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IAPAC

MONTHLY

**"It's what your God,
of whatever name,
would want
you to do..."**

**Charging forward: Leveraging
a time of great momentum
into concrete progress**

**TherapyEdge and IAPAC
collaborate to improve
HIV patient outcomes**

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**"It's what your God,
of whatever name,
would want you to do..."**

Stephen Lewis

In an address delivered to the African Religious Leaders Assembly on Children and HIV/AIDS in Nairobi, Kenya, the Special Envoy of United Nations Secretary-General Kofi Annan plead the case for a rescue mission to save Africa's children from the scourge of HIV disease.



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REPORT FROM THE PRESIDENT

JHACI: A low-cost, high-impact intervention

José M. Zuniga

The April 2002 *IAPAC Monthly* featured an update on development of the Global AIDS Learning & Evaluation Network (GALEN), a program of the International Association of Physicians in AIDS Care (IAPAC) designed to train, evaluate, and certify as “HIV care specialists” physicians in resource-limited settings within developing world countries. Since publication of that update, GALEN has been received with almost universal support and encouragement—most recently last month at the XIV International AIDS Conference in Barcelona. Yet, more than this, recent events in the global community have opened the opportunity for GALEN to soon be injected into a comprehensive pilot program that will bring together a combination of funding, medical education, and drug access for select clinics in desperately underserved rural, developing world settings.

At a press conference held July 10, 2002, at the XIV International AIDS Conference’s media center, IAPAC announced that GALEN would act as the keystone of an inter-organizational pilot program to provide comprehensive support to four rural HIV care clinics. The Joint HIV/AIDS Care Initiative (JHACI) pairs IAPAC with the Albert Einstein College of Medicine Institute of Global HIV Medicine in New York; the Royal Free Centre for HIV Medicine in London; the Thai Red Cross AIDS Research Centre in Bangkok; and the University of Ottawa in Canada. The Pan American Health Organization (PAHO), which is the Regional Office in the Americas for the World Health Organization (WHO), is a facilitating partner.

Through this multisectoral partnership, JHACI will assist in its pilot phase a clinic in each of four select countries—Haiti, Jamaica, South Africa, and Thailand. JHACI will provide a sum of funding to these clinics to cover basic operating expenses, and will also deliver HIV medical education through GALEN and bidirectional physician exchanges, while brokering the appropriate introduction of donated HIV-related and -specific medications and technologies as per the “Building Blocks” framework for HIV/AIDS comprehensive care co-authored in June 2000 by PAHO, IAPAC, and UNAIDS.

JHACI comes first and foremost as a

response to the desperate need to increase the capacity of overburdened and under-resourced rural clinics in developing world settings. JHACI represents the collective desire of its partner institutions to address the very serious concerns now raised by funding and drug access schemes such as the UNAIDS/WHO Accelerating Access Initiative and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) that will make available advanced antiretroviral therapies into settings that may not be able to provide for their ethical and appropriate administration.

JHACI is a project rooted in a commitment to action. It stresses that more than simply drugs and money, those providing

What will JHACI offer?

Financial support

JHACI will provide each clinic with an as yet undetermined amount of funding to cover annual operating costs (average: US\$20,000/year).

Medical education

JHACI partners will utilize IAPAC’s GALEN curriculum to certify “HIV care specialists” at the JHACI-assisted clinics. In addition, JHACI will arrange for continuing medical education (eg, I-Med Exchange, on-site clinical symposia, journals, clinical management guides and tools). IAPAC member physicians will conduct onsite education of healthcare professionals.

Medical exchange

JHACI partners, with assistance from IAPAC, will coordinate bi-directional exchanges of physicians and allied

health professionals. Selected healthcare professionals will have the opportunity to obtain short-term training at the Albert Einstein College of Medicine Institute of Global HIV Medicine, Royal Free Centre for HIV Medicine, Thai Red Cross AIDS Research Center, or University of Ottawa. IAPAC physician members (as well as promising residents and post-doctoral fellows) will have the opportunity to receive short-term training at the JHACI-assisted clinics, thereby promoting bi-directional knowledge sharing and sustained future collaborative activities.

Drug donations

JHACI partners will negotiate donations of and price discounts for HIV and diagnostic technologies, to include antiretroviral drugs.

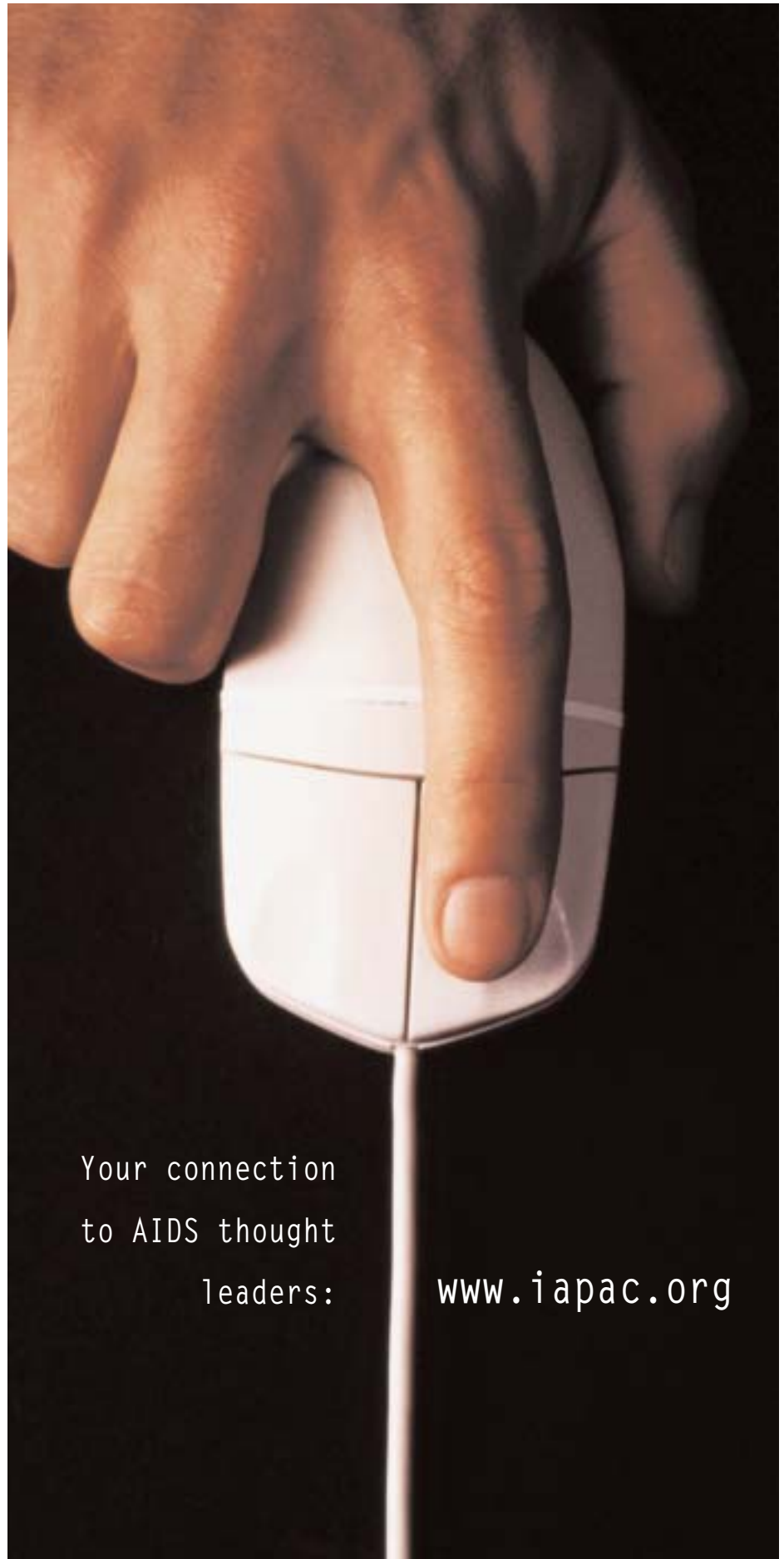
care to persons living with HIV/AIDS in limited-resource settings require an adequate health system infrastructure through which to operate, and the clinical management knowledge needed to effectively treat HIV disease and a host of related opportunistic infections and co-infectious diseases. Not only is this capacity important to ensure ethical treatment, but it is a critical measure required to ensure patient adherence to therapy regimens, to prevent mass biological resistance to drug options, and to limit secondary health complications which may occur through drug toxicity.

Overall, the objectives of the pilot phase of JHACI will be to enhance the quality of care provided to HIV-infected men, women, and children at the JHACI-assisted clinics; to enhance the capacity of Haitian, Jamaican, South African, and Thai medical staff at these clinics to offer care and support to HIV-infected patients; and, ultimately, to prepare the ground for these clinics to become Centers of Excellence within their respective national borders. An important goal of this pilot phase is to learn valuable lessons leading to JHACI's expansion beyond the initial four clinics and the initial four countries.

Through both the aforementioned provisions and IAPAC-led monitoring and evaluation of progress and impact, JHACI will offer an opportunity to achieve significant reductions in HIV-specific and HIV-related morbidity and mortality. Moreover, JHACI signals an important consensus by IAPAC and our partners that there exist significant opportunities to provide low-cost, high-impact interventions in redress of the HIV/AIDS pandemic, but that these cannot exist unless there is commitment to multisectoral, inter-institutional cooperation.

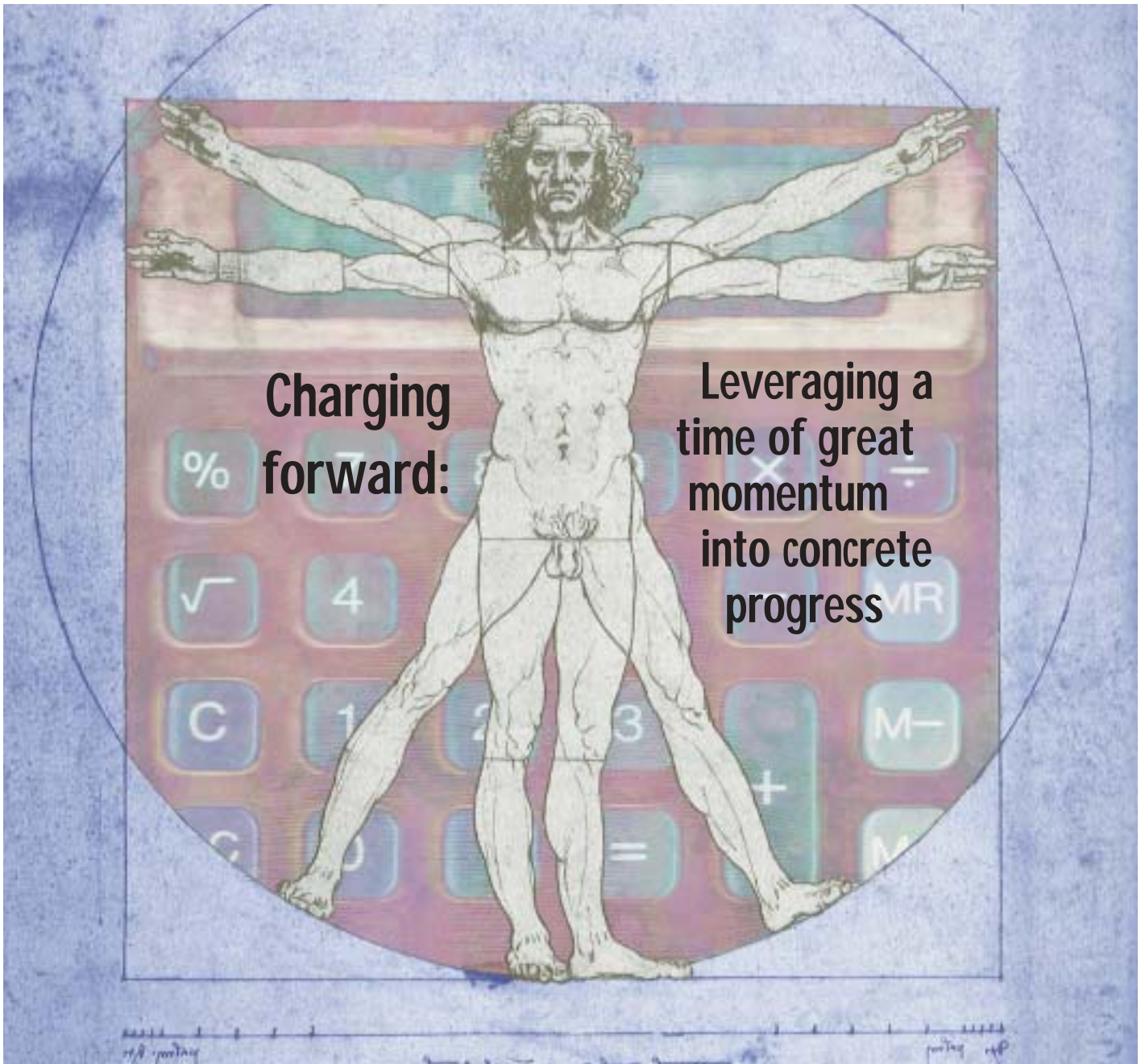
Toward our ultimate implementation of JHACI, I applaud and thank IAPAC's partners for their visionary commitment. IAPAC offers the strength and experience of its 12,000-plus members in these ongoing endeavors, all of which provide every reason to expect not that the pilot stage of JHACI will be guided toward ethical and clinical success, but that JHACI will be introduced globally within the foreseeable future. ■

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



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**Charging
forward:**

**Leveraging a
time of great
momentum
into concrete
progress**

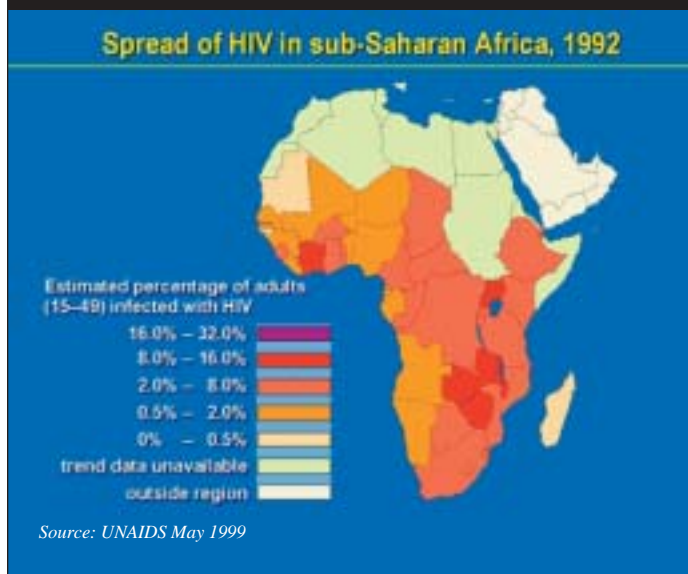
Editor's Note: The following keynote address was delivered April 15, 2002, at the 5th International Conference on Healthcare Resource Allocation for HIV/AIDS, which was sponsored by the International Association of Physicians in AIDS Care (IAPAC), in association with the Brazilian National STD/AIDS Program, European Commission, Pan American Health Organization (PAHO), and World Health Organization (WHO).

Debrework Zewdie

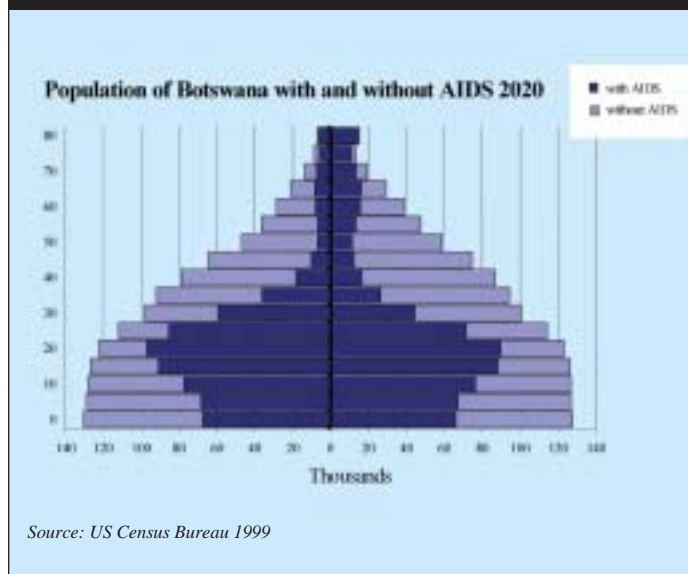
Honorable Minister, distinguished colleagues, ladies and gentlemen, it is a tremendous honor and privilege to be here to discuss how to translate the current momentum into concrete progress in the expansion of HIV/AIDS care in resource-limited settings.

Let me first of all express my deep felt gratitude to the organizers of this conference for inviting me to give the keynote address. This conference could not have been held in a better place. Brazil is one of the first few countries that dared to use its national budget to provide comprehensive care to those infected by the HIV virus. I am glad to be here and salute you, the people and government of Brazil, for your leadership.

Slide 1. Estimated adult prevalence, 1992



Slide 2. Demographic impact of HIV/AIDS



Mr. Chairman, my presentation will focus on three broad areas: 1) the state of the epidemic and the response to date; 2) experiences and rationale for expanding comprehensive care; and end by 3) the road ahead, keeping up the momentum and moving towards achieving concrete progress.

The story so far ...

The story of the HIV/AIDS epidemic is a chronicle of a disaster foretold. Two decades after it was diagnosed, more than 65 million have been infected, of whom more than 22 million have died, 14 million have been orphaned and 40 million are living with the virus. Let me give one example (slide 1). This slide shows how only 10 years ago, Botswana had less than 500 cases. In 2002, Botswana now has one of the highest prevalence rates in the world and is home to 290,000 people living with HIV. This increase (slide 2), among other things, shows a frightening demographic turn for the worse.

During the first decade of this epidemic, with a few notable exceptions, both developing and developed countries failed to address the epidemic strategically. Few would speak openly about AIDS, and even fewer elevated it to a broader developmental issue. At about the same time, international support began to fade. In donor countries, stabilizing HIV incidence, promising new therapies, and disbelief of the worsening epidemiological projections blunted the sense of urgency that had motivated rapid action in the late 1980s.

This persistent denial and lack of concrete successes in the hardest hit countries, mainly in Africa, also sowed seeds of doubt among donors that more money could, or would, be effective in blunting the epidemic.

The international response was also starved for funds. Annual global resources for AIDS had nearly quadrupled in the first years of the global strategy, from US\$44 million in 1986 to US\$165 million in 1990. Then growth in funding began to stagnate. By 1996, total global resources had leveled off at about US\$300 million per year, two-thirds of which came from only three donor countries. This was, by any measure, insufficient.

By the mid-1990s there was a scientific breakthrough in the development of highly active anti-retroviral drugs. This brought hope to many and indeed for those who had access, AIDS became a treatable chronic condition. Despite rhetoric that it could not be done, countries such as Brazil, Thailand, and Costa Rica took bold steps to provide [antiretroviral drugs] to their people. The per capita income of these countries is about 10 times more than the per capita income of the poorest countries in the world and the HIV prevalence rate is also lower.

Despite the lack of good feasibility studies, however, access to care for resource limited settings was escalated to the highest level by activist groups and the international AIDS community. There are a number of issues that prevented the care agenda from moving ahead to reach

millions. Let me mention the two that paralyzed the debate and prevented forward movement. The first one was the prohibitive cost of the drugs and the infrastructure required for proper administration of the drugs; the second one was lack of capacity and long-term sustainability.

Until very recently, the issue of access to care for resource-limited settings was not even considered by several bi- and multilateral donors, including the World Bank. While drug prices have come down substantially, the thinking behind access to drugs has not. The argument has been that for most developing countries the per capita health expenditure is US\$12, and providing comprehensive care, which costs more than many countries could afford, was viewed as impossible and irresponsible. One has also to remember in many of these countries neither the basics of prevention such as condom distribution and cleaning the blood supply system nor basic care such as treating opportunistic infections and palliative care were implemented in large scale.

The HIV/AIDS epidemic also brought to the forefront the long neglected problem of health infrastructure in many of these countries. Many argued, even if the drug was available for free there is no way to ensure proper use, distribution and administration. These arguments made it look impossible for developing countries to benefit from this hope for life.

The issue of access to care emulates the history of capacity building and technical

Direct expenditures avoided due to ARV combined therapy Brazil 1997/2000

- Direct expenditures avoided: US\$ 771 million
- 234,000 hospitalizations avoided
- Costs avoided with:
 - Opportunistic AIDS-related disease treatment
 - 80% reduction of hospitalizations



cooperation for the last fifty years of development. Let me quote a presentation by Evelyn Herfkens, the Dutch Minister for Development: “We can deliver our four-wheel drives, our procedures, and our policy documents. And we can deliver foreign experts but we have not really been transferring knowledge.... we should know the underlying causes when capacity constraints are being felt.”

Sustainability and cost effectiveness concerns have paralyzed access for many years. While it is easy to dismiss these questions as hard-hearted, that does not make them any less real. A dollar spent on one thing cannot be spent on something else. Until recently, these therapies were *so* expensive, and resources for AIDS were *so* scarce, that countries faced heart-breaking choices between treating a fortunate few or giving far cheaper life-saving services (such as vaccines or tuberculosis treatment) to many others.

Today, however, the calculus is rapidly changing, for four reasons:

First, the cost of these drugs is plummeting. Activism and competition have worked together to make these therapies 70, 80, 90 percent more affordable. While countries must still face hard choices, what is affordable grows with each passing day. Moreover, the more these drugs are used, the more these prices will eventually drop as more suppliers join the market. So what we do today will affect how much we can do tomorrow. And what we *learn* by starting today will help us be more effective tomorrow.

Second, the amount of resources for AIDS is growing rapidly. Donors have realized that if countries hit by AIDS deplete their other development investments to respond to AIDS, it will be like trying to fill a leaky bucket. HIV preys on underdevelopment, on lack of education, on inequality. If we lay down our gloves in those fights today, we will be hit back by HIV even harder tomorrow. What we need is more resources for *both* AIDS and development, and that is what donors committed to in Mexico last month.

Third, the benefits of preventing AIDS deaths are becoming quantifiable. Brazil, again, serves as a good example (slide 3). This slide shows *some* of the savings from implementing ART. In summary, some of the impacts of comprehensive care are reduced mortality, reduced morbidity, reduced hospitalization, and tremendous cost saving. And these are only the savings to the health system. To [perform] a proper cost-effectiveness calculation, one needs also to add in the value of the extra productive years of those affected, the reduced years of orphanhood for their children, the averted strain on families and communities, and the preservation of educated manpower for the public and private sector alike.

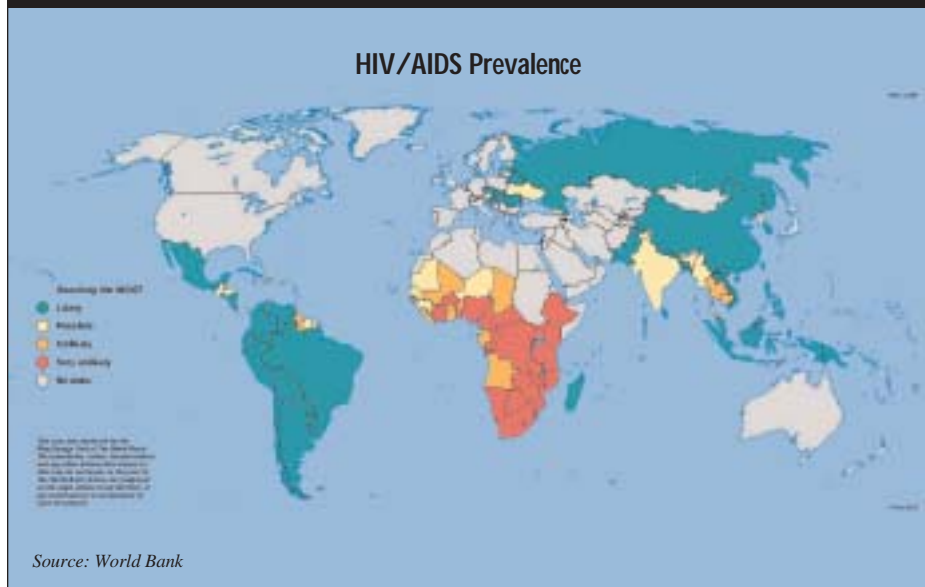
Finally, there will be a great *indirect* benefit to expanding care—the strengthening of health systems around the world. Let us be blunt. Far too many developing countries have neglected their health systems over the past generation, for reasons you know better than I. AIDS is a wake-up

call, and it will not be the last. The fact that so few health systems now have the foundation in place to administer widespread therapy gives these countries the strongest possible motivation for giving these systems the attention they deserve. If we do not seize this chance to show what we can do, it may take another generation and another pandemic before another opportunity arises.

A new chapter

In early 1998, renewed attention to the epidemic began to translate into renewed action. Since then, virtually every agency and donor, as well as a wide range of foundations, firms, academic institutions, nongovernmental organizations, and civil society have begun to revitalize their efforts. The scale of finance has grown markedly. Even more important, the focus on collaboration and partnerships has been revived. Let me cite a few examples:

- The *United Nations* system as a whole has taken on HIV/AIDS as a global issue, and in some unprecedented ways. The July 1999 Special Session of the General Assembly, the January 2000 Security Council’s Special Session on HIV/AIDS, and the June 2001 United Nations General Assembly Special Session on HIV/AIDS are some of the milestones.
- The *pharmaceutical industry* has launched several initiatives in the past two years. In early 2000, the five major manufacturers of HIV/AIDS drugs



entered a dialogue with the UNAIDS Secretariat and co-sponsors to make these drugs more accessible and affordable in developing countries. In late 2000, several of the firms agreed to reduce prices by as much as 90 percent for some of the most common antiretroviral medications. Many have also initiated programs in the highly affected Southern African countries. What brought about real change, however, is the availability of generic drugs and the competition created as a result.

- Finally, through the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), new resources are being marshaled. To date, the Global Fund has attracted US\$1.9 billion. The first round of proposals has been submitted and will be approved next week. How successful this initiative becomes will be another defining moment in the history of HIV/AIDS. The Global Fund is one of the most innovative opportunities in the response to HIV/AIDS globally and we should all make sure that it succeeds.

Promise of the new approach

What, if anything, sets this upsurge of activity apart from the mobilization of the late 1980s? Four promising factors stand out.

First and most important, governments of both developed and developing countries are increasingly showing the necessary leadership. Inadequate political commitment had long been the missing link in many of the responses.

Second, this rejuvenated international response is more strategic, comprehensive, and collaborative than were its predecessors. Governments, agencies, and other entities now share a broad consensus that the global response must:

- Be guided by *national strategies* and led by *national AIDS authorities*;
- *Build capacity* in resource-limited settings for prevention, care and treatment;
- Be *multisectoral* in design and implementation;
- Build on *partnership with all interested actors* from the public and private sectors and from civil society, especially associations of people living with HIV/AIDS;
- Directly support *local, community-led actions*; and
- Ensure prevention and care go hand in hand.

In designing their programs, nearly all donors and agencies are now working through national authorities in prevention, care, and treatment and coordinating with one another in a cluster of common efforts, including UNAIDS, the Global Alliance for Vaccines and Immunization, the International AIDS Vaccine Initiative, and the Global Fund.

Third, the new commitment is being matched by new funding. For example, between September 2000 and February 2002 the World Bank launched the Multi-Country HIV/AIDS Program (MAP) for Africa and the Caribbean, which set aside US\$1 billion and US\$155 million, respectively, in concessional funds to support

national programs. Unlike previous programs these funds will be used for the full spectrum of prevention, care, and treatment. Within a year, 16 African and six Caribbean governments had reached agreements. Nearly US\$570 million of the money has been committed. That represents more than four times as much as *total* external support for AIDS in Africa in 1998. Under the Highly Indebted Poor Countries initiative, donor and recipient governments have agreed to channel savings from debt relief to fund HIV/AIDS programs.

Fourth, efforts of the past two years have been driven by a far broader understanding of the pandemic, both in the professional AIDS community and in the general public. In the professional sphere, experience has proven the effectiveness of many replicable means of preventing HIV and caring for those living with AIDS.

Perhaps even more important has been the growth in public awareness. Over the past three years, AIDS has commanded ever-widening public attention in Africa, Europe, and the Americas.

Charging forward: future or failure?

Mr. Chairman, ladies and gentlemen: What do we have to do to keep this momentum, and how do we achieve concrete progress in the expansion of care in resource-limited settings?

First, governments of these countries, their people, and the international community must ensure that they have the capacity to carry out and sustain their own response. In the past, too little capacity was built, sustained, or retained. Capacity means more than trained personnel. It means strong systems supporting health, education, nutrition, social welfare, and community development, among other things. HIV has preyed on weaknesses in these core systems and on the poverty, inequality, and social exclusion. If these contributory causes are not addressed, many of the developing countries will remain ever vulnerable to HIV as well as to [a] panoply of long standing endemic ills. If they are addressed, the effort against AIDS could also produce beneficial spin-offs in a wide range of related areas.

However, fixing the problems mentioned above takes time. The way forward will be finding short cuts to reach those who need help now while working to

solve the long-term concerns. These two must go hand in hand. For example, the [World] Bank programs for Sub-Saharan Africa and the Caribbean can be used to cover 60 to 80 percent of the needs within the spectrum of comprehensive care. As most of us know, antiretroviral therapy is only at the end of this spectrum. Additional resources from the Global Fund can supplement these resources and be used to buy antiretroviral drugs. These resources could be used to quickly build capacity for the short term and at the same time lay the foundation for sustainable capacity.

There are several examples of these short cuts worth mentioning. AIDS Empowerment and Treatment International (AIDSETI), an organization of people living with HIV/AIDS, has managed to reach thousands with left over drugs from rich countries in only a very short time. This organization has established a system where each patient's data is computerized, and they know where each pill has gone and how many people live with a better quality of life.

Second, the global response must remain vigilant to keep the current momentum (slide 4). Let me show you two slides that demonstrate the readiness of countries to reach the millennium development goals (MDGs) for achieving primary completion rate by 2015. Countries in red and yellow are unlikely to reach this goal. We constructed this second slide (slide 5) to show that the same countries that are unlikely to reach the MDGs are also the ones that are hit hardest by the HIV/AIDS epidemic. It looks very similar to the health goals as well. These are the kinds of evidence we should use ... upon those who are in charge of the development agenda to show that without dealing with the HIV/AIDS epidemic effectively, it will be difficult to reach any of the MDGs.

The struggle against HIV/AIDS will likely be long. Setbacks are inevitable. The virus may take turns for the worse, as may whole societies in the countries most affected. It is vital for the developing world and its global partners to prepare themselves and their constituents for a protracted effort. A retreat to denial or complacency would amount to a reprise of the retreat of the 1990s, with catastrophic consequences.

Third, we need to address comprehensive care in terms of "how" and "when" not

"if" and "perhaps." While the global community needs to make clear that no magic bullet is likely for years, if ever, people in resource-limited settings should no longer be denied from benefiting from these therapies. While it is true that universal treatment is not yet within reach, we cannot bring it in reach without starting wherever we can. Indeed, the sooner we begin trying, the sooner prices will fall and the sooner we will learn the "locally specific" knowledge that will help make treatment feasible and accessible for millions.

We have been working in prevention for more than two decades now. We know that prevention works. We also know that prevention has never been given a chance. Many countries hit hardest by the epidemic never had the means to scale up prevention to cover whole nations. Prevention remains important and cheaper than treatment. However, with over 40 million people living with the virus, we need to realize that to care for those already infected is to give prevention a huge incentive. Knowing one's sero-status becomes meaningful only if there is hope for treatment. Care should never be seen as taking away resources from prevention; at this stage of the epidemic we cannot do prevention without care.

Let me go back and use the rationale by the Dutch Minister of Development. Let us provide menus of care with several choices and empower the governments and the people living in resource-limited settings so that they can choose what is feasible and what works for them. Remember they also observe the miracles that have happened and are happening in people living with HIV/AIDS in the North who can afford these drugs and lead a better quality of life.

Let us pledge to ourselves today that when we leave Rio [de Janeiro] we will not waste any time despairing of the obstacles we need to overcome to expand care to people in resource-poor settings. Instead, let us pledge to accelerate action to overcome obstacles. [Let us]:

- do everything possible to bring down the cost of drugs further and remove the barriers to encourage the production of generic drugs;
- scale up pilot programs using the good examples from Haiti, Senegal, and Uganda to reach millions while at the same time building the capacity and infrastructure;
- work more in finding better drugs, that can be administered easily;

- learn from past lessons;
- use the power and commitment of the community to help in the better administration of comprehensive care;
- make sure we focus on building capacity—let us think of local capacity primarily when we think of technical assistance; let us pledge today that for every technical assistance we will train at least one individual;
- assure that sustainability of HIV/AIDS programs is a pact between the North and the South. Let us make AIDS the epidemic that helped us turn around the capacity issue. At a minimum, let us not say there is no capacity if we are not prepared to do something about it; and
- put cost-effectiveness within context. Yes, for a country with [annual] US\$12 health expenditure, a US\$300 drug is not cost-effective. Instead, let us [conduct] our cost-effectiveness analysis with all costs and benefits included and without an *a priori* assumption about the resources available.

Finally, Honorable Minister and distinguished colleagues, there are 40 million people living with HIV, who given proper care and treatment could lead normal lives, otherwise they are sentenced to premature death. Let us imagine that these 40 million people are citizens of one country. Let me compare this nation of people living with HIV to countries with populations of similar size: Colombia (41.5 million), Myanmar (45 million), and South Africa (42.1 million). Who among us is prepared to write off the future of Colombia, Myanmar, and South Africa? We need to remember that, "everyone has the right to be cared for and to die with dignity."

It is in our hands to leverage this time of great momentum and promise. If we use it appropriately and effectively we will indeed make sure that millions and not hundreds are cared for.

Let us liberate ourselves; change our mind-set from it cannot be done to each of us pledging "I will contribute to make it happen!" AIDS, which has been a global tragedy for so long could yet become a testament to global solidarity.

Charge forward we must! We dare not fail! ■

Debrework Zewdie is the Coordinator of the Global AIDS Campaign at the World Bank in Washington, DC.

TherapyEdge and IAPAC collaborate to improve HIV patient outcomes

Web-based software designed to
support HIV patient management
and enhanced clinical response



TherapyEdge, Inc. announced in July 2002 that it will collaborate with the International Association of Physicians in care (IAPAC) to provide members worldwide with access to the TherapyEdge-HIV™ system. TherapyEdge-HIV is a Web-based software program that employs artificial intelligence to assess a patient's clinical status, alert for potential medical issues, and present viable, individualized therapy options based on their likelihood of success, in real time.

As part of the newly announced collaboration, TherapyEdge is offering IAPAC members two weeks of complementary

access to TherapyEdge-HIV. For details regarding TherapyEdge-HIV complementary access, and special subscription pricing, please contact IAPAC Director of Membership Joey Atwell at jatwell@iapac.org, or register directly with TherapyEdge at www.therapyedge.com.

"TherapyEdge-HIV," stated John W. Mellors, Chief of Infectious Diseases and Director of the HIV/AIDS Program at the University of Pittsburgh, "does in milliseconds what would take me 20 or 30 minutes sitting down in a quiet room, leafing through a patient's charts, checking the past medical history, virus resistance

profiles, drug doses and interactions, pulling together all my knowledge."

Complete patient assessment

TherapyEdge-HIV graphically tracks and automatically processes a patient's clinical data—including medical conditions, medications, genetic tests for drug resistance, drug efficacy, and toxicity data—through an extensive knowledge base of pharmacological and clinical information. These knowledge bases are created and continuously maintained in collaboration with world-renowned HIV clinicians and researchers. The system's intelligent alerting

system checks for drug interactions, medical conditions or side-effect issues, as well as abnormal lab results and drug dosing. When a change in therapy is indicated, TherapyEdge's advanced artificial intelligence engine and knowledge base instantly generates patient-specific, optimized treatment alternatives that clinicians can review and compare. Clinicians can use the system to rapidly transform disparate data into individualized comprehensive treatment plans for patients. TherapyEdge distributes this actionable medical knowledge anywhere in the world to subscribers via the Internet. Additionally, the system de-identifies patient data and provides a longitudinal database that can be queried for drug efficacy data, clinical outcomes, and quality of care information. The system can therefore support the validation and effectiveness of health services and therapeutic interventions.

"TherapyEdge HIV gathers and integrates patient data, the latest clinical research, and therapy options in a way that would

otherwise take an enormous amount of time for me to do diligently," said Gary Blick, Medical Director of CICLE Medical in Norwalk, Connecticut, a TherapyEdge clinical evaluation site. "Since TherapyEdge focuses this knowledge on an individual-patient basis, it simplifies the onerous research and administrative tasks that would otherwise take me away from delivering quality personalized patient care."

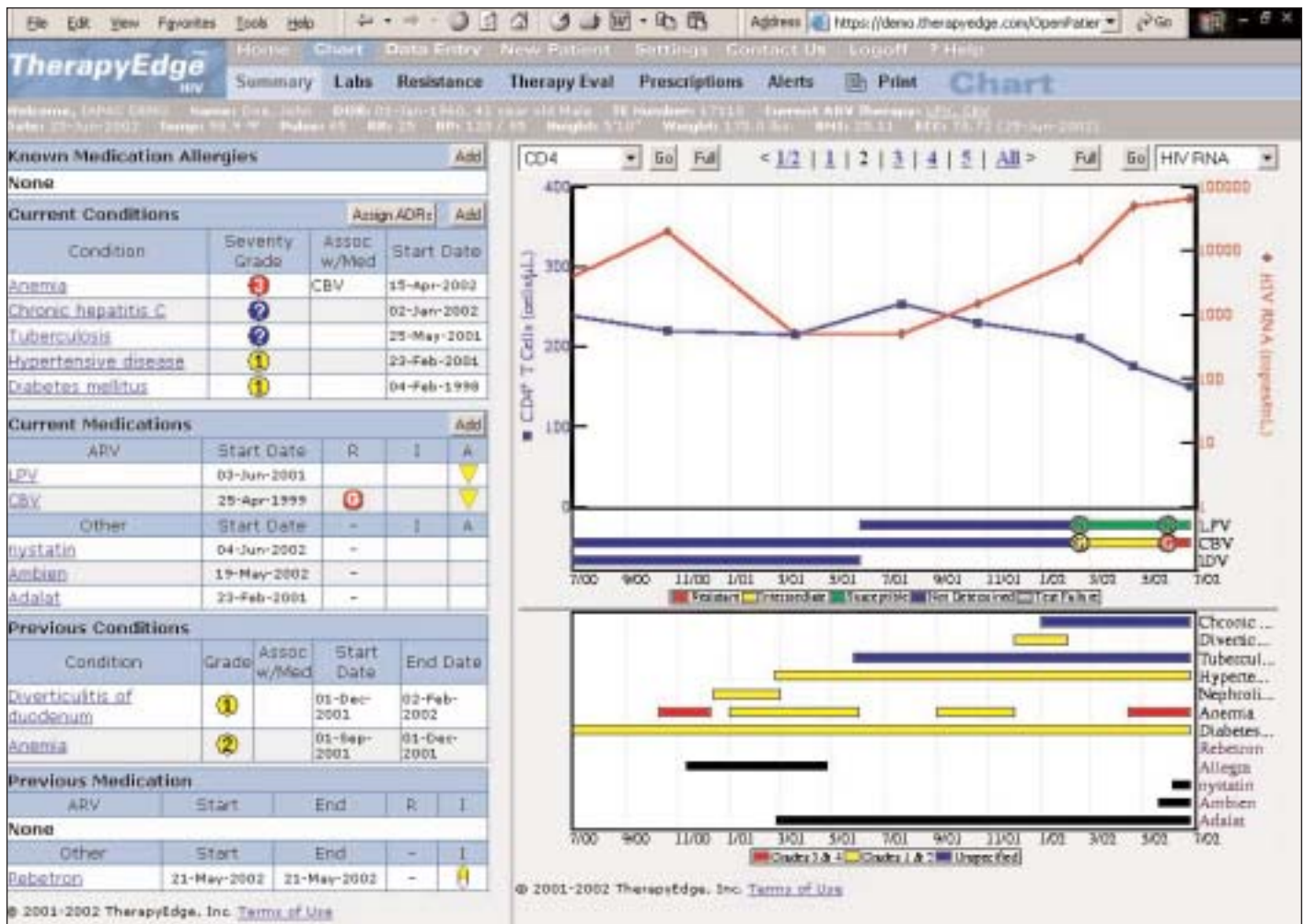
Comprehensive HIV genomic analysis

Like other systems, TherapyEdge-HIV can search gene sequences for mutations among the 99 protease and 560 reverse transcriptase codons and report which drugs to avoid. But TherapyEdge-HIV surpasses other systems by considering not just how mutations affect single drugs, but how they affect combinations. For example, with M184V, where valine replaces methionine at position 184, most programs warn that M184V makes HIV resistant to lamivudine (3TC), ignoring that it also increases susceptibility to

zidovudine (ZDV). In combinations using ZDV (and if there are no other ZDV-related mutations), TherapyEdge-HIV recommends prescribing 3TC to maintain selective pressure for the mutation's retention, so that ZDV can be potentiated. TherapyEdge-HIV also considers ways to overcome resistance through higher doses or inhibiting drug metabolism to make the drug last longer in the body. The system interprets virtual phenotype and actual phenotype data in a similar manner.

Rationale for TherapyEdge-HIV

For a patient never before treated, initial therapies are easily selected and can often keep HIV at bay for years. But as many as half of all patients either cannot tolerate their medications' side effects, or HIV acquires drug resistance. Given fewer therapeutic options, clinicians sometimes struggle to determine viable alternatives. Issues ranging from pill burden and side effects to dose adjustments, complexities of administration and co-morbid conditions



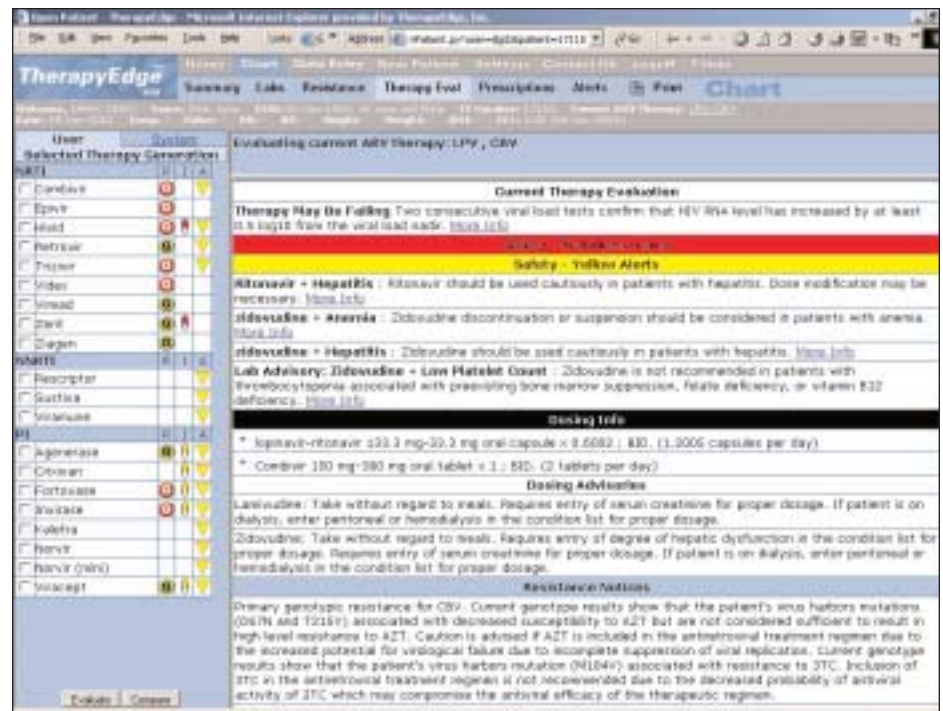
further complicate the decision-making process.

That there are now thousands of combinations, including “boosted” protease inhibitor hybrids, does not make the selection process easy. “The virus changes into an almost endless variety of forms,” explained Mellors, an authority on HIV drug resistance. “Individuals react differently to different medicines. The medications interact in so many different ways that you can’t keep them in your head with any accuracy. To keep these things sorted out and optimized is a real challenge.” Indeed, the body of knowledge required to make a good choice—keeping the pill burden light, avoiding bad drug interactions and exploiting good ones, sidestepping drug toxicities—is constantly evolving.

With TherapyEdge-HIV, the clinician inputs the patient’s characteristics “and with a series of keystrokes asks the artificial intelligence system what regimens it would recommend and rank them,” said Donna Mildvan, Chief of the Infectious Diseases Division at Beth Israel Medical Center in

New York. Working by “the rules of the best practices according to a panel of experts,” she said its answers are “very comparable” to what experts recommend.

TherapyEdge-HIV has undergone extensive evaluation and testing in clinical centers with large numbers of HIV-infected patients, and is the result of five years of



TherapyEdge HIV

Home Chart Data Entry New Patient Settings Contact Us Logout Help

Summary Labs Resistance Therapy Eval Prescriptions Alerts Print Chart

epkama, (PAC) 0801, Name: Dr. John, DOB: 03-Jan-1960, 41 year old Male, TE Number: 17115, Current ARV Therapy: LDC, DDI
 Label: 27-Jun-2002, Temp: 98.4 F, Pulse: 65, RR: 15, RR: 120 / 35, Height: 5'10", Weight: 175.0 lbs, BMI: 25.11, HFA: 14.72 (29-Jun-2002)

View Genotype History View VirtualPhenotype History View Phenotype History

View Previous Genotype Test

Order date: Test manually entered Laboratory: Lab Corp Test Type: Genotype - In-House

Specimen Date: 30-May-2002 Status: Complete Show TherapyEdge Resistance Interpretation Rules

Gene	Mutations	ARV Drug	Test Int.	TE Int.	Explanation	
GAG Reverse Transcriptase	K65R, D67N, E122K, M184V, T215Y, K219Q	NRTI	3TC	Resistance	R	M184V is associated with resistance to 3TC.
			ABC	Partial Resistance	R	D67N, M184V, T215Y, and K219Q are associated with resistance to ABC.
			AZT	Partial Resistance	R	D67N, T215Y, and K219Q are associated with resistance to AZT. M184V is associated with attenuation of the T215F/Y mutation, potentially reducing the level of AZT resistance due to T215F/Y.
			d4T	No Evidence of Resistance	I	D67N and T215Y are associated with decreased susceptibility to d4T.
			ddC	Partial Resistance	R	K65R, D67N, M184V, T215Y, and K219Q are associated with resistance to ddC.
			ddI	Partial Resistance	R	K65R, D67N, M184V, T215Y, and K219Q are associated with resistance to ddI.
			TDF	No Evidence of Resistance	I	K65R is associated with decreased susceptibility to TDF.
		NNRTI	DLV	No Evidence of Resistance	S	-
			EFV	No Evidence of Resistance	S	-
			NVP	No Evidence of Resistance	S	-
Protease	M40I, L90M	PI	APV	Partial Resistance	I	L90M is associated with decreased susceptibility to APV.
			IDV	Partial Resistance	S	-
			LPV	No Evidence of Resistance	S	-
			NFV	Partial Resistance	I	L90M is associated with decreased susceptibility to NFV.
			RTV	No Evidence of Resistance	S	-
			SQV	Resistance	R	L90M is associated with resistance to SQV.

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development and collaboration with leading clinicians and researchers in the field of HIV/AIDS, pharmacologists, and leading software experts.

How TherapyEdge-HIV works

TherapyEdge-HIV combines information derived from evidence in the medical literature, expert medical opinion, standardized drug databases—augmented in the area of HIV antivirals—and standard medical terminology as the basis for clinical decision support. The information contained in the system is continuously updated to reflect the latest available knowledge in the field of HIV/AIDS.

Four knowledge base subsystems—pharmacology, resistance, clinical data, and therapy assessment—are used to continuously assess a patient’s status. These subsystems, integrated with the system’s artificial intelligence technology, generate the patient-specific alerts/warnings, based on analyses of laboratory as well as resistance test results, current/prior medical conditions, allergies and current or previous medications.

When a change in HIV therapy is necessary, the system looks at all the possible

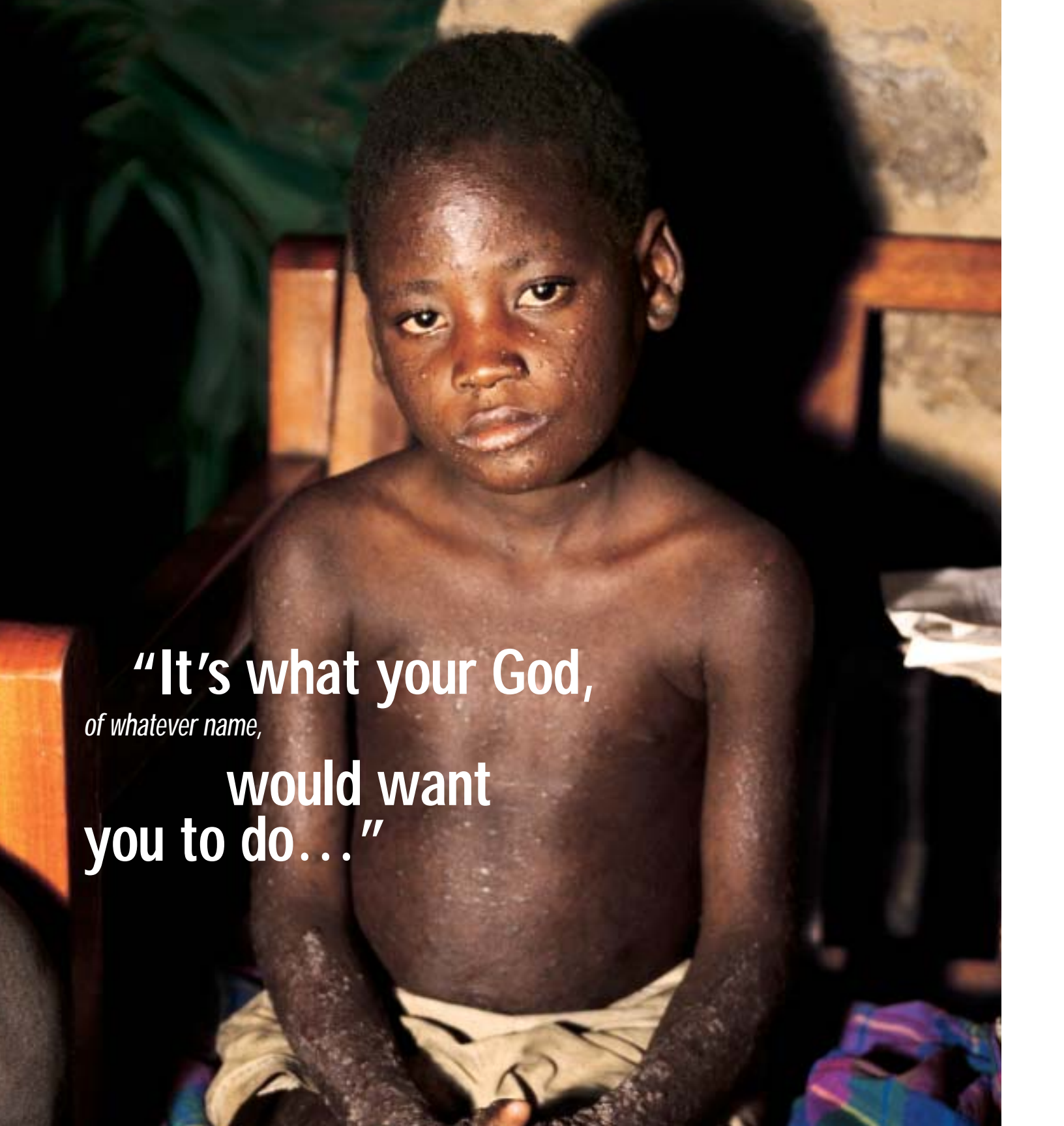
ways of treating a patient, eliminates those that are contraindicated, and sorts the remainder from the most to the least fit by using thousands of filtration rules. For example, if a drug causes a patient an allergic reaction, filtration drops it from further consideration. In addition, tournament rules rank the drug combinations that pass through the sieve of filtration rules. Tournaments weigh combinations in terms of criteria doctors judge important for effective therapy and patient compliance, including potency, regimen simplicity, and preserving other treatment options if resistance develops. Tournament rules, like filtration rules, get updated continuously as HIV medicine progresses. Together with HIV resistance interpretation, the filtration and tournament rules bring to bear the disparate details and emerging research an HIV specialist may know, but that might slip a busy mind pressed for time.

TherapyEdge-HIV can therefore rapidly generate patient-tailored treatment options in milliseconds. Or, “the alternative [task] for the user,” comments Mildvan, “is to say ‘Here is what I, the clinician, am considering

using. Do you see any problems with that? Do you see any preferences for other regimens?” In other words, how does artificial intelligence see my choice? It’s really a cross check of your judgment as a clinician.”

About TherapyEdge, Inc.

TherapyEdge, Inc. was founded in 2000 after receiving US\$12.5 million in private financing from Tibotec-Virco, a subsidiary of Johnson & Johnson, Inc., and Pythagoras Participations. The company, which is based in Durham, North Carolina, has a staff of 20 in the areas of pharmacology, HIV clinical research, software development, artificial intelligence, and related technologies. A clinical advisory panel comprised of distinguished researchers and specialists in the area of HIV/AIDS has been collaborating on the development of TherapyEdge-HIV since inception. The late David W. Barry, former CEO of Triangle Pharmaceuticals, first conceived and started working on the TherapyEdge-HIV product in 1997. For further details on the company, visit www.therapyedge.com. ■



**“It’s what your God,
of whatever name,
would want
you to do...”**

***Editor’s Note:** The following address was delivered June 10, 2002, by Stephen Lewis, Special Envoy of United Nations Secretary-General Kofi Annan, to the African Religious Leaders Assembly on Children and HIV/AIDS in Nairobi, Kenya.*

I feel entirely privileged to address this meeting; it’s actually the first time that I’ve ever addressed a large gathering of religious leaders, and I am appropriately chastened by so auspicious an occasion. What’s more, I want to speak with direct and

sometimes uncomfortable frankness, so I appeal to all of you, at the outset, to let the milk of human kindness flow through your veins and to treat me with compassion.

Your eminences, the direct impact of the pandemic on children, in all its aspects,

will be set out for you later this morning by Carol Bellamy, the Executive Director of [the United Nations Children's Fund (UNICEF)]. She is obviously the right person to do so. For my own part, suffice to say that there are now estimated to be 13 million children orphaned by AIDS in sub-Saharan Africa, with the number almost certain to double by the end of the decade. In human terms, in the history and literature of vulnerable children, there's never been anything like it. In fact, of course, there's never been anything like the HIV/AIDS pandemic. Comparisons with the Black Death of the 14th century are wishful thinking. When AIDS has run its course—if it ever runs its course—it will be seen as an annihilating scourge that dwarfs everything that has gone before.

What it leaves in its wake, in country after country, in every one of the countries you represent, are thousands or tens of thousands or hundreds of thousands or, eventually, even millions of children whose lives are a torment of loneliness, despair, rage, bewilderment and loss. That doesn't mean orphan children can't be happy; it simply means that at the heart of their individual beings there is a life-long void.

The numbers are overwhelming, the circumstances are overwhelming, the needs are overwhelming.

Nor do I intend to quote, in a pretend-learned fashion from religious texts. It would be presumptuous and foolhardy on my part. That is your collective world, not mine.

Rather, I would wish to suggest to all of you, as religious leaders drawn from across the continent, that it is time, it is well past time that you summoned your awesome reserves of strength and followers and commitment to lead this continent out of its merciless vortex of misery. There is no excuse for passivity or distance. No excuse for immobility or denial. No excuse for incremental steps when you, collectively, have the capacity to rally both Africa and the world if you choose to do so.

The timing could not be better. Let me tell you why, and bare my most protected inner thoughts in the telling.

I think we may have reached a curious and deeply distressing lull in the battle against AIDS. Over the last two years, much has happened. The political leadership of Africa has come alive to HIV/AIDS, conferences have been held in profusion, from Durban to Addis to Abuja to New

York to Ougouadougou. [People living with HIV/AIDS] have raised powerful and insistent voices, the [Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund)] has been established, goals and targets have been set, drug prices have been driven down dramatically by generic manufacturers, there are more data and analysis and reports and commentary and studies and sheer newspaper copy available than any library on earth could accommodate, and significant numbers of modest interventions are being pursued.

So it isn't that things have ground to a halt; it's just a cumulative feeling of inertia rather than energy, of marking time, of oh so slowly gathering forces together for the next push, of incrementalism raised to the level of obsession. The Global Fund has received no new sizeable contributions for many months. The G8 Summit later this month in my country, Canada, has made it clear in advance that significant additional money will not be forthcoming. The [New Partnership for Africa's Development (NEPAD)] document, which is the heart of the G8 discussions, and the centerpiece for the future of Africa, deals hardly at all with HIV/AIDS. A series of reports to be released in the near future, just prior to and during the [XIV] International AIDS Conference in Barcelona next month, will acknowledge progress made, but at the same time recite blood-chilling statistics on the situation of youth and children—statistics which make you wonder whether the world has fallen into a stupor of indifference.

It's not only that we can't rest on our laurels; it's the fact that the laurels are fig-leaves. Let me be brutally honest: in the dead of night, I sometimes think to myself that we're losing the war against AIDS—although I do recognize the feeling for what it is: an unwarranted moment of despair. What we need is another massive shot of adrenalin to take the battle to the next level, and you, your eminences, the representative religious leadership of Africa—you are the shot of adrenalin, the energizing force, the catharsis of faith, hope and determination which can propel us forward.

That's the reason for this conference. As always, children and women carry the burden of abandonment, vulnerability, stigma, shame, poverty and desperation. They constitute, for you, the cause you must lead.

You constitute, for them, the meaning of salvation in terms both spiritual and practical.

Who else, beyond yourselves, is so well placed to lead? Who else has such a network of voices at the grass-roots level? Who else has access to all communities once a week, every week, across the continent? Who else officiates at the millions of funerals of those who die of AIDS-related illnesses, and better understands the consequences for children and families? Who else works on a daily basis with faith-based, community-based organizations? In the midst of this wanton, ravaging pandemic, it is truly like an act of Divine intervention that you should be physically present everywhere, all the time. I ask again: who else, therefore, is so well placed to lead?

So where is that leadership? Dare I say that the voice of religion has been curiously muted? There are notable exceptions as there always are. Some of the finest work combating AIDS on the continent is done through religious communities. But you will admit that, overall, the involvement of religion has been qualified at best. I haven't the slightest interest in recrimination or finger pointing. My interest, our interest, should only be, where do we go from here?

I want to suggest, in the strongest possible terms, that you should resolve, at this conference, in the name of all the children, infected or affected, to seize the leadership, re-energize the struggle, and turn the pandemic around. I want to suggest, in the strongest possible terms, that you leave Nairobi this week, with a solemn pledge to yourselves: that you will never again tolerate, even for a moment, lassitude or passivity in the face of so monumental a catastrophe. I want to suggest that the draft declaration of the conference, when definitive, be embraced as though it were legally binding.

All of us, who are your friends, understand the difficulties. We know that certain of the faiths have problems around sexual activity and the use of condoms. We know that there are internal struggles around the leadership roles of women—not to be taken lightly when gender is such a visceral part of the pandemic. We know that the religious leadership at all levels of society needs training, in order to do an effective job in educating your adherents. We know that even amongst religious leaders, there are numbers who are HIV-positive, and have themselves felt the lash and pain of

stigma from colleagues. Religious leaders are human; they face the same challenges and foibles as other mortals.

But religious leaders invoke a higher level of morality; that's why every contentious issue must be treated afresh. The sacred texts, from which all religion flows, demand a higher level of morality. And if ever there was an issue which bristles with moral questions and moral imperatives it's HIV/AIDS. The pandemic, in the way in which it assaults human life, is qualitatively different from all that has gone before. There is no greater moral calling on this continent today than to vanquish the pandemic.

No one expects you to do it, one faith at a time. Somehow, you must come together, in a great religious partnership, so that everyone is involved, at every level. You should formalize the arrangement; you should create an actual structure. Your draft plan of action mandates the World Conference on Religion and Peace to make it happen. Let it be done.

Nor can you do it by faith alone. You have to extend the partnership to representatives of civil society, to associations of [people living with HIV/AIDS], to the [United Nations] family, to women's groups everywhere, to the private sector and to government itself. The pandemic demands that you move beyond the protective insularity of religion. It is often argued that there must be a separation of church and state, that is to say, the religious and the secular. But AIDS puts the argument to the rout. If the church or the mosque or the temple don't work in concert with the state, then death is the victor.

Let me take it further. There should be a series of targeted interventions. Religious communities provide vital care to the ill and the dying at village level. Somehow, the individual projects must be taken to scale across the countries themselves. Religious leaders can confront stigma from every religious podium in every community, changing the values of the community through repetition and education, week in and week out. Religious leaders should lead a campaign to abolish school fees throughout the continent, because whether it's fees, or the costs of registration, books, or uniforms, vulnerable and orphaned children, invariably penniless, are denied the right to go to school. You want a moral issue: why should a just society, a society which has ratified the Convention on the Rights of

the Child, allow such a state of affairs? One visit to the slums of Kabera, here in Nairobi, will reaffirm the sorry consequences for children. It is entirely consistent therefore, that religious leaders should throw themselves behind the Hope for African Children Initiative because there is no dilemma more urgent, more demanding, or more intractable than the dilemma of orphans.

Let me take the argument further still. Religious leaders must do something about the mothers who are infected and are dying prematurely, leaving behind those orphans who wander the landscape of Africa, soon to be an entire generation seething with resentment and fear. May I strike a personal note? The thing I find by far most emotionally difficult as I travel through Africa, is meeting with young women, stricken by AIDS, who know they're dying or soon to die, with two or three young children, and they ask me, frantically, "What's going to happen to my children when I've passed—who will look after them?" And then, in an understandably accusatory tone, they say to me "What about us?" And then they add, without using these exact words, but the meaning is clear: "You Mr. White Man, you have the drugs to keep us alive, but we can't get them. Why? Why must we die?" And I want to tell you: I don't know how to answer that. I have never in my adult life witnessed such a blunt assault on basic human morality. In my soul, I honestly believe that an unthinking strain of subterranean racism is the only way to explain the moral default of the developed world, in refusing to provide the resources which could save the mothers of Africa.

But right now, as I stand before you, I want to know: what will the religious leaders do about it? Surely, in the face of such a violation of fundamental moral tenets, you have an obligation to intervene.

And that takes me to my final proposition. In the last analysis, religious leaders are the best chance to influence the political leadership of the North as well as of the South. You have contacts everywhere. You have brother and sister churches and mosques and temples on all the continents. They support you, they often fund you, [and] they show solidarity with you. Your religious sway is not just Africa, it's the world. And what politician would refuse to meet with you? Who turns down a request

for a meeting from a religious leader? You have an entry to the citadels of secular power that none of the rest of us enjoy.

What does it mean? It means that you should have a say in the Global Fund—you should storm the rhetorical ramparts and demand that the major [member] countries of the [Organization for Economic Cooperation and Development (OECD)] contribute the money which they have promised—the famous 0.7 percent of [gross national product (GNP)]—but never delivered. You should have some sort of collective standing or voice at the G8 meeting. You should have a separate session [at the XIV International AIDS Conference] in July 2002. You should have a presence in international decisions, wherever those decisions are made. You want a precedent? The Vatican has Observer status at the United Nations, and often speaks, including at the UNICEF Executive Board; no government on [the UNICEF Executive Board], at least while I was there, ever took exception to the Vatican's right to participate.

Religious communities historically have followed one of two tracks. There was the religious leadership which successfully fought for the eradication of slavery in the Congo; the eclectic leadership which supported the conscientious objectors in the Vietnam War and helped, thereby, to bring that foul war to an end; the Islamic and Hindu leadership which supported UNICEF's immunization campaigns in Asia and the Middle East, overcoming the fears of the citizens, and doubtless saving millions of children's lives; the Judeo-Christian leadership that resisted the infant formula companies and supported the right to breast-feeding.

And then there was the other, woeful track; the religious leadership that supported apartheid; the religious leadership that was complicit in the genocide in Rwanda; the religious leadership that was silent during the Holocaust.

No one wants a choice between the two. It's simply that when the history of the AIDS pandemic is written, you want it said that every religious leader stood up to be counted; that when the tide was turned, the religious leaders did the turning; that when the children of Africa were at horrendous risk, the religious leaders led the rescue mission. It's what all of us beg you to do; I submit to you that it's what your God, of whatever name, would want you to do. ■



I N T H E L I F E



Anita Rachlis

Vanity Fair readers have every month since 1993 enjoyed *The Proust Questionnaire*, a series of questions posed to celebrities and other famous subjects. The *Vanity Fair* questionnaire—modeled after a questionnaire Marcel Proust was asked to fill out in the late 1800s—reveals much about the respondents' lives, thoughts, values, and experiences. In May 2002, *IAPAC Monthly* introduced "In the Life," through which IAPAC will feature members who have been asked to bare their souls through their answers to ten questions.

This month, *IAPAC Monthly* is proud to feature Anita Rachlis, who is Head of the Division of Infectious Disease and Medical Director of the Ambulatory HIV Clinic at Sunnybrook and Women's College Health Sciences Centre in Toronto.

What proverb, colloquial expression, or quote best describes how you view the world and yourself in it?
"Every cloud has a silver lining."

What activities, avocations, or hobbies interest you? Do you have a hidden talent?
I have a passion for travel and opera.

If you could live anywhere in the world, where would it be?
Santorini, the southernmost Cycladic island in the Aegean Sea, to watch the sun set over the Santorini Caldera.

Who are your mentors or real life heroes?
Michael Back, who inspired an interest to pursue a career in infectious diseases; Donald Cowan, my first physician-in-chief, who recognized the values of an infectious disease consultant; and Peter Ellis, the CEO of our hospital, who supported the need for an HIV clinic.

With what historical figure do you most identify?
Mohandas Gandhi as he was quoted, "We must become the change we want to see."

Who are your favorite authors, painters, and/or composers?
Authors—Robert Ludlum and Robin Cook; Painters—Chagall and Rembrandt; and Composers—Mozart, Verdi, and Puccini

If you could have chosen to live during any time period in human history, which would it be?
The second half of the 20th century, because of the feminist movement providing women with equal opportunity.

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

In your opinion, what are the greatest achievements and failures of humanity?
Human achievements include immunization and the Human Genome Project. Human failures include war and the constant abuse of human rights.

What is your prediction as to the future of our planet one full decade from present day?
In 10 years from now, I predict further destruction of the environment and destruction of the societal infrastructure in Africa. Ten years later, I predict worldwide immunization against HIV, the elimination of malaria and tuberculosis, and a prioritization by governments of the environment. ■



[Strength in Numbers]

[IAPAC Welcomes New and Renewing Members]

In July 2002, the International Association of Physicians in AIDS Care (IAPAC) welcomed 23 new and/or renewing dues-paying physician members from six countries. IAPAC thanks the following physicians for their support of the association's mission to improve the quality of care provided to all men, women, and children living with HIV/AIDS.

Gloria Addo-Aydensu, *USA*
Beatrice Austin, *USA*
José Azocar, *USA*
Karl Brown, *USA*
Neczeper Daniel, *USA*
Michael Davis, *USA*
Jack A. DeHovitz, *USA*

Robin Goggans, *USA*
Marc N. Gourevitch, *USA*
Wolfgang Guthoff, *Germany*
Ross Hewitt, *USA*
Stan Houston, *Canada*
Anthony Japour, *USA*
Debbie Johnson, *USA*
Patrice Joseph, *West Indies*
Arata Kochi, *USA*
Sharon Martens, *USA*
Rodica Matusa, *Romania*
Sai Kyaw Min, *Philippines*
Amjard F. Najjar, *USA*
Alexandra Olympios, *USA*
Richard Parker, *USA*
Marjorie Vincent, *USA*
Olga Wildfeuer, *USA*

There will be 2,000 new IAPAC physician members commencing September 1, 2002, courtesy of Abbott Laboratories. Through an agreement signed in July 2002, Abbott Laboratories is subsidizing two-year memberships for these 2,000 US HIV/AIDS-treating physicians. A list of these new members will be published in an upcoming issue of the IAPAC Monthly. IAPAC thanks Abbott Laboratories for its generosity!

To learn more about IAPAC physician and allied health professional membership, please contact Joey Atwell, Director of Membership, at (312) 795-4941 or jatwell@iapac.org.

[IAPAC Member Named US AIDS Policy Director]

Joseph O'Neill, a physician member of the International Association of Physicians in AIDS Care (IAPAC), was appointed July 19, 2002, to serve as the new Director of the White House's Office of National AIDS Policy (ONAP). O'Neill, who currently acts as Head of the Office of HIV/AIDS Policy at the US Department of Health and Human Services (DHHS), replaces Scott Evertz, who has served as ONAP Director since April 2001.

In addition to fulfilling a role coordinating the US response to HIV/AIDS across many federal government departments, the ONAP Director is also a member of the White House Domestic Policy Council and is thereby empowered with a voice to provide input on a broad range of issues touching upon the health and well-being of all Americans. Further, the ONAP serves as the Executive Secretariat for President

George W. Bush's Cabinet Task Force on HIV/AIDS, which is co-chaired by US Secretary of State Colin Powell and US Secretary of Health and Human Services Tommy Thompson.

IAPAC President José M. Zuniga welcomed O'Neill's appointment, saying that "leadership and expertise in the US response to HIV/AIDS of the caliber that Joe O'Neill can offer is urgently required." Zuniga praised the Bush Administration for its choice of O'Neill — "a pragmatic, no-nonsense physician who has witnessed the suffering of those affected by HIV disease and who is in touch with the realities of how best to address the challenges that lie ahead." He added that IAPAC looks forward to working with O'Neill as he undertakes the challenge of coordinating the US government's response to HIV/AIDS, at home and abroad.

In passing the reigns to O'Neill, Scott Evertz will now step into a new role as Special Assistant to DHHS Secretary Thompson. Zuniga stressed the importance of the duties Evertz will execute in strengthening DHHS strategy to combat HIV/AIDS worldwide. "Specifically," Zuniga explained, "Evertz has an immediate task to bolster US contributions to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund)."

"In his tenure as ONAP Director, Scott Evertz has been a behind-the-scenes advocate for HIV/AIDS issues within the Bush Administration," Zuniga stated. "I am hopeful that at a time when the Bush Administration must enhance its response to the global HIV/AIDS pandemic, he will now advocate for the diverse needs of men, women, and children worldwide who stand to benefit from US munificence."



Democracy slippage jeopardizes human development

Although scores of countries took steps toward democracy during the 1980s and 1990s, progress in many is stalled and some are slipping back to authoritarian rule, putting human development at risk, according to the annual United Nations Development Program (UNDP) Human Development Report released July 24, 2002, in Manila.

The report, entitled “Deepening Democracy in a Fragmented World,” notes that while 140 of the world’s nearly 200 countries hold multiparty elections, only 82 are fully democratic, with institutions such as a free press and independent judiciary. It calls for a new wave of democracy building to give ordinary people a greater say in both national and global policy making.

“The central message of this report is a simple one: to promote human development successfully we need to put the politics back into poverty eradication,” said Malloch Brown. “That means ensuring that the poor have a real political voice and access to strong, transparent institutions capable of providing them with the kind of personal security, access to justice, and services from health to education they so desperately need.”

Sakiko Fukuda-Parr, Director of the UNDP Human Development Report Office and lead author of the report, said that having the means and the freedom to fight for one’s rights, to shape decisions about the future of one’s own community, to gain access to crucial information and markets—in short, having a choice in life, is at the core of human empowerment.

Most parts of the world have made progress in human development, but 21 countries registered a decline in the Human Development Index (HDI), based



on life expectancy, adult literacy, and per capita income, during the 1990s. Fully 52 countries ended the decade poorer than at its beginning, and though the number of people living in extreme poverty was nearly halved in Asia, it grew in all other regions, jeopardizing countries’ progress towards the Millennium Development Goal of halving severe poverty by 2015.

Aid to developing countries fell during the decade, and for Africa it was halved, dropping from US\$39 to US\$19 per person annually. Donor countries continued to subsidize their farmers at a rate of US\$1 billion a day, more than six times their total aid to poor countries, flooding markets with cheap imports and squeezing out poor country farmers. The number of refugees and internally displaced persons worldwide grew by 50 percent.

These trends are “deeply troubling,” said Fukuda-Parr. “All this adds up to a world in urgent need of a political order that can

achieve greater inclusion, an order in which all people and countries can have a say in decisions that affect their future, and one with rules and institutions which command trust among all people and countries.”

With specific regard to health, the report states that democracies engender an environment conducive to communication about critical health issues, “such as the negative implications for women of a large number of births, the benefits of breast feeding, and the dangers of unprotected sex in the context of HIV/AIDS.” In these areas, according to the report, open dialogue and public debate can disseminate information and influence behavior. For example, sharp declines in fertility in highly literate Indian states such as Kerala were due not only to high literacy but also to its interaction with public debates on the benefits of smaller families. The UNDP summarizes that free, open public debates are the cornerstone of a constructive role that democracies can play in promoting development.

Of note, the top five HDI countries in this year’s UNDP Human Development Report are Norway, Sweden, Canada, Belgium, and Australia—all of which account for an average life expectancy at birth of 78.9 years. The five lowest-ranking HDI countries are Burkina Faso, Mozambique, Burundi, Niger, and Sierra Leone—all of which account for an average life expectancy at birth of 42.1 years. ■

Editor’s Note: The UNDP has commissioned the Human Development Report by an independent team of experts to explore issues of global concern every year since 1990. To view the 2002 Human Development Report, visit www.undp.org.



S A Y A N Y T H I N G



What was said at the XIV International AIDS Conference...



Peter Piot

No nation would refuse to fight an invading army because some expert argued it would be cheaper to invest in defenses against future invasions. It is not a matter of prioritizing lives now over lives tomorrow.

Peter Piot, Executive Director of UNAIDS, in a July 7, 2002, speech at the Opening Ceremonies that welcomed more than 13,000 delegates to the fourteenth global gathering exclusively devoted to HIV/AIDS. Piot forcefully argued "the quality of future lives depends on the quality of life today." He further challenged governments, the private sector, nongovernmental organizations, and citizens of the world to increase their individual and collective efforts to combat HIV disease.

... if countries, rich and poor, live up to the commitments they made at the Special Session, 29 million of these infections, or more than 60 percent, could be averted. Delaying this response by just one year is going to cost another 5 million lives.

Bernhard Schwartländer, Director of the World Health Organization (WHO) HIV/AIDS Department, in an opening plenary session presentation July 8, 2002, based largely on a paper published in the July 6, 2002, issue of The Lancet. In his presentation, Schwartländer (one of the co-authors of The Lancet paper) predicted there would be another 45 million people living with HIV/AIDS by 2010 unless governments make available a comprehensive package of interventions agreed to during last year's United Nations General Assembly Special Session on HIV/AIDS.

While the best time to plant a tree is 20 years ago, the next best time is now.

Helene Gayle, Director of the HIV/AIDS and Tuberculosis Program at the Bill & Melinda Gates Foundation, during a July 9, 2002, plenary session presentation entitled, "Prevention Now! A Vision for the Future." Gayle, who formerly headed HIV, tuberculosis, and sexually transmitted diseases prevention efforts at the US Centers for Disease Control and Prevention (CDC), said that intensified prevention interventions implemented without delay might avert 45 million new HIV infections this decade.

Those workers have used their bodies and sacrificed their bodies and their families to ensure that that company makes the enormous amounts of profit it does on the world market for gold and other minerals.

Zachie Achmat of the Treatment Action Campaign (South Africa) in a media statement issued July 10, 2002, from Cape Town, South Africa, denouncing Anglo American plc for canceling a fledgling pilot program that was to have provided antiretroviral therapy to HIV-infected employees. Achmat appealed to Anglo American and other private sector companies to accept responsibility for expanding access to HIV/AIDS care within their respective workforces.

I commit to balance in the interventions that we support. We will fund prevention... lots and lots of prevention. We will fund treatment... lots and lots of treatment.

Richard Feachem, Executive Director of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), during a senior lecture he delivered July 9, 2002. His much anticipated speech helped to quell some criticisms around the Global Fund's first dispersal of funds earlier this year, as well as turn up the heat on affluent countries, including the United States, accused of not committing significantly more money to support United Nations Secretary-General Kofi Annan's brainchild.