After a year of COVID-19 we can still learn from the experience of AIDS

A year on from his blogpost reflecting on what could be learned from the response to the AIDS epidemic of the 1980s, **Donald Nicolson** *returns to his previous post to assess how, if at all, the hard learned lessons of AIDS and its social dimensions have informed current government policies and responses to COVID-19.*

Around this time last year I wrote about how COVID-19 represented an exceptional public health emergency. I proposed that Public Health responses could be informed by experiences of the AIDS epidemic in the UK during the 1980s and from conceptualising COVID-19, like AIDS, as a social phenomenon. Here, I return to the four key lessons I identified in my previous post: Known unknowns, government inaction, social discrimination, and public information; take stock; and consider whether these constitute a missed learning opportunity.

Known unknowns and knowledge Gaps

In the 1980s, with no medical solution to AIDS, attention by necessity focused on behaviour change and creating social conditions that reduce transmission. Such efforts were echoed by campaigns to encourage hand washing, social distancing and ultimately national lockdowns to halt the spread of COVID-19. In contrast to AIDS, where knowledge of the HIV virus took years to develop, and a vaccine remains to be found; scientific knowledge of COVID-19 has developed rapidly. Creating, regulating, and rolling out multiple vaccines in under one year has been exceptional. However, in the UK and other countries, the social knowledge to make lockdown truly effective, for instance, on key issues such as welfare support, education and mental health, has often been reactive or deprioritised. This points to deeper issues around the use of social knowledge in scientific and health policymaking, and a potential agenda to refocus evaluative modes of social research towards more pre-emptive concepts such as preparedness and response. In this respect it is notable that remaining unknowns, such as long COVID, have been made prominent by the work of patient groups and social action, as opposed to more strictly scientific methods. A process reflected in the patient-led activism of gay people in the 1980s, who were ignored by Governments and the medical establishment.

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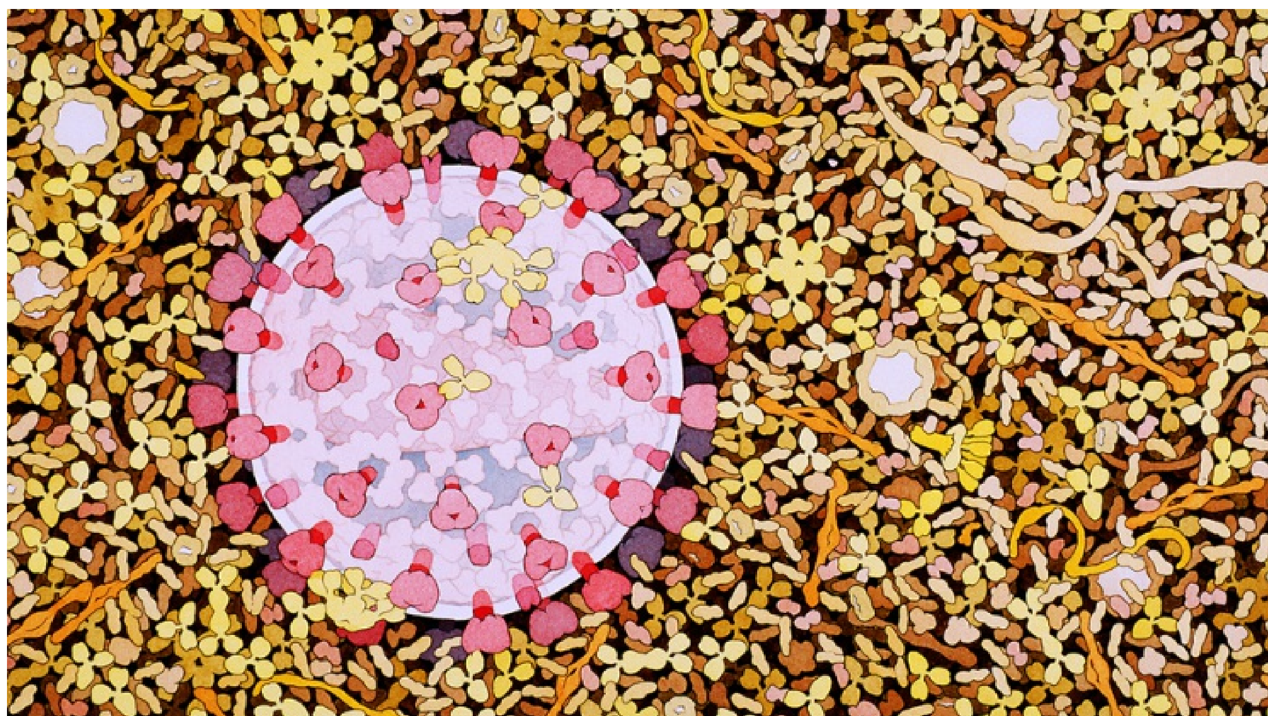

Government inaction

By the time of writing last year, it was clear COVID-19 was an exceptional threat to public health. However, the inability of governments to balance exceptional public health requirements with other competing interests has led to erratic policymaking, mixed messaging, and likely undermined public health responses. For very different reasons, the AIDS epidemic was initially defined by government inaction, both in the UK and USA. However, in both instances it highlights the important role played by governments in creating enabling environments for effective public health responses. Questions remain around the exact human cost of repeated government inaction over implementing lockdowns and other public health measures. However, without adequate government structures, tools that worked in East Asian and Pacific countries (effective track, trace and isolate system, and lockdown) have not been successfully transferred, remarkably so in the case of the UK's £37 billion contract to implement its own track and trace system.

Discrimination and moral panic

The moral panic in the 1980s that surrounded AIDS and discrimination towards people with HIV, was driven by associated risk behaviours, e.g., injecting drug use and unprotected sexual intercourse between men. The prevalence of COVID-19 has likely reduced the stigma attached to the virus. Notwithstanding, growing discrimination along racial and geopolitical lines reflected in hate directed towards East Asian communities in the UK and US. However, the pandemic has also opened up complex issues around health as well as socio-economic inequalities. Some have argued that COVID-19 does not discriminate by socio-economic status. The different experience of the pandemic between those furloughed, or working in often low paid frontline jobs and those afforded the relative luxury of homeworking is stark. This difference, and its political dimensions, were apparent in a recent survey revealing entrenched public attitudes attributing the unequal economic impact of COVID-19 to individual characteristics.

Communicating information to the public

For many in the UK, the most memorable aspect of the AIDS epidemic was the public information campaign and the exceptional drive in particular by the mainstream media; e.g., television dedicating one week of prime-time programming to inform people about the risks, something neither done before or since. The current pandemic has seen similar media campaigns, although filtered through a much more diverse and decentralized media landscape. This has resulted in greater and more overt politicisation of the COVID-19 pandemic, such as the Great Barrington Declaration and the promotion of unethical and ultimately impractical concepts, such as the 'focused protection' of particular sections of society. The consequences of how different societies respond to this 'infodemic' will likely be a lasting legacy of the current pandemic.

A missed learning opportunity

AIDS largely affected specific groups in the 1980s, and (despite initial concern), there was no credible threat to society as a whole in the UK. The failure to contain COVID- 19 has necessitated dramatic societal-wide measures. However, the historic and ongoing efforts to control AIDS can and still does provide insights into the COVID-19 pandemic.

At the time of writing the UK has one of worst COVID-19 death rates globally. There is good reason to attribute this to aspects of the UK governments' response. Perhaps the clearest lesson from the response to AIDS and which COVID-19 has taught again is the need for clear and decisive political action, underscored by a realistic appreciation of the relationship between public health and the economy. Where there was decisive action, such as New Zealand, there have been fewer lockdowns and lesser economic impacts.

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The COVID-19 pandemic isn't going anywhere fast (the clue is in the word pandemic). Almost forty years on, AIDS is still a major Public Health challenge, and it is likely COVID-19 will become endemic to different regions. Here current approaches to AIDS, which see the virus from a socio-ecological perspective provide insights into how particular communities can be engaged and mobilised to bring the virus under control and for which social research and social knowledge is key. Further, the failure to address global health inequalities in response to AIDS, which resulted in millions of deaths in sub-Saharan Africa, presents a clear warning that COVID-19 vaccines and medications should be distributed equitably. The response to AIDS still presents a template and a salutary lesson form which to improve future public health policy. Had more governments done so, fewer people might have been infected, died, or developed long-term conditions as a result of COVID-19.

Note: This review gives the views of the author, and not the position of the LSE Impact Blog, or of the London School of Economics.

Image Credit: David S. Goodsell, The Scripps Research Institute, HIV in Blood Plasma 1999, doi: 10.2210/rcsb_pdb/goodsell-gallery-002 (CC BY 4.0).