of health systems to respond to a growing demand for care and support for people with HIV/AIDS and those affected.
>
> Examples of societal factors influencing vulnerability include cultural norms, laws or social practices and beliefs that act as barriers to essential prevention messages–on the promotion of condoms, the importance of safer sex, etc. Such societal factors lead to the inclusion, neglect or deliberate social exclusion of people depending on their private lifestyle, behaviours or choices, and more pertinently due to socio-cultural characteristics.

Almost universally however, the epidemic has disproportionately affected individuals and communities who are marginalized or discriminated against for reasons of sex, age, ethnicity, race, sexuality, economic status, and cultural, religious or political affiliation. To address the vulnerability of such individuals and communities to HIV/AIDS, it is particularly essential that the response be expanded beyond risk-reduction strategies.

Stigmatization for reasons of sexuality, sexual behaviour, substance use or the mere fact of being HIV positive has fuelled the HIV epidemic since its emergence. Public fear of HIV/AIDS further reinforces stigmatization towards people who, for social, racial, behavioural or any other reasons, are alleged to be at higher risk of acquiring HIV infection. This stigmatization can limit the access to appropriate HIV prevention, care and support for people who may be most in need.

Young people of both sexes account for most of the current HIV infections in the world today. Their experience demonstrates how a combination of personal, service-related and societal factors can influence vulnerability.

During the transition from childhood to adulthood, some young people may experience feelings of 'invulnerability' as well as a desire to experiment. They may also not have been provided with information on subjects such as sex and drugs. As a result they may knowingly or unknowingly take risks that expose them to infection.

From a service perspective, young people may use paediatric services or adult health clinics, neither of which are fully equipped to respond to their specific needs, sensitive to young women's and men's development, and provide confidentiality and quality health care.

From a societal perspective, young people are seen to have limited rights and are expected to conform to norms established for them until the day when (sometimes four or five years after the average age of sexual onset) they can claim full legal autonomy. Their right to confidentiality is often violated, their access to information is restricted, and their sexuality is repressed.

Some progress has been made in understanding the multiple causes and manifestations of **gender inequality**, with greater appreciation of specific actions that can be undertaken. In the absence of policies and programmes that work towards bridging the gender gap, many HIV/AIDS-related efforts may prove to be ineffectual and short-lived.

Equal access to education, fair income distribution, sharing of ownership, equal employment opportunities and wages, equality before the law and in the area of customary practices are among the specific actions that can bridge the gender power gap effectively. Many of these changes require efforts at the legal and policy level, as well as challenging predominant cultural norms [4].

Poverty is also seen as enhancing vulnerability to HIV. The growing rates of HIV/AIDS in economically disadvantaged communities of the industrialized world and in developing countries emphasize the role played by poverty in fuelling the epidemic. There has long been worldwide recognition of the negative impact of poverty on health and of the need to undertake aggressive action towards poverty alleviation and development.

Internal economic disparity is as critical as the overall level of wealth in the context of vulnerability. Violations of rights, physical and mental abuse, sexual exploitation, and withdrawal of entitlements deepen the gap between those who benefit from economic growth and those who suffer its ill effects. All these factors fuel the epidemic.

Development policies and programmes themselves may have positive and negative effects on the spread and impact of HIV/AIDS. Thus, it is critical during the social planning process to reflect carefully on these potential consequences.

Such would be the case of an economic development initiative that would increase disproportionately the economic gap between its immediate beneficiaries and others. The latter may in fact thus become vulnerable to HIV/AIDS owing to increasing marginalization on economic grounds and the need for dependence on alternative means of livelihood which may expose them to the risk of HIV/AIDS.

Designing interventions and policies that address vulnerability is complex because the interaction between factors such as gender and poverty may reduce only some aspects of vulnerability in some contexts, but it may enhance vulnerability in other contexts. For example, while data suggest that, in most cultures, poverty exacerbates the conditions in which HIV is transmitted, there is evidence to indicate that the trend is not uniform. There are emerging epidemics among the better-off sections of society partly owing to the economic power to engage in behaviour that creates risk such as buying sex or injecting drugs. Undoubtedly, economic power does create possibilities for engaging in safer behaviour; using the above-mentioned examples, this would mean capacity to buy and, thus, use condoms or to ensure single use of needles and syringes. Whether safer behaviour is more likely to occur with improvement in one's economic situation may depend on other factors including what is socially valued and culturally encouraged, educational status, and gender.

It is important to recognize that the factors that influence vulnerability in the context of gender are not uniform across cultures and within different social segments, especially in terms of how they interact with other factors such as age and socio-economic background including education and earning capacity.

A similar situation is true for education; data from studies in a few African countries, especially in the early years of the HIV epidemic, suggest that infection rates are at times higher among the more educated groups, especially among men [5]. These findings suggest links between higher social status and opportunities for greater sexual contacts in some contexts. At the same time, in some of the same countries, young women with more education responded more favourably to HIV prevention efforts to promote safer sex. Such findings caution against over-simplification of the vulnerability paradigm.

In the context of HIV/AIDS, the ultimate aim of risk and vulnerability reduction is to enable people to exert control over their own risk by a process of individual and collective empowerment as well as to develop societal responses that create an environment in which safer and protective behaviour can be practised.

4. EXPANDING THE RESPONSE TO HIV/AIDS

As stated earlier, risk-reduction strategies constitute the major approach being used in HIV/AIDS programmes since their inception. Clearly, enough evidence exists to show that many such efforts do work and merit strengthening. Successes in HIV prevention using the risk-reduction approach have been documented over the past few years [6, 7]. These include programmes that focus on condom promotion, voluntary counselling and testing services, provision of information, needle and syringe exchange programmes, provision of STD diagnostic and treatment services, and prevention of mother-to-child transmission. However, current programmes have several limitations. Some of them would benefit greatly from access to the best practices that have emerged from the worldwide effort respond to the epidemic. Often, programmes are irrelevant to the changing needs of the communities for whom they are designed owing to lack of involvement of affected communities. Some also lack resources and thus cannot be taken to scale. Interventions may also be undertaken in isolation, rather than in support of each other.

Where programmes work, it is important to provide facts about what does and does not work, and what is the most efficient approach. An evidence-based approach can not only help to ensure greater accountability and value for money, but also provide much for others to learn from.

In order to have a significant impact on the epidemic, risk-reduction interventions must be rigorously designed according to best practices and adapted to local needs; they need to gather and share evidence of what makes them work and how. Such efforts, when effective, need to be expanded considerably, and replicated worldwide. The strengthening of risk-reduction strategies thus forms a major dimension of expanding the response to HIV/AIDS.

The other dimension of expanding the response that complements risk-reduction efforts is the **reduction of vulnerability.** Such efforts need to be focused first within both HIV/AIDS-specific and other health-related programmes. Secondly, they need to be implemented within other sectors in order to bring about a multisectoral approach towards harnessing the comparative advantages of these sectors where efforts will influence the spread of HIV. The cost of including HIV/AIDS in these broader programmes is often marginal.

Vulnerability-reduction measures are necessary by themselves in the context of social justice and for overall development. However, in the context of HIV/AIDS, such measures create an enabling and supportive environment for risk-reduction strategies to work. Vulnerability-reduction strategies in HIV/AIDS are based on the recognition of individual risk-taking behaviours, and of the personal and societal factors that influence them. Hence, an expanded response to HIV/AIDS becomes possible at several levels: it reduces risks themselves through direct prevention, care and support and impact-alleviation efforts; and it influences vulnerability through social, cultural and economic change.

The latter approach of engaging sectors and partners not specific to HIV/AIDS is not entirely new to many countries. However, until now, with the exception of some countries like Zambia, Uganda and Thailand, to name a few prominent examples, such a broadened response has received neither adequate attention nor resources. Furthermore, in some cases, it has unfortunately amounted to the haphazard dispersion of HIV/AIDS activities within health and social programmes, with questionable impact on the epidemic.

In Zambia, different ministries have made specific commitments to addressing HIV/AIDS. The Cabinet Office has developed HIV counselling services. The Office of the President has encouraged the inclusion of HIV prevention messages in all speeches of the country's top political leaders. The Ministry of Defence has developed a plan for creating an orphans' fund to help with the upkeep and education of orphans of officers and men of the defence forces. The Ministry of Agriculture, Food and Fisheries proposes to train extension workers in social mobilization techniques for HIV/AIDS prevention and care, and in coping mechanisms for rural populations. The Ministry of Local Government and Housing is reviewing land policies and establishing AIDS offices in all its units across Zambia. The Ministry of Tourism is incorporating HIV/AIDS into the curricula of wildlife management schools and hotel and tourism managing institutes.

The next five-year Thai national AIDS plan will address how social and economic development can contribute to the control of HIV/AIDS, integrating HIV prevention and care efforts into the National Economic and Social Development Plan for 1997–2001. To care for people with AIDS, whose numbers are expected to increase steadily for the next five years, increased resources will be needed. Here too, Thailand is taking a broad-based multisectoral approach. In addition to working to improve access to hospital medical care and treatment, community and family-based care approaches are being expanded, and efforts are under way to address problems of social and economic support for and discrimination against those with HIV and AIDS. The Ministry of the Interior, which is responsible for community development, organizes training in non-discrimination and in basic family care for village headmen, housewives' organizations and youth groups. The Ministry of Education, which is responsible for Buddhist temples, promotes Buddhist teachings on compassion for monks, who then teach temple-goers. In some villages the Ministry helps the temples to house and care for indigent people with HIV. The Office of the Prime Minister, which is responsible for mass media, provides financing and secures corporate funding for messages on compassion, non-discrimination and family care through television, radio and newspapers, and encourages the private sector to incorporate these messages into their commercial advertisements.

If other sectors and partners are to address the epidemic, they need to understand HIV/AIDS as a social and development issue and not just one of health. This understanding on the one hand merits planning, for the social, economic, political and indeed all development-related consequences of the epidemic so as to mitigate its impact. On the other hand, it involves recognizing that social and development programmes themselves can in fact exacerbate the epidemic, and therefore, ensuring that appropriate measures are taken, especially in the case of those who are marginalized.

The construction of a major highway, the launching of a waterworks project, or the creation of free-trade zones necessitates consideration of the ways in which such activities may fuel the epidemic through disintegration of families, rapid urbanization, absence of familiar social-support systems or other consequences. It is necessary to implement measures to ensure that these negative effects may be countered in order to reduce risks to populations affected.

While some elements of vulnerability reduction can be acted on in the short- or medium-term through changes in law and policy, others will require a lengthy process of cultural, structural and environmental changes in most societies. By setting medium-term and long-term goals for action aimed at vulnerability reduction, one can create a manageable universe out of daunting and seemingly overwhelming challenges.

This phased and multi-dimensional approach helps to deal with the urgent needs of the epidemic, while simultaneously working on broader changes in society that will take time to bring about, but which are essential to any long-term impact on the epidemic.

> Actions aimed at reducing vulnerability in the short or medium term may include, for example: changing laws and policies that discriminate against specific populations; changing laws that enhance risk, for instance, by prohibiting payment of wages in bars or prohibiting alcohol sale during pay days, adding taxes on alcohol; and giving special attention to the needs of vulnerable populations like women in ongoing development schemes. They would also include ensuring that HIV/AIDS programmes are culturally appropriate, and increasing the access of available services and programmes to vulnerable populations.
>
> Long-term actions aimed at reducing vulnerability may include inducing cultural changes, in particular with respect to the status of women. In the area of social norms and values, particularly with regard to sex, they may aim at bridging economic disparity through poverty-alleviation policies and programmes. Also, they may work towards strengthening the overall capacity of health systems to cope with illness and death related to HIV/STD.

Epidemiological, economic, social and behavioural data can be of critical importance to better understand the factors that trigger vulnerability in any given society, as well as to identify where and how societal transformation is needed. The relevance, quality and eventual impact of such vulnerability analysis will be enhanced by a broader participation, especially by those living with HIV/AIDS and affected individuals and communities, in the process of reviewing available information, sharing experiences and designing the main avenues for focused action.

Expansion of the response, however, neither suggests only 'more of the same', nor promotes an unfocused approach; it does not even imply more resources for HIV/AIDS-specific efforts alone. What it does imply is that best practices guide and influence the quality of the response; and that the response be more inclusive, such that the epidemic is taken into account when planning or implementing programmes in other sectors that are affected by and impacting on the HIV/AIDS epidemic. Such inclusiveness is more likely to accelerate and strengthen the efforts of these sectors in the first place, as well as to integrate HIV/AIDS-specific activities better, so as to ensure their long-term sustainability and effectiveness. It also brings new and untapped resources to bear on the epidemic.

> For example, a young woman will benefit from sexual health education and access to services in reducing her risk of acquiring HIV infection. In the medium term, such information and services aimed at risk reduction need to be integrated in comprehensive adolescent health programmes that focus on sexual negotiation skills and empowerment of women. Vulnerability analysis may conclude that gender inequity in employment opportunity or income level places this young woman and many others like her at a disadvantage, and reduces their ability to adopt safer behaviours. Vulnerability reduction requires short-term measures to increase women's economic self-reliance through alternative income-generating schemes and skill-building training programmes. Medium-term vulnerability reduction, on the other hand, calls for changes in labour laws and regulations, while long-term changes are needed in social norms and values related to gender equity and sex. The combined effect of the factors affecting this young woman's risk and vulnerability may be further mitigated through her participation in peer-support groups and other social support networks.

Expanding the global response to the epidemic involves strengthening risk-reduction efforts based on accumulated knowledge and innovations, combined with enhancing those that aim at vulnerability reduction by creating a social and economic climate in which risk behaviour is likely to be minimized. This process requires coordinated short-term and medium/long-term action by individuals and communities, as well as governments and private concerns, with the involvement of those living with and those affected by HIV/AIDS.

5. PATHWAYS TO EXPAND THE RESPONSE TO HIV/AIDS

Expanding the response to HIV/AIDS may follow several routes. Few communities or nations will need to expand their response to HIV/AIDS in all these ways at one and the same time. Yet moving along only one of the pathways to the neglect of others will not be adequate for real expansion of the response. The need to prioritize and focus action remains critical in this effort. Over-arching these pathways are the following principles:

- Analysis of factors that enhance risk and vulnerability in order to develop a focused national strategy;
- Expansion of the quality and scope of HIV/AIDS strategies through identifying, promoting and applying best practice in short-term and long-term risk-reduction strategies and actions, and taking them to scale; and
- Enhancing the response to include those strategies that address vulnerability through short-term and long-term measures, thereby
  - reaching vulnerable populations and addressing the socio-economic and cultural factors that influence vulnerability;
  - ensuring that interventions and strategies support and complement each other to provide an umbrella of comprehensive and mutually reinforcing services;
  - strengthening and introducing where needed, evidence-based strategies for risk-reduction and continuing to monitor and improve them and disseminating the evidence.

This may include ensuring best practices in information, education and the provision of prevention, care and support services; the replication of strategies that have proven successful; the design and implementation of new strategies to respond to evolving needs; the incorporation of HIV/AIDS work in other ongoing health and social programmes; the promotion and protection of the human rights of people living with HIV/AIDS; and a focus on those most vulnerable to HIV/AIDS in society.

An expanded response to HIV/AIDS may proceed in several dimensions:

- **Expanding coverage,** geographically and by population, by reaching out to underserved communities in both urban and rural areas; demographically, by reaching out to women and men in the most vulnerable age groups, particularly young people and marginalized populations; and by addressing other factors that affect coverage for stigmatized and marginalized populations such as sex workers and injecting drug users, with for instance special attention to and resources for programmes serving mobile populations (migrants, displaced persons, refugees, and mobile occupations).

A range of innovative mechanisms needs to be used to reach some populations. For example in rural areas the services of companies marketing popular products could be used to distribute condoms to their distributing outlets; young people may be reached better through media that are popular with the young and through young peoples' organizations.

- **Focusing action,** by directing public HIV resources in the first place to those who are most vulnerable to HIV infection, and are least likely to benefit from privately funded programmes for prevention, care and support.

- **Expanding partnerships in the design, implementation and evaluation of HIV/AIDS-related policies and programmes** by enlisting the coordinated participation of governments, nongovernmental organizations, private sector, communities and individuals—in particular, people living with and affected by HIV/AIDS. Through local and affected communities one will have a better grasp of factors influencing risk and vulnerability and to be able to identify sustainable ways to address them. Simultaneously, bringing in new partners that should be involved but have not been so, such as the private sector, is critical. A multisectoral response is thus crucial to an effective response to HIV/AIDS.

The expansion of partnership in every element of the programme implies the sharing of responsibilities, mutual accountability, and effective coordination mechanisms.

- **Involving all relevant sectors** by:

  - advocating for and integrating HIV/AIDS prevention and care into development initiatives and efforts;
  - projecting and monitoring the impact of socio-economic development on people's vulnerability to HIV/AIDS;
  - promoting impact-alleviation, providing support and care, and preventing HIV as essential considerations for all socio-economic planning; and by
  - capitalizing on the strengths of all sectors including religious groups, armed forces and such other groups.

Participation of all sectors of society and the economy in the response to HIV/AIDS should not merely imply the inclusion of an HIV/AIDS project in a particular sector's work, but the analysis of sectoral factors that may influence people's risk-taking behaviours and vulnerability to HIV/AIDS, the sectoral contribution to reducing risk and vulnerability in these populations, and the accountability of these sectors in these areas.

- **Increasing resources mobilized in support of HIV/AIDS prevention and care** by mobilizing and making optimal use of available and diverse human, institutional and financial resources nationally and internationally, and by strengthening resources not just for direct HIV/AIDS-related work but for all related socio-economic and health-related efforts.

> While all available resources, whether local, national or international, should be used more judiciously, efforts should also be made towards skill-building in further mobilization of resources. These efforts will not only reduce the spread and impact of HIV/AIDS, but will also strengthen the capacities of different sectors to become self-sufficient. In terms of resources this is not an impossible task. For instance, the incorporation of sex education into an existing school curriculum does not need additional resources and allows access to large numbers of young people.

- **Enhancing the sustainability of HIV/AIDS programmes over time** by strengthening local and national self-reliance in the design and implementation of short-term and medium- or long-term initiatives and thereby building national capacity to do so.

> Renewed efforts towards community mobilization; decentralization of the responsibility of HIV/AIDS programmes, and delegation of authority and resources to the level that is the closest possible to the community; and more effective advocacy for an expanded response to HIV/AIDS are all necessary to expand the sustainability of the response to the epidemic.

Each of these dimensions necessitates the **exchange of knowledge and experience** gained in expanding the response to the HIV/AIDS epidemic by sharing information locally, nationally and internationally, with emphases on documenting the effectiveness and the impact of innovative approaches and on advocating evidence-based approaches. The design and application of **effective monitoring, evaluation and research methods** for an analysis of the epidemic—both its dynamics and its determinants—are equally essential if we are to draw lessons for shaping the response. The need for **research on new technologies for prevention and care and on societal and behavioural interventions** becomes all the more critical for strengthening an expanded response.

6. CONCLUSION

The paradigm being proposed is neither totally new and untested nor impossible to put into action, both from the perspective of public health in general and HIV/AIDS in particular. Several countries have already moved along the proposed dimensions to some degree: Thailand, Uganda and Zambia, to name a few. HIV/AIDS has multiple facets such as biomedical, socio-economic, political, and cultural, and these provide strong arguments for the need for a multi-dimensional approach. Such a model includes two dimensions: **persuasive,** targeting the individual for changes in **risk** behaviour, and **enabling**, as it is more directed at societal and contextual factors that permit and encourage safer behaviour in the context of HIV/AIDS and the lowering of vulnerability to HIV/AIDS. It also takes into consideration the comparative advantages of different sectors in influencing the response and argues strongly for a sustainable response that empowers those affected by the epidemic.

Few communities or countries—if any—will consider that their current response to the epidemic does or will not require any further expansion. The process of moving along the proposed dimensions, however, needs to be promoted along with tools to put this into practice. The process of national strategic planning and review proposed by UNAIDS provides an opportunity to implement and monitor this expansion in the different directions, bearing in mind the broad principle of enhancing the quality and scope of the response*. Additional measures and tools may be developed as needed on the basis of experience gained over time in proceeding along these dimensions.

In arguing for expanding the response, UNAIDS recognizes that many questions are likely to emerge. For instance, will the focus on vulnerability imply a neglect of the urgent needs of the epidemic to the advantage of those changes that are more difficult to bring about and which other sectors have been working towards for several years, often with little success? With the recent news of advances in treatment, is there really need to focus on those aspects of the epidemic that are more difficult to influence? Are the limited resources likely to be adequate to address what appears to be an expanded agenda? Can we provide data to establish a direct linkage between influencing broader societal change and limiting the spread of the HIV/AIDS?

Some of these questions have been addressed, even if partially in this document. There will be additional questions that will continue to emerge. The world has to respond effectively and with courage to what is a complex epidemic that demands a multi-dimensional and dynamic response. UNAIDS assigns priority to collecting evidence to show that such a response serves long-term needs while meeting the short-term ones, and that it is both ethically and technically sound.

---

* *UNAIDS and its cosponsors provide technical assistance to countries in national strategic planning along these lines. Modules that focus on specific aspects such as situation assessment, response review, strategic planning, and resource mobilization are available.*

REFERENCES

1 World Health Organization. The Global AIDS Strategy. WHO AIDS Series; 11, Geneva:WHO, 1992

2 Mann J and Tarantola D. "Introduction" in *AIDS in the World II*, Oxford & New York: Oxford University Press, ISBN 0–19-509097–7, 1996.

3 Tawil O, Verster A and O'Reilly K. Enabling approaches for HIV/AIDS prevention: Can we modify the environment and minimize the risk? *AIDS,* 1995; **9**:1299–1306.

4 Reid E. *Placing Women at the Centre of the Analysis.* Issues Paper 6, HIV and Development Programme, UNDP, New York: UNDP, 1990.

5 *Confronting AIDS: Public Priorities in a Global Epidemic.* A World Bank Policy Research Report, Oxford & New York: Oxford University Press, ISBN 0–19-521117–0, 1997.

6 Aggleton P. *Success in HIV Prevention: Some Strategies and Approaches.* UK: AVERT, 1997

7 HIV Prevention Works: Report of the Official Satellite Symposium, XIth International Conference on AIDS, Vancouver 1996.