AIDS in 2003: Moving Forward, Falling Back

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The history of the AIDS epidemic has been shaped by an ongoing dialectic between moving forward in some areas, while at the same time falling back in others.1 Regrettably today, we must report that the world continues to face the same tension between progress and failure in its enduring efforts to control and overcome this pandemic.

A vivid microcosm of this appears in the pages of this issue of the Canadian Journal of Public Health. Herein, we find two articles, one chronicling one of the major successes achieved thus far, the other demonstrating the ongoing challenges we face. Dena Schanzer (pages 135-39) presents a thorough account of trends in AIDS mortality in Canada over the 11 years from 1987 through 1998. Her analysis, as highlighted in Figure 1 of her article, demonstrates the breathtaking success that was achieved in reducing HIV mortality in the mid 1990s. HIV/AIDS deaths declined 65% between 1995 and 1997. These declines in HIV/AIDS mortality (Figure 4) and in person-years of life lost to HIV infection (PYLL; Figure 5) far outstripped any gains we made with respect to Canada’s other major killers. These accomplishments are clearly attributable to the advent of protease inhibitors and highly aggressive anti-retroviral therapy (HAART) regimens that became widely available in Canada during this critical period. Medical science has produced relatively few agents that are effective against viruses, let alone retroviruses. In light of this, the development and dissemination of highly effective anti-HIV drug combinations, within 11 years of the discovery of this previously unknown and formidable retrovirus, represents one of the most stunning successes in the history of the pandemic.

Yet in the pages of this same issue, we see evidence of continuing deficiencies. The survey of Ontario physicians reported by Guenter and colleagues (pages 93-97) demonstrates that as recently as July 2000, significant gaps in physician knowledge about prenatal HIV testing still persist. While this might not have been such a concern in bygone days when we had little to offer in the way of perinatal prevention, this is now far from the case. Variations of the same drug regimens described above are now able to virtually eradicate perinatal transmission, with rates as low as 1%.2 It is therefore disconcerting to see that as recently as July 2000, significant gaps in physician knowledge about prenatal HIV testing still persist. While this might not have been such a concern in bygone days when we had little to offer in the way of perinatal prevention, this is now far from the case. Variations of the same drug regimens described above are now able to virtually eradicate perinatal transmission, with rates as low as 1%.2 It is therefore disconcerting to see that as many as 47% of surveyed physicians were unaware of the province’s prenatal testing policy, and that a significant proportion did not routinely offer HIV counselling and testing to pregnant women.

Throughout the world in 2003, we are continuing to see this juxtaposition of moving forward in some areas, while at the same time failing in others. Though the combination therapies described earlier have represented a therapeutic miracle, their benefits have reached only a tiny minority of people with HIV around the world. While some progress has been made in making these treatments available in middle income countries, Brazil being a notable example, they remain far out of reach for most developing countries where 95% of people with HIV infection live. For this reason, we can expect more than 3 million people including 600,000 children to die of their HIV infection in 2003, almost all of them in the developing world.3

On the prevention front, we see the same combination of progress and failure. Prevalence rates are continuing to decline in countries such as Uganda, Zambia, Thailand and Cambodia. More recently, in Addis Ababa, Ethiopia, infection levels among women aged 15-24 attending antenatal clinics dropped from 24.2% in 1995 to 15.1% in 2001.4 Almost always, these gains occur when governments overcome denial and are willing to acknowledge the HIV/AIDS problem openly and exercise the political will to confront it. However, while this progress was being made, ominous spread of HIV was occurring elsewhere in the world. There has been rapid spread of HIV, primarily via injection drug use, throughout the newly independent states of the former Soviet Union.5 Moreover, the past few years have witnessed dramatic spread of HIV in India, China, and Indonesia. It is estimated that 4 million people in India are now HIV infected, with another 1 million infected in China.6 In Jakarta, the prevalence of HIV among injection drug users rose from very low levels in 1998 to as high as 50% by 2001. While the epidemic remains localized within these countries at the present time,7 their collective total population exceeds 2.5 billion people, a huge potential target for HIV. Even if the prevalence in these countries only rose to 5%, this would represent 125 million people, more than triple the number of people who have been infected to date.

Regrettably, there is only bad news for the family members and communities left behind by the pandemic. A total of about 15 million children will have been orphaned by AIDS by the end of 2003. A study in Zambia found that 65% of households dissolved following the death of the mother.8 Household income has been found to fall by 80% or more in the majority of households where the father has died.9 Strategies to deal with the excessive medical and burial costs often include selling off remaining assets such as land and animals, and removing children, particularly girls, from school so that they can generate income. A grim milestone may be achieved this year or next when the number of prevalent and incident cases of HIV in women could exceed those in men. This

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has already occurred in Africa. The impact will be enormous, especially given that, in rural areas of sub-Saharan Africa and Asia, women contribute more than 50% to food production and are the cornerstone of agrarian societies. Inexorably, the social, economic and demographic shocks and aftershocks of HIV will be felt around the world for decade upon decade to come.

A glimmer of hope appeared in June 2001 when the United Nations General Assembly held a Special Session about the crisis and published its Declaration of Commitment on HIV/AIDS. This document contains the words “We, heads of State and Government and representatives of States and Governments...solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows.” The document went on to list 67 actions that each country vowed to undertake, including the establishment of an annual global fund of $7 to $10 billion US to combat the pandemic. For the first time, wealthy countries had officially adopted a course of action and committed resources on a global scale. It was regrettable that only $2.1 billion US had been pledged to the fund, and only $300 million US were actually received. Commitment means moving forward; lip service means falling back.

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Le sida en 2003 : quelques pas en avant, quelques pas en arrière

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L’histoire de l’épidémie de sida a été marquée par la dialectique entre les avancées dans certains domaines et les reculs dans d’autres. Malheureusement, aujourd’hui tout indique que le monde vit encore la même tension entre progrès et échecs dans ses efforts persistants pour maîtriser et vaincre cette pandémie.

On retrouve la même dialectique, en microcosme, dans les pages de ce numéro de la Revue canadienne de santé publique. De deux articles sur le sujet, l’un relate l’une de nos grandes réussites jusqu’à maintenant, et l’autre explique les défis qu’il nous reste encore à relever. Dena Schanzer (pages 135 à 139) présente un compte rendu exhaustif des tendances de la mortalité due au sida au Canada sur une période de 11 ans (1987-1998). Son analyse, comme on le voit à la figure 1 de l’article, met en évidence la réussite épuisante qu’a été la réduction de la mortalité due au VIH au milieu des années 1990. Les décès liés au VIH/sida ont diminué de 65 % entre 1995 et 1997. Ces baisses de la mortalité due au VIH/sida (figure 4) et des années de vie perdues en raison des infections à VIH (PYLL; figure 5) ont surpris de loin les progrès réalisés à l’égard des autres grandes maladies mortelles au Canada. Ces exploits sont clairement liés à l’avènement des inhibiteurs de protéase et des traitements antirétroviraux hautement actifs, qui se sont diffusés à grande échelle au Canada durant cette période critique. La science médicale a découvert relativement peu d’agents efficaces contre les virus, a fortiori contre les rétrovirus. Par conséquent, la mise au point et la diffusion d’associations de médicaments anti-VIH très efficaces, à peine 11 ans après la découverte d’un rétrovirus formidable et inconnu jusque là, comptent parmi les réussites les plus marquantes de l’histoire de cette pandémie.

Ce même numéro renferme cependant un constat de lacunes. L’enquête auprès des médecins ontariens dont Guenter et ses collègues (pages 93 à 97) font le compte rendu montre qu’aujourd’hui encore, qu’en juillet 2000, il subsistait des écarts importants dans la connaissance du dépistage anténatal du VIH par les médecins. Ce n’était pas vraiment préoccupant à l’époque où il n’existait presque rien en matière de prévention péritanaire, mais c’est loin d’être le cas maintenant. Avec des variantes des régimes posologiques mentionnés plus haut, on peut désormais pratiquement éradiquer la transmission péritanaire (les cas réfractaires ne seraient plus que 1 %) ? Il est donc déconcertant de voir qu’un bon 47 % des médecins interrogés n’étaient pas au courant de la politique provinciale de...