

**In Brief**

*Editor's Note: Due to limited space in The Voice, the T•II CANN Editorial Committee is often faced with the daunting task of deciding which important information to include with each issue. Since a lot of the information is important to our readers, T•II CANN has created the "In Brief" column to give you this information in a summary format and direct you to the source of the information.*

- ◆ Research reported at the International Conference on Emerging Infectious Diseases in Atlanta shows that healthcare workers face a 20 to 40 times greater risk of contracting hepatitis C virus (HCV) than HIV from an accidental needle stick. (Reuters Health Information Services - [www.reutershealth.com/7/20/00](http://www.reutershealth.com/7/20/00)).
- ◆ According to a recent UNICEF report, many teachers in sub-Saharan Africa are dying from AIDS. Last year alone, at least 860,000 children lost an instructor to the disease. In Kenya, 1,500 teachers died in 1999, compared to 10 teachers' deaths in 1993. (Christian Science Monitor — [www.csmonitor.com/7/25/00](http://www.csmonitor.com/7/25/00) P. 1: Crawley, Mike).
- ◆ The National Health Law Program (NheLP) is proud to announce a new feature on its website, a page devoted to new resources for low-income health law professionals: <http://www.healthlaw.org/resources.shtml>. This page is a simple list of resources, both online and in print, compiled by NheLP staff attorneys. (National Health Law Program, [www.healthlaw.org](http://www.healthlaw.org), 7/21/00).
- ◆ Recently, the Centers for Disease Control and Prevention (CDC) used the young Men's Survey (a cross-sectional, multisite survey conducted between 1994 and 1998), to estimate the prevalence of HIV and related risk behaviors in young men who have sex with men. Overall HIV prevalence for the group was 7.2 percent, and the rate was lowest in Seattle and highest in New York City. (Journal of the American Medical Association—[www.jama.com](http://www.jama.com), 7/12/00—Vol. 284, No. 2, P. 198; Velleroy, Linda A.; MacKellar, Duncan A.; Karon, John M.; et al.).

**EDITORIAL**

**Will History Condemn Us As "Voyeurs Of Death?"**

By Gary Rose, Public Policy Chair, T-II CANN

The XIII International AIDS Conference in Durban, South Africa presented the developing world with a stark choice. Will we act today to stem the HIV/AIDS pandemic or will we be, as Justice Edwin Cameron, an HIV positive judge on the South African High Court, asked in the opening plenary, as Germans who tolerated genocide or white South Africans who ignored apartheid?



Dr. Peter Piot, Director, UNAIDS and Gary Rose, TII CANN Director, Public Policy at 13th International AIDS Conference in Durban, South Africa

The costs of inaction were made clear in Durban. According to UNAIDS data, between 19 million and 30 million men, women, and children were already infected in sub-Saharan Africa by the end of 1999. In some countries seroprevalence rates are astonishingly high - 35.8 percent of all adults in Botswana, 19.9 percent in South Africa (up from 12 percent two years ago). Data presented at the conference suggested that India, China, and other developing countries could prove to be epicenters of even larger epidemics in the coming years. Without a miracle, the vast majority of HIV-infected people in the developing world are sentenced to death, many of them in the next ten years.

The human, moral, political, medical, and economic effects of these numbers were also illustrated in a manner that made the responsibility to act inarguable. While the space available here is too limited for describing all the effects of the disease in the developing world, the following examples are illustrative of the toll the pandemic is reaping in the developing world:

- ◆ **Effect On Medical Care:** A physician from Kenya working in a hospital serving 2 million people in a slum outside Nairobi has no tools at all for treating his patients.

The patient's only choice when they come to the hospital with late stage AIDS or one of its more ghastly clinical manifestations is "whether it is cheaper to die at the hospital or at home." Of course, the physician has no access to the antivirals that have so sharply decreased AIDS-related deaths in the developed world.

The physician also has limited access to clean water and electricity, to any kind of palliative medicine, including aspirin, or to the relatively inexpensive drugs available for many of the opportunistic infections killing his patients; diarrhea, pneumonia, meningitis, and TB. Making matters worse, HIV is killing thousands of physicians, nurses, and other health care providers in the region while thousands of others are burnt out from being forced to treat patients with a complete lack of resources. The situation in this clinic is repeated in thousands of hospitals and clinics throughout the developing world.

- ◆ **Effect On Populations:** Accurately forecasting the depopulation HIV/AIDS will cause in many developing countries is difficult because, as Dr. Peter Piot, head of UNAIDS, stated, "the world has never experienced death rates of this magnitude among young adults of both sexes across all social strata." UNAIDS' projections, however, derived from available data, suggests that the lifetime risk for 15 year old boys of dying from AIDS is nearly 50 percent in Kenya, 65 percent in South Africa, and over 80 percent in Botswana. The percentage of

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# News on The Immune System

Contributed By:  
Richard Jefferys of AIDS Treatment Data Network

The past few years have seen important breakthroughs in understanding how the immune system may be able to control HIV. A doctor from Harvard University, Bruce Walker, has led much of this new research. This article will provide background on how the immune system normally works against viruses, followed by information on Dr. Walker's research into how the immune system responds to HIV.

The immune system is what usually protects us from illness. In the case of HIV, the immune system isn't usually able to control the virus on a long-term basis. On average, ten years after being infected with HIV, a person's immune system starts to become seriously damaged by the virus. Damage to the immune system can lead to serious illnesses called opportunistic infections. This typically slow but ongoing process of immune system damage is called disease progression.

Researchers have been studying a few HIV-positive people who don't experi-

ence disease progression. They don't show damage to their immune system. They don't develop opportunistic infections. They have little or no measurable HIV in their blood. Dr. Walker may have found an explanation for this very effective immune system response to HIV.

## How Does The Immune System Normally Control Viruses?

The immune system is made up of different types of cells, some of which are called lymphocytes. One group of lymphocytes are called T4 (or CD4) helper cells. Your T-cell count is the number of T4 helper cells in your blood sample. T4 cells help coordinate the immune response to infections. When it comes to dealing with viruses like HIV, the T4 helper cells work alongside another type of lymphocyte called T8 (or CD8) cells. T8 cells include cytotoxic T-lymphocytes (CTLs). The job of CTLs is to kill cells that have become infected with viruses or other disease-causing organisms. When the CTLs kill enough infected cells, viruses like HIV can be kept in check and a person does not get sick.

When you're exposed to a virus, only some of your T4 cells will respond. T4 cells have what are called receptors on their outer surface. It is these receptors that trigger T4 cells to respond to invading organisms like HIV. The receptor system works like locks and keys. The receptor on the T4 cell is the lock and any piece of foreign material (like a piece of virus) acts like a key. A piece of foreign material that can trigger an immune response is called an antigen.

Until a T4 cell meets an antigen that fits its receptor, the T4 cell is called a naive T4 cell. If a naive T4 cell happens to meet an antigen that fits its receptor, the T4 cell goes into action by making lots of copies of itself (the technical term for this is proliferation). When this happens, the T4 cell is no longer called naive, it's now an activated T4 cell.

Out of all the billions of naive T4 cells in your body, only a few will have the receptor for each possible antigen. A T4 cell whose receptor matches HIV antigens (pieces of HIV that can trigger an immune response) won't do anything at all if it comes into contact with herpes virus antigens or influenza virus antigens, and a T4 cell whose

receptor matches herpes antigens won't respond to HIV antigens. This is why T4 cells make lots of copies of themselves when they meet their matching antigen - from a small pool of cells, the immune system gets a whole bunch of duplicate T4 cells whose receptor also matches the antigen. These cells are called specific for that antigen, and they help coordinate the rest of the immune system - especially the T8 CTLs - so that the invading virus can be controlled.

These newly created, activated T4 cells don't live all that long. After a few days they die off, because the immune system hopes that the big burst of activated T4 cells will have controlled the virus. This burst of immune system activity when you're first exposed to a virus is part of the reason you feel sick. Some of the activated T4 cells, however, don't die off but become what's known as memory cells. These memory cells live in the body for a long time, and if the same virus becomes active they make copies of themselves very quickly, much faster than naive cells do. One way to think about memory T4 cells is as a rapid-response team, programmed to respond to antigens from one particular virus or disease-causing organism. Memory T4 cells are usually made automatically after any infection that triggers a T4 cell response.

A good example of immune system memory is Epstein-Barr virus (EBV). Most people become infected with this virus during their lives. When you're first exposed to EBV, it's common to experience symptoms called mononucleosis or mono. Mono often involves a few days of fever, fatigue, sore throat, and swollen lymph nodes. During this time, naive T-cells are becoming activated by EBV. These activated cells help bring the EBV under control. About 95 percent of the activated cells die off within a few days. The rest don't die, but develop into memory cells. You now have a rapid-response team against EBV. The virus is still in your body, but the EBV-specific memory cells keep it under control.

Cytomegalovirus (CMV) is another virus that about half the population of the United States have been exposed to. The immune system controls CMV in the same way it does EBV. People with AIDS can lose their memory T4

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# National ADAP Educational Forum Highlights

Contributed By: James C. Arvantes, Associate Consultant at Martin Medical Services in Washington, D.C. and editor of *Positive Populations*.

*Note from the Editor: This article is a continuation of the review of the Forum published in the July/August issue of The Voice.*

## Medicaid Waivers Could Transform ADAPs

The Health Care Financing Administration (HCFA) is urging state Medicaid programs to submit 1115 (a) waivers to expand eligibility to people living with HIV and AIDS before they become sick and disabled, a move that has profound implications for the nation's AIDS Drug Assistance Programs (ADAPs).

"The most important advice I can give you is to get those waiver applications coming in now," said Timothy Westmoreland, Director of HCFA's Center for Medicaid and State Operations. Westmoreland said he has talked with "every single Medicaid director in the country," urging them to submit concept papers on how they would structure a Medicaid waiver for the pre-disabled with HIV and AIDS. "We will consider anything that comes in the door," he said.

HCFA approved Maine's Medicaid demonstration plan in February, making it possible for the state to provide a prescribed set of benefits to people with HIV disease who do not yet qualify for Medicaid and to thus preclude the onset of illness and disability in some patients. Under the proposal, the state Medicaid program will provide a limited set of services - antiretroviral therapy, office visits, lab services, case management, hospitalizations, mental health, and substance abuse services to people with HIV disease with incomes less than 300 percent of the federal poverty level.

The waiver represents a watershed since it is the first time the federal government has approved Medicaid eligibility for a prescribed set of services. Maine's waiver will make it easier for other states to obtain HIV waivers for the pre-disabled, according to Westmoreland. If approved, the proposals could turn ADAPs into ancillary programs by allowing the pre-disabled to spend little or no time on ADAP before accessing Medicaid services.

"Maine has broken down the door," Westmoreland said simply. "Road blocks have been broken for the first time and we are anxious to consider other forms of HIV waivers."

Many generally assume that disability is the only way people with HIV disease qualify for Medicaid. But there are, in fact, six ways poor people with HIV qualify for the program and these include the following: being over the age of 65, under age 18, pregnant, blind, members of families with children, and, of course, disability. Much of HCFA's efforts are focused on generating waivers aimed at eliminating the disability requirements for the pre-disabled with HIV disease, thus primarily impacting single, sighted people with HIV who cannot access Medicaid without a disability designation.

HCFA, for example, is reviewing an official waiver proposal from Massachusetts and is expected to "move very quickly" on that request, according to one agency official. In addition, it is reviewing concept papers from Georgia, Washington, D.C., and an unofficial concept paper from the Texas Medicaid program. California is expected to submit a concept paper within the next few months and Florida has submitted claims data to the Kaiser Family Foundation for review. "The early process of the state government and the federal government deciding about waivers is very fluid," explained Westmoreland. "There is a lot of conversation and bully pulpit back and forth."

The first step in the process is for state Medicaid agencies to send in a "relatively brief concept paper," outlining the parameters of services, eligibility criteria, and projected costs. "Concept papers are familiar to every state Medicaid director," Westmoreland said. "I have maybe three or four from each state on different topics. Tell your state [Medicaid officials] to send in concept papers on how they might enlarge eligibility for HIV."

By law, states cannot spend more under an 1115 (a) waiver than they would spend without the waiver, meaning that the proposals have to meet the requirements of budget neutrality. Westmoreland acknowledged that budget neutrality is the hardest obstacle to overcome but, as Maine proved, it can be accomplished.

## Medicaid Limitations

The HIV Quality Care Network was founded in 1998 to respond to the rapid increase in managed care in both the public and private health care sec-

tors. The network, comprised of medical programs throughout the United States, also contains a Center for HIV Quality Care, which is responsible for defining and disseminating appropriate standards for HIV care and determining the cost of HIV disease at various stages of illness. In the process, the center has identified several Medicaid program limitations including:

- ◆ Several state Medicaid programs do not have medical needy programs, optional programs that enable disabled persons to use their medical expenses to spenddown and qualify for Medicaid if they do not currently meet the financial requirements for Medicaid. These states include Alabama, Alaska, Arizona, Colorado, Delaware, Idaho, Indiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, South Carolina, South Dakota, Texas, and Wyoming. A few of these states, though, have alternative state run programs that operate as medically needy programs.
- ◆ Missouri and Ohio both have medical spenddown provisions for the aged and disabled. Texas, meanwhile, has a spenddown for families and children but not for aged and disabled.
- ◆ Ten state Medicaid programs have monthly drug limits in place, including:
  - **Arizona:** a three drug monthly limit that can be increased to six;
  - **California:** a six drug monthly limit;
  - **Florida:** a six drug monthly limit;
  - **Georgia:** under 21 - more than six medications requires authorization; those over 21 using more than five drugs per month requires authorization;
  - **Mississippi:** a ten drug monthly limit;
  - **North Carolina:** a six drug monthly limit;
  - **Nevada:** a three drug monthly limit;
  - **South Carolina:** a five drug limit for people over 21;

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- **Texas:** a three drug limit in the states fee for service Medicaid program; and
- **West Virginia:** a ten drug monthly limit.

"In a number of cases these limits are on the books but they are not enforced or they are not enforced for AIDS patients," Lubinski said.

In Florida, for example, the six drug monthly limit is not enforced for people with AIDS and other illnesses that are considered terminal. Lubinski warned, however, that if Medicaid expenditures start increasing rapidly, state officials could enforce the limitations.

- ◆ The center's website, <http://www.id-society.org>, contains comprehensive state health care profiles, including detailed depictions of state Medicaid programs and Medicare data.

**Corrections Emerges as an Important Consideration for ADAPs**

The high prevalence rates of HIV/AIDS and other illnesses among incarcerated populations has pushed correctional health care to the forefront of the US

public health system. Further, corrections have become an important consideration for the nation's ADAPs, said Lydia Watts, Director of the HIV/AIDS Initiative at the Rainbow/PUSH Coalition in Washington, D.C.

HIV disease is eight to ten times higher in correctional institutions than the general population, while AIDS is five times higher behind bars, according to federal statistics. Moreover, 17 percent of the nation's AIDS cases pass through correctional facilities each year. At the same time, 35 percent of all people with tuberculosis spend time behind bars on an annual basis and 35 percent of people with hepatitis C are behind bars at some point in any given year. These statistics, in turn, have immediate and long lasting implications for ADAPs; many ex-offenders with HIV and other co-morbid conditions coming out of jails and prisons end up on the drug assistance programs.

"Jails, prisons, and juvenile facilities can no longer be out of sight and out of mind," said Watts, the former Director of Correctional Health Care Initiatives for the Chicago Department of Health and co-chair of this year's ADAP conference.

In many cases, the incarcerated are "medically disenfranchised" and as a result, correctional settings represent their "first and only option to access care," Watts said. ADAPs, for their part, often serve as the first entry point of care for recently released offenders.

**Minority Populations**

Watts, an African-American woman, urged program participants to think about the AIDS epidemic in the context of minority populations. African-Americans comprise 12 percent of the US population but 36 percent of the nation's total AIDS cases and 43 percent of new AIDS cases. AIDS-related illnesses are now the leading cause of death for African-American men and women in this country between the ages of 25 and 44, Watts noted.

"I am a women of reproductive age and I represent the fastest growing group of new and reported AIDS cases in the United States," she said. "I am the daughter of an African-American man and a sister of African-American men and my brothers in this struggle represent 33 percent of total reported AIDS cases and 47 percent of HIV cases among all genders." ■

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children for whom one or both parents have died increased from 2 percent prior to the advent of AIDS to between 7 percent and 11 percent today.

- ◆ **Effect On Economies And Development:** HIV/AIDS is already devastating the economies of many countries in sub-Saharan Africa. The impact will be the destruction of economic and development advances, in instances the work of many decades. Countries are losing people in agriculture, administration, healthcare sector, and education. For example, in the first 10 months of 1998, Zambia lost 1,300 teachers equaling two-thirds of new teachers trained annually. In Zimbabwe, agricultural output fell by 50 percent in the last five years, primarily due to AIDS. Soon, many businesses, large and small, will be unable to operate in the region because of workforce depletion.

UNAIDS estimates that to help solve the problem of HIV in sub-Saharan Africa it will take approximately \$3 billion a year. The Durban challenge will be to secure commitments for a historic, coordinated, response from a

wide variety of public and private entities. These entities and a summary of their required roles include, but are not limited to:

- ◆ **National Governments in Developing Countries Hardest Hit by HIV/AIDS:** The cornerstone of a successful HIV prevention or provision of care is an ongoing commitment by the governments of affected countries. The Ugandan government, for example, which initially ignored its raging AIDS epidemic, decided to make fighting AIDS a top national priority. With the assistance of UNAIDS, WHO, and others, Uganda created a national HIV prevention program that has substantially reduced the numbers of new HIV infections. Thailand, which had experienced a shocking growth in its epidemic, chose to wage a war against AIDS and has met with similar success.

Alternatively, South Africa is a relatively rich country that, if it developed the will to act and obtained appropriate assistance, could build upon its existing health care system to assist the estimated 10-20 percent of its population that is already HIV-infected, and to prevent the majority of new HIV

infections. Instead, like many developing countries, the government has created transparent and frustrating excuses for not responding. The current President's assertions that HIV may not cause AIDS and that anti-HIV drugs may be poisonous, for example, seem a convenient diversion from his administration's unwillingness to provide meaningful prevention or care programs.

- ◆ **Other National Governments:** National governments outside the AIDS epicenters of the developing world must provide political, strategic, and financial leadership in supporting programs that will provide access to effective care and prevention programs in the developing world. They must exercise their leadership in international programs -- such as the World Bank and the United Nations -- to create strong and appropriate strategic planning and program development. They also must provide financial support for those programs in their national budgets, or by providing tax credits and other financial incentives for encouraging multinational companies

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cells against CMV. That's why CMV can cause disease in people with AIDS. In fact, all opportunistic infections are caused by the loss of the memory T-cells that were controlling the infection.

### **Why Can't The Immune System Control HIV?**

With most viruses, the immune response described above would eventually control the problem as it does with Epstein-Barr virus. The trouble with HIV is that there is one type of cell it infects most easily - T4 helper cells. HIV takes over T4 helper cells and uses them as factories for making more HIV. In fact, the cells that are most easily infected by HIV are T4 helper cells that have been activated. In other words, the HIV-specific T4 helper cells that first respond to the virus are the first T4 cells to be infected. Most importantly, it seems that HIV infection of activated T4 cells prevents HIV-specific memory T4 cells from working properly. HIV-specific T8 CTLs seem to develop normally, but without help from HIV-specific memory T4 cells, they don't kill HIV-infected cells efficiently.

Dr. Bruce Walker has found evidence of this in his studies. In most people,

activated HIV-specific T4 helper cells seem to die off without leaving behind any working HIV-specific memory T4 cells. This leaves the rest of the immune system without the HIV-specific memory cells - the rapid response team - needed to coordinate the immune response and control the virus. Eventually HIV gets the upper hand. The total number of T4 cells starts to drop, and people become at risk for developing opportunistic infections.

However, it turns out that a few people develop HIV-specific memory T4 cells that work very well. There is a test called the lymphoproliferative response test (LPR) that can detect HIV-specific memory T4 cells in a blood sample. Dr. Walker used this test to look for HIV-specific memory T4 cells in long-term non-progressors. These individuals haven't experienced immune system damage from HIV or progressed to AIDS, even 18 years or more after being infected. In these long term non-progressors, the T4 cell count remains normal and the HIV viral load is very low or undetectable without any treatment.

Dr. Walker found that these long-term non-progressors have strong HIV-specific memory T4 cell responses. With

the help of these memory T4 cell responses, HIV-specific T8 CTLs in long-term, non-progressors are able to kill HIV-infected cells very efficiently. In people with progressing HIV or AIDS, no evidence of strong HIV-specific memory T4 cell responses could be found. This may be a very important finding - researchers have been trying for a long time to work out why some people progress to AIDS while others remain healthy.

### **Can Early Treatment Save HIV-Specific Memory T4 Cells?**

Dr. Walker is studying a small group of people that have been treated with combination HIV drugs within days of becoming infected. This period is called primary infection. The very early results suggest that the drugs have protected their HIV-specific T4 cells from infection by HIV, and allowed HIV-specific memory T4 cells to develop. The hope is that the development of HIV-specific memory T4 cells will mean the immune system can control the virus on a long term basis, as it does in long term, non-progressors.

### **Can New HIV-Specific Memory T4 Cells Be Created?**

Studies have looked for evidence of HIV-specific memory T4 cells in long-term infected people responding well to anti-HIV drugs. Unfortunately, they cannot usually be found, even in people who have had too little HIV in their blood to measure for over two years.

The promising recent news is that there may be ways of creating new HIV-specific memory T4 cells. A doctor from New York University, Fred Valentine, presented some very early results on a study of a vaccine called Remune taken with combination anti-HIV drugs. Remune is given via a shot under the skin every three months. This vaccine was invented by Jonas Salk, who also invented the original polio vaccine.

In his study, Dr. Valentine found that the vaccine seemed to be able to create HIV-specific memory T4 cells. The theory is that the vaccine is able to trigger naive T4 cells, and they develop into HIV-specific memory T4 cells while the anti-HIV drugs are keeping the virus under control. Several studies have found that the number of naive cells in the body can increase after about six months of treatment with HAART.

Several studies of Remune combined with HAART are now ongoing. These studies should show if Remune can help the immune system control any HIV that the drugs can't get rid of. In

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working in the developing world to lend financial and technical support. Finally, they will need to contribute more of their own technical and medical expertise.

- ◆ **International Organizations:** Non-governmental organizations (NGOs) representing the health and development communities -- the United Nations (especially UNAIDS and WHO/WHA), the World Bank, national and international AIDS organizations, and the international philanthropic community -- have historically provided the central support systems for ongoing relief efforts. It will fall upon these and other NGOs to coordinate their efforts with those of the other partners and to provide leadership in the creation and implementation of effective and appropriate interventions.

- ◆ **The International Pharmaceutical Industry and Other Industries:** Numerous corporations (large and small) are wrestling with the enormous human toll exacted by the HIV/AIDS pandemic and its impact on their ability to do business in the developing world. Between high infection rates and lowered life expectancies, an extraordinary

depletion of the region's human capital is already underway. The pandemic also threatens the political and social stability of many developing countries. For these and other reasons, both national and multinational companies operating in the developing world must join together to provide financial and technical support for coordinated efforts to end the epidemic. Responsibilities will range from educating their own work forces about HIV/AIDS to providing financial support toward efforts in those countries where they currently conduct business, or plan to do so in the future.

The list of activities required in this battle against HIV AIDS, and the unified strategies required to implement them is far too long and complex to detail in this statement. Top-line concerns, however, must include:

- ◆ The development and dissemination of effective AIDS preventive and therapeutic vaccines;
- ◆ The development and implementation of effective, community-based and operated campaigns to change those attitudes and behaviors that are the growth medium for HIV;

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- ◆ The enhancement of health systems, and the economies required to support them, capable of delivering essential, consistent medical care to people living with HIV, its co-infections and related diseases endemic to resource-poor countries;
- ◆ Utilization of the vast community based AIDS response expertise that countries in the developed world possess to assist in the creation of viable local "African infrastructure" via training, information exchange, the Internet, special transnational training, or a host of similar mechanisms;
- ◆ Encourage the development of new therapies appropriate to the needs of specific countries and their specific national and local epidemics, including the clinical trial networks required to pinpoint appropriate therapeutic approaches;
- ◆ An agreement that HIV/AIDS is a public health problem rather than a political problem. Unless we can agree on that basic principle, the efforts outlined above are unlikely to succeed and
- ◆ Some agreement by the pharmaceutical companies, who have not done so already, to immediately

institute pricing policies, or drug donation policies (or combinations thereof) that will prove adequate in addressing the scope of this problem. Temporary changes in traditional "market driven" policies on intellectual property may have to be utilized. The industry must realize that in this case, any "delay = death" on a massive scale. As the President's Executive Order suggested, giving Africans access to the cheapest drugs available, whether on or off patent, has become an inescapable moral duty. It may also be wise for the Administration to meet with the pharmaceutical industry to assure them that any "emergency exceptions" to intellectual property protections will be limited to, for example, HIV, TB, malaria, and sleeping sickness.

To date, T•II CANN has concentrated its limited resources on improving access to care in the United States. Durban has forced us to expand our mission to include access to care in the developing world. Exactly what form this participation will take remains to be decided. Cooperation with an existing program on drug donation with a Southern Africa focus, however, is at present, the most appealing method by which our "network" can provide help and sup-

port. We will conduct our work in this area as the junior partner to the "African Network," which is presently developing at an astonishing rate to meet the African AIDS challenge.

The title of this editorial is drawn from a speech by Laurie Garrett, a world-renowned AIDS reporter. She expressed the fear that, while many millions of people in the developed world were watching the reports from Durban and were being profoundly moved by them, they had become "voyeurs of death" because they were unlikely to act on what they were witnessing.

As Judge Cameron so eloquently put it, "[Inaction in the face of this devastation] cannot be right, and it cannot be allowed to happen. No more than Germans in the Nazi era, nor more than white South Africans during apartheid, can we say that we bear no responsibility for 30 million people in resource-poor countries who face death from AIDS unless medical care and treatment is made accessible to them."

The options are clear. Will we continue to be "voyeurs of death" or will we act as partners to Justice Cameron in taking on this challenge? The choice is ours, but it must be made at once. ■

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addition to Remune, there are several other new vaccines that may be able to trigger the development of HIV-specific memory T4 cells.

Another approach is being called strategic treatment interruptions (STI).

The theory here is that short (two weeks to a month) interruptions in HAART treatment will allow HIV to replicate, triggering naive T-cells to respond. By restarting HAART, researchers hope that some of these responding T-cells will be protected from HIV infection and thereby mature

into functional, HIV-specific memory T-cells. Preliminary results from studies have been encouraging, although sometimes confusing due to differing lengths of the STIs that have been employed. ■



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