

MAPPING THE ROOTS OF HIV/AIDS COMPLACENCY: IMPLICATIONS FOR PROGRAM AND POLICY DEVELOPMENT

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In the American press, references to “HIV/AIDS complacency” first began to appear in the mid-1990s, generally referring to decreased societal mobilization around and support for organized efforts to prevent and treat HIV/AIDS. A typical example comes from a Florida newspaper headline: “Drop in AIDS Donations Blamed on Complacency” (1995). In part, complacency grew out of a desensitization to the threat of HIV/AIDS among the public of the industrialized “north”—brought on by the misperception that new, improved treatments had ended the epidemic.

Following the introduction of a new class of antiretroviral agents, the protease inhibitors, industrialized nations that could afford these new combination therapies began to report marked decreases in HIV-related mortality (Valdiserri, 2003). For example, in 1996 the United States reported the first substantial decrease in deaths among persons with AIDS—13% fewer AIDS deaths than had been reported in 1995 (Centers for Disease Control and Prevention [CDC], 1997). Similar reports issued from Australia (Dore, Li, McDonald, Ree, & Kaldo, 2002) and Europe (Cascade Collaboration, 2000; Morcroft et al., 1998).

Although not a cure as prematurely hailed by some, the development of highly active antiretroviral therapy (HAART) was undeniably a major victory in humanity’s struggle with the virus. Dramatic accounts of bedridden persons near death returning to work as a result of HAART, popularly referred to as the “Lazarus effect,” did much to blunt the public’s perception of HIV/AIDS as an invincible killer.

Then, too, HIV/AIDS—though still a gravely serious disease—was no longer a mystery killer. Years of concentrated scientific study had revealed its causative agent, modes of transmission, and had offered a variety of antiretroviral agents. More to the point, maintaining a “crisis mentality” decades into the AIDS epidemic posed an increasing challenge for organizations responding to HIV/AIDS, the media, and members of the public—many of whom had grown impatient for news of a “breakthrough” or cure.

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An earlier version of this article was presented at the Second International Policy Dialogue on HIV/AIDS, Warsaw, Poland, November 12–14, 2003. The Policy Dialogue was jointly sponsored by UNAIDS and Health Canada. The author gratefully acknowledges the critical feedback of the Warsaw meeting participants.

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PREMISE

This article explores the assumption that perceptions about the threat of HIV/AIDS have changed over the course of the epidemic. For want of a better term, this phenomenon will be referred to as “HIV/AIDS complacency” and will be defined as minimizing, discounting, or discrediting the threat of HIV/AIDS. Although the majority of examples cited will explore the phenomenon at an individual level, this analysis assumes that HIV/AIDS complacency might also manifest at a community level (e.g., decreased endorsement of norms supporting safe sexual practices related to perceptions that HIV infection is no longer a “fatal” condition)—or at a societal level (e.g., decreased support for ongoing HIV prevention activities in favor of other priorities).

The construct of “HIV treatment optimism” will be viewed as a discrete, although not sole, contributor to HIV/AIDS complacency. As above, the notion of safer behavior fatigue (decreased vigilance toward maintaining safer sexual and drug-related behaviors) could also be included in the proposed definition of complacency, should we consider the behavior lapse as resulting from a decreased perception of HIV/AIDS risk rather than as an erosion of necessary prevention skills.

The concept of HIV/AIDS complacency is controversial in some quarters and it must be acknowledged that other constructs could be put forward to explain the reported changes in attitudes and behaviors described herein. With these caveats in mind, this article provides an overview of the emerging phenomenon of HIV/AIDS complacency, what is known about its impact on prevention and treatment efforts in the industrialized world and implications the phenomenon may have for the developing world, particularly vis-à-vis the anticipated scale-up of antiretroviral (ARV) treatment programs. Underlying this discussion is the assumption that, left unchecked, HIV/AIDS complacency could lead to increased HIV transmission and disease burden.

COMPLACENCY DECONSTRUCTED

INCREASES IN UNSAFE SEXUAL BEHAVIORS AND STIs

Toward the end of the 1990s, reports began to appear describing increases in unsafe sexual behaviors among groups at risk for or already infected with HIV. This upturn in unsafe behaviors was often associated with increasing rates of STIs (sexually transmitted infections). Using data from cross-sectional community interviews, researchers from San Francisco found that the percentage of MSM (men who have sex with men) who reported both unprotected anal intercourse and multiple sexual partners had increased from 24% in 1994 to 40% in 1999 (Katz et al., 2002). Another study, also from San Francisco, reported that rates of male rectal gonorrhea had increased from 21 to 38 cases per 100,000 adult men between 1994 and 1997 (CDC, 1999). And multiple outbreaks of syphilis within MSM communities across the United States further added to fears that increases in HIV rates might soon follow (Wolitski, Valdiserri, Denning, & Levine, 2001).

Reports of increases in unsafe sexual behaviors and STIs have not been limited to the United States. In the HAART era, several European countries have also reported increases in sexual risk taking (see “Special Issue on HIV/AIDS Prevention,” *Eurosurveillance*, 7(2), February 2002). Reported increases in high-risk sexual behaviors have been accompanied by increases in reported gonorrhea rates (France, the Netherlands, Sweden, Switzerland, and the United Kingdom) and outbreaks of syphilis (France, Ireland, the Netherlands, and the United Kingdom) among European MSM (Nicoll & Hamers, 2002).

ASSOCIATION OF HAART WITH UNSAFE SEXUAL BEHAVIORS

The temporal association between the availability of HAART and resurgent unsafe sexual behaviors led researchers to begin looking more carefully into the relationship between the two phenomena. Using data from public health registries, epidemiologists in San Francisco conducted an analysis of persons who had an STI diagnosed after the date of their AIDS diagnosis. Two percent ($n = 233$) of 11,516 persons diagnosed with AIDS between 1995 and 1999 were diagnosed with an STI after the date of their AIDS diagnosis (Scheer, Chu, Klausner, Katz, & Schwarcz, 2001). Having ever been on HAART, younger age, African American ethnicity, and a higher CD4+ count at AIDS diagnosis were independently associated with developing an STI after an AIDS diagnosis (Scheer et al., 2001).

A community-based survey of 554 self-identified homosexual men recruited from a gay-oriented street fair in Chicago during 1997 revealed that a “substantial minority” (ranging from 6% to 21% across various items) reported reduced concern about HIV related to treatment advances (Vanable, Ostrow, McKirnan, Taywaditap, & Hope, 2000). Of note, reduced HIV concern was an independent predictor of sexual risk—especially among HIV positive men (Vanable et al., 2000).

Investigators surveying a convenience sample of 511 men attending a gay pride festival in Atlanta, Georgia, in 1997 developed a subsample of 298 men with the following criteria: identified as gay or bisexual, had not tested positive for HIV, and were not currently involved in a long-term sexual relationship (Kalichman, Nachimson, Cherry, & Williams, 1998). Twenty percent of these 298 men reported engaging in unprotected receptive anal intercourse in the past 6 months. Compared to men at lower risk, those who practiced high-risk sex were more likely to endorse beliefs that new AIDS treatments reduced risks for HIV transmission (Kalichman et al., 1998).

Kelly, Hoffmann, Rompa, and Gray (1998) obtained similar results from a community sample of 379 MSM attending a gay and lesbian pride celebration in a large midwestern United States city. Ten percent of their respondents agreed or strongly agreed with the statement “AIDS is now very nearly cured,” and 13% felt that the threat of AIDS was less serious than in the past (Kelly et al., 1998). Overall, 8% of the men interviewed indicated that they practiced safer sex “less often” in light of new AIDS treatments; the response was even higher—18%—for HIV-positive men on HAART (Kelly et al., 1998).

In Australia, cross-sectional surveys of over 4,000 gay men conducted during early 1998 showed that 96% understood that HAART wasn’t a “cure” for HIV and that persons with undetectable HIV viral loads could still “pass on the virus” (93%) (Van de Ven, Kippax, Knox, Prestage, & Crawford, 1999). However, men who agreed with the statements “I’m less worried about HIV infection than I used to be” and “An HIV-positive person who is on combination therapy is unlikely to transmit HIV” were more likely to report unprotected anal intercourse with casual partners ($p < .001$) (Van de Ven et al., 1999).

A predominantly male (88%) sample of 147 HIV-infected persons recruited from a Canadian HIV outpatient clinic were asked to complete a questionnaire about perceived risk of HIV transmission and safer sexual and injection drug use practices (Kravcik et al., 1998). Nineteen percent felt that the need for safer practices was reduced by protease inhibitor therapy, leading the investigators to opine that “the potential for recidivism to unsafe sex and drug using practices . . . requires further research” (p. 128).

Most of the 773 gay men who completed an anonymous questionnaire in London in the spring of 1998 did *not* endorse optimistic statements concerning improved treatments (“I am less worried about HIV”) or reduced infectivity (“New therapies make people with HIV less infectious”) (Elford, Bolding, Maguirer, & Sherr, 2000). But among HIV-negative men, optimism around improved treatments was associated with unprotected anal intercourse with a partner of unknown or discordant HIV status (Elford et al., 2000).

Stolte, de Wit, Dukers, & Coutinho (2000) prospectively investigated the association between different treatment beliefs and changes in HIV-related sexual risk behavior among a cohort of 73 homosexual men from the Netherlands. Between 1999 and 2000, eight of their participants (11%) reported switching from condom-protected intercourse with casual partners to receptive anal intercourse with casual partners without using condoms. Decreased perceived threat of HIV/AIDS “was found to have a significant effect in the group that switched from no risk to risk, compared to the only no-risk group (OR of 2.98, CI 1.42–6.26)” (Stolte et al., 2002).

Findings of reduced perceptions of HIV/AIDS risk related to improved treatments are not limited to homosexuals. A 1999 survey of 196 largely heterosexual, inner-city clients of AIDS service organizations in New York City revealed that 33% of the sample agreed with the statement that “being HIV-positive isn’t that big a deal now that treatments are better” (Demmer, 2002). Fifteen percent of respondents believed that protease inhibitor combination therapies reduced the risk of HIV transmission, and 23% of the respondents reported practicing safer sex less often following the availability of improved HIV treatments (Demmer, 2002). Among another cohort of HIV infected New Yorkers, most of them infected through injection drug use or heterosexual activity, persons on HAART were nearly twice as likely to report unprotected sex compared to those who were not (McGowan et al., 2004).

ASSOCIATION OF HAART WITH NONSEXUAL BEHAVIORS

Most of the published literature on treatment optimism examines the relationship between optimistic attitudes about HAART and sexual behaviors. Kravcik and his colleagues (1998) also considered the relationship between treatment optimism and intravenous drug use with needle sharing. However, they were unable to find any significant differences among HIV-infected persons’ views about the importance of safer injection practices, based on treatment status.

Between December 2000 and July 2001, a cohort of 931 IDUs were surveyed in Baltimore concerning their attitudes to HIV infection, HIV treatment and HIV-related risk behavior (Tun, Celentano, Vlahov, & Strathdee, 2003). Although 10–20% of the cohort endorsed various statements supporting the belief that HAART reduced HIV transmissibility through needle sharing, this perception was not associated with their reported frequency of needle sharing—either among seropositive or seronegative IDUs (Tun et al., 2003). In multivariate analyses, only “safer injection fatigue” (“It’s too much of a hassle to use clean needles all the time”) was associated with increased needle sharing (p. 1957).

Surveying 220 clients of an HIV case-management organization in Philadelphia in the summer of 1999, Holmes and Pace (2002) dichotomized their sample into those who were pessimistic about their life expectancy versus those who were optimistic—the majority. Compared with the pessimists, the optimists were not only more likely to report more “safe sex nonadherence” (57% vs. 29%, $p = .004$) but were also more likely to report medication non-adherence (26% vs. 13%, $p = .04$).

POTENTIAL MECHANISMS FOR HIV/AIDS COMPLACENCY

The literature on perception and understanding of health risks embraces the notion that “social, cultural, and economic factors are central to how individuals perceive and understand health risks” (World Health Organization, 2002, p. 14). As such, understanding and reacting to the risk of HIV/AIDS is not just a matter of factual knowledge but also encompasses the diverse values, beliefs, and circumstances related to the virus and its transmission. Likewise, this description of potential mechanisms for HIV/AIDS complacency recognizes that there may be multiple reasons for minimizing, discounting or discrediting the threat of HIV/AIDS.

As the previous review documented, attitudes about improved ARV treatments have been associated with reduced perceptions of threat related to HIV/AIDS—at least in the industrialized world. But in some instances the role of treatment optimism in breeding HIV/AIDS complacency may be overstated. A survey of nearly 6,000 gay men in five major cities in Australia, Canada, England, and France found that “very few were optimistic in the light of new drug therapies for HIV infection” (International Collaboration on HIV Optimism, 2003, p. 548). Although this study did find that men who reported unprotected anal intercourse with a casual partner were more likely to have higher mean “optimism scores,” researchers were quick to caution that treatment optimism may have been used as a “post hoc rationalization to justify sexual risk taking” among these individuals (p. 549). And researchers in France (Desquilbet et al., 2002; Miller et al., 2000) and Switzerland (Wolf et al., 2003) have shown that patients’ knowledge of their response to HAART (as measured by viral load) is not a major determinant of unsafe sexual behaviors.

Thus, evidence suggests that factors other than optimistic attitudes about improved treatments are likely involved in tempering perceptions of HIV/AIDS risk. Therefore, the proposed taxonomy of factors contributing to HIV/AIDS complacency is bifurcated into contributing factors that are specifically related to HAART and those that are not.

COMPLACENCY FACTORS RELATED TO HAART

In countries having the resources to make HAART widely available, changes brought about by improved ARV treatments can influence perceptions of HIV/AIDS risk in at least three ways: by altering perceptions about the consequences of HIV infection, by enforcing the belief that HAART results in decreased transmissibility of HIV, and by enhancing the appearance of vitality and health among infected persons.

Perception That Consequences of HIV Are No Longer Severe. Increased HIV/AIDS survival may reinforce the perception among high-risk groups and those already infected that the consequences of HIV/AIDS infection are no longer severe. As such, persons may be less motivated to consistently maintain risk avoidance or risk reduction practices. This association has been described in many of the studies previously reviewed.

Another notable example of this dynamic can be found within recent debates about AIDS pharmaceutical advertisements and their potential impact on the health beliefs and behaviors of those at risk for or living with HIV disease. In San Francisco in 2001 an anonymous survey of 997 men attending a public STD clinic revealed that 76% of the homosexual respondents (compared with 38% of heterosexual respondents) “reported seeing HIV drug advertisements that portrayed men who are healthy, handsome and strong” either every day or at least once a week (Klausner, Kim, & Kent, 2002, p. 2349). The authors found that regardless of sexual orienta-

tion, men who reported more frequent exposure to the advertisements were more likely to agree that “the advertisements affected an individual’s decision to have unprotected sex” (p. 2350). And among homosexual men, HIV-positive respondents reporting frequent exposure to advertisements were more likely to report unprotected anal intercourse compared with HIV-positive respondents who had infrequent exposure (27% vs. 17%, $p < .04$) (Klausner et al., 2002).

Because of the cross-sectional nature of these data, one cannot conclude that AIDS drug advertisements depicting robust, physically active persons result in unsafe sexual activity. Nevertheless, the U.S. Food and Drug Administration was concerned enough about this potential dynamic to send an “advisory letter” to several HIV pharmaceutical manufacturers in April 2001. The letter warned manufacturers that their advertisements “didn’t include important limitations associated with the products” and that “images in many of the ads didn’t seem to be representative of people who are being treated for HIV infection” (Michaud, 2001).

Perception that HAART Results in Decreased Transmission. Although not a consistent finding, several studies report an association between HAART, undetectable viral load and decreased perceptions of sexual transmission risk (Huebner & Gerend, 2001; Kravcik et al., 1998; Venable et al., 2000). In a survey of 472 men attending a gay pride festival in the midwestern United States, Suarez and his colleagues (2001) found that for the most risky sexual behaviors, HIV-positive persons on HAART with an undetectable viral load were perceived as “posing no greater risk of infection than were individuals with unknown HIV status” (p. 474).

There is a sound biological basis for perceptions that decreased viral load may result in decreased HIV transmission at a population level (Anderson & May, 1991). Because it has been shown that viral load is “the chief predictor of the risk of heterosexual transmission of HIV-1” (Quinn et al., 2000, p. 921), it is reasonable to speculate that widespread use of HAART might contribute to decreased transmission of HIV at a population level (Porco et al., 2004; Velasco-Hernandez, Gershengorn, & Blower, 2002). But the same logic may not apply at the level of the individual. Persons on HAART with no detectable levels of viral RNA in their plasma may still carry virus in their semen (Zhang et al., 1998). Furthermore, protease inhibitor-resistant HIV-1 may emerge in the semen of patients receiving HAART (Mayer et al., 1999). Some modelers predict that any potential prevention advantage brought about by decreased viral load among a population of treated individuals could easily be overcome by an increased frequency of unsafe sex (Porco et al., 2004; Velasco-Hernandez, Gershengorn, & Blower, 2002).

Enhanced Vitality and Improved Appearance. In a Brazilian study, 40 heterosexuals, 20 injection drug users, and 10 MSM were recruited from three public health facilities in Rio de Janeiro; half of the participants were infected with HIV (Kerrigan et al., 2002). Based on in-depth interviews, the researchers determined that “some participants acknowledged the existence of HAART optimism and associated risk behavior” (p. 186). However, the construction of treatment optimism in this setting was not found to be associated with knowledge or awareness of lower viral loads (i.e., lower viral loads may lead persons to perceive themselves or others to be less infectious). Instead, optimism was more likely related to “people feeling better and no longer looking sick” (Kerrigan et al., 2002, p. 186). On a related note, researchers in the United Kingdom have suggested that it might be more difficult to recruit individuals into prevention interventions in the HAART era, “when HIV is less visible” (Elford, Bolding, & Sheer, 2004, p. 156).

COMPLACENCY FACTORS NOT SPECIFICALLY RELATED TO HAART

At least two factors, not specially related to improvements in ARV treatment, may attenuate perceptions of the threat of HIV/AIDS: temporal changes in the general perception of HIV/AIDS risk and competing priorities for public attention.

Temporal Changes in the General Perception of HIV/AIDS Risk. In America, public opinion surveys have shown successive decreases in the number of persons who identify HIV/AIDS as the “most urgent health problem facing this nation” (Kaiser Family Foundation, 2002). Serial surveys conducted in 1997, 2000, and 2002 revealed that 38%, 26%, and 17%, respectively, of a nationally representative random sample of American adults identified HIV/AIDS as the most urgent health problem facing America (Kaiser Family Foundation, 2002). When responses were broken out by race/ethnicity, African Americans and Hispanic Americans were more likely than whites to characterize HIV/AIDS as “the most urgent health problem” (p. 3)—but they too showed attitudinal declines over time.

The 2002 Kaiser survey showed that Americans had a higher level of concern for the global HIV/AIDS epidemic: Thirty-three percent of those surveyed characterized HIV/AIDS as the “most urgent health problem *facing the world*” versus 17% of the same sample who saw it as the “most urgent health problem *facing the nation*” (Kaiser Family Foundation, 2002, p. 5). But the global numbers too had decreased from the previous response to the same question, asked some 2 years earlier.

Health Canada (2003) reported similar trends. A telephone survey of 2008 Canadian adults (18 years of age and older) conducted in August 2002 “appear(ed) to indicate that public perceptions about the seriousness of HIV/AIDS is waning” (p. 2). Comparing results from 1989, 1998, and 2002, the survey demonstrated a progressive decrease in the percentage of Canadians who rated HIV/AIDS as “very serious”: 83% in 1989, 69% in 1998, and 54% in 2002.

Research on perception of risk indicates that risks can be characterized on at least two dimensions: degree of “dread” and degree of the “unknown” (Slovic, 1987). Dread risks are those that can be described as having catastrophic potential, fatal consequences and over which persons have minimal control. Unknown risks, as their name implies, are risks that are judged to be unobservable, unknown, new, and delayed in their manifestation of harm. Although technical experts tend to rank health risks in terms of their annual mortality rates, the lay public reacts most strongly to those risks that are perceived to be both “dreaded” and “unknown.”

Based on the above construct, one concludes that some decrease in the public perception of the threat of HIV/AIDS is a function of time and increased experience with the disease. As we have learned more about HIV/AIDS, how the disease is transmitted, what steps can be taken to prevent its transmission, the actual isolation of the causative virus, levels of dread and uncertainty have been reduced—thus decreasing the perception of risk in the public’s mind.

Downs (1972) identified a related phenomenon in his description of the “issue-attention cycle.” He hypothesized that problems gradually fade from “the center of public attention”—even if they are unresolved—because “more and more people realize how difficult and how costly . . . a solution to the problem would be.” Although Down’s description of the issue-attention cycle predated the onset of the AIDS epidemic by nearly a decade, it provides another basis for explaining the phenomenon of HIV/AIDS complacency.

Competing Priorities for Public Attention. Finally, it must be recognized that emerging priorities, whether health related or otherwise, compete with HIV/AIDS for the attention of the public and the policy makers. Over time, “attention to a problem will eventually wane even if the objective conditions related to that problem have not changed” (Swain, 1997, p. 10). Domestic AIDS media coverage in U.S. newspapers has declined over time (Agoston, 1996), suggesting another factor contributing to the perception that the threat of HIV/AIDS has decreased.

Media analysts suggest that “stories containing or promoting drama tend to rise to a place of social prominence” (Swain, 1997). Consider a palpable example from the American experience. Shortly after the tragic events of September 11, 2001, an editorial appeared in the *Journal of the American Medical Association*, asking the question “Will the focus on terrorism overshadow the fight against AIDS?” (Voelker, 2001). Another illustration is the substantial U.S. media attention given to severe acute respiratory syndrome, or SARS, in 2003, although the condition was not responsible for a single U.S. death—compared with over 16,000 U.S. AIDS deaths in 2002 (CDC, 2002). In other nations of the world, emerging conflicts, political machinations, or economic downturns may easily displace HIV/AIDS from the headlines—even in countries with substantial HIV/AIDS mortality.

CONTRIBUTING FACTORS NOT RELATED TO COMPLACENCY

As acknowledged in the earlier Premise section, other factors and circumstances, not encompassed under the rubric of HIV/AIDS complacency, may be contributing to the observed increases in unsafe sexual behaviors described in this article. Although not the focus of this discussion, one must acknowledge the potential influence of, among others, increased longevity, prevention burnout and “postcrisis prevention strategies” on the apparent resurgence of unsafe sexual behaviors observed in various industrialized nations.

Increased Longevity: More Opportunities for HIV Transmission. A predictable outcome of improved HIV/AIDS survival in industrialized nations is increasing HIV/AIDS prevalence—meaning that more persons are living longer with HIV/AIDS than ever before. Furthermore, the majority of persons with HIV/AIDS report that they are sexually active. Interviews of adults with HIV/AIDS conducted in 12 U.S. states between 1997 and 2000, reveal that 69% are sexually active with one or more partners (Centers for Disease Control and Prevention, 2004). Therefore, we must recognize that increased longevity can translate into additional opportunities for HIV transmission—which need not be related to individual changes in the perception of HIV/AIDS threat. Another way of explaining this phenomenon can be found in the transmission model described by Boily, Bastos, Desai, and Masse (2004). According to Boily’s model, the wide-scale use of HAART spares “high-risk” persons from illness and death, thus increasing the overall level of risky sex over time.

HIV/AIDS Prevention Burnout. The phenomenon of HIV prevention burnout, another factor that may be contributing to increases in unsafe sexual behaviors, is not necessarily associated with changing perceptions of HIV/AIDS risk. As noted in a recent U.S. publication from the CDC (2001): “Twenty years into the HIV epidemic, many older men who adopted safer sex practices in response to the initial health crisis are finding it difficult to maintain these practices over the course of a lifetime” (p. 6). And individual burnout may be amplified by waning group norms in support of safer sex.

Among U.S. gay men enrolled in a longitudinal AIDS study, 549 reported unprotected anal sex in the past 6 months (Ostrow et al., 2000). Not surprisingly, researchers found an association between sexual risk taking and decreased concern about HIV transmission due to HAART; but they also found that HIV “burnout” was independently associated with unprotected anal sex among HIV-infected men. Likewise, in a qualitative analysis involving 18 gay Scottish men, Flowers, Knussen, & Duncan (2001) found that “many participants talked about a general fatigue with HIV risk reduction” (p. 670).

Post crisis HIV/AIDS Prevention Strategies. Kippax and Race (2003) have argued that “condom avoidant HIV prevention strategies” are not consistent with “relapse” or “a return to the bad old days and ways” among Australian MSM (p. 8). They believe that gay men are using relevant medical and epidemiological information “to think about how much risk they are prepared to take and under what conditions” (2003, p. 8). Thus, what appears to be unsafe or high-risk sex to an outside observer (e.g., reported anal intercourse without condom use) may be, as these social researchers pose, a considered strategy to reduce harm (e.g., an HIV-positive man taking the receptive role during anal intercourse with a partner of unknown serostatus). The availability of postexposure prophylaxis for sexual exposure, in some locales, may likewise serve as a mediating variable in a sexually active individual’s cognitive assessment of the risk/benefit of a specific sexual encounter (Waldo, Stall, & Coates, 2000).

APPROACHES TO MINIMIZE HIV/AIDS COMPLACENCY

Social scientists and policy analysts will continue to study the emerging phenomenon herein identified as HIV/AIDS complacency. Although gaps in our knowledge base are evident, it is prudent to anticipate the potential for HIV/AIDS complacency to contribute to increases in HIV transmission and disease burden. What follows is a collection of potential policy and program actions to address HIV/AIDS complacency. In recognition of the various levels at which the phenomenon can manifest, proposed actions are divided into individual-level approaches, community and organizational-level approaches, and societal-level approaches.

Government should play a major role in addressing HIV/AIDS complacency as part of its commitment to ensuring healthy populations. Thus, each of the cited recommendations can be acted upon by government through its ability to raise and disperse public funds, enact regulations and policies, and pass legislation (Gostin, 2000). However, it would be foolhardy to assume that government, alone, is capable of holding HIV/AIDS complacency at bay. To ensure success, other sectors, including at-risk communities, media, faith-based organizations, and private industry, must also be involved in the effort. This caveat recognizes the fact that “individuals, communities, and varied social institutions can form powerful collaborative relationships to improve health that government alone cannot replicate” (Institute of Medicine, 2003, p. 2).

INDIVIDUAL-LEVEL APPROACHES

- Support research that strives to better understand how persons at substantial ongoing risk for HIV transmission/acquisition conceptualize risk in the era of HAART—especially young people.
- Develop and test interventions to encourage the early diagnosis of HIV infection.

- Conduct formative and epidemiological research among newly infected persons to determine what personal, community, and contextual factors played a significant role in their HIV infection; identify potential motivators for remaining free of HIV infection.
- Develop and test messages specifically targeted to persons who are living with HIV/AIDS that underscore the continued importance of preventing further transmission of the virus.
- Develop and test messages targeting HIV negative individuals emphasizing the importance of knowing partners' HIV serostatus.

COMMUNITY AND ORGANIZATIONAL-LEVEL APPROACHES

- Strengthen efforts to monitor behavioral trends (including drug use), STI, and HIV rates among adolescents and adults for evidence of increases in HIV risk/transmission.
- Continue to monitor and study community norms around various HIV-related risk (and risk reduction) behaviors and practices in the industrialized nations of the world.
- Conduct formative research among communities in developing world settings to determine whether the phenomenon of HIV/AIDS complacency, or its antecedents, are emerging along with increased availability of ARVs.
- Support the development and implementation of targeted community-level “anticomplacency” campaigns using a social marketing approach.
- Strengthen school-based programs that make young people aware of the continued threat of HIV/AIDS—even in the era of HAART.
- Work with health care facilities and medical provider organizations to develop guidelines and policies that promote the inclusion of HIV prevention messages as a routine component of primary care for persons with HIV disease.
- Develop educational fora that provide journalists with a deeper understanding of the ongoing threat of HIV/AIDS—even in the era of HAART.
- Reenergize community coalitions in the industrialized nations to confront increases in high-risk sexual behaviors and STI outbreaks among persons at risk for or infected with HIV.
- Conduct operational research to identify and categorize organizational variables, including procedures and practices, that may inadvertently reinforce HIV/AIDS complacency.

SOCIETAL-LEVEL APPROACHES

- Provide ongoing education to policy makers and legislators about the importance of maintaining long-term support for HIV prevention efforts, even in an era of improved treatments.
- Develop national communication strategies to proactively combat HIV/AIDS complacency, including long-term support for efforts to sustain public understanding about the ongoing threat of HIV/AIDS.
- Develop structural interventions to encourage routine voluntary HIV testing in medical care settings.
- Develop, where necessary, reimbursement and health care payer mechanisms that support the integration of HIV prevention services into the provision of HIV treatment and care.

- Provide private sector incentives to encourage employers to provide information on the continued threat of HIV/AIDS—even in the HAART era.
- Continue long-term investment in HIV prevention capacity for the public sector (e.g., training, skills development, infrastructure to support surveillance and program implementation, etc.).
- Forge coalitions with local and national entertainment media to facilitate the communication of accurate information about the ongoing threat and costs of HIV/AIDS.
- Increase investment in HIV prevention research—for both behavioral and clinical prevention strategies, including vaccine and microbicide work.
- Monitor national trends in public funding for HIV prevention and treatment for potential associations with various manifestations of HIV/AIDS complacency.
- Conduct policy analyses of other modern-day epidemics to understand (and anticipate) how changes in disease perceptions evolved in the wake of advances in biomedical science—including vaccine development.

CONCLUSION

It is reasonable to anticipate some degree of complacency as a function of our ongoing experience and familiarity with HIV/AIDS. The reasons, outlined above, include those that are directly related to treatment improvements and others that are not. Moreover, the phenomenon has been reported across various geographical and behavioral groups. To date, most reports have issued from the industrialized north, but there is evidence that similar dynamics can evolve in a developing world setting having access to ARV treatment (Kerrigan et al., 2002). Therefore, we must carefully monitor attitudinal and behavioral trends in communities of the developing world where improved access to ARV is anticipated or under way.

Because increases in unsafe behaviors among persons already infected with HIV have been prominently reported as a manifestation of HIV/AIDS complacency, a predictable consequence of efforts to combat complacency will be a greater focus on persons living with HIV/AIDS as primary targets of prevention efforts. Logical though this approach may be, careful attention should be given so that subsequent prevention efforts do not result in inadvertent stigmatization of persons living with HIV/AIDS.

Experience in other public health domains suggests that “disease complacency” is not unique to HIV/AIDS. A major historical example can be found in the chronology of efforts to conquer tuberculosis (TB). As noted in one recent analysis, a “paradoxical combination of complacency and defeatism led over the years to a near total dismantling of the World Health Organization’s tuberculosis control program” (Institute of Medicine, 2000, p. 35). In the United States, “dwindling resources for TB prevention and control in the 1970s promoted the decay of local TB control programs and set the stage for the disease’s subsequent resurgence” (U.S. Advisory Council for the Elimination of Tuberculosis, 1999, p. 10). In part, TB complacency in the United States was due to “consistently declining rates of tuberculosis” (Institute of Medicine, 2000, p. 35)—a situation resembling the minimization of the threat of HIV/AIDS related to declines in AIDS morbidity and mortality in those countries able to afford HAART.

This review is not intended to imply that HIV/AIDS complacency is the most important challenge we face on the global AIDS front. Clearly, among the developing nations of the world, the urgency of HIV treatment access is *the* pressing priority. And those who deal with disenfranchised populations in the United States and other industrialized nations are likely to agree that access to needed HIV prevention and treatment services is a higher priority than concerns about HIV/AIDS complacency per se. But this exposition does embrace the notion that minimizing or discounting the threat of HIV/AIDS, for whatever reason, may be harmful to the health of individuals and communities and, as such, should be confronted in a proactive manner.

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