AIDS in Africa: is the world concerned enough?

If African countries are left to confront the HIV/AIDS pandemic with the small level of outside support they have received to date, few are likely to succeed and the spread of instability will heighten global insecurity.

by Salih Booker and William Minter

APWIDE WORLD PHOTOS

AIDS RIBBON MONUMENT *was unveiled by South Africa's deputy president, Jacob Zuma, to mark the opening of the 13th world AIDS conference in Durban, South Africa, July 2000.*

In 2001, an estimated 3 million people died in the global AIDS pandemic. Of those deaths, 77% were in sub-Saharan Africa, home to just over 10% of the world's population. Of 40 million people living with HIV/AIDS in December 2001, 28.1 million were in sub-Saharan Africa.

Since it began two decades ago, the pandemic has taken more than 22 million lives, more than 17 million of them in sub-Saharan Africa. In comparison, approximately 450,000 have died of AIDS in the U.S. during the same period; the total population of the U.S. is half that of sub-Saharan Africa. There are estimated to be more than 13 million orphans who have lost their mothers or both parents to AIDS, 12 million of them in sub-Saharan Africa.

In the U.S. and other developed countries, the death trend from AIDS has been declining since the introduction of life-prolonging drugs in 1996. In Africa, however, it is still rising rapidly and, unless it is reversed, AIDS may kill as many as one in every three young adults in a number of countries. Estimates of the likely economic impact differ in detail, but there is a growing consensus among international agencies, insurance companies and business analysts that for many countries it will be catastrophic. Health services are already being overwhelmed by AIDS patients in many countries, and deaths among teachers are devastating educational systems. Mining and manufacturing companies see the death rate among skilled workers as a significant disincentive for investment and as a threat to profits. AIDS poses the greatest single hindrance to economic development in the world's poorest region and will dramatically increase global economic disparities with destabilizing consequences for the entire world.

By January 2000, a U.S. National Intelligence Estimate had identified global infectious diseases, including HIV/AIDS, as a major threat to national security. Despite this formal recognition, the warning failed to evoke a sense of national urgency, just as was the case be-

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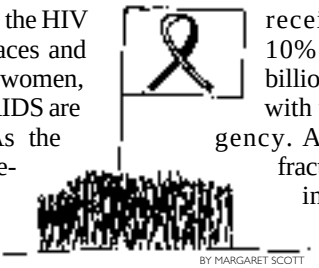
AP/WIDE WORLD PHOTOS

THOUSANDS OF PROTESTERS *demand affordable access to AIDS drugs at a march during the international AIDS conference in South Africa in 2000.*

fore September 11 in response to official warnings of the possibility of terrorism inside the U.S. In the wake of the September 11 attacks, the AIDS pandemic remains a critical test of whether policymakers can be farsighted enough to pay attention to a wider range of global threats.

In every country, rich or poor, denial has crippled the response to AIDS. But poverty increases the risks and reduces the capacity to respond. For two decades, the pandemic has raced ahead of the global response. While the HIV virus affects people of all races and income levels, both men and women, most of those now dying of AIDS are black, poor and female. As the president of Botswana recently remarked, the survival of entire nations is at risk. AIDS has already become the worst plague in human history. The world's persistent failure to respond raises fundamental questions of global human rights and international economic policy, as well as more specific issues of U.S. bilateral relations with Africa, priorities for assistance programs, and U.S. obligations for global public investment.


BY MARGARET SCOTT

In 1987, when the first anti-AIDS drug began to slow the death rate in the U.S., 10 times as many people were dying of AIDS in Africa as in the U.S. But it was not until July 2000, when Durban, South Africa, hosted the first global AIDS conference to be held in Africa, that the world began to pay attention. Since then, protests against pharmaceutical companies and emerging competition from generic drug producers in developing countries have resulted in somewhat reduced drug prices. The lowering of costs has meant that policymakers could begin to conceive of ways to actually defeat the pandemic in Africa, by investing massively in treatment efforts and new prevention programs that together could turn the tide. An unprecedented UN special session in June 2001 produced new pledges to act. Yet, in late 2001, UN Secretary General Kofi Annan's new Global Health Fund had received much less than 10% of the estimated $10 billion a year needed to cope with the global health emergency. And only a minuscule fraction of those with AIDS in Africa had gained access to anti-AIDS drug therapy.

U.S. policymakers must consider the following questions:

- At a time when the U.S. has a renewed appreciation for the vulnerability of all life and the need for international cooperation to defeat global threats, can Washington afford to ignore this growing danger to human security? With HIV infection still spreading worldwide, with no cure yet in sight, what will happen if the U.S. continues to treat the international HIV/AIDS pandemic as a relatively low priority?
- How can the U.S. address factors that block a priority response to the pandemic, such as stigma, discrimination and the assumption that black lives are expendable?
- What are the most effective combinations of prevention, treatment and research to combat HIV/AIDS and cope with its disastrous consequences for individuals, families and communities?
- Can international responsibility for this global pandemic be satisfied by those resources wealthy countries are willing to make available as development assistance, or does the U.S. share a universal obligation to protect the global right to health? And does the U.S. have a national security interest in doing so?
- Are economic policies imposed by international financial institutions and demands for repayment of foreign debt, even at the expense of resources for health and education, among the causes of the growth of the pandemic?
- Should the high cost of AIDS drugs be protected by patent rights for large pharmaceutical companies, or should governments and the World Trade Organization (WTO) give priority to public health in such an emergency and override patent rights, if necessary, to ensure the cheapest production of essential medicines? ■

From disease to pandemic

AIDS (acquired immunodeficiency syndrome) was first identified as a medical condition in 1981 and named in 1982. It is not a single disease but rather a weakening of the body's immune system so it loses its normal capacity to defend against infections. The diseases that take advantage of this weakness are called "opportunistic" infections. AIDS cases are tracked either by tests that measure the level of certain types of infection-fighting cells (T4 lymphocytes) or by the presence of the most distinctive opportunistic infections.

HIV (human immunodeficiency virus) was identified in 1983 as the cause of AIDS. It is transmitted by sexual contact, by the use of infected blood, or

from mother to infant during pregnancy, delivery or breast-feeding. Both the chances of transmission in a given contact, and how rapidly the virus produces symptoms of AIDS, are highly affected by general health conditions and other factors. The median time lag between infection by HIV and the onset of AIDS is estimated at 10 years.

Although drugs are available to treat the most common opportunistic infections, no cure or vaccine has yet been discovered. Since 1996, HAART (highly active antiretroviral treatment) has been available to slow the effects of HIV on the body's immune system.

The long time between infection and visible disease syndrome, in addition to the complexity of the virus itself, has complicated research on the origin and spread of AIDS, as well as the search for a cure. Together with reluctance to speak openly about sexually transmitted diseases and the stigmatization of people living with HIV/AIDS, this delayed-action characteristic of AIDS has encouraged denial and contributed to slowness in responding to the pandemic.

The first AIDS cases in Africa were identified less than two years after the first cases in the U.S., and HIV/AIDS spread there far more rapidly than in the U.S. Yet research and public attention until very recently was almost entirely determined by the pattern in North American nations and other highly industrialized countries. In particular, AIDS has been identified as afflicting "high-risk" groups such as gay men, intravenous drug users, and hemophiliacs or others coming into contact with infected blood. Some scientists at first refused to accept that HIV could be transmitted by heterosexual intercourse. At one point, Haitians in the U.S. were the focus of attention and stigmatization, while scientists speculated that HIV might have reached the U.S. from Haiti. In fact, researchers later concluded that HIV had most likely been carried to Haiti by tourists from the U.S.

Despite a few dissenters, almost all researchers now accept that HIV produces AIDS. There is also consensus on the principal means of transmission, and therefore on the general strategy for prevention. But there is little consensus on which factors are most important in determining the speed with which it spreads.

Virus transmission from one person to another depends both on the characteristics of the virus and on a wide variety of risk factors, some open to individual choice and others not. Most significantly, social factors decisively influence the "acceleration" of transmission which makes a disease "epidemic" (widespread) or "pandemic" (reaching national or global proportions).

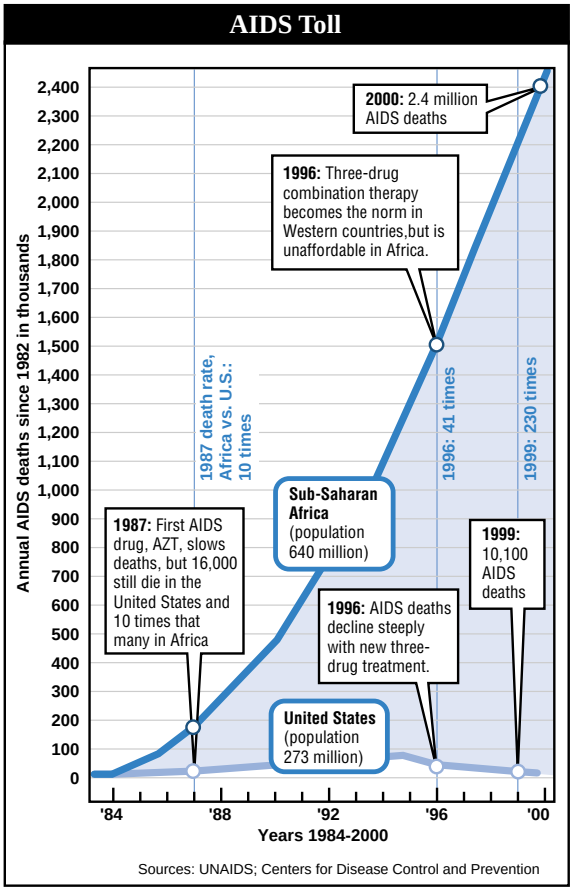
Social and economic conditions, as well as levels of access to health services of all kinds, are primary determinants of who lives and who dies as a result of the AIDS pandemic. Both the internal vulnerabilities of Africa's societies and their marginalization within the current world order are reflected in the catastrophic course of HIV/AIDS on the continent. The same factors are at work elsewhere: the Caribbean is the second-most-affected region worldwide, in the U.S. AIDS is increasingly concentrated in minority communities, and the poverty-stricken South Asian subcontinent will possibly be the next region to experience explosive growth rates in infection.

HIV/AIDS in Africa

The most striking feature of HIV/AIDS in Africa, as compared with the pattern in developed countries, is that from the start it has not been concentrated in narrowly defined high-risk groups (such as gay men), but rather has spread in all population categories. Most significantly, in Africa more women than men are infected with HIV. As many as one quarter of those dead of AIDS have been children infected through mother-to-child transmission. While African societies have a strong tradition of caring for orphans through extended families and community efforts, both are being overwhelmed by the millions now orphaned by AIDS.

In wealthier countries, transmission through infected blood was quickly addressed through heightened security in blood banks and medical facilities. In the U.S., debates over how to prevent infection through contaminated needles focus on users of illegal drugs. In contrast, in many African countries the infection has probably been spread by impoverished health services, through inadequately screened blood and insufficiently sterilized needles that are reused in injecting medicines or vaccines. This was particularly the case in the decisive early stages before much was known about HIV; due to lack of

MICHAEL SAMUEL GRAPHICS



resources, it is still happening today.

The years of delay between infection and disease appearance meant that the pandemic had a massive head start before it was even detected. Any sexually active adult was at risk, most often without knowing it, as was anyone inadvertently exposed to infected blood. A few African countries responded quickly and urgently to the threat; most did not. In any case, the problem was soon so massive as to be beyond most countries' capacity to respond alone.

There were many reasons for denial, in addition to the aversion to frank talk about sex that Africans shared with most in the developed world as well. For many Africans, AIDS was simply one more threat to survival, and not the most immediately visible, as compared to war, drought, violent crime, impoverishment, or other endemic killer diseases such as malaria. The image of AIDS in the popular global media and in medical circles as well was of a disease of gay white men. When international attention did begin to focus on AIDS in Africa, it also came with unfounded speculation about African "promiscuity" that aroused resentment and distrust rather than reinforcing joint efforts to combat the pandemic.

In Africa as elsewhere, HIV does spread more rapidly within high-risk groups such as prostitutes and people who have multiple sexual partners. Patterns of sexual contact—influenced by such factors as wars, refugee movement and migrant labor, as well as culture and religion—influence how the virus spreads. But it is the broader societal context, including weak health services, poverty, and especially the subordinate position of women, that provides the most powerful determinants of disease spread. Indeed, in Africa a far wider and more diverse range of people could be considered high risk simply because of the hardships of life that most Africans face.

The effects of weak or absent health services play out in many ways. The chances of transmission of the virus in a single sexual encounter are much greater when there are other untreated sexually transmitted infections. Yet treatment for such diseases is not widely available. Prevention campaigns require encouraging people with no symptoms to be tested for HIV, but facilities for testing are in short supply. And when there is no chance of access to treatment, there is scant incentive to be tested. Without adequately screened blood supplies, a surgeon may have no choice but to weigh saving a life with a transfusion against the chance of infection. Hospitals unable to provide good nutrition or sanitation may themselves spread disease.

Research also indicates that immune systems in Africa are more vulnerable, probably because they are exposed to stress from more diverse disease threats. Once infected with HIV, a person is more vulnerable to any other infections present in the environment. Notably, tuberculosis is among the most frequent opportunistic infections associated with AIDS in Africa. The dominant types of HIV found in Africa are more virulent than the dominant type in North America. For many reasons, death comes more rapidly to AIDS patients in Africa.

Poverty, in more general terms, also has profound effects in spreading the pandemic. Throughout Africa, cities are growing rapidly. More than one third of Africans now live in cities, and there are more than 30 cities with populations above one million. Yet these cities, which continue to draw people fleeing war or poverty in the countryside, do not provide adequate housing, sanitation or jobs. Most significantly, families must often split themselves between city and countryside to put together enough income to survive. Both the lack of stable family life in the city and the visits by men to their families in the rural areas help promote the spread of AIDS.

Vulnerability of women

The effect of poverty is multiplied by the vulnerable position of women, who face both subtle and violent subjugation and exploitation in many African societies. Some may seek survival through commercial sex or through marriage relationships they would not otherwise choose. Even when knowledge levels and awareness about HIV/AIDS are very high (as is now the case in many African countries), and when condoms are available, male resistance severely limits the options for a woman to insist on use of a condom. This is particularly hard within marriage, since consistently using condoms implies a decision not to have children.

Tragically, just as the pandemic was taking off in the 1980s, the World Bank and the rich-country bilateral creditors that hold Africa's foreign debt were insisting on austerity policies that further weakened health services and accentuated poverty. Many countries were forced to cut health budgets and impose user fees for services that were previously free, which reduced access by the poor to health services and consequently increased sexually transmitted infections. Paying off foreign debts was given higher priority than long-term investment in health and education.

There are of course pronounced differences within the continent, which is more than three times the size of the U.S. There is almost no data available on the pattern of AIDS in Africa north of the Sahara Desert, but prevalence is

thought to be low there. Within sub-Saharan Africa, regional differences are significant. So far, most West African countries are less affected than those in Central, East and Southern Africa. In East and Central Africa, regional wars and the movement of soldiers and refugees were one of the major forces propelling the pandemic in the 1980s and 1990s. In addition to deliberate rapes by some forces, such as those who carried out the genocide in Rwanda in 1994, war anywhere in the world has always been accompanied by sexual violence, prostitution and other social dislocation which facilitates disease spread.

Southern Africa also suffered war. During the final years of apartheid in the 1980s, South Africa's efforts to defend white-minority rule brought devastation to its neighbors. In this region, it was primarily in the 1990s that the pandemic exploded. The accelerants included good transport networks linking South Africa and its neighbors, the pull of South Africa's more advanced economy, and the migrant-labor system inherited from the apartheid era. In addition, the HIV subtype predominant in Southern Africa is the most virulent and easily spread. Cruelly, the pandemic was taking off just as the whole world celebrated with Nelson Mandela the South African victory over apartheid.■

How four African countries cope

THE PATTERN of HIV/AIDS and the response to it vary significantly by country as well as by region. Uganda in East Africa and Senegal in West Africa are two examples of relative "success" in coping with the pandemic. Botswana and South Africa, neighbors in Southern Africa, are both among the most gravely affected countries in the world. Currently Botswana is among the pioneers in fighting back against HIV/AIDS; the South African response has so far been profoundly ambivalent.

UGANDA

Uganda was one of the earliest countries to be devastated by HIV/AIDS, beginning in the early 1980s when it spread in the aftermath of the war that overthrew the repressive regime of Idi Amin. Uganda has also long been cited as a model of how to respond since by the mid-1980s, the government had become strongly engaged in reinforcing early responses by the health sector and community groups. President Yoweri Museveni and other officials spoke openly about HIV/AIDS and the government also initiated a multisectoral approach to confront the pandemic and encourage collaboration with nongovernmental initiatives.

By 2001, an estimated 2.2 million (nearly 10% of Uganda's total population of 24 million) were estimated to have been infected with HIV; approximately 800,000 of them were estimated to have already died of AIDS. Almost every Ugandan family has been affected. In 1999, the AIDS death toll was approximately 110,000, about 75 times as great on a per capita basis as in the U.S.

By extraordinary efforts of public education, testing, condom distribution and other prevention measures, with religious groups as well as government and other civic groups joining in, Uganda began to reverse the rate of HIV infection in the 1990s. At the end of the decade, the rate had declined from as high as 15% of adults in the early 1990s to 8% at the end of 1999.

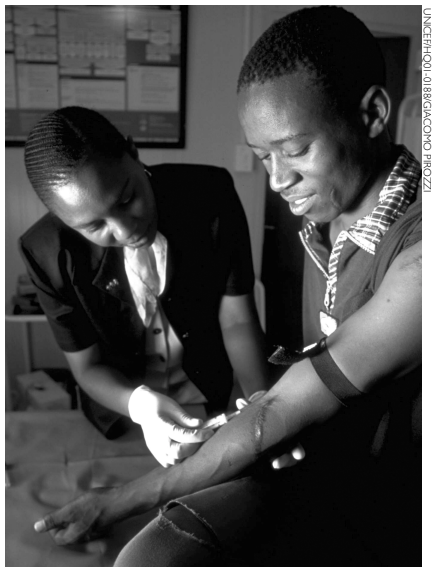
Even so, UNAIDS estimated that as many as 770,000 adults and 53,000 children were living with HIV/AIDS at the end of 1999. In 2001, stigmatization of people with HIV/AIDS was still a powerful reality in Uganda. Only a small fraction of Ugandan AIDS patients had access to antiretroviral treatment; a program for all HIV-positive pregnant women to prevent mother-to-child transmission was only launched in late 2001. Despite Uganda's reputation compared with other countries, AIDS activists sharply criticized the lack of consistent government efforts to step up the campaign against the pandemic.

SENEGAL

At the end of 1999, Senegal, with a population of some 10 million people, had an HIV-prevalence rate of less than 2% of the adult population, one of the lowest in sub-Saharan Africa. Senegal's success to date in avoiding a wider epidemic is apparently due to multiple factors: (1) universal prevalence of circumcision, which decreases the risk of virus transmission, in this predominantly Muslim country; (2) low and still-decreasing rates of premarital and extramarital sex; (3) early and strong engagement of Muslim and Christian religious leaders, as well as government and community groups, in promoting the use of condoms in any extramarital sex, as well as delay for youth in beginning sexual relations; (4) strong and long-established government health programs to treat sexually transmitted diseases and provide other primary health-care services; and (5) explicit concentration of prevention and health measures on sex workers, a policy made possible by the early legalization of prostitution in 1969.

BOTSWANA

A relatively prosperous and well-governed African country adjoining South Africa, with about 1.6 million people, Botswana is nevertheless one of the countries worst affected by AIDS. It has served as a source of migrant labor for South Africa's mines, and as a land-transport route linking South Africa with countries to the north. Before the 1990s, HIV prevalence was less than



UNICEF/HQ01-0186/GIACOMO PIROZZI

IN GABORONE, BOTSWANA, *a nurse draws blood during a medical examination at a UNICEF-supported clinic that provides free health services, including information, voluntary testing and counseling for HIV and other sexually transmitted diseases.*

JOAO SILVA/THE NEW YORK TIMES

TO CURB THE SPREAD OF HIV *in Swaziland, King Mswati III issued the controversial decree that young women must stop having sex for the next five years and must wear brightly colored tassels (umcwasho) to indicate their celibacy. Lungile Ndlovu, regally appointed leader of the maidens, believes it will be no problem, but many Swazis disagree.*

10%. But rates shot up in the 1990s, to the current estimate of some 36% of the adult population. Life expectancy, which had risen to 67 in the mid-1990s, was projected at less than 50 by the end of the decade. While health authorities were alarmed, other government officials and society at large were slow to realize the scale of the catastrophe.

Now, however, Botswana is fighting back. Prevention campaigns have gone into high gear. The government plans universal coverage of drugs to prevent mother-to-child transmission for the 24,000 HIV-positive women giving birth each year. The national diamond company, half-owned by the government, is paying for treatment for workers who need it, and officials are committed to providing access to all citizens. Botswana is collaborating with Harvard University and others on a high-tech laboratory for research particularly targeted at HIV/AIDS in Southern Africa.

SOUTH AFRICA

According to estimates for the year 2000, almost 4.2 million of some 43 million South Africans were infected with HIV, the largest number of any country in the world. Although it is the African country best prepared in economic and political terms to cope, according to *The Washington Post*, it has "proven among the least capable of overcoming economic inequality, bitter distrust and social barriers" that fuel the pandemic.

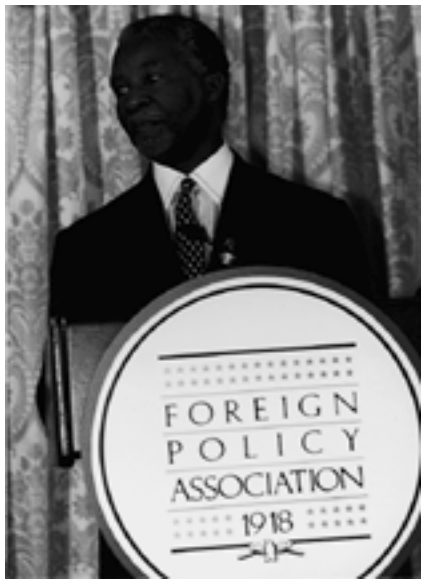
The combination of low levels of social cohesion inherited from the apartheid era, combined with relatively high incomes and population mobility, provided an ideal environment for the epidemic to spread, according to Alan Whiteside, one of South Africa's leading researchers on AIDS. While South Africa's political transition to democracy in the 1990s was rightly applauded around the world, the economic and social patterns of racial division and inequality were more resistant to change. In fact, despite advances for many black South Africans, poverty, social disruption and criminal violence continue to grow as a result of earlier socioeconomic divisions and current economic policies that put market stability for investors at the top of government priorities.

The response to the pandemic by South African government officials has been beset by denial and ambivalence, and has lacked internal coherence. At the same time, AIDS activists and health professionals in South Africa—including many in the government—have actively taken practical initiatives at many levels, and have taken the lead in working for national and global action to lower drug prices, combat stigma and confront the overwhelming impact of AIDS on African countries.

Initially ambivalence was fueled by the stereotype of AIDS as a gay white men's disease—the pattern among white South Africans and the one most widely publicized until the mid-1990s. The pandemic also hit South Africa relatively late. Given the lag between infection and the onset of AIDS, and the stigma-based reluctance to identify AIDS as the cause of death, AIDS only ranked 12th in statistics on the causes of death as late as 1995. Top South African leaders, preoccupied with the transition to democracy in the mid-1990s and with a host of issues after the democratically elected government took power, failed to take AIDS seriously enough.

South African President Thabo M. Mbeki, who succeeded Mandela in 1999, bears much of the responsibility for the continuing failure. While AIDS activists and medical professionals agree that President Mbeki is correct in pointing to the close links between poverty and AIDS, they reject his doubts about the connection between HIV and AIDS, his use of outdated statistics, and his government's refusal to maximize use of AIDS drugs to stop mother-to-child transmission and to prolong the lives of those living with AIDS.

Nevertheless, it was the 13th international conference on AIDS, hosted by South Africa in July 2000, that marked the beginning of world attention to AIDS in Africa. In the year that followed that conference, AIDS activists and the South African government joined in defense against a pharmaceutical company lawsuit that had challenged a South African law making it easier to obtain AIDS drugs more cheaply. In response to worldwide media attention and activist support, the companies withdrew the suit.



FOREIGN POLICY ASSOCIATION

THABO M. MBEKI, *thought by many to be slow in recognizing the seriousness of AIDS, speaks to a Foreign Policy Association World Leadership Forum, September 2000.*

The debate in the South African government and wider society about what to do remains intense. Medical professionals both within and outside the government warn of the dangers of continued ambivalence. Church and trade union leaders have joined AIDS activists in demanding action, comparing the crisis to a new apartheid. But the outcome is uncertain. ■

Overcoming a global challenge

If African countries are left to confront the HIV/AIDS pandemic with the small level of outside support they have received to date, few are likely to succeed in checking or reducing the pandemic. And success in any one country can easily be reversed due to the spread of AIDS among neighboring countries. No state is an island when it comes to AIDS, and there are no national fire walls. At an African summit on HIV/AIDS in April 2001, government leaders pledged to try to increase their health budgets to some 15% of expenditures. But they will have little chance of meeting this pledge unless foreign debts are cancelled or substantially reduced and unless economic growth and capital inflow expand far more rapidly than anyone predicts. Even if such budget commitments are achieved, they would fall far short of meeting the challenge.

The U.S., with less than 20,000 people a year dying of AIDS, spends almost $11 billion on HIV/AIDS. Less than 5% of this amount goes for efforts to combat the pandemic internationally, where AIDS kills 3 million people a year. At the special session of the UN General Assembly on HIV/AIDS held in New York in June 2001, the world's nations affirmed that AIDS is a global threat and that fighting the pandemic is a global responsibility. They also pledged to support UN Secretary General Annan's target of $10 billion a year for a global health fund. The sum is very modest in comparison with developed countries' budgets and economies, but the question for the U.S. and other wealthy countries remains whether they will ante up.

Prevention, treatment, research

At the UN special session in June 2001, the world's governments agreed that treatment and prevention were both essential, and that research must give greater attention to the search for a vaccine, particularly for strains of HIV in the most affected regions. Despite such general agreement, however, disagreements in practice on priorities still have profound implications. In 2001, for example, investment in research on a vaccine for AIDS still accounted for less than 1% of health research and development worldwide. U.S. officials still refused to acknowledge the urgent need for access to antiretroviral treatment for Africans.

Until 2000, few questioned the fact that Africans had little or no access to antiretroviral drugs that in 1996 had begun to slow the death toll from AIDS in the U.S. and other developed countries. AIDS activists protesting against artificially high drug prices and the worldwide attention that followed the Durban conference in July 2000 led to a dramatic shift in world opinion. The case of Brazil's successful government program, which supplies low-cost treatment to all who need it, showed that treatment not only prolongs lives but also provides an incentive for people to be tested. In countries that offer no hope of treatment, the odds are stacked against persuading those infected to be tested and join prevention efforts. The consensus grew that treatment and prevention are both essential and intrinsically interrelated.

The U.S. government, despite signing on to the conference consensus, continued to deny funding and to lobby against including antiretroviral treatment in multilateral programs for poor countries. USAID (U.S. Agency for International Development) administrator Andrew Natsios touched off a furor of protest when in an interview with the *The Boston Globe*, June 7, 2001, he claimed Africans could not follow instructions for taking AIDS medicines because they "don't know what Western time is....Many people in Africa have never seen a clock or a watch their entire lives." AIDS protesters and medical professionals attacked Natsios's statement as reflecting both racist indifference to African lives and ignorance of the medical facts about AIDS treatment. U.S. officials have acknowledged that Natsios's statement may have been insensitive, but he has issued no retraction and the U.S. has not abandoned its opposition to making antiretroviral treatment widely available in Africa.

The issue of patents

Lack of access to antiretrovirals is linked to many factors, but above all to cost. In the U.S. a full course of "triple therapy" costs between $10,000 and $15,000 a year. Manufacturing costs represent much less than 5% of that price: indeed, Indian generic drug manufacturer Cipla offers the combination drug at $350 a year. The high prices result from drug-company patents giving monopoly pricing power to the original manufacturers, protected by vigorous lobbying against use of generics on the part of drug companies and their home governments, particularly the U.S.

In fact these patents are determined by national laws and do not yet apply in many countries, including India and many African nations. International trade rules also explicitly provide for the right of countries to take such measures as granting "compulsory licenses" to meet urgent public health needs. Brazil, for one, has aggressively taken advantage of its rights to pressure drug companies for lower prices and to defend the right to manufacture its own generic varieties of the drugs. Most African countries, however, have lacked the will or capacity to challenge the drug companies.

Ironically, the drug companies helped fuel an international campaign against their pricing policies by bringing a suit in 1998 against Mandela to block new legislation that would give South Africa greater flexibility in purchasing and manufacturing medicines. The suit delayed implementation of the law by at least three years. But by the time it was due to come to trial in March 2001, South Africa's Treatment Action Campaign (TAC) had been joined by supporters worldwide, including groups

AP/WIDE WORLD PHOTOS

UN SECRETARY GENERAL *Kofi Annan, background second from left, and others unfurl an AIDS memorial quilt at the opening of a three-day session on AIDS, June 25, 2001.*

such as Doctors without Borders, Oxfam, ACT-UP and Africa Action, to mobilize against it. These protests—and widespread media coverage—resulted in the companies dropping the suit. The U.S. government also moderated its stance.

Some African governments, including Nigeria and Kenya, made plans to import generic antiretrovirals from India. Drug companies reacting to public exposure and to competition began to lower their own prices, and even offered some products free to developing countries. But the companies continued to argue that they needed strong patent protection and high prices to provide capital for research and development of new drugs. Critics responded that the drug companies had among the highest profit rates of any industry and that much of the research on drugs was in any case funded by the public sector.

In 2001, the debate on affordable drugs for AIDS continued in two major arenas: criteria for drug purchases by international agencies and international trade rules. In both, the U.S. government joined with the pharmaceutical companies in opposing greater flexibility. Advocates of affordable medicines argued that international health agencies should create a database of available drugs and pricing, and that the new Global Health Fund and other buyers should be able to choose the best quality and lowest-cost alternatives, including generic products. The developing-countries group, with the support of international nongovernmental organizations, successfully pushed for explicit statements within the context of WTO talks that trade rules, including the agreement on Trade-Related Intellectual Property Rights (TRIPS), should not be used to hamper countries' efforts to make drugs affordable.

In contrast, U.S. officials argued that voluntary price discounts by drug companies were adequate and that strong patents were vital to preserving incentives for research on new drugs. They also contended that the existing TRIPS agreement provided all the flexibility countries needed to manage their health policies, and that no clarification was needed.

Public investment issue

Cost estimates for HIV/AIDS prevention, treatment and support in low- and middle-income countries worldwide run between $7 billion and $10 billion a year, as much as five times current levels. These estimates do not include funds for research, for general health infrastructure, or for alleviating the economic impact from the loss of human resources. The poignant questions are: Who will pay? And what are the consequences if no one does?

The sums are in fact very small compared with government budgets or national economies in the well-endowed countries. A U.S. commitment of some $3 billion a year, a sum appropriate to the U.S. share in the world economy, would be equivalent, for example, to only 1% of the U.S. defense budget, less than one tenth of the tax rebate sent to U.S. taxpayers in 2001, and only 50% more than the cost of one B-2 bomber.

African countries must also shift their own budget priorities, but many are still paying more each year in debt service to international financial institutions than they spend on health: Sub-Saharan African countries spend about $13.5 billion a year to service their foreign debt. Since 1996, the World Bank and the International Monetary Fund (IMF), together with bilateral creditors, have managed a program for debt reduction for heavily indebted poor countries (HIPC). Even World Bank analysts agree that implementation of this has been slow and that today the remaining debt burden of most countries is still unsustainable. Almost all of the remaining debt is owed to the international financial institutions themselves, the result of perpetual recycling of earlier debt with new loans being used to pay off old ones rather than to service new productive investment.

Even before recent attention to the HIV/AIDS pandemic, African countries and international campaigners for debt relief or cancellation argued that more drastic action was needed to erase unpayable debts. Not only is the debt unsustainable and a primary obstacle to new development efforts, but much of it was also illegitimate in the first place, incurred to bolster undemocratic regimes such as Mobutu Sese Seko in the Congo and the apartheid regime in South Africa. Even conservative business analysts have concurred there is no point to pretending the loans can be paid and that there should be an international equivalent to domestic bankruptcy procedures for individuals and businesses. UN Secretary General Annan has proposed temporary suspension of debt payments from the most indebted countries, along with a new international commission to find a sustainable solution, including debtors as well as creditors, in contrast to the creditor-dominated HIPC process.

Ironically, in 2001, the World Bank's own new initiatives on HIV/AIDS were still in the form of loans, increasing African indebtedness, despite critics (including the incoming U.S. secretary of the treasury) who argued that it was better to acknowledge from the start that grants rather than loans were needed. Some countries, like Malawi, have turned down offers of loans for AIDS programs because they would only increase indebtedness that already undermines the health-care system.

The Global Health Fund launched by Annan, with the target of raising $7 billion to $10 billion a year, was pro-

jected to be operational by the beginning of 2002. In late 2001, however, pledges still fell far short of the goal—only $1.5 billion—much of it for multiyear periods.

The U.S. had promised only $200 million for its initial contribution to the Global Health Fund. In the aftermath of the UN special session, some members of Congress had proposed larger sums, but these became even more marginalized after 9/11.

Continued failure to match the scale of the pandemic with adequate responses to combat it will impose massive costs on the U.S. as well as African countries. The loss of human lives, the collapse of economies, and the spread of instability will heighten global insecurity in both predictable and unpredictable ways. The cost of new humanitarian and security requirements will, within 10 years or less, far exceed the cost of "scaling up" action now. The question remains: Will the U.S. and other developed countries have the vision to join Africa now in confronting the pandemic or will the failure of imagination and solidarity persist?

U.S. policy options

❑ **1. The U.S. government should commit at least $3 billion a year to the Global Health Fund and other channels for combating the HIV/AIDS pandemic and the wider health emergency it represents. Both moral obligation and national security require the U.S. to give priority to global health.**

Pro: There are many reasons that the U.S. should contribute to combating HIV/AIDS in proportion to its share in the world economy and its role in global leadership. In addition to the moral obligation to defend the global right to health, the consequences of continued failure to establish a base level of human security against disease will damage not only Africa but also the U.S. If nations collapse, they will provide ongoing reservoirs for the worldwide export of humanitarian crises and terrorism.

Con: Granted, the U.S. government could do more, but there are many higher priorities for official U.S. resources, both domestic and international. The U.S. is already the largest bilateral donor to international AIDS efforts and filling the gap should be left to private foundations, businesses and other nongovernmental initiatives, including faith-based programs.

❑ **2. The U.S. should support cancellation of unpayable debts owed by African and other developing countries to the World Bank and the IMF. Access to new grants and loans should be linked to the capacity to implement effective development programs, including combating disease and promoting public health.**

Pro: Most African countries are still paying out unsustainable amounts to the international institutions that are supposed to be promoting development. The chances for scaling up national investment in health care, including specific measures against HIV/AIDS, are slim without significant debt cancellation.

Con: Canceling debt would erode the future creditworthiness of African countries and would not provide significant new resources for other purposes. The HIPC debt-reduction programs should be continued and expanded.

❑ **3. In both bilateral programs and support for multilateral efforts, the U.S. government should follow a balanced approach to combating HIV/AIDS. It should put equal emphasis on prevention and treatment and place a high priority on the search for a vaccine.**

Pro: Providing treatment as well as prevention is not only a moral imperative: In the U.S., even with the high cost of drugs, it has lowered total health costs by keeping more patients out of hospitals; Brazil has had even greater success along these lines and has reduced AIDS-related deaths by 50%. In Africa, prolonging life and enabling more people to remain productive members of society is also essential for reducing the loss of skilled professionals and workers, and enabling more parents to raise their children. In the long run, greater investment in the search for a vaccine is the only hope for victory over AIDS.

Con: Those arguments might be convincing if there were enough money to go around. Prevention is still more cost-effective in terms of future lives saved than treatment to prolong the lives of people who are doomed anyway.

❑ **4. The U.S. should endorse the developing countries' position explicitly stating that nothing in current or future trade agreements should be interpreted to "curtail the ability of developing and least-developed-country members to avail themselves of every possible policy option to protect and promote public health."**

Pro: Patents are a temporary monopoly and both national and international law have recognized that exceptions can be made to defend the public interest. The U.S. should join in unequivocally affirming the priority of public health over the most expansive interpretations of patent rights.

Con: There is ample flexibility in current regulations for countries to take the actions they need to get essential drugs for their citizens. The problem is not trade rules but lack of policy consistency and adequate financing. Announcing greater flexibility would encourage abuse by generic drug manufacturers, at the expense of U.S. companies.

❑ **5. Both in bilateral relations with African countries and in the policies it advocates for multilateral financial institutions, the U.S. should stop promoting a one-sided economic agenda that advances trade liberalization and budget cutting, at the expense of productive public investment in health, education and infrastructure. Instead, it should work with African governments, civil society and development specialists to implement balanced development policies that can address the structural roots of Africa's marginalization in today's world economy.**

Pro: The standard package of economic policies promoted by the U.S. and the World Bank should include adequate investment in health, education and all kinds of infrastructure. In the long-term, "free-market fundamentalism" is bad economics. African countries will never be able to have self-sustaining economies unless both African governments and their partners make adequate investments in human resources.

Con: Health, education and other such investments are important. But African countries must first get their economies straightened out so that they can generate enough resources to make these investments. The best way to do that is to open their economies to the world market, attract foreign investment and increase exports. ■

OPINION BALLOTS are on pages 69–70

DISCUSSION QUESTIONS

1. Imagine you are a participant in a cabinet meeting in an African country, considering the national response to a commission reporting that one third of your citizens is likely to die of AIDS. What would you say if you were the minister of health? The minister of finance? The foreign minister?

2. Just before the world AIDS conference in South Africa in July 2000, UNAIDS director Peter Piot commented on the world's failure to respond to the worst pandemic in human history. "If this had happened with white people," he said, "the reaction would have been different." Many AIDS activists charge that the world's response to the pandemic reflects an international "double standard" in which black lives are valued less than white lives. Do you agree? Why, or why not?

3. The constitution of the World Health Organization, adopted in 1946, says "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief and economic or social condition." The U.S. government opposes any "rights-based" approach to HIV/AIDS and other health or socio-economic problems, saying that this might create legal obligations that governments are unwilling or unable to fulfill. Do you agree? Why, or why not?

4. In your opinion, under what circumstances should patent protection for a drug be suspended in the public interest? What do you think is the most effective way to encourage research in the interest of global public health?

5. What is the relationship between investment in public health and economic growth? Discuss to what extent public health advances are results of economic growth, and to what extent they are requirements for economic growth. What are the likely results, for Africa and the world, of failure to control the AIDS pandemic?

READINGS AND RESOURCES

Baylies, Carolyn, and Bujra, Janet, **Aids, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia.** New York, Taylor and Francis, 2001. 256 pp. $25.95 (paper). Essays by African scholars.

Farmer, Paul, **Infections and Inequalities: The Modern Plagues.** Berkeley and Los Angeles, University of California Press, 2001. 389 pp. $17.95 (paper). Essential book on the connection between disease and poverty by a physician with extensive personal experience in Haiti.

Garbus, Lisa, "Sub-Saharan Africa: Profile." AIDS Reseach Institute, University of California, San Francisco, May 2001. **http://hivinsite.ucsf.edu/InSite.jsp?page=cr-02-01**

Garrett, Laurie, **The Coming Plague: Newly Emerging Diseases in a World Out of Balance.** New York, Viking Penguin, 1995. 730 pp. $15.95 (paper). Chapter 11 of this book provides a well-informed account of the first decade of HIV/AIDS in both North America and Africa.

Rosenberg, Tina, "Look at Brazil," **The New York Times Magazine**, January 28, 2001, p. 26+. **www.nytimes.com/library/magazine/home/20010128mag-aids**

Whiteside, Alan, and Sunter, Clem, **AIDS: The Challenge for South Africa.** Cape Town, Human & Rousseau, 2001. 180 pp. $10.95 (paper). Written for South Africans, this book summarizes the facts about the pandemic and its impact, and calls for national action against it on many fronts.

AFRICA ACTION, 110 Maryland Ave., NE, #508, Washington, DC 20002; (202) 546-7961; Fax (202) 546-1545. **www.africapolicy.org**. ■ Information and advocacy group on African issues, with a current focus on "Africa's Right to Health."

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), 1600 Clifton Rd., Atlanta, GA 30333; (404) 639-3534; (800) 311-3435. **www.cdc.gov** ■ U.S. government agency conducts programs aimed at understanding infectious diseases and creating practical strategies to fight epidemics.

GLOBAL TREATMENT ACCESS CAMPAIGN. www.globaltreatmentaccess.org. ■ Coalition of groups working for affordable AIDS drugs and essential medicines. Website has current news and action alerts.

THE HENRY J. KAISER FAMILY FOUNDATION, 2400 Sand Hill Road, Menlo Park, CA 94025; (650) 854-9400; Fax: (650) 854-4800. **www.kff.org**. ■ Website provides background publications, statistics, and access to a daily news service on HIV/AIDS-related issues.

JOINT UNITED NATIONS PROGRAM ON HIV/AIDS (UNAIDS), 20 Avenue Appia, CH-1211 Geneva 27, Switzerland; (41-22) 791-36-66; Fax (41-22) 791-4187. **www.unaids.org** ■ UNAIDS is the coordinating agency for UN action on HIV/AIDS. Its website has documents and links with the most recent and comprehensive reports and conference proceedings.

TREATMENT ACTION CAMPAIGN (TAC), PO Box 31104, Braamfontein, 2017, South Africa; (27-11) 403-7021 or (27-21) 403-0390; Fax (27-11) 403-2106. **www. tac.org.za.** ■ TAC is a leading AIDS activists group in South Africa.

WORLD HEALTH ORGANIZATION (WHO), Avenue Appia 20, 1211 Geneva 27, Switzerland; (41-22) 791-2111; Fax (41-22) 791-3111. **www.who.org** ■ UN's chief health organization provides up-to-date information on current health concerns.