¿Por qué desciende el Sida en Zimbawe?

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The earnestness with which the worldwide media scrutinizes Church statements about AIDS can only mean that they are deeply interested in promoting what has been most responsible for major reductions in its prevalence. Right? Then why haven't you heard about the plunging prevalence of AIDS in Zimbabwe? It dropped almost in half, from an astonishing 29 percent of all adults nationwide in 1997 to 16 percent in 2007, according to an important study published in February. The study was briefly summarized by the *New York Times*, but its findings generated little buzz because the decline did not occur the way it is supposed to.

In a nutshell, changes in sexual behavior - substantial reductions in casual, extramarital, and commercial sex - accounted for the drop in AIDS. Condom use did not shoot up during the same period; it had increased somewhat earlier but stayed rather constant while the precipitous declines in HIV transmission occurred - so condoms can't explain this decline. Progress does not hinge, as commonly portrayed, on Vatican permissiveness about condoms.

Accordingly, the study authors argue that behavior changes deserve much greater policy emphasis. It is a tribute to them that they do so clearly and firmly, since the "risk reduction" philosophy is still king in public health circles - despite its prolonged and colossal failures to reverse AIDS and other epidemics. The study shows, however, perhaps a bit too much deference towards that philosophy by depicting Zimbabwe's success as "surprising."

Surprising? Zimbabwe fits the broad pattern of success: HIV declines in every one of a handful of other African countries are always most attributable to partner reduction. Indeed, condom promotion has not reversed any of the severe African epidemics, according to a rigorous review commissioned - and then scandalously ignored - by UNAIDS. In other words, if Zimbabwe's AIDS prevalence had plummeted due to condoms, it would have been the exception to the rule.

The study also concludes that other factors long (though baselessly) viewed as impediments to HIV prevention, such as fear and diminishing affluence, actually played complementary roles in the decline. Acknowledging fear of AIDS has been fiercely discouraged; tapping into it, western activists maintained, would only create stigma and "drive the epidemic underground." But it seems entirely reasonable and rational that personal exposure to the suffering and death of a loved one from AIDS might motivate people to greater prudence in matters sexual. Indeed, many Zimbabweans reported that to be the case.

Truth be told, forbidding a healthy fear of AIDS is just another manifestation of the modern secular (and imposed) belief that the behaviors driving HIV epidemics are to remain entirely free from any hint of disapproval. This, of course, is a tactic of moral intimidation, not a worthy instrument in the public health arsenal. Coddling ideologues, not capitalizing on natural fear, is what has really proven counterproductive.

Poverty, we also still hear, leads to more AIDS. But we've known for years that some of the poorest countries in Africa have the lowest AIDS rates, while some of the wealthiest countries have some of the highest AIDS rates. Even within high HIV prevalence countries, AIDS rates tend to be higher among the well off than among the poorer classes. This

might seem counterintuitive, but without "disposable income," people are less equipped to afford or sustain the multiple sexual partnerships that drive HIV transmission. The hardship and anxiety of Zimbabwe's economic deterioration over the past decade, it turns out, had a silver lining. Economic collapse, thankfully, is not a precondition for behavior change.

The poverty of an uncouth and callous utilitarianism, however, in which the good is equated with the "safer," and hope for another way of life remains at best an unwelcome afterthought, is another matter altogether. This intellectual and spiritual poverty, which reigns amidst widespread material sufficiency, saturates HIV prevention policy, but it has not proven to be nearly as protective against HIV as relative material poverty. Nonetheless, many public health leaders still seem convinced that economic improvement - by which is usually meant some form of redistribution - is a prerequisite for AIDS control. As Emory University's Dr. Carlos del Rio put it recently: "You talk about 'Can we decrease the HIV burden in the United States?' I would say, 'What can we do to decrease poverty in the United States?'"

No doubt he meant to express magnanimity of spirit and earned applause for this sentiment, but it actually reveals deeply unflattering philosophical presuppositions about human nature and capabilities. Are we really to assume that people below a certain material threshold are unable to control their behavior? (Or that no one is capable of changing and no one really should anyway, but that people, by virtue of being above an unspecified material threshold, will therefore comply perfectly with the technical recommendations, which have thus far failed to reverse HIV burdens?)

Persons are thus viewed as less than fully human - as objects dependent upon constantly supplied "services" - while much greater influences on human behavior remain deeply discounted. Had he meant to target a peculiar, mostly western form of poverty - the misery, squalor and despair characteristic of a *modus vivendi* rather than poverty as penury - he would have been on firmer ground.

Zimbabwe's progress is heartening, but we should not find it surprising any longer. It reinforces the preponderance of evidence and obliterates any justification for shying away from emphasizing behavior change as *the* optimal means of avoiding AIDS. But it would be surprising, sad to say, if public health leaders actually executed that recommendation without apologies.

For people morally blinded by what they would *like* to be the case, even demonstrably poor ideas can seem too precious to give up.