Combating HIV/AIDS in developing countries

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Combating HIV/AIDS in developing countries

Requires empowering people to act on their own terms

In July 2004 the international community will convene in Bangkok, Thailand, for the 15th international AIDS conference. The gathering occurs at an opportune time in global health as just months earlier, the World Health Organization and UNAIDS launched the “3 by 5” programme—a global initiative to provide antiretroviral therapy to 3 million with HIV/AIDS in developing countries by the end of 2005.1 Additionally in the past few years the Global Fund to Fight AIDS, Tuberculosis, and Malaria was created, to finance a scaling up of resources for interventions against all three diseases (www.theglobalfund.org/en/). These initiatives are augmented by increases in funding from private, national, and international sources. Together these efforts represent one of the most important trends in global health over the past five years. The movement for increased funding for HIV/AIDS in developing countries has brought attention to the issue and initiated a process of responding to it.

Focusing on prevention of HIV and on expanding access to antiretroviral treatment for people living with AIDS is critically important to the fight against HIV/AIDS, but alone this strategy is not enough to tackle the problem. Combating HIV/AIDS in low and middle income countries requires more than prevention and treatment—important as this two pronged strategy is. It requires improving the conditions under which people are free to choose safer life strategies and conditions for themselves and future generations. An alternative view of the HIV/AIDS problem recognises the inter-relatedness of health and other valuable social ends (for example, education, employment, or civil rights) and also emphasises the importance of individual agency or freedom—that is, people’s ability to act and bring about change in terms of their own values and objectives and thus to live a life they value—for the prevention and treatment of disease.2,4 Freedom is essential for both individual and collective action and is critical for changing policy, norms, and social commitments.5 These key elements are part of an alternative way of thinking about HIV/AIDS policy and several points are relevant to this view.

Firstly, this alternative viewpoint appeals to a particular vision of the good life that is derived from Aristotelian political philosophy6 and Amartya Sen’s capability approach.7,8,9 According to Aristotle, society’s obligation to maintain and improve health is grounded in the ethical principle of human flourishing, which holds that society is obliged to enable human beings to live flourishing and thus healthy lives. This view sees development as expansion of individual freedom instead of judging development by gross national product or personal income.10–12 Similarly it sees health policy as expansion of individuals’ choices or opportunities for a healthy life, instead of judging health policy by health spending or defined benefits, important as these are.13 This perspective stems not only from moral and political philosophy, but from empirical evidence synthesised by the scientific community on the effectiveness of HIV prevention and AIDS treatment strategies.12

Secondly, sustainable prevention and treatment of HIV/AIDS requires empowering people to act and bring about change in their own terms—at the individual as well as the collective level. Combating HIV/AIDS in developing countries thus requires more than disease specific interventions, it must also include a country’s broader development strategies. At the individual level, for example, better education, especially for women, makes individuals more likely to protect themselves from contracting HIV.12 Moreover, improved economic, cultural, political, and social conditions for women improve the effectiveness of HIV/AIDS prevention and treatment programmes because women can choose safer life strategies and conditions for themselves and their children. Such conditions can be created through employment and cultural values, ownership of assets, and political and civil opportunities that empower them in the family and in their relationships with men.14,15

Women in developing countries are affected disproportionately by HIV/AIDS. Nearly 60% of individuals living with HIV/AIDS in sub-Saharan Africa are women,16 thus efforts to reduce gender inequalities in social, economic, and political opportunities is critical.

In north America, western Europe, Australia, Thailand, Senegal, Uganda, and Brazil the spread of HIV/AIDS has been slowed through multiple prevention strategies. These include health education, behaviour modification, social, economic, and political environments that allow individuals to protect themselves against infection, promotion of condoms, HIV testing and counselling, reducing mother to child transmission, needle exchange and blood safety programmes, and treatments for sexually transmitted
Compulsion and psychiatry—the role of advance statements

Liberation cannot be handed to the oppressed by the oppressor

M ost psychiatrists accept reluctantly that from time to time they need to force patients to have treatment against their wishes. The British government’s proposed changes to the Mental Health Act will increase compulsion in three ways. They will remove the requirement that a patient’s condition must be severe enough to warrant admission to hospital, thus enabling compulsory treatment in the community; they will re-incorporate people with personality disorder; and they will introduce wider definitions of mental disorder and of treatment. Users of mental health services have long been concerned about compulsion and have tried to combat it. Twenty years ago groups such as Survivors Speak Out pioneered the use of crisis cards as a way of resisting compulsion in mental health emergencies. More recently, partly in response to the proposed legislation but also as part of a growing critical debate within the profession, psychiatrists have turned to advance statements (or advance agreements if made consensually with a mental health professional), in the hope that these will reduce compulsion and facilitate a more collaborative engagement with service users.1-3

An advance statement is a declaration made by a service user about preferences for treatment should future episodes of psychosis impair capacity. However, as no evidence exists for such interventions, the paper by Henderson et al in this issue is welcome (p 136).3

They found that patients who had joint care plans—a form of advance statement about care—were less likely to experience compulsion and spent fewer days detained in hospital than the control group. These results conflict with those from the only other study in this area. Papageorgiou et al found that advance statements had no impact on the outcome of care in terms of frequency of compulsory readmission or days spent in hospital.5 Although joint care plans and advance statements differ, they share a collaborative approach to planning care in order to minimise compulsion. Despite this, many patients in both studies decided not to

5 Ruger JP. Ethics of the social determinants of health. Lanham (in press).