THE WISDOM OF WHORES

Bureaucrats, Brothels and the Business of AIDS

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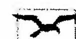

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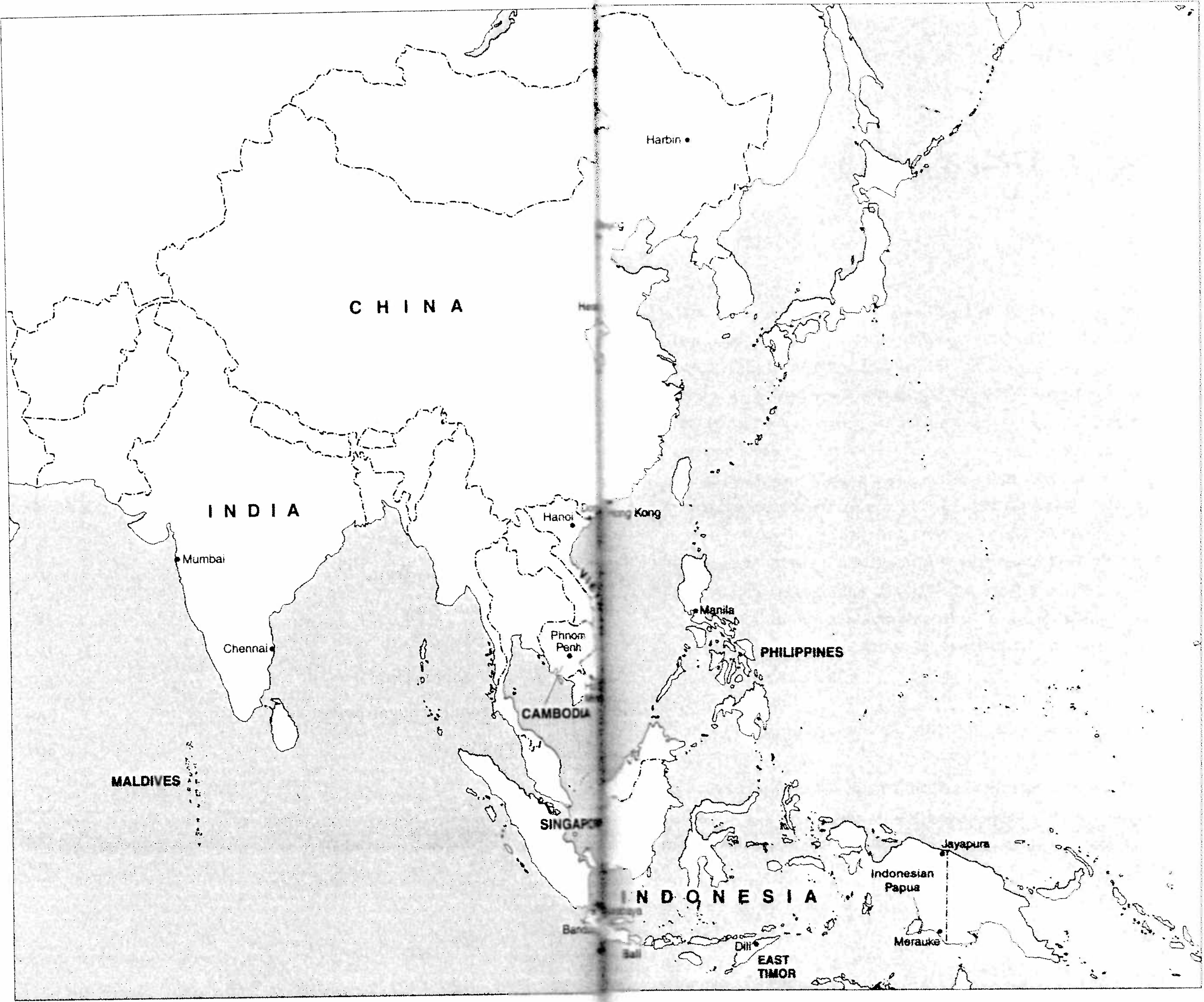
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PREFACE

The Accidental Epidemiologist

When people ask me what I do for a living, I say, 'Sex and drugs.' I used to say I was an epidemiologist, which is also true. But most people looked blank. Epi— what? Perhaps something vaguely distasteful to do with skin.

Saying I do sex and drugs saves me explaining that epidemiology is the study of how diseases spread in a population. It saves me from the social suicide of admitting that I am a scientist, a glorified statistician, a card-carrying nerd. And it is a good conversation starter. Everybody has something to say about sex and drugs.

I've discovered that fact in a decade of researching sex and drug injection around the world. Not an obvious career choice for a nice Catholic girl, perhaps. In fact, not a career I even knew existed for most of my life. I became an epidemiologist by accident.

As a child, I followed my corporate exec parents around Europe, learning cuisines and languages, wandering through flea markets and billiards halls. When I was fifteen I went to visit a school friend in Hong Kong. We threaded our way through

alleyways slithering with eels in great plastic tubs, we dodged bow-legged hawkers shuffling between swinging baskets of lychees, we stuck our tongues out at lollipops of dried terrapins, crucified on their bamboo sticks. We gyrated with rich kids in flashy nightclubs, and peeked into tawdry girlie bars. Then we grew bolder, walking into the girlie bars, ordering beers and chatting to bored sailors, bored bankers, bored hookers – anyone who would chat. I discovered that everyone has something interesting to say. I was hooked on Asia, hooked on nightclubs and girlie bars, hooked on chatting to anyone who would chat.

I took a degree in Chinese and set off back to Hong Kong, bouncing into a job as a foreign correspondent with Reuters news agency – about as fab as it gets for someone who just likes to chat. I reported on liberation wars and stock market booms and the massacre of hopeful students by hopeless despots. I visited brothels and orang-utan sanctuaries and military graveyards. I went to mass with the pope and school with rice farmers in the paddy fields. I learned some new languages and chatted with thousands of interesting people, and I got paid for it. I loved it, but I did grow tired of trying to reduce human experience to 600 words on a two-hour deadline.

Elbowing through the crowds of Hong Kong, New Delhi, Beijing, Jakarta, I became interested in the politics of population control. Sex and birth, health and death, priests and condoms, forced vasectomies and contraceptive 'safari camps' (line 'em up on fold-out camp beds and stick in the coils). The different approaches taken by the mega-nations of Asia would determine their own future, and perhaps the world's. There were days when that seemed more interesting than writing reports on the dollar–rupiah forex market. On top of that, I'd fallen for a boy who had moved to London and had a giant, generously rent-free house. So in 1993 I quit the job, moved to London and signed

up for a Masters degree in medical demography. I wasn't quite sure what it entailed, but I knew I'd learn some number-crunching and have luxurious hours in wood-panelled libraries just thinking. Deadlines be damned.

On the wall outside the wood-panelled library of the London School of Hygiene and Tropical Medicine danced giant gilded sculptures of mosquitoes, fleas and tsetse flies – the vectors of the diseases the School specialised in in the heyday of colonialism. The library itself seemed a relic from those days, its leather armchairs and leather-bound volumes musty in the dappled mid-afternoon sunlight. Outside the oasis of the library swarmed doctors and virologists, lab technicians and statisticians from every part of the globe. I was moderately numerate – all those stock market and forex stories – but my exposure to other sciences ground to a halt at fourteen, when I took my last biology exam. A degree in classical Chinese and five years in graveyards and paddy fields did not seem like adequate preparation for a new life as a scientist, I thought, as I picked up the folders for the two courses required of every student at the school. Statistics and epidemiology. Epi— what?

In the first lecture, we 'reviewed' all the major study types. For example, in the case-control study you find a group of people with a disease, and then look for people who are much the same but without the disease. You compare the two groups to see if they have different risks. It's a relatively cheap method, but it doesn't tell you much about the order in which things happen. I can't remember all the examples used in the lecture, but let's say you want to look at causes of depression in women. You start with 600 depressed women, find another 600 who match them in age, ethnicity and educational status, and then ask them all about their lives. Let's say you find out that women who are depressed are six times more likely not to have had sex

in the last year as women who are cheerful. That means if you're not having sex you get depressed, right? But hang on, couldn't it be that women who are moping around looking miserable don't get laid much?

Perhaps you'd be better off with a cohort study. You start off with several thousand women who are perfectly happy. Then you follow them over time, recording their behaviours, and see which of them get depressed. If you find that women who have sex are less likely to become depressed than women who aren't getting any, it suggests it is the lack of sex that causes the depression, not the depression which stops you getting laid. You can throw out the 'misery guts' theory and recommend more good sex as an intervention to promote mental health.

This may have been a review to most people there, but it was all new to me. The barrage of 'facts' that we see in the newspapers every day took on a new perspective. Red wine is good for you. No, no, red wine is bad for you. Well, actually, red wine is good for you but only if you are white, over sixty, and drink less than 65 millilitres a day. Even for scientists, the stats are not straightforward. Suddenly, epidemiology began to look interesting.

At the end of that first lecture, the professor asked a question. Why was there a fourteen-year gap between the first case-control study showing a strong association between smoking and lung cancer, and the first US Surgeon General's report on the dangers of smoking?

Stony silence from the highly educated doctors and technicians in the room, men and women who were adding a public health qualification to an existing wealth of medical experience. Maybe this was because it was the first lecture of the year and people were shy. I was not a doctor. I did not have an existing wealth of medical experience. I had not had any scientific education in twenty-five years. But I was not shy. A journalist's

work depends on a willingness to ask questions of people who are better informed and more powerful than you. It depends on regarding nothing as sacred and everything as open to question. I was by far the least qualified of the 300 or so people in that echoing lecture theatre, but I was full of been-there-done-that bravado. I stuck up my hand.

'You're asking the wrong question,' I said.

Even I was aware that the air in the lecture theatre had suddenly turned heavy. Heavy enough to crush the bravado. I blundered on, more doubtful now.

'Surely, the key question is: how much money did British American Tobacco and Philip Morris give to US Senate campaigns in that fourteen-year interval?'

Immediately, there was a shower of laughter and the air cleared. A forest of hands shot up, everyone competing to explain in technical terms that I only partly understood: case-control studies are subject to recall bias, case-control is not the most appropriate method for looking at causes of death, what is really needed to confirm the findings is a cohort study that follows both smokers and non-smokers over time, and and and . . .

All of these answers were correct, of course. But did that mean the Big Tobacco answer was wrong?

Science does not exist in a vacuum. It exists in a world of money and votes, a world of media enquiry and lobbyists, of pharmaceutical manufacturing and environmental activism and religions and political ideologies and all the other complexities of human life.

There's plenty of evidence that a lack of sound science was not the only thing that dragged down action to discourage smoking. The 1950 study showed that there were twenty-one times more non-smokers among men who did not have lung cancer than

among men who did have lung cancer. If that's hard to follow, it's because one of the downsides of a case-control study is that you can't say A leads to B. So yes, you don't want to make public health policy just on the results of that one study. But another 7,000 studies showing similar and stronger results were published before the US Surgeon General risked the wrath of the rich and powerful tobacco companies by saying that smoking is bad for you. Well, he didn't actually say bad for you. He said 'a health hazard of sufficient importance to warrant appropriate remedial action'. Nowhere in the Surgeon General's 387-page report did he venture what 'appropriate remedial action' might be.[1]

The report was released during a carefully orchestrated 'lock-in' of accredited journalists, held on a Saturday morning. 'The date chosen was a Saturday morning to guard against a precipitous reaction on Wall Street,' according to an official history of the 1964 Surgeon General's report posted on the US Centers for Disease Control (CDC) website. Which sounds to me like an admission that science, case-control study or no, is not the only thing politicians consider when making decisions about public health.*

The more I thought about it, the more I liked epidemiology. It's actually not unlike investigative journalism. You need to ask the right questions of the right people. You need to record the answers carefully, analyse them correctly and interpret them sensibly, and in context. And you have to communicate the

* This statement, along with a number of others that might be deemed unfriendly to Big Tobacco, was removed from the CDC website in early 2007. To view both the original web page and its replacement versions, and to find links to most of the documents, papers and illustrations mentioned in this book, see http://www.wisdomofwhores.com/references. For a rigorous account of tobacco industry lobbying practices, see Glantz et al., 1996, available online at http://ark.cdlib.org/ark:/13030/ft8489p25j.

results clearly to people who might do something about them. Journalism (day-to-day news journalism, at any rate) is frustrating because you don't always have the time or the tools for thorough analysis. Epidemiology gives you that. But it seemed to me that epidemiology often falls at the last hurdle: the communication.

I soon learned that the world of epidemiologists, perhaps like any professional *demi-monde*, is deeply divided. On the one side are those who believe an epidemiologist's job is to do good science. End of story. Turning good science into sensible policy is someone else's job. This camp, which apparently includes the editors of the scientific journal *Epidemiology*, actually believes that it is wicked for epi-nerds to get involved with policy, because it compromises their scientific neutrality.[2]

The other camp believes that epidemiology and public health are inseparable. Public health is not glamorous, and it is not especially well paid. You work in public health because you want to save a lot of lives. If you're going to do that effectively, you can't stop at the perfect study design, or even at the publication of your perfect paper in *The Lancet* or the *New England Journal of Medicine* (the dream of epidemiologists in both camps). An epidemiologist is a scientist, yes, but in the public health camp that's not enough. Something that works in the lab but doesn't work at the ballot box might be good science, but it is unlikely to get translated into good public health. So you have to *do* good science, and then *sell* good science.

An idea that kept gnawing at me as I lounged in the library's leather armchairs: we could save more lives with good science if we spent less time worrying about publishing the perfect paper and more time lobbying, more time schmoozing the press, more time speaking in the language that voters and politicians understand. If we behaved more like Big Tobacco, in fact.

I could have chosen to work on malaria, or dengue fever or maternal mortality. But if your real interest is the shadowy area where science does battle with politics, you want to go for the issue that makes politicians most squeamish. And in the mid-1990s, it seemed that issue was AIDS.

AIDS had first blundered into my consciousness in New York in 1981, when I was working in a fashion advertising agency for a year before going to university. Headlines in the *Village Voice* newspaper screamed about GRIDS – Gay Related Immune Deficiency Syndrome. At first, the screaming fell on deaf ears. At the weekends, when I'd sometimes follow the city's gay swarms out to the beach at Fire Island, I'd have to tread carefully to avoid tripping over men entwined with one another in the dunes. Entwined couples were much more common than condoms on Fire Island in those days. Within a year, GRIDS had worked its way into New York's consciousness. Cafés grew hushed when yet another skeletal figure shuffled in. Drinks with friends in the city's gay bars were often interrupted by volunteers from the Gay Men's Health Crisis, handing out leaflets and condoms. By that time drug injectors, haemophiliacs and Haitians had been added to the list of 'victims', and the disease was renamed Acquired Immunodeficiency Syndrome, or AIDS. The very word AIDS seemed to strike terror into the hearts of politicians. Ronald Reagan presided over the emergence of the epidemic in the United States. He witnessed American and French scientists race to identify the virus that caused it. He saw his old acting buddy Rock Hudson waste away. But it wasn't until September 1985 that he managed to say the word AIDS in public.[3] Rock Hudson died of AIDS two weeks later.

The same year, a wasting disease ravaging Uganda which the locals called 'Slim', was identified as AIDS, and every region of the world reported at least one case. Britain had clocked up 275 cases by the end of 1985. The tabloids were hysterical about 'Acquired Immoral Deficiency Syndrome', and public bodies such as the Blood Transfusion Service were tiptoeing towards the truth with genteel warnings about the dangers of 'intimate contact'. When reported cases topped 1,000 in 1987, the government grew less squeamish. Through every letter-box in the country, all 23 million of them, fluttered a leaflet giving chapter and verse about HIV, condoms and safe sex.[4]

AIDS didn't make it to the London School of Hygiene's curriculum until I was there, in 1994. By then we knew that almost all HIV-infected adults got their infection when having anal or vaginal sex, or while injecting drugs with shared needles. Infected blood products could spread the disease, though that was on the wane. And mothers could pass HIV on to their infants, in the womb, at birth or while breastfeeding. We knew that in rich countries, AIDS was a disease of gays and junkies, of prostitutes and their clients. Those groups were affected in some poorer countries, too. But in black Africa and the Caribbean, HIV didn't seem so picky. It seemed happy to target just about anyone who had sex.

Sex, drugs and plenty of squeamish politicians. AIDS was the disease for me.

That choice shaped the next ten years of my life. It set me up for a decade of adventure, discovery, hilarity, hope, disappointment. It allowed me to explore the guts of worlds I had barely known existed. From prostitutes, rent boys, pimps and clients I learned about the sex trade. Addicts, cops and rehab workers taught me about the parallel universe of drugs. Perhaps the hardest world to find my way around was the AIDS industry itself, a world where byzantine international bureaucracies fight turf wars with one another, with pharmaceutical giants, with activist NGOs. A world where money eclipses truth.

AIDS was not a fashionable subject at the start of my career in public health, the starting point for this book. It was assuming pride of place as the number one killer of young adults in more and more countries, but many people still preferred to close their eyes to it. Our first task was to draw more attention to the disease, to persuade governments to do something to prevent their growing HIV epidemics, and to find cash to help them do it. I immersed myself in these tasks, in the company of a colourful band of characters crowded into the corridors of an upstart UN agency in Geneva. We painted glittering portraits of prevention success and thundered about the tragic consequences of failure. We manhandled estimated infections and manipulated maps. We did well at drawing attention and finding cash, but appallingly badly at persuading governments to do the right thing.

Perhaps if we had better information? I threw myself into the task of helping countries understand their epidemics better. We wrote guidelines and toolkits, manuals and handbooks, instructing people how to measure their epidemics better. Then I took the guidelines off to Asia and road-tested them in Indonesia, in China, in East Timor, in the Philippines. I encountered a world of women with penises who sell anal sex to men who are completely heterosexual. I found men who buy sex from women and sell it to men. I found heroin addicts who fly aeroplanes and Muslim fundamentalists who run protection rackets for brothels.

I learned a lot about the warts that exist on the underside of all those health statistics you see in your newspapers every day. They make things seem so simple, those numbers, but they're boiled up out of cauldrons of uncertainty, of best guesses, of spilled samples, of errors corrected on the fly. When we did begin to produce HIV statistics that we thought were fairly solid,

I found that they often didn't support the conventional wisdoms of the AIDS world. Was it true that the HIV epidemic in Asia would soon explode like that in Africa? No. Were most prostitutes the victims of trafficking or coercion? No. Would more premarital sex put more young people at risk for HIV? Quite the reverse.

Bit by bit, we got a better idea of what was really going on, what put people at risk of HIV in Asia, and what we should be doing about it. We imitated Big Tobacco as best we could, packaging up the data for different politicians, lobbying various interest groups, massaging the media. And still, we found it really hard to get governments to do the right thing.

I started to take a look around at the wider picture. And everywhere, I saw the same thing. We were collecting more and more really good information, and then not acting on it. Two things were getting in the way – ideology and money. In the AIDS industry, we have too much of both.

Most ideologies are religious or political, but we also stumble over the politically correct convictions of the AIDS activists who led the initial charge against HIV. Whatever their source, these ideologies influence what we do about sex and drugs and determine how we do it. Money, of course, follows the dominant ideologies. But it also sucks in people who don't really care about the problem, who are truly queasy about sex and drugs, but who want some of the cash. When AIDS was unfashionable, we had thought that more money would make it easier to do the right things to prevent a wider epidemic. Now that it is a boom industry, it has become clear that money can actually be an obstacle to doing the right thing.

This book tells the tale of the worlds I have encountered during the boom years of the HIV industry. It is rooted firmly in my experience, and the experiences of the people who have held

my hand and walked me through the brothels, shooting galleries and boardrooms where the future of AIDS is shaped. Unlike many books about AIDS it does not focus primarily on Africa, where two-thirds of HIV infections have been transmitted so far. Most of the characters, the stories, the data come from Asia (and particularly Indonesia) where I have done most of my research. You will not find apocalyptic accounts of an AIDS tsunami about to engulf the world's most populous continent. But you will find that if you count up just the female, male and transgender sex workers of Asia and their clients, and you add in Asia's drug injectors and the men who cruise for new partners in the continent's blossoming gay scene, you'll come up with a number that is not all that far off the entire adult population of sub-Saharan Africa. And you'll find, too, that the HIV epidemic in Asia looks very much like the epidemic in the West, in Latin America and in Eastern Europe. The people I'll introduce you to may live in exotic subcultures, but their wisdoms, the lessons we learn from them, are often universal.

Perhaps if I had known in the mid-1990s what a roller-coaster of triumph and despair HIV would turn out to be, I'd have chosen to work on maternal mortality. Perhaps if I had known how people at the next dinner table would react when my table traded stories about drinking foreskin soup, I'd have gone for dengue fever. Or if I had known how often I would be taken aside by a friend or acquaintance in meltdown because they had just tested HIV positive (or their brother had, or their girlfriend, or their boss). Perhaps if I could have foreseen how our lobbying successes would lead to billions of dollars of taxpayers' money being shovelled down an ideological drain, I would have chosen differently.

But in the mid-1990s I didn't know any of this. A career in sex and drugs? It seemed like a good idea at the time.

1

Cooking Up an Epidemic

How do you launch a career in sex and drugs? Like any other career: try to be in the right place at the right time.

In 1996 the right place was UNAIDS, a brand new and slightly amorphous 'joint programme' that was supposed to stop the United Nations agencies bickering about whose job it was to deal with AIDS.

A decade earlier, the World Health Organization (WHO) had tried to stamp its authority on the epidemic by establishing the Global Programme on AIDS. It made the fatal mistake of trumpeting the fact that Human Immunodeficiency Virus (HIV) had serious consequences for social and economic development. 'Development? Then it's our business!' said the United Nations Development Programme. 'Economics? That's us!' said the World Bank. UNICEF fretted that children were involved, the United Nations Population Fund ruled over contraception and thus condoms. The United Nations Educational, Scientific and Cultural Organization found that AIDS ticked all the boxes in UNESCO's own title. None of these agencies was actually doing much about AIDS, but they didn't want those medics at WHO