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Anna Persson

Martin Sjöstedt

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THE QUALITY OF GOVERNMENT INSTITUTE
Department of Political Science
University of Gothenburg
Box 711
SE 405 30 GÖTEBORG

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Abstract:

According to research, HIV/AIDS is not a disease among others but displays a number of specific characteristics. To begin with, it is primarily a sexually transmitted disease and hence involves a large number of taboos compared to many other diseases. In addition, the incubation period is extremely long compared to most other diseases. Furthermore, protection from HIV/AIDS demands sacrifices in the form of behavior changes within the (very) private sphere that not only involves material, but also non-material, costs. Since HIV/AIDS differs from other diseases in these regards, the combating of the disease demands a different approach compared to, for example, the combating of Malaria and Tuberculosis.

In this paper, we investigate whether these insights have penetrated the international donor community. Every year, billions of dollars are disbursed to fight HIV/AIDS. Yet, the progress has been slow and the disease continues to spread. By reviewing contemporary international HIV/AIDS policy, this paper tests if the lack of success in the fight against HIV/AIDS can potentially be explained by the misconceptualization of the disease on behalf of donors..

Anna Persson
The Quality of Government Institute
Department of Political Science
University of Gothenburg
anna.persson@pol.gu.se

Martin Sjöstedt
The Quality of Government Institute
Department of Political Science
University of Gothenburg
martin.sjostedt@pol.gu.se

Introduction

During the past decades, the worldwide spread of the human immuno-deficiency virus (HIV) has created one of the deadliest epidemics in history. In 2006, a total of 39.5 million people were living with HIV. Sub-Saharan Africa is clearly the most affected area of the world with more than 24 million people estimated to be infected with HIV in 2006 (UNAIDS & WHO 2007). Being home to merely 10 percent of the global population, sub-Saharan Africa is thus home to more than 60 percent of the HIV-positive people in the world.

The international donor community's policy response to the disease has been unprecedented. In the last decade, international and domestic funding for AIDS has increased from millions to billions, and by the end of 2007, AIDS funding reached nearly $10 billion. This represents an almost forty-fold increase since 1996 when the figure was $260 million (UNAIDS 2009). Much of the increase can be ascribed to a series of new funding initiatives and mechanisms such as UNAIDS, the Global Fund for AIDS, tuberculosis and malaria, the World Bank's Global AIDS Programme and the US President's Emergency Plan for AIDS Relief (PEPFAR). Domestic spending has also increased and now represents about one third of all the money going into the global AIDS response (UNAIDS 2009). Yet, despite all these resources, the disease continues to spread, and especially in sub-Saharan Africa. This paper aims at increasing our understanding about why the money does not seem to work for the people that need it most. As such, the paper asks: Why is it that people in sub-Saharan Africa continue to die from HIV/AIDS despite all the resources allocated to preventing the further spread of the disease?

In this paper, we argue that there is a need to reassess the problem of HIV/AIDS and that one potential explanation to why the international donor community's response to HIV/AIDS is partly ineffective is that it is based on a mischaracterization of the problem. More specifically, we argue that many assumptions that drive current HIV prevention strategies are unsupported by rigorous scientific evidence, and that AIDS programmes are as a consequence not adequately designed. For a start, the actors involved in HIV prevention lack a deeper understanding of the high costs and sacrifices involved in sexual behavior change. In addition, they have dismissed the fact that the HIV epidemic in sub-Saharan Africa is generalized and pre-dominantly heterosexual and as such requires other solutions than HIV epidemics in countries where transmissions are concentrated among sex workers, men who have sex with men, and injecting drug

users. Moreover, the causes to HIV have in many instances been misunderstood. While poverty, structural and gender inequalities, and the sexual behavior of so called high-risk groups do certainly increase the magnitude of the problem, the vulnerability to HIV infection does not ultimately depend on these factors.

In the remainder of this paper, we further develop the argument that one potential reason to why HIV continues to spread in sub-Saharan Africa despite extensive resources is that the actors involved are to a considerable extent misinformed as regards what kind of problem HIV is. In the first section, we critically survey the status of current research and ask what the research community has to say when it comes to the question of what kind of problem HIV/AIDS is and how it can best be combated. In the second part of the paper, we then explore how international donors define and characterize the problem of HIV/AIDS. In order to be able to assess the extent to which HIV prevention strategies are in fact supported by rigorous scientific evidence, we will analyze policy documents of the largest donors involved in HIV prevention, i.e. UNAIDS, Global Fund for AIDS, tuberculosis and malaria, the World Bank's Global AIDS Programme and the US President's Emergency Plan for AIDS Relief (PEPFAR). Given that current research provides an accurate characterization of the problem, the larger the mismatch between this characterization and the characterization given by the international donor community the more important it might be for international donors to reassess their policy on HIV/AIDS.

HIV/AIDS and the research community

The rapid spread of HIV in sub-Saharan Africa came as a surprise to most researchers. While virtually no one in Botswana was infected by the virus in 1985, 10 percent of pregnant women carried the virus in 1992, and by 2005 almost 40 percent did. In South Africa, prevalence rose from 5 percent in 1993 to 20 percent in 2005 (Epstein 2007). While in the industrialized parts of the world, HIV is by and large confined to well-known risk groups such as prostitutes, injecting drug users, and men who have sex with men, the disease has struck quite differently in Africa where HIV is today a generalized, mainly heterosexual disease (Potts et al. 2008). Especially, heterosexual women are at risk of getting infected. In fact, young women aged 15-24 are up to 2.5 times more likely to be infected than men belonging to the same age group (WHO 2004).

In this section of the paper, we critically survey the scientific literature aiming to explain why HIV rates in Africa are comparatively high. As such, we first explore the

large literature emphasizing the materialistic and capacity aspects of the spread of HIV. In this literature, HIV has been viewed mainly as a developmental and structural problem, and the role played by sexual behavior has not been explicitly addressed. Yet, given the lack of success of preventing the further spread of the disease, recent research more explicitly address the role played by sexual behavior (Oster 2007; Stoneburner & Low-Beer 2004; Kirby 2008). This literature is discussed in the second part of this section. In the third part, we then discuss theories of behavior change. The literature on behavior change has mainly been concerned with the question of why people continue to dice with death despite the great amount of resources and information available. There is now a growing consensus that the reason why people continue to engage in risky sexual behavior is that protection against HIV demands sacrifices that are potentially very costly (Lieberman 2007). In the fourth part of this section we discuss the implications of this recent research when it comes to the question of what should be done to prevent the further spread of HIV.

The characterization of HIV as a problem of lack of resources, information, and political will

Until quite recently, the social scientific literature on HIV/AIDS in sub-Saharan Africa tended to treat HIV as a disease among others. Consequently, the rapid spread of the disease was commonly attributed to the usual suspects when it comes to public health crises of poor countries, such as a lack of material resources, information, and political will. According to this literature, if only development issues and structural inequalities are taken care of the spread of the disease will take an ending. Especially ***poverty*** has been seen as a major factor contributing to the spread of the disease both *directly* in the form of lack of power, education, material resources and choice, and *indirectly* in the form of the increased vulnerability to other diseases brought about by poverty – such as Malaria and Tuberculosis – which by impairing the immune system increase the risk of getting infected by HIV/AIDS (Abu-Raddad, Patnaik & Kublin 2006).

A related factor which has commonly been put forward in the literature is ***weak state capacity***. According to the state capacity explanation, a major reason to why HIV continues to spread in Africa is the general lack of administrative skills, effective systems, health facilities and educated personnel available to the state to carry out its functions in terms of HIV/AIDS prevention in the region (Gauri & Lieberman 2004; Swidler 2003). In some instances, the lack of state capacity is even a result of the rapid

spread of HIV since the loss of civil servants to HIV/AIDS, with their training, expertise, and networks of personal contacts, hampers the state's ability to provide services, including AIDS prevention and treatment programs (de Waal 2003). In this sense, researchers argue, a weak state capacity and the spread of HIV/AIDS tend to form a vicious circle which is very difficult to break.

Yet another account that has commonly been put forward is the role played by ***political leadership*** (Gauri & Lieberman 2004; Parkhurst & Lush 2004). In fact, it has become close to conventional wisdom to attribute the policy successes of countries such as Uganda to good leadership, and South Africa's stalled response to poor leadership (Gauri & Lieberman 2004; Swidler 2003). Probably no world leader has been more rebuked for his statements on HIV/AIDS than the South African president Mbeki, leading many to conclude that it is due to his personal negligence that the South African response has been so weak.

In sum, until recently, the literature on HIV/AIDS commonly assumed that the spread of HIV/AIDS could largely be attributed to the lack of resources, information, and political will. However, to most people's surprise, the empirical evidence does not entirely support such a claim. For example, while recognizing that Mbeki's words and deeds certainly have had a negative influence on the prevention of HIV/AIDS in South Africa, given the fact that for example Botswana is far ahead most other African countries in terms of openness and commitment of its leaders but still faces among the highest HIV prevalence rates on the continent, researchers now argue that it is problematic to attribute variation in HIV/AIDS prevalence only to individual leaders (Persson & Sjöstedt 2008; Gauri & Lieberman 2004; Patterson 2006). Similarly, while poverty certainly makes the disease even more difficult to live with, it can still not explain why HIV is many times more widespread in Africa than in other poor regions of the world. Nor can it explain why the most impoverished, parasite infected, and war-torn countries such as Liberia, Congo, Sierra Leone, and Somalia have low HIV prevalence rates while rich and peaceful countries such as South Africa and Botswana are so severely affected. In addition, there is evidence indicating that within the richer countries it is in fact not the poorest people that are at the highest risk but rather traders, small-scale businessmen, and other relatively rich and healthy people. Moreover, if we look at Botswana and South Africa – two of the strongest and wealthiest states in Africa – they are still among the weakest when it comes to the capacity to stop the spread of HIV/AIDS (Epstein 2007). Furthermore, while Malaria

rates in Botswana and South Africa are low compared to most other African countries, HIV/AIDS prevalence rates are still among the highest on the African continent.

Taking the limits of more materialistic and capacity-oriented approaches to HIV/AIDS seriously, there has recently been a shift in the HIV/AIDS literature. More specifically, while not dismissing the fact that material resources and the political capacity to actually provide and channel resources are important factors when it comes to preventing the spread of HIV/AIDS, more recent approaches have increasingly emphasized the importance of sexual behavior change for preventing the spread of HIV/AIDS, as well as the costs and sacrifices involved in such behavior change on behalf of individuals. In the next section, these new scientific findings are discussed further.

The characterization of HIV as a result of risky sexual behavior

There is now a general consensus holding that variation in the spread of HIV/AIDS can by and large be understood as a result of variation in patterns of sexual behavior (Kirby 2008; Oster 2007; Persson & Sjöstedt 2008; Epstein 2007; Potts et al. 2008; Green et al. 2006). Yet, since the onset of the epidemic in Africa, researchers have debated what kind of sexual behavior that is in fact the most "risky" in terms of that it leads to the rapid spread of HIV. In the beginning of the epidemic, researchers argued that HIV was spreading rapidly in some parts of Africa because people had a sexual behavior characterized by high rates of casual and premarital sex (Caldwell, Orobuloyeb & Caldwell 1999). This research also pointed to the desire to have many children, the tradition of polygamy, and the relative freedom of many African women. Other researchers pointed to exotic African customs such as widow cleansing where a village elder gets to sleep with all newly widowed women, or dry sex where plants and substances are used in order to increase friction. However, since such sexual customs are quite rare, and people in most AIDS-afflicted areas actually practice wet sex, recent research has began to question the viability of such interpretations. Moreover, recent research has confirmed that Africans are not more promiscuous than people in other regions of the world. More specifically, sexual debuts occur generally at the same age in Africa as in Europe or the United States. Moreover, Africans report roughly similar, if not fewer, lifetime partners than do people in the West, and considerably fewer than in many countries in Asia, where prostitution is far more common (Epstein 2007). Yet, HIV prevalence is orders of magnitude greater in southern Africa compared to in both Asia and the West.

A different argument is that Africans are more vulnerable to HIV since there traditionally has been a comparatively high degree of sexual mixing between so called high-risk groups and everyone else (Garnett & Anderson 1993). According to this argument, sex across social boundaries – between rich and poor, urban and rural, old and young – creates an "epidemiological pump" that makes the disease spread more quickly. Since the majority of the AIDS patients in East African hospitals in the 1980s were either prostitutes or migrant workers this explanation made sense in the early years of the epidemic. Consequently, researchers advocated that policies and interventions should target prostitutes, mine workers, truck drivers, soldiers, and other migrants, and provide them with condoms and treatment for other sexually transmitted diseases. However, in the 1990s the virus began to spread to men and women in general, and teachers, shopkeepers, and policemen were now as likely to be infected as were prostitutes and migrant workers. This made a large number of researchers question the argument that risky sexual behavior is the behavior conducted by the traditional high-risk groups of men who have sex with men, injecting drug users, and sex workers and their typical clients (i.e. truck drivers, mine workers, soldiers, traders, and other migrant men). As argued by Epstein (2008), the paradox was apparent not only to AIDS researchers, but also to people who had watched numerous non-promiscuous friends and relatives succumb to the disease. In line with this insight, researchers are now arguing that other types of sexual behavior than the ones discussed above are in fact more risky, and one of the main reasons to why HIV continues to spread. More specifically, a large number of researchers now argue that multiple, concurrent partnerships are among the most important components of risky sexual behavior (Epstein 2008; 2007; Halperin & Epstein 2004; 2007; Morris & Kretzschmar 1997; Mah & Halperin 2008; Potts et al. 2008).

Multiple, concurrent partnerships mean that people have more than one, long-term relationship at the time. As such, multiple, concurrent partnerships link sexually active people up in a giant network, connecting them not only to one another but also to the partners of their partners' partners — and to the partners of those partners, and so on — via a web of sexual relationships. As argued by Epstein (2007, 2008), this pattern of behavior creates a superhighway for HIV since, if one person is infected, everyone else is also at high risk, including those with only a few long-term partners. For example, research has shown that in societies where concurrent partnerships are common, women are at high risk of getting infected although they are faithful to their

husbands (Mah & Halperin 2008). Moreover, since the viral load, and thus infectivity, is much higher during the initial weeks or months after infection, a recently infected person is much more likely to transmit the virus than a person who has been infected for a while. Thus, when a serially monogamous HIV-positive person eventually finds a new partner, his/her ability to infect has been reduced. Someone at the hub of a network of concurrent relationships, however, is likely to infect all of his partners very rapidly when he/she is first infected. By contrast, serial monogamy traps the virus within a single relationship for months or years. According to the same logic – and quite ironically – sex with an infected prostitute may actually be safer than sex with someone in a network of long-term concurrent relationships. In addition, the clients of prostitutes are more likely to use a condom than are people involved in relationships in which there is a degree of intimacy and trust, such as in long-term concurrent relationships.

In sum, recent research suggests that long-term concurrency might be an important factor explaining the size of an HIV epidemic, the speed at which it infects a population, and its persistence within a population (Mah & Halperin 2008). Since long-term concurrency is far more common in Africa than in Asia and in the western hemisphere, there is good reason to believe that this factor is of importance for explaining the severity of the disease in Africa. Parallel to this new notion of risky sexual behavior, research within the area of sexual behavior change has focused on the factors that impact on the propensity of people to actually change their sexual behavior. In the next section, we explore this literature more in detail.

HIV as politics of sacrifice

Given the increased emphasis on the behavioral aspects of the spread of HIV, researchers now ask why a large number of people – and even those living in countries with access to condoms and information about the dangers of HIV – continue to dice with death by taking sexual health risks. A large number of researchers now agree that the reason why people continue to take sexual health risks is that engaging in safe sex demands *sacrifices* on behalf of individuals. The long incubation period of AIDS implies that behavior changes often imply higher costs at least in the short term than getting infected by the disease (Oster 2007). The costs can be both material and non-material in kind. More specifically, HIV/AIDS prevention demands individual sacrifice in the sense that it involves the acceptance of new information, including public sexual education campaigns and/or discussions about abstinence and partner reduction. As argued by

Lieberman, such campaigns can be upsetting because they implicate members of society in the practice of sexual behavior that they often would prefer to remain completely private. AIDS policies have also involved the testing of the blood of citizens, and monitoring knowledge of the epidemic and sexual behavior which has often been viewed as a nuisance and/or potentially embarrassing and maybe even frightening (Lieberman 2007). In the process of childbirth, AIDS policies have included direct interventions such as mandatory blood tests, placing HIV-positive women on drug therapies, and the requirement that they deliver babies by caesarean-section in order to prevent viral transmission. AIDS policies have furthermore demanded that HIV-positive women refrain from breast-feeding, which is a particularly significant sacrifice in societies where breast-feeding is widely practiced and valued. Not to breast-feed in such societies is often understood as a public display of HIV status (Lieberman 2007).

Attempts to stop the spread of the disease have in addition involved demands for behavior changes such as condom use, abstinence, and partner reduction (Oster 2005). These behavior changes can potentially be costly in many different ways, and especially for women. For example, since women often depend economically on their husbands or boyfriends, it is often impossible for them to refuse sex or negotiate for condom use even if they know that their partner has had other sexual relationships (Patterson 2006). Furthermore, since motherhood is crucial for many women's identity, women may also be less likely to request their husband to use condoms, since this protection prevents pregnancy. For the very same reason, marriage has in fact become an additional risk factor for contracting HIV in countries with high HIV prevalence levels (Patterson 2006). Additionally, since the welfare system is under-developed in most poor countries, children act as an economic as well as a social insurance for the household. Consequently, the alternative cost for giving up children is rather high in most developing countries not only for personal reasons, but even for economic ones.

In sum, what the literature referred to above argues is that, in order to successfully stop the spread of HIV/AIDS, people must perceive the costs involved in sexual behavior change to be lower than the costs involved in refraining from such change. While previous attempts to stop the disease have recognized some of the costs involved, they have focused more on the direct economic costs such as, for example, expenses for condoms and tests. As such, what this literature – if not yet explicitly – assumed was that if only people got access to information and condoms they would also change their behavior and the spread of HIV/AIDS would be hampered. Consequently

the previous literature has commonly ignored other important costs involved such as taking in new information, and accepting the need for sexual behavior changes and preventive care. Without such acceptance of intrusions into the private sphere, reducing the cost of condoms risks having only limited impact. In the next section, we discuss the implications of these findings for the future fight against HIV/AIDS.

Implications – what should be done according to research?

In the previous sections of this paper, we have revealed the limitations of material and capacity oriented explanations to the spread of HIV/AIDS. In addition, we have explored the literature that focuses on the behavioral aspects of the spread of HIV. This literature reveals a shift in the notion of what comprises risky sexual behavior. While in the early days of HIV research, prostitutes and migrant workers were singled out as so called high risk groups, recent research now point to the fact that it is the practice of multiple and concurrent partnerships that has contributed most significantly to making HIV a generalized and predominantly heterosexual epidemic in many African countries. Following from this insight, there is now a large literature arguing that sexual behavior change demands costly sacrifices on behalf of individuals. While these costs can be material as well as non-material, there are indications that it is predominantly the latter category that plausibly explain why people do not change their sexual behavior and for example abandon the practice of multiple and concurrent partnerships. This section specifies the implications of these arguments when it comes to HIV prevention.

To start with, since long-term, concurrent partnerships seem to be a main factor behind the spread of HIV, HIV programmes should focus on partner reduction, i.e. on the B (for be faithful) in the widespread ABC campaigns (where A stands for abstinence and C for condoms). More specifically, they should encourage people to stick to one partner and hence not engage in concurrent partnerships. As has been argued in some research, an alternative to partner reduction (and probably a better one) is to encourage condom use. However, as previous research has demonstrated, this approach has by and large been ineffective. This is because the intimacy and trust that identifies many long-term relationships tend to reduce condom use.

Secondly, since HIV is a generalized problem in sub-Saharan Africa, prevention campaigns should focus not only on so called high risk groups but rather be universal and broad in scope. As such, HIV prevention programmes should be framed and fought as a collective problem, rather than as a problem belonging to the state, certain groups

or individuals. The focus should consequently be on broad social change and every sexually active person, i.e. not only on the sexual behavior of the so called high-risk groups such as sex workers, gay men, injecting drug users, and their sexual partners. Being a disease that strikes against everyone in society, it must also engage everyone. In short, since research demonstrates that HIV poses a huge threat to *everyone*, including those with few, or even just one, trusted long-term partner, what is needed is a reformulation of the notion of risky sexual behavior.

Thirdly, given the non-material sacrifices involved in sexual behavior change – such as accepting new information and acting on the recommendations – the actors involved in HIV prevention must be perceived as legitimate. In addition to the access to material resources, what is at stake if the spread of the pandemic is to be stopped is, in other words, that individuals in a first step perceive such intrusions into the private sphere to be *legitimate*. First when this is case, they will act upon the recommendations given by the state or other actors. In other words, it is reasonable to assume that the ability of the main actors involved in trying to stop the spread of HIV/AIDS to intrude into the private sphere and foster behavior conducive to the prevention of HIV/AIDS depends on the degree to which citizens perceive their recommendations and actions as legitimate. The more currency in terms of perceptions of legitimacy available to main actors, the stronger capacity they will have to prevent the spread of the disease. This aspect of HIV prevention has been recognized particularly in the literature on AIDS governance (Strand 2007). More specifically, this literature has been concerned with what institutional arrangements make responses to HIV/AIDS more effective. Particularly, the AIDS governance framework has emphasized the importance of exploring the role played by various government structures and governance regimes in order to understand the spread of HIV (Heywood 2002). For example, there has been a discussion regarding whether human rights-oriented or more authoritative AIDS governance regimes are the most effective in combating HIV/AIDS. While for a long period of time the human rights approach – stating that HIV testing must be voluntary and confidential, and risk groups and people living with HIV must not be stigmatized – was commonly assumed to be the most effective one, researchers have more recently began to questioning this approach, instead arguing in favor of more authoritative approaches (Strand 2007). Yet, since research has so far not produced any straightforward answers to the question of which actors are the most legitimate when it comes to HIV prevention, rather than suggesting a specific type of actor scholars now

suggest that the most effective response probably is multi-sectoral and engage a wide variety of national participants. In particular, responses should encourage open communication about AIDS and the activities that put people at risk of infection, while at the same time combating stigma and discrimination. As such, the fight against HIV should be patriotic duty, requiring openness, communication, and strong leadership from the village level to the State House (Green et al. 2006). By involving the affected communities themselves in programme design and implementation, it is ensured that the programme is carefully tailored to the communities' needs, and that it is seen as something done "with them" rather than "to them". The work of small community-based organizations has been vital to each of these successful programmes. It is argued that strong non-governmental organization and community-based support produce flexible, creative and culturally appropriate interventions that help facilitate individual behavior change as well as changes in community norms, despite extreme levels of household poverty. Such "low-tech" approaches is said to have led to the sensitization and subsequent involvement in AIDS awareness and education of not only health personnel, traditional healers, and traditional birth attendants, but influential people normally not involved in health issues such as political, community and religious leaders, teachers and administrators, traders, leaders of women's and youth associations and other representatives of key grassroots community groups (Green et al. 2006; Kirby 2008; Wilson 2004).

Finally, the fact that younger women are at 2.5 times higher risk of getting infected by HIV compared to men in the same age has led to a lot of research on the impact of gender inequality on the spread of HIV/AIDS. According to this research, the reason why HIV spreads so rapidly in sub-Saharan Africa is that women in this region is comparatively more vulnerable to sexual abuse – and hence HIV – since they have fewer legal rights and less access to education, material resources, and paid work than women in other parts of the world. Consequently, it is often impossible for them to refuse sex or negotiate for condom use even if they know that their partner has had other sexual relationships (Patterson 2006, Walker et al. 2004). In other words, for HIV programmes to be successful they should focus explicitly on gender relations and the expectations women and men respectively have on their partners and relationships.

In sum, the implications derived from recent research on the spread of HIV/AIDS in Africa are that – in order to be effective – the actors involved in the fight against HIV/AIDS should promote condom use and partner reduction, focus on all groups in

society, aim at including as many stakeholders as possible in the process in order to gain legitimacy, and focus on gender relations. In the next section, we explore what has actually been done to prevent the further spread of HIV.

The characterization of HIV in the donor community

This section investigates to what extent the new research findings presented above have penetrated the donor community. As such, we first give an account of the main actors involved, and then we analyze their policies. What is being done on the issue of HIV/AIDS?

The main actors involved

The main actors involved in the fight against HIV/AIDS are UNAIDS, Global Fund for AIDS, tuberculosis and malaria, the World Bank's Global AIDS Programme and the US President's Emergency Plan for AIDS Relief (PEPFAR).

PEPFAR is United States' initiative to combat the global HIV/AIDS epidemic, launched in 2003. As of 2008, $18 billion had been spent and plans to extend the spending for further years are being negotiated. The Global Fund is an independent public-private partnership that was first proposed by the United Nations' Secretary-General, Kofi Annan, in 2001, and officially came into being in 2002. The objective is to raise funds and pool money from governments, businesses and individuals around the world, and channel them into programmes to fight AIDS, Tuberculosis and Malaria. By May 2008, The Global Fund had distributed a total of US$5.67 billion. Around 58 percent of these funds have been spent on HIV and AIDS (Avert 2009). The World Bank is another large multilateral donor to the HIV/AIDS response in developing countries. By the end of 2006, its Global AIDS Programme had dispersed US$879.22 million to 75 projects to prevent, treat and reduce the impact of HIV and AIDS (Avert 2009). The World Bank is together with the Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), and the World Health Organization (WHO) cosponsors of UNAIDS, founded in 1996. According to the official statement, UNAIDS' mission is to lead, strengthen and support an expanded response to HIV and AIDS. This includes preventing transmission of

HIV, providing care and support to those already living with the virus, reducing the vulnerability of individuals and communities to HIV and alleviating the impact of the epidemic. Five major components make up the role of UNAIDS: 1) Leadership and advocacy for effective action on the epidemic; 2) Strategic information and technical support to guide efforts against AIDS worldwide; 3) Tracking, monitoring and evaluation of the epidemic and of responses to it; 4) Civil society engagement and the development of strategic partnership; 5) Mobilization of resources to support an effective response. UNAIDS estimates that by 2010 US$15.077 billion will be needed to achieve universal access to HIV prevention (Potts et al. 2008).

Policies on HIV/AIDS

As argued previously, the implications derived from recent research on the spread of HIV/AIDS in Africa is that, in order to be effective the actors involved in the fight against HIV/AIDS should: 1) promote condom use and partner reduction; 2) focus on all groups in society; 3) aim at including as many stakeholders as possible in the process in order to gain legitimacy, and; 4) focus on gender relations. In this next section, we explore the extent to which the international donor community shares this characterization of the problem of HIV.

First, when it comes to the promotion of condom use and partner reduction, most donors apply the ABC approach. Yet, they vary in terms of the definition of this approach. For example, PEPFAR follows an ABC strategy through "population-specific interventions" that emphasize:

- **A**bstinence for youth, including the delay of sexual debut and abstinence until marriage
- **B**eing tested for HIV and being faithful in marriage and monogamous relationships
- **C**orrect and consistent use of condoms for those who practice high-risk behaviors.

For UNAIDS, on the other hand, ABC means:

- **A**bstinence or delaying sexual debut
- **B**eing safer by being faithful to one partner or by reducing the number of sexual partners

- **C**orrect and consistent use of condoms for sexually active young people, couples in which one partner is HIV-positive, sex workers and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure.

However, while the importance of condoms and partner reduction is widely recognized among most international donors, few have recognized the importance of refraining from long-term concurrent partnerships. In fact, until 2006 the public documents of UNAIDS did not even mention long-term concurrency, and until 2008 UNAIDS statistical reports in sexual behavior did not include any information on multiple sexual partnerships, let alone long-term concurrency (Epstein 2008). Moreover, although UNAIDS surveys nowadays report sex in the past year with a non-regular partner, this variable fails to capture people who have multiple long-term concurrent partners, and who are thus at high risk of infection themselves and of passing the infection to others. In 2008, the agency's report on the global AIDS epidemic was even accused of using a flawed analysis of two epidemiological studies to cast doubt on the concurrency hypothesis. In addition, it ignored a large body of evidence in favor of the theory (Epstein 2008). UNAIDS has no practice documents dealing with the risks posed by networks of long-term concurrent partnerships. The organization's "Know your Epidemic, Know your Response" studies rely on models that do not account for long-term concurrency and make assumptions about sexual behavior that behavioral studies do not substantiate. In fact, for years the agency misrepresented the fall of HIV prevalence in Uganda as being the result of condoms and abstinence, even though a large number of independent reports show that partner reduction was the most important behavioral shift. Likewise, UNAIDS has consistently attributed the HIV declines in Thailand and the US gay community to condoms alone, even though partner reduction played a prominent part in these cases too. The UNAIDS 2008 report also stated that increases in multiple sexual partnerships occurred in countries where infection rates had recently declined, even though evidence for such increases does not exist (Epstein 2008; Potts et al. 2008).

Similar to UNAIDS, the Global Fund and the World Bank's Global AIDS Programme do not explicitly discuss the issue of concurrency. While they focus on the importance of having sex only with spouses or regular partners, they pay less attention to the number of regular partners people have at the same time. In comparison, PEPFAR has been quite progressive when it comes to the question of faithfulness. In fact,

PEPFAR is the only actor to explicitly advocate monogamy. PEPFAR's financial guidelines state that in countries where HIV is generalized, at least half of all funds directed towards prevention should be for activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction (Avert 2009). However, there are reasons to believe that PEPFAR, rather than basing the policy on scientific evidence of what is most effective in combating HIV/AIDS, allocates money largely on a moral basis. Although one would think that the bases of recommendations are less important than the actual recommendations, PEPFAR's moralistic approach has sparked a lot of controversy both between PEPFAR and other donors and between PEPFAR and partner countries. On the one hand, this has led to a less harmonized aid policy. On the other, the moral foundation on which PEPFAR's policy is based has led some organizations to refuse funding from the organization. In particular, PEPFAR's condom policy has been criticized.

The critique directed against PEPFAR on this matter is in fact much in line with the ***second*** implication derived from recent research, i.e. that HIV prevention programmes should focus on *all* groups in society, and not target only certain groups. According to PEPFAR's policy, condom promotion is only directed towards those who practice what has traditionally been viewed as high-risk behavior, i.e. the behavior of prostitutes, sexually active discordant couples (in which one partner is known to have HIV), substance abusers, and others. Condoms are thus not provided or promoted to young people in general. Organizations promoting condoms beyond so called high-risk groups have therefore refused funding from PEPFAR since they believe PEPFAR's condom policy might lead to re-stigmatization of condoms, and will promote the notion that condoms do not work as a form of HIV prevention. In particular, the Global Fund has criticized PEPFAR on this notion, and much has been made of the apparent rivalry between these two organizations. However, when it comes to the importance of focusing on all groups in society, the Global Fund has actually had a very similar record. More specifically, while briefly mentioning the need for sustaining behavior change campaigns to the general population, the Global Fund still primarily advocates a focus on what they call "vulnerable populations", i.e. marginalized and stigmatized groups such as sex workers, injecting drug users, and men who have sex with men. To the extent that they actually recognize that HIV goes beyond these traditional high-risk groups, they primarily focus on the clients of sex workers, i.e. men who go to prostitutes, and the role they play in infecting their own wives. As regards the question of risk groups, UNAIDS and the World Bank are not much different from PEPFAR and the

Global Fund. In the World Bank's Global HIV/AIDS Program of Action, drug users, men who have sex with men, and sex workers are pointed at as populations at high risk of infection (World Bank 2005). When it comes to estimations of where resources are most needed, UNAIDS stipulate that a total of 42 percent of the resources should be allocated to preventing HIV in high-risk groups, identified as sex workers, injecting drug users, men who have sex with men, prisoners etc. (Figure 1).

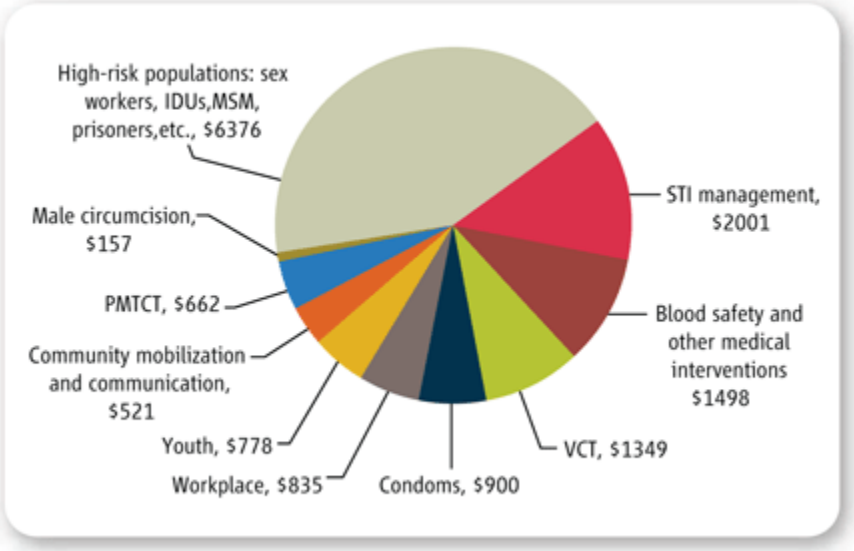

Figure 1. *UNAIDS resource allocation estimates to achieve "universal access" to HIV prevention by 2010 (Potts et al. 2008)*

By only targeting these groups, UNAIDS – as well as the other donor agencies – do not recognize that in a generalized epidemic *everyone* is at risk, and especially when multiple, concurrent partnerships are common. As such, most people continue to be unaware of how risky their behavior in fact is. As argued by Epstein (2008), the near exclusive emphasis on so called high risk groups may in fact be the most destructive misconception about HIV/AIDS in Africa. More specifically, it may have hindered prevention and promoted denial and stigma by implying that people with HIV are necessarily "promiscuous". This stigmatization may also have been a contributing factor to domestic violence, especially since many infections are not – as is commonly assumed – brought into the relationship by the man, but by the woman (Potts et al. 2008).

The ***third*** implication from recent research is that prevention programmes by and large are ineffective if not perceived as legitimate by the targeted populations. In order to maximize legitimacy they should be multi-sectoral and engage a wide variety of national participants. The international donors in one way or another all seem to emphasize community participation and civil society engagement. In general, the first generation of prevention programs recognized the importance of mass information, education, and communication campaigns to raise awareness, and social marketing to increase condom availability. There were also imperatives to foster self-help and empowerment amongst those who were already infected by the disease, particularly by supporting self-help groups and disseminating techniques to encourage individuals to testify publicly. These were considered an important tool for building awareness and contributed to growing activism on the part of African people with HIV/AIDS. Moreover, the legacy of Jonathan Mann (former director of WHO's Global Program on AIDS in the early years of the epidemic) has been to enshrine human rights as an anchoring principle of the response: specifically, HIV testing must be voluntary and confidential, and risk groups and people living with HIV must not be stigmatized (Lesley 2008). More pragmatically, this has translated into widely, if not necessarily explicitly adopted, affirmative action policies that call for greater involvement especially of people living with HIV, and communities affected by HIV, in the response to the epidemic.

However, the attempts to involve civil society in HIV programmes have been quite heavily criticized. For example, in an article from 2004, Nguyen and Stovel argued that community mobilization programmes have largely been "cookie-cutter campaigns" fashioned out of standardized strategies and interventions applied throughout the world, often by the same consortia of NGOs and international aid donors (Nguyen & Stovel 2004). In fact, with the point of departure in the chart of UNAIDS' resource allocation estimates (Figure 1), you cannot help but wonder if the emphasis on community participation is rhetoric rather than an actual basis for policy. In UNAIDS's estimation of the resources needed to achieve universal access to HIV prevention, a mere 3.5 percent go to community mobilization and communication.

Of the implications derived from recent literature, it seems to be the ***fourth*** implication – i.e. the need to take gender into account – that has gained the strongest support in the international donor community. For example, the World Bank (2005) recognizes the increasing feminization of the disease and that women – and particularly young women and girls – are made especially vulnerable to the disease by physiological

and social factors. In a similar vein, UNAIDS identifies gender inequality as one of the main drivers behind the spread of HIV. In 2006 Peter Piot, the former Executive Director of UNAIDS, stressed the need to address the drivers of the epidemic:

> "It is patently clear that we need to make real headway against the fundamental drivers of this epidemic, especially gender inequality, stigma and discrimination, deprivation and the failure to protect and realize human rights. This challenge is perhaps the greatest of all those facing the AIDS response. And there can never be a technological fix for these social issues. We need positive social change – and all of us in the AIDS effort must be willing to back this. I am increasingly convinced that just expanding programmes, doing more, even much more, is not going to stop this epidemic. To reach universal access to HIV prevention and treatment care and support, we need to pay attention to the drivers." (UNAIDS 2007).

Priority actions to address gender inequalities among other things include the recognition of the importance of open communication about gender relations and women's empowerment and laws and policies that protect women and girls against sexual violence and gender discrimination of all kinds. It also advocates a larger involvement of women in policy- and decision-making on AIDS. Moreover, all the international donors support national governments in their attempts to expand access to sexual and reproductive health care programmes and integrate HIV into these, promote campaigns and community dialogue to change harmful gender norms, engage men and boys and eliminate violence against women and girls, keep girls in schools and make schools free of sexual violence and exploitation, and build the capacity of women's organizations and gender equality organizations as key partners in the development of national AIDS strategies. In other words, while none of the international donors seem to be in the forefront as regards community mobilization in general – i.e. community mobilization which goes beyond the traditional high-risk groups – the gender dimensions of HIV/AIDS prevention seem to be considerably more comprehensive and all-encompassing in both policy and practice. However, if this more comprehensive approach towards gender should have a chance to have a more sustained impact on HIV prevalence rates, condoms and partner reduction need to be included as well.

Summary and conclusions: The continuing spread of HIV

This paper demonstrates that there is to some extent a mismatch between research and policy when it comes to how the problem of HIV/AIDS is characterized. Given that recent research accurately characterizes the problem of HIV, this mismatch may be partly to blame for the continuing spread of HIV/AIDS in sub-Saharan Africa. More specifically, comparing the policy and practice of the largest international donors with recent research findings, this paper finds that there are two major mismatches between research and policy.

First, the international donor community tends to mischaracterize the notion of risky sexual behavior. According to recent research on multiple concurrent partnerships, risky sexual behavior does not exclusively involve the usual suspects, i.e. prostitutes and their clients, men who have sex with men, and injecting drug users, but *everyone*. The implications of this finding are twofold: A) Since long-term concurrent partnerships seem to be a main driving force behind the spread of HIV, prevention programmes should focus on partner reduction. B) In order to be successful, HIV prevention programmes should focus on all members in society. That is, they should not target so-called high-risk groups, but rather be universal. Yet, as demonstrated in this paper, the main donors involved in HIV prevention continue to view the usual suspects as the main targets for HIV prevention campaigns. In addition, they do not pay any explicit attention to concurrency.

Secondly, in comparison to the academic literature international donors do not sufficiently recognize the fact that sexual behavior change is potentially costly, and especially for women. According to recent research, these costs can be both material and non-material in kind as they involve such things as money for condoms, accepting new information, and other intrusions into the private sphere. The implications of this finding are twofold: A) In addition to the access to material resources, what is needed in order for the disease to be prevented is that people perceive intrusions into the private sphere to be legitimate. Consequently, donors should aim at including as many actors as possible in the process and encourage open communication. That is, they should promote multi-sectoral, community mobilization. B) Since women are at 2.5 times higher risk of getting infected, and are as a consequence of gender inequality often not able to negotiate for condom use, in order for HIV campaigns to be effective they should more explicitly continue to focus on gender relations and the expectations women and men respectively have on their partners and relationships.

In conclusion, as demonstrated in this paper, some of the assumptions that drive current HIV prevention strategies are unsupported by rigorous scientific evidence. Consequently, there is a risk that many AIDS programmes do not reach their full potential. While it cannot be certain that acting upon the implications of recent research will solve the problem of HIV/AIDS, the urgency of – and great human suffering caused by – the epidemic calls for the employment of all possible means.

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