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I A P A C



M O N T H L Y



**Will AIDS finally
teach us the meaning
of sustainable human
development (for all)?**

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Will AIDS finally teach us the meaning of sustainable human development (for all)?

Scott A. Wolfe



There is evidence that HIV/AIDS is starting to be seen as a shared global burden. And, it is becoming clear that anti-HIV/AIDS efforts will meet with limited success if underlying conditions such as poverty, inequality, and stagnant development are left unaddressed. Could these twin understandings combine to create a new wave in international political thought, one that strives for global equity?

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REPORT FROM THE PRESIDENT

Hope for turning of the tide

José M. Zuniga

In last month's Report From the President [see "Routing out indifference," *IAPAC Monthly*, January 2003], I commented that the world stands at an historical crossroads. We are living in a moment that will come to be remembered either for the global measures that were taken to stem the devastation of HIV/AIDS, or for our failure to act due to indifference, thus incurring a catastrophe far beyond our imagination. Events that have occurred since that report's publication have given me some hope that the latter will not come to pass. Though it is far from an adequate solution in and of itself, I believe that the "Emergency Plan for AIDS Relief" that US President George W. Bush unveiled in his January 28, 2003, State of the Union address is a substantial move in the right direction. Indeed, if fulfilled, and if taken as an example by other US and world leaders, this relief plan, along with a subsequent US\$16 billion proposal for domestic HIV/AIDS programs in 2004, a respectable 7 percent spending increase over 2003, constitute first steps away from the possible abyss that lies before us.

The announcement of US\$10 billion in new international funding for the fight against HIV/AIDS over the next five years (above the US\$5 billion that will come from existing international AIDS programs), and the details that were revealed about the plan in the days following the address, took much of the HIV community by surprise. Not only was no advance warning given that a major initiative was in the offing, but in the plan's details we are presented with considerable advancements in the president's level of commitment. These

relate not only to financial commitment to fighting the pandemic, but also the president's apparent willingness to prioritize scientifically appropriate policy ahead of socio-political alliances.

When they took office two years ago, the Bush Administration was skeptical about the efficacy of spending on HIV treatment in the developing world. Moreover, because both major US political parties are often too careful about the concerns of the pharmaceutical industry, from which they receive substantial monetary contributions, little progress has been made in addressing the issue of generic antiretroviral medications. But in a promising sign of change, fully half of the funding proposed in President Bush's relief plan would go toward medical treatment, including the procurement of generic antiretroviral medications. According to President Bush, this is meant to subsidize "humane care for millions of people suffering from AIDS," to include the provision of antiretroviral therapy to at least 2 million people. Further, whereas the president's most important political backers include social conservatives, and his administration has largely privileged "abstinence only" prevention within the United States, the prevention efforts funded by his plan would follow widely accepted HIV prevention models, including condom distribution and "safer sex" education.

The relief plan is not a panacea. More importantly, it is at present merely a proposal. I would be remiss, therefore, to treat this development as a veritable victory in the battle against HIV/AIDS. A certain amount of reticence might be justifiable given the Bush Administration's failure to deliver on a June 2002 promise of US\$500 million for an urgently needed

initiative to prevent mother-to-child transmission of HIV in Africa and the Caribbean. Ultimately, President Bush is not wholly culpable for this failure. Nonetheless, he bears some level of responsibility, as do members of the US Congress, for allowing political brinkmanship to derail such an important initiative.

There are also ways that the new relief plan could be improved. For example, too small a portion of the new funding—US\$700 million—is apportioned to the relief plan's first year, though we know that money is better spent earlier than later in this race against exponentially increasing HIV infection and AIDS-related death rates. And because the plan concentrates its efforts on 12 African and two Caribbean nations, the world community must take care that other regions with burgeoning AIDS epidemics are not ignored. In addition, there is also a case to be made that additional US funding should be sent to support the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). The United States should increase its level of commitment from the proposed US\$1 billion contribution if for no other reason than the fact that AIDS works in negative synergy with these other two epidemic diseases.

These concerns, however, do not justify the icy reception that several AIDS organizations and patient advocates have given President Bush's announced commitment. It is imprudent to disallow the Bush Administration the opportunity to fulfill their promises before going on the attack. I hasten to add that I am not coming to the president's defense out of a naive belief that promises always lead to action. I would argue, however, that a stubborn unwillingness to move out of an adversarial

relationship with the Bush Administration on this and other issues of social justice is both a mistake and a disservice to the spirit that guides us forth in the battle—belief in the possibility that the *status quo* can be disrupted. In short, I judge President Bush's commitment to the struggle against the AIDS pandemic to be real. We must allow him the opportunity to deliver, and we must determine to work with his administration so that we ensure that these precious dollars are most effectively and appropriately spent.

Some of the plan's potential shortcomings would seem to reflect the president's broad-based political inclinations. As in his domestic education plan, which calls for regular national testing of student achievement and rewards schools that keep their charges above a minimum level of competence, President Bush is very concerned with verifiable results. This might be a motivation behind the gradual scale-up in funding called for in his Emergency Plan for AIDS Relief, given a previous reluctance to commit to international relief mechanisms such as the Global Fund.

I believe that the best way to elicit further compromise, and obtain the best result, is to engage the White House in sincere debate on the aspects of the relief plan that warrant review—to include rather than to decry. Thankfully, several key opinion leaders among whom are members of the International Association of Physicians in AIDS Care (IAPAC) are active members of such a debate. These members include Joseph O'Neill, Director of the US Office of National AIDS Policy; and Peter Mugenyi, Director of the Joint Clinical Research Centre in Kampala, Uganda (who, incidentally, sat next to Mrs. Laura Bush at the State of the Union address). It would appear that President Bush has shown a willingness to bend from his accustomed stances in the interest of formulating an effective HIV/AIDS strategy, both domestically and globally. IAPAC welcomes and encourages this willingness, all the while advocating for future increases in commitment.

A new political atmosphere has been created around HIV/AIDS, both domestically and internationally, owing to the will for change that President Bush has evinced. In this atmosphere, two separate bills were introduced to the US Senate in the days immediately following the State of the Union address that would increase

funding well beyond the proposed relief plan. One of these plans, for instance, calls for US\$3.35 billion in HIV/AIDS spending in 2004, a considerable portion of which would be earmarked for the Global Fund. Congress has historically appropriated beyond what three consecutive presidents have asked for in HIV/AIDS funding. Thus, one of these proposals seems likely to pass. Global

leaders should emulate this example. It is still far too early to say, but I believe we can allow ourselves to hope, at least, that we may be witnessing the start of a turning of the tide. ■

José M. Zuniga is President of the International Association of Physicians in AIDS Care, and Editor-in-Chief of the IAPAC Monthly.



Photo Credit: www.whitehouse.gov

US President George W. Bush delivering this year's State of the Union address.

This nation can lead...

Editor's Note: The following is an excerpt from US President George W. Bush's State of the Union address, delivered January 28, 2003, in Washington, DC.

Today, on the continent of Africa, nearly 30 million people have the AIDS virus, including 3 million children under the age 15. There are whole countries in Africa where more than one-third of the adult population carries the infection. More than 4 million require immediate drug treatment. Yet across that continent only 50,000 AIDS victims—only 50,000—are receiving the medicine they need. Because the AIDS diagnosis is considered a death sentence, many do not seek treatment. Almost all who do are turned away.

A doctor in rural South Africa describes his frustration. He says, "We have no medicines. Many hospitals tell people, 'You've got AIDS. We can't help you. Go home and die.'"

In an age of miraculous medicines, no person should have to hear those words. AIDS can be prevented. Antiretroviral drugs can extend life for many years. And the cost of those drugs has dropped from US\$12,000 a year to under US\$300 a year, which places a tremendous opportunity within our grasp.

Ladies and gentlemen, seldom has history offered a greater opportunity to do so much for so many. We have confronted and will continue to confront HIV/AIDS in our own country. And to meet a severe and urgent crisis abroad, tonight I propose the Emergency Plan for AIDS Relief—a work of mercy beyond all current international efforts to help the people of Africa.

This comprehensive plan will prevent 7 million new AIDS infections, treat at least 2 million people with life-extending drugs, and provide humane care for millions of people suffering from AIDS and for children orphaned by AIDS.

I ask the Congress to commit US\$15 billion over the next five years, including nearly \$10 billion in new money, to turn the tide against AIDS in the most afflicted nations of Africa and the Caribbean.

This nation can lead the world in sparing innocent people from a plague of nature. ■



Needed: Committed and daring voices

José M. Zuniga

A year ago to date, during Black History Month in the United States, my monthly report to our association's members and partners called for greater attention to the troubling increase of HIV/AIDS within the African-American community—most notably among African-American women—and urged greater leadership from within the African-American community in raising awareness of both the problem, and the remedies necessary to reverse this trend. Citing a passionate letter written by Martin Luther King Jr. from Birmingham, Alabama—a letter in which he criticized the complacency of conservative, southern Baptist ministers at the peak of the civil rights movement—I suggested that committed and daring voices are today needed to speak out against the silence and reservations that exist within the African-American community about HIV disease.

One year later, that challenge has been embraced. Over the past several months, not only have media giants Viacom and MTV launched a major HIV awareness campaign, with prominent prevention and treatment issues to be filtered into television programs targeting African-American audiences, but more recently, the Black Media Task Force on AIDS announced a multi-partner media campaign billed as the “Drumbeat Project.” In a “black media” driven effort aimed at opening dialogue around sexuality and HIV/AIDS, the Drumbeat Project will commit an estimated US\$5.7 million worth of airtime and ad placements to tackle the stigma and silence surrounding HIV disease in the African-American community. These private sector initiatives,

particularly commendable since industry is often wary of broaching controversial issues, are a promising sign of an awakening to our collective responsibility.

As business and advocacy groups such as the Black AIDS Institute carry forth the torch of action in this regard, it is now time for government, religious communities, and additional civil society groups to further acknowledge the existence of HIV/AIDS in our midst and to commit to fast action. Only through a genuine and dedicated effort by all such groups to stem the stigma and discrimination that surrounds HIV and to openly encourage testing and HIV care will we be able to ensure the health and prosperity of future generations.

Further, it is incumbent upon US government representatives, and leaders of faith communities that are dedicated to addressing the needs of the African-American community to rally in support of continuing commitment to global efforts to provide care and treatment for people living with and affected by HIV. Where the global AIDS pandemic so disproportionately affects people of color—most notably in sub-Saharan Africa—it is imperative that leaders within the African-American community, link the ongoing challenges and success of community development efforts within the United States to broader international challenges. This logical and, one might argue, moral extension of the continued struggle to address race, ethnicity, and culture as backbones of inequality, poverty, and disease in the United States is critical to communities and nations around the world that are being devastated by the impact of HIV/AIDS.

It is a sign of hope that resources and

voices have been harnessed with ever-greater urgency over the past year to combat HIV/AIDS within the African-American community. Yet, there is so much more that must be done and so many more actors who must become involved. In speaking not only as a citizen of the United States, but as the chief executive of an international professional association with strong roots in the southern Africa region, it is clear to me that the leadership (or lack thereof) within the African-American community on difficult issues such as HIV/AIDS has an impact reaching far beyond the borders of this country. Indeed, where so many of this world's dispossessed and poverty-stricken populations look to the world's strongest nation for assistance, and where Africans and those within the African diaspora look to the continuing struggle for equality and development in the United States as a barometer of civilization, the relative action and inaction of leaders within the African-American community has an immeasurable consequence.

As media campaigns designed to address HIV within the African-American community are executed in 2003 and beyond, it is my most heartfelt hope that the light of dignity that is shone on those men, women, and children living with HIV/AIDS, as well as those whom prevention efforts successfully touch, will be intensified by increased participation in the process of change by groups and individuals from all sectors and all walks of life. ■

José M. Zuniga is President of the International Association of Physicians in AIDS Care, and Editor-in-Chief of the IAPAC Monthly.



P E R S P E C T I V E

HIV care in 2003: A viewpoint

Praphan Phanuphak

The year 2002 held promise for expanding global access to HIV care and treatment, including anti-retroviral therapy. This was particularly the case in developing countries. Most importantly, the Global Fund to Fight AIDS, Tuberculosis and Malaria began operation, following its founding in 2001. The World Health Organization (WHO) developed guidelines for the use of anti-retroviral medications in developing countries.¹ In many places, the price of anti-retroviral treatment has been markedly reduced, mainly through generic production. Several international organizations and projects came into existence or expanded their efforts in 2002, including the International Association of Physicians in AIDS Care (IAPAC), TREATAsia, PharmAccess, the MTCT-Plus Initiative of Columbia University, the International Treatment Access Coalition (ITAC) and many others. Yet there remains so much left to be accomplished, and the question remains, how can we build on this solid foundation to do a better job of fighting the pandemic worldwide?

The most important task is getting the message to policy makers of the need to fund HIV care. And by “policy makers,” let me explain: I mean everyone from the leaders of United Nations agencies; to the US President and Congress; to other heads of state and governments; to hospital directors, and department and division heads; all the way down to the financial decision makers in individual families. We must build on the successes of the last two years, during which many of the preliminary successes mentioned above could be attributed to educating decision makers on



the importance of treatment. We must continue to help those who hold the purse strings to understand that HIV prevention and care are not mutually exclusive—that, instead, these functions should be integrated, so that one can benefit the other. We must ensure that adequate funding is available for both prevention and care.

The Global Fund opens the door for antiretroviral therapy in resource-limited countries. In my opinion, too many countries still view the fund as a tool for funding education and prevention campaigns, and for treatment and prevention of opportunistic infections. These are functions that governments should be undertaking with their own resources. I am also concerned that too many countries expect the Global Fund to entirely underwrite programming. It would be better if the Global Fund required recipient countries to provide some level of matching funding, in order to ensure the country's commitment. The matching fund requirement could be scaled according to gross domestic product (GDP), or another

appropriate indicator of national resources. Another necessary change would be to the restriction mandating that each country may only submit one proposal. This restriction gives individual ministries of health too much power of oversight, and prevents healthy competition that can cause the best potential grantees to rise to the surface.

Guidelines on the use of antiretroviral medications in resource-limited settings were developed in 2002. The emerging difference between antiretroviral treatment in the developed and developing worlds can be summarized as follows:

- when public funds are used to provide antiretroviral medications in the developing world, these medications are less likely to be offered to patients with CD4 counts between 200 and 350 cells/mm³;
- the use of monitoring tools (CD4, viral load, resistance testing) will be more restricted or discouraged in resource-limited settings; and
- some antiretrovirals may not be available in certain resource-limited settings due to licensing issues, the cost of the drugs, and the need for cold storage.

One apparent discrepancy is that cost is not usually listed among the top considerations in guidelines for developing world use of antiretroviral medications. But it is one of most important limiting factors. For example, abacavir is usually on the top of the recommended antiretroviral list, but its price prohibits its use in developing countries. We would be better off stating that all highly active regimens are, essentially, equally effective and allow physicians in the developing world to choose the cheapest regimen available. Evidence does exist that abacavir or nevirapine-containing regimens are as effective as protease inhibitors or efavirenz-containing regimens.^{2,3}

The bottom line issue in antiretroviral treatment in developing countries is price reduction of medications and laboratory monitoring. Production and importation of good quality generic antiretroviral medications should not be discouraged because of the fear of trade sanctions or other international manipulations. As many older antiretroviral medications as possible should be made available for generic production. This will drive down the price of brand-name antiretroviral medications by virtue of free market competition. A multi-tier pricing policy should be adopted by all antiretroviral producers, generic and brand-name. Governments should give tax benefits to these companies. They should also undertake measures to prevent the smuggling of reduced-price antiretroviral medications into rich countries.

The training of physicians and other healthcare providers in antiretroviral use is also a necessary challenge, especially in the case of large-scale training in countries where rapid scale-up of antiretroviral therapy is planned. Local experts must be identified to carry out such nationwide training, and

measures such as the Global AIDS Learning & Evaluation Network (GALEN) are good mechanisms by which to identify trainers within these networks. Training courses must have several levels and must be concise since medical personnel are usually very busy. Follow-up training, or continuing education, must be maintained. Training that will lead to attitude change and the sensitization of healthcare providers to patient concerns is of utmost importance as well, since skills necessary to assess and enhance treatment compliance among patients being treated with antiretroviral medications are critical to ensuring adherence and to preventing drug resistance.

To that end, HIV-infected individuals must be well informed and prepared for antiretroviral therapy. Balanced information must be provided with regard to all means of care, including alternate care options. The importance of adherence to prescribed antiretroviral medications should be regularly reiterated, with use of patient reference hand-outs where they are available. Working to eliminate the stigma associated with HIV, and the creation of peer support groups

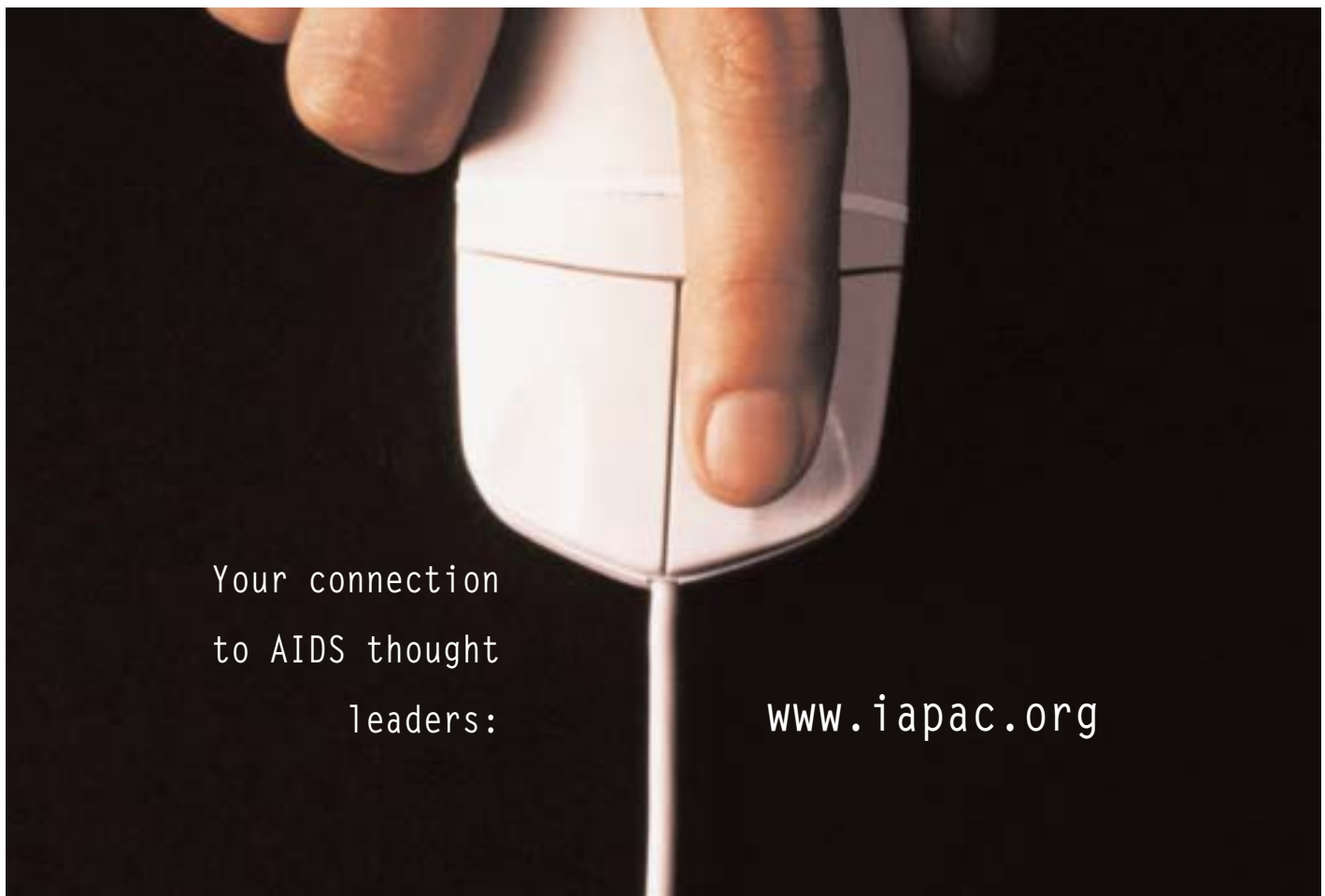
are other methods by which adherence can be improved.

In conclusion, we begin in 2003 on a good base for launching substantial antiretroviral therapy scale-up in many resource-limited countries. The mechanisms are there, even if they require some perfecting. The main ingredient of which we need a larger portion is the world's will to make further progress. ■

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*They say behind the mountains are more mountains. Now I know it's true.
I also know there are timeless waters, endless seas, and lots of people
in this world whose names don't matter to anyone but themselves.
Edwidge Danticat, Krik? Krak!*

Scott A. Wolfe

The Haitian proverb featured in the above citation—that behind the mountains there are more mountains, or *deye mon, genyen mon*, in the original créole—is unfortunately more than a literal reference. That mountains, impediments to movement, are symbolically heaped one in front of the other along a seemingly infinite journey of human struggle, testifies to humble acknowledgement of what for the vast majority of this world's inhabitants is an unmistakably cruel fate. Where modern technological existence lavishes upon “the few” of this world the luxury of many and varied *options*, even the primal possession of one's name remains a cold and solitary comfort for most.

Where this dichotomy could exist with such terrifying history, and in continued contempt of persistent media images and messages that point to the undeniable misery and treachery faced by many of our brothers and sisters worldwide, one cannot help but wonder what hope there is for global change. We might well ask “what use yet another declaration on the need to rise to the challenges of global development assistance?” For, standing in humanity's hall of records, one is almost deafened by the pitch of global injustice and apathy that has become the orchestral standard.

As if the cardinal tragedies of mass poverty, famine, civil strife, and traditionally epidemic diseases such as malaria, tuberculosis, and schistosomiasis had not already been enough to cast doubt on the dream of human equality and prosperity, the AIDS pandemic has now slashed a 20-plus year cleave at the borderland of our greatest hopes, and worst fears. However, despite this mood of despair, it may be that this pandemic is finally teaching us important lessons about the need for global commitment to sustainable development assistance.

HIV disease is the first epidemic disease that has been experienced and recognized on a truly global scale, and with the magnifying intensity of modern media coverage. It is increasingly understood as a threat that transcends all barriers, and therefore

requires unprecedented international cooperation. Such is the increasingly popular logic that informs not only the momentum behind the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM or Global Fund), but also the concerted pressure that has been placed on public and private institutions to act. Industry (both pharmaceutical and otherwise), governments, and funding institutions are called on to share the responsibility required to stem the pandemic.

From the early whisper of warning and plea from global communities first hit by the disease, accentuated by the voices of scientific and development communities pointing to growing trends, word of the AIDS pandemic has finally attained a heightened pitch. Although still not enough awareness exists about the true severity of the pandemic and the urgency with which we must harness collective will and resources, messages and lessons are now beginning to crack the hard surfaces of even the most resistant and unconcerned groups. By contrast, this has never been the case with malaria, for example.

Yet for all of the rhetoric that exists about stemming the AIDS pandemic, this awareness has not yet compelled most governments and institutions from the “developed world” to honestly examine, let alone address, the imbalanced relations of global development and underdevelopment that drive this pandemic. Rather, it would seem that in keeping with a long history of healthcare-related development assistance spending on the part of the more affluent industrial world, the commitments being harnessed at this stage are still disproportionately informed by a “disease-centric” perspective, focused on containment of disease and issues of national economic security.

Despite this, greater pressure and commitment to stemming the tide of the pandemic indicates forward movement. And, it may suggest that we are going through the formative stage of a larger process of global cooperation that would be informed by concern for human development everywhere, before all else. However, in focusing on the immediate concern of HIV disease

and its global implications, it appears ever clearer that we *will* be forced to appreciate an emerging truth: if we want to slow the spread of HIV and halt its devastation anywhere, we must commit to do so *everywhere*. That is to say that, as we focus on the poorer nations of the world that carry the heaviest burden of this and many other epidemic diseases, there must be a commitment to fighting more than “a disease.” For the various tolls being taken by HIV/AIDS demonstrate that in order to eliminate this disease, and therefore its global spread, we must eliminate the poverty, and inequitable international relations and global structures which continue to perpetuate the conditions which fuel the pandemic. It is in moving from a focus on disease to a focus on development, more broadly considered, that a new stage of global consciousness might come to be.

Shifting the focus of discussion

If, in fact, the foregoing suppositions about a gradual global “awakening” are correct then this shift in consciousness is intimately bound to greater appreciation of the complex meaning of globalization. It may just be that through the example of HIV/AIDS we are coming to understand that globalization means much more than the extension of travel, trade, and communications to all corners of the earth. Rather, globalization is a comprehensive and intertwining process of causes and effects wherein wealth and poverty, “development” and “underdevelopment,” the “self” and the “other” are (and have always been) inextricably connected.

The consequence of our increased attention to the shared burden of HIV/AIDS will hopefully prove to be an understanding that only by focusing on the underlying factors of poverty and inequity that continue to fuel the pandemic will any of us ultimately be safe from its effects. If such a monumental accomplishment of civilization—captured in the growing body of political thought over the past thirty-odd years that has pointed to the emergence of a global civil society¹—still appears distant, it may at least be that we are beginning to take

view of the hazy outlines of that far off land.

It is perhaps indicative of such a *zeitgeist* that numerous attempts have been made in recent years to shift the weight of discussion from the sheer human devastation being wrought by HIV/AIDS in sub-Saharan Africa and other regions, to the rippling effect that this death and debilitation will have upon the economic viability and civil development of communities and states the world over. And so, where the sheer statistics that we face—a conservatively estimated 42 million HIV-infected adults and children worldwide; 3.1 million AIDS deaths in 2002 alone;² and prevalence rates reaching up to 38 percent of the adult population in the most affected countries³—have failed to adequately move us on the grounds of basic human compassion, illustrations of the far-reaching politico-economic consequences of the pandemic seem to now be agitating even the most conservative among us.

Ever more sophisticated, if not variably motivated, reports have recently pointed to the potentially menacing implications of national AIDS epidemics to global finance and human security, illustrating the evident interconnectedness of our disparate realities. In a recent *Foreign Affairs* article, for instance, Nicholas Eberstadt drew our attention to the impending threat to human capital in Eurasia, and to global security more broadly, from worsening national epidemics in the region. Attesting to the relative infancy of the body of research underlying such analysis, however, this fellow of the Washington DC-based think tank American Enterprise Institute for Public Policy Research noted that “two decades into the pandemic, the state of economic thinking about this complex set of interactions can still be described fairly as introductory and exploratory.”⁴ And so, Eberstadt and others have begun to engage mainstream sources in an attempt to encourage discussion and study of the multiple consequences of HIV-related morbidity and mortality on global political and economic stability.

Elsewhere, a report commissioned by the US Central Intelligence Agency (CIA), released in September 2002, described the “next wave of HIV/AIDS” in reference to rapidly growing epidemics in Nigeria, Ethiopia, Russia, India, and China. This analysis was used as a gateway to preliminary discussion around the security threats posed by the pandemic.

Such reports, buttressed by comments made by US Secretary of State Colin Powell, US Health and Human Services Secretary Tommy Thompson, and others, that HIV/AIDS is the greatest threat before us today, point to what seems an expanding consciousness of an imminent global catastrophe.

What is novel is that this attention to the potential impact of HIV/AIDS across national and regional divides, has moved from out of the relatively limited domain of epidemiologists and public health officials. If ever so slowly, key leaders and stakeholders (to say nothing of the masses) in countries that account for the lion’s share of global income and politico-economic clout are starting to realize that time is of the essence not merely for distant peoples in far away lands, as has been the prevailing disposition regarding long-standing epidemics such as malaria, but for everyone everywhere.

Of course, public health officials, development advocates, and economic analysts have for over a decade now pointed to the implications of HIV epidemics on the development of communities and economies. But this has typically been done from within strict national perspectives. Seldom, except within the annals of highly academic text and in the messages of the most outspoken critics of global political economy, has connection been made between the factors underlying the prevalence of HIV/AIDS in those countries most affected by the disease and those countries where epidemics remain relatively controlled. Instead, discussion has been widely limited to the parameters and lexicon of “monitoring” and “future susceptibility” which are the hallmarks of epidemiology.

The burden of this disease, as well as underlying reasons for its disproportionate prevalence around the world, has only more recently entered into the formal discourse and been analyzed from the vantage of “political economies of development and underdevelopment.” While it may remain unclear what the ultimate international fallout from veritable AIDS holocausts in various countries and regions could be (in both economic and political terms) we are beginning to see that global destabilization is imminent unless we shift our focus from policies and practices of mere containment of disease, to a broader development assistance approach.

HIV/AIDS and development

Assessing the current and future macro-political and economic implications of the growing HIV pandemic proves difficult. Given that, until recently, primary attention has been focused on HIV disease in sub-Saharan Africa, whose share of global trade hovers between 2 and 3 percent,⁵ little assessment has been made of the impact of HIV upon global markets and global political processes. However, just as economic decline in the countries of the Pacific Rim in 1998 caused a wave of panic to reverberate the world over, so too does it appear that evidence of growing epidemics in regions of the world other than sub-Saharan Africa has many observers that were, until recently, quite silent about the disease in far off places, finally giving sober second thought to the degrees of separation that stand between us.

Foremost, this bespeaks an unpardonable general apathy regarding the fate of the African continent. As the World Bank has noted, “the region’s [Africa’s] income is not much more than Belgium’s, and is divided among 48 countries with a median GDP of just over \$2 billion—about the output of a town of 60,000 in a rich country.”⁶

There is, however, a shift in concern occurring now that evidence of growing epidemics outside of Africa has been brought to the table. In light of this shift, it is becoming clear that we must reconsider the concept of sustainable development. Some observers suggest that there is no purely reasonable or strategic ground for commitment to sustainable development, and that society’s decision regarding whether to work toward it remains merely ethical in nature.⁷ But there may in fact be global effects evident in this pandemic which could cause us to reconsider such a premise.

Where concerns are coming to the fore about the spread of disease and its potential effect on production, trade, and political structures in areas recently determined to have exploding incidence rates, added to by clinical concern over viral resistance and transformation, there may very well be some *highly* reasonable grounds for committing to global efforts to halt HIV disease.

While the ultimate global repercussions of the AIDS pandemic remain speculative, very clear evidence exists of the impact of HIV/AIDS upon the sustainable development of individual communities and nations. We should take our lead from these examples,

and extrapolate from them what may be the further implications for balances of international relations. An undeniable example of the devastation to national economic and social development from HIV/AIDS, for instance, is present before us today in the Horn and Southern Africa regions where a terrifying depletion of the adult workforce in over 20 countries has agricultural outputs to below the level necessary to achieve minimum nourishment. This is exacerbating an otherwise curable famine.

Latest figures from the Food and Agriculture Organization of the United Nations (FAO), for example, indicate that not only has AIDS killed approximately seven million agricultural workers since 1985 in the 25 hardest-hit countries in Africa, but could kill sixteen million more before 2020. The most-affected African countries could lose up to 26 percent of their agricultural labor force, threatening to deepen a crisis wherein food consumption has already dropped by 40 percent in homes afflicted by HIV/AIDS.⁸

This most poignant example of the effect of HIV/AIDS upon economic and social stability is perpetuated in a vicious cycle by weakening both the current and future workforce, and by the chain of effects accelerated by a reduced agricultural output's consequences for national income. Uganda is a good example of a country on the "brink." It has achieved great success in keeping the adult prevalence rate to an estimated 5 percent.⁹ However, where agriculture accounts for 43 percent of Gross Domestic Product (GDP), 85 percent of export earnings and 80 percent of employment, and where 85 percent of Uganda's 22 million people live in rural areas and depend mainly on agriculture,⁹ that 5 percent infection rate, when measured against loss to agricultural production, has the potential to cast sustainable development (including keeping HIV prevalence at current rates) into further doubt.

The compounding and cataclysmic implications of HIV-related death and associated losses in agricultural output not only in Uganda, but throughout sub-Saharan Africa demonstrate what we can only expect will be an increasingly dire situation unless HIV is figured into broader strategies for development assistance, addressing poverty and disease concurrently. The effects of this confluence of disease and economic productivity across all sectors are not strictly measured in lives lost and

food made unavailable. Rather, they further translate into both reduced household income, causing individuals to seek other means of income (often high-risk work such as commercial sex), and reduced national income. In a vicious cycle, this then further disables social spending on education, general healthcare, and other measures necessary to maintain and increase social and economic development.

More than simply in agriculture, workforces in all sectors of the economy, and not only in sub-Saharan Africa but in several other regions such as the Indian subcontinent and rural China, are quickly being depleted by HIV disease. For many countries this causes a tumble in economic productivity, and further frustrates already daunting challenges to climb out of decades-old cycles of foreign debt. As a key AIDS economist from South Africa recently put it, "HIV/AIDS is a hidden tax on trade and investment and is hampering Africa's chances of attracting foreign investment and of boosting its economic development through free trade...The loss of key government workers [from AIDS-related diseases] means work is not done efficiently, investment is reduced and economic growth slowed down...HIV/AIDS is equivalent to an additional production cost."¹⁰

It is in light of this workforce depletion that a few private sector companies—Debswana Diamond Company,¹¹ the Heineken company, and Harmony Mining Company¹² to name a few—have initiated programs to make antiretroviral therapy available to employees. Examples of this sort of commitment, however, are scarce. Where there is such an evident need for collective action, many other companies continue to waiver on the issue, opting instead to conduct expensive "risk assessment" studies in order to determine whether or not to either open or continue commercial operations in countries greatly burdened by HIV/AIDS.

As if we required any further corroboration of the intimate link between health and sustainable human and economic development, HIV/AIDS is providing it. Looking to the future, and considering that the number of children infected with HIV in the developing world, as well as numbers of children orphaned by AIDS deaths are both on the rise,^{13,14} little hope is in sight for future economic recovery unless immediate steps are taken to ensure the health of both current and future workforces.

In addition to critical consideration that must be given to correlations between HIV/AIDS and economic productivity, it behooves us to appreciate the importance of social spending—most notably health-care spending—on not just health, but also economic returns. In this regard, a study recently commissioned by the US National Bureau of Economic Research drew upon and referenced a long history of health economics theory and research in revisiting questions about the economic outcomes of healthcare spending.

Author William D. Nordhaus analyzed figures from the United States over the past century, and employed the concept of "health income"—national income that may be attributed to a host of factors, such as increased span of life, that are correlated to healthcare spending. He concluded that the economic derivatives of healthcare spending were *at least* as responsible for economic welfare in the United States as other consumption expenditure. In fact—and this is important to both "developed" and "developing" world environments—the author continued to suggest that, "it is an intriguing thought to contemplate that the social productivity of healthcare spending might be many times that of other spending. If this is anywhere near the case, it would suggest that the image of a stupendously wasteful healthcare system is far off the mark."¹⁵

While the immediate implications of this for more affluent states such as Canada, the United States, the United Kingdom, and others, are obviously different than for resource-limited countries, the clear lesson is that if nations are able to invest appropriately in the health of their populations, economic development will be greatly enhanced. The global community and international financing institutions should take notice.

Far from enabling development, the mechanisms that are currently employed by the World Bank, International Monetary Fund (IMF), and the Paris Club of creditors force restrictions on social spending, and favor service privatization, limiting the ability of states to maintain nationalized capital and to make middle- and long-term investments in human capital. The narrow perspective reflected in these "structural adjustment" lending programs—focusing on markets and production mechanisms, rather than on the middle- to long-term returns of investment in human

capital—cannot remain if we are to achieve the economic growth that is intended.

If we agree that HIV must be addressed from within a broader program of development assistance, linking disease, poverty, and economic productivity—even if out of concern for mere containment of the disease—then it is imperative we address what lies in the way of achieving this.

Balancing emergency and long-term development responses

Where commitment on the part of the more affluent countries of the North to assist in redressing the pandemic is increasing, be it altruistic or out of national interest, it is imperative to understand the numerous challenges that lay ahead, as well as the scope of measures required to make successful use of energies and resources. What is needed if we are to combat this disease is both an emergency response and a long-term developmental response.

The former, which amounts to quick negotiation of increased access to anti-retroviral therapy for the 95 percent of HIV-infected people who currently have no access to these drugs; increased spending on the healthcare infrastructure required to ensure the effective and ethical care and treatment of people living with and affected by HIV/AIDS worldwide; and fulfillment of pledges made to key mechanisms such as the Global Fund that are strategically positioned to have an important impact, is slowly taking shape. It is the latter, however—the long-term commitment to appropriate development assistance and restructuring of global governance mechanisms—that is the greater obstacle facing us.

The past year has been somewhat promising with regard to the acceleration of “emergency responses” to the pandemic. The publication of antiretroviral therapy guidelines by the World Health Organization (WHO) in 2002 has now led to an unprecedented gathering of global partners—convened as the International HIV Treatment Access Coalition (ITAC)—to determine how to most effectively expand access to these life-saving and -enhancing drugs, as well as to build healthcare capacity in resource-limited settings through training, quality assurance, and information exchange measures.

Adding to this good news, the Global Fund has disbursed its first sets of funds for the prevention and treatment of the

three epidemic diseases that it seeks to address, and has recently amassed greater support from global advocates to ensure that pledges made by governments are expeditiously fulfilled. US President George Bush’s proposal of US\$10 billion in new funding for an Emergency AIDS Relief Plan, intended to provide assistance to twelve African and two Caribbean countries over five years, is a further sign of promise. We should hope that this leads to actual fulfillment on promise and to further commitments from other international and national leaders.

In addition to the above, several pharmaceutical companies—most recently Pfizer, Gilead Sciences, and Pharmacia—have announced new or expanded drug access programs. And, as mentioned above, there is indication that a small but growing number of non-pharmaceutical companies in Southern Africa are showing some commitment to assuming responsibility for the health and welfare of employees and their families.

The clearest indication of what remains to be done in our emergency response is that as of December 2002, the Global Fund was operating with deposits still significantly short of the approximately US\$2.1 billion that has been pledged by governments, institutions, and individuals. Furthermore, this total pledge itself pales in comparison to the variously estimated US\$10-15 billion that will be required if we are to create a lasting effect. And so, where there are signs of hope for an expanded emergency response, it remains incumbent upon the global community of care providers, persons living with HIV/AIDS, and other groups and individuals to redouble existing pressures and advocacy efforts.

What is more consternating than the lingering inadequacy of our emergency response, however, is that a concomitant, long-term development response to poverty and disease has not been forthcoming. This long-term approach would amount to full global commitment to effecting the remedies—including foreign debt relief, increased aid spending, and regulated trade mechanisms¹⁶—that are necessary to assist countries carrying the greatest burden of HIV/AIDS. These measures are required immediately not only for the worst-off among the world’s countries, but also for those which currently risk crossing critical HIV prevalence thresholds,

propelled ever closer to the precipice by poverty and civil unrest. In heeding the wisdom of the proverb which holds that the best time to plant a tree is forty years ago, and the second best time is today, we must humbly acknowledge the millions of lives that might have been saved on the African continent and elsewhere, had we committed current levels of international support for HIV/AIDS and poverty reduction fifteen years ago.

Where many governments and populations are already crippled by massive foreign debt, poverty, famine, disease, and civil unrest, antiretroviral drugs and HIV-specific funding, in and of themselves, will never be enough. It is critical that we see this. Those of us who are fortunate enough to stand at arm’s length from the harsher realities of the pandemic often see a “disease” that can be fully addressed through disease-focused funding for prevention and treatment. We are rightfully excited when such measures are announced. However, where millions and millions of people the world over face the more imminent and pressing threat of death due to starvation or civil violence, a more radical response is required.

The compounded ills and impoverished conditions that exist in countries where the pandemic has hit hardest make disease-centered interventions inadequate. In such conditions what appears a horrifying possibility to many—namely, the risk of HIV infection in settings where one in three adults is HIV-positive, and the subsequent inevitability of AIDS-related death—is for *millions* of others a secondary, though evident, concern. Even where treatment is unavailable, death from AIDS is for many of these millions a relatively long-term threat when measured against the potential for death by starvation, violence, or other endemic diseases such as malaria. For much of the world, these are everyday realities that, not to undervalue the threat posed by HIV/AIDS, are more imminent.

It is critical that we attune ourselves to these realities. If we desire to make most effective our global spending for public health, HIV-specific funding for prevention and treatment must be undertaken with appropriate attention to context. Further, however, it must be carried toward shore on a larger wave of development assistance spending and international finance restructuring.

Many of the realities faced in countries

where HIV/AIDS is truly epidemic are frighteningly raw. Lest we waste millions of dollars on ineffective prevention programming, for instance, we must appreciate that absent viable opportunities for employment, education, and social support, and faced with crushing poverty in sub-Saharan Africa, for example, young girls and women will continue to turn to commercial sex work in order to feed themselves and families; young children (many orphans) in search of food and goods will continue to pilfer contaminated waste sites littered with discarded syringes and medical waste; and hosts of other high-risk activities will proceed unabated—*regardless* of the risk of infection—if HIV/AIDS is not approached within a larger framework of development assistance that targets the conditions of poverty that drive it.

We will fail in our mission if we do not shift some of our attention toward the vast landscape and history of “underdevelopment” in resource-limited areas that HIV/AIDS has now settled into, and further perpetuates. Only in so doing, effecting broad countermeasures in response, will we weed out the root causes of our current global predicament.

Understanding root causes: debt and poverty

An overwhelming number of countries that are already being devastated by HIV/AIDS, or are at critical junctures, remain unable to effect positive change at the national level due to both continued financial indebtedness to global lenders, and counterproductive debt restructuring programs imposed by the World Bank, IMF, and the Paris Club. Over the past thirty years, many of the world’s poorest nations—which are typically those most heavily burdened by HIV/AIDS—have plummeted further and further into foreign debt while an almost inverse chart-line of escalating poverty and disease has cut across this.

While the reasons for this continued debt are many, they ultimately relate back to the massive international borrowing undertaken immediately following achievement of national independence by most of the current least developed countries (LDCs). Loans were issued in this era according to a *development theory* model of political economy which held that “development” was a strict function of investment in technological and industrial capacitation. They could not be repaid in

the global environment that came to prevail in the late 1970s and 1980s. It was of no assistance that many of these loans were made, and continued to be made, to repressive and unrepresentative governments which came to predominate in the developing world during the era of Cold War proxy-politics. Ultimately, “in the 1980s, when the shocks of the 1970s oil crisis, rising interest rates and falling global prices for primary commodities began to take a toll, the debt crisis in the developing world began to unfold.”¹⁷

Faced with this mounting debt since the mid-1970s, populations have looked on helplessly as HIV, malaria, tuberculosis, and other endemic diseases have effectively weaved themselves into the fabric of their societies. Under the restrictive ilk of World Bank/IMF Structural Adjustment lending Programs (SAPs), which, among other things, restricted social spending; imposed the devaluation of national currencies in order to increase export attractiveness; and insisted upon privatization of national enterprise to achieve “competitiveness,”—all in favor of foreign debt re-servicing before national development—governments have tumbled further and further into debt, entrenching ever greater poverty, disease, and civil discord.

This state of affairs prevailed from 1975 until 1996 when, finally recognizing the inability of many countries to re-service their foreign debt under existing programs, the World Bank and IMF implemented the Heavily Indebted Poor Countries Initiative (HIPC) in 1996.¹⁸ Through the HIPC Initiative, countries deemed to have an “unsustainable” level of debt were promised eligibility for debt cancellation (as opposed to further debt reservicing lending), so long as they continued to effect structural adjustment programs dictated by these institutions. During the nearly thirty years that these programs of financial “assistance” have been lethargically negotiated, and renegotiated, poverty and disease have entrenched themselves in most countries that this assistance targets. Some thirty years later, these twin demons of poverty and disease still reinforce each other, almost geometrically, rendering many countries and populations in risk of veritable extinction.

Enhancing the long-term development response to HIV/AIDS

Having shifted from those archaic debt-

assistance programs to a promising new mechanism in 1996 (the HIPC Initiative), the World Bank and IMF have taken a small, positive step forward, carrying the world with them. However, this mechanism and the principles which continue to drive it must be rethought and amended in order for it to achieve its potential. For as it stands, this initiative is only a shell. Not only must social spending be included in the basket of responses that are deemed critical to economic development, but the underlying premises of “sustainable” versus “unsustainable” debt that make countries eligible for debt relief under this new program must be reconsidered. In addition, complementary attention must be paid to ensuring a fair place in the global marketplace for the agricultural and manufacturing goods of countries for whom even the smallest percentage increase in the share of global trade would have a marked impact. A very clear example of this is pressure that must be placed on the US government to reconsider exorbitant farm subsidies, which effectively render other countries’ agricultural exports non-competitive.

In rough terms, this is how the HIPC Initiative works: Any country deemed by the World Bank/IMF to have an “unsustainable debt burden,” which amounts to either a debt to export ratio of 150 percent or a debt to government revenue ratio of 250 percent after having tabled and implemented a comprehensive Poverty Reduction Strategy Paper (PRSP), which is monitored by the World Bank and IMF, is considered eligible for debt relief. This is called *Decision Point* in the HIPC process. However, before being granted actual debt relief funding in order to return the country to a “sustainable debt status” (not to eliminate the debt) the country must adopt structural adjustment programs dictated by the IMF and World Bank, to the satisfaction of the Executive Boards of each.¹⁹ When and where approval is ultimately given, and debt relief funding is released, the country is said to be at *Completion Point*.

To date, 42 countries have been approved for HIPC status (in other words, have passed *Decision Point*). However, only six have reached Completion Point, meaning that an additional six years have passed during which the vast majority of approved HIPC countries have been further crippled by unmanageable debt; have been restricted in social spending; and have watched escalating prevalence rates

Table 1. HIPC initiative countries and adult HIV prevalence rates

Angola (5.5%)	Ghana (3.0%)	Nicaragua (0.2%)
Benin (3.6%)	Guinea (N/A)	Niger (N/A)
Bolivia (0.1%)*	Guinea-Bissau (2.8%)	Rwanda (8.9%)
Burkina Faso (6.5%)*	Guyana (2.7%)	São Tomé & Príncipe (N/A)
Burundi (8.3%)	Honduras (1.6%)	Senegal (0.5%)
Cameroon (11.8%)	Kenya (15.0%)	Sierra Leone (7.0%)
Central African Republic (12.9%)	Lao PDR (<0.1%)	Somalia (1.0%)
Chad (3.6%)	Liberia (N/A)	Sudan (N/A)
Comoros (N/A)	Madagascar (0.3%)	Tanzania (7.8%)*
Congo (7.2%)	Malawi (15.0%)	Togo (6.0%)
Côte d'Ivoire (9.7%)	Mali (1.7%)	Uganda (5.0%)*
Dem. Rep. of the Congo (4.9%)	Mauritania (N/A)*	Vietnam (0.3%)
Ethiopia (6.4%)	Mozambique (13.0%)*	Yemen (0.1%)
Gambia (1.6%)	Myanmar (N/A)	Zambia (21.5%)

* Countries which have reached the HIPC Initiative Completion Point.

Source: UNAIDS, July 2002.

for HIV and other deadly diseases set in, while mere consideration of debt relief has been given consideration by these finance institutions. Table 1 lists these 42 countries, with their associated adult prevalence rate of HIV infection, as of July 2002.

The HIPC Initiative, while offering the promise of debt relief funding, is fundamentally flawed for two reasons. First, the definitions of “sustainable” versus “unsustainable” debt that inform the Initiative do not consider social factors that are both a direct result of and a determining factor in the debt to productivity ratios that are employed as definitions. As Jeffrey Sachs has noted:

A ratio of debt to exports of 150 percent or a ratio of debt to government revenue of 250 percent cannot truly be judged to be sustainable or unsustainable except in the context of each country's needs, which themselves must be carefully spelled out. It is perfectly possible, and indeed is currently the case, for a country or region to have a “sustainable” debt (and significant debt servicing) under these formal definitions while millions of its people are dying of hunger or disease.²⁰

In other words, not only on humanitarian grounds is this arbitrary eligibility system inadequate, but in pure economic terms it does not bear in mind the very debilitation of populations which will ultimately affect the export potential and national income potential of a country. The system merely looks at figures, as they exist,

without considering other trends in order to forecast priorities for spending.

In addition, countries which either do not fall below those set debt to export or income ratios, or *do*, but have not tabled adequate SPRPs *are not even eligible* for debt relief under the HIPC Initiative. This, though they may be wallowing in foreign debt incurred over the past thirty years, and plummeting further downward due to the multiple effects of HIV and AIDS.

Interestingly, a quick glance at the 42 countries in Table 1 demonstrates that Botswana, Lesotho, Swaziland, and Zimbabwe (to say nothing of South Africa) are not currently approved for debt relief even though each has an adult HIV prevalence rate above 30 percent, and despite the fact that select development indicators point to the dire need for international assistance (Table 2). The combined total impact on these four select countries is formidable disease, falling life expectancy, and diminished individual productive years; flights of capital and decreases in foreign investment; decreased gross domestic product and revenue; and, to add insult to injury, serious declines in the net amount of development assistance being provided by all external sources. It paints a bleak picture of what the future holds in store.

Ironically, World Bank President James Wolfensohn himself stated in 2000 that, “many of us used to think of AIDS as a health issue... We were wrong. AIDS can no longer be confined to the health or social sector portfolios. AIDS is turning

back the clock on development.”²¹ Again in late 2002, through the World Economic Forum, Wolfensohn declared that, “you cannot separate profit from social responsibility... Unless we address the question of poverty, we have no future.”²²

Yet, the HIPC Initiative which falls under the auspices of the World Bank and the IMF continues to perpetuate conditions which do not treat HIV/AIDS as part of a broader development agenda. For if they did, eliminating foreign debt and exacting measures to increase human capital in these countries would be a top priority. It would seem that not only does “social responsibility” not figure into these institutions’ calculations of how debt relief and poverty reduction should be achieved, but neither does sound development economics. In September 2002, the IMF announced its intention to eliminate restrictions on social spending and forced industry privatization from its structural adjustment programs, enabling governments greater discretion over development planning. However, there remains clear evidence, most recently pointed out in an Inter Press Service report about the institution’s structural adjustment dictates in Zambia and Nicaragua,²³ that promise has not met with practice.

If we are truly to stem and then turn the tides of this pandemic, nationally and globally, then steps must be taken to eliminate the arcane precepts and restrictions which are currently in place to relieve the debt that strangles countries most deeply affected by HIV/AIDS. Until these structural changes are made, poverty will not be reduced, and ensuing empowerment of governments to build sustainable forces of human capital and enterprises will not occur. Instead, we will have emergency measures to prevent and treat HIV and AIDS—measures gained through hard fought battles—that will ultimately prove band-aid solutions.

In reducing debt, we must attune funding commitment and levels, through the HIPC Initiative as well as other development assistance mechanisms, to country specific needs, measured against firm and realistic development objectives. These needs would include estimated costs of HIV and AIDS upon productivity, as well as carefully calculated costs of providing care, treatment, and prevention interventions for HIV/AIDS. Many studies, both national and regional, already point to these HIV/

Table 2. Key development indicators for Botswana, Lesotho, Swaziland, and Zimbabwe

	Life expectancy at birth (years) 1997 / 2000	Foreign direct investment, net inflows (current US\$) 1997 / 2000	GDP - Annual % Growth 1980-90 / 1990-2000	Aid per capita (current US\$) 1997 / 2000
Botswana	47.3 / 39.0	100.0 million / 30.0 million	10.3 / 4.7	79.3 / 19.2
Lesotho	48.4 / 44.0	268.0 million / 118.0 million	4.5 / 4.1	47.1 / 20.4
Swaziland	57.6 / 45.6	-15.3 million / -43.7 million	6.5 / 3.3	29.5 / 12.6
Zimbabwe	44.5 / 39.9	135.0 million / 78.7 million	3.6 / 2.5	28.1 / 14.1

Source: World Bank. World Development Indicators database, April 2002.

AIDS-specific costs to economic productivity, as well as what funding levels are necessary to address national epidemics.²⁴ What has not yet been effectively accomplished is to situate these analyses within a broader development assistance matrix, that may be applied by governments and foundations, and which would guide the decision-making process and mechanisms of macro-political and -economic institutions such as the World Bank and IMF.

Jeffrey Sachs, in a recent study that provides a basic blueprint for addressing the global debt crisis and future international development, outlines such a proposal. He notes that:

Debt reduction for the HIPCs [as for other countries] should not be based on arbitrary criteria such as a 150 percent debt-exports ratio, but rather on a systematic assessment of each country's needs for debt reduction and increased foreign assistance, measured against explicit development objectives. The right starting point for assessing needs should be the internationally accepted targets for economic development that are (ostensibly) the guiding framework for the global development partnership between rich and poor countries. The targets are enshrined in the Millennium Development Goals (MDGs), a set of eight major goals and eighteen intermediate targets endorsed by all UN members at the Millennium Summit in New York in September 2000 and recently reconfirmed by the UN membership in the Monterrey Consensus of the United Nations Conference on Financing for Development in Monterrey, Mexico, in March 2002. The MDGs are quantified goals for poverty alleviation, reduction of hunger, reduction of disease burden, and other targets, mostly for the year 2015.²¹

In this proposal, debt and a host of important social and development indicators are correctly perceived and treated as a web of issues that can only be effectively addressed in common. For our purposes, HIV and AIDS would rightly be fixed within a matrix of impediments and targets, both affected by and affecting the other social and economic indicators within that matrix. The MDG framework (Table 3) provides a basic guide for this already. Employing this framework, and feeding it with greater quantified and correlated data, priority could be given to the relative advantages and needs for development funding. Absent such rich, holistic analysis and planning—informed by development partnerships that the World Bank and IMF are uniquely positioned to contribute to—we truly have little way of determining what the ultimate impact of current global conditions will be.

A growing global civil society?

The lessons that the pandemic has taught and will surely continue to teach us demonstrate that the scourges of famine, disease, and massive poverty that lay before us are not isolated object areas in distinct regions and communities, but are parts of a living human mosaic which we, through our everyday decisions, help to weave. If we are coming to appreciate this—if at first through concerns for global economic stability and national security—then we may in fact be experiencing the teething pains of a truly global, civil society.

In addressing the global pandemic, it will become increasingly evident that “the interrelations between HIV/AIDS and poverty can operate at several levels and call for action to alleviate poverty itself as much as for interventions to be disproportionately targeted towards the poor, the weak, and the marginalized.”²⁵

This, again, is a restatement of the need to move away from the disease-centric approach which continues to predominate.

The implication of this is that we must eliminate global debt and poverty as part of our solution to the more focused problem of HIV/AIDS. In practical terms, and at some sacrifice, this means that the rich nations of the world will have to absorb outstanding foreign debt in order to rightfully give back to countries in need much of what has variously been expropriated from them during colonial and post-colonial periods of global capitalism. As if we need any reminding of the historical correlation between global wealth and poverty, Tony Barnett and Alan Whiteside provide a most poignant and topically appropriate example:

In the late nineteenth and early twentieth centuries, availability of impermeable rainwear and motor tyres in the rich world were rooted in the brutalities associated with wild rubber supplies in King Leopold's Congo. Ironically, this was true also of the rubber condoms that facilitated the birth control revolution in Western Europe and North America, the mechanism for the famous Western “demographic transition.”²⁶

And so, having moved into the eye of the globalization hurricane, these conditions of development and underdevelopment—mainly fashioned in periods that most of us did not witness—remain constant today through historical debt and the consequent debilitation to countries through resulting poverty.

This is not to suggest that there is something inherently wrong with the “market” per se, but that global imbalances and disproportions speak to a history of correlated development and underdevelopment. These must be addressed and redressed. Clearly, “free” market economics has advantages that we would not want to do away with. The market ensures the relatively efficient manufacture and provision of goods and services, the harnessing of human capital in service of technological and social research and discovery, and the delivery of these with primary regard for the almost metaphysical ebb and flow of human needs and wants.

What is pernicious about the market, however—evidenced in continued insistence on foreign debt re-servicing—is its tendency to err in favor of and to crystallize around the narrow interests of those who

Table 3. United Nations millennium development goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Source: United Nations Development Program, 2002

are better able to manipulate the gray areas between needs and wants, between access and excess, between debt owing to mismanagement versus that due to historical inequities. And so, what is required is regulation and commitment to a global development program, as described above, that is driven by development goals rather than based on strict financial objectives.

At the same time it is imperative that recipient governments commit to transparency and reform, and continue to work toward identifying strategies for poverty reduction and civil participation in this process. Development assistance funding cannot be expected from governments and institutions that have little evidence that corruption and bureaucracy will not impede equitable distribution within a recipient nation. It is incumbent upon the global community to strike a balance, neither wastefully giving over money indiscriminately to suspect political institutions, nor (as is currently the case with aid money being withheld from Haiti) to use this as an excuse for inaction.

Just as the social contract that underlies most democratic politics speaks of the greatest good for the greatest number of people, and of a collective responsibility to nourish the delicate vine that binds us, so too must we truly come to appreciate that there are no degrees of separation between members of the global family. This is what HIV/AIDS may be finally teaching us. If, indeed, this is true, then the positive consequences that might ensue are certainly not a *fait accompli*, some predestined end point of an advancing historical spirit. Rather, this forward movement will lie in the very intimate and deliberate decisions that we daily make, and on the concern we show regarding the

interrelations of disparate, global groups. The lesson is that we must all undertake the task of learning about and untangling the web of relations that sometimes disables health and economic development where they are most desperately needed, while lavishing excess upon others.

Public health professionals, who witness not only the individual but the communal debilitation that is wrought by diseases such as HIV/AIDS, must be at the vanguard of this movement, advocating as witness-agents on behalf of *health for all* as the core of any and all human development efforts. For the maxim “to first do no harm” cannot and must not lie exclusively within the realm of clinical practice. It must extend to a commitment to take cognizance of, understand, and speak to the complex social, political, and economic factors which, through our collective agency, do a continued harm that may be difficult to measure and attribute to individual factors, but which is quite palpable.

As we work to make a difference in this battle let our “turf” not be limited to the issues of drug access, HIV program funding and HIV care provider development. Lest our work amount to “all sound and fury signifying nothing” as Shakespeare might say, we would be well-served to take our lead from the impassioned words of the late Jonathan Mann, who reminded us: “Let our busied work not be simply that, but rather a blaze of fury and passion put in the reflective service of human development.” In our activities as in our engagement of the world in general, those of us who battle against HIV disease must remind the world what a precious gift and privilege basic health is. This comes from the painful evidence before us of what it means to live without standards of health, and very often without hope that “development” may ever be visited upon those for whom we care, and often treat. In so doing we may be bringing forth the spirit of a new, and promising age. ■

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3. According to the AIDS Epidemic Report cited above, the highest adult and child prevalence rates in the world remain in the Southern Africa region: Botswana (38.8 percent); Zimbabwe (34.7 percent); Swaziland (33.4 percent); and Lesotho (31 percent).
4. Nicholas Eberstadt. “The Future of AIDS.” *Foreign Affairs*, November/December 2002. 81:6. 22-45.
5. According to the World Trade Organization, Africa’s total share of global merchandise trade in 2001 was an average of 2.3 percent. It is noteworthy that the Republic of South Africa alone accounted for just over one fifth of that. World Trade Organization. *International Trade Statistics 2002*. Tables III.1 and III. 2.
6. World Bank. *Can Africa Claim the 21st Century?* Washington DC: 2000.
7. See, for instance, Hans Kung. *A Global Ethic for Global Politics and Economics*. Oxford University Press. New York: 1998. p. 242: It is bad that apparently no scientific reason can be given which with even a quasi-axiomatic logic show compellingly that a policy of sustainable human development must necessarily be practiced. Even advocates of a sustainable development have recognized that this is an ethical decision: the need to select particular elements of the environment and particular living conditions which are worth preserving cannot be proved either in purely economic or purely ecological terms. This is a matter of cultural self-understanding: it is not a matter for an individual science but one of ethics and politics.
8. Food and Agriculture Organization of the United Nations. *AIDS hitting African farm sector hard*. May 2002.
9. UNAIDS. *Report on the global HIV/AIDS epidemic*. July 2002.
10. Alan Whiteside, Professor of Health Economics, Natal University, Durban, South Africa. Quoted in *Agence-France Presse*. 01/17/03.
11. Debswana, it should be noted, is jointly shared by the Government of Botswana and DeBeers Mining, and so is an exceptional case.
12. It is particularly encouraging to note that Harmony Mining Company recently entered into an agreement with the Southern Africa Regional Office of the International Association of Physicians in AIDS Care (IAPAC-SARO), based in Johannesburg, South Africa, to not only make antiretroviral therapy available, but to subsidize training of healthcare workers by the organization at a company-owned, IAPAC-SARO managed hospital.
13. It is estimated that there were a total of 3.2 million children under fifteen living with HIV/AIDS at the end of 2002, up from 2.7 million at the end of 2001 (an 18.5 percent increase). UNAIDS. *AIDS Epidemic Update*. December 2002 and December 2001.
14. According to UNICEF, approximately 13 million children worldwide have lost either a mother or both parents to AIDS, as of 2002.
15. William D. Nordhaus. *The Health of Nations: The Contribution of Improved Health to Living Standards*. National Bureau of Economic Research, NBER Working Paper Series. Cambridge, MA. March 2002. p. 42.
16. For an exhaustive overview of trade-related poverty reduction strategies see: Oxfam. *Rigged Rules and Double Standards: Trade, Globalization, and the Fight against Poverty*. 2002.
17. Ann-Louise Colgan. *Africa’s Debt - Africa Action Position Paper*. July 2001.
18. For a broader overview of the HIPC Initiative see Jubilee Research’s HIPC Tracking Program at www.jubileeplus.org and Jeffrey Sachs, et al. *Implementing Debt Relief for the HIPCs*. Center for International Development. Harvard University. Cambridge: August 1999.
19. International Monetary Fund. *Debt Relief Under the Heavily Indebted Poor Countries Initiative (HIPC): A Factsheet*. August 2002.
20. Jeffrey D. Sachs. *Resolving the Debt Crisis of Low-Income Countries*. Brookings Paper on Economic Activity. I: 2002.
21. World Bank News Release 2000/172/S. “Wolfensohn Calls for War on AIDS.” January 10, 2000.
22. World Economic Forum. *Social Responsibility is Part of Making Profits*. Rio de Janeiro. November 20, 2002.
23. Emad Mekay. “IMF Strong-Arming Debtors Despite New Lending Guidelines.” *Inter Press Service*. December 10, 2002.
24. See, for example, Karl Theodore. *HIV/AIDS in the Caribbean: Economic Issues—Impact and Response*. The University of the West Indies, St. Augustine. Department of Economics; Health Economics Unit. November, 2000.
25. Alakwa Malwade Basu. “Poverty and AIDS, The Vicious Cycle” in *Population and Poverty in Developing Countries*. Ed. Massimo Livi-Bacci and Gustavo de Santis. Clarendon Press. Oxford: 1998. p. 145.
26. Tony Barnett and Alan Whiteside. *AIDS in the Twenty-First Century: Disease and Globalization*. Palgrave MacMillan. London: 2002. p. 359.



A B S T R A C T S

Journal of Acquired Immune Deficiency Syndromes

Health-related quality of life after one year of highly active antiretroviral therapy

P Carrieri et al.

[The researchers] investigated the impact of the first year of highly active antiretroviral therapy (HAART) on health-related quality of life (HRQL). Medical data for patients in the French APROCO cohort were collected at enrollment (M0) and month 12 (M12). A self-administered questionnaire gathered information about HRQL (Medical Outcome Study 36-Item Short Form Health Survey) and toxicity-related symptoms. Using the twenty-fifth percentile of HRQL scales in the French population as a threshold, patients with normal values in at least three mental and three physical scales were considered to have a "normal HRQL." Of the 1,053 patients followed through M12, HRQL data at M0 and M12 were available for 654. Among the 233 patients with a normal baseline HRQL, 63 (27 percent) experienced a deterioration of HRQL at M12. Among the 421 patients with a low baseline HRQL, 121 achieved a normal HRQL at M12. Logistic regression showed that factors independently associated with a normal HRQL at M12 were normal baseline HRQL, baseline CD4 count <500 cells/mm³, time since HIV diagnosis less than eight years, undetectable HIV-RNA at M12, and lower number of self-reported symptoms at M12. An assessment of HRQL should be integrated to efficacy outcomes to evaluate and compare long-term strategies properly and to optimize the durability of response to antiretroviral therapy.

JAIDS 2003;32(1):38-47.

Pediatric Research

CD8 T-cell numbers predict the response to antiviral therapy in HIV-1-infected children

S Resino et al.

[The researchers'] objective was to study the probability of achieving undetectable viral load levels in HIV-1-infected children after 36 months of highly active antiretroviral therapy (HAART). A prospective, multicenter, longitudinal study in 41 HIV-1-infected children on HAART was undertaken. Viral load was quantified using standard molecular assay. CD4 and CD8 T-cell subsets were determined by flow cytometry. The probability of achieving undetectable viral load was determined using Kaplan-Meier curves according to groups by percentage CD8 at baseline (CD8 <25 percent or >25 percent). Lower baseline CD8 T-cell levels conditioned a less effective virological response to HAART in children, independent of baseline CD4 T-cell numbers and viral load levels. A greater number of children (81 percent) from CD8 >25 percent group than from the CD8 <25 percent

(40 percent) presented undetectable viral load levels ($p=0.013$). Additionally, the CD8 >25 percent group showed a 4.5-fold higher (95 percent confidence interval: 1.1-19.2) relative proportion for achieving viral load <400 copies/mL than the CD8 <25 percent group ($p=0.039$). We concluded that monitoring CD8 T-cell numbers may be valuable in deciding when to start HAART in vertically HIV-1-infected children.

Pediatr Res 2003;53(2):309-312.

Clinical Infectious Disease

Influence of coinfection with hepatitis C virus on morbidity and mortality due to human immunodeficiency virus infection in the era of highly active antiretroviral therapy

EM Tedaldi et al.

To ascertain the impact of hepatitis C virus (HCV) infection on human immunodeficiency virus (HIV) disease progression and associated death in the era of highly active antiretroviral therapy (HAART), we examined mortality rates, the presence of other diseases, and antiretroviral use in an observational cohort of 823 HIV-infected patients with and without HCV coinfection during the period of January 1996 through June 2001. Analyses were used to compare patient characteristics, comorbid conditions, and survival durations in HIV-infected and HIV-HCV-coinfected patients. HIV-HCV-coinfected persons did not have a statistically greater rate of acquired immunodeficiency syndrome or of renal or cardiovascular disease, but they did have more cases of cirrhosis and transaminase elevations. There were proportionately more deaths in the HIV-HCV-coinfected group. Age, baseline CD4 count, and duration of HAART were significantly associated with survival, but HCV infection was not. HAART use was a strong predictor of increased duration of survival, suggesting that treatment is more important to survival than is HCV coinfection status.

Clin Infect Dis 2003;36(3):363-367.

Tropical Medicine & International Health

The absence of HIV seropositivity contrasts with a high prevalence of markers of sexually transmitted infections among registered female sex workers in Toliary, Madagascar

S Xueref et al.

In a cross-sectional study in 1998, [the researchers] assessed human immunodeficiency virus (HIV) and syphilis infections and their risk factors among the 316 registered female sex workers (FSWs) of Toliary, southwest Madagascar. No case of HIV

infection was detected, but 18.4 percent of registered FSWs had syphilis. Only half of these women regularly used condoms. In a multiple logistic regression analysis, risk factors for syphilis infection were multiple clients per week and, paradoxically, regular use of condoms. The variables associated with irregular use of condoms were younger ages of registered FSWs, multiple clients per week and Malagasy clients. The high prevalence of syphilis infection associated with irregular use of condoms might facilitate a very fast spread of HIV infection among these FSWs. Promotion of condom use and surveillance of sexually transmitted infections and HIV infection incidence are needed in the south of Madagascar.

Trop Med Int Health 2003;8(1):60-66.

HIV Medicine

Discrepant results in the interpretation of HIV-1 drug-resistance genotypic data among widely used algorithms

GH Kijak et al.

The aim of this study was to assess the concordance on the interpretation of HIV-1 drug-resistance genotypic data by three widely used algorithms: Stanford University Database (SU), TruGene (Visible Genetics, Canada) (VG) and VirtualPhenotype (Virco, Belgium) (VP). Genotypic data from 293 HIV-1-infected individuals with treatment failure was interpreted for 14 antiretroviral drugs by the three algorithms. Complete concordant results among the three systems for all the drugs studied were found in 40/293 (13.7 percent) samples. Low concordance in the interpretation was observed for most nucleoside reverse transcriptase inhibitors (NRTIs), while results agreed highly for all nonnucleoside reverse transcriptase inhibitors (NNRTIs) and most protease inhibitors (PIs). In pair-wise comparisons, discordant interpretations between SU and VP were found in over 50 percent of the samples for didanosine, zalcitabine, stavudine and abacavir, and the level of disagreement between VG and VP exceeded 40 percent for the same drugs. Major discrepancies (high-level resistance interpretation by one algorithm with sensitive interpretation by another) were observed between VG and VP in over 10 percent of the cases for didanosine, zalcitabine, stavudine and abacavir. On the other hand, the three algorithms had concordant results for lamivudine in over 90 percent of the cases. This work demonstrates the great level of discordance in the interpretation of genotyping results among algorithms, clearly showing the necessity for clinical validation. Moreover, these results suggest that a joint effort from the scientific community as well as national and international HIV societies is needed to achieve a consensus for the interpretation of genotypic data.

HIV Med 2003;4(1):72-78.



I N T H E L I F E



Sai Kyaw Min

Vanity Fair readers have every month since 1993 enjoyed *The Proust Questionnaire*, a series of questions posed to celebrities and other famous subjects. In May 2002, *IAPAC Monthly* introduced "In the Life," through which IAPAC members are asked to bare their souls by answering 10 questions.

This month, *IAPAC Monthly* is proud to feature Sai Kyaw Min, who is a specialist in dermatology and sexually transmitted diseases at the KYAW Specialist Clinic in Myanmar, Burma.

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

"Life is what you make it." And I devote myself to my patients, not myself.

What activities, avocations, or hobbies interest you? Do you have a hidden talent?

I am always interested in learning and treating the new kinds of diseases.

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

Melbourne, Australia, because of the clean air and scenic places.

Who are your mentors or real life heroes?

Gandhi. He advocated equality among human beings.

With what historical figure do you most identify?

Einstein, because of his miracle findings.

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

Michelangelo.

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

Between 1948 and 1962, when there was democracy in our country (Burma).

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

A researcher and inventor for all human beings.

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

Achievements: Telecommunications

Failures: New kinds of diseases (eg HIV) and also wars.

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

Infectious diseases (eg HIV/AIDS) will be eradicated. ■



SAY ANYTHING

e
The only choice for many girls is to become a sex worker. They are then heavily exploited and don't know much about HIV.

Hor Bun-leng, Deputy Director of Cambodia's National Center for HIV/AIDS, Dermatology, and STDs, as quoted in a January 15, 2003, San Francisco Chronicle article that was part of the newspaper's "AIDS in Asia" series. Though the economically feeble nation has the highest HIV infection rate among Asian countries, the article's author observed that an aggressive approach to preventing the disease's spread has resulted in a declining number of new infections. In 1994, an average of 120 people were infected every day; by 2002, that number had dropped to 20. United Nations and Cambodian government officials attribute the sharp decline to a law requiring commercial sex workers to use condoms.

e
This pandemic cannot be allowed to continue, and those who watch it unfold with a kind of pathological equanimity must be held to account. There may yet come a day when we have peacetime tribunals to deal with this particular version of crimes against humanity.

UN Secretary-General Kofi Annan's Special Envoy for HIV/AIDS in Africa, Stephen Lewis, in a January 9, 2003, press briefing, as quoted by the Associated Press. Since his appointment, the Canadian diplomat has been an outspoken advocate for the needs of men, women, and children living with and affected by HIV/AIDS. His travels across Africa have been documented in numerous publications, including the August 2002 issue of the IAPAC Monthly.

e
Before we can even fight the disease, the stigmas need to be removed and doctors need to get on board.

An unidentified Iranian physician interviewed by the BBC about taboos faced by HIV-infected people in his country. The Iranian government recently issued a directive urging healthcare workers not to turn away HIV-infected patients. According to sources interviewed by the BBC for its December 30, 2002, report, strict social mores regarding sexual relations discourage Iranians from seeking medical care for HIV disease.

e
That's totally false. I never said that. And when the fact checker called me and asked if I said that, I said no. I said no. This is unbelievable.

Robert Cabaj, Director of Behavioral Health Services for San Francisco County, denying in a January 23, 2003, Newsweek on-line article a controversial statement attributed to him in a Rolling Stone feature story about gay men who actively seek HIV infection. According to Rolling Stone, Cabaj estimated that 25 percent of all new HIV infections among gay men in the United States are a result of a practice referred to as "bug chasing." While this behavioral phenomenon has been known to exist for several years now, little research has been conducted to determine just how widespread the phenomenon may be. In response to the Rolling Stone article, which drew considerable attention in the two weeks before its official publication February 6, 2003, Cabaj and other US experts have asserted that gay men who "bug chase" do not account for a significant proportion of new HIV infections.

e
I do not believe that I have done anything morally wrong.

Latife Gueye, head of Africa Aids Africa (AAA), quoted in a London Sunday Telegraph article about the alleged re-sale of antiretroviral drugs originally sold at a steep discount to this internationally funded organization. AAA was set up by Senegalese President Abdoulaye Wade for the purpose of providing these otherwise prohibitively expensive drugs at low cost in Africa. Gueye was arrested for allegedly exporting US\$18 million worth of GlaxoSmithKline-manufactured antiretroviral drugs back into Britain after the UK-based company supplied them to AAA at one-tenth of Western market value. Gueye claimed he was re-selling the drugs in order to make money for much-needed medical equipment. Senegal's President labeled Gueye's alleged actions "a disaster for Senegal's AIDS program."

e
When I was on drugs, they could still accept me and forgive me, but when I got sick with HIV, they had nothing more to give.

A Chinese HIV-infected patient identified only as "Mr. Sheng" in a January 14, 2003, New York Times article examining problems of stigma faced by people living with HIV/AIDS in China. Sheng was describing the treatment he received from his family, who made him leave their home when they discovered he was HIV-positive. According to the article, new laws meant to discourage HIV discrimination — in areas such as employment, medical treatment, and housing — are thus far having little effect.