The plague that isn't

Poverty is killing Africans, not an alleged AIDS pandemic, says U.S. policy adviser

Charles Geshekter

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And South Africa is more advanced than most African countries in that it conducts HIV tests in surveys of about 18,000 pregnant Africans annually. The HIV-positive numbers are then extrapolated. But there are two problems with this: The women are given a blood test known as ELISA, which frequently gives a "false positive" result (one condition that can trigger a false alarm is pregnancy). Even the packet insert in the ELISA-test kit from Abbott Labs contains the disclaimer: "There is no recognized standard for establishing the presence or absence of HIV-1 antibody in human blood."

Secondly, it's well understood that many endemic infections will produce so much cross-contamination that a single ELISA test is virtually useless. When I asked Thuli Nxege, a 28-year-old domestic worker from a rural Zulu township, what made her neighbours sick, she cited tuberculosis, and added that the lack of sanitary facilities and having open latrine pits adjacent to village homes made it difficult to prepare clean food.

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The scandal is that long-standing ailments that are largely the product of poverty are being blamed on a sexually transmitted virus. With missionary-like zeal, but without evidence, condom manufacturers and AIDS fund-raisers attribute those symptoms to an "African sexual culture." Rev. Eugene Rivers of Boston has launched a crusade to change African sexual practices — a crusade reminiscent of Victorian voyeurs whose racist constructs equated black people with sexual promiscuity.

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I'd argue that wearing red ribbons or issuing calls to condomize the continent will do little for the health of Africans. By contrast, a 1998 study of pregnant, HIV-positive women in Tanzania showed that simply providing them with inexpensive micronutrient supplements produced beneficial effects during and after pregnancy. The researchers found that women who received prenatal multivitamins had heavier placentas, gave birth to healthier babies and showed a noticeable "improvement in fetal nutritional status, enhancement of fetal immunity and decreased risk of infections."

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This means that those who question AIDS in Africa put their own funding at risk. I saw this at first-hand when I visited Swaziland in mid-December at the invitation of their HIV/AIDS Crisis Management Committee. I was driven from the airport to the hotel in a late model 4-wheel drive vehicle. It had been donated by UNICEF and was covered with AIDS posters urging Swazis to "use a condom, save a life." The committee included representatives of the major government ministries, as well as church and women's groups.

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Full marks for Mike

A recent high-school grad applauds the Ontario Premier's tough stand with teachers

LYDIA LOVRIC

Premier Mike Harris recently announced that Ontario's teachers will supervise extracurricular activities before and after school starting this fall, whether they want to or not. As a recent high-school graduate, I applaud the Premier for his efforts to ensure that high-school students receive access to a well-rounded education that includes sports and academic clubs or organizations.

Unfortunately, some secondary-school teachers, upset with changes made by the provincial government, have decided to protest by punishing students. Ever since the introduction of Bill 160 three years ago — a bill that requires teachers to teach seven instead of six classes a day — certain teachers have simply refused to supervise extracurricular activities.

Although teachers in Ontario currently spend four hours and 10 minutes in the classroom each day, they claim that additional time is required to plan and prepare lessons and mark students' work. As someone who has only recently completed high school, I know that teachers do spend time preparing lessons. But I also know that many secondary-school teachers are responsible for the same courses year after year, greatly reducing the preparation needed.

An example: One math teacher at my high school put all his lessons on overheads and brought these to each of his classes. He taught the same math courses year after year and simply used the overheads again and again. English teachers teach the same texts and therefore have much less to prepare. They don't have to study *Julius Caesar* or *A Tale of Two Cities* from scratch if they covered both the year before. I fail to see why all this prep time is needed.

I also don't understand why so much marking time is required. Nearly every teacher I had in high school marked papers and tests during class time. Many actually had the students mark. It was common for us to exchange quizzes and tests with fellow classmates so the teacher wouldn't have to mark each one individually. In any event, I don't believe that teachers spend such an incredible amount of time grading papers at home when so much is done in class.

Obviously, there are exceptions. I've had some incredible teachers who are extremely dedicated and work very hard, both in and out of the classroom. But they seem to be the exception at the high-school level and not the rule.

Before the introduction of Bill 160, Ontario teachers spent the least amount of time in the classroom compared with teachers in other provinces. Now Ontario teachers are at the national average — yet teachers outside the province still seem to find time for the extracurriculars that are currently a problem in Ontario. Requiring our teachers to be in the classroom for a little more than four hours a day and spend some time supervising extracurricular activities is not outrageous — especially when one factors in the two months of summer vacation teachers enjoy.

There are many other professions that require 10- to 12-hour workdays, and even then, employees still bring work home, and work the occasional weekend, to ensure that the job gets done. Why then, do teachers seem to be so out of touch?

Extracurricular activities are an integral part of a well-rounded education. I've probably benefited more from extracurricular activities than I have from actual classes. Sports ensure good physical fitness and teach strategy and sportsmanship. Academic clubs, such as debating, serve to strengthen one's mind and ability to communicate with others intelligently. Studies also indicate that students who participate in extracurricular activities are less likely to become involved in risky behaviour. Clearly, these activities benefit not only the students, but society as a whole. Teachers need to stop taking students hostage by withholding extracurricular activities. Nobody wins from such bully tactics.

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Lydia Lovric is a freelance writer and a student at McMaster University. She has served as a member of the provincial delegation at the Forum for Young Canadians in Ottawa.

THE GLOBE AND MAIL

Comment

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Poverty is killing Africans, not an alleged AIDS pandemic, says U.S. policy adviser Charles Geshekter

Charles Geshekter
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Illustration

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The writing is on the wall for UNAIDS

PERSONAL VIEW **Roger England**

The creation of UNAIDS, the joint United Nations programme on HIV and AIDS, was justified by the proposition that HIV is exceptional. The foundations of exceptionalism were laid when the "rights" arguments of gay men succeeded in making HIV a special case that demanded confidentiality and informed consent and discouraged routine testing and tracing of contacts, contrary to proved experience in public health. But exceptionalism grew—to encompass HIV as a disease of poverty, a developmental catastrophe, and an emergency demanding special measures, requiring multisectoral interventions beyond the leadership of the World Health Organization.

The exceptionality argument was used to raise international political commitment and large sums of money for the fight against HIV from, among others, the World Bank, through its multi-country AIDS programme, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US Presidents' Emergency Plan for AIDS Relief. With its own UN agency, HIV has been treated like an economic sector rather than a disease.

The proposition of exceptionality is now under stress. The poverty argument has been exposed as baseless. The country surveys carried out by Measure DHS (Demographic and Health Surveys) of, for example, Ethiopia, Kenya, and Tanzania show that prevalence is highest among the middle classes and more educated people. Although HIV can tip households into poverty and constrain national development, so can all serious diseases and disasters. HIV is a major disease in southern Africa, but it is not a global catastrophe, and language from a top UNAIDS official that describes it as "one of the make-or-break forces of this century" and a "potential threat to the survival and well-being of people worldwide" is sensationalist. Worldwide the number of deaths from HIV each year is about the same as that among children aged under 5 years in India.

Why a UN agency for HIV and not for pneumonia or diabetes, which both kill more people?

MIKE HUTCHINGS/REUTERS

Is the global HIV industry too big and out of control?

Similarly, multisectoral programmes were misguided and have got nowhere slowly and expensively. Some small projects of non-governmental organisations (NGOs) have successfully integrated sectoral efforts, but government ministries such as agriculture and education have not succeeded in the HIV roles imposed on them. Vast sums have been wasted through national commissions and in funding esoteric disciplines and projects instead of beefing up public health capacity that could have controlled transmission. Only 10% of the $9 billion (£4.5 billion; €5.8 billion) a year dedicated to fighting HIV is needed for the free treatment programme for the two million people taking those treatments. Much of the rest funds ineffective activities outside the health sector.

It is no longer heresy to point out that far too much is spent on HIV relative to other needs and that this is damaging health systems. Although HIV causes 3.7% of mortality, it receives 25% of international healthcare aid and a big chunk of domestic expenditure. HIV aid often exceeds total domestic health budgets themselves, including their HIV spending. It has created parallel financing, employment, and organisational structures, weakening national health systems at a crucial time and sidelining needed structural reform. Massive off-budget funding dedicated to HIV provides no incentives for countries to create sustainable systems, entrenches bad planning and budgeting practices, undermines sensible reforms such as sector-wide approaches and basket funding (where different donors contribute funds to a central "basket," from which a separate body distributes money to various projects), achieves poor value for money, and increases dependency on aid. Yet UNAIDS is calling for huge increases: from $9 billion today to $42 billion by 2010 and $54 billion by 2015. UNAIDS is out of touch with reality, and its single issue advocacy is harming health systems and diverting resources from more effective interventions against other diseases.

Steadily, the demand is increasing for better healthcare systems, not funding for HIV. Mozambique's health minister stated: "The reality in many countries is that funds are not needed specifically for AIDS, tuberculosis, or malaria. Funds are firstly and mostly needed to strengthen national health systems so that a range of diseases and health conditions can be managed effectively."

HIV exceptionalism is dead—and the writing is on the wall for UNAIDS. Why a UN agency for HIV and not for pneumonia or diabetes, which both kill more people? UNAIDS should be closed down rapidly, not because it has performed badly given its mandate, which it has not, but because its mandate is wrong and harmful. Its technical functions should be refitted into WHO, to be balanced with those for other diseases.

Putting HIV in its place among other priorities will be resisted strongly. The global HIV industry is too big and out of control. We have created a monster with too many vested interests and reputations at stake, too many single issue NGOs, too many relatively well paid HIV staff in affected countries, and too many rock stars with AIDS support as a fashion accessory. But until we do put HIV in its place, countries will not get the delivery systems they need.

Roger England is chairman, Health Systems Workshop, Grenada roger.england@healthsystemsworkshop.org

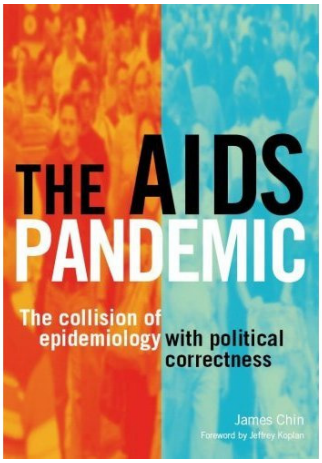
A longer version of this article with references is available on bmj.com

The AIDS Pandemic: The Collision of Epidemiology With Political Correctness

by James Chin

Dr. Chin was former Chief of the Surveillance, Forecasting, and Impact Assessment (SFI) unit of the Global Programme on AIDS (GPA), of the World Health Organization (WHO), Geneva, Switzerland. He was instrumental in developing the computer model used by the World Health Organization to estimate HIV prevalence in Africa. Reportedly, Dr. James Chin quit in protest over the WHO's consistent use of the most hyperbolic computer estimates, and then wrote this book.

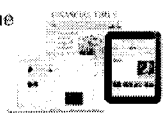
Radcliffe Publishing, 2007



This book exposes the extent AIDS programs developed by international agencies and faith-based organizations are more socially, politically, and moralistically correct than epidemiologically accurate or relevant. This is the first book to provide an objective assessment of the AIDS pandemic, offering clear and rational conclusions drawn to challenge the position of UNAIDS and most AIDS activists (*Amazon.com*).

About the Author:

- Clinical Professor of Epidemiology, School of Public Health, University of California, Berkeley



Disease research funds neglect big killers

By Andrew Jack in London
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Three quarters of funding to find treatments for "neglected diseases" goes to just three big killers, according to a pioneering attempt to track support to health research by governments, companies and philanthropists.

HIV/Aids, malaria and tuberculosis consume respectively 42 per cent, 18 per cent and 16 per cent of the estimated $2.6bn given for research and development in 2007, while less than 6 per cent goes to pneumonia and diarrhoeal illness, the two largest killers in the developing world.

EDITOR'S CHOICE

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Editorial: Limits to genetics - Aug-12

Editorial Comment: Health and safety - Dec-21

Trials dash prostate cancer vitamin hope - Dec-09

The figures highlight mismatches between disease impact and funding, as well as heavy reliance on a handful of donors. They will help fuel a debate about where to allocate resources likely to become increasingly scarce in the next few years as a result of the global financial crisis squeezing public and private donors alike.

The study, conducted by the George Institute for International Health in Australia, and funded by the Bill & Melinda Gates Foundation, showed that 60 per cent of funding came from just two entities – the US National Institutes of Health and the Gates Foundation.

The European Commission, the US Department of Defense and the US Agency for International Development were the next most important, while the pharmaceutical industry contributed 9 per cent.

Mary Moran, the study leader, said: "The good news is that neglected diseases are on the global agenda. The bad news is that some of the biggest killers have few advocates."

At the launch of the report in London on Wednesday, John Worley from the Department for International Development, called for "better priority setting mechanisms", while stressing that the UK government remained committed to health as part of its pledge to raise development funding to 0.7 per cent of gross national income by 2013.

Chris Hentschel, head of the Medicines for Malaria Venture, a product development partnership which raises and allocates funds for the development of new malaria treatments, stressed the difficulties of how to allocate funding in order to ensure the maximum improvement in health.

Andrew Farlow, from Oriel College at Oxford University, cautioned that most current funding came from large industrialised countries running substantial budget deficits, and argued that for sustainability, more should come instead from emerging economies with budget surpluses such as China.

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The HPTN 052 trial results on the effect of treatment on the sexual transmission of HIV[1] should help transform the fight against HIV. They should pave the way for the development of normative guidance by international technical agencies to inform investments. The Global Fund is finalising its 5-year strategy for 2012–16, with an ambitious target to accelerate the scale-up of antiretroviral treatment (ART). At present, more than half of the 6 million people who receive ART in low-income and middle-income countries do so through programmes supported by the Global Fund.[2]

As suggested in the new HIV investment framework proposed by experts from UNAIDS and other key institutions,[3] ART needs to be combined with targeted behaviour-change programmes to develop an integrated response to the HIV epidemic that will support change at the individual and community levels, develop community responses, reduce stigma, and ensure the optimum uptake of biomedical and other services.[4] These basic programme activities need to be underpinned by crucial programme enablers such as targeted communication interventions[5] to achieve an optimum comprehensive response.

As we celebrate the game-changing results from the HPTN 052 trial about the effects of treatment on HIV transmission, we should not hastily abandon non-biomedical elements of HIV prevention but support a comprehensive and integrated response guided by the new proposed investment framework to ensure an effective response.

We declare that we have no conflicts of interest.

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The Global Fund to Fight AIDS, Tuberculosis and Malaria, 1214 Vernier, Swtizerland

1 The Lancet. HIV treatment as prevention—it works. *Lancet* 2011; **377:** 1719.
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A strategic revolution in HIV and global health

Your Editorial (June 18, p 2055)[1] sees a new leadership role for UNAIDS in global health, with AIDS at the leading edge of a new movement for integrating health responses to disease. This Editorial is obviously based on the self-serving press releases and reports of UNAIDS. The UNAIDS Strategic Plan[2] on which these are based was itself prepared by consultants charged with saving UNAIDS in the light of rapidly increasing awareness of its irrelevance to global health. Only when the writing was so clearly on the wall for UNAIDS did the organisation commission this work to try to reposition UNAIDS given that international funding is shifting from HIV to health systems development.

This play for leadership based on strengthening health systems and integrating vertical programmes now being promoted by UNAIDS is, of course, an admission that the organisation was ill-founded in the first place: it has been the main promoter of the biggest vertical programme in history. So UNAIDS is now to assume "a potentially new leadership role in global health"?[1] The idea is farcical. It should be closed and *The Lancet*'s Editor has said as much in an earlier Comment.[3]

UNAIDS tops a significant list of self-serving UN organisations existing mainly to keep international bureaucrats and their technocrats in jobs—an aim *The Lancet* seems keen to support in this case. If *The Lancet* does not have the time to critique properly this UNAIDS spin on reality, then it should at least decline to promote it. If more integrated and efficient health systems are to materialise, they will be achieved at country level by those who for a decade have been fighting the disease-dedicated funding fads of international agencies—led of course by funding for HIV. That this is now changing is good. That it needs global leadership is debatable. That this leadership could be provided by UNAIDS is ridiculous.

I declare that I have no conflicts of interest.

Roger England
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1 The Lancet. A strategic revolution in HIV and global health. *Lancet* 2011; **377:** 2055.
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Body-mass index, abdominal adiposity, and cardiovascular risk

The conclusion of the Emerging Risk Factors Collaboration (March 26, p 1085),[1] that measures of abdominal obesity do not add to the association of body-mass index (BMI) with cardiovascular disease, is not supported by the data in the paper or those from several independent studies.

First, after adjustment for systolic blood pressure, diabetes, and total and HDL cholesterol, the waist-to-hip ratio had a hazard ratio that was significantly greater (1·12, 95% CI 1·08–1·15) than that of BMI (1·07, 1·03–1·11; p for heterogeneity=0·028; assuming the two regression coefficients are correlated at ≥0·4,

Etica & Politica / Ethics & Politics, IX, 2007, 2, pp. 330-370

Myths and Misconceptions of the Orthodox View of AIDS in Africa

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"Nothing in life is to be feared. It is only to be understood."
Marie Curie

"To kill an error is as good a service as,
and sometimes even better than, establishing a new truth or fact."
Charles Darwin

ABSTRACT

This article rebuts conventional claims that AIDS in Africa is a microbial problem to be controlled through sexual abstinence, behavior modification, condoms, and drugs. The orthodox view mistakenly attributes to sexual activities the common symptoms that define an AIDS case in Africa - diarrhea, high fever, weight loss and dry cough. What has really made Africans increasingly sick over the past 25 years are deteriorating political economies, not people's sexual behavior. The establishment view on AIDS turned poverty into a medical issue and made everyday life an obsession about safe sex. While the vast, self-perpetuating AIDS industry invented such aggressive phrases as "the war on AIDS" and "fighting stigma," it viciously denounced any physician, scientist, journalist or citizen who exposed the inconsistencies, contradictions and errors in their campaigns. Thus, fighting AIDS in Africa degenerated into an intolerant religious crusade. Poverty and social inequality are the most potent co-factors for an AIDS diagnosis. In South Africa, racial inequalities rooted in *apartheid* mandated rigid segregation of health facilities and disproportionate spending on the health of whites, compared to blacks. *Apartheid* policies ignored the diseases that primarily afflicted Africans - malaria, tuberculosis, respiratory infections and protein anemia. Even after the end of *apartheid*, the absence of basic sanitation and clean water supplies still affects many Africans in the former homelands and townships. The article argues that the billions of dollars squandered on fighting AIDS should be diverted to poverty relief, job creation, the provision of better sanitation, better drinking water, and financial help for drought-stricken farmers. The cure for AIDS in Africa is as near at hand as an alternative explanation for what is making Africans sick in the first place.

AIDS Anal Afr. 1995 Dec;5(6):4-5.

WHO criticised for "inflating" AIDS figures.

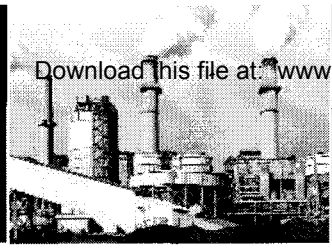
Derbyshire SW.

Abstract

The World Health Organization (WHO) has issued exaggerated projections about AIDS deaths that the press picked up to paint an apocalyptic future for Africa. Computer models used by WHO estimate that 2-3 million people in Africa are suffering or have died from AIDS since the early 1980s and another 10 million are carrying HIV. WHO surveys during 1987 indicated HIV seroprevalence rates from 5% to 30%. The Global Program on AIDS (GPA) utilized these data to predict 6.5 million new AIDS deaths annually by 1997, which would reduce population growth in urban areas by over 30%. This projection seems to be an exaggeration. The same 1987 figures were used to predict AIDS deaths for 1992. **Using the highest seroprevalence rate of 30%, the WHO model predicted a high scenario of 6 million new AIDS deaths in 1992, when in fact the cumulative cases were only 331,376 in 1994.** Even the low scenario of a 5% seroprevalence rate predicted 750,000 new AIDS cases for 1992, whereas the 1% rate suggested 500,000 new AIDS cases. Another projection made in 1994 estimated only 350,000 new AIDS cases for Africa in 1994. The discrepancies between projections and recorded figures are attributable to lack of statistical data and reliable reporting of mortality. National estimates are derived from censuses and surveys which are overextrapolated. **Since 1985, AIDS has been defined in Africa on the basis of clinical observation (chronic diarrhea or prolonged fever and persistent cough or herpes) because of lack of HIV testing facilities.** However, it is impossible to tell whether someone who develops malaria does so because of AIDS or because of normal impaired immunity. This definition has inflated the estimated AIDS figures. **The danger of the AIDS epidemic is dwarfed by 3.5 million deaths from tuberculosis and 16.8 million deaths from malaria since the beginning of the AIDS epidemic. The frightening scenario looms that widespread, but curable, diseases are wrongly classified as AIDS-related complex, thereby foregoing appropriate treatment**. [Bold added]

PMID: 12319962

http://www.ncbi.nlm.nih.gov/pubmed?term=12319962



Capturing carbon 184

Autism and the synapse 190

slowed, the nuclei may never be accelerated to 40 EeV, he says.

Whatever its cause, the fall-off leads some to question the need to build a bigger array, as the Auger team hopes to do in the Northern Hemisphere. "Once you see the cutoff—even if you disagree about what it is—then building a bigger detector hardly gets you anything," because there are so few higher energy particles to capture, says Gordon Thomson, a Hi-Res member from Rutgers University in Piscataway, New Jersey. Members of the Hi-Res and AGASA teams are building a detector in Utah called the Telescope Array, which will be three-eighths the size of Auger. That may be just the right size, Thomson says.

Others say that only a bigger array can amass enough data to trace the fall-off in detail. "Now we understand that above the GZK cutoff there are ten times less cosmic rays than we thought 10 years ago, so we may need a detector ten times as big as Auger," says Masahiro Teshima of the Max Planck Institute for Physics in Munich, Germany, who worked on AGASA and is working on the Telescope Array.

The few highest energy, straightest flying particles will be crucial for determining whether high-energy cosmic rays emanate from particular points or patches in the sky, says James Cronin of the University of Chicago, Illinois, who, with Watson, dreamed up the Auger array in the early 1990s. Such "anisotropy" might reveal the rays' origins, and "if we can show an anisotropy, then that's a brilliant breakthrough," he says. Mapping the sky could take a decade—although Cronin and Watson hint they may have already seen something exciting that's not yet ready for release. **–ADRIAN CHO**

HIV/AIDS

India Slashes Estimate of HIV-Infected People

Contrary to previous estimates, India does not have more HIV-infected people than any country in the world, says a new analysis by government health officials. Improved and widened surveys of the country's massive population has led India's National AIDS Control Organization (NACO) to slash by more than half the estimated number of people infected, from 5.7 million to 2.5 million. NACO, which announced the new figures on 6 July, says HIV thus infects 0.36% of the country's adults, rather than 0.9%. "The figures are now much more realistic," says N. K. Ganguly, the head of the Indian Council of Medical Research in New Delhi who chaired a meeting that reviewed the new NACO numbers. Ganguly, who long worried that epidemiologists had exaggerated the scale of India's epidemic, adds that he was "very happy" that a look back analysis also found that HIV was not gaining ground in this huge country.

The Joint United Nations Programme on HIV/AIDS (UNAIDS), which advised NACO and earlier issued the higher estimate, supports the new figures. "We're much more confident that the estimates being put out are as accurate as they can be," says epidemiologist Peter Ghys, who heads the UNAIDS branch that produces the oft-cited estimates for most countries.

In the past, India's HIV estimates have relied heavily on a limited number of "sentinel" surveillance sites, like clinics for pregnant women. But such analyses capture more data from urban than rural areas and miss many high-risk groups such as injecting drug users or men who have sex with men. The new analysis includes data from 400 new sentinel sites added since 2006—there were just 764 in 2005—as well as voluntary blood samples taken from more than 100,000 people in a national household survey.

NACO's estimates of HIV-infected people still are far from exact, ranging from 2 million to 3.1 million. But that's more certainty than portrayed by UNAIDS in 2006, which estimated India's HIV-infected population at 3.4 million to 9.4 million. The range is "some indication that at the time we were not as confident as we are today about the estimates," says UNAIDS's Ghys.

The lowered estimates and the reanalysis of data back to 2002 indicate that the country has had a stable epidemic with a "marginal decline" last year, NACO says. This challenges the idea that India is on an "African trajectory"—with the virus moving from concentrated risk groups such as sex workers and truck drivers to ▸

Country	HIV/AIDS cases (millions)	Adult prevalence (%)	Population (millions)
South Africa	5.5	18.6	44
Nigeria	2.9	3.9	135
India	2.5	0.3	1,129
Mozambique	1.8	16.1	21
Swaziland	0.22	33.4	1.1
United States	1.2	0.6	301

No longer number one. Much wider sampling, including a national household survey that goes well beyond the "sentinel" surveillance sites, like the clinic above in Kolkata, has led to new, lower estimates of size of the AIDS epidemic in India.

CREDITS: MALCOLM LINTON (PHOTO); UNAIDS/CIA/NACO (DATA)

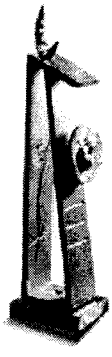
the general population—a controversial assertion made by epidemiologist Richard Feachem, former head of the Global Fund to Fight AIDS, Tuberculosis and Malaria (*Science*, 23 April 2004, p. 504). India expert and epidemiologist Robert Bollinger of Johns Hopkins University in Baltimore, Maryland, co-authored a 9 October 2004 *Lancet* article with Indian colleagues that explicitly criticized Feachem's prediction. "Frankly, I wouldn't be surprised if there were 6.1 million or 5 million or 2.5 million infected people, but the point is the epidemic is different in India," says Bollinger. A key distinction, he says, is outside of commercial sex workers, Indian women rarely have more than one sexual partner at the same time, a major driver of epidemics.

Suniti Solomon, who runs a private clinic in Chennai, YRG Care, stresses that India still faces a formidable challenge. "Whatever the numbers, if we are complacent ... the virus will spread faster," says Solomon. And she says many infected people still do not have access to anti-HIV drugs. The country is also seeing "worrying" rates of people who fail to respond to treatment and need more expensive second-line drugs, she says.

According to an April report issued by UNAIDS, the World Health Organization, and UNICEF, India had just over 55,000 people receiving anti-HIV drugs as of November 2006. The report, which relied on the old calculations of HIV prevalence, estimated that the number of people in need of immediate treatment ranged from 627,000 to 1.6 million. The new numbers mean "fewer people need treatment today and will need treatment in the future," says Ghys. Yet he, too, cautions that this doesn't suddenly make scaling up treatment simple.

UNAIDS's latest figures estimate that 39.5 million people worldwide are infected with HIV, which the revised Indian numbers would lower to 36.3 million. South Africa now has the unfortunate distinction of having more HIV-infected people—5.5 million as of 2005—than any country in the world.

–JON COHEN



AWARDS

Science Wins Communication Award

Science and *Nature* have jointly been named recipients of the prestigious 2007 Prince of Asturias Award for Communication and Humanities.

The award is made annually by Spain's Prince of Asturias Foundation, formed in 1980 under the presidency of His Royal Highness Prince Felipe de Borbón, heir to the throne of Spain. The foundation honors accomplishments by individuals, groups, or organizations in eight categories: communication and humanities, social sciences, arts, letters, scientific and technical research, international cooperation, concord, and sports.

In a statement, the foundation noted: "Some of the most important and innovative work of the last 150 years has appeared on the pages of *Science* and *Nature*, thus contributing to the birth and development of many disciplines, including Electromagnetism, Relativity, Quantum Theory, Genetics, Biochemistry and Astronomy. ... In 2001, the international community learned of the description of the human genome from the pages of both publications."

This year's awardees in other categories are former Vice President Al Gore (international cooperation), Bob Dylan (arts), developmental geneticists Ginés Morata of the Spanish National Research Council and Peter Lawrence of Cambridge University in the United Kingdom (scientific and technical research), and Hebrew writer and professor Amos Oz of the Ben-Gurion University in Israel (letters). Awards for social sciences, sports, and concord have not yet been announced.

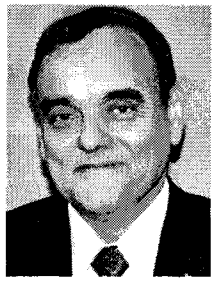
"We are delighted and deeply honored that our journal's contributions to public discourse on science and technology have been recognized by Spain's Crown Prince Foundation," said *Science*'s Editor-in-Chief Donald Kennedy.

The awards will be presented at a ceremony in Oviedo, Spain, in October.

CREDITS (TOP TO BOTTOM): NOAA; 2007 PRINCE OF ASTURIAS FOUNDATION

SCIENCESCOPE

Winds of Change



The head of the U.S. National Hurricane Center in Miami, Florida, has been placed on leave after a rebellion by fellow forecasters and staff. William Proenza (left), a longtime National Weather Service official and forecaster, has publicly complained about the center's budget since becoming director 7 months ago. One gripe was that its parent agency, the National Oceanic and Atmospheric Administration (NOAA), hadn't prepared to replace the aging QuikSCAT, a NASA satellite. Proenza had warned that its loss could worsen 3-day hurricane track forecasts by 16%.

But prominent center staff questioned the satellite's importance. And, in an unusually public letter last week, 23 of 50 center staff called for Proenza's removal, lamenting the "unfortunate public debate" over the center's forecasting ability. In May, NOAA chief Conrad Lautenbacher called Proenza's bluntness "one reason why we love him," but in a letter this week to center staff, he said there was "anxiety and disruption" at the center and that Proenza was leaving. Officials, who aren't saying why the move was made, have put center deputy Edward Rappaport in charge.

–ELI KINTISCH

Space Probes Add Side Trips

NASA is sending two decorated veterans out to collect more scientific data. After already having traveled 3.2 billion kilometers to pick up 1 microgram of dust from comet Wild 2 and having dropped it back to Earth for analysis, NASA's Stardust spacecraft will be visiting comet Tempel 1 in 2011. NASA's Deep Impact spacecraft fired a massive copper projectile at the comet on 4 July 2005, and researchers want Stardust to image the resulting impact crater to learn about the structure and porosity of the comet's nucleus. "A revisit is always a good idea," says Gerhard Schwehm, head of solar system science at the European Space Agency, although he warns that "Stardust's hardware was designed for a different purpose."

Meanwhile, Deep Impact also has been given a new assignment. It plans to fly past comet Boethin on 5 December 2008 after looking for transiting planets around other stars. NASA science chief Alan Stern says the new missions get "more from our budget."

–GOVERT SCHILLING

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South Africa: Deaths From AIDS Grossly Distorted

A new report by Health Alert has recalculated AIDS associated death estimates in South Africa- suggesting a significant inconsistency with presupposed numbers.

The country's AIDS prevalence is widely considered to be of epidemic proportions. WHO/UNAIDS statistics suggest hundreds of thousands of deaths each year in the state alone, so it follows that substantial research funding is being pumped into drug development by corporations, governments and philanthropic bodies alike.

Health Alert's new report *Where are the Bodies? — HIV/AIDS Statistics in South Africa*, however may turn existing policy towards the treatment of the disease on its head. The report challenges the assumptions underlying global estimates for the prevalence and distribution of HIV; raising further questions as to the actual market size for products related to treating infection.

Estimates from UNAIDS abound that the Republic of South Africa had 360,000 HIV/AIDS deaths in 1997, new tabulated surveillance data indicates only 6,635 deaths were actually attributed to HIV/AIDS.

UNAIDS also estimated that the country had 2.9 million people living with HIV/AIDS (PLWH) in the same year. Even given the 11-year survival period a substantial cluster of those individuals should have died by 2008; however the county tabulated a total of 136,000 HIV/AIDS deaths for the 11 years 1997-2008 inclusive, a figure far less than estimates would lead us to expect.

Report author Chris Jennings said 'One problem is that epidemiological models incorporate a misconception about the HIV incubation period.

'At the outset of the AIDS epidemic, the Centers for Disease Control actively tracked and

Contents

'At the outset of the AIDS epidemic, the Centers for Disease Control actively tracked and interviewed patients, and determined that HIV incubation averaged 8- 18 months. Fifty percent (50%) of these patients died within 12 months of manifesting opportunistic infection. Therefore the first AIDS deaths occur 20 months after infection, not 10 years as currently conceived; changing the distribution curve'.

The surveillance data has been inputted into Computer models using specific algorithm's to generate the results.

Health Alert report that pharmaceutical companies invest $300 million into developing anti-retroviral drugs thanks to an over-estimated market, but the most threatening diseases to mortality in the third-world; pneumonia, diarrhoea and tuberculosis, receive only marginal funding by comparison.

The organisation is not alone in its claim that the disease has been lent a disproportionate weight in terms of global policy and attention.

In establishing its own off-shoot agency UNAIDS, the UN has treated HIV 'like an economic sector rather than a disease', Roger England, chair of small Grenada-based think tank Health Systems Workshop, commented.

Health Alert challenges the common statistics oft cited by the UN with regards the epidemic in the country;

'The supposed HIV seroprevalence rates in the Republic of South Africa exceed all plausible limits of heterosexual HIV transmission,' states Jennings.

He continues that the 'scale and scope of the epidemic have been grossly distorted in the RSA and other indigent, tropical settings', suggesting that 'theoretically, the heterosexual African black men of the Republic of South Africa would have to sleep with 5 – 20 times as many sex partners as the gay men of NYC in order to instigate a geometrical AIDS growth pattern equalling that in the United States at the start of the AIDS epidemic', re-iterating that the global epicentre for the disease remains New York City.

Whilst it is hugely important to maintain an accurate grasp on seropravalance, there is also the risk that these explicit statements may feed the arguements of 'AIDS denialists' in the country. For many years under Thabo Mbeki's presidency, the prevalence of HIV was widely disputed at high levels of government, with dietary remedies recommended over anti-retroviral drugs. Accurate data is crucial in the successful treatment of the disease and healthcare provision in the county, so it is hoped any policy changes following this research will serve to benefit the sufferers.

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