global issues

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Health Systems for HIV/AIDS & Other Diseases

"Diseases such as AIDS destroy countless lives and undermine the success of many nations. Prosperous nations must work in partnership with developing nations to help remove the cloud of disease from our world's future."

President George W. Bush, October 20, 2001

Cover Design: The cover incorporates the well-known symbol of the AIDS ribbon with the symbol of Aesculapius (Greek: Asklepios) identified in both Greek and Roman mythology as a physician. His powers of healing eventually made him a cult figure, worshipped as a God.

From the Editors

On World AIDS Day, December 1, 2001, the Joint United Nations Program on HIV/AIDS reported "AIDS has become the most devastating disease humankind has ever faced" with 40 million people now infected. As recognition of the magnitude of the problem has grown in recent years, consensus has emerged that building effective partnerships is absolutely fundamental if societies are to save lives and ease the suffering of persons with HIV/AIDS or other life-threatening maladies such as malaria and tuberculosis. Partnerships bring together civic, medical, and government resources to shape an overall response to disease, addressing prevention, treatment, and care.

The partnership process and the development of health care systems that grow from it result in priorities for the allocation and application of scarce health care resources. The specific structure that emerges will be different for each organization or country, reflecting the context in which it is developed.

In this publication, we present initiatives and strategies that government officials, medical professionals, private citizens, and people of faith are devising to prevent disease and improve health care for today and the future.

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FOCUS

U.S. Targets Global AIDS Pandemic

By Scott Evertz
Director, White House Office of National AIDS Policy

The Bush administration develops a multidisciplinary strategy to address HIV/AIDS domestically and internationally.

In response to the unique challenges presented by the HIV/AIDS pandemic, President Bush has initiated an innovative and integrated approach to setting our priorities and implementing our agenda. First and foremost, domestic and international issues will be coordinated and integrated to present a holistic approach to the problem. This approach is mirrored medically in our commitment to an integrated attack on the disease through care, treatment, and prevention. The administration recognizes that the United States, in order to help its own citizens, must be part of a larger, global solution, and that any successful attack on HIV/AIDS must be accompanied by a general effort of nations to improve the overall health and well being of their citizens. While the war on terrorism obviously occupies many of our immediate thoughts, the global fight against HIV/AIDS remains part of the important work of America, and that work continues.

The Bush Administration Approach

In April 2001, President Bush launched his campaign against HIV/AIDS by naming me the Director of the White House Office of National AIDS Policy (ONAP) and expanding our mandate. The mission of the office now includes the international and national security aspects of the pandemic, and coordination of international and domestic policy relating to U.S. efforts to combat the disease abroad. Our office is the principal entity in the U.S. government responsible for the overall formulation, support, and coordination of policy on HIV/AIDS.

In order to better coordinate the administration's international and domestic fight against the HIV/AIDS pandemic, and to implement our policy decision that international and domestic efforts should be integrated, President Bush established a Presidential Task Force in May 2001 to ensure the most effective response by the United States to the growing threat of the global HIV/AIDS pandemic. The task force is co-chaired by Secretary of State Colin Powell and Secretary of Health and Human Services Tommy Thompson, and includes high-level representatives from all major foreign and domestic affairs agencies.

The task force held its first meeting in July 2001 at the

White House. In addition to the improved coordination it provides, the task force is a physical manifestation of the importance this administration places on this issue. The task force will forge new domestic partnerships to work with our international partners on this issue.

Important elements of our fight against HIV/AIDS are our own civil society institutions and nongovernmental organizations (NGOs). As part of this effort, President Bush has continued the Presidential Advisory Council on HIV/AIDS, retaining several existing members, as well as adding several new appointees. The advisory council serves as a main channel for advice and communication with all those elements of U.S. society most interested in and affected by HIV/AIDS. The newly constituted council will, for the first time, also provide views and ideas on the international aspects of our campaign against HIV/AIDS, and we hope other countries will learn from our experience and establish mechanisms to ensure broad public participation in and support for their own national campaigns to combat HIV/AIDS.

U.S. Leadership on the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis

Internationally, we have moved aggressively to use this new structure to help mobilize the global fight against HIV/AIDS. In June 2001, the United Nations held a Special Session of the General Assembly to debate and address the global problem of HIV/AIDS. Under the personal initiative of Secretary-General Kofi Annan, and with strong support from the United States, the nations of the world have undertaken to establish an independent mechanism to raise and coordinate the distribution of massive amounts of new and existing resources to combat the pandemic worldwide. The United States, at the direction of the Bush Administration, has been at the forefront of this effort, and has made an initial commitment of $200 million in the first year of the fund. This is the largest commitment to the fund to date.

As this article goes to press, we are negotiating with the affected countries (both donors and recipients) and organizations for the establishment of new, innovative, accountable, and transparent mechanisms for the disbursement of global assistance to fight HIV/AIDS, malaria, and tuberculosis. We are committed to this new fund using an integrated approach of care, treatment, and prevention. While the fund will be used to support direct programs to combat HIV/AIDS, malaria, and tuberculosis, obviously, the general health care infrastructure of the affected nations will also be a matter of concern. Our commitment to the success of this fund is one of the cornerstones of our international strategy. The United States also continues to lead the world in medical research efforts, not only on HIV/AIDS directly, but on many other emerging and re-emerging infectious diseases. As we work against the HIV/AIDS pandemic, we remain mindful of the value of the hundreds of collaborative research efforts around the world sponsored by the U.S. Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). The Bush administration has proposed and supported increases of several hundred million dollars in the current budgets of these key institutions.

Continuing U.S. Bilateral Efforts

While we are fully committed to the multilateral, global effort to combat HIV/AIDS, we believe that direct, bilateral programs must be enhanced and coordinated on a global basis. The United States has consistently been the largest provider of bilateral international assistance in the fight against HIV/AIDS, and is likely to remain so. The United States has bilateral cooperative programs with dozens of countries around the world, including 25 in sub-Saharan Africa alone. Yet, as we work around the globe, we never forget that international health begins at home.

Recognizing the inherent connection between America's health and the health of our neighbors, President Bush sent Health and Human Services Secretary Tommy Thompson and me to the U.S.-Mexico border region in October 2001 to work with our southern neighbor on general health issues of mutual concern, including HIV/AIDS. We visited clinics that care for a cross-border population and met with Minister of Health Julio Frenk of Mexico to discuss the need for an improved health care infrastructure on both sides of the border. This visit is another example of how we are working to put our policies into practice.

Here in Washington, D.C., it has been my pleasure to participate in several international visitor programs for groups especially interested in issues related to HIV/AIDS. These meetings and discussions have helped educate me as to what caregivers and policy makers are facing around the world in the fight against the pandemic. Such programs are an important part of our direct, bilateral efforts in the international fight against HIV/AIDS. Importantly, the respective experiences of

our domestic programs can be shared, adapted, and transferred to each other as a new tool against the disease. Once again, our openness to such opportunities is a reflection of our belief that you cannot separate the disease into foreign and domestic compartments. ONAP will continue to make a special effort to be available to our foreign colleagues for the sharing of experiences and ideas.

Conclusion

At least 40,000 people become newly infected with HIV/AIDS in the United States every year, and while our principal task must be to bring better care, treatment, and prevention to our own country, I am committed to that same goal for those millions afflicted around the world. Here at the White House we will work for the best possible cooperation and coordination among not only our own government, but with like-minded colleagues around the globe. For us, an enduring lesson of the HIV/AIDS pandemic is that the health of the world is the health of America. ❏

Diplomacy Is Central to Building Public Health Infrastructure

By Jack C. Chow, M.D.
Deputy Assistant Secretary for International Health and Science
U.S. Department of State

The Department of State works to advance U.S. objectives and interest in establishing a healthier world community through diplomacy.

The campaign to save human lives from the global HIV/AIDS pandemic is more compelling than ever before: with 40 million people living with the virus and nearly 3 million dying from the disease in the past year, the world community is awakening to the need to confront the pandemic through tangible, effective action.

It is well recognized by public health professionals that an integrated approach to prevention, treatment, and supportive care is critical to mitigating the disease's impact on individual lives and to averting the pandemic in vulnerable regions and communities. Central to that approach is establishing the capacity in both heavily affected and at-risk countries to deliver care and provide essential services. This entails having sufficient numbers of trained professionals, hospitals, clinics, laboratories, research facilities, and equipment. Linkages among these resources are also essential to provide operational effectiveness, sustainability, and overall coordination. The complexity of confronting an epidemic of the size and impact of HIV/AIDS increasingly requires health data and surveillance systems, logistical know-how, and management capabilities.

The U.S. government is the leading provider of direct assistance to developing countries in building health system capability. Several U.S. agencies, including the Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH), support the in-country training of doctors, researchers, epidemiologists, and health professionals, and provide technical assistance on establishing and maintaining systems.

In the area of international health, the role of the Department of State is to advance U.S. objectives and interests in establishing a healthier world community through diplomacy. In recognition of the growing challenge in spurring action against HIV/AIDS and other major diseases, the department has created the new Office of International Health Affairs (IHA) within the Bureau of Oceans, International Environmental, and Scientific Affairs. This new office, building upon the previous Office of Emerging Infectious Diseases, is the State Department's focal point for global health affairs, linking and coordinating actions by governments, nongovernmental organizations (NGOs), private companies, and health communities.

IHA supports three overarching goals towards fighting the AIDS pandemic: mobilizing resources, galvanizing national leaders towards effective action, and garnering citizen support for destigmatization and for national health investments.

Mobilizing Resources

Resources are vital in building public health infrastructure and providing essential services to people living with HIV/AIDS. The State Department is now leading negotiations that would create a new Global Fund to Fight AIDS, Tuberculosis, and Malaria. This new fund would attract, manage, and disburse additional resources through a new public-private partnership that would make a sustainable and significant contribution to the reduction of infections, illness, and death caused by these three diseases. It is anticipated that partnerships formed in countries at risk of, or heavily impacted by, AIDS and

the two other diseases would receive funding to enhance access to prevention, treatment, and care; boost training of health professionals; and build community-based programs. These partnerships, composed of governments, NGOs, and private sector entities, would target gaps in their public health systems, intervene to close them, and establish lasting systems.

In recognition of the importance of averting the HIV/AIDS pandemic in a large, strategic region such as Asia, IHA, through the OES Initiatives program, awarded a grant to the University of Washington that will help establish a "network of networks" in regional disease surveillance against HIV/AIDS in Asia. This grant was announced during President Bush's October 2001 visit to the Asia Pacific Economic Cooperation (APEC) forum in China.

Galvanizing National Leaders

The State Department actively seeks to establish HIV/AIDS and global health issues at the forefront of contemporary diplomacy. State has assured the inclusion of health in key diplomatic venues such as the U.S.-European Union and G-8 summits, and actively participated in meetings of the U.N. General Assembly's Special Session on HIV/AIDS, APEC, the Association of South-East Asian Nations (ASEAN), the Southern African Development Community, and several others.

By making a persuasive case to national governments and social leaders that the fight against HIV/AIDS is in their national interest, the State Department spurs the commitment by those leaders to take effective action and make compelling choices in support of their national health policies. No member of the global community can afford, either in terms of human suffering or economic costs, to fail to recognize or to forestall the impending devastation that has already begun to ravage national economies, stability and security, and social infrastructure. Political commitment at the highest level of government, as well as throughout a nation's societal institutions, makes the crucial difference in stemming the epidemic.

The role of our diplomatic posts has been and will continue to be vital in the campaign against HIV/AIDS. With over 250 diplomatic and consular posts around the world, staffed with excellent and dedicated foreign service officers in political, economic, and science counselor roles, health attaches provided by the Department of Health and Human Services, and USAID field professionals, the State Department is uniquely situated to convey the importance of health to the world community. The State Department has sponsored major chiefs-of-mission conferences in Africa, one in Zimbabwe and another in Kenya, focused on HIV/AIDS, and will be planning additional conferences in the near future in regions where the epidemic is poised to accelerate.

Garnering Public Support

No national or international policies against the pandemic can succeed without the direct support of citizens. A well-informed citizenry is the first line of defense against the spread of the disease. Citizens must know the steps they can take to lower their risk of getting infected or spreading the infection. They must know what resources are needed to create and maintain public health infrastructure. They must understand how to dispel the fear and prejudices surrounding HIV/AIDS.

The State Department recognizes the importance of listening and speaking to citizens around the world about what needs to be done to support public health needs. In my role as the Deputy Assistant Secretary for International Health and Science, I have met and spoken to many individuals and groups concerned about global health issues. Overcoming nascent and well-established problems in global health requires a dialogue with people who have new and compelling ideas. I have been hearing many excellent suggestions and proposals on how the United States and the world community can work together. I, along with the staff of the IHA office and the State Department, will continue to reach out to the people of the United States and the international community to hear their comments, criticism, and ideas.

The lasting need for strong public health infrastructure both domestically and internationallly serves to confront HIV/AIDS as well as other debilitating diseases. As the challenge grows in complexity and intensity, it is more and more evident that diplomacy will be essential in assembling the resources, political support, and citizen recognition needed to make a tangible, sustainable impact. The State Department, as the lead U.S. foreign affairs agency, will play an increasingly important role in spurring action on an unprecedented scale and scope. ❑

COMMENTARY

Family Health International: A Leader in the Fight Against HIV/AIDS

By Gail Goodridge and Benjamin Weil

Goodridge is Director of Field Programs for Family Health International's HIV/AIDS Prevention and Care Department. Weil is an editorial consultant specializing in HIV/AIDS.

An international nongovernmental organization pursues a variety of strategies to help build health care infrastructure and preventive HIV/AIDS programs on the local level in the developing world.

Virtually every organization striving to improve public health has had to come to grips with the HIV pandemic. International organizations working on HIV/AIDS issues face the triple challenge of dealing with the multiple causes and repercussions of the pandemic; strengthening the links among HIV/AIDS prevention, care, and support; and forging partnerships with governments and nongovernmental organizations (NGOs) to implement effective responses.

"HIV/AIDS is truly unique in its potential to undermine societies," says Tony Bennett, associate director of Field Programs for Family Health International (FHI), a nonprofit organization founded in 1971 to improve global public health. "HIV continues to spread rapidly in many parts of the world, requiring a forceful, comprehensive, and long-term response from the international community."

FHI, a U.S.-based organization, has been a leader in the fight against HIV/AIDS for 15 years. The organization, with more than 500 employees in over 25 countries, has worked to curb the epidemic and mitigate its impact in every region of the developing world. FHI's ability to manage complex programs, its early leadership addressing HIV/AIDS as a major threat to health and development, and its network of international partners convinced the U.S. Agency for International Development (USAID) to entrust the organization with its flagship HIV/AIDS projects.

FHI's first USAID-sponsored project was the AIDS Technical Support Project (AIDSTECH), which operated from 1987 to 1992 with a budget of $40 million. Under AIDSTECH, FHI managed 185 subprojects in more than 35 countries. In 1991, USAID selected FHI to operate the AIDS Control and Prevention (AIDSCAP) Project, a six-year, $200 million program that would become the largest international HIV prevention effort to date. Under AIDSCAP, FHI worked closely with a wide range of partners to design, implement, and evaluate more than 800 HIV/AIDS and sexually transmitted infection (STI) interventions in 50 countries. Since 1997, FHI has conducted USAID's Implementing AIDS Prevention and Care (IMPACT) Project, a five-year, $150 million program with more than 680

subprojects in 40 countries. FHI will also manage the $200 million IMPACT II project planned for 2002-2007.

When FHI began working on HIV/AIDS there were few precedents. By developing innovative approaches to prevention, care, and support, FHI has identified valuable lessons. For example, FHI has learned that messages compelling people to use condoms and avoid risky sexual behavior are not enough to halt the spread of HIV. It is also critical to understand the determinants facilitating transmission, identify the motivations behind risky behavior, provide strategies and build skills to reduce risks, and ensure that support services are in place for people infected and affected by HIV.

The crucial link between prevention and care merits particular emphasis. For many years, governments and donor agencies believed that concentrating on prevention would avert the need for care and support services. Yet recent studies show that care and support for people living with or affected by HIV/AIDS are requisite components in stemming further spread of the virus. For example, voluntary counseling and testing (VCT)—the mainstay of psychological support—is an important element in promoting safer sexual behavior which, in turn, prevents HIV infection. The prevention-to-care continuum also includes provision of antiretroviral drugs for people living with HIV/AIDS; management and prevention of STIs, tuberculosis, and other opportunistic infections; prevention of mother-to-child transmission of HIV; and programs for orphans and other children vulnerable to HIV infection.

One of the most important lessons learned by FHI is that partnerships with governments and local organizations are essential in developing HIV/AIDS programs that continue beyond the period of donor funding. FHI works with a broad range of partners to increase local governmental and NGO capacity to carry out prevention, care, and support projects in Africa, Asia, Eastern Europe, Latin America, and the Caribbean. A review of three country projects demonstrates how FHI and its partners have translated goals and objectives into actions and results.

Lesedi: STI Services for Women in a South African Mining Community

South Africa is home to one of the fastest-spreading HIV epidemics in the world. Rural poverty, job-related migration, and high STI rates fueled an increase in HIV prevalence among pregnant women (a group epidemiologically representative of the general population) from less than 1 percent in 1990 to more than 20 percent in 1999. Commercial sex workers near South African mines cater to thousands of male migrant workers living in single-sex hostels, leading to high STI rates among miners and their female partners. The presence of other STIs increases the risk of acquiring HIV.

In 1996, with USAID funding, FHI and Harmony Mine Hospital launched the Lesedi Project in South Africa. The project established mobile clinic services and a peer educator network to reach women at risk in the vicinity of the Harmony Mines. The women helped to design the services, and peer educators were selected from among the population being served. Local researchers determined the ideal sites for mobile services. Further research, in partnership with area residents, suggested that periodic screening for STIs and treatment of all women regardless of STI symptoms—an approach known as presumptive treatment—would ensure coverage for most at-risk women. All women referred to the clinic by peer educators were encouraged to return monthly for prevention counseling and presumptive treatment with a single dose of an antibiotic to treat chancroid, gonorrhea, chlamydia, and incubating syphilis.

During the first nine months of the project, more than 400 women attended the clinic at least once for examination, counseling, and treatment. During this same period, STI prevalence among these women fell by 70-85 percent; rates of gonorrhea/chlamydial infection among local miners dropped by 43 percent; and reported incidence of ulcers decreased by 78 percent. Self-reported condom use rose from nearly zero to 20-30 percent of commercial sex encounters. A cost-benefit study concluded that the project, which cost $53,760 per year to operate, was generating annual medical savings of $539,430 due to lower levels of STIs to be treated. At the end of the project's first year, Harmony Mines, with support from the South African Department of Health, assumed the management and implementation costs of the project, and expanded its geographical and demographic coverage. The Lesedi Project is being replicated in several South African mining regions.

Pantè: Condom Social Marketing and Community-Based Distribution in Haiti

Haiti has the highest adult HIV prevalence rate in the world outside of Africa. Extreme poverty and high

unemployment—at least 50 percent—have hastened the spread of the virus, as have political and economic instability and severe environmental degradation. Commercial sex, displacement of the population from rural to urban areas, the separation of families, and a rising sense of desperation among unemployed, out-of-school youth have all increased, fueling an HIV prevalence rate of 10 percent in urban centers and 4 percent in rural areas by 1999.

From 1991 to 1996, FHI and Population Services International (PSI), an NGO promoting greater access to health care and services, collaborated on a condom social marketing project implemented by Haitian NGOs at the community level and funded by USAID. Before the project, condoms were commercially available for approximately 25 U.S. cents—a prohibitive price in Haiti, where average annual per capita income was only $400. Condoms were generally available in cities and towns but not in most villages or rural areas. Condom sales averaged about 30,000 per year in 1990. By 1996, when the project ended, annual sales had increased to over 540,000.

Two factors help to explain the project's success. First, PSI launched "Pantè" (Creole for panther), Haiti's first socially marketed condom. USAID ensured that this brand would be available for 3 U.S. cents each. Second, the project partnered with four NGOs already involved in HIV/AIDS prevention and trained 175 staff to serve as both wholesale distributors and retail sales agents. These community-based distributors, who received a percentage of condom revenues, were able to access areas out of reach of FHI and PSI and established points of sale in nightclubs, beauty salons, small shops, and other outlets.

The Pantè social marketing project—later partnered with nine local NGOs—ultimately helped to create 3,000 new points of sale, spread throughout Haiti's administrative départements and 95 percent of its administrative communes.

Voluntary Counseling and Testing in Kenya

Under the IMPACT Project, FHI is working with such partners as the Government of Kenya, the University of Nairobi, the University of Ghent, the Liverpool School of Tropical Medicine, the U. S. Centers for Disease Control (CDC), PSI, and local NGOs to expand voluntary counseling and testing services in Kenya. Quality counseling, immediately before and after HIV testing for both negative and positive clients, in addition to follow-up counseling in the weeks after testing, is essential to behavior change and helping clients live positively with HIV. VCT services in Kenya officially began in March 2001 with the launch of rapid HIV testing. The project is implementing two models of service: integrated VCT services for women and men who attend government and NGO health facilities; and "stand-alone" services mainly for young people, men, and healthy people who do not visit government or NGO facilities. Together with the Kenya Ministry of Health and National AIDS Control Council, FHI is also helping to develop policies, standards, and guidelines for VCT services, as well as related curricula and testing protocols.

Since services were initiated, the project has provided VCT services to nearly 10,000 clients at 32 sites in 10 districts. All sites provide same-day counseling and testing with rapid-test kits, and a network for referrals to all clinical and social service agencies and NGOs that assist HIV-positive clients. Some sites also refer clients to services for prevention of mother-to-child transmission of HIV and the provision of tuberculosis prophylaxis. The CDC plans to extend VCT services through support for 20 additional stand-alone sites, and the Government of Kenya is expanding services to more than 200 sites throughout the country, with the assistance of the World Bank-financed DARE project, a large-scale HIV/AIDS program also underway in Kenya.

Conclusion

FHI's long-running partnership with USAID has resulted in extensive HIV/AIDS prevention and care programming in the developing world. FHI and its collaborators have demonstrated the value of partnership, capacity building, and linking prevention and care efforts in responding to HIV/AIDS and strengthening local health-care delivery. HIV/AIDS program managers have learned which approaches are most effective and how to achieve results. The global leadership of the U.S. government has enabled organizations such as FHI to have an impact on HIV/AIDS and health care at the community level. Maintaining and increasing funding levels for international HIV/AIDS programming will help FHI and its partners to scale up these efforts and achieve results at the national level. ❏

Goodridge also serves as Deputy Project Director of the FHI's Implementing AIDS Prevention and Care Project.

HIV/AIDS Prevention and Care in Developing Nations: The Building Blocks Model

By Rafael Mazin, M.D, M.P.H.
Regional Advisor on HIV/AIDS Prevention and Comprehensive Care
Pan American Health Organization/Regional Office of the World Health Organization for the Americas

Health professionals have learned a great deal about the epidemic and use those lessons to help shape treatment strategies for the future.

The HIV/AIDS epidemic in the Americas has entered its third decade, and its steady growth brings ever more tragic results. Approximately 2.7 million people are currently living with HIV in the region—1.4 million of them in Latin America, 390,000 in the Caribbean, and nearly 1 million in North America.

Every day some 600 to 700 new HIV infections occur in the region, with estimates of deaths from HIV/AIDS reaching 100,000 in the year 2000.

The past five years have been marked by great strides in the prevention and control of HIV/AIDS however. Treatment with antiretroviral (ARV) drugs is certainly one of the most significant developments. Since 1996 mortality from HIV/AIDS has been reduced by as much as 90 percent in the industrialized countries with ARV treatment. It has also been successful in Latin America and the Caribbean when comprehensive care has been combined with carefully planned prevention and communication strategies.

In the last two decades, we have learned some important lessons about HIV/AIDS care and prevention. Let's first examine the prevention strategies. It is often assumed that communities already understand the cause of HIV/AIDS, the risk behaviors associated with transmission of the virus, and the specific practices that make prevention possible. Several demographic and social phenomena belie this assumption. For example, many children who are now adolescents were not the original targets of public awareness campaigns and thus do not have the information they need to take precautions when they become sexually active. At the same time, the saturation that occurs as part of the information dissemination process reduces the impact of the messages and causes people to "tune-out" or forget what they have learned.

Moreover, the social amplification of certain ideas or interpretations of the news can alter what one once learned about the disease. For example, extensive media coverage about the advantages of the antiretroviral cocktail has generated a widespread but erroneous belief that the available treatment constitutes a cure and that preventive measures can therefore be ignored. Thus, it is absolutely essential for countries to persist with prevention and communication campaigns geared especially to young people and particularly vulnerable groups (men who have sex with men, intravenous drug users, and sex workers, among others).

Information campaigns should be grounded in the most up-to-date knowledge about the use of the media to persuade, to alter behaviors, and to encourage the use of preventive measures on a permanent basis. In addition to being carefully planned, the campaigns must be evaluated regularly to take advantage of the lessons learned and make ongoing adjustments.

Our evaluation of the progression of this epidemic also reveals that greater attention must be devoted to the health care needs of people living with HIV/AIDS. These needs are not limited to primary medical care, but involve comprehensive care—a wide range of services including psychological counseling, emotional and social support, nutritional interventions, and many other specific actions. Addressing all these needs not only improves the physical condition of patients but their emotional state and quality of life as well, allowing them to live with dignity and self-respect.

HIV/AIDS comprehensive care programs must strive to achieve equity in the provision of care. For this reason the design of HIV/AIDS care programs and their monitoring and evaluation should be based on minimum standards, which all implementing participants should abide by and use as a reference to evaluate performance.

The Pan American Health Organization (PAHO) has convened a series of expert consultations to evaluate the problems communities face in the provision of care. Their meetings resulted in the publication of "Building Blocks: Comprehensive Care Guidelines for Persons Living with HIV/AIDS in the Americas." The document presents a model for care that is intended to provide guidance for communities as they develop plans to meet the needs of persons living with HIV/AIDS (PLHAs), their families, and caregivers.

The panel of experts looked at the provision of care with a "real-world" perspective, recognizing that communities weigh their decisions about the provision of care in dramatically different settings. The panel studied what types of care and treatment can be provided when communities and medical facilities have limited resources. What are the degrees of limitation in resources?

The experts decided that three different dimensions of care must be taken into consideration as standards are set:

(a) the utility of any health care intervention;
(b) the functionality of the intervention in a given social and economic context;
(c) the capacity at the different levels of the health care system to carry out that particular intervention.

With these considerations and dimensions of care in mind, the PAHO panel attempted to define what types of interventions and responses can be provided in relation to resource availability. These experts envisaged three different scenarios under which policy makers and health care professionals might be working as they attempted to help PLHAs in their communities—resource-limited settings, resource-competent settings, and resource-optimal settings. The panel directed its standard-setting work to the resource-limited setting, the most difficult working environment for the health care community.

In the resource-limited setting, the panel assumed a health care infrastructure in which testing and basic medications are available in a limited amount, at all health care levels. Interventions are focused on secondary prevention activities such as treatment and prevention of opportunistic infections, and the avoidance of potentially harmful behaviors. This health care approach will stop the further deterioration of a patient's immune system and provide symptomatic relief.

The panel also examined how standards of care for PLHAs might progress as resources increased in a given setting. Improvements in physical/infrastructure resources, financial resources, technical resources, and support services may all have a tremendous impact on improving patient care. Upgrading the skills and expanding the numbers of trained health providers and caregivers will also make a tremendous contribution to allow a given community to provide better care and improve the quality of life for PLHAs.

The wide range of activities necessary to meet the medical, social, and emotional needs of PLHAs should be incorporated as "building blocks" into the complex structure of comprehensive care programs as soon as the resources become available. Interventions proposed for resource-limited settings constitute the minimum standards proposed to ensure improvement of clinical condition and the quality of life of PLHAs. However, every effort should be made to ensure that the quality of comprehensive care gets as close as possible to the standards proposed for the resource-optimal settings.

"Building Blocks" presents a care model that is meant to provide guidance in the development of policies and strategies and promote discussion about the full spectrum of care required to meet the needs of PLHAs, their families, and caregivers. We are pleased to see that it has raised considerable interest in the region. All Latin American countries sent representatives to a recent meeting in San Pedro Sula, Honduras, where the adaptation of the model at a national level was examined. Some of these countries have already developed plans for implementing pilot projects in 2002. ❏

"Building Blocks: Comprehensive Care Guidelines for Persons Living with HIV/AIDS in the Americas" is available at http://www.paho.org/English/HCP/HCA/BuildingBlocks.pdf

HIV/AIDS Prevention and Care Training through African Religious Infrastructures

By William W. Rankin
President, Global AIDS Interfaith Alliance

The Global AIDS Interfaith Alliance (GAIA), a non-profit organization-made up of top AIDS researchers, doctors, religious leaders, and African medical officials—most of whom are associated with religiously based clinics and hospitals—is working at the grass-roots level to build an HIV-AIDS infrastructure in Africa.

It is well known that in vast parts of Africa religious organizations constitute one of the few entities, frequently the only entity, having any sort of infrastructure capabilities. Moreover, religiously based health care systems comprise about 40 percent of all African health systems. These tend to reach remote areas with high rates of new infections.

The Global AIDS Interfaith Alliance was organized to collaborate with developing country religious and inter-religious organizations, and the health care systems they operate, to prepare trainers in a broad array of HIV prevention and care strategies. This paper briefly describes our work with one such religious infrastructure—the Anglican Church of Tanzania (ACT). The methods used here are typical of the work we do elsewhere.

The Anglican Church of Tanzania

Tanzania is frequently listed among the world's five poorest. ACT is spread throughout the country, and is subdivided into 17 regional jurisdictions called "dioceses," each under the ecclesiastical authority of a bishop, clergy, and lay leaders. In large regions, the bishop is accountable to an archbishop.

The parish—the primary organization at the local level—encompasses a wide geographic area containing between 6 and 20 congregations known as "outstations," usually centered around a central congregation. This main congregation usually has a major school, clinic, or other community service organization attached to it. The school or clinic may be located in one multi-use cement block building with a tin or thatch roof. A handful of the outstations may have a smaller school or clinic as well. During the week the benches used for church services become school benches or desks. When a doctor, nurse, or health worker visits, the benches are placed outside and used for people waiting to enter the clinic.

Altogether, Tanzania has a system of 12 hospitals and 35 rural clinics owned and operated by the Anglican Church. ACT's health officer coordinates the activities of the health care system, working closely with the medical directors of the hospitals and the clinic supervisors in their jurisdiction.

Training in HIV Prevention and Care

GAIA worked with a small planning team within this ACT infrastructure to bring about the training of counselors and health workers in HIV prevention and care. The planning team, in turn, coordinated strategies with the bishops, health system personnel, clergy, and lay leaders in each of the 17 dioceses.

The process was begun in 2000 by making e-mail contact

from GAIA's headquarters in San Francisco with eight individuals in Tanzania who had been selected by the ACT health officer, an Australian physician serving as a medical missionary in Tanzania since 1992, and by the archdeacon, a chief administrative officer who reports directly to the archbishop. Our negotiations were aimed at setting up a five-day workshop/conference to be held in Dar es Salaam in November 2000. The conference would include 120 participants, each elected by their home diocese or representing one of ACT's health facilities.

In September, two of us traveled to Dar es Salaam to meet with the workshop planners and settle final details related to conference topics, speakers, venue, logistics, and the likelihood that the conference outcome would be effective, locally specific, and result in measurable action plans. All planners agreed that the action plans to be created at the November training sessions should not be predicated upon receipt of outside funds, since these could not be guaranteed in advance.

An important run-up to the November event was a gathering of the Tanzanian Church's 17 bishops on October 10, 2000. They issued a strong endorsement of the forthcoming conference, acknowledging the severity of the epidemic, and noting especially its virulence among the young. The bishops called for an urgent response by the church, which provided legitimacy for the conference.

The event was held at a Roman Catholic conference center in Dar es Salaam, and included representatives from UNESCO, various Tanzanian protestant denominations, the East Africa AIDS Support Network, the Tanzanian Roman Catholic Church, a Tanzanian ecumenical Christian organization, the Africa Inland Church, the USAID Tanzania mission, the Islamic Council of Tanzania (BAKWATA), and the Ugandan Anglican Church's priest-in-charge of HIV/AIDS work. (We have found a strong interest in several African countries in how Uganda has achieved success in reducing HIV incidence.) The presence of these guests created subsequent training opportunities.

The conferees, coming from every corner of the country, listed their goals as clarifying the church's role in prevention, care, and support; disseminating the most current information on transmission; analyzing cultural practices and social issues that bear upon the rate of new HIV infections; developing appropriate advocacy skills; and, most important, developing detailed, locally sponsored action plans.

Numerous topics were presented by Tanzanian specialists on issues such as HIV prevention, care (including orphan care), nutrition, breastfeeding, destigmatization of AIDS victims, and spiritual support and counseling of those infected or affected by AIDS. Participants also discussed breaking down public denial, raising the age of girls' sexual debut, reducing the number of sex partners, strengthening the status of women, testing for and treatment of sexually transmitted diseases (STDs), specifying the educational and care opportunities of religious organizations, and the formation of educational strategies for targeted groups, including youth, mothers, and men who work away from home.

Participants spent the afternoons of each day, and the entire final day, with colleagues from their home diocese in an effort to apply the information generated at the workshop toward the development of locally appropriate action plans. In the end, 17 action plans were created, each with specific strategies, goals, objectives, and timelines, and each specifying the individuals responsible for implementing various portions of the action plans. Each action plan would be implemented at the local level, with oversight by lay leaders, then priests, then the diocesan bishop. The ACT health officer and the archdeacon provided day-to-day oversight.

Results

An earlier survey of HIV/AIDS activities in ACT, undertaken in May 2000, showed that only seven of the 17 dioceses had funded HIV prevention and care programs. None of these programs were very sophisticated.

By the end of the workshop, on November 5, 2000, each of the 17 dioceses had developed its own locally specific action plan. Some of these were built on programs already in place; but most greatly expanded these, or initiated new programs altogether. The action plan of the Morogoro Diocese, for example, called for meetings with local government and religious leaders on AIDS issues, the formation of AIDS monitoring committees and voluntary HIV testing and counseling programs, the development of AIDS marital counseling programs, and the training of more than 300 educators and health workers on how to conduct HIV testing and counseling. Since November 2000, the ACT health officer and other designated officials have visited every diocese to monitor

progress, help solve problems, and offer encouragement. Plainly, ACT's infrastructure reaches many people and its hierarchy is a crucial factor in continuing effective follow-up. The key to each action plan is local community education, done within and through religious congregations and the health care system on a very low budget. Some outside funds subsequently came into this picture to fortify particularly promising results, as determined by follow-up visits.

Other follow-up included an invitation to ACT Archbishop Donald Mtetemela to meet with former President Clinton at the White House on December 1, 2000—World AIDS Day; contact with BAKWATA concerning replicating the Dar es Salaam training sessions with the Islamamic Council of Tanzania; an emergency grant to a hospital in Dodoma, in the country's center, to enable the continuing purchase of vital medicines during a temporary stoppage of outside funds; the formation of the Tanzanian Interfaith Association to enable a combined religions seat on the newly formed Tanzania AIDS Program; and a major training workshop, essentially copying the Dar es Salaam sessions, in Tanzania's western region (Kasulu, Western Tanganyika) for 250 clergy of all denominations, including Islam.

Conclusion

We believe ACT's infrastructure, through its bishops, local clergy, and lay leaders, all combining to reach out through the parish and outstation organizations, have consequential, continuous, and wide-ranging beneficial effects throughout the country.

GAIA has learned much in working respectfully and successfully with a relatively broad array of religious and inter-religious individuals, organizations, and health care systems. We think the infrastructures of these are significantly valuable in enabling, supporting, and sustaining desperately needed HIV prevention education and care.

For Further Information

A detailed report of the 5-full-day workshop/conference in Dar es Salaam, including the resulting 17 diocesan action plans, is available upon request. ❏

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Rotary International Builds Partnership for Better World Health

By Luis Giay
Chairman of the Rotary International Foundation

As momentum builds to mobilize an international effort against HIV/AIDS, world leaders advocate a strategy of creating partnerships to engage all of a nation's strengths in improving health and conquering disease. Rotary International is a service organization that has been engaged in a 20-year commitment of money, time, and effort to eradicate polio. Those working to address HIV/AIDS can learn much from the Rotary experience.

Poliomyelitis was once a parent's worst nightmare. A healthy child could suddenly be stricken with fever and pain in the limbs, paralyzed within only a matter of hours. When one child was diagnosed with the highly infectious viral disease, dread swept through a community that other children might also succumb. If children survived death, lifelong disability remained a probable outcome.

Dr. Jonas Salk became an international hero when he developed the first vaccine against the disease in the 1950s. Its use to immunize young children quickly became commonplace in the developed world.

Comprehensive, inclusive vaccination programs did not come to the developing world so quickly. In 1985, Rotary International created PolioPlus, setting a goal to protect all the world's children and eradicate polio by 2005, the 100th anniversary of Rotary's founding. We were the first to have the vision of a polio-free world.

As the world's first and one of its largest non-profit service organizations, Rotary members brought considerable human resources to the challenge—1.2 million members working in over 30,100 clubs in 163 countries. The women and men of Rotary are business and professional leaders who initiate community projects that address many of today's most critical issues such as violence, AIDS, hunger, the environment, and health care.

Prestigious partners joined in the campaign against polio. The World Health Organization (WHO), Rotary, the United Nations Children's Fund (UNICEF), the U.S. Centers for Disease Control and Prevention (CDC), and many donor governments around the world formed the Global Polio Eradication Initiative (GPEI).

The results have been significant. In the late 1980s, an estimated 350,000 cases of the disease occurred each year. In 2000, only 3,500 cases were reported worldwide, a 99 percent decrease. The disease appeared in 125 countries at the beginning of the GPEI and now circulates in no more than 20 countries, mainly in South Asia and sub-Saharan Africa.

Eradicating the last traces of the disease may be the most difficult challenge. The GPEI strives to maintain political commitment while the polio threat has diminished, and to reach children in the most isolated places, many torn by civil unrest and active conflict.

But perhaps most threatening to the program is the lack of funds needed to eradicate this crippling disease. The GPEI estimates that a total of $1,000 million is required between 2001-2005 to ensure delivery of more than 6,000 million doses of oral polio vaccine to 600 million children around the world. Of this amount, $600 million has already been pledged, leaving a $400 million gap. Half of those funds are urgently required before the end of 2002.

To help meet this funding challenge, Rotary and the United Nations Foundation are collaborating to secure funds from the private sector, philanthropists, and foundations.

This challenge is not out of reach with support from the many committed members who offer their time, compassion, and professional expertise to work for the health of children everywhere. Through its public advocacy efforts, Rotary has played a major role in the decisions by donor governments to contribute more than $1,000 million to polio eradication since the effort began.

The campaign has made significant progress in West and Central Africa in 2001. During synchronized National Immunization Days (NIDs) in July, 15 million children under five were immunized in Central Africa. In West Africa, NIDs have been underway in the final quarter of the year as 16 nations renewed their commitment to eliminate the crippling virus. Their goal has been to give oral polio vaccine to 80 million children.

The political commitment to this ambitious endeavor came from the highest levels as leaders of the Economic Community of West African States (ECOWAS) signed the Lungi Declaration in that Sierra Leonean city, pledging regional support to the eradication of polio.
In Lungi, at the launch of the effort, Nigerian President Olusegun Obasanjo said, "If we eliminate polio in Sierra Leone, but we don't in Nigeria, we are not safe. If we eliminate polio in Mali, but we don't in Burkina Faso, we are not safe. That is why all of West Africa must work together to eradicate this disease."

Earlier in the year, an NID event was also held in India, currently the country with the single greatest occurrence of polio cases. In the largest public health event ever organized in the world, 152 million children were immunized against the virus with the participation of 100,000 Rotary members joined by their friends and families.

Rotary clubs play a key role in readying a region for an NID. Members prepare and distribute a variety of mass communication tools to inform parents of an upcoming vaccination program, even those families isolated by conflict, geography, or poverty. During an NID, Rotarians work side-by-side with public health workers as they administer the oral polio vaccine. Depending on the needs of a given area, Rotary members will create extensive maps, locating every village as a destination for the immunization teams. They go house-to-house, to markets, and refugee camps. They paddle pirogues to tiny islands, and set up immunization posts at national borders to reach any vulnerable child.

Rotary volunteers also help authorities locate the proper cold storage facilities, and transport the vaccine to every immunization post. They pack lunch boxes, organize distribution teams, and transport meals to health workers at immunization centers. They have solicited corporate jets, helicopters, and vehicles to help transport vaccine to the most isolated places where it is needed.

Millions of other volunteers mobilized by Rotary have given their time to the polio vaccination campaign over the years. In addition to mobilizing these considerable human resources, Rotary has contributed approximately $438 million to the effort, a figure that will grow to $500 million by 2005.

Protecting children from a crippling virus brings its own rewards today and provides greater assurance that children can thrive to become productive world citizens.

As the years of this campaign have unfolded, and the eradication of this terrible disease comes within our reach, it appears that Rotary's work with so many governments and public health agencies around the world may reap another dividend. Members involved in this campaign have lent their own community standing to the cause. In mobilizing our communities for an NID, we have helped raise community awareness about public health in even the smallest villages and towns. We have helped educate parents about the threat of disease and the importance of vaccination. And we've helped to educate tribal leaders and warring factions that conflict of the moment should be set aside to ensure that children can be protected from disease. That is why President Ouman Konare of Mali called the NIDs a "lever for peace" as the Lungi Declaration was signed.

Rotary has helped build a collective conscience worldwide for improving the health of the human family. While parents of the developed world see their own children and grandchildren in good health, Rotary has helped remind them that other loving parents in lands far away may not be able to share the same confidence of good health that their children enjoy.

U.S. Surgeon General David Satcher has said of our PolioPlus program, "The future of public health depends upon our ability to develop growing partnerships, especially public/private partnerships. Of all the partnerships that we developed while I was at the CDC, and had an opportunity to work with, none has been more impressive than the partnership with Rotary International and the other partners throughout the world working on the global eradication of polio."

The world stands firmly on the threshold of victory. Thanks to the achievements of the last two decades, over two billion children have received the oral polio vaccine and are successfully protected against the disease. It is estimated that four million children who might have been polio victims are today playing and walking normally due to the efforts of Rotary and our global partners.

It is our hope that the lessons learned through PolioPlus and its comprehensive strategy will be applied again and again when fighting other diseases. That will be our legacy for future generations.

What finer gift for the children of the world? ❏

REPORTS

UNAIDS/WHO Report: A Global Overview on the HIV/AIDS Epidemic

Following is the Global Overview excerpted from the annual report "AIDS Epidemic Update 2001" released November 28, 2001, by the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). The report, released in conjunction with World AIDS Day on December 1, says AIDS has become the most devastating disease humankind has ever faced. Eastern Europe is experiencing the fastest-growing AIDS epidemic in the world, with 250,000 new cases in 2001, and more than 28 million people now live with the virus in sub-Saharan Africa. The entire report, which assesses the current status of the epidemic in the various regions of the world, can be found at the following Website:www.unaids.org/epidemic_update/report_deco1/index.html

AIDS Epidemic Update

December 2001

Global Overview

Twenty years after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS has become the most devastating disease humankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth-biggest killer.

At the end of 2001, an estimated 40 million people globally were living with HIV. In many parts of the developing world, the majority of new infections occur in young adults, with young women especially vulnerable. About one-third of those currently living with HIV/AIDS are aged 15-24. Most of them do not know they carry the virus. Many millions more know nothing or too little about HIV to protect themselves against it.

Eastern Europe and Central Asia—Still the Fastest-Growing Epidemic

Eastern Europe—especially the Russian Federation—continues to experience the fastest-growing epidemic in the world, with the number of new HIV infections rising

steeply. In 2001, there were an estimated 250,000 new infections in this region, bringing to 1 million the number of people living with HIV. Given the high levels of other sexually transmitted infections, and the high rates of injecting drug use among young people, the epidemic looks set to grow considerably.

Asia and the Pacific—Narrowing Windows of Opportunity

In Asia and the Pacific, an estimated 7.1 million people are now living with HIV/AIDS. The epidemic claimed the lives of 435,000 people in the region in 2001. The apparently low national prevalence rates in many countries in this region are dangerously deceptive. They hide localized epidemics in different areas, including some of the world's most populous countries. There is a serious threat of major, generalized epidemics. But, as Cambodia and Thailand have shown, prompt, large-scale prevention programs can hold the epidemic at bay. In Cambodia, concerted efforts, driven by strong political leadership and public commitment, lowered HIV prevalence among pregnant women to 2.3 percent at the end of 2000—down by almost a third from 1997.

Sub-Saharan Africa—The Crisis Grows

AIDS killed 2.3 million African people in 2001. The estimated 3.4 million new HIV infections in sub-Saharan Africa in the past year mean that 28.1 million Africans now live with the virus. Without adequate treatment and care, most of them will not survive the next decade. Recent antenatal clinic data show that several parts of southern Africa have now joined Botswana with prevalence rates among pregnant women exceeding 30 percent. In West Africa, at least five countries are experiencing serious epidemics, with adult HIV prevalence exceeding 5 percent. However, HIV prevalence among adults continues to fall in Uganda, while there is evidence that prevalence among young people (especially women) is dropping in some parts of the continent.

The Middle East and North Africa—Slow but Marked Spread

In the Middle East and North Africa, the number of people living with HIV now totals 440,000. The epidemic's advance is most marked in countries (such as Djibouti, Somalia, and the Sudan) that are already experiencing complex emergencies. While HIV prevalence continues to be low in most countries in the region, increasing numbers of HIV infections are being detected in several countries, including the Islamic Republic of Iran, the Libyan Arab Jamahiriya, and Pakistan.

High-Income Countries—Resurgent Epidemic Threatens

A larger epidemic also threatens to develop in the high-income countries, where over 75,000 people acquired HIV in 2001, bringing to 1.5 million the total number of people living with HIV/AIDS. Recent advances in treatment and care in these countries are not being consistently matched with enough progress on the prevention front. New evidence of rising HIV infection rates in North America, parts of Europe, and Australia is emerging. Unsafe sex, reflected in outbreaks of sexually transmitted infections and widespread injecting drug use, are propelling these epidemics, which, at the same time, are shifting more towards deprived communities.

Latin America and the Caribbean—Diverse Epidemics

An estimated 1.8 million adults and children are living with HIV in Latin America and the Caribbean—a region that is experiencing diverse epidemics. With an average adult HIV prevalence of approximately 2 percent, the Caribbean is the second-most affected region in the world. But relatively low national HIV prevalence rates in most South and Central American countries mask the fact that the epidemic is already firmly lodged among specific population groups. These countries can avert more extensive epidemics by stepping up their responses now.

Stronger Commitment

Greater and more effective prevention, treatment, and care efforts need to be brought to bear. During the year 2001, the resolve to do so became stronger than ever.

History was made when the United Nations General Assembly Special Session on HIV/AIDS in June 2001 set in place a framework for national and international accountability in the struggle against the epidemic. Each government pledged to pursue a series of many benchmark targets relating to prevention, care, support and treatment, impact alleviation, and children orphaned and made vulnerable by HIV/AIDS, as part of a comprehensive AIDS response. These targets include the following:

- To reduce HIV infection among 15-24-year-olds by

25 percent in the most affected countries by 2005 and, globally, by 2010;

- By 2005, to reduce the proportion of infants infected with HIV by 20 percent, and by 50 percent by 2010;
- By 2003, to develop national strategies to strengthen health-care systems and address factors affecting the provision of HIV-related drugs, including affordability and pricing. Also, to urgently make every effort to provide the highest attainable standard of treatment for HIV/AIDS, including antiretroviral therapy in a careful and monitored manner to reduce the risk of developing resistance;
- By 2003, to develop and, by 2005, implement national strategies to provide a supportive environment for orphans and children infected and affected by HIV/AIDS;
- By 2003, to have in place strategies that begin to address the factors that make individuals particularly vulnerable to HIV infection, including under-development, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation of women, girls, and boys;
- By 2003, to develop multisectoral strategies to address the impact of the HIV/AIDS epidemic at the individual, family, community, and national levels.

Increasingly, other stakeholders, including nongovernmental organizations and private companies worldwide, are making clear their determination to boost those efforts.

New resources are being marshaled to lift spending to the necessary levels, which UNAIDS estimates at $7,000 to $10,000 million per year in low and middle-income countries. The global fund called for by United Nations Secretary-General Kofi Annan has attracted about $1,500 million in pledges. In addition, the World Bank plans major new loans in 2002 and 2003 for HIV/AIDS, with a grant equivalency of over $400 million per year. All the while, more countries are boosting their national budget allocations towards AIDS responses. Several least developed countries have received, or are in line for, debt relief that could help them increase their spending on HIV/AIDS.

More private companies are also stepping up their efforts. Guiding some of their interventions is a new international code of conduct on AIDS and the workplace, which was ratified earlier this year by members of the International Labor Organization (the new, eighth cosponsoring organization of UNAIDS).

The challenge now is to build on the new-found commitment and convert it into sustained action—both in the countries and regions already hard hit, and in those where the epidemic began later but is gathering steam.

Beyond Complacency

The diversity of HIV's spread worldwide is striking. But in many regions of the world, the HIV/AIDS epidemic is still in its early stages. While 16 sub-Saharan African countries reported overall adult HIV prevalence of more than 10 percent by the end of 1999, there remained 119 countries of the world where adult HIV prevalence was less than 1 percent.

Low national prevalence rates can, however, be very misleading. They often disguise serious epidemics that are initially concentrated in certain localities or among specific population groups and that threaten to spill over into the wider population.

Nationwide prevalence in Myanmar, for instance, has been put at 2 percent. Yet, national HIV rates as high as 60 percent are being registered among injecting drug users and almost 40 percent among sex workers. Moreover, in vast, populous countries such as China, India, and Indonesia (where individual provinces or states often have more inhabitants than most countries), national prevalence all but loses meaning. The Indian states of Maharashtra, Andhra Pradesh, and Tamil Nadu (each with at least 55 million inhabitants) have registered HIV prevalence rates of over 2 percent among pregnant women in one or two sentinel sites and over 10 percent among sexually transmitted infection patients—rates far higher than the national average of less than 1 percent. In the absence of vigorous prevention efforts, there is considerable scope for further HIV spread. Even HIV prevalence rates as low as 1 or 2 percent across Asia and the Pacific (which is home to about 60 percent of the world's population) would cause the number of people living with HIV/AIDS to soar.

All countries have, at some point in their epidemic histories, been low-prevalence countries. HIV prevalence

among pregnant women attending antenatal clinics in South Africa was less than 1 percent in 1990 (almost a decade after the first HIV diagnosis there in 1982). Yet, a decade later, the country was experiencing one of the fastest growing epidemics in the world, with prevalence among pregnant women at 24.5 percent by the end of 2000.

Low-prevalence settings present special challenges. At the same time, they offer opportunities for averting large numbers of future infections. Today, we are seeing rapidly emerging epidemics in several countries that had previously recorded relatively low rates of HIV infection —proof that the epidemic can emerge quickly and unexpectedly, and that no society is immune. In Indonesia, where recorded infection rates were negligible until very recently (even among some high-risk groups), there is new evidence of striking increases in the infection rates of HIV. Prevalence has risen significantly among female sex workers in three cities at opposite ends of the Indonesian archipelago, with similar increases also evident at other sites. Among women working in massage parlors in the capital of Jakarta, HIV prevalence was measured at 18 percent in 2000. Blood donor data now show a tenfold rise in HIV prevalence since 1998. Elsewhere, longer-standing epidemics could be on the verge of spreading more rapidly and widely. Nepal and Viet Nam, for example, have registered marked increases in HIV infection in recent years, while in China—home to a fifth of the world's people—the virus seems to be moving into new groups of the population.

In other areas of the world, too, time is fast running out if much larger AIDS epidemics are to be averted. For instance, in the Russian Federation, only 523 HIV infections had been diagnosed by 1991. A decade later, that number had climbed to more than 129,000. In a country where injecting drug use among young people is rife (and there are high levels of sexually transmitted infections in the wider population), there is an urgent need for action to avoid an even larger number of new infections.

Prompt, Focused Prevention

Countries that still have low levels of HIV infection should avert the epidemic's potential spread, rather than take comfort from current infection rates. The key to success in low-prevalence settings where HIV is not yet a risk to the wider population is to enable the most vulnerable groups to adopt safer sexual and drug-injecting behavior, interrupt the virus's spread among and between those groups, and buy time to bolster the wider population's ability to protect itself against the virus.

This means, first, determining which population groups are at highest risk of infection and, second, mustering the political will to safeguard them against the epidemic. At the same time, it is vital to defuse the stigma and blame so often attached to vulnerable groups and to deepen the wider public's knowledge and understanding of the epidemic.

Young people are a priority on this front. Twenty years into the epidemic, millions of young people know little, if anything, about HIV/AIDS. According to UNICEF, over 50 percent of young people (aged 15-24) in more than a dozen countries, including Bolivia, Botswana, Côte d'Ivoire, the Dominican Republic, Ukraine, Uzbekistan, and Viet Nam, have never heard of AIDS or harbor serious misconceptions about how HIV is transmitted. Providing young people with candid information and life skills is a prerequisite for success in any AIDS response. ❑

Trade Agreement Will Improve Pharmaceutical Access

Drug treatment can prolong the lives of HIV-positive patients, but the high cost of these pharmaceutical products has made such therapy prohibitive for most developing world patients. There has been extensive international discussion about ways to resolve this cost problem. A recent ministerial conference of the World Trade Organization (WTO) held in Doha, Qatar, resulted in an important agreement that recognizes "WTO Members' right to protect public health and, in particular, to promote access to medicines for all." The agreement further recognizes that countries can define "a national emergency or other circumstances of extreme urgency" and specifically includes "public health crises." For such circumstances, WTO member nations are relieved from the full impact of their obligations under intellectual property rights. Using this exemption, developing nations will be able to arrange for the production of lower cost drugs for patients in their countries.

A statement from UNAIDS said the WTO decision "will have an impact on the global response to the epidemic, including the ability of developing countries to meet the needs of their people living with HIV for access to life-saving medicines."

Declaration On The Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health

1. We recognize the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria, and other epidemics.

2. We stress the need for the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems.

3. We recognize that intellectual property protection is important for the development of new medicines. We also recognize the concerns about its effects on prices.

4. We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all.

In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS

Agreement, which provide flexibility for this purpose.

5. Accordingly, and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:

(a) In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.

(b) Each Member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted.

(c) Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria, and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

(d) The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.

6. We recognize that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.

7. We reaffirm the commitment of developed-country Members to provide incentives to their enterprises and institutions to promote and encourage technology transfer to least-developed country Members pursuant to Article 66.2. We also agree that the least-developed country Members will not be obliged, with respect to pharmaceutical products, to implement or apply Sections 5 and 7 of Part II of the TRIPS Agreement or to enforce rights provided for under these Sections until 1 January 2016, without prejudice to the right of least-developed country Members to seek other extensions of the transition periods as provided for in Article 66.1 of the TRIPS Agreement. We instruct the Council for TRIPS to take the necessary action to give effect to this pursuant to Article 66.1 of the TRIPS Agreement. ❏

Further information about endeavors to accelerate access to these medications and other treatments is available at http://www.unaids.org/acc%5Faccess/index.html

The Role of the Private Sector

The following is excerpted from "The Report of the Findings of the Corporate Council on Africa's Task Force on HIV/AIDS." This October 2001 study examined how American corporations can best address the deepening HIV/AIDS crisis in Africa. As part of that analysis, the task force included profiles of existing company efforts that it considered demonstrative of the "best practices" currently in use to address disease, prevention, and health care. Merck and Company, Inc. was selected within the pharmaceutical sector, and provided this description of its initiatives

Merck & Company, Inc., is a global, research-driven pharmaceutical company that discovers, develops, manufactures, and markets a broad range of human and animal health products, including antiretrovirals for the treatment of HIV infection, directly and through joint ventures, and provides pharmaceutical benefit services through Merck-Medco Managed Care.

Motivation for Action

Merck is committed to improving the lives of people living with HIV/AIDS worldwide, with a focus on our traditional area of strength: research and development into new antiretroviral therapies and vaccines that will serve the largest population in the most effective manner. Since 1986, Merck has striven to advance the treatment of HIV/AIDS, spending hundreds of millions of dollars on one of the largest medicine and vaccine research programs in company history.

With 95 percent of the world's 40 million HIV-infected people living in developing countries, better and faster access to care is essential. Although there is no cure for AIDS, medical care in industrialized countries is significantly extending the lives of people living with HIV infection. The challenge now is to improve access to care, including treatments for opportunistic infections and antiretroviral therapy in the hardest hit regions of the world. This is especially challenging in sub-Saharan Africa, where it is estimated that more than two-thirds (28 million) of the world's HIV-infected people live, and yet, resources allocated to health care can be as low as one dollar per person per year.

Merck Response to HIV/AIDS

Merck continues to seek out and support initiatives that address the issue of HIV/AIDS management and drug access in the developing world. Recognizing that a number of approaches are needed to identify the most promising and efficient ways to combat the HIV/AIDS pandemic, Merck is undertaking initiatives and establishing partnerships with multinational organizations to address the impact of HIV/AIDS in the developing world. These include a new major project in Botswana, the Enhancing Care Initiative, and the U.N./Industry Accelerating Access Initiative.

Price Reduction for Medicines

On March 7, 2001, Merck announced a dramatic price decrease in their antiretroviral products to a level where

they will not be making any profit. The new prices are $600 per patient per year for Crixivan and $500 per patient per year for Stocrin in developing countries. This is the first time that a member of the class of protease inhibitors has been offered to developing countries at such a low price. These prices apply to developing countries and will be made available to all customers (governments, NGOs, and private-sector employers) who can make the medicines accessible to patients. The only condition is that the medicines must be used in the country where they are sold, and not exported. The offer extends to all low Human Development Index (HDI) countries, according to the United Nations Development Program (UNDP), and all medium HDI countries with an adult HIV prevalence rate of 1 percent or greater.

Botswana Comprehensive HIV/AIDS Partnership (BCHAP)

The Republic of Botswana, in cooperation with the Bill & Melinda Gates Foundation and Merck & Company, Inc., have established the Botswana Comprehensive HIV/AIDS Partnership, a new initiative designed to advance significantly HIV/AIDS prevention, health care access, patient management, and treatment of HIV/AIDS in Botswana, where nearly one in three adults is infected with HIV.

The overall goal of the BCHAP is to bring together the best of the public/private sector to demonstrate the ability to significantly advance HIV management and treatment through a tightly defined initiative in a select resource-scarce setting. While significant resources and expertise will come from various global partners, the project seeks to develop leadership and commitment within the country so that the project can be sustained after the pilot phase. This is critical to the project's success.

Since the public announcement on July 10, 2000, Merck and the other principals of this unique endeavor have been working closely to establish the governance of the project, finalize the internal and external management structure, and initiate multidisciplinary task forces in the Republic of Botswana. Additionally, an evaluation of the level of HIV/AIDS awareness, prevention programs, and the care and treatment of people with HIV/AIDS in Botswana is underway. This evaluation will support the development of a detailed plan that will specify goals, benchmarks for success, and resources needed to complete the project as well as ensure that it can be sustained past the initial five-year commitment.

The Bill & Melinda Gates Foundation will dedicate $50 million over the five years of the project to help Botswana fundamentally strengthen its primary health care system. Merck and the Merck Company Foundation will match the Bill & Melinda Gates Foundation funding for the development and management of the program. Merck and Company, Inc., will also donate antiretroviral medicines, (Crixivan and Stocrin) for appropriate treatment programs decided in conjunction with the Republic of Botswana (and in accordance with nationally approved guidelines) for the duration of the program. Boehringer-Ingelheim has pledged to donate medication for the prevention of mother-to-child transmission of HIV infection, and Unilever PLC will contribute expertise in setting up distribution systems and public communications and awareness programs.

Enhancing Care Initiative

Merck is supporting the Enhancing Care Initiative (ECI), a multidisciplinary, multinational partnership designed to improve the care of people with HIV/AIDS in the developing world, including several countries in Africa. Coordinated by the Harvard AIDS Institute and the Francois Bagnoud Center for Health and Human Rights at Harvard's School of Public Health, this five-year initiative includes local experts on HIV/AIDS, community groups, and governmental and non-governmental organizations. The multidisciplinary approach works through local teams of experts, including patients, physicians, nurses, economists, and government officials. The teams assist in designing the infrastructure essential to implement feasible and cost-effective improvements in HIV/AIDS clinical case management and health care delivery. To date, the Enhancing Care Initiative involves in-country multi-disciplinary teams in Senegal and KwaZulu Natal Province in South Africa, and outside Africa, in Brazil and Thailand. The program advances basic knowledge about HIV/AIDS care-related policies and programs, supports development of proposed intervention strategies in developing countries, and provides assistance in building the necessary infrastructure to achieve these improvements. As an example, in Senegal the initiative completed an overall assessment of HIV/AIDS care; finalized direct and indirect cost analysis of HIV/AIDS testing, counseling, and a national program of antiretroviral therapy; performed an economic analysis; and prepared recommendations for appropriate interventions.

UN/Industry Accelerating Access Initiative

The UN/Industry Accelerating Access Initiative is a cooperative endeavor of UNAIDS, the World Health Organization (WHO), the U.N. Children's Fund (UNICEF), the U.N. Population Fund (UNFPA), the World Bank, and five research-based pharmaceutical companies (Merck, Boehringer-Ingelheim, Bristol-Myers Squibb, F. Hoffmann-LaRoche, and GlaxoWellcome).

The Accelerating Access Initiative is designed to accelerate sustained access to, and increase the use of, appropriate good quality interventions for the prevention, treatment, and care of HIV/AIDS-related illnesses (and the prevention of perinatal transmission of HIV) in developing countries.

Accelerating Access employs a country-led process. Improving access to HIV care and treatment is more than just drugs. Offers of significant discounts are available to countries that decide they want to invest in antiretrovirals now, and those discussions are proceeding through the Accelerating Access Initiative. Merck is working with UNAIDS and the other U.N. agencies to respond to the individual needs of different countries in a way that makes sense to country officials who carry the primary responsibility for the health of their populations.

To date, 58 countries from Africa, Central Europe, and Latin America have sought information or expressed an interest in participating in the endeavor. In October 2000, Senegal was the first country to reach an agreement with the companies, followed by Uganda in December. To date, 12 countries have completed agreements and products are being shipped at the reduced prices.

Common Principles

Participants in the UN/Industry Accelerating Access Initiative have set out a common vision of how to tackle the HIV/AIDS epidemic most effectively in developing countries. A "Joint Statement of Intent" issued in May 2000 articulated the following principles:

- Unequivocal and ongoing political commitment by national governments;
- Strengthened national capacity;
- Engagement of all sectors of national society and the global community;
- Efficient, reliable, and secure distribution systems;
- Significant additional funding from new national and international sources;
- Continued investment in research and development by the pharmaceutical industry.

Results and Lessons

Given the dimensions of the HIV/AIDS access crisis, and the urgency to find answers, Merck stands ready to play our part in the search for sustainable solutions. Today, many stakeholders are beginning to make important contributions, often through creative new partnerships. As U.N. Secretary General Kofi Annan has said, "No company and no government can take on the challenge of AIDS alone. What is needed is a new approach to public health—combining all available resources, public and private, and using all opportunities, local and global[1]."

By working in this spirit—finding new approaches that work—Merck believes that we can find innovative solutions to help the millions of people living with HIV/AIDS who do not have adequate access to care and treatment today. Merck, and the research-based pharmaceutical industry, will continue to be a constructive partner in these efforts, and we look forward to continuing to work with other stakeholders to defeat a common enemy—HIV. ❑

1 Kofi Annan, "The Global Challenges of AIDS," Diana, Princess of Wales Memorial Lecture, London, England, June 25, 1999. Available at www.un.org, press release SG/SM/7045.

To obtain a complete copy of "The Report of the Findings of the Corporate Council on Africa's Task Force on HIV/AIDS," contact Ingrid White, the program coordinator for the task force at the Corporate Council on Africa in Washington, D.C. E-mail iwhite@africacncl.org or call (202)835-1115, ext. 15.

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