Deadly failure of nerve
Bill Bowtell
The Australian
28 July 2007
P. 26

The HIV pandemic need never have happened. There is nothing inherent in the human immunodeficiency virus that made its transition from minor problem to global pandemic inevitable. The virus is relatively weak, not contagious and spreads slowly in human populations. The appalling truth is that the main driver of HIV, which causes AIDS, was the failure of political will to translate scientific evidence into effective containment policies.

Within a few years of its first notification in the West in the early 1980s, medical science conclusively identified the nature and properties of the virus, devised workable -- if not infallible -- tests for its presence and developed the first promising treatments for prolonging the lives of those infected.

In the turbulent wake of the first explosion of cases, a thousand flowers of responses bloomed across the world. They ranged from executions of HIV-positive people, repressive sanctions, quarantine and denial to mass education and practical and evidence-based policies based on prevention.

Many governments were, and remain, reluctant to offend social, cultural and religious beliefs about sexual behaviour, drug consumption and sex work, especially among the young. Nevertheless, by the end of the '80s it was possible to judge these responses and determine which had worked best to lower new infection rates to sustainable levels.

These outcomes were reported at the time to a plethora of international conferences, in specialised journals, government reports and the media. By the end of the '80s, all the information and evidence about HIV-AIDS that was needed to bring the incipient global pandemic under control and implement long-term management was available.

The feasibility of preventing its spread had been demonstrated in Australia and The Netherlands and in large developing countries such as Thailand.

The emergence of effective treatments gave hope and incentive to those who might have been reluctant to come forward for HIV testing. The technologies that were crucial if prevention were to be sustained were cheap and able to be widely and quickly distributed.

By 1990, the global caseload was only about eight million, most in sub-Saharan Africa. Large areas of the globe, including most of the Asia-Pacific region (apart from Thailand) and central Asia had been scarcely affected.

There was, in short, a critical window during a decade from 1985 in which decisive preventive action almost certainly could have contained the global spread of the disease. The peer-reviewed evidence in favour of behavioural prevention was abundant and well reported at innumerable conferences, meetings and in scholarly journals. At all levels, experts pushed for leading countries and international agencies nominally responsible for dealing with HIV-AIDS to adopt rational and pragmatic harm-reduction policies.

The consequences of not acting to prevent the spread of HIV were clearly known and accurately predicted, yet those who should have responded did not do so. The failure of national governments and international agencies to act in time to avert the HIV-AIDS pandemic is shameful and enraging.

In the 20th century, the world witnessed many examples of governments and politicians steadfastly failing to act in time to avert mass murder, death and destruction. Credible warnings were issued and ignored about the Holocaust, Stalinist Russia, Pol Pot's Cambodia, the Balkan wars and the Rwandan genocide. The failure to intervene in time to prevent these tragedies cost millions of lives. But, in its scale and scope, the global failure to contain HIV-AIDS has caused more deaths and suffering than even the worst of these appalling episodes.

Those who naively declared war on HIV-AIDS in the '80s rapidly came into conflict with the aims and objectives of two other wars, the war on drugs and the war on sex.

The war on drugs was declared by the US in the '70s. The use of illicit drugs is dangerous and ought always to be discouraged or reduced. No responsible parent of politician would think otherwise. But this war concentrated on the reduction of supply without any coherent domestic effort to minimise demand or reduce harm. Successive administrations have devoted billions of dollars to futile attempts to eradicate the feedstock and supply of various forms of narcotic drugs, from opium poppies to cocaine.

Notwithstanding its position as the world's greatest consumer of illicit drugs, the US maintained an official position of zero tolerance. It was therefore impossible for the government to condone any policy shift that might be seen as being soft on drugs. Zero tolerance of drugs meant high tolerance of HIV and AIDS.

The war on drugs is comparatively recent; the war on sex has ancient roots. The Catholic Church is its institutional vanguard, but the values that underpin it are shared by fundamentalist Islam and evangelical Protestantism. When AIDS emerged, the hierarchy of the Catholic Church immediately realised that the use of condoms to prevent HIV transmission would subvert its opposition to the use of condoms for contraception.

For more than two decades, the UN and its specialised agencies have been a battleground for these brawls. The foundation of UNAIDS in 1996 gave some hope that the balance would tip in favour of large-scale, effective international HIV-prevention policies. Yet these hopes were fulfilled more by rhetoric than in practice. Throughout the '90s, the US, the Vatican and its ideological allies pursued their wars on drugs and sex through the UN.

As bitter as this split was, it at least had the merit of being obvious. The lines between the opposing points of view were clearly drawn. Through time, the consequences of not providing condoms to prevent transmission became apparent when judged against the results in those countries where they were widely distributed. Despite the war on drugs, many countries embraced harm-reduction policies and adopted needle and syringe exchange programs to contain HIV infection among injecting drug users.

Gradually, the accumulation of scientific evidence in support of effective prevention began to wear away at least the intellectual foundations of these misbegotten wars. Nevertheless, religious and ideological opposition to behavioural prevention has not abated.

In the past decade, however, behavioural prevention has also been increasingly discounted from a more unexpected direction: from sections of the scientific and medical establishment. In 1996, the first highly effective AIDS drugs were introduced. Since then, a conventional wisdom has emerged within some elements of the medical and scientific community that discounts prevention as achievable or practical. This school of thought has been greatly influenced by the development of effective anti-retroviral treatments.

During these 10 years, medical science has brought to the market therapies that have greatly reduced the viral levels of HIV-positive people, significantly delayed the onset of AIDS illnesses and generally restored reasonable health and wellbeing to infected people who have access to the treatments. These new therapies have been unalloyed good news for those with HIV and a

tribute to the excellence of the science and research that created them. Generally, better treatments mean people have an incentive to be tested. Development of these treatments has led many scientists and researchers to conjure the attractive prospect of HIV-AIDS becoming a long-term, manageable condition, perhaps equivalent to diabetes.

Politically, the emergence of effective treatments offered a seemingly happy third way between the protagonists of the great cultural and religious conflicts that marked the early years of the pandemic. While there was bitter and irreconcilable division about how the spread of HIV could or should be prevented, almost everyone agreed on the need for increased funding and support for care and treatment. Yet this apparently more benign framework created a dangerous set of perverse incentives that distort the global management of the pandemic.

Most of the billions of extra dollars devoted to HIV-AIDS in the past decade have been absorbed by drug companies, doctors and the medical system for care and treatment.

During this decade, the results are spectacular and depressing. In a perverse way, funding care and treatment is contributing to the uncontrolled growth of the pandemic, not in any deliberate way, of course, but that is the effect. If we pay billions to care and treat, we can hardly be surprised if caseloads rise. If little goes into prevention, we can hardly be shocked that the spread of HIV continues unchecked and uncontrolled.

This situation is dangerously dynamic and inherently unstable. It is based on assumptions that fail even the most elementary critical scrutiny. The idea that new and effective treatments for HIV will somehow contain the pandemic is wrong, yet the new consensus, backed by billions of donor dollars, creates the illusion that the pandemic is being contained. This may be comforting, but it remains an illusion unsupported by evidence or logic.

If we want HIV-AIDS prevention to work, we will have to pay for it and do it properly in the developing and developed worlds. The present global caseload is 40 million. It is growing at a conservatively estimated rate of four million cases, or 10 per cent, each year. The sheer size of this caseload poses new forms of general health and financial risks.

It is increasingly clear that the world cannot afford the real costs of treating even the present caseload, the size of which is transforming the nature of the threat, with immense new costs on national economies and the international system. The costs of providing anti-retroviral therapies to a significant proportion of a global caseload that may number 80 million people within a decade are staggering and have not yet fully been assessed by UNAIDS actuarial calculations.

Assuming, conservatively, that each course of therapy costs $US1000 ($1130) a person a year, the cost quickly reaches into the billions of dollars even before accounting for the expanded human and capital infrastructure required to deliver it or the opportunity costs involved in treating HIV-AIDS at the expense of other priorities. Notwithstanding the good intentions of the UN, the harsh political and economic reality is that these costs are beyond the capacities of governments and donors to fund without diverting resources from other critical development areas.

A large and growing caseload also increases the threat that HIV will increase its resistance to drug therapies and facilitate the spread of new strains of dangerous pathogens, especially highly drug-resistant tuberculosis.

By definition, HIV prevention must be directed not where the problem is but where it is not: at younger, sexually active people and those most likely to experiment with injecting drugs (also most likely to be young). They are unlikely to visit clinics and hospitals but they can be reached in schools, shopping centres, workplaces, sporting and entertainment venues, and through television, radio, films, phones and the internet. Young people at greatest risk of infection won't be found in churches, synagogues, mosques and temples but in places where they can have sex and even do drugs. Many young people hang out in cyberspace. To work, HIV prevention

messages must be delivered to young people where they are, in ways that make sense to them. Above all, prevention campaigns work best when they are stripped of moral judgments and editorialising about virtue and social improvement.

What is required is a considered economic case for the primacy and viability of prevention. The focus of this must be this region, where a second HIV pandemic is just beginning. Prevention strategies must be the key priority to avoid a repeat of the African catastrophe. The basic economic structure of health systems must be reconfigured to create incentives every bit as attractive as those that already exist in the system to create care, treatment and research. We accept that the surest way to manage global warming is to create and manipulate economic incentives, costs and prices. This is surely what must be done in relation to the future control of HIV.

If we can provide the right incentives and rewards, and couple them with public health messages that make sense to the most vulnerable groups of young people, the spread of HIV will be controlled far more effectively than any punishment, prohibition, injunction, fatwa or prayer has been able to.

When it comes to controlling and managing HIV, the lesson from the millions of a lost generation who died prematurely and painfully is that stern gods are less than useless.

This is an edited extract from "Applying the Paradox of Prevention: Eradicate HIV", in the spring 2007 edition of Griffith Review, which will be launched at the Byron Bay Writers Festival today. Bill Bowtell is director of the HIV-AIDS project at the Lowy Institute for International Policy. As senior adviser to the Australian health minister from 1983 to 1987, he was an architect of Australia's response to HIV-AIDS and was national president of the Australian Federation of AIDS Organisations. He recently completed a Lowy Institute policy brief, HIV-AIDS: The Looming Asia Pacific Pandemic. This week Sydney hosted a big HIV-AIDS international conference.

The Griffith Review site is at: www.griffith.edu.au/griffithreview