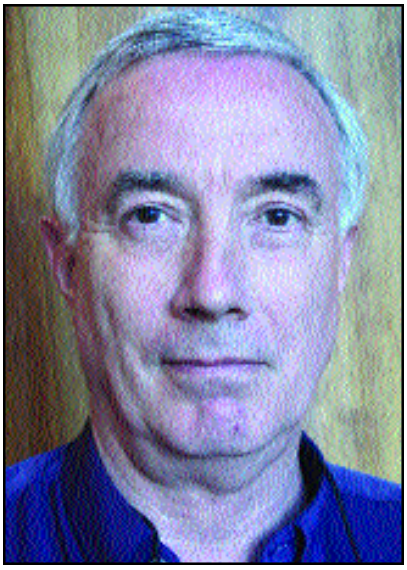
SA IN LINE FOR AIDS BILLIONS



Professor Roy Anderson, head of the Department of Infectious Disease Epidemiology at London University's Imperial College.
Picture: Chris Bateman

South Africa was being targeted as the first recipient of some of the Bush administration's R120 billion global commitment to fight AIDS and should 'jump in with both feet' to consolidate its position.

This was the tip from Professor Roy Anderson, one of the world's top AIDS researchers and head of the department of Infectious Disease Epidemiology at the Faculty of Medicine at London University's Imperial College.

Speaking to the SAMJ at the Durban conference on 'Empirical Evidence for the Demographic and Socio-Economic Impact of AIDS' at the end of March, Anderson said that the United States Department of Health had custody of the grant. This was because the WHO, UNAIDS and the World Bank were unable to reach agreement over who should distribute the money.

Two delegates from the US State Department attended the Durban AIDS conference to update themselves on the latest evidence on the pandemic in this country - which Anderson said was further proof that SAwas the top prospective recipient.

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Anderson was described by Professor Alan Whitehead, director of the Health Economics and HIV / AIDS Research Division (HEARD) at the University of Natal (which organised the conference) as the world's 'most consistently accurate person on HIV / AIDS projections'.

Anderson continued by saying that because of AIDS, South Africa, Botswana and Zimbabwe would for the first time this year experience negative population growth ranging from -0.1 to -0.3. Without AIDS, growth rates would have been between 1.1 and 2.3.

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Five other countries in sub-Saharan Africa would experience growth rates of nearly zero. Were it not for AIDS they would have had population growth rates of two per cent or greater.

'It's quite extraordinary how the world ignores this problem - interventions cost such a small amount of money when you consider that it is the largest and most lethal epidemic in history with 42 million people infected'.

Anderson added that several African leaders in the sub-Saharan region needed 'a heavy dose of reality'.

Asked how he and his peers in the international scientific community viewed the South African government's response to the pandemic he said most were 'very puzzled at your political leadership'. He cited the recent appointment of AIDS dissident, Dr Roberto Giraldo as a nutritional advisor to Health Minister Dr Manto Tshabalala-Msimang:

'Colleagues I talk to throw up their hands and look at the sky...you're one of the countries with the worst problem'.

While he understood President Mbeki's contention that AIDS was a disease of poverty, if Nelson Mandela was still in power 'he would be on the radio and television daily pushing the ABC message'.

'This has to be a (political) priority, otherwise you'll lose half your population,' he warned.

The lion's share of research funding needed to go into vaccines of which even an imperfect variety slowed HIV-positive progression towards AIDS and lowered infectiousness towards susceptible sexual partners.

Licensing imperfect vaccines however could prove to be a major task and the US Food and Drug Administration (FDA) had to be persuaded to 'take a long, hard look at this'.

It was 'crucial' to encourage the biggest but sometimes reluctant pharmaceutical companies to continue and enhance investment in this field.

Glaxo, for example, had reduced its investment to 'exceedingly low' levels.

'We have a responsibility to persuade them to stay in this very difficult area'.

One danger of imperfect vaccines was that vaccination could be linked to increased risk behaviours.

The recent plateau of HIV prevalence among people under 20 in South Africa showed that spending on the ABC of prevention was effective and at least as

important as providing antiretroviral therapy (ART).

Anderson's most emphatic message to physicians and nurses was that they should ensure patients' compliance with ARV drug regimens. ARV drugs held proven benefits for the individual patient, communities and women in the later stages of pregnancy and were 'a humanitarian necessity' because they improved the quality of life of people living with AIDS (PWAs) 'enormously'.

'Most physicians, whether they're First or Third World, don't truly understand the importance of adherence. I cannot think of a virus where adherence is more important. Most of us are pretty lax around antibiotics and the like, but with HIV it matters enormously because the virus mutates so quickly'. In one AIDS patient with 10 to the power 10 of viral particles, every mutation across the entire genome was possible every day.

'You simply cannot afford to miss a day of taking these drugs. Any slight concentration drop creates the ideal circumstances where more resistance develops'.

Anderson said 80% of resistance to ARVs that emerged in Europe and the USAwas due to poor adherence.

ART's greatest benefit for the community was that it lowered the overall community viral load and thus susceptibility to the disease.

Anderson added that several African leaders in the sub-Saharan region needed 'a heavy dose of reality'.

Intervention with sex workers worked best in the first five to 10 years of the epidemic, after which the focus had to shift to community-based interventions. The classic epidemic spread was from sex workers to men to pregnant women.

Anderson said South Africa was the only country in Africa that had the capacity to manufacture protease inhibitors - by far the most effective ARV drug - and urged the government and private sector to do all that it could to make this happen.

'I'd like to see this happen in South Africa, India, South Korea and perhaps Thailand - it's not that difficult to manufacture these drugs, the problem is ensuring safety and quality. If it's not up to scratch, it'll be the quickest to develop drug resistance'.

Recent studies of human genetics had shown that our genomes and the genetic diversity within populations reflected our past experience of major epidemics.

What made AIDS different, and in many specialists' minds more threatening than past pandemics, was its potential to influence human demography.

Another major difference was that the case-related death rate was 90-100% of those infected in the absence of treatment, compared with history's next worst disease, the plague which killed 30 - 40% of the young and elderly who were infected.

Chris Bateman

AGE OLD REMEDY IMPACTS HIV - MRC

Ongoing safety and efficacy research on traditional African medicines at the MRC points to at least one compound being responsible for dramatic weight gain, a drop in viral loads and increased CD4 cell counts among AIDS patients.

Still in the very early stages of testing, the compound, which originates from the North West Province, is being kept a closely guarded secret because of intellectual property rights.

Dr Gilbert Matsabisa, head of Indigenous Knowledge Systems at the MRC, told the SAMJ that 30 test patients, some of whom were unable to walk and others who suffered from acute pneumonia, oral thrush and diarrhoea showed major improvement

The MRC says some traditional remedies have remarkable immune-boosting properties.