

The International* Response to the AIDS Pandemic

This chapter presents my biases and observations on the international response to the AIDS pandemic from the initial efforts of WHO in the early 1980s to the past decade of efforts by UNAIDS and as of 2002, the Global Fund for AIDS, Tuberculosis, and Malaria (ATM). I have relied on a paper[†] prepared by one of the first WHO staff assigned to help Jon Mann develop a global AIDS program to describe WHO's response to AIDS from its recognition in 1981 until 1987. The description of the international response to AIDS included in this chapter primarily reflects my personal involvement and views and cannot be considered a comprehensive review of the international response to the AIDS pandemic. I will describe the personal politics that I believe prompted Jon Mann to resign from his position as Director of the Global Programme on AIDS (GPA) in 1990, and how after Jon's departure, GPA was converted into a "typical" WHO program by Mike Merson (Jon's successor as Director of GPA). I will conclude by providing a brief overview of the international response to the AIDS pandemic after UNAIDS replaced GPA/WHO in the mid-1990s.

Beginning of the International Response

After the initial report of AIDS in the CDC's MMWR in June 1981, WHO began to gather specialized information on AIDS on a modest scale and subsequently distributed that information in its own Weekly Epidemiological Record (WER). AIDS activity by WHO was restricted to this exchange of information until 1985, when the first International AIDS Conference was held in Atlanta. Participants at the Conference, and in particular the organizer, the United States Centers for Disease Control (CDC), brought heavy pressure to bear on the WHO delegate Dr. Fakhri Assaad, Director of the WHO Communicable Diseases Programme, to persuade the Organization to expand its AIDS activities. On Dr. Assaad's return to Geneva, and at his instigation, WHO convened a meeting of experts and received from them an urgent recommendation to set up an AIDS control program. WHO's reaction was unenthusiastic because funds and staff were lacking and the majority of WHO's Regional Offices (RO), authentic strongholds within the Organization, were reluctant to see their resources reallocated to tackle a problem which seemed to pose no threat to the countries within their area. However, thanks to Dr Assaad's persistence, an international network of some 30 WHO collaborating centers, most of them virus laboratories, was set up; he was then

* In recent years, a distinction has been made between *global* versus *international* health. International health focuses on providing aid to countries while global health relates to health issues that transcend national borders. A global approach is needed to respond to the AIDS pandemic, but we have had primarily an international response.

[†] Tarantola D (1996) The international AIDS control effort in Africa: the big picture and the little details. *Le Journal du SIDA*. 86–87: 109–16.

able to communicate directly with them from WHO Headquarters (HQ) in Geneva, and thus short-circuited the Organization's bureaucracy. In June 1986, almost one year after the appeal was made to WHO, the Organization set up a small monitoring and information unit with a physician (Jonathan Mann), a secretary (Edith Bernard), and a typewriter.

The Director-General (DG) of WHO, Halfdan Mahler was quite bold to include among global health priorities a problem which was seen, in the mid-1980s, as predominantly affecting minorities in wealthy countries, and in particular homosexuals and drug addicts. He knew that by launching a new program, WHO was running the risk of distracting the attention of Member States and international funding agencies, which had been mobilized with great difficulty in the previous decade, to support Primary Health Care. At the end of 1986, Mahler decided to implement a global program to respond to the pandemic because he had gradually realized the potential seriousness of the situation. At the second International Conference on AIDS, held in Paris in June 1986, alarming news was presented on the spread of HIV/AIDS in several African countries. The problem was again mentioned at Brazzaville in September 1986, at the annual meeting of the Member States of WHO's Africa Region. At the meeting, the Ugandan Minister of Health informed Halfdan Mahler of the worrying AIDS situation in his own country: his concerns were echoed by several other African delegates.

President Museveni of Uganda in a speech at Kampala in December 1995 said that he realized the gravity of the AIDS epidemic in his country somewhat by chance in 1986: "I sent 60 people to Cuba (for military training) and at that time we did not carry out HIV tests because we thought that everybody was all right. When the 60 got there, the Cubans tested them because they are very, very strict. Out of the 60, 18 [close to a third] were found to be HIV positive. When I went to the Non-Aligned summit in Harare that year, Fidel Castro took me aside and said: 'You know there is a big problem in your country,' and he told me the story. I had a meeting with Dr Okware* and his group in my office and I did not give them kind words, but out of our quarrel – the quarrel between the political leadership and these doctors – we evolved a program of talking openly about AIDS and educating people about its spread." As a result, President Museveni instructed his ministers to undertake a national and international effort to respond to the epidemic.

GPA/WHO: Early Years

I took early retirement from my position in California and joined WHO in March 1987 as a short-term consultant (STC). When I arrived in Geneva, I was assigned to a small cubicle – perhaps 6' by 10', the standard size for all STC. A few weeks after my arrival in Geneva, Jon asked "...Jim, how are we going to get the AIDS pandemic under control?" My response was – all we have to do is eliminate poverty,† prostitution, promiscuity, and drug abuse, and then it will all be downhill! I think Jon then and there decided to assign me to a more technical job – to

* I worked with Sam Okware on a World Bank mission in Malawi in 1997. He told me that in his initial AIDS unit there were 11 staff persons and in less than a decade eight of his staff had died, all presumably from AIDS.

† I remained on the poverty bandwagon until the mid-1990s.

gather and analyze global HIV/AIDS numbers. This was more than OK with me since I had already admitted to having no expertise in being able to “stop the storm” of sexual risk behaviors in California during the 1970s.

I brought along with me a Zenith portable computer that had been “mine” when I was the Head of the Infectious Disease Section of the California State Health Department. The computer was the size and weight of a large piece of luggage or similar to the weight and size of Anne’s sewing machine (it had 64k of RAM). It turned out that I was the only person in the Special Programme on AIDS (SPA) who had a computer and it was erroneously assumed that I was a computer expert.* In those days, virtually all offices used Wang machines for word processing and SPA had Wangs but no computers. It turned out that IBM was interested in donating to SPA a total computer system with technical support for a couple of years and this included access and use of the global communication services of IBM’s global network at that time. However, petty technical turf problems arose because WHO had just finished wiring the WHO building with a local LAN system that was a generation or two behind what IBM proposed to provide for SPA. The head of the Information Technology (IT) Division at WHO refused to have the IBM system installed just for SPA and as a result, IBM donated only a few desktop computers and printers and walked away.

My initial impressions of SPA, that within a few months was renamed GPA, was that everyone was totally dedicated to his/her work: we were all playing catch-up to get GPA off the ground and into the field so we could help countries evaluate and deal with whatever HIV/AIDS problem might be present. It seemed that all staff worked at least 15 to 16 hour days. I would leave at 7 or 8 pm and still there would be almost half of the staff working away. I would return before 8 am and find more than half of the staff working. This hectic pace was kept up pretty much unchanged until a year or so after Jon resigned and Mike Merson took over as the new director of GPA. I’ll discuss this in more



Jon Mann (far right in first row) and senior GPA staff in late 1987. Reprinted by permission of WHO/Erling Mandelmann.

*I continue to rely heavily on my number two son (Bennett) for technical assistance for all of my computer needs.

detail later but a year after I resigned from my position at GPA in early 1992, I had an occasion to pass through Geneva on my way to a meeting in Europe. I visited the GPA offices and found the pace of work to be pretty much of an ordinary WHO office – very quiet and not filled until after 9 am and half empty by 4 pm. It was like day versus night – there just wasn't the same *esprit de corps* and vitality of the initial GPA years!

GPA Was Not a Typical WHO Program!

From the beginning, GPA did not function or operate like a typical WHO office. Some of the WHO administrative offices that I had to visit really didn't open much before 9 am, and if you went to most WHO offices after 4 pm you more often than not were likely to find it closed for the day. I have never worked with such dedicated public health professionals. Jon would frequently tell the news media that he had to sail the GPA boat while at the same time he was trying to build it! GPA initially also did not adhere to WHO's bureaucratic rules that required all communications from HQ (Geneva) to be routed through WHO's regional offices* and often prepared documents for the Regional Director's (RD) signature. With the hectic pace of program development; the need to communicate rapidly with consultants, national governments and ministries of health; and to schedule and arrange country visits as soon as feasibly possible; GPA had to bypass the Regional Offices (RO). Instead of routing all correspondence through the RO for clearance or approval, which would often take weeks or longer, GPA routinely sent copies of correspondence to the RO to keep them informed but not ask or require their approval.

This was an operational routine that, to say the least, rankled all of the Regional Directors. In addition to correspondence, staff support and/or allocation of program funds from HQ for all WHO programs was to be provided to countries through the RO. Jon had worked for a couple of years in Africa; even though he did not work in a WHO program he knew first hand of the inefficiency and outright corruption in the African Regional Office (AFRO) that was then headquartered in Brazzaville, Congo. He vowed that no GPA staff or country funds/support would be provided through AFRO. My Combating Childhood Communicable Diseases (CCCD) project design team's visit to Geneva and SSA in 1979 included a visit to AFRO, and I was forewarned of the problems in dealing with AFRO. Consequently, our project design team made sure that the CCCD program was not passed through WHO (Geneva) in order to keep our funds out of the potential clutches of AFRO!

The GPA strategy was to get an initial country visit with a small technical program team to help form (if one did not already exist) a national AIDS program office to develop a short-term national AIDS plan. This was to be followed by a longer more in-depth planning mission by a GPA team. The second visit would entail close collaboration with the national AIDS program and other local and/or international experts/partners to develop a medium-term country plan (covering about 5 years) for responding to the nation's AIDS problem. Upon

* AMRO, also known as PAHO for the Americas, EURO for western European countries, EMRO for countries mostly in the Middle-East and North Africa, SEARO for south and southeast Asian countries, and WPRO for western pacific and east Asian countries.

completion of the medium-term country plan, GPA orchestrated an external donor meeting wherein all interested, potential donors would meet to review and critique the country's medium-term plan. Donors were invited to pledge support for any and all portions of the country plan. This process assured that the country's medium-term AIDS plan would be as comprehensive and complete as possible: Further, it would not require piecemeal development of any part of the plan at the specific behest of a potential donor. This process also tried to minimize or avoid individual donor evaluation meetings. All donors were required to accept a single comprehensive evaluation process in which each donor could participate in, but not dominate.

Thus, GPA inserted itself as the "gatekeeper" for participation of donors or potential donors to national AIDS programs. This requirement, imposed by GPA on all external donors, was received with mixed feelings that ranged from mute agreement with the logic behind this requirement to bitter resentment that an upstart WHO program was precluding independent evaluation missions that were traditional among agencies such as USAID, the World Bank, UNICEF, etc. There were some institutional grumblings, but in the late 1980s, Jon was at the zenith of his power and he had the unfailing support of Halfdan Mahler. All of the UN agencies were "kept in line" and had to acknowledge the primacy of GPA as the "gatekeeper" for all external support for national AIDS programs. A major early GPA concern was that UN agencies would want to be independent of WHO to pursue their own agendas, and this did materialize. In particular, UNICEF wanted to focus their AIDS program support exclusively on the "innocents," i.e. children, thereby virtually ignoring other vulnerable populations characterized by their socially unacceptable behaviors. The administrative mechanism that kept WHO at the center of the UN response to the AIDS pandemic was called the "WHO-UNDP Alliance" and there was a memorandum of understanding setting the respective roles of the two agencies. Among other functions, UNDP was expected to facilitate coordination across the UN and to mobilize resources for support of AIDS programs as well as the transfer of funds by WHO to countries. They operated this financial function quite efficiently.

Jon's Rise and Fall

In retrospect, Jon's triumphs over WHO's bureaucracy and the power and independence of other UN Agencies were to become his eventual downfall. From 1987 to 1990, GPA grew from just Jon and his secretary to a massive global program that had hundreds of staff throughout the world and an annual operating budget of several hundred million dollars. During this period, Jon was adjusting to his "rising star status" and was meeting with the Pope and other global leaders. He was a very articulate and charismatic speaker. His enthusiasm and conviction that persons living with HIV/AIDS had the basic human right to a healthy life propelled Jon's rising star status to that of "superstar." Jon's eloquence in public speaking was maximized in Europe because the French media could not get enough of him! I frequently told Jon that he was just an average epidemiologist, but he would have made a great Rabbi! I'm sure that the preferential treatment Jon received from the Geneva press corps compared with how they treated the new WHO DG, Nakajima, was

a factor in the obvious animosity between the two. I remember clearly scheduled news conferences when Nakajima would open the conference reading in his stilted and fractured English or French a prepared statement. All of the reporters would be visiting with each other and there would not be a single camera or recorder on. When Nakajima was finished, all of the cameras and lights would go on: the reporters turned their recorders on and were ready to hear Jon's message – delivered without notes – and then respond to questions in English or French without pause. I can still see Nakajima smoldering and fuming in the background.

Why Jon Resigned from GPA

The exact reasons why Jon suddenly resigned as director of GPA in 1990 will never be fully known. I had expected Jon to provide all the details in a book describing his professional sojourn with AIDS at WHO, but his unexpected death in the Swiss Air 111 crash in September 1998 occurred before such a book could be written. What I have pieced together from my sporadic contacts with him after his resignation, the basic cause was simple burn-out! On several occasions after his resignation, I asked Jon why he didn't share any of the administrative and political problems he had with Nakajima's office with his senior staff. Jon's answer was that he did not want to get any of us involved because that would have been the kiss of death for us from the DG's office. Jon was acutely aware of the battles he would have with Nakajima, who succeeded Mahler in 1988, about GPA's almost complete independence from the Regional Offices. During Nakajima's campaign to become Mahler's successor, I'm sure that he assured his fellow Regional Directors that GPA would be made to behave as a typical WHO program if he was elected the next DG. Jon, on the other hand, kept saying that GPA staff and funds would be routed to African countries through AFRO, "...over my dead body!" Thus, the battle lines were clearly drawn before Nakajima's arrival. Of course, Jon's upstaging Nakajima at all international AIDS conferences and press conferences did nothing to endear Jon to Nakajima.

The apparent straw that broke Jon's back was a personal political game played by the DG's office in connection with Jon's travel authorization papers for a high level European AIDS meeting that Jon had organized and at which he was to be the keynote speaker. Apparently, Nakajima was initially not invited to this meeting and was rightfully miffed. Jon recognized this oversight and ensured that Nakajima received an invitation and was also asked to give a short opening speech. Jon's travel secretary* had sent Jon's travel request for this meeting to the DG's office for approval a couple of weeks before the meeting, but each time the travel secretary called to ask if the travel request had been approved, she was told that the DG was traveling or busy and to call back later. This administrative "dancing" went on up to the last day before the meeting and Jon was convinced that the DG's office was daring him to flaunt WHO travel authorization requirements. Jon told me that this "cat and mouse" game

* Jon had a head secretary, an appointment secretary, a travel secretary and a special occasions secretary as well as Kathleen Kay, his personal executive assistant, and he kept working them all overtime!

was both personally and professionally wearing; he just plain “snapped” and submitted his resignation without conferring with anyone, not even his administrative superiors at CDC, Atlanta. Immediately afterward, high officials from Washington DC and Atlanta tried to get Jon to reconsider and to withdraw his resignation, but Jon did not change his mind. He was, in my opinion, just “totally burnt out.”

After Jon resigned, Nakajima appointed Mike Merson to take over GPA. I was on duty travel when Jon formally turned GPA over to Mike. I was told by several colleagues who were present at this GPA staff meeting that Jon introduced Mike as the lone WHO senior staff who had envied and coveted his position from the beginning. Who furthermore over the years consistently sought to undermine and stab him in the back. With this brief introduction, Jon abruptly left the assembled GPA staff with their new director.

Mike Merson and the Dismantling of GPA

After Mike was made head of GPA, I can say with sincerity and conviction that all of GPA’s unit chiefs gave him their full professional support. However, this did not prevent Manuel Carballo and Daniel Tarantola from being targeted for elimination from GPA. One of Mike’s first moves was to reorganize GPA to get rid of Manuel Carballo’s Social Behavioral Research unit and thereby eliminate Manuel’s position. This administrative maneuver was not unexpected because Manuel was the very upfront and visible campaign manager for Nakajima’s main rival for the position of DG. The GPA management committee chided Mike for removing such an important research unit, but by then Manuel had moved to another position in Geneva. Several months later, Mike again reorganized GPA to abolish Daniel Tarantola’s position. This was also expected since Daniel had worked in the Western Pacific Regional Office (WPRO) when Nakajima was the regional director of that office. Daniel believed that Nakajima considered him to be a disloyal employee since Daniel, as a member of the WPRO staff grievance committee, invariably sided with staff who filed grievances against the RD.* Halfdan Mahler was aware of the bad relationship Daniel had with Nakajima: one of his last personnel actions before he turned WHO over to Nakajima was to promote Daniel to a P-6 position. This protected Daniel from being easily dismissed by the DG’s office, but could not protect him from being reorganized out from GPA! I did not consider myself in danger of being reorganized out of GPA but I resigned from my position in early 1992.

Why I Resigned from GPA

I resigned abruptly from WHO in early 1992 for a variety of personal and professional reasons. As described above, I was thrilled with my work at GPA for the first few years when Jon was “...trying to sail his boat [GPA] as he was building it.” I doubt very much if I would have resigned if Jon had still been director of GPA. My decision to take early retirement from California to join WHO in 1987 took my wife Anne by surprise. It was a difficult situation for her to suddenly,

* According to Daniel, Nakajima set a WHO record for having the most staff grievances filed against any RD!

without warning, cut her family and personal ties in Berkeley to accompany me to Geneva. We managed to work out a jetsetter arrangement for her to set up a home for us in Geneva while keeping our house in Berkeley for her needed travel back to California for family matters and for her scheduled meetings of the Board of Pensions of the United Methodist Church. Since I joined WHO at the relatively old age of 54 and the mandatory retirement age at WHO was 60, I never considered my move to Geneva as a very long-term venture. After Jon's resignation, Mike's dismantling of senior GPA staff, and conversion of GPA into a "typical" WHO program, my incentive and desire to stay at WHO plummeted. I had just signed a contract extension for two more years in late 1991 when I received, in early 1992, an invitation from Taiwan to participate in an international AIDS conference in Taipei. I immediately took this invitation to the WHO legal office and asked how I might be able to go to Taipei for this conference. I was told that as a WHO employee I could not go to Taiwan. I asked if I could take vacation time to attend the conference and the head of the legal unit said "read my lips – there is no way that you can go to this conference since you are a WHO employee!" I then told him that I'd resign from WHO to go to this conference. He said that since I signed a two year contract I had to give 90 days notice before I could resign. A quick look at the date of the conference indicated that it was exactly 91 days away. I told the legal officer that effective immediately I was tendering my resignation and that I'd go back to my office to draft an official memo of resignation and have it on his desk before the end of the day! That evening, I again surprised Anne by telling her that I just resigned from GPA/WHO and that we would be returning to California.

I did attend the AIDS conference in Taipei and it was necessary that my resignation from WHO adhered to all of the rules. Dr. ST Han, who had succeeded Dr. Nakajima as the Regional Director at WPRO (Manila), somehow got wind of my participation at the Taipei conference. He apparently called WHO (HQ) in Geneva to ask how come Jim Chin, a staff member of GPA/WHO, was attending a meeting in Taipei. He was informed that effective the day of the Conference Dr. Chin was no longer employed by WHO!

Donor Disenchantment with GPA

After the first few "honeymoon" years, bestowed by the major donors to GPA, a combination of donor fatigue and disenchantment of some donors of GPA's operating procedures began to be palpable about the time I resigned from GPA. This disenchantment continued to fester and a couple of years later, in 1994, a group of donors suggested the creation of a joint United Nations program on AIDS. The initial idea was to compel WHO to broaden its partnership with other United Nations agencies and with NGOs. The reasons that donors, and later the developing countries, ratified this decision – which was confirmed by a resolution of the World Health Assembly in May 1994 – include those below.

For the developing countries, assistance from donors was stagnating because of the inability of WHO to provide sustained technical support and adequate funds since the Organization was embroiled in "decentralization" of GPA's implementation. I have no doubt that this decentralization of GPA's operations was simply Nakajima paying his political debt to the WHO Regional Offices, i.e., to make GPA a typical WHO program that would route staff and funds to countries through the

Regional Offices. In the vast Africa region, while AFRO was simultaneously tackling internal management problems and the repercussions of the political instability prevailing in Congo, where its Headquarters were located, decentralization had led to the virtual paralysis of WHO support for national AIDS programs. Donors, for their part, were impatient to see AIDS take its place within the broader framework of social and economic programs with some permanency. Without GPA/WHO as an all powerful gatekeeper, international donors would be able to incorporate funds hitherto allocated to AIDS into complex assistance packages that would conceal the actual decline in the overall amount of funds allocated for AIDS programs. By eliminating GPA/WHO as the gatekeeper, this would also make it difficult if not impossible to directly monitor AIDS funding within the total global development envelope.

Pressure was brought to bear from many angles by the bilateral development agencies, United Nations agencies, beneficiary countries and NGOs for the new program to play a coordinating rather than a direct operational role, especially its gatekeeper role! The underlying motives of the donors and recipient country programs were diverse. In short, the approach around which a consensus emerged made room for a diversity of groups – whether governmental or not – which, during the previous years, had gradually built up their own capacity to intervene.

UNAIDS

UNAIDS was established in 1995 as an advocacy and coordinating agency that almost immediately turned over responsibility for AIDS program funding and technical guidance to other international agencies and donors. However, UNAIDS did not turn over responsibility for the estimation and projection of HIV/AIDS numbers. Since UNAIDS, has declared itself to be primarily an advocacy agency, its objectivity in making or accepting high estimates and projections needs to be questioned. UNAIDS primary mission is to bring coordinated support for HIV/AIDS programs from UN agencies to countries. In this respect, they have not done a great job, largely due to poor UN leadership in countries and territorial fights. My observation of how UNAIDS works in countries is that they establish a theme team of major donors to coordinate all support for country AIDS program activities. I call these “dream” teams since each UN agency or external donor is essentially free to do whatever it wants to do with its support funds or staff. This loose system of “coordination” works well if there is a strong team leader. Usually, however, the group with the largest interest and budget will get to do whatever they believe is best for the country’s AIDS program and/or for the donor agency. I often saw what I considered outright chaos with regard to applications for funding to individual donors: arguments over program priorities would be decided by the second golden rule – “Those who have the gold, make the rules!” In addition, a multitude of individual applications for donor support, as well as individual evaluation missions that GPA/WHO had strived to avoid, began to suck up a tremendous amount of country program staff time.

Through the 1990s, most of the UNAIDS country-based staff were, in my opinion, poorly prepared for their task. Most of them, lacking experience, credibility and authority, merely became assistants to the local UN Resident Coordinator. UNAIDS was also expected to lead and coordinate policy development across UN Agencies and other partners. In this respect, they have done a reasonable job

where there was a vacuum of interest on the part of UN agencies, but a poorer job when territorial battles impacted on inter/agency collaboration (i.e., UNICEF on children, WHO on care and treatment).

Finally, UNAIDS was supposed to act as an international advocate: in this area, Peter Piot has in the opinion of some, performed well. There has been a plethora of statements, declarations, and resolutions, including those from the UN General Assembly and Security Council for the support of national AIDS programs. This advocacy has helped considerably in the creation of the Global Fund and in limiting instances of HIV-related human rights violations by some governments.

The Global Fund

The concept of a global fund for disease control was apparently first suggested by Bill Foege, a former Director of the CDC (Atlanta), and a former President of the American Public Health Association. I suspect that David Heymann who at the time was Director of Communicable Diseases at WHO presented this proposal to Dr. Gro Brundtland, the WHO Director-General who succeeded Nakajima. She went to the G-8 meeting in Okinawa in July 2000 to present this grand global disease control scheme. The initial idea was to create a global fund and initiative to fight “diseases of the poor.” The G-8 did not take up this idea but it was picked up by Japan and a group of countries and eventually became the Global Fund when it was endorsed by the UN Secretary-General Kofi Annan in 2001. However, WHO was not selected as the implementing agency. The primary reasons WHO did not get to manage the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) were basically the same as those that led to the creation of UNAIDS – to get donor agencies and poor developing countries out from under the dominance of GPA/WHO. UNAIDS was not selected to be the implementing agency of the GFATM for several reasons:

- 1 UNAIDS declared itself as an advocacy organization and not as a scientific or technical agency
- 2 UNAIDS did not have much interest in dealing with other, albeit important and major diseases and
- 3 several of the GFATM founding countries, such as the US, Japan, and Germany, did not want the Fund to be administered by any UN organization. The UK and France were on the opposite side, and developing countries were in the middle, eager to keep their relationship to the UN system while also positioning themselves to access the Fund’s money regardless of the implementing agency.

Eventually, WHO was “awarded” the responsibility of providing administrative backing to the Fund (at cost). The World Bank got the honor of safekeeping and channeling funds to countries. WHO was then called upon by countries to help them put together their application to the Fund, always within very short deadlines. The Fund’s somewhat naive expectation was that applications would be prepared primarily with the combined efforts of government, private sector, and NGOs. WHO was not paid for this extra effort and staff time, which was a flaw or a bonus in the Fund’s design, depending on one’s perspectives.*

*Many of the observations and insights about UNAIDS and the Global Fund were provided to me by a former senior WHO official who wants to remain anonymous – his initials are DT.

Development of Global Priorities for Disease Prevention and Treatment

How are national or international health priorities determined for disease prevention and treatment programs? The simple direct answer to this question is that there has not been an objective or consistent method used to determine global health priorities for international disease prevention and treatment. In fact, until the WHO's 3 by 5 ART program, there was a virtual taboo on international support of "routine" treatment programs since this was considered to be a bottomless pit by virtually all international donor agencies. International support for the directly observed treatment strategy (DOTS) program for TB was rationalized on the basis that the DOTS program is primarily a prevention program. Treatment of TB cases renders potentially infectious patients non-infectious and thereby prevents TB transmission to household or close contacts. There have been some scattered attempts to assign priority rankings for major diseases objectively but no method of ranking has been formally accepted by the international health community. The Global Burden of Disease (GBD) ranking of disease and deaths represents the most objective assessment of the relative impact of all major diseases: it may provide the foundation to help international agencies develop a means to rank public health disease prevention and treatment programs. In addition, in 1993 the World Bank published the first edition of "Disease Control Priorities in Developing Countries" (DCPP) with contributions from WHO and public health specialists from both developed and developing countries. This volume examined the priority of 25 conditions based on their public health significance and the cost-effectiveness of preventive and patient management interventions in low- and middle-income developing countries. In 2002, a new DCPP was funded by the Bill & Melinda Gates Foundation. The new DCPP is a joint project of the Fogarty International Center (FIC) of the National Institutes of Health (NIH), the World Health Organization (WHO), and the World Bank. An expanded second edition of DCPP was scheduled to be published in 2005. As of early 2006, the new DCPP has not been released.

No method of ranking causes of disease, disabilities, and death (total disease burden) has, until recently, included risk factors and risk behaviors as the underlying or attributive cause. The WHO's International Classification of Diseases (ICD-10) criteria for assigning causes of death do not include risk factors or risk behaviors. Thus, although there is clear acceptance that tobacco smoking is the primary cause of most lung cancers, ICD-10 coding rules assigns all lung cancer deaths to the disease cancer. This classification of causes of disease and death by conditions is useful for healthcare planning, yet for disease prevention or health promotion a classification of causes of deaths attributable to risk factors or risk behaviors would be more useful. During the past few decades, there has been an increasing awareness of the importance and role that risk factors and behaviors play in disease causation. For example, there is no question that HIV is the etiologic agent responsible for the acquired immune deficiency in all AIDS cases and deaths. However, it is also evident that without HIV risk behaviors epidemic HIV transmission cannot occur. Thus, WHO developed in 2002 a standardized method, designated as counterfactual analysis that estimates different prevalence of a disease by

comparative risk assessment.* Counterfactual analysis compares diseases and deaths under the prevailing population distribution of a specific risk factor or behavior to a counterfactual exposure distribution. The difference is presumed to be the avoidable or preventable incidence of the disease as a result of changes in the risk factor or behavior. This very simplistic approach is quite logical, but remains to be validated.

My review of the GBD estimated disease burden for 2001 convinced me that prevention of several childhood diseases for which effective vaccines are available – measles, tetanus, and whooping cough[†] – was inadequate. These preventable diseases need to be added to the Global Fund portfolio. The GBD estimates confirm that HIV/AIDS is an almost unparalleled human disaster in SSA. In 2001 almost 20 percent (one out of every five) of all deaths in this region were attributed to AIDS. In contrast, AIDS deaths are not, and will not be, a leading cause of adult deaths in virtually all countries outside SSA. Indisputably in SSA, HIV/AIDS must be given the highest public health priority, but outside SSA, it is more logical to give the highest health priority to the prevention of disease and death attributable to tobacco.

Challenges to International Disease Prevention and Treatment Programs

The basic objectives of HIV/AIDS programs are to prevent HIV infection and provide care and treatment to those infected. With unlimited resources, both objectives might be attained; but with limited resources, a natural tension and competition for resources exists between prevention/control and treatment/care programs. Aside from most developed countries in North America and Western Europe, only a few countries/city states such as Brazil, Australia, New Zealand, Japan, South Korea, Taiwan, Hong Kong, and Singapore, have adequate resources to support both types of programs. In most developing countries, there are insufficient resources to support prevention programs adequately: therefore, the cost of routine anti-HIV drug treatment is completely out of reach. Furthermore, international health agencies have traditionally not funded basic treatment programs in developing countries.

The 3 by 5 program[‡] WHO started in 2003 represented the beginning of international support for HIV treatment programs. The best estimate of HIV-infected persons in developing countries needing ART in 2003–2005 was about 9 million: thus, the target of 3 million on ART by the end of 2005 would have covered only a third of the estimated need. The 3 by 5 target was not met and it is estimated that less than 1.5 million were on ART by the end of 2005. In the ideal world,

* World Health Report 2002, *Reducing Risks, Promoting Healthy Life*.

[†] I started my international health work in 1979 as the leader of a USAID project design team that developed the Combating Childhood Communicable Diseases (CCCD) program in SSA. It is disheartening now, 35 years later, that these “easily” preventable childhood diseases are still killing millions of children annually in Africa.

[‡] The 3 by 5 target was to distribute anti-retroviral treatment to 3 million people in 50 developing countries by the end of 2005. In late 2005, Dr. Jim Yong Kim, director of WHO’s HIV/AIDS department, made a public apology that the WHO had not moved quickly enough to meet its ambitious target.

there would be sufficient support for both prevention and treatment/care programs for all major diseases. However, for most developing countries, the tension and competition between prevention versus treatment/care programs will continue. As a result, risk and harm reduction programs required for effective HIV prevention will continue to be severely under funded.

At the G-8 summit in July 2005, under the presidency of the United Kingdom, the world's most powerful eight nations announced their commitment to "... an AIDS-free generation in Africa, significantly reducing HIV infections, and working with WHO, UNAIDS and other international bodies to develop and implement a package of HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010." The G-8 declaration was further enhanced by adoption of the universal access concept by the United Nations General Assembly World Summit in September 2005. The outcome document of the World Summit endorsed "...developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it." Whether this moral commitment will be kept is uncertain. Weak health systems, including poor infrastructure and limited trained medical and technical staff, prevent the absorption and effective use of available resources. Although funding has increased considerably during the last three years, it remains insufficient. Sustainable financing mechanisms are still not in place to meet the full costs of implementing HIV prevention, treatment and care programs for all those affected. What is clearly needed is some type of regular and consistent international support, along the line proposed by French President Jacques Chirac in early 2005. His proposal would require a tax on airline tickets to help fund the global fight against HIV/AIDS, tuberculosis and malaria. However, his proposal would raise funds only for treatment and not include support for prevention. The airline tax would be a surcharge on tickets issued to passengers departing from airports in countries participating in the program. President Chirac said the tax would be simple to impose, economically neutral and would take countries' economic status into account. At the end of an AIDS Conference held in Paris in early 2006, 12 countries gave support to a French initiative to impose a surcharge on airline tickets to boost money for developing nations. In addition to France, Brazil, Chile, Cyprus, Congo, Ivory Coast, Jordan, Luxembourg, Madagascar, Mauritius, Nicaragua and Norway agreed to adopt the measure. Britain, while not adopting the tax, said it will divert money from an existing surcharge on air travel for the same purpose: fighting AIDS, tuberculosis and malaria in poor countries, especially in Africa. In July, 2006, France will be the first country to institute the tax, which will add 1–40 euros (\$1–\$47 US) to each ticket.

Richard Feachem, the Executive Secretary of the Global Fund, has both appealed and challenged the richest countries in the world to meet their moral commitment to adequately support the international efforts to prevent, control and to provide treatment for the most severe and prevalent infectious diseases. Such an international effort would only require a very small fraction of the current global costs for fighting human terrorism. I'm optimistic that global funding for global disease prevention and treatment will eventually be established as a basic international and global responsibility – but the biggest question and problem is when?

AIDS is one of the most severe infectious disease pandemics to occur within the last millennium. However, as I have consistently noted throughout this book, HIV is not and cannot be a “generalized” infectious disease agent. This is because HIV transmission requires a significant exchange of infected blood or sexual fluid. If we exclude HIV transmission in healthcare settings and from infected mothers to their children, only persons with the highest levels of HIV risk behaviors* and the regular sex partners of HIV-infected persons are at any measurable risk of infection. The patterns and prevalence of HIV risk behaviors are markedly different in different regions and populations: this accounts for the marked differences in the patterns and prevalence of HIV infection and AIDS cases (HIV/AIDS) currently observed globally.

Summary and Conclusions

The international response to the AIDS pandemic outside of developed countries was hindered by the initial perception that HIV/AIDS was an American disease of homosexual men and injecting drug users. The myths that HIV is not the cause of AIDS and that poverty, not promiscuity, is the driving force of the AIDS problem in poor developing countries have been prominent obstacles to the development of effective behavior change programs in many SSA populations.

The international response to the AIDS pandemic in developing countries formally started in the late 1980s when WHO created the Global Programme on AIDS (GPA). Initial international support for GPA was unprecedented and within a couple of years, GPA grew from Jon Mann and a single secretary to a staff of several hundred with a budget of several hundred million dollars. However, international “turf” problems and petty personal jealousies within WHO doomed GPA’s ability to maintain its primary role as the “gatekeeper” to prevent international agencies and donors from pushing their way into a country to pursue their own agendas and priorities.

The AIDS pandemic has exposed the major problems and inequities of international health programs. Prior to the AIDS pandemic, no international agency or donor provided support for “routine” treatment for any disease as part of its international health commitment. Effective, but expensive anti-retroviral drugs that are needed on a daily to weekly schedule have significantly extended the lifespan of HIV-infected persons. These drugs are now provided to virtually all HIV-infected persons who need them in most developed countries. The WHO’s 3 by 5 program established an international health precedent by setting a target for the provision of anti-retroviral treatment (ART) to HIV-infected persons in poor developing countries. The responsibility for further development of international support for ART in developing countries has been assumed by the Global Fund. As of late 2006, it is not clear if the moral commitment made in mid-2005 by the world’s richest countries to assure universal access to ART in resource-poor countries by 2010 will or will not be met.

I believe there will be significant shortfalls in keeping this commitment over the next decade. However, I’m also “blindly optimistic” that as the concept of global health takes firmer root, there will be a comprehensive and equitable

* These include unprotected sex with multiple and concurrent partners and routine sharing of drug injecting equipment.

international commitment to support prevention and treatment programs for all of the major human diseases. This will not be accomplished in my life time, and for this failure, shame on my generation! This is a commitment that I believe that my grandchildren's generation can and will accomplish – if not, shame on them!

How will historians in future centuries look upon the international response to the AIDS pandemic? I don't think that they will look too kindly at the inequity of the international response, especially at the initial lack of meaningful support for HIV treatment programs. Historians will, I hope, look back to the AIDS pandemic as the beginning of true global health programs.

