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Public discourse on health problems throughout the world has largely focused on the physical as opposed to the psychological. Physical disease has taken precedence over psychological and behavioral disorder. When psychological and behavioral disorder has been targeted, "disorder" most often becomes "disease." Health care providers with the greatest social status, prestige, and salaries are most often physicians, as opposed to psychologists, other behavioral scientists, and lay psychologists. The chickens (of this undue focus on the "bio" of the biopsychosocial continuum of health care) have come to roost with the AIDS pandemic.

Following accounts of speeches and plans stemming from this week's special session of the United Nations (UN), one should be impressed with the psychological and behavioral variables--including those perceived as sociocultural--that have had and are having a significant effect on AIDS incidence and prevalence, prevention and treatment. For example, the very mention of some high-risk groups like homosexuals, prostitutes, and users of intravenously injected drugs is being contested by representatives of some UN members, as is the very participation of representatives of such risk groups. As well, practices such as the issuing and use of condoms, "inheriting" wives from one deceased brother to a surviving brother, developing reading-based prevention programs for illiterate population segments, discounting the sexuality of people over 50 years-old, genital mutilation and body piercing with shared needles, and general taboos against sexual discussion are all impacting on the AIDS pandemic. Yet a primary theme of public discourse continues to be the issuing of anti-retroviral drugs for infected individuals without due concern for the psychological, behavioral, and sociocultural context.

Until the privileged status of the physical in health matters is attenuated, AIDS may well continue to take its toll in an accelerating fashion throughout the Third World. The security toll--e.g., the weakening and deaths of population segments expected to significantly contribute to national wealth, to be political leaders, and to guide the youth of today and create the youth of tomorrow--also will continue to mount. So will trends towards Third World political implosion, destabilization, and AIDS-related mobility bringing ever more risk to the so-called First World.

If ever there was a time for a global community health perspective that concurrently recognizes the unique biopsychosocial factors affecting myriad population segments, that time is now. In fact successful containment and management of AIDS--led by Third World experts on the nonphysical aspects of health care in their unique environments--may have a very positive security consequence beyond turning around the security toll. Through a scourge and tragic pandemic may arise an empowerment of the wretched of the earth toward yet other global challenges that lay ahead. (See Annan says UN's "historic" session on AIDS will produce clear battle plan. (June 27, 2001). http://www.un.org; Annan stresses key role of people living with AIDS in efforts to battle pandemic. (June 26, 2001). http://www.un.org; Castaneda, X., Brindis, C., & Castaneda Camey, I. (2001). Nebulous margins: Sexuality and social constructions of risks in rural areas of Central Mexico. Culture, Health & Sexuality, 3, 203-219; Dubois-Arber, F., & Haour-Knipe, M. (2001). HIV/AIDS institutional discrimination in Switzerland. Social Science & Medicine, 52, 1525-1535; Ryan, A. (2001). Feminism and sexual freedom in an age of AIDS. Sexualities, 4, 91-107; Schatz, P., & Dzvimbo, K. P. (2001).The adolescent

sexual world and AIDS prevention: A democratic approach to programme design in Zimbabwe. Health Promotion International, 16, 111-125; Steinhauer, J. (June 27, 2001). U.N. united in AIDS fight but split over what to do. The New York Times, http://www.nytimes.com.) (Keywords: AIDS, Health Care, International Health, Physicality.)