GETTING TO ZERO INEQUITY

BUILDING BRIDGES BETWEEN AIDS AND THE SOCIAL DETERMINANTS OF HEALTH

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UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

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FOREWORD

EXPANDING THE MOVEMENT FOR HEALTH AND SOCIAL JUSTICE

Leaders in the global AIDS response have understood that to achieve universal access to HIV prevention and treatment services, national HIV strategies must examine and address the social determinants of HIV risk, vulnerability and impact.

Over the past 30 years, the AIDS movement has delivered some of the most remarkable results in the history of global health, by dealing directly with issues of social justice, gender and sexuality, human rights and human dignity —issues that shape the way people feel, act and live. The achievements of the AIDS response over three decades provide examples of strategies that can be used in other struggles for social justice. Through partnership, strategic advocacy, and inclusive programme planning and implementation, urgently needed services can be delivered and transformative social change promoted.

The World Conference on the Social Determinants of Health provides an unprecedented opportunity to bring together the expertise and passion of advocates working in HIV with our colleagues working more broadly on gender, human rights, environmental sustainability and economic and social development. Working together we can build country ownership and use national and international partner resources wisely to accelerate achieving all the Millennium Development Goals (MDGs).

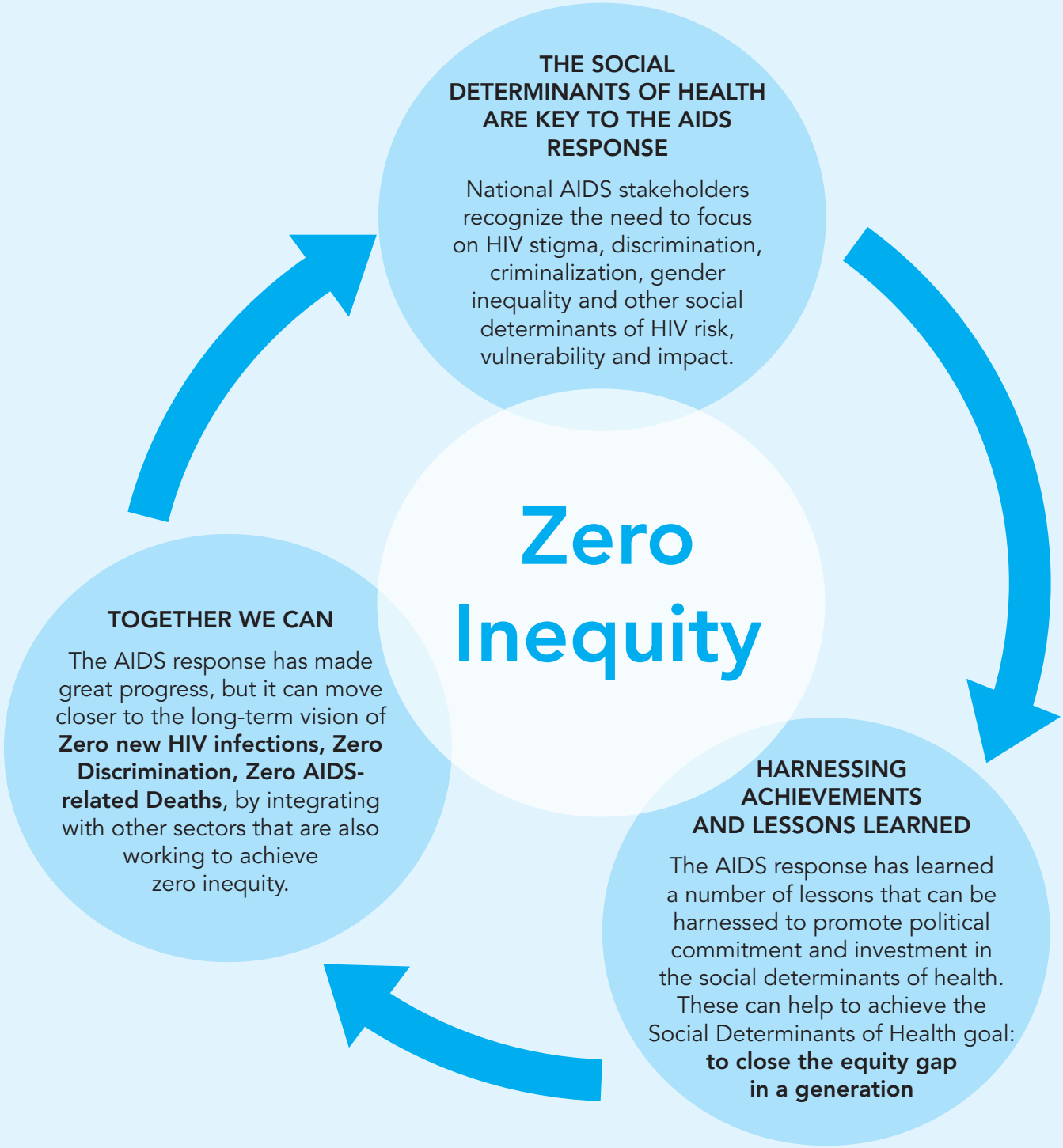
In Rio de Janeiro and beyond, it is time to build bridges and work together to save and improve more people's lives.

Michel Sidibé
Executive Director

The Social Determinants of Health include the distribution of power, income, goods, and services, globally and nationally, as well as the immediate, visible circumstances of peoples' lives, such as their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, and rural or urban settings; and their chances of leading a flourishing life.

Commission on Social Determinants of Health [i]

FIGURE 1: THE SOCIAL DETERMINANTS OF HEALTH AND THE AIDS RESPONSE



Where are we now in the global AIDS response?

NEW HIV INFECTIONS ARE FALLING.

TABLE 1: 33 COUNTRIES REDUCED NEW HIV INFECTIONS >25%

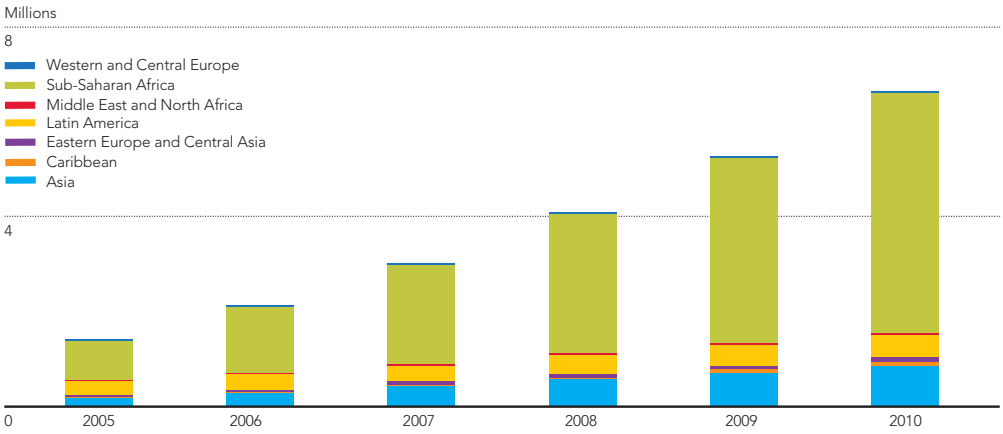
Belize
Botswana
Burkina Faso
Cambodia
Central African Republic
Congo
Côte d'Ivoire
Dominican Republic
Eritrea
Ethiopia
Gabon
Guinea
Guinea-Bissau
India
Jamaica
Latvia
Malawi
Mali
Mozambique
Myanmar
Namibia
Nepal
Papua New Guinea
Rwanda
Sierra Leone
South Africa
Suriname
Swaziland
Thailand
Togo
United Republic of Tanzania
Zambia
Zimbabwe

Fifty-six countries have either stabilized or reduced new HIV infections by more than 25% in the past 10 years. New HIV infections in infants have dropped by 26%—a significant step towards the elimination of new HIV infections in children and keeping their mothers alive by 2015. Over 6.6 million people are on antiretroviral treatment, which has reduced AIDS-related deaths by more than 20% in the past 5 years.

While the rate of new HIV infections has declined globally, the total number of new HIV infections remains high, at about 7000 per day. The global reduction in the rate of new HIV infections hides regional variations. Above-average declines in new HIV infections were recorded in sub-Saharan Africa and in South-East Asia, while Latin America and the Caribbean experienced more modest reductions of less than 25%. There has been an increase in the rate of new HIV infections in Eastern Europe and in the Middle East and North Africa.

MORE THAN 6 MILLION PEOPLE ARE ON HIV TREATMENT.

FIGURE 2: NUMBER OF PEOPLE ON ANTIRETROVIRAL THERAPY IN LOW- AND MIDDLE-INCOME COUNTRIES, 2005–2010



Source: UNAIDS, AIDS at 30: nations at the crossroads[ii]

This publication focuses on six lessons learned in the global AIDS response that can help translate Social Determinants of Health knowledge into practice to reduce health inequities.*

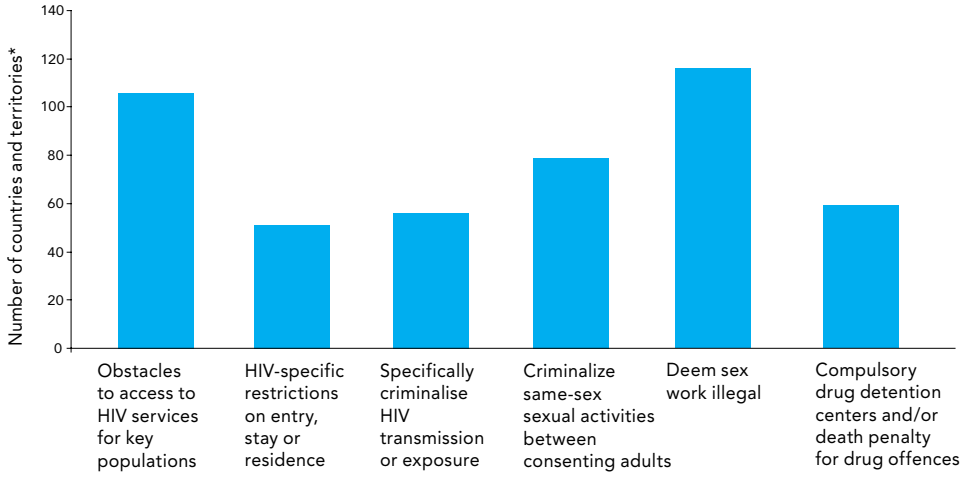
*Inequities are "avoidable health inequalities" (Commission on the Social Determinants of Health)[iii]

1. Rights based, evidence-informed strategies can save millions of lives.

HUMAN RIGHTS ARE FUNDAMENTAL TO THE AIDS RESPONSE.

From the outset of the epidemic, communities affected by HIV have mobilized to respond to their needs. Analysis of the mechanisms of HIV transmission and the epidemiology of who is most affected also puts people living with HIV, sex workers, people who use drugs, men who have sex with men and transgender people and, in generalized epidemics, women and young people, at the forefront of the AIDS response. This strategy works.People who are most often at risk are mobilizing and connecting to demand and use life-saving HIV prevention and treatment services as well as non discrimination and participation. However, inequities persist. Access to HIV prevention and treatment for populations at higher risk of infection is still far too low, due to punitive and discriminatory laws, outmoded policies and stigma and discrimination.[v] As of April 2011, 79 countries, territories and areas criminalize consensual same-sex relations; 116 countries, territories and areas criminalize some aspect of sex work; and 32 countries have laws that allow for the death penalty for drug-related offences.

FIGURE 3: FOCUSING ON: LAWS THAT IMPACT HIV RESPONSES



* Number of countries and territories with selected types of laws that impact HIV responses. The data were compiled on 209 countries and territories, and not all reported on each type of law.

Source: GNP+ et al., reproduced in UNAIDS 2010[iv]

Human rights are central to a successful AIDS response. The United Nations General Assembly calls for " Universal Access to comprehensive HIV prevention, treatment, care and support". "Universal" means no-one in need is excluded.

Michel Sidibé,
UNAIDS Executive Director

2. Changing the game requires a deliberate political strategy.

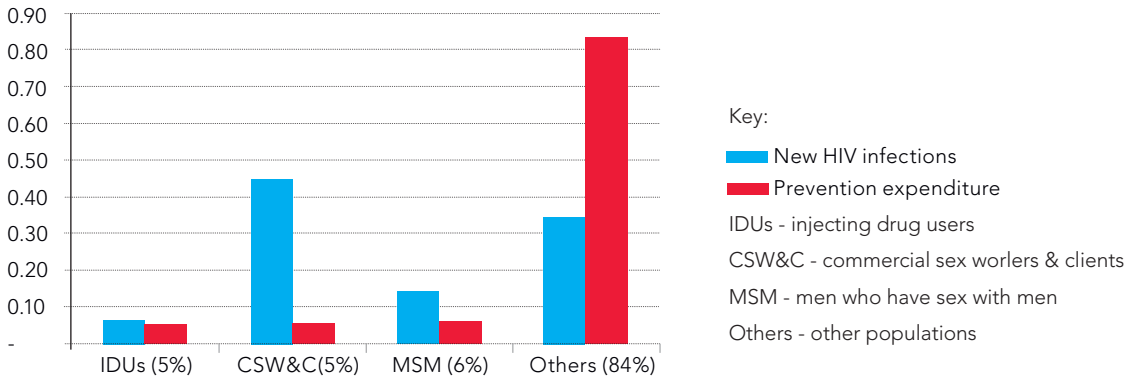
The global AIDS response influenced high level political agendas and resource flows, beyond the traditional domain of public health. This was no accident. Leaders listened to the concerns and interests of all stakeholder groups and used the architecture of international development assistance to respond. They catalyzed governments to commit publicly to ambitious and measurable goals and targets (see Box 1, page 15). National AIDS programmes developed evidence-informed, multi-sectoral national strategic plans to define and meet their current needs and to achieve their programmatic targets. Diverse national and international groups joined in common cause, used scientific evidence, and spoke with one voice to advocate, at the highest political levels, for the funding needed to implement the plans. The momentum established by the first health-focused UNGASS[vi] has been nurtured in the calls for "3x5" (to have 3 million people on AIDS treatment by 2005) and universal access.

National responses, including government, civil society, academia and the private sector, worked together to build a system to measure resource needs and gaps, and to account for available resources. They collaborated and established principles, such as the "three ones" (one national AIDS authority, one national strategic plan and one monitoring and evaluation system[vii]) to harmonize and coordinate efforts and to reduce transaction costs. Expanding on the model of National Health Accounts, they established new, multi-sectoral methods for tracking HIV resource flows and expenditures. This allowed stakeholders to examine the match between national HIV programme needs and where the money went (Figure 4). This has supported the credibility of calls for more resources for HIV.

FIGURE 4: KNOW YOUR EPIDEMIC/KNOW YOUR RESPONSE.

A "modes of transmission" synthesis method enables countries to compare their estimates of new HIV infections (who is most at risk), with the way HIV expenditures have been distributed. This kind of practical analysis helps identify unmet needs and improve the allocation of HIV resources.

Distribution of new infections and share of prevention expenditure by population, Morocco



Source: Analysis based on National AIDS Spending Assessment in Morocco (Dec 2010); Modes of Transmission analysis in Morocco, (2010)

3. Achieving health for all requires facing the facts and leaving no one behind.

HIV can only be transmitted through unprotected sex, injecting drug use, contaminated blood, and from mother to child. Effective HIV programmes engage with people from socially marginalized groups such as sex workers, men who have sex with men, transgender people, people who use drugs, prisoners, and others who are legally, economically or politically vulnerable, because they are most likely to be exposed to and affected by the virus. Effective programmes and HIV leaders have broken age-old silences around gender inequality to address the vulnerability of women and girls, and they call attention to the psychosocial as well as medical needs of HIV-affected children.

People working in AIDS have had to face the facts, overcoming taboos to talk openly about gender, sexuality and sexual diversity, adolescent risk taking, drug use, addiction, compassion and social exclusion, harmful social norms, punitive laws, religion, faith, citizenship and power – topics traditionally avoided by health providers and policy-makers for being too 'difficult' or controversial. Yet achieving equity requires evidence-informed dialogue about the full range of issues that matter to people – dialogue and constructive debate that leaves no-one behind.

4. Success stems from partnerships and supporting new leadership.

People living with and affected by HIV are the heart, soul and engine of successful HIV responses, and participation is a human right. Yet affected communities should never have to stand alone. Policies and social norms can leverage - or undermine - the energy of community action.

Successful responses have removed policy and normative barriers that constrain people's passion and compassion, honouring and learning from the experience of people in affected communities, to create national and global responses that meet real needs.

Successful programmes have built bridges of collaboration and respect between the various stakeholders — including multiple sectors and the opinion leaders and authorities that interact with affected communities every day (such as family, teachers, faith leaders, health care providers, employers, police and judges, and politicians).

Successful programmes are building new leadership, especially leadership for positive health, dignity and prevention among people living with HIV, and leadership by and for young people. Young people are driving the prevention revolution.

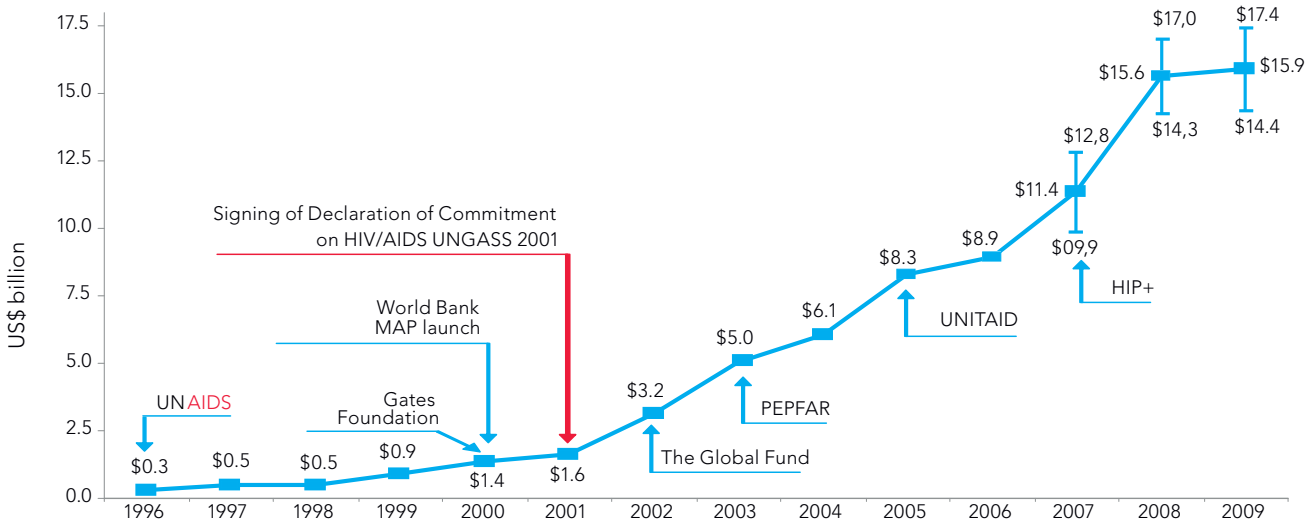
5. Social mobilization and strategic advocacy can move mountains.

AIDS is profoundly social and inherently political. Without the mobilization of and coordinated advocacy by people living with, affected by and concerned about HIV there would be little political will to bring about the investments and social transformation that have been at the root of success.

In a world with HIV, social change to enhance gender equality, provide education for young people, provide access to justice and harm reduction for drug users, and promote sexual and reproductive health and rights is a matter of life and death. AIDS threw into sharp relief the inequities in access to AIDS treatment within and between nations. Communities responded by creating strategic local and global alliances which used evidence, advocacy, and awareness of global health architecture to inform the world about this injustice and to demand that treatment be made available everywhere, equitably. These efforts elevated the ideal of universal access to the global political agenda in the United Nations General Assembly, in the parliaments and congresses of donor countries, and in the private and philanthropic sectors, achieving a nearly 10-fold increase in investments in the HIV response in low- and middle-income between 2001 and 2009, from US$ 1.6 billion to US$ 15.9 billion (Figure 5).

Just as AIDS activists fought for equity in AIDS treatment, they brought countries and sectors together to ensure that trade agreements and intellectual property protections do not pose undue barriers to treatment access. Social norms, national policies and laws were changed. Innovative mechanisms[viii] – such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and UNITAID – were established to raise and disburse funds. Nearly all Member States (182 of 193) have followed through on their "UNGASS" commitments to track indicators and report their results to the Secretary General of the United Nations every two years (Box 1). These experiences from the AIDS response can be used to bring more visibility and resources to address the Social Determinants of Health.

FIGURE 5: INCREASES IN FUNDING FOR AIDS RESPONSES BETWEEN 1999 AND 2009.



BOX 1: BOLD, TIME-BOUND TARGETS AGREED DURING THE UNITED NATIONS HIGH LEVEL MEETING ON AIDS, JUNE, 2011:

In June, 2011, UN member states united once again at a UN General Assembly High Level Meeting (HLM) on AIDS to reaffirm and extend the ground-breaking commitments they made in the UN General Assembly Special Session (UNGASS) in 2001[ix] and in the 2006 Political Declaration on HIV/AIDS.[x] The 2011 Political Declaration not only recommits the global community to achieve universal access to HIV treatment, care and support by 2015 but also articulates a number of global targets. In the 2011 Declaration members agreed to:

- Push towards eliminating new HIV infections among children in the next five years;
- Increase the number of people on life saving treatment to 15 million and reduce tuberculosis related deaths in people living with HIV by half in the same time period;
- Eliminate gender inequality, gender based abuse and violence, and to increase the capacity of women and adolescent girls to protect themselves from HIV infection;
- Review laws and policies that adversely impact on the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV;
- Expand access to essential HIV prevention commodities, particularly male and female condoms and sterile injecting equipment, and deploy new bio-medical interventions as soon as they are validated including earlier access to treatment as prevention.

Source: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/june/20110610psdeclaration/

6. Strike the right balance between urgent needs and long-term structural change.

The need for scaled-up and improved HIV prevention and treatment services remains urgent. Effective AIDS responses also recognize that expanding access to basic health services is only part of a systems approach that creates demand for effective services, shapes aspirations for health and happiness, and builds resilient, socially inclusive societies. They ensure that health services care for people who are in need while reducing vulnerability and impact.

Evidence pinpointing social vulnerabilities and evaluating social and legal policies in low- and middle-income countries is scarce compared to the wealth of data about biomedical issues in HIV prevention, treatment and care. National AIDS programmes need a combination of biomedical, behavioural and structural interventions to meet their prevention and treatment objectives.

To be more user-friendly, efficient and sustainable over the long term, HIV policies and services must be attuned to their social and political context. They can be increasingly integrated into other health and development efforts, for example, by strengthening health systems, reducing factors that put people at risk of HIV-related tuberculosis, including HIV prevention and treatment in maternal, neonatal and child health services, ensuring that sexual and reproductive health programmes respect the rights of people living with HIV, and promoting HIV-sensitive approaches to social protection and gender equality.

- Policies and programmes to achieve MDG6 (Combat AIDS, Malaria and other Diseases) support and depend upon all the MDGs, both directly and through integration and synergies within health and with other development sectors.
- Overcoming direct social barriers to integrated health services takes locally owned, sustained, inter-sectoral effort over 5-10 years or more.
- National HIV programmes will be strengthened by scaling up capacity development, intervention research and policy analysis on the social determinants of health, including determinants of HIV vulnerability and risk.

Moving Forward:

By leveraging experience from the AIDS and Social Determinants of Health fields, together we can achieve much more by 2015 and beyond

Encourage higher aspirations to enhance social welfare and human rights

In low- and middle- income countries, there is a deficit of evidence on the short-and long-term costs in relation to benefits of social welfare programmes and policies.[xi] Urgent competing priorities hold sway, and there are far fewer expert analysts to make the argument for investment in welfare and human rights programmes.[xii]

Social determinants of health are life-and-death issues. This is widely recogognized. However, investments in social welfare and human rights programmes have not matched this understanding. Attention to social determinants in low- and middle-income countries is not porportionate to investment in curative health services. Macro-economic policies and political pressures for immediate results too often block investment and fair financing to address social determinants of health.[xiii]

- Political leaders globally have the opportunity to elevate attention to the social determinants of health from a technical policy debate to a central platform in intergovernmental meetings, such as Rio+20 and the MDG Summit in 2015.

- The BRICS countries* can elevate the Social Determinants of Health to the G77 and the G20 agendas, and can continue to lead the way in capacity development and in terms of their own domestic investments.

- Policies and programmes to achieve MDG6 (Combat AIDS, Malaria and other Diseases) support and depend upon all the MDGs, both directly and through integration and synergies within health and with other development sectors.

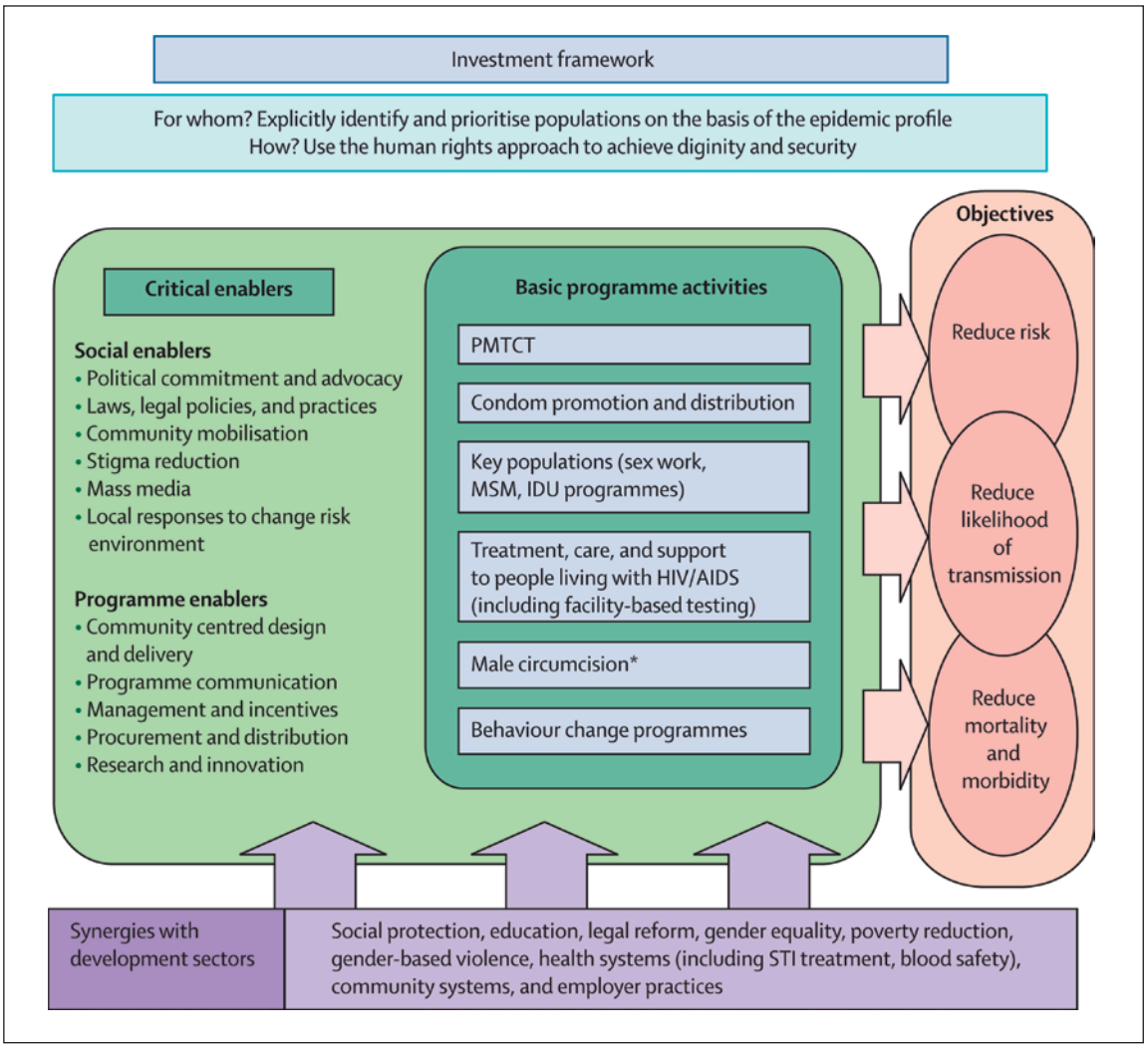
* Brazil, Russian Federation, India, China and South Africa.

Promote smart investments

A new UNAIDS Investment Framework developed by AIDS leaders (Figure 6) shows that understanding and addressing the underlying social determinants of HIV vulnerability and risk is even more than the right thing to do: it is a smart investment. Without an enabling social, legal and economic environment, even well-designed and implemented clinical services cannot perform efficiently and achieve optimal results. Smart, evidence-informed, investment in reversing gender inequality and promoting human rights will stretch limited resources and ensure that lasting improvements in social conditions are central to health and development policy in all countries.

The AIDS Investment Framework clarifies the routes to optimizing national AIDS responses by identifying distinct programmatic categories of action: basic programme activities which can be scaled up according to population need and have a direct effect on HIV transmission, morbidity and mortality; critical enablers which determine the environment in which basic activities will be successful or not; and synergies where an 'HIV-lens' can enhance the impact of development efforts in sectors beyond HIV itself – for example in education, social protection, justice and law, gender, youth and social development. The Investment Framework analysis recommends that between 19% and 36% of HIV resources be invested in critical social and programme enablers, and between 22% and 27% be invested in synergies with other development sectors between the present and 2020.

FIGURE 6: A NEW INVESTMENT APPROACH TO AIDS FUNDING.



Source: Reproduced with permission from the Lancet. Schwartlander et al 2011[xiv].
PMTCT (Prevention of Mother to Child Transmission of HIV); MSM (Men who have Sex with Men); IDU (Injecting Drug Users).

Foster solidarity and joint action toward shared goals

A distinctive strength of the global AIDS response has been its emphasis on unity and solidarity. This core value is more important than ever, as the global economic crisis precipitates a decline in financial resources for AIDS and other global health and development efforts. The AIDS response has been a pathfinder for action on social determinants of health ranging from gender equality to HIV-sensitive social protection in low- and middle-income countries. By using the holistic, longer-term approaches of Social Detrminants of Health, together we can continue that progress and counter pressures that fragment development efforts and that delay genuine, equitable partnership. Working together, AIDS and Social Determinants of Health advocates can commit to joint action to:

- Build alliances and ensure solidarity amongst sectors involved in all the "critical enablers" of strong HIV, health and development programmes.
- Utilize the comparative advantage of each willing player, and work together to define constructive, empowering and efficient ways forward.
- Recognize the political challenges around an equity agenda, and develop joint strategies to address resistance to the 3 Rs (rights, regulation and redistribution)[xv] of the equity agenda together.
- Build sustainable capacity within low- and middle-income countries to conduct social, economic and political research and analysis, to promote greater equity, efficiency and effectiveness, and scale in integrated health and development programmes.

Conclusion

The root causes of health inequities lie in societal conditions, not just in the status of health services. Tackling the social determinants of health requires multi-sectoral diagnosis, and inter-sectoral action. Action must be informed by evidence, rooted in broader development policies and alert to the political dimensions of public health. Both the Social Detrminants of Health and the HIV fields have made important advances in delivering as one, across distinct communities, stakeholders and sectors. Further success requires more evidence, strategy, inclusion, leadership, and commitment to balance the quest for immediate results and long-term social change.

Joined by common ideals of solidarity and social justice, the AIDS and Social Determinants of Health communities can do much more to expand the demand for integrated and rights-based approaches to health and development. We can build and connect networks, create alliances and support action to put social determinants on the global political agenda.

Building bridges and joining forces with other movements for health and social justice will accelerate progress across the MDGs, optimize efficiency in the use of resources, save and improve more lives, and help to create a world in which Zero Inequity becomes a reality.

End Notes:

i CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

ii UNAIDS. AIDS at 30: Nations at the crossroads. Geneva, 2010.

iii CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

iv UNAIDS. Getting to zero: UNAIDS Strategy 2011-2015. Geneva, 2010. Available at http://www.unaids.org/en/strategygoalsby2015/.

v UNAIDS. UNAIDS Report on the Global AIDS Epidemic. Geneva. 2010. Available at www.unaids.org/globalreport/global_report.htm.

vi 2001 United Nations General Assembly. United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. New York. United Nations, 25-27 June 2001.

vii UNAIDS. The "Three Ones" in action: where we are and where we go from here. Geneva, 2005

viii Dodd R. and Lane C. 'Improving the long-term sustainability of health aid: are Global Health Partnerships leading the way?' Health Policy and Planning; (25):363-371, 2010.

ix 2001 United Nations General Assembly. United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. New York. United Nations, 25-27 June 2001.

x 2006 United Nations General Assembly. 60/262. Political Declaration on HIV/AIDS. New York. United Nations, 2006. Available at http://data.unaids.org/pub/Report/2006/20060615_hlm_politicaldeclaration_ares262_en.pdf.

xi Blas E. and Kurup, S.K. (Eds.) Equity, Social Determinants and Public Health Programmes. World Health Organization, 2010.

xii International Social Science Council. World Social Science Report, Knowledge Divides. UNESCO, 2010.

xiii CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

xiv Schwartlander B, Stover J, Hallett T, Atun R, et al. Towards an improved investment approach for an effective response to HIV/AIDS. Lancet, 2011; vol. 377: 2031-2041.

xv Labonté R. and Schrecker T. 'Rights, Redistribution and Regulation'; in Labonté, R. Schrecker, T. Packer, C. and Runnels, V. (Eds.) Globalization and Health: Pathways, Evidence and Policy, New York: Routledge, 2009.

20 Avenue Appia
CH-1211 Geneva 27
Switzerland

+41 22 791 3666
distribution@unaids.org

unaids.org

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