AIDS and the Evangelicals
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Holly Burkhalter

Prodded by its conservative evangelical base, the Bush administration has pushed AIDS to the forefront of its international agenda, backing record increases in US assistance for AIDS treatment abroad and beginning to address issues such as sex trafficking and the dangers of HIV transmission from unsafe injections and blood transfusions.
any of us with experience battling the AIDS pandemic in the global north are familiar with a story—perhaps it describes your own experience—which unfolds something like this: a physician who has been treating patients with HIV/AIDS since its outbreak in the early 1980s is startled by not being able to remember exactly the last time he or she lost a patient to HIV disease; it was years ago. Where once there was nothing to do but hold patients’ hands, offering a modicum of support and relief from pain and suffering as so many died, now there is effective treatment, and it has had the result of bringing dawn to night.

Such stories are often used, effectively and justifiably, to illustrate the point that in much of the world, where health systems are not well developed and national economies are weak, the darkness of the night that is HIV/AIDS without antiretroviral therapy (ART) has not lifted. Want of money and privilege keeps essential medicines from those who need them most.

Recent events have conspired to remind us, however, that these stories, for all that they point to a very real problem of unequal access to medicines in general, leave out some of the complexity of the problem.

While HIV/AIDS morbidity and mortality have been greatly reduced in wealthy nations, people in these countries, most often the poor and medically indigent, continue to die of HIV disease. Many more may stave off the grips of AIDS-related death but lack the care and support, and often the state-of-the-art treatment, that would allow them to approximate, if not attain, the greatest possible quality of life available. We have accomplished much, but the shortcomings of “the system” are very real.

It is a system dependent on the priorities of politicians who must increase funding for HIV treatment assistance nearly every year, and whose willingness to do so fluctuates with the strength or weakness of the economy, as well as their relative confidence that this is a perceived priority among their respective constituencies. In this regard, a few visionaries who have taken up this noble call continue to stand against a backdrop of seas of public representatives for whom this plague remains a far lesser concern. It is also a system reliant on pharmaceutical companies that, while a driving force behind development of life-sustaining treatments, must answer to the dictates of market forces. And, it is a system in which privatization of healthcare service delivery and the trumping of patient care by cost concerns has obfuscated the evident moral imperative that no patient in the wealthiest nation should have to go without appropriate care.

This ad hoc response, despite its flaws, has had impressive results and ones for which those in the United States and other wealthier nations should be extremely grateful. But we should ask ourselves the degree to which it is truly effective and, more important, sustainable over the course of the decades to come. I believe that the answer is relevant not only to those of us in the United States—the country with which I have the greatest personal familiarity—but for the entire audience of this international publication. We are able to anticipate difficulties associated with ongoing ART in the developing world by looking at challenges that have cropped up in the places where sustaining widely available ART is an issue of the here and now. It is imperative that these lessons be heeded and that planning for ART scale-up in poorer settings addresses the need for novel approaches to sustainable care and treatment.

The increasing costs of ART are beginning to outpace the funding of government programs designed to bring HIV treatment to medically indigent HIV-positive patients in the United States. The AIDS Drug Assistance Program (ADAP), a network of state initiatives that receive a large part of their funding from the national government through the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, is in disarray, with 13 states closing enrollment to new patients. As of fiscal year 2004, 700 patients find themselves on ADAP eligibility waiting lists, and that number is expected to increase fully ten-fold over the course of this year if a funding increase is not secured. Additionally, we are seeing in some states the explicit exclusion of once-sacred drugs—specifically the prohibitively expensive antiretroviral enfuvirtide (ENF)—Continued on page 52
Call for Abstracts

At the UN Millennium Summit in September 2000, world leaders placed sustainable development at the heart of the global agenda by adopting eight time-bound Millennium Development Goals (MDGs) that set clear targets for reducing poverty, hunger, disease, illiteracy, conflict, environmental degradation, and discrimination against women by 2015.

While the MDGs are highly intertwined and complementary, Goal 6 commits nations to specifically “combat HIV/AIDS, malaria, and other diseases.” The UN Millennium Project—spearheaded by Jeffrey Sachs (Columbia University)—has identified ten priority areas through which to achieve Goal 6. Four years after the UN Millennium Summit, the 7th International Conference on Healthcare Resource Allocation for HIV/AIDS (7th ICHRA) aims to assess global responses to Goal 6 as well as our relative success in addressing the related ten priority areas.

IAPAC thus welcomes abstract submissions for the 7th ICHRA along the following ten tracks (representing the ten priority areas):

Track 1 Access to Treatment
Track 2 Health System Investment to Support HIV/AIDS Services
Track 3 Prevention of HIV Transmission
Track 4 HIV/AIDS and Vulnerable Populations
Track 5 Integration of HIV Prevention, Care, and Treatment Efforts
Track 6 Empowerment of Women to Combat HIV/AIDS
Track 7 Strategies to Address HIV/AIDS in Orphans and Vulnerable Populations
Track 8 Enhancing the United Nations Response
Track 9 Expanding and Improving Implementation of Domestic and International Funding for HIV/AIDS
Track 10 Empowerment of Governments and Measures for Accountability

Visit www.iapac.org to submit your abstract(s) and/or for further information about the 7th ICHRA, abstract submission guidelines, and abstract review procedures.
The improved tolerability, dosing flexibility, and resistance properties of new protease inhibitors (PIs) have triggered a reassessment of the role that PIs may play in first-and second-line antiretroviral therapy. The US Food and Drug Administration (FDA) approved two new PIs – atazanavir (ATV) and fosamprenavir (fos-APV) — last year for use in the United States. Atazanavir has been available for clinical use for approximately six months, and US treatment guidelines were revised November 10, 2003, to include information on its use in HIV-infected adults and adolescents.1 Fosamprenavir, which is a new formulation of the existing PI, amprenavir, was approved October 20, 2003, for use with or without ritonavir (RTV) boosting in antiretroviral-naive and -experienced patients. Current treatment guidelines do not include information on its use in either patient population.

Craig Sterritt, Program Director of Medscape HIV/AIDS, recently interviewed Jeffrey Nadler, Professor of Medicine at the University of South Florida College of Medicine, in Tampa, Florida. Nadler served as principal investigator of the pivotal NEAT study, which examined the use of fos-APV as initial therapy in previously untreated HIV-infected adults.2 Although Nadler has a professional relationship with GlaxoSmithKline, which markets fos-APV, Sterritt interviewed Nadler for this Q&A article because of his extensive clinical experience with this new antiretroviral drug.

**Sterritt:** Will fos-APV have a place at the table for initial therapy despite the popularity of nonnucleoside reverse transcriptase inhibitor (NNRTI)-based first-line regimens among clinicians and declining acceptance of PI-based therapy among patients?

**Nadler:** Yes, I think it very well may have. For initial PI-based regimens, the latest US treatment guidelines recommend the use of lopinavir/ritonavir (LPV/r). I think the advent of fos-APV, and also ATV, calls for a reassessment of that, even though they are new drugs. There is strong evidence that these new agents are better tolerated than LPV/r, and there is accumulating evidence that ATV, and possibly fos-APV as well, have markedly better side effect profiles than existing PIs with respect to lipids. And, in terms of patient acceptance and adherence, both represent a considerable step forward in terms of convenience, as they can be administered once daily. Certainly in terms of first-line or first-PI therapy, they appear to perform at least as well as previously available PIs in terms of potency.

**Sterritt:** What advantages does fos-APV offer in terms of convenience?

**Nadler:** One key advantage of fos-APV is that it can be used either once a day or twice a day. This flexibility allows one to tailor the administration of fos-APV to whatever NRTIs are included in the regimen. One of the things that we’ve come to learn from research of adherence issues is that the requirement of different numbers of pills at different dosing intervals represents an added disincentive to optimal patient adherence. In other words, many patients prefer symmetrical dosing, whereby the same number of pills is taken every time. The other key advantage to fos-APV is that, like its predecessor APV, it has no food requirement. This means, for example, that someone using fos-APV once daily can wake up in the morning, take their pills, and be done for the day. They don’t have to worry about waiting an hour after meals or anything like that. Food just isn’t an issue. And, compared with its predecessor, APV, it really is a new chemical entity. It’s water-soluble like nelfinavir (NFV), so it’s formulated as a very compact tablet. One 750 mg tablet is bioequivalent to four of the old APV capsules, but without the excipients that caused most of the gastrointestinal side effects.

So you’ve got a low pill burden, flexibility, and convenience, which make it an attractive option to patients in early stages of therapy. And it’s got the potency that we like about the PIs and a high genetic barrier to resistance, which some would argue make PIs preferable to the NNRTIs for initial therapy, at least in some cases.

**Sterritt:** Fos-APV is approved for use either once daily in combination with RTV or twice daily with or without RTV boosting. Should fos-APV be boosted in all or in some patients?

**Nadler:** In the NEAT study, which looked at first-line therapy, twice-daily fos-APV was equally as effective as NFV when used unboosted. However, I really don’t think that’s the best way to use fos-APV. Optimally, I believe fos-APV should be boosted in PI-naive as well as PI-experienced patients, and regardless of dosing frequency.

**Sterritt:** How do you feel that fos-APV compares with the other new PI option, ATV, which appears to have a unique advantage over other PIs in terms of lipid side effects?

**Nadler:** Well, again, they’re certainly comparable in terms of their low pill burdens. Fos-APV, when used unboosted, requires only two pills twice a day; but even when it’s boosted with RTV, you still have a maximum of four pills a day, whether you take it once or twice a day.
In terms of side effects, with fos-APV you don’t have the problem of hyperbilirubinemia, even though with ATV that’s probably more of a number to worry about than a clinically significant problem, unless the patient becomes icteric, which can be stigmatizing, even if otherwise benign. Of course, in the case of both new PIs, we have yet to see how issues of tolerance and side effects will play out in the real world as opposed to the clinical trial setting.

Further, at least for now, there appear to be fewer drug-drug interactions with fos-APV as compared to ATV. And, where that plays out is that with ATV, which must be taken with food to optimize absorption, if you have patients on gastric-acid inhibitors, whether proton-pump inhibitors or H2 blockers, that can have a significant impact on the bioavailability of ATV—especially when it’s used without boosting. There are also some antiarrhythmic interactions with ATV that are apparently less of a problem with fos-APV. Again, we will have to wait and see whether this potential distinction will be validated in the clinical setting.

With respect to lipids, although blood lipids do go up with boosted fos-APV, the increases are fairly modest. And although the LDL cholesterol (LDL-C) and triglycerides go up on average, levels do not commonly go above the National Cholesterol Education Program treatment intervention cutoffs. Also, as was recently presented at the 9th European AIDS Conference in Warsaw,3 HDL cholesterol (HDL-C) levels go up as well with fos-APV, so that the HDL-C/LDL-C ratio remains fairly stable. This phenomenon, which is seen with nevirapine (NVP), is not commonly seen with other PIs.

As yet, though, we don’t know whether this will translate into actual “cardioprotective” effects associated with higher HDL-C levels when they occur naturally, or whether this will offset any potential deleterious effects associated with increases in LDL-C levels. But if you have a patient with multiple risk factors for cardiovascular disease—male, smoker, overweight, sedentary lifestyle, family history of cardiac disease in a first-order relative, etc.—you’d want to look for agents that are least likely to disturb lipid levels. Atazanavir appears to fit that profile, and there’s accumulating evidence that fos-APV looks pretty good in that regard as well.

Sterritt: Are there situations in which you presently prescribe a PI-based regimen, rather than an NNRTI-based one, as initial therapy? Will the advent of fos-APV, and for that matter ATV, affect your practices in this regard?

Nadler: Certainly. You can profile patients and I try very hard to tailor my selections for first-line therapy to the needs and circumstances of the individual patient. And the improved pill burden, flexibility, and convenience of the newer PIs make it easier to do so, as there are now fewer tradeoffs between the NNRTIs and the PIs.

Sterritt: Can you give us an example?

Nadler: The current treatment guidelines state that efavirenz (EFV) plus Combivir (zidovudine [ZDV]/lamivudine [3TC]) is an excellent and generally preferable first-line regimen; that recommendation is based on excellent long-term and comparative data, and that regimen has kind of become the benchmark. However, you need to take your Combivir with food (due to the ZDV component), whereas EFV is best taken on an empty stomach, at or shortly prior to bedtime. As we know, there are some patients who won’t do as well with nighttime dosing, because they have a more disruptive evening schedule. For instance, a working mother with small children or a person with a history of sleep disturbance, especially if it’s associated with underlying psychiatric disease; such a person may not tolerate the early central nervous system (CNS) symptoms associated with EFV. For such patients, a morning dosing routine may be much more practicable, and morning dosing of a once-a-day fos-APV- or ATV-based regimen may prove a superior option. Then you have to consider other variables: If the person is known to never eat breakfast in the morning, then ATV won’t be the way to go, due to the food requirement.

Of course, when there are reasons not to use EFV, many would opt for NVP. But there are those who, in the case of, say, your typical 35-year-old ex-heroine user with hepatitis C coinfection, might shy away from using NVP because of its potential (albeit uncommon) hepatotoxic effects. Again, in this instance, the newer PIs, which are very well tolerated and permit once-daily dosing, represent attractive new options.

This is nothing new, and most clinicians are accustomed to prescribing LPV/r-based initial regimens for selected patients. The new PIs, though, appear to offer more in the way of convenience and tolerability and, in the case of ATV and possibly fos-APV as well, improved lipid profiles. In these ways, they compare more favorably to the NNRTIs, and for this reason will probably come to be used more frequently in first-line therapy.

Sterritt: Where and how do you see fos-APV fitting in for patients who have failed one or more PI-containing regimens?

Nadler: I think that with respect to using fos-APV as a second PI, we can look back to APV, and its “Achilles’ heel,” the 84 mutation, which is the least common of the four major protease-associated mutations (PRAMs): 33, 82, 84, and 90. So, unless there’s really advanced PI failure, with accumulation of multiple PRAMs and secondary mutations (and you have to look out for the 46 and 54 series of mutations in this regard), I think it’s likely that fos-APV will prove an equal—and in many cases superior—option to most other PIs, including ATV, for patients who have failed other PIs.

Sterritt: Is that true with respect to LPV/r as well?

Nadler: In the CONTEXT trial, RTV-boosted fos-APV was found to be equivalent to LPV/r by two of three measures of efficacy.4 At 48 weeks, however, boosted fos-APV failed to demonstrate noninferiority to LPV/r by the measure designated by the protocol as the primary endpoint for efficacy.5 But it was only fractionally off in that regard and, again, boosted fos-APV did show equivalence to LPV/r by the two other measures. My opinion is that there really isn’t any real difference between the two drugs in this setting, which isn’t surprising, as the mutational patterns for the two agents overlap significantly.

Something that is important to note here is that in contradistinction to the major study of ATV/r in PI-experienced patients, the CONTEXT study included patients who had documented failure on one or more previous PIs, as well as documented PI resistance. The A1424-045 study, which compared boosted ATV with LPV/r in PI-experienced patients, did not require that subjects have documented drug resistance; many of the patients enrolled had only a single previous PI failure, and a number of those were due to intolerance.
Sterritt: So you feel that there are more robust data for fos-APV in advanced stages of therapy. Do you think fos-APV will prove a better option for patients with multiple PI failures?

Nadler: Perhaps, but here we’re talking about patients with very narrow options. In my own practice, and especially with regard to new agents, I feel that this may be the time to order a high-quality resistance test, such as an actual phenotype, as opposed to a genotype-predicted phenotype, to help guide selection of agents that retain the greatest degree of activity against the patient’s virus.

Sterritt: What about the use of fos-APV in salvage therapy?

Nadler: I think its use in true salvage therapy is pretty limited, because of the overlap with the PRAMs, which is true for all available PIs, and that includes ATV. I think for true salvage in the PI class we’re still awaiting new agents. I think some patients will respond to tipranavir (TPV), and that if preliminary findings for TMC 114 hold true in larger trials, we may yet see useful agents for true salvage in this class of drug.

Selectively, however, and with the use of high-quality resistance testing, we may still be able to get some bang for our buck with currently available PIs, including fos-APV and also, possibly, ATV.

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References
Concentrations of indinavir (IDV) are reduced by over 80 percent if the first-line anti-tuberculosis (TB) drug rifampicin is taken at the same time, even when IDV is boosted by ritonavir (RTV), according to a small Danish study published in the February 1, 2004, edition of Clinical Infectious Diseases.

Both IDV and rifampicin are metabolized using the P450 (CYP) 3A4 enzyme, but rifampicin induces the enzyme’s activity, causing a substantial reduction in blood concentrations of IDV. In comparison, an earlier small study found that it was possible to maintain therapeutic blood concentrations of saquinavir (SQV) during rifampicin therapy if the standard dose of SQV was boosted by the addition of RTV 100 mg.

Accordingly, Danish investigators conducted a prospective, open label study to see if therapeutic concentrations of IDV during rifampicin treatment were maintained by adding the 100 mg RTV booster. The study enrolled six HIV-positive treatment-experienced patients, all of whom had an HIV viral load below 20 copies/mL and a median CD4 count of 35 cells/mm³. Rifampicin was provided for four days at a dose of 300 mg daily before the collection of study blood samples. Individuals enrolled in the study had 12-hour steady state IDV concentrations measured. Indinavir was dosed at 800 mg twice daily, boosted by a 100 mg twice-daily dose of RTV.

The investigators originally planned to enroll a total of eight patients, but stopped the study early because of the dramatic decreases in IDV concentrations observed in the first six patients. An 87 percent reduction in steady-state IDV concentrations was recorded 12 hours after dosing with rifampicin, and the RTV concentration was reduced by 94 percent.

“‘There is [a] clinically significant interaction between IDV, RTV, and rifampin,’” the investigators conclude, adding that, “our results strongly indicate that the administration of rifampin with a combination of IDV (800 mg) and RTV (100 mg)... could lead to sub-therapeutic concentrations of IDV.”


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High EFV concentrations affect sleep

Michael Carter

High blood concentrations of efavirenz (EFV) are correlated with poor sleep, according to a Spanish study published in the February 1, 2004, edition of Clinical Infectious Diseases.

The investigators also found that patients with sleep problems who were taking EFV were likely to spend more time awake during the night, to have less REM sleep, and to wake up more often during the night than both HIV-positive patients on EFV who enjoyed normal sleep or HIV-negative volunteers.

Investigators recruited 18 HIV-positive patients taking EFV. These individuals were diagnosed with sleep disturbance after completing a sleep diary. The study also involved 13 HIV-negative controls. Sleep was assessed using electroencephalogram monitoring and the HIV-positive patients had their plasma EFV levels monitored in the morning, 12 hours after taking their daily bedtime dose.

The HIV-positive patients and controls were closely matched as regards age and sex, and at the time of sleep assessment, the HIV-positive patients had a mean CD4 count of 424 cells/mm³, median viral load was 90 copies/mL, and the mean duration of EFV treatment was six months.

Individuals with EFV-related insomnia had low sleep values (mean 81 percent) compared to normal sleep values in either the EFV-treated patients without insomnia or healthy volunteers (above 90 percent sleep value). Individuals taking EFV with sleep problems spent more time awake during the night, mainly due to higher frequency of night arousals than either the EFV-treated patients without insomnia or the healthy volunteers (4.1 versus 2.6 versus 2.1).

Poor EFV sleepers were also significantly more likely to have difficulty falling asleep (sleep latency mean 30.9 minutes versus 10.9 minutes for healthy volunteers). The day (mean 32.5 minutes versus 12.1 minutes EFV-treated with no insomnia and 10.3 minutes healthy volunteers).

Patients with insomnia also had less REM sleep than healthy volunteers (mean 14 percent versus 22.6 percent for both other groups, p < 0.05), and less non-REM deep sleep (mean 9.1 percent versus 21.6 percent healthy volunteers, p < 0.05).

HIV-positive patients with insomnia had higher concentrations of EFV (4.3 mg/L versus 2.7 mg/L), but this difference did not reach statistical significance. However, sleep efficiency below 90 percent was almost twice as common in individuals with plasma concentrations of EFV of 4 mg/L or above (62.5 percent versus 37.5 percent, p = 0.04).

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ty six countries in the world. There may be for a prevention-only approach to the pandemic, the strategy has proved neither morally nor medically sustainable.

Ignoring AIDS treatment is tantamount to condemning to death the more than 30 million Africans who have the disease—most of whom are in the prime of their lives.

Moreover, an estimated 95 percent of Africans do not know their HIV status, partly because the stigma associated with AIDS discourages them from participating in counseling and testing programs. A better-informed population could move more effectively to control the spread of the disease, but absent the possibility of treatment, people have little incentive to learn whether they have the virus or not.

Jim Kim, a senior official at the World Health Organization (WHO) and one of the world’s leading AIDS experts, has noted that making treatment available would actually help prevention. He testified before the US Senate that even in Uganda, where prevention efforts have been among the most successful in Africa, prevalence seems resistant to reduction below 8 percent when preventive approaches are used alone. Along with most other infectious disease experts, therefore, he advocates comprehensive programs that integrate prevention and treatment into a mutually supporting package.

Yet seven years after the development of the “cocktail” of drugs now widely used to treat AIDS in the West, fewer than 1 percent of sub-Saharan Africans and 5 percent of Asians who need it have access to it. The single most important impediment to universal treatment is the exorbitantly high cost of the medication. Pressure from AIDS activists has driven down the price of treatment from thousands to hundreds of dollars annually. Yet even at these prices generic drugs remain well out of reach for the poor in the developing world; extensive foreign aid for treatment programs is therefore essential.

In 2001, accordingly, United Nations (UN) Secretary-General Kofi Annan announced the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and asked wealthy donor nations for US$7 billion to US$10 billion a year. In June 2001, the UN General Assembly met in special session and endorsed a comprehensive approach to disease management, including integrated prevention, care, and treatment. US President George W. Bush pledged US$200 million to Annan’s fund and boosted bilateral assistance efforts, but US funding for foreign AIDS programs still hovered at less than a fifth of what activists considered an appropriate share of the global burden. After that, support for treatment for people with AIDS in the world’s poorest countries gradually increased in the US Congress and among nongovernmental organizations (NGOs). But the real turning point in US AIDS policy came when conservative Christians made the cause their own.

A duty to treat

Until recently, almost all foreign-funded global AIDS programs have been directed toward prevention. Whatever justifications there might be for a prevention-only approach to the pandemic, the strategy

Enter the evangelists

In February 2002, Franklin Graham, son of acclaimed evangelist Billy Graham and founder of Samaritan’s Purse, an evangelical charity based in South Carolina, convened the first “international Christian conference on HIV/AIDS.” More than 800 evangelical Protestant and Catholic leaders and overseas missionaries from AIDS-stricken countries gathered in Washington, DC, for the meeting, titled “Prescription for Hope,” and demanded treatment for the sick and the dying. Graham’s superstar status among evangelicals and the conference’s state-of-the-art visuals, gospel choruses, and heartbreaking testimony from African ministers and health workers convinced American religious conservatives that it was their moral duty to do something about the pandemic.

The highlight of the conference came when 81-year-old US Sen. Jesse Helms stated, “I’m so ashamed that I have done so little” to help the victims of AIDS in Africa. Within days, Helms published an op-ed in The Washington Post promising to secure US$500 million to prevent mother-to-child transmission of HIV. By focusing on the “innocent victims” of AIDS, Helms publicized the fact that in Africa the disease was usually transmitted heterosexually, reaching audiences who had previously disregarded its spread among homosexuals or considered it a God-sent punishment.

Bush went on to make a dramatic commitment to tackling the pandemic in his 2003 State of the Union address. In a speech designed to prepare the world for war in Iraq, he announced an “Emergency Plan for AIDS Relief,” and committed US$15 billion over five years to the cause. The plan promised to provide treatment for two million people and enough support to prevent seven million new HIV transmissions in Africa and the Caribbean.
Although scale-up of this program has been slow, the conservatives’ endorsement of the US president’s intention to put millions of people on antiretroviral therapy has settled the controversy over treatment once and for all.

Transmission problems
Conservatives have also provided welcome leadership in helping reduce the transmission of HIV/AIDS through unsafe needles and blood transfusions. According to the WHO, unsafe healthcare accounts for at least 500,000 new HIV transmissions every year and possibly many more. Yet reducing this number has not been a priority for the international health establishment, which considers such numbers trivial compared to the number of people infected through heterosexual intercourse. But a leading conservative, US Senator Jeff Sessions, has taken this issue to heart.

When a new study was published in early 2003 suggesting that transmissions from unsafe healthcare could represent far more than 7 to 10 percent of new cases, as the WHO estimates, The Washington Times covered the story, conservative groups picked it up, and Sessions held two hearings on the topic. Some AIDS activists feared that religious conservatives would use the issue to discredit and undermine prevention efforts and justify diverting funds from condom distribution and reproductive health programs. But Sessions’ safe healthcare initiative proved them wrong. While calling for new studies to clarify the source of HIV transmission, Sessions neither refuted the role of sexual transmission in the pandemic nor criticized safe-sex programs. By the end of 2003 he had built bipartisan support for mainstreaming the issue of injection and blood safety into US-funded prevention strategies, reversing decades of neglect and offering considerable support for building proper health infrastructure in the poorest countries in Africa.

Conservatives in the US House of Representatives, meanwhile, have highlighted another neglected but significant source of HIV transmission: the violent sexual exploitation of trafficked women and children. The issue is hardly minor; the US State Department estimates that India alone has 2.3 million women and underage girls forced into its sex industry, and, in Africa, AIDS is fueling an epidemic of sexual predation against ever-younger girls as older men seek safe sexual partners. The pandemic is also generating millions of orphans and street children throughout the developing world who are especially vulnerable to rape and to being forced into the commercial sex industry.

Forcibly prostituted women and sexually exploited children are not “sex workers” but victims of crimes, including multiple rapes daily. They are particularly vulnerable to HIV transmission, but their needs are not addressed by conventional prevention programs, which are designed for voluntary sex workers and stress empowerment, healthcare, and access to condoms. Reducing harm for trafficking victims involves not encouraging safer sex but removing them from the sex industry and providing them with shelter, rehabilitation, counseling, and healthcare. The predators who sustain the forced-sex trade and child rape industry, meanwhile—the traffickers, brothel owners, and complicit police and other authorities—should be punished severely, with significant jail time. Yet this almost never occurs, and most trafficked women and children languish in sexual servitude with no hope of release. Many who provide health services to sex workers acquiesce in the forced exploitation of children and women in the brothels where they work because they are unwilling to jeopardize their access by reporting pimps and brothel owners. Several of the most prominent service providers in Thailand, for example, actively oppose rescue and rehabilitation, and some rehabilitation facilities in India refuse to accept child prostitutes who have been rescued.

Hoping to discourage trafficking, US Representative Chris Smith, a conservative Catholic and an anti-trafficking leader in the US House of Representatives, offered a provision to Bush’s AIDS bill that prohibited funding to any organization that did not oppose trafficking and prostitution more generally. According to one of Smith’s aides, the measure was aimed at service provider groups who were “a little too casual about Sway Pak”—a notorious redlight district in the Cambodian capital of Phnom Penh that offers very young Vietnamese girls to Western customers. Smith and like-minded religious conservatives are appalled by trafficking and child prostitution and by the notion that prostitution can be a voluntary choice. Their view—which is hardly limited to the extreme right—is that prostitution is always a compelled choice, through either violence or destitution, and that glamorizing it as “work” trivializes the harm it does to the women in it.

It is certainly the case that many in the commercial sex industry, whether trafficked or not, wish to leave it and would do so if alternative employment were available. It is certainly the case that many in the commercial sex industry, whether trafficked or not, wish to leave it and would do so if alternative employment were available.
organize around their own needs, such as the Sonagachi program in Calcutta. Sonagachi is credited with raising condom use in neighborhoods with organized brothels from less than 1 percent to more than 80 percent, reducing police violence toward prostitutes, and providing services for prostitutes’ children. It is true that Sonagachi and similar programs are unabashedly “pro-prostitution” in that they aim to empower women within the sex trade rather than urge them to leave it, but Sonagachi’s adult women sex workers are also reported to be vigilant in opposing the presence of children in their brothels. Despite what people on both sides of the controversy might think, there is no reason why this sort of effort cannot coexist and complement well-designed anti-trafficking campaigns.

Moral hazards

The involvement of conservative groups in shaping AIDS policy has been most problematic in the area of general AIDS prevention strategies, where their distinct sexual mores have led them to dissent from what most others consider medical best practice. For example, since condoms, if used properly and consistently, are at least 90 percent effective in preventing HIV transmission, the US Agency for International Development (USAID) has quietly provided millions of them annually to AIDS-stricken countries. Now that religious conservatives have taken up the AIDS cause, however, such programs have come under attack. Thus the Family Research Council has insisted that the Bush administration’s AIDS plan not become “an airlift for condoms,” while conservative religious groups convened by US Senator Sam Brownback have taken aim at various prevention programs that the plan had considered funding.

By the time legislation implementing Bush’s vision—the US Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003—was completed, conservatives in the US House of Representatives had succeeded in redirecting one third of its AIDS prevention funding toward programs urging abstinence before marriage. The conservatives are inspired by Uganda’s “ABC” (Abstinence, Be Faithful, and Use Condoms) program, which has helped lower prevalence dramatically, and are particular fans of its A and B components, which, if faithfully adopted, might offer nearly total AIDS protection.

As Chuck Colson and William Bennett of Empower America argued in a recent essay, “African nations that promoted condom use alone, and which have the highest condom user rates on the continent... also suffer the highest HIV prevalence rates. Clearly, condoms must no longer be considered the first line of defense against HIV...”

Unfortunately, however, scientific evaluation and medical surveillance paint a different picture. Studies of Ugandan AIDS prevalence that try to assess the relative contributions of abstinence, multiple-partner reduction, and condom use in lowering infection rates have found that abstinence actually made the smallest contribution, while condoms and partner reduction had the largest impact. David Serwadda, a Ugandan physician who chairs the Global HIV Prevention Working Group, has stated, “As a physician who has been involved in Uganda’s response to AIDS for 20 years, I fear that one small part of what led to Uganda’s success — promoting sexual abstinence — is being overemphasized in policy debates.”

At home, meanwhile, the US government currently provides US$100 million per year for abstinence education, making the aid conditional on schools’ commitment to neither endorse condoms nor provide instruction on their use. Kenneth L. Connor of the Family Research Council has suggested extending such policies to Africa, on the grounds that “responsible moral behavior is the first and best line of defense against AIDS, and is the only message we should send young people worldwide.”

But here again, researchers who have compared abstinence-only and comprehensive sex education programs in the United States have found little evidence that the former had any effect on sexual behavior or contraceptive use among sexually active teenagers. And, sexually inactive teens who received comprehensive sex education were more likely both to delay sexual initiation and to use condoms once they did start having sex than their peers who received abstinence-only instruction.

Another problem with the abstinence approach is that it fails to single out certain marginalized groups who are especially at risk of HIV infection. Outside southern Africa, for example, AIDS prevalence is highest among sex workers, intravenous drug users, and homosexuals. Since these groups suffer discrimination and persecution within their own countries and are often denied access to government health and prevention programs, experts concerned with stopping the spread of the pandemic believe those groups should be singled out for special attention. Yet USAID is reportedly now under heavy pressure to scale back or eliminate outreach, peer counseling, and condom distribution to at-risk groups. The US National Institutes of Health (NIH) and the US Centers for Disease Control and Prevention (CDC), moreover, are reportedly screening out research proposals containing the words “homosexual,” “prostitute,” and “drug user” in their titles, and whistle blowers within the agencies have reported pressure to approve scientifically unsound HIV projects.

On common ground

The AIDS pandemic is almost incomprehensible in its enormity, and in most of the developing world it is still in its early stages. As the world’s richest, most powerful, and most scientifically advanced nation, the United States can and should play a uniquely active role in combating this scourge.

The entry of religious conservatives into the struggle has helped galvanize US AIDS policy and has given the issue a welcome hearing in the US Congress and the White House. They have put treatment on the political map, and have focused attention on certain unjustly neglected issues such as sex trafficking and transmission through unsafe healthcare practices. The challenge now is for all those concerned about AIDS to fight the pandemic on all fronts, preventing transmission where it occurs and treating all those in need.

Whatever their views on other issues, conservatives, liberals, and the medical community should be able to reach at least a rough consensus on the most effective practices in both prevention and treatment. The AIDS pandemic will not wait while one successful prevention program is traded for another or scarce resources are squandered on unsound approaches. If a common front can be matched with some common sense, the results could be truly impressive.

Holly Burkhalter is Director of US Policy and of the Health Action AIDS campaign at Physicians for Human Rights.

Editor’s Note: This article is reprinted with permission from Foreign Affairs, where it was first published in the January/February 2004 issue.
A B S T R A C T S

Journal of Acquired Immune Deficiency Syndromes

The NEAT study: A 48-week open-label study to compare the antiviral efficacy and safety of GW433908 versus nelfinavir in antiretroviral therapy-naive HIV-1-infected patients

Rodriguez-French A et al.

OBJECTIVE: To compare the efficacy, durability, and tolerability of GW433908 (908) 1,400 mg twice daily (BID), with nelfinavir (NFV) 1,250 mg BID.

METHODS: This was an international, multicenter, randomized, open-label study (NEAT) in antiretroviral therapy (ART)-naive HIV-infected adults with plasma HIV-1 RNA (vRNA) at screening ≥5,000 copies/mL. Patients were randomly assigned to 908 or NFV (2:1) for a minimum of 48 weeks, with a background of abacavir (ABC) and lamivudine (3TC). RESULTS: A total of 166 patients received randomized treatment with 908 BID and 83 received NFV BID. The population was diverse with regard to race and gender (76 percent Hispanics and blacks, 31 percent female) and had advanced HIV disease at screening (45 percent had vRNA >100,000 copies/mL, 48 percent had CD4 counts <200 cells/mm^3). Twenty percent had a history of AIDS or death in HIV-infected patients receiving HAART.

HIV Medicine

Evaluation of the impact of highly active antiretroviral therapy on immune recovery in antiretroviral naive patients

Al-Harthi L et al.

OBJECTIVES: To examine the extent of immune reconstitution in treatment-naive patients with CD4 T-cell counts <500 cells/mm^3 following 48 weeks of highly active antiretroviral therapy (HAART).

RESULTS: Thirteen antiretroviral naive patients were evaluated longitudinally for 48 weeks on HAART utilizing immunologic and lymphocyte phenotyping assays, including lymphocyte proliferation assay, flow cytometric evaluation of cell surface markers, and delayed type hypersensitivity skin tests. Virologic responses were monitored using commercially available viral load assays and gag/pol mRNA quantification using simultaneous immunophenotyping/UltraSensitive fluorescence in situ hybridization (ViroTect In Cell HIV-1 Detection Kit; Invitrogen, Frankfurt, MI). Thymic function was evaluated for a subset of four patients using real-time polymerase chain reaction (PCR) for T-cell receptor excision circle (TREC) quantification and thymic scans using computerized axial tomography (CT) of the thymus.

CONCLUSIONS: HAART initiation resulted in a significant decline in plasma viremia and percentage of infected peripheral blood cells, and a rise in CD4 T cells from a baseline median of 207 cells/mm^3 to a week-48 median of 617 cells/mm^3.

British Medical Journal

Stable partnership and progression to AIDS or death in HIV-infected patients receiving highly active antiretroviral therapy: Swiss HIV cohort study

Young L et al.

OBJECTIVES: To explore the association between a stable partnership and clinical outcome in HIV-infected patients receiving highly active antiretroviral therapy (HAART).

SETTING: Seven outpatient clinics throughout Switzerland. PARTICIPANTS: The 3,736 patients in the cohort who started HAART before 2002 (median age 36 years, 29 percent female, median follow-up 3.6 years).

MAIN OUTCOME MEASURES: Time to AIDS or death (primary endpoint), death alone, increase in CD4 cell count of at least 50 and 100 above baseline, optimal viral suppression (a viral load below 400 copies/mL), and viral rebound.

CONCLUSIONS: During follow-up 2,985 (80 percent) participants reported a stable partnership on at least one occasion. When starting HAART, 52 percent (545/1,042) of participants reported a stable partnership after five years of follow-up 46 percent (190/412) of participants reported a stable partnership. In an analysis stratified by previous antiretroviral therapy and clinical stage when starting HAART (US Centers for Disease Control and Prevention group A, B, or C), the adjusted hazard ratio for progression to AIDS or death was 0.79 (95 percent confidence interval 0.63 to 0.98) for participants with a stable partnership compared with those without. Adjusted hazards ratios for other endpoints were 0.59 (0.44 to 0.79) for progression to death, 1.15 (1.06 to 1.24) for an increase in CD4 cells of 100 counts/µl or more, and 1.06 (0.98 to 1.14) for optimal viral suppression.

Stoke

Acquired immunodeficiency syndrome and the risk of stroke

Cole JW et al.

BACKGROUND: Although acquired immunodeficiency syndrome (AIDS) is thought to increase the risk of stroke, few data exist to quantify this risk. This is the first population-based study to quantify the AIDS-associated risk of stroke.

METHODS: We identified all incident ischemic stroke (IS) and intracerebral hemorrhage (ICH) cases among young adults 15 to 44 years of age in central Maryland and Washington, DC, who were discharged from any of the 46 hospitals in the study area in 1988 and 1991. Using data from the medical records, two neurologists reviewed each case to confirm the diagnosis. Cases of AIDS among these patients with stroke were defined using Centers for Disease Control and Prevention criteria (1987). The number of cases of AIDS in the central Maryland and Washington population during 1988 and 1991 was determined from regional health departments working with the Centers for Disease Control and Prevention.

RESULTS: A total of 166 patients received randomized treatment with 908 BID and 83 received NFV BID. The population was diverse with regard to race and gender (76 percent Hispanics and blacks, 31 percent female) and had advanced HIV disease at screening (45 percent had vRNA >100,000 copies/mL, 48 percent had CD4 counts <200 cells/mm^3). Twenty percent had a history of AIDS or death in HIV-infected patients receiving HAART.
IAPAC, with its broad mission to improve the healthcare of all who have been affected by the AIDS pandemic, is working to ease suffering and to ensure that persons living with HIV/AIDS are able to live productive lives. Though the battle ahead is one requiring the greatest of global commitments, even small donations from concerned world citizens with the means to provide a small amount of financial assistance can make a notable impact.

The same poverty that engenders higher infection rates in the developing world also means an inadequacy of healthcare infrastructure and, often, the inability of physicians and allied health professionals to access the training and information that they require to effectively treat those in their care.

With your donation of US$60 (or more), you can help IAPAC in its mission as an agent of change. For only US$60, IAPAC can sustain the cost of an annual membership for a physician in the developing world, thus enabling physicians in the regions most heavily burdened by HIV disease to gain greater access to critical clinical and policy information and to more fully partake of specialized HIV/AIDS medical training provided in the countries where it is most needed.

For additional information on how you can make a difference, contact Joey Atwell, Director of Membership, at (312) 795-4941 or jatwell@iapac.org, or complete and submit an on-line application at www.iapac.org.
Focus on Hepatitis

Treatment of chronic HBV in HIV-coinfected patients

Hepatitis B virus (HBV) and HIV share similar routes of transmission. As a consequence, up to 80 percent of HIV-infected patients have serological markers of present or past HBV infection. The prevalence of HIV-infected persons carrying hepatitis B surface antigen (HBsAg) varies according to geography and risk category, being higher among men who have sex with men and in developing countries. Global figures of 8 percent to 11 percent have been given, whereas HBsAg positivity was found in 6 percent of men who have sex with men in a US cohort.

The clinical impact of hepatitis virus infection in HIV-positive patients has progressively grown since the introduction of highly active antiretroviral therapy (HAART), given the dramatic increase in survival experienced by these patients. On the other hand, HIV acts as a cofactor and accelerates the progression of liver disease due to hepatitis viruses.

Thus, according to a US study, HIV infection increases up to 12.7-fold the risk of liver-related mortality in HBV/HIV coinfected patients, especially in those with low CD4 counts. Similar findings have been reported for hepatitis C virus (HCV)/HIV-coinfected patients.

Not surprisingly, chronic viral hepatitis in recent years has become one of the most frequent causes of hospital admissions and mortality among HIV-infected patients. In this way, chronic HBV and HCV actually behave as opportunistic infections in the context of HIV infection.

The goals of treatment of chronic HBV may be categorized in several steps, from less to more ambitious. First, treatment should pursue suppression of HBV replication, as reflected by the achievement of significant reductions in and/or clearance of serum HBV DNA. Second, therapy may shift HBV infection from active (hepatitis B e antigen [HBeAg]-positive) to nonreplicative forms of chronic HBV infection, reflected by anti-HBe seroconversion. Third, ideally, any anti-HBV therapy should pursue disappearance of the chronic HBV carrier status (HBsAg positive), reflected by anti-HBsAg seroconversion.

A back-and-forth interference between HIV and HBV takes place when both infections coexist. As a result, the treatment of chronic HBV poses specific problems in the context of HIV infection. On the one hand, anti-HBV drugs show poorer performance, with lower response rates and faster selection of HBV-resistant strains. On the other hand, drugs active against both HBV and HIV (eg, lamivudine [3TC]), if not used appropriately, can induce the selection of resistance mutations in the HIV genome. Therefore, the management of both infections should be carefully coordinated.

Interferon-alfa therapy

In summary, data on the effect of interferon [IFN]-alpha against HBV/HIV-coinfected patients are scarce. Although they suggest that the response to IFN is superior to the response to no treatment, the response seems to be lower than in HIV-negative patients. The available data are insufficient to determine the optimal candidates for IFN-alfa treatment among HIV/HBV-coinfected patients. However, subjects with CD4 counts >350 cells/mm³ and transaminase levels elevated to at least twice the upper limit of normal might get the greatest benefit from IFN-alfa therapy.

Lamivudine

Lamivudine is a nucleoside reverse transcriptase inhibitor (NsRTI) recently licensed for the treatment of chronic HBV at a dosage of 10 mg/day. It is able to suppress HBV replication and normalize alanine aminotransferase levels in up to 70 percent of patients with HBeAg-negative chronic hepatitis. It also induces HBeAg seroconversion in 23 percent of patients with HBeAg-positive chronic hepatitis B. It is active against 3TC-resistant HBV mutants. Adefovir does not have significant antiretroviral effect at this dosage and could be given to HIV-infected patients who are not taking HAART. There is a theoretical risk of inducing HIV resistance, which deserves careful evaluation.

Adefovir

Adefovir is a nucleotide reverse transcriptase inhibitor (NtRTI) recently licensed for the treatment of chronic HBV at a dosage of 10 mg/day. It is able to suppress HBV replication and normalize alanine aminotransferase levels in up to 70 percent of patients with HBeAg-negative chronic hepatitis. It also induces HBeAg seroconversion in 23 percent of patients with HBeAg-positive chronic hepatitis B. It is active against 3TC-resistant HBV mutants. Adefovir does not have significant antiretroviral effect at this dosage and could be given to HIV-infected patients who are not taking HAART. There is a theoretical risk of inducing HIV resistance, which deserves careful evaluation.

Tenofovir

Tenofovir has lost favor in the treatment of HBV infection in HIV-coinfected patients since the approval of tenofovir (TDF) for the treatment of HIV infection. Like adefovir, TDF is an NtRTI with both anti-HIV and anti-HBV activity. It has been proven to be a very potent inhibitor of HBV replication in vitro, even in the presence of 3TC resistance mutations. In recent studies of TDF, HBV DNA levels decreased by 4 log₁₀ on average, despite the fact that the majority of patients carried 3TC resistance-associated mutations. No breakthroughs in HBV replication derived from the emergence of resistance mutations to tenofovir have been seen thus far.
New drugs for HBV

The new compounds being tested for the treatment of HBV infection may be grouped into two categories. (Table 1) The first includes drugs active against both HBV and HIV. Another group includes medications with activity against HBV alone. These latest drugs might be indicated preferentially for persons who have not yet met criteria for beginning HIV therapy.

Entecitabine (FTC), a new NsRTI, has been recently approved for the treatment of HIV infection. It is well tolerated and has potent anti-HBV activity. It should not be used after 3TC failure, because both drugs show cross-resistance. Moreover, FTC resistance mutations in HBV were selected in 19 percent of patients after two years of FTC treatment.

Entecavir, another NsRTI with anti-HBV activity, has been shown to be a potent inhibitor of HBV replication. Patients treated with entecavir at doses of 0.5 mg and 1 mg (as a single daily dose) had mean decreases in plasma HBV DNA levels of 2.8 and 2.5 logs, respectively, at four weeks, 3.8 and 4.4 logs at 24 weeks, and 4.5 and 5.1 logs at 48 weeks of treatment. No significant adverse events occurred, and 26 percent of subjects achieved undetectable HBV DNA levels at 48 weeks with both doses. The results were superior when transaminase levels were elevated at baseline. Entecavir has also been proven to be effective in patients previously treated with IFN-alfa and against 3TC-resistant HBV strains.

Within the NsRTI family, telbivudine and clevudine are compounds in earlier stages of development as anti-HBV drugs. Of interest, preliminary data suggest that the inhibition of HBV replication is superior over monotherapy with either drug when 3TC and telbivudine are given in combination. The development of other NsRTIs with anti-HBV activity, such as L-Fd4C (2,3-Dideoxy-2,3-didehydro-L-fluorocytidine) and DAPD (amdoxovir), is in earlier phases, and data are scarce.

Famciclovir, the prodrug of penciclovir, inhibits HBV replication, but it is less potent than 3TC and shows cross-resistance. These facts, along with its thrice-daily dosing, have decreased the amount of interest in this drug as an anti-HBV agent. The results of studies of the efficacy of thymosin (thymic-derived peptides) are conflicting.

Finally, a new class of drugs, called heteroaryldihydropyrimidines (HAPs), is currently in preliminary stages of research as anti-HBV agents. They seem to act as inhibitors of the HBV nucleocapsid.

**Table 1. New anti-HBV nucleoside analogues in development**

<table>
<thead>
<tr>
<th>Drug activity, drug</th>
<th>Phase of development</th>
<th>Active against YMDD mutants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-HIV/HBV activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emtricitabine</td>
<td>III</td>
<td>No</td>
</tr>
<tr>
<td>DAPD (amdoxovir)</td>
<td>II</td>
<td>Yes</td>
</tr>
<tr>
<td>Only anti-HBV activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entecavir</td>
<td>III/IV</td>
<td>Yes</td>
</tr>
<tr>
<td>Telbivudine</td>
<td>III</td>
<td>No</td>
</tr>
<tr>
<td>Clevudine</td>
<td>III</td>
<td>Yes</td>
</tr>
<tr>
<td>L-Fd4C</td>
<td>III</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Treatment for HBV/HIV-coinfection**

All HBV-infected persons with active HBV replication (positive for HBsAg and detectable HBV DNA) and elevated transaminase levels should be considered candidates for HBV treatment, even if criteria for HAART are not met yet.

However, the optimal time for initiating anti-HBV therapy in coinfected patients has neither been established nor is it clear which drug(s) should be used. An integrated approach against both HIV and HBV is needed. On the basis of the advice of different panels of experts, if HBV infection is the only viral infection to be treated, IFN-alfa (preferably any of the pegylated forms) could be a valid option. However, given the low response to standard IFN-alfa and the lack of data on the effectiveness of pegylated IFN-alfa in HBV/HIV-coinfected subjects, it is desirable to treat these patients within clinical trials and in healthcare centers with experience.

Adefovir monotherapy (at dosages of 10 mg/day) may be considered a reasonable alternative option for treating HBV infection in HIV-positive patients who do not meet the criteria for HAART. However, the potential risk for selection of resistance mutations in HIV with long-term use should be of concern, although this option is being supported by recent European guidelines for the treatment of HBV.

The use of 3TC, FTC, or TDF in monotherapy should be avoided in HIV/HBV-coinfected patients, because these drugs favor the selection of HIV resistance mutations.

In patients who meet criteria for the treatment of HIV infection, a HAART regimen containing 3TC, FTC, and/or TDF should be administered. Of note, TDF seems to show a higher activity against HBV than do FTC or 3TC and has a great genetic barrier for resistance. However, the experience with TDF is scarce.

For patients who have already received 3TC as part of HAART and who have detectable HBV viremia, resistance of HBV to the drug should be suspected. Emtricitabine is not useful for treatment of HBV infection in these patients. However, adding or replacing it with TDF is a reasonable approach. If HIV is already suppressed, adefovir might also be considered.

As for the role of combination therapy in HBV treatment, data are scarce. In a recent study among non-carriers of HIV that compared adefovir with adefovir/3TC, combination treatment was not found to be superior to adefovir alone in the first 12 months of treatment.

**Editor’s Note:** This article is a summary review of Nunez M et al. Treatment of Chronic Hepatitis B in the Human Immunodeficiency Virus-Infected Patient: Present and Future. Clin Infect Dis 2003;37:1678-1685. Reprinted with permission from HIV and Hepatitis.com (www.HIVandHepatitis.com).
Tracy Evans-Gilbert

*Vanity Fair* readers have every month since 1993 enjoyed *The Proust Questionnaire*, a series of questions posed to celebrities and other famous subjects. In June 2002, *IAPAC Monthly* introduced “In the Life,” through which IAPAC members are asked to bare their souls.

This month, *IAPAC Monthly* is proud to feature Tracy Evans-Gilbert, Director of Pediatric HIV Services and Research of the Bustamante Hospital for Children in Kingston, Jamaica.

*IN THE LIFE*

What proverb, colloquial expression, or quote best describes how you view the world and yourself in it?

Fear God and keep His commandments: for this is the whole duty of man. Ecclesiastes 12:14

What activities, avocations, or hobbies interest you?

Do you have a hidden talent?

I enjoy jogging in the early morning around a local dam. My hidden talent is singing. I used to travel around the island on weekends singing with a gospel group for five years.

If you could live anywhere in the world, where would it be?

I would like to remain right here in Jamaica, but on a beachfront in Negril on the north coast.

Who are your mentors or real life heroes?

My mentor is Joyce Meyer, an evangelist.

With what historical figure do you most identify?

Queen Esther in the Bible. She exemplifies beauty and the power of a woman that influences leadership.

Who are your favorite authors, painters, and/or composers?

My favorite painter is my 3-year-old son. My favorite composer is Beethoven.

If you could have chosen to live during any time period in human history, which would it be?

I would choose to live during the age of the ministry of Christ.

If you did not have the option of becoming a physician, what would you have likely become, given the opportunity?

I would have become a missionary and evangelist.

In your opinion, what are the greatest achievements and failures of humanity?

The greatest achievement: Spreading the gospel throughout the world. The greatest failure: Not acknowledging Jesus as the Savior.

What is your prediction as to the future of our planet one full decade from present day?

The return of Christ to judge the world.
We use the best methodology that is currently accepted by the [World Health Organization], and we consistently say people need to understand that these are estimates because we are not doing incidence, we are doing prevalence.

Nono Simelela, Director of the South African Health Department’s HIV/AIDS Programme, quoted in a January 11, 2004, Johannesburg Sunday Times article responding to concerns that the AIDS epidemic in her country—considered to be 4.69 million out of a population of 45 million—might be an overestimate. The issue arose following release of results from the Kenya Demographic and Health Survey, which claims that only one million people in that country are HIV-infected—two million fewer than the Joint United Nations Programme on HIV/AIDS (UNAIDS) previously estimated. Surveys in Mali, South Africa, and Zambia had previously hinted that the HIV/AIDS infection figures could be much lower than predicted. Responding to the Kenyan study’s claims, UNAIDS Chief Scientific Advisor Catherine Hankins said to the Agence-France Presse: “There’s something wrong there.”

Looking after jailbirds is not a priority in a democracy.

Michel Hunault, a French member of the European Parliament, in a January 11, 2004, Agence France-Presse report about fears that incoming European Union (EU) member states will cut funding to prisons as they effect budget cuts necessary to bring their economies in line with those of the eurozone. Living conditions in Eastern Europe’s dilapidated and overcrowded prisons fall far short of the standards expected of countries joining the EU. Indeed, eight of the 10 countries about to enter the EU were under communist dictatorship for half a century and their legacy is an outdated prison system where AIDS and tuberculosis flourish. In central Europe, between 160 and 200 people are serving time in prison for every 100,000 of the national population, a ratio up to twice as high as the average in the 15 current EU member countries. The proportion is even higher in the three Baltic states featured in the Agence France-Presse report, which were part of the Soviet Union until late 1991—Estonia, Latvia, and Lithuania. The World Health Organization (WHO) has warned that overcrowding encourages the spread of tuberculosis, and in particular the highly resistant strain that has developed with the spread of the AIDS pandemic.

It’s not condoms that bring you peace. It’s time for the youth of Uganda to respect their relationships and religious oaths to be free from HIV/AIDS instead of relying on condoms.

Nsabuga Nsamba, a member of Uganda’s Parliament, in a January 4, 2004, article in The Monitor entitled, “Member of Parliament Sparks Off Condom Debate.” While speaking to young people at his home, Nsamba claimed that condoms promote promiscuity, and he accused organizations that distribute condoms to youth of encouraging immorality. An official from Uganda’s The AIDS Service Organization (TASO) dismissed Nsamba’s remarks and added that TASO has no plans to stop distributing free condoms.

We’re dealing with a company that, for whatever reason, is supplanting their own bad common sense for medical science.

Eric Ciasullo, Chairman of the Board of Directors of the National Association of People Living with AIDS (NAPWA), quoted in a January 5, 2004, San Francisco Chronicle article about former Cirque du Soleil acrobat Matthew Cusick. According to his legal team, days before Cusick was to begin a temporary stint on the Russian high bar for the Las Vegas show “Mystere,” his employer fired him allegedly because he is HIV positive. Cusick voluntarily disclosed his serostatus to Cirque du Soleil’s management a year before he was fired, and had been cleared to perform as a “healthy athlete” by the company’s doctors. However, he was abruptly told that his role as an acrobatic catcher might expose fellow artists and patrons to risk.
IAPAC physician members recently ranked www.iapac.org:

- Is the information reliable? YES
- Is the Web site easy to navigate? YES
- Is the information comprehensive? YES
- Is the information clearly presented? YES

For up-to-the-minute HIV/AIDS information, visit www.iapac.org.