Vaccine Vexations

The have-nots are getting less than they bargained for

January 1, 1999 By Dave Gilden

The HIV vaccine is big news these days, and for its October 1 front-page piece on a small, preliminary trial, *The New York Times* sent a reporter all the way to Uganda. Yet despite interviewing dozens of people and no doubt spending tens of thousands of dollars, the reporter missed the real story, failing above all to grasp the trial's contentious ethical background.

There are two main aspects to the long-running controversy over vaccine trials. One involves informed consent: It's widely accepted by researchers that participants must be warned that they may receive either the candidate vaccine or a placebo, and since neither one offers protection, they must also be rigorously counseled on safer sex. But the Times got it wrong, misreporting that the trial did not involve such education of volunteers. Worse, it gave a positive description of the usefulness of abridging informed consent to speed along research.

The more hotly debated issue is whether Third World vaccine recipients who become infected with HIV should receive expensive combination antiretroviral treatment. The objection goes beyond the economics to a more arcane scientific point. The vaccine trial doesn't end for a volunteer who gets HIV. In fact, an effective HIV vaccine may allow many to become infected. The real question is whether the vaccine-induced immune response can contain the virus and thus render the infection harmless. This is impossible to judge if combo therapy reduces a volunteer's viral load to undetectable.

The medical relativism that denies drugs to these newly infected guinea pigs is justified only by the lack of antiretrovirals for PWAs in poor countries. But in all the debates over vaccine development, this fundamental ethical conflict is largely ignored. The Times article argued unreflectively, as many experts do, that vaccines are the Third World's sole HIV management measure. AIDS will "destroy an entire generation," the article stated, unless "somebody comes up with a vaccine." But HIV will kill tens to hundreds of millions of people in any case.

It will likely take another 10 to 15 years—if ever—to produce a vaccine that offers major protection against HIV. Judging by past experience with the polio and hepatitis B vaccines, most of those who receive the vaccine first will be North Americans and Europeans. Vaccinating the rest of the world and eradicating HIV, if possible, will take decades longer. Right now, there are as many as 40 million people with HIV worldwide, and 90 percent have no access to combination therapy. Most of

these left-outs will die of AIDS, as will many of the hundred million more who become infected before the vaccine comes to them.

Even in the United States, anti-HIV treatment is becoming more expensive, and efforts to bring the new medical advances to everyone have been stymied. There is virtually no research into more-accessible treatments that could be used here, let alone in developing nations. While ignoring the search for such alternative therapies, the National Institutes of Health is rapidly expanding its HIV vaccine initiative, now budgeted at $179 million, or 10 percent of the total HIV research budget.

As we test vaccine candidates among impoverished populations, let’s be clear about the limitations of this technological fix. As Sam Avrett, director of the AIDS Vaccine Advocacy Coalition, says, “Vaccines can only be a small part of the AIDS agenda. To control the epidemic we will need good health care infrastructures, strong traditional HIV prevention efforts and continued treatment research and access.”

Until recently, there was little pressure in the United States for an HIV vaccine because activists feared cutting the hard-won resources for treating those already infected. With the new push for vaccine development—but not broad treatment access—that fear is now playing itself out on a global scale. If a preventive vaccine ever succeeds in halting HIV’s spread, we might congratulate ourselves for not getting bogged down by these ethical issues. But our self-satisfaction will last only until the next emerging disease spreads worldwide. Then, too late, we will lament the lost opportunity to create an integrated public health infrastructure to thwart epidemics before they happen.

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