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The Global Picture of AIDS

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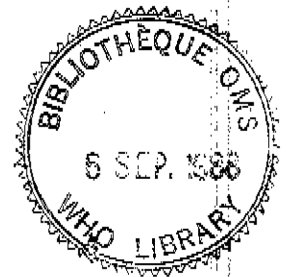

An address presented 12 June 1988 at the
IV International Conference on AIDS
Stockholm, Sweden

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by
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12 June 1988

Your Majesty, Excellencies, Ladies and Gentlemen:

At this fourth international AIDS conference, we once again have the precious opportunity to pause, with new knowledge and deepening experience, and consider the global and the historical dimensions of AIDS.

As of 1 June 1988, a total of 96,433 AIDS cases were reported officially to the World Health Organization from 136 countries: 43 from Africa, 40 from the Americas, 28 from Europe and 25 from Asia and Oceania (Figs 1 & 2). Forty-one countries reported more than 100 cases each; 52 reported more than 50 cases each, including 19 countries in the Americas, 15 in Europe, 15 in Africa, and 3 from Asia and Oceania (Fig. 3). One year ago, just over 51,000 cases had been reported from 113 countries. There are, of course, many logistic, social and even political reasons why reported cases represent only a portion of actual AIDS cases. Therefore, we estimate the actual cumulative number of AIDS cases to date at approximately 200,000, or slightly more than twice the reported number.

Figure 1

AIDS CASES REPORTED TO WHO
1 JUNE 1988

Continent	No. of Cases	No. of Countries or Territories reporting 1 or more cases
AFRICA	11 530	43
AMERICAS	71 343	40
ASIA	254	21
EUROPE	12 414	28
OCEANIA	892	4
TOTAL	**96 433**	**136**

Figure 2
Countries reporting AIDS cases to WHO as of 1 June 1988

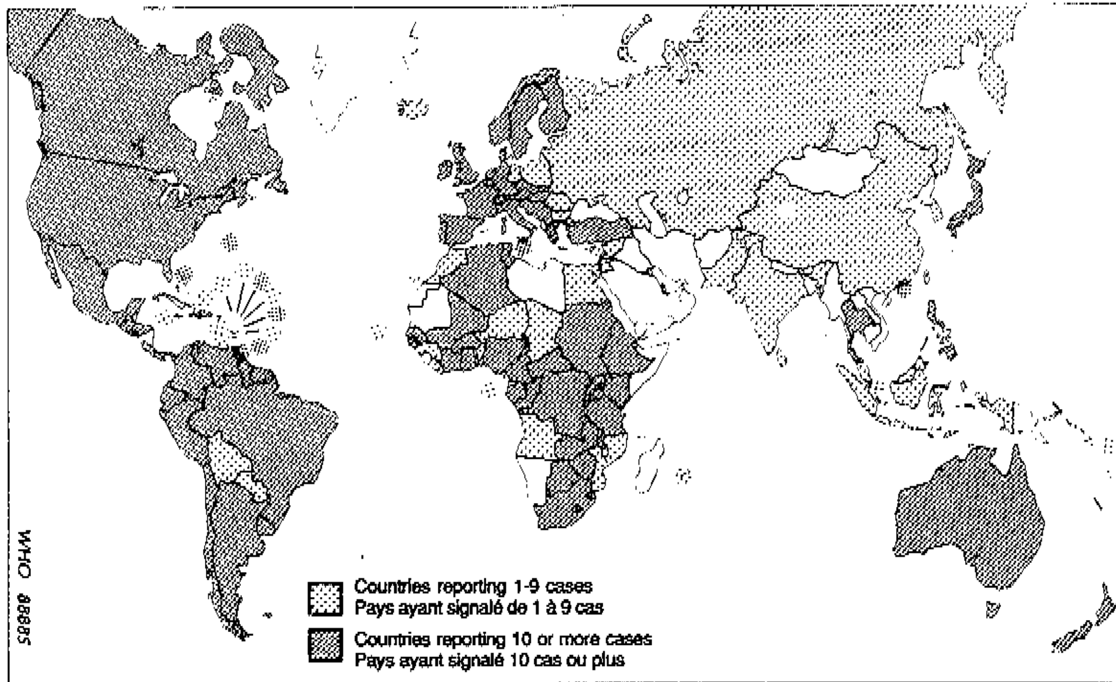
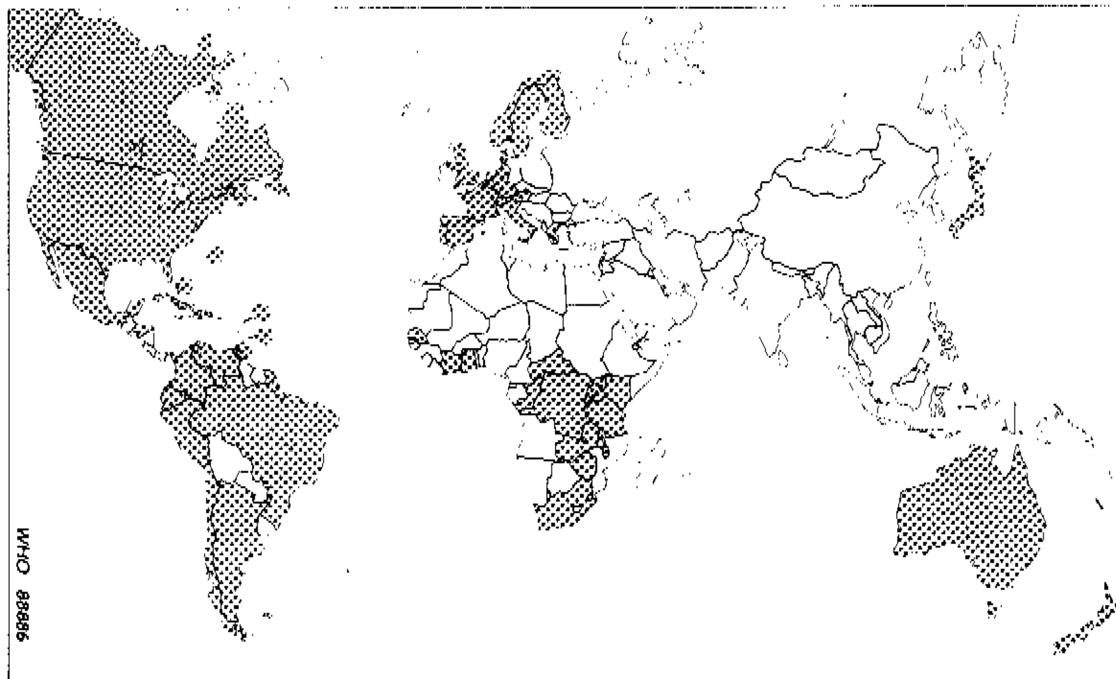


Figure 3
Countries reporting over 50 AIDS cases to WHO as of 1 June 1988



AIDS and human immunodeficiency virus infections are not distributed randomly, for HIV has affected different groups or sub-groups around the world at different rates and at different times. The dramatic increase in human movement during the past twenty years has linked virtually every piece of the world into a single living organism in constant movement. In this world, HIV has recently spread, as fast and far as individual and social behaviours, and the biology of the virus, as modified by possible co-factors of its human hosts and environment, would permit. Thus, the local, national and global pattern of AIDS is highly variegated, and is continuing to evolve.

With available information, we can distinguish three broad but distinct patterns of infection. Everywhere, the modes of HIV transmission are fundamentally the same – sexual, blood contact, and perinatal – but details of personal and social risk behaviours in different areas influence the relative frequency and expression of these three modes of spread.

In Pattern I areas, HIV likely began to spread extensively during the mid-to-late 1970s. In Pattern I, sexual transmission of HIV occurs predominantly among homosexual and bisexual men; over 50 percent of homosexual men in some urban areas have been infected. Heterosexual transmission also occurs in these areas, and is increasing. Transmission through blood contact in pattern I areas of the world now principally involves persons with drug-injecting behaviour, as blood for transfusion and blood products have been made essentially safe. Perinatal transmission is uncommon because relatively few women have thusfar been infected, but will increase as heterosexual transmission increases. Areas where this pattern is presently found include: North America, Western Europe, Australia, New Zealand, and many urban areas in Latin America.

In Pattern II areas, HIV also likely began to spread extensively during the mid-to-late 1970s. In Pattern II, sexual transmission is predominantly heterosexual. Up to 25 percent of the 20-40 year old age group in some urban areas are already infected, along with up to 90 percent of female prostitutes in some areas. Transmission through HIV-contaminated blood transfusions continues where HIV screening of blood is not yet routine. While drug-injecting behaviour is rare in Pattern II, the use of unsterile needles or other skin-piercing instruments can contribute to HIV spread. Perinatal transmission is a major problem in those areas where 5 to 15 percent or more of pregnant women are HIV infected. Areas where this pattern is presently found include: sub-Saharan Africa and increasingly in Latin America, especially in the Caribbean.

In Pattern III areas, HIV appears to have been introduced later, during the early-to-mid 1980s. Thusfar, only one percent of AIDS cases are reported from Pattern III countries. Early AIDS cases were generally associated with contact with Pattern I and II areas or imported blood or blood products. While HIV infection has not yet penetrated into the general population of Pattern III countries, indigenous transmission is occurring and HIV infections are being increasingly recognized among persons with risk behaviours, such as prostitutes and persons with drug-injecting behaviour. Areas where this pattern is presently found include: Eastern Europe, the Middle East, North Africa, and most countries in Asia and the Pacific.

Of course, these three patterns oversimplify, for different patterns may co-exist within a single country, or even within a large city. Also, the patterns are not immutable.

While certain clear limits are set by the HIV's limited modes of transmission, the range, pattern, timing and extent of transmission depend upon an extraordinary blend of individual behaviour, social practices and possible biological co-factors. Therefore, as in the life of a single person, risk behaviour may well vary over time, so social evolution, political unrest, economic disruption or success will also influence, over time, the social context within which risk behaviours flourish or recede.

As we reflect, now, on the brief history of global AIDS, we can distinguish three periods: of silence, of discovery and of mobilization (Fig. 4). The first period, starting in the mid-1970s, was the time of the "silent pandemic", during which HIV spread – unnoticed – to at least five continents.

Figure 4

History of Global AIDS

Silent period	**1970's–1981**
Initial discovery	**1981–1985**
Global mobilization	**1985–1988**

Without conscious defences during this period, for the virus was silent in its passage and unrecognized, HIV could have – but did not – spread even more widely.

It is – or should be – shocking to our modern pride that such a global explosion could occur without even being detected. Also, it is extraordinary that the global HIV epidemic started just as the tools became available to detect human pathogens of this kind. Was this a highly fortuitous coincidence, or might we in the past have failed to see that which existed?

The description of AIDS in 1981 ended the silence and inaugurated the second period in the history of global AIDS – a period of discovery which culminated symbolically at the first International AIDS Conference in 1985. During this period, the modes of transmission were defined, the virus was discovered, and the capacity to detect anti-viral antibodies led to discovery of the large numbers of infected persons and to awareness of the long latency between infection and manifest disease.

Confronting a new problem also requires conceptual tools – of these the act of naming itself is critical. A name was not immediately available. Had one of the early proposed names – Gay-Related Immune Deficiency, or GRID – been selected, it would have failed by locking us into a stigmatizing concept and delaying recognition of the broad social and geographical dimensions of the problem. Premature naming was avoided and within less than a year, the name AIDS entered the global vocabulary – a name which helped broaden scientific and social vision.

The first international AIDS conference, in April 1985, brought this new information together. At that Conference, along with dawning awareness of the broad impact of AIDS, the first stirrings were felt of a powerful international solidarity. Yet there was also another, even more personal dimension. For in 1985 the world had not yet awakened to AIDS; for those in Atlanta there was also – as there is here tonight in Stockholm – the profound and simple human experience of community – of realizing deeply that we are many and that from common purpose we are strong.

Immediately after the Conference, a group of scientists and health professionals met with the World Health Organization – and set the stage for the third period – the global mobilization against AIDS.

To realize how dramatic and extraordinary this global mobilization of the last two years has been, we must recall the chaotic international situation in early 1986. Wildly varying estimates circulated about HIV infection rates and numbers of AIDS cases. Most AIDS-affected countries in the developing world lacked the technical capacity to assess the scope of HIV infection. Rampant speculation about the origin of AIDS combined with a pervasive stigma attached to the disease, contributing to a confrontative international atmosphere and a reluctance to share information. And those AIDS-affected countries in the developing world which sought international assistance were generally uncertain about how to proceed, while the international assistance community, also uncertain, reacted with caution and ambivalence.

The urgency of the situation called for urgent action. The World Health Organization, with responsibility to direct and coordinate international health work, took up this challenge. The global fight against AIDS required a global strategy – mobilization – and concerted action.

The Global AIDS Strategy has three objectives: to prevent HIV infection; to provide support and care to those already HIV-infected; and to link national and international efforts against AIDS.

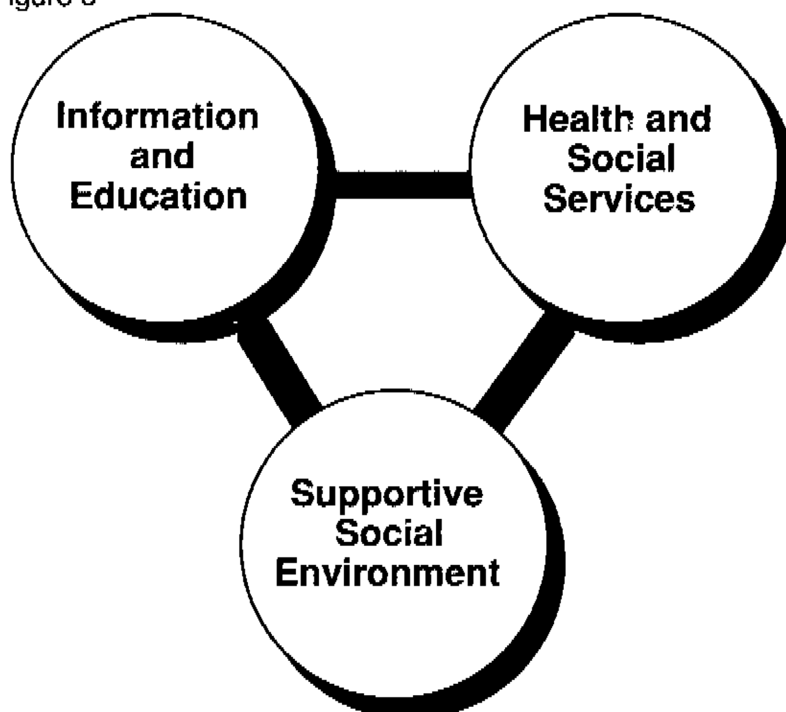
The first objective, preventing HIV transmission, is achievable precisely because HIV is transmitted through specific individual behaviours and through readily identifiable practices in the health system. For this reason, the proper focus of prevention is behaviour, not infection status.

In order to influence behaviour, information and education programmes are needed in all countries. Yet information and education alone are not sufficient. Health and social services are needed to support and strengthen behaviour change. For good intentions are not enough. How can we educate IV drug users without making treatment programmes available? How can we expect long-term behaviour change among HIV-infected persons without long-term access to counselling, support and advice? How can we expect condom use if condoms are unavailable, costly and of poor quality?

The third essential component in prevention is a supportive social environment. Public support must be firmly marshalled behind rational and humane AIDS prevention and control programmes. We have seen all over the world that as people are informed about AIDS, panic and groundless fears recede and as leaders speak knowledgeably and clearly about AIDS, public confidence and commitment increase and illusory and simplistic solutions to the problems of AIDS are rejected.

Each element of this triad – information/education programmes, health and social services, and a supportive social environment – is required in national AIDS prevention programmes (Fig. 5). A deficiency of any part will weaken the whole and does not give prevention a fair chance.

Figure 5



The second objective of the Global AIDS Strategy is to reduce the personal and social impact of HIV infection. This means ensuring humane care, of a quality at least equal to that provided in that society for other diseases, to those who are ill, and to provide counselling, social support and services to all who are infected.

The third objective, to unify national and international efforts against AIDS, has speedily become a reality. The World Health Organization has done this by mobilizing people and financial resources – with many of you, your organizations, your governments – to help countries around the world to develop their own strong and comprehensive national AIDS programmes. As of 1 June 1988, 151 countries – including virtually all developing countries – have requested support. Through hundreds of expert missions, technical evaluation and assessment visits have already occurred in 137 of these countries; 106 countries have developed short-term national AIDS plans, to cover an initial 6-18 month period; urgent technical and financial support has been delivered to help start this work without delay.

At the same time, in over 40 expert meetings, WHO has worked to establish the technical basis and consensus for national policy formulation, including such issues as: AIDS and international travel; criteria for screening and testing programmes; neuropsychiatric aspects of HIV infection; AIDS and prisons; breast-feeding and childhood immunization; HIV infections among intravenous drug users; and social aspects of AIDS prevention and control programmes.

National AIDS committees are now developing medium term, 3-5 year, comprehensive national AIDS plans. These national plans are the key to organizing, mobilizing and coordinating national and international resources for AIDS prevention and control. Already, in Uganda, Rwanda, Ethiopia, Senegal, Tanzania, Zambia, Kenya, Mozambique and Zaire, such medium term plans have received full funding from bilateral and multilateral agencies. Each plan is different, reflecting specific national needs, yet consistent with the Global Strategy. Over 50 such national medium-term plans will be completed by the end of 1988; for other countries, short-term programmes will be succeeded by medium-term programmes during 1989. There is simply no precedent in the history of global health for the speed, intensity or scope of this global mobilization against AIDS.

Symbolic of this achievement, in October 1987, AIDS became the first disease ever discussed on the floor of the United Nations General Assembly. The World Health Organization's insistence that AIDS is a global health problem with enormously important social, cultural, economic and political dimensions and impact led to formal resolution by the General Assembly to mobilize the entire United Nations system in the worldwide struggle against AIDS. AIDS thus joins the central issues of our time in demanding global solidarity.

A second unique event occurred in late January of this year. A World Summit of Ministers of Health, organized jointly by WHO and the government of the United Kingdom, brought together more Ministers of Health than have ever come together, for any purpose, at any time. Their common statement – the London Declaration on AIDS – calls for the full opening of channels of communication in each society; the forging of a spirit of social tolerance through information, education and social leadership; and the protection of human rights and dignity in AIDS prevention programmes. 1988 was declared a year of global communication about AIDS – to culminate in World AIDS Day on 1 December 1988. We hope you will use the opportunity, the platform that the day provides, to tell the world what you are doing about AIDS and demonstrate by your presence the extraordinary range and scope of the fight against AIDS – in your community, your country, and all over the world.

Thus, the first period of this pandemic was remarkably short. The discovery period rapidly provided the basic knowledge from which a realistic worldview of AIDS could be constructed. The third period, of global mobilization, was exhilarating in its conceptual and organizational achievements. Now, and looking to the future, as the Chinese symbol for crisis is composed of two distinct units, one of which says "danger", the other "opportunity", what are the dangers – where is the opportunity?

In seeking to anticipate the future of the epidemic, we estimate that approximately 150,000 new cases of AIDS will occur during 1988. The number of new AIDS cases during this year will likely equal the total number of cases which had occurred from the mid-1970s through 1987. If we adopt the conservative estimate that 5 million people are infected today with HIV, at least one million new AIDS cases may be expected during the next five years. Unless measures are developed to prevent HIV-infected persons from developing HIV-related illnesses, these new AIDS cases cannot be averted. The consequences in virtually all countries – social, economic, cultural and political – of such a dramatic increase in AIDS during the next few years must be anticipated and faced now.

What is the potential for spread of HIV? As HIV infection appears lifelong, the virus does not need to spread rapidly to have a tremendous and gradually expanding cumulative impact. Yet studies of intravenous drug users, homosexual men and women prostitutes have shown clearly that if the virus is present in the community and the behaviours that transmit infection are sufficiently common and intense, HIV has the capacity to create explosive epidemics. For example, the HIV seroprevalence among IV drug users seeking treatment in Bangkok increased from zero percent in 1985-86, to one percent in 1987, to nearly 16 percent during the first three months of 1988. This epidemic curve – already documented in New York City, Edinburgh and Milan – threatens every community of IV drug users in the world.

Differential rates of spread into and within various segments of different populations has been the rule and is likely to continue. As one example, in Trinidad and Tobago, among persons with AIDS attributable to sexual transmission, the proportion linked with heterosexual contact increased from zero percent in 1983-84 to 47 percent in 1987. While some portions of the world's populations whose behaviours permit rapid HIV dissemination may already be saturated, many vulnerable populations remain – for now – relatively unaffected.

We do not – we cannot – have precise numbers, but it is likely that several hundred million people around the world may have behaviours which make them potentially vulnerable to infection with HIV. The only present way risk can decline where virus is present is for behaviours to change, and this new behaviour must be sustained.

Thus, while it has become somewhat fashionable to reassure and state that HIV will never threaten certain populations, we believe that virology, immunology, social science and epidemiology require us to take the long view – and a more somber view. Let us remember that we are still in the early phases of a global epidemic whose first decade gives us every reason for concern about the future.

Now the work – and the opportunity – lie ahead. As a global community, we have responded with incredible speed and coordination – we have designed and are now carrying out a global strategy.

The hard task of implementing, monitoring and evaluating AIDS programmes will require new reserves of commitment and creativity. For we recognize that in doing this work we must inevitably confront the inadequacies of our health and social systems. For if effective health information and education delivery systems already existed; if intravenous drug use was already effectively prevented or treated; if integrated blood transfusion services already existed in the developing world; if we already possessed useful information on sexual practices in each society – then the challenge of AIDS prevention would be correspondingly less. But AIDS remorselessly highlights and exposes the weaknesses, the inadequacies and inequities of our existing health and social systems and the gaps in our knowledge of others and ourselves.

In this way, the fight against AIDS has become part – a key element – in a broader fight for health – for all. There are three major themes in this challenge: interdependence; communication; and justice. The themes, and the vision, are not new – but the circumstances and the opportunity are ours, of our time alone.

In AIDS, we see clearly how health and individual behavior are linked with each other and how both are inextricable from a specific social context. We see that health cannot be distinguished from social, cultural, economic and political life. At the national level, we see clearly that the condition of the few cannot be separated from the fate of the many.

Inter-dependence is also international, and AIDS is a global problem of a new order. HIV infection is already present in or threatens every country in the world. To an unprecedented extent, peoples around the world know of AIDS and when they think about AIDS they view it as an inherently global rather than as a strictly local or national problem. Finally, the effort called forth to fight AIDS – in biomedical and social science, in public health – is irrevocably international. More than smallpox, already absent from the industrialized world when the decision was taken to banish the disease entirely; more than concern about nuclear war, which has been a major preoccupation only in some areas of the world; more than these, AIDS is understood and felt as a common threat in developing and industrialized countries, North and South, East and West. In a deep and remarkable way, the child with AIDS is as the world's child; the man or woman dying with AIDS is the image of our own mortality. And in AIDS we realize – perhaps for the first time, the human truth that while countries differ in their technical and financial resources, no country can claim precedence for psychological insight, the capacity to care, or the social strength to bear the burden. Finally, AIDS has shown that in this world, walls – that ancient reflex – that ancient defence – no longer protect and that isolation, silence, and exclusion – of individuals, groups or nations – leads not to safety but creates a danger for us all.

The second theme is communication. It is evident – in the fact of this conference – that global communications and exchange are powerful forces in our world. We can be moved to insight by dwelling, for just a moment, on the extraordinary event today – on the people gathered here, from where we have come and where we go from here. For this meeting resonates richly with travel and movement across all borders – intellectual, cultural, geographical. The world has fundamentally changed with acceleration of the speed and extent in movement of ideas, objects and people.

The third theme is justice, for AIDS prevention and control requires us to speak about rights, dignity and discrimination.

The public health rationale for preventing discrimination against HIV-infected persons is cogent and practical. If HIV infection, or suspicion of HIV infection, leads to stigmatization and discrimination – such as loss of employment or forced separation from family – then those already HIV-infected and those who are concerned they might be infected will take steps to avoid detection and will avoid contact with health and social services. Those most needing information, education, counselling or other support services would be driven away and this would seriously jeopardize efforts to prevent HIV infections. Stigmatization and discrimination – these are threats to public health. Thus, in an African country, prostitution was driven underground by government campaigns in the mid-1970s; now, the AIDS programme is unable to reach prostitutes with AIDS prevention messages, condoms and other support. In a Caribbean nation, women detected as HIV-positive at antenatal clinics risked deportation which led to a dramatic decline in attendance at antenatal clinics.

Where laws require pre-marital HIV testing, requests for marriage licenses have declined. In contrast, where anonymous testing was made available, the demand for HIV testing increased dramatically, particularly among persons with high risk behaviours.

In thinking about AIDS, some seek to oppose the "right of the many" to remain uninfected against the "rights of the few" who are already HIV-infected. This is a false dilemma, for the protection of the uninfected majority depends precisely upon and is inextricably bound with protection of the rights and dignity of infected persons. The recent resolution by the 166 Member States of the World Health Organization, stated the point succinctly: "...respect for the human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups, is vital to the success of national AIDS prevention and control programmes and of the global strategy."

Thus, as we start this Conference, as we enter this next era in the history of global AIDS, we should pause a moment and reflect upon the extraordinary events of the past few years. There simply has never been anything quite like this before – and the world is changing dramatically as a result.

Against AIDS – we know now that we will learn to dominate the disease – through resolute commitment to inter-dependence, communication, and justice – and that we will not allow the disease itself or the fears and forces which it can unleash to dominate us. Against AIDS – we will prevail together, for we will refuse to be split, or to cast into the shadows those persons, groups and nations that are affected.

The danger of AIDS brings with it an historic opportunity. For we live in a world threatened by unlimited destructive force. Yet through AIDS and our common fight we are led onwards, irresistibly, towards a new vision of the possible – a new paradigm of health – expressing a universal message out of the special circumstances and insights of our time. Beyond our personal effort and beneath the surface of the days and months, we can feel the tectonic plates of our world shift – for they are moving. Alert to meanings as well as to facts, to danger and to opportunity, we carry forth, with increasing confidence and boldness, each in our own way, this universal creative message, as the history of global AIDS urges forward the history of our time.

AIDS
A worldwide effort will stop it.