

Putting AIDS in Perspective

From "Putting a Plague in Perspective" by DANIEL HALPERIN

Cambridge, Mass.

ALTHOUGH the United Nations recently lowered its global H.I.V. estimates, as many as 33 million people worldwide are still living with the AIDS virus. This pandemic requires continued attention; preventing further deaths and orphans remains imperative. But the well-meaning promises of some presidential candidates to outdo even President Bush's proposal to nearly double American foreign assistance to fight AIDS strike me, an H.I.V.-AIDS specialist for 15 years, as missing the mark.

Some have criticized Mr. Bush for requesting "only" \$30 billion for the next five years for AIDS and related problems, with the leading Democratic candidates having pledged to commit at least \$50 billion if they are elected. Yet even the current \$15 billion in spending represents an unprecedented amount of money aimed mainly at a single disease.

Meanwhile, many other public health needs in developing countries are being ignored. The fact is, spending \$50 billion or more on foreign health assistance does make sense, but only if it is not limited to H.I.V.-AIDS programs.

Last year, for instance, as the United States spent almost \$3 billion on AIDS programs in Africa, it invested only about \$30 million in traditional safe-water projects. This nearly 100-to-1 imbalance is disastrously inequitable — especially considering that in Africa H.I.V. tends to be most prevalent in the relatively wealthiest and most developed countries. Most African nations have stable adult H.I.V. rates of 3 percent or less.

Many millions of African children and adults die of malnutrition, pneumonia, motor vehicle accidents and other largely preventable, if not headline-grabbing, conditions. One-fifth of all global deaths from diarrhea occur in just three African countries — Congo, Ethiopia and Nigeria — that have relatively low H.I.V. prevalence. Yet this condition, which is not particularly difficult to cure or prevent, gets scant attention from the donors that invest nearly \$1 billion annually on AIDS programs in those countries.

I was struck by this discrepancy between Western donors' priorities and the real needs of Africans last month, during my most recent trip to Africa. In Senegal, H.I.V. rates remain under 1 percent in adults, partly due to that country's early adoption of enlightened policies toward prostitution and other risky practices, in addition to universal male circumcision, which limits the heterosexual spread of H.I.V. Rates of tuberculosis, now another favored disease of international donors, are also relatively low in Senegal, and I learned that even malaria, the donors' third major concern, is not quite as rampant as was assumed, with new testing finding that many fevers aren't actually caused by the disease.

Meanwhile, the stench of sewage permeates the crowded outskirts of Dakar, Senegal's capital. There, as in many other parts of West Africa and the developing world, inadequate access to safe water results in devastating diarrheal diseases. Shortages of food and basic health services like vaccinations, prenatal care and family planning contribute to large family size and high child and maternal mortality. Major donors like the President's Emergency Plan for AIDS Relief, known as PEPFAR, and the Global Fund to Fight AIDS, Tuberculosis and Malaria have not directly addressed such basic health issues. The Global Fund's director, Michel Kazatchkine, has acknowledged, "We are not a global fund that funds local health."

Botswana, which has the world's most lucrative diamond industry and is the second-wealthiest country per capita in sub-Saharan Africa, is nowhere near as burdened as Senegal with basic public health problems. But as one of a dozen PEPFAR "focus" countries in Africa, this year it will receive about \$300 million to fight AIDS — in addition to the hundreds of millions already granted by drug companies, private foundations and other donors. While in that sparsely populated country last month, I learned that much of its AIDS money remains unspent, as even its state-of-the-art H.I.V. clinics cannot absorb such a large influx of cash.

As the United States Agency for International Development's H.I.V. prevention adviser in southern Africa in 2005 and 2006, I visited villages in poor countries like Lesotho, where clinics could not afford to stock basic medicines but often maintained an inventory of expensive AIDS drugs and sophisticated monitoring equipment for their H.I.V. patients. H.I.V.-infected children are offered exemplary treatment, while children suffering from much simpler-to-treat diseases are left untreated, sometimes to die.

In Africa, there's another crisis exacerbated by the rigid focus on AIDS: the best health practitioners have abandoned lower-paying positions in family planning, immunization and other basic health areas in order to work for donor-financed H.I.V. programs.

The AIDS experience has demonstrated that poor countries can make complex treatments accessible to many people. Regimens that are much simpler to administer than anti-retroviral drugs — like antibiotics for respiratory illnesses, oral rehydration for diarrhea, immunizations and contraception — could also be made widely available. But as there isn't a "global fund" for safe water, child survival and family planning, countries like Senegal — and even poorer ones — cannot directly tackle their real problems without pegging them to the big three diseases.

To their credit, some AIDS advocates are calling for a broader approach to international health programs. Among the presidential candidates, Senator Barack Obama, for example, proposes to go beyond spending for AIDS, tuberculosis and malaria, highlighting the need to also strengthen basic health systems. And recently, Mr. Bush's plan, along with the Global Fund, has become somewhat more flexible in supporting other health issues linked to H.I.V. — though this will be of little use to people, especially outside the "focus" countries, who are dying of common illnesses like diarrhea.

But it is also important, especially for the United States, the world's largest donor, to re-examine the epidemiological and moral foundations of its global health priorities. With 10 million children and a half million mothers in developing countries dying annually of largely preventable conditions, should we multiply AIDS spending while giving only a pittance for initiatives like safe-water projects?

If one were to ask the people of virtually any African village (outside some 10 countries devastated by AIDS) what their greatest concerns are, the answer would undoubtedly be the less sensational but more ubiquitous ravages of hunger, dirty water and environmental

devastation. The real-world needs of Africans struggling to survive should not continue to be subsumed by the favorite causes du jour of well-meaning yet often uninformed Western donors.

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