

THE SHIFTING HIV/AIDS PARADIGM: Twenty Years and Counting

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In just a few months, we will have known about the AIDS pandemic for 20 years. Initially, the HIV epidemics, and the official public responses to them, were defined through a medical paradigm traditionally applied to infectious disease control. If people were aware of risks and were given the means to protect themselves from these risks, it was believed, the epidemics would be tamed. Safe sexual practices, the screening of blood and blood products for HIV, the use of sterile injection equipment among drug users, and the avoidance of pregnancies by HIV-infected women would eliminate the risk of infection. By 1986, enough was known about the infectious agent (the virus), host factors (human biology and behaviors), and modes of prevention (risk elimination approaches) that the World Health Organization was able to launch a global strategy against HIV/AIDS. In response to the outcry from people affected by HIV that they suffered from both the health consequences of infection and intense discrimination, the protection of human rights of people living with HIV/AIDS formed an intrinsic part of the initial WHO Global Strategy. From a public health perspec-

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tive, there were at least two pragmatic reasons why human rights figured importantly in the strategy. First, discrimination against people known to be HIV-infected was detrimental to their access to essential care, support, and livelihood. Second, discrimination would discourage individuals at risk of becoming infected from seeking HIV testing and counseling, and from playing an active role in prevention. Yet HIV continued to spread unabated among people who enjoyed few of their civil, political, economic, cultural, and social rights. The epidemics were focused increasingly and disproportionately on the poor and the marginalized.

The true dimensions of the linkages between HIV and human rights became clearer in the early 1990s. The realization of human rights was indeed critical to the survival and dignity of people living with HIV, but it was also a critical component in reducing the risk of acquiring infection among those whose vulnerability was determined by inequalities and stigma associated with a host of attributes, including race, gender, social and economic status, sexuality, and behaviors. The global response expanded beyond the original medical paradigm to address factors that were no longer under the purview of the health sector, such as gender inequality, economic disparity, mobility, and insecurity. The “risk-vulnerability” paradigm developed in the early 1990s, grounded in health and human rights principles, provided a broader and clearer perspective of the determinants of the spread and impact of HIV and helped to redefine the HIV epidemics. More importantly, it offered organizing principles and a framework for action that built on both best practices in public health (themselves based on the valuable experiences arising from HIV/AIDS prevention and care initiatives around the world) and states’ international human rights obligations. The range of interventions expanded, now cutting across numerous sectors and involving a wider variety of actors, and so did the temporal dimensions of this broadened approach, in order to allow for the needed social and economic reforms. If it was indispensable to respond immediately and with more vigor to prevention, care, and support needs, there was also a new understanding that it was equally important to work more aggressively in the long term

towards a greater realization of the human rights of populations particularly vulnerable to HIV. The infectious disease control paradigm had shifted towards a socio-epidemiological paradigm incorporating human rights principles.

Then, beginning in 1996, the discovery of new molecules for the treatment of HIV led to another paradigm shift, bringing into renewed focus the role of medical interventions in combating and mitigating the impact of the epidemics. While the disparity between populations in the North and in the South in levels of vulnerability to HIV had been documented for more than a decade, it was now recognized that the ever-growing inequity between these two worlds in their access to care and treatment had to be bridged as well.

In several Latin American countries, national courts, strongly inspired by international human rights treaties, have now created an obligation on the part of the State to provide access to anti-retroviral treatments. In Africa, particularly in the countries most severely affected by the epidemics, claims for access to available therapies are mounting and increasingly being heard. The rights to the highest available standard of health, to care, to the product of scientific progress, and to international solidarity have been invoked in efforts to make new therapies accessible to the majority of the world population living with HIV. While no one appears to be denying the importance of prevention and of the reforms needed to reduce vulnerability to HIV, the emerging emphasis on care is raising new issues of access to services and technologies, distributive justice, and human rights. There is now an intense and growing debate, often extending to open confrontation, between the protection of human rights and of intellectual property rights as set out under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement). The main point of tension has been the conflict between, on the one hand, the protection of patent rights on pharmaceuticals (in particular, highly active anti-retroviral treatments, which are, under current arrangements, largely unavailable to the developing world), and, on the other hand, the rights of all people to life, to the highest attainable standard of health, to nondiscrimination, and to the benefits of scientific progress.

While it would seem legitimate to argue that human rights rank higher in the hierarchy of international rights than rights found in other sorts of treaties, conventions, or agreements, attaining the optimal balance cannot happen overnight and will require sustained debates involving civil society, governments, and international organizations.

The importance newly accorded to care and treatment in responding to the epidemic has created additional expectations and put greater responsibilities than ever onto the medical sector. The ongoing re-medicalization of HIV means that much more is expected from medical services, the international pharmaceutical industry, national finance ministries, and international donors than ever before in the history of the epidemics. Recent debates around priorities in national and international resource allocation to HIV/AIDS have often centered around two issues: (a) the amount of "health dollars" to be made available for effective care and treatment of HIV when resources for prevention are already insufficient; and (b) the rapidly rising cost of HIV/AIDS programs when resources allocated to other important health issues such as tuberculosis, malaria, unsafe pregnancy, and childhood diseases are already inadequate.

In response to these concerns, national AIDS programs are seeking additional resources to cover expanding care services. Meanwhile, international initiatives are now being mounted to jointly address these issues and others in a concerted effort against what are being termed the "diseases of poverty." For the first time in decades of structured international development, lending institutions that were hesitant to invest more heavily in health infrastructure and services have now become more open and engaged toward the financing of prevention and care programs through various mechanisms, including the awarding of new grants, the restructuring of loans, and the alleviation of existing debts.

Today, stated political commitment to mobilize against HIV/AIDS has attained unprecedented levels. HIV/AIDS was even recognized earlier this year by the United Nations Security Council as a threat to security. It now tops the list of priorities of all those concerned with human well-being. Yet the gaps between statements and financial resource allo-

cation, and between available resources and the capacity to use them effectively, are widening dangerously. The changing environment requires an immense amount of new energy and creativity in the response to HIV/AIDS. Never before has there been such an imperative need, nor such stated large-scale international solidarity. The global response to HIV/AIDS must be recast again with both a sense of immediacy, inspiring urgent action, and a long-term perspective. There is little doubt that even as treatments become increasingly accessible in developing countries—and even if hoped-for vaccines become a reality—HIV/AIDS will remain at the forefront of global challenges for decades. The time has come for the world institutions and economies to prepare for decades of sustained efforts on AIDS, similar to what was proposed at the Rio Earth Summit (Agenda 21) in 1992. Such a long-term vision is needed for several reasons. First, it can provide broad, unifying goals against which every developmental policy or program may be tested. Second, it implies that financial arrangements should not be limited to short-term debt alleviation measures while new debts are being contracted. Rather, they must take a longer-term perspective even in responding to the immediate crisis. This means engaging in the support and reconstruction of sectors such as health and education, which are being severely weakened by the direct or indirect impacts of AIDS, and investing in long-term development actions that reduce, rather than exacerbate, people's vulnerability to the epidemics.

Responding to the immediate crisis demands that prevention, care, and support programs be considerably expanded. This in turn requires that successful small-scale projects be adequately funded and replicated many times over. It also requires active efforts toward the destigmatization of HIV/AIDS, a sine qua non for universal access to voluntary HIV testing and counseling in which access to effective therapies also plays a key role.

Reconstructing essential services calls for long-term projection of, and bold response to, the attrition of skilled human resources, particularly in the health and education sectors, both public and private. Efforts here will contribute directly to reducing the risk of acquiring HIV, reducing vul-

nerability to exposure to HIV or inadequate care, and create an indispensable basis for human development and national autonomy.

Long-term development action to further reduce the sustainability of the epidemic and mitigate its impact involves applying the best available methods, as imperfect as they are, to project over a period of several decades the amounts and types of investments that will be required to mitigate or eliminate the social and economic factors that fuel the epidemics by exacerbating poverty, widening inequity in income and health, intensifying unattended mobility and forced migration, and endangering security.

All of these diverse, complex, and often intertwined approaches, combining bold short-term or long-term actions, need to be structured towards a clear goal and grounded in universally agreed-upon organizing principles. The goal is the elimination of HIV/AIDS as a public health hazard, thereby achieving better health, development, and realization of human rights. And the organizing principles derived from both public health best practice and human rights are central to an expanded response.

At 20 years, the HIV/AIDS epidemics have had major impacts on how we look at health from the perspectives of human rights, human development, and security. The effectiveness and long-term sustainability of the global response to HIV/AIDS require that prevention, care, and support be mainstreamed in all civil, political, economic, social, and cultural actions. But this process should not distract us from this historical human challenge. For the successes and failures of our response to the HIV/AIDS epidemics will continue to suggest new ways to advance health and human rights.