The long war

Manuela Moraru and colleagues review the complex challenges presented by HIV/AIDS

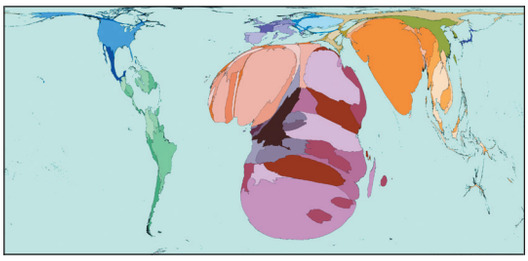
Can you think of a cause that in some countries has led to the death of almost an entire generation, and the prevalence of which continues to increase? HIV/AIDS fits this description. More than 25 million people have died of AIDS since it was first diagnosed in the early 1980s. Almost three million of these deaths occurred in 2005.[w1] The figure shows the worldwide distribution of people living with HIV/AIDS.

Recent international agreements on the need for an integrated approach to HIV/AIDS have resulted in the allocation of large amounts of money for many organisations. For example, the Global Fund to fight AIDS, tuberculosis, and malaria was established in 2002 as a partnership of governments, civil services, the private sector, and affected communities. It currently mobilises 20% of international financing to combat HIV/AIDS.[w1 w3] Unfortunately only one in every six Africans in need of treatment receives it.[w1] The "lessons learnt so far confirm that success in the global fight against HIV/AIDS does not come without great effort."[w4] So it is valuable to reflect on where this effort has taken us and the future direction of AIDS work.

Taking on the pandemic

We identify two levels of intervention directed to the general population: prevention of new infections and treatment and care of people infected with HIV. These two aspects must be considered together.[w5]

Designing integrated, widely accepted programmes is certainly not enough to assure effective results. Developing national AIDS strategies and single national bodies to coordinate HIV/AIDS related activities is considered crucial in a comprehensive and effective fight against HIV infection. Resources, human and financial, are also essential for the success of any kind of programme. Although funding has increased, obstacles to scaling up prevention and access to treatment persist. Funding is often not directed to those in greatest need.[w1] Access to current HIV/AIDS programmes leaves room for improvement. Programmes need to adapt to each communities' needs to be effective.



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Global HIV infection in 2003. Size of territory is proportional to number of infected people aged 15-49 years. Thus the area of each place is in proportion to the number of people who are currently living with HIV. Colours show human development index, ranging from the lowest, dark red, in central Africa to the highest, violet, in Japan. Reproduced with permission from Anna Barford and Danny Dorling

People who are already somehow marginalised from society are likely to have worse access to health care. Although data show no systematic bias against women in the delivery of HIV/AIDS programmes,[w1] other trends of discrimination in the supply of services persist.

Injecting drug users, men who have sex with men, and sex workers and their clients are particularly at risk of contracting HIV. But only 9% of men who have sex with men and less than 20% of injecting drug users received any kind of prevention service in 2005.[w1] And only about 24% of infected injecting drug users receive antiretroviral therapy.[w5]

In the case of injecting drug users, the low rates of treatment might be because of the providers' perception about how addicts would use these services. The association of antiretrovirals with opiate substitution treatment can lower risk of infection and assure adherence to treatment.[w6] Stigma and discrimination seem to have influenced access to services by men who have sex with men. Homophobia is considered a significant obstacle to effective responses to HIV.[w1] In a similar way, marginalisation and even criminalisation of sex work in several countries have contributed considerably to the spread of HIV infection.

Less acknowledged groups of population at high risk of infection are prisoners and displaced people and refugees. Both groups were often left out of the design of programmes to deliver services. Although the latter might have similar needs to the general population, prisons are places where drug misuse, violence, and rape are more common.

Although programmes to support orphans are now developed and specific treatment needs for children are well recognised, older people are still not considered in the design of HIV/AIDS programmes. Statistics up to 2005 usually include the adult population only aged up to 49 years.[w1] But elderly people are also at risk of HIV infection, partly because of a lack of education about prevention. Also diagnosis itself might be delayed because symptoms are easily misinterpreted as indicators of other geriatric diseases. Although elderly people are a lower priority group, they should not be forgotten when considering equitable access to AIDS programmes.[w8]

At the other end of the age spectrum, young people aged 15-24 years old represent almost half of all new infections.[w1] Although widespread education programmes are powerful weapons to curb infection rates, less than 50% of young people have comprehensive knowledge of how HIV infection occurs.[w1] This is yet another area for improvement.

Finally, membership of several of the groups at higher risk of infection adds more challenges, underlying the complexity of the problem. Misconceptions and prejudices hinder equal access to HIV/AIDS programmes[w3] and broader social equality. Wider specific targeting, transparency, and open discussions about HIV/AIDS can counter this and facilitate positive individual and community responses to the epidemic.[w9]

Complex approach

Success in the fight against HIV/AIDS requires a complex approach. As the issues above indicate, the challenges surrounding HIV/AIDS are firmly embedded in social, economic, and political contexts. These contexts are central to consideration of the current situation and future action. Sensitivity to norms and values is integral to successful programmes. Poor health and high poverty have a positively correlated relationship; very poor health is often equated with severe poverty. Also manifestations of poverty impede interventions because limited resources restrict health care.

Lastly, political stability and support are necessary to nurture sustainable and effective long term programmes. Of course addressing all of these elements exceeds the remit of HIV/AIDS work alone and enters the realm of concern over international inequalities.[w10] The path is long and tumultuous. But that is no excuse for inaction.

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References w1-w10 are on studentbmj.com