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Confronting the pandemic: the World Health Organization's Global Programme on AIDS, 1986-1989

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Introduction

This article focuses on the role of the World Health Organization (WHO), through its Global Programme on AIDS (GPA), in directing and coordinating the global response to HIV/AIDS from 1986 to 1989.

WHO, like virtually all community, national and international institutions, did not initially appreciate the importance of AIDS. From 1981 to 1985, WHO limited its role to collecting and exchanging technical information about AIDS. Then, in April 1985, immediately following the First International Conference on AIDS in Atlanta, Dr F. Assaad, Director of WHO's Communicable Diseases Division, organized a meeting of international AIDS experts, who called for WHO to become actively involved in expanded AIDS work without delay [1]. This recommendation led to the creation of a small program on AIDS at WHO headquarters, staffed initially with one professional officer and one secretary in June 1986.

In mid-1986, there was no consensus about the significance of AIDS as a threat to world health. Limited information from studies of small population samples, often sensationalist media coverage, and concealment of available information by governments concerned about international stigmatization all contributed to uncertainty about the magnitude and scope of the AIDS problem.

The lack of a coherent national response to AIDS in most countries mirrored the confusion about AIDS among official development agencies and international organizations. In addition, as the main thrust of WHO's work since the late 1970s had been on promoting primary health care, AIDS was initially perceived as a potential competitor for attention and resources. However, information from the Second International Conference on AIDS (Paris, June 1986), along with data

available to WHO through official and unofficial channels, clearly indicated that AIDS was an urgent global health problem, requiring a new, major effort by the organization responsible for directing and coordinating international health work.

Global mobilization

Whilst reorientating its own perspectives on AIDS, WHO sought to generate commitment of people, institutions and resources to AIDS. To accomplish this fundamentally important task, four activities were required: alerting the world to the realities and dangers of AIDS; articulating direction and a conceptual framework for thought and action; linking the awakened and intensified concern about AIDS to an identifiable sequence and range of concrete actions; and implementing an aggressive, active worldwide program. The ensuing commitment had to be international, decentralized and sustained, ensuring the involvement of diverse social and governmental sectors and non-governmental organizations. Effective mobilization also required strong support for local leadership while promoting linkage to a global network and policies, and helping countries to develop organizational structures and resources to ensure long-term program survival, despite inevitable changes in local and national leadership.

To alert and stimulate a global response to AIDS, the pandemic had to be defined; a common conceptual framework, technical understanding and language about AIDS was required. First, WHO declared AIDS to be a global problem, and estimated that as of early 1987, a worldwide total of 5-10 million people were infected with HIV [2]. Three global patterns of HIV/AIDS were defined, based on the predomi-

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nant risk behaviors for HIV transmission and the timing of HIV introduction or extensive spread [3]. An AIDS case definition for worldwide use was adopted and a clinical definition proposed [4]. Estimates of the number of cumulative AIDS cases (about three times greater than official reports) and short-term projections (over 1 million people developing AIDS by the end of 1991) were also developed. WHO emphasized the potential for dramatic future increases in HIV spread, both within already affected areas and in previously unaffected areas. Throughout the world, AIDS had become a touchstone for pre-existing prejudices which created barriers to prevention and control efforts. To depoliticize these issues, WHO reiterated the limited routes of HIV spread and emphasized that HIV was a 'naturally occurring' virus of 'unknown geographical origin' [5].

This epidemiologic 'boundary setting' established the technical background for a conceptual definition of the broad HIV/AIDS problem. First, HIV/AIDS was identified as a 'worldwide epidemic', which did not respect national boundaries and affected both the industrialized and developing world. Second, WHO emphasized that AIDS would affect all parts of the existing health system (for example, immunization, maternal and child health, family planning), that HIV-related immunodeficiency would create potential interactions with other diseases, such as tuberculosis, and that AIDS would reveal critical, pre-existing deficiencies and inequities in existing health systems. WHO then situated AIDS within a broad definition of health, drawing attention to the 'third epidemic' of social, cultural, economic and political reaction and response to HIV/AIDS [6]. Finally, the threat posed by AIDS to socioeconomic development was highlighted, based on its selective impact on young and middle-aged adults, and its capacity to reverse recent gains in infant and child survival.

WHO then articulated a framework for action: the Global Strategy for the Prevention and Control of AIDS. The Global AIDS Strategy was designed to establish clear common principles, with a capacity for evolution as well as adaptation to diverse national and local conditions. The Strategy defined three objectives: preventing HIV transmission; reducing the personal and social impact of the pandemic; and unifying national and international efforts against AIDS. Each objective then served as the nidus for development of policies, guidelines, specific materials, training programs and other instruments for national and community use. For example, preventing transmission through blood was a specific problem within the overall objective of preventing HIV transmission. Further elaboration of this effort would then involve preparing guidelines on indications for blood transfusion, WHO-coordinated efforts to define the operational characteristics of dif-

Blood Safety Initiative' to work with the major international organizations concerned with blood and to utilize public awareness about HIV to strengthen blood systems worldwide.

A series of basic principles to articulate further provide a context for the Global AIDS Strategy also proposed. The HIV/AIDS pandemic was viewed as a problem requiring both urgent and broad effort at community, national and international levels. The importance of taking preventive action while the pandemic was still relatively new was stressed. WHO expressed guarded optimism that prevention was possible through informed and responsible individual social behavior, along with realism regarding the long-term nature of the HIV/AIDS problem. By stating repeatedly that 'business as usual' approaches and status quo of health and social systems would not be sufficient to face the challenges of HIV/AIDS, WHO sought to give impetus to creative and innovative approaches. The importance of sustained social and political commitment was emphasized, and WHO insisted that all countries needed a comprehensive national AIDS program, integrated within the national health system and linked together in a global network. WHO declared that support for human rights and prevention of discrimination were entirely consistent with the overall objective of protecting the public health. Finally, the Global AIDS Strategy was understood to require adaptation and updating as both the pandemic and the response to it evolved.

Therefore, the Global AIDS Strategy had at least three roles: as a practical framework for development of common policies, guidelines and materials; as an evolving vision of what would be required to confront HIV/AIDS; and as a metaphor for a global response and global solidarity in the face of a new pandemic.

The next task facing WHO was to gather universal support both for the strategy and for WHO's central role in directing and coordinating the global response to the pandemic. This process was undertaken from May 1987 to January 1988.

In May 1987, the World Health Assembly declared AIDS to be a 'worldwide emergency', requiring 'urgent and vigorous globally directed action' [5]. The World Health Assembly's Global AIDS Strategy was unanimously endorsed and all countries were urged to create or strengthen national AIDS programs 'in line with the ... global strategy'. WHO was also requested to 'issue guidance ... on a continuing basis as new information comes to light and the [WHO AIDS] program evolves' [5].

The following month, at their annual summit held that year in Venice, the leaders of the seven major industrialized countries (and the European Economic Community) declared AIDS to be 'one of the biggest p

all countries 'to cooperate with WHO and support its [AIDS] program [7]. Then, on 20 October 1987, the United National General Assembly received a special briefing on AIDS (debating on a disease for the first time in its history), confirmed WHO's 'essential global directing and coordinating role' and directed all UN agencies to support WHO 'in conformity with the Global Strategy' [8].

Next, it was vital to provide ministers of health with a forum for sharing experience and mobilizing commitment to AIDS prevention and control. A world summit of ministers of health was organized jointly by the UK government and WHO. This summit, held on 26-28 January 1988, brought together more ministers of health than any previous meeting on any subject (117 ministers, with a total of 148 countries represented). The combination of national AIDS presentations by more than 100 countries, technical discussions on AIDS information/education programs, collegial high-level dialogue and the summit's 'London Declaration on AIDS Prevention' provided extraordinary impetus for national AIDS programs to be further developed in countries around the world.

The WHO Global Programme on AIDS

WHO's AIDS program had two major operational tasks: to support and strengthen national AIDS programs, and to provide global leadership and help ensure international collaboration.

National program support

Although the development of national AIDS programs was a critical part of the Global AIDS Strategy, it highlighted most clearly the limitations and strengths of WHO as an intergovernmental organization. In general, WHO was accustomed to providing countries with external, technical advice, along with very limited funds, scholarships and study grants. However, to confront HIV/AIDS, WHO sought to go far beyond this limited, technical and rather politically uncontroversial role, to assist countries in developing their own strong and comprehensive national AIDS program by offering a wide range of services, from technical cooperation in planning to financial resources, training, and helping in coordinating international support on behalf of national efforts. Thus, the WHO effort was rapid and broad, in an effort to respond to widely diverse national needs.

Figure 1 illustrates the basic sequence in WHO-national government interactions. By late 1986 and early 1987, when WHO received financial support for its AIDS program, it provided services and other resources, on request, to countries around the world. Urgent support often included help assess-

ing the epidemiological situation, establishing laboratories to perform HIV testing, developing early information/education programs, and educating health workers about HIV/AIDS. In addition, financial support was rapidly made available; thus, a median of US\$175 000 was provided for immediate use for 44 African countries (range, US\$31 000 for the Seychelles to US\$644 000 for Zaire). This early, positive experience of countries working with the WHO AIDS program, including prompt response and financial support, created substantial enthusiasm among ministries of health for collaboration with WHO (as well as pressures on other WHO programs to perform in a similar fashion).

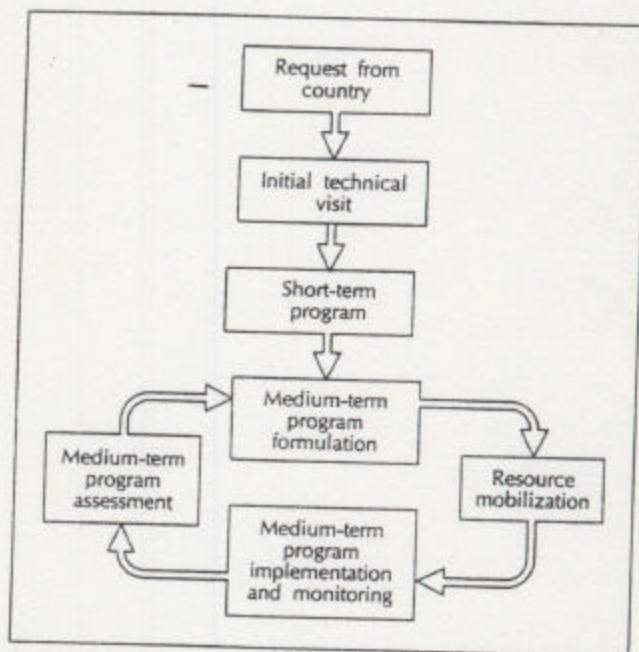


Fig. 1. Development of national AIDS programs.

Beyond urgent, initial support, WHO worked with national AIDS programs to develop a medium-term plan (MTP), for a 3-5 year period. The MTP was the key document for creation of a national consensus as well as for international resource mobilization. It was a national document whose overall compatibility with global policies and guidelines resulted from extensive discussions and technical support provided by WHO to governments.

Once the MTP was prepared, WHO helped organize a 'resource mobilization' meeting in the national capital city. WHO used the MTP to ensure optimal external support in several ways. First, WHO obtained agreement of external donors to give their support within the framework of the MTP. Second, the MTP was sent to all potentially interested donors, rather than only to those donors with traditional links to the country. Third, WHO established a new mechanism, so that donors who did not have an office in the country could still provide bilateral funding in support of the MTP.

components of the national program were seen as interdependent; critical elements which are less attractive to donor agencies (such as infrastructure support and certain operational costs) were seen as integral to the success of the entire program.

The theme of coordination through the MTP also extended to the evaluation phase. Rather than external donors conducting separate program reviews (at great cost to program implementation), WHO promoted and helped organize a single program review, bringing all donors together.

The number of countries requesting WHO support rose rapidly; by November 1988, 144 countries had received initial support, 116 had written their short-term plan and 47 had completed their MTP. By the end of 1989, 159 countries had received GPA support, 95 had developed MTP and 10 had completed their first annual national program review.

To accomplish this work, over 1300 consultant missions were organized by GPA in 1988-1989. The range of technical support was broad, including design, implementation, monitoring and assessment of national AIDS programs, as well as specific areas such as epidemiology, laboratory services, health promotion, blood services, clinical management, counseling and condom services management. Yet GPA support extended far beyond the traditional definition of technical support; operational support to national AIDS programs included equipment, supplies, staff (by late 1989, 40 professionals were in WHO posts assigned to work within national AIDS programs) and training. For example, the number and scope of WHO-organized training programs increased from 20 activities in 1987 to 137 in 1989, most of which focused on 'training of trainers'.

From 1987-1989, US\$166.9 million was mobilized for support of 65 national MTP. Of this total, 46% was provided through traditional bilateral aid channels, 39% was provided by bilateral donors through special arrangements with WHO ('multilateral-bilateral' channels), and the remaining 15% was provided directly by WHO.

In summary, support to national programs was a major priority for GPA during the period 1986-1989. WHO's strengths of universality and neutrality, combined with its capacity to work closely with governments, provided the opening for GPA to accelerate markedly the process of national AIDS program development. These strengths also helped ensure an unprecedented level of external coordination and cooperation with national programs.

However, critical and persistent problems remained

problems. Despite the growing number of countries reporting AIDS cases, some countries still refused to report, or to report in an open manner, their national HIV/AIDS situation. In many countries, AIDS was still seen as an unsavory issue, which was staffed by young health professionals. Then, as AIDS funding and prominence increased, conflicts arose between the dynamic AIDS staff and the medical/health hierarchy.

Within WHO, the pace of work on AIDS created substantial tensions. By 1988, the AIDS program became the largest single program within WHO (testifying to inadequate funding for other programs rather than excessive attention to AIDS). In addition to the unprecedented administrative pressures created by recruitment of hundreds of staff, delivery of support (including financial resources) to a very large number of countries, (at one point, well over half of all after hours telephone calls and telexes from WHO headquarters were from the AIDS program) and organization of expert meetings, often on an urgent basis, the size and dynamism of the program created tensions and stresses within the organization.

Then, as national programs matured, they encountered many serious problems, including delivery of support to the community level, relationships with nongovernmental organizations, linkage with other sectors of government and integration with other activities and programs in the health sector. In addressing these issues, the AIDS program sought to align, as far as possible, WHO's fundamental identity as an organization of member states (nations) with its perceptions of critical needs for global AIDS prevention and care.

Global activities: policies and research

The Global Strategy provided a broad framework, which called for more specific guidance, materials and supportive training. From 1986-1989, GPA sought to fulfill the World Health Assembly's directive 'to issue guidance on the prevention and control of AIDS on a continuing basis'.

The mechanism most favored by GPA was the technical consensus meeting, adapted for rapid and broad dissemination of meeting conclusions. Often at relatively short notice, GPA would assemble between 10 to 50 experts on a specific topic, selected with regard to disciplinary and geographical diversity, for a 1-5-day meeting. These meetings produced short consensus statements and usually held a post-meeting press briefing; the full reports were completed and distributed in record time, often within weeks after the meeting. The conclusions and recommendations of the WHO expert consultation were widely publicized; this had an

Health Assembly resolutions were actively promoted and distributed, including to non-governmental organizations and journalists, for whom they were useful tools to remind governments of the commonly agreed policies in AIDS prevention and control.

Meetings were held in response to four needs: to develop or clarify policy; to collect and link available scientific information to policy; to develop criteria and standards for general use; and to help cement inter-organizational cooperation and further policy development in other agencies.

An important example of policy development occurred in early 1987. Following reports from several countries of impending restrictions on entry of HIV-infected travelers, GPA organized a meeting on 2-3 March 1987 to review several issues regarding international travel and AIDS. The assembled experts addressed two specific questions: the potential value of border controls in limiting the international spread of HIV; and whether HIV-infected travelers should be using public conveyances. On the first, central issue, the expert consultation concluded that 'HIV screening programs for international travels would, at best and at great cost, retard only briefly the dissemination of HIV' and that such programs would be wasteful and difficult to justify, particularly in light of the 'epidemiological, egal, economic, political, cultural and ethical factors mitigating against adoption of such a policy' [9]. Of course, no restrictions on use of public conveyances were justified for HIV-infected people, other than general restrictions regarding general state of health, as for any other health problem. This strong position on international travel restrictions was extensively publicized and contributed to preventing an impending wave of restrictive legislation.

Many meetings were designed to bring emerging scientific information to bear upon a policy issue. For example, in early 1988, reports of neuropsychological abnormalities among otherwise healthy HIV-infected people (Centers for Disease Control stages II and III) led to calls for mandatory HIV screening of pilots, among others. GPA organized a meeting of 48 experts for a several-day, two-part consultation. In the first part, all available (and mostly unpublished) data were presented and the experts were asked for their views on the meaning of the data. They concluded that there was 'no evidence for an increase of clinically significant neuropsychological abnormalities' in such people; 'otherwise healthy HIV-1-infected individuals are more likely to be functionally impaired from a neuropsychiatric viewpoint than uninfected persons' [10]. Then, the second part of the meeting brought the scientists together with policy experts, to translate the science into policy. The meeting consensus was that there was no justification for HIV-1 serological screening in asymptomatic people. Concern about public

safety was refocused on detecting impaired job performance due to any cause, rather than on HIV testing. In addition, the meeting proposed an important international research program (which was initiated) and follow-up meetings were recommended (and held) to consider the policy in light of emerging data.

Similarly, the emerging scientific data on the relationship between HIV and other sexually transmitted diseases (STD) led to a series of expert meetings, collaboration with the WHO program on STD, and arrangements for an internationally recognized STD expert to spend a year with GPA to help advance the integration of HIV/AIDS and STD services at the national and community level [11].

Once HIV testing methods became widely available, enthusiasm for screening programs increased worldwide, particularly for mandatory screening. GPA decided to develop long-term guidance in this matter, not by approving or disapproving of screening *per se*, but rather by identifying the criteria and issues which had to be considered and resolved before any screening program could be carried out. The expert meeting, held on 20-21 May 1987, concluded that only if a rather substantial list of conditions were met could an HIV screening program be considered appropriate or useful [12]. The immediate effect was to substantially dampen the instinctive enthusiasm for screening and to refocus attention on how best to meet the objectives of preventing HIV transmission.

Finally, GPA sought to engage many other organizations in collaborative work and to stimulate complementary policy development within other agencies. As an example, from 17 to 29 June 1988, GPA organized a meeting on AIDS and the workplace in association with the International Labor Organization (ILO). Epidemiologists and other health experts met with representatives of business, unions and governments. The consensus statement emphasized that, for the vast majority of workplace settings, there were no real risks of HIV spread [13]. HIV screening was strongly discouraged, and healthy or ill HIV-infected workers were to be treated as any other healthy or ill worker, respectively; workplace education was emphasized, along with development of workplace policies before an HIV-related situation emerged; the need to avoid discrimination was stressed. The consensus statement was widely disseminated through international ILO channels as well as through WHO mechanisms.

A total of 67 policy-related meetings were held from 1986 to 1989, including five in 1986, 18 in 1987, 19 in 1988 and 25 in 1989. Each meeting's specific proposals were rapidly and widely disseminated to specific target audiences (national programs, health workers, international agencies) and to the general public.

In two fields — human rights and work with non-governmental organizations — GPA created major policy innovations which carried great promise for future development, but which conflicted with traditional attitudes within the organization.

The GPA commitment to human rights emerged from two sources: increasing awareness of the relationship between antidiscrimination and effective HIV prevention efforts and sensitivity to human rights issues. Accordingly, as of mid-1987, GPA designed and implemented a strategy on AIDS and human rights.

First, GPA developed further the public health rationale for preventing discrimination in HIV/AIDS programs. In December 1987, 1 month prior to the London Summit, GPA published a document on 'Social Aspects of AIDS Prevention and Control', stating that a failure to prevent discrimination would endanger public health [14]. HIV-infected people 'should remain integrated within society to the maximum possible extent and be helped to assume responsibility for preventing HIV transmission to others'. From this time, GPA integrated the principle of non-discrimination into its support for national AIDS programs, refusing, despite political pressures, to fund discriminatory activities within country programs (for example, laboratory support for mandatory screening activities). These issues brought into sharp focus the latent conflict between the principle of respect for national integrity and decision-making, and global agreements on policy, or conformity with global principles.

In January 1988, the London Declaration firmly stated that human rights and dignity must be protected, that discrimination undermines public health goals, and that a spirit of 'social tolerance' must be forged. Then, in May 1988, to complete the policy-making process, the World Health Assembly unanimously adopted a resolution entitled, 'Avoidance of discrimination in relation to HIV-infected people and people with AIDS' (WHA 41.24). The public health rationale was clearly articulated: 'respect for human rights and dignity of HIV-infected people, people with AIDS and members of population groups is vital to the success of national AIDS prevention and control programs and of the global strategy'.

The second component of the human rights strategy was to establish mutually supportive links with the human rights community, both official and non-governmental. GPA rapidly discovered that communications between official health agencies and human rights groups were rather unusual and infrequent. Yet in general, once the issues had been clearly explained, human rights organizations expressed willingness to join in efforts to address AIDS-related discrimination. GPA sought to bring AIDS and human rights groups together at the community and national, as well as in-

of human rights concerns in AIDS, from monitoring relations to preventing discrimination, as a critical part of HIV prevention efforts. These involved a series of meetings with United Nations human rights bodies, including the United Nations Commission on the Status of Women. An AIDS-human rights resolution before the United Nations Commission on Human Rights was broadened in scope, with great importance for the future. Ultimately, the Commission approved a resolution on non-discrimination in the entire field of health not just AIDS.

GPA efforts in human rights were often successful in preventing adoption of discriminatory national policies, but less effective in ameliorating already established situations. For example, the Cuban national AIDS policy was and remained in direct conflict with World Health Assembly resolutions. Several visits to regional and headquarters WHO staff to Cuba failed to produce any substantial change in policy. Particularly disturbing to WHO was the unverified Cuban claim that their program had been extremely effective in preventing spread of HIV within Cuba. Therefore, in mid-to-late 1989, in concert with regional officials, the AIDS program at headquarters proposed that an expert external evaluation of the Cuban program be undertaken. This proposal was discussed at length during Director of GPA's visit to Havana in early 1990, but was not accepted by the Cuban government.

The second major area of innovation developed by GPA involved work with non-governmental organizations. Recognizing that non-governmental organizations were vitally important in HIV/AIDS prevention and care, GPA looked beyond the national governments in efforts to reach to the community level, and strongly promoted non-governmental organization involvement in national AIDS program planning, implementation and evaluation. GPA collaborated directly with non-governmental organizations working internationally, such as the League of Red Cross and Red Crescent Societies, the International Council of Nurses, Street Kids International and the Names Project. A total of US\$1.6 million was devoted to such work in 1989. GPA also helped to develop a 1989 World Health Assembly resolution (WHA 42.34) emphasizing the vital and complementary role of non-governmental organizations in AIDS work at all levels.

Recognizing the limits of international and national level activities, GPA expanded and diversified its support to non-governmental organizations at a national level. It created innovative mechanisms to help deliver technical and financial resources to non-governmental organizations at the local or national level. GPA channeled funds to non-governmental organizations through national AIDS programs, but this process was sometimes slow and inefficient. It was

the further transmission of the funds risked becoming hostage to national and local politics, and where relations between ministries of health and health-related non-governmental organizations were difficult, the funds might not be transferred. GPA therefore developed mechanisms to send resources directly to non-governmental organizations with prior governmental approval and developed the 'Partnership Program' to link local or national non-governmental organizations to non-governmental organizations working internationally. GPA then stimulated and supported the first international meeting of AIDS Service Organizations (ASO), held in Vienna during 28 February-3 March 1989 [15].

The close relationship being developed between WHO and non-governmental organizations at all levels was probably threatening to some national governments. For example, GPA commissioned studies on official 'structural impediments' to non-governmental organizations and their work, intending to look beyond immediate AIDS matters to the broader problems of interference with non-governmental organization development at the country level. However, as the winds of change within WHO moved the organization back to status quo ante thinking, the GPA-non-governmental organization relationship suffered.

Research

GPA's research and technical dimensions reflected its belief that WHO should be most active where its efforts could be most creative and useful, avoiding competition with well-funded national and private research agencies and initiatives. GPA's scientific and technical work (biomedical, epidemiology, health promotion and social/behavioral) focused on four tasks: providing relevant technical assistance to national AIDS programs; exchanging information and materials; identifying, coordinating and supporting an international research agenda; and articulating a global perspective on several critical scientific issues.

GPA interpreted its mandate in an activist fashion; for example, when serologic tests for HIV infection were developed, GPA organized training for laboratory scientists from nearly 100 countries. Then, when plethora of test kits were marketed, GPA organized multicenter evaluation of the field performance and operational characteristics of all commercially available tests, along with a laboratory proficiency testing system.

GPA sought to fill gaps in the international research agenda. For example, it gave substantial attention to social and behavioral research. As a first step, a consultation was organized to identify priority issues. Next, it sought to help national AIDS programs conduct locally relevant research. For example, as surveys of knowledge, attitude, beliefs and practices (KAP) were

conducted, GPA developed a package of core materials (protocols and instruments). Extensive training activities to help national AIDS programs use and adapt these materials were carried out.

In addition to stressing the importance of social/behavioral, health promotion and epidemiological research at the local, national and international levels, GPA sought to improve the quality of international collaboration in research. In 1989, GPA made an inventory of research projects in 35 African countries and discovered that over half of the international collaborative efforts were unknown to the national AIDS program [16]. Concerns about 'safari research' led to the proposal of standards for international research collaboration (similar to those any industrialized researcher would expect from their colleagues), which were to be incorporated into the proposal review criteria of research funding agencies. This effort was part of broader activities to strengthen the research capabilities — biomedical, epidemiological, health promotion and social/behavioral — of developing countries.

Finally, looking towards development of new technologies, GPA helped to establish consensus about the scientific and ethical dimensions of future AIDS vaccine evaluation [17,18]. GPA also proposed to help prepare locations for international, collaborative AIDS vaccine testing and raised concerns about equity of vaccine distribution.

Provisional conclusions

In late 1989, GPA identified several areas of success along with critical problems for the future.

A global strategy, including its major component policies, had been developed and approved. Many United Nations agencies, including, most notably, the United Nations Development Program (UNDP), the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Fund for Population Fund (UNFPA) had become involved, with varying levels of commitment, in the work against HIV/AIDS. The official development assistance agencies had been mobilized to support national and international endeavors; the importance of non-governmental efforts had been recognized. Virtually every country in the world had a national AIDS program, albeit in varying phases of maturity and quality; technical and/or financial support had been delivered by GPA to over 150 countries, and an unprecedented level of resources had been mobilized in support of national programs, in a relatively coordinated and cooperative

Within WHO, GPA had become the largest single program, having received US\$153 million in contributions from 19 countries and two United Nations agencies during the period 1986–1989. GPA spending increased from less than US\$1 million in 1986 to US\$75 million in 1989. Of these resources, 70% was used to support national programs, 17% global activities and 13% for WHO overhead costs. GPA staff had increased from two people in June 1986 to over two hundred people working in WHO headquarters alone. New initiatives in the areas of health and social services, condom and virucide services, integration with STD programs, global blood safety and self-injecting drug users were underway in response to needs expressed by workers in the field. Active collaboration had been established with over 15 other WHO programs, such as nursing, mental health, tropical diseases, STD and reproductive health.

The work of 1986–1989 helped to reveal important weaknesses and deficiencies. At a national level, while initial accomplishments were often dramatic, the capacity of national AIDS programs to deliver effective support, especially at community level, was often weak and sometimes non-existent. Well-known and longstanding problems of human resources and infrastructure hampered more effective implementation of MTP. Difficulties in articulating and implementing effective relationships between AIDS and other health programs created serious operational problems. The effort required to sustain coordination among a (wonderfully) increasing number of participants and agencies, both national and international, became nearly overwhelming.

Accordingly, in late 1988 and early 1989, GPA organized a wide-ranging and systematic re-examination of its mission, successes and failures, in order to strengthen and develop the program in the early 1990s. Hundreds of private consultations, meetings in every WHO region, discussions with the Global Commission on AIDS, the donor agencies, people with HIV infection and AIDS, non-governmental agencies and national AIDS programs worldwide were held.

The net result of this process was a major reformation of GPA. GPA priorities were based on the projected needs for AIDS prevention and care in the 1990s, taking into account GPA experience and the actual or potential role of other organizations.

Several key elements of the new plan merit emphasis. First, GPA's leadership role would continue to evolve from an emphasis on 'directing' — considered necessary in the early phases of global mobilization — to 'coordinating' the diverse efforts of many organizations. However, strategic leadership and advocacy were needed for a series of key issues, including: AIDS

sis on the role and status of women; equitable sharing of the benefits of international scientific research including diagnostic, therapeutic and preventing technologies; strengthening of social and political commitment to HIV/AIDS; and building of strategic alliances within and beyond the health sector.

At the national level, delivery of support to the community level is the critical challenge. The new plan focused on practical integration with, or revitalization of existing parts of the health system, including programs for STD, maternal and child health, and broader capacity for delivery of primary health care. The gap between what was already known about HIV/AIDS prevention and care and its application at the community and national level led to two approaches. First, based on practical experience in 1986–1989, GPA support for national AIDS programs was to be refocused. Second, GPA recognized that innovation and creativity most often occur at the community level; therefore, a more organized process of 'global learning' was needed, in order to learn from and apply the enormously rich practical experience of AIDS prevention and care worldwide during the 1980s.

However, at WHO, critical changes had occurred in the institutional environment. In July 1988, a new Director-General took office. A highly bureaucratic system was instituted, which delayed program implementation, and undermined GPA's capacity to deliver sustained high levels of support at the national level. In creating institutional pressure to scale down and align GPA with other WHO efforts, the tension between GPA's vision of the future and *status quo* thinking became unbearable. In December 1989, the new GPA plan and its associated budget of US\$109.4 million were approved by the GPA Management Committee but its implementation was blocked within WHO. In early 1990, a change in GPA program management occurred, signaling an end to the first phase of GPA history.

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