EDITORIAL / ÉDITORIAL

HIV/AIDS—The New “Great Teacher”

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When I was in medical school at McGill University in the early 1980s, my favourite book for quick reference and late-night cramming was The Merck Manual. I still occasionally peruse my well-worn 14th edition published in 1982. In the index under “A”, the section reads as follows: “...Agraphia, Ahumada-del Castillo syndrome, Airsickness, Airways obstruction...” Who could have known back then that the next edition would contain the new listing “AIDS” between “Ahumada-del Castillo syndrome” and “Airsickness” with more than 20 pages devoted to it?

Since AIDS was first recognized as a distinct syndrome in 1981, the HIV epidemic has truly become a pandemic of global proportions and impact. According to UNAIDS statistics, as of 1 July 1996 there were an estimated 21.8 million people in the world living with HIV infection and a total of 5.8 million cumulative deaths due to HIV/AIDS. For Canada, an estimated 32,000-36,000 were living with HIV infection at the end of 1994 and 10,242 cumulative AIDS deaths were reported as of 30 September 1996.

These numbers hide a very important feature of the HIV/AIDS pandemic—the tremendous diversity of groups affected and of issues raised by the problem. This diversity is well illustrated by the four HIV/AIDS articles in this issue of the Journal (pages 14, 18, 23, 27) and was also clearly apparent at the XI International Conference on AIDS in Vancouver this past summer. One of the most widely reported findings at the Conference was the impressive short-term effectiveness of new anti-HIV drugs such as protease inhibitors. And yet even this news caused very diverse reactions: euphoria in some that a cure might be just around the corner, and concern in others that this perception could lead to complacency and to reductions in funding and prevention activities. Indeed, this finding highlights some of the most problematic issues in the HIV/AIDS field: how to minimize the development of resistant strains when the drugs must be taken with strict regularity; how to ensure quick access to potentially useful drugs without compromising individual safety; how to ensure equal access to treatment and prevention options for a disease which has its greatest impact on the poor and disadvantaged; and how to balance corporate profits with humanitarian concerns (as the activists’ Conference slogan “greed equals death” demanded to know).

At the X International Conference on AIDS in Yokohama in 1994, another HIV treatment was the focus of media attention. The results of the ACTG 076 trial had just been released which showed that HIV-infected pregnant women could reduce the vertical transmission of HIV by as much as two thirds by taking zidovudine during pregnancy and delivery.1 This finding also raised a number of complex social and ethical issues. Now that a treatment was available to potentially improve the health of unborn children, should HIV testing and appropriate therapy be offered to all pregnant women? Should it be recommended? Should it be made mandatory? And how could any of these options be made available in the developing world where the vast majority of HIV-infected women live and where even basic antenatal services are often not available? These questions are still being debated today.

In keeping with the diversity and contrasts of the HIV/AIDS field, there have also been important “low-tech” advances in treatment to parallel these more “high-tech” advances. Once it was realized that other sexually transmitted diseases (STDs) facilitated the transmission of HIV, it seemed logical that strengthening basic STD control would help prevent HIV infections. Indeed this type of “back to the basics” approach clearly works as shown by the Mwanza trial in Tanzania.2 This randomized controlled trial of 12 communities found that improving STD treatment services could reduce HIV incidence by about 40%.

Just as the HIV/AIDS pandemic has greatly stimulated research in immunology and anti-retroviral chemotherapy, so has it stimulated research in the behavioural sciences to improve the effectiveness of prevention programs. Although behaviour change has proved difficult to effect and maintain, there have been some notable successes. For example, in Thailand, programs to promote condom use between commercial sex workers and their clients have had impressive results: among 21-year-old male military recruits in northern Thailand, condom use at last commercial sexual encounter increased from 61% in 1991 to 92% in 1995 and HIV prevalence dropped from 12% to just under 7%.3

In Canada, the HIV-associated behavioural problem of greatest concern at present is the sharing of injection equipment among injection drug users (IDUs). Cities such as Montreal and Vancouver are experiencing serious HIV epidemics among IDUs despite the existence of active needle exchange programs.4,5 It appears that needle exchange programs are not enough in themselves to change behaviour and prevent HIV transmission. Intensive efforts are currently underway to better understand the high-risk behaviours of IDUs and the utilization patterns of needle exchange sites.

One of the main determinants of high-risk behaviour of IDUs may well turn out to be their low self esteem, their feeling that they are unable to influence the circumstances of their lives. This is yet another dimension to the HIV/AIDS pandemic and it is clearly evident in the developing world where the majority of HIV transmission is via the heterosexual route. Women are rarely equal partners in sexual relation-

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Depuis qu’en 1981, le sida a pour la première fois été reconnu comme un syndrome distinct, l’épidémie d’infection par le VIH s’est véritablement muée en une pandémie de proportions et d’incidence mondiales. Selon les statistiques publiées par ONUSIDA, au 1er juillet 1996, on estimait à 21,8 millions le nombre de personnes séropositives au VIH dans le monde entier et à 5,8 millions le nombre total de décès cumulatifs dus au VIH et au sida. Au Canada, à la fin de 1994, on estimait qu’entre 32 000 et 36 000 personnes étaient infectées par le VIH et au 30 septembre 1996 le nombre de décès cumulatif dus au sida s’élevait à 10 242.

Ces statistiques dissimulent une caractéristique importante de la pandémie du VIH/sida, à savoir l’extrême diversité des groupes touchés et des questions posées par ce problème. Quatre articles de ce numéro de la Revue (pages 14, 18, 23, 27) illustrent très bien cette diversité, laquelle est également clairement ressortie à la XIe Conférence internationale sur le VIH/sida tenue à Vancouver l’été dernier. L’un des résultats dont on a le plus parlé à la Conférence a été la remarquable efficacité sur très peu de temps des nouvelles thérapeutiques contre le VIH telles que les inhibiteurs de protéase.

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VIH/sida—Une nouvelle grande source d’enseignements

Pour tout, même ces nouvelles ont causé des réactions très diverses : l’euphorie chez certains comme quoi on était sur le point de trouver un moyen de guérison, et l’inquiétude chez d’autres à l’idée que cela risquait de susciter une certaine complaisance et des réductions des fonds et des activités de prévention. Cette découverte fait d’ailleurs ressortir certaines des questions les plus problématiques dans le domaine du VIH et du sida : comment minimiser le développement des souches résistantes lorsque les médicaments doivent être pris de façon strictement régulière; comment garantir un accès rapide à des médicaments potentiellement efficaces sans compromettre la sécurité individuelle; comment garantir un accès égal aux diverses options de traitement et de prévention d’une maladie qui touche surtout les personnes pauvres et désavantagées; et comment trouver l’équilibre entre la course aux profits des entreprises et les questions humanitaires (ainsi que le rappelait le slogan scandé par les activistes à la Conférence, à savoir «la cupidité, c’est la mort.»)