Europe's Response to the AIDS Epidemic

An Interview with Dr. Lieve Fransen, Head of the Human and Social Development Unit at the Directorate-General for Development of the European Commission

By Wendy Knerr

What role has the European Union (EU) played in confronting HIV and AIDS in the world? From its Member States to the European Institutions, Europe hosts the largest number of donors to development aid in the world. This means that its policies and funding decisions have a major impact on the work being done in developing countries, including efforts to prevent HIV and provide treatment and care. Moreover, now that HIV/AIDS is increasing at rapid rates within the Europe region itself, what might the EU's role be in stemming the epidemic?

To find some answers, we spoke with Dr. Lieve Fransen, who has been involved in the fight against HIV and AIDS for more than 20 years, first as a physician and researcher in Africa, and now as Head of the Human and Social Development Unit at the Directorate-General for Development of the European Commission. As both a physician and a policymaker, Dr. Fransen plays a pivotal role in guiding EU policy on funding and support for HIV/AIDS programmes. She was the founder and Executive Director of the AIDS Task Force of the European Commission's HIV/AIDS programme for developing countries and is currently a Board Member for the Global Fund to fight AIDS, Tuberculosis and Malaria.

What do you feel have been some of the successes that the EU member states and the EU institutions have helped bring about with regard to HIV/AIDS?

Lieve Fransen: First, I'd like to mention that at the end of October we released a progress report that outline's the [European] Commission's perspective on where we have been successful and where there are still gaps with regard to our actions on the three communicable diseases (Tuberculosis, Malaria and HIV/AIDS). So this is a good place to start in answering your question.

Overall, since 2000, the Commission and the member states together have been quite successful in giving HIV, TB and Malaria higher profiles throughout the world, as well as other related issues like sexual and reproductive health and rights and the need for choice. This has certainly been a goal of the Commission, and it has been supported by most member states.

The Commission and member states have also had collective success in increasing resources for the three communicable diseases, with the Commission alone increasing resources by four or five times what they were previously. Plus, there has been more political visibility and leadership and more internal cooperation between the different Commission departments, including trade, health, research, etc.

I think another area where we have been really successful is in developing partnerships with WHO/UNFPA , UNAIDS and with other organizations, including NGOs, for the very first time. Policy dialogue is much more open now, including NGOs, people living with HIV and AIDS, industry, and other groups. Since about the year 2000 we started holding policy & information consultations with these groups, and they have increasingly been seen as real partners. Our policy area has been at the forefront of these efforts.

There's one more area where I feel the Commission has been really successful, and this is in pushing down the price of drugs. We have been leaders in putting the drug price issue on the agenda, and since we organised a ground breaking round table in September 2000 prices of key products have gone from very high to much lower today.

What do you think are some of the areas where EU member states and the EU institutions could improve with regard to their response to the epidemic?

LF: My main concern is that we have not succeeded in accelerating sufficiently the delivery of access and resources at country level. Health and HIV and sexual and reproductive health are not really in the foreground of the Country Strategy Papers[1]. Also, we have not succeeded sufficiently in developing human and institutional capacities faster in the South to confront these issues. We generally leave it to the countries, but often they do not already have the capacities in place. With regard to sexual and reproductive health and rights, we also have a human resources gap in the South and a brain drain in many countries. We need to invest more in the capabilities of people in the South so that we can keep human resources in social sectors where they are most urgently needed.

We also have not succeeded in having enough civil society voice.
For HIV, we have done better – not thanks to our own instruments, but thanks to our instruments created in the Country Coordinating Mechanisms[2] (CCMs) [for the Global Fund]. The CCMs are not perfect, but they always include non-state actors, including people living with HIV and AIDS, gender activists, women's groups and also businesses. This has enabled us to make a quantum leap in including the voices of civil society in policies.

The worst story is, of course, that we haven't managed to control the epidemic. And we haven't done enough to ensure that people have choices with regard to sexual and reproductive health. UNFPA's recent report[3] showed that there has been progress politically on sexual and reproductive health, but not in access. Examples are that commodities are not accessible and we have not improved maternal health. There's still a lot to be done.

What steps should the Member States and the Commission take in the coming years to make an impact on the epidemic?

LF: On the most basic level, I would like to see us do more of what we – meaning Europe – have done well already, and for us to fill in the gaps that I mentioned before.

Aside from that, one of my wishes is to make a major step forward in ensuring that we have a common strategy for dealing with the epidemic. All of the Member States and the Commission share a common vision, but we also must have a common strategy. Now, there are 26 partners – the 25 member states and the Commission – often doing virtually the same things. We all know that we need to make commodities available, improve gender equality, make life skills education more appropriate and available to young people, but if we keep working separately as we are now, we are wasting time.

Based on your experience with the epidemic in Africa, are there lessons that could apply to the epidemics in Russia, Central Asia and other former Soviet countries, where the disease is spreading?

LF: Before I worked on HIV, I worked in Africa, and HIV came as part of my work in several countries there. What I learned from this was that each country has to go through the same phases of facing the epidemic – denial, complacency, anger, urgency. These are the same things people go through in reaction to illness. Because of this reality, transferring lessons-learned from one country to another is difficult.

I can say, though, that it helps a great deal if the political leadership can get past the denial phase quickly. This is best done by having a political leader speak out and be courageous, bold and honest about the connection between HIV sex including homosexuality and drug use in some regions. It also helps if a political leader pays attention to the poorest and most vulnerable groups, which are the most vulnerable to HIV, because they are also the most powerful force in fighting HIV and we have to invite them into the dialogue.

In Europe, we have a mixed epidemic. I was involved with caring for the first people infected with HIV in Belgium at the hospital in Antwerp, and I'll always remember the odd mixture of patients I was dealing with. There were artists,

1 Country Strategy Papers, which are produced by all countries that receive funding from the EU, are used as the basis for national programmes for development in each country.
2 Country Coordinating Mechanisms (CCMs) are country-level partnerships that develop grant proposals and submit them to the Global Fund, monitor their implementation and coordinate with other donors and domestic programs.
3 UNFPA, 'The State of the World Population Report 2004'. (http://www.unfpa.org/swp/swpmain.htm)

ballet dancers, gay people, and then a group of Africans, mostly wealthy Africans who could afford to come to Europe for treatment.

So the epidemic in Europe is quite varied, but the reaction has been similar to other regions. For example, ten to 15 years ago, I said there was going to be a major epidemic with TB and other communicable diseases in Russia, and then six or seven years ago, I worked with the issue of HIV in prisons in Russia. Finally, after 10 years, people have woken up to these problems.

Unfortunately, some of my colleagues are saying that the epidemic in the countries neighbouring the EU – like Russia and Ukraine – is different because, until recent years, it concentrated mostly among drug users. I don't see why it's different. An epidemic of HIV clearly has a phase of introduction in a country. For example, in America, this was in the gay community but it didn't stay there. As public policy makers, we shouldn't be blind to the fact that it will enter the general population eventually and the epidemic moves in phases in each country.

No matter where or how the epidemic starts in a population, we still have to be honest about sex and protect ourselves from risk with condoms (safe sexual practices) improve gender equality and supply clean needles. The epidemic goes to the first group, then to others, then to the general population, and it's frustrating because people don't see further than what is happening now. It would be wrong only to focus on drug use because, in a few years, it will be more than just drug users' problem.

What impact do you think the meetings in Dublin could have on the epidemic globally and in Europe and Central Asia? [4]

LF: The positive impact of the first meeting in Dublin is that Europe moved forward. We are now putting some of the conference conclusions into our policy framework for HIV/AIDS, Malaria and Tuberculosis and external action...and this includes the Cairo agenda issues. This will go to the Council of Ministers and then it becomes policy. We are now making this into concrete policy that will affect all external action outside the EU, which means all action in Ukraine, Russia, the Mediterranean, developing countries – everywhere outside of the 25 member states.

As a physician, could you comment on the efforts to integrate or mainstream sexual and reproductive health and HIV/AIDS services – pros, cons, etc.?

LF: I find mainstreaming of sexual and reproductive health and HIV a non-issue if we only approach it from our own perspective. As a woman, I don't have an isolated problem with a disease and then a separate one with contraception. What we are trying to do is to create more choice. People need to have the right to choice, including which partner they choose to be with, how they choose to protect themselves, etc. It's all part of life. So I find it strange that people need to go to one place to get a condom, another to get their disease treated and another to have a baby. Also, I think it's been a failure of women's organizations that they haven't dealt sufficiently with this issue and haven't had an integrated approach to choice.

However, I'm not necessarily translating that people-focus into donor funding. Last year we had a single budget line for sexual and reproductive health and HIV/AIDS. I agreed we split them because I could see a movement against sexual and reproductive health and there was momentum for HIV funding. We have to be opportunistic. The Commission has seen a 150% increase in funding for HIV and only a 20% increase for SRH.

What do you see as the priority areas for research on microbicides and a vaccine, especially since the second Dublin Conference on New Technologies that took place in June?

LF: In terms of vaccines, if the vaccine protects and is safe, people in the developing and the developed worlds will be interested in it. However, I don't see a safe and available vaccine for the next ten years ... but anything can happen, anything can change.

For microbicides, my expectations are more positive for the moment. I think science has progressed enough so that we will have a microbicide that works in the next few years. We should make more investments in microbicide research and production, and we should prepare women for microbicides. We did a study with women in 11 countries that showed a lot of interest in microbicides. This tells me that the forward momentum needs to continue, especially with women's advocates. Microbicides will not work without a strong lobby from women's groups because it is not a product that stands to be highly profitable for pharmaceutical companies.

Overall, we need to demand more investment in microbicides because we need a protective measure that women can control. And, as I said before, it's women's organizations that have to take action. I come from a generation of women's groups where there was much more energy for issues affecting women. Where HIV is on the agenda, it is because of people living with HIV and gay groups. Sixty per cent of people living with HIV are women, but they are not vocal. I hope that young women will begin to speak out.

4 See page 12 for more information about the Dublin conferences.