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HIV/AIDS: THE TWENTY INJUNCTIONS OF LONDON

SUMMING UP THE CONFERENCE ON HIV BEHAVIOURAL INTERVENTIONS

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Michael Waugh

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HIV/AIDS: the twenty injunctions of London Summary of the Conference

The Hon Justice M D Kirby AC CMG

Past Member of the WHO Global Commission on AIDS; Chairman of the Executive Committee, International Commission of Jurists, Sydney, Australia

SUCH IS LIFE AND DEATH

An air of unreality pervaded London in the last days of this conference. The Prime Minister (Mr John Major), in a political pre-emptive strike, decided to resign his party leadership to confront his political opponents. The media was full of the news. Yet in all truth, everyone attending this conference knew of the supreme insignificance of this event for the future of humanity. By way of contrast, the issues of this conference touched nothing less than the future life and suffering of millions. Yet getting impartial and even minor attention to HIV/AIDS is becoming less and less easy. Such is life. Such is death.

The focus of this conference has been behavioural challenge. A millennium of English law has taught the extreme difficulty of translating statutory and judge-made rules into real action by individual human beings in given circumstances. It has therefore been fascinating to me, a judge, to watch the debates of the behavioural scientists and to reflect upon the imperfect state of the art by which we hope to modify human behaviour in effective ways and with measurable impact in the face of HIV/AIDS.

For us, the participants, the conference has been a rich learning experience. But our common humanity (shared with the objects of our study) obliges us to state our experiences and to spread the messages which we have heard these past 3 days. That is why I have prepared this summary. It represents no more than my own perceptions. Doubtless they are charged with my own discipline, interests and capacity to hear and comprehend important messages. But, if one of us does this, it will help all of us to consider the lessons which we have each derived, and to pass them on.

There is no need to review the enormity of the problem of HIV/AIDS worldwide. This was given. Throughout the meeting there was precious little sermonizing. Some glimpse at the size of the subject of our study was given by Professor John Dwyer of Australia. By reference to the major means by which HIV causes AIDS to spread (unprotected sexual intercourse), Professor Dwyer pointed out that simply in the time we had been talking, on WHO estimates, there had been more than a billion acts of sexual intercourse. Three hundred thousand pregnancies had resulted. Ten thousand cases of HIV sero-conversion.

Correspondence to: Justice Michael Kirby, High Court of Australia, Canberra, ACT 2600, Australia. At the time of this address the author was President of the New South Wales Court of Appeal.

TWENTY INJUNCTIONS

I have organized my impressions of the conclusions of this conference in the form of 20 injunctions. The injunction was a most useful legal remedy, devised by the Lord Chancellors of England to require those to whom the orders were addressed to act in accordance with their terms. The injunction was imposed on the conscience of the recipient. It had grave consequences if disobeyed. Most of us—indeed almost all—live in countries which are the children of the English legal system. So let us reflect upon the 20 injunctions of London. They are injunctions derived from the discussions at this conference about the impact of behavioural and science studies on the HIV/AIDS epidemic.

(1) Facing the difficulty of measuring intimate human behaviour

There is a need, first, to face up to the basic difficulty of measuring human behaviour in matters so intimate as sexual activity, injecting drug use and childbirth—the 3 principal entry points of HIV. Dr Kenneth Calman, in his opening remarks, pointed to the high complexity of health prevention generally—the difficulty of measuring impact and time lags. To this, Dr Peter Aggleton urged the need to try to do better—to devise better tests accurately to record behavioural data. Random controls should sometimes be possible. Much of the time of this meeting was addressed to methodology, theory, system. But not too much. Dr Tom Coates pointed out that pilot schemes in California might not meet perfect models of clinical trials, as would be the case for drugs. But there was a serious attempt to tackle the methodological issues whilst at the same time getting on with the urgent task of fighting the spread of the virus. Dr Don Des Jarlais pointed out that many drug trials are not conducted by strictly randomized methods. How much less can we demand such precision in the scrutiny of intimate human conduct. For example, many drugs

are never tested for the potential gender differentiation of their impact. But they are still cleared for use, with great benefit. In the face of HIV/AIDS something of the same compromise between perfection and possibility must be accepted. It is inherent in the inescapable difficulty of measuring intimate human behaviour with scientific precision.

(2) Improving the rigour of behavioural analysis

Despite this, there were many calls for greater rigour in behavioural analysis in the area. The rallying cry was given early by Professor Anne Oakley who propounded the second injunction. We need to ensure greater rigour in behavioural analysis in the face of HIV/AIDS. Dr Ellen Stover of NIH described the 7 city randomized trial presently under way in the United States of America as an example of this technique on a very big scale.

Professor Oakley described her examination of 850 published studies by reference to criteria of accuracy derived from scrutiny of reports of drug trials. The 850 were reduced to a mere 18 which ultimately passed her stringent criteria. In her view, we can ignore 90% of the published literature on behavioural modification if we are hoping to derive, with assurance, serious practical conclusions of high accuracy. Several speakers agreed with the general truth of this point — they called for an enrichment to replace the 'impoverishment' of the social sciences. In this field great care was needed against being misled by well-meaning enthusiasts. Professor Oakley described the feeling of searching for behavioural needles in a haystack of published works. Publications had been pushed forward by the very urgency of the HIV/AIDS challenge. She accepted that behavioural sciences were still young. They are often weak in their treatment of experimental data. But she urged that in HIV/AIDS we should be doing better. In particular, follow-up and time analysis needed to be more precise and more long-term before conclusions of dubious reliability were boldly drawn.

This injunction provoked much commentary. Many participants privately (and, in Dr Tom Coates' case, openly) questioned whether their publications had made it to the rock-hard 18. Others suggested that it was a *chimera* to seek such perfection in this area. Dr Graham Hart pointed out that in drug trials themselves, much evidence was anecdotal and imprecise. The tension between the achievable rigour and the need for urgent action was never fully resolved. But Professor Oakley's thesis is one which this conference certainly sends forth to researchers in this area. Professor Oakley's expressed impatience with scientific 'double standards' in behavioural studies will stay with us. And it was interesting to see how workers in the field, e.g. Dr Charles Abraham and Dr Herman Schaalma, explained their models with a clear understanding of the behaviouralist theories which they were testing in the classrooms of Tayside and the Netherlands. As Professor Anke Ehrhardt wisely said — in the end, we are all concerned to find the acceptable balance between scientific rigour and urgent intervention in the face of a great crisis which every day costs lives and causes much suffering, propelling behavioural and other scientists into a sense of great urgency.

(3) Defining terms commonly used in behavioural discourse

The third injunction was a connected one. Behavioural scientists must define their terms. For example, Dr Aggleton emphasized that there was not a real consensus about what 'counselling' actually involves. It is rarely well thought out or described, still less defined. Yet how often is it used in this realm of discourse. Professor Martin Fishbein, a doyen of theory but also intensely practical, stressed that 'change in behaviour' was not an event but a process. Professor Tony Coxon suggested that self reports that 'the condom broke' may sometimes simply be a code phrase for 'I forgot to use it'. Dr Oakley and many others insisted on testing behavioural interventions over time. But she agreed that what was 'time' was disputable. Yet, ordinarily it was certainly more than a mere 3 months.

(4) Integrating behaviour with clinical sciences

The fourth injunction was that it is imperative to integrate behavioural sciences with clinical sciences. This point was made at the outset by Dr Jack Whitescarver of NIH and by Dr King Holmes at the very end. It is part of NIH's current strategy. The danger of a meeting such as this, in different hands, would have been that it could have led to a frolic of behaviouralists without integrating their interventions with appropriate clinical strategies. Professor Roy Anderson told us of the typical pattern of most epidemics. They have their own dynamic which may make precisely accurate evaluation of interventions very difficult indeed. We returned to this integrative theme in the marvellous paper by Dr Margaret Chesney of San Francisco. She told of the work of her colleagues. Helping individuals and communities living with HIV/AIDS and under constant stress. Turning this disaster so that every day it becomes an educator.

(5) Learning quickly from strategies which appear to work

The fifth injunction is the need to acknowledge quickly that some strategies do have an impact. Most vividly this was brought out at the beginning of the conference by Dr Tom Coates. In the first year of the acknowledged HIV/AIDS epidemic 82,000 people sero-converted in San Francisco. In 1992, the recorded figure was 650. This suggests (at least to some degree) that community messages, the media and other means of promoting behavioural change were working in whatever imperfect way. Figures

like these give hope and encouragement that behavioural interventions can sometimes have an impact.

There were other data of this kind. Dr Schaalma's evidence from The Netherlands was most instructive. Why are teenage pregnancies and abortion rates so much lower in that enlightened country? The only answer that could be offered was the enlightenment itself—sex education in schools 30 years ago to current parents had allowed candid discussions by those erstwhile pupils with their children about sexual matters. But, in the face of HIV/AIDS, there is no time—even if there were a possibility—to spread Netherlands' enlightenment across the Channel, still less across the world.

Some societies have done better than others in the fight against HIV/AIDS. Perhaps this is because they have mixed strategies to achieve synergy of the kind which Professor Roy Anderson described. Remembering acute cultural differences, we do well to target differentially the techniques available for different countries. But we should keep Dr Hart's warning in mind. There is a great pressure here to be seen to be doing something. It is natural. But it should not blind efficient social scientists to the reality that interventions will work differentially in different places. The object of an intelligent strategy must always be to maximize the effectiveness of what is done. Not just to do things—such as printing more leaflets or broadcasting vapid advertisements enjoining everyone to 'Stay healthy', that mean nothing at all to most listeners.

(6) Getting in early with useful strategies pays dividends

Many interventions illustrated the sixth injunction. If you can design a good anti-HIV/AIDS strategy it is important to introduce it early. Dr Tom Coates illustrated this with hopeful figures from Sydney (Australia) and Lund (in Sweden). What a contrast these reports made with the figures from the commercial sex workers (CSW) in Bombay. Professor Dwyer's note of despair about Asia will ring in our ears when we are far from here. So far as the epidemic in Asia was concerned, we knew the virus. We knew the peril. Asia was at first untouched. Now, it is fast becoming the epicentre of the epidemic precisely because the essential behavioural interventions did not come early enough. Every day the virus marches further within those centres of high population. Professor Roy Anderson stressed this point today. Early intervention, even if of limited efficiency, will have a disproportionate benefit in the long run.

(7) Targeting the groups at special risk

The seventh injunction is that intelligent behavioural strategies must target the 'underclasses' most at risk of HIV/AIDs. Much time at the conferences was spent examining those strategies. Many papers dealt with the early response of the white gay communities in western countries. In an ironic way, the epidemic has mobilized their purpose. It has led to important changes in the worldwide struggle for human rights relevant to sexual orientation. But there are other tales:

On young people's sexuality: The papers of Drs Abraham and Schaalma, and the vivid use of video in Tayside and in Holland as an accessible medium of getting vital information to the young in terms which they understand, trust and may follow.

On drug-using populations: From needle exchange throughout Australia to the shooting galleries of New York, the lessons which Dr Des Jarlais and Professor Gerry Stimson brought is that success can be achieved in this group. There is distinct evidence of less needle sharing in New York. The new problems of hepatitis B and C need now to be addressed.

The commercial sex workers in Bombay, Thailand, Burma and other lands came under attention. The success in targeting them in Thailand has not, so far, been repeated in other countries, as Dr Geeta Bhave showed. Yet modest gains have been achieved, even in Bombay. The most fearful statistics in Bombay was that even after instruction, so poor are these sex workers and so disempowered, that 97% of them still feel unable to refuse a client who resists condom use. Professor Dwyer was not being unkind when he said that an infected sex worker was a 'menace'. Yet what strategy in life do we offer as the alternative?

The homeless mentally ill men in New York described by Dr Ezra Susser showed how many special groups can be identified when we turn our mind to them. In my own country, I would mention the special dangers to the indigenous Aboriginal and Torres Strait Islander peoples. Dr Coates mentioned the very young men in the United States engaging in sexual activity with infected people over thirty—for commercial reasons, for experiment or for sheer survival. The global issue of street children needs more attention. In the struggle of stigmatized gay groups from Montreal to Brazil there are behavioural lessons to be derived from the papers for this conference. Heterosexual males, hardly an underclass, but certainly an important and sometimes neglected category need to be examined, as emphasized by Dr Ehrhardt and Dr Stover.

(8) Targeting communities and groups—not just individuals

The eighth injunction is that intervention must go beyond the individual to communities and to societies as a whole. This idea came out of many papers. Dr Coates said that this was the future strategy which we should pursue. Many illustra-

tions were given ranging from educational work in Professor Jeffrey Kely's gay bars in middle America to the STD clinics of Zaire and the newly emerging gay groups of Dr Richard Parker's Brazil, struggling against machismo. The cae of the 'gay hero' project described by Professor Kelly was very instructive. It involved picking out a local opinion leader, who could influence peer behaviour in connection with the potentially lethal combination of alchol and sex. We need to find many of these heroes to speak to their particular communities everywhere — and also to practice what they preach.

(9) Targeting co-factors — especially treatment of STDs

The ninth injunction is the need to study co-factors for the light which they will throw upon patterns of the epidemic and the success of behavioural modification strategies. Unwanted pregnancies are a clear indication that condom use strategies amongst young heterosexual couples have failed in a given case and in a group. STDs are another important indicator. As Professor Thomas Quinn pointed out, when rectal gonorrhoea in gay men in western countries goes up, it is a clear warning that there is a need to reinforce condom messages. However, Professor Anderson pointed out that the modes of transmission of HIV and other STDs vary. HIV has the potential, by itself, to swamp STDs and indeed to influence their incidence.

The many ways in which other factors impact on risky behaviour was illustrated several times — from homelessness in New York, to lovelessness of young pregnant women in Atlanta, to the alcohol induced bravado in the brothels of Bombay. Dr Coates pointed to the rapid drop in STDs in Thai brothels after the HIV/AIDS campaign began. From 13% before the campaign to just 0.3% last year. But Professor John Dwyer and Dr King Holmes warned that these indications of success need constant reassessment. There are other considerations. Dr Holmes' research, for example, teaches the importance of closing down the 'factories of HIV' which coalesce around the cases of STDs. The importance of STD assistance was brought out in several papers relevant to any practical campaign to reduce the targets and vectors of the AIDS virus.

(10) Facing up to the economics of HIV/AIDS

The tenth injunction is that we must always be realistic in assessing behavioural interventions. We must keep our eyes on costs. There is an economics of AIDS, as even the World Bank has lately recognized. Dr Stover asked — can we afford 14 face-to-face counselling sessions if that is what is really needed to secure behavioural change in a given individual or group? It is all very well talking about 3 counselling services of 3 hours. But where is the money coming from?

This practical economic point was made at the outset by Dr Coates. Evewn in western countries there are just not enough counsellors — still less the funds. Dr Stover suggested that at the beginning of the HIV/AIDS epidemic many researchers stayed away because of the uncertainty of the funding base. Dr Hart soberly warned us that the funding is just not there in large amounts — especially (said one intervention from the floor) in conservative local authorities in Britain. It is the same in all our countries. The lack of funding was a constant theme of the conference. Lack of funds for research has reached even the enlightened Netherlands, according to Dr Schaalma. Dr Abraham despaired at the lack of funds to train teachers in AIDS education at £750 each. Even if one life only were saved, £750 seems a rather modest cost. Professor Anderson pointed out that cost forces on us choices which we should try to make rationally. Professor Dwyer suggested that this point should be turned on its head. Nations should be made to confront the opportunity costs. Perhaps the potential costs to the so-called Tiger economies of Asia in a decade or so is the only means by which the urgent message about HIV/AIDS will be conveyed to the economic rationalists who now dominate the government and Treasury in every land.

(11) Addressing the basic difficulties

The eleventh injunction is the need to face squarely the great difficulties which behavioural modification involves. Dr Richard Krause went back to basics with the copulation of the fruitfly — so well believed of scientists. If copulatory behaviour is planted by a billion years of evolution, in the lower spinal cord, as well as the higher cortex of the brain, we should not assume that it will be easy to modify even in human beings. Many speakers suggested the deep problems that underlie this epidemic — ranging from the powerlessness of Bombay's dowry-less sex workers to the suspicion of Tayside youth that participation in safer sex videos is somehow deviant sexual behaviour. Changing the machismo culture of Brazil may seem to be nearly impossible. Confronting the poverty, hopelessness, homelessness and loneliness of the world is a really tall order. Yet, if we are realistic in confronting HIV/AIDS we have to tackle basic causes. Professor Dwyer suggested that, until male attitudes to women — especially of the lower castes — were changed in India, not much progress would be made in reducing the spread of HIV/AIDS. Behavioural interventions must be accompanied by efforts to secure fundamental social and economic reforms. It is a huge task.

Professor Coxon cautioned us that, even in the so-called success story of white gay males, the relative lack of condom use might be much more widespread than we thought. Dr Mark Smith urged facing the hard questions of differential harm in needle provision. He found it ironical that a

government, which does not provide housing or food, can still, in some places at least, provide a sterile needle—not always an easy idea to sell to African American leaders in the struggle for equality and dignity. The sheer practicalities of condom provision in Zaire was described by Dr Coates. When condoms were available, they were used and STDs dropped. When they were not, STDs and HIV incidence rose at once. Practical logistics must be squarely addressed if we are to be serious and realistic about risk reduction.

(12) Addressing the problems of self-assessment in behavioural surveys

The twelfth injunction is the need to face up to scepticism about behavioural interventions dependent on self-assessment and self-reporting. Professor Quinn described follow-up by this method as depressing. But Dr Fishbein cautioned that much depended on the way in which the inquiry was conducted. Professor Sevgi Aral demonstrated that a private conversation with a computer (if that is possible) may produce greater accuracy and honesty from a respondent. But in Bombay they are a long way from this.

Professor Fishbein addressed more basic problems. Behaviouralists must avoid arrogance. In this business there were absolutely fundamental problems. Many people do not now how to put on condoms. Some actually take them off before sex. Twelve per cent in one survey admitted to reusing them. So we should not be too disappointed with poor self-reports on condom use. Perhaps questions should be more acutely focused on unprotected sexual incidents. Indeed, asking about condom use may actually bias the answers to those which the subject knows the inquirer wants to hear.

(13) Adopting simple campaigns but avoiding the naive

The thirteenth injunction is to go beyond naïve campaigns for behavioural modification. The history of HIV/AIDS in every land is littered with them. From the 'Stay healthy' television advertisements in Britain to the printed instructions on condoms in Bombay when only 12% of the CSWs can read and which condoms are generally not available and, if so, are not enforceable. On the other hand, street theatre may be simple but sometimes effective means of education. Dr Susser's banana, used in illustrating condom use in homeless men in New York, is etched on our collective memory. The injunction 'put this on your banana' is the modern equivalent to Dr Krause's drill sergeant in the Second World War instructing his troops with a twelve inch broom handle. By way of contrast to this simplicity, the ultimate in sophistication was presented by Professor Roy Anderson—a giant of epidemiological research—with his analysis of factors which affect both national and global strategies.

(14) Transferring knowledge into action in a given situation

The fourteenth injunction is the acute need to study the transfer of the provision of vital information in actual human conduct. Here comes the crunch.

Professor Dwyer told us of the gap in the transference by the health workers in Wollongong in Australia, between what they learnt and taught and what they personally did. Dr Coates urged the constant need to go beyond the 'dance of distancing'—by which HIV/AIDS is secretly thought to be 'other peoples' problems'. The history of HIV, he said, is itself a history of denial. Professor Kelly's gay hero was one strategy learnt from techniques used upon mid-western farmers in the United States to see what persuaded them to introduce new grains in their farming. And if all this seemed difficult, Professor Fishbein and Dr Susser cautioned that getting real change in conduct was actually the easy part. Maintaining changed behaviour was the real challenge. A sobering message of this conference is that the giving of information is just not enough. Richard Parker found high levels of knowledge about HIV/AIDS in Brazil. The problem for action was to overcome deep-seated cultural norms which impede behavioural change. Clearly, this transfer into action is the critical point for behavioural research in the future. If we can learn what works, in the desperately urgent area of HIV/AIDS, we may have lessons for future programmes designed to tackle problems of gambling, coronary disease, and the issues of smoking and other drug excess in many lands.

(15) Refocusing the issue of HIV/AIDS and women

The fifteenth injunction is the urgent necessity, as Elizabeth Reid has put it, to put women at the centre of the analysis of HIV/AIDS. No longer men without penises (as Dr Ehrhardt bluntly put it), many valuable years had been lost in the consideration of the particular focus of HIV/AIDS as it affects women.

The issue secured, rightly, a lot of attention in this conference. Dr Abraham's video film was taken to task because the men were too polite and not thought to be brutal and urgent enough. Dr Krause insisted on the inter-relationship of women's disempowerment and poverty—also brought out in Dr Bhave's study of the Bombay brothel, described to the conference. The spectre of a disempowered woman having to submit to penetrative sex with a partner suspected of being infected—known of the risk but unable to do anything to protect herself—is one which demands global action. Various possibilities for future research were mentioned. They ranged from the female condom and germicides to economic empowerment and a social attack on male attitudes. Dr Parker pointed out that, in this, many

men are themselves victims of their own cultural programming. But the statistics of sub-Saharan Africa show the growing impact of HIV/AIDS on women. This problem needs a new sense of urgency.

(16) Preserving a global perspective

The sixteenth injunction is the need to keep a global perspective. It is easy to retreat into western complacency while the great struggle is fought, helplessly, elsewhere. Dr Whitescarver made this point at the outset of the conference. It stayed with us to the end. The continued extension of United States and other generosity to developing countries was emphasized. But all speakers who touched this problem cautioned about the need for cultural sensitivity. Dr Coates stated that what works in Swiss condom advertisemens or in Thai brothels will not necessarily work even in neighbouring countries. Dr Mark Smith drew a contrast between needle exchange in The Netherlands and Harlem, New York. Professor Quinn described a rally in Uganda after which STDs actually rose in the district. Well meaning measures may not work. There are so many variables where human behaviour is involved. Dr Krause called on us to think globally and to act locally. Professor Dwyer threw down a challenge to our hosts, the RSM and NIH, to consider sponsoring a conference for key political leaders in Asia—or at least to address the problem of getting real action there. It is a challenge which hangs in the air.

(17) Spending more on prevention

Time will not stand conveniently still for the perfect behavioural model. Urgent things must be done. Countries need to spend more on prevention. Dr Smith explained very bluntly the political difficulties. But the challenges must be faced. Dr Coates pointed out that, in the United States of America, the spending on HIV/AIDS last year was:

Treatment	$9.4 billion
Research	$1.6 billion
Prevention	$0.6 billion

This is not a rational proportion of spending. Yet it is the reality. In the design of strategy HIV/AIDS strategists should learn from the partly successful anti-smoking campaigns in many western countries. They should use, from the start, as many participants have done, the subjects of the campaign. The use of street theatre was illustrated by Dr Susser in New York and Dr Parker in Brazil. Professor Dwyer described the success of street theatre in the Philippines until the government succumbed to Church pressure and stopped it for alleged 'indecency'. From a Nigerian participant came the appeal for a flow down of cash from donors to the grass roots workers seeking to educate villagers about HIV/AIDS. This may become a strategy of Dr Peter Piot, the new director of UNAIDS. But several participants cautioned about the need to keep an eye on the big picture and to avoid thinking only locally in a global challenge requiring rigorous international oversight at all times.

(18) Remembering always the ethical and human dimensions

The eighteenth injunction is that we should never forget that we are dealing here with ethical issues and human subjects. Despite the call for rigour in research, there is neither the time nor the possibility to hold off action where it is needed and may be beneficial. This was illustrated by the participant who said that the government should stop talking about HIV/AIDS in British prisons. Leaving a few condoms around would not go amiss. It is not simple to measure, still less to control peoples' sexual and drug actitivities. The reasons are obvious. Even when we do try to differentiate we are left, at the bottom line, with serious moral questions. Dr Coates expressed this thus. We may get United States annual sero-conversions 'down' to 40,000 a year. But by what ethical standard do we say that this is 'acceptable'? Or 30,000? Or 20,000? Or 10,000? Dr Margaret Chesney reminded us, in case we were forgetting, of the enormous human stress and suffering that is involved in just a single case. That reminder is a healthy moral and human corrective to a purely statistical analysis of this epidemic.

(19) Facing the need for more political sophistication

The nineteenth injunction is that there is a need for more political sophistication. Dr Coates pointed out there is a real risk that western politicians, led by the western media, will think that HIV/AIDS is now 'licked'. Dr Smith suggested that the next conference should include political scientists and economists. Dr Krause suggested that advertising behaviourists should be invited. Dr Holmes, drawing on Roy Anderson's research, suggested that we in western countries are on the cusp of a still growing major global epidemic so that complacency was out of the question. Many, many participants contrasted their needs with the drying up of public funding. Dr Hart, Dr Abraham and even Dr Schaalma from Holland, stressed this point. Dr Storer mentioned the importance of government officials who often control the gateways to research funding. All of these people must be involved in consideration of the future of HIV behavioural studies.

Professor Dwyer pointed out that, if we think we have problems in our own countries, they melt into insignificance in comparison with those which exist in Asia. The Burma Minister who forbids 'pornographic' condom instructions. The Nigerian generals who gobble up AIDS funding. Everywhere deceit

and resistance — the living examples of Mark Smith's thesis of a worldwide divergency between official morality and what many people actually do. Such impediments do not only exist in non-western countries. Dr Stover told us of how the United States congress has stopped a number of important studies for 'moral' reasons. Dr Michael Waugh emphasized the need for countries such as Britain (which in the past exported laws and policies reinforcing spent moralities) to contribute to the repair work, if they can, in their former colonies. No one should underestimate the difficulties of securing political action. Even in this enlightened kingdom, contrast the media extravaganza of the past 3 political days with serious attention to the urgent world and national problem which this conference has been tackling. Perhaps, behaviouralists ought to become more skilled in using the media and in the use of conferences such as this. Why, for example, would it not have been appropriate to invite key Ministers, Opposition health spokesmen and/or their staffers to sit in and learn about this great problem from such an audience of unique insights? Perhaps, in this regard, an important opportunity has been lost?

(20) Adopting a heightened sense of urgency

The twentieth injunction is that there is a need to raise a greater sense of urgency. Tom Coates' question, years ago, to Ellen Stover remains: *'What are you doing'*. It is a question which is still with us all. This really emerges from all of the papers for this conference, singly and collectively. Tom Coates put it in the context of the urgent need to address basic issues of justice and health: sex education for the young; a rational drug treatment strategy; the provision of universal healthcare in countries which treat the human right to health as an empty and unattainable goal. Professor Dwyer breathed a proper measure of passion into his urgent remarks. This is a great and frightening challenge to our species. It is not over. As Tom Coates said, the years behind, remarkably enough, are actually the easy ones. Sustaining the effort in the global age of HIV/AIDS 'normalcy' is a much greater challenge. Those who participated in this conference will go away appropriately fired up. But it is our moral, scientific and civic duty to convey this sense of urgency to others.

On the first day of the conference, with Professor Dwyer, I went to the House of Lords to appear before the Parliamentary Committee on HIV/AIDS. We walked past Westminster Hall where the common law of England was first developed and from where it spread to the 4 corners of the world. There was the very point where King Charles I was tried and convicted. He was executed not far away by the people of this land in an assertion of democracy that was profoundly to affect modern government in all our countries.

Yet I was deeply disappointed by the sense of bureaucratic apathy I found in the responses to the Lords' committee. A report on AIDS in prison had lain on the Home Secretary's desk for $3\frac{1}{2}$ years. Meanwhile, prisoners have certainly been infected, for want to decisive action. It is a disgrace. I said so. But the Minister and his officials alone cannot be blamed. I suggested that the worst offenders should be taken to Traitor's Gate. But I am afraid that there is not enough room in the Tower of London for all of the people who have failed to realize the urgency of this great challenge to Britain and the world. We too have been partly responsible for this failure.

THE WORDS OF THE CONFERENCE

The participants in the conference will go from London with many words ringing in their ears:

- *Dr Tom Coates* who lifted the veil on his own experience. A most distinguished scientist, he began the conference with a proper dynamic, mixing rigorous research with a real sense of personal urgency
- *Dr Peter Aggleton* telling us of how individuals are constantly 'switching their behavioural lodgings'
- *Professor Ann Oakley* who recounted what she had been urged. 'Forget all the methodological stuff. Just tell me what works'
- *Professor Jeff Kelly* whose research in middle America was summed up: 'We've got to search for John — the hero in the red flannel shirt'
- *Professor Martin Fishbein* whose unforgettable words included 36% of condom users start sex with a condom and then take it off. Twelve per cent actually re-use them. And 'Never trust a behavioural scientist'
- *Dr Mark Smith* who said 'To be gay or black you've got to be better. You can wince about it. But it's a fact of life'
- *Dr Graham Hart* who reminded us all, 'We are obliged to deliver the health dividend'
- *Professor Tony Coxon:* 'There can't be 15% condom breakages. That would be a breach of British standards!'
- *Dr Charles Abraham* in the video which he showed us of 'Mark (The Mouth) Thompson' whom no one would ask for a spare condom
- *Dr Richard Krause:* 'AIDS is the metaphor of our troubled age' and 'a billion years of evolution are not easily modified'
- *Dr Richard Parker* who urged 'Behaviour modification is itself a misnomer'
- *Dr Esra Susser:* 'The problem is not one of getting cooperation from New York's homeless men. It is of getting away from these men.' Who will forget the man who put the condom on the banana and then left it safely beside his bed as he made love
- *Professor John Dwyer:* 'We are losing the struggle at this moment'
- *Dr Margaret Chesney:* 'This is a very tough virus', and

- *Professor King Homes:* 'This is a slide I stole from WHO'—(a very serious admission to make in the presence of a judge).

THE IMAGES OF THE CONFERENCE

And what are the images we will take away from London in June 1995?

- A recollection of the generous host organizations and of the efficient conference committee
- Of Louisa Raine and her co-workers in the RSM—surely amongst the most attentive conference organizers of the many conferences we go to
- Of the Honour Boards of the Presidents of the RSM dating back to 1805—providing a perspective of nearly 2 centuries and of the long haul that epidemics present to medicine and to society
- Of Dr Roy Anderson's population diagram. It looked like a shoe in a box—but what it was, in fact, was the picture of the mixing parameters affecting billions of people—living human beings—everywhere on this blue planet
- Of the photo of the great room of homeless men in New York—a room of despair and now a room which HIV/AIDS has quietly entered
- Of the graphic cartoon of Dr King Holmes showing the disempowerment of women and its awful significance for the spread of HIV/AIDS, and
- Of the photo of the CSWs in Bombay: pretty young women with floral dresses all fashioned from the same roll of cloth—a hand over her face—hiding her private thoughts and dignity. But who will hide her from HIV/AIDS?