Given the metaphor—“developing” and "developed”—that defines relationships between countries, it is no surprise that whatever other inequalities there are between richer industrialized countries and poorer, less industrialized nations, there is also the “pedagogic inequality” between the teacher and the taught. “Our” resources are sent “over there” to develop them. In the case of AIDS, technical expertise from North America, Western Europe, and Australia continues to inform the responses to the HIV epidemic in many parts of Africa, Asia and the Pacific, Central and Eastern Europe, and—to a lesser extent—Latin America and the Caribbean.

It is difficult to imagine the reverse: teams of experts from Uganda or Thailand sent to advise AIDS professionals and communities affected by the HIV epidemic in New York or Cleveland or Seattle. Nor is this one-way dialogue between the “First” and “Third” worlds merely the result of the former’s greater resources. More fundamentally, it is born of valuing “our” experience and expertise over “theirs,” a perspective whose roots go deep into the colonial past.

There are real and important differences in experience and specific areas of technical expertise, backed by significantly greater research and academic resources, that legitimate the provision of HIV-related technical assistance by richer countries to poorer ones. But, such “benignly” unequal relationships—between donors and recipients, between teachers and the taught—inhibit a more valuable exchange of insights into the HIV epidemic as an expression of social and economic inequalities. This article looks at these insights and some of the lessons that AIDS service providers and policy makers in the United States can learn from them.

Recognizing Inequalities

Anyone who has worked with HIV in countries labeled “developing” cannot fail to be struck by the intimate connections between the epidemic and the development process. A United Nations study of the HIV epidemic in Myanmar’s Shan State, bordering Thailand and China, concluded that: “It is more than coincidence that the HIV epidemic now coursing through these borders has arisen in tandem with economic deregulation and liberalization. And in large part, the pace and geographic spread of HIV infection is connected to larger, externally driven economic forces.”

Clearly, micro-events such as HIV risk behaviors are connected to macro-factors such as politics and economics, but this quotation suggests, more interestingly, that there are links between the patterns and pace of HIV infection and specific social and economic policies and decisions.

Multilateral institutions responsible for international development financing and policy are now recognizing these links. The World Bank is beginning to acknowledge the need for more research into the sexual health implications of its policies and programs, in the same way that it has accepted the need for assessing environmental impact. The United Nations Development Programme has begun a dialogue on linking responses to the HIV epidemic to the organization’s broader development mandate in the context of United Nations Theme Groups on AIDS, which now exist in most developing countries.

Why is it difficult to imagine similar scenarios in the United States, in which public health concerns would feature prominently in discussions of economic
Editorial: Technical Persistence
Robert Marks, Editor

The divide between the “developed” world and the “developing” one seems to be as big as it has ever been. War, famine, and natural catastrophe—and now, ecotourism—are still the events that bring poorer countries to the voyeuristic attention of their richer neighbors.

Stories about the disaster of the AIDS pandemic allow the public to glimpse these “foreign cultures” while keeping them at a distance. People who work with HIV in richer countries may be a little more knowledgeable about the struggles that people in poorer countries must confront. Informed by journal articles and conferences, many of us have become informed about the challenges of inadequate health care budgets and infrastructures, health crises that exceed the severity of HIV, and unstable political situations. Advocates, following in the footsteps of the late Jonathan Mann, continually remind us that richer nations have an ethical responsibility stretching beyond their borders to provide technical and financial assistance to poorer countries. The result is that we are used to seeing “third world” countries only in terms of their need for help. That need cannot be overstated, but focusing on it alone negates the value of the experiences of people in poorer nations.

In this issue of FOCUS, we consider the question: are there lessons that the “developing” world can teach the “developed” world? Alan Greig finds several, mostly in terms of ways of thinking about the epidemic. The concept of vulnerability, which he emphasizes in his article, is particularly important because it reminds care providers that societal context has a real impact on mental health and on actions, for example, risk behaviors, that seem related primarily or only to an individual’s mental health.

Joe Wright’s discussion of vaccine implementation is another way of acknowledging both the plight of poorer nations and the universality of the challenges they face. It will be difficult not only to develop a vaccine, but also to finance, publicize, distribute, and administer a vaccine program—in both poor and rich countries. And should the world successfully implement a vaccine, it is likely that the lessons learned in poorer nations will be important ones for their richer cousins.

The fact is that “rich” and “poor” are conditions that exist in all countries: the aspiration to be self-sufficient, to have enough, is common to all of us; the experiences of scarcity and abundance are ones that cross all borders. If necessity is indeed the mother of invention, then it is likely that the most innovative approaches to our most fundamental quandaries are to be found where people have been forced by adversity to think most creatively. It may also be that sharing technical assistance back and forth rather than merely granting it to poorer nations might lead to the more effective and committed involvement of richer nations in the well-being of poorer ones.

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The concept of vulnerability provides a framework within which to understand the effects of gender, race, and class on HIV risk.

Social, economic, and individual contexts that affect the way people live, limit the choices available to them, and influence the choices they make in relation to HIV disease. Recognizing vulnerability grounds discussions of risk in the reality of people's lives. It offers a better way of thinking about the complex relationships between behavior and context, the individual and the community, and public health and politics than do the epidemiological notions of "risk groups" and risk behaviors. These notions not only abstract individuals from their life-contexts, but also serve to distance "us" from "them." The concept of vulnerability provides a framework within which to understand the effects of gender, race, and class in determining people's differential exposure and response to the risk of HIV infection. It encourages a more complex discussion of risk and responsibility, for example in relation to men and heterosexual HIV transmission in patriarchal societies. HIV prevention work with such men must explore the tension between the responsibility that results from their power over women, and the vulnerability produced by constructions of masculinity that help to define male sexuality.

The concept of vulnerability can also be used to connect responses to the HIV epidemic to broader movements for social change and social justice. The International HIV/AIDS Alliance, a non-governmental organization (NGO) that links the technical and financial resources of richer countries to community and non-governmental responses in poorer countries, has focused much of its effort on strengthening the capacity of community NGOs to integrate HIV work into their existing activities. For example, in Sri Lanka and Cambodia, HIV prevention work has been linked to efforts to rebuild a sense of community in the context of violent conflict, while in Africa, economic development strategies have been used to respond to the epidemic.3

Linking HIV work with social development and social justice is rarely discussed in the United States. One exception may be the harm reduction movement, in its efforts to reduce drug-related harms (including HIV transmission) while accepting the twin realities of the continuing desire to use drugs and of the conditions of social and economic deprivation that give rise to much problematic drug use. Recognizing the implications of these realities has led the Harm Reduction Coalition, the institutional voice of the movement at the national level, to state that it "locates itself within a broader progressive movement for social justice."4

But, for two reasons, the response to the epidemic in the United States—a response that may have been appropriate given the political conditions early in the epidemic—has stifled the emergence of more examples of this connection between social development and HIV prevention. First, pressures to preserve AIDS budget lines and visibility within public health structures have ensured that health paradigms and public health departments have dominated the official responses to the HIV epidemic in this country. Second, community organizing has centered around a politics of experience ("being affected by the epidemic") and a politics of identity ("being gay" and, much more tentatively, "being an injecting drug user"). Because of its inherent exclusions, this approach has inhibited discussion of AIDS as a collective concern and responsibility linked to fundamental issues of social justice and human rights. As early as 1986, Cindy Patton noted that AIDS organizing within the gay and lesbian community was compromised "as the apocalyptic promise of lesbian/gay liberation has failed to overcome racism, sexism, classism, and even homophobia within the movement."5

Mobilizing Communities

Here again, the "third world" may have lessons for the "first." Notwithstanding possible differences between the experience of community in richer and poorer countries, U.S. AIDS service providers could learn from HIV prevention approaches through community mobilization that are emerging in parts of the "developing" world. Influenced in part by the work of Paolo Freire, community-based organizations in poorer countries have worked with "community" as both a site of oppression and an expression of collective resistance to that oppression. Within this framework, it becomes possible to identify a collective response to the HIV epidemic by addressing the social inequalities and values that heighten people's vulnerability. This has been an important part of the work of the Khmer Buddhist Association, which has integrated HIV prevention into its development work with rural communities in northern Cambodia, for example, educating the community about gender equality.6

The practice of community mobilization for HIV prevention as it emerges in parts of

the less industrialized world also has much to teach providers in this country. This practice has been inspired by the work of Robert Chambers and others who have pioneered approaches to increasing community participation in rural development projects. It is a practice that challenges traditional relationships between social programs and the communities they are intended to serve, emphasizing the resources and expertise that communities themselves possess and identifying the role of outside programs as one of facilitation and enabling. This approach to community mobilization uses a variety of participatory techniques, including drawing, diagramming, and drama/role play, to maximize community participation in program work.

The International HIV/AIDS Alliance, among others, has recognized the importance of participatory approaches to HIV needs assessment, program development, and evaluation. A recent report notes that:

The participatory nature of the work carried out during the community assessment phase helps many NGOs to better understand community vulnerability. Participatory assessments strengthen relationships between NGOs and communities, by requiring NGOs to listen and to ask questions of communities rather than making assumptions. . . . By actively involving the community in the assessment, a participatory process can also engender a community commitment to and ownership of the problems identified and responses planned. In this way, the assessment process helps to mobilise community concern about and action on HIV prevention.7

The benefits of community mobilization through a participatory practice of program development are becoming evident in the HIV prevention work supported by the International HIV/AIDS Alliance. For example in Bangladesh, the alliance has supported the Society for Health Education, Agriculture and Self Sufficiency (SHEASS), a local NGO, to organize community support for a harm reduction center for drug users. Prior to this initiative, SHEASS had run a detoxification center. But it recognized that not only was the center failing most of its participants, who did not complete the program or resumed drug use after leaving the center, it was also doing nothing to counter the extreme marginalization experienced by drug users in the wider community. Conducting a participatory community assessment, SHEASS staff heard firsthand about this marginalization: a female drug user asked, “If other people know that I use drugs then what will happen to me? . . . Society will push me in the street.”7

Staff used the participatory assessment process to begin community dialogue about the rights and humanity of people who use drugs. SHEASS argued that as members of the local community, drug users had the same rights to services and resources as the rest of the community, but the assessment made clear that the whole community was underserved by health and welfare services. In response, SHEASS converted the detox center into a harm reduction agency, offering a range of services to reduce the harm associated with drug use and offering basic health and welfare services to the broader community.

Conclusion

The U.S. response to HIV and AIDS has much to learn from places in the world that usually receive its assistance. An understanding of the HIV epidemic in terms of vulnerability, an inclusive conception of community, and a participatory approach to HIV program development could all make a significant difference to the way people think about and deal with AIDS in this country. But we must unlearn our “first” world privilege in order to learn these lessons.

Clearinghouse: Global HIV Issues

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If a vaccine that could stop HIV was found, it would be one of the most important public health tools of its time. Vaccines have been the key to the global control of other viral diseases. Vaccines have eliminated smallpox, nearly eradicated polio, and greatly reduced the harm of a number of other diseases. Vaccines are relatively cheap and accessible to countries in the developing world. The world needs an HIV vaccine. But once a vaccine is proven, the world will face the challenges of using it.

For a variety of reasons, ranging from science to politics to economics, candidate HIV vaccines have taken a long time to move beyond small-scale trials. Large-scale efficacy trials require thousands of at-risk people and massive logistical commitment. Currently, there is only one HIV vaccine efficacy trial underway, and a second will not start for at least another year. In the event that the current trial shows spectacular results, the trial might be stopped early; more likely, the data from this trial will not be available until 2002. But while researchers test new vaccine concepts in laboratories and clinical trials, those engaged in HIV prevention efforts need to begin thinking about what to do if a successful vaccine arrives.

If enough people are not vaccinated, their vulnerability extends beyond themselves.

Making Vaccines Work: It Takes a Village

Preventive vaccines against viral diseases train the body’s immune system to recognize and eliminate a virus before the virus arrives in the body. But not even the most successful vaccines work 100 percent of the time. At least some people remain vulnerable to a virus even after mass vaccination. Vaccination campaigns take advantage of the fact that as long as most people are mostly protected, a virus is left with fewer and fewer opportunities to spread. In diseases where the virus lives only in humans, this imperfect but much-improved defense of most people in a population can effectively eliminate the virus’s habitat, and the virus can eventually be eradicated from a population.

Implementing a vaccine program requires the cooperation of entire communities. If a critical mass of people remains unvaccinated, vulnerability to disease extends beyond this mass. The more that vaccinated people encounter people who carry the virus, the more likely it is that on one of those occasions, the virus may overcome the individual protection that community-wide vaccination provides.

The good news is that risk for HIV is not like that of quickly spreading diseases which spread through the air, water, or casual contact. This means that to have a significant impact on the epidemic, only those at high risk—not everyone in the world—would have to be vaccinated. The bad news is that most people do not see themselves as being at risk for HIV. And anywhere there is stigma against people with HIV, there will be social, political, and cultural barriers to vaccination.
The Hepatitis B Experience

The experience with the hepatitis B vaccine foreshadows some of the other problems an HIV vaccine might encounter. Hepatitis B is transmitted through sex and exposure to blood and spreads more quickly and easily than HIV. But, even many of the adults who most need a hepatitis B vaccine—for instance, gay and bisexual men in the United States—still do not get vaccinated.

A recent industry-funded survey conducted under the auspices of the Gay and Lesbian Medical Association (GLMA) showed vaccination rates just under 50 percent among one sample of urban gay men. The cost of vaccination for those without insurance coverage is surely part of the problem. But the survey showed that gay male patients who were open with their doctors about their sexuality were much more likely to have received the hepatitis B vaccine, suggesting that if getting an HIV vaccine requires announcing one’s potential risk for HIV, many people may remain unvaccinated.1,4

“Universal” HIV vaccination—that is, required vaccination—would also face substantial challenges. For instance, new laws in some U.S. states requiring hepatitis B vaccination for schoolchildren have encountered vocal opposition. Some parents believe that their children should not take even the marginal medical risk of vaccination; conservatives have particularly argued against childhood vaccination for a disease like hepatitis B, which they associate with behaviors they believe their children should never engage in anyway: sex and drug use.5,6

The Money Problems

The biggest barriers to distributing a vaccine, though, will probably be economic. If successful, most HIV vaccines currently in development would be produced using a series of new biotechnological manufacturing processes, many of which are patented and require royalty payments in addition to their often-high intrinsic cost. While the price of any future vaccine is difficult to predict, HIV vaccine prices could easily exceed the resources of many of the poorest countries in the world. Many of these countries also lack effective health care infrastructures, and so would need additional help in actually distributing vaccines.

Economic barriers, among others, affect not only the distribution of an HIV vaccine but also its development. The World Bank is currently working on the idea of a global purchase fund that would help buy HIV vaccine for countries in the developing world. Such a fund would support the distribution of a vaccine as well as allay investor fears about the size of the possible HIV vaccine market.7

The International AIDS Vaccine Initiative (IAVI), a non-governmental organization, is taking a different tack: funding vaccine research efforts in exchange for patent rights. If their funded research projects yield a successful vaccine, IAVI can trade patent rights to vaccine manufacturers in exchange for concessions on pricing and distribution. This socially-oriented venture capital approach has just started to fund research projects, so it is too early to know the strategy’s impact. But with a $25 million grant from Microsoft’s Bill Gates and millions more from the British government among others, IAVI has a good chance of having some effect.8

Planning for the Future

Clearly, the most important factor in the distribution of a successful HIV vaccine, once it arrives, would be the desire of people around the world to use such a vaccine. Thus, the demand for such a vaccine must be created well before it arrives. We can increase community understanding and desire for HIV vaccines in two complementary ways: by emphasizing the importance of HIV prevention generally (and thereby building a natural demand for a vaccine), and also by making education about the vaccine research process a part of HIV education. Since any HIV vaccine would by necessity be accompanied by ongoing HIV prevention efforts—probably undertaken by many of the same people who are engaged in these efforts today—prevention advocates should begin thinking now about how to make an HIV vaccine part of HIV prevention in the future.

Authors

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Global Interventions for Drug Users

According to a worldwide review of HIV prevention approaches for injection drug users, researchers in developing and transitional countries commonly undertake research to quickly obtain HIV risk and substance abuse information in order to develop appropriate policies, interventions, and programs. But, although many HIV prevention interventions in these countries have proven to be sustainable, the effectiveness of many of these programs has not been assessed.

The World Health Organization (WHO) Programme on Substance Abuse has developed a “Guide on Rapid Assessment and Response Methods for Drug Injecting” to standardize methodology for conducting action research. In addition, experts have begun to use non-standardized methods, including ethnographic studies, interviews with key community members, peer-administered questionnaires, and videotaping drug preparation and use.

Once this data is gathered, HIV prevention efforts must be developed with an awareness of cultural and societal restrictions on behavior change among injection drug users. In Ho Chi Minh City and Hanoi, for example, professional injector-dealers generally control all aspects of the injecting process, including administering injections. This leaves the injection drug user with little opportunity for determining if injection equipment is shared or cleaned. In response to such situations, interventions should target the injector-dealer as well as the drug user with strategies such as peer outreach programs utilizing former injection drug users and drug user advocacy groups.

In some countries drug users have formed drug users’ advocacy organizations, in part to implement HIV prevention programs. Some communities in Asian countries have set up drug treatment programs without government support or formal approval. These rely upon principles of community involvement and an integration of primary health care services. Some of these community-based drug treatment programs promote rehabilitation before detoxification, which encourages improvement in health status and social functioning while participants and their families prepare for detoxification and abstinence.

Although there have been no formal evaluations, anecdotal reports indicate that some of these programs are effective.

Prenatal HIV Testing in Africa and Thailand

A survey of studies of pregnant women in developing countries found that clients were more likely to accept and complete HIV counseling and testing if they had previously been tested for HIV, if they attended a site that offered voluntary counseling and testing services prior to the study, and as the number of local voluntary counseling and testing sites increased. The rate at which participants were willing to receive voluntary HIV counseling and testing ranged from 33 to 95 percent, depending on study site, with a median overall acceptance rate of 69 percent.

Results were based on responses to standardized questionnaires completed by 13 teams of researchers studying ways to reduce mother-to-child transmission in urban areas in sub-Saharan Africa and Thailand. Each individual study team agreed to offer routine voluntary HIV counseling and testing through their affiliated prenatal clinic.

During initial counseling sessions, a median of 92 percent of clients chose to continue with voluntary HIV counseling and testing. However, the number of clients who attended disclosure sessions varied with each clinic from 33 percent to 100 percent. Researchers found no correlation between the seroprevalence among clients at individual prenatal clinics and the percentage of clients who accepted voluntary counseling and testing.

Furthermore, increased use of services did not correlate with counselor training, with duration or techniques of pre-test counseling, or with particular clinical trials conducted at these clinics.

There was no correlation between seroprevalence and the percentage of clients who accepted counseling and testing at these sites.
A Successful Response to HIV in Thailand

After experiencing a rapidly growing HIV epidemic that began in 1987, Thailand has implemented a national response that has dramatically lowered rates of HIV infection, according to a review article of the literature on the Thai approach.

In a comparison of two national behavioral surveys from 1990 and 1993, the percentage of Thai men reporting premarital or extramarital sex dropped from 28 percent to 15 percent, the percentage visiting sex workers dropped from 22 percent to 10 percent, and consistent condom use with sex workers increased from 36 percent to 71 percent. Such behavioral changes have led to decreased rates of HIV infection. For instance, studies of HIV incidence among northern Thai military conscripts found a 10-fold decline between 1993 and 1995.

Active data collection monitoring national epidemiological, social, and behavioral trends has become crucial for understanding the causes of the epidemic and for guiding Thailand’s response. Regular dissemination of these data to different levels of the government and the public has helped to mobilize human resources, advocate for programs, and convince Thai society to act aggressively towards HIV prevention.

The success of Thailand’s response to the epidemic is due in large part to the cooperation of all segments of Thai society and a pragmatic approach. In 1991, Thailand initiated as a national policy the “100 percent condom program,” which enlisted the cooperation of sex workers to ensure condom use with clients. To support this program, the government also began to distribute almost 60 million free condoms a year to sex workers.

Further contributing to the effectiveness of the Thai response is the use of at least two avenues of prevention for each major target population. For example, out-of-school youth receive workplace education, exposure to mass media, and community-based peer education. The current phase of the response is placing greater emphasis on destigmatizing HIV infection and empowering infected people to be a resource for care and prevention.

Feasibility of a Continuum of Care

Using Zambia as a test case, a review article proposes the use of a model for a continuum of care for people with HIV that can be feasible and effective in resource-poor settings.

About 90 percent of the world’s HIV disease cases occur in resource-poor settings. People infected with HIV in these constrained environments face specific needs for food, shelter, access to primary care and empathy, social acceptance, and financial security for survivors. To address these needs, it is important to enable people to freely and easily move among levels of the care continuum extending from the home to the hospital and including various levels of care linked with strong discharge planning and referral networks.

Complementary to Zambia’s goal of decentralizing health services, a continuum of care at the district level would consist of community-based voluntary counseling and testing services, community-based home-care programs, health facility-based home-care programs, clinical and nursing care, blood transfusion services, a continuum of care coordinator, and technical committees for research, monitoring, evaluation, and training. The continuum of care coordinator would ensure that clients become linked to these services.
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