

## Book

### Unexpected political immunity to AIDS

What I will miss most about former WHO Director-General Lee Jong-wook, who died tragically on the eve of the World Health Assembly just a few months ago, is his wry, self-deprecating sense of humour. At the end of one particularly hectic day, he said to me, “think about the people in schools of public health all over the world developing elaborate theories about why WHO did this or that or the other thing. So often, the basis for a particular policy is just that that’s what we decided.” And then he laughed, mostly at himself. He wasn’t being glib or boastful. He was making fun of the fact that the office of the Director General faces so much pressure from so many different stakeholders with conflicting interests that the specifics of a particular policy decision are determined more by political compromise than some grand vision or design. The task for WHO, all too frequently, is to make compromises that aren’t overly compromising, in the knowledge that whatever decision is made there will be fallout from those who will, inevitably, be unhappy with the outcome.

Before his election in January 2003, Lee had told the Executive Board of WHO that one of his highest priorities if elected would be to bring the organisation back into the centre of the global struggle against HIV. He promised that he would take bold action. With this in mind, I suggested that because his predecessor, Gro Harlem Brundtland, had announced the target of having 3 million people on HIV treatment by the end of 2005, we ought to embrace it. Lee listened patiently and said he would think about it.

One day, he announced that he had been talking to many global health leaders and had asked them whether or not he should go forward with what we were already calling “3 by

5”. Everyone he spoke with advised him against embracing a target that would be so difficult to reach. I asked him what he was going to do. “Oh we’ll do it”, he said. “Someone has to tell the world to do something about this epidemic and it might as well be WHO.”

In his new volume *AIDS and power: why there is no political crisis—yet*,

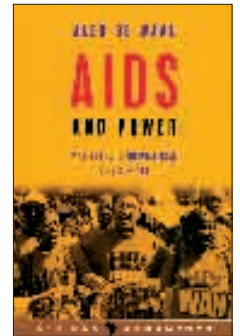
Alex de Waal examines the various doomsday predictions of the effect of AIDS on political process and democracy in Africa. While noting that the effect of AIDS is devastating at a magnitude that we have yet to understand, de Waal argues that “the epidemic does not threaten the continent’s rulers—democratic or otherwise” and that “the evidence to date suggests that African social and political systems will absorb the impact of HIV/AIDS, albeit at a very high cost, borne chiefly by poor women.” De Waal’s complex analysis moves deftly from epidemiological data to Weberian social theory as he argues that the global response to AIDS in Africa, although not effective in preventing new infections, has dampened the political impact of the epidemic in ways that were unforeseen. According to de Waal, denial, the nature of activism, the structure of bureaucracies that allows them to flourish in the midst of disaster, and the direct benefits of the epidemic for many governments all contributed to mitigating the political impact of AIDS in Africa.

Judging by results of the Afro-barometer public opinion survey,

a first-of-its-kind pan-African poll started in 1999, AIDS is rarely a top-ranking concern. The time delay between infection and becoming sick, the abstract quality of population-based numbers, and the many religious condemnations of AIDS and its sufferers have all had a role in the denial of the epidemic.

But of far greater interest is de Waal’s claim that a process of “normalisation” has kept AIDS out of the top tier of concerns. Dipping into the anthropological literature, de Waal argues convincingly that “denial” of the epidemic occurs in contested moral worlds where struggles over meaning play out in ways that both fascinate and horrify. While the unspeakable suffering of poor women and children is so often hidden, religious authorities of all persuasions use the epidemic to make brutally judgmental points about the moral failings of their fellow citizens. As for any hope of breaking through this often ugly tangle of metaphors, de Waal cites data generated for his book that suggest that a free press producing high-quality news, analysis, and opinion can have a strong effect on political commitment to AIDS programmes. One can only hope that he’s correct.

AIDS activism has changed our society indelibly. Activists have awakened the entire world to the suffering of people living with HIV and AIDS and fundamentally altered the way we view science, drug development, and even sexuality. After securing treatment access for themselves through bitter struggles and enormous sacrifice, leaders in the American gay AIDS activist community could have averted their gaze from the exploding problem of HIV and AIDS among the poor in Africa. But people like Eric Sawyer, Mark Harrington, and Gregg Gonsalves unexpectedly turned



**AIDS and Power: Why There is No Political Crisis—Yet**  
 Alex de Waal. Zed Books, 2006.  
 Pp 176. £12.99.  
 ISBN 1-84277-707-6.

their attention to the developing world and have worked tirelessly for universal access to HIV treatment. Their counterparts in developing countries, people like Noerine Kaleeba and Lydia Mungherera of Uganda and Zackie Achmat and Mark Heywood of South Africa, are no less heroic and often acted in much more difficult personal circumstances.

De Waal is appropriately respectful of all that the African AIDS activists have accomplished but he points out that theirs was not a “revolutionary” project. South Africa is the most important example. After fighting side by side to overthrow the apartheid regime, AIDS activists have not called for the fall of the African National Congress, despite its many failures in responding to the AIDS pandemic. As de Waal points out, African AIDS activists have not needed to call for revolutionary overthrow of their governments since they have “been part of an international revolution and entered welcoming citadels far more powerful than any they could have imagined storming.”

But even if AIDS activists were not working for the overthrow of their governments, de Waal, along with many others, had argued that the devastating lowering of life expectancy and the explosion in the number of AIDS orphans would surely threaten African democracies. The evidence now shows that, during the life of the AIDS pandemic, the number of democracies in Africa has in fact grown. De Waal argues that he and other prognosticators misrepresented the threats of the epidemic. Also, the internal structure of African polities enabled them to withstand not only AIDS but famine, poverty, war, and other calamities that chronically plague the continent. Indeed, in Uganda and elsewhere, AIDS has represented an unparalleled opportunity to increase incoming aid dollars and to control the social discourse in a manner that has enhanced the stability of incumbent regimes.

De Waal’s view of the political dimensions of the prevention/treatment discourse is especially interesting. He doesn’t object to the current attention on treatment, as so many have, but instead focuses on the lack of an equally robust commitment to prevention. He points out that the “default mode for governments and institutions is to secure their own survival and they are doing very well on this score. They are prolonging lives through treatment. But they are doing miserably in terms of preventing new HIV infections because they haven’t been required to succeed.” Although de Waal acknowledges that a focus on treatment has actually increased resources for all AIDS activities including prevention, his greatest fear is that “treatment roll-out will simply become the best mechanism for managing the risks of AIDS, a substitute for prevention measures.”

I share de Waal’s concerns about the lack of commitment to prevention. As treatment scale-up progresses with great energy, igniting a similar passion and momentum in prevention efforts must be our highest priority. But de Waal writes about broad access to HIV treatment in Africa as if it were the most natural and predictable course for the global response to the epidemic. It was not. The response to Lee’s declaration of the 3 by 5 target was met with jubilation among people living with HIV and AIDS and other activists, but among donors and African governments, the response was mixed at best and not infrequently hostile. The US President’s Emergency Plan for AIDS Relief (PEPFAR) had committed to treating 2 million people by the end of 2008 in 15 countries, but it had not made any demands on African governments. By committing to work with governments to scale up HIV treatment and reporting on progress every 6 months, WHO added an important dimension. Lee knew from his work with vaccines and child survival that a clear target with a clear end date and regular reports

on progress could have a powerful effect on national governments. He also knew that his own advocacy for treatment scale-up as Director General of WHO could make all the difference.

It is difficult, of course, to determine the relative importance of 3 by 5, PEPFAR, the Global Fund to Fight AIDS, TB and Malaria, and other efforts in creating a world in which keen observers like de Waal could write about widespread efforts at HIV treatment scale-up in Africa as entirely predictable and natural. In meeting with many ministers of health throughout Africa and visiting countries engaged in treatment scale-up, it is clear to me that 3 by 5 has made an important difference. Without PEPFAR and the Global Fund, we wouldn’t have got anywhere, but 3 by 5 put pressure on African governments in a unique way. For many, 3 by 5 was the first time that anyone had held them accountable for an HIV-related outcome. They had become very good at HIV-related process, such as high-level meetings and declarations of commitment, but the outcome focus of 3 by 5 jolted many of them into action when faced with an outcome that would be measured and reported for all the world to see.

In writing this review, I am saddened by the realisation that Lee never had the opportunity to read this extremely well argued volume that I would place squarely in a “post 3 by 5” genre. His advocacy of access to treatment of HIV for the poorest people in the world, which was met at times with crudely expressed hostility from some of the most powerful governments in the world, made a great and important difference, especially to the poor living with HIV. De Waal’s new volume provides us with a clear picture of the way forward. Now if we only had a clear target and clear end date for prevention in Africa...

*Jim Kim*  
KIMJ@hsph.harvard.edu

## Book

### The changing nature of HIV/AIDS in Europe

25 years ago, when HIV/AIDS first began to enter the public consciousness, I was a junior doctor in London, caring for my first patient with this fearful new disease. In an isolation room, this young man died a dreadful, lonely death. His family and friends stayed away. Hospital domestics refused to clean his room. He received his food when a tray was slid along the floor to his bed. We doctors remained frightened by our ignorance of this new infectious disease and unclear what our role was in the face of such uncertainty.

*HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management* brings together, in a series of essays by leading authorities, a coherent reflection of the past 25 years' experience of HIV across the continent. The book causes one to reflect on how much has changed for some, but how little for others. Since the early 1980s my career, like that of many, has followed the unfolding HIV pandemic in Europe.

By 1997, as a consultant in London, I was responsible for the care of some 200 people with AIDS and many more infected with HIV. I had told many patients, years earlier, that monotherapy with zidovudine offered their best hope, only to find out within a few years that viral resistance was reducing its therapeutic benefits. Medicine offers costs as well as benefits, and although we act with the best of intentions we can be attracted to false hope and it is our patients who pay the price.

The benefits from combination antiretroviral treatment, at least to the few in the west able to access it, have been remarkable. On my return in 1998 from the USA after a year away, I expected half of the AIDS patients under my care to have died. But only one person had succumbed, and he from a non-AIDS-related death. It felt as if treatment was truly transforming a death sentence into a chronic condition.

The subtitle of this book captures this optimistic outlook. But across Europe the experience of this disease varies widely—and this book explores in some depth the causes and consequences of the unfolding epidemics of HIV across the continent, and the divergent policy and practice responses.

Europe is, broadly, witnessing the epidemiological unfolding of two

**“The chaos of HIV control in the former Soviet Union will be with us for many years to come. In 25 years' time, we will look back and question why we could not meet this challenge on the European Union's doorstep.”**

different scenarios in eastern and western Europe. The former Soviet Union is the setting of a peculiarly post-Soviet epidemic, with explosive outbreaks of HIV, particularly among injecting drug users. During the past decade, I have been working in the region. Although many errors were made in the west during the early years of the AIDS epidemic, most of these were the result of ignorance. In eastern Europe, however, errors are being made, not through ignorance, but through a calamitous failure to learn the recent lessons of history. Much of the body politic in this region seems unable to respond coherently to this impending public-health disaster. Inert, rigid public-health institutions remain rudderless in what one can only describe as a leadership vacuum.

Most individuals initially diagnosed with HIV in the former Soviet Union were left without hope. For a few “deserving” individuals, single, intermittently available, monotherapy with antiretrovirals was offered—a reminder of errors made a decade earlier in the west. Now, since HIV “treatment for all” has become part of

global political rhetoric (if not reality), determinations of who should receive treatment, the consequences of drug-resistant HIV, and the challenge of resourcing and coordinating prevention activities will confront public-health systems in the region in new ways that they seem unprepared to meet.

The chaos of HIV control in the former Soviet Union will be with us for many years to come. In 25 years' time, we will look back and question why we could not meet this challenge on the European Union's doorstep. The answer, I suspect, will be our international inability to encourage political leadership in public health at the nation-state level and introduce timely reform of national public-health systems, alongside a willingness to implement public-health “solutions” of a technical nature on a global scale without paying sufficient attention to health-system context.

While in eastern Europe the HIV epidemic is largely geographically self-contained and self-generating, in western Europe the epidemic is closely linked to the global pandemic. This acknowledgment of interconnectedness is being translated, through global health initiatives, into policy responses that aim to support control especially in high-prevalence countries, notably in sub-Saharan Africa. Yet on the ground, responses in western European seem schizophrenic. In Europe migration policy is a politically flammable issue; HIV could cause it to combust. National policy responses to HIV/AIDS are often incoherent, despite the fact that these governments support more unified global responses. In years to come, this complex environment is likely to remain an important challenge to the control of HIV/AIDS in western Europe.

Richard Coker

Richard.Coker@lshtm.ac.uk



**HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management**  
Srdan Matic, Jeffrey V Lazarus, Martin C Donoghoe, eds.  
WHO, 2006. Pp 282. CHF 50.00/  
US\$45.00. ISBN 92-890-2284-1.



## Profile

### Ernest Darkoh: confronting the challenge of HIV/AIDS in Africa

Ernest Darkoh has just become a father for the first time. But already this 36-year-old public-health doctor is thinking about his intended legacy: “to set up some health systems that truly work for Africa”. Given his track record in implementing the acclaimed antiretroviral roll-out programme in Botswana, and his plans for HIV/AIDS testing and treatment in other African countries, his ambition of revolutionising health care on the continent might not actually be so far-fetched. “HIV treatment models are based on western concepts of low prevalence, very acute conditions, high speciality equipment and staff. African countries have generally tried to mimic that kind of structure”, he says. Darkoh says his mission is to develop new models better suited to address large-scale needs. And he is better equipped than most to succeed.

An American citizen born to Ghanaian parents, he grew up in east Africa and got a medical degree and masters in public health from Harvard University and an MBA from Oxford University. He joined McKinsey & Company management consultants and was hired, in 2001, by the government of Botswana to develop a strategy for a mass public antiretroviral roll out in a country that had an HIV infection rate of nearly 40% at the time. After the McKinsey study, Darkoh stayed on. “I always felt if I was going to wake up in the morning and do hard work, I want to do it in Africa because the needs are so profound”, he said. “In the USA, I’d just be another doctor and I’d need a microscope to see the impact I’ve had. Here the need is phenomenal but your ability to make a difference is equally phenomenal.”

Backed by funding from the Merck Company Foundation and the Bill & Melinda Gates Foundation, Darkoh became head of Botswana’s National Antiretroviral Treatment Programme. When he started, most people didn’t even know their HIV status. By the time he left Botswana in April, 2005, he had set up a programme that currently treats more than 65 000 people. “It has stopped almost all the deaths”, he said. Joy Phumaphi, Botswana’s former Minister of Health and an assistant director general at WHO, said Darkoh’s “energy, drive, passion, and commitment” silenced the cynics.

Darkoh went on to team up with John Sargent and Jeff Butler to form BroadReach Healthcare, a company that aims to “marry public-health good intention with private-sector results orientation”. One of its first projects was to draw up China’s first successful treatment proposal for The Global Fund to Fight AIDS, Tuberculosis and Malaria. BroadReach’s other programmes include project management training on HIV/AIDS in Ethiopia and Tanzania; training health providers in the Caribbean; and a large-scale community-based treatment programme in South Africa.

In South Africa, BroadReach is training members of community and church groups to identify, educate, and

support people with HIV/AIDS in urgent need of treatment. “We work hand in hand with national and local-government authorities to target people in remote rural areas who would otherwise not survive the current queues.” A call centre with a few experts supports thousands of non-expert providers and patients in the field. Day-to-day patients’ support has been shifted to community groups, which relieves pressure on busy hospitals. Each patient’s clinical information is captured in a database that continuously monitors his or her progress and alerts a case manager of any changes. “We set out to create a model that can be large scale but provide individual monitoring”, Darkoh explains. He reckons that, with the funding, their network would be able to treat some 500 000 people—about the number that the Treatment Action Campaign says is in urgent need of antiretrovirals. Currently, BroadReach receives all of its \$4.2 million funds from the President’s Emergency Plan for AIDS Relief (PEPFAR).

Darkoh’s experience in Botswana taught him key lessons, including the need for speed. “Capacity building is a sprint, not a marathon. When I see projects based on 10-year time lines, I am concerned because more than half of the people will be dead in 5 years if we do not reach them today.” Botswana also impressed on him the need to promote opportunities for prevention and to diagnose and treat people early to cut the cost and complexity of treating patients facing imminent death. “There have always been queues before there was HIV”, he said. “But if you get into the queue do you want to get in when your CD4 count is 2 or when your CD4 count is 400 or 600? If we don’t get to the point where most of the people in the queue have CD4 counts of 600 and are being monitored, then we will be locked into this model of forever only treating the sickest and treating them after they have lost their livelihoods and infected other people.”

He pleads passionately for making HIV testing routine, which had dramatic results in Botswana, with testing success jumping from below 20% to above 90%. “You need to radically revise testing policies so that it becomes your duty to know your status”, Darkoh insists. Finally, he says his time in Botswana taught him that “with focused effort, political will, and good planning it can absolutely be done. But we must dare to imagine health care differently.”

Phumaphi said Darkoh’s strength was that he worked with the existing primary health-care system rather than trying to impose an alien one. “The way he works with communities, working them into the system, makes the ownership of the programme rest on the shoulders of the communities. It is a very important element of sustainability”, she said.

Clare Kapp  
clarekapp@hotmail.com