
GUEST EDITORIAL

Science, Surveillance and the Epidemiology of HIV

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By the end of the first decade of AIDS, scientists had warned and surveillance data had shown that HIV would spread around the globe if trends and early indicators were accurate. Unfortunately, because HIV, and at that time AIDS, had been associated with (and portrayed to be a disease that only affected) both men and women who used illicit intravenous drugs and men who identified as homosexual and engaged in anal sex with other men, surveillance data were largely ignored by policymakers and misunderstood by leaders in public health and social welfare. Those affected and infected were seen as unworthy of consideration, as unimportant political constituencies, and as sinners deserving of their fate. The science, while it was ignored, was allowed to exist. In fact, the emerging science of AIDS began to shape the community responses and it was not challenged.

During the second decade of AIDS, public health science showed that transmission of HIV could be prevented through the utilization of public health modalities such as risk and harm reduction strategies, including the distribution of bleach kits and clean syringe exchange; and

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utilization of HIV prevention strategies including the use of condoms, safer sex practices and the reduction of sex partners. Again, policymakers and social and public health leaders did not embrace public health science. Talking about clean needles and bleach kits "encouraged" drug use. Talking about condoms and safer sex practices translated into promoting sex out of wedlock, specifically gay sex. And while the best public health science suggested otherwise, policymakers and public health leaders did not want to deal with or talk about two politically unpopular topics: drugs and sex.

As we begin the third decade of responding to the HIV crisis in the United States and around the globe, we are faced with the realities that the map of infections has shown. No corner of this nation is untouched by HIV. At a time when we should be widening and deepening the public and social response to HIV and developing public health policies targeting community level interventions, we are faced with the following tasks: integrating public health data with intervention strategies, relating public health science to individual lives, and anchoring HIV health and social policy outside of the political arena. Why?

Globally, more than 20 million men, women and children have died from AIDS. Since the first cases of Kaposi's sarcoma were reported in five homosexual men in Los Angeles, California in the early 1980s, more than 550,000 Americans have died from AIDS and HIV-related health problems. Today, every day five Americans die from AIDS and 100 Americans become infected with HIV. So why, in 2003, is it so hard to set a scientifically-based research and public health agenda to address it?

Today in HIV, instead of public health science leading the way, political science, the politicization of science and the science of counting votes, has taken a firm hold of HIV and HIV-related public health issues and is challenging public health science. Lessons learned from responding to HIV are no longer used as vehicles for improving our nation's public health infrastructure and health care delivery system; instead, HIV is now the principal vehicle to carry a politically conservative agenda on which health is one among many on a long list of items. Evidence suggests that invitation and permission to alter our nation's scientifically-based public health response to HIV has been given to politics in exchange for votes. This trend must stop. Its effects must be reversed.

Basic laboratory science has confirmed that HIV is spread when blood, semen, vaginal fluid, or breast milk from someone with HIV gets into the body and blood stream of another person. Public health science

has further identified and confirmed through research four possible modes of HIV transmission: sexual activity, sharing needles, from mother to fetus or newborn, and blood-to-blood contact in the cases of transfusions and organ transplantations. As a result of screening and testing technologies, HIV has all but been eliminated from the blood supply. Further, transmission of HIV from mother to child has been dramatically reduced as a result of testing, prenatal care, and antiretroviral treatment including during labor and delivery.

Today, the majority of cases of HIV infections are a result of unprotected sex and sharing needles. Community-level educational and behavioral health programs focusing on safer sex practices and condom utilization and distribution have been shown to be effective in reducing the transmission of HIV and providing protection against it. Likewise, syringe exchange and other harm/risk reduction programs providing information about HIV and other blood borne infectious diseases, in addition to their primary mission of getting dirty needles out of circulation, have been successful in reducing HIV transmission. So why, as we begin the third decade of responding to HIV in the U.S., is there a debate about the utility of these scientifically tested methodologies?

After more than 20 years of successful HIV prevention interventions at the individual and community level resulting in nationwide reduction in new HIV infections, why are organized and concerted efforts aimed at substituting and funding scientifically untested approaches to HIV prevention being introduced: abstinence until marriage and fidelity in marriage?

There is no debate that HIV is a serious public health problem. In some communities and neighborhoods in the U.S., HIV is a public health crisis. Effective HIV prevention strategies must include the utilization of scientifically sound methodologies that target those at greatest risk: sexually active adults and individuals who share syringes and needles. For those concerned with the condom versus fidelity in marriage approach to HIV prevention, one must remember that 50% of marriages in the U.S. end in divorce, usually because of infidelity. Correct and consistent use of condoms has been shown to have higher percentages of success than marriage rates.

With the field of HIV practice shifting from sound scientific discovery and planning to that of whimsical pronouncements, advocates in HIV practice and policy must pay careful attention to the existing HIV infrastructure, understanding what steps are necessary to insure the maintenance of our nation's current efforts to address the epidemic. Without close attention to the existing HIV system of programs and pol-

icies, what has been a successful community-driven public health strategy, may all but disappear in exchange for programs and policies that include mandatory testing, criminalization of HIV, public disclosure and unproven "programs" based upon moral judgments and pronouncements.

The field of HIV practice must continue to include the necessary resources that will provide those living with HIV the resources to meet their medical and social needs. HIV prevention programs must continue to rely on scientifically evaluated programs that have arisen from needs tested interventions. The field of HIV practice has been built upon providing services to address needs including access to medicine, specialists, housing, nutrition and other supportive services. In the same vein that social work practice is built upon identifying and finding solutions to need, the field of HIV practice must continue to engage in assessment of situations and the provision of programs to meet these needs. The challenges arise when need is identified by ideology and not by science. How can the field of HIV practice identify the required resources when the ability to judge is not based on experience, but on value?

As providers of services to meet these needs, HIV practitioners must be involved in the process to identify, articulate and respond with programs that have proven effectiveness. Social workers, HIV prevention specialists, caregivers and everyone involved in responding to HIV should pay close attention to the changing winds. Without our voices, providing a backbone to respond to this epidemic, much stands to be lost. Social work is based on providing services to those less fortunate, to those who have no other means, but it is not enough simply to provide for those who cannot. The fields of social work and of HIV practice have moved well beyond the "do good" mentality into deliberate and dedicated reactions to identified problems.

Public policy is whatever government chooses (wants) to do or not do. Political science has been associated with the institutions and structures of government and political behaviors and processes associated with policymaking (Dye, 1996, p. 2). In the case of HIV, government was reluctant to get involved, and the policies that followed government's lukewarm engagement reflected the lack of attention given to the serious nature of this epidemic. Developing sound federal health policy on HIV rests on knowing the facts, not the opinions. To build a workable, intelligent national health policy to respond to the epidemic, we must first know the facts (Johnson, 2003).

Providers must be aware of the facts that have built this nation's response to the HIV epidemic, but also to the changing ebb of political

thought. We cannot stand idly by while political voice undermines proven science. This community of HIV providers of services must yet again stand ready to voice our needs, and more importantly, our response to these needs. Grounded in the history of solving real problems for real people, HIV practitioners in the social services stand well-poised to shape the future of our nation's HIV and AIDS policy.

At the end of 2001, a reported estimated total of 344,178 persons in the United States were living with AIDS and an estimated 950,000 Americans were living with HIV (CDC, 2002). Nearly 240,000 Americans living with HIV were unaware of it and 42,000 new infections had occurred. Instead of a steady march toward the guarantee and institutionalization of quality medical care, service and community support for people impacted by this disease, HIV prevention education, clinical care and services remain an exception to the rule. They are not included as part of an integrated public health system (Martin, 2003).

Much work must be done to shift the focus in the fight against HIV and AIDS until it is over. After two decades of public health advocacy, the collective HIV community faces new and unforeseen challenges. The political agenda of the HIV community of clinicians must understand, examine and keep a close watch on the science of HIV. Through this attention to the science, the HIV community has been and must continue to lead the response to HIV, as it did to AIDS in the preceding two decades. It remains our best strategy not only for the third decade, but also for those years beyond. Without the combination of our skills and the science, HIV will continue and our response will be diminished.

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