In San Francisco and across the United States, HIV prevention programs and research have come under increasing criticism. As HIV rates rise among gay men and a conservative Congress questions the sexual content of HIV prevention materials, some people have begun to ask whether or not prevention efforts in this country have made a difference.

Internationally, it seems, there is similar skepticism. At the XIV International AIDS Conference in Barcelona, Spain, attendees were greeted with a report from the Joint United Nations Programme on HIV/AIDS (UNAIDS) quoting grim statistics on a pandemic still in its early stages, with no stabilization of the epidemic in Africa and with exploding epidemics in Eastern Europe and Central Asia. Although the conference was full of stories about how prevention programs across the world are making a difference, the overall message focused on the staggering numbers of people living with HIV and the need for improved care and treatment for them.

The Debate Is Over

"The debate is over. The debate between prevention and treatment is over. We must have both." This assertion, made by Peter Piot, the director of UNAIDS, was met with booming cheers and applause at the opening ceremony for the Barcelona conference. The "debate" to which he referred was provoked by a study by University of California San Francisco researchers Elliot Marseille and Jim G. Kahn on an international comparison of the cost effectiveness of prevention versus HIV antiviral treatment [ThOrG1468].

The study found that prevention was 28 times more cost-effective than treatment, something that has been true since the beginning of the epidemic. The authors concluded that "funding HAART [highly active antiretroviral treatment] at the expense of prevention means greater loss of life."

The study results raised fears that there would be a temptation to sacrifice treatment initiatives to more efficient prevention ones, even though there are currently 40 million people living with HIV and only a small fraction of those are receiving any kind of antiviral treatment. There was certainly no evidence of this trend—or a "debate"—in Barcelona, where the talk about access to treatment overwhelmed other topics. In fact, there has never really been a debate between prevention and treatment. Prevention, be it for HIV, breast cancer, spinal injuries, or schizophrenia, has always taken a back seat to treatment, especially when pharmaceutical companies are involved. The public is always more interested in helping the sick or injured than in making sure no one gets sick or injured again.

The Role of Care and Prevention

Although there is often comparison, even competition, between the two, care and prevention can work together, and several conference presentations dealt with strengthening treatment services as a way of bolstering prevention. An evaluation of an HIV-positive care and support program in India, for instance, found that the service had a parallel effect on prevention: increased visibility of HIV-related care raised community interest in HIV prevention [WeOrF1362].

On a more intimate scale, a few presentations discussed the role of HIV caregivers in HIV prevention. For example, at the conference’s Community Forum, community organizer Mandeep Dhaliwal noted that the motivation of HIV-negative caregivers in South Africa to think about HIV testing or HIV prevention diminishes...
**Editorial: Mental Dis-Ease**

Robert Marks, Editor

HIV treatment works. So many lives that were near the end have been reclaimed that the process has been christened "the Lazarus effect." It should surprise no one, however, that people in poor countries have so far been excluded from this good fortune. If the rhetoric of the Barcelona International AIDS Conference is to be believed, that will change soon, as richer countries pony up funding to support treatment everywhere.

HIV disease is now called chronic and manageable. For the moment, let's believe that it is. Let's believe even that the world will come up with the $10 billion estimated as the annual cost of responding to the global pandemic. This would be amazing and wonderful. Why am I skeptical?

Look at what's happening in countries with access to treatments. People must deal with the lifelong demands of complex HIV antiviral regimens and their side effects. They must also cope with HIV-related stigma and fear, constraints on sex, and a post-HIV future they thought they'd never have. The bottom line is that HIV treatment has not solved the challenges of epidemic in rich countries, much less in poor ones.

Not only is treatment a formidable undertaking, it has yet to conclusively prove effective in preventing HIV transmission, despite some people's hopes and assertions. Rates of HIV infection are rising in the United States and other rich countries. As one U.S. study found, in a national sample of young men who have sex with men and who tested HIV-positive, between 60 percent and 90 percent had no idea that they were infected and had believed that they were at low risk. And as Lisa Loeb reports in this issue of *FOCUS*, emerging epidemics in Eastern Europe, China, and India are beginning to explode, and in Africa, seroprevalence rates that had soared to as much as 30 percent have, in some cases, reached 45 percent.

Until HIV treatment is a matter of painlessly popping pills and sustained health care, among people with HIV. A Los Angeles "prevention for positives" intervention, linked the separate divisions for HIV-positive and HIV prevention services, and used wellness case management and a health promotion program to address the individual needs of clients [TuPeF5492]. Another project for HIV-positive youth across the United States found that a small group intervention led to significant reductions in sexual risk and substance use, as well as improved quality of life, while individual and telephone sessions had less impact [ThPeD7706].

**The Medicalization of Prevention**

The conference highlighted an increasing emphasis on medical approaches to prevention. Presentations cemented the notion that lowering viral load levels will reduce or eliminate the odds of HIV transmission. One report suggested that an effective prevention program should target treatment to people in high-risk groups— for example, sex workers in South African
An unproven pharmaceutical intervention should not be preferred over cheaper and simpler ones just because it is politically more acceptable.

Another manifestation of medical approaches to prevention is the use of HIV prophylaxis. A program in the war-affected area of Brazzaville, Congo, offered HIV and sexually transmitted disease (STD) prophylaxis to anyone who was a victim of sexual violence within the prior 72 hours. In a six-month follow-up, researchers found no instances of HIV seroconversion [MoORD1109]. HIV prophylaxis has been used for many years with victims of rape or people with known HIV exposure, including health care workers facing needlestick injuries with HIV-positive blood and mixed status couples experiencing condom breakage. However, other presentations at this conference introduced the idea of using HIV prophylaxis in at-risk populations for individuals without a known incident of exposure, for example, HIV-negative sex workers and HIV-negative individuals in couples with HIV-positive partners without specific exposure risks.

In a session entitled “Brave New World: Thinking Faster Than the Epidemic,” Australian researcher Dennis Altman observed the increasing medicalization of prevention [WeORE229]. He noted that most of the conference presenters spoke from a biomedical—and not a social, political, or cultural—perspective. For instance, although many presentations discussed barriers to treatment, there were few presentations on the role of religion or cultural tradition in creating barriers to prevention.

At the same time, Altman noted that health care practitioners seemed to be accepting more responsibility for prevention. While this increases the availability of prevention education, it may compromise its quality, since many clinicians are untrained in HIV prevention. In this vein, several studies presented results from projects that integrated prevention education and risk assessment into general medical practice. In one survey of physicians who serve HIV-positive clients in four U.S. cities, prevention counseling was less than optimal. Physicians were more likely to counsel newly diagnosed patients than established patients and were reluctant to counsel patients with competing mental health and substance abuse problems [MoPPD2019].

Old-Fashioned Prevention

While the Barcelona conference focused on prevention in collaboration with treatment, presenters did report on some “old-fashioned” prevention interventions. They highlighted programs for women, especially young women; notably absent were the programs for gay and bisexual men that have been so present in the past. This may be appropriate for an international forum, since gay men comprise only a small percentage of the pandemic, even though they are a large part of the epidemics in the United States, Canada, Australia, and Europe.

There were conflicting reports of increased risk behavior among men who have sex with men. Canada, the United States, and the United Kingdom reported increased risk behaviors among these men, while Spain and Brazil noted no increase [D11336, ThOrD1450, TuORC1147, TuPeC4742]. There were also conflicting reports about “treatment optimism”: studies from Canada and Brazil found optimism to be a reason for increased risk, while those from the United Kingdom found no link [D11336, MoPeD3696, ThOrD1450].

On the other hand, this was also the first international conference where the role of heterosexual men was addressed in a noticeable way in presentations on the social, cultural, and physical risk factors for heterosexual men and heterosexual couples. Most of these programs were based in Africa, Asia, and South America, and many sought to reach men at venues where they are not usually targeted with health information.

A Zambian program sought to increase the involvement of men in parent-to-child-transmission prevention by having male
outreach workers talk to women in the waiting room of clinics and then go to the houses of these women to invite their husbands for voluntary testing and counseling [MoOrF1032]. In Vietnam, social marketing campaigns and peer educators addressed men in factories, barbershops, shoe-shine stands, and motorbike taxis [TuPeF5231]. One U.S. program developed a group for fathers with sons 11 to 14 years old that focused on adolescence, STD and HIV infection, and communication skills for talking with their sons [TuPeD4911]. The Men as Partners project in South Africa holds workshops for men only or men and women together to explore issues about men’s and women’s roles, relationships, power imbalances, and gender-based violence [SB28].

Several studies looked at couples and at women’s perceptions of men and their needs. A study of mixed status couples in California found that the main reason most women did not use condoms was the desire for intimacy, not condom refusal by male partners [MoOrE1028]. In a Bangladeshi study of sexual activity among men and women, 35 percent of women said they always or sometimes enjoyed being forced to have sex, and some women reported refusing sex to see if their husbands would force them, which the women then interpreted as a symbol of love [MoOrE1028]. The study also found that most of the men reported that their first intercourse was with a sex worker, and many reported sexual problems, including no full erection and having three or more “sex worries.”

The New Global Fund to Fight AIDS

The conference was dominated by the call for “treatment now.” Activists demanded “Where’s the 10 billion?” referring to the newly formed Global Fund to Fight AIDS, Tuberculosis, and Malaria and its goal to provide $10 billion in the first year. The fund has raised only $2 billion. In the first round of proposals, more than 300 requests were submitted, and 58 projects from 38 countries were awarded grants. The second round of funding has just been launched.

Sixty percent of the grants in the first round were awarded to programs addressing HIV, and 9 percent to programs addressing both HIV and the other diseases. Despite all the treatment activism, most of the HIV organizations that applied did not ask for money for HIV antiviral treatment. Economist Stefano Bertozzi suggested that the fund should first provide significant help to countries like Honduras—about to receive $10 million in aid—and then carefully measure successes and failures to guide future awards [WeOrE228].

The Future of Prevention

The discourse at the Barcelona conference represents a shift in focus toward global governmental responsibility for the pandemic as well as medical treatment and medications as a means of prevention. While prevention was evident in many poster presentations and was on the minds of many delegates, it took a back seat to treatment.

The next few years will likely see an increase in the number of partnerships and collaborations between care facilities and prevention programs, as well as the use of HIV antiviral treatment and other pharmaceutical strategies as preventive tools. Securing funding for traditional prevention programs, even though these may remain more effective and cost-efficient, will likely be a challenge in the coming years.

Clearinghouse: The AIDS Conference

Conference-Specific Information
To view all the abstracts accepted by the XIV International AIDS Conference in Barcelona and to find additional information, visit the official conference web site at: http://www.aids2002.com.

Journals and Newsletters
AIDS Treatment News covered the conference in its August 9, 2002 issue (number 382). For ordering information, contact AIDS Treatment News at: c/o Philadelphia FIGHT, 1233 Locust St., 5th floor, Philadelphia, PA 19107; 800-873-2812; 215-985-4952 (fax); aidsnews@aidsnews.org (e-mail); http://www.aids.org (web site).

The Journal of the American Medical Association included an article on the XIV International AIDS Conference in its August 14, 2002 issue. To order, contact American Medical Association at: Subscriber Services, P.O. Box 10946, Chicago, IL 60610-0946; 800-262-2350 or 312-670-7827; 312-464-5831 (fax); ama-sub@ama-assn.org (e-mail); http://jama.ama-assn.org (web site).

The Lancet Infectious Diseases included an article on HIV vaccine presentations from the conference in its September 1, 2002 issue. To order, contact The Lancet Publishing Group at: 360 Park Avenue South, New York, NY 10010-1710; 212-633-3800; 212-633-3850 (fax); http://infection.thelancet.com (web site).

Treatment Issues, published by the Gay Men’s Health Crisis in New York, focuses on the conference in its July/August 2002 issue. To order, contact GMHC Treatment Issues at: The Tisch Building 119 West 24th Street, New York, NY 10011; 212-367-1235 (fax); ti@gmhc.org (e-mail); http://www.gmhc.org (web site).

Barcelona Reports on People with HIV Emphasize Treatment Issues
Mallory O. Johnson, PhD

The theme of the XIV International AIDS Conference in Barcelona—Knowledge and a Commitment for Action—was reiterated by many speakers who asserted that we already have the scientific knowledge to help HIV-positive people worldwide but lack the political commitment to take necessary action. The conference attempted to meld the needs for prevention and treatment interventions and to dismiss the notion that more of one has to mean less of the other.

For example, as International AIDS Society president Stefano Vella said, perinatal prevention may ultimately fail if we allow the parents of HIV-negative children to die from AIDS. In the pursuit of the conference theme, however, there was limited discussion of the psychosocial and mental health issues and needs of people with HIV.

Psychosocial Issues for People with HIV

In this context, there were strikingly few sessions covering research related to psychological adjustment and coping with HIV. A number of sessions focused on the role of stigma in HIV testing and access to treatment in the developing world; some of these presented interventions to enhance community acceptance of HIV testing and care and to reduce this stigma. Somewhat surprisingly, research from the rural United States described similar social and political obstacles, and in one case, the misallocation or failed use of funds earmarked for HIV prevention and care [TuPeG5627].

While there were a number of sessions exploring psychosocial issues of HIV-positive and orphaned children [TuPeF5312, TuOrF1211, MoPeF4091], presentations on psychosocial issues for HIV-positive adults were absent. Judging from the few presentations on these topics, it may be that the reason for this scarcity relates to the fact that current research is not uncovering new findings. Among the reports that were presented, most focused on the prominence of depression, substance use, and stigma among HIV-positive people around the world, and none broke new ground [WePeC6244, E11661, TuPeG5647]. The responses to these challenges often included integrating psychosocial services into medical care settings [TuPeG5647], and the implementation of support groups in such diverse areas as Burundi [WePeF830], Finland [WePeF6873], India [WePeF6845], and Uganda [F12234].

Disclosure of HIV serostatus appeared in a number of sessions describing its positive impact on well being among Latino gay men [MoPeE3714] and African American men [WePeF859]. One study suggested that selective, planned, and well-prepared disclosure—rather than indiscriminant disclosure—facilitates social support and mediates against depression [WeOrF1327].

It may seem misguided to focus on psychosocial issues among people with HIV when millions are dying due to a lack of medical treatment. Certainly, in many countries, basic prevention and treatment needs are paramount. However, the stigma, depression, and substance use that remain prevalent among people with HIV are the same factors that are correlated with new infections. Addressing these issues among HIV-positive, as well as HIV-negative, people is critical to addressing the epidemic.

Future Conferences
December 1–3, 2002, Mumbai, India: Hope 2002 International Conference on Substance Abuse and HIV. For information, contact The Hope 2002 Secretariat at: DAIRRC Headquarters, H-1, Sitaram Building, Palton Road, Mumbai 400001, India; 91-22-3453253; 91-22-3421416 (fax); yusufmerchant@sanskritiindia.com (e-mail); or http://www.hopeconference.org/Aimsobjectives.html (web site).


March 30–April 2, 2003, Miami: 15th National HIV/AIDS Update Conference (NAUC). For information, contact Jennifer Artonite, Conference Director at: AmFAR, 120 Wall Street, 13th Floor, New York, New York 10005-3902; 212-806-1631; 212-806-1608 (fax); nauc@amfar.org (e-mail); or http://www.amfar.org/cgi-bin/iowa/nauc (web site).

July 7–10, 2003, Milan: AIDS Impact 2003: 6th International Conference on Biopsychosocial Aspects of HIV Infection. For information, contact: Organizing Committee, Università Vita Salute San Raffaele, Clinical Psychology and Psychotherapy Unit, Via Stamira d’Ancona 20, 20127 Milan, Italy; 39-02-26433238; 39-02-26433408 (fax); aidsimpact@hsr.it (e-mail); or www.aidsimpact.com (web site).


July 11–16, 2004, Bangkok: XV International AIDS Conference. For information, contact IAS Headquarters at: P.O. Box 4249, Folkungagatan 49 SE: 102 65, Stockholm, Sweden; or secretariat@ias.se (e-mail).
Adherence

As has been the case with the past few international conferences, there was a substantial focus on adherence to HIV antiviral medications. While there were no oral presentations on the topic, a number of posters presented data on factors related to nonadherence. While none reported anything dramatically new, there was continued evidence for the role of substance use [WePeB5817, WePeB5843] in nonadherence. In addition, depression was linked to poor adherence in a number of HIV-positive populations, including adolescents [WePeB5826], the urban poor [TuPeC4724], the incarcerated [MoPeB3259], and those enrolled in clinical trials for new medications [MoPeB3259]. Two presentations offered further evidence against the ability of providers to predict and detect adherence problems among their patients [WePeB5845, MoPeE3723].

There were a number of interventions aimed at improving adherence, ranging from psychosocial support to directly observed therapy [MoPeB3246, MoPeB3204]. However, as one researcher pointed out, there are very few documented adherence interventions that meet criteria for randomized controlled trials [MoPeB3215], compromising the ability of these studies to truly test the efficacy of interventions. Despite these limitations, there were promising approaches to enhancing adherence, including clinic-based adherence counseling [MoPeB3284] and the involvement of nurses, social workers, and HIV-positive peer educators adherence interventions [WePeB5857].

HIV Antiviral Treatment

The bulk of presentations most relevant to the mental health of people with HIV, in fact, related to the breadth and ease of HIV antiviral treatment. Sessions forecasted improvements in existing classes of antiviral drugs and highlighted the promise of medications focused on new targets, for example, fusion and entry inhibitors and integrase inhibitors. One study found a lack of resistance development with T-20 fusion inhibitors in patients with multiply resistant virus (having previously been treated with an average of 11 different drugs) [MoPeA3026]. The high cost and difficult administration—subcutaneous injections twice a day—of T-20, however, present potential drawbacks to its broad implementation [TuPeB4480].

Additional sessions presented findings that are being used to shape treatment guidelines. In an analysis of aggregated cohort samples of 12,574 HIV-positive individuals, researchers suggested that CD4+ cell levels at initiation of antiviral treatment and then six months later are the best predictors of progression to AIDS or death [TuOrB1140]. Viral load, however, did not have the predictive power that might have been expected.

Findings such as these are constantly refining best practices for when to start, stop, and change therapy. The translation of guidelines into practice was a topic of debate at the conference [WeOrB231–236]. For example, Gundo Weiler explored the controversies of withholding or prescribing treatment to HIV-positive active drug injectors who would otherwise meet guidelines for therapy [MoPeB3267]. Similarly, presentations explored the implementation of guidelines [MoPeG4290] and the role of such guidelines in resource-limited regions [G12705, ThPeF8225, TuPeB4655]. Finally, a number of sessions on structured treatment interruptions (STIs) made the point that under certain circumstances, STIs can work—but only in 10 percent to 30 percent of cases. In light of virologic and clinical risks, these presentations left the impression that we still do not know enough to integrate STI into routine clinical care.

Conclusion

The Barcelona conference offered few new insights for providers working with people with HIV living in the United States and other developed countries. Many delegates, from all countries, experienced instead impatience and frustration due to the lack of commitment on the part of governments to take actions that we know are needed, appropriate, and effective. Nonetheless, the conference left many delegates hopeful that the 2004 conference in Bangkok will show progress in creating a continuum between treatment and prevention, easing access to care in the developing world, and leading to advances in treatments and services in the developed world.
Many Epidemics, Two Causes: The Virus and Our Inertia
Lisa Loeb, MPH

HIV is now present in virtually every country in the world but, with incidence and prevalence continuing to rise in most of the hardest hit communities and without the promise of a protective vaccine, the pandemic can be characterized as being in its early stages. Over the past five years, there has been staggering growth within certain pockets of the epidemic. Eastern Europe is experiencing the "fastest-growing epidemic in the world": in Russia, for example, HIV incidence increased 1300 percent between 1996 and 2001 [MoOr102]. In sub-Saharan Africa, there are now an estimated 28.5 million people living with HIV, and 3.5 million of these were newly infected last year. Fewer than 0.1 percent of sub-Saharan people with HIV have access to HIV antiviral treatment.1

Half of all new infections in the poor world are now among young adults aged 15 to 24. In the hardest hit countries, the classic population figure, a pyramid, is turning into a chimney: young adults are dying along with their children, and the elderly must support and care for those left behind. These countries are losing parents, teachers, and police, and life expectancies are falling along with their children’s generation. In the rich world, epidemics remain limited to specific population groups, generally the poor or stigmatized; however, reductions in incidence achieved through the mid-1990s, particularly among men who have sex with men, have reversed and rates are rising again. Since the early 1980s, epidemiologists have regularly introduced terms to describe the unfolding epidemic: remember the first time you heard “Gay-Related Immunodeficiency Disease” or “vertical transmission”? Four years ago we recognized multiple HIV epidemics through terms like “emerging” and “explosive.” Two years ago, I learned about “clades” (a group of related HIV isolates or subtypes), presented about "condom migration" (when a new barrier method fails to demonstrate decreases in risk because individuals substitute the new method for condom use, leading to no net gain in protection), and, with others, lobbied to replace the term “mother-to-child” transmission with "parent-to-child" transmission. This year’s conference in Barcelona again described new insights into the evolving epidemic using new terminology.

A “Syndemic” with No “Natural Limit”
Researchers working with men who have sex with men agreed upon the word “HIV syndemic” to characterize the situation in rich countries. This term denotes the synergistic relationship among multiple epidemics, the prevalence of each of which is elevated among these men: HIV, alcohol and drug abuse, depression, and "life adversities" such as childhood sexual abuse or partner violence [MoPeC3443]. Scientists conferred the somber news that HIV disease appears to be “intrinsically incurable” given current treatments [MoOr103]. Even among patients whose viral loads have fallen below detectable levels, HIV maintains a "stable reservoir of latent memory cells," a holding tank of resting cells that “remembers” how, under the right conditions, to produce newly active virus. Still, even if HIV antiviral treatment cannot "cure" a person of HIV, it can arrest "virus evolution," the mutation and formation of rogue strains within one person [WeOr190].

Researchers have begun to reconsider some previously dismissed "comorbid" infections, specifically, herpes simplex virus-2 (HSV-2) and syphilis, each of which plays a key role in the acquisition, as well as the disease progression, of HIV. In rural Uganda, 43 percent of the people in one sample were infected with HSV-2, and the risk of acquiring HIV was significantly associated with the presence of HSV-2 infection [MoOrC1011]. Among a group of HIV-positive men who have sex with men in the United Kingdom, new syphilis infections have increased from almost zero to 6 percent annually since 1996 [MoOrC1013]. This resurgence among a population in which syphilis had been almost eliminated may

References

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reflect the expanded sexual marketplace of the Internet as well as the increased pool of sexually active, HIV-positive people.

The resurgence of risk behavior, sexually transmitted infections, and HIV acquisition among men who have sex with men is now pervasive in rich countries. In one U.S. study, the rate of new HIV infections among men who have sex with men was nine times the rate among women and heterosexual men [TuPeC4865]. In another study that focused on race and ethnicity, annual HIV incidence was 14.7 percent among young African American men who have sex with men versus 2.5 percent among their White counterparts [MoPeC3427].

Finally, earlier predictions of plateaus in incidence and prevalence rates in the hardest-hit countries have proved optimistic. While epidemiologists had hoped that HIV would find a “natural limit,” no such maximum prevalence rate has yet surfaced. In 1997, 39 percent of all pregnant women in Botswana were infected; in 2001, the number grew to 45 percent.1 Approximately one in nine South Africans is currently infected.2 In Nigeria, China, India, and Russia, all vastly populated and poor, incidence rates have risen beyond the “5 percent threshold at which incidence often accelerates.”1

The Will to Implement What Works

While the terminology used by presenters in Barcelona described the current hot spots and theories, the most compelling epidemiological news was not so much about statistical “p values” and “incidence trajectories,” but about history. The history of HIV epidemiology is rich with effective prevention programs that were not implemented, essential drugs that were not distributed, and dire predictions that went unheeded. Having not learned from the past, the world should prepare to relive the history of sub-Saharan Africa within eastern Europe and eastern Asia.

At the Geneva conference four years ago, participants heard of explosive epidemics. At the Durban conference two years ago, we saw in the streets and townships of South Africa the results of one. At the Barcelona conference, we prepared to watch the replay, the devastating effects that the virus will wreak in India, Russia, and China. This time, however, there is a key difference: we have proven ways to avoid or mitigate these explosions. The conference presented evidence of successful programs in a variety of settings: at Ugandan prenatal clinics [TuPeF5404], at American syringe exchanges [TuOr142], and even at a rural clinic in Haiti, one of the poorest countries in the world [ThOr240]. But will we use this evidence? Will we fund these programs?

What we are missing is the political will to implement these programs. The World Health Organization has clearly defined the appropriate response. It will include both prevention and treatment—in both the rich world and the poor—and it will cost $10 billion annually for the next five years. If fully implemented by 2005, this response would reduce the number of new HIV infections this decade from 45 million to 16 million.3

Conclusion

According to epidemiologist Kevin DeCock, as epidemiology is the scientific basis of public health, so social justice is its philosophical foundation [TuSl104]. Our priorities should move beyond sifting out new epidemiological developments toward re-coupling human rights with the scientific endeavor. How can there be food to eat for uninfected children when their parents have died of AIDS? How can there be education or safety when the majority of teachers and police in a nation have died?

Helen Gayle, director of the Gates Foundation’s HIV/AIDS program, quoted the ancient Greek historian Thucydides: “Justice will come when those who are not injured are as indignant as those who are” [TuOr142]. In Barcelona, the voices of the indignant were clear and irrepresible—even the politicians who spoke could not ignore them. Whether our voices will be heard by those with the power and the money to bring about change remains to be seen.

Next Month

Over the past couple of years, the landscape of HIV treatment, shaken by the new treatment paradigm in 1996, has undergone smaller but significant changes. In the November issue of FOCUS, Kathleen A. Clanon, MD, FACP, Medical Director of HIV Services at Alameda County Medical Center, reviews these changes and their implications for clinical care. She focuses on when to begin treatment, strategic treatment interruptions, drug resistance, and new HIV antiviral drugs.

Also in the November issue, Janet Tobacman, MPA, HIV and STD Health Education Program Coordinator at Kaiser Permanente in Northern California, discusses the role of medical providers in HIV and STD prevention and in the HIV counseling and testing process.
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