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GLOBAL AIDS

into the 1990s

Jonathan M. Mann, MD, MPH
Director, Global Programme on AIDS
World Health Organization



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Global AIDS into the 1990s

by

Jonathan M. Mann, MD, MPH

Director, Global Programme on AIDS
World Health Organization

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At the end of the 1980s – the first decade to know of AIDS, what is the status of the three epidemics – the epidemic of human immunodeficiency virus (HIV) infection, of HIV-linked disease and of social, cultural and political reaction and response? What is the state of the world's confrontation with AIDS – the global effort for prevention of infection, for care of the infected and ill and for unity within and among the nations? Tonight in Montreal, as the world looks towards the 1990s, we also consider what we must yet accomplish and yet overcome – to face a difficult and uncertain future.

As of 1 June 1989, a cumulative total of 157 191 people with AIDS were reported officially to the World Health Organization from 149 countries (Figs. 1 and 2). Of reported cases, 69% are from 43 countries in the Americas; 16% from 47 African countries; 14% from 28 European countries; and the remaining 1% from 31 countries throughout Asia and Oceania. However, reporting is incomplete; the actual cumulative global total of AIDS is estimated at nearly one-half million, more than three times the number reported.

Figure 1
Reported AIDS cases
1 June 1989

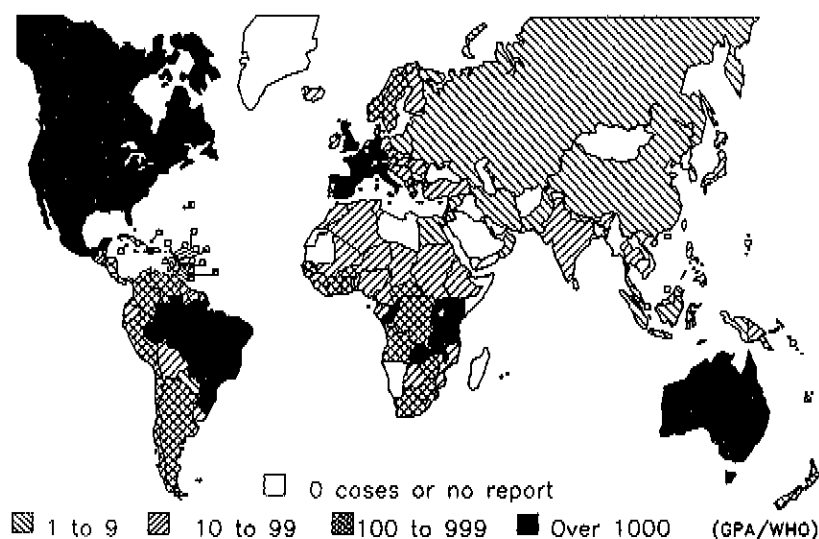


Figure 2
Reported and estimated AIDS cases
1 June 1989

Area	Cumulative number reported	Number of countries	Estimated
Africa	24 686	47	270 000
Americas	108 830	43	175 000
Asia	369	24	<1 000
Europe	21 855	28	32 000
Oceania	1 451	7	2 000
Total	157 191	149	480 000

Nevertheless, it is the epidemiology of HIV infection which provides a more complete and current view of the pandemic. At the beginning of this decade, only about 100 000 persons worldwide were infected with HIV. During the 1980s, between 5 and 10 million people became infected; if we consider only the more conservative figure of 5 million, about 2.5 million of these persons would be in Africa, 2 million in the Americas, 500 000 in Europe and about 100 000 in Asia and Oceania.

Beyond absolute numbers or continental distribution, there is an important contemporary development – the global epidemic of HIV infection remains dynamic and is continuing to expand, in three ways.

First, HIV infection is generally and sometimes dramatically increasing in already affected areas. For example, in Thailand, HIV seroprevalence among intravenous drug users in Bangkok was about 1% in late 1987; it was 20% a year ago; it is now over 40%. Several years ago, HIV seroprevalence among female prostitutes was less than 1/1000; now it is about 1/400 and in some focal areas exceeds 1%. Recently, infection was geographically limited in Thailand; now, HIV infection has been reported in 70 of the country's 73 provinces.

Second, the epidemic has recently expanded its geographical scope, reaching countries and regions previously unaffected or only slightly affected by HIV. For example, several surveys among female prostitutes in South-Eastern India have documented HIV seroprevalence of between 3% and 7%; prostitutes are also infected in Calcutta and Bombay. In the capital city of Côte d'Ivoire, HIV-1 seroprevalence among adults increased from less than 1% to at least 4% within two years. This pattern is being observed increasingly throughout West Africa, where a widespread HIV-1 epidemic is underway and gaining speed in many large cities.

Third, the pandemic has become extraordinarily complex and increasingly diverse at the national, provincial and community level, reflecting the great variety of social, economic and cultural circumstances which create, enlarge and maintain the potential for exposure to HIV. One stunning example has occurred in the USSR in Elista, a city between the Black and Caspian Seas. An HIV-infected man infected his wife; their infant was infected and on becoming ill, was admitted to a childrens' hospital. The reuse of unsterile needles and other invasive equipment led to transmission of HIV to pediatric patients; in all, over 50 children in several cities have been infected. In Brazil, the proportion of AIDS cases linked with drug injecting increased from 3% to 13% in one year, reflecting a new urban epidemic of cocaine injecting; seroprevalence among drug injectors in Rio de Janeiro and Sao Paulo is 16%; and HIV infection and AIDS have now been documented in Rio de Janeiro's large population of street children. In Europe, the proportion of AIDS cases attributed to drug injection increased from 6% in 1984 to 34% in 1988; in Italy and Spain, drug injectors now account for over 60% of AIDS cases.

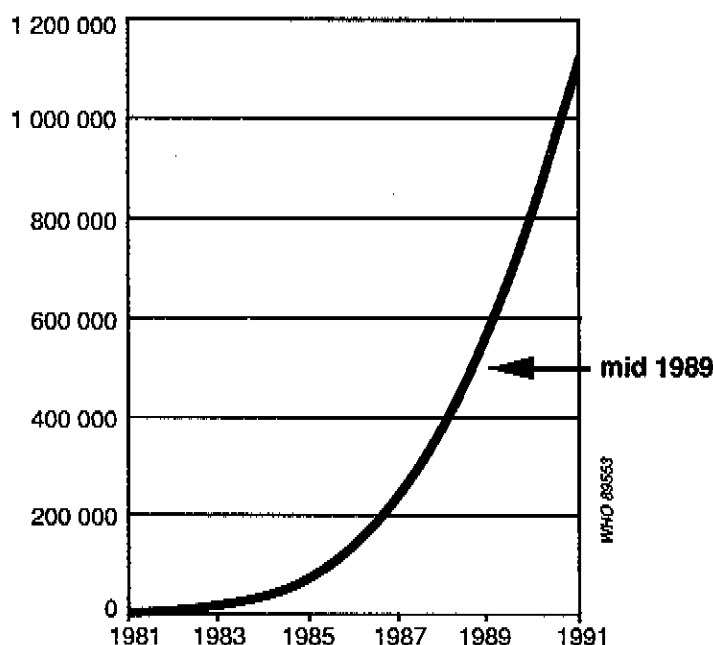
The second epidemic is of HIV disease, including AIDS. Worldwide the number of people with AIDS is rising sharply: from about 70 000 from 1980-85, to 300 000 people developing AIDS from 1986-88, to an estimated 700 000 in the 3-year period 1989-91. Thus, the cumulative total of AIDS cases is expected to double from today to the end of 1991, to over 1.1 million (Fig. 3).

The third epidemic – of social, cultural, economic and political reaction and response – threatens increasingly to overshadow and overwhelm the epidemics of HIV and AIDS. Myths about HIV and AIDS persist, generally involving fears about casual contact. In surveys throughout the world, from 10% to 30% of people still believe that HIV can spread through a handshake and that it is not safe to ride a bus or share a workstation with an infected person. Also, sadly, the twisted bring forth their twisted ideas, spreading their talk of "secret germ warfare", "massive cover-ups" and "AIDS conspiracies". This is harmful, for an African Minister of Health recently reported a reduction in condom use linked to a rumour that condoms have been contaminated with HIV.

Finally, assaults on the rights and dignity of HIV-infected people continue to arise, involving work, education, housing and travel, even in countries which have thus far steadfastly resisted such discrimination.

In summary, the three worldwide epidemics remain unstable, volatile and dynamic – for they are compounded of many elements of human behaviour – individual and collective. The pandemic has not peaked – and none of its constituent elements can yet be said to have stabilized.

Figure 3
Projected Global AIDS Cases



Yet there is today, in many countries, a strong and growing capacity to prevent infection and for care of the ill; there is a steadily enlarging body of scientific knowledge; and there is learning based on years of hard work. From this experience, there is today a new realism in the national and global response to AIDS; based on action – not theory and yielding results – hard won.

Over two years ago, the foundation was established for an international programme of concerted action and common purpose – the Global AIDS Strategy. The Global AIDS Strategy has met this need, providing a practical framework for national efforts, literally around the world, and for international programmes. The World Health Organization's Global Programme on AIDS is working with 154 countries, providing financial support of over US\$ 60 million to 127 countries and technical support through over 1 000 consultant and expert missions for planning, training and implementing in the field. National AIDS programmes have been developed rapidly, with great energy and local creativity; such programmes now exist in most countries and will be established in all of the world's 187 countries and areas, by the end of this year.

Through this work has come an increasing recognition of the power and importance of community-based organizations. These community organizations have often been pioneers, leading the way for more timid or reluctant governments. Whether they already existed and redirected their efforts to AIDS, or whether they arose as new needs emerged, these organizations have in common the critical ability to reach people, to deliver information people will believe and to give support where governments cannot reach or in ways that governments cannot provide. This is one of the far-reaching and practical lessons of the decade: that in AIDS programmes there is a direct relationship between the strength, diversity and involvement of community-based and nongovernmental organizations and the level of success which can be achieved. The importance of community – community action and community responsibility – in AIDS prevention and treatment was saluted in a resolution of the World Health Assembly in Geneva just three weeks ago.

In many countries, there is evidence that behavioural changes have occurred or are occurring which will help prevent HIV infection. Through several years of experience in many countries, it is clear that regardless of the cultural and social context, three elements have been present wherever positive behavioural changes have occurred. First, locally relevant and targeted information and education has been provided by credible sources. Second, the information and education has been linked with those health and social services needed in order to support and strengthen behaviour change. Finally, the entire

programme must be imbued with the theme of support; a supportive social environment is a requirement, not a luxury. These are the principles which emerge from experience – they can be adapted to any setting – to any culture. Unfortunately, wherever information remains inadequate, inaccurate or frankly misleading, where needed health and social services do not yet exist, or where the entire effort is undermined by a discriminatory and punitive social environment – in these places, prevention has not yet been given a chance.

The Global AIDS Strategy has also succeeded in bringing human rights squarely into the world of public health. At the national and international levels, we have acquired increasing experience and skill in drawing closer together the practice of public health and the principles of human rights.

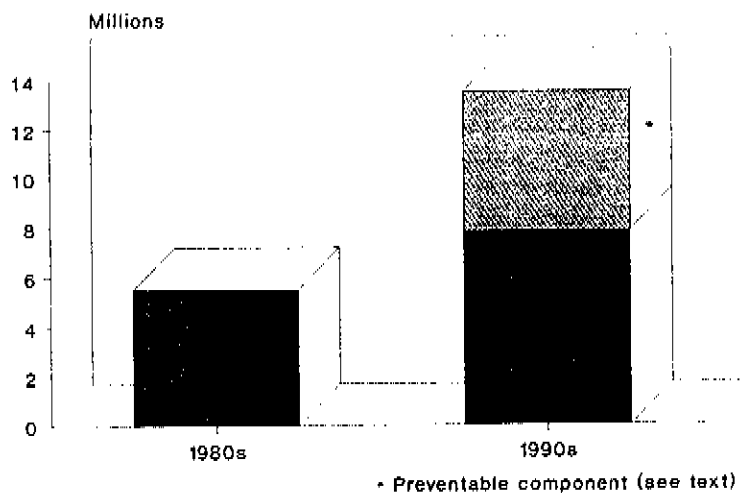
Yet we recognize the limits of current national and international progress. Initial steps – creating national AIDS committees, planning new programmes, conducting large-scale public information campaigns – have generally been carried out. However, the implementation of national AIDS plans remains incomplete and the transition from first efforts to a sustained and sustainable national AIDS programme remains a major challenge. Also, the struggle against discrimination is never finally, or forever won; it requires vigilance and continued effort – steady work.

The history of the global epidemic – the history of the global response – has been so short and so intense. Yet we have a continuing responsibility to look ahead and to develop a view, however limited and imperfect, of the future. To predict trends of HIV infection and AIDS in the 1990s, the Global Programme on AIDS recently completed a Delphi study, using this method to collect and synthesize expert opinion.

The projections are based on the assumptions that 5 million adults had already been infected and that during the next decade no effective vaccine or treatment would be available. The Delphi estimates were then fitted into a model to project AIDS cases to the year 2000.

The Delphi study predicted that during the 1990s, about three times more HIV infections would occur than had occurred during the 1980s (Fig. 4). Over one-third of these new HIV infections were considered preventable by a globally coordinated AIDS programme in concert with national programmes.

Figure 4
WHO/GPA Delphi Projections:
Adult HIV Infections



Further, approximately nine times more adults were predicted to develop AIDS during the 1990s, compared with the 1980s (Fig. 5). About half of the people who will develop AIDS during the 1990s were already infected with HIV during the 1980s. Over one-third of the AIDS cases resulting from new infections in the 1990s were considered preventable through global and national efforts. Therefore, whether considering the cumulative number of adult AIDS cases worldwide (Fig. 6) or comparing the annual number of new AIDS cases in 1990, 1995 and the year 2000 (Fig. 7), the HIV/AIDS situation in the decade of the 1990s will be more serious, and perhaps much more serious than what we have experienced during the 1980s. In particular, the number of people with AIDS will increase greatly and needed health and social services must be planned – and developed – now.

Figure 5
**WHO/GPA Delphi Projections:
Adult AIDS Cases**

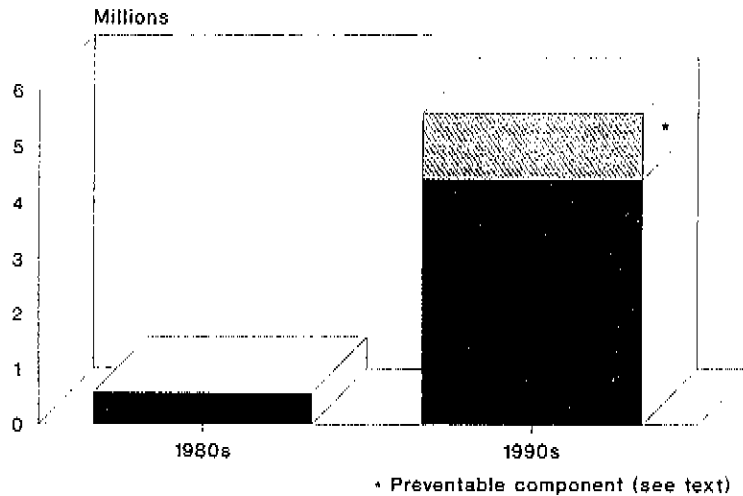


Figure 6
**WHO/GPA Delphi Projections:
Cumulative Adult AIDS Cases**

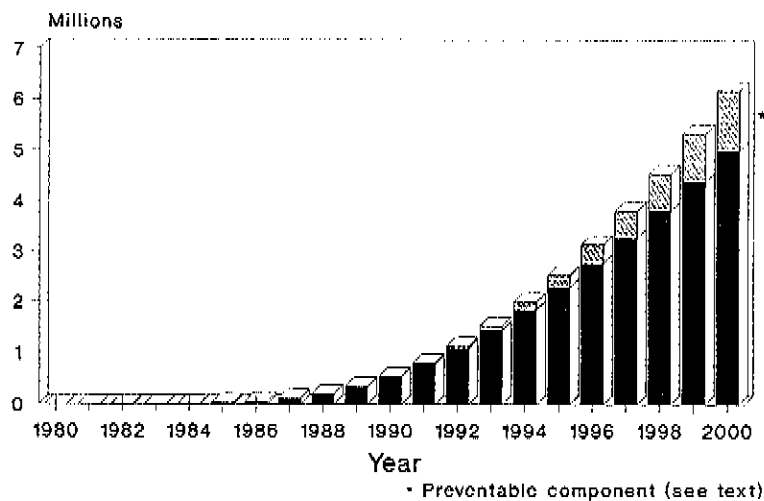
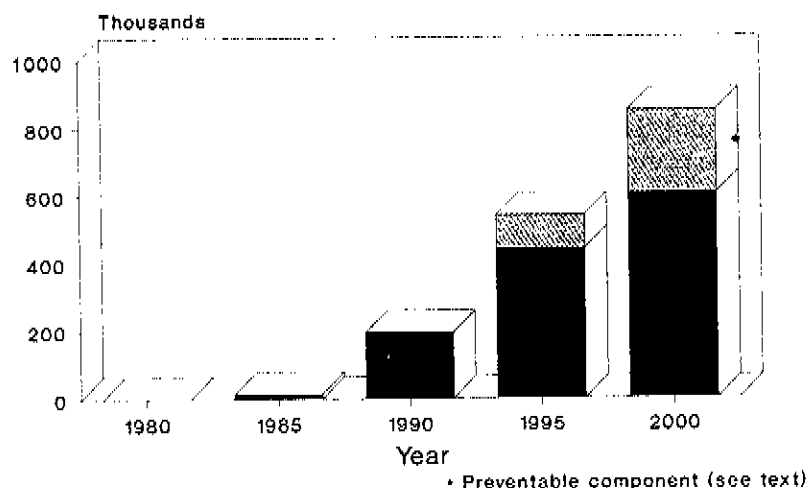


Figure 7
WHO/GPA Delphi Projections:
Annual Adult AIDS Cases



Looking to this future, with confidence in the work already accomplished, the experience gained and the soundness of the Strategy, national AIDS programmes must accomplish three tasks.

First, programmes must be consolidated. To ensure sustained capability in the coming decade, stronger linkages must be forged with other health and social programmes, more attention must be paid to programme staff and staff development, and the capability for management, planning and evaluation must be improved.

Second, programmes need to identify specific areas which merit focus and strengthening. In every community and country, AIDS has inevitably highlighted certain pre-existing and complex health and social problems. Worldwide, the broad issues are similar, yet the specific circumstances and emphasis are quite varied. For example, in India, AIDS focused attention onto the quality of blood products; in Italy, to drug injectors; in Pakistan, onto the blood transfusion services; in the United Kingdom, to health education, particularly of youth; in the Soviet Union to the quality of health services; and in Sri Lanka to prostitution and control of sexually transmitted diseases. Each AIDS programme must select its own priority areas for particular emphasis; commitment to these deep and longstanding problems upon which AIDS has focused renewed attention, is yet another contribution of the efforts against AIDS to improving health for all.

Finally, AIDS programmes must continue to innovate, for some of the challenges which AIDS presents to individuals and society will require new approaches – for prevention, for care and to assure equity in the provision of health and social services, including therapeutic agents and, eventually, vaccine. AIDS programmes must not stop challenging the *status quo* – when the *status quo* is simply not good enough.

To convert the initial efforts of the 1980s into strong and resourceful programmes to deal with HIV infection and AIDS during the 1990s will therefore require sustained energy and commitment. Yet the epidemics of HIV and AIDS are but two of the three we will continue to face. The third epidemic, of social, cultural and political reaction and response, may be as important to our future as the virus itself.

Around the world, there is evidence of growing complacency among some – and growing fatalism among others. Complacency invites marginalization – of groups or nations – and could tragically reduce the commitment of human and financial resources at this critical moment in national AIDS programme development. Fatalism can lead either to passive hopelessness and despair or to proposals for simplistic and extreme solutions.

Therefore, taking the measure of the future, solidarity is a transcendent and dominant need. In the 1980s, we have learned and we have taught that discrimination and stigmatization of HIV-infected people must be prevented – for the sake of all. More recently, we have discovered that beyond the limited concept of anti-discrimination there is a more positive and active quality – a respect for human rights and dignity – a spirit of active tolerance. Yet even beyond anti-discrimination and tolerance, there is a higher call – to solidarity.

Solidarity is at once a personal and a universal matter, for it raises the fundamental question of what is the “self” and what is the “other”. One of the glories of our era is that we have witnessed the birth of global solidarity – imperfect, struggling, yet nevertheless real – in the creation of the United Nations, in the concern about nuclear war, in the growing worldwide resolve to protect the environment, and in AIDS.

We must practise the wisdom that refuses to separate the condition of the few from the fate of the many. We must prevent the emotional negligence which leads to indifference to the fate of peoples and nations. We must continue to face painful and intractable aspects of life and society: ignorance, fear, discrimination, prejudice and hate; abandoned children; prostitution of boys and girls, men and women; drug injection; the suffering of those who are infected and ill and those who live with them; and death itself. Concerned with AIDS, we are drawn to solidarity. This solidarity gives us confidence to continue to look into the face of AIDS – and know that we will not turn away.

We need this week together in Montreal, for periodically we must refresh our sense of unity, speak to each other and renew our willingness to share across all boundaries – of race, religion, culture, language, profession, sexual preference, HIV-infection status, and national origin. Together, we have created an unprecedented worldwide movement, linking villages, cities and nations. Together, we have created this common effort – this common purpose; it must be preserved and cherished, for if we lose confidence and support from each other, to whom can we turn? AIDS has taught us to seek actively this solidarity – or we shall be alone.

As we mature as individuals, our innate feeling of personal immortality evolves into an awareness of our mortality, and this helps us in our search for understanding. And at some time we accept our common humanity, and this knowledge also helps us better to understand. Are we – is the world – now mature enough, now wise enough – to accept that the deepest meaning of solidarity requires that we consider ourselves as if we too were infected with HIV – that we are all – on a human level – seropositive?

As we turn towards the decade of the 1990s, we implicitly test the future, weighing our skills, strength and character against the challenge. The dynamism of modern science inspires us, the deep internationalism of the global fight against AIDS strengthens us, and the remarkable history of the 1980s – of our personal and collective efforts – gives us courage and confidence.

While many tragedies and struggles leave no visible trace once they are past, no imprint on the world’s spirit, we know that AIDS in the 1980s has altered us – in our world, in our countries, in our communities – and in our hearts. From our experience in the decade now passing, our hard-won knowledge, – we know that we, and those who think and work and believe as we do, will not simply survive – we will prevail. For finally, it is the commitment and strength of individuals – hundreds and thousands of individuals – whose humanity and whose acts of solidarity illuminate the world – and our future.



AIDS
A worldwide effort will stop it.