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## Social, medical and social sciences' requirements for the prevention and fight against Aids

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## **Social, Medical and Social Sciences' Requirements for the Prevention of and Fight Against AIDS**

*R. Rosenbrock*

1. The primary prevention of AIDS, with the present level and foreseeable development of medical knowledge, is the only area of Health Policy through which the spreading and thus the number of victims of the disease can effectively be reduced. As is already the case in Europe with the, for the most part, only decades previously conquered important old communicable diseases, it also appears necessary and possible with AIDS, to break the dynamics of the disease's propagation before medical science can contribute with its effective weapons of immunization and therapy (McKeown 1979/1982).

AIDS-prevention is therefore now and for the foreseeable future a primarily non-medical task. The planning and organization of the prophylaxis of AIDS requires first of all the mobilization of the knowledge already gained in the social sciences. Within this framework there fall to medicine above all two indispensable tasks: One is that every prophylactic concept is based on the immunological and epidemiological knowledge to be gained about the mechanisms of infection, probabilities of infection and risk situations. The other is the competency of the doctors treating in private practice and hospitals, essential for goal-orientated education. The use of further non-therapeutic tools of medicine, above all the HIV-antibody test, must orientate themselves on the logic of prophylaxis. The HIV-antibody test itself is, at the present level of knowledge, *not* a measure of prevention (see below, par. 7).

On the other hand the Social Sciences and Health Policy must also learn from medicine. Currently in the case of AIDS it is above all a question of the suitable application of deliberation and decisionmaking rules, as they have been developed, for example, in pharmaceutical research and its application. Accordingly a medicine or measure may then be used and only then, when under rational consideration of the total context the desired effects clearly predominate and the undesirable effects are tolerable. This rule applies not only to every diagnostic and therapeutic measure of individual medical care but also to the measures to be taken, or as the case may be, the measures to be avoided within the Health Policy. *Besides* the immediate health criteria, aspects of Civil Rights and Liberties must also be included. In this respect the State Health Policy also needs a form of social pharmacology (see below, par. 10). State, medicine and social sciences would, when fighting AIDS, do well to remember the established fact in health science that the limitation of health risks cannot, in general, realistically be orientated on the concept of zero risk, rather for the time being must follow strategies of the gradual elimina-

tion of the greatest risks. This also applies when the concept of «risidual risk» is presently politically abused in many ways (see below, par. 9).

2. In the case of AIDS, changes in behaviour have become an actual necessity for all those people who have sex involving penetration with changing partners or administer i.v. drugs with unsterile needles and syringes. AIDS-prevention is therefore at the present level of knowledge, an enduring effective form of behaviour control in potentially dangerous situations. The nature of this situation (privacy, sexuality, and mostly illegal drug use) as well as it being widespread exclude forms of external control (coercion, sanctions, threats, police etc.). Methods of influencing behaviour which lead to an optimal overall level of self-control, have to be sought and optimized. Involved therefore is the organization of a wide societal learning process. The more successful (e.g. personal hygiene, the use of contraceptives, safety-belt laws) and the less successful (e.g. smoking, alcohol, stress etc.) efforts by Health Policy to change behaviour permanently provide, through prevention campaigns, important reference points for this difficult but achievable undertaking.

A reliable concept for AIDS-prevention through behaviour must contain the answers to 4 questions:

- What should/must be learnt? (par. 3)
- Who should/must learn? (par. 4)
- Which objective and subjective factors facilitate or hinder this learning? (par. 5)
- How can this learning process be optimally organized? (par. 6)

The following can solely serve to give a rough summary.

3. What should/must be learnt? At the present level of knowledge the following situations hold an epidemiologically relevant risk of an HIV-infection when at least one of the participants is infectious (in the order of risk-loading):

- a) Receptive and insertive anal intercourse
- b) The use of needle and syringe by more than one person
- c) Receptive and insertive vaginal intercourse
- d) The entering of infected blood or sperm in damaged blood-carrying vessels on the body's surface (as in techniques of sado-masochism, S/M).

The results of descriptive epidemiology indicate unanimously that oral-genital as well as oral-anal contact in comparison to the other activities hold either no or a negligible risk of transmission. All other forms and techniques, including intimate body contact, obviously contain no pertinent risk of transmission. The risks of a) and c) can, with reasonable certainty, be avoided through the use of condoms: Including all mistakes in their use, the Pearl-Index (safety of contraceptive aids) shows with condoms 1–3 unwanted pregnancies in 100 user years. The risk of b) can be eliminated through the use of sterile needles and syringes (optimally disposable syringes), the risk of d) through the discontinuance or reduction in severity of appropriate sexual techniques. Under these conditions, even sexual intercourse with sero-positives (i.e. infected people who are symptomless, non-manifest or latent) is effectively transmission-free. Special protective measures of certain professions (medical care, cooks, hairdressers, tattooists etc.) and in institutions (families, hospitals, prisons, drug rehabilitation centers etc.) are not necessary when observing the normal rules of hygiene, even when one has more rigorous standards regarding what constitutes the normal risks in life. Through adherence to the, from the

forementioned, derivable rules of prevention (safer sex, sterile needles and syringes), according to the unanimous opinion of questioned immunologists, virologists and epidemiologists as well as other professionals, the newly infected would be reduced by at least 99%. Compared with other diseases, above all the modern chronic mass-illnesses, the conditions for the prophylaxis of AIDS based on the «message of prevention» can be assessed as extremely encouraging.

There is still much for medical research to do in this field: Stages, mechanisms and points of entry of the physiological transmission and of the (external) transmission mechanisms of the HIV are, by far, not sufficiently clarified. Open questions arise in respect of the viral volume and concentration as well as the resorption through differing mucous-membranes and through micro-lesions and by different types of cells. Their answer could, for example, exclude or specify a possibly existent residual risk of transmission through oral techniques and could also, with regard to the probability of transmission through the vagina, eventually produce a still further specification pertinent to prevention.

Now as then unclear (and obviously little researched) is whether physiological or psycho-social factors facilitate/impece the establishing of the virus. To the, physiologically defined, potential co-factors belong, for example, prior damage of the immune system, the use of immuno-suppressant drugs (as medicines or, for example, amylnitrate – poppers – associated with sexual intercourse). Also the possibility of sociological and psychological co-factors is obviously not a subject of AIDS-research.

These and further medical questions also arise in connection with secondary prevention, i.e. the prevention or retardation of the transition from the symptomless infection stage to ARC or AIDS. Millions of lives, worldwide, could depend upon the timely answer to this question.

What therefore should/must be learnt? The use of condoms and disposable syringes. That is, of course, much more than just a technical problem: As to sex, this means amongst other things that the, for decades one-sided off-loading of responsibility for the prevention of the undesired consequences of sexual activity on the woman (conception and transmission are in *this* case equivalent), must again be transferred to the man. The necessary contribution of women in the accomplishment is obviously important. It has to be learnt that the use of condoms is not a declaration of mistrust and not an «AIDS confession» but rather a simple matter of course. It has to be learnt that to opportunely clarify the use of condoms during the sometimes very short lead-time of sexual encounters. And – last but not least – the technique of condom-usage has to be learnt.

#### 4. Who should/must learn?

At risk is, at the present level of knowledge, the entire sexually active population in as much as they do not live a strictly monogamous life, as is the group of the i.v. drug users. The majority of the population lives non- or partially monogamous. Approx. 90% of men and women already at the age of 20 had several sexual experiences, over half of those men and women in steady partnerships depart occasionally from monogamy. Promiscuity has become, for significant heterosexual and homosexual population groups a forming element of identity in their way of life. Approx. 50 000 men and women use i.v. drugs. The total target population (i.e. population at risk) of AIDS-prevention is therefore, for the most part, identical with the sexually active population. Therefore the message (condom-use for sexual practices involving penetration) is to begin with, in regard to the sexual transmission of HIV, uniform and is therefore suitable for a population-wide «blanket-message». The target population, for the fine controlling of prophylaxis, divides

itself, of course, into a finite number of sub-groups which are differentiated by characteristics of sexual alignment, their contact and sexual habits («scene») as well as by social strata. Concerning heterosexuals, in short is to mention: Children, adolescents and young adults with changing partners in search of their sexual and commitment identity; people living promiscuously in the scenes of discotheques, bars, clubs; personal ads, office affairs, prostitution, sex-tourism; S/M; people living monogamously with occasional «affairs»; bi-sexuals. In the gay-population (2–3% of the male and female population): Those men, mostly young, with specific problems of «coming out»; scenes; bars, clubs; public toilets («cottages, tea-rooms»), saunas/bath houses; personal ads; prostitution; sex-tourism; leather, S/M. With all prevention endeavours concerning sex, the problem of the disinhibiting effects of recreational drugs must be considered. Concerning i.v. drug users there are likewise different scenes according to social background, peer grouping and forms of association, monetary source.

These characteristics form partly overlapping groups of risk-carriers. The characteristics are at the same time suitable, objective and localized points of contact for a, in its content, technically and socially identifiable with the milieu, transmission of the prevention message.

#### 5. Which objective and subjective factors facilitate or impede the learning?

It is in the first place to be remembered that the aim of prevention is only to be achieved through a behavioural change in intimate and in part taboo areas. These areas are normally not subject to public or even state influence. AIDS-prevention as a public health function must break through the barriers of «what's normal». Such efforts must address a subject which, through an extremely and for the most part risk-obscuring publicity in the mass-media, is already overly fearladen (and thereby prone to suppression and denial). Moreover, the initially visible groups affected (gays, addicts, prostitutes) can in particular hardly expect, for historically easily understandable reasons, especially in Germany, anything else from public or state «measures to protect the public well-being», other than objectively unfounded repression and exclusion. This impedes the functionally necessary communication between these groups and the protagonists of Health Policy – from both sides. A fundamental requirement for officially organized learning in the area of intimacy is a special climate that creates confidence within all sections of society – also an precisely for those particularly endangered and traditionally fringe groups. Therefore *two indispensable and objective preconditions* for the success of AIDS-prevention are confidence stabilizing or creating measures, by establishing a non-discriminating public opinion on the problems to be dealt with, and the guaranteeing of anonymity in counselling and helping to overcome individual problems. It is a question of a social climate that enables officially provided learning in the area of intimacy. Each step, even when only symbolic, in the direction of repression and exclusion endangers the entirety of the efforts at education intent on prevention. None of the conceivable and, for example, proposed repressive measures e.g., those of *K. D. Bock et al. 1987*; *G. G. Frösner 1987*) can claim an effect in regard to the reduction of the number of HIV-infections which could even closely compete with the connected loss in the effectiveness of prevention through education.

AIDS-prevention is dependant upon the availability of prophylactic aids (condoms, disposable syringes). The free and ubiquitous access to these aids (including state-run institutions) is a *third objective prerequisite* for the success of prevention.

On the *subjective side* there are *three facilitating and three impeding factors* to the learning of the prevention measures that are of special importance.

a) Facilitating is the widespread publicity of the subject. One can assume an almost blanket sensitization. There exists the *chance* to follow this up with objective and becalming education. The long-term success depends mostly on whether the mass-media, swayed more by commercial than ethical standards, can forego the circulation boosting use of the primeval fears and desires which are flamed by this topic (sex, orgies, perversion, addiction, death, «unknown enemies» etc.).

The prevention is facilitated further, in that – for reasons of the physiological nature of the disease (transmission effectively only in closely defined situations) – the prevention message can be very simple (safer sex and sterile needles and syringes). Each complication of the message would quite considerably increase the difficulty of its bringing to the entire population, to all social strata and to, in part, fringe groups. Prevention messages are successful on the complexity level of «buckle up – then start up»; «Have you had your pill today» etc.

Prevention is thirdly facilitated through education, in that the objectively necessary change in behaviour demands no fundamental intrusions into individual living habits: deviation from monogamy, promiscuity and drug use can even, under the threat of AIDS, be retained without specific risk of AIDS. The necessary changes in behaviour are «includible» into the individual ways of life. A disease for which the prevention by the individual actually requires sexual abstinence, monogamy or abrupt exit out of the drug scene, could hardly be defeated without a major reconstruction of society. Conversely: Where AIDS is in fact used as an excuse to pursue ethical, moral, sexual or drug policies, «Health Policy» can err into its antithesis.

b) Prevention is, above all, impeded in that, with sex-life and drug usage, areas of life are addressed in which the behaviour is not only under the control of rationality. (*U. Clement*, 1986; *St. Quensel*, 1982). An effective success cannot be achieved with an educational campaign appealing only to reason. Rather, the different emotional and unconscious levels of importance of sexual behaviour and drug use must be at least equally addressed. The significance of sexual addiction behaviour differs considerably from scene to scene, according to sexual alignment as well as to age range, social stratum, region and situation. Each of the forms and methods of communication of the prevention message, specific for each target group, must therefore adopt the, in part, rudimentary level of knowledge in sexology, sociology, socio-psychology, socio-pedagogics, communications science as well as the problem and milieu competency from within the affected groups. Whilst during the course of the prevention campaign further increasing these resources and at the same time translating them into action. More or less elaborate and more or less explicit rudiments can be found in all national prevention campaigns (especially advanced AIDS-Hilfe Schweiz 1986).

Impeding for prevention are the longevity and uncertainty of the risk: The risk of AIDS must be prevented through present behaviour, an outbreak might occur in one to five or maybe first in ten years. Preventive behaviour is also therefore dependant upon whether a similarly longterm attitude, at least in a rudimentary form, exists on a conscious and emotional level. This difficulty of prevention can be compensated, at least in part, through personal experience and the sharing of the fate experienced by the already ill and dying victims.

Effective prevention is also impeded in that a long-term stable change in behaviour is necessary. Short-term effective but easier to handle impulses of behavioural influence such as shock, fear, threats etc. cannot, for this reason, be successfully employed. According to all experiences, their effect on long-term behaviour is even counterproductive as they can always lead to denial, suppression and outbursts.

In summary it can be said that, above all, the possibilities to create (or negatively influence) the objective preconditions for prevention through education, lie within the competency of centralized and decentralized official protagonists. The subjective facilitating and impeding factors of prevention must be taken into consideration in regard to content, form and means of the prevention message, whoever drafts it.

#### 6. How can the learning process be optimally organized?

It has been previously indicated,

- That a widespread blanket message (centralized originator) as well as the specific addressing to numerous target groups (decentralized originator) are required for AIDS-prevention;
- That these messages should be coordinated in content and timing;
- That the configuration of the messages satisfy the professional criteria of communications-sciences including that of advertising psychology;
- That the few risk situations of HIV-transmission and the methods of prevention must be clearly and openly described;
- That the message takes into account the conscious as well as the emotional factors;
- That the message must positively accept the respective situations and characteristics of the intended target groups, or at least take them as given;
- That the message, specific to target groups, must use the communication forms, media and language of the respective target group;
- That the messages are not allowed to work with fear and shock, but definitely should awake rationally substantiated fear;
- That it involves (until the availability of a vaccine) not a one-time activity, rather a long-term campaign with a balanced mix of initial, reminding and stabilizing impulses.

There are many conceivable models which can fulfill these requirements to a greater or lesser extent. At the present, almost all of the affected countries are experimenting, in this connection, with different accents as to contents and organizational forms.

The observed differences internationally lie above all:

- In the mix-ratio between state and non-state activities;
- In the extremely precarious mix-ratio between education and repression;
- In the role of the HIV-antibody test lying between the widest possible application (e.g. Federal Republic of Germany) and «a policy of test-discouragement» (e.g. The Netherlands, *J. V. Wijngaarden, 1986*);
- In the acceptance of non-monogamous individuals and of homosexuality;
- In the emphasizing of the prevention campaign specifically on AIDS (as a qualitatively new threat) or, more generally: on venereal diseases (a first definition of the target population, linking up with the existing resources of knowledge);
- In the weighting of blanket messages and education specific to target groups;
- In the methods of communication;
- In the extremity of the messages and – last but not least –



– In the readiness to adopt in the face of the threat of AIDS a vital pragmatism, e.g. in prisons, in dealing with i.v. drug addicts and prostitutes.

These large differences and their dependency on nationally differently arisen situations (differing state influencing; societies; organization of medical systems; treatment of sexuality and minorities etc.) prohibit the construction of a quasi-ideal model. Against this, a few universal requirements and problems should be pointed out. The quality of every message-transmission is dependant upon three elements, the originator, the communications' method and the recipient.

*The provider* must be known, familiar and trustworthy. For the message to be accepted from this source, the latter may not be under suspicion, for example, as being double-dealing: In this case education and repression are almost totally exclusive. Centralized and decentralized providers have different tasks; the decentralized providers must have the possibility to refer to the messages of the centralized providers in content and symbolism. The more decentralized the originator, the more can the characteristics, specific to the target group, region and commune, be taken into consideration in the content, style and language. The strength and (rectifiable) weaknesses of decentralized communication can be observed every day within the quickly and spontaneously created network of over 45 regional AIDS-help groups in the Federal Republic of Germany (refer to Deutsche AIDS-Hilfe 1987). In general: The simpler the message and the easier its contents can be incorporated into the respective life-styles, the greater is the chance that it is registered. «Registering» includes the three levels: information-assimilation («understanding»), acceptance («attitude») and realization («behaviour»). Whether the government (in the German Federal Republic, this includes the Bundeszentrale für gesundheitliche Aufklärung – Federal Office for Health Education) or para-official organizations (medical insurances, AIDS-foundations etc.) are more effective as a centralized originator, must be considered carefully. Decentralized originators are the self-help organizations, the institutions of the public health system and the medical system (doctors in practices and the hospitals), in as much as they possess a trustworthiness within the target groups and sufficient qualifications in questions of sexuality and AIDS. The former is at least severely shaken by every form of centralized diagnosis registration which makes the practicability of back-trekking to patient-records kept by name. The latter represents at the present time a critical restriction.

*The methods of communication* (the channel) must be directed to the addressees, in fact they must actually seek out the addressees; the Health Policy has an obligation to deliver (Bringschuld) the prevention message. The methods of communication (channels) must be as «noise»-free as possible, that is they can only be used for the information that is actually essential for prevention. An utilization for other means (e.g. ethical, moral, sexual and addiction policies) decreases the degree of effectiveness of the message and can frankly have the opposite result. The information concerning those risk situations which can be prevented (unprotected sexual activities including penetration, use of unsterile needles and syringes) has to be emphatically separated from the more or less speculative and sensationalized horror stories produced for reasons of circulation (risks in every day life, through tears, kissing etc.). Ultimately, the centrally sent (official) mass-summons to undergo the HIV-antibody test can also lead to a strong «noise factor» in the methods of communication and therefore decrease the effectiveness of the prevention campaign (see par. 7).

There can already be a sensibility on a wide front, with regard to AIDS, registered (will- ingness to receive the prevention message), above all in respect to the recipients in the

initially visible affected groups (male homosexuals, i.v. drug users, prostitutes). This can nevertheless overturn into suppression and denial through the combination of extreme signals (tabloid, yellow and, in part also «serious» press) with more or less open accusations and disorienting information about the risk situation. Despite considerable input, the non-monogamous heterosexual scenes are little sensitized at this time. The initial characterization of AIDS as a «gay plague» has in this case caused obstacles to prevention which have to be overcome through a careful response, specific to scene.

In respect to all prevention efforts through education it has to be taken into account that it is not sufficient to consciously understand the threat of AIDS and the necessities of prevention. The message must also be aimed at the emotional and unconscious facets of the individual. It can be assumed that the combination of blanket messages, propaganda specific to target groups, telephone counselling and personal contact achieve the best results.

7. There are a series of compelling medical reasons for the use of an HIV-antibody test, securing blood products and transplants, differential and exclusion diagnosis, advising pregnant women from the risks groups, responsible epidemiological research on the basis of «informed consent». A medical reason for an examination for the early diagnosis of an untreatable disease from the viewpoint of the rules of medical practice does not exist. Especially when the possibility and the moment of the disease's occurrence is as uncertain as it is with AIDS. An indiscriminate mass-screening of such an untreatable and in its occurrence so uncertain an illness as AIDS also contradicts the rules of medical practice and epidemiological principles (see *M. L. Burr, P. C. Elwood* 1985). Severe psychic disorders, up to psychosis and suicide, are induced in 50% of those affected through being informed of a positive test result. These «undesirable effects» also rule out the wide and indiscriminate application of the test in the face of the absence of a medical treatment (see, for example, *J. M. G. Wilson, G. Jungner* 1968). For this reason, the undifferentiated application of the test on symptomless candidates and all the more, the test use in indiscriminate mass-screening, contravenes all internationally accepted rules of medical practice, as they have, amongst others, been laid down by the WHO in the Oxford Textbook of Public Health. Also according to the existing German medical insurance laws (Reichsversicherungsordnung – RVO), the indiscriminate test-application is not part of the function of the doctor under that system (§ 181a RVO).

There must therefore be weighty reasons to justify its broad and widely recommended use. One such reason could be that the test, or being informed of the test's result, could provide a significant contribution to AIDS-prevention. This however, is hardly the case. Just the opposite: In relationship to prevention, the test is altogether counter-productive.

a) It is neither plausible, nor do the empirical studies show that the test can give more effective impulses for behavioural changes than the instruments of education concerning risks. Shock and fear of death are altogether not a particularly suitable instrument for starting rational behaviour control.

b) A positive test result can provoke short-circuit reactions («desperado effect») with counter-productive consequences.

c) A negative test result can promote recklessness in dealing with risk situations.

d) The public summons to test, as part of prevention, decreases the essentially necessary clarity (and therefore the effectiveness) of the prevention message. The rules of preven-

tion apply, of course, to *all* people in risk situations independent of their sero-status. The Federal Government's medical policy message: «Who should go for the test? Anyone who thinks he has been infected», should read from a prevention standpoint: «Who should go for a counselling service? Anyone who thinks he has been infected».

e) Combined with the HIV-antibody test is the discussion of an obligation to register, forced testing, «Berufsverbot» and further employment, social and housing legal questions.

These factors all work against the principles of prevention and bring no health benefit.

An obviously difficult lesson for medicine is, not only in regard to the HIV-antibody test, the foregoing of a technical diagnosis because, in so doing, the results cause more damage to health than benefit. The ever increasing chasm between diagnostic possibilities and therapeutic capabilities in medicine attains, in the case of AIDS, a new level in respect to Health Policy.

8. A prevention campaign which satisfies the requirements outlined here, necessitate an immunological, sexual and social science foundation. The necessary levels of knowledge are at the present only partly available. On the one hand, this points to research questions to be handled in a quick and applied manner, on the other, prevention campaigns can't wait until our knowledge is to some extent complete. Feasible (and proven) are procedures by which three directions are simultaneously covered:

a) We must, on the basis of incomplete knowledge – as well as possible – coordinate and react efficiently.

b) The remaining questions are tackled in an applied manner through research – from the standpoint of the necessities of prevention.

c) The prevention campaign is continually (i.e. as a matter of course) evaluated and changed in the light of national and international experience with the inclusion of the latest research results (see Congress Report 1977; *F. Hauß/F. Naschold/R. Rosenbrock* 1981).

9. The starting point of every prevention campaign is the realistic assessment of the target dimensions (scope). In the case of AIDS it cannot – as by all infectious diseases with the exception of smallpox – presently be orientated on a complete elimination of the risks and numbers affected. All available investigations show that even with incompletely and, in part, even with falsely conceived prevention campaigns, behavioural effects, in the area of 50–80% of the target groups, can be achieved. There are empirical and conceptional reasons for the hypothesis that these percentages can be stabilized and increased through coordinated efforts. In assessing the results of prevention, it must be taken into account that the effect of every prevention strategy can be reflected in the actual figures, only after three to five years at the earliest.

10. AIDS-prevention is prevention through behaviour. There exists a close relationship between the changing of behaviour and the circumstances in which the behaviour takes place (see *R. Rosenbrock* 1985). The success of behavioural influence, in respect to AIDS-prevention, is intrinsically linked to the idea what well-founded confidence exists in the reliability of the information and in the absence of repression for all those who are or have been confronted with risk situations. The mixing of education and repression can

inflict severe damage to education strategies, up to a complete neutralization of their effectiveness. The concretely discussed and, in part implemented, beginnings and forms or repression are altogether, in respect of their total health effect (i.e. only in the case of AIDS: preventive) unproven. The area of possible compromises is, from the standpoint of effectiveness concerning health, extremely small. These circumstances impede the political treatment of the problems because arriving at a compromise through bargaining is the normal practice in politics. A handling of the AIDS problem «half education – half repression» would bring considerably into question the effectiveness of education. The result could be a further increase in the number of cases which could increase the call for repression, unreasonable in terms of health policy. The line has to be drawn between the two great alternatives: education, persuasion, support, care, civilization against the causing of hysteria, intimidation, exclusion and repression. In this matter the medical and non-medical health sciences carry a great responsibility. They should make it clear that, in the case of AIDS, the way of prevention and education – disregarding all Civil Rights' questions – is at the same time the most effective way for health.

The paper in hand contains some important results from the book: Rolf Rosenbrock, AIDS can be defeated faster – Health Policy exemplified by an infectious disease, VSA-Verlag, Hamburg 1986. Therein is listed the underlying literature. A further summary of the results of this examination has been published as a WZB-Discussion Paper (Rolf Rosenbrock, AIDS and Preventive Health Policy, IIVG/pre 86 – 210) and can be obtained gratis from: WZB, Griegstraße 5–7, D-1000 Berlin 33.

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