



UNAIDS OUTLOOK REPORT | 2011

OUTLOOK



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30 years into the AIDS epidemic

**30 milestones, thoughts, images, words,
artworks, breakthroughs, inspirations
and ideas in response**

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Foreword

In the lifetime of the AIDS epidemic, we have seen how one virus can change the course of history. Incredible transformation and deep entrenchment—AIDS has brought out the best and worst of humanity.

HIV demands strong political will and commitment. It forces us to confront difficult issues such as sex, drugs and discrimination. HIV challenges us to innovate to get ahead of the disease.

Our understanding of the virus and human nature has grown over the decades. There have been tremendous moments of clarity, real progress and people who have inspired great hope.

Nearly 30 million people have lost their lives to AIDS. On this, the 30th year of the epidemic, we honor their memories, reflect on what we have learned and reach for our shared vision.

Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths.

A handwritten signature in black ink, reading "Michel Sidibé". The signature is written in a cursive style and is positioned above a horizontal line that extends to the right.

Michel Sidibé
UNAIDS Executive Director

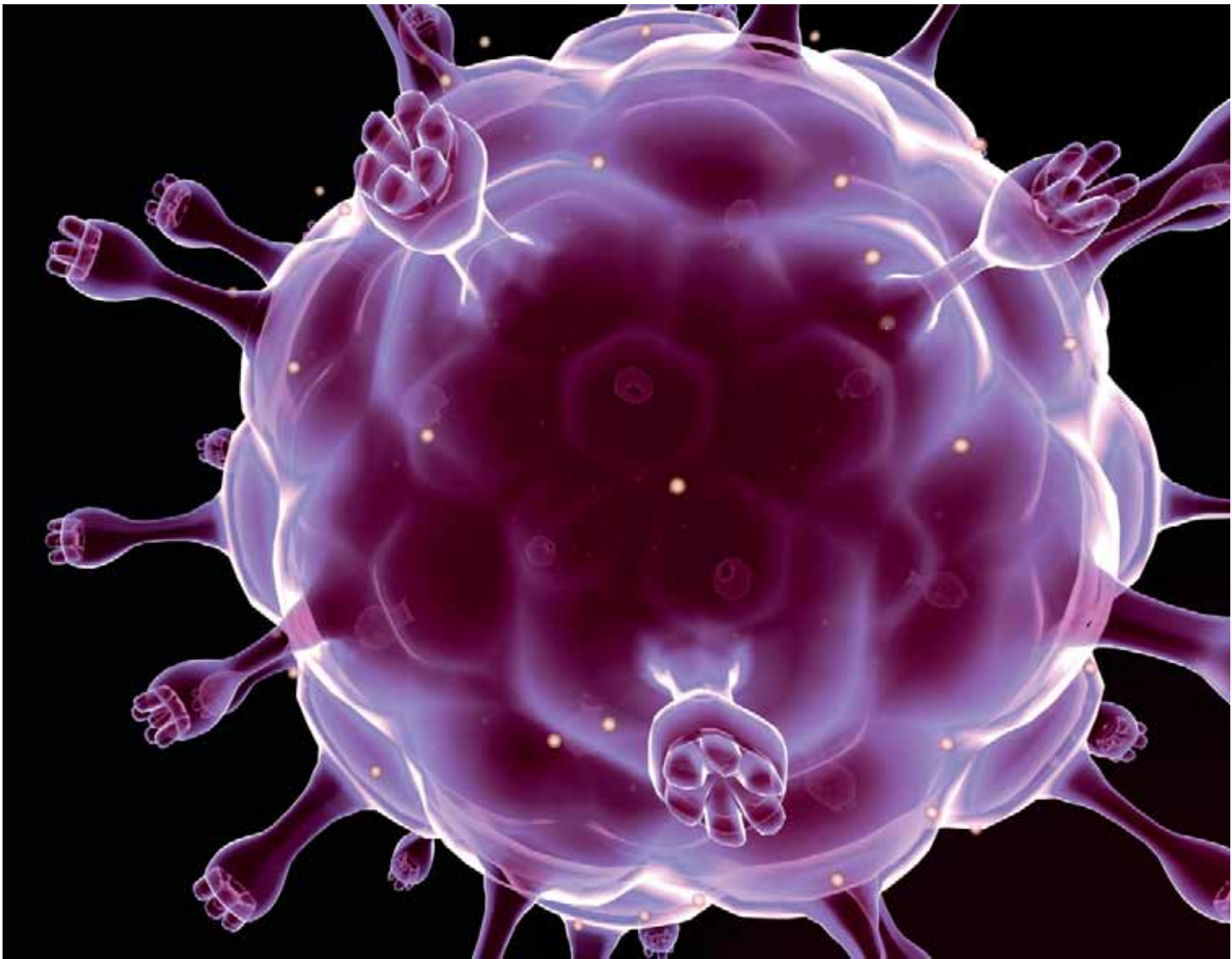
01

The virus

Since the discovery of the virus, we have learned that HIV infection is much more complex than we initially thought, and the mechanisms leading to AIDS pathogenesis are still today not entirely understood.

Françoise Barré-Sinoussi
Nobel Lecture

The virus



How HIV works in the body

Once the Human Immunodeficiency Virus (HIV) enters the human body, its goal is to enter specific cells—using the body to replicate and grow.

Because the virus cannot replicate on its own, it looks for cells to invade—most commonly T cells that it can use. Ironically, these are the same cells that help strengthen the immune system to protect the body.

A T cell has CD4 receptors on its surface. The virus first binds to the CD4 receptor. It then binds to a second receptor, either CCR5 or CXCR4 to enter the T cell. The virus empties its contents into the T cell; HIV enters the nucleus, the command centre of the cell, and begins a takeover.

Inside the nucleus, HIV uses its enzyme to change its genetic information from RNA to DNA, thereby forcing the cell to produce HIV parts and stop the T cell from doing its original job of fighting off germs and infection.

The virus parts are then assembled and, when completed, the new virus is pushed out of the T cell and looks for another T cell.

At the same time the virus is replicating itself in T cells—other healthy T cells are trying to fight off HIV.

A blood test can measure how many healthy T cells there are in the blood. If the T cell or CD4 count falls below 350 cells per cubic millimetre (mm^3) of blood, HIV treatment should be started, according to 2010 WHO guidelines.

(left) A scanning electron microscope image of HIV. The glycoprotein complex on its surface enables the virus to attach to and fuse with target cells to initiate the infectious cycle.

02

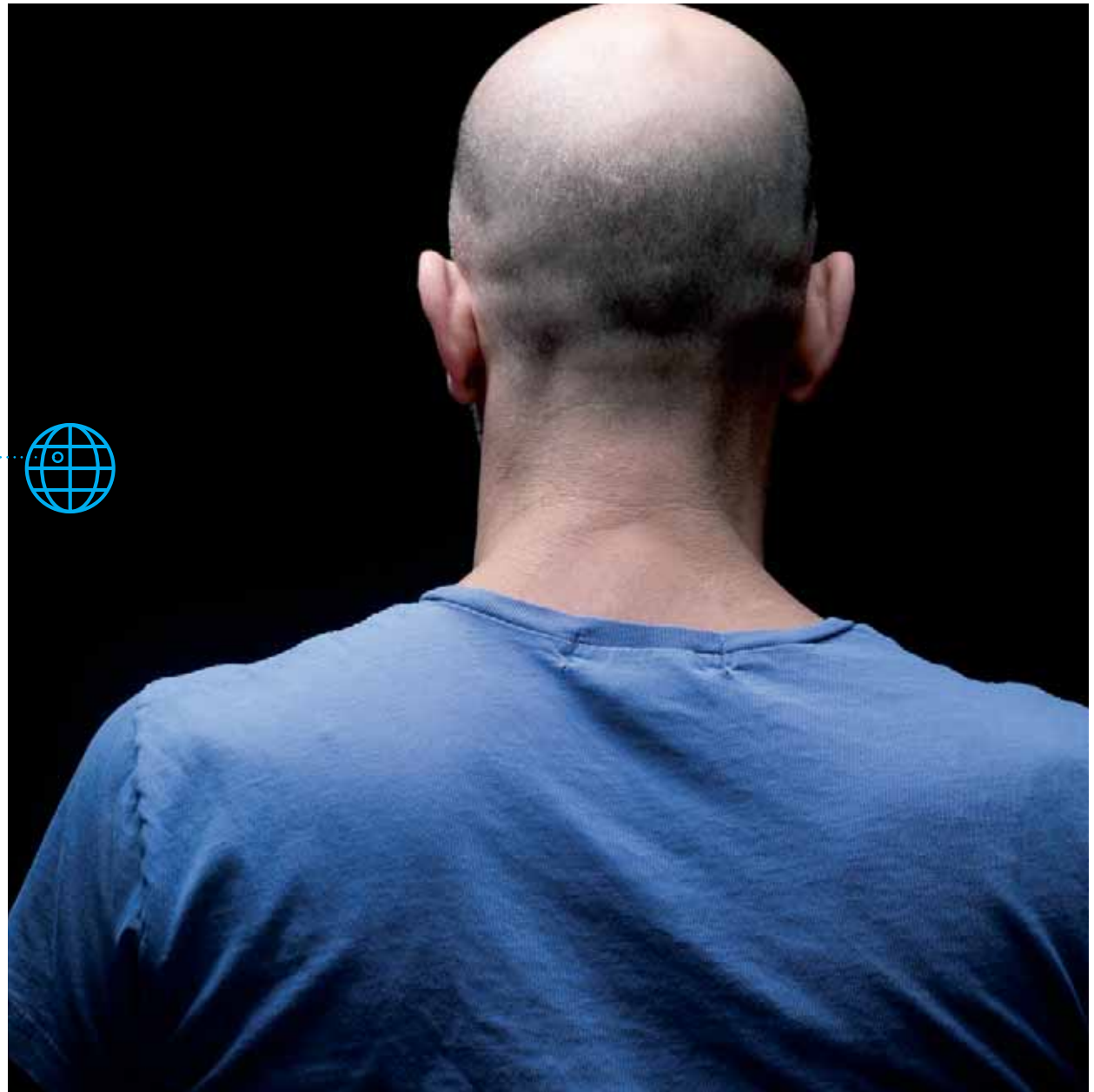
Solving the mystery of AIDS

Thirty years ago when the first AIDS cases were reported, imagining the enormity and complexity of the disease was difficult. Many doctors across the globe contributed to solving the mystery of AIDS. They often confronted a strange mix of symptoms and conditions they had never seen before.

Compassion, commitment and a desire to unlock the mystery drove them onward.

Solving the mystery of AIDS

**A real whodunit
involving medical
detectives across
the globe**



A real whodunit involving medical detectives across the globe

His name was Michael, and his doctor remembered him as a tall, good-looking man with high cheekbones and closely cropped, bleach-blonde hair.

“I have a better memory of that patient than people I treated yesterday,” said Michael Gottlieb, his doctor.

Even though 30 years has passed since the 31 year old gay man checked into the UCLA Medical Center, this case continues to reverberate across the medical world today.

Michael sought treatment because of unexplained fever and weight loss.

“He was really skinny. I was concerned because he had lost about 25 pounds,” said Dr Gottlieb.

But what was even more puzzling was that Michael had *Pneumocystis carinii* pneumonia (PCP). Until early 1981, PCP was considered a rare disease that occurred mostly among people with cancer who had been treated with chemotherapy.

The problem was that Michael did not have cancer and had not undergone chemotherapy.

The mystery deepened when a blood test revealed he had a severely damaged immune system.

“He was profoundly immune deficient. I was worried, but while I thought his prognosis was guarded, I didn’t realize his immune deficiency was irreversible,” said Dr Gottlieb.

The doctor hypothesized that an environmental agent or a virus had temporarily suppressed the

immune system. Little did he know that he was embarking on a medical whodunit that would take many of the world’s best medical sleuths to solve. Together, they would uncover one of history’s worst epidemics.

But back in January 1981, ignorance was bliss. The mystery patient appeared light-hearted, confident that his doctors would find and fix what troubled him.

Dr Gottlieb said, “He seemed to think his condition could be easily treated.”

On the other coast of the United States, a dermatologist at New York University’s Medical Center was stumped by an equally bewildering case. For the second time in a month, a young gay man had consulted Alvin Friedman-Kien because of a strange skin condition.

“He was a Shakespearean actor on a Broadway show. He was concerned about these purple spots on his face, which he tried to cover up with makeup,” recalled Dr Friedman-Kien.

A biopsy showed that the Princeton graduate had a type of skin cancer called Kaposi’s sarcoma. Until then, Dr Friedman-Kien had only treated a handful of Kaposi’s sarcoma cases, and they were usually older men of eastern European or Mediterranean origin. He wondered why he had seen two cases of this rare disease in less than a month among patients with remarkably similar profiles yet unlike all his previous cases.

Dr Friedman-Kien did not know that colleagues at Bellevue Hospital Center, also in New York, were



Solving the mystery of AIDS



growing increasingly alarmed by the number of young gay men they were treating for very rare infections.

Jeffrey Greene was in the middle of his infectious disease fellowship at Bellevue, and he was puzzled by a patient with three highly uncommon infections. One of these was PCP—the same lung infection that had surprised doctors in California.

“Seeing any of these opportunistic infections was rare, and seeing them all in one person was almost unheard of,” said Dr Greene. “He had extreme shortness of breath, and we had to put him on a ventilator.”

Within weeks, Dr Greene said he saw another case of PCP in a young gay man. Then some time later, he was doing rounds on Bellevue’s seventh floor when he glanced at an X-ray two of his colleagues were discussing. What he saw was chillingly familiar.

“I asked them whether the patient was gay. The two doctors dropped their pens and looked at me as if I was some kind of seer. They asked me how I knew that,” said Dr Greene. “That X-ray looked the same as the ones for the other two patients with PCP.”

This third case spooked the young medical fellow. He said he looked at the hospital’s archives and found no cases of PCP in the past five years. Now, suddenly there were three cases and they all fit the same ominous pattern.

“That was my ‘aha’ moment,” said Dr Greene.

Other doctors were also becoming concerned by the sudden increase in cases with strikingly similar

features. Dr Friedman-Kien went into a frenzy of calling medical colleagues to ask whether any had patients with Kaposi’s sarcoma. Within a few weeks, he had heard of six cases with the rare type of cancer.

And in Los Angeles, Dr Gottlieb had been busy uncovering new cases of PCP. By early spring 1981, he had found four cases of the lung infection among young gay men in the Los Angeles area.

“I had a cluster of patients,” said Dr Gottlieb. He said he knew he was onto something important that would be good to get out to a medical journal. So he started exploring where he could publish quickly.

While doctors on both coasts were on the trail of a strange new disease, the premier medical detective agency in the United States noticed their concerns. At the Centers for Disease Control and Prevention (CDC) in Atlanta, a drug technician was puzzled.

For Sandra Ford, the numbers seemed out of line. She handled orders for pentamidine. This antibiotic was used to treat PCP and was only available through an investigational new drug license, which required doctors to request it through the CDC. Until early 1981, Ms Ford received about 90 orders for the drug per year and never any refills. But now she was receiving an increasing stream of calls from doctors for orders and for refills. By April, she grew so uneasy that she wrote a memo to her boss.

Around the same time, news of the article Dr Gottlieb was writing for the CDC’s *Morbidity and Mortality Weekly Report* began to filter through the CDC. When the report came out on 5 June 1981,



David Serwadda, previously with the Uganda Cancer Institute, currently with the Makerere University School of Public Health.



James Curran, previously with the Centers for Disease Control and Prevention, currently with the Rollins School of Public Health, Emory University.

it was the first to describe a syndrome that would initially be called GRID (Gay-related immune deficiency) and later be known as AIDS. But even back then, the CDC knew that the findings were important and began setting up a task force.

“The article in its draft form was sent to me, and we started to do active surveillance even before it was published,” said James Curran, who was working on a study of a new hepatitis vaccine for gay men. Because of that research, he had contacts with doctors who treated the gay community. He therefore headed the CDC’s new Kaposi’s Sarcoma and Opportunistic Infections Task Force and began chasing down leads. At the time, it was hard to imagine the sheer magnitude of the problem.

“Probably by the time that article came out there were already about 250 000 gay men infected with HIV around the country,” said Dr Curran.

A few days after the first CDC bulletin on the epidemic, Dr Curran flew to New York and came face to face with the disease. Just like Dr Gottlieb, he recalls his first patient with AIDS clearly. The CDC researcher was struck because this person seemed such a mirror image of himself.

“He was a young man who was about my age and, like me, had grown up near Detroit,” said Dr Curran. “He had attended an Ivy League college like me. The only difference was that I was straight and he was gay.”

At this early stage of the epidemic in the United States, sexual orientation seemed to divide those who became sick and those who did not, but half a world away, doctors in Africa were having a completely different experience.

In 1978, Bila Kapita had returned to Kinshasa, Democratic Republic of the Congo from a training programme in cardiology in Belgium. He was struck by what he saw as he wandered through the wards. People were dying mysteriously at Kinshasa General Hospital’s 2000-bed facility.

“I saw many cases of diarrhoea, meningitis, strange skin diseases and numerous people in a coma for no known reason,” said Dr Kapita. “Most of these people were wasting away before they finally died. No treatment did anything. We didn’t have any name for this disease.”

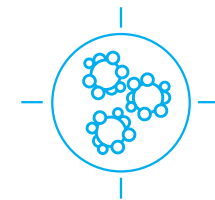
He was not the only one in Africa wondering what was happening. Many doctors in hospitals and clinics in various parts of Africa were starting to notice the perplexing symptoms that seemed to strike people in the prime of their lives.

“By the end of 1979, we started to notice men and women coming to the hospital who had prolonged fever, diarrhoea and extreme weight loss,” said Tina Lwanga, who was a nurse in Kalisizo Hospital. The small town of Kalisizo is located near the shores of Lake Victoria in the Rakai district of Uganda.

Here, the local people had begun to fear a disease they called ‘slim’ because most patients slowly wasted away before they died.

“Many people thought they were bewitched. You would find families where the husband and wife had both died, leaving behind their children,” said Ms Lwanga. “People were panicking because they didn’t know the cause.”

In this distant corner of Uganda, the United States appeared far away. But by April 1982, the doc-



Solving the mystery of AIDS



tor in charge of Kalisizo Hospital filed a report describing around 20 patients in one ward with the strange wasting disease.

In Uganda's capital, Kampala, a young research fellow at the Uganda Cancer Institute was interested in the articles he was reading about the new epidemic of Kaposi's sarcoma in the United States. In this eastern African region, Kaposi's sarcoma was actually a fairly common tumour.

"We normally found the skin cancer on the feet and upper hands. The tumour was usually benign and would melt away," said David Serwadda. "But I began seeing it on the trunk and mouth of patients who were very sick."

The virus was first discovered in 1983. By early this year, it was clear that this new immune disease was not just occurring in the United States. There were reports of cases in the United Kingdom and other European countries, and several researchers noted many cases among Africans living in Europe.

In Kinshasa, Dr Kapita began to wonder whether the disease that was making waves in the United States could be happening in his hospital. He said he started to follow closely the strange wasting cases he had noted earlier.

By the time a small group of foreign scientists touched down in Kinshasa in 1983, Dr Kapita could already point out about a dozen people in his hospital whom he thought had the new immune disease.

In these early days, there was still no antibody test for the virus causing AIDS. This test was only invented in 1985. For the scientists in Kinshasa, it

took several weeks of makeshift laboratory work on blood samples to confirm that the patients had the disease. What particularly struck the researchers was that the cases were divided almost evenly between women and men.

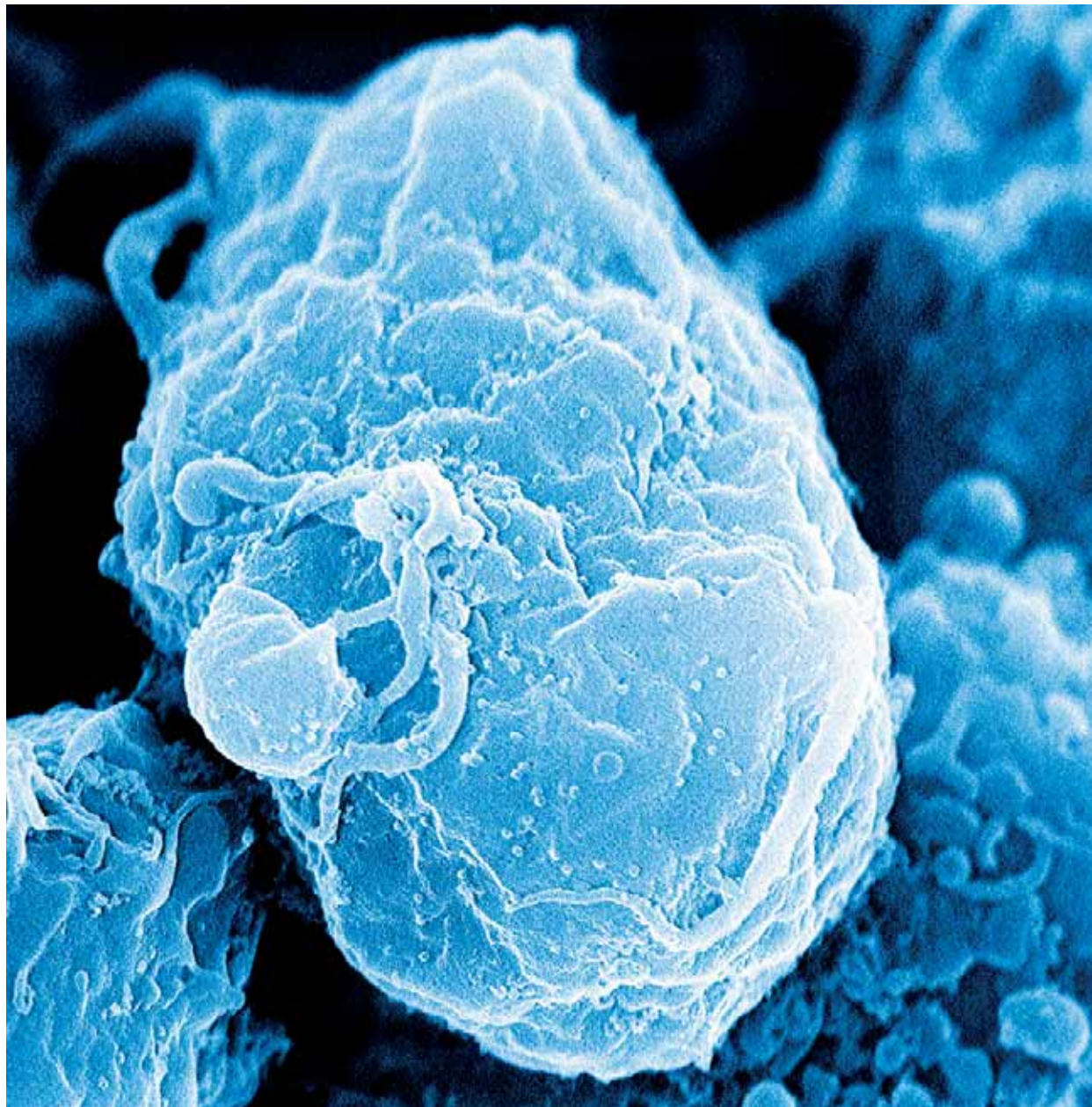
"We were rather doubtful about our results, since in the United States the disease was still mainly seen as a cancer among gay people, and this was not the case with our patients," said Dr Kapita. It would take several more years before the many faces of the epidemic would become clear. It would also take decades of political, scientific and social debate to unravel the complexities of the AIDS epidemic and mobilize the world to rise to the challenge and introduce an effective response.

But in those early days, many doctors would say they were driven by the tragedy and triumph of the human spirit they witnessed daily. They were inspired by both a commitment to their patients and a desire to unlock the mystery.

"I remember one of my early patients looking at me, expecting me to have an answer, and I didn't," said Dr Gottlieb.

"I have never been so proud of my patients as I was of the early AIDS cases," said Dr Greene, "I would make house calls and see unspeakably horrible things, but at the same time I would see people dealing with this awful disease with such dignity. There was a real fellowship between doctors and patients."

HIV-1 virus burgeoning from a membrane of a lymphocyte in culture.



03

Data

Data play a critical role in the AIDS response. Policy is developed through data, and vital decisions are made daily based on facts and figures. Sometimes it is easy to forget—behind every number is a person; behind every fact is a story.

65 million

[59 million–71 million]

CUMULATIVE HIV INFECTIONS,
1970–2009

2.1 million

[1.8 million–2.5 million]

NEW HIV
INFECTIONS,
1990

3.2 million

[3.0 million–3.4 million]

NEW HIV
INFECTIONS,
1997

2.6 million

[2.3 million–2.8 million]

NEW HIV
INFECTIONS,
2009

29 million

[25 million–33 million]

CUMULATIVE AIDS-RELATED DEATHS,
1970–2009

300 000

[200 000–440 000]

AIDS-RELATED
DEATHS,
1990

2.1 million

[1.9 million–2.3 million]

AIDS-RELATED
DEATHS,
2005

1.8 million

[1.6 million–2.1 million]

AIDS-RELATED
DEATHS,
2009

34 million

[30.9 million–36.9 million]

PEOPLE LIVING WITH HIV,
2010

15–16 million

ELIGIBLE FOR HIV TREATMENT IN
LOW- AND MIDDLE-INCOME COUNTRIES,
2010

about 9 million
WAITING FOR TREATMENT,
2010

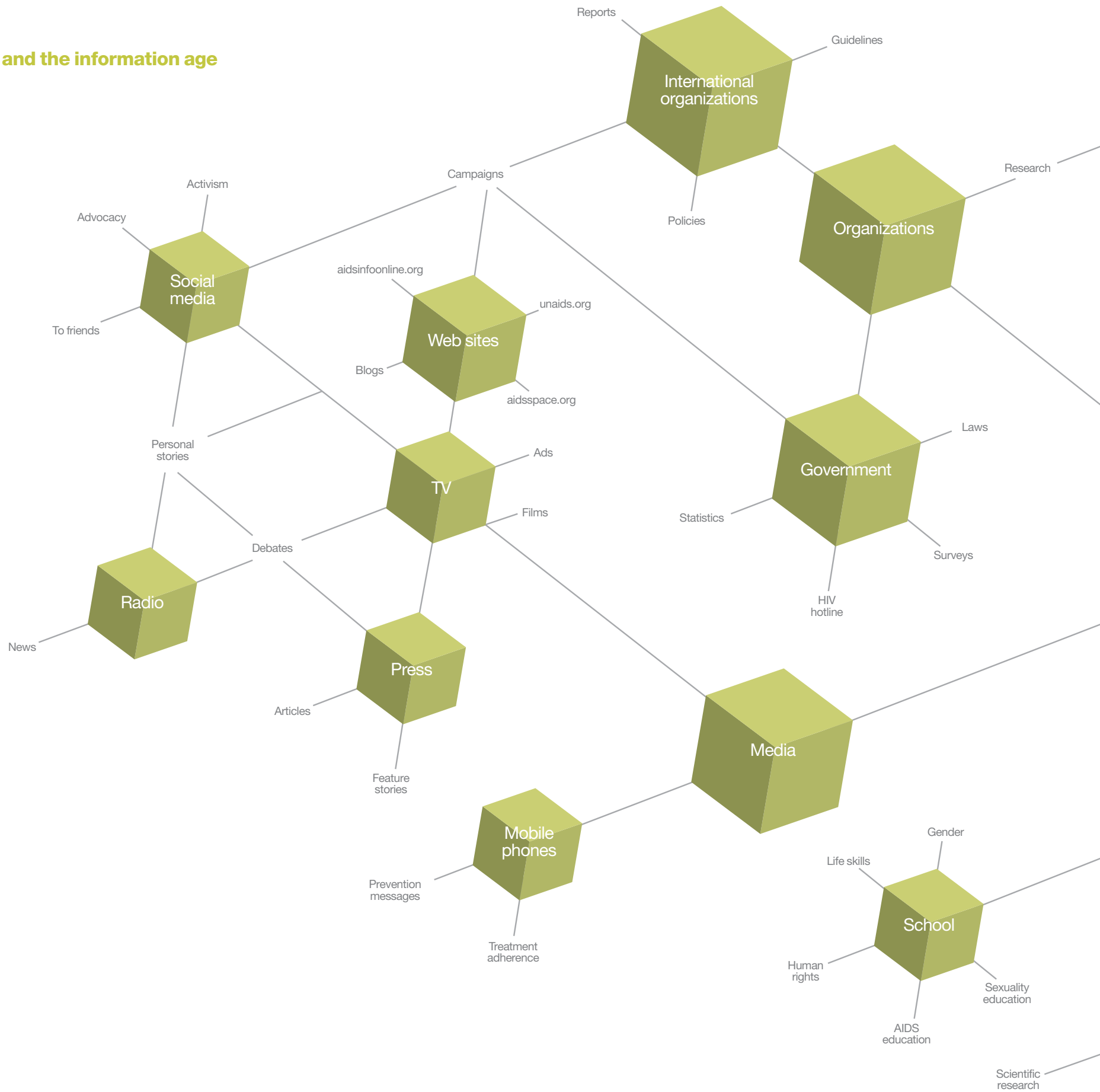
6.6 million
ON TREATMENT,
2010

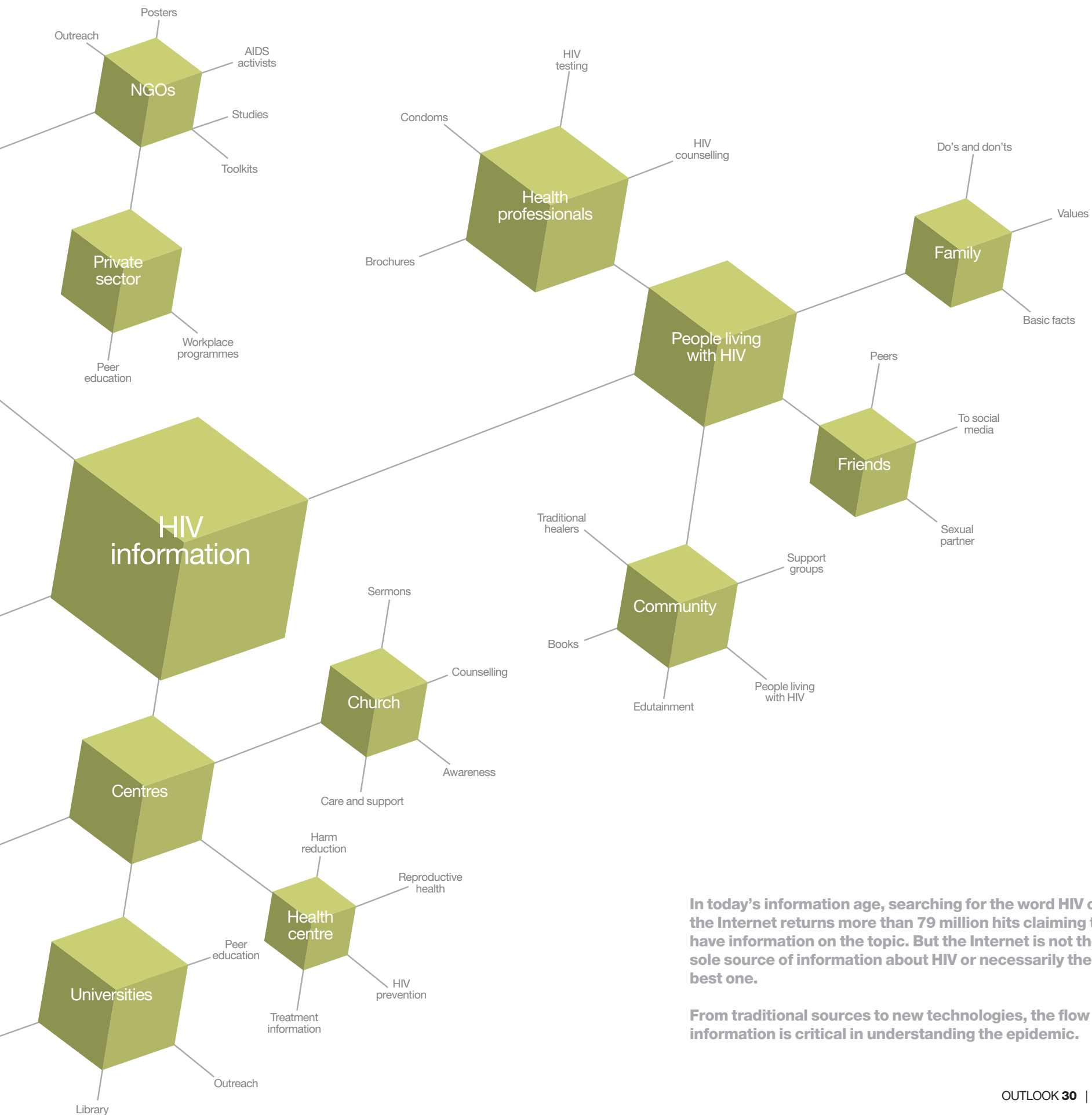
04

HIV and the information age

Information flows in many dimensions. From people living with HIV to doctors, friends, teachers and the media—all play a critical role in providing information about AIDS.

HIV and the information age





In today's information age, searching for the word HIV on the Internet returns more than 79 million hits claiming to have information on the topic. But the Internet is not the sole source of information about HIV or necessarily the best one.

From traditional sources to new technologies, the flow of information is critical in understanding the epidemic.

05

Campaigns count

What is the purpose of a campaign? Is it to generate awareness, rouse people into action, help influence a decision or effect positive behaviour change?

Since the HIV epidemic began, campaigns have worked towards achieving a range of such outcomes, from overcoming ignorance about HIV transmission to encouraging HIV prevention.

A collection of visual HIV awareness strategies over the years

During the past 30 years, many media channels have been used to help convey messages. Public service announcements in TV and radio, soap operas, newspaper advertisements, glossy spreads in magazines, street art and the Internet are examples of the channels that have conveyed messages including the importance of using condoms, of confronting stigma and discrimination against people living with HIV and of mobilizing political support for access to treatment.

Two of the most universal media channels for generating HIV awareness have been posters and billboards. Omnipresent in many countries, posters plastered on city streets and billboards positioned along busy highways have communicated HIV messages—messages specific to local and national contexts and often reflecting the social norms and practices that contribute to spreading HIV within a community.

On the following pages, HIV awareness posters from around the world present a glimpse of the diverse visual strategies used to communicate HIV issues. Some campaigns apply emotion and fear; others attract the viewer by using erotic images, familiar situations or popular symbols.

The result is a compelling, stimulating and thought-provoking collection of HIV awareness posters that equally displays the evolution of communicating about HIV worldwide.

The images featured are courtesy of the Museum für Gestaltung Zürich; the Massachusetts College of Art and Design, Boston; James Lapidés, International Poster Gallery, Boston; and Richard Deagle, ACT UP, New York.



United States, 1989

Ignorance = Fear; Silence = Death

Artist: Keith Haring

Design: ACT UP

Collection of Richard Deagle, ACT UP

Campaigns count



Sweden, 1993

Be a rubber hero: love power

Design: Garbergs Reklambyrå AB for the Swedish Association for Sexuality Education

Museum für Gestaltung Zürich

ఎయిడ్స్

ఈ క్రింది సందర్భాలలో ఎయిడ్స్ వ్యాధి వ్యాపిస్తుంది.



వైరస్ సోకిన వ్యక్తి రక్తాన్ని ఇతరులకు ఎక్కించడం వలన



కలుషితమైన మూడులు నిరంతరం వాడడం వలన



వైరస్ సోకిన వ్యక్తితో భౌగోళిక సంబంధం వలన



వైరస్ సోకిన తల్లివారి నుండి కడుపులోని బిడ్డకు

ఈ క్రింది సందర్భాలలో ఎయిడ్స్ వ్యాధి సంక్రమించదు.



లొడుము వలన



కదిసి ఆడటం వలన



కదిసి వినియోగం వలన



కలిసి తినడం వలన

ఎయిడ్స్ గురించి తెలుసుకోవండి... ఎయిడ్స్ రాకుండా జాగ్రత్త పడండి... నిరోధం వాడండి.

ప్రెసిఫర్, ఎయిడ్స్ కంట్రోల్ ప్రాజెక్ట్, 100, 5వ ఫోటోగ్రాఫ్, నల్లూరు, మద్యం బజార్, హైదరాబాద్.




India, 1993

How AIDS is transmitted and how it is not

Design: unknown. AIDS Control Project, Government of Andhra Pradesh, Hyderabad

Collection of Jim Lapidés, International Poster Gallery, Boston

Campaigns count



Trinidad and Tobago, 1994
AIDS. Don't be afraid, be aware

Design: Illya Furlonge-Walker, National AIDS Programme

Museum für Gestaltung Zürich



Singapore, 1994

All the smartest bodies in town are wearing rubber

Design: Action for AIDS, Singapore

Museum für Gestaltung Zürich

Campaigns count



Austria, 1995

Humanity is infectious. Playing with children living with HIV isn't

Design: PK & P, Aids-Hilfen Österreichs

Museum für Gestaltung Zürich

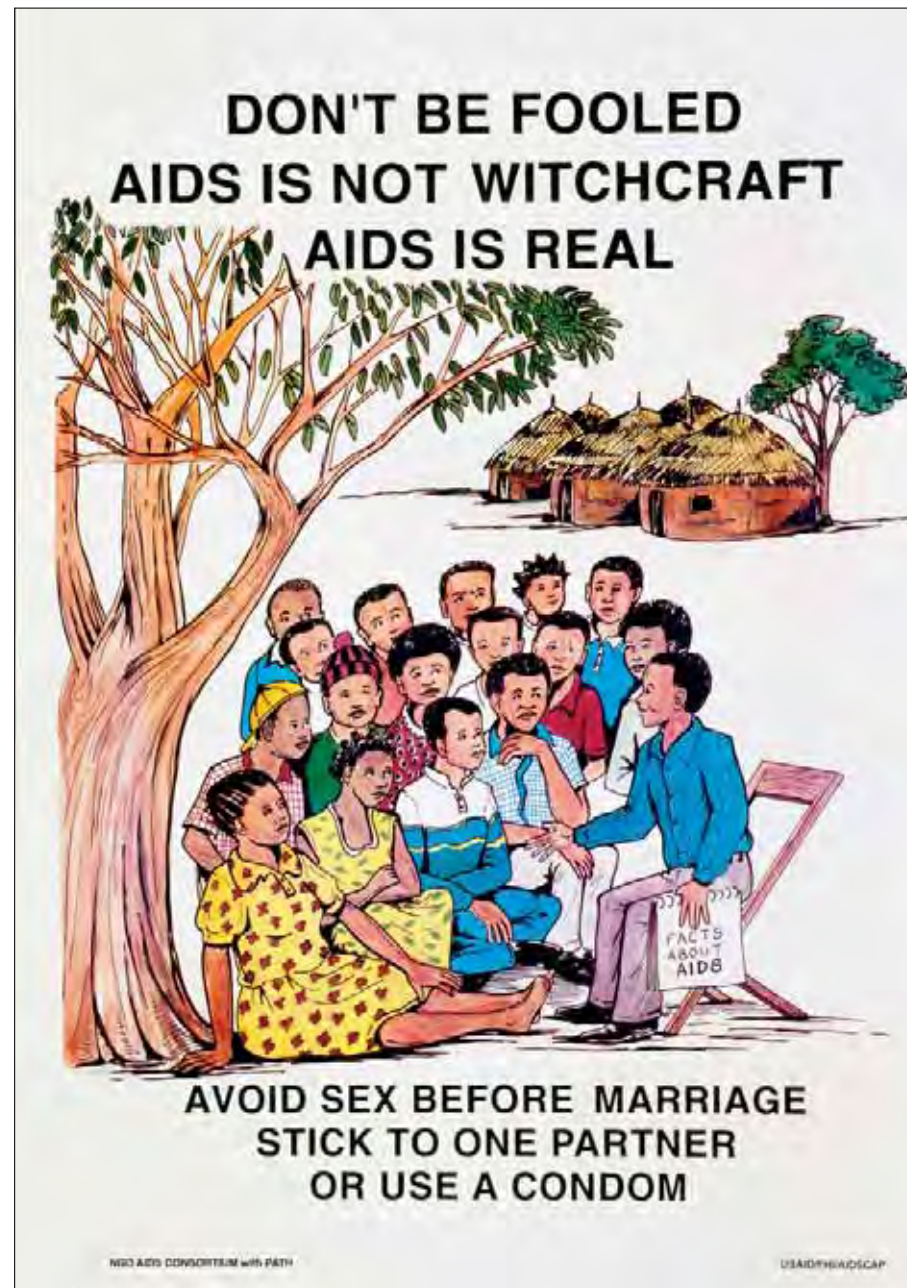


India, 1995

Go and tell the nation frankly and unambiguously that if they want to avoid AIDS they should use condoms regularly

Design: Indian Health Organization

Museum für Gestaltung Zürich

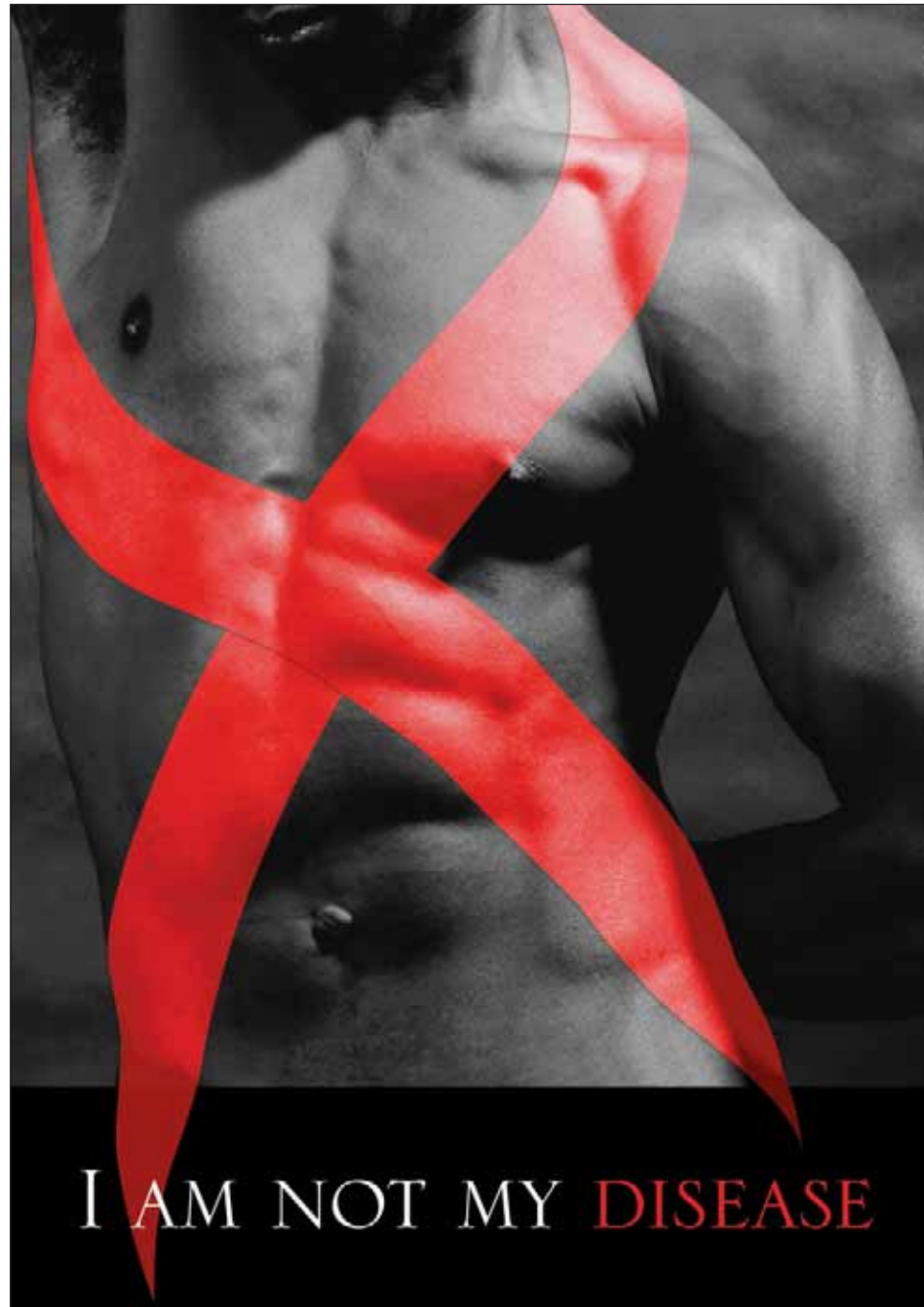


Kenya, 1997

Don't be fooled. AIDS is not witchcraft, AIDS is real. Avoid sex before marriage. Stick to one partner or use a condom

Design: Kenya AIDS NGOs Consortium, Nairobi

Museum für Gestaltung Zürich

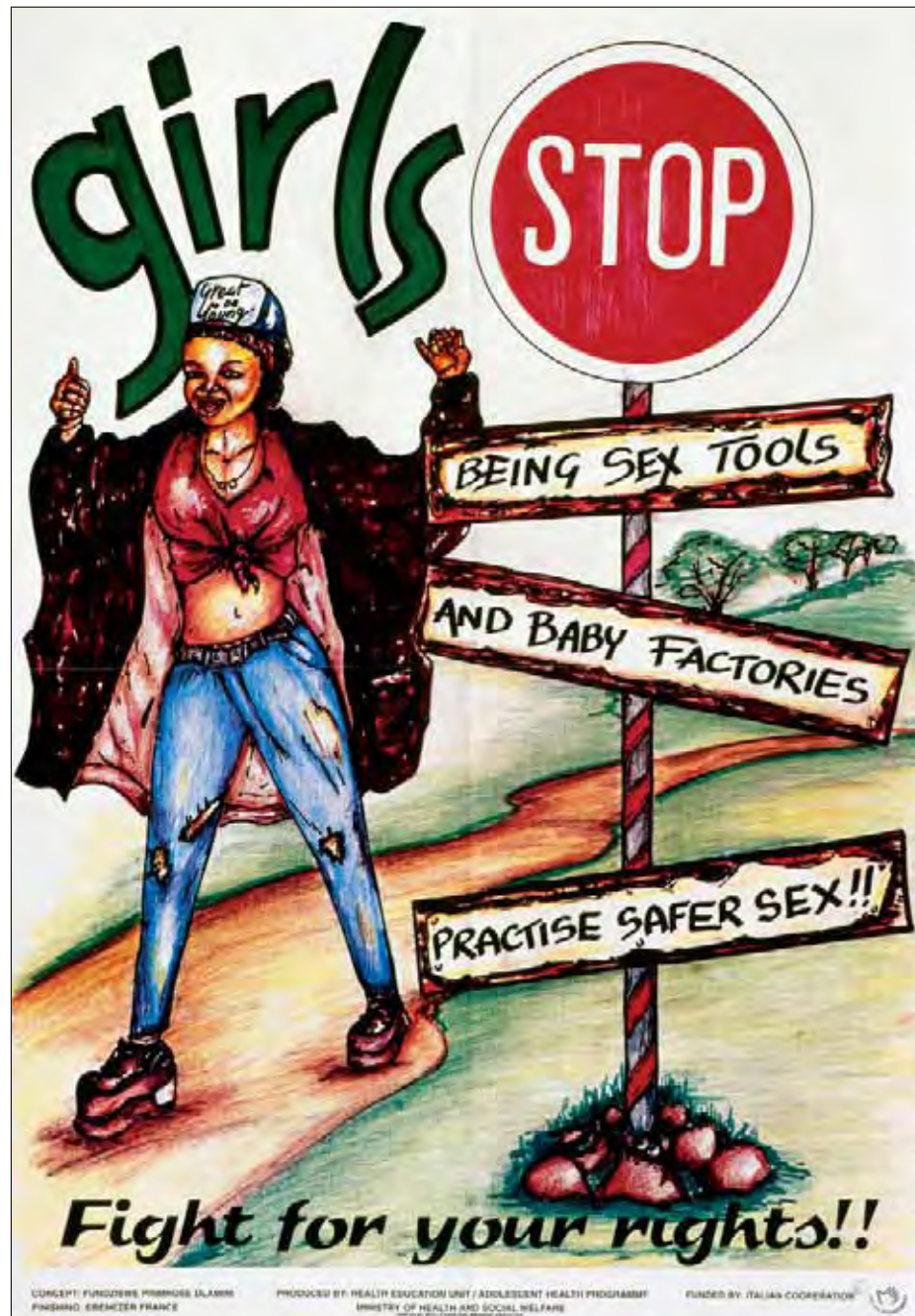


Zimbabwe, 1998
I am not my disease

Design: Chaz Maviyane-Davies. Photography: Ian Murphy
Client: Aujourd'hui Pour Demain, Switzerland

Collection of the Massachusetts College of Art and Design, Boston

Campaigns count

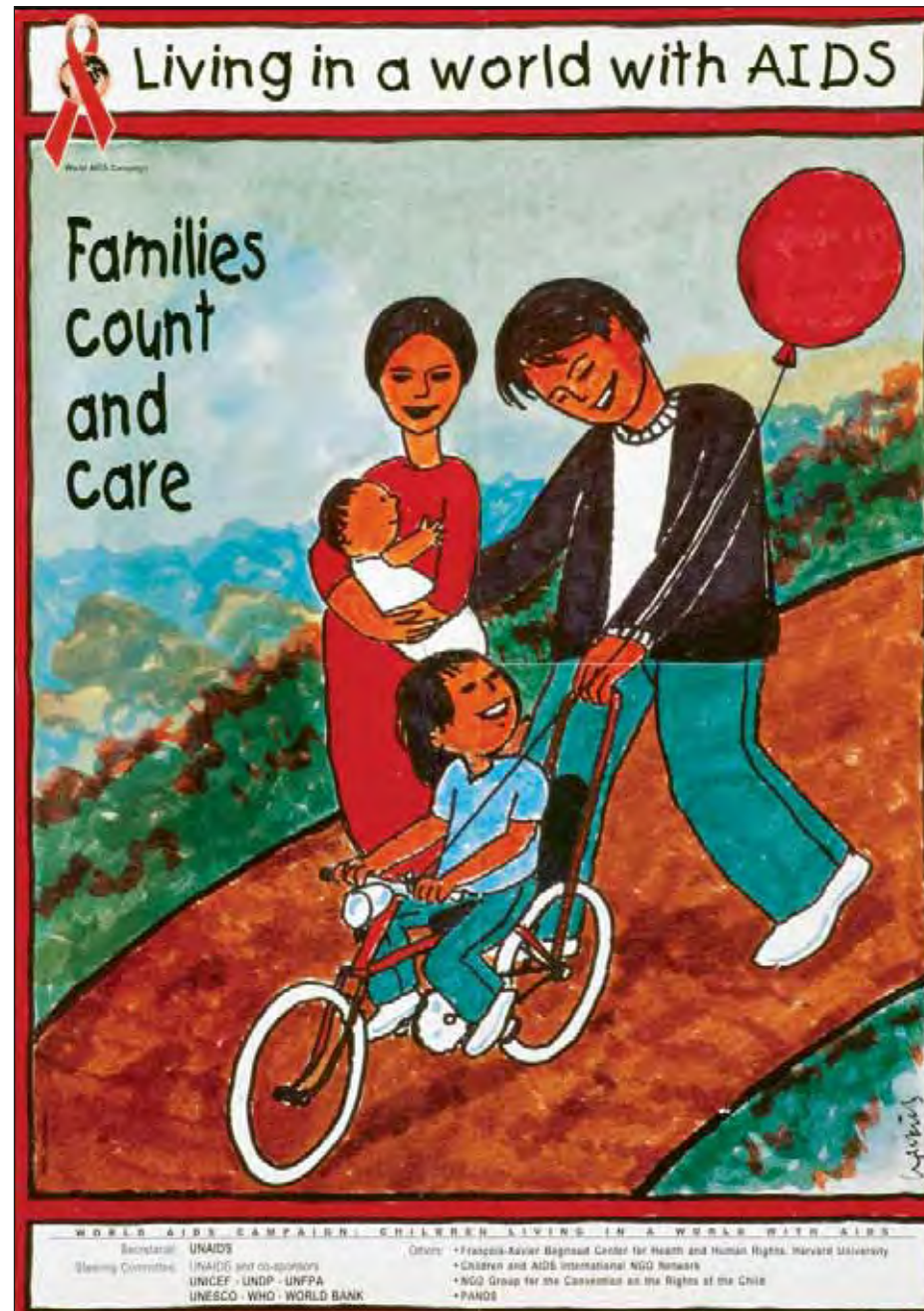


Swaziland, 2000

*Girls! Stop being sex tools and baby factories. Practise safer sex!!
Fight for your rights!!*

Design: Ministry of Health and Social Welfare, Health Education Unit

Museum für Gestaltung Zürich



Uganda, 2000

Living in a world with AIDS: families count and care

Design: Claudius Ceccon, UNAIDS

Museum für Gestaltung Zürich

Campaigns count



Germany, 2005
AIDS ribbon

Design: Ivo Gadea, Deutsche AIDS-Hilfe e.V.

Collection of Jim Lapidés, International Poster Gallery, Boston



Portugal, 2009
Fight AIDS, not people with AIDS

Design: Sara Gama
Translation: Rita Ferreira

Collection of the Massachusetts College of Art and Design, Boston

Campaigns count

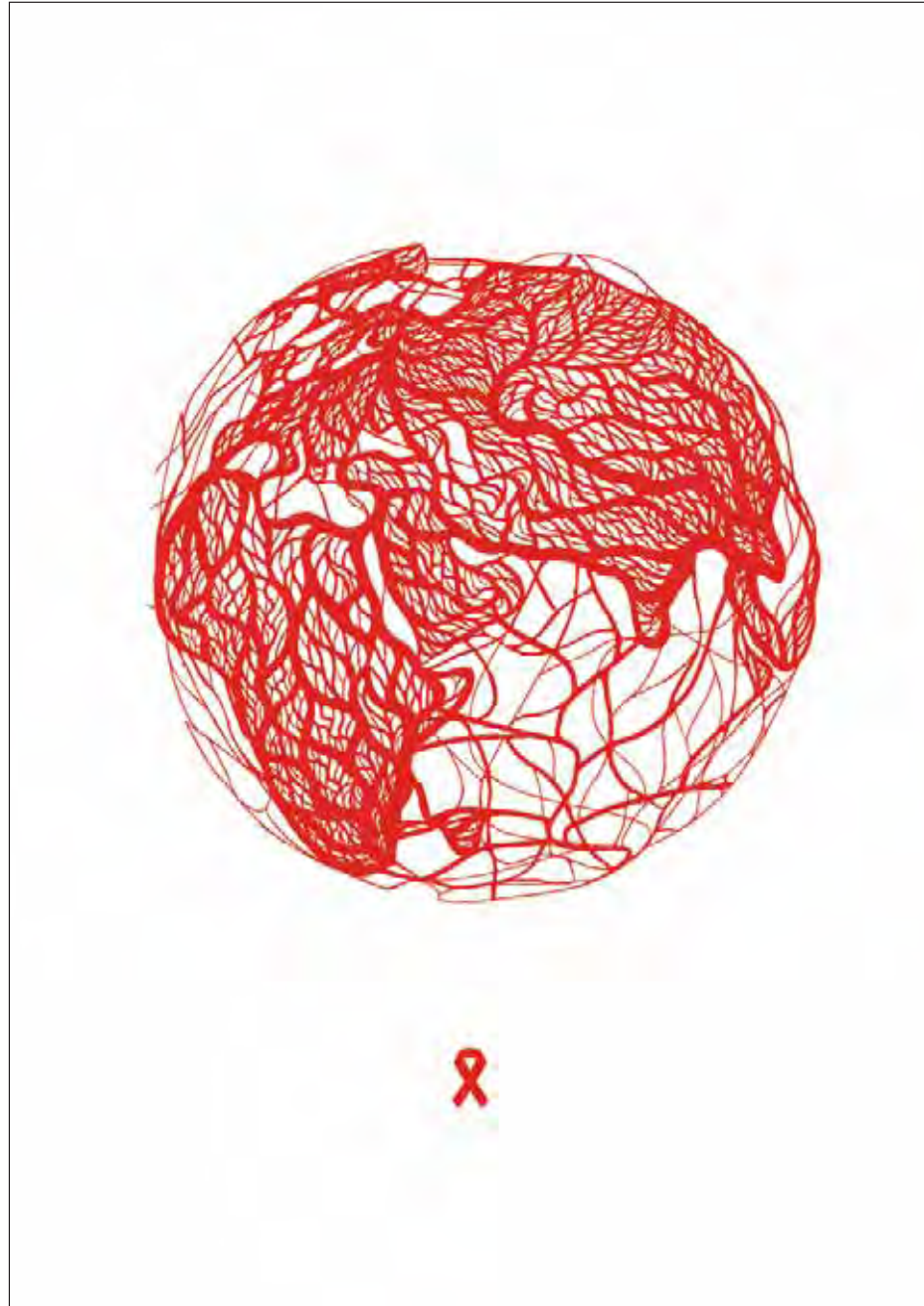


United Kingdom, 2009

Crime! Being HIV+ is not a criminal offense

Design: Selcuk Ozis

Collection of the Massachusetts College of Art and Design, Boston



Finland, 2010
Connected globally

Design: Pekka Piippo

Collection of the Massachusetts College of Art and Design, Boston

Campaigns count



Avram Finkelstein, an activist, author and graphic artist based in the United States.

The campaign the movement built

Avram Finkelstein, an activist, author and graphic artist based in the United States, shares details on the creation of the SILENCE = DEATH poster project—a well-known AIDS awareness campaign developed in the late 1980s that was rooted in the early days of the HIV epidemic in New York City.

Controversial in its visual composition and equally so in the tactics used to promote it, the SILENCE = DEATH poster project was the work of a collective composed of young artists, activists and concerned citizens who were personally affected by HIV. The project evolved from posters and stickers to buttons and T-shirts widely worn by people throughout the world. It helped identify and galvanize a movement for action on access to HIV prevention and treatment services. The poster continues to be used today as a symbol of AIDS activism.

Q&A with Avram Finkelstein

How did you get involved in the SILENCE = DEATH project, and what were your motivations for engaging in AIDS activism?

In 1981, my first boyfriend started showing signs of what was later identified as HIV infection, and in 1984 he died of AIDS. At that time, it was an impossible world to be in—no one was talking about HIV in the public sphere. It was a very lonely and isolated period. Many people were experiencing similar feelings and, eventually, I formed a collective with five of my friends. We tried to meet every week to talk about the personal challenges we were facing as well as the social and political aspects of the epidemic.

Through this collective, which later joined with other activists to form ACT UP (AIDS Coalition to Unleash Power), we felt that it was necessary to bring AIDS to the surface in the public sphere, and one of the best ways to do that at the time was through posters. It is important to understand that, in New York City, there is a long history of young people communicating through posters and other forms of street art. We drew on those strategies.

As for my motivations, I think every individual back in the early days of AIDS had a different set of answers as to why he or she got involved. I already had a history of social activism, and I realized quite early on that the AIDS crisis was political, highly layered and complex.

Can you share some of the steps in developing SILENCE = DEATH?

We knew we had to create a poster. Back then, you literally could not go anywhere in Manhattan without seeing advertising posters lining the city—you'd be in a taxi and see all kinds of posters zip by. With that environment in our minds, we agreed that the poster would have to be visible from a car and at the same time legible at the street level. We also realized it was no longer the 1960s, and because we were in a very politically conservative moment, people were no longer interested in standing on the street to read long paragraphs and manifestos. All these aspects influenced the poster.

As for the composition of the poster, it was intended to be heavily coded and cryptic. The pink triangle was targeted to the gay and lesbian audience, but we turned it upside down to distance the image from any implication of victimhood. This generated a lot of confusion and interest. The pure black background was meant to define the poster's space in the cluttered, urban environment,

but the colour and the typeface also had many similarities with fashion ads, which made it visually attractive and hip. And the fact that we placed the poster in high-traffic areas and alongside fashion and movie ads further raised its visibility. Finally, we consciously limited the amount of text on the poster. There was a short manifesto and, because we wanted to engage the audience, we asked various questions to the viewer such as “Why is the government silent about AIDS?” Then we called on people to turn anger, fear and grief into action.

Developing the SILENCE = DEATH poster took about six months. We posted the first one in early 1987, and a few weeks later we successfully saturated most of the city. Overall, there were people who were fairly confused by the poster and did not know how to approach it, but it caught their attention—and that was our initial objective, a consciousness-raising project. The activist community understood the poster right away, and the movement that sprung up around it helped clarify its meanings.

How do you think HIV awareness campaigns have changed over the past three decades?

HIV awareness campaigns evolved as the epidemic progressed, focusing on different messages surrounding public and personal responsibility. In the early 1990s in the United States, many campaigns sexualized and eroticized safer sex, basically to make HIV prevention attractive. Another important point to consider is that the concept of public health was a recent one in the United States when the AIDS crisis began. Our national health policies were barely 50 years old. In many ways, health was still considered a private issue and not a public one, so the challenge was to entice people, not scold them.

Would the SILENCE = DEATH visual and message work today?

This is a question I get asked a lot—but it is a good one. The short answer is yes. But allow me to share my overall thesis. It is now easy to see that the poster was at a watershed moment. The group that came together to form the message did so because of what we were experiencing.

But SILENCE = DEATH was not formed in a vacuum—it represented the reality of the time. HIV was not being discussed in the public sphere despite the fact that people were dying. The message then was about empowerment and action, and a community formed around the poster because people living with HIV and affected by the epidemic wanted radical change to take place. We were giving voice to that community.

The only main difference today would be the delivery of the message. No one puts posters up; you need portability and interactivity. Someone with a handheld device at a demonstration can get a message out worldwide without having to wait for the press to report on it.

Tweeting SILENCE = DEATH would work, but having a visceral encounter, an actual presence on the street, is still required to underscore that the community the image represents is physical, not virtual. We should not forget that the responsibility for people to take part in campaigns and to educate themselves is unchanged. As we have seen with recent developments in Egypt, I think we are resorting back to the power of ‘one voice’ to spur change.



United States, 1986

Silence = Death

Design: ACT UP

From the collection of Richard Deagle, ACT UP

06

Red ribbon

Twenty years on, the red ribbon has become the most widely recognized symbol of the AIDS movement.

A ribbon runs through it

How a strip of red fabric helped symbolize—and unite—the AIDS movement

When British actor Jeremy Irons stepped out into the spotlight at the 1991 Tony Awards (for achievement in live Broadway theatre) wearing a small red ribbon, little did he know that the piece of red fabric he introduced to the world that evening would go on to symbolize an entire movement.

An artists' collective based in New York City called Visual AIDS created the red ribbon—or AIDS awareness ribbon. The group's members designed the red ribbon as a symbol of solidarity to build public support for HIV and to demonstrate compassion for people living with HIV. To debut this newfound symbol to the world, the collective knew they needed a high-level event to help set the red ribbon off on a path towards eventual public acceptance.

Before the Tony Awards, Visual AIDS members approached many of the attendees and presenters to seek their support. At award time, thanks to the group's campaigning efforts, the ribbon was visible on a number of actors, including Mr Irons. At the next major awards event in the United States, this time the 1992 Academy Awards (Oscars), most celebrities were wearing a red ribbon.

According to the editor of *The Encyclopedia of AIDS*, Raymond A. Smith, the red ribbon only hit mainstream, international audiences at the tribute

concert for Freddie Mercury, lead vocalist and songwriter of the group Queen, who died from AIDS in late 1991. Less than a year after his death, more than 70 000 fans turned out at London's Wembley Stadium to honour Mr Mercury's life and raise money for HIV research.

“The who's who of the music world turned out for the concert wearing the red ribbon,” says Dr Smith, also Adjunct Assistant Professor at Columbia University in New York. “Paired with thousands of ribbons distributed to concertgoers, the symbol became quickly entrenched with the AIDS movement.”

Another powerful sign of the red ribbon's acceptance as the symbol for the AIDS movement, according to Dr Smith, was the United States Postal Service's issuing a 29-cent stamp in 1993 featuring a simple red ribbon with the text 'AIDS awareness'.

“In the United States, especially at that time, postage stamps were usually reserved for very major events or themes,” adds Dr Smith. “The dedicatory stamp was a real marker of the ribbon's significance.”

Why a red ribbon?

As to why Visual AIDS chose a red ribbon, Dr Smith believes the familiarity of the symbol, above and beyond anything else, was the main reason. “Long before it became associated with HIV, the red ribbon was used at county fairs to signal second place winners, as well as on Christmas trees and wreathes, so it was very easy for people to take on. The red ribbon wasn’t unique [to AIDS], but it did speak quickly to people.”

In contrast to the AIDS Memorial Quilt, an equally well-known AIDS symbol in the United States that emerged in the late 1980s and today has more than 44 000 individual memories of people who died from AIDS, Dr Smith argues that the red ribbon caught on because it was much more accessible, “The red ribbon, in its simplicity, enabled anyone with a piece of red fabric to show support. That made it very powerful.”

Accusations of kitsch and complacency

But as much as the red ribbon helped identify the AIDS movement, Dr Smith points out that some AIDS activists also viewed the symbol’s increasing proliferation as potentially having a downside as well. Critics, he points out, had two main arguments. First, the red ribbon became too commodified—mugs, bumper stickers, porcelain Christmas tree ornaments—and second, it morphed into a symbol of complacency.

“The statement ‘red ribbons are not enough’ emerged very early on,” says Dr Smith. “It was viewed that if people felt that by putting on a red ribbon they were really doing something, then it might actually be not really a positive thing but an example of a lack of commitment or serious engagement.”

A universal symbol

However, despite its critics, the red ribbon has been universally credited with helping unite and identify the AIDS movement, not just in the United States but throughout the world. Many institutions engaged in the AIDS response have adopted the red ribbon as part of their brand identity in some way, from national AIDS commissions and associations of people living with HIV to international organizations, including UNAIDS, which introduced a red ribbon logo when it was founded in 1996.

Thanks to the widespread acceptance and recognition of the ribbon as a way to mobilize the public on an issue, other health awareness initiatives, states Dr Smith, have benefited, such as breast cancer (pink ribbon) and Alzheimer’s disease (dark purple ribbon).

“People living with HIV have led the way in terms of patient advocacy and activism. The fact that other diseases have ribbons shows how AIDS activism has mobilized a generation of people around a range of diseases and has made them empowered in their own health care.”

As for the future of the red ribbon, Dr Smith believes it will continue to serve an important role in AIDS advocacy and awareness. “We live in a world that is full of corporate icons and images,” he says. “With the ribbon, it sort of reached this ubiquitous iconic status that I imagine will be with us as long as the AIDS epidemic is.”



On World AIDS Day in 1993, the United States Postal Service issued the AIDS awareness stamp featuring the red ribbon.

Red ribbon



The red ribbon reminds me of my commitment to fight HIV and AIDS.

The red ribbon means cooperation to me.

The red ribbon reminds me of hope and of the need to stand together to fight not only HIV and AIDS but discrimination too.

It's a symbol of solidarity.

The red ribbon for me means the blood of our mothers, our sisters, our brothers, our uncles, our aunts, our nephews, our grandfathers, our grandmothers, our neighbours, our business associates, our pastor, our priest, our vibrant politicians, our imam, our future leaders robbed from us by HIV, ultimately a constant reminder of the people we cherish who have been taken away or are alive on medication.

The red ribbon is the symbol of unity, courage and determination to get nearer to the zero infection target.

The red ribbon is a reminder of how extremely meaningful a life is. And it's also an encouragement to rekindle the spirit in fighting for life.

The red ribbon to me is a symbol of unity, strangeness within you and hope in coming to terms with your HIV status. Knowing that you have HIV, but you are not the disease. The strength and power to continue realizing that millions of people are still not receiving universal access to treatment, and that we cannot fade the hope we hold that people living are human and have the exact same right as every other human to live life to its fullest. The energy and symbol that we must continue our advocacy and reach the goals of UNGASS.

Finally, it is a time to celebrate my life as a person living with HIV, because I am living another day. Celebrate the lives of those we have lost to this disease and make sure that with each breath, we are speaking a message for those who were lost to HIV, and by placing the red ribbon on my jacket I am celebrating those lives.

For me this is a warning signal reminding me to be safe and stop any risky step in my life ... we like to live ... but life needs us without HIV.

To me the red ribbon means life, love and solidarity!

It is a universal sign of solidarity, care and love to people affected by and infected with HIV. It reminds me that there is still hope and that we can't stop hoping!

The red ribbon is a symbol of love, support and care for all of us who are affected by and infected with HIV.

The red colour is bold, it's sexy and it makes a statement. People who want to actively prevent the spread of HIV realize that spreading the word is all of the above. For those living with HIV, they are all these things, regardless of a checkmark on a blood test. Red is the colour of passion, and the red ribbon symbolizes a unique passion that drives the HIV cause in a way no other cause has ever been driven before.

The red ribbon reminds us that education will be the biggest factor in eradicating HIV.

07

Elements of the AIDS response

The world has adopted a bold vision: zero new HIV infections, zero discrimination and zero AIDS-related deaths. Achieving this means clearly understanding the elements that are required. When combined and used appropriately, these elements can accelerate progress. The search for new elements is ongoing.

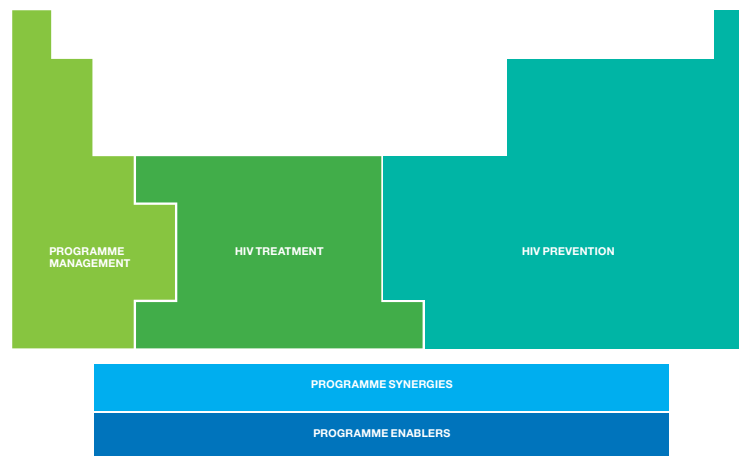
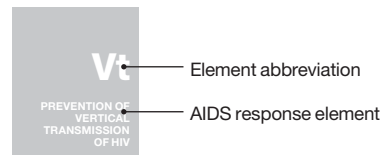
Elements of the AIDS response

The global AIDS response has evolved in the past 30 years. At the very beginning, the focus was on raising awareness of HIV prevention. There were few treatment options, and AIDS was seen as a death sentence. The HIV epidemic brought with it an epidemic of stigma and discrimination. Together, they spread across the world. Few countries were spared. The complexities of the epidemic began to emerge as surveillance activities began in earnest.

The world did not sit idly by either. Communities bonded together and began finding ways to stop the spread of HIV. Scientists discovered the cause and began to develop prevention and treatment methods to counter the virus. Governments were mobilized and civil society organizations began to provide care and support services. Private companies started to take steps to protect their workers.

Treatment options emerged, and AIDS is no longer invariably a fatal disease. New HIV infections among children can be stopped. Women living with HIV are staying healthy through pregnancy, delivery and during breastfeeding. TB and HIV programmes are increasingly integrated. New tools for HIV prevention are emerging and being tested. HIV programmes are no longer in isolation. Investments in AIDS programmes have increased substantially.

Periodic table key



Periodic table

Pc POLITICAL COMMITMENT			
Ci ENGAGEMENT OF CIVIL SOCIETY	Me MONITORING AND EVALUATION		
Ps PRIVATE SECTOR ENGAGEMENT	Sv HIV SURVEILLANCE		
Aa AIDS ACTIVISM	Sb BEHAVIOURAL SURVEILLANCE	Rd DOMESTIC RESOURCES	T2 TREATMENT 2.0
O 'THREE ONES' PRINCIPLES	Rm RISK-MAPPING	Rb BILATERAL ASSISTANCE	Cb CAPACITY BUILDING
Fb RELIGIOUS LEADERS' SUPPORT	MoT MODES OF TRANSMISSION	Rp PHILANTHROPY	Ts TECHNICAL SUPPORT
U COUNTRY OWNERSHIP	Rt RESOURCE TRACKING	Ri INTERNATIONAL ASSISTANCE	PI PROCUREMENT AND LOGISTICS
		Rhi HEALTH INSURANCE	Srh SEXUAL AND REPRODUCTIVE HEALTH
		Rpi PROGRAMME INCENTIVES	Hr PROTECTING HUMAN RIGHTS



08

An HIV prevention revolution

**If HIV infection can be prevented, why
did 2.6 million people become newly
infected with HIV in 2009?**

An HIV prevention revolution in the making

Thirty-three countries, some with the highest rates of HIV infection in the world, are now seeing a significant drop in the number of people newly infected. This decline has largely been attributed to behaviour change. People are adopting safer sexual practices and having fewer sexual partners, and young people are choosing to have sex later. Condom use is also rising—in Botswana, 80% of men used a condom at last high-risk sex.

So if HIV infection can be prevented, why did 2.6 million people become newly infected with HIV in 2009? Thirty years into the HIV epidemic, **OUTLOOK** explores some of the controversies in HIV prevention programming, talks to leading experts and sketches a way to accelerate the HIV prevention revolution already in the making.

Not yet at full speed

HIV prevention programmes have been put in place in almost all countries in the world. According to data from 106 low- and middle-income countries reporting AIDS spending, 22% of resources were spent on HIV prevention in 2009. Nevertheless, many national prevention efforts have not delivered the desired impact, are often deemed inadequate in scale and are accused of being poorly focused.

According to Laurie Garrett, Senior Fellow in Global Health at the Council on Foreign Relations in the United States, prevention has never been taken on in a consolidated and serious effort. “We have never really applied the full available HIV prevention toolkit in any place, and most

importantly, we have not seen very many countries exercising leadership from the top, saying that ‘this is our primary focus,’” says Dr Garrett.

Political leadership is often considered a key component of a successful response to HIV, but a certain type of leadership is required. Dr Garrett notes that, in countries in which leaders have been most outspoken on preventing HIV, they have also sometimes stigmatized key populations at higher risk and individuals living with HIV. This made the prevention effort seem punitive, according to Dr Garrett.

Since the epidemic began 30 years ago, HIV has carried heavy stigma. As the virus is primarily transmitted by sexual behaviour and drug use, the epidemic has forced countries to face up to how gender dynamics and sexual orientation shape vulnerability. An effective response also means empowering some of the most vulnerable and sometimes ostracized groups in society. This is not always politically palatable.

“One of the things that historically made it so difficult to deal with HIV is that many governments and people were in denial about HIV,” says Shalini Bharat, Professor at the School of Health Systems Studies at the Tata Institute of Social Sciences in India. “It has these links to sexuality and sexual behaviour, and with all the moral tones to it, it became very difficult to open it up for discussion.”

Indeed, 80% of HIV transmission is sexual, but fortunately, according to Dr Bharat, political leaders and nongovernmental organizations are no

**HIV PREVENTION REVOLUTION:
VISION AND GOALS**

**UNAIDS VISION:
ZERO NEW HIV INFECTIONS**

**TO FULFIL THIS VISION, THE FOLLOWING GOALS FOR
2015 HAVE BEEN SET.**

**HALVED SEXUAL TRANSMISSION OF HIV, INCLUDING
AMONG YOUNG PEOPLE AND MEN WHO HAVE SEX
WITH MEN, AND TRANSMISSION IN THE CONTEXT OF
SEX WORK**

ELIMINATED VERTICAL TRANSMISSION OF HIV

HALVED AIDS-RELATED MATERNAL MORTALITY

**ELIMINATED ALL NEW HIV INFECTIONS AMONG
PEOPLE WHO USE DRUGS**

longer in denial mode. More worrisome, she says, is that the general public sometimes still is.

Carlos Cáceres, Professor at the School of Public Health and Administration at the Cayetano Heredia University in Peru, sees another barrier to the slow uptake of HIV prevention. “Prevention has been complicated by the contrasting views of a large number of donors,” says Dr Cáceres. “A challenge is to harmonize a view of prevention given the diminishing resources and to implement a single plan that meets the criteria set up for a ‘prevention revolution.’”

Key to success in HIV prevention, according to Dr Cáceres, is to have adequate knowledge of the epidemic and the response. This approach, Dr Cáceres says, avoids duplicating what others have done, particularly if it has not worked.

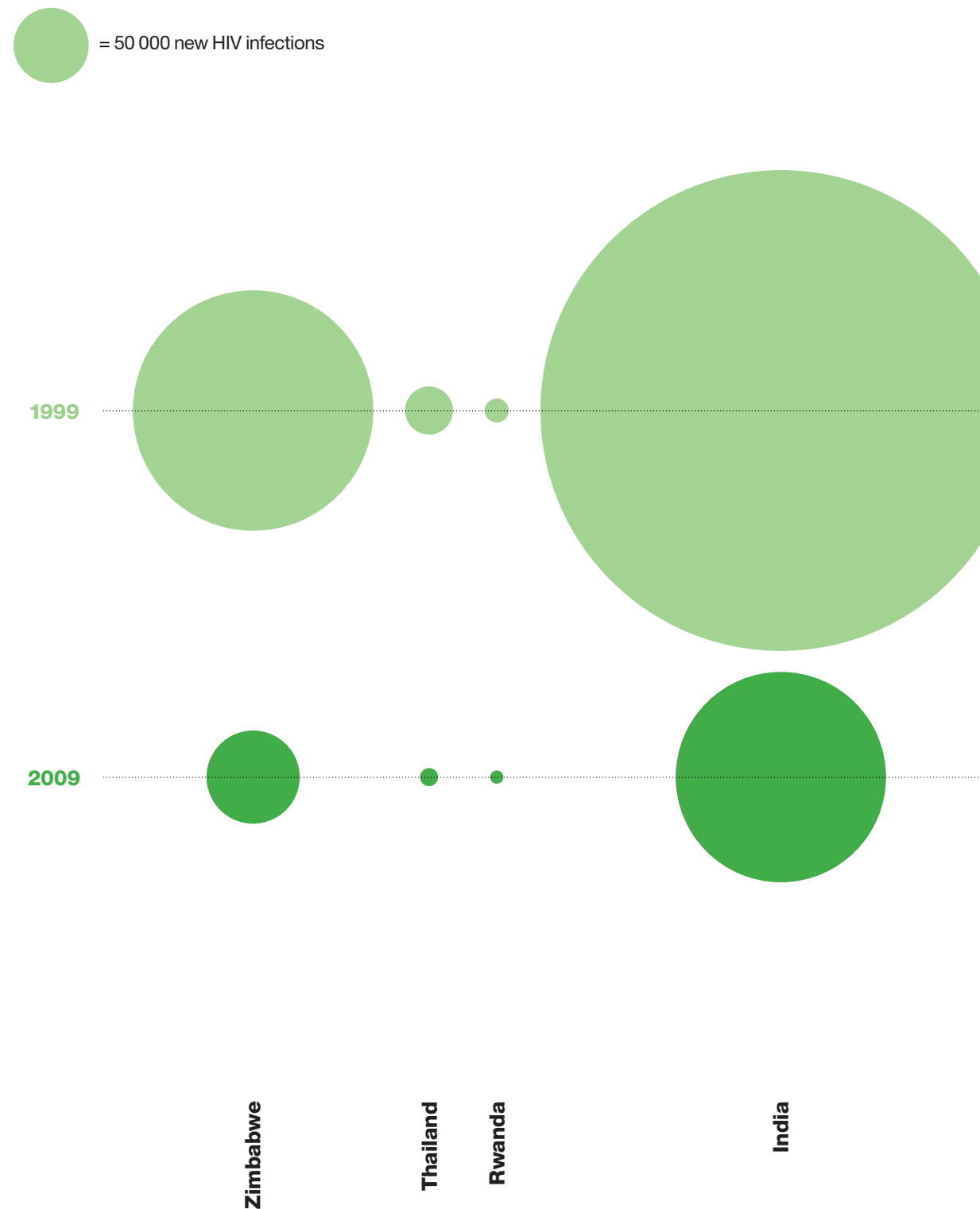
Local knowledge of the epidemic and the response

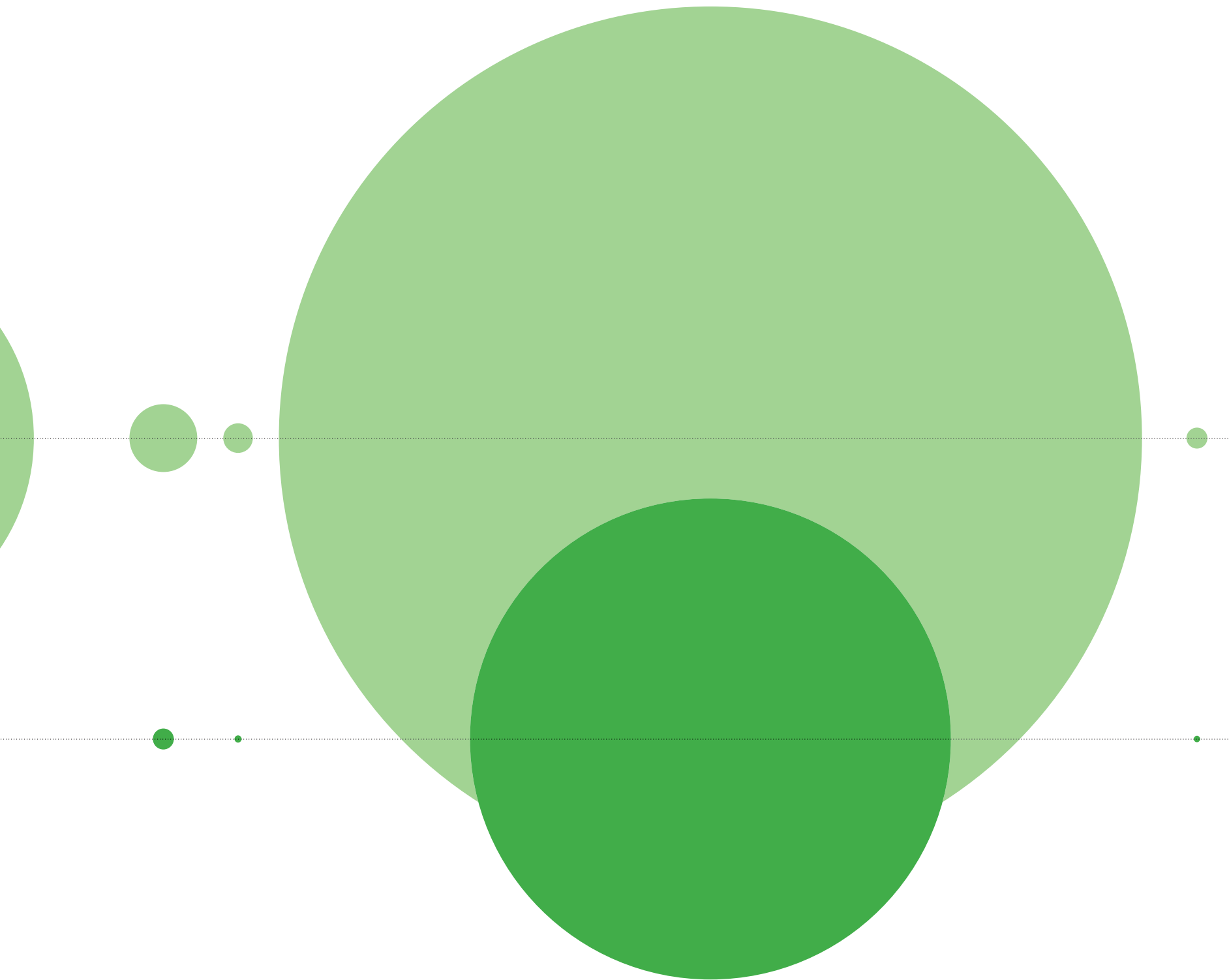
To achieve this, UNAIDS and partners promote an approach called ‘know your epidemic, know your response’. The basic principle is that all countries need to know which sections of the population are becoming newly infected with HIV, what HIV prevention activities are under way, and how many people access these services. With this information, the two can be aligned to ensure that the key populations at higher risk are also the people reached with HIV prevention programmes. This is not always the case.

Countries often fail to focus spending where it would have the greatest impact. According to a review of available evidence commissioned by the World Bank, some West African countries provide minimal resources towards HIV prevention programmes for sex workers, men who have sex with men and people who inject drugs. This is the case, even though the percentage of new infections among these key populations is more than ten times greater than that of the general population.

For example in Asia, 90% of resources for young people are spent on low-risk youth—representing just 5% of the people who become newly infected with HIV. Meanwhile, young men who have sex with men and young people who use drugs are left without access to services, according to the Commission on AIDS in Asia.

Estimated new HIV infections, comparing 1999 and 2009





Côte d'Ivoire

Namibia

South Africa

**Central
African
Republic**

“The ‘know your epidemic, know your response’ approach is very, very important. I see a lot of countries where the response is not based on sound evidence,” says Dr Bharat.

Many countries lack the data needed to effectively plan HIV prevention activities to reach the right people. “The ‘know your epidemic, know your response’ approach is very, very important. I see a lot of countries where the response is not based on sound evidence,” says Dr Bharat.

In sub-Saharan Africa, heterosexual sex is the main mode of HIV transmission. In Lesotho, for example, the HIV prevalence exceeds 15% in all districts, for both sexes and almost all age groups, according to the 2009 Demographic Health Survey. The only exception is among women 15–19 years old and men 15–24 years old where HIV prevalence is lower. In societies in which HIV has become so widespread, social and sexual norms need to be fully re-examined, and the whole community needs to be mobilized in the response.

In some countries, people in steady, long-term partnerships often have high rates of new HIV infection. A recent study from 14 countries in sub-Saharan Africa showed that, in stable heterosexual relationships in which one partner is living with HIV and the other is HIV-negative, the woman is living with HIV in 47% of cases. This shows that women are nearly as likely as men to be the person living with HIV in a serodiscordant couple, challenging the stereotypical view that men more often bring HIV into the relationship.

New HIV prevention frontiers

Given that more than 7000 people globally acquired HIV infection every day in 2009, the sense of urgency in the need for an HIV prevention revolution is not misplaced. Hope is increasingly being placed on recent promising developments within new prevention technologies. According to Seth Berkley, President and Chief Executive Officer of the International AIDS Vaccine Initiative, the next few years will be critical to improving new prevention technologies that show potential.

In 2009, an HIV vaccine was found to be 31% effective. Although the degree of effectiveness was relatively low, the results represent the first demonstration that a vaccine has a protective effect in preventing HIV infection among adults. This exciting progress was followed by the results of the Caprisa 004 microbicide study in July 2010, which showed a 39% reduction in the risk of acquiring

HIV infection. Further, the iPrEx initiative showed that oral pre-exposure prophylaxis was 44% effective in reducing the risk of HIV infection in men who have sex with men.

Dr Berkley is optimistic that new prevention technologies hold the key to stopping the HIV epidemic, although he feels that nothing short of an HIV vaccine will end it. “We need to fully invest in developing new health technologies for HIV prevention. All three [of the above technologies] have shown proof of concept in humans,” says Dr Berkley.

Perhaps surprisingly, another major shift in the universe of HIV prevention is HIV treatment. Treatment is already being used as one of the key pillars to reduce mother-to-child transmission of HIV and as post-exposure prophylaxis. Attention is now turning to maximizing the prevention effect resulting from the low levels of the virus in the body fluids of people living with HIV who are receiving treatment. This combined treatment and prevention approach holds potential to reduce the onward transmission of HIV on both the individual and population levels.

But even the most ardent treatment advocates are still sceptical that it is possible to ‘treat our way out of the epidemic’. The best bet, according to Dr Garrett, is still a combination approach integrating technological and social tools. Dr Bharat optimistically adds that behavioural approaches are required to achieve broader understanding and even for new prevention technologies to work. “Once these new technologies are available, how do you make them acceptable in the communities?” Dr Bharat asks.

From prevalence to incidence

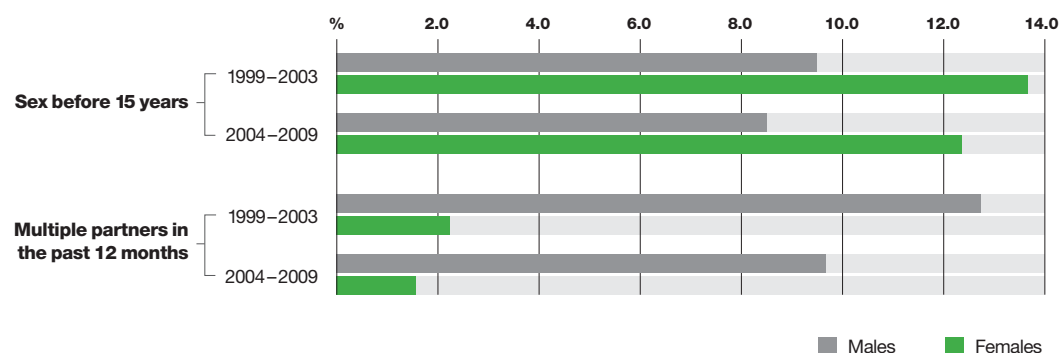
More effective responses require more precise information. Prevalence measures have been the mainstay of HIV reporting, but prevalence only says something about how many people are living with HIV at a given time in a given area. Incidence, in contrast, measures how many people become newly infected in a given period in an area.

For example, in Peru, the HIV prevalence was 0.4% in 2009, with 75 000 people living with HIV in the country. However, the number of people

Young people and sexual risk

People aged 15–25 years who had sex before age 15 years and who had multiple partners in the past 12 months

Source: Demographic and Health Surveys and United Nations Population Statistics.



newly infected was estimated to be between 1000 and 1600 in the same year.

“Twenty years ago, prevalence was a reasonable measurement of success or failure because we didn’t have any treatment to keep people alive,” says Dr Garrett. “But now we do, and thankfully millions of people are getting that treatment. What that means is that our prevalence measure is becoming less and less useful; it’s telling us how many people are alive, but it’s not telling us what kinds of new HIV infections are occurring.”

Dr Garrett explains, “If incidence measurement is done very well, you can also determine in what sort of population groups and what parts of the country new infections are occurring so that national leaders have a snapshot view every few months of what is going on with their epidemic, why certain people are getting infected, where the new infections are occurring and where therefore they need to target scarce resources for HIV prevention.”

Dr Bharat believes that this is where the scientific community should focus its efforts, “We need to be very concerned about among which populations new infections are appearing, which means we have to understand what continues to make people vulnerable.”

An HIV prevention revolution: the way ahead

“Political leadership is key. Unless heads of state, ministers of finance and all sectors of societies outside the traditional health arena take

prevention of HIV very, very seriously, then it’s hopeless,” says Dr Garrett. Adding to this, Dr Bharat argues that a prevention revolution also needs to transform the unequal gender norms and structural factors that put people at risk.

For an HIV prevention revolution to come about, Dr Cáceres says that HIV prevention efforts need to be based on adequate knowledge of each epidemic and the response and to combine biomedical, behavioural and structural approaches, with one eye on cost-effectiveness and the other on the relationship between prevention and treatment.

There have been some remarkable successes in HIV prevention. The number of people newly infected with HIV is clearly dropping for the first time as a result of changes in behaviour in many of the countries that have had the highest levels of people acquiring HIV infection historically.

HIV prevention works when young people are empowered to act on information and access services, when men and women have access to and choose to use condoms and when countries and communities are mobilized to invest in effective and comprehensive evidence-informed programmes around sex work and drug use. This is the goal of the HIV prevention revolution already in the making and what is needed to achieve zero new HIV infections.

09

A typology

Classification always carries a risk of oversimplifying and stereotyping. Nevertheless, finding recognizable categories is part of human nature.

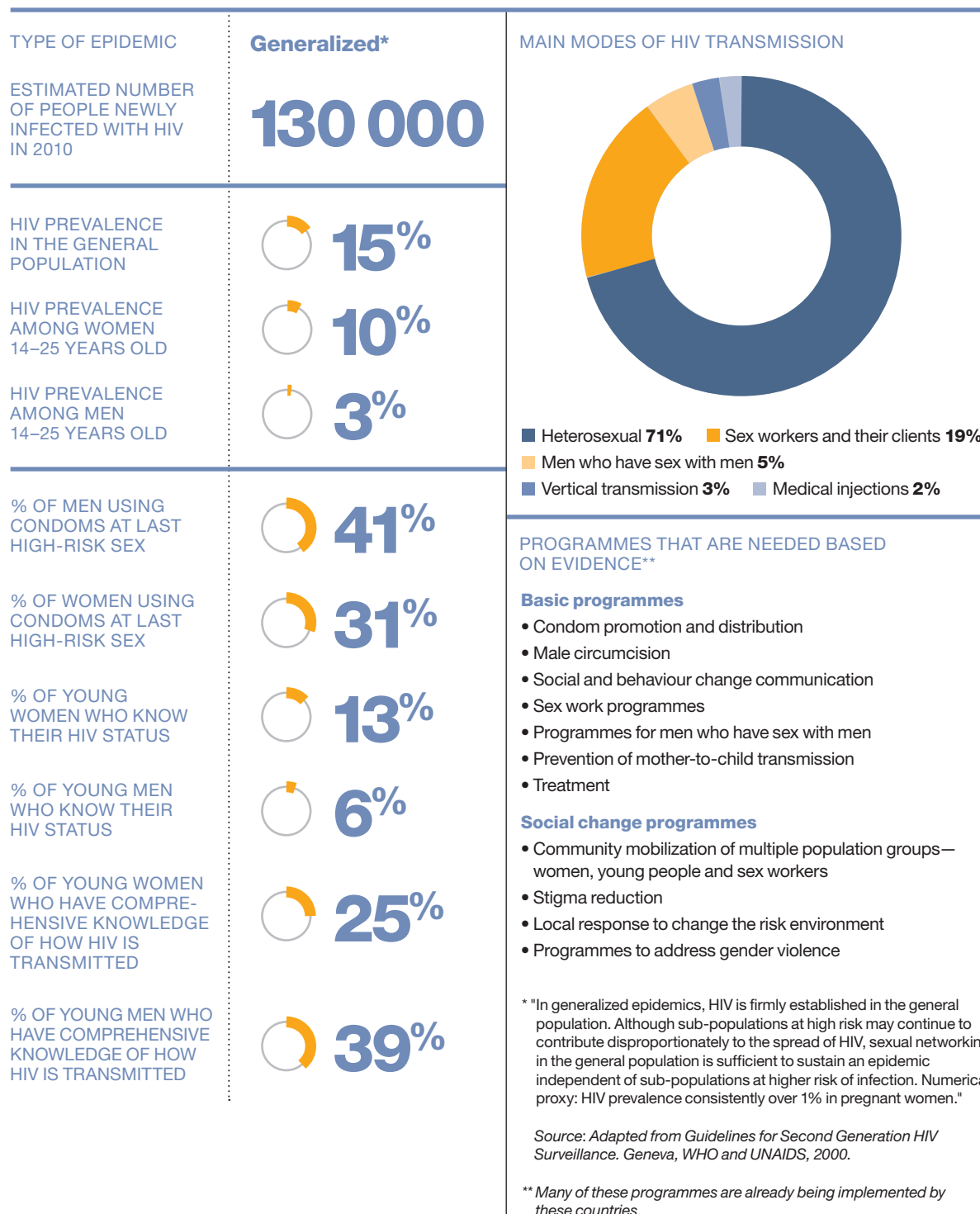
In relation to HIV, a clear understanding is needed of who may be at higher risk of acquiring HIV in any given country. However, this should never lead to generalizations.

A typology

The global AIDS epidemic is not a single homogeneous HIV epidemic—each country is different. In some countries, HIV is mainly transmitted through people using contaminated drug-injection equipment; in others, HIV is transmitted during unprotected heterosexual sex. In some countries, sex workers and their clients comprise most people newly infected with HIV. Even within a country there may be regional differences or differences between rural and urban areas.

To illustrate the diversity of the AIDS epidemic, two scenarios are compared: one concentrated in populations at higher risk and the other in a country with a generalized HIV epidemic.

Mozambique



Ukraine

TYPE OF EPIDEMIC	Concentrated*	MAIN MODES OF HIV TRANSMISSION
REPORTED NUMBER OF PEOPLE NEWLY INFECTED WITH HIV IN 2009	19 840	<p>■ Heterosexual sexual transmission, including sex workers 44% ■ Injecting drug use 36% ■ Other 20%</p>
HIV PREVALENCE IN THE GENERAL POPULATION	1%	<p>PROGRAMMES THAT ARE NEEDED BASED ON EVIDENCE**</p> <p>Basic programmes</p> <ul style="list-style-type: none"> • Condom promotion and distribution to key populations at higher risk • Sex work programmes • Programmes for men who have sex with men • Harm reduction, including sterile needle–syringe programmes and opioid substitution therapy • Prison programmes • Treatment <p>Social change programmes</p> <ul style="list-style-type: none"> • Community mobilization of people who use drugs • Stigma reduction • Local response to change the risk environment <p>* "HIV has spread rapidly in a defined sub-population, but is not well established in the general population. The epidemic state suggests active networks of risk within the sub-population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub-populations and the general population. Numerical proxy: HIV prevalence consistently over 5% in at least one defined sub-population. HIV prevalence below 1% in pregnant women in urban areas."</p> <p>Source: Adapted from <i>Guidelines for Second Generation HIV Surveillance</i>. Geneva, WHO and UNAIDS, 2000.</p> <p>** Many of these programmes are already being implemented by these countries.</p>
HIV PREVALENCE AMONG PEOPLE WHO INJECT DRUGS	30%	
HIV PREVALENCE AMONG THE INCARCERATED POPULATION	6%	
HIV PREVALENCE AMONG MEN WHO HAVE SEX WITH MEN	9%	
HIV PREVALENCE AMONG FEMALE SEX WORKERS	4%	
% OF FEMALE SEX WORKERS USED CONDOMS AT LAST SEX	80%	
% OF MEN WHO HAVE SEX WITH MEN USED A CONDOM AT LAST SEX	64%	
% OF PEOPLE WHO INJECT DRUGS REACHED WITH HIV PREVENTION PROGRAMMES	32%	
% OF SEX WORKERS KNOW THEIR HIV STATUS	46%	
% OF MEN WHO HAVE SEX WITH MEN KNOW THEIR HIV STATUS	43%	
% OF PEOPLE WHO INJECT DRUGS HAVE KNOWLEDGE OF HOW TO PREVENT HIV INFECTION	55%	

10

Treatment through time

HIV treatment gains have been hard won from day one. It is not surprising that a virus as complex as HIV would require an equally complex plan of action for treatment.

Through the years, efforts have been made to simplify HIV treatment and bring down costs so that even more people can have access.

Treatment through time

The progress made in providing access to treatment for people living with HIV might be unprecedented in global public health history.

The following timeline shows how 6.6 million people are accessing live-saving antiretroviral therapy today, thanks to the leadership and commitment of governments, civil society organizations and, above all, exceptional individuals.

1987 A new treatment emerges that is hailed as the first significant step in responding to HIV. The United States Food and Drug Administration approves zidovudine (AZT), the first nucleoside reverse-transcriptase inhibitor to be used in preventing HIV replication among people living with HIV.

1993 Scientists and people living with HIV express concern when the Concorde Study in France, Ireland and the United Kingdom does not demonstrate any delay in progression to AIDS for asymptomatic people living with HIV given zidovudine as a single drug. Debates continue about the efficacy of zidovudine.

1996 At the XI International AIDS Conference in Vancouver, Canada, researchers announce new developments in HIV treatment with the launch of protease inhibitors for routine clinical care. A cocktail of three antiretroviral drugs taken in combination not only reduces viral load much more effectively than any one drug but also promises to prevent the development of resistance, which emerges rapidly among people treated with single drug therapy.

These new therapies give people living with HIV and scientists new hope of eliminating HIV infection. However, a year later scientists find that HIV ‘hides’ in reservoirs in the body, making the virus impossible to totally eliminate with current therapies, highlighting that AIDS would remain a chronic disease, at best.

In high-income countries, rapid uptake of antiretroviral therapy gives rise to the Lazarus syndrome, with treatment almost miraculously restoring the health of many people with AIDS. But at a cost of up to US\$ 20 000 per person per year, large populations outside the high-income countries cannot feasibly start and stay on these drugs.

In November, Brazil’s President signs Federal Law 9313, which requires the federal government to provide free HIV medication through the public health system to everyone who needs it. Human rights arguments provide an important rationale for enacting the legislation.

In late 1996, data from AIDS Clinical Trials Group study 076 (ACTG 076) clearly show that using zidovudine during pregnancy and at the time of delivery drastically reduces the transmission of HIV from mother to child. These findings lead to protocols that today drastically reduce vertical HIV transmission.

1997 France’s President Jacques Chirac becomes the first major leader to highlight the divide in access to treatment. Speaking at the X International Conference on STD and AIDS in Africa in Abidjan, Côte d’Ivoire, in December, President Chirac states that, “We have no right to accept that there should now be two ways of fighting AIDS: treating sufferers in the developed countries, and simply preventing infection in the South. ... We must do all in our power to ensure that the benefit of the new treatments is extended to deprived populations in Africa and elsewhere in the world.”

Also in December, UNAIDS launches the HIV Drug Access Initiative in Uganda and Côte d'Ivoire, representing the first introduction of antiretroviral therapy in sub-Saharan Africa. The first people receive treatment in Uganda and Côte d'Ivoire in early 1998 and in Chile later that year.

The HIV Drug Access Initiative is a milestone towards the now well-accepted principle of differential pricing for medicines for low- and middle-income countries at a time when there were few generic suppliers of antiretroviral drugs.

1998 The Pharmaceutical Manufacturers Association of South Africa and 39 pharmaceutical companies file a lawsuit against the South African government over a law that would allow the country to import and manufacture cheaper generic HIV drugs. Nongovernmental organizations such as Oxfam, Médecins Sans Frontières and the recently created Treatment Action Campaign side with the South African government in an unprecedented joint global effort to demand affordable medicines to treat HIV. Due to the national and international pressure, the pharmaceutical industry drops the lawsuit on 19 April, allowing the Medicines Amendment Act to enter into force.

1999 Data from a trial that took place in Uganda between 1997 and 1999 reveal that a single dose of nevirapine given to the mother at the onset of labour and to the baby after delivery roughly halved the rate of HIV transmission. Since 2000, many thousands of babies in resource-poor countries have benefited from this simple intervention, which became the mainstay of many programmes for preventing the vertical transmission of HIV until more effective regimens were introduced in later years.

2000 In January, the United Nations Security Council takes up a health issue for the first time. Six months later, the Security Council passes Resolution 1308, which emphasized the threat to security

posed by AIDS and drew attention to the need for treatment in the specific case of military personnel 'where appropriate'.

UNAIDS and WHO announce in March a joint agreement with five pharmaceutical companies to reduce the prices of antiretroviral drugs.

UNAIDS launches the Accelerating Access Initiative in May in conjunction with pharmaceutical companies, WHO, the World Bank, UNICEF and UNFPA. This initiative stimulates the development of treatment access plans in 39 countries, all of which conclude individual pricing agreements with the companies. However, the roll-out of the initiative is slow and hindered by individual countries needing to negotiate prices and conditions.

The XIII International AIDS Conference in Durban in July, the first to be held in Africa, significantly accelerates global momentum to expand HIV treatment access. Although Brazil had been a pioneer among low- and medium-income countries in providing treatment as early as 1996, a worldwide movement for treatment access focusing on the needs of the world's poorest countries emerges as a major force at the Conference.

Hundreds of members of the Treatment Action Campaign, many of them living with HIV, march to the conference centre demanding access to antiretroviral drugs. The event marks another milestone in a worldwide activist movement in which people from around the world begin to assert their right to treatment.

In September, Lieve Fransen, HIV coordinator at the European Commission, calls representatives from ACT UP, Médecins Sans Frontières, generic manufacturers such as Cipla, and chief executives from the seven largest pharmaceutical companies to sit together with the heads of WHO and UNAIDS to agree on a tiered price agreement for patented drugs for the treatment of HIV, tuberculosis (TB) and malaria. At the meeting, the CEOs express their willingness to launch such a

Treatment through time

scheme. At the same meeting, Cipla announces that generic first-line antiretroviral drugs are available at US\$ 350 per person per year.

2001 The Ministerial Conference of the World Trade Organization (WTO) adopts the Doha Declaration on the TRIPS Agreement and Public Health on 14 November. It reaffirms the TRIPS flexibility that allows WTO Members to circumvent patent rights to manufacture generic drugs for HIV and other priority diseases. The Declaration confirms that the TRIPS agreement “does not and should not prevent Members from taking measures to protect public health” including “medicines for all.” Up until then, compulsory licences to produce patented products without the consent of the patent owner had been granted mainly to supply the domestic market. The 2001 Doha Ministerial Conference decides that countries unable to manufacture the pharmaceuticals may obtain cheaper copies elsewhere if necessary.

A presidential decree by Brazil’s President Fernando Henrique Cardoso declares access to HIV treatment a matter of public interest. The decree is the first step to allow the country to import and locally produce generic medicines. Brazil uses the decree to negotiate lower medicine prices with pharmaceutical companies.

In 2001, the United Nations Commission on Human Rights resolves that, in the AIDS epidemic, access to treatment is an essential component of full realization of the right to health.

The first United Nations General Assembly Special Session on AIDS takes place in June. United Nations Member States commit to scaling up a comprehensive response involving prevention, treatment, care and support. The Declaration of Commitment is the first internationally agreed, time-bound set of goals, based on agreed indicators of progress. On treatment, Member States commit to “... make every effort to: provide progressively and in a sustainable manner, the highest attainable

standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled antiretroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance ...”

Although the Declaration represents a substantial increase in worldwide commitment, its cautious language on treatment and the absence of a specific target still indicate concerns about the feasibility of expanding access.

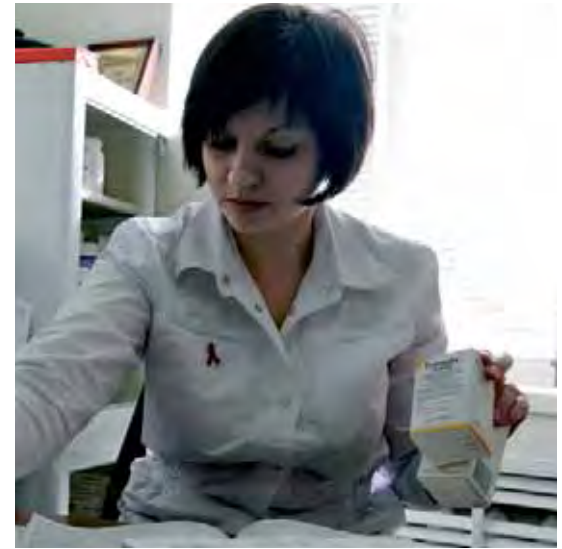
2002 The Global Fund to Fight AIDS, Tuberculosis and Malaria is launched.

Supported by the World Bank, WHO and UNICEF include antiretroviral drugs in a call for expressions of interest to manufacturers to supply HIV-related drugs to low- and middle-income countries. WHO also starts a prequalification programme to assess drug quality.

The prequalification of generic antiretroviral drugs by WHO, the creation of the Global Fund and the Global Fund’s decision to make generic antiretroviral drugs eligible for funding lead to increased market penetration of generic antiretroviral drugs and further price reductions from 2002 to the present.

WHO publishes the first edition of its guidelines for HIV treatment in resource-limited settings in March. These guidelines include simplified schemes for treatment and clinical diagnosis, including reduced requirements for laboratory support. These approaches are intended to facilitate wider access to large populations needing treatment in the poorest countries and recognize that the general health benefits for these populations would dramatically outweigh the risk of failure to detect and to correct for adverse reactions and treatment failure.

In April, WHO takes the important step of adding 10 antiretroviral drugs to its Model List of



Treatment through time

Essential Medicines, pointedly noting that “cost was not a factor in determining suitability of the drugs for the list.” Both the Model List of Essential Medicines, including antiretroviral drugs, and the WHO treatment guidelines are today well-accepted standards.

2003 **At the XVI International AIDS Conference** in Barcelona in July, WHO Director-General Gro Harlem Brundtland addresses several goals for the health sector that would go on to frame WHO’s work on HIV, stating, “We are aiming for 3 million people worldwide to be able to access [antiretroviral drugs] by 2005.”

In 2003, a breakthrough comes when fixed-dose combination therapies arrive, reducing the number of pills per day from 10–15 to as few as two. These medicines are easier for children and adults to take than multiple tablets with different schedules. This promotes adherence to HIV treatment and boosts outcomes.

In January, United States President George W. Bush announces that his government would contribute US\$ 15 billion to the worldwide AIDS response during the next five years, with treatment forming a major component of the initiative and explicit targets to “... prevent 7 million new HIV infections, treat at least 2 million people with life-extending drugs, and provide humane care for millions of people suffering from AIDS, and for children orphaned by AIDS.”

In December, WHO Director-General Lee Jong-wook officially launches the “3 by 5” Initiative to enable 3 million people living with HIV in low- and middle-income countries to receive antiretroviral therapy by the end of 2005.

2004 **The United States** Food and Drug Administration approves the first generic formulation of an HIV medication, which meant that money from the United States President’s Emergency Plan for AIDS Relief could now be used to buy the less expensive generic medicines.

Disbursement Round 4 of the Global Fund is launched in January 2004, receiving considerable technical input from WHO and other partners, and becomes the unofficial ‘treatment round.’ It leads to a near doubling of the number of people to be receiving treatment through Global Fund-supported programmes.

2005 **Medication advances continue**, but the long-term side effects of using HIV medication become more evident. Experts now agree that, given the currently available medicines, waiting to start treatment may be wise for many people living with HIV who have high CD4 counts.

Although the targets of the “3 by 5” Initiative were not fully met, without the Initiative, the numbers of people receiving treatment would not have tripled in just two years or increased eight-fold in Africa.

2006 **UNITAID** is launched to create an international drug purchase facility. Its mandate is to contribute to scaling up access to treatment for AIDS, malaria and TB in low-income countries by leveraging price reductions in high-quality drugs and diagnostics and accelerating the pace at which these are made available.

In November, the Thai government decides to issue a compulsory licence for the antiretroviral drug efavirenz. Although the patent owner, Merck, was already selling this drug at a reduced price, the government could offer it at half that price by producing generic versions of the drug. The government follows this by announcing in February 2007 that it would also break the patent on Kaletra® (lopinavir + zidovudine) and that more compulsory licences would follow.

2007 **In May**, Brazil announces the issuance of a compulsory licence to import a lower-cost version of Merck’s patented formulation of efavirenz, following Thailand’s decision five months earlier to break the patent for the same drug, along with others.

2008 **Coverage of antiretroviral therapy** and services to prevent mother-to-child transmission exceeds 40% for the first time.

2009 **An estimated 5.2 million people** in low- and middle-income countries are receiving life-saving HIV treatment. However, 10 million people still need treatment and do not have access.

2010 **WHO calls for earlier treatment** for people living with HIV, as evidence demonstrates better outcomes for people living with HIV even with higher CD4 counts. Starting antiretroviral therapy earlier boosts the immune system and reduces the risks of HIV-related death and disease. It also lowers the risk of HIV and TB transmission.

On 8 June, the UNTAID Executive Board decided to move forward with the new Medicines Patent Pool Foundation. The Foundation is expected to obtain its first licences within a year. A patent pool brings together the patent rights held by various owners such as universities, pharmaceutical companies or government institutions and makes them available on a non-exclusive basis. Through this mechanism, developers of pharmaceutical products could access a one-stop shop for patents. In return, producers pay a royalty to the patent holder. Such a pool could make it easier to produce new medicines that combine several pharmaceutical compounds patented by different companies into a single pill.

The Medicines Patent Pool could make newer medicines more affordable in low- and middle-income countries by opening up manufacture to different producers. Although some older medicines for the treatment of AIDS have become increasingly affordable, newer products are still very expensive. The need for affordable HIV treatment will become more urgent as increasing numbers of people living with HIV develop resistance to first-line therapy and need second-line treatments.

In November, UNAIDS and WHO welcome new research published by the iPrEx study team showing that an antiretroviral drug combination, taken daily as a prophylaxis, in conjunction with the use of condoms, could reduce the risk of HIV infection among HIV-negative men and transgender women who have sex with men.

UNAIDS and WHO present a new approach to simplify the way HIV treatment is currently provided and to scale up access to life-saving medicines. Treatment 2.0 could decrease the number of AIDS-related deaths drastically and also greatly reduce the number of people newly infected with HIV.

Treatment 2.0 is designed to maximize the efficiency and effectiveness of HIV treatment by focusing on five priorities: optimizing drug regimens, advancing point-of-care and other simplified platforms for diagnosis and monitoring, reducing costs, adapting delivery systems and mobilizing communities.

Modelling suggests that, compared with current treatment approaches, Treatment 2.0 could avert an additional 10 million deaths by 2025. In addition, the new approach could reduce the number of people acquiring HIV infection by up to 1 million annually if countries provide antiretroviral therapy to all people in need, following revised WHO treatment guidelines.

11
Faces of HIV

Young and old. Women and men. Rich and poor.

The 34 million people living with HIV are in every region of the world and from all walks of life: sports, politics, civil society, law and many more.

After 30 years, the AIDS epidemic has many faces.

Greg Louganis

Olympic champion diver
Malibu, California

For many people, Greg Louganis is the greatest diver the world has ever seen. He was only 16 and still inexperienced when he won his first Olympic medal—silver at the 1976 Montreal Games. Eight years later, he became the first man to win gold in both the platform and springboard diving events in more than half a century. Then in 1988, competing against divers half his age, Mr Louganis did what no one had ever done before. He won double gold medals for diving in two consecutive Olympics. More than 20 years later, he is still the only diver to have ever accomplished that feat.

His victory in 1988 was all the more sweet because it happened after the world watched in horror as Mr Louganis struck the board with his head in his ninth qualifying dive. Thirty-five minutes later, after receiving stitches, he resumed diving and the following day went on to win the gold.

But behind the successful champion was a very troubled man. In many ways the risky sport was his safe haven.

“It was easier for me to focus on diving. It was in many ways a blessing,” said Mr Louganis, who remembers a difficult childhood. He said that he even attempted suicide. When he was older, he coped with an abusive personal relationship.

Then, six months before the 1988 Olympics, Mr Louganis learned that he was living with HIV and began treatment right away.

“Back then, when you were diagnosed HIV positive, that was a death sentence,” said Mr Louganis. “It was scary. Every time I got a cold, I used to think ‘Oh my God, I’m going to die.’”

He retired from diving and threw himself into another passion—training dogs for agility competitions. He also took up other physical activities such as yoga.

In 1995, he made headlines again with his autobiography, *Breaking the Surface*, where he revealed that he was gay and HIV positive.

“I wanted my story to motivate the people living with HIV to be responsible and to understand that life isn’t over yet,” said Mr Louganis. “Some people don’t think that AIDS has touched their lives. A lot of people saw me at the Olympics and they were cheering for me. All those people cannot say that they have not been affected by AIDS.”

Recently, Mr Louganis captured the public eye, as he has returned to diving—this time as a coach in California. SoCal Divers has hired him to train athletes in diving and life skills. He says his experience in training dogs has helped.

“Training dogs teaches patience. You don’t train a Jack Russell terrier and not learn patience,” said Mr Louganis.

He plans to be a mentor to the USA Diving family to help get a United States team back on the Olympic podium in 2012.

His motto: “If you are reaching for the stars and don’t encounter a few clouds, you aren’t reaching high enough.”



Faces of HIV



Svetlana Izambaeva

Miss Positive

Kazan, Russian Federation

In 2005, Svetlana Izambaeva, a hairdresser, took home the top prize in a beauty pageant for women living with HIV. Until then, she had not revealed her HIV status to her clients or friends, but soon she says everyone was gossiping about the pageant. So Ms Izambaeva decided to go public. “I was very scared. I was frightened of phone calls,” she said. “Customers would say ‘You’ve been cutting my hair and you’ve got AIDS,’ I cried every night.”

But she persevered and created her own foundation, which advocates for the rights of people living with HIV and provides services to children, women and young people.

In 2009, Ms Izambaeva’s mother died, leaving her 10 year old brother Sasha an orphan. She and her husband tried to adopt him, but she was denied custody because of her HIV status and her

brother was placed in an orphanage. Ms Izambaeva filed a lawsuit, and thanks to her dogged determination and the help of other organizations, she won her case. Sasha now lives with her brother, her two children and her husband.

She said, “When I disclosed my HIV status, I walked into darkness. I didn’t know what would happen. I never thought of becoming a leader. I just wanted to see things through. Now I’ve learned that if you go to the end, others can follow.”

Tokugha Yeptomi

Doctor
Chennai, India

In November 1995, Tokugha Yeptomi was planning his wedding. He was the senior eye specialist at Naga Hospital in Kohima, Nagaland and had made a blood donation to help a relative at a hospital.

After a shopping trip for wedding clothes, he was told the marriage was off. The relative had told his fiancée's family that Dr Toku was HIV positive. Back in June, the hospital had informed his cousin of Dr Toku's HIV status, but Dr Toku says he was never informed.

The disclosure led to the cancellation of his wedding and to embarrassment and ostracism. Dr Toku left his hometown and started working at YRG CARE in Chennai, caring for people living with HIV.

He sued the hospital for breach of confidentiality, but the justices dismissed the case, saying that the potential bride had been 'saved' and that people living with HIV have no right to marry.

India's Supreme Court eventually overturned the decision that denied people living with HIV the right to marry.

Today, Dr Toku is married and has a new life around his advocacy work. He has devoted much of his time to educating health care professionals in South-East Asia on HIV management. He has also helped to start a matchmaking service for people living with HIV.

Dr Toku teaches prospective couples the lessons he learned the hard way, "I say looks, religion, caste and wealth don't mean anything. You just need to support each other."



Micaela Cyrina

Student
São Paulo, Brazil



Micaela Cyrina studies visual arts at Faculdade Santa Marcelina in São Paulo, Brazil.

She loves to share her passion with children in the community, giving them art lessons. “We teach art for life, to develop motor and social skills and to awaken an appreciation for art,” said Ms Cyrina.

For as long as she can remember, HIV has been a part of her life. After her parents died of AIDS-related diseases, she went to live in a shelter for children living with HIV at the age of six years.

“It was scary to be all by myself, but the other children gave me a lot of strength. I miss everybody a lot today. Some of them have died and others have gone a different way. Some people I still keep up with,” said Ms Cyrina.

She is active in a network of young people that tries to raise awareness of HIV prevention and treatment.

“Many women are not independent. They believe in romantic love and are ready to give themselves up,” said Ms Cyrina. “That kind of attitude can prevent people from using condoms. But I say our body is our greatest asset. We need to take care of it.”

Richard Berkowitz

Writer

New York, USA

Writer, AIDS activist and S & M hustler—Richard Berkowitz has championed safe sex in each of these ways.

He has also been living with HIV for more than 25 years. Mr Berkowitz was part of a group of gay men living with HIV who drafted a manifesto for people living with HIV called the *Denver Principles*. This historic 17-point statement outlines the rights and responsibilities of people living with HIV.

It begins: “We condemn attempts to label us as ‘victims,’ a term which implies defeat, and we are only occasionally ‘patients,’ a term which implies passivity, helplessness and dependence upon the care of others. We are ‘people with AIDS.’”

The activists presented the manifesto at the close of the Fifth National Lesbian/Gay Health Conference in Denver, Colorado in 1983, marking the first time people living with HIV declared their right to participate in decision-making at all levels.

Mr Berkowitz said, “The audience responded with a 10-minute ovation. At a time when all that

was asked of us was to lie down and die, we were gay men, people with AIDS, people with courage, dignity and pride.”

He says he is the last survivor of that band of AIDS pioneers.

In the early days of the epidemic, Mr Berkowitz along with Michael Callen, a singer, and in consultation with their doctor, Joseph Sonnabend, wrote a pamphlet *How to Have Sex in an Epidemic: One Approach*. It advocated using condoms and had other practical tips for reducing risk and is widely considered the first safe-sex guide.

“In these difficult economic times, more people are discovering what poor people have always known: sex is not only one of life’s greatest joys—it’s one almost everyone can afford. That makes the history of the invention of safe sex as timely as ever,” said Mr Berkowitz.



He Tiantian

Teacher

Guangxi Province, China



He Tiantian is a teacher who likes to paint and practice yoga. But only a few of her friends and family members know about another world that keeps her busy.

Five years ago, He Tiantian's life fell apart: she had surgery and found out that she was living with HIV. With that diagnosis began a life of shadows. She says she would sneak into the HIV clinic with her collar pulled up and a hat covering her face. "I felt like a criminal," said Ms Tiantian.

Thanks to the Internet, she learned that she was not alone. Ms Tiantian met other people living with HIV in online chat rooms. Slowly she emerged from her cave. "I realized it was very important for people living with HIV to communicate and help each other. So I started an organization called Dandelion, which provides psychological support for people living with HIV."

In 2009, Dandelion led a national network—the Women's Network against AIDS, which gives training to local women's groups and works with them to advocate for equal treatment.

Ms Tiantian has told her bosses that she is living with HIV, and they have been very caring and supportive. She says that she has not experienced discrimination in her daily life because she has only told a few people about her HIV status.

Her motto: "Life is just like riding a bike: the only way to avoid falling over is to keep going forward."

Chris Smith

House of Lords and Former Secretary of State
London, United Kingdom

Almost 30 years ago, a young politician in the United Kingdom made history. He addressed a political rally opposing a possible ban on gay employees with the following: “Good afternoon, I’m Chris Smith, I’m the Labour MP for Islington South and Finsbury and I’m gay.”

That was the first time that any Member of Parliament in the United Kingdom had openly stated his or her sexual orientation. Surprisingly, that disclosure was unplanned. Instead Lord Smith said he made a snap decision as he approached the podium.

The reaction was almost entirely positive, and Lord Smith went on to become Secretary of State for Culture, Media and Sport from 1997 to 2001.

In January 2005, he made another statement. He became the first Member of Parliament in the United Kingdom to say that he was living with HIV. This time, the revelation came after a long personal journey.

When Lord Smith was first diagnosed in 1988, he says he thought of it as a private matter, especially since his HIV status did not affect his job

performance. But he was prompted to change his opinion by Nelson Mandela, former President of South Africa, who called for more openness when he revealed that his son had died of AIDS-related causes.

Lord Smith said, “Getting HIV is not a bundle of fun, but I wanted people to know that you don’t have to shut up shop. If you take your medications you can lead a normal life. You can contribute to society.”



Edwin Cameron

Constitutional Court justice
Johannesburg, South Africa



Edwin Cameron has been described as the best legal mind of his generation in South Africa. He started out as a lawyer during the apartheid era, fighting forced removal, military conscription, unfair labour practices and censorship. In 1994, he was one of the first judges President Nelson Mandela appointed in the new democratic South Africa.

In 1999, he was in the running to serve in his country's highest tribunal, the Constitutional Court. Then he made a fateful decision. He told a stunned judicial commission, "I am living with AIDS."

With that statement, Justice Cameron became the first and, to this day, the only person in public office in South Africa to acknowledge having HIV. He was driven to speak out because of a brutal attack in a Durban township. A poor black woman was killed after she spoke about living with HIV on a local radio station.

"I thought if this woman, without any protection, living in a township, not behind a palisade like I do in my middle-class suburb, not with the income of a judge can speak out, I thought that I should do the same," said Justice Cameron.

He received a very different reaction to his statement. "I was greeted with this absolute flood of loving approbation from all over Africa. I got letters from all over the world, said Justice Cameron. "I got back to an office filled with flowers. It was a wonderful response."

But the revelation later put his legal career on hold. Although he was promoted to the Supreme Court of Appeal, he did not seek to win appointment to the Constitutional Court. Justice Cameron believed his chance of success was slim: not only had he publicly revealed that he was living with HIV, but he had also openly criticized President Thabo Mbeki for his views on AIDS. President Mbeki led the South African government from 1999 to 2008 and questioned the scientific evidence for the cause of AIDS through sexual transmission by HIV, refusing at first to make antiretroviral therapy available.

Shortly after President Mbeki left the government, Justice Cameron was promoted to justice of the Constitutional Court. Although his legal career is full of remarkable achievements, Justice Cameron is perhaps proudest of his contribution to the HIV movement in South Africa. His highly successful memoir *Witness to AIDS* recounts his personal experience with the disease.

"I have a very deep and long-standing personal stake in the epidemic and in wanting to get across a message that this is manageable," said Justice Cameron. "We don't need to have this extortionate degree of suffering and death. We really can do something practical about it."

Prudence Mabele

Activist

Pretoria, South Africa

Prudence Mabele was one of the first in South Africa to disclose that she was living with HIV. She was diagnosed in 1990 and went public in 1992. Her motivation was to break the silence and stigma surrounding HIV, and she wanted to set a precedent and encourage other women living with HIV to do the same.

Ms Mabele is the founder and executive director of Positive Women's Network (PWN), a nongovernmental organization that provides support and information to women living with HIV in South Africa. The organization's work spans from promoting gender equality and equity to educating on sexual and reproductive health to promoting women's rights.

"I decided to create PWN to educate positive women and give them the means to empower themselves and take control over their own lives, and support other women living with HIV," said Ms Mabele.

She often goes out to communities with outreach coordinators to speak to women about HIV prevention, gender-based violence, women's rights and health issues.

In her free time, Ms Mabele loves listening to jazz, especially from South Africa and the United States. Hugh Masekela, Jonas Gwangwa, Jimmy Dlodlu and Gloria Bosman—the list is endless. But she says she is a workaholic.

"One of the greatest satisfactions I get from my work is to see a woman taking steps toward knowing herself more, accepting her HIV status, learning about staying healthy and, ultimately, becoming a leader and an agent of change," said Ms Mabele.



12

Art and AIDS

**Art should be something that liberates
your soul, provokes the imagination and
encourages people to go further.**

Keith Haring

Keith Haring

Keith Haring (1958-90) was among the young artists, performers, and musicians whose work responded to urban street culture of the 1980s. When he arrived in New York City at the age of 19 to enroll in the School of Visual Arts, Mr Haring found an alternative art world thriving outside the gallery and museum system, in the downtown streets, the subways, and clubs.

Inspired by the graffiti artists whose marks covered the city's subway cars, Mr Haring began to draw in white chalk over the black paper used to cover vacant advertising panels on the subway platforms. Not only was Mr Haring able to reach a large and diverse audience with his subway drawings, but, eventually, the subway became, as Mr Haring said, a 'laboratory' for working out his ideas.

In 1982, Haring began exhibiting in galleries and museums around the world and participated in many diverse public projects, ranging from literacy campaigns to anti-AIDS initiatives. Building on earlier impulses to draw on everything from refrigerator doors to vinyl tarpaulins, Haring continued to use a variety of media in order to communicate essential themes such as birth, death, love and war.

Keith Haring died in New York in February 1990 of AIDS. Before his death, Mr Haring established a foundation in his name. The mission of the Keith Haring Foundation is to sustain, expand, and protect the legacy of Mr Haring, his art, and his ideals. The Foundation supports not-for-profit organizations that assist children, as well as organizations involved in education, research and care related to AIDS.



Keith Haring, circa 1980
Polaroid Self-portrait
Polaroid

Image courtesy of the Keith Haring Foundation

Art and AIDS



Keith Haring, 1986
Untitled
Marker on paper

Image courtesy of the Keith Haring Foundation



Keith Haring, 1987
Untitled
Silkscreen

Image courtesy of the Keith Haring Foundation

Art and AIDS



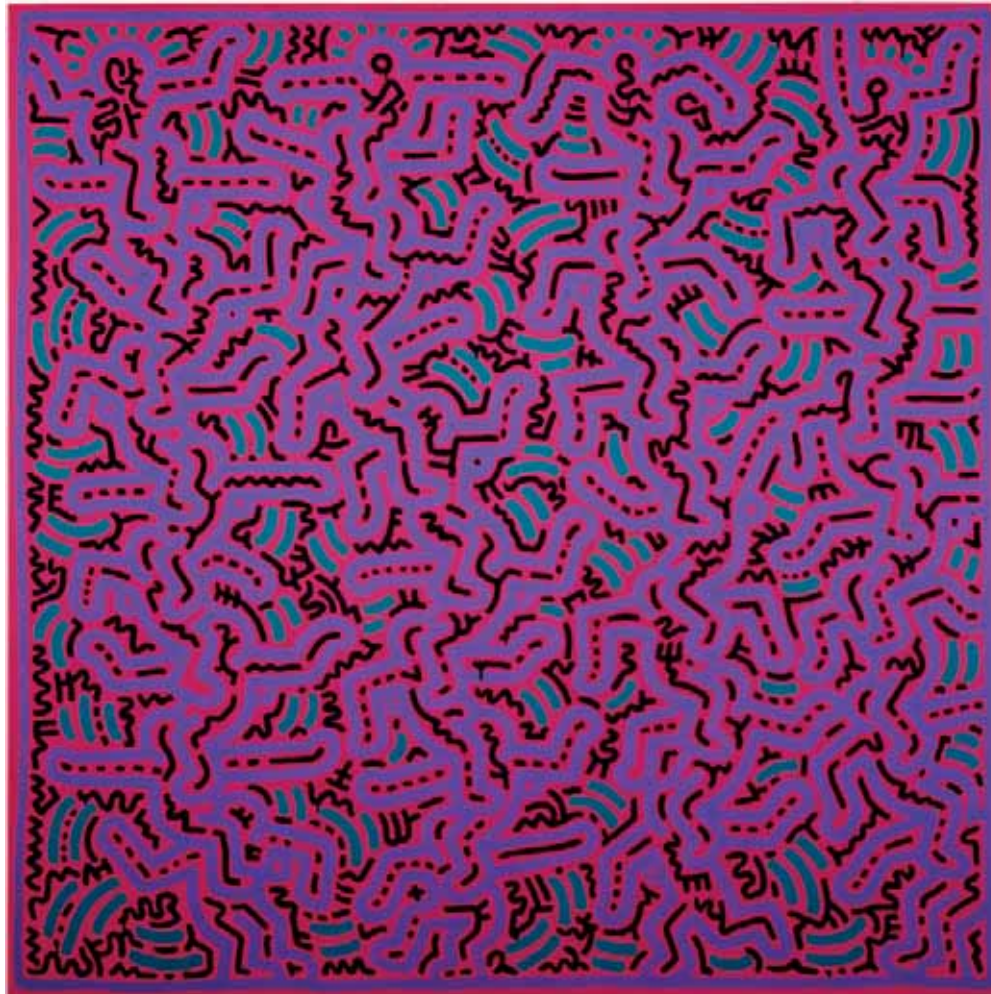
Keith Haring, 1982
Untitled
Acrylic on canvas

Image courtesy of the Keith Haring Foundation



Keith Haring, 1984
Untitled
Acrylic on foamcore

Image courtesy of the Keith Haring Foundation



Keith Haring, 1984
Untitled
Acrylic on canvas

Image courtesy of the Keith Haring Foundation



Keith Haring, 1989
Untitled
Acrylic on canvas

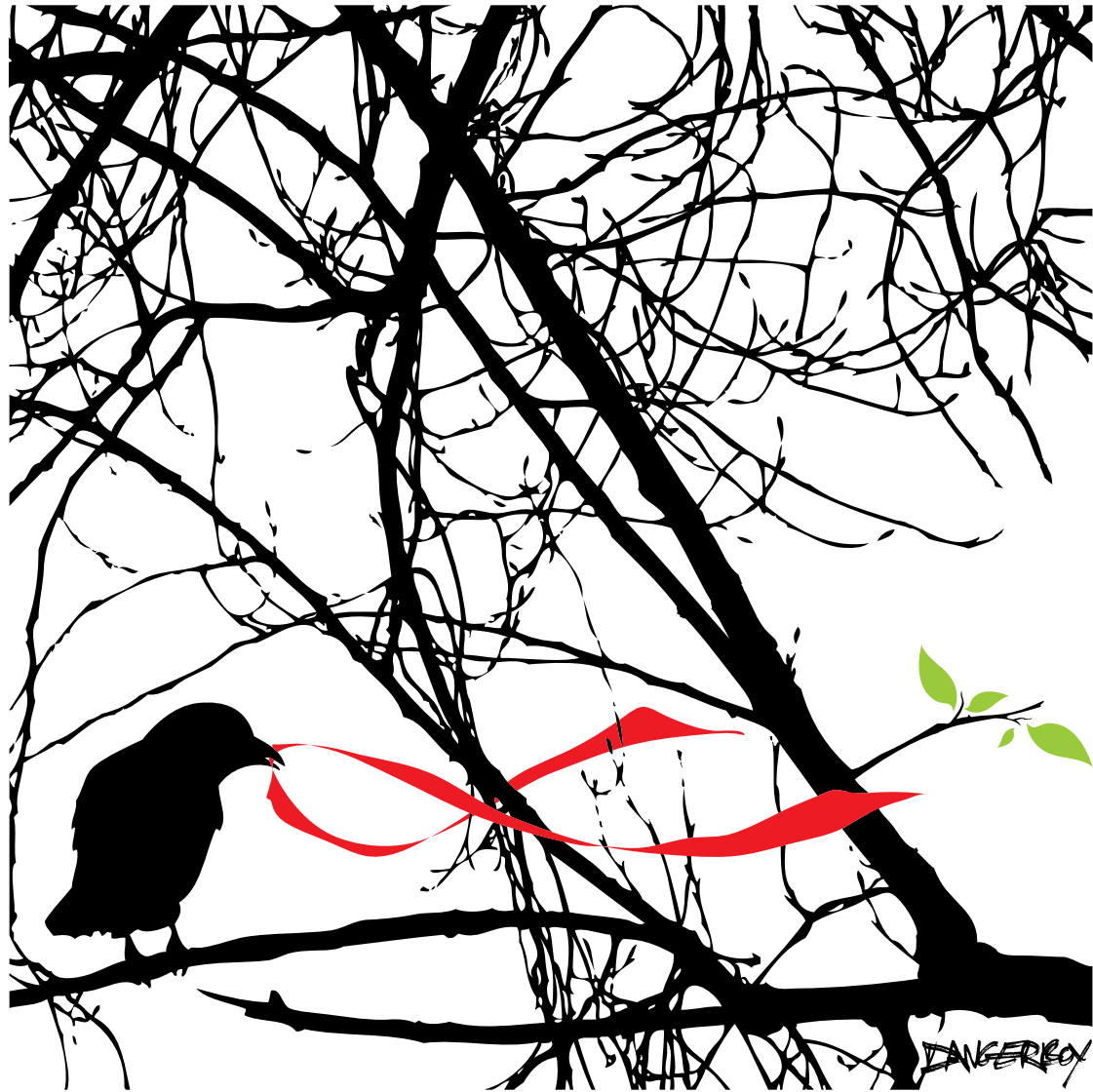
Image courtesy of the Keith Haring Foundation

The Nest

Morgan McConnell
British Columbia, Canada

Canadian graphic artist Morgan McConnell, who works under the pseudonym Danger Boy, created *The Nest* to represent the importance of keeping HIV awareness, research and education alive; “We need to give the next generation a chance to live without HIV and we need to remember what those before us fought and died for,” says the artist. His work won the 2008 AIDS Walk for Life design competition, a national campaign in Canada to raise awareness and money for national HIV programmes.

Image courtesy of the artist.



David and Carol

Art can come from a visceral place and often evokes a reaction to match. Independent art curator Carol Brown, based in Durban, South Africa, and David Gere, Director of the Art and Global Health Center at the University of California, Los Angeles in the United States, have collaborated on projects for nearly 10 years. Together they share their thoughts on art in the era of an AIDS epidemic.

Their conversation starts around the tiny village of Hamburg in the Eastern Cape province of South Africa. This hamlet gave rise to one of the most extraordinary artworks related to AIDS—the *Keiskamma Altarpiece*.

Carol: When I stumbled across the Altarpiece at the Grahamstown Arts Festival in 2006, I realized I had never seen anything like it before. It was absolutely amazing. Although I am South African, I had never even heard of the artists. A few of the 130 women who pieced and embroidered it were gathered around; they told me that it had been made in a rural village ravaged by AIDS. I was so emotionally affected by it that I immediately sent an e-mail to David in Los Angeles.

David: Carol's message said, "I just found this masterpiece." And you have to know that Carol does not use the word 'masterpiece' casually, so I knew it really meant something.

Carol: A large part of the impact of the Altarpiece stems from its scale—6.5 metres wide by 4.2 metres tall—and from its elaborately embroidered details. It tells the story of the Hamburg community in 2005, when so many were dying,

and it also speaks of the tremendous self-esteem that had risen around the women at a very low ebb of their lives, making it possible for them to produce this incredible work of art.

David: Carol Hofmeyr, who conceived of the Altarpiece and oversaw its creation, sent me a little YouTube-style film via e-mail, to entice me. Basically, what you see in the film is the moment in Grahamstown when the Altarpiece was first assembled. There is huge excitement in the air because, up until that point, the dozens of women who worked on it had only seen the small parts for which they were individually responsible, which they had sewn on their laps. They had never seen the whole thing stretched and assembled.

In the film, the panels have just been sewn together and framed into their larger wooden structure, and the hinged layers of it are being swung open for the first time. People begin jumping up and down, literally bursting out of their seats. They clap and sing, because the only appropriate response to the birth of the Altarpiece is to praise it and to praise themselves for having made it.

Even with only Carol's two-line 'masterpiece' e-mail and this little video as evidence, I knew the Altarpiece was something we would want to share with larger numbers of people, which we did in 2006 at the XVI International AIDS Conference in Toronto.

It was laid out in the beautiful St. James Cathedral in Chicago. The first time the panels opened up there, I felt as though I was witnessing a distilled form of anxiety, grief and hopefulness—all sewn into this one colossal artwork. The experiences of the creators seemed palpable in every stitch.

Carol: The Altarpiece is not a static artwork; it is like a performance. When the women who worked on it are opening and closing the 'doors,' it is

accompanied by songs of hope and joy. And when the final panel is opened—with its life-sized photographs of three grandmothers and the grandchildren they care for—the Altarpiece becomes a rousing prayer rally. If we look back on the entire history of art in the world, the greatest artworks have come out of experiences and social situations such as this. They have been protests against war or famine, or statements about religion. Art has always had to have something underpinning it.

The AIDS epidemic has had an enormous effect, especially on South Africa. The art emerging from it has been very much about our own experiences and how it has affected our lives, and therefore it has a great deal of gravitas to it.

David: No artist who makes work about HIV is trying to make money. AIDS art is not made to buy and sell.

Carol: As David says, this art is not being made for a market—it is being made as an act of self-expression and of solidarity with what is happening all around. That is why the Keiskamma Altarpiece is so remarkable, because it has been imagined into existence by an entire community working together.

David: I feel there is enormous individual creativity involved in the artwork we see in this era, but there is also a great deal of communal expression too, borne of a desire for art to speak for larger numbers of people fighting for treatment access or basic human rights.

Carol: What art and artists can do more successfully than other media is to show that we are not alone in anything we do. What touches one touches us all.

David: May the world stop and listen.

The Keiskamma Altarpiece

Created by a group of 130 women from Hamburg and neighboring villages in the Eastern Cape province of South Africa, the *Keiskamma Altarpiece* is a message of hope for people living with HIV.

The community of 3000 people has been deeply affected by the AIDS epidemic. The idea came from Carol Hofmeyr, a physician from Johannesburg, who with her husband, Justus Hofmeyr, moved to Hamburg in the Eastern Cape province as part of the AIDS response. Carol Hofmeyr had recently completed a degree in fine arts and worked with women in the area on economic empowerment programmes through arts

and crafts. The ambition to create the Altarpiece grew from making simple cushions and handbags.

The *Altarpiece* was inspired by the 16th-century *Isenheim Altarpiece* created by German artist Matthias Grünewald during the time of the disease called Saint Anthony's fire (ergotism, caused by ergot poisoning).

The *Keiskamma Altarpiece* replaces the biblical figures on the Grünewald work with images of members of the Hamburg community. Part of the grandeur of the artwork is its scale, as well as the ingenuity of its stitchery and beadwork.

The *Keiskamma Altarpiece* was brought to international attention by the curatorial team of MAKE ART/STOP AIDS at the XVI International AIDS Conference in Toronto, Canada. Since its founding, the Keiskamma Art Project has continued to create and share its art with the world, including the recent *Keiskamma Guernica*, after Pablo Picasso, and a forthcoming commission for The A.R.T. Show, addressing the problems and possibilities of the post-treatment era in southern Africa.



Hamburg, South Africa, 2000
Keiskamma Altarpiece
Detail images

Image courtesy of the Keiskamma Art Project

Art and AIDS



Hamburg, South Africa, 2000
Keiskamma Altarpiece
Open panels (Resurrection)

Image courtesy of the Keiskamma Art Project



Hamburg, South Africa, 2000
Keiskamma Altarpiece
Open panels (Reality)

Image courtesy of the Keiskamma Art Project



Science, Mystery and Magic II (Superman), 2011

Thukral & Tagra
Oil on canvas

Image courtesy of the artists



Essentials (Clark Kent & Lois Lane), 2011

Thukral & Tagra
Acrylic on canvas, pair of canvases

Image courtesy of the artists

13

Remembered

In 30 years, 30 million lives have been lost to AIDS. OUTLOOK remembers six activists around the world who made a difference in their communities.

Remembered

Suzana Murni

Pioneering HIV activist in Indonesia



Suzana Murni was the first person in Indonesia to speak openly about her HIV status. Diagnosed with HIV in 1995, she formed a peer support group called Spiritia together with friends living with HIV and people affected by the virus. The group soon expanded into a national organization, the Spiritia Foundation, linking people living with HIV across the country.

As a campaigner for Spiritia, Suzana staunchly advocated the greater involvement of people living with HIV at all levels of policy- and decision-making. She spoke regularly at national and global conferences, calling for an end to stigma and discrimination and equal access to antiretroviral therapy.

Suzana started taking antiretroviral drugs in 2001 but was soon after diagnosed with lymphoma. She passed away in 2002, surrounded by family, including a two year old adopted son. Her vision lives on today in the organization she created and through a collection of poetry.

Together building hope

A poem written by Suzana Murni, 1996

Tonight
A candle is lit
For you,
For friends with shared feelings
And for them who have already preceded us.
They have already passed away in order not to surrender.
And for friends that have taught us that pain and despair
Obviously can resurrect strength
That which during this time we've been unaware of.

If, of course, this problem is the virus,
That destroys the human immune system,
Tell me,
Why do I feel pain more mentally than physically?
And why must I be prevented
From giving you a parting kiss
At the final moment of your life?

At this moment I see
How you are inhumanely isolated by people in your community.
I witness in my mind's eye
As your body is wrapped in plastic
While your soft blanket that I recognize
Is thrown into a hot flame
That glows of strong rejection of yourself
After much suffering
Because of the virus.

And I,
Through all of this, am close with you
Accompanied with sadness and emptiness.
All will soon become like this
Without time to hope that help will arrive,
Without hope for a future.
And I, myself, still don't know
That which I am hoping for will arrive tomorrow or not?

Tonight
I light this candle for you
For all meaning that I have already gotten
About life and love.

For the soft touch and sincerity
That isn't limited by nationality and language.

For friends that have already fought
And those that still firmly resist.

This candle radiates, my friend.
Our hope knitted together will illumine tomorrow's
Morning sun
And send forth melodious song
That still wishes us to hear.

Warmth steadily returns
Because love never ends
Radiating its rays to the Earth.

Embrace love, which makes us feel strong
And willing to face all challenges
Love's miracle that lives on
Because life is indeed precious.

Taia Suslova

Activist with the organization FrontAIDS



As an activist with FrontAIDS, Taia Suslova fought tirelessly for the rights of all people in the Russian Federation to access antiretroviral therapy, including people who inject drugs. When the state denied access to HIV treatment to people who use drugs, Taia handcuffed herself to the doors of government buildings in Kaliningrad and St Petersburg, chanting, “We will live! That is our policy!” Taia herself did not receive timely treatment for her TB, HIV and opiate dependence; she died of AIDS-related TB in 2008 at the age of 36 years.

Every day, thousands of people like Taia who are living with HIV and also have TB die prematurely around the world. In Eastern Europe and Central Asia, the number of people living with HIV nearly tripled during the past decade. A rapid rise in HIV infections among people who inject drugs at the turn of the century caused the epidemic in the region to surge.

Taia is fondly remembered in the following passage by her friend Irina Teplinskaya. This tribute was originally written for the Andrey Rylkov Foundation for Health and Social Justice, an organization that advocates for the human rights of people who use drugs in the Russian Federation.

Tribute to Taia

Irina Teplinskaya remembers her friend Taia

I signed out of the penitentiary in April of 2007, where I was dying from AIDS and lung disease. They brought me to the anti-TB clinic, since my family refused to take me home. I survived, by some miracle, but had nowhere to go. During that period of my life, I understood, for the first time, that family is not those who are tied to us by blood but those who stop our wounds with their own flesh. The people who treated me and the patients who helped me get back on my feet became like dear family, and that is why I stayed on at the clinic as a nurse's aide.

It was February of 2008. The clinic was full to capacity. The most severely ill patients were placed on the first floor, and those who could walk, more or less, were on the second floor. The ambulance brought in a young woman; I noticed her for the first time as she made her way upstairs. It took her a long time to go up; she was out of breath and made several stops on a single landing. My eyes were immediately drawn to her hands—thin hands and long fingers with cared-for nails and a very pretty manicure. I was surprised: how could a woman in such bad shape manage to pay attention to her hands? But that was her, in a nutshell: Taia.

I stopped, offering to help her up the stairs. We got to talking and became friends then and there. She surprised me with her inborn intelligence and good breeding, her goodwill and sense of personal dignity. She was all lit up by some kind of inner light, and she warmed everything around her.

The medical personnel treated her badly, and I could not fathom why. It turned out that Taia had been a patient here before but left because she had started using drugs, and there is no aid for drug dependence in the clinic. She had a very difficult diagnosis, one with no chance of survival: caseous pneumonia, a severe form of TB. She had months or days to live, nobody knew how long.

I looked at Taia's X-rays: they showed almost no lungs, just a few alveoli. But how she held up! Thin, fragile, almost transparent from her sickness, she carried herself with the bearing of a queen. Her death came slowly—an agonizing five months. The body resisted and the immune system was good, due to her antiretroviral medicines. But there was nothing to breathe with. I knew how death came for those with her diagnosis: because of the lack of oxygen, people blow up like a balloon. That is how a fish must feel when it is thrown onshore.

We knew that we both had used heroin before. That is why I started bringing it in, to lessen her suffering. We shot up together and locked ourselves for the night in the nurses' room, where she told me endless stories about her son Serezha, about her grandfather, about Andrey Rylkov, whom everyone knew as Irokez, about her activism with FrontAIDS. She felt better with the heroin, and she was a great storyteller; I could listen to her indefinitely.

By May, she had taken a turn for the worse. She stopped eating, barely slept, and did not get up. Every morning, I came to see her and helped her fix herself up—wash up, change her underwear. She was ashamed of her helplessness. When she stopped getting up, she asked for pencils and markers and spent her sleepless nights drawing by the nightlight. She drew very strangely, fancifully: never-before-seen winged horses, violet lion-rabbits, strange unearthly flowers. She gave the drawings to her grandfather, who passed them on to Serezha.

She was an ordinary woman, a loving mother—just a person with problems, small faults, drug dependence. And yet she was not like everyone else; she was able to rise above the crowd and to do so without taking any steps. She loved life, loved people, and people loved her.

Remembered

Godfrey Sealy

Trinidad and Tobago playwright and activist



About 1% of the adult population in the Caribbean is living with HIV. Studies have found particularly high HIV prevalence among men who have sex with men, ranging from 6% in the Dominican Republic to 32% in Jamaica. In many countries across the region, stigma and discrimination against men who have sex with men hamper access to HIV prevention, treatment and care.

Peter Richards, a journalist, pays tribute to Godfrey Sealy, a champion of the gay and lesbian community and one of the first people in Trinidad & Tobago to speak publicly about living with HIV. This is an abridged version; the full article originally appeared in Inter Press Service on 2 May 2006.

Gay, HIV-positive and totally fearless

A tribute from Peter Richards, 2006

When he was diagnosed with HIV in 1989, Godfrey Sealy, a Trinidad and Tobago playwright and activist, pled with Caribbean policy-makers and the general public not to relegate sex issues to the back burner.

“AIDS is about sex. It is the primary means by which people get infected. If we feel we can hide sex from ourselves and our children, we will be encouraging the spread of the virus,” he wrote in a newspaper article in September 1989.

Now, nearly two decades later, his colleagues and friends are paying respects to the memory of a man who, up until his death last Wednesday at the age of 46, was still fighting to end the stigma that has contributed to the Caribbean’s HIV/AIDS rate—after sub-Saharan Africa, the second highest in the world.

His theatrical friends staged a memorial and said that any money donated will go to the AIDS foundation in Trinidad and Tobago. Titled *Remembering Godfrey*, the memorial featured most of the big names in local theatre.

The Trinidad-based Caribbean Epidemiology Centre (CAREC) said it too wanted to acknowledge Sealy’s “sterling contribution to the fight against the epidemic in his native country and the wider Caribbean.”

“We were moved by his personal courage to openly discuss his status despite the real possibilities of societal stigma and discrimination that is usually directed at HIV-infected persons,” said Jones P. Madeira, CAREC’s information adviser.

Madeira said Sealy’s work contributed immensely to initiatives by several regional and international agencies aimed at reducing the stigma and discrimination against persons living with HIV/AIDS and also inspired the creation and growth of such HIV/AIDS support groups as Community Action Resource, Artistes against AIDS and the Port of Spain-based Caribbean Regional Network of People Living with HIV/AIDS.

“Mr. Sealy’s own battle with the illness was an outstanding example of fortitude and courage, and his survival of close to two decades as an HIV-positive person served as an inspiration and encouragement to those who would otherwise despair quite easily in the face of infection,” Madeira said.

Dr Brader Braithwaite, research director of the Gay Research Initiative on AIDS Prevention in the Caribbean, said that, through Sealy, she recognized the benefits and ‘hands on’ use of cultural communication, in particular the use of drama in the dissemination of AIDS prevention messages.

Sealy wrote the first Caribbean play about AIDS, entitled *One of our Sons is Missing*, and another of his works, *The Wicked Wench of the World*, a pantomime in the carnival genre addressing HIV and discrimination, was performed at the Fifth International Conference on AIDS in Montreal in 1989.

“With Mr Sealy’s passing, CAREC feels that the Caribbean has lost a true champion in the battle against HIV/AIDS in the Caribbean, and who should be remembered not only for widening the response to the epidemic in our region, but also for making persons living with HIV/AIDS a part of the solution rather than being considered the problem,” CAREC said.

Tamara

Mother, cook and co-founder of an HIV support group in Lebanon

Tamara, a professional cook from Beirut, Lebanon, was diagnosed with HIV in 1996. In candid discussions with journalist Cosette Karam Al Andary, she shared her reflections on living with the virus.

The journalist published a biography of Tamara's life called Shahed Nour (Witness of Light) in 2008; several excerpts from the book follow.

In collaboration with the nongovernmental organization Soins Infirmiers et Développement Communautaire (SIDC), Tamara co-founded a support group in 2000 for people living with HIV. She continued to participate in group meetings until 2007, when declining health prevented her from attending. Tamara died in 2008 at the age of 48, leaving behind one daughter.

Witness of Light

Reflections of Tamara by Cosette Karm Al Andary, 2008

... The doctor looked at us, my husband and me. I felt a heavy atmosphere in the room; then my trembling voice broke the silence, uttering, "If you don't tell me what is wrong with me, I won't take any medicine." He left his chair, walked towards me and gently stroked my shoulder. "Do we have to go through all this romance to tell me?" I said, joking and trying to feign strength. "If it's cancer, then tell me it is." The doctor replied, "If only it were cancer; I'm really sorry, but you have AIDS." All I remember are the words "Mother Mary" that I uttered repeatedly as I lost consciousness. ...

... It was a heavy burden to carry. I wanted to resign from life. I threw myself out of the car on our way back home, trying to commit suicide. I did so after tears dried in my eyes, trying to convince my husband that I had not betrayed him. I was horrified at the thought that our parents would learn of my disease. Jad also choked back tears. He did not say much; he just uttered a few words: "We have to accept our fate." ...

... I deserted Jad for three years. My humanity petrified in my heart, and I became armed with some strange cruelty. At times, I reached the point of insolence. I told him that our presence under one roof had become a formality, and that I did not want him to touch me. I remember, one night, wearing a rather too-open dress for the evening, and I came back late. Jad tried repeatedly to break the ice between us, pleading with me to forgive him. ...

... We agreed to say to those asking questions that I had leukaemia, to justify my repeated visits to the hospital. I was not ashamed of how others would perceive us. The main reason we buried the horrible truth in our hearts was our fear of not being accepted at the workplace. Despite the volcano of anger that was boiling inside me, I tried, the best I could, to provide my husband with a nutritious diet—an 'antibiotic' for AIDS. ...

... When the news spread among friends and family, their major concern was how my husband picked up the virus. I was the first to be accused; they began by putting the blame on me. My husband and I greatly suffered because of them, and I suffered more after his death—even though he told them, before he died, that he had been the one to transmit the infection to me. I told my daughter I had leukaemia, not HIV, so she wouldn't blame me one day, blame her father or hate us both ...

... Jad passed away after a 10-year struggle with the disease. In addition to AIDS, he had an opportunistic infection, cancer, adding agony to his battle. He was helpless and could not accomplish anything; he was only able to talk. He stayed in bed for a long time. I supported him and catered to his daily needs. During that period of our marriage, I didn't allow my emotions to control me. I didn't allow myself to be a prisoner of my anger; I started to love Jad in different way. In fact, his patience triggered an internal strength that gave peace and security to my heart ...

... Our society is unjust, cruel and destructive. I wanted to die to end my suffering and to stop the gossip going around me, the looks of disgust. There are other infectious diseases—why are people living with HIV, in particular, perceived as unethical? I isolated myself in the house away from the others. A few of my loving friends visited me, but many abandoned me. Had it not been for my deep faith in God, I would not have been able to survive and endure the words and actions of others all of those years ...

... Today, I am living in extreme harmony with myself, although my body is giving way to the disease. No matter where they strike from, Satan's arrows no longer scare me. There are many of these arrows—wherever goodness settles, evil hovers. I am living the final stages of my disease in peace with myself as well as others. I believe that we are destined to our fate. Don't bid me farewell me with elegies because I long for the moment when my spirit is joined with eternal life. My last wish? It's to feel my last heartbeat in the hands of the Heavenly Father ...

Remembered

Nkosi Johnson

Child activist and co-founder of Nkosi's Haven in South Africa



Nkosi Johnson was born with HIV in a poor township east of Johannesburg, South Africa. He first came to public attention in 1997 when a primary school refused to accept him as a student because he was living with HIV. The incident caused a national furor, and the school later reversed its decision.

Together with his foster mother, Nkosi founded Nkosi's Haven in 1999, a non-profit organization that supports women and children living with HIV and children orphaned by AIDS.

In July 2000, 11 year old Nkosi spoke at the XIII International AIDS Conference in Durban. In a globally televised address, Nkosi's bravery and determination in the face of adversity inspired millions of people around the world. Excerpts from his speech follow.

Nkosi died of AIDS-related causes the following year, at the age of 12. In his short lifetime, he had a powerful impact on public perceptions around the AIDS epidemic.

Kofi Annan, former United Nations Secretary-General, praised Nkosi's courage, saying, "We have lost a voice." Former South African President Nelson Mandela referred to Nkosi as an "icon of the struggle for life."

South Africa has the world's largest HIV epidemic. In 2009, AIDS accounted for about 35% of deaths among children younger than five years and was the main cause of maternal mortality in the country.

"Don't be afraid of us—we are all the same!"

Excerpts from Nkosi's speech at the XIII International AIDS Conference, 2000

Hi, my name is Nkosi Johnson. I live in Melville, Johannesburg, South Africa. I am 11 years old and I have full-blown AIDS. I was born HIV-positive.

When I was two years old, I was living in a care centre for HIV/AIDS-infected people. My mommy was obviously also infected and could not afford to keep me because she was very scared that the community she lived in would find out that we were both infected and chase us away.

I know she loved me very much and would visit me when she could. And then the care centre had to close down because they didn't have any funds. So my foster mother, Gail Johnson, who was a director of the care centre and had taken me home for weekends, said at a board meeting she would take me home. She took me home with her and I have been living with her for eight years now.

She has taught me all about being infected and how I must be careful with my blood. If I fall and cut myself and bleed, then I must make sure that I cover my own wound and go to an adult to help me clean it and put a plaster on it. I know that my blood is only dangerous to other people if they also have an open wound and my blood goes into it. That is the only time that people need to be careful when touching me.

In 1997, mommy Gail went to the school, Melpark Primary, and she had to fill in a form for my admission, and it said "Does your child suffer from anything," so she said yes: AIDS. My mommy Gail and I have always been open about me having AIDS. And then my mommy Gail was waiting to hear if I was admitted to school. Then she phoned the school, who said we will call you and then they had a meeting about me.

Of the parents and the teachers at the meeting, 50% said yes and 50% said no. And then on the day of my big brother's wedding, the media found out that there was a problem about me going to school. No one seemed to know what to do with me because I am infected. The AIDS workshops were done at the school for parents and teachers to teach them not to be scared of a child with AIDS. I am very proud to say that there is now a policy for all HIV-infected children to be allowed to go into schools and not be discriminated against.

And in the same year, just before I started school, my mommy Daphne died. She went on holiday to Newcastle; she died in her sleep. ... Ever since the funeral, I have been missing my mommy lots and I wish she was with me, but I know she is in heaven. And she is on my shoulder watching over me and in my heart.

I hate having AIDS because I get very sick and I get very sad when I think of all the other children and babies that are sick with AIDS. I just wish that the government can start giving AZT [zidovudine] to pregnant HIV mothers to help stop the virus being passed on to their babies. Babies are dying very quickly ...

Because I was separated from my mother at an early age, because we were both HIV positive, my mommy Gail and I have always wanted to start a care centre for HIV/AIDS mothers and their children. I am very happy and proud to say that the first Nkosi's Haven was opened last year. And we look after 10 mommies and 15 children. My mommy Gail and I want to open five Nkosi's Havens by the end of next year because I want more infected mothers to stay together with their children—they mustn't be separated from their children so they can be together and live longer with the love that they need.

When I grow up, I want to lecture to more and more people about AIDS—and if mommy Gail will let me, around the whole country. I want people to understand about AIDS—you can't get AIDS if you touch, hug, kiss, hold hands with someone who is infected.

Care for us and accept us. We are all human beings. We are normal. We have hands. We have feet. We can walk, we can talk, we have needs just like everyone else. Don't be afraid of us—we are all the same!

Ryan White

An early public face of AIDS in the United States



Ryan White of Kokoma, Indiana, was diagnosed with severe haemophilia as an infant. In 1984, at the age of 13 years, he acquired HIV through a blood transfusion. Although doctors said Ryan posed no risk to other students, fear and misinformation flourished, and he was barred from attending middle school.

In the mid-1980s, AIDS was widely associated with the male homosexual community in the United States. Media interest and visibility around Ryan's story helped change public perception of the disease across the country.

Ryan White was invited to testify before the President's Commission on AIDS in 1988. Excerpts from his testimony follow.

In April 1990, Ryan died just one month before his high school graduation. Several months later, the United States Congress signed into law the bipartisan Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, the country's largest federally funded programme for HIV. The CARE Act funds treatment for low-income, uninsured and underinsured people living with HIV.

"I'm just one of the kids"

Testimony before the President's Commission on AIDS, 1988

I came face to face with death at 13 years old. I was diagnosed with AIDS: a killer. Doctors told me I'm not contagious. Given six months to live and being the fighter that I am, I set high goals for myself. It was my decision to live a normal life, go to school, be with my friends, and enjoy day-to-day activities. It was not going to be easy.

The school I was going to said they had no guidelines for a person with AIDS. The school board, my teachers, and my principal voted to keep me out of the classroom for fear of someone getting AIDS from me by casual contact. Rumours of sneezing, kissing, tears, sweat and saliva spreading AIDS caused people to panic.

We began a series of court battles for nine months, while I was attending classes by telephone. Eventually, I won the right to attend school.

We knew AIDS was not spread through casual contact. Nevertheless, parents of 20 students started their own school. They were still not convinced. Because of the lack of education on AIDS, discrimination, fear, panic, and lies surrounded me.

I was labeled a troublemaker, my mom an unfit mother, and I was not welcome anywhere. People would get up and leave so they would not have to sit anywhere near me. Even at church, people would not shake my hand.

This brought on the news media, TV crews, interviews, and numerous public appearances. I became known as the AIDS boy. I received thousands of letters of support from all around the world, all because I wanted to go to school ... Entertainers, athletes, and stars started giving me support. Many became my friends, but I had very few friends at school. How could these people in the public eye not be afraid of me, but my whole town was?

It was difficult, at times, to handle; but I tried to ignore the injustice, because I knew the people were wrong. My family and I held no hatred for those people because we realized they were victims of their own ignorance. We had great faith that, with patience, understanding and education, my family and I could be helpful in changing their minds and attitudes around.

Financial hardships were rough on us, even though Mom had a good job at G.M. The more I was sick, the more work she had to miss. Bills became impossible to pay. My sister, Andrea, was a championship roller skater who had to sacrifice too. There was no money for her lessons and travel. AIDS can destroy a family if you let it, but luckily for my sister and me, Mom taught us to keep going. Don't give up, be proud of who you are, and never feel sorry for yourself.

After two and a half years of declining health, two attacks of pneumocystis, shingles, a rare form of whooping cough, and liver problems, I faced fighting chills, fevers, coughing, tiredness and vomiting. I was very ill and being tutored at home. The desire to move into a bigger house, to avoid living AIDS daily and a dream to be accepted by a community and school became possible and a reality with a movie about my life, *The Ryan White Story*.

My life is better now. At the end of the school year [1986–1987], my family and I decided to move to Cicero, Indiana. We did a lot of hoping and praying that the community would welcome us, and they did. For the first time in three years, we feel we have a home, a supportive school and lots of friends.

I'm feeling great. I am a normal happy teenager again. I have a learner's permit. I attend sports functions and dances. My studies are important to me. I made the honour roll just recently, with 2 A's and 2 B's. I'm just one of the kids, and all because the students at Hamilton Heights High School listened to the facts, educated their parents and themselves, and believed in me.

14
Orphans

Nearly 17 million children have lost one or both parents to AIDS. Most of these children live in sub-Saharan Africa. Through art—their stories of hope and courage emerge.

Orphans

States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

United Nations Convention on the Rights of the Child, Article 27

Since the AIDS epidemic began three decades ago, nearly 30 million people have died from AIDS-related illnesses—most in the prime of their lives. They have left behind families of ageing parents and orphans.

Nearly 17 million children have been orphaned by AIDS-related deaths, most in sub-Saharan Africa. Each one of them has a story of loss but also of courage and hope.

Glynis Clacherty has been working with orphaned children across Africa and recording their stories. “All over Africa there are children affected by AIDS. There are orphan children who have had to cope with multiple deaths in their families, as they

have lost their mother and father, older sisters and brothers, and aunts and uncles,” she says.

Through the medium of art, she has been able to help children better deal with their loss and move forward. “The pictures and stories drawn by the children give us an idea of how very difficult their lives are but also how they support each other in meeting basic needs, managing their grief and continuing school despite the obstacles put in their way,” says Ms Clacherty.

“Children are often playing the role of child carers,” Ms Clacherty points out. “There are children living with and looking after their older grandparents, there are children who are caring for sick parents and there are children looking after younger siblings.”

A study conducted by Ms Clacherty for Save the Children UK found that orphaned children have a strong sense of responsibility. They are able to seek out help from the sympathetic adults they know and able to make a living from various tasks. The children also showed maturity and emotional strength in the way they parented younger siblings.



Angola, Uganda, Nigeria and Zimbabwe

In Angola, Uganda, Nigeria and Zimbabwe, children who care for their ill parents participated in a research project to record their life experiences. The children shared information on such issues as how they earn money. They also identified problems they face including lack of food and being denied access to school because

they can not pay for uniforms, books or school fees. One boy who cares for his father, uncle and his younger brother outlines his day to show how he manages to go to school and all the household tasks.



Our house

This is our house. I am the one looking after it. My mother is sick.

— Girl, 9 years old
Zimbabwe

Orphans

South Africa

In Johannesburg, South Africa, children whose parents have died are part of a support group at the Sophiatown Community Counselling Centre. At the center they draw and tell stories about their loss and their lives now.



Mum's necklace

*My mother loved me ...
She used to buy for me what I asked.
She used to teach me how to read books and read the Bible.
She used to teach me how to fold the blankets.
Then my mother got sick.
When my grandfather came to visit she did not recognize anyone anymore.
After that she stayed for three days then she died.
My mother had a necklace with mother Mary on it. It was gold.
She wore it all the time but when she went to bathe she took it off.
She gave it to me.
It makes me think that when I wear it she is always there for me.*

— Girl, 10 years old
South Africa



When I am sad

When I think of my father, I am sad; then I go and lie down on the grass and I look at the stars in the night. I feel better when I go and do that. I just lie there and feel better.

When Pedro is sad, he asks his dad for 1 dollar and goes to the cinema and watches funny movies. Ephraim dances, Lillian goes on her own far from other people, Grace reads and goes to another world. Helena sings church songs, Michel sings gospel ...

... but I lie on the grass and look at the stars.

— Boy, 11 years old
South Africa

Zimbabwe

Many children in Zimbabwe, orphaned by AIDS, cross the borders into Mozambique and South Africa to find work. Their goal is to send money home to their grandparents and younger siblings. At a regional seminar on migration in Johannesburg, the children drew pictures about the reasons they left home.



When I left my country, I was happy because I had that belief that it was going to be fine. But you know home is best. Leaving home is not an easy thing to do.

— Boy, 13 years old
Zimbabwe

Botswana

In Botswana, children created ‘memory books’ as part of the Regional Psychosocial Support Initiative (REPSI). Together they recorded memories, thoughts, stories and feelings about the parents they have lost.



This is my mum holding me tenderly when I was still a little girl—thank you Mum for everything.

— Woman, 18 years old
Botswana



This is a good memory. I remember when my Mum bought me a school uniform. I was happy I was running all the way to school. Who I am today is because of my mum.

— Woman, 18 years old
Botswana

United Republic of Tanzania

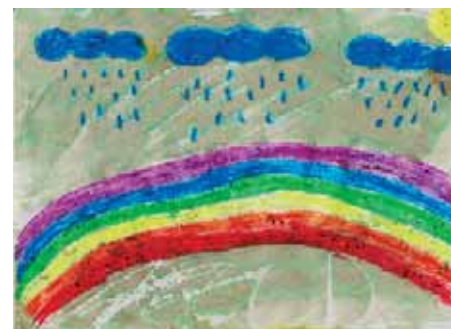
In the United Republic of Tanzania, orphans who live with grandparents learned how to run a small business as part of the Kwa Wazee project. The children each received a loan to raise poultry or plant vegetables. This allowed them to become more independent, stay in school, and to earn money for food.



Grandmother

My bibi (grandmother) loves me. She looked after me from a baby. Now it is my time to look after her. I can never leave her.

— Boy, 17 years old
United Republic of Tanzania



Future

I could not plan for my future before, but now I can plan more. Before I was thinking about my dead parents; now I have found there are other orphans like me. We work together to help our grandparents and to make our future bright.

— Girl, 14 years old
United Republic of Tanzania

15

Women and AIDS

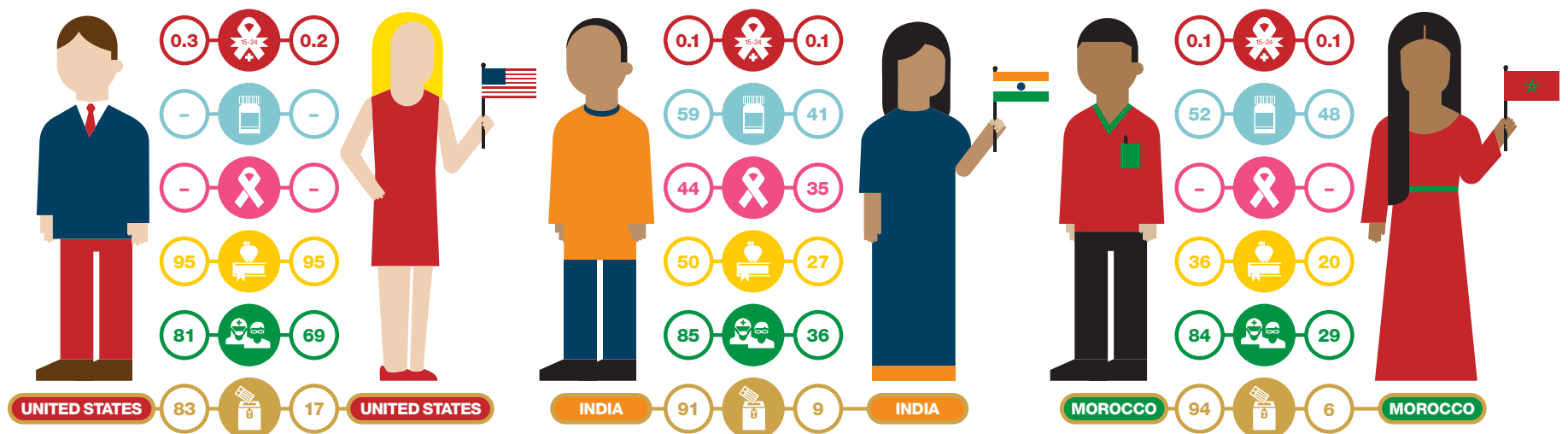
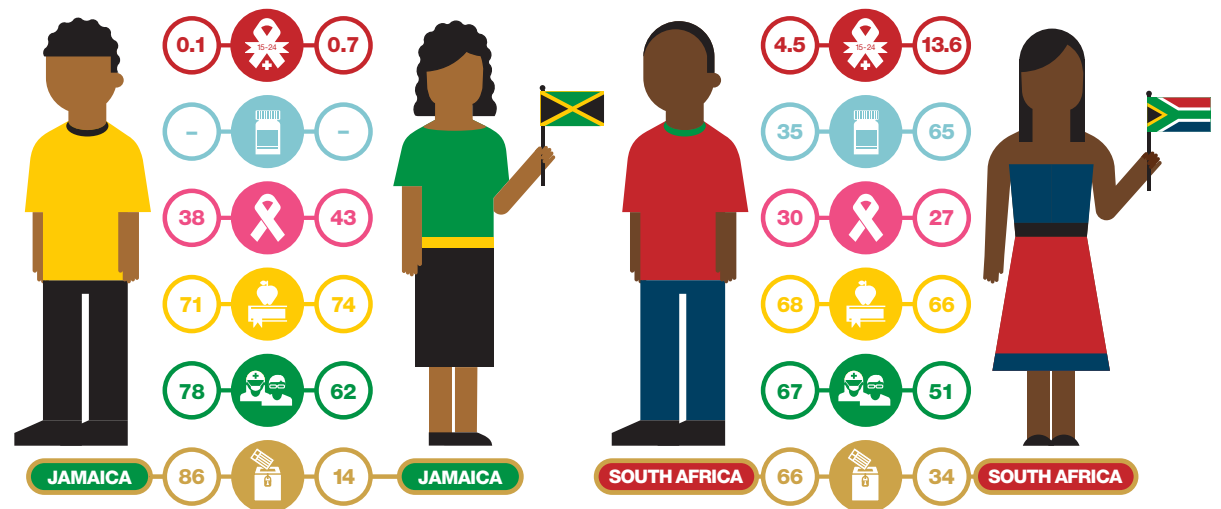
Thirty years into the AIDS epidemic, women and girls are still the most affected—nearly 16 million are living with HIV. More than one quarter (26%) of the people newly infected with HIV are women 15–24 years old. OUTLOOK examines the gender gap and HIV.

Women and AIDS

Half the sky: the gender gap and HIV

Globally, women make up half the people living with HIV. At almost 16 million, the number of women living with HIV is equal to the entire population of countries such as the Netherlands, Kazakhstan or Burkina Faso.

Reducing women's vulnerability to HIV requires a comprehensive approach. This includes increasing women's participation in the political process, access to the labour market, and equal right to education and health. Together, they have the potential of reducing new HIV infections among women and girls.





Source: UNAIDS Report on the global AIDS epidemic 2010 and UNDP Human Development Report 2010, *The Real Wealth of Nations: Pathways to Human Development*.

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Preventing mother-to-child transmission

All children born free of HIV and their mothers living to see them grow—this hope is becoming a reality. There is global consensus that new HIV infections among children can be virtually eliminated everywhere by 2015.

Preventing mother-to-child transmission



Rebecca Awiti and her triplets with United Nations Secretary-General Ban Ki-moon and UNAIDS Executive Director Michel Sidibé.

Rebecca Awiti gave birth to quadruplets—all of them HIV negative. She is among a growing number of pregnant women living with HIV who can access antiretroviral prophylaxis to prevent passing on the infection to their children. Sadly, one child died, but Rebecca Awiti and her partner have three children—each free of HIV. In addition to raising three young children, Rebecca also works for a nonprofit organization called Women Fighting AIDS in Kenya.

During the past 30 years, much research has been carried out to ensure that babies are born HIV free. If a mother is living with HIV, she can transmit the virus to her baby during pregnancy, labour and delivery or through breastfeeding. Without any intervention, as many as 45% of infants born to HIV-positive mothers will become infected, depending on the duration of breastfeeding.

In high-income countries, the transmission of HIV from a mother to her child has been virtually eliminated thanks to effective voluntary testing and counselling, access to antiretroviral prophylaxis and treatment, safe delivery practices, family planning and safe infant feeding.

Despite progress, access to services to prevent children from becoming newly infected with HIV remains low in some of the most resource-limited countries.

In 2009, only half (53%) of the pregnant women living with HIV in low- and middle-income countries received some form of services to prevent them from transmitting the virus to their children. An estimated 370 000 children younger than 15 years were newly infected with HIV in 2009.

Preventing HIV transmission to children alone is not enough. Efforts to ensure that women living with HIV are healthy through pregnancy, delivery and breastfeeding is important too. Up to 60 000 pregnant women die yearly because of HIV. In some high-burden countries, HIV is associated with about 50% of all maternal deaths. In 2009 about 15% of all mothers received ongoing antiretroviral therapy for their own health based on WHO's new eligibility criteria.

To address the urgent need for scaling up, UNAIDS Executive Director Michel Sidibé has called for eliminating new HIV infections among children by 2015 and keeping their mothers alive. This will require a comprehensive four-pronged approach, as set out by the United Nations. These include keeping women of childbearing age free of HIV, preventing unintended pregnancies among women of childbearing age, providing antiretroviral prophylaxis to prevent transmission from mother to child and providing appropriate treatment care and support for women living with HIV, their children and families. These approaches must be considered as part of the existing continuum of comprehensive programmes to provide access to HIV prevention, treatment, care and support for men, women and children.

Why new HIV infections among children?



Informed choices

- Only 20% of women in low- and middle-income countries have access to family planning advice and options.

Unintended pregnancies

- Globally, 38% of pregnancies are unintended; some studies estimate that figure to be between 51% and 90% among women living with HIV.

Unknown HIV status

- Only 20% of the people living with HIV know their HIV status.
- Only 26% of the pregnant women in low- and middle-income countries were offered an HIV test in 2009.
- If a pregnant woman living with HIV does not know her status, she will not be able to access services to prevent her child from becoming infected with HIV.



Stigma and discrimination

- Stigma and discrimination, fear of violence and other social repercussions can prevent women from taking HIV tests, accessing HIV prevention and treatment services or adopting safe infant feeding options.

Accessibility

- Many women live far from antenatal clinics and health centres, with little access to transport, making visits difficult.

Prevention and treatment

- Only half the estimated 1.4 million pregnant women living with HIV in 2009 received antiretroviral therapy as prophylaxis to enable them to stop transmitting HIV to their babies.
- After delivery, only 35% of infants born to mothers living with HIV received infant antiretroviral prophylaxis to prevent HIV infection.



Safe feeding

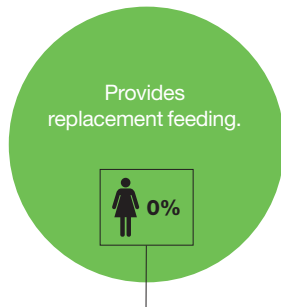
- HIV can be transmitted through breast milk. For women who choose to breastfeed, the risk of transmitting the virus through breast milk can be reduced to less than 2% if they continue to take antiretroviral therapy during the breastfeeding period either as a prophylaxis or for their own health. When families choose to breastfeed without antiretroviral therapy for the mother or child, the risk of infection can be up to 20%.

Preventing mother-to-child transmission

The road to elimination of new HIV infections among children

- Pregnant woman or child without HIV
- Pregnant woman or child living with HIV
- Breastfeeding mother living with HIV

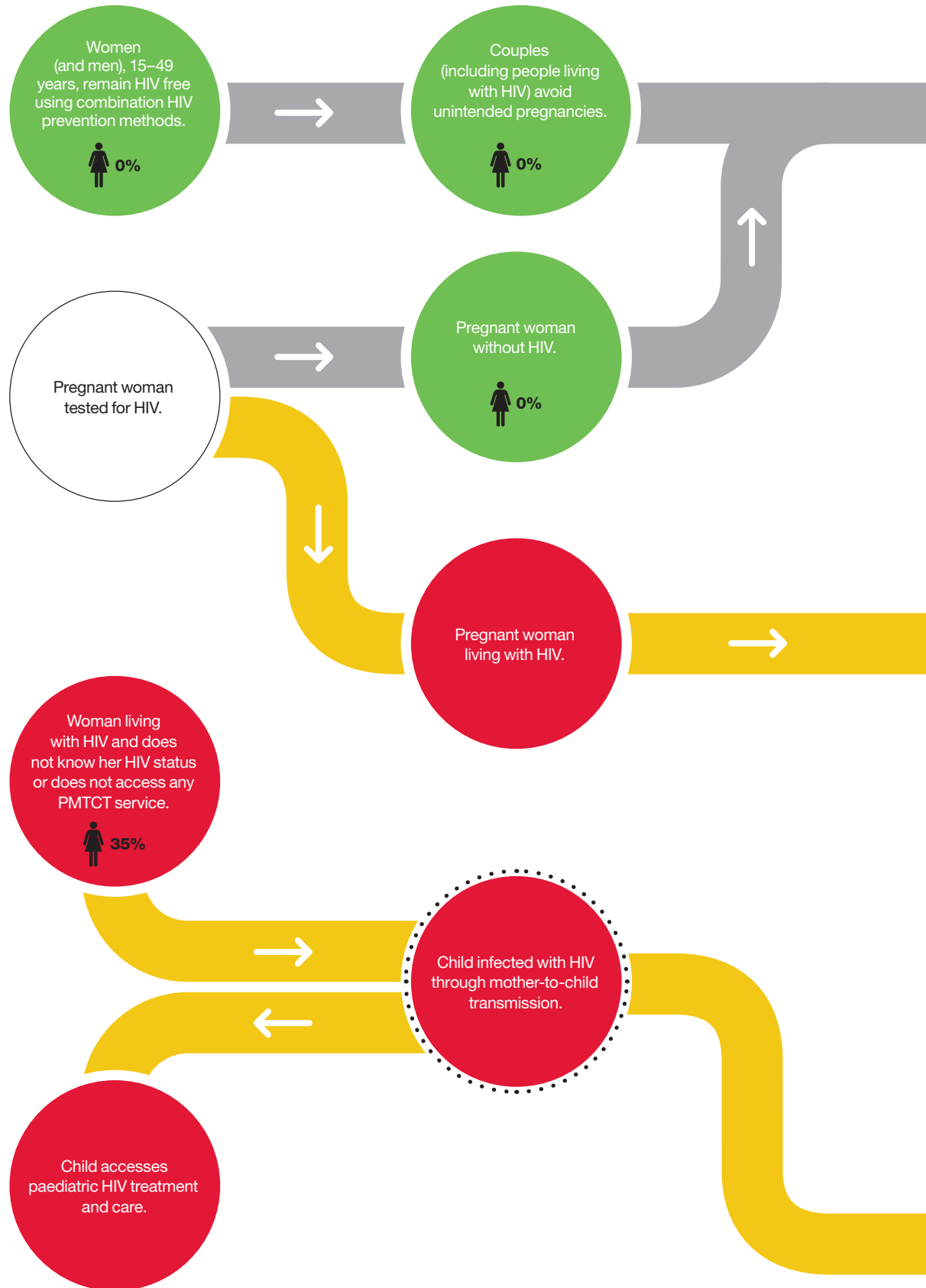
- No HIV transmission
- HIV transmission

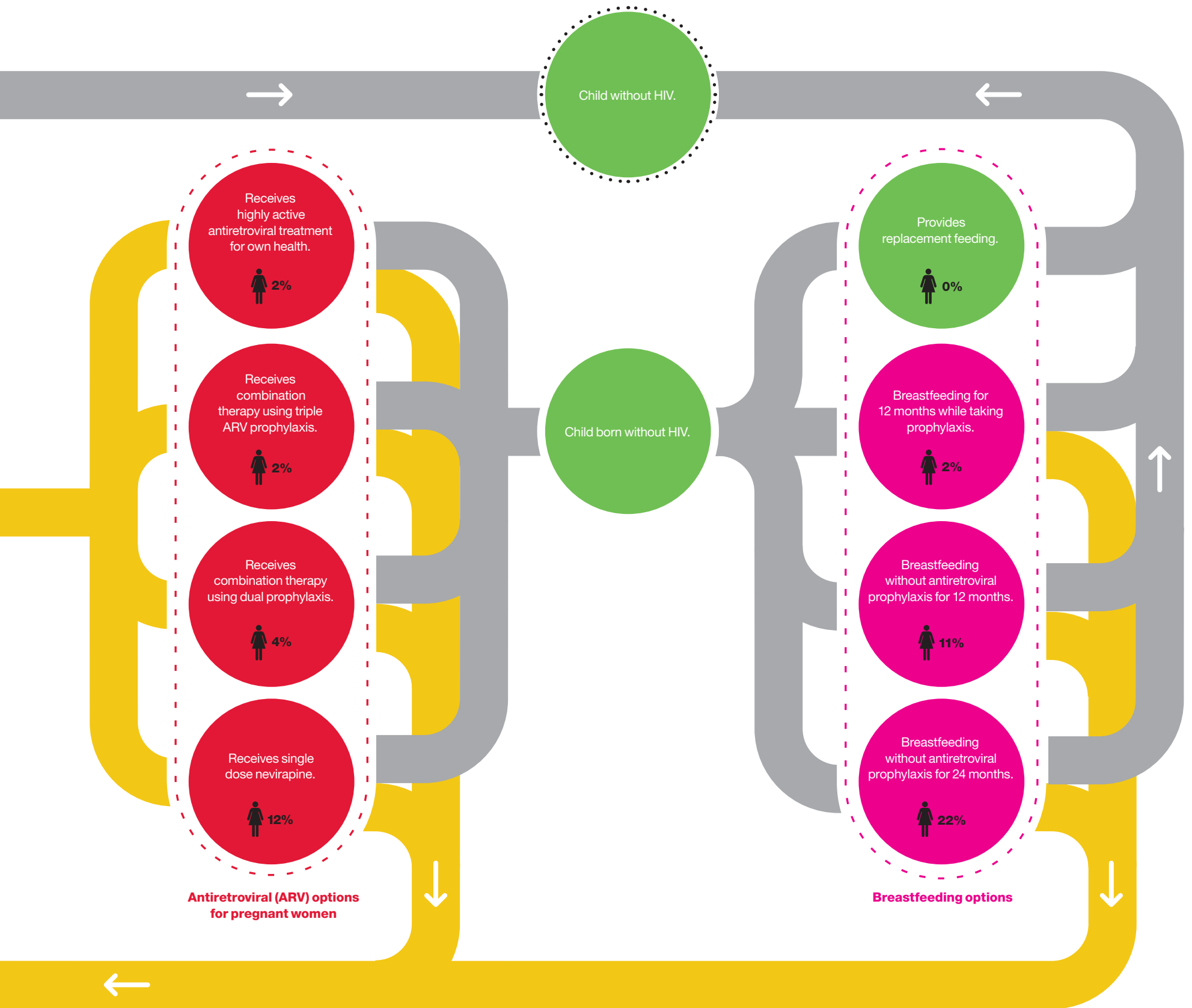


Risk of HIV transmission to children

OR

Monthly risk of HIV transmission to children through breastfeeding





Preventing mother-to-child transmission



Mahehloa is determined to stay healthy for her children, "I walk to work, I eat fruit every day and I pray to God that He will make me strong so that I can do what I can for my children."

Mahehloa Pitso from Lesotho

It was the end of 2007 ... 14 November 2007 to be exact. ... I will always remember that date. I was six months pregnant with my second child and on my way to the antenatal clinic for a check-up and tests. I had discussed taking an HIV test with my partner, Marlyn. It was something I had to do and he was very supportive, so we went to the clinic together.

At the clinic, I went through the pre-test counselling, but I really was not myself that day. I was so anxious. What if I am HIV positive, what will I do, what will happen to the baby? ... all these thoughts raced through my mind.

When the test came back positive, I could not believe it. It was not easy for me to accept at all. All I could think about was, I have plans, I have so many things to do in this world but I am HIV positive—what is going to happen to me, what is going to happen to my baby?

It was very difficult for me—my family did not accept the news at all. I do not think I could have got through it without Marlyn; he has been great. Even though we are a discordant couple (he is HIV negative), he was very supportive and helped me to come to terms with being HIV positive. I was lucky; not all women have such support.

Here in Lesotho, it is mostly the women who find out their HIV status first when they go for antenatal check-ups. So it is up to them to break the news to their partners. This is so difficult because many men just do not accept it—they reject their partners and refuse to take a test themselves. It is very hard for women here.

After the initial shock, I thought, enough is enough, I want to go on, live life and live positively.

But I was still worried about my baby. At that time, I did not know that treatment to prevent HIV from being transmitted to my baby existed. We did not know about preventing mother-to-child transmission back then. That is when the nurses at the clinic told me that, from seven months onwards, I could start the treatment that would protect my baby.

Luckily, my CD4 count was above 350, so I did not need to use the antiretroviral drugs for my own health. The nurses advised me on how to take the prophylaxis, and they gave me the zidovudine for my baby, the nevirapine ... the whole basic package.

I made sure I took my medication exactly when I was supposed to. I did not even want to be one minute late—if I had to take it at 8:00, I made sure I took it at 8:00.

I took the medication exactly as they told me up until I gave birth. But even after I had Emlyn, I was worried that he might have contracted HIV. But something inside me told me he had not, I had done all the right things, gone to all the check-ups—so I just hoped for the best.

I had to wait for six weeks to see whether Emlyn had HIV. That is when I found out he was HIV negative; it was such a relief.

I continued with the treatment for another three months because I was breastfeeding. But then I started to have problems. My CD4 count had dropped and my doctor told me I had contracted TB.

This was a real strain for me. The clinic that I was going to in Mabote where I am working now is



(top) Mahehloa Pitso starts her day at 5:30. She is a working mother with two children.

(bottom) Emlyn was born HIV free because Mahehloa took antiretroviral drugs to protect him when she was pregnant and breastfeeding.

Mahehloa also has a daughter, Relebohile. Relebohile is in the top 10 of her class. Most of Mahehloa's salary goes towards private school fees for Relebohile, but she does not mind. "It will give her a better future," she says.



(above) Mahehloa has many things to take care of: the children, the washing, fetching the water, planning the meals and cooking. Her days are busy.



(left) Mahehloa's partner Marlyn supported her when she found out she was living with HIV and accompanied her to her antenatal check-ups throughout her pregnancy.

(below) Mahehloa supports other mothers by sharing her experience and teaching them about family planning, preventing mother-to-child transmission, breastfeeding and how to live healthily with HIV.

(right) Mahehloa now works with mothers2mothers, which supported her throughout her pregnancy. Mothers2mothers is a nongovernmental organization that supports mothers living with HIV to enable them to live healthy lives and protect their babies from becoming infected with HIV.



close by, but now I had to go to Senkatana—that is where the TB clinic is, but it is a long way away. I had to take a taxi from Mabote to Senkatana.

It was very expensive, but I did it because I wanted to be OK for my children. Marlyn came with me to all the visits; he helped me a lot.

I had to take treatment for TB for six months and, like the antiretroviral drugs, I made sure I took it very well until I got better. And now I am fine, I am OK!

I had so much support from the nurses at the Mabote clinic and from my counsellors at the mothers2mothers group (a nongovernmental organization that supports mothers living with HIV to help them live healthy lives and protect their babies from becoming infected with HIV) that I wanted to give something back—to help other mothers who are going through the same thing. So I now work with mothers2mothers as a counsellor.

The work is hard. Stigma and discrimination is a major problem, especially around here. If there were no stigma and discrimination, then it would be so much easier to cope. Sometimes the other mothers have to come to me just to take their antiretroviral drugs because they cannot do it at home because they fear discrimination if people in their communities find out they are HIV positive.

The discrimination is worse than the disease. That is why most people are dying: because of fear of discrimination, people do not accept their status and do not seek help. People living with HIV, especially mothers, need support from their families and their communities but they just do not get it.

I think the community needs to be educated about HIV. They do not know enough about HIV. They do not even know what the disease is or how you can get it. That is why it is so important to teach communities about HIV. Many mothers do not come to the clinic until they are really ill, and even if they test positive, they ignore it because of the discrimination they will face if people find out.

We want mothers to live positively and live normally. The mothers2mothers programme brings me a lot. If I had not joined this movement, I would not be where I am today. I would not have taken the treatment to prevent mother-to-child transmission and would not have been able to make sure Emlyn was born HIV free.

I love my job. It is rare now to see an HIV-positive baby at our clinic. If we do, it is not good because that means we are not doing our job properly.

Special children, special challenges

In 2009, only 6% of the children born to mothers living with HIV were tested in time to receive life-saving treatment.

Without treatment, one third of children born with HIV will die by their first birthday, 50% by the age of two years and 80% before they reach five years old.

Only 28% of children in need had access to treatment for HIV in 2009 versus 37% of adults.

2.5 million children were living with HIV in 2009, and 1.3 million needed treatment for HIV.

In 2009, about 260 000 children younger than 15 years died of HIV-related causes. Most were younger than five years, and more than 90% lived in sub-Saharan Africa.

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Civil society activism

Thirty years into the AIDS response and at a time when the world faces competing global priorities, civil society activists give us a timely reminder that the whole architecture of the AIDS response—at the global level and in countries—is to service and support communities.

Often working 24/7 for the sake of a just AIDS response, they have been massive agents of change across the globe.

Civil society activism

Betty Makoni

Betty Makoni founded the Girl Child Network in Zimbabwe in 1998. It is now an international platform recognized for its innovation and effectiveness in delivering girls' empowerment programmes within communities.

Civil society means people organizing themselves at the community level. We are the problem-makers, we are the problem-solvers. The solutions are with us.

One main way you can prevent HIV infection is to reach young girls and support their empowerment. You give them basics so that they do not go to older men for marriage. That's a community response. That's civil society taking over and owning the processes of change. Young girls often do not have the power to negotiate for safe sex. A woman like myself, I even find it difficult to say "use a condom". What about a girl who is 15 with no livelihood?

We started the Girl Child Network in 1998 with a group of 10 girls and, by 2008, we had reached 70 000 girls with school empowerment clubs. But it did not end there. We realized that the issues were being brought into the community—to their parents and traditional leaders. Even the traditional healers who thought that sex with virgins was a cure for HIV started to form community-based organizations. Village monitoring communities began where chiefs and other leaders were the ones on the ground formulating programmes to protect girls.

Previously we did not know that a chief could lead a HIV prevention programme. We always thought: "maybe a doctor, maybe a social worker; maybe those people in the city are the ones who have the knowledge". But we found a lot of very positive cultural practices in communities, and we took advantage of these.

Curbing gender-based violence has been a community response that I have witnessed, resulting in men shying away from polygamous marriages, shying away from taking young girls. Education, the elimination of gender-based violence and an end to apologies about gender inequality in a community—these can bring about the real changes we need.

Community role models are also great agents of change. In some villages, you can point to the graves and say "that is Maria who did not go to school, whose parents married her off". In contrast to Margaret, whose parents supported her in going to school and who now has a good job. So these are not just statistics; these are individual stories.

I have seen the transformation of a girl coming from a village where there is virtually nothing, where she is supposed to die a silent death of AIDS, to a woman who is in the fullness of her potential. It shows that 10-year implementation of a community programme that is focused on empowerment as a holistic package can bring about change.

The limitations of our HIV programmes are caused by the limitations that do not take into

account the religious and cultural barriers where a woman is disempowered in the first place.

In terms of responding to HIV, civil society plays a critical role in the ownership of the programme. If a community owns the response, it becomes less expensive. It becomes your responsibility as a community to formulate programmes, to implement them, to evaluate them. And how they benefit you is related to how passionate you are about implementing them. This is not like a 9-to-5 job. This is actually the community working 24/7 to make sure that there are no new infections.

Whatever strategies are formulated, they have to keep the communities in mind. Change does not happen at any other level except at the community level.





Michael Kirby

Honourable Michael Kirby, retired judge of the High Court of Australia, an AIDS activist since the 1980s. He is a member of the UNAIDS Reference Group on HIV and Human Rights and the Global Commission on HIV and the Law.

HIV and AIDS affect ordinary people. Civil society grows out of ordinary people. It is civil society that makes a difference between a community that cares and reacts to the problems of each other and a community that is autocratic and ruled from top down and does not involve its citizens and other people living in it.

Civil society speaks up for the vulnerable, and that is not always the case, even in democracies. That is why civil society is so important for a vibrant, human rights-respecting community. In the matter of AIDS, we certainly need civil society to speak for the vulnerable.

I have been involved in the AIDS world since the mid-1980s. I detect a feeling of exhaustion, and certainly a feeling that the funding we have assumed will be available for antiretroviral therapy for people living with HIV will keep on expanding to meet the needs of people who are sick. That cannot be certain any longer. And that is something that should engage civil society, but I get a feeling that it is rather discouraged by current developments.

This includes many factors: the financial situation; the shortfalls in the replenishment for the Global Fund to Fight AIDS, Tuberculosis and Malaria and for other forms of support for HIV treatment; and the current negotiations to reduce the TRIPS

[Trade-Related Aspects of Intellectual Property Rights] flexibilities and to enhance the intellectual property protections for pharmaceutical companies. Also, the need to access the second-line and third-line therapies, which are often within patent protection but threaten to increase the costs of antiretroviral therapy for hundreds of thousands and potentially millions of people.

The ultimate irony and cruel blow will be if, having got people onto antiretroviral therapy, by a combination of the global financial crisis, the downturn in the available funding plus the need for new line therapies, we ultimately have to withdraw the availability of treatment for people who are currently receiving it. That would be a real cruel blow for the international community to inflict on sick people.

I attended a dialogue with religious leaders in March 2010, sponsored by UNAIDS. Everything went swimmingly until the last moment, when a document was produced for the purpose of indicating the levels of agreements that were achieved. When I suggested that that document would not have much power if it did not refer to the vulnerable groups—men who have sex with men, sex workers and people who inject drugs—the religious people present said they could not sign on to a document that made any reference to such groups.

So long into the epidemic, 25 years into the global response, the fact that people will turn a blind eye to the realities of the world and to people who are suffering and will refuse to even name them by name is a rather discouraging fact. And if we look at the countries that have laws that impede sensible strategies and human rights-respecting

strategies for these groups, we have to admit that we have not made very much progress.

The main barriers to achieving universal access to HIV prevention, treatment, care and support are the global financial crisis, the general malaise and exasperation and the rise of political, social, cultural and religious opposition, even to speaking about these subjects.

We saw an example of that in the recent resolution before the United Nations General Assembly, which sought even to take out of a regular resolution the condemnation of extrajudicial killing of homosexuals. Ultimately, the words “on the grounds of sexual orientation” were restored on an amendment proposed by the United States. But the fact that so many countries could even consider taking that out is very discouraging. We have to be very realistic.

That is the one thing I learned in the earliest days of the epidemic in the WHO Global Commission on AIDS. And I learned it from a very fine public health expert, June Osborn from the United States. All strategies and all policies on AIDS must be founded on sound empirical data, not on hopes, not on fears, not on prejudice, not on dogma, but sound empirical data.

Well, the sound empirical data in many countries at the moment is that the rich do not want to pay too much and want to reduce what they are paying, and the poor do not want to talk about the ways in which people get infected with HIV and do not want to remove the legal barriers that stand between those people and the health messages that are essential to their lives.

Gracia Violeta Ross

Gracia Violeta Ross co-founded Bolivia's first organization for people with HIV: the Bolivian Network of People Living with HIV/AIDS. She has been an advocate since 2000, when she discovered that she was living with HIV.

Today in Bolivia people have access to HIV treatment. This came about as a response to a case brought by people living with HIV to the Inter-American Commission on Human Rights. In 2002, 52 people living with HIV demanded that the Bolivian state take precautionary measures to avoid our deaths. The Commission found in favour of people living with HIV, and the Bolivian government responded in 2004 by sourcing the first donations of antiretroviral medication from Brazil.

By that time, only 22 of the original 52 signatories were still alive.

A new constitution in Bolivia puts strong civil society at the centre of policy-making and programming. Civil society in Bolivia consists of a wide variety of groups organized by ethnic identity, sex, regional affiliation, labour and many others. In relation to AIDS, all the responses in Bolivia can be traced back to an initial push from civil society.

Civil society, however, is facing an identity crisis, and activists who have been working tirelessly long term are facing exhaustion. There are competing global priorities, and HIV is not perceived as a priority any more.

I am disappointed at the overemphasis of some civil society groups on certain issues such as the right to an identity. This has produced a backlash from governments on the fundamental right to health and life. I also feel strongly that, to reach the vision of zero new infections, zero AIDS-related deaths and zero discrimination, we have to shift the direction of planning and programming so that instead of it coming from Geneva and New York down to the countries, it all happens the other way around. Also, we need accountability about results. Otherwise, the future and basic funding for AIDS will be bleak.

Looking to the future and the main barriers to achieving universal access to HIV prevention, treatment, care and support services in Bolivia, I am concerned by a lack of political commitment and the country's high dependence on international cooperation, which can be fickle.

Civil society is the force that drives change at the country level, and governments respond to our needs. Civil society is in the centre of the problems and solutions.

We were ready to act before any resources were available, and we will continue to do so. This is because this advocacy elevates fundamental human rights for all, especially the right to health and the right to life.



Civil society activism



Mark Heywood

Mark Heywood is a founding member of the Treatment Action Campaign South Africa, which advocates for increased access to treatment, care and support services for people living with HIV.

From the very earliest days of the epidemic in the 1980s, civil society has been the motor driving the response to HIV. It was affected people who said that this is a human rights question, who drew attention to non-consensual testing for HIV and who drew attention to discrimination against people who tested positive for HIV.

That is not to say that the United Nations, governments and scientists played an unimportant role. But how the AIDS epidemic differed to other global health threats in the past is this: the consistent voice of civil society has meant that it has been difficult for people with power to drop the ball. Civil society created the need for accountability, answerability, urgency and resources.

Although we elect governments, they do not tend to act in the best interests of people unless they are under pressure to do so. And while organizations that exist at the level of the United Nations take their mandate from the real world, they get detached from the real world. It takes affected people to bring them back to earth and to shape their agenda. I think that is what civil society has done and so I think it has been a very, very positive influence.

The big question now is: how do you sustain the civil society movement? You cannot take it for granted as it does not 'just exist': it has to be built.

At the end of the day, civil society movements that are built in space are not very strong. A civil society movement gains power only to the extent that it is genuinely representative of ordinary people.

In South Africa, 1.5 million people are on treatment. A decade ago, nobody was on treatment. But there are still 3.5 million who will need treatment. The strength of all civil society is always in the local. We have to keep strong organized constituencies; otherwise, we do not have power against our government or in relation to what is happening in the international community.

We need to keep focus on what we call 'treatment literacy': making ordinary people understand why treatment is important. Empowering people is not just in relation to their national government but in relation to their local government and their local clinic.

Civil society effort is about making citizens out of people. Because a citizen is somebody who knows what their rights are, who knows their relationship to the structures of government and who is prepared to be outspoken and to demand what they are entitled to and play a role within their society. You do not build these things overnight. I think people talk too easily about civil society. They do not understand what a sweat it takes: the labour of constructing a movement, educating people, creating trainers, the difficult political decisions that have to be made at times, the difficult experience of being in a civil society movement. The Treatment Action Campaign literally started with 10 people in our first demonstration in Cape Town in December 1998. It was through that group of people, the actions,

demonstrations and advocacy—that we were able to grow from 10 to 20 to 100. And at the height of the campaigns of the Treatment Action Campaign, we had probably about 30 000 active volunteers.

What troubles me now is how do we sustain it? You cannot artificially sustain civil society. It is not just about pumping money in, although money is very important.

You can say that we have had 25 years of a growing movement that starts in the United States and literally spreads throughout the world. As we sit here in 2011, developed countries are now consumed by other global challenges, whether it is climate change or other threats. But my view is that nothing has made HIV less urgent or less important than it was 10 or 20 years ago. Also, civil society has to renew itself constantly because people who have been leading organizations for 15–20 years get tired.

I think that movement is sputtering now. If you do not keep it strong, then I predict that the AIDS response in the next two to three years will slide downhill. So it worries me because I think there are many challenges faced in the global response to HIV, but the challenges will be much greater if there is not a driving force to drive things forward.

I believe it is really important for any donor, for UNAIDS, for anybody who genuinely believes in trying to resolve the AIDS crisis, to understand that civil society is not just an offshoot of the response. To understand that civil society is absolutely integral, central to the response.

Civil society activism



Daouda Diouf

Daouda Diouf works for Enda Santé in Senegal. The organization has expanded its initial focus on gay men and sex workers to providing prevention and anti-discrimination education and counselling to a wide range of people living with HIV. It is active in 18 countries across West and Central Africa.

Civil society was at the forefront in convincing people and government and decision-makers of the emergency and the specific character of the HIV epidemic. It draws attention to which part of the epidemic has the greatest burden on the community so that we have been able to say to leaders, “Here is where we should invest more of our efforts and our resources.”

Civil society also plays the role of watchdog in terms of good governance and transparency. Not only the governance and transparency of how money is used, but also the governance to make sure that we are using adequate strategies that are able to respond to the needs of people who are affected by HIV. That these involve people with HIV and marginalized groups and that human rights are a key component of the response.

We bring in the experience of people—because HIV is about people and their lives—of family and community. Meeting the needs of the community experience is vital for a response to be successful.

In many countries where the service delivery of HIV treatment, care and support has been efficient, it is because of the involvement of civil

society in helping to decentralize these services, bringing them closer to the people and communities.

The reduction of stigma and discrimination has mainly been the struggle, the fight of civil society organizations. For example, in many countries now, people are including marginalized groups such as men who have sex with men and people living with HIV at the centre and as key actors of the response thanks to civil society efforts. There are concrete examples in many countries in Africa, particularly where civil society has played a very critical role.

In my organization, we are trying to strengthen community groups and marginalized population groups so that they have more access to services and for their rights to be respected. In West Africa, stigma is still a very high barrier to universal access to HIV services.

And in many country responses, the human rights dimension is still very minimal. I think that as long as human rights are not at the centre of the response, there will be major barriers to access to care and treatment.

18

Voices for the voiceless

Voices have shaped the AIDS movement. People living with HIV, activists, politicians, nobel laureates, presidents and communities have all contributed in raising and solving the issues confronting the AIDS response. Giving voice to the voiceless makes change happen.

Voices for the voiceless

HIV prevention

The problem of HIV infection affects society as a whole, without exception. And for this very reason, everyone and, certainly, our children must have more information about the HIV/AIDS epidemic. Forewarned is forearmed.

Maria Kiseleva

Abstinence, being faithful and correct and consistent condom use are the only ways to successfully reach everyone when discussing HIV prevention. I believe that the abstinence message alone does not solve the AIDS epidemic.

Ashley Judd

Wait, stick to one partner or use a condom.

Kumar Sangakkara

People living with HIV have the right to live well with HIV, including having a healthy sexual life.

Javier Hourcade Bellocq

We must stop being complacent. The more we reduce the HIV prevalence, the more we must work hard to keep it low.

Robert Joseph Mettle-Nunoo

AIDS occupies such a large part in our awareness because of what it has been taken to represent. It seems the very model of all the catastrophes privileged populations feel await them.

Susan Sontag

Leaders at the highest levels must be attentive to the AIDS response in their countries. We must urgently implement efficient and non-discriminatory HIV prevention initiatives.

Jacques Chirac

Be smart. Protect yourself. Stand up for equal rights for all.

Michael Ballack

We need men and women to sit down and talk to each other about sex honestly and openly. That would help us fight AIDS so immediately. But our lack of communication is hugely problematic.

Emma Thompson

Women

We must take responsibility for our own life. It is possible only if we overcome internal barriers. Many women suffer from self-stigmatization, they think about themselves and their children as outcasts. And it's a dead end. I'm trying to change it.

Indira

One is that if women's sexuality in Africa wasn't under assault, if women were able to say no, if women weren't subject to predatory attacks by men, or predatory behaviour generally, then you would have a disease in Africa called AIDS. But you wouldn't have a pandemic.

Stephen Lewis

If you have unequal access to education, you are at risk of HIV. If you have unequal access to resources, you are at risk. If you have an inability to have a say in your society's social, economic and political life, you are also at risk. And if you, as a woman, are viewed with less justice than a man is, then you are definitely at risk.

Marina Mahathir

Marriage is the main risk factor for HIV infection among women.

Hakima Himmich

We can only improve HIV prevention for the trans community in Latin America through respect from health services towards each trans woman and for her identity.

Marcela Romero

Often women say that they know that they take risks, but they have no choice. Women and men are not equal in these negotiations on the use of condoms.

Maha Aon

One of the biggest challenges I am facing as a woman living with HIV since 1998, approximately, is achieving my goals of getting married and having babies in a country like Bolivia that denies the HIV epidemic and where women who speak about their HIV-positive status are rare and not suitable for marriage.

Gracia Violeta Ross

Preventing mother-to-child transmission

We can prevent mothers from dying and babies from becoming infected with HIV. That is why I am calling for the virtual elimination of mother-to-child transmission of HIV by 2015.

Michel Sidibé

Liberia commits to virtually eliminate mother-to-child HIV transmission. I believe Liberia can attain zero babies born with HIV.

Ellen Johnson Sirleaf

Isn't it an immense injustice that thousands of children still are born with HIV, when treatment exists, when no baby needs to be born with HIV?

Carla Bruni-Sarkozy

Let me reiterate the government's commitment at the highest level to vigorously combat HIV and AIDS in Ghana, provide the necessary resources, bring mother-to-child transmission to zero level, to prevent innocent children born infected and to continue sustained efforts to reduce stigma against those infected and affected.

John Dramani Mahama

Stigma and discrimination

I live in the hope of a world that will be free not only of disease but of fear and discrimination.

Dominic D'Souza

It has been both unfortunate and unfair for HIV infection to be considered a shameful disease, for people living with HIV to be judged as blameworthy and for AIDS to be equated with certain death. I have personally seen that dignity and hope have been strongest among those whose lives were changed by HIV.

Naomi Watts

HIV attacks our body; the stigma and discrimination affects our soul, our mind. With the treatments available today, the wounds of the body can be treated. Scars of the soul and spirit can take decades to fade or even last forever.

Tarik

People have value as human beings whatever happens, or whatever disease happens to you. Everybody has their own values so you don't need to be discouraged. You must uplift your spirits and strength. I say these words not only to the patients but also to everybody ... high and low status depends only on each person. Everybody needs to know that they can consider themselves a dignified person.

Aung San Suu Kyi

HIV does not make people dangerous to know, so you can shake their hands and give them a hug: heaven knows they need it.

Diana, Princess of Wales

Today we are facing real social challenges because it is very difficult for a transgender to live a proper life; in many instances, we hide our lifestyle. Many families throw their transgender children on the street without any options for survival except to become another sex worker.

Suzu Q and Tanoa

Like all of us, my friends who are living with HIV should have the opportunity to live full and dignified lives.

Yao Ming

Stigma and discrimination helps to poison people's hearts and lead them to forget the human virtue of compassion.

Thomas Cai

The answer to AIDS is really an answer about what kind of society and what kind of values you would like to live by. Stigma on AIDS is like going back to the Middle Ages.

Mohamed ElBaradei

Voices for the voiceless

Hope

I dream of a life without HIV/AIDS; I dream of the baby born today as living his/her whole life free from HIV fears.

Amira Herdoiza

Live for today, appreciate loved ones, make plans and step over the fear of the unknown future—this is what I'm learning today.

Sergei Fedorov

A thousand pressing issues come with each day. But there are only a few that you will want to talk about in retirement with your children. The continuing fight against global AIDS is something for which America will be remembered. And you will never regret the part you take.

George W. Bush

We want to be artists, teachers and doctors — even get married and have kids.

Keren Dunaway-Gonzalez

Zero usually means 'nothing'. But when it comes to HIV, it means 'everything' in the world. Zero infections, zero discrimination and zero AIDS-related deaths has to be the goal for us all, including China.

James Chau

The global HIV/AIDS epidemic is an unprecedented crisis that requires an unprecedented response. In particular, it requires solidarity—between the healthy and the sick, between rich and poor and, above all, between richer and poorer nations. We have 30 million orphans already. How many more do we have to get to wake up?

Kofi Annan

We are all HIV-positive.

Diamanda Galás

It is my hope that together we can move closer to the day when we can eliminate this disease from the face of the Earth.

Barack Obama

I have learned more about love, selflessness and human understanding from the people I have met in this great adventure in the world of AIDS than I ever did in the cutthroat, competitive world in which I spent my life.

Anthony Perkins

I strongly believe that, in the world with no vaccine against AIDS, information remains the only remedy to apply in fighting the virus.

Elena Pinchuck

Community mobilization

It is not about being proud to come out and admit that the disease is with us. It's about being realistic. That's when fighting it can begin.

Zackie Achmat

People living with HIV still suffer the dictates of the enemies of humanity; our war against the exclusion and denial depends on our engagement and our commitment to ensure our participation in the response to HIV/AIDS effectively. We must occupy space, nature abhors a vacuum, and we need to prove that our destiny is in our hands.

Nawel

Universal access to HIV/AIDS prevention is the goal for which I struggle to build equity; the way I build it.

Fernando Muñoz

I thought nothing would improve unless we organized.

Sunil Pant

If we are to turn this pandemic around, South Africans have to really understand what the virus is, how it is spread, that it is not a death sentence thanks to medical treatment and to put an end to the fear and stigma of living with HIV.

Jimmie Early Perry

Although the road ahead is still long, we are on the right path to achieve a world without AIDS. This goal will be reached by following a model of research—continued basic and clinical research, investment of both public and private sectors, public health interventions and the participation, which should be strongly acknowledged, of people living with HIV/AIDS.

Françoise Barré-Sinoussi

AIDS advocacy

The HIV epidemic is complicated by the attitude of society towards HIV-positive people. Often they are perceived as dangerous, unworthy of treatment. The task of the media is to tell people the truth about the disease and help ordinary people to change their attitude towards people living with HIV and AIDS.

Vladimir Pozner

All men, women and children cannot fight on an equal footing against this disease. Unfortunately, access to prevention, screening and treatment remains impossible to many.

Princess Stéphanie of Monaco

We can and we must stand for the value of life, confident of the dramatic and inspiring results that would follow, for the poorest of the poor, and surely for ourselves and our children as well.

Jeffrey Sachs

We have failed to take HIV/AIDS seriously. That failure is a betrayal of our struggle for social justice and hope for our society.

Nelson Mandela

We have to stop blaming the victims and stop looking for reasons for leaving them to look after themselves. We are in it together.

Amartya Sen

I believe AIDS is the most important issue we face, because how we treat the poor is a reflection of who we are as a people.

Alicia Keys

When we walk away from global warming, Kyoto, when we are irresponsibly slow in moving toward AIDS in Africa, when we don't advance and live up to our own rhetoric and standards, we send a terrible message of duplicity and hypocrisy.

John F. Kerry

HIV treatment

We have broken the trajectory of the AIDS epidemic. But we still have a long way to go. Everybody should have the same rights like you and me. Right to education, right to choices, right to live a happy, healthy life and right to not be stigmatized against.

Toumani Diabaté

The survival of thousands of people depends on our behaviour. All fighting HIV.

Comlan Houessou

I'd lost 99.9% of my best friends to AIDS. Why did I live and they die? It's simple—I had access to these [antiretroviral drugs].

Loon Gangte

I tell you, it's funny because the only time I think about HIV is when I have to take my medicine twice a day.

Earvin 'Magic' Johnson

What is startling is the bleeding of the CRN+ membership due to deaths linked to adherence issues, signifying the continued need for attention to the pervading psychosocial factors that led to this situation.

Yolanda Simon

Access to treatment is a basic human rights issue. People do not have to die from AIDS.

Annie Lennox

I recommend the same therapies for all humans with HIV. There is no reason to believe that physiologic responses to therapy will vary across lines of class, culture, race or nationality.

Paul Farmer

We must categorically reject any attempt to so-called 'normalize' AIDS or treat this epidemic as just one of many medical problems.

Peter Piot

19

Invested resources

The AIDS response is a shared responsibility. Investments in AIDS have increased from millions to billions. However, resources available for HIV prevention, treatment, care and support are beginning to decrease, even as results show value for money and the demand for services grow.

Invested resources

How we invest in AIDS

“Ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results.” This was the commitment that leaders made in 2001 when they signed the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS.

Since then, annual investments in AIDS have increased rapidly—from US\$ 500 million in 1996 to nearly US\$ 16 billion at the end of 2009. However, there are indications that annual investments have decreased in 2010.

Investments have been a shared financial responsibility: nearly half the resources invested in the AIDS response has come from low- and middle-income countries and the other half from donors.

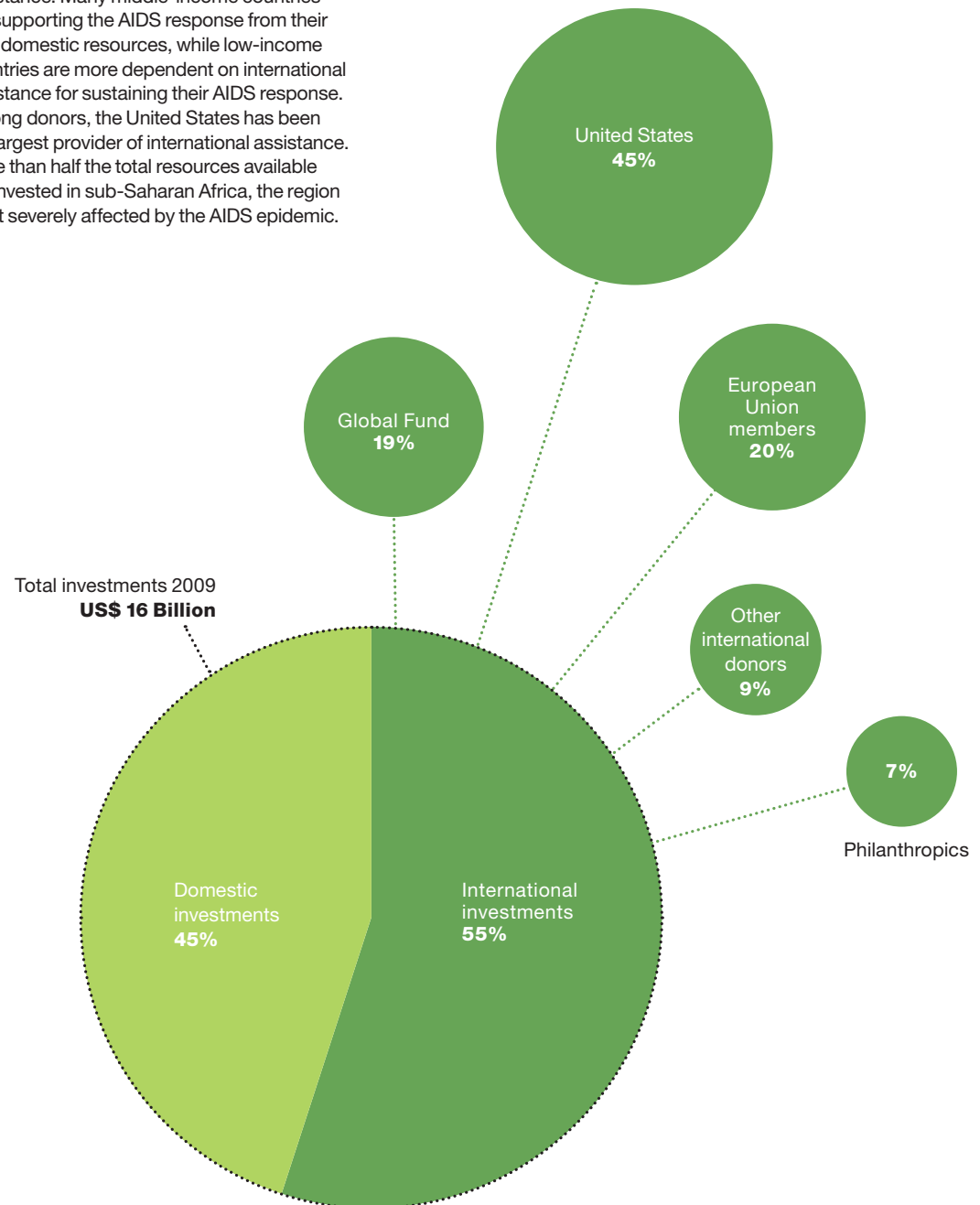
Investments are paying off; the trajectory of the AIDS epidemic has been broken. Fewer people are becoming newly infected with HIV. Fewer people are dying of AIDS-related causes.

The slow economic recovery in 2011 has put pressure on donors and low- and middle-income countries and their investments in the AIDS response. Even when investments were rising, resources available have always fallen short of the needs. At the end of 2010, about 9 million people were waiting for HIV treatment in 2010, and 2.6 million people were inadequately protected from HIV infection in 2009.

As HIV infection becomes recognized as a chronic condition, rather than a medical emergency, more needs to be done with less—increasing cost-effectiveness, improving efficiency, reducing duplication, reducing unit costs, setting priorities and ensuring fair-share investment.

AIDS investments— a shared responsibility

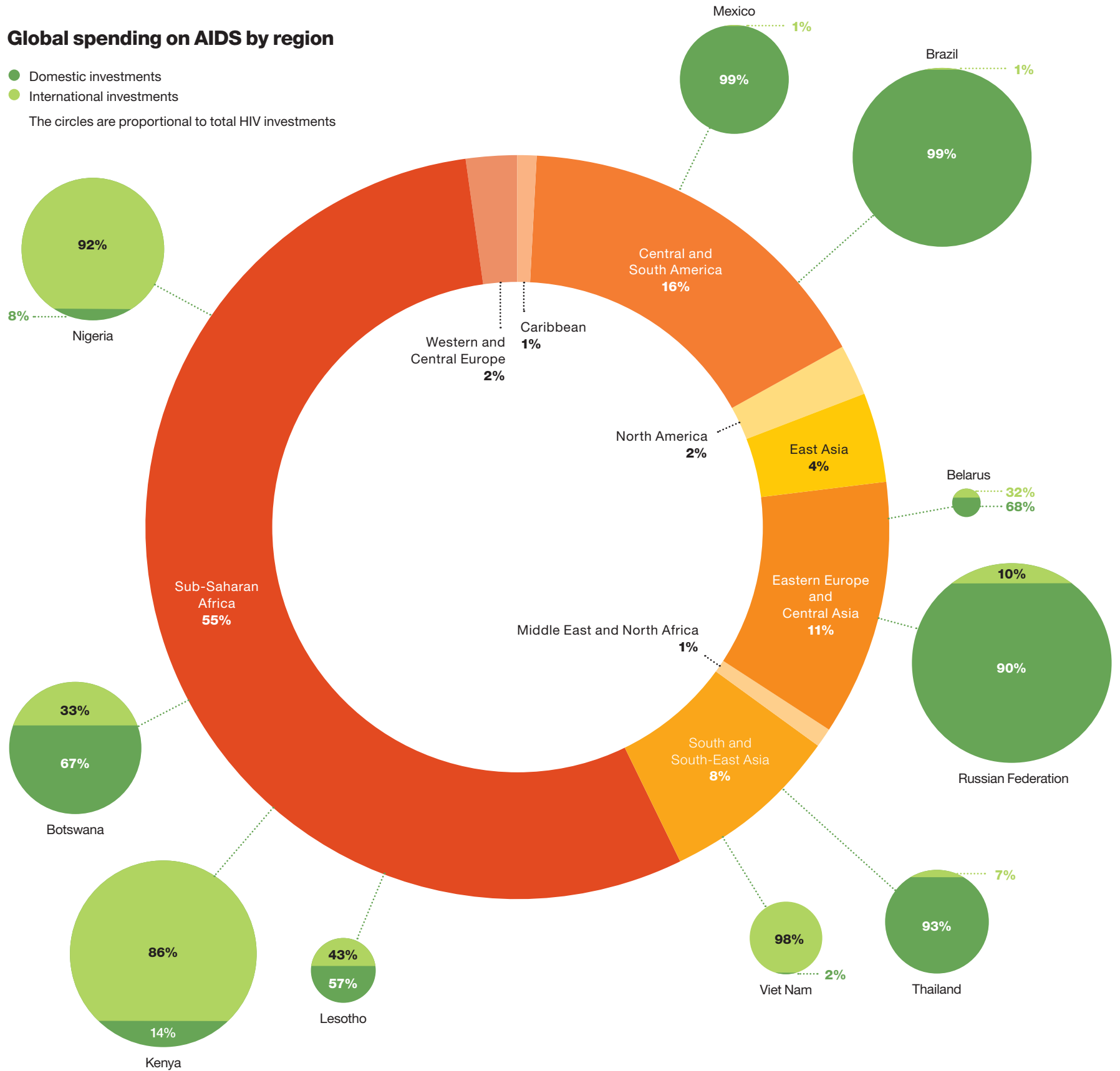
Responsibility for financing the AIDS response is shared. Nearly half of all resources available for the AIDS response comes from domestic sources; the other half is international assistance. Many middle-income countries are supporting the AIDS response from their own domestic resources, while low-income countries are more dependent on international assistance for sustaining their AIDS response. Among donors, the United States has been the largest provider of international assistance. More than half the total resources available are invested in sub-Saharan Africa, the region most severely affected by the AIDS epidemic.



Global spending on AIDS by region

- Domestic investments
- International investments

The circles are proportional to total HIV investments



Invested resources

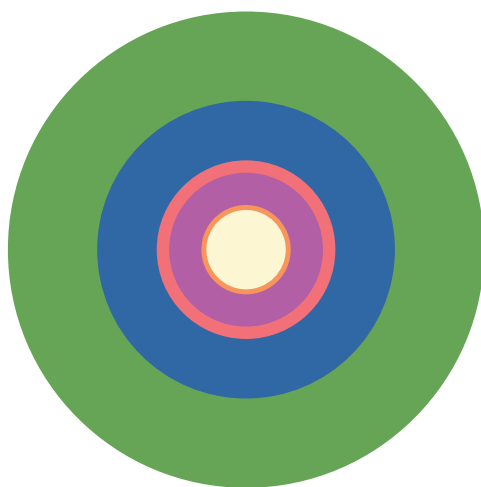
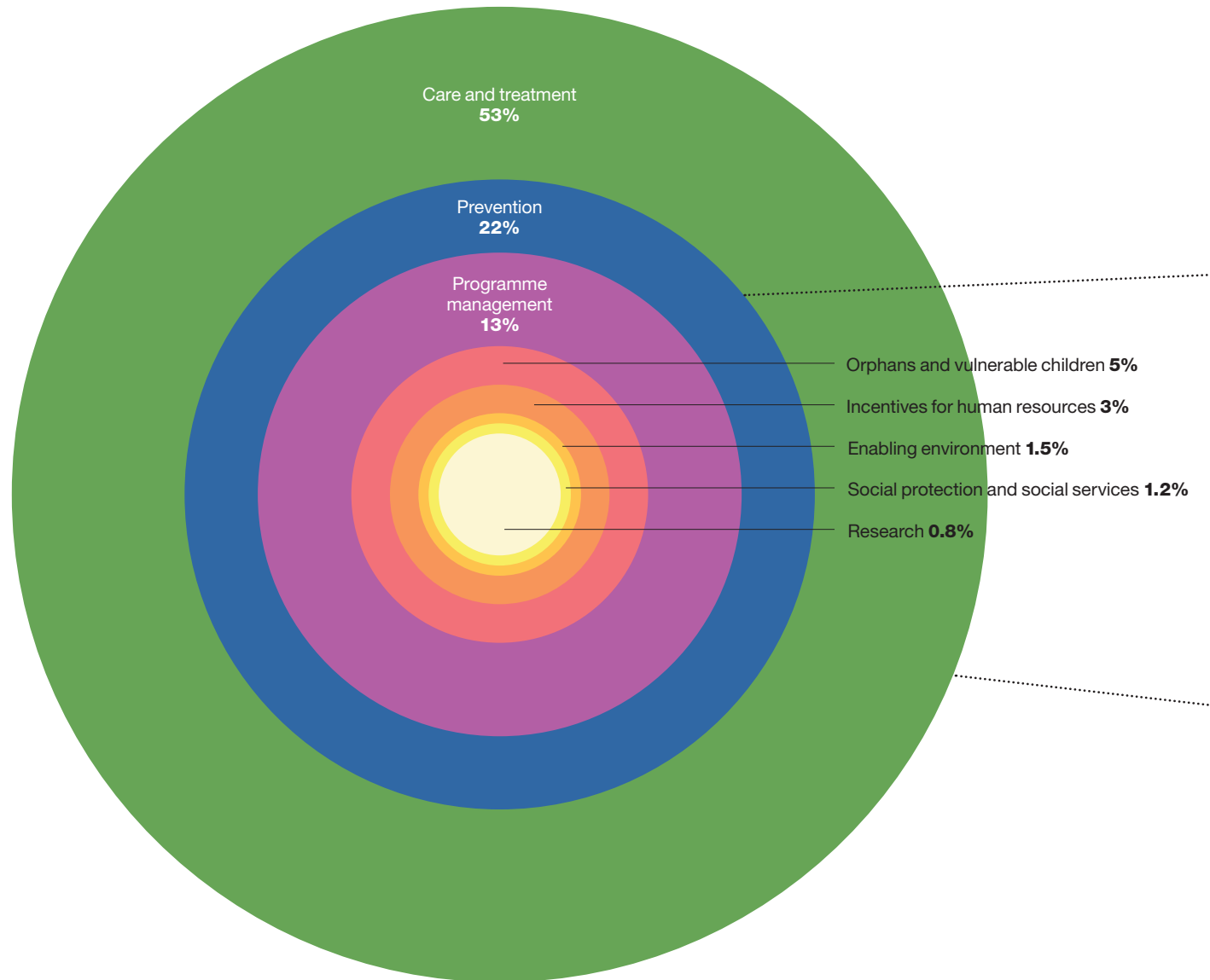
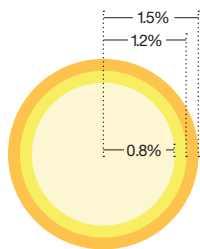
Where does the money go?

More than half of all resources available are invested in treatment programmes. These investments are a lifeline for more than 6 million people receiving HIV treatment in low- and middle-income countries. Nearly a quarter of resources available are allocated for HIV prevention activities.

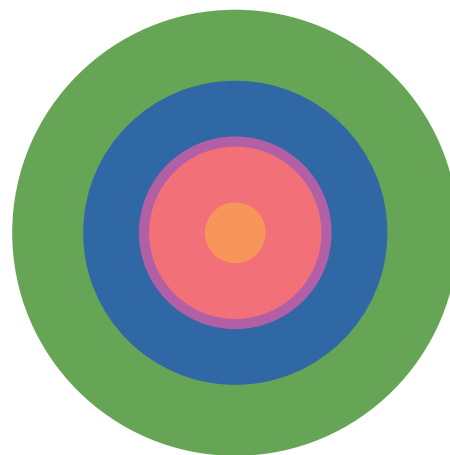
These charts show investment data from 90 low- and middle-income countries. Investment patterns vary from country to country.

- Care and treatment
- Prevention
- Programme management
- Orphans and vulnerable children
- Incentives for human resources
- Enabling environment
- Social protection and social services
- Research

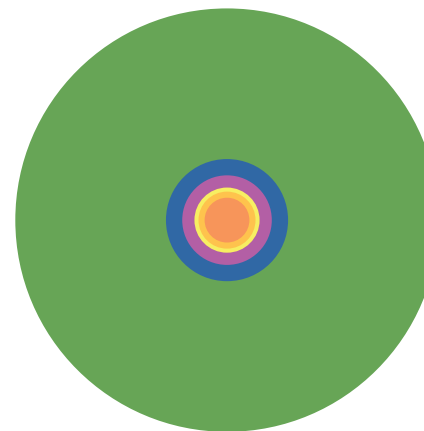
The circles are concentric and % values are measured from the centre.



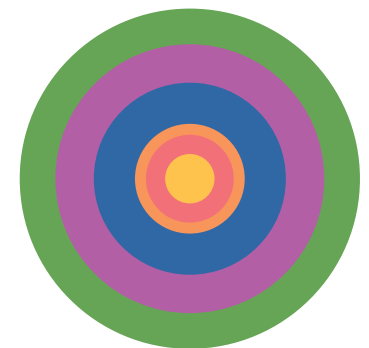
Russian Federation



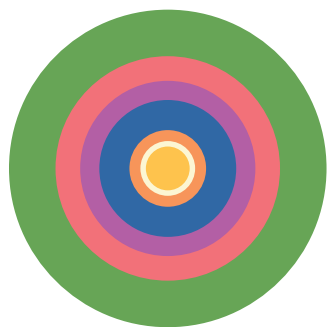
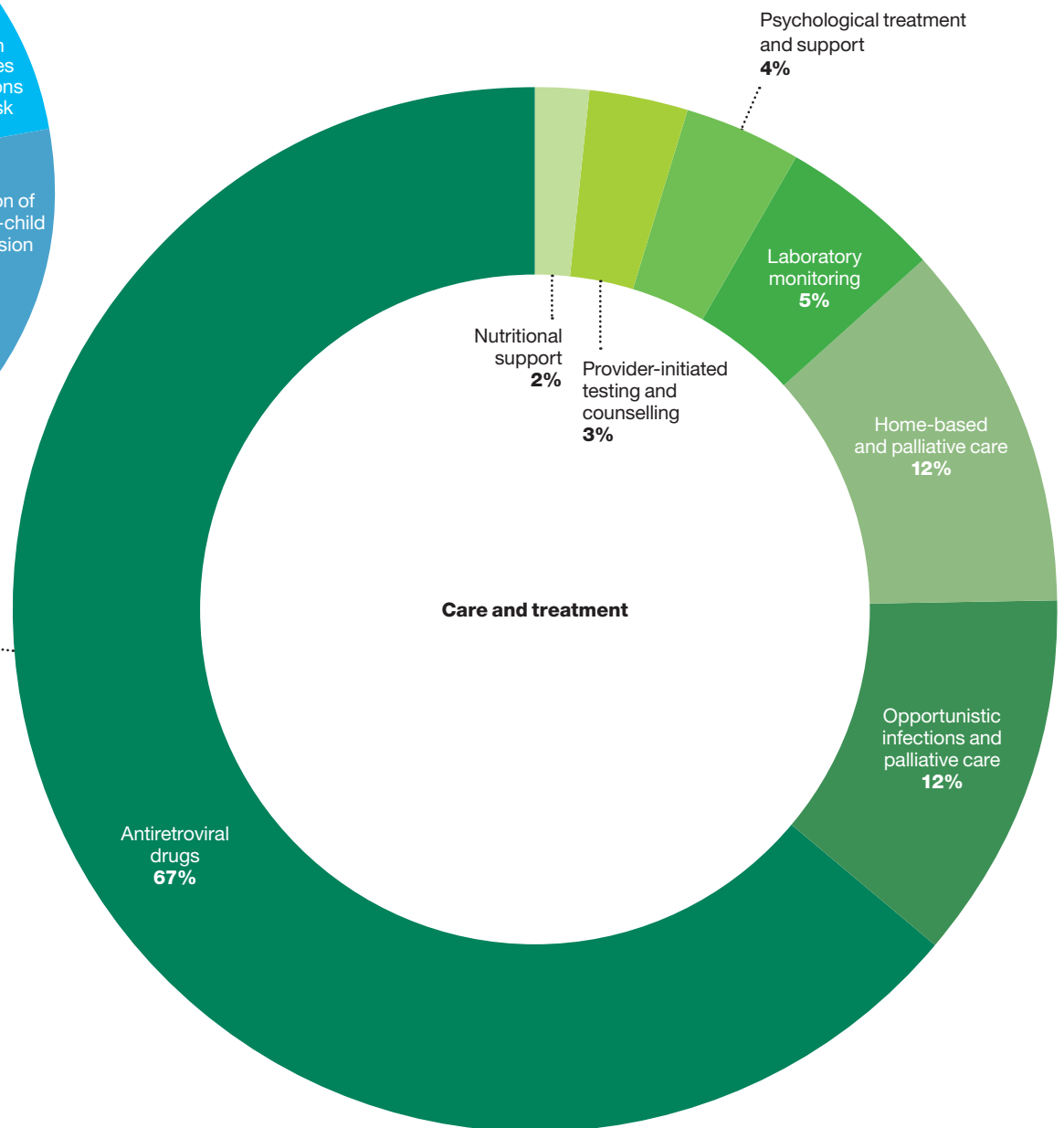
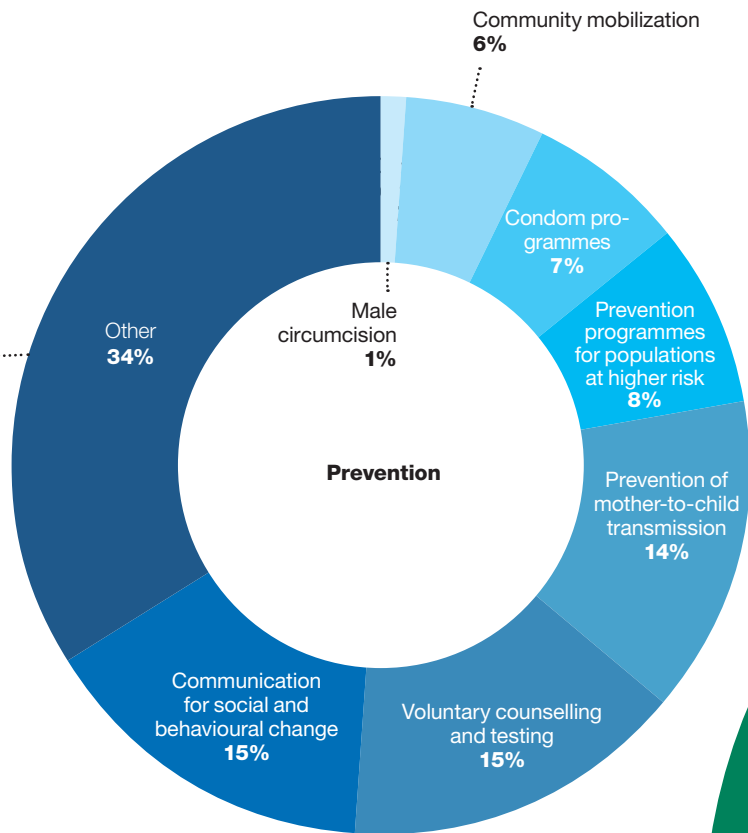
Kenya



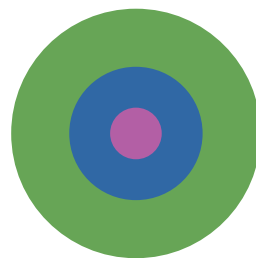
Brazil



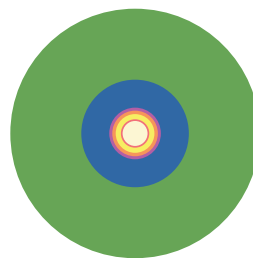
Nigeria



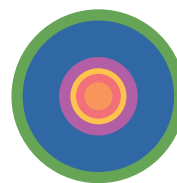
Botswana



Mexico



Thailand



Viet Nam



Lesotho



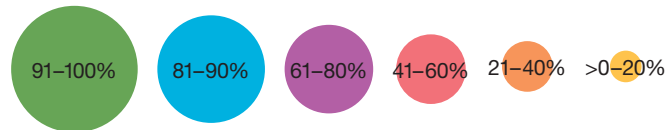
Belarus

Invested resources

Who is paying for AIDS treatment?

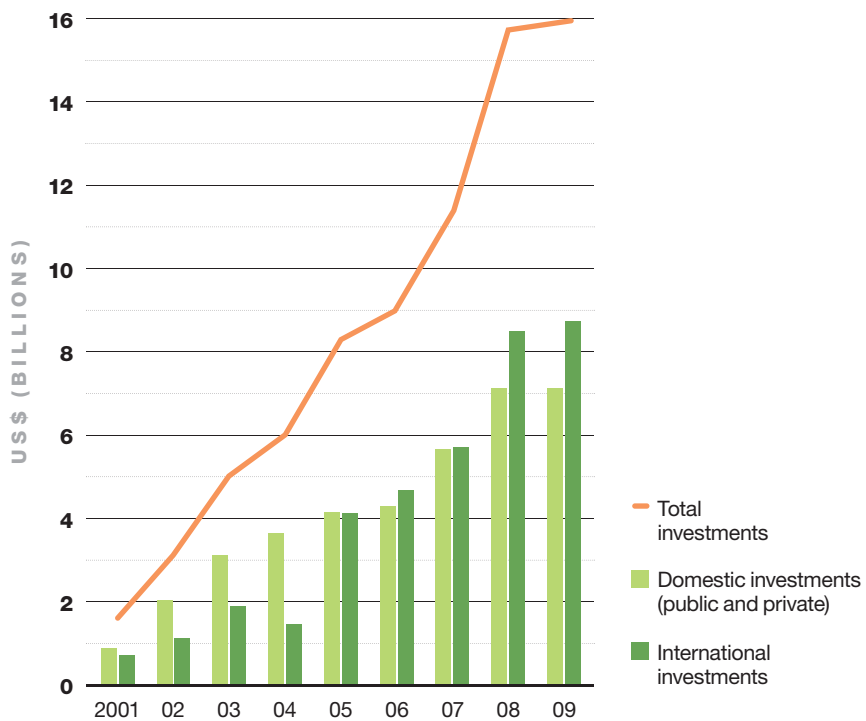
International donors provide the vast majority of resources for HIV treatment in sub-Saharan Africa. As donors reduce investments, treatment programmes risk becoming the most severely affected. Most of these investments are for first-line treatment regimens, which are far less expensive than second-line treatment. India produces more than 80% of the generic medicines supplied to Africa. The dual reliance—external funds paying for treatment and reliance on a single country for drug supply—can make ‘sustained access to treatment’ a major risk factor for AIDS responses across the world. This is why UNAIDS is advocating for Treatment 2.0. This is a new direction for the global community—to reduce costs, introduce smarter and efficient treatment regimens and simple-to-use diagnostics, as well as make treatment accessible to all in need.

% international investments in countries' AIDS response:

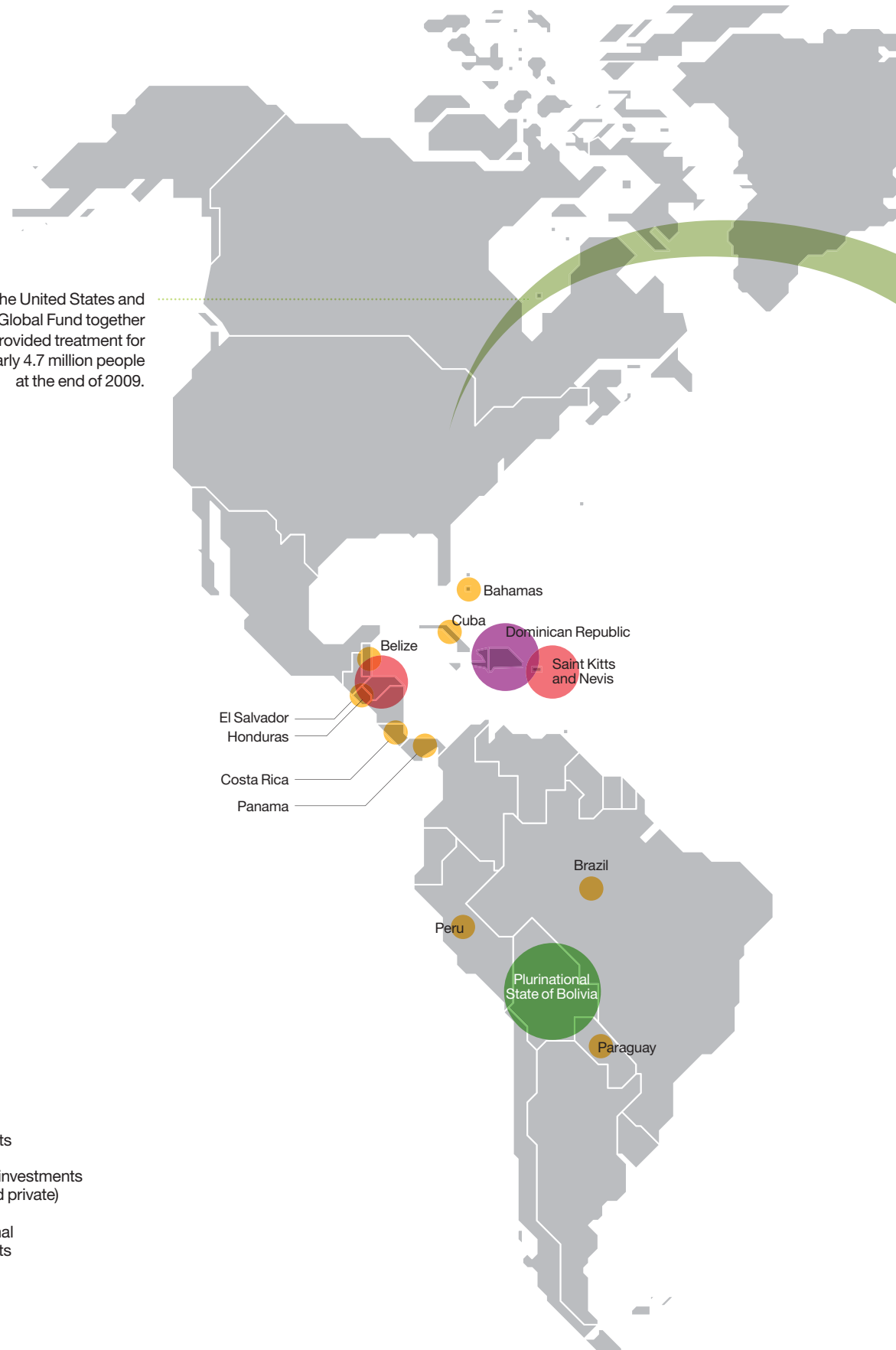


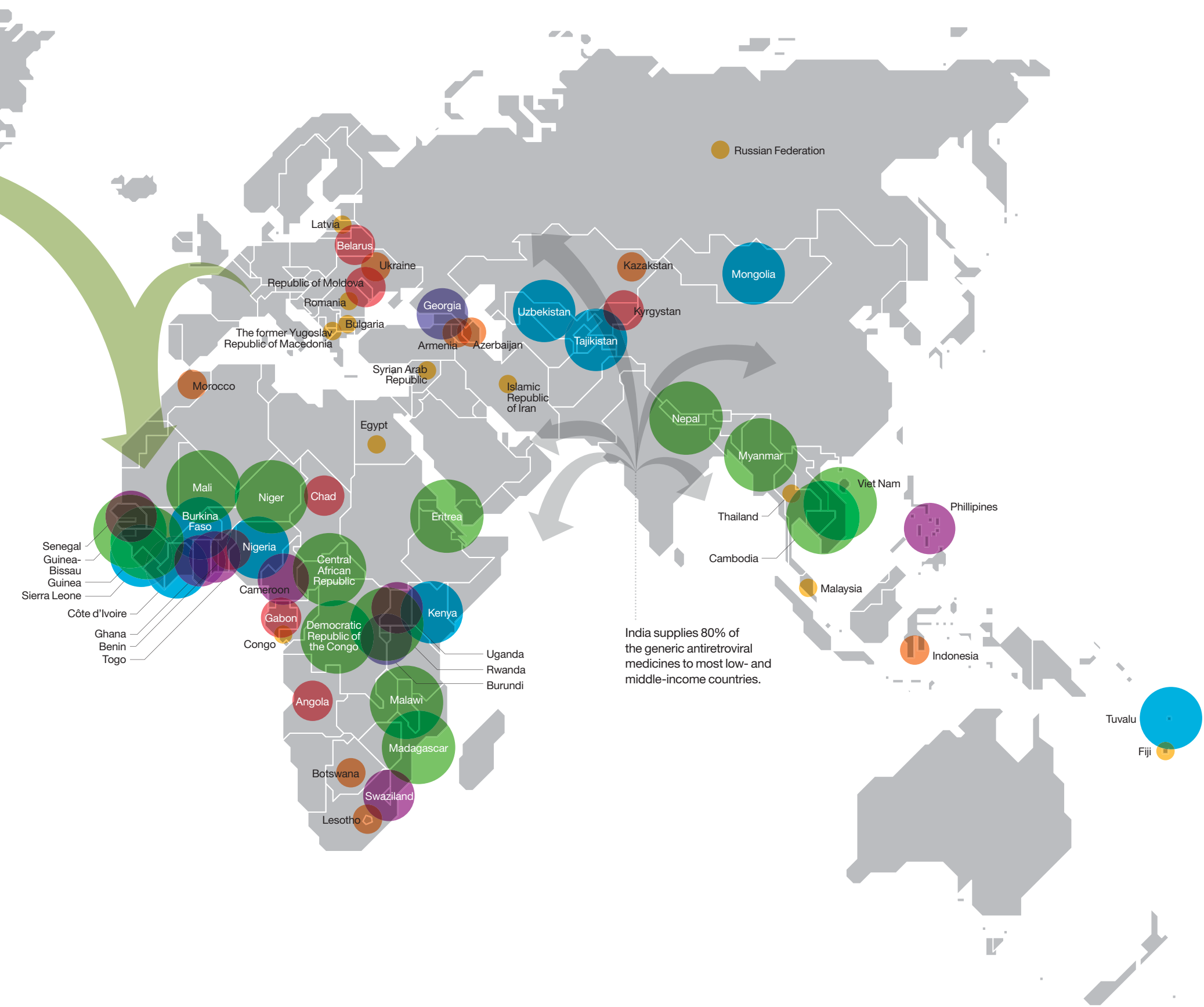
Investments in the AIDS response are reducing

During the economic crisis, the total resources available for the AIDS response has declined.



The United States and the Global Fund together provided treatment for nearly 4.7 million people at the end of 2009.





20

Millennium Development Goals

AIDS and the Millennium Development Goals have a two-way relationship.

On the one hand, the AIDS response is essential in order to achieve all the Millennium Development Goals. On the other, efforts towards achieving the Millennium Development Goals will be crucial to reach universal access goals towards HIV prevention, treatment, care and support.

How achieving the Millennium Development Goals supports the AIDS response

1 Eradicate extreme poverty and hunger

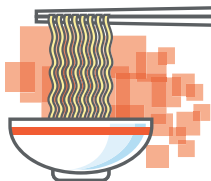


- Employment for women and men reduces vulnerability to HIV infection.
- Food security for families keeps girls and boys in school as parents do not need them to

work to augment the family income.

- Adequate nutrition helps increase people's adherence to AIDS treatment.
- Food availability is crucial for people living with HIV, who have higher energy requirements than average (adults 10–30%, children 50–100%).
- Limited options for earning an income can increase the need to be mobile for work, which puts people at higher risk of exposure to HIV.
- Reducing poverty means that fewer women will sell sex as a means of survival.
- Access to microcredit and developing skills contributes to income security among people living with HIV.

2 Achieve universal primary education



- Universal primary education keeps children who are orphaned by AIDS in schools.
- Provision of mid-day meals ensures that vulnerable children have access to vital nutrition.

- Providing schoolbooks and uniforms free of charge reduces stigma and discrimination.
- Safe schools protect girls from exploitation and abuse.
- Safe transport to and from school reduces the risk of children encountering sexual violence and



3 Promote gender equality and empower women



- Empowered women are better able to negotiate safer sex.
- Women's access to employment reduces vulnerability to HIV among women and children.
- Equal inheritance rights

support

widows and children orphaned by AIDS.

- Eliminating gender-based violence reduces women's vulnerability to HIV.



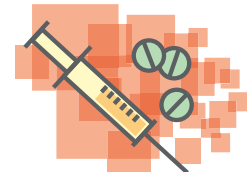
4 Reduce child mortality



- Strengthened treatment and care for children living with HIV enables them to lead healthy lives.
- Better neonatal conditions and family care practices increase the

survival rates of children born with HIV.

- Access to adequate nutrition helps children living with HIV survive and thrive.
- Immunization of children living with HIV increases child survival.



5 Improve maternal health

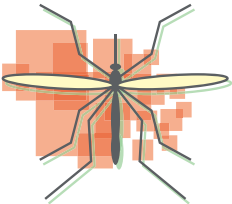


- Strong health systems are able to support women during pregnancy, detect HIV early and ensure that every birth is safe.
- Reproductive health services enable women and men living with

HIV to plan their families and avoid unintended pregnancies.

- Integrating HIV into antenatal care helps to avoid the transmission of HIV from mother to child.
- Improving maternal care supports women living with HIV and their children.
- Continuing access to treatment for mothers living with HIV increases child survival and care and reduces orphanhood.

6 Combat HIV/AIDS, malaria and other diseases



- TB treatment significantly reduces AIDS-related deaths.
- Preventing TB reduces the burden of AIDS care.
- Encouraging everyone with TB to be tested for HIV helps to

increase people's access to HIV treatment and care.

- Preventing malaria reduces child and maternal mortality among people living with HIV.

7 Ensure environmental sustainability



- Access to clean water and sanitation helps to encourage safe infant feeding practices among parents living with HIV.
- Safe housing and clean sanitation reduces opportunistic

infections among people living with HIV.

- Reducing violence and providing essential social welfare, health and security services helps reduce HIV-related vulnerability and risk among women, girls and boys living in slums.



8 Develop a global partnership for development



- Public-private partnerships help in developing new drugs and diagnostic tools for HIV prevention and treatment.
- Universal health care coverage makes HIV treatment, care and

support sustainable and affordable.

- Private-sector engagement helps sustained access to life-saving medicines and prevention tools.



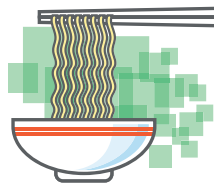
How the AIDS response supports the achievement of the Millennium Development Goals

1 Eradicate extreme poverty and hunger



- Access to treatment means healthier adults who can earn a living for their family and contribute to the human resource base of their countries.
- HIV prevention, treatment, care and support services reduce vulnerability to poverty.
- Reducing AIDS-related orphanhood means fewer children are vulnerable to extreme poverty and hunger.
- Preventing HIV infection helps to reduce overall strain on health care systems and to reduce long-term health-related costs.
- Social protection programmes alleviate the poverty burden on families and individuals affected by AIDS.

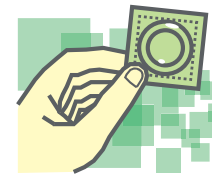
2 Achieve universal primary education



- Sexuality education helps girls and boys to prepare for adulthood.
- HIV prevention and treatment programmes for schoolteachers protect the workforce and help schools to function.
- School health programmes help adolescents to learn about sexual and reproductive health.
- Children learn important life skills and get social support in school settings.



3 Promote gender equality and empower women



- HIV provides an entry point for discussing difficult issues such as violence, sexual health and rights, and same-sex relationships.
- Marginalized women find a voice by being involved in AIDS programmes. Empowered in this way, they are better able to claim all their rights.
- Access to post-exposure prophylaxis reduces HIV risk among women and children who are sexually abused.
- Research and development into women-initiated and -controlled HIV prevention methods supports women's empowerment.

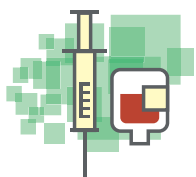


4 Reduce child mortality



- Preventing mother-to-child transmission of HIV leads to fewer babies being born with HIV, which in turn reduces child mortality.
- Access to HIV drugs for children reduces child mortality.
- Early diagnosis of HIV among children leads to effective treatment and care for children.
- Prophylactic treatment provided to children living with HIV stops opportunistic infections and reduces child deaths.
- Parents adopting safe infant feeding practices reduce the risk of HIV transmission to babies and lowers nutrition-related child deaths.

5 Improve maternal health

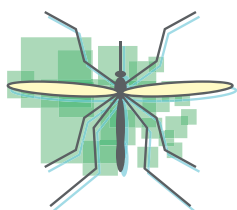


- Early detection of HIV among pregnant women can help to prevent HIV among their children.
- HIV is the leading cause of maternal deaths in sub-Saharan Africa—preventing HIV among

women of reproductive age prevents HIV-related complications during pregnancy.

- Strong health systems can address all the health needs of pregnant women.
- Providing antiretroviral therapy for pregnant women living with HIV reduces maternal deaths and HIV among children.

6 Combat HIV/AIDS, malaria and other diseases

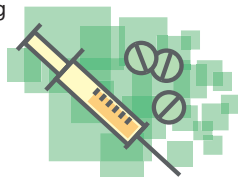


- Reducing new HIV infections helps to reduce new TB cases.
- TB screening of people living with HIV increases TB case finding and reduces TB deaths.
- Early treatment of HIV significantly reduces the incidence of and deaths from TB.

■ Treating latent TB infection among people living with HIV (isoniazid preventive therapy) prevents the active development of TB disease and TB deaths.

■ Antiretroviral therapy helps to reduce malaria among pregnant women by improving their immune system.

■ The AIDS response has helped to strengthen health systems.



7 Ensure environmental sustainability



- Preventing HIV among slum populations and migrants has improved their quality of life.
- Well-designed HIV prevention programmes address issues of violence and gender equality and

provide life skills for women and children.

- The AIDS response has strengthened health services for people living in slums.
- The AIDS response has helped to strengthen hospital waste disposal systems that are environmentally sound.
- Safe hospital waste disposal systems protect ragpickers, scavengers and children from coming into contact with contaminated materials.
- Clean needle-syringe and harm reduction programmes for people who use drugs minimize environmental risks.



8 Develop a global partnership for development



- Scaling up access to treatment has involved new models for public-private partnerships.
- Shared funding of the AIDS response between public and private donors has demonstrated

that investment in health is a shared responsibility.

- AIDS activism has led to global understanding that access to health care and medicines is a public good.
- Innovation in vaccine and drug development has opened new avenues for partnerships on other health issues.
- South-South cooperation has helped to increase access to life-saving HIV medicines and prevention commodities.



21

Stigma and discrimination

Stigma is caused by silence, rejection and isolation. It leads to discrimination and all its harmful results. Stigma and discrimination are strongly entrenched and present very real obstacles to achieving universal access to HIV prevention, treatment, care and support and the Millennium Development Goals.

The word stigma was originally a common Greek noun (στίγμα) meaning a mark or a sign

Stigma is a process of damaging the character of a person in the eyes of others. It occurs when somebody or a community expresses severe social disapproval of a person or group and sets them apart as unwanted.

HIV-related stigma is often layered on pre-existing stigma concerning socially marginalized and vulnerable groups, including people who inject drugs, people living in poverty, men who have sex with men, sex workers and ethnic minorities. It often emerges from pre-existing social norms, including sexuality, marriage and gender roles.

Conversely, people living with HIV may be implicitly associated with stigmatized behaviour. Stigma is caused by silence, rejection and isolation. It causes added stress to people and leads to discrimination and all its harmful results.

When stigma is acted upon, the result is discrimination

Discrimination is the arbitrary distinction, exclusion or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person's confirmed or suspected HIV-positive status—regardless of whether these measures are justified.

The guilt–innocence spectrum

A gradient of guilt to innocence persistently surrounds HIV. In many cultures, sex workers or people who inject drugs who acquire HIV infection are still considered 'guilty'. At the other end of the spectrum, monogamous wives who contract HIV from their husbands may be considered 'innocent', and babies who become infected with HIV during pregnancy, birth or breastfeeding become the ultimate 'victims'.

Getting to zero

Stigma and its resultant discrimination are strongly entrenched and present very real obstacles to achieving universal access to HIV prevention, treatment, care and support and the Millennium Development Goals. The UNAIDS vision therefore includes three aspirations: zero new HIV infections, zero discrimination and zero AIDS-related deaths.

Unravelling the pathways of stigma



Stigma and discrimination



The silver screen spotlights stigma in China

A Chinese boy in a school uniform is sobbing in the middle of some bushes. He is crying because he has been ostracized for living with HIV. The camera zooms in on a close-up of his face. This is a scene from a recently released documentary, *Together*.

This touching performance is definitely art mimicking life. Twelve-year old actor Hu Zetao knows only too well how his character feels. He was infected with HIV through mother-to-child transmission. In real life, Hu says he suffers constant discrimination. When his father remarried, his stepmother refused to use the same bowls and chopsticks Hu used. The young boy is one of the three people living with HIV on centre stage in the new documentary.

The documentary follows the making of a feature film, *A Tale of Magic*, which is set in a Chinese village seriously affected by HIV and directed by Gu Changwei, an internationally renowned director. For the movie, Mr Changwei wanted to have people living with HIV appear in the movie as characters or work as part of the film crew. He spent many hours in online chat rooms searching for people living with HIV who would be willing to participate.

“It was really difficult. At one point I thought that no one would want to show their face, and you would only see people with blurred faces and masks,” said Mr Changwei.

After interviewing 30 people, the filmmakers found six people living with HIV who could leave their regular jobs and join the film crew. In the end, three agreed to go public. Aside from Hu Zetao, the two other people living with HIV who



Hu Zetao in a scene from the documentary, Together.

are identified are Ms Liu and Mr Xia. Ms Liu works in a primary school and is a counsellor for people living with HIV. Mr Xia lives in a temple and has also experienced discrimination because of his HIV status.

The documentary on Mr Changwei’s movie took almost two years to film. It was directed by another Chinese filmmaker, Zhao Liang, who says he saw a real transformation on the film set.

“The change was extremely obvious. After the film, crew members came to understand things, they stopped being afraid very quickly and were happy being in close contact with people living with HIV,” said Mr Liang.

The documentary was screened for the first time in Beijing on World AIDS Day, 1 December 2010. It was also shown at the 61st Berlin International Film Festival in February 2011.

The experience has helped Hu Zetao. After the shooting wrapped up, he told the film director that when he returned home, he was no longer eating separately from his family.

A crew member who is not HIV positive said, “Our experience here says it all. There are so many celebrities here and a famous director—all living together. So, from this experience you can see that AIDS is absolutely nothing to fear.”

Zhang Ziyi, an actress, said, “When we first started working together, we slowly got to know each other. What changed for me is that I forgot who was who. We were all just participants. I wish society could be like our movie crew, embracing and accepting people affected by AIDS supporting and loving each other.”

22

Commentary

**With paper, pen and pointed opinions
—social commentary has driven the AIDS
response forward.**

The AIDS response in South Africa: Zapiro's viewpoint

South Africa's response to the AIDS epidemic evolved over the years—grounded by a strong civil society movement, media freedom, responsive judiciary, a progressive constitution, community leadership and, most importantly, the courage and resilience of common South Africans to demand action.

Progress against the epidemic has been hard won. At the end of 2009, nearly one million people were accessing HIV treatment versus 30 000 in 2004. The number of people newly infected with HIV has been reduced by more than 35% in the last decade. HIV infection rates among young South Africans seem to be slowing. National HIV prevalence surveys show that the number of young people newly infected with HIV has declined by more than 25%.

South Africa's new leadership recently set ambitious targets to achieve universal access to HIV prevention, treatment, care and support. It has embraced an evidence-informed approach to AIDS and increased domestic investment for its AIDS response.

Nevertheless, this has not been easy. During the past two decades, South Africa has surmounted many challenges and complexities—the end of apartheid and the rapid rise of the AIDS epidemic; complacency and denialism, the high cost of drugs, raging stigma and discrimination; unhelpful social and cultural norms; violence

against women and girls; mercurial political leadership; and a society that had begun to accept AIDS-related deaths as normal.

Zapiro, aka Jonathan Shapiro, an award-winning cartoonist and activist, has closely followed his country's AIDS response and given voice to the voiceless. In 1992, he created an AIDS education comic focused on HIV prevention entitled *Roxy—life, love and sex in the nineties*. Shortly thereafter, he shifted his attention to HIV treatment and was greatly influenced by the work of civil society organizations and activists.

Zapiro's cartoons are an expression of events as they unfold. “Even the funniest cartoons I did were really an expression of shock at the ravages of disastrous policies and callousness towards people living with HIV and dying of AIDS. President Zuma's administration, under Minister of Health Aaron Motsoaledi, has made great strides and has taken the advice of courageous activists who were demonized not so long ago. These days I do far fewer AIDS-themed cartoons,” he says.



1997



1997



1998



1999



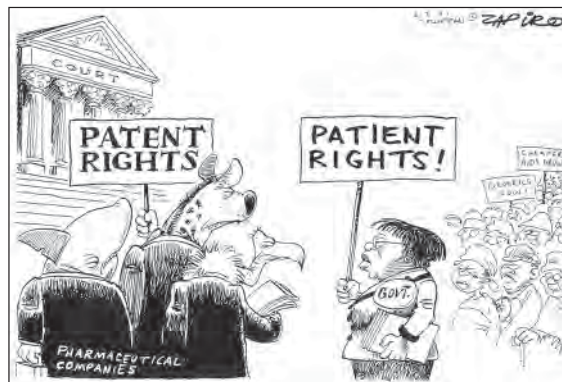
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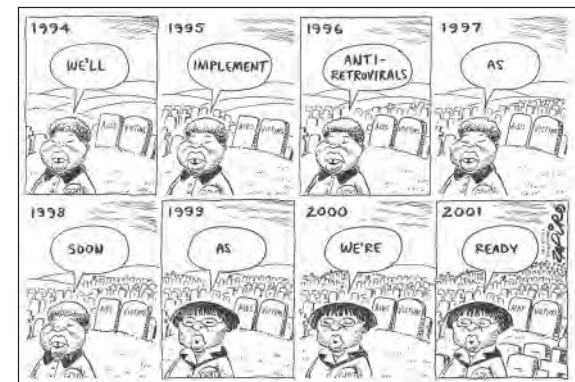
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2000



2001



2001



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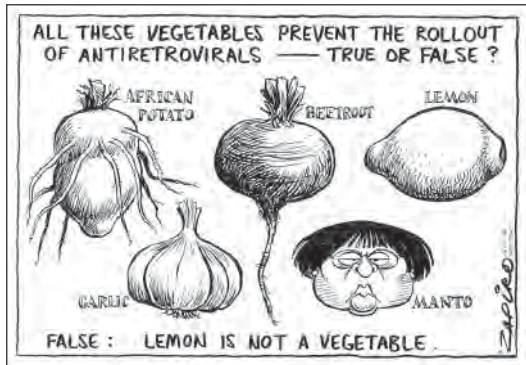


2002



2003

Commentary



2004



2005



2005



2006



2006



2009



2010



2010



2010

Facts: South Africa

5 600 000

People living with HIV

3 300 000

Women living with HIV

1 900 000

Orphans

1 000 000

People on HIV treatment

340 000

People newly infected with HIV

310 000

AIDS-related deaths

Source: UNAIDS Report on the global AIDS epidemic 2010.

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AIDS and the gay media

Long before the Web, texting, Facebook and Twitter, magazines and newsletters were a main source of information for many people and a way to connect with other like-minded individuals.

For the lesbian, gay, bisexual and transgender (LGBT) community, gay- and lesbian-themed publications were often regarded as a lifeline, keeping people connected and informed. Even today, despite the availability of thousands of LGBT online resources, magazines still serve an important function.

AIDS and the gay media

To understand the role of the lesbian, gay, bisexual and transgender (LGBT) media, past and present, OUTLOOK interviews four editors to get their insights on how LGBT media address homophobia, HIV-related issues and civil rights.

New York City's *OutWeek*: a pioneer in gay journalism

Q&A with Gabriel Rotello, founding editor and co-publisher



For two years, between 1989 and 1991, *OutWeek* magazine brought news and views that mattered to New York City's gay, lesbian and bisexual community. The magazine hit the city's streets at a time when the HIV epidemic was growing rapidly and political

commitment to address the epidemic was weak. *OutWeek* helped rally concerned citizens around the AIDS movement and played an equally important role in advocating for access to HIV services and the protection of civil rights. At its zenith, *OutWeek* had a weekly circulation of 40 000, and although the magazine focused largely on news within New York City, subscribers were located throughout the United States.

How did *OutWeek* magazine come into existence?

OutWeek was founded on the simple fact that no one was reporting on HIV at the time. The epidemic had already affected thousands of people in New York City alone but no one was writing about it. I was a member of the activist group ACT UP and felt that, despite rare instances in local newspapers, coverage of HIV was scant and often unsupportive in tone. I knew something had to be done. After a lot of research on how to get a magazine up and running, and a lot of lobbying, I decided to create *OutWeek*.

I am not a journalist, and most of the initial writers and volunteers were not journalists either; we were mainly from ACT UP. But it was easy to solicit an amazing amount of talent and creativity because everyone was young and angry at what

was going on. Interestingly, many of the *OutWeek* editorial staff went on to become some of the most influential journalists.

What did you hope to achieve with the magazine?

OutWeek was based on activist journalism. We were not merely reporting the news but we were making news, and we took very strong stands on several issues we felt were central to the epidemic. We received national coverage for some of our activities, such as outings of closeted public officials, as well as for our investigative journalism. *OutWeek* provided a strong voice, advocating for action on HIV. Looking back, I can say that we played a decisive role in increasing the coverage of AIDS in the United States and in helping break the conspiracy of silence at the time.

How did the HIV epidemic define, shape and drive the magazine? Did *OutWeek* cover other issues related to the gay, lesbian and bisexual community?

HIV totally affected the magazine—otherwise *OutWeek* would not have been created. At a personal level, and why I initially joined ACT UP, the death of my partner to AIDS energized me enough to get involved. But beyond HIV, *OutWeek* covered all issues at the time, and we did receive criticism from some AIDS activists as they were frustrated that we reported on broader LGBT issues and not just on AIDS. But as HIV was the number one issue, significant coverage was devoted to it. And in many cases you could not separate HIV from, say, anti-gay violence or homophobia.

Would there be an audience for *OutWeek* today?

Yes, I think so. HIV transmission is still very high among the gay population, so there is a need for activism around HIV prevention and other issues. But you cannot just create that momentum either. In the United States, HIV has largely been subdued by antiretroviral therapy and the emergence of other topics such as gay marriage and gays in the military. If there were an *OutWeek* today, I do think it would be able to create news on a regular basis and focus debate on key issues affecting the LGBT community.



OutWeek
Price per issue: US\$ 1
Number of issues: 106
outweek.net

Ukraine's *Odin Iz Nas*: one of us

Q&A with Stanislav Naumenko, editor



As Ukraine's only LGBT magazine, and one of the oldest publications of its kind in eastern Europe, *Odin Iz Nas* (One of Us) has a broad mandate to fulfil. The magazine strives to bring Ukraine's LGBT population relevant and timely

news and features on human rights, sexual health, HIV-related issues and popular culture, all in an attractive package that tries to appeal to young and older readers alike. Available at newsstands and newsagents throughout Ukraine as well as in Moscow and St Petersburg, *Odin Iz Nas* has struggled against an unfavourable political and social climate in which homophobia and discrimination have flourished largely unchallenged. It is against this backdrop that the magazine's editorial team remains dedicated to help the country's LGBT community stay connected and informed.

How did *Odin Iz Nas* get started?

The idea to create a gay magazine first surfaced at the beginning of the 1990s, and in 1995, the first editor-in-chief Leonid Nefedovich and publisher Aleksandr Fesenko formulated the idea of the magazine. In December 1996, the first issue was published. The Ukrainian gay community was rather disjointed at the time, and the magazine provided many gays with a sense of belonging. Buying *Odin Iz Nas* at a newsstand was like a little coming out for any Ukrainian gay man who was starting to believe in himself and for a better future for LGBT people.

What have been some of the milestones and challenges experienced since publishing *Odin Iz Nas*?

In 2001, the magazine received a 'survivor' award from the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights. In fact, our fight for survival, to keep publishing the magazine despite the odds, has been continuing since the beginning, basically the past 15 years. Finding funding has been an extremely hard task, considering that mainstream Ukrainian companies are still not willing to advertise in a gay publication, and gay businesses here are scarce.

In 2003, a new censorship law was passed in Ukraine that restricted the erotic content of the magazine, and thus, that decision turned away some of our readers. Yet, because of the talent and hard work of the editors, the magazine has renewed its concept and brought in new readers among younger lesbians and gay men. In December 2010, the editor-in-chief received an award from the International HIV/AIDS Alliance – Ukraine, recognizing the important contribution of *Odin Iz Nas* to the national response to the HIV epidemic.

What is the current state of the civil rights environment for the LGBT community in Ukraine, and what are some of the main challenges facing the country and the region?

Despite the decriminalization of homosexuality in Ukraine in 1991, public attitudes towards homosexuality remain very negative. The anti-gay position of the Orthodox Church and the homophobic statements made by conservative politicians contribute to a generally negative view of gay people. To counteract that, our magazine and Ukrainian LGBT organizations have implemented campaigns to advocate for the rights of LGBT people. In 2002, I was a candidate for the Parliament, representing the RADUGA (Rainbow) political party, which openly supported gay rights and promoted a wide discussion of gay topics on TV and in the press. Economic inequality in Ukraine has also polarized public opinion around such issues as gay rights. And even though Ukrainian LGBT activists are hard-working and well organized, there are only a few of them, so the influence of Ukrainian LGBT organizations on the political situation in the country remains minimal.

How has Ukraine's HIV epidemic shaped or influenced *Odin Iz Nas*?

The magazine has addressed HIV since it was founded. In each issue, we publish HIV prevention materials, discussions of safer-sex practices, stories about living positively with HIV and interviews with gay men living with HIV. Over the last six years, such publications were supported by the International HIV/AIDS Alliance – Ukraine. This support allowed us to improve the quality of HIV-related publications and generally helped the magazine. In the future, we hope to address HIV topics extensively and continue our work in promoting HIV prevention.



Odin Iz Nas

Price per issue: Hrv 15 (about US\$ 2)

Number of issues: 68

AIDS and the gay media

India's *Bombay Dost*: a friend to many

Q&A with Nitin Karani, co-editor



When India's first-ever magazine for gays, lesbians and bisexuals emerged more than 20 years ago, it experienced the common set of challenges upstarts often encounter, from recruiting good writers and editors to securing sufficient funding to print. But the

Bombay Dost (Bombay Friend) had one hurdle that many peer publications in other parts of the world probably did not have to overcome: defining itself as a gay publication in a society and culture in which the concept of gay did not exist. From its early beginnings as a mail-order only newsletter to a web-based and widely distributed magazine throughout major Indian cities, the *Bombay Dost* continues to provide a connection to gay life and news.

How did the *Bombay Dost* come into existence?

In 1990, a group of men, self-identified homosexuals, led by Ashok Row Kavi, decided to create a simple newsletter in Hindi and English featuring gay issues, places to meet up, information about sexually transmitted infections and so forth. Six hundred copies were printed, and we managed to get a mailing address for the newsletter at a business centre. After about a month's time, a group member went back to the business centre only to realize that mail from all over the country had been pouring in, and not just from the big cities, but from the North, Kashmir and Punjab regions. It was at that point that the group realized a large community was out there of people looking to connect and escape the isolation they felt. It is important to understand that the *Bombay Dost* did not start from zero—it started from minus zero. It had to initially take on an educational role because the concept of being gay was not part of Indian society.

When you started the magazine, what did you hope to achieve?

That the *Bombay Dost* could help to set up a broader LGBT movement and basically connect self-identified homosexuals with each other. It may seem like a simple idea now, but community

mobilization for survival was how we perceived it at the time. The magazine also helped many other gay people across India come together and set up their own community-based organizations.

How did HIV initially influence the magazine—and today?

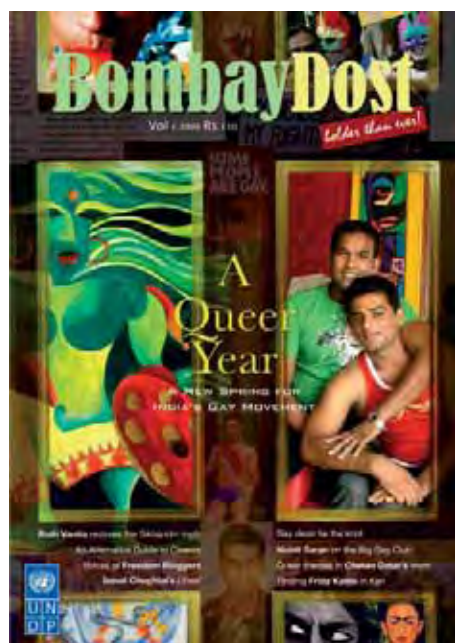
When we first started the magazine, the emergence of HIV was an editorial priority for us, but it was clear that very few people interested in the magazine were seeking information on HIV and sexually transmitted infections. The reality is that many men were looking for ways to connect and have encounters. But building on this reality and the necessity to expand our outreach on HIV, we formed the Humsafar Trust, a community organization focused on men who have sex with men issues. This decision enabled us to do much more in the area of HIV prevention and care and support.

Today, while the magazine focuses from time to time on HIV issues, for example, the importance of protecting oneself or negotiating safer sex, the majority of our readers look for stories on popular culture. There has been a definite shift on HIV awareness, almost exhaustion, and many people just do not want to know about HIV. Nevertheless, despite this background, the magazine aims to promote a healthy lifestyle.

What have been some of the challenges in publishing the magazine?

Funding has been and continues to be the major challenge. Because of the lack of advertising support and funds in general, the magazine was suspended in 2002. It was revived in 2009 with a completely new look and focus. We have moved to more culture and entertainment news, but we do continue to share political news and issues as viewed by the gay community, such as civil rights and gay marriage.

The team behind the *Bombay Dost* is entirely volunteer-driven; we all have full-time jobs. But it is a love of labour for us because we believe in what the magazine stands for and despite the hurdles we still love the idea of the *Bombay Dost*.



Bombay Dost

Price per issue: Rs 150 (about US\$ 3)

Number of issues: three since redesign in 2009
bombaydost.co.in

Nicaragua's *Fuera del Closet*: opening the door for sexual diversity

Q&A with Hazel Fonseca, editor and executive director of the Xochiquetzal Foundation



Published since 1993 as the magazine of the nongovernmental organization Xochiquetzal Foundation, *Fuera del Closet* (Out of the Closet) is the only publication of its kind in Nicaragua focused on LGBT, gender, HIV and sexual and reproductive health issues. The magazine has developed a strong following throughout the country and region for its special features and vocal position on sexuality and sexual freedom. The magazine was the first in Nicaragua to openly portray a person living with HIV, in 2003. Ever since, it has continued to bring a human face to the country's HIV epidemic.

What is meant by the title *Fuera del Closet* and what do you feature in the magazine?

The title goes beyond the common concept of coming out with regard to sexual orientation. It represents the necessity to have broader discussions and acceptance of sexuality in all aspects of life, private and public. Editorially, we address sexuality and other related themes from a scientific and neutral perspective, free of the prejudices and preconceptions attached to the traditional view of sexuality in Nicaragua. *Fuera del Closet* also works to change the ideas around sexual pleasure and sexual identities. We do all of this through scientific articles, the presentation of research, surveys, interviews and featuring poetry, painting and photography as expressions of the LGBT community.

What are some of the challenges facing the LGBT community?

The challenges are countless, starting with the fact that we are in Latin America. Despite Nicaragua being a pioneer in the region by having an ombudsperson for sexual diversity tasked with defending the rights of the LGBT community, there is a need for respectful treatment across all other government institutions as well as the creation of health services specifically for the

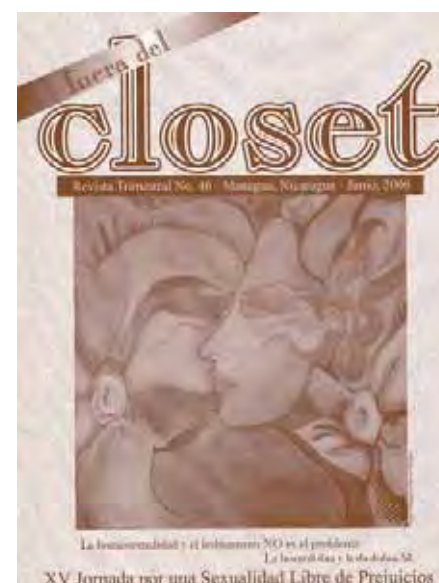
LGBT community. The situation for the LGBT community in neighbouring Central America is one of constant human rights violations.

Do mainstream media in Nicaragua cover issues related to the LGBT community?

In Nicaragua, there is not broad media coverage of the LGBT or sexual diversity rights movements. One of the big newspapers in Managua has published a few articles, putting forward a perspective of the situation for gays and lesbians, and the Foundation and other civil society groups have partnered with the media to provide guidance on language and to address information requests about sexuality. But, generally speaking, the media organizations in Nicaragua are not very respectful of people with different sexual identities.

How has *Fuera del Closet* supported the country's AIDS response?

The Foundation, through *Fuera del Closet*, was the first organization in Nicaragua to promote a rights-based approach to HIV testing. We have also published studies about HIV prevalence among populations at higher risk as well as articles on treatment advances. Overall, the magazine has contributed to humanizing the epidemic by demonstrating that no one is immune to HIV and that people living with HIV can lead very productive lives. In everything we do through *Fuera del Closet*, we attempt to bring forward personal experiences related to sexual diversity and HIV.



Fuera del Closet

Price per issue: free

Number of issues: 60 (four times per year)

fundacionxochiquetzal.org

24

Law and 'other'

One lesson learned from 30 years of AIDS is that exclusion only drives the HIV epidemic.

Many countries have laws or policies that undermine HIV responses: often punishing, rather than protecting, people who are most vulnerable to HIV exposure as well as stigma and discrimination, including hate crimes.

Men pay Anna for sexual services. She is 25 years old and carries out her work clandestinely. This places her on the margins of society and at risk of violence.

Jean is homeless and injects drugs. He has no access to shelter or health services, and every day is a question of survival.

George is a truck driver who enjoys consensual sex with men. When his community discovered this, he was physically attacked and outcast as a social pariah.

Anna, Jean and George (not their real names) are living in societies in which their behaviour is criminalized. This behaviour places them at higher risk of exposure to HIV and marks them as a 'moral threat' to their respective majority communities. They are 'other'.

Their human rights and participation within their societies are violated in two ways—implicitly by stigma and social prejudice and explicitly by the law. Although each of them is at higher risk of contracting HIV, they are among the least likely to be approached with HIV information or to be cared for by public services.

One lesson learned from 30 years of AIDS is that exclusion only drives the HIV epidemic. Intolerance and judgement conspire against respect for others and rob people of their dignity.

The global view

Many countries have laws or policies that undermine HIV responses: often punishing, rather than protecting, people who are most vulnerable to HIV exposure as well as stigma and discrimination, including hate crimes.

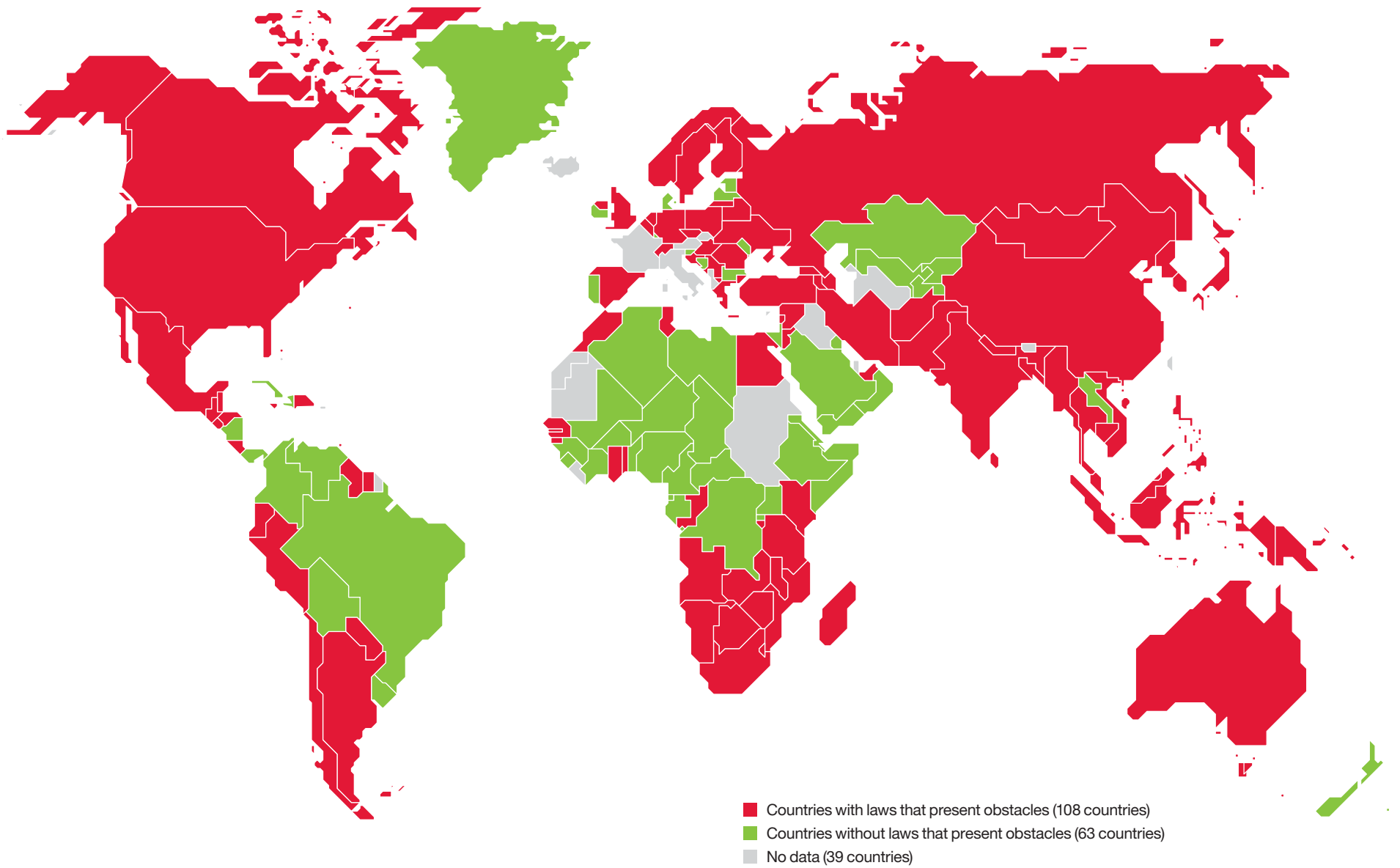
In 2010, 106 countries reported having laws, regulations or policies that present obstacles to access to HIV prevention, treatment, care and support for vulnerable subpopulations. More than 100 countries, territories and areas criminalize some aspect of sex work. Same-sex relations between consenting adults are criminalized in 79 countries and punishable by the death penalty in six of these.

Justice and morality

According to Anand Grover, United Nations Special Rapporteur in his 2010 report to the Human Rights Council, countries justify the criminalization of certain acts as the protection of public morality and decency or the protection of the health of the public at large.

Mr Grover goes on to argue that the criminalization of consensual same-sex behaviour (together with sexual orientation and gender identity), sex work and HIV transmission detrimentally affects the health outcomes for individuals, even if the laws around these practices are not enforced or enforced infrequently. Legislation impedes public health access by discouraging those engaging in risky behaviour to seek out services because of fear of prosecution or judgement driving people underground and alienating them from outreach efforts.

Countries with laws, regulations or policies that present obstacles for populations at higher risk or other vulnerable subpopulations to access prevention, treatment, care and support



Source: 2010 National Composite Policy Index (NCPi) reports submitted by countries.

FACT

Although it has no public health benefit, 49 countries, territories or entities impose some form of restriction on the entry, stay or residence of people living with HIV based on their HIV status.

FACT

Same-sex relations between consenting adults are criminalized in 79 countries. Six impose the death penalty.

The Special Rapporteur notes that “criminal laws concerning consensual same-sex conduct, sexual orientation and gender identity often infringe on various human rights, including the right to health.” He points out that the criminalization of certain types of behaviour denies people their dignity and can reduce their self-esteem. This disempowerment may hamper their access to health services, including HIV prevention and treatment.

The law can be an equally powerful instrument for protecting rather than persecuting vulnerable people: for example, in guaranteeing equal inheritance and property for women and girls and in protecting people living with HIV against discrimination. Research in Kerala, India has shown that women with property experienced less marital violence and were better able to negotiate safe sex, thus potentially reducing their vulnerability to HIV. The report also found that insecure property rights exacerbate the impact of HIV.

UNAIDS advocates for protective laws and measures to ensure that all people in need benefit from HIV programmes and have access to justice, regardless of health status, sex, sexual orientation, drug use or sex work.

Infringement of rights

In addition to marginalizing people, legislation prohibiting some of the behaviour that puts people at higher risk of exposure to HIV infringes people’s rights.

Some 160 countries are parties to the International Covenant on Economic, Social and Cultural Rights, which stipulates that health facilities, goods

and services must be accessible for everyone, especially the most vulnerable or marginalized sections of the population, without discrimination. These countries have committed to take measures to protect vulnerable or marginalized groups in order to protect the right to health.

However, around the world there are cases in which these rights are not being upheld. Maclean Kanya, a sex worker and human rights activist in Uganda, explains how health services are not universally available to her. “When we visit health centres, some health workers say, ‘But you are just a sex worker and we are just wasting our [antiretroviral drugs]. Why should we give you our treatment? We have to give it to someone who needs it.’ That is total discrimination,” she said in an interview with IPS Africa.

Criminalization of transmission or exposure

In some parts of the world, there is a worrying trend towards rolling back progress towards a rights-based approach to HIV by enacting laws to criminalize HIV transmission or exposure.

This criminalization has not demonstrated any public health benefit, nor have these laws been shown to significantly affect sexual conduct or reduce risky behaviour. Experts working in the AIDS response agree that criminalization is counterproductive to public health as it discourages people to be tested for HIV and disproportionately affects vulnerable people.

For example, a woman may test positive for HIV before her husband does when she accesses sexual and reproductive health services, but this risks her

being blamed for bringing HIV into the marriage. Sipiwe Hlope, a woman living with HIV and founder of the support group Swazis for Positive Living, has observed this in Swaziland. “People think the disease originates with women. Why? Because it is the women who are tested first, when they are about to give birth.”

Addressing a gathering of jurists in South Africa in 2009, Edwin Cameron, a Justice on the Constitutional Court of South Africa, highlighted that “criminalization is radically incompatible with a public health strategy that seeks to encourage people to come forward to find out their HIV status.”

Past legacies

Many countries are reviewing anachronistic laws that discriminate based on sexual orientation. In the landmark 1998 case *National Coalition for Gay and Lesbian Equality and Another v. Minister of Justice and Others*, the Constitutional Court of South Africa struck down three separate sodomy laws, noting the right of all people to dignity and equality in concluding that discrimination based on sexual orientation was prohibited under South Africa’s Constitution.

In 2010, Fiji overturned a law that criminalized same-sex acts. In 2009, the High Court of Delhi ruled that Section 377 of the Indian Penal Code was unconstitutional. The Naz Foundation (India) Trust—the nongovernmental organization that won the case—argued that by criminalizing private, consensual same-sex conduct, Section 377 perpetuated negative and discriminatory beliefs towards same-sex acts, driving activities underground and crippling HIV prevention efforts.

Legal moralism threatens fair and effective responses

In 2009, Ban Ki-moon, the Secretary-General of the United Nations, explained clearly what is needed for a fair and effective response to HIV: “Successful AIDS responses do not punish people; they protect them. ... We must ensure that AIDS responses are based on evidence, not ideology, and reach those most in need and most affected.”

“I urge all countries to remove punitive laws, policies and practices that hamper the AIDS response,” said Mr Ban.

Legal moralism imposed by a state using its power to enforce society’s collective morality risks profoundly harming the most vulnerable and marginalized by not safeguarding human rights.

A Global Commission on HIV and the Law was launched in June 2010 to develop actionable, evidence-informed and human rights-based recommendations for effective HIV responses that promote and protect the human rights of people living with and most vulnerable to HIV.

According to the Commission, “The true test of a humane society is reflected in its commitment to protect the rights of minorities.”

To realize UNAIDS’ vision of zero discrimination, the Joint Programme has set a goal for 2015: reducing by half the number of countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses to HIV.

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Condoms and prevention

Condoms are an essential part of the prevention revolution. Other essential elements include: access to information about HIV, access to treatment, harm reduction measures, waiting longer to have sex, being faithful, reducing multiple partners and concurrent relationships, ensuring human rights and reducing stigma.

Condoms and prevention



The latex condom for men—when used consistently and correctly—is the most efficient available technology to reduce the sexual transmission of HIV. With more than 7000 people becoming newly infected with HIV globally each day, UNAIDS promotes the use of male and female condoms together with all other scientifically proven methods of HIV prevention.

Introduction

Effective condom programmes focus on reaching both the general population and people at higher risk of HIV exposure, such as sex workers and their clients, people who inject drugs and men who have sex with men. People are more likely to use condoms when they are available at no cost or at a heavily subsidized price. In 2009, donor governments provided 2.7 billion male condoms and 29 million female condoms to developing countries.

HIV prevention programmes have shown measurable results in recent years. Among people aged 15–24 years, for example, the rate of new HIV infections declined by more than 25% in 15 of the most heavily affected countries in sub-Saharan Africa between 2000 and 2008. Recent declines in HIV incidence have been linked to important behaviour changes, including increased condom use, delayed sexual debut and fewer sexual partners.

However, condom use remains far too low in many regions. According to a recent analysis of 23 countries with comparable data, only 28% of adult men and 24% of adult women who had more than one sexual partner during a 12-month period used condoms.

On a global scale, the annual rate of people becoming newly infected with HIV continues to outpace treatment successes. It's estimated that for every two people who become newly infected with HIV, one person starts antiretroviral therapy.

Q&A with Aine Collier

Did you know condoms have featured in the lives, loves and letters of people throughout the ages? Aine Collier, author of *The Humble Little Condom: A History*, helped **OUTLOOK** trace some memorable moments in the history of the condom—from ancient Egypt through modern times. Ms Collier is an Associate Professor of English at the University of Maryland University College.

What is the origin of the word condom?

The etymology of the word is not known. The legend that persisted well into the 20th century was that King Charles II of England wanted to keep his military disease-free and asked his surgeon, Dr Condom, to come up with something to prevent infection. While there is no record of this man ever existing, Charles' men, at least some of them, did practice safe sex. One of the oldest condoms ever found intact belonged to an officer in the King's army.

The probable origin of the word is found in medieval Latin: *condos* means preserve and receptacle; *conduma* means 'with roof of a house'; and *cumdum* is either a scabbard worn over a sword or an oilskin case for holding the colours of a military regiment.

What is the most creative name that you have seen to describe the condom?

Cap, capote, pouch, male shield, rubber, American instruments, Spanish letters, prophylactic, *preservatif*, johnnie, sexy boot, overcoat, Frenchie, *badruche*, raincoat, nodder, propho, *gummi*, sheath, quandom—the humble condom must have had more euphemisms applied to it over the

centuries than any other object in history. But perhaps the most inventive are found in France in the 1890s. Parisian men had their choice of wearing *le porc-épic* (the porcupine), *le conquérant* (the conqueror), *le corcorico* (the cock-a-doodle-do) or *le sainte-nitouche* (the 'she looks as if butter would not melt in her mouth').

Before condoms were mass-produced in the 1900s, did people make their own?

Many people made their own condoms at home before the 20th century. In fact, it was very much a cottage industry, as most condom 'manufacturers' worked from their own kitchens. In 1824, this 'recipe' was printed on a broadsheet and probably distributed by the growing number of birth control advocates in some of the United States' big cities:

Ordinary condoms are made from sheep's intestinal caeca soaked in water for some hours, turned inside out, macerated again in weak alkaline changed every 12 hours, scraped carefully to remove the mucous membrane, leaving the peritoneal and muscular coats; exposed to the vapour of burning brimstone, washed with soap and water; blown up, dried, cut to length of 7–8 inches, bordered at the open end with a ribband.

And the traditional colours for the ribbands? Blue and pink, a nod to feminine tastes.

Condoms and prevention

A walk down condom lane

Compiled by Aine Collier and UNAIDS

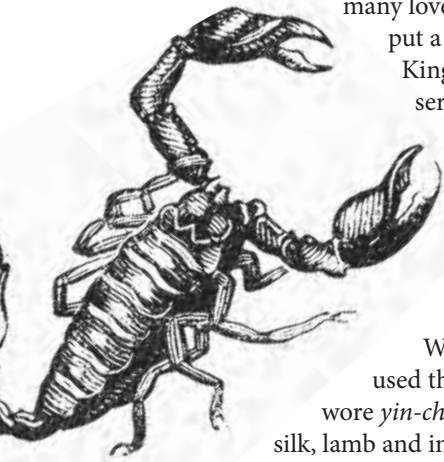
1350–1200 BC

In the twelfth dynasty of ancient Egypt, men wore glans condoms made of bladder or animal intestines. These condoms, covering only the head of the penis, evolved from traditional labourers' loincloths. Women used pessaries, the ancient version of a female condom.



200 AD

The story of King Minos, appearing in a book of Greek legends, described how the King had many love affairs. In revenge, his wife put a curse on him, causing the King to have semen full of serpents and scorpions. To protect his partners from these beasts, he wore a condom!



1400s

Wealthy Chinese men who used the services of sex workers wore *yin-chia*—condoms made of silk, lamb and intestine—as birth control devices and for cleanliness. Japanese men wore *kawa-gata* (literally, 'penis sack'), first as a form of birth control and later to prevent disease.



1550s

Italian anatomist Gabriele Fallopius, who discovered the fallopian tube, recruited 1000 men to wear his 'new' invention: a linen condom soaked in a lye solution. He hoped it would prevent the spread of syphilis, a deadly epidemic at the time. Fallopius declared the condoms a great success when none of his volunteers became infected.

1655

A French novel called *L'Escole des Filles*—the first book to feature the condom—was a must-read in the royal court of King Louis XIV.



1666

England's Birth Rate Commission attributed a recent drop in the country's fertility rate to the use of 'condons.'

1708

The first poem dedicated to the condom, entitled *Almonds for Parrots*, parodied the "happy invention" that "quenched the heat of Venus' Fire and yet preserv'd the Flame of Love's Desire." The author's identity remains a mystery.



1750s

Venetian adventurer and legendary womanizer Giacomo Casanova used condoms, which he called 'English riding coats,' to avoid impregnating his mistresses.

1783

The *Classical Dictionary of the Vulgar Tongue*, published in England, defined the condom as: "Cundum, the dried gut of sheep, worn by men in the act of coition to prevent venereal infection, said to have been invented by one Colonel Cundum." This is the first time the word condom appeared in a dictionary.

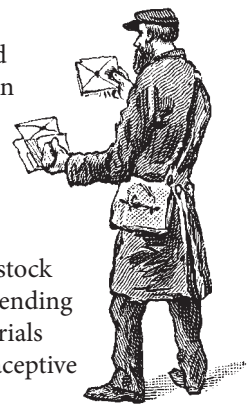
1837

United States inventor Charles Goodyear discovered rubber vulcanization, a process whereby natural rubber is turned into a material that is elastic and durable. Goodyear coined the term rubber to describe condoms made from the substance—a euphemism that has stood the test of time.



1860s

During the Civil War in the United States, both Confederate and Union soldiers could order condoms through mail-order companies.



1873

The United States passed the Comstock Act, a federal law that prohibited sending "obscene, lewd or lascivious" materials through the mail, including contraceptive devices.

1912

German chemist Julius Fromm developed a new and improved manufacturing technique for condoms called cement dipping, which produced a thinner, seamless condom. Fromm patented his invention in 1916.



1914–1918

During the First World War, the United States was the only country with soldiers in Europe that did not provide condoms and promote their use. The rates of syphilis and other sexually transmitted infections soared among American soldiers.

1920

Researchers accidentally discovered latex, or rubber suspended in water, while searching for a way to produce fine surgical gloves. Frederick Killian, a condom manufacturer in Ohio, was the first to use the new material.

1926

Frederick Killian created the first condom assembly line. Latex condoms performed better for the consumer than their rubber counterparts: they were stronger, thinner and had a longer shelf life.

1930–1931

At the Lambeth Conference of 1930, the Anglican Communion sanctioned the use of birth control by married couples. The Roman Catholic Church responded by issuing the *Casti Connubii*, affirming its opposition to all forms of birth control.



1939–1945

By the time of the Second World War, the United States Government actively promoted condom use among American soldiers through posters, films and lectures. European and Asian countries on both sides of the

conflict also provided condoms to their troops.

1957

British manufacturer Durex introduced the lubricated condom.



1955–1965

In the United States, 42% of the people of reproductive age used condoms as birth control.

1965

President Lyndon B. Johnson announced United States support for promoting contraceptives in developing countries. This marked the beginning of the exportation of condoms made in the United States as foreign aid.

1970s

Italy and Ireland repealed laws prohibiting the use of birth control. Previously, condoms were contraband: Irish custom officials confiscated millions of condoms smuggled in from Great Britain, and savvy Italians brought them in from France.



1980s

With the emergence of the AIDS epidemic in the 1980s, condom promotion campaigns were launched across Europe and North America, despite opposition by some political and religious figures. The Swiss AIDS Foundation developed its own condom brand, Hot Rubbers, for gay men.

1988

Charles Everett Koop, Surgeon General of the United States under President Ronald Reagan, took unprecedented action in mailing the pamphlet *Understanding AIDS* to all households in the United States. Religious activists, upset by the pamphlet's advocacy of condom use, called for Koop's resignation.

1991

The British Safety Council called for the first National Condom Week. Its slogan: "Slip into something safe and sexy."



1993

The United States Food and Drug Administration approved a female condom made of polyurethane.

1994

Addressing the United Nations on World AIDS Day, United States Surgeon General Joycelyn Elders stirred up controversy when she said that the United States was not using the most powerful medium—television—to educate people about AIDS. "Our country has really not made a commitment," she said.

2005

Despite billions of dollars spent on education about safe sex, condom commercials were not shown on United States television before 11 pm until 2005.



2006

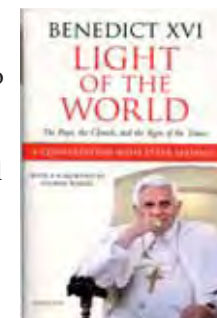
The Philippines, the last anti-condom holdout in Asia, legalized condom use. Condom sales skyrocketed.

2009

According to the United Nations Population Fund, donor governments provided 2.7 billion male condoms and 29 million female condoms to low- and middle-income countries.

2010

In a book entitled *Light of the World: the Pope, the Church and the Signs of the Times*, Pope Benedict XVI appeared to soften the Vatican's stance on condoms. When asked by the author if the Catholic Church is actually not opposed in principle to the use of condoms, Pope Benedict said, "She [the Vatican] of course does not regard it as a real or moral solution, but, in this or that case, there can be nonetheless, in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality."



‘Condom King’ Mechai Viravaidya



Activist and opinion leader Mechai Viravaidya is Thailand’s best-known advocate of safe sex and family planning. Together with the Thai government and his grassroots organization Population and Community Development Association (PDA), Mr Viravaidya—affectionately known as ‘Mr Condom’—helped lead a successful drive to lower the country’s birth rate through the community-based distribution of oral contraceptives and condoms. Between 1974, when the PDA was founded, and 2000, the annual population growth rate in Thailand fell from 3.3% to 0.5%.

After addressing the country’s immediate family planning needs, Mr Viravaidya and the PDA took on a range of other health and development issues, including HIV education and prevention. As a Cabinet Minister in the early 1990s, Mr Viravaidya was the chief architect of Thailand’s National AIDS Plan—the most comprehensive national response to the epidemic, at that time, in Asia.

In recognition of its pioneering work in HIV prevention and family planning, PDA was honoured in 2007 with the Gates Award for Global Health, from the Bill & Melinda Gates Foundation. During the past three decades, Mr Viravaidya has received a number of other accolades, including the Ramon Magsaysay Award (1994), the United Nations Population Award (1997) and the Prince Mahidol Award (2009). In 2010, Mr Viravaidya was appointed to the UNAIDS High-Level Commission on HIV Prevention.

OUTLOOK spoke with Mr Viravaidya about his social enterprise Cabbages and Condoms youth involvement in HIV prevention, and more.

Q&A with the ‘Condom King’

What strategies did you use in the 1970s to make condoms widely available across the country?

We ensured that condoms were available in every village, every shop. We gave out condoms in the streets. We had condom blowing championships for more than a quarter million rural school-teachers. Condoms were blown up as balloons and used as batons in relay races. We gave out condoms at bus stops, bus stations and toll booths. We gave them out everywhere, except at funerals.

But it’s important to note that condoms, at that time, were the symbol of family planning rather than the major contraceptive that was used. The main contraceptive—by far—was the pill, followed by the intrauterine device (IUD) and sterilisation. Condoms were used in between, like a spare tire. But they were very important to get people to think and to talk about contraceptives.

Was the Thai population quick to embrace condoms, or were they a hard sell?

It took time, and we used a great deal of humour in our approach. We made condoms fun, relaxing and available everywhere. We said, “The condom is clean if your mind is not dirty. It’s made from a rubber tree, just like a tennis ball. So if you’re embarrassed by a condom, you must surely be more embarrassed by the tennis ball—there’s more rubber in it.”

What policies did you recommend to the Thai government in the 1990s to curb the country’s rate of new HIV infections?

When I was brought in as a Cabinet Minister for Tourism, Broadcasting and Communications in 1991, I told the Prime Minister that we needed to

have AIDS as the major issue on the agenda. I felt that nothing else would be useful if we didn't stop AIDS. I said that AIDS is not a health problem, it's a societal and development problem, and everybody who could affect any change in attitude and behaviour needed to be involved.

I told the Prime Minister that he needed to be the chairman of the national AIDS endeavour. Every institution had to be involved—religious, business, educational. We asked every company to help train their staff in HIV prevention; we told the companies, “Dead staff don't work, and dead customers don't buy.” So the whole country backed it.

Can you tell us about your restaurant chain “Cabbages and Condoms”—what are some of the obstacles and successes you have faced along the way?

One cannot expect to live off the generosity of others forever. Even great empires fail. We needed resources to support the activities of our organization, and we knew that we had to help ourselves. So we started 35 years ago with a social enterprise where the profits were used for charitable purposes such as family planning, AIDS, education, environment, gender equality, human rights, poverty alleviation and so on. We generated our own money and, to this day, about 70% of our entire operating costs are funded by our own social enterprises.

“Cabbages and Condoms” is in every guidebook—we have almost 300 people every night. We never close. The restaurants are also places where people can feel comfortable about the condom. We have condoms everywhere. We have Tiger Woods and Santa Claus condoms. Everything that possibly can be made of condoms is made of condoms.

We have 17 restaurants now in Thailand, two in Japan, and one in England. We would like to have more resources to expand our business.

At what stage should young people learn about condoms and safe sex?

Children should learn about condoms when they're 4 or 5 years old—as balloons, so that their first impression is fun and light. Even in our restaurant, kids blow up condoms as balloons, and

it's fun. I use my own grandchildren, who are 5 years old, as junior condom ambassadors.

Condoms are a lifesaver and a girl's best friend. It's the guns and tanks and the aeroplanes that you should be embarrassed by, not the condoms. My grandchildren give out condoms all the time. When Bill Gates Senior was here last year, they gave him condoms.

How can we get more young people involved in an HIV prevention revolution?

Youth are the best people to explain HIV prevention to other youth. So we work through a lot of youth organizations—in particular, student councils of every school in Thailand. We get them to hold trainings and we give them a budget. They help to promote family planning, safe sex and HIV prevention. We now have youth condoms with nice colours, designed by and for youth.

How do you counter critics who claim that the effectiveness of condoms as a method of HIV prevention is exaggerated?

We know the truth, so why bother with them? These people would not have said such things had they been a bit more knowledgeable about basic research. Other than no sex at all, the condom is the best defence we have at the moment against HIV.

As world leaders gather this June for the United Nations General Assembly High Level Meeting on AIDS, what message would you send them about the state of the AIDS epidemic globally?

Do more! Leaders are not leaders at all unless they act to prevent people from dying. Every prime minister, every president should lead the drive against new HIV infections because we have lost more people to HIV than all the soldiers killed on both sides during World War II. HIV is a major problem, and we have to solve it. Every leader in the world must be involved—otherwise they should think about resigning.

Leaders are not leaders at all unless they act to prevent people from dying.

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Sex and drugs

People who inject drugs, sex workers and people who pay for sex are some of the population groups at higher risk of HIV infection. Only 32% of drug users have access to HIV prevention services; for sex workers the figure is 47%. This means that many people lack the ability to protect themselves from the elevated HIV risk their behaviour presents.

Where comprehensive services for sex workers and drug users have been put in place, fewer people have acquired HIV. But what do 'comprehensive' services mean?

Sex and drugs

Comprehensive package of HIV services for people who inject drugs

Sterile needle-syringe programmes

According to experts, access to needle-syringe programmes would result in marked decreases in HIV transmission, by as much as 33%–42% in some settings.

Opioid substitution therapy and other drug dependence treatment

Opioid substitution therapy is highly effective in reducing drug injection use that puts people who use drugs at risk of exposure to HIV. It has also been shown to improve people's access and adherence to HIV treatment, thus reducing deaths from AIDS.

HIV testing and counselling

Improving the access of people who inject drugs to HIV testing and counselling enables them to be informed about their status, learn about HIV and how to prevent it, as well as get HIV treatment and care.

HIV treatment

People who inject drugs have less access to HIV treatment than people who do not. Evidence shows that people who inject drugs can successfully follow treatment and benefit from antiretroviral therapy.

Health care including sexual health

By enabling people who inject drugs to have access to general medical services, their wider health needs can be addressed including, preventing and treating sexually transmitted infections. Having access to nutrition, sanitation and clean water are also key to living healthy lives.

HIV prevention commodities

Access to condoms for people who inject drugs and their sexual partners reduces the sexual transmission of HIV. Condoms, when used correctly and consistently, reduce the risk of HIV infection by about 90%.

Information, education and communication

Information about HIV and how to prevent it is needed for people who inject drugs and their sexual partners.

Vaccination, diagnosis and treatment of viral hepatitis

HIV programmes for people who inject drugs that include programmes to vaccinate against hepatitis C virus help prevent the spread of other blood borne viruses.

HIV and Tuberculosis

People who inject drugs who are living with HIV have weakened immunity and are at increased risk of acquiring tuberculosis (TB), a potentially fatal disease. A comprehensive package of HIV services for people who inject drugs should also include the prevention, diagnosis and treatment of TB.

“ Even where services are available, such as in Nepal, they might not always be accessible. Sometimes I get clean needles, sometimes I don't. Particularly during office holidays. ”

“ The funny thing is, in our country, the Ministry of Health distributes needles and syringes but then the Ministry of Home Affairs arrests us for carrying them. ”

“ I am happy that I have access to methadone, but there is no treatment facility for other related infections and diseases. Many drug users don't even have access to methadone. ”

“ As a drug user, I am totally neglected by society. Even a street dog has more value and dignity than a drug user. I am always discriminated by health care providers. ”



Bijay Pandey
A leader of an organization for people who inject drugs in Nepal



Jamil Ahmed
A drug user and member of Procheshta, a self-help group in Bangladesh

Comprehensive package of HIV services for sex workers

Social change

Action is needed to address the structural barriers, including policies, legislation and customary practices that prevent sex workers from accessing and using HIV prevention, treatment, care and support services. Having access to employment enables people to have alternatives to sex work for income generation.

Ending discrimination

Policies and programmes are needed to ensure sex workers are free from violence, abuse and discrimination.

Information, education and communication

Information about HIV for sex workers and their clients helps people to be informed about how to stay HIV-free.

HIV prevention commodities

Access to high-quality male and female condoms and water-based lubricants for sex workers reduces the sexual transmission of HIV. Condoms, when used correctly and consistently, reduce the risk of HIV infection by about 90%.

HIV testing and counselling

Ensuring sex workers have access to HIV testing and counselling is vital and should be followed up with treatment, social support and care and for sex workers who test positive for HIV.

Primary health care

All sex workers should have access to high-quality primary health care, including tuberculosis management and sexual and reproductive health services, especially sexually transmitted infection management. Effective antenatal care should include services to prevent the transmission of HIV to children. Having access to nutrition, sanitation and clean water are also key to living healthy lives.

Reduce alcohol and drug dependence

Access to alcohol and drug-related harm reduction programmes, including sterile needles and syringes and opiate-substitution therapy for sex workers who also use drugs would lower the risk of their behaviour resulting in HIV infection.

Social protection

Welfare services, including social support mechanisms for vulnerable households can help reduce a person's chance of adopting higher risk behaviour including sex work which increases risk of becoming infected with HIV.

Source: WHO, UNODC and UNAIDS.

“If someone hits a woman in the street, people and the police would intervene. But when it comes to a sex worker, she has no chance to be defended—neither by a passerby nor by the police.”



Elena

A sex worker from Ukraine

“Health workers often disclose the medical status of your health or are simply unwilling to provide medical services if they suspect you of being a sex worker.”



Rehena Akhtar

A sexworker from Bangladesh

“The most important work to protect ourselves from HIV is to change the sexual behaviour and attitude of male clients. Because they need to use condoms to prevent HIV transmission during sexual encounters.”

“Many sex workers are exposed to physical violence when on the streets. When reports are filed, cases are usually ignored owing to the nature of the work.”



Miriam Edwards

A sex worker from Guyana who has worked to create an alliance of Caribbean sex workers

27

Universal access

A decade ago there was a deep and wide divide between people who had and people who did not have access to HIV prevention, treatment, care and support.

Today the gap is closing. And what was once a dream is becoming a reality in countries around the world through ambitious universal access goals.

The pursuit of universal access goals

In recent years, countries, partners and communities have recognized the need to respond to the complex developmental challenges inherent in the response to the HIV epidemic. In 2005, the Group of Eight industrialized countries (G8) made the first commitment to achieving universal access to HIV prevention, treatment, care and support:

“We will work to achieve...with the aim of an AIDS-free generation in Africa, significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010.”

Achieving countries' universal access goals to HIV prevention, treatment, care and support means closing the gap between those who get care and those who do not by ensuring the availability of more equitable, affordable and comprehensive HIV services. Governments subsequently incorporated this commitment into the 2006 Political Declaration on HIV/AIDS. Given the substantial differences in the HIV epidemics around the world, priorities have been determined on the nature of the epidemic, including the level of HIV prevalence to a specific region and whether the epidemic is widespread or concentrated among people with a higher risk of acquiring HIV infection, such as people who inject drugs or men who have sex with men.

Significant advances have been made towards the goal of universal access globally.

- More than half the pregnant women living with HIV in low- and middle-income countries have received antiretroviral drugs to prevent the mother-to-child transmission of HIV. Such programmes have notably contributed to lowering the number of babies newly infected with HIV and significantly reducing deaths among children younger than 15 years of age.
- Since 2004, access to treatment has grown 13-fold. More than 6 million people were accessing life-saving antiretroviral therapy at the end of 2010—up from 5.2 million at the end of 2009.
- As a result of the scaling up of treatment and the wider availability of care and support to people living with HIV, the annual AIDS-related deaths have steadily decreased from the peak of 2.1 million in 2004 to an estimated 1.8 million in 2009.
- The programmes for preventing sexual transmission have also improved. Eleven countries, including Botswana, India and South Africa, reported that 75% or more of either men or women used a condom at last higher-risk sex.

FACT sheet

UKRAINE ::::::::::::::::::::



BLOOD SAFETY
No data



NOTABLE ACHIEVEMENTS



AIDS-related deaths: rose from 13 000 in 2001 to 24 000 in 2009.

Number of people newly infected with HIV (increasing or decreasing): increasing.

Estimated treatment coverage: 10%*

87% of people who inject drugs reported using sterile injecting equipment the last time they injected.

The proportion of people who started injecting drugs in the past two years who acquired HIV infection (and are thus more likely to represent incident infections rather than ones acquired much earlier) decreased from a peak of 30% in 2004 to 11% in 2008.

88% of female sex workers reported the use of a condom with their most recent client.



MAIN CHALLENGES:

Between 39% and 50% of people who inject drugs are believed to be living with HIV.

58% of sex workers are being reached with HIV prevention programmes.

59% of schools provided life skills-based HIV education in the last academic year.

CAMBODIA ::::::::::::::::::::



BLOOD SAFETY
100%



NOTABLE ACHIEVEMENTS



AIDS-related deaths: dropped from 7400 in 2001 to 3100 in 2009.

Number of people newly infected with HIV (increasing or decreasing): decreasing.

Estimated treatment coverage: 94%*

96% of female sex workers reported the use of a condom with their most recent client in 2007. In 2009, 99% did.

86% of men reported using a condom the last time they had anal sex with their male partner in 2009.



MAIN CHALLENGES:

Percentage of schools that provided life skills-based HIV education in the last academic year: 26% in 2007 and 34% in 2009.

42% of pregnant women were tested for HIV in 2009.

45% of infants born to women living with HIV receive treatment for preventing mother-to-child transmission.

COSTA RICA ::::::::::::::::::::



BLOOD SAFETY
100%



NOTABLE ACHIEVEMENTS



AIDS-related deaths: grew from less than 100 in 2001 to less than 500 in 2009.

Number of people newly infected with HIV (increasing or decreasing): increasing.

Estimated treatment coverage: 68%*

0 cases of mother-to-child transmission of HIV were recorded in the past two years.

100% of people living with HIV who have TB receive treatment for both infections.

100% of schools provided life skills-based HIV education in the last academic year.

Men who have sex with men reached with HIV prevention programmes increased from 26% in 2007 to 64% in 2009.



MAIN CHALLENGES:

Sex workers reporting the use of a condom with their most recent client: 92% in 2007 and decreasing to 89% in 2009.

49% of sex workers in 2009 received an HIV test in the past 12 months.

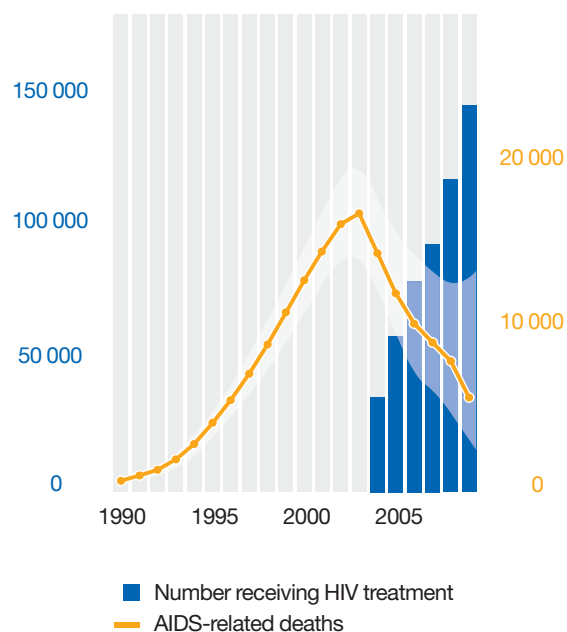
Source: UNAIDS Report on the global AIDS epidemic 2010.

* Source: WHO Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2010.

Universal access

Treatment and care

Scaling up antiretroviral therapy versus deaths from AIDS



BOTSWANA: A BRIEF STUDY

Overview of the HIV epidemic

Botswana continues to experience one of the most severe HIV epidemics in sub-Saharan Africa, with 320 000 people living with HIV in 2009 of a population of less than 2 million. In 2000, life expectancy in Botswana was an estimated 50 years for both men and women because of the epidemic. Since then, it has been rising but remains a low 55.5 years in 2010. HIV remains Botswana's most important social and public health challenge.

The response

Botswana has received international recognition for its achievements in the national response to the HIV epidemic. The country has strengthened its response mainly by expanding HIV prevention, treatment and care programmes for the general population and by increasing access to programmes for preventing the vertical transmission of HIV for pregnant mothers living with HIV.

Q&A with Sheila Tlou

Sheila Tlou is a former Member of Parliament and former Minister of Health of Botswana. She has played a key role in the HIV response in Botswana since 1985. Dr Tlou is currently the Director of the UNAIDS Regional Support Team for Eastern and Southern Africa.



What are some of the recent achievements in Botswana's AIDS response?

Considerable effort and domestic resources have been invested into trying to achieve universal access to HIV prevention, treatment, care and support for people living with HIV in Botswana. The major successes include one of the highest rates of coverage of antiretroviral therapy and programmes for preventing the mother-to-child transmission of HIV in the world. In Botswana, antiretroviral therapy coverage exceeds 90%, and services for preventing the mother-to-child transmission of HIV are currently available in all health facilities as part of maternal and child health services.

What are the greatest barriers to universal access in Botswana?

Stigma is still a major barrier. Hospitals and clinics provide services for preventing the mother-to-child transmission of HIV to 93% of pregnant mothers living with HIV, but the other 7% cannot access these services mainly due to stigma, logistics and issues relating to gender inequality. For example, a woman may want to get treatment or go to a clinic to get an HIV test, but if her husband will not allow it, she will forgo that service.

I would also say that key populations are not a main focus of the outreach programmes due to the stigma and criminalization of both sex work and homosexuality. The police will not harass sex workers, and indeed there exists some degree of tolerance, but there are no public services particularly for these groups. Some NGOs do provide services for sex workers, but definitely not for men who have sex with men. The government maintains that, at HIV service delivery points, everybody has access and no one is asked to specify their sexual preference or state whether they are a sex worker; everyone has equal rights to the services offered to them. However, these key populations need to have specific programmes directed towards them, and this has not been achieved yet.

What new measures should Botswana take to address the AIDS epidemic?

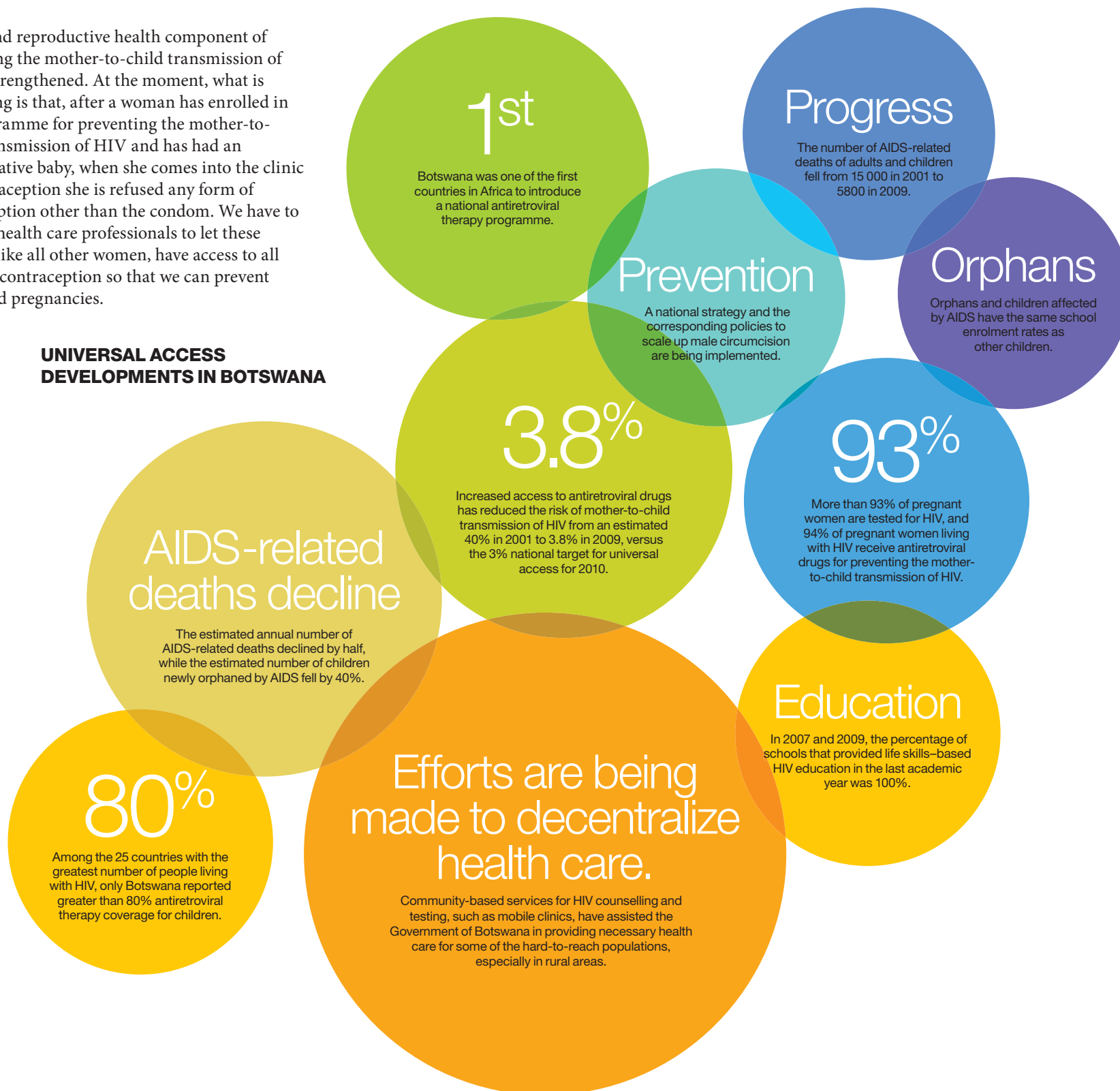
First, Botswana needs to make sure that refugees have access to all HIV services. Even registered refugees in Botswana, regardless of the fact that the rollout is near universal, do not have access to comprehensive HIV prevention, treatment, care and support services.

The next would be to review laws that criminalize sexual behaviour and to reach out to key populations such as sex workers and men who have sex with men. They have the right, like all Botswana's citizens, to access HIV prevention, treatment, care and support services.

Third, Botswana needs to make sure that the

sexual and reproductive health component of preventing the mother-to-child transmission of HIV is strengthened. At the moment, what is happening is that, after a woman has enrolled in the programme for preventing the mother-to-child transmission of HIV and has had an HIV-negative baby, when she comes into the clinic for contraception she is refused any form of contraception other than the condom. We have to reorient health care professionals to let these women, like all other women, have access to all forms of contraception so that we can prevent unwanted pregnancies.

**UNIVERSAL ACCESS
DEVELOPMENTS IN BOTSWANA**



28

TB and HIV

Tuberculosis (TB) is a leading cause of illness and death among people living with HIV. In 2009, about 400 000 people living with HIV died from TB.

TB can be cured.

Most people living with HIV who also have TB are in sub-Saharan Africa. Studies have shown that halving the number of TB deaths among people living with HIV by 2015 can be achieved simply by scaling up existing services to prevent and treat TB.

TB and HIV





Thobani Ncapai

Thobani Ncapai lives in Khayelitsha, near Cape Town in South Africa. He has a 16 year old son who loves math and accounting.

In 1998, Thobani was diagnosed with tuberculosis (TB) and learned he was HIV positive at the same time. The TB was treated, and a nurse at the TB clinic encouraged him to seek treatment for HIV. With her help and with the support of his family and community, in 2001 Thobani became one of the first people in Khayelitsha to start antiretroviral therapy.

Ten years later he has a research contract with the University of Cape Town, is an active member of his community, is still receiving first-line HIV treatment and says, “I am happy and I am enjoying life like any other person.”

TB and HIV



TB tornado: Lucica Ditiu in motion

“She was so poor and yet able to do so much. I mean, they were using a piece of wood under a sheet as a pillow.” Lucica Ditiu is telling the story of a nurse she met in a remote part of Albania. “She wanted her TB treatment register to be perfect. She didn’t have a computer so she would cut names and letters out of the newspaper. Amazing! It’s people that matter.”

In January 2011, Lucica, as she likes to be called, took over the reins of the Stop TB Partnership—an alliance of more than 1600 international organizations, countries and donors working to eliminate TB.

The new Executive Secretary wants to make it easier for nurses in Albania, civil society across Africa and people everywhere to get access to TB information, diagnosis, treatment and support.

About 2 billion people—one third of the world’s population—are infected with the TB bacilli, the microbes that cause TB. One in 10 will become sick with active TB in his or her lifetime. The risk of TB is even higher among people living with HIV. TB is a leading cause of death among people living with HIV. In 2009, about 400 000 people living with HIV died from TB.

“TB needs to have attention,” said Lee Reichman, Executive Director of the New Jersey Medical School Global Tuberculosis Institute. He thinks Lucica is the person to get it.

“I am a tornado ... I like to raise things in the air and spin them all. And most of the time they fall in the right place,” said Lucica, describing herself. These days she and the things are spinning fast. A connectivity junkie, most mornings she starts e-mailing at 04:00. “People love getting e-mails from her,” said Dr Reichman, and notes that they

love her out-of-office messages even more. “She just takes a little bit of time to entertain everybody and to do a spectacular job.”

After dropping her eight year old son off at school, she is ‘crazy busy’, meeting people talking about how to work better together within the TB community and beyond.

She became a doctor almost by chance: winning a medical school competition in Romania she had only entered to show her parents she could win it. She found she liked it, “I love people, I love helping people.”

Her fascination with TB started at a hospital where she was analysing data and spending time with seemingly healthy people with TB. “They were cooped up in a ward with virtually nothing to do,” she said. The origin of the TB treatment called DOTS, directly observed treatment, short course, is a bit misleading, as it can take six months or longer to complete. The people receiving treatment often feel fine after a few weeks. The difficulty is to ensure that people finish the treatment or they could risk developing multidrug-resistant TB or the even scarier extensively drug-resistant TB. Both can be transmitted to other people.

“It’s complicated, and basically I hate to lose,” she said when asked about DOTS. Never one for idle hands, she started health education sessions with people with TB to try to increase their chances of completing treatment once they left the hospital phase.

As a final step, after receiving money from Romania relief efforts, she along with staff and volunteers hand-wrote 20 000 follow-up postcards. One side showed the electricity about to be turned off and the other side said ‘Please don’t interrupt

TB is a leading cause of death among people living with HIV. In 2009, about 400 000 people living with HIV died from TB.

FIVE THINGS TO KNOW ABOUT LUCICA DITIU

- 1. IS A WORKAHOLIC.**
- 2. LOVES CLOTHES AND SHOES.**
- 3. LIKES CHURCH BUT DOES NOT ATTEND AS MUCH AS SHE WOULD LIKE.**
- 4. GOT LOTS OF GREAT COMMENTS WHEN SHE BLOGGED FROM A GLOBAL FUND BOARD MEETING AND IS THINKING ABOUT DOING IT AGAIN.**
- 5. HAS A PINK PIG AND A PINK RABBIT BY HER DESK, AND BOTH MAKE NOISE. SOMETIMES SHE TAKES THEM TO MEETINGS TO USE AS TIMERS.**

it. “Can you believe it, hand-by-hand we wrote the messages, so that is how I started with TB,” she exclaimed.

Jean-Pierre Zellweger, a TB specialist in Switzerland, has known Lucica for more than 20 years. He credits her enthusiasm and competitive spirit for making a difference in her home country. “Remember, she comes from a country with the worst epidemiology in Europe. In those times Romania was just a nightmare,” he said. “She was largely responsible for the improvement.”

More than 40 million people have been cured of TB in the last 30 years. Five million more could be reached by 2015 with increased access. This is something Lucica is working on in her own way, pointing to a Marilyn Monroe postcard that reads—“success is also a matter of format.” She firmly believes in substance and style.

Early in her career in Romania, she worked at a glossy magazine between hospital shifts to help make ends meet. “People were always surprised to find out that a doctor wanted to interview them,” she said. If TB had not captured her attention, she thinks she would be running one of the fashion magazines she likes so much. “I get on the airplane, and everyone on the mission is reading briefing papers and I have *Marie Claire*,” she said with excitement. “I love fashion.”

Her outfit today is on the sober side by her standards, a green and black dress reminiscent of a 1960s shift worn over a turtleneck, and she has a collection of bracelets on both wrists. Surprisingly discreet gold earrings dot her ears partly hidden under windblown brown hair.

Shaking her head, she laughs—gesturing towards the offending waves, “I could write a book on hairdressers. I know, I know, I spend a fortune and it looks like this.” Although it is difficult to miss her apple-sorbet green nails, her signature rings keep your attention. She has one ring on each finger, including both thumbs.

“When I interviewed for the job, my friends said, ‘Lucica, you might want to tone things down—maybe not the rings,’” she said. “I looked down at my bare fingers and said ‘**** it’ and put them back on.”

Her competitive nature comes out when she is asked to describe her approach to TB. “TB is smarter than us,” she said, bluntly sizing up her opponent. “It tricks us—using our own stupidity. It has been smart and lucky.” She thinks TB got lucky because it was forgotten in a “dusty cupboard in the corner”. She is planning to take it out of the closet.

Alasdair Reid, UNAIDS HIV/TB Adviser, says that it is about time. “HIV is about sex, among other things and, as everyone says, ‘sex sells!’” he said. “TB is about spit, lungs and poverty, and it is much more difficult to grab people’s attention. The Stop TB Partnership needs to raise the public and political profile of TB as an issue of global importance everyone should care about.”

Concerning integration with the HIV response, Lucica clearly sees that TB can no longer stand alone. “I’ll tell you what the problem is. For a long time, the TB response has been vertical and dominated by medical staff.”

Because of this, she says a strong civil society of people infected with and affected by TB has been slow to emerge. Strong stigma and discrimination has not helped. “Patients have not really been empowered. They were not aware of the duties, responsibilities and rights as patients,” she said. She has observed the opposite in the AIDS response and thinks there is a way to merge the two.

Lucica also points to global structures such as the Global Fund to Fight AIDS, Tuberculosis and Malaria that have not necessarily encouraged integration. She hopes even within her own organization, the World Health Organization, where the Partnership is managed, that people will work together more closely. She calls it going from ‘kingdom building’ to ‘kingdom merging’.

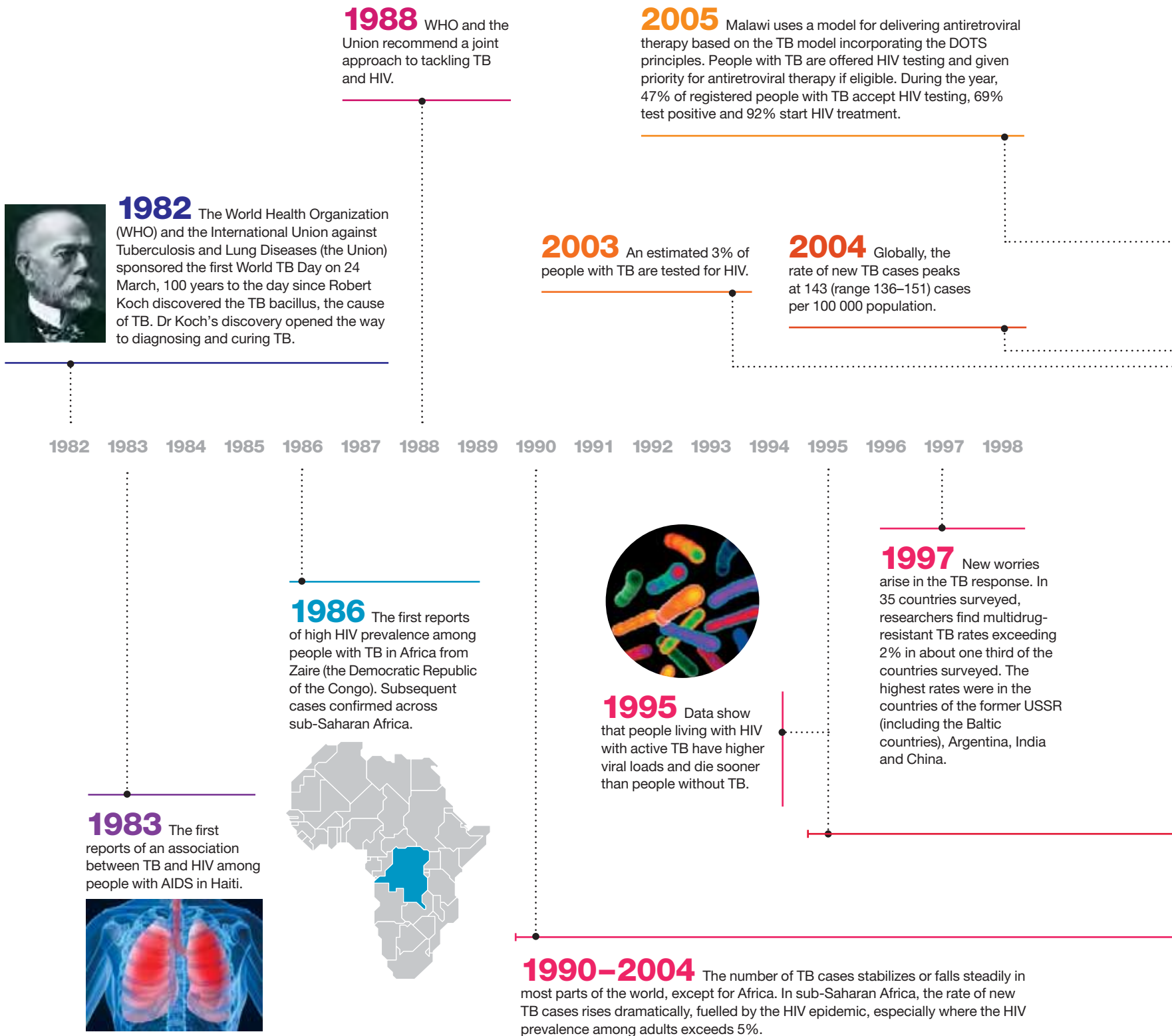
It is a good thing that the good doctor believes in transparency, as she might have a difficult time not being frank. This is one of her dreams for the Stop TB Partnership. “I really hope to be able to put openness, clarity, accountability and inclusiveness around the table—in a partnership job, partners should trust each other.”

“Lucica is not afraid of challenging the status quo, pushing boundaries and speaking her mind,” said Dr Reid.

Her friend Dr Zellweger is sure that Lucica will make a difference, “I would just remind her that she is working in a fascinating field and not to get distracted with things that are less interesting. There is something important to be done.”

As she leaves her office, she says that, in her interviewing days, she was always looking for the key line that would sell magazines. She wonders what her headline is, and then she whirls down the hall and vanishes.

Timeline of HIV and TB





2010 WHO endorses a new TB testing tool that does not require trained laboratory technicians. It can also diagnose TB and multidrug-resistant TB cases in less than two hours. Each machine costs US\$ 17 000, and each test requires a cartridge costing US\$ 17.

2006 WHO convenes an urgent meeting to discuss the implications of a deadly outbreak of extensively drug-resistant TB among people living with HIV in South Africa. Extensively drug-resistant TB is resistant to the most important first- and second-line anti-TB drugs.

2007 There are an estimated 0.5 million cases of multidrug-resistant TB; 27 countries (including 15 in the WHO European Region) account for 85% of all cases.

2008 An estimated 22% of the people with TB are tested for HIV. Globally, the percentage of people successfully treated for TB reaches the highest level of 86%.

2010 A study published in the *American Journal of Tropical Medicine and Hygiene* suggests that the Gambian pouched rat could be trained to detect the TB bacillus. Researchers say the data are preliminary but hope that this 1.5 kg mammal, with a highly developed sense of smell, could one day be part of routine first-line screening for TB. The rats are already helping to detect landmines.



2010 Global funding for the TB response reaches US\$ 4 billion.

2010 A five-year study known as CAMELIA (Cambodian Early versus Late Introduction of Antiretroviral Drugs) found that, among 661 people with TB who were living with HIV, the people who immediately received TB treatment followed two weeks later by antiretroviral therapy were nearly 35% more likely to survive than those who waited eight weeks before starting HIV treatment.

2010 A new campaign allows travelers to donate US\$ 2 to TB, malaria and AIDS issues every time they pay for a flight, a rental car or a hotel room. It is estimated that the MASSIVEGOOD campaign could bring in more than US\$ 600 million in four years.

1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015



2002–2007

Data from Botswana indicate a decline in the number of TB cases reported nationwide that coincides with rapid roll-out of antiretroviral therapy. Improvements in Botswana's national TB programme during this same period, including case detection and reporting, mean that this decline probably reflects a true reduction in TB infections due to antiretroviral therapy.



2006 Jorge Sampaio, the former President of Portugal, is appointed as the UN Secretary General's first Special Envoy to Stop Tuberculosis.

2009 New WHO guidelines recommend that everyone with TB who is living with HIV should receive antiretroviral therapy, regardless of their CD4 count.

2009 TB continues to be a leading cause of death among people living with HIV, accounting for an estimated 380 000 deaths.

2009 An estimated 3.3% of all new TB cases had multidrug-resistant TB.

2009 An estimated 1.6 million people with TB (26% of the total) are tested for HIV. In sub-Saharan Africa, which accounts for 78% of the people with HIV-related TB, the HIV prevalence among people with TB is as high as 80% in some countries. However, only 79 000 people living with HIV (0.2%) receive isoniazid preventive therapy, which can greatly reduce a person's risk of developing TB disease.

2015 Date for world to reach Millennium Development Goal 6—halting and beginning to reverse the tuberculosis epidemic and to reach the UNAIDS/STOP TB Partnership target of halving TB deaths in people living with HIV.

1995–2008 The overall TB response shows a cumulative total of 36 million people with TB successfully treated in DOTS programmes (the internationally recommended strategy for TB control), with up to 6 million deaths averted.



2009 Stop TB Ambassador Luis Figo is the main character of an educational comic book that provides key information on TB.

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New science

Scientific breakthroughs have made a clear difference in the AIDS response. No one knows for sure what the next 30 years will bring, but recent advances offer an optimistic future.

New biomedical advances in HIV prevention

An AIDS vaccine or even cure is still many years away, but new scientific advances are bringing hope to people living with and affected by HIV. The table on the right provides at-a-glance information on the results of three trials on new technologies being currently developed to prevent HIV infection.

Although much more needs to be done before these technologies can be made widely available, they represent significant advances in the scientific response to AIDS.

	RV144	CAPRISA 004 (Centre for the AIDS Programme of Research in South Africa)	iPrEx (Pre-exposure Prophylaxis Initiative)
Type	Vaccine	Vaginal microbicide gel	Tablets containing antiretroviral drugs
Study population	General adult population aged 18–30 years	Women aged 18–40 years	Men who have sex with men aged 18–67 years
Product	ALVAC-HIV and AIDSVAX B/E	1% tenofovir gel	Tenofovir/emtricitabine tablet
Study design	Four 'prime' doses of ALVAC-HIV and two boost doses of AIDSVAX B/E (prime-boost strategy) versus placebo injections	1% tenofovir gel used once in the 12 hours before sex and once in the 12 hours after sex versus placebo gel	Daily tablet combining tenofovir (300 mg) and emtricitabine (200 mg) versus daily placebo tablet
Trial result	31% efficacy	39% effectiveness	44% effectiveness
Date results published	20 October 2009	19 July 2010	23 November 2010
Study breakthrough	This large trial is the first demonstration that a vaccine can prevent HIV infection	This is the first trial to provide proof of concept that a vaginal microbicide could provide women with a safe and effective way to prevent the acquisition of HIV	These results constitute proof of concept of the safety and partial effectiveness of oral pre-exposure prophylaxis
Number of participants	16 395 men and women	889 women	2499 men
Funding	United States National Institutes of Allergy and Infectious Diseases and National Institutes of Health United States Army Medical Research and Materiel Command	Department of Science and Technology, South Africa United States Agency for International Development Family Health International	United States National Institutes of Allergy and Infectious Diseases and National Institutes of Health Bill & Melinda Gates Foundation
Product manufacturers	Sanofi Pasteur and Global Solutions for Infectious Diseases	Gilead Sciences	Gilead Sciences
Next steps (research)	Studies to determine how the vaccine worked	Trials to confirm the findings and studies to prepare for implementation	Studies of pill-taking, sexual behaviour and viral resistance when clinic visits are less frequent
Published article	Rerks-Ngarm S et al. Vaccination with ALVAC and AIDSVAX to prevent HIV-1 infection in Thailand. <i>New England Journal of Medicine</i> , 2009, 361:2209–2220.	Abdool Karim Q et al. Effectiveness and safety of tenofovir gel, and antiretroviral microbicide, for the prevention of HIV infection in women. <i>Science</i> , 2010, 329:1168–1174.	Grant RM et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. <i>New England Journal of Medicine</i> , 2010, 363:2587–2599.
Web site	hivresearch.org	caprisa.org	globaliprex.com





30

Hope

**I live in the hope of a world that will
be free not only of disease but of
fear and discrimination.**

Dominic D'Souza

We have a request. Can you adults find it in yourselves to trust us? We can handle responsibilities and make sensible decisions. And so maybe it's not so much a request as a challenge: make us partners in this process. Allow us to make decisions that affect our lives—decisions that we are capable of making. After all, it was you who gave the world the Convention on the Rights of the Child.

Excerpt from the foreword of a UNAIDS publication from 2001—HIV/AIDS and young people: hope for tomorrow—written by three students at Bhavan's Vidya Mandir Elamakkara, a secondary school in Kochi, India in 2001.

Fahed Majeed runs 10×10 Design Consultants, an architecture company with offices in Kochi and Bengaluru, and travels the region for his clients. Nisha Menon is a freelance writer, penning copy for videos, brochures and web sites from her home town in Kochi. Madhavendra Shenoy is an audit executive at Ernst & Young in Bengaluru. Mythili Menon is pursuing a PhD in linguistics at the University of California, Los Angeles. Rashmi Anthony and S. Ganesh work as human resources managers—Rashmi for Mahindra Satyam in Hyderabad and S. Ganesh for Bharti Airtel in Chennai.

What do they have in common?

Each student was, at various times, a peer educator and part of an AIDS awareness club started by their school counsellor, Janaki Shankaran, in 1996. At their school, Bhavan's Vidya Mandir Elamakkara, they learned about HIV and taught their peers how to protect themselves from HIV. They learned about values—human dignity, respect for gender and rights—lessons they would carry into the future.

How did the students get involved? How have these students fared? Where has life taken them? What have they done with the AIDS education and life skills they acquired at school? Have they made informed decisions?

OUTLOOK tracked down six peer educators, then aged 16 and now adults, and talked with them about their memories.

Fahed Majeed vividly remembers the first time he heard about AIDS—during biology class. The school counsellor was looking for volunteers. “It was completely new and I think I was partly curious,” he says. “There wasn't any other activity I was involved in, so I thought, let's give it a shot and see where it takes me.”

“We were coaxed into it, but we got into it deeply once we understood the seriousness of it,” says Nisha Menon. Rashmi Anthony had just come back to India after living most of her life in Dubai. “I was interested in activities and social clubs, and an AIDS awareness club was a natural fit,” she says.

Madhavendra Shenoy had a little bit of help from his classmates Rashmi and Nisha. “I was very shy to join because none of the boys volunteered to be a part of this. So I was a bit shy and a bit sceptical. Then Rashmi and Nisha told me ‘Don't feel shy, if you're able to convey this message to others it would be a big help.’”

Mythili Menon aspired to serve the United Nations. “I felt I could give something to society and help people,” she says. “I joined a lot of clubs in school—the nature club, the social service club and the AIDS awareness club. I was more outside the class than inside the class during my school days.” S. Ganesh was influenced by the talk of AIDS around him. “Yes, we were aware of AIDS as a pressing danger of the time,” he says.

Their duties spanned from talking about HIV prevention among their own friends to spreading awareness in other schools and their neighbourhoods. Talking with younger peers was not easy. “There was a lot of sniggering around and people laughing when we talked about a condom,” Rashmi recalls. “It wasn’t easy to be in the AIDS awareness club,” says Mythili. “People would make fun of you if you were part of the AIDS awareness club. They would say ‘oh, you’re part of the AIDS club’ and I would be like ‘no, it’s not an AIDS club, it’s the AIDS awareness club,’” she says.

“I used to talk to neighbourhood peers, but it was always strange,” remembers Fahed. “The response you got was that AIDS wouldn’t affect us,” he says. “That was the age when sex was being explored; everybody had different ideas, but when it came to AIDS it was always ‘not applicable to us, it’s kind of alien,’” Fahed recalls his friends telling him.

All six were fortunate to have encouraging and understanding parents. “In my family everyone’s quite open. I have an older brother. Both of us have been given enough freedom to decide and choose our course of action. So even if I had certain doubts, I could speak to my mom or dad,” says Rashmi.

Learning and talking about HIV helped them in learning some useful skills. Fahed was paired with his classmate Krishnakumar and asked to speak before an audience of more than 100 students from another school. Both had never set foot on a stage before. Together they decided that the best way to get over their fear of public speaking was to go up to the school stage and practise speaking in front of an empty auditorium after school finished. They stopped practising only when the school janitor kicked them out. “It kind of just completely opened me,” says Fahed.

S. Ganesh believes that the exposure to the AIDS programme made him more socially conscious. “At that time, AIDS was an epidemic that everyone,

including me, was just getting to know. So on one level, it was a revelation of sorts. But the education also inspired a sense of social responsibility in me: that I have to do something in my own small way to stop the spread of the epidemic and reduce stigma,” he says. S. Ganesh had the opportunity 10 years later. As a human resources manager, he spends a lot of time recruiting people and helping them to grow professionally. At one company for which he worked, he received information that two candidates were living with HIV. S. Ganesh knew what to do. His school had prepared him.

“It was actually my call. I was heading the recruitment there. The candidates went through the entire hiring procedure—they cleared all tests and interviews. I said we go ahead with the hiring because according to policy per se we were not allowed to discriminate against these individuals.” He went a step further. He took steps to maintain confidentiality and ensure health care. “Both still work in the organization. They lead particularly normal lives. So there’s a happy ending,” he adds. Today S. Ganesh works for a large mobile phone service provider. He is helping to shape their corporate social responsibility programmes, including supporting people living with HIV. “My mindset is—yes, we’ve got to do something.”

A few hundred kilometres away, Rashmi has a similar story to tell. While at school and later during her college days, she volunteered at an AIDS care centre in Kochi as part of her school project. Curious about what her daughter was doing, Rashmi’s mother joined her, and together they learned about people living with HIV and their needs. After earning her Master of Business degree, she joined one of India’s leading software



Students participating in peer education.



Bhavan's Vidya Mandir Elamakkara school.



Students at Bhavan's Vidya Mandir Elamakkara on World AIDS Day.

development companies, headquartered in Hyderabad. In its glory days, the company was an example of social responsibility. When the company began to draft its workplace policy on HIV, Rashmi was on the team. “I was the only one in the room who had actually met people living with HIV and had some understanding of the issues. I helped write the AIDS policy,” she says proudly. She helped the company set up a hotline for education and support and negotiated health coverage from insurance providers. The company ran awareness programmes for its staff. “There were very few calls to the hotline, so now we have converted it into a general crisis hotline,” she adds.



Nisha Menon producing a documentary.

The AIDS awareness club has also helped to shape values about gender equality and respect. “During my school days, girls and boys felt very shy talking to each other, even just for a handshake. Now I see that a woman is no different from a man. I treat everybody the same,” says Madhavendra. “I have seen this across all my friends also. They don’t discriminate now between women and a men,” he emphasizes.

Although there has been some progress on gender equality and respect, women still live in a state of fear, according to Mythili. “It is impossible for a woman to be outside after 6:30 or 7:00 pm alone and walk without actually thinking that she might not reach her home,” she says. She believes that society still needs to change and that this can only happen over a long period of time.

Today Rashmi feels that she is a confident young professional who can stand up in a room full of men and hold her ground. “I have no other choice if I have to be successful,” she says. “Nowadays girls are also very smart. They’re equal to boys. They’re very educated, very knowledgeable. And they’re also aware of what is right and wrong,” says Madhavendra.

S. Ganesh handles gender-related issues on a day-to-day basis across a wide region. Discussions about gender issues at school have played a major role in decisions he makes today. “I think at a very young age—at 15, 16 or 17—I think that we form our social scheme of things in terms of how I’ve got to set my social thoughts right,” he reckons. “I think I’ve become a far more balanced individual because of the learning that I got during that period, and definitely the interactions that we’ve had for HIV education have helped,” he adds.

Another barrier that AIDS and sexuality education at school broke was perceptions about homophobia. “I think it’s made me a better person, a lot more sensitive,” says Mythili. “I meet a lot of people who are gay. It’s easier for me to understand them than a lot of other people who probably haven’t been exposed to such programmes,” she adds.

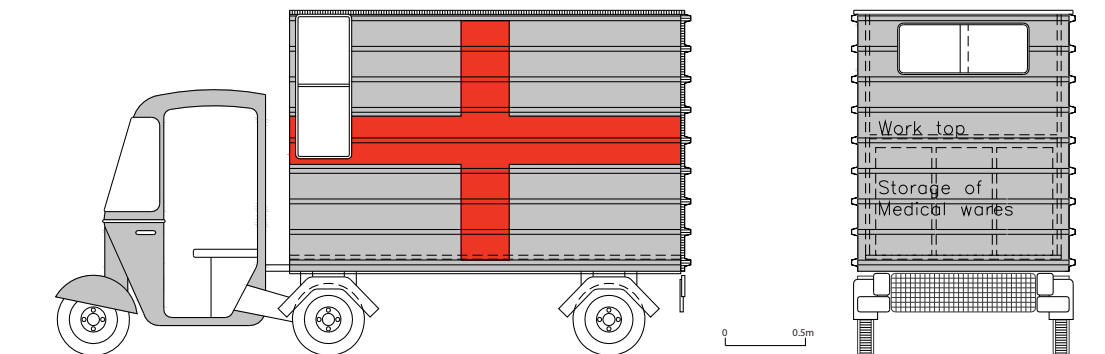
An official from the National AIDS Control Organisation once visited their school to talk to them about children’s rights. During the talk, he happened to mention the fact that homosexuality was criminalized in India. S. Ganesh had stood up in indignation and asked, “What does the government have to do with this?,” apparently leaving the speaker surprised but smiling. Today S. Ganesh is happy that the Delhi High Court has finally overturned the law. “Everyone’s got a life to live and the right to express their individuality, sexual orientation and gender,” he believes.

“The problem has to be addressed at a grassroots level. It has to come from primary education, secondary education. It cannot be tackled later in life. So I think it’s really important that people be made aware of AIDS at a very young age.”

Mythili Menon

Years after they left the school AIDS awareness club, they still find themselves correcting facts and dispelling myths in conversations with friends and colleagues. “People have half information. They don’t know the whole thing. There are still a lot of misconceptions about how HIV is spread. I’ve broken a lot of misconceptions with a lot of my friends,” says Rashmi. Madhavendra has also been talking to friends casually. “I often talk about how important our health is and about the consequences of our sexual relationships,” he says.

Fahed trained to be an architect, and today runs a successful award-winning design firm. While at college in Bengaluru, he volunteered at the Asha Foundation, a nongovernmental organization working with people living with HIV. The Foundation used a minivan to visit suburban areas to organize awareness sessions and offer HIV testing and counselling. The minivan was



Elevation drawings of Fahed Majeed's mobile AIDS van.



Fahed Majeed at work.

very cumbersome and not practical for carrying equipment, educational materials and the staff to these remote areas. Fahed put his skills to work and designed a mobile AIDS van that was customized to the needs of the organization. The mobile health care unit he designed was capable of carrying two health care workers and function as an outpatient clinic.

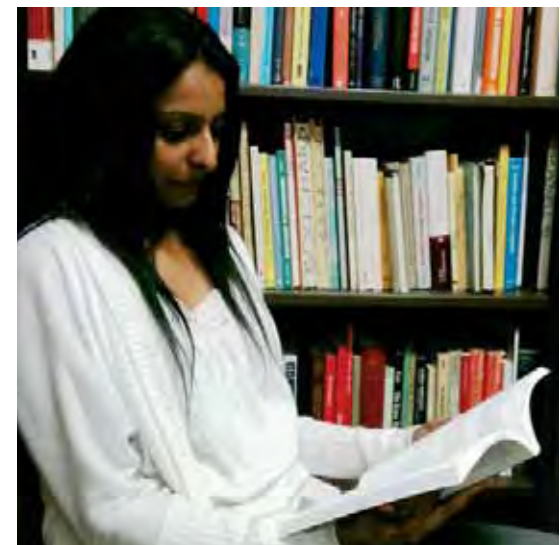
All of the one-time-students believe that awareness about HIV has increased. “I think youngsters are more aware about HIV and using protection, even if they start their sexual activity early,” says Nisha, now a freelance writer and producer who writes on a whole range of subjects, including social issues. “I see a lot of campaigns going on television nowadays. It is not a taboo anymore,” she says. S. Ganesh agrees, “I think the awareness of the epidemic itself is high, and we are aware of the fact that probably we might on a daily basis meet or interact with a person living with HIV.”

They express surprise when told that only about one third of young people have complete knowledge about HIV. “Yes, actually I’m very surprised. I just feel the biggest drawback of youngsters nowadays is an attention span of 10 minutes and that’s it—you’re done—they’re not listening anymore,” says Nisha. “You have to boil

everything down to 10 minutes on YouTube today,” Madhavendra adds. “I wouldn’t know where it went wrong, but I guess there’s still time to correct it. It’s never too late,” says Nisha.

AIDS and sexuality education has to start early, they say unanimously. “The problem has to be addressed at a grassroots level. It has to come from primary education, secondary education. It cannot be tackled later in life. So I think it’s really important that people be made aware of AIDS at a very young age—probably at 13, 14 or 15. I think that would be the right age,” says Mythili.

A new generation of children and adolescents attend the Bhavan’s Vidya Mandir Elamakkara school today. Fahed caught up with his old counsellor when he took his daughter, Janaki, to school. Will he talk to her about AIDS? “Yes, without doubt,” he says. “But I think they will learn earlier from Janaki herself,” he says, smiling at his daughter.



Mythili Menon is pursuing a PhD in linguistics.

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