

AIDS and Africa: Still a Sad Story

There was good news earlier this year about one of the world's most threatening public health problems. In his State of the Union message to the U.S. Congress, President Bush announced a commitment of \$15 billion to combat the AIDS epidemic in Africa. It was a surprise, and a source of hope, for those of us who have believed that this tragedy is an enduring challenge for the developed world. Unfortunately, it is too soon to start the cheering.

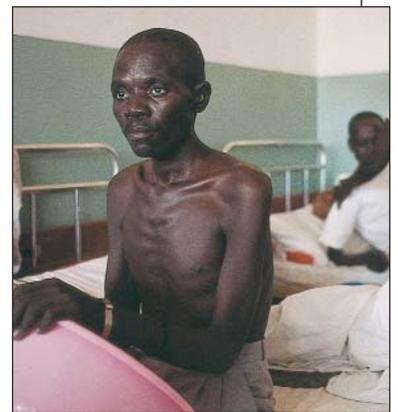
This journal has paid close attention to the African AIDS crisis since its early days. Jon Cohen of *Science's* News staff was embedded in the problem long before anyone thought to use that term for deeply engaged journalism. His accounts followed the trials and tribulations of vaccine development, the supply of antiretroviral drugs, and the strange doubts of South Africa's President Mbeki about the linkage between HIV and the disease. Naturally, there is keen interest in the new commitments from the United States and how the resources promised by Bush will be allocated and spent. Unfortunately, there is also some doubt about the status of the new funds. Moreover, it is uncertain how the developed nations can best support the capacity of the health care systems, especially in South Africa, that must deal with the problem even if the new money is assured.

To begin with the presidential promise: Not all of the \$15 billion is new money. It includes previous annual commitments of about \$5 billion. How the new and the old dollars will be allocated is undecided; the administration proposes to defer most to later years and to channel most of it through already-existing bilateral arrangements with 14 nations that support the initiative to block mother-child transmission. The rationale for selecting these is not clear; why, for example, is South Africa on the list but Swaziland and Lesotho, enclosed within that country, are not? Many hope that instead the majority of the new support will be routed through the Global Fund to Fight AIDS, Tuberculosis and Malaria, the multilateral system already in place with United Nations sanction. Some senators are rooting for the second choice, because it may protect the programs from ideological gag rules (memories of the "Mexico City" Reagan-era prohibitions linger) and because the Global Fund has a good record of getting the money where it is supposed to go. That will all be worked out through negotiations with Congress, which are now under way.

Suppose the money gets there, with minimal restrictions. How will it help? Here we focus on South Africa, where the new democratic government and significant national capacity should provide some advantages. In that country, skepticism from the Mbeki government has hampered progress for the five million citizens who are infected: South Africa is one of the 14 nations receiving U.S. aid for mother-child transmission prevention initiatives, but the government won't push antiretroviral therapies for the poor. Prevention programs do deserve high priority. With vaccine development still far off, education programs are key to other prevention strategies. But what about those who are already infected?

There the problem is with the health care system itself, which until the end of apartheid consisted of medical care given by and largely to whites. At Baragwanath Hospital, hotshot white surgical residents from the University of the Witwatersrand honed their skills by treating gunshot and head trauma victims from neighboring Soweto, but most then brought their new skills to nicer neighborhoods. In the 1980s, the organization called Medical Education for South African Blacks (MESAB) successfully raised enough money in the United States to provide bursaries for over 6000 nonwhite health care professionals. That has been a welcome drop in a large bucket, but even that kind of help, ironically, is harder to get now than in the days of apartheid, when the divestment movement helped MESAB by generating some useful corporate guilt.

The result is that there isn't a lot of care for the 20% of adult South Africans who already have the disease. That wouldn't be so bad if there were an available supply of antiretroviral or other drugs. There isn't, and that means that palliative care is a huge and largely unmet need. Prevention may deserve first claim on the new money. That's appropriate: In epidemic situations, we call first on the goddess Hygeia. But in South Africa, and perhaps elsewhere as well, there is much need for her sister Panacea.



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