Learning From Success: Global Priorities for HIV Prevention: Thomas Parran Award Lecture

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There are remarkable similarities between the ideals which Thomas Parran espoused nearly 60 years ago and the principles which we now confront us, know to be successful in the fight against AIDS globally. These include:
- the importance of separating scientific and medical arguments from those which concern sexual morality, and
- the need to act simultaneously on a number of fronts in order to prevent new infections and in order to ensure that those already infected receive the care and support they need.

While nowadays we might not agree with all of Parran's admonitions—In particular, his use of fear as a means of motivating health seeking behavior and behavior change—his work laid the foundations for much of what is now regarded as good practice when it comes to HIV prevention and control.

This paper will begin with a description of some of the main features of the global epidemic of HIV and AIDS in order to highlight its nature and dynamics, as well as the seriousness of the problem. It will then review some of the principles which we now know to underpin effective work in the fields of HIV-related prevention and care. Third, it will highlight some of the challenges which still remain and some of the diversions which may deflect us from the task of containing and controlling the epidemic. This may be of special relevance to those working in the United States, a country which, despite its wealth, power, and political influence, has still to control its domestic epidemics of HIV and sexually transmitted infections (STIs) among homosexually active men, among injecting drug users, and among blacks and Spanish-speaking people.

The Global Picture
Since the start of the global pandemic, an estimated 14 million people have died from HIV-related disease (2.5 million in 1998), and another 65 million, each evolving with its own dynamics. While a few 33.4 million are estimated presently to be living with HIV. In 1998, many countries have been able to slow or arrest the epidemic, in other parts further 5.8 million people were infected with HIV, or 11 men, women, and children every minute. Half of all new infections occur among young people aged 15 to 24, making this an epidemic with particularly high HIV prevalence among sex workers, 36% among young people seeking serious consequences for future generations. In many parts of the world, the epidemic is completely out of control.

Sub-Saharan Africa remains the region which has been hardest hit by the Central and Southern America, the picture is presently mixed. HIV and AIDS and the region with the fastest growing epidemic. It has been in other parts of the world, the epidemic has exploited the fault recently been estimated that over 8% of all people aged 15 to 49 in all of the unequal society, affecting most seriously those who are sub-Saharan Africa are infected with HIV, and it is not unusual to reach almost the most vulnerable. In many countries, the greatest toll so far has been in parts of Africa, where the epidemic is more critical than in other regions. In many African cities, HIV has become rapidly the leading cause of death in adults, and in American countries. It has recently been estimated that among Kenya, Botswana, Zimbabwe, Zambia, Uganda, and Malawi, AIDS has had a major impact upon average life expectancy with themselves as 'homosexual' or 'gay', as many as 30% may be HIV infected, and the reported rate of infection among people injecting drugs varies from 5 to 11% in Mexico to approximately 50% in the number of children have been orphaned, and grandmothers have had to Argentina and Brazil. There is evidence of rising rates of transmission that on the responsibility of caring for grandchildren when their own children born and women in many countries. In Brazil, for example, sons and daughters have died. AIDS has now become truly global where there exists good surveillance data, the national/female ratio of development problem for Africa.
Caribbean it has recently been estimated that, in some localities, up to 8% of pregnant women may have HIV infection. This is not to say, of course, that the epidemic cannot be brought under control. There are signs that in parts of Northern Europe and in Australia, the incidence of new infections has stabilized or may be declining; there is evidence from countries such as Uganda and Thailand that with the right programs the epidemic can be slowed1,4; and there is evidence from Senegal that early effective intervention can keep infection rates at low levels. In Uganda, for example, surveillance testing in urban centers has shown a 40% drop in HIV prevalence among pregnant women over the past 5 years linked to changes in sexual behavior among both men and women. In Kampala, Uganda, for example, 46% of men recently interviewed reported using a condom in their last nonregular sexual encounter, and 31% reported always using condoms with "casual" partners. Young women report delaying the onset of intercourse, reducing the number of sexual partners, and increasing condom use. In Thailand, there is clear evidence of a decline in the number of visits to sex workers and an increase in condom use among male military recruits. Simultaneously, there has been a decline in HIV prevalence among members of this same age group from 8% in 1992 to less than 3% in 1997.

So What Can We Do?

In a speech before the International Relations Committee of the U.S. Congress in 1993, I described two prerequisites for any likely to say knowledge about HIV and its routes of transmission. These have influenced international thinking for the need an effective vaccine to protect against infection. The bottom line: to 10 years of the epidemic and continues to be advocated by these for the present is that we need to apply what we know works. This doesn’t mean that health education is simply a question of providing not need new breakthroughs in technology, simply the commitment of people with the facts. In reality, of course, people need much more than information to protect themselves and others against infections. Having attitudes which makes behavior change seem worthwhile and having the skills to negotiate for safer sex and safer injecting practices are also vital.

Developing skills in sexual communication and negotiation requires translation. Attitudes are hard to change. It would be easier, we would have very little practice and support. This is especially true when it comes to being effectively mobilizing the resources necessary to respond assertively about your wishes and needs, especially if you are a woman. Effective to the global epidemic, AIDS-related prejudice and or a younger person. Many societies nowadays deny young people the discrimination would be rare, and people would be much more willing opportunity to practice skills of sexual and drug-related to HIV and AIDS. These issues which relate to them personally: communication and negotiation. This is why UNICEF, together in order to change attitudes, we need to change perceived norms about promoting life skills approaches to education about health and personal safer sex and condom use, perhaps through social marketing and other programs that have been effective in promoting condom use in countries in Africa.

Changing knowledge and attitudes alone (and even providing skills) is not enough. Environmental and societal factors also need to be tackled as part of insufficient to bring about risk reduction. What good is it to work on HIV prevention. The Ottawa Charter for Health Promotion woman in Pakistan or India, for example, to know how HIV is transmitted when she cannot refuse to have sex with an unfaithful supportive environments for health. These are essential if people are to challenge. What value is this knowledge to a young woman selling secks, to act on what they have learned, yet too often they are in the Philippines in order to support her family back home, and to succeed. It is now widely understood that societal factors-including may be offered more money when she has unsafe sex with a client than power relationships and social inequalities—render some groups more when he uses a condom? Every day, hundreds of thousands of women systematically vulnerable to STDs and HIV than others.

Environmental factors influencing people’s vulnerability to HIV and AIDS include famine and natural catastrophes such as those caused by hurricanes, floods, and famine. In each case, people may be forced to live away from their homes in circumstances and conditions that are not of their choosing. Environmental factors also include access to protective technologies such as condoms and clean needles and syringes. They may extend to rules and regulations governing sexual contact within a particular setting or society. It is now known, for example, that introducing formal rules to make sex work in brothels safer can have a dramatic effect on the transmission of HIV and other STIs, as has occurred in Thailand. Moreover, as the late Jonathan Mann so passionately believed, there are good reasons to believe that efforts to promote human rights including freedom from exploitation, freedom from sexual violence, and freedom from discrimination and stigmatization, be it on the basis of sexuality or HIV status, are likely to have beneficial effects.

Both individual persuasion and societal enablement are needed to alter the course of the epidemic. Programs and interventions that only pay attention to one of these variables simply do not work.

Some Key Principles

But where should we begin, and how should we focus our efforts? Beyond this, however, it is important to provide awareness raising internationally, a number of key principles are clear. First, activities for the population as a whole. Key messages need to be repeated frequently, we need political commitment stretching from the local to national levels. Without this, there will be no lasting interest and avoid monotony. Such has been the case in Switzerland, support for prevention efforts. Second, it is important to direct our efforts to where the epidemic really is, and not where we imagine it to be. Many countries, for example, have spent hundreds of thousands of dollars to believe that HIV and AIDS have gone away, with possibly dollars on HIV prevention among groups which were not significantly disadvantaged longer-term consequences. A key component of awareness at risk, instead of first asking where is the epidemic now, and what existing work should be the promotion of social solidarity and the might be controlled. Focusing programs and interventions need to be multisectoral and multilevelled, since HIV
HIV infection is operationally feasible and can contain the epidemic.

does not respect the boundaries between one government department
and another. Joint action is needed by the public, private, and
voluntary sectors to prevent new infections and to provide support and
care to people already living with HIV disease. Collaboration between
different government departments is a key part of such a response.
Nongovernmental and community organizations have a key role to
play in reaching people living with, and affected by, AIDS, and in
combating the stigmatization and discrimination that often
accompanies the epidemic.

People living with HIV and AIDS have much to contribute to programs by
tackling social inequalities of gender, wealth, education, and
development and implementation. Not only does their activism stimulate societally
involvement enhance community participation and 'ownership' of themake some groups more vulnerable than others, and their existence
epidemic, it helps minimize its potentially negative effects. There is makes it difficult for interventions focusing on individuals alone to
considerable body of research to show that when a public health threat is overcome.
However, reducing societal vulnerability requires political
traits are invisible and unpredictable, public society is high and community commitment is at the highest level. All too often, politicians and policy
responses are unpredictable. Programs and activities that offer opportunities are reluctant to make this kind of commitment for fear of
visiting and cultural stigma to people living with HIV and AIDS, and which allow changing elements of the status quo. They need to be persuaded that
acceptance of people to contribute to prevention efforts are essentially the spinoff of efforts to tackle social inequality for other health
Taxes can promote unrealistic fears and reduce levels of fear, problems, and for social development is likely to be substantial, as has
been discovered with respect to investment in young women's
education.

The Role of Technology

So far, and in keeping with many of the commitments that The female condom. When appropriately used, the female condom
understood through Thomas Parran's work some 50 years ago, I have offered a safe and effective means of reducing the likelihood of acquiring
emphasized the profoundly social nature of the global epidemics of STIs. It offers women a means of protection over which they have
HIV and AIDS. I will turn now, however, to consider the promise of greater control and is a form of protection that some men welcome. In
new technology. When HIV and AIDS first appeared, there were few data. In 1998, representatives from 15 countries in Eastern and Southern
means of prevention other than behavior change and the male condom in Pretoria to discuss how best to include the female
condom. With the passage of time, however, there has been considerable technological advance. The female condom, this overwhelmingly enthusiastic and confirmed earlier findings from
possibility of an effective vaginal microbicide. Significant advance have been made in relation to the male to child transmission. The possibility of a
the prevention of mother to child transmission, and the possibility of a child, all of which had indicated the potential of this new
postexposure prophylaxis (PEP) against HIV infection. All offer new options in the global struggle against AIDS.

A vaginal microbicide. Work to develop a microbicide for vaginal to child transmission. In the last few years, significant advance
Mother to child transmission. In the last few years, significant advance
and/or oral use has been stepped up recently, and a substantial has been made in relation to the mother to child transmission. The
number of products are in preclinical evaluation. Several others are in ACTG 076 trials using zidovudine has been shown to be effective in a
state of advanced clinical development. Ideally, a vaginal microbicide reducing mother to child transmission by about two-thirds in the
needs to be inexpensive, safe, stable, and easy to store. It needs to be used in conjunction with breastfeeding. More recently, a trial in Thailand using a
long term use has been stepped up recently, and a substantial has been made in relation to the mother to child transmission. The product with all these qualities may be available in the next few years.

Postexposure prevention (PEP). The administration of zidovudine
after percutaneous exposure to HIV can significantly reduce the risk
of infection. While zidovudine is currently the only drug for which
efficacy data exist, several countries have now used double and triple antiretroviral therapy as a preventive measure. This
kind of intervention is likely to have enhanced antiretroviral activity
and may be used with HIV strains that are widely resistant to
zidovudine. It should be made readily available to health care workers
who have been accidentally exposed to HIV. There has been much
recent debate about the use of antiretroviral drugs as a means of
prevention following sexual exposure to HIV. While this form of
treatment is available from some centers in Europe and the United
States, there is as yet no reliable data to indicate whether its can prevent
the sexual transmission of HIV infection. Important questions remain
to be answered about the costs of this kind of intervention and its likely impact on safer sexual behavior.

Some Diversions

There has been much progress in programs and AIDS over the last 15 years. It is vital to recognize that for every community that has responded
decade and a half. The challenge now lies in 'scaling up' globally what positively to the epidemic, several have not. In many countries, people
has been learned so far. Across the world, countries with HIV and AIDS are still denied basic human rights and freedoms,
are beginning to move from denial and victim blaming to more comprehensive and accurate position of the organisation for which I work,
inductive responses in which people with HIV and AIDS are recognized and that of our United Nation's partners. HIV antibody testing is still
as playing a key role to play in prevention and care. Those communities as a means of selection in employment, as a means of making
which have had the greatest success in reducing new cases of infections about the quality of health care people we receive, and to
have been among the first to make this transition. However, caution is required travel across borders. This is unacceptable and must be
necessary, lest we be lulled into a sense of false security about what was recognized for what it is - a quite ineffective means of control and a
future may hold. In particular, I would like to highlight a number of ways biomedical and human resources
factors that hold the potential to disrupt program planning and
development and which may deflect international efforts to prevent it is necessary to guard against the tendency to see HIV and AIDS as
purely scientific or medical issues. The social dimensions of HIV and AIDS are at least as important as the biomedical aspects, and we need to maintain our investment in social and educational programs concurrent with our investment in immunology, virology, and pharmacology. While priority must be given to identifying and making available an effective vaccine, people need education and support in making the behavioral changes to protect against infection. The medical and social dimensions of HIV and AIDS are very much interrelated. It is important to recognize the folly of efforts to privilege biomedical above social and educational issues, or vice versa.

There has been much talk recently about the 'science' of HIV am sometimes very worried when I hear calls for evaluation using prevention, particularly among those who would seek to identify the most rigorous, but artificial, of procedures such as the largely nonexistent social 'magic bullets' to protect against infection. randomized controlled trials. We can come to know what works in HIV bringing about and supporting behavior change (or consolidating prevention in many different ways. Global experience teaches us that already safe behaviors) is in fact as much an art as a science. Amenable, frequently complex programs are those most likely to explained earlier, there are no 'interventions' that, regardless of success. These are exactly the kinds of activities it is most difficult to context, bring about predictable behavioral results. Instead, there are evaluate using scientific designs that seek to isolate the effects of principles for success in program design which need to be scaled up and variables (such as a discrete educational program or a and applied in diverse settings across the world. This has implicatiaparticular style of peer education) on individual behaviors.

Recent years have seen a normalization of much HIV-related work, but experience shows that prevention efforts must be sustained if there is not to be a rise in infections among the newly sexually active, as well as among those for whom earlier messages have lost their relevance. The enhanced availability in some countries of potentially more effective therapies requires us to develop new prevention messages, including those that address some of the 'new myths' about AIDS. At a meeting on this issue coorganized by UNAIDS and the UCSF AIDS Research Institute in 1998, some of these myths were discussed. They included the myth that a nondetectable viral load equates to noninfectiousness, the myth that once a cure for AIDS is close there is no need to practice safer sex and safer drug use, and the myth that the less is no need any longer to aggressively invest in HIV vaccine development. When there is a need to balance budgets, it can be tempting to cut that for which there is little public demand and, as Thomas Parran himself discovered, STI prevention is rarely a popular issue among politicians and the public at large. But such action is shortsighted, since it will lead to only greater problems in the future for which funders and policy makers will ultimately find themselves called to account.

Conclusions

When AIDS was first identified in the early 1980s, the world reacted often hear people complaining that AIDS is 'too political.' There are with disbelief. A not uncommon response was for countries and some compelling reasons for this, not only because HIV is transmitted individuals to claim that AIDS simply could not happen to them. Through very private behaviors on which there is a wide spectrum of Religion, national character, the strength of the family-all were said to influence society, and not only because it chronically affects young protect against what in retrospect we understand to be a sexually active who speak up for their rights, but above all because effectively transmitted and blood borne disease. As time passed, these initialcountering the HIV epidemic and its consequences requires tough responses were replaced by those which sought to blame 'others' for political choices—such as on sex education for children and HIV users, sex workers, and homosexually active men—who were socially disadvantaged, and as citizens, we need to recognize this fact and invest marginalized within their own society. Only because of courageous and far more political strategies to ensure that AIDS and STIs are on the action by individuals and governments have more effective, just, and political agenda and that technically sound policies that respect human socially inclusive responses emerged. And only through these rights become the norm, I believe that only in this way will we remain programs of action and education that distinguish scientific from those to the best principles that guided Thomas Parran's work as moral considerations we have begun to control HIV and AIDS.

Surgeon General of the United States of America.

References


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