EDITORIAL

GLOBAL AIDS

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HIV/AIDS is the greatest health crisis the world has faced. In two decades, 40 million lives have been lost and 40 million people live with the virus, 95% of them in developing countries (see Figure 1).[1] Today the average life expectancy in sub-Saharan Africa is 47 years: without AIDS it would be 62.[2] AIDS destroys countries and saps their vitality as teachers, health professionals and businessmen die. Loss of civil servants weakens core government functions and threatens security. One of the important lessons learnt in attempts to halt the epidemic is that health professionals must collaborate with other disciplines as risky behaviour is fed by gender inequality and poverty.

The recent College symposium offered a comprehensive picture of the social, economic and health aspects of the epidemic.[3] Discussion ranged from the interaction between malaria and AIDS in Malawi (with both diseases, the risk of dying is five times higher), to recent vaccine research (disappointing), to isoniazid prophylaxis (fails to improve survival in Africa). Professor Solomon Benatar from Cape Town debated the ethical and economic reasons why sub-Saharan Africa carries 75% of the global AIDS burden. Resources (including health staff) are being siphoned out of the continent with a cynicism which, as Benatar suggested, '[indicates that] the lives of people of colour are less valuable'.[3] Africa is saddled with $305 billion debt while its share of trade is barely 2% and investment in the continent has shrunk to $11 billion a year.[4]

FIGURE 1
Adults and children estimated to be living with HIV/AIDS, end 2003. Reproduced by kind permission of UNAIDS www.unaids.org © 2003.

HOW DEPENDABLE ARE THE STATISTICS?
HIV prevalence varies considerably across Africa – ranging from 1% in Mauritania to almost 40% in Botswana. In Zambia, the confidence intervals have uncertainty ranging between 15–30%, though 20% prevalence is usually quoted. 'There is more uncertainty about the accuracy of south Asian estimates,' said Professor Geoff Garnet from Imperial College, London.[3] In India, with four to five million infected, the disease is spreading from cities to rural areas. However, the epidemic trajectory appears to be different from Africa, perhaps because rates of extra marital sexual contacts are lower.[5] There is no room for complacency as a 1% increase in Indian HIV prevalence would result in an extra five million infected.

Prevalence in sub-Saharan Africa (as measured between 1997 and 2002) appears to be levelling off.[6] This apparent stabilisation masks the fact that persistently high numbers of annual new infections match the equally high number of AIDS deaths (2·3 million last year). Antenatal estimates, used commonly as national estimates, tend to over-inflate prevalence. Uganda's prevalence has fallen markedly, but there is debate on how much is due to the maturity of the epidemic or to Uganda's leadership, its support for female education and empowerment, and outlawing gender violence. There is evidence from Zimbabwe that young people now have fewer sexual partners.[3]

In the UK there were 7,000 new HIV cases diagnosed last year, 26% in men who have sex with men (MSM); 84% of these were probably infected within the UK.[7] However, since 1999, the number of HIV infections diagnosed in the heterosexual population has exceeded those in MSM. Of the 120 new heterosexual infections in Scotland last year most were acquired from the African continent. Scotland now has 1,200 people on antiretroviral (ARV) therapy. The continuing upward trend in other sexually transmitted diseases may not presage well for a future AIDS epidemic.

RISK FACTORS
One of the biggest risks for acquiring AIDS in Africa is childhood loss of one or more parents.[3] This is associated with earlier sexual activity and a lack of schooling, which is worrying with 11 million AIDS orphans currently in southern Africa, and a forecast of 40 million for the next ten years. These are children who are on the streets, denied food, schooling and parental control.

Poverty causes mass migration, lack of housing and female economic dependence all of which erect barriers to health-protective behaviour. Drug abuse is the cause of epidemics in 110 countries mainly eastern Europe, China and Indonesia.[8] HIV prevalence among injecting drug users can rise to 40% or more within two years of the introduction of the virus to the community.

ACCESS TO THERAPY

Since 1996, ARV drug cocktails have improved the quality and lengthened the lives of those with AIDS in rich countries, but fewer than 2% of those currently requiring ARVs in Africa can obtain them. Millions of people were, until recently, viewed by the world as 'too poor to treat'. In 2003, the WHO Director General, Lee Jong-wok, set an ambitious target to reach three million people with antiretroviral therapy by 2005 (the '3 by 5' policy). The five pillars of the strategy are: global leadership, advocacy, sustained country support, standardised tools for ARV delivery, reliable supply of medicines and rapid application of new knowledge.[9] But who will benefit? The special vulnerability of young women means they should have special access, which will not be easy, given their second-class status.

The Global Fund to Fight AIDS, Tuberculosis and Malaria and bilateral programmes, like the US President's Emergency Plan for AIDS Relief (PEPFAR) have been launched to support the '3 by 5'. Although the benefits of ARVs are universally acclaimed, there is concern that widespread and inappropriate use can cause viral resistance which may be accelerated by treatment expansion. Resistance to every currently licensed drug has been observed.[10]

THE LOTHIAN ZAMBIA PROJECT

The flow of funds must be supported by technical and human resources for safe use of new drugs and technologies. This is difficult in countries like Zambia with poor health infrastructure and annual health spend of about $5 per person. It is much to the credit of Lothian NHS to be the first UK health authority to twin with a resource poor country (Zambia) with the purpose of exchanging technical support for capacity building, not only for ARV therapy, but also for better understanding of wide-ranging prevention programmes in both Scotland and Zambia.[11,12]

SIGNS OF HOPE

Uganda and the experience of Thailand and Cambodia have demonstrated that consistent political commitment can bring the epidemic under control. Behavioural change, combating sexual exploitation of women and children, fewer sexual partners, condom use, safe blood transfusion, voluntary testing and counselling, all contribute. By treating pregnant women with ARV drugs the transmission rate to babies can be greatly reduced. But controlling the HIV epidemic requires a large-scale investment in the public health infrastructure, as well as tackling poverty.

In February 2004, Tony Blair launched the Commission for Africa to generate action to achieve the Millennium Development Goals during the British presidency of the G8 and EU next year. One of these goals is to reverse the spread of HIV/AIDS. So far the global community has been less than generous in responding to the epidemic. But, as Professor Benatar argued, when the lives of billions are devalued, our own long-term security and well-being are also threatened.[3] Money, knowledge and weapons may cease to protect us. US Secretary of State Colin Powell said, 'AIDS is a catastrophe far worse, by orders of magnitude, than any other problem or crisis we have on the face of the earth right now . . . worse than terrorism.'[13] Doctors have a role in ensuring that political leaders fulfil their commitments to put forward significant resources and support.

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