EDITORIALS

Good Politics, Bad Politics: The Experience of AIDS

Historically, many of the improvements in public health have their roots in a synergistic combination of political leadership and science. The potency of this synergy between politics and science is illustrated by many of the public health advances made in the late 19th and 20th centuries. Improvements in European children's health, for example, occurred when politicians responded to calls from their electorates to end child labor. Similarly, declines in tuberculosis started before treatment was even available, because of social activism that resulted in improved living conditions.[1] Incidences of tobacco-related illnesses were finally reduced when doctors and the antismoking lobby prevailed upon governments to boost taxes and institute smoking bans.

Progress in the response against AIDS is no exception. In fact, the response to AIDS is probably the most striking contemporary example of how intertwined politics, policy, and public health are.

Why has the global response to AIDS been so highly politicized? One key reason is the prejudice and discomfort around the ways HIV is transmitted. Another is that the epidemic is fueled by injustices. AIDS both exposes and exacerbates multiple fault lines of social and economic inequality and injustice, which in themselves are highly political.[2] An expanding AIDS epidemic reveals a political system's weak points, whether at the national or the community level.

Politics has been the main driver of action as well as inaction and denial regarding AIDS. On the one hand, positive political action at both the grassroots and governmental levels has greatly enhanced the global response to AIDS. Political action on AIDS has also been an opportunity to correct underlying injustices and mobilize positive political momentum around issues such as gay rights. On the other hand, politics has been a negative force at times, blocking important policy developments and evidence-informed action on AIDS, particularly access to antiretroviral treatment in poor countries, prevention of sexual transmission of HIV, and harm reduction in injection drug users. Inaction reflects a political denial, an unwillingness to engage in sensitive issues, such as those inextricably linked to HIV transmission. Inaction on AIDS may also result from competition from development issues such as infrastructure enhancement and income-generation programs. Moreover, the fact that the symptoms of AIDS do not immediately manifest themselves—either in individuals or in society—allowed the epidemic to go unnoticed and unchecked at a point when decisive political action could have seriously reduced its spread and impact.

AIDS has always been highly political, not least because of the nature of HIV transmission and the stigma associated with sexual intercouse and injection drugs. Initial progress on HIV prevention in the 1980s in Western countries was largely because of gay activism and community mobilization and, in some countries, effective government action. In Africa, The AIDS Support Organization, started in Uganda in 1987, is a prime example of community-based action initiated to support those affected by AIDS before treatment was available, whereas the Treatment Action Campaign, launched in South Africa just over 10 years later, very effectively used community-driven political and legal action to ensure widespread access to a scientifically sound response to AIDS in an environment of denial.[3]

In the early years of the epidemic, AIDS was not a mainstream political issue outside of public health and gay rights circles. This started to change when Jonathan Mann created the special program on AIDS at the World Health Organization. First, Mann introduced a rights-based approach as the basis for a global AIDS strategy, which is still a guiding principle of most AIDS programs today. He also worked hard to engage ministers of health in each country and through the World Health Assembly and global and regional conferences. His successor, Michael Merson, made the first attempts to widen the AIDS response beyond the health sector, particularly in Africa, where the epidemic was increasingly affecting all walks of society.

The quasi-simultaneous introduction of highly effective antiretroviral therapy in the West and the launch of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 created an entirely different environment that was ultimately far more conducive to political action on

At the "AIDS in the Heartland" conference held in Indianapolis, Ind, on February 7, 1987, Ryan White, age 15, with his mother Jeanne White looking on implored an audience of nearly 900 health care professionals with these words: "Whatever you do, please don't isolate us." Photograph by Seth Rossman. Printed with permission of AP Wide World.

AIDS. In 1997, the World Bank Multi-Country AIDS Program for Africa started to catalyze new funding for AIDS.

In 2000, a United Nations (UN) Security Council debate—the first ever for a health issue—and a special session in the UN General Assembly in 2001 both confirmed AIDS as a political issue requiring global action and recognized that health clearly belonged on foreign policy as well as domestic agendas. UN Secretary-General Kofi Annan's call[4] for a "war chest" of 7 to 10 billion dollars at a special Organization of African Unity summit on AIDS in Abuja, Nigeria, gave political leaders a global financial target around which to mobilize. The setting of financial targets, increased international political will, scientific progress, the establishment of new institutions and political processes, and increases in official development assistance all converged to significantly increase financial and political commitments to AIDS.

The UN General Assembly Special Session on HIV/AIDS (UNGASS) culminated in the Declaration of Commitment[5] adopted in the General Assembly by all member states of the United Nations in 2001. It was followed in 2002 by the creation of the Global Fund to fight AIDS, Tuberculosis and Malaria and in 2003 by the launch of the United States President's Emergency Plan for AIDS Relief. As the *Economist* wrote 5 years later, "It does not take an overgenerous interpretation of history to allow that UNGASS played a large part in bringing about the changes. . . . The rate at which money has been made available for AIDS (from all sources, including afflicted countries as well as the taxpayers of the rich world) underwent a step change in 2001."[6](p 24–25)

As a result of these and other initiatives, spending on AIDS in developing countries increased to around $10 billion in 2007, up from $250 million at the creation of UNAIDS. We are starting to see results in the number of lives saved, through a declining incidence of new HIV infections in a growing number of countries in Africa, the Caribbean, and Asia and through access to antiretroviral therapy for more than 2 million people living with HIV in the developing world.

Nevertheless, AIDS, like so many other issues, is at risk of being neglected or mishandled because governmental terms are often not long enough to see the implications of action or inaction or because those in power hesitate to lead on controversial issues. Fierce policy debates rage on the issues of sex workers, homosexuals, and injection drug users, as well as around providing sexual education in schools and the feasibility of basing HIV prevention policies on "moral grounds."

Human rights have been a core component of AIDS strategies since the global AIDS program was launched and have been the anchor of the political and policy-level work of UNAIDS. Political leadership has been key in advancing agendas, whether by civil society groups (from AIDS activists to religious organizations), or by government (more than 40 heads of state or their deputies now head national AIDS bodies) or by those in public health[7] who broke away from traditional medical models.

Some leaders, on the other hand, have denied the links between HIV and AIDS, turned a blind eye to the impact of AIDS on society, and willfully blocked progress. But what is it that motivates some leaders to take action more than others? Jacob Bor's analysis of the determinants of AIDS leadership in 54 developing countries points to the fact that "political leaders do not operate in a vacuum"[8] and that freedom of the press and high levels of HIV prevalence were, in general, key determinants of decisionmaking.

Times change, and political will is one of the things most vulnerable to change in the AIDS response. Resolutions such as the United Nations General Assembly Declaration of Commitment on HIV/AIDS were made when the right elements came together. The document is still there and the pledges still stand, but the political environment continues to evolve, and a constant process

of revitalization and coalition building will be required to build and sustain an exceptional response for many decades. If we had had today's level of political leadership and levels of funding for AIDS 10 years ago, we would not be where we are now: striving to bring down infection levels of more than 4 million new infections a year and 8000 deaths daily.[9] The challenge for us in 2007 is to continue to build and sustain that leadership and funding over the next 10 to 25 years in the face of changing political priorities and demands.

As the years following the 1994 International Conference on Population and Development revealed, the political environment in 1994 allowed for a new paradigm of reproductive health and rights. However, although that paradigm has, to a large extent, been resilient, the realization of the program of action to come out of that conference has been limited by the political realities in individual countries[10]—a lesson those working on AIDS would be well advised to heed.

Earmarking funds, for example, is a tactic that has been an opportunity for targeted funding for AIDS, such as in the US Congress, but it risks making funds hostage to political agendas such as restrictions on HIV prevention funding that call for one third of HIV prevention resources to be allocated to abstinence-only prevention education.

Action on AIDS has been truly transformational for public health. AIDS has also introduced a new paradigm for the involvement of affected individuals and communities and changed the dynamics between caregivers, the pharmaceutical industry, public health establishment and international organizations, and affected communities. Arguably the most extreme public health issue of our time, AIDS has underscored the imperatives to think and act beyond the confines of the classic public health arena, adopt comprehensive approaches, and engage leadership at all levels.[11]

Building on the early history of political action around other health issues, the experience of the AIDS response, both the good political action as well as the challenges of bad politics and denial, has important lessons for the public health community. Early engagement of political leadership at all levels is, without doubt, essential to effectively address significant public health issues. Alone, it cannot ensure an effective response, but in combination with community mobilization, a public health apparatus, continuing economic development, and innovations in science, it can help bring about advances in even the most challenging health issues. ■

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National Institutes of Health Science Agenda: A Public Health Perspective

The United States spends $2 trillion per year on health care, 2 to 3 times per capita than that of other developed nations.[1] Despite this staggering financial investment, our citizens have a lower life expectancy than those in many other countries,[1,2] and it has been reported that patients receive only about half the evidence-based care that they should.[3] To lead us out of this dilemma, the National Institutes of Health (NIH) have set national health research funding priorities to investigate approaches that are predictive, personalized, preemptive, and participatory—the "4 P's."[4,5] These words represent succinct talking points that have broad appeal. However, source documents suggest that the vast majority of NIH dollars will be steered toward technological interventions,[4,6] especially pharmacogenetics. The NIH's version of the 4 P's curiously ignores another important "P": prevention.

Central to views of prediction and preemption are identifying individual genetic risks and developing pharmacogenetic treatments that would preempt disease before it starts. These are exciting and promising areas of research. However, although the United States already leads the world in high-tech health care, it trails in most indicators

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