

# The Cities Report

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**END THE AIDS EPIDEMIC IN CITIES BY 2030.** ACHIEVE 90% TREATMENT TARGETS BY 2020. COMMIT TO 90% TREATMENT, AND PREVENTION SERVICES. END HIV IN **AT THE CENTRE.** RESPECT HUMAN RIGHTS AND EQUITY. WORK IN PARTNERSHIP WITH COMMUNITIES TO GAIN RESILIENT SOCIETIES. **ADDRESS THE CAUSES** OF HIV. USE ALL MEANS INCLUDING MUNICIPAL ORDINANCES TO ADDRESS ISSUES THAT MAKE PEOPLE VULNERABLE TO HIV. WORK WITH COMMUNITIES TO BUILD AND FOSTER TOLERANCE AND INCLUSION. **SOCIAL TRANSFORMATION.** LEVERAGE INNOVATION TO BUILD SOCIETIES THAT ARE EQUITABLE, INCLUSIVE, AND SUSTAINABLE. INTEGRATE HEALTH AND SOCIAL PROGRAMMES TO ADDRESS HIV. **AND ACCELERATE THE AIDS RESPONSE.** DEVELOP AND IMPLEMENT PROGRAMMES. ENCOURAGE AND FOSTER COMMUNITY LEADERSHIP AND DEMAND AND TO DELIVER SERVICES RESPONSIVELY. **FOR INTEGRATED PUBLIC HEALTH AND DEVELOPMENT.** INTEGRATE HIV INTO CITY PLANS AND RESOURCES FOR A FAST-TRACKED RESPONSE. AND MOBILIZE ADDITIONAL RESOURCES AND STRENGTHEN CAPACITY. **WORLD.** MEASURE RESULTS AND ADJUST PROGRAMMES TO BE EFFECTIVE. SHARE EXPERIENCES, KNOWLEDGE AND BEST PRACTICES. CAN BE IMPROVED. REPORT ON PROGRESS.

**30. COMMIT TO ACHIEVE THE 90-90-90 HIV**  
**PROVIDE SUSTAINED ACCESS TO HIV TESTING,**  
**AND STIGMA AND DISCRIMINATION. PUT PEOPLE**  
**AND LEAVE NO ONE BEHIND. ACT LOCALLY AND**  
**EVANIZE GLOBAL SUPPORT FOR HEALTHY AND**  
**OF RISK, VULNERABILITY AND TRANSMISSION.**  
**ANCES AND OTHER TOOLS TO ADDRESS SOCIAL**  
**V, AND OTHER DISEASES. WORK CLOSELY WITH**  
**NCE. USE THE AIDS RESPONSE FOR POSITIVE**  
**VATIVE SOCIAL TRANSFORMATION TO BUILD**  
**RESPONSIVE, RESILIENT AND SUSTAINABLE.**  
**TO IMPROVE THE DELIVERY OF SERVICES. BUILD**  
**OP AND PROMOTE INNOVATIVE AND ACCESSIBLE**  
**UNITY LEADERSHIP AND ENGAGEMENT TO BUILD**  
**SIVE TO LOCAL NEEDS. MOBILIZE RESOURCES**  
**PMENT. INVEST IN THE AIDS RESPONSE. ADAPT**  
**KED RESPONSE. DEVELOP INNOVATIVE FUNDING**  
**STRATEGIES. UNITE LEADERS FROM AROUND THE**  
**GRAMMES TO BE FASTER, SMARTER AND MORE**  
**GE AND DATA ABOUT WHAT WORKS AND WHAT**  
**END THE AIDS EPIDEMIC IN CITIES BY 2030.**

# The Cities Report



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THE LAST WORD

Teresia Njoki Otieno



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**TRANSFORMING** *cities*





# ON THE WEB

[unaids.org](http://unaids.org)

## Mapping it out

On the go or at your desk—highlights from the UNAIDS OUTLOOK Cities report are now available through a new interactive map and journal. Go online to discover what cities are doing around the world in the AIDS response: [www.unaids.org/citiesreport](http://www.unaids.org/citiesreport)

## UNAIDS.org

Go to the [unaids.org](http://unaids.org) website to download the full report and check out related resources.

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## THE FINE PRINT

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Joint United Nations Programme on HIV/AIDS (UNAIDS).

ISBN 978-92-9253-066-2

JC2687

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS unites the efforts of 11 UN organizations—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and works closely with global and national partners to maximize results for the AIDS response. Learn more at [unaids.org](http://unaids.org) and connect with us on Facebook and Twitter.

# Foreword

## *Placing cities on a Fast-Track to end the AIDS epidemic*

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**“We stand  
shoulder to shoulder  
with community and  
city leaders”**

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**T**he future of human health and development is being shaped by cities and urban areas. More than six of every 10 people will live in urban centres by 2050. The actions of city leaders will therefore have a profound impact on public health, especially in low- and middle-income countries, where more than 95% of urban growth is expected.

Cities are engines of transformation. They are home to the largest and most dynamic economies and they are energized by young, mobile and diverse populations with talent, creativity and innovation.

Urban areas are also home to millions of people who have fallen through the cracks of social, political and economic life. People who lack access to education, health services and prevention measures face significantly higher health risks. Under these social conditions, many diseases, including HIV, spread more quickly. Additionally, poor sanitation and crowding foster the spread of tuberculosis, which is the leading cause of death among people living with HIV.

Cities need to address their significant disparities in access to basic services, social justice and economic opportunities. Using a Fast-Track AIDS response, cities can improve social equality for people affected by HIV and those living with the disease, while also addressing related public health challenges in new and innovative ways to prevent disease.

A Fast-Track AIDS response means that by 2020, 90% of people living with HIV will know their HIV status, 90% of people living with HIV who know their status receive HIV treatment and 90% of people on HIV treatment have a suppressed viral load. These are the 90-90-90 targets. The Fast-Track Targets for 2020 also call for reducing new adult HIV infections to fewer than 500 000 people worldwide and eliminating HIV-related stigma and discrimination. Combined, these targets provide a fragile, five-year window to set the world on track to ending the AIDS epidemic by 2030.

This is why, on World AIDS Day 2014, mayors from around the world are gathering to launch the Paris Declaration on Fast-Track Cities and pledging to achieve the 90-90-90 targets by 2020. The mayors are declaring their leadership and their cities' commitment to accelerating the scale-up of HIV prevention and treatment and achieving zero discrimination.

Cities will only reach the Fast-Track Targets by leaving no one behind: ensuring that marginalized and stigmatized people can access sexuality education, HIV testing and prevention options such as condoms and effective HIV treatment. They must also scale up tuberculosis care. A Fast-Track AIDS approach requires cities to work with vulnerable people and populations at particular risk, including sex workers, people who inject drugs, transgender people and men who have sex with



men. Cities must also be safe and free of violence, especially against young women and girls.

The Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat) and the International Association of Providers of AIDS Care (IAPAC) will fully support the Fast-Track Cities initiative. The initiative is aimed at engaging mayors and other urban leaders and generating support from many sources, including affected communities and key populations, as well as development and multilateral partners. Mayors and city governments will lead the Fast-Track Cities initiative—individually and jointly—in partnership with communities, civil society, public health officials, clinicians, law enforcement agencies and others.

We are optimistic that cities will succeed in this bold endeavour, because we have already seen cities successfully adopt accelerated AIDS responses. San Francisco is actively engaging multiple partners in a strategy to end its AIDS epidemic. Cities such as Bangkok, New York, Paris and Vancouver have also significantly reduced HIV transmission by improving access to HIV services, including widely available voluntary HIV testing, earlier initiation of HIV treatment and unfettered access to combination HIV prevention.

Ending the AIDS epidemic globally requires cities to be fully engaged. Cities work at scale and they generate plentiful

evidence about what works. They have opportunities to scale-up the most effective programmes and to reach large numbers of people living in relatively compact areas in a holistic manner.

A scaled-up, Fast-Track AIDS response will inspire cutting-edge services and pave the way for cities to address other public health challenges, including sexual and reproductive health, maternal and child health, gender-based violence, improved tuberculosis care and other communicable and noncommunicable diseases. Cities can also encourage new types of public-private partnerships and civil society involvement in the delivery of health and other services. This approach can transform institutions and societies at large and unlock powerful opportunities to tackle barriers that deprive many people of the full benefits of city life.

Ending the AIDS epidemic in urban areas will need more than increased funds and resources. It requires the commitment of leaders who can inspire and harness the compassion and generosity of citizens to bring about lasting change. It also requires energized communities that can accelerate and sharpen the focus of local AIDS responses and share knowledge about best practices.

We stand shoulder to shoulder with community and city leaders as they commit to achieve the 90-90-90 targets by 2020 through the Fast-

Track Cities initiative. Cities can ease the unnecessary suffering and disproportionate human and financial costs and consequences of ill health and death due to HIV. Together, we can achieve a new era of cities as nurturing centres of equity and access to health and prosperity.

*Anne Hidalgo  
Mayor of Paris  
France*

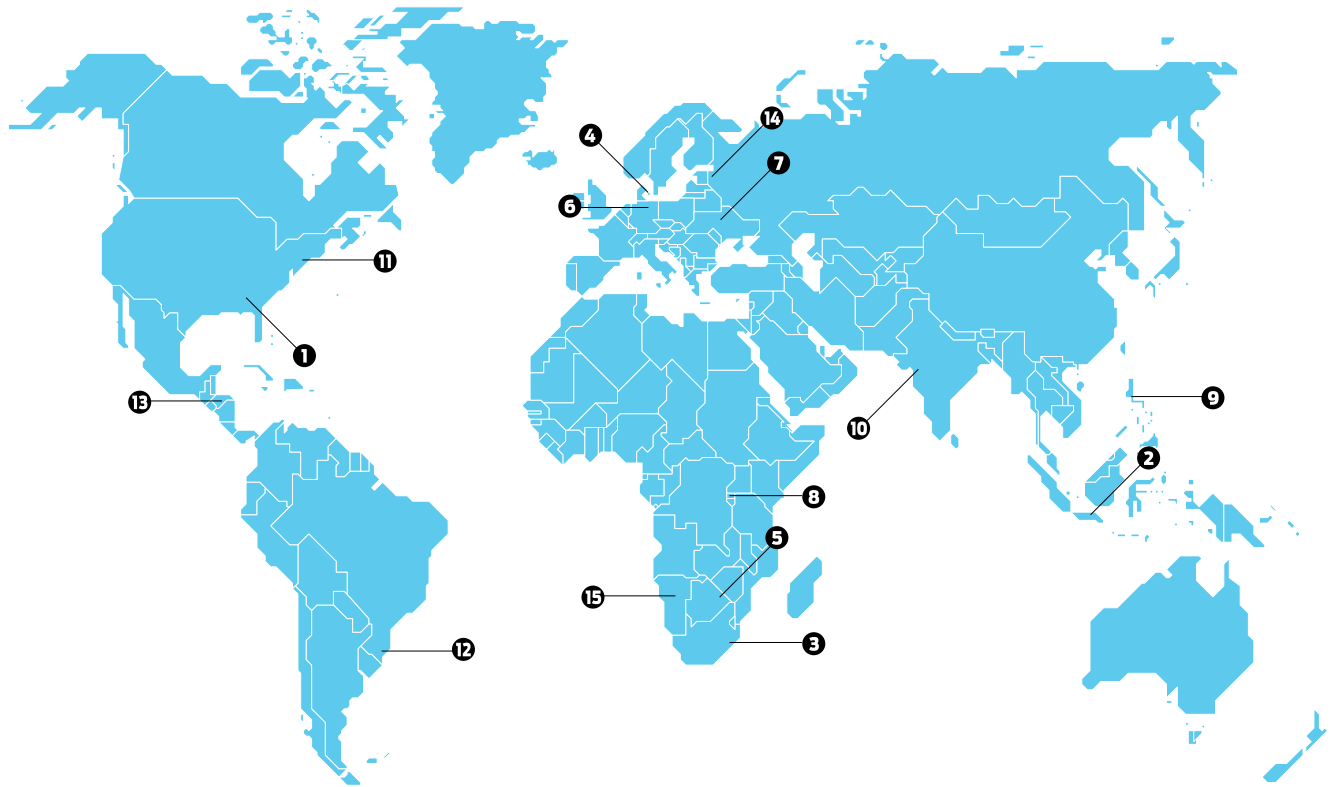
*Michel Sidibé  
Executive Director  
UNAIDS*

*Joan Clos  
Executive Director  
UN-Habitat*

*José M. Zuniga  
President/CEO  
International Association of  
Providers of AIDS Care*

# DID YOU KNOW?

*A snapshot of what cities are doing around the world in the AIDS response.*



## 1 Atlanta

Atlanta, United States of America, is using early HIV detection and new reporting strategies to reduce HIV infections.

## 2 Badung

People living with HIV in Badung, Indonesia, holding an identity card can access free HIV treatment and health care, thanks to local government health insurance.

## 3 eThekweni (Durban)

eThekweni (Durban), South Africa, is committed to eliminating new HIV infections among children. Mother-to-child transmission rates in the city are now less than 1%.

## 4 Copenhagen

Copenhagen, Denmark, is engaging with sex workers where they live and work to better offer HIV counselling and testing.

## 5 Francistown and Gaborone

In 1999, Francistown and Gaborone, Botswana, piloted their first mother-to-child programme. Today, 96% of pregnant women living with HIV are accessing antiretroviral medicines.

## 6 Hamburg

Hamburg, Germany, is working with migrants to improve HIV outreach services.

## 7 Kiev

Kiev, Ukraine, is the home base of the All-Ukrainian Network of People Living with HIV with more than 400 employees across the country providing HIV services to 40 000 people each year.

## 8 Kigali

Orange Day in Kigali, Rwanda, raises awareness and promotes action to prevent gender-based violence.

## 9 Manila

Health officials in Manila, capital of the Philippines, are working with the police and entertainment venues to distribute condoms and to promote HIV testing for transgender people and men who have sex with men.

## 10 Mumbai

Mumbai, India, has expanded its diagnosis and treatment of drug-resistant tuberculosis, resulting in an 8-fold increase in patients accessing treatment for drug-resistant tuberculosis in 2013, compared to 2011.

## 11 New York

Started in 1981, Gay Men's Health Crisis in New York, United States of America, was the world's first HIV service organization.

## 12 Curitiba

Curitiba was the first city in Brazil to implement rapid HIV tests and to use mobile clinics to reach populations at risk for HIV.

## 13 San Pedro Sula

The local government of San Pedro Sula in Honduras finances an educational and cultural programme for HIV prevention among young people.

## 14 Saint Petersburg

Saint Petersburg in the Russian Federation hosts the Silver Rose—a network supporting sex workers to access HIV services.

## 15 Windhoek

New HIV infections were mapped against the availability of key HIV-related services in Windhoek, Namibia, resulting in the expansion of services to informal settlements.

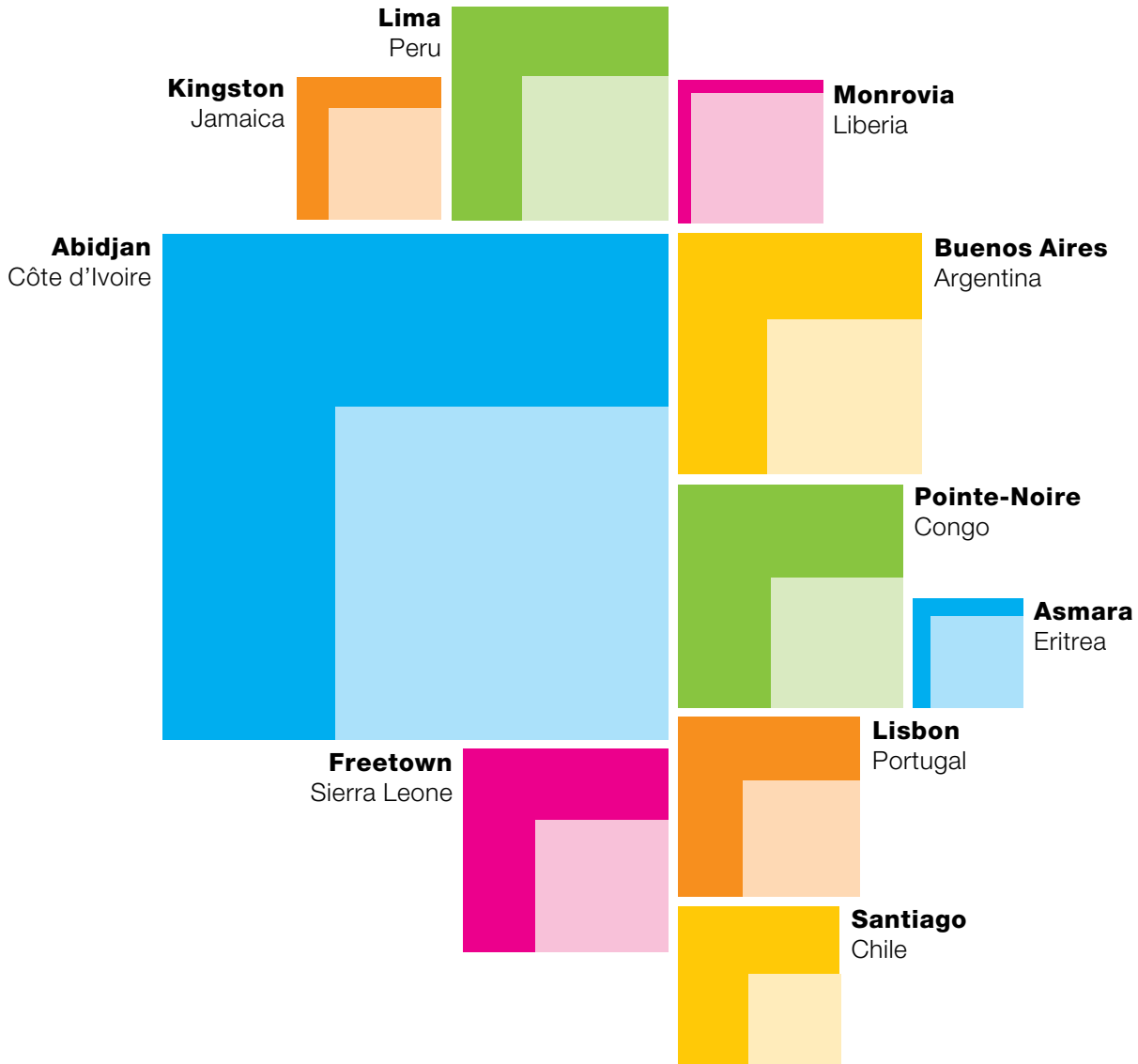
# state of cities

## OUTLOOK EXPLORES

*why Fast-Tracking cities will help reach the 2020 targets and end the AIDS epidemic by 2030*

**Countries with a high proportion of people living with HIV in one city**

*Cities are home to large proportions of people living with HIV*



→ People living with HIV (PLHIV) in the country  
 → People living with HIV (PLHIV) in the city

10 000

**Liberia:**  
80% of PLHIV live in Monrovia

**Eritrea:**  
73% of PLHIV live in Asmara

**Jamaica:**  
64% of PLHIV live in Kingston

**Peru:**  
45% of PLHIV live in Lima

**Côte d'Ivoire:**  
43% of PLHIV live in Abidjan

**Argentina:**  
43% of PLHIV live in Buenos Aires

**Sierra Leone:**  
43% of PLHIV live in Freetown

**Portugal:**  
43% of PLHIV live in Lisboa (Lisbon)

**Congo:**  
39% of PLHIV live in Pointe-Noire

**Chile:**  
37% of PLHIV live in Santiago

# Quick facts about cities and HIV

## 01

By 2030, an estimated 60% of the global population will live in cities—twice as much as in 1950.

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## 02

Between now and 2030, the number of people living in cities is expected to grow from 3.6 billion to 5 billion.

---

## 03

90% of the world's urban population growth between now and 2030 is predicted to be in low- and middle-income countries, mostly in Africa and Asia.

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## 04

Cities and urban areas bear a major part of the global HIV burden—in sub-Saharan Africa, nearly half (45%) of people living with HIV reside in urban areas. In many countries outside of sub-Saharan Africa, such as Brazil, Jamaica, and the Russian Federation, cities are home to more than half of all people living with HIV nationally.

---

## 05

More than 60% of urban residents in Africa live in slums; in Asia, at least a third of urban residents do so. Cities will struggle to control their AIDS epidemics as long as these populations are marginalized from the benefits of city life.



*Moscow*



*Paris*



*Rio de Janeiro*



*New York City*



*Miami*



*London*



*Sydney*



*Venice*



*Shanghai*

# why cities

**AROUND 52% OF THE WORLD'S POPULATION**  
*live in urban areas—so much potential!*





# Why cities

*Each year brings new evidence of progress being made in the global AIDS response. Clear goals and sustained commitment, as well as community mobilization and scientific innovations, have brought the world to the point where it is no longer a matter of whether we can end the AIDS epidemic, but when.*

## Why Fast-Track cities?

Ending the AIDS epidemic by 2030 is feasible if the world's major cities act immediately and decisively to Fast-Track their AIDS responses by 2020.

**Cities need to reach Fast-Track treatment targets of 90-90-90 by 2020:**

- ▶ 90% of people living with HIV knowing their HIV status;
- ▶ 90% of those diagnosed with HIV receiving antiretroviral therapy; and
- ▶ 90% of people on antiretroviral therapy achieving undetectable levels of HIV (viral suppression).

Leaders recognize that where access to HIV testing, treatment, and prevention has been optimized and taken to scale, including in many cities around the world, AIDS-related deaths and new HIV infections have been dramatically reduced. Reaching these targets would avert nearly 28 million new HIV infections and more than 20 million AIDS-related deaths by 2030.

Two of the most dramatic events of the past few decades have converged in cities. One is the astonishing growth of

cities themselves, with an ever-greater proportion of humanity living and working in them.

Cities are vibrant hubs of economic growth, learning and innovation, creativity and community dynamism, which make them ideal platforms for developing better, fairer societies. But cities are also marked by inequity which can stand in the way of development.

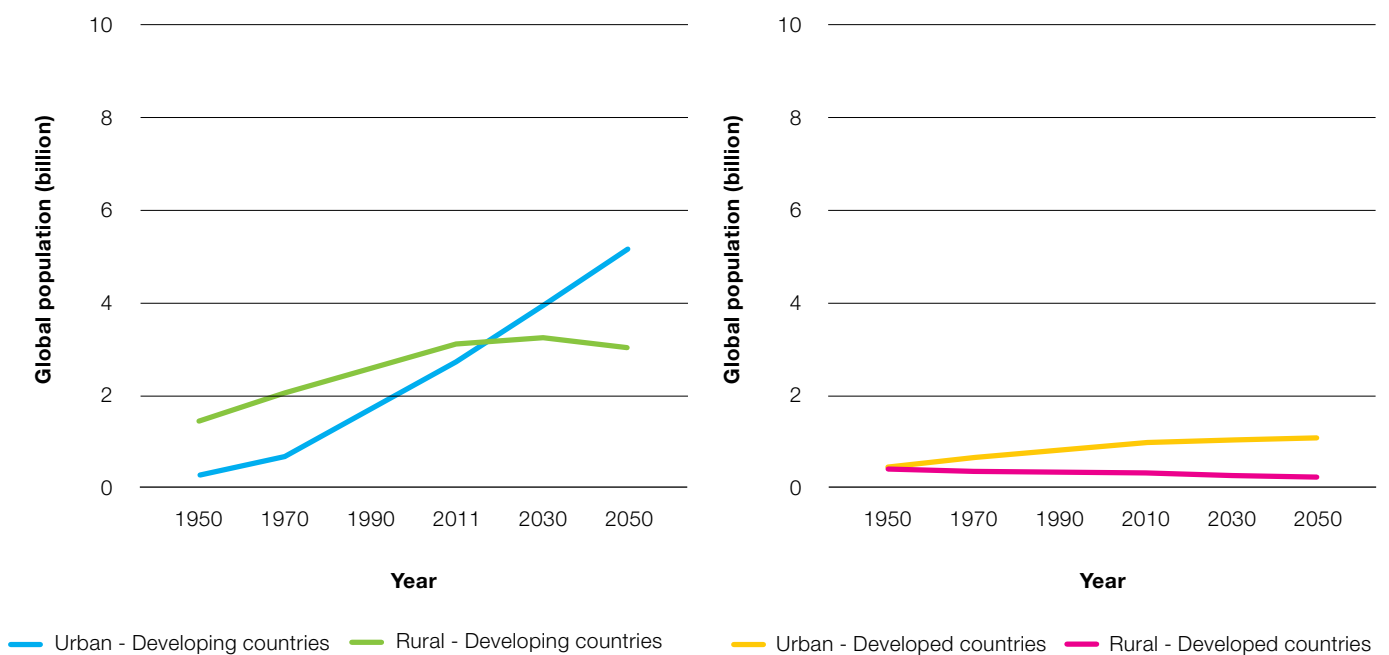


## Targets

By 2020	By 2030
90-90-90 Treatment	95-95-95 Treatment
500 000 New infections among adults	200 000 New infections among adults
ZERO Discrimination	ZERO Discrimination

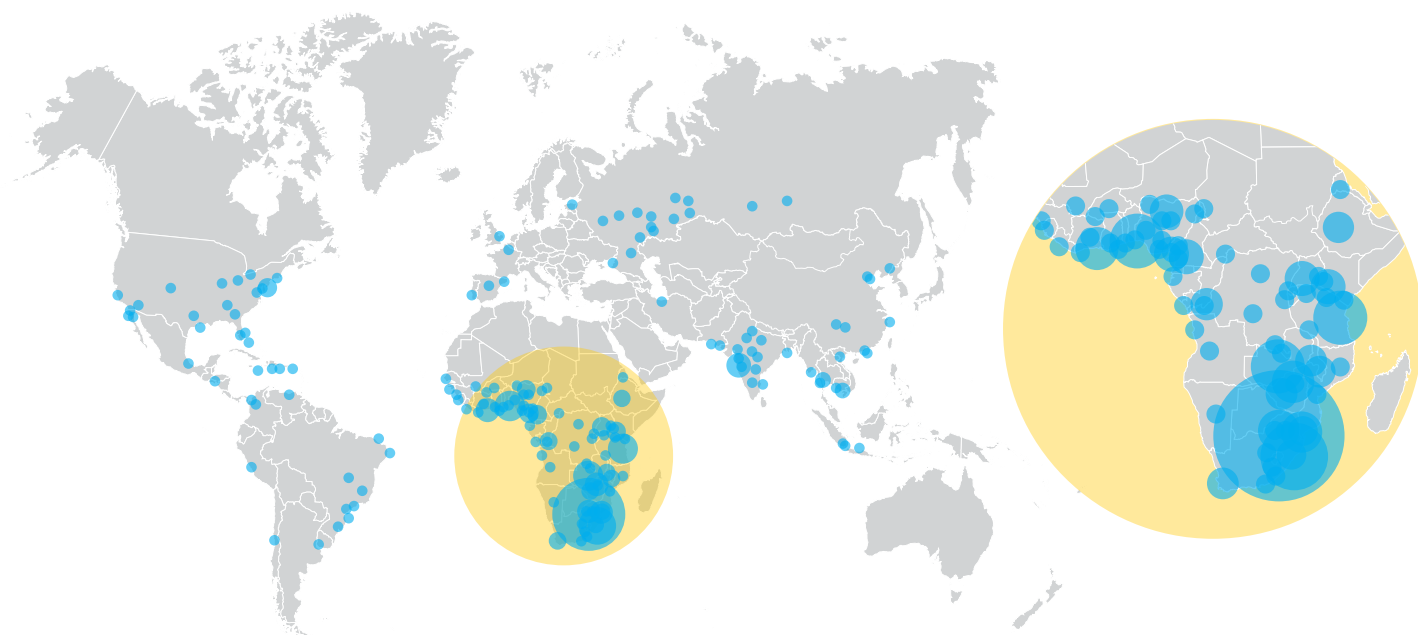


**Fig. 1**  
Urban and rural population trends in developing and developed countries, 1950–2050



**Fig. 2**

World map of 200 cities with the greatest estimated number of people living with HIV, 2013



The second event is the global AIDS epidemic. In all regions, large proportions of people living with HIV reside in urban areas, and sometimes in quite specific parts of cities and towns. Ending the epidemic requires ensuring that resources, services and support for preventing and treating HIV reach those populations and locations. Cities offer unique opportunities for doing this. Fast-Tracking HIV responses in cities—without neglecting efforts in rural and other areas—will therefore be crucial for ending the AIDS epidemic.

### The amazing growth of cities

The world is urbanizing at a rapid pace. Around 52% of the world's population live in urban areas—that proportion is expected to reach 60% by 2030. A few generations ago, in 1900, that figure was around 10%.

Nearly all (about 90%) of the world's urban population growth between now and 2030 is expected to be in developing countries, mostly in Africa and Asia (Fig. 1). Some of the fastest growing cities are in Asia, and also in Africa, the region hardest hit by HIV.

The pace, scale and character of urbanization have a decisive effect on

people's health and well-being, especially those living in impoverished and poorly serviced parts of cities. In 2012, almost 30% of urban populations in low- and middle-income countries, and more than 60% in sub-Saharan Africa, lived in slum areas. UN projections show that one in three new city dwellers may soon be living in a slum. These trends are spurring support for including a goal on "inclusive, safe and sustainable cities and human settlements" in the post-2015 sustainable development goals.

### Cities' burdens of HIV

In all regions of the world, cities and urban areas bear a large share of the global HIV burden. Importantly, this is the case in many of the 30 Fast-Track countries, which UNAIDS has identified as priorities for accelerating the global AIDS response because they account for 89% of all new infections.

The extent to which HIV affects cities is apparent when one focuses on the 200 cities with the biggest burdens of HIV. Together, those cities are estimated to account for more than one quarter (26%) of the 35 million [33.2 million–37.2 million] people living with HIV globally (Fig. 2 and Fig. 3). For example, in Brazil, about 15 cities account for nearly 60% of the national total of people living with HIV. In



the United States of America, 21 cities (among the top 200) account for 40% of the national total of people living with HIV. It is estimated that more than half of the people living with HIV in the Russian Federation are living in 15 cities. In Viet Nam, about one third (31%) of people living with HIV reside in only two cities, while in Pakistan, a single city, Karachi, is home to over 30% of people living with HIV.

The importance of city AIDS epidemics is also evident in sub-Saharan Africa. Based on data from 25 countries that have conducted nationally-representative household-based population surveys, HIV prevalence among people aged 15–49 years in the region is, on average, twice as high in urban areas as in rural areas (and in Ethiopia, HIV prevalence in urban areas was nearly seven-fold higher in 2011) (Fig. 4). In several countries in this region, including those with major AIDS epidemics, urban areas account for the majority of people living with HIV, and the urban share of HIV infections appears to be increasing in many of them.

### Effective action in cities is essential if the world is to end the AIDS epidemic by 2030

In countries with large AIDS epidemics, the numbers of people living with HIV are so high that effective actions in cities are likely to influence national outcomes. Even where the epidemic is smaller, cities tend to be home to large numbers of people belonging to key populations. Evidence from all regions of the world shows that key populations are at higher risk of HIV infection but receive limited attention in HIV programmes. This is particularly the case for sex workers and their clients, people who inject drugs and men who have sex with men. Ensuring that these populations receive HIV prevention, treatment and care services in a protective environment can greatly contribute to ending national AIDS epidemics.

Thailand famously used its “urban advantage” in the 1990s when it successfully focused its HIV strategy on increasing condom use among sex workers and their clients in Bangkok and other major cities. Although not

flawless, this approach succeeded in reducing new HIV infections significantly in a few years. Using the opportunities available today, such Fast-Tracking approaches can have a dramatic effect, even in countries with large epidemics. This requires detailed strategic information that can guide targeted prevention programmes and enable maximum coverage of HIV testing and treatment services.

### Tackling inequity in cities

Cities boast many attractions, but the benefits of city living are seldom distributed equitably. Income inequality is often worse in cities and towns than in rural areas, health disparities in cities can be severe. The effects are visible especially in urban slums and informal settlements. Globally, an estimated 1 billion people live in overcrowded and poorly serviced slums; the vast majority of them in developing countries. It is estimated that more than 30% of city residents in less-developed countries live in slum areas; in sub-Saharan Africa, that proportion exceeds 60%.

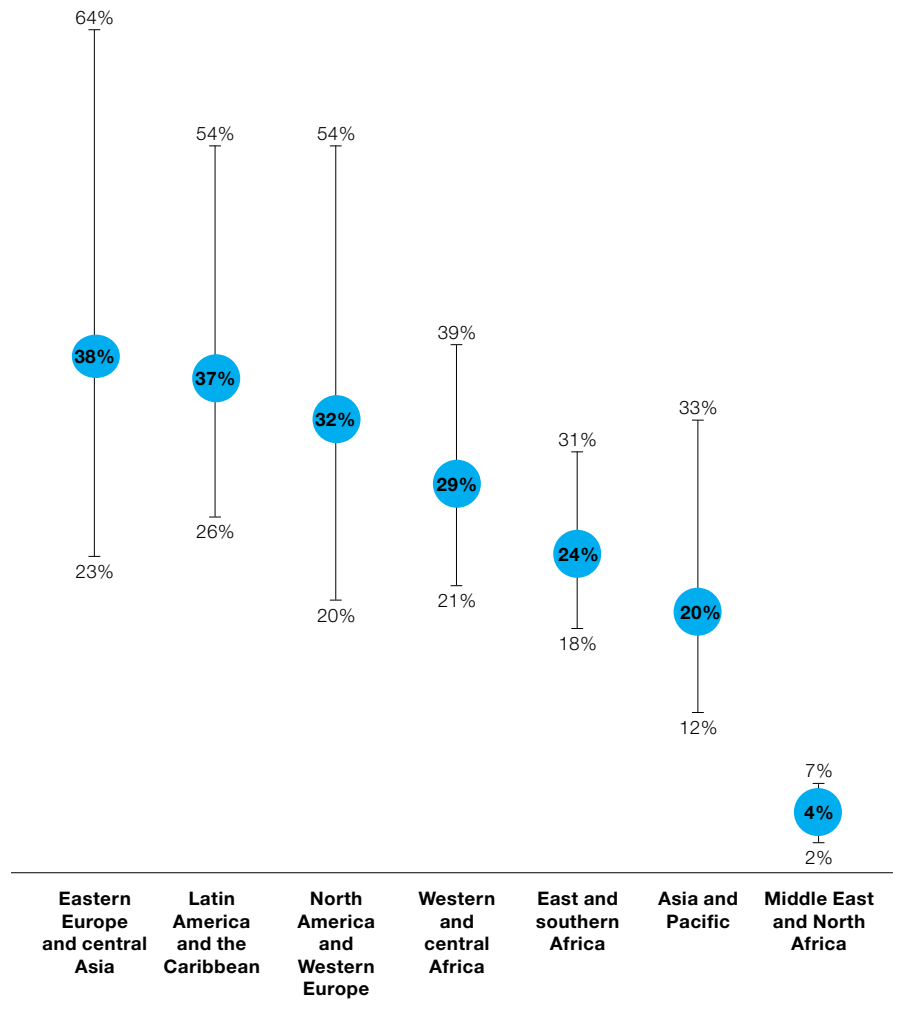
These communities often struggle to compete for essential services. Many of them lack secure land tenure, and urban growth plans, infrastructure schemes, pricing policies and administrative procedures often neglect their needs and entitlements. Lack of shelter, safe water, acceptable sanitation, nutrition, and basic education and health care are endemic problems, along with high unemployment, crime and physical insecurity, and environmental hazards. These conditions leave people vulnerable to ill health and disease, and block access to treatment and care. For example, food insecurity and overcrowded and poor-quality housing are known to be associated with tuberculosis.

Such disparities also play out in some AIDS epidemics. In Kenya and South Africa, for example, the risk of acquiring HIV appears to be higher in urban slums than in other parts of cities or in rural areas. Nationally, HIV prevalence in South Africa in urban formal settlements is half (10%) that in urban slums (20%). In Nairobi, Kenya, 12% of slum dwellers were found to be living with HIV, compared to 5% of residents in the rest of the city.

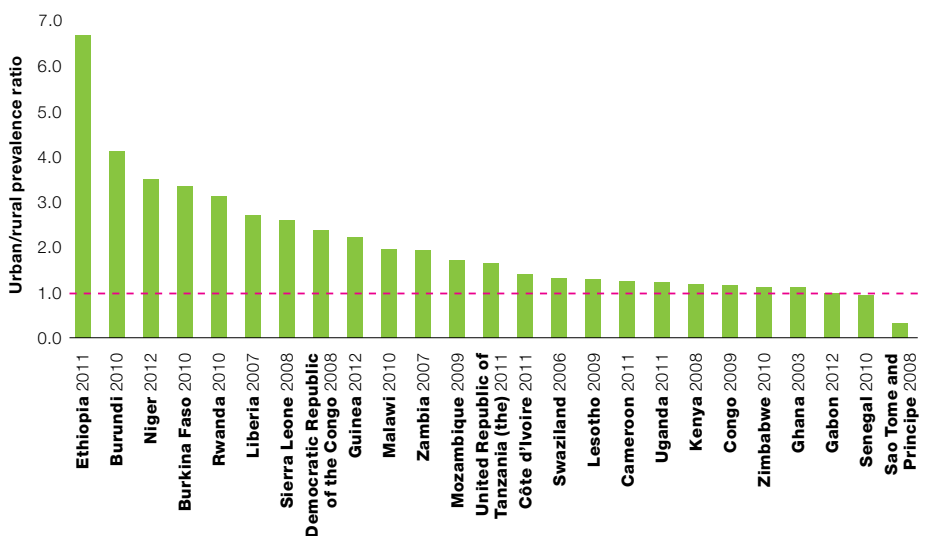
HIV infection and health services are not always evenly distributed in cities. Although most new HIV infections in the Namibian capital, Windhoek, occur in its informal settlements, there are few health services in the populous neighbourhoods. Informal settlements in Durban, South Africa, were found to have the lowest coverage of HIV testing among infants, the highest rates of mother-to-child HIV transmission and the lowest rate of enrolment on HIV treatment compared with other areas.

Preventing and controlling HIV in such circumstances therefore requires approaches that tackle the underlying social inequities. Even within health systems, measures can significantly improve access to health services for all people in need. But the efforts have greater force when they link with actions across other developmental sectors, when they are rights-based, and when they involve the active participation of affected communities. Social inclusion is the first step in the important process of transformation.

**Fig. 3** Proportion of all people living with HIV who live in the 200 cities with the biggest HIV burdens, by region



**Fig. 4** Ratio of urban versus rural HIV prevalence among people aged 15-49 years for selected countries



## HIV risks in city life

City life can involve numerous risks, some of which also boost the chances of acquiring HIV. Cities are hubs for many of the HIV epidemics that are driven by injecting drug use and paid sex. The anonymity cities offer also enables people to express their sexuality more freely. Despite their vulnerability to HIV, key populations in cities often lack access to HIV prevention and treatment services.

In Thailand overall, an average 7% of men who have sex with men are estimated to be living with HIV, but in Bangkok, the figure is closer to 25%. Similarly, in Nigeria, the HIV infection level among men who have sex with men is 17%; in the Federal Capital Territory it is more than twice as high (38%), while a study in 24 Mexican cities among men who have sex with

Migration into cities is sometimes also associated with elevated risk of acquiring HIV. In Khutsong (Carletonville), a mining town in South Africa, female migrants are 1.6 times more likely to be HIV-positive than non-migrants. In India, HIV infection among people who migrated from rural to urban areas is about three times the national level (1.0% versus 0.3%). In many African and Asian countries, migration in and out of cities can be an important factor linking different networks of HIV transmission.

Cities also need to scale up tuberculosis testing and care. Tuberculosis is one of the leading causes of death for people living with HIV and effective tuberculosis treatment is an essential component of the AIDS response. In cities that have long had effective municipal tuberculosis programmes, HIV services can easily be integrated with tuberculosis services.



men found that about 17% of them were HIV-positive. HIV prevalence among people who inject drugs in cities is also many times higher than in the general population at 9% [2–19%] in 20 cities in the United States, for example, and between 25% and 56% in five Indonesian cities.

It takes special efforts to enable key populations to protect themselves and their partners against HIV. But when stigma and harassment are avoided, and health and other services fit the realities and needs of these populations, HIV infections decrease.

## Cities have been leading the way

Cities have been at the forefront of the AIDS response since the epidemic began. From Bangkok to San Francisco, Kampala to Zurich, Johannesburg to São Paulo, courageous community activists and health workers, and far-sighted public officials, created programmes that inspired a global movement to end the AIDS epidemic. They have led the way with rights-based approaches that have reduced HIV infections among some of the populations worst affected by the epidemic.

Three decades later, that movement has turned the tables on the AIDS epidemic. There were almost 40% fewer new HIV infections globally in 2013 compared with 2001. In more than three dozen countries, new infections have declined by more than half. Around 13.6 million people living with HIV are receiving life-saving HIV treatment, which has averted more than 7.6 million deaths since 1995.

Cities' AIDS responses vary greatly in their reach and effectiveness. Some have succeeded in reversing their AIDS epidemics (for example, Chennai and Sydney) and some have drastically cut new HIV infections (for example, New York). But their efforts—and achievements—are not yet the norm. HIV infections are increasing again among certain key populations in a few cities that seemed to have their epidemics under control. This is a reminder that sustained and adaptive efforts are needed to stay a step ahead of the epidemic.

Particularly in low- and middle-income countries, HIV testing and prevention efforts typically only reach about one fifth to one quarter of city dwellers who are most at risk of acquiring HIV. In many cities, only between one third and one half of people living with HIV are accessing antiretroviral therapy. These gaps affect key populations especially. Most cities need to substantially increase their current levels of programme coverage, particularly working with sex workers, men who have sex with men and people who inject drugs. ■

# urban advantage

**AROUND THE WORLD**

*The role of cities in ending the AIDS epidemic*

# Why cities have such a big role in ending the AIDS epidemic

Cities around the world have been harnessing these kinds of urban advantages to save lives and improve people's well-being.



*Throughout history, cities have attracted newcomers with the promise of freedom, opportunity and a better life. They provide jobs, they offer refuge to those fleeing conflict or natural disasters, and they excel as spaces of learning, creativity and innovation.*

All this makes cities powerful engines of economic growth and development. The top 300 cities in the world are home to about 19% of the global population, yet generate nearly half of the global gross domestic product.

Many of the advantages that generate such economic power also foster other benefits. When large numbers of people live and work in close proximity, transaction costs are lower and public spending on infrastructure and services becomes more economically viable. Cities also favour the networking of talent, knowledge and resources.

Jobs are more numerous, social services are more plentiful, better resourced and easier to access, and health systems are stronger in cities than in the countryside. As a result, incomes are higher, literacy rates and education levels (especially for women) are higher, and life expectancy is longer for city dwellers compared with their counterparts in rural areas. Doctors

and other health professionals tend to prefer working in cities rather than in remote areas. Many cities host academic and research institutions, including teaching hospitals, some of which have proved to be invaluable partners with public health authorities. Transportation options are greater, making it easier for residents to access services. It is easier to reach people with information and outreach services.

Cities around the world have been harnessing these kinds of urban advantages to save lives and improve people's well-being. In the early days of the AIDS epidemic, San Francisco focused its efforts on bathhouses and other venues frequented by men who have sex men, and managed to bring its epidemic under control. HIV transmission in and beyond the sex trade was held in check in Dakar, Senegal, by offering sex workers screening and testing for sexually transmitted infections. The HIV services that *la Clinique Confiance* has been providing to sex workers and their clients in Abidjan, Côte d'Ivoire, continue to be hailed as good practices in the AIDS response.

The political and social culture is often more tolerant in cities than across countries as a whole. This grants cities the flexibility for pioneering programmes that fit people's lives and needs, rather than bowing to prejudice or populism. The more compact nature of municipal governments also makes it easier for city officials to build support for effective public policies across various departments. Vancouver, several European cities (including Frankfurt, Lisbon and Zurich) and several cities in Australia, including Sydney, have opted for public health rather than a purely punitive approach to injecting drug use by providing safe, supervised injecting spaces where counselling and other support are available. In some of these cities, HIV infections among people who inject drugs decreased significantly once effective harm reduction programmes were introduced. The public health-focused approach also proved to be less expensive than jailing people for using drugs.

City life also favours the social and political activism and mobilization that drive health and developmental breakthroughs. Much of the impetus





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**Much of the impetus for the early response to AIDS in cities such as New York City and Paris, or the campaign that led to South Africa's rollout of free antiretroviral therapy, came from city-based organizations and activists.**

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for the early response to HIV in cities such as New York City and Paris, or the campaign that led to South Africa's rollout of free antiretroviral therapy, came from city-based organizations and activists, such as the Treatment Action Campaign. In Indonesia, a coalition of civil society organizations recently used opportunities to participate in city policy-making to spearhead a process that is expanding health insurance coverage for impoverished residents in the cities of Semarang and Pekalongan (East Java). Approaches that embrace the participation of citizens and employ the knowledge and experience of affected communities point the way forward for cities.

These kinds of advantages position cities ideally to adapt, strengthen and expand their own responses in ways that can take the global AIDS response to a new level, but at the moment, not enough cities are capitalizing on these advantages. For example, despite Thailand's progress toward scaling up antiretroviral therapy, less than 40% of people living with HIV in Bangkok receive treatment compared to 56% nationally. A population-based survey in South Africa shows that ART coverage in urban localities is less than

in rural informal settlements (28% compared to 35%). Stigma, resource constraints and other barriers continue to impede HIV testing and treatment efforts in many cities.

If the urban advantages are seized, an effective city response will go further than saving lives. A ramped-up AIDS response fuels new, cutting-edge service delivery platforms that can pave the way for cities to address other public health challenges—including tuberculosis, sexual and reproductive health issues, maternal and child health, gender-based violence and non-communicable diseases. It can unlock powerful opportunities to tackle the social and health barriers that deprive too many people of the benefits of city life. It breaks through political and institutional gridlock so other things can get done. It builds new, innovative public-private partnerships based on evidence and results. ■

# meet the innovators

**VIBRANT HUBS OF CREATIVITY AND LEARNING**

*Cities have nurtured and challenged some of the most  
innovative people in the AIDS response*

## Vuyiseka Dubula

### Cape Town, South Africa

*Former Secretary-General of the Treatment Action Campaign (TAC) between 2007 and 2014, South African National AIDS Council People Living with HIV Sector Leader and Programmes Director for Sonke Gender Justice*

#### What inspired you to get involved in the AIDS response?

My involvement in the AIDS movement was inspired by my struggle for access to treatment after I received my own HIV-positive results in 2001. I was told, “You have an illness but go home and wait for your death” because of the unavailability of treatment. It was not available—not because it did not exist but because it was too expensive for poor people like me to afford. This motivated me to get involved in the movement for both personal survival and to support the political struggle—to make sure that we do not perish silently as people living with HIV in South Africa. The struggle for affordable medicines is not over. There is still more room for everyone to add their voice to get more affordable third-line antiretrovirals (ARVs) and tuberculosis drugs.

#### What have you tried to change?

Together, as a collective of people living with HIV under the umbrella of the Treatment Action Campaign (TAC) we have managed to demonstrate the power of ordinary people to hold

power to account. We have demonstrated this through the Treatment Literacy Programme as a vehicle to empower people with knowledge and organizing in communities to create a force for change.

Personally, this experience provided a space for me to participate in real politics from below. For instance, to fight for my sexual health and reproductive rights as a young woman—to have healthy children and live a normal, productive life with uninterrupted access to ARVs. Access to treatment is not a means to an end in itself. Instead, adherence is the main goal for any person in order to enjoy the full benefits treatment has to offer. The change begins with me. My viral load has been undetectable since August 2004. My two children and my husband remain HIV-negative.

#### What are you most proud of?

I am very honoured to be counted among comrades from TAC, Equal Education, Social Justice Coalition and Sonke Gender Justice, whose lives are dedicated to social justice. Without these organizations and many more, South Africa would not be the same. I am proud to have contributed to the post-liberation politics of our country and I am still committed to see no more new HIV infections, deaths, discrimination, gender inequality and gender-based violence in the world, beginning with South Africa. We are the generation that cannot afford to sit and wait. We need to get out there and be part of change.

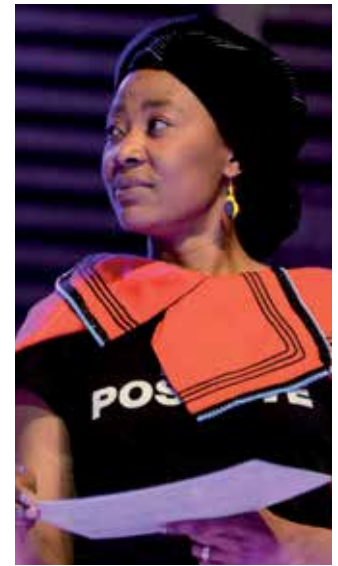
I am very proud to be alive and enjoy the small things in life, such as being able to run the Comrades Marathon, further my education and be a role model to my siblings to show that HIV is not a death sentence. I love being able to be a mother to my two kids and grow with them.

#### What are your most hopeful moments about today?

Movements like TAC still bring hope to many people that the struggle is not only about pills, but also about improving the health system to deliver quality, affordable and safe HIV services for all. The current Minister of Health, Dr Aaron Motsoaledi, is a symbol of hope and one wishes we could clone his dedication and passion to other critical areas of service delivery, such as education.

I am hopeful that we are not very far from finding a cure and a vaccine for HIV. I am hopeful that my daughter and my son will stand a better chance to escape HIV infection if we also address social and gender inequalities.

However, without financial commitments both domestically and globally to sustain the HIV response we will fall short in achieving our goals. We all owe it to ourselves and future generations to see this struggle to the finish line.





**Diane Havlir**

**San Francisco,  
United States**

*Chief of the HIV/AIDS Division and Positive Health Programme at San Francisco General Hospital, Professor of Medicine at the University of California, San Francisco, and Founder of the San Francisco Getting to Zero Consortium*

**What inspired you to get involved in the AIDS response?**

I chose to do my residency in internal medicine at the University of California, San Francisco, because of the AIDS epidemic. I started my career at the Inpatient Medical Service at San Francisco General Hospital, which was home to the first AIDS ward in the United States. Our service was filled with young men, suffering with every possible manifestation of AIDS. In the early 1980s, the average life expectancy of patients admitted there was 18 months—it was where people went to die. The patients and their partners were

devastated by the outlook, but compassion and courage also characterized those early days. I saw first-hand the power of community advocacy and the importance of physician participation. So how could I not get involved in AIDS? There were so many unresolved questions, and such an urgency to answer them.

**What have you tried to change?**

My current work at the global level in research stems from my experience in the AIDS ward—a constant struggle to understand the disease, how to treat it and how to develop strategies that [keep] our patients alive and healthy. Over the last 25 years, I have conducted numerous studies on antiretroviral therapy, drug resistance and the beneficial effect of starting antiretroviral therapy early in persons with HIV and tuberculosis.

We know that by finding people early and keeping them healthy, we stop the cascade of getting sick, dropping out of work and ending up in the hospital—and even transmitting the virus to a partner. The worst-case scenario is ending up in the intensive care unit, which still happens in San Francisco in this day and age.

**What are you most proud of?**

In 2010, here in San Francisco, we were the first clinic in the world to offer treatment to everyone, regardless of CD4 cell count. This then became adopted as our public health policy. Before, we had waited for peoples' CD4 count to fall to a certain level in order to avoid toxicities of the

drugs, and then we would start HIV therapy. Now we know the virus is doing harm and destruction even earlier. And the harm of the virus outweighs the toxicity of the medicines. Last year, we launched a citywide programme to get HIV patients on ART the same day they are diagnosed. This is a game-changer—for the health of people living with HIV and to prevent the transmission of the virus.

**What are you most hopeful about today?**

It is such an exciting time. The response has been completely reenergized by the recent breakthroughs in prevention research and understanding the impact of early treatment. While there is still no cure for AIDS, and the rate of new HIV infections in the United States has remained relatively stable, San Francisco is redoubling its response. We established a multisector San Francisco Getting to Zero consortium aspiring to be the first city to reach zero new HIV transmissions,

zero AIDS deaths and zero stigma through a coordinated strategy.

Today, though, viral suppression is somewhere around 50%. It is double the national average, but it's not good enough. Getting people tested, linked to care and virally suppressed will rely on integrating diagnosis, treatment on demand, and outreach services such as housing, substance abuse counselling, and mental health counselling under one umbrella of care.

**Charles King**

**New York,  
United States**

*President of Housing Works, Inc.*

**What inspired you to get involved in the AIDS response?**

I am an ordained Baptist minister and served as the associate pastor of a congregation at Immanuel



Baptist Church in New Haven, Connecticut, United States of America, in the early 1980s. Over the course of three years, I helped to bury some two dozen parishioners or their family members who died of AIDS—yet the subject of AIDS was never discussed at the funeral or even with the family. That changed for me at the bedside of our minister of music, who was dying of AIDS. I offered to pray for him during a hospital visit, and he informed me that it would not do any good as God was punishing him because he was a homosexual. At that moment, AIDS forced me out of the closet as a gay man. When I left his hospital room, I went straight to the office of the pastor to tell him that I was going to come out as a gay man and start doing something about AIDS. He gave me the pulpit to preach a sermon on AIDS and about four months later I came out to the congregation. I have been an AIDS activist ever since.

### **What have you tried to change?**

I found my role in the response to AIDS serving homeless people who are living with the virus. My first advocacy was to establish the right to housing for people with AIDS who were still using drugs and to prove the efficacy of housing as a threshold for all other services. Our second effort was to prove that formerly homeless people with AIDS could develop job skills and enter the workforce even before the availability of antiretroviral therapy (ART). Since then, our advocacy has broadened to address all of the many

social drivers of the epidemic, particularly discrimination and social and economic marginalization. No matter how they manifest, these drivers are the same drivers of inequality and most health disparities.

### **What are you most proud of?**

I am most proud of having had to opportunity to give voice to some of the most marginalized people living with HIV over the course of the last 30 years. Beyond that, I am incredibly proud that we have proven, at least in North America, the vital role of housing for both treatment and prevention of HIV. As well, I am proud that we have been able to demonstrate that homeless people, including people who use drugs, are as capable as anyone of adherence to ART and of contributing to society if given the opportunity. I would like to see these learnings expanded to the rest of the world.

### **What are you most hopeful about today?**

This summer (2014), in response to mobilization by Housing Works and other community-based organizations, New York State's Governor, Andrew Cuomo, made a public commitment to end AIDS as an epidemic in our state by 2020. I have been asked to co-chair the taskforce that is developing the blueprint for achieving this. I am hopeful that if the Governor adopts this blueprint, New York will be the first political jurisdiction to end the epidemic and thus provide a model for other political jurisdictions around the globe.



**Powes Parkop**

**Port Moresby,  
Papua New Guinea**

*Governor*

### **What inspired you to get involved in the AIDS response?**

As Governor of Port Moresby, among my top priorities has been addressing issues of safety, security and cleanliness in the city. My vision is to transform the city in order to improve the quality of life and instill pride in all our residents. Rapid urbanization has brought many challenges to Port Moresby. The expansion of informal settlements, high unemployment rates, alienated youth and alcohol abuse have heightened safety and security issues and stretched the capacity of our city's services.

For women in Port Moresby violence and abuse has become a constant and ever-present threat and this is not acceptable. These vulnerabilities not only put women at higher risk of contracting HIV but also enhance and sustain social inequalities for the whole city. We must address these

social issues in order to transform our city for the betterment of the lives of our residents. The National Capital District Council and I have been working with United Nations Women (UN Women) to implement the Safe Cities programme in the marketplaces of Port Moresby to ensure that women can safely earn their living. I have seen the power of the AIDS response to address fundamental social issues—like gender inequality and vulnerability. I believe that with strong leadership and the right interventions, the dynamism of the city and the AIDS response can be embraced to build a healthier and more resilient community.

### **What have you tried to change?**

I have worked hard to clean up the city in order to bring about a sense of pride in the local people, and to ensure that they can live and earn a living without the risk of violence and abuse. A central aspect of my vision for the city relies on building social inclusion at the local level—including people living with and at higher risk of HIV. I participated in the International AIDS Conference in Melbourne, Australia, in July 2014, which reinforced my beliefs of the clear need for cities to act where our national counterparts may be unable. I urged AIDS stakeholders to communicate to city leaders on the clear political benefits of investing in a strong AIDS response as well as other health and social issues.

City leaders must be reminded that this is in everyone's interest. I was very inspired by what I heard at

the AIDS Conference and today I am committed to reforming Port Moresby legislation that prevents people from accessing relevant, rights-based HIV services—particularly sex workers. Given the deterioration of our health services over the past three decades it is also of critical importance that I work with private and public stakeholders to improve the health system in the city.

**What are you most proud of?**

I am proud of the buai (betelnut) ban, which has brought about an incredible change in the cleanliness of the city. The chewing of buai not only made the city very dirty, due to the rubbish from the husks and the spitting of red muck everywhere, but also has many health issues like increased risk of mouth cancers, the deterioration of teeth and the spreading of tuberculosis through spit. This ban is the first step necessary to bringing about social change in the city. Our residents must take pride in our city and its appearance in order for them to actively participate in social transformation and the improvement of our health system.

I am proud of the work that we have been doing with UN Women on the Safe Cities initiative because the safety of our women and children is of critical importance.

I am proud of the transformations taking place at Port Moresby General Hospital (PMGH), both the city and country's largest



health facility. An opt-out HIV testing programme for pregnant women attending PMGH is a significant part of scaling up testing in the city.

**What are you most hopeful about today?**

Since the International AIDS Conference I have consulted with the UN country team as well as the National AIDS Council Secretariat on improving, simplifying and scaling up counselling and treatment services in the city as well as improving the city's regulation of sex work. I am confident that together we can work to ensure that those who need it most are able to access testing and treatment in Port Moresby.

**Pham Thi Hue**

**Hai Phong, Viet Nam**

*Founder of Red Flamboyant Cooperative Hai Phong, author and mother*

**What inspired you to get involved in the AIDS response?**

When I first found out that I was HIV-positive, my family and I experienced such stigma and discrimination from my community that I

attempted to commit suicide several times. Then I had a chance to learn more about HIV and understood why people stigmatized those with HIV. It was because they did not have adequate understanding about HIV and thought that those infected with HIV were bad people. That was my motivation to get involved in the HIV response—to help people understand more about HIV.

After I came out as a person with HIV, many people contacted me seeking my support since they could not share [their status] with anyone due to the fear of stigma. Helping others overcome their fears and hopelessness is really motivational. What inspires me the most is the acceptance and respect I have gained from my family and community. My son is also very proud of what I have been doing for the community.

**What have you tried to change?**

I have been working hard to change the way society sees us. I show people how I live and contribute to society to change people's attitudes about HIV.

Over the past 12 years, I have had many opportunities to meet with leaders in local and central government. In every meeting, I have tried to express the life, challenges and hopes of people living with HIV, in hopes that government policies best meet the needs of our community.

### What are you most proud of?

I am proud of the many trips I have made to all 63 provinces in Viet Nam to help and inspire other people who are living with HIV so that they can become stronger and more confident.

I am proud of myself. I have proven that a person with HIV still can live and work like anyone else. I am proud of family, my husband and my son. We have worked very hard to help each other stay healthy and fight HIV. We now have a very happy family, where my son always feels loved.

### What are you most hopeful about today?

The way society treats people living with HIV has changed, even though stigma and discrimination still exist. People living with HIV now have access to treatment and I hope we still have access to this life-saving therapy when donors leave Viet Nam. The Government of Viet Nam does show strong commitment to the global goal of ending AIDS in 2030. However, many challenges still remain and we, as people living with HIV, need to continue our fight for ending stigma and discrimination, to ensure access to treatment and other HIV services and for our

rightful role in the response.

## Jean-Luc Romero

### Paris, France

*President, Elus Locaux Contre le Sida (ELCS)*

### What inspired you to get involved in the AIDS response?

I have lived with HIV for over 25 years, and I wanted to transform my individual struggle into a collective struggle. That is why I created Elus Locaux Contre le Sida (ELCS) in 1995, and publicly disclosed my HIV status. The association now has over 16 000 members in France. For me, the fight against AIDS is a promise—a promise renewed every day. And a promise is made to be held!

### Why are cities important?

Cities are key to any response around HIV. I have advocated for the response from cities for nearly 20 years as president of ELCS! Cities can organize extremely effective outreach and together can influence international plans. Take the International Association of Francophone Mayors and Metropolis, for example. These two organizations bring together cities, and have both taken strong positions for the removal of obstacles affecting freedom of movement and settlement of people with HIV worldwide.

### What have you tried to change?

The outlook on a disease that one never considers for oneself but, which has



already killed [almost] 40 million people, among whom our friends and loved ones. The outlook on HIV by policy that too often gets stuck in an ideological position, far from the realities faced by civil society. The view that one can give to a person with HIV, a view in which, although infrequently, one finds benevolence but much more prejudice and fear. I try to change this outlook, simply because it is a matter of life or death.

### What are you most hopeful about today?

The fact that the end of AIDS is no longer a utopian dream, but an attainable reality! We now have the means to do so as long as there is sustained political commitment

to overcome challenges: financial investment, of course, but equally importantly the social space where the rights of all people are respected. On this last point, work is needed. So my three words for today are: hope, vigilance and commitment!

## Mamadou Sawadogo

### Ouagadougou, Burkina Faso

*Chairman, National Network  
of People Living with HIV*

#### **What inspired you to get involved in AIDS response?**

I tested positive in November 1996 during my training as a nurse. Far from resigning myself, my instinct of self-care and helping others took over. Faced by prejudice against HIV and AIDS and thinking that I was going to die sooner than I thought, I got involved with laboratories to donate my serum to science in order to save other lives. During this time, two films—the testimony of Philly Lutaaya, a prominent Ugandan musician, and the film “Philadelphia”, strengthened my commitment, but also shifted my strategy towards improving my community’s knowledge on HIV.

My actions in the field of community awareness and my exchanges with medical experts have fostered striking partnerships with other activists involved in the

response to AIDS. Thus, with the creation of a local association of people living with HIV in Burkina Faso (Responsabilité Espoir Vie Solidarité, REVS +), we were better organized to act on the ground; to save future generations through actions in the community, and in particular in schools and among serodiscordant couples.

#### **What have you tried to change?**

Through our work in the association REVS + we helped change perceptions towards HIV and AIDS and towards people living with HIV. With the introduction of the national network of people living with HIV (REGIPIV-BF), we were able to organize support for people living with HIV across different provinces of the country—giving them confidence on the care they received and empowering them to manage their own health. We supported and motivated families to take responsibility for members of their family with HIV who needed care. Since 2003 we have facilitated access to antiretroviral therapy and care for country provinces. In a few words, since 1998 we changed the collective

awareness on HIV in the country, resulting in a strong political commitment from the highest authorities.

#### **What have you done that you are most proud of?**

The fact I dared, with my wife who is HIV-negative, to take action on an issue that nobody wanted to engage openly before 1997. To have played a role in supporting leadership development among people living with HIV in all provinces of the country. To have been able to affect policy change and alignment in the decentralization of antiretroviral therapy since 2003.

#### **What are you most hopeful about today?**

If we continue to build bridges, using new information technology and communication platforms, solidarity between individuals, communities and continents can continue to grow. Because through solidarity there is hope.







## Alex Wodak

### Sydney, Australia

*Emeritus Consultant, Alcohol and Drug Service, St Vincent's Hospital; President, Australian Drug Law Reform Foundation; and Co-founder and former President of the International Harm Reduction Association*

#### **What inspired you to get involved in the AIDS response?**

From 1982 for the next 30 years I was the Director of the Alcohol and Drug Service at a major teaching hospital in Sydney, Australia. My job included looking after people who used drugs. A study published in the early 1980s showed that a large number of men who had sex with men had contracted HIV in one year in an area close to my hospital. I realized that this could be the start of a generalized epidemic and that people who injected drugs were the critical bridge population. I was terrified of the prospect of a generalized epidemic. If it ever happened, it would have very serious health, social and economic costs to the nation—and would have

started in the geographical area, and among the very population, I was responsible for! Doing nothing was never an option. We had to find and implement effective prevention measures quickly. Providing sterile needles and syringes was obviously the key.

#### **What did you try to change?**

I looked with admiration and envy at the explosive, dynamic, purposeful, disciplined response to HIV by men who have sex with men. I knew that getting people who inject drugs to respond as a community was a critical part of the battle. I began by trying to get all the stakeholders working on this problem. Several of us started advocating for needle and syringe programmes, but these were politically blocked at the time. I realized that an act of civil disobedience was unavoidable if an HIV epidemic among and from people who inject drugs was to be prevented. A group of us started providing sterile injecting equipment in November of 1986. I also worked hard to expand and liberalize the methadone treatment programme. I worked on community development—helping in

1989 to start an organization for, and run by, people who inject drugs.

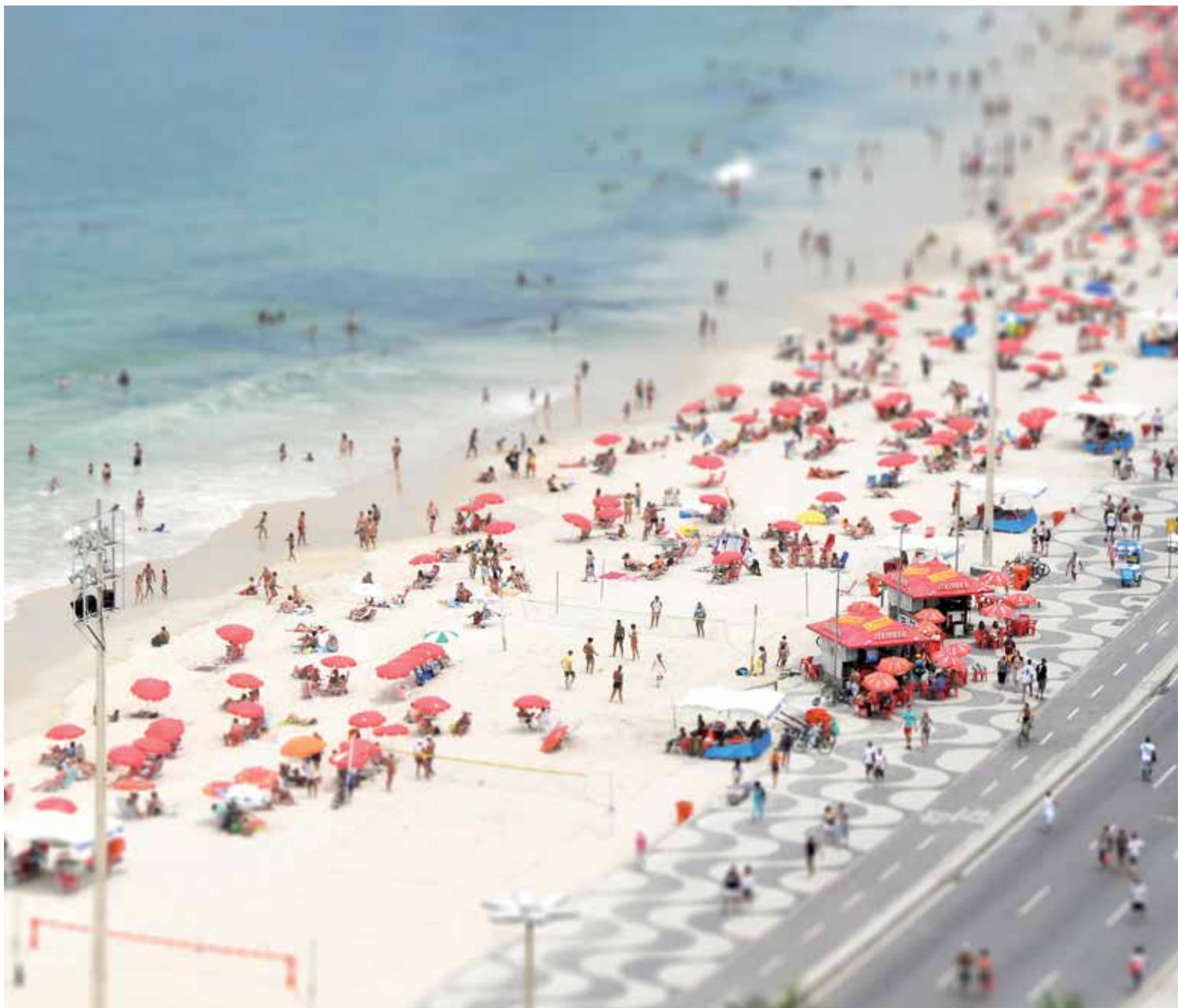
But what made HIV prevention almost impossible was the policy of global drug prohibition. So in 1987 I started supporting drug law reform publicly, knowing that this would be the longest and most difficult battle. Our hard work paid off. Australia was among the first countries to ensure that a needle syringe programme was adopted and implemented nationally. By 1988, needle and syringe programmes were available in all six states and two territories. Now in 2014, 42 million needles and syringes are distributed annually.

#### **What are you most proud of?**

Why should I be proud of doing what I was paid to do—protecting the health of vulnerable people and the entire community? I am ashamed that it took me so long to finally have the courage of civil disobedience to distribute sterile needles and syringes. I am proud to have worked with wonderful people to help prevent a terrible epidemic. Few people can ever do much worthwhile on their own. I was only able to contribute to the control of HIV in Australia and other countries by working with others. One thing that I am proud of is that a friend had to cancel a research project on HIV in small children because there weren't enough children with HIV to study.

#### **What are you most hopeful about today?**

Some good things are happening in areas that mean a lot to me. The abject failure of drug prohibition is now increasingly acknowledged though most countries continue to define drugs as primarily a criminal justice problem. The pace of change is very slow. Drug law reform has started in quite a few countries. But HIV infections have been increasing in many countries for some years, including my own country. It is good to see hepatitis C incidence decreasing among people who inject drugs in many countries. It is also good to see harm reduction and medical male circumcision increasingly accepted as core HIV prevention methods. I am also delighted that there is greater acceptance of the need for evidence-based and rights-based approaches. ■



# RICHARD SILVER

*New York-based photographer Richard Silver collaborated with UNAIDS to share his visually stunning photographs of cities. Noted for his tilt-shift style of showing city life in miniaturization and for showing iconic building through time-slicing—his work offers viewers a different perspective on cities.*

## Q&A



### Richard Silver Photos:

p.14, New York  
p.16, London  
p.18, Shanghai  
p.22, Paris  
p.23, New York  
p.32-33, Rio de Janeiro  
p.36-37, Tokyo

1

### What made you focus on cities?

As a photographer, cities offer so many opportunities and for me, as an architectural lover, cities are my favourite destinations in the world. Skyscrapers and people—the hustle and bustle—cities just excite me like no other places on earth.

2

### You have a very distinctive style. What made you interested in “tilt-shift”?

Back in 2006 I was surfing the web looking for something to inspire me photographically. I happened to stumble upon Olivo Barbieri’s tilt-shift photos of Rome. He is an Italian photographer specializing in this style. I figured out how to achieve the same effect using Photoshop and not the conventional tilt-shift lens. I have been tilt-shifting every place I travel to since then.

3

### You live in the heart of one of the most vibrant cities in the world—how does New York influence you?

Almost everything in this city can be photographed and done differently by each photographer. I concentrate my energies mostly towards the architectural aspects of New York. Over the past few years I figured out a new style of photographing called “time-sliced”. I photograph iconic buildings at sundown and slice the photos together to make one single image. I use approximately 30 different images taken over a course of 1.5 hours to complete the image. Only a city such as New York could give me the inspiration needed to seek out my personal style.

4

### You’ve been all over the world. Are there some things that are the same in cities everywhere?

I love to watch a city wake up. In the early morning, the people out are the people who actually open the city. The garbage men, business owners cleaning up the storefronts, lots of delivery people—newspapers being dropped off, food being delivered and of course some people just getting home from the night before. The quietness that the early morning offers always feels to me like the city is mine and mine alone before everyone else gets to come in.

5

### Can you share with us a city story?

I was in Mumbai, India in 2013 and I was taking my time-sliced photos of the Gateway to India. When I do my time-sliced photos, I stand in the same place for about an hour and a half just clicking away during sunset. I become a sort of a fixture. Sometimes, a few people might ask me what I am doing but in Mumbai everyone asked me. People were telling me stories of how they would bring their families here to watch the sunset or get together to catch up on things. There was such curiosity, friendliness and openness—it made me feel so special.

6

### What is the best thing about cities?

Cities offer diversity. You can go to almost any major city in the world and you will find the mix of old and new architecture, all different kinds of people in all age groups, rich and poor working together along with vast varieties of transportation. Cities also



give us glimpses of the past as well as what the future holds for us.

7

### What challenges do you see cities facing?

Too many people, too much traffic and pollution. In many of my recent trips I have been stuck in the most annoying traffic jams. The need for better public transportation, fewer cars in the cities and a need for cleaner air are things that need to be addressed sooner rather than later. Cities are bursting at their seams— all at the expense of health and in my opinion happiness.

8

### What made you interested in working on this cities initiative?

Being asked to collaborate on this project is a highlight in my photographic career. When I think of UNAIDS and the art world, Keith Haring is what comes to my mind immediately as I am a huge fan of his work. I take pride in being able to say that my photography will be associated with an artist such as Keith Haring. If my work can help in the fight against AIDS, then I am all in for that fight.

# building foundations

**TRANSFORMING CITIES**

*starts with lessons learned*

# How AIDS responses can help change cities for the better

Making the most of cities' advantages requires tackling some of the challenges they face, including poverty and overcrowding, insecurity, and the breakdown or lack of basic services. The many benefits that cities offer are also not distributed equitably, sometimes to distressing degrees. Inclusiveness and equity do not yet define many of the world's cities.

Cities that have been successful in reversing their AIDS epidemics have used approaches that empower and respect the rights of affected communities, tackle discrimination, address violence and exclusion, strengthen accountability, and put equity centre stage. They have found the courage to change regulations or enact by-laws to facilitate evidence-informed public health programmes. Cities have realized that the most effective actions prioritize the rights and needs of residents, irrespective of their legal status or entitlements. They also recognized that the efforts had to fit with the realities of people's lives, which led them to try innovative ways to support and harness community participation. Sometimes simple alternatives, such as changing clinics' opening hours, have led to dramatic improvements.

Successful programmes have drawn on the knowledge, energy and networks of affected communities and other stakeholders, rather than operating in a top-down fashion. They have linked and collaborated with nongovernmental and community organizations, and with academic institutions. This has enabled them to tap the problem-solving creativity that is intrinsic to life in dynamic and growing cities, and to experiment with new methods to

track their HIV epidemics, map where interventions are lacking, and plot the provision of quality services and medicines to the people who need them. They have been able to solicit and make productive use of technical support. And they have carefully monitored and assessed their efforts, and adjusted or discarded elements that did not work.

## No such thing as impossible: some lessons from the HIV response for transforming cities

### Go to the roots of the challenge.

AIDS responses show that the most effective and cost-efficient way to safeguard people's health is to enable them to protect themselves against infection and ill health. This approach works best when factors like social and economic inequity and marginalization are also addressed.

### Make resources reach further.

With creative methods, it is possible to provide vital, ostensibly challenging services—such as HIV treatment—on a massive scale in all kinds of settings without overwhelming systems. Providing HIV treatment services at local health facilities and delegating certain tasks to nurses and community health workers rebooted the global HIV treatment effort.

### Tap the power of participation.

Inclusive and participatory HIV programmes tend to be the most successful, especially in reaching marginalized populations. When programmes genuinely involve affected communities, they become more robust and acceptable. They are more likely to fit people's actual circumstances and needs, accountability is stronger, and the results tend to improve.

### Diversify funding.

Negotiating predictable flows of funding and drawing them from a range of sources provides the fiscal security that multi-year strategies require and makes it easier to take the creative risks that can lead to new breakthroughs.

Successful programmes have drawn on the knowledge, energy and networks of affected communities and other stakeholders, rather than operating in a top-down fashion.

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1

Million

people accessing antiretroviral therapy globally in 2003

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13.6

million

people accessing antiretroviral therapy globally in June 2014

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**Collect and use accurate information.**

Accurate and up-to-date understandings of where HIV infections are occurring in cities, who needs and is able to access essential services, and where shortages or overstocks of medicines, commodities or staff are occurring are the cornerstones of successful AIDS responses.

**Keep people's rights centre-stage.**

A human rights-based approach is essential for AIDS responses, for both principled and pragmatic reasons. Coercive or discriminatory approaches violate fundamental human rights norms, and they drive people away from

health and HIV prevention, treatment, care and support services. Cities can use protective by-laws and regulations, and engage with communities to advance rights-based responses to HIV.

**Link services for greater impact.**

Linking or integrating essential services can make it easier, less time-consuming and more attractive for people to use them. When linked, tuberculosis and HIV services show good results. Linking HIV with harm reduction services for treating drug dependence is proving highly effective, as is the integration of HIV services with primary health care and with sexual and reproductive health services.



### **Make essential services easier and more affordable to use.**

HIV programmes prove that it is possible to make high-quality medicines and services widely available, affordable and easy to use, even in trying circumstances. This is being done by transforming health financing systems, streamlining procurement and supply management systems without compromising on quality, negotiating price cuts with corporations, and developing simpler drug treatments and monitoring methods. As a result, the number of people receiving antiretroviral therapy globally soared within a decade from less than 1 million in 2003 to almost 13 million in 2013.

### **Use basic technologies creatively.**

The expansion of HIV treatment has meant finding ways to avoid sudden stock-outs of HIV test kits and medicines. Procurement, distribution and stock management systems have been overhauled to quickly react to changing conditions. A special application enables patients and health workers to use their mobile phones to alert health officials to actual or potential shortages of HIV medicines. Mobile phone reminders are also being used to support adherence to treatment. Not only does this improve HIV treatment, it creates new channels of accountability between citizens and the state that bring quick gains to all sides. ■

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# Cultural Icons

## AIDS in popular culture—works that changed the response forever

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### 1 | *The Keiskamma Altarpiece*

*South Africa*

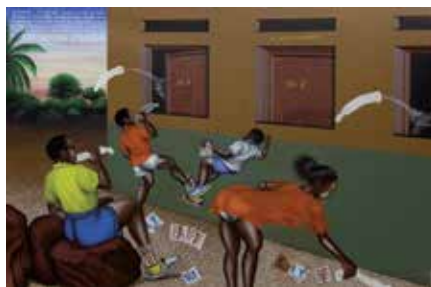
Created by a group of 130 women in the Eastern Cape province of South Africa, the Keiskamma Altarpiece is a message of hope for people living with HIV. The Altarpiece is composed of images of members of the Hamburg community in the Eastern Cape province of South Africa. Part of the grandeur of the artwork 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, August 2006.

### 2 | *Les Capotes Utilisées*

*Democratic Republic of the Congo*

Cheri Samba's paintings reveal his perception of the social, political, economic and cultural realities of his country. Condoms were introduced on a massive scale in Kinshasa in the late 1980s. The painting, *Les Capotes Utilisées* (1990) shows several condoms

being thrown out by unseen lovers from a hotel, while children turn this detritus of AIDS prevention work into toy balloons. It is a commentary about changing culture and sexual habits in Kinshasa. Mr Samba, a leading contemporary African painter, stated, "My art is part and parcel of my environment. It draws its inspiration from the people, it is concerned with the people, and it is meant for them."



2 |

### 3 | *The AIDS Memorial Quilt*

*United States*

Photo: The AIDS Names Project

In June of 1987, a small group of strangers gathered in a San Francisco storefront to document the lives they feared history would neglect. Their goal was to create a memorial for loved ones who had died of AIDS, and to help people understand the devastating impact of the disease. The NAMES Project AIDS Memorial Quilt was created and in 1987 the Quilt was displayed for the first time on the National Mall in Washington DC. Over the years the Quilt has grown to 1.3 million square feet and said to be the largest piece of community folk art in the world.

Today the Quilt is a powerful visual reminder of the AIDS pandemic. More than 48,000 individual 3-by-6-foot memorial panels—most commemorating the life of someone who has died of AIDS—have been sewn together by friends, lovers and family members.





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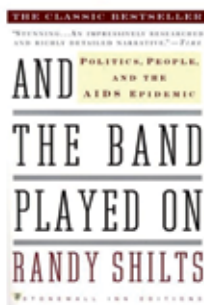
8 |



8 |

4 | **And the Band Played On:**  
*Politics, People and the AIDS Epidemic*  
Written by San Francisco Chronicle journalist Randy Shilts, *And the Band Played On* chronicles the discovery and spread of HIV. An international bestseller, a nominee for the National Book Critics Circle Award, and made into a critically acclaimed movie, the book went beyond the headlines to investigate the social and scientific aspects of the disease.

Openly gay, Mr Shilts refused to accept HIV as what was then labeled a 'gay disease', and through his work he demonstrated the effects of the inequities and stigma against people living with HIV. Mr Shilts was tested for HIV while he was writing the book; he died of complications from AIDS in 1994.



5 | **Mother Theresa**  
*India*

One of India's best known artists, Maqbool Fida Husain was born in 1915. Known for his emphatic understanding of the human condition, Mr Husain did not shy away from controversy—from oil on canvas to documentaries and performance art installations. In one of a series of paintings around



the theme of Mother Teresa, a mother and child are shown together—symbolizing the hope that exists in the response to AIDS.

6 | **Philadelphia**  
*United States*

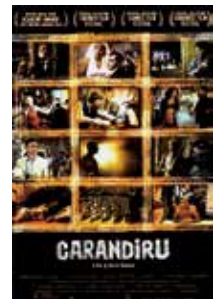
*Philadelphia*, an American drama, was one of the first mainstream Hollywood films to acknowledge HIV, homosexuality and homophobia. The film follows Beckett, a young lawyer at a high-profile law firm. He is gay and has HIV. When his law firm discovers the news, he is fired. Beckett wants to sue, but has trouble finding a lawyer to take his case. What follows is a powerful tale of Beckett's legal, medical and emotional journey. The film was shot in Philadelphia, United States, an early centre for AIDS activism, and employed approximately 50 people living with HIV as extras in the film. *Philadelphia* was written by Ron Nyswaner, directed by Jonathan Demme and starred Tom Hanks and Denzel Washington. The film is credited with changing the national dialogue around HIV by helping to foster more honest and accurate public awareness of the epidemic.



7 | **Carandiru**  
*Brazil*

The film *Carandiru* is inspired by the real-life experience of Dr Drauzio Varella, a doctor supervising an AIDS-awareness programme in one of Latin America's largest and most notorious prisons. Built to house 3000 inmates, *Carandiru* had more than 7000. Violence, abuse and injecting drug use ensued. The film puts a human face on the violence and lawlessness faced

by many of Brazil's megacities. The film also depicts the experience of AIDS in prison, and the unique meeting place of the Doctor's infirmary as a means to explore a panorama of human histories, compassion and injustice. The film was directed by Hector Babenco and written by Babenco, Fernando Bonassi, Victor Navas and Drauzio Varella.



8 | **Street Art**

Since the 1980s, street art has become a popular medium for artists to communicate directly with the public at large, outside the confines of the formal art world. There exists a strong current of activism and subversion in urban street art, which can act as a powerful platform for political expression and provocation for public discussion and self-reflection. The origins of the modern street art movement can be traced back to New York City's graffiti boom of the 1980s, led by artists such as Keith Haring and Jean-Michel Basquiat; the same era in which many young artists battled the emerging HIV epidemic. Alongside Keith Haring (who died of AIDS in 1990), David Wojnarowicz (who died of AIDS in 1992) was among the pioneers to utilize street art to combat conservative attitudes towards the epidemic and express his own despair and rage as a young man dying of AIDS. In recent years, urban artists around the world have increasingly embraced the medium of street art in the form of murals, performances and installations, particularly in times of political and social turmoil.

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**CITIES ARE** *leading the way*



# city profiles

**12 CITIES IN 24 PAGES**

*Bangkok | Dakar | eThekweni (Durban) | Kingston | Melbourne | Mumbai  
Nairobi | New York | Paris | Quezon City | San Francisco | São Paulo*

# Bangkok




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## Strong partnerships are at the heart of the city's achievements in the AIDS response.

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Strong, flexible partnerships are at the heart of the city's HIV achievements. Longstanding collaborations with academic and research institutions have been crucial, providing a strong information and evidence base for projects.

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*Bangkok's innovative response to its AIDS epidemic is multisectoral, integrating information and health services for people most at risk while tackling stigma at its roots.*

### OVERVIEW OF THE HIV EPIDEMIC

Approximately one quarter of new HIV infections in Thailand occur in Bangkok. As is common in the Asian region men who have sex with men, sex workers and people who inject drugs are most affected. The city's epidemic grew rapidly in the 1980s, as large numbers of sex workers and their male clients acquired HIV. The 100% condom programme implemented throughout Thailand in the 1990s, hailed as one of the most successful programmes of its time, had a significant impact on the epidemic in Bangkok. Continued rigorous efforts of the Bangkok Metropolitan Administration, the Ministry of Public Health and NGOs in the city have brought down the number of new HIV infections to fewer than 1900 per year and rates continue to decrease.

# Bangkok

## THE AIDS RESPONSE

Bangkok's AIDS strategy aims to end the city's epidemic by 2030. The Bangkok Metropolitan Administration (BMA) manages the strategy, in close partnership with the Ministry of Public Health, the private sector, civil society and community organizations, academia and international organizations.

In addition to tracking the epidemic's evolution and providing a range of HIV prevention services, the strategy includes efforts to monitor stigma and discrimination. A sexuality education programme for city schools helps students learn about sexual diversity, gender issues and HIV. Bangkok's health facilities, the BMA's hospitals and community health centres are being transformed into one-stop shops that offer HIV services such as counselling and testing as part of the standard health screening package. Bangkok, in line with the rest of Thailand, has introduced universal health care for Thai residents and its substantial migrant population. Increasingly, services for key affected populations are being integrated into regular services. BMA's community mobile clinics provide after-hours outreach services. Civil society entities including: Thai Red Cross, SWING, Rainbow Sky and PSI, further complement these efforts with community-based information and services. There is a special focus on reaching men who have sex with men with an effective HIV response. The BMA has set up a GAYBKK club

that uses social media to encourage men who have sex with men to take HIV tests and access other HIV prevention and treatment services. Set up two years ago, GAYBKK already has more than 20 000 members. Civil society partners have designed internet cafes as safe spaces that offer friendly entry points for HIV services.



## WHY THIS CITY IS MAKING A DIFFERENCE

As one of the key locations of Thailand's HIV epidemic, Bangkok's response is crucial to reaching the national goal of ending AIDS by 2030. Strong, flexible partnerships are at the heart of the city's HIV achievements. Longstanding collaborations with academic and research institutions have been crucial, providing a strong information and evidence base for projects. By "knowing its epidemic", Bangkok has been able to focus its resources more effectively to reach most affected populations. Progress has been impressive: new HIV infections have fallen by 69% since 2000. Almost 90% of women living with HIV in Bangkok were accessing services for preventing mother-to-child transmission of HIV in 2013.



## GOVERNOR OF BANGKOK

"As the Governor of Bangkok, I have the responsibility for the well-being of the people of Bangkok. I am concerned that HIV continues to impact adversely on the city's economy, society, public health and human resources, and I am committed to ending the AIDS epidemic by 2030. I am confident that through the dedication and collaboration of all sectors of society, with innovation and optimization of action, our target to end AIDS can be achieved, thus helping Bangkok to be a healthier city and a desirable place to live that offers quality of life and happiness for its citizens. We hope that with strong partnership and dedicated effort by all sectors, we shall be able to end AIDS by 2030. We are confident that together, we can."

*Mom Rajawongse  
Sukhumbhand Paripatra,  
Governor*

## DID YOU KNOW?

Famous for its vibrant entertainment, shopping and other tourist attractions, Bangkok is one of the most populous cities in south-east Asia. Known as the city of happiness, Bangkok extends over an area of 1500 square kilometres and boasts the longest name of any city in the world, *Krung Thep Maha Nakhon*. Bangkok is among the first cities in the world to offer transgender public toilets.



# Dakar



## The city is accelerating progress towards achieving the Abuja+12 commitments.

*With a national response based on bold commitments and investments, Dakar, Senegal, is keeping HIV prevalence low and leaving no one behind.*

### OVERVIEW OF THE HIV EPIDEMIC

**D**akar, the capital of Senegal, is located on a peninsula that covers less than 1% landmass of the country but is home to 23.2% of its population. Dakar is an industrial city and characterized by a large migrant population with 5739 inhabitants per square kilometre, compared with the average country density of 65 inhabitants.

Although the city's HIV prevalence is lower than the national average, 44% of those on antiretroviral therapy in Senegal receive their treatment in Dakar. The HIV burden is higher among the city's key populations. Overall HIV prevalence in Dakar has been low and continues to decline from 0.6% in 2005 down to 0.4% in 2010-2011. New HIV infections in Senegal have declined by about 60% between 2001 and 2013.

In 2013, 18% of all pregnant women in the country were screened in Dakar. Of all the pregnant women living with HIV nationwide, 15% were diagnosed in the city.

## Dakar



### THE AIDS RESPONSE

The 2011–2015 national strategy aims to reduce the rate of new HIV infections by 50% and providing treatment for 80% of people living with HIV. The key programmes include: the prevention of mother-to-child transmission of HIV; treatment, care and support for people living with HIV; surveillance of HIV infection; safe blood transfusions; and HIV testing and counselling. HIV services are decentralized to district levels across all regions in the country.

In addition to integrating prevention of sexual HIV transmission in educational programmes, Dakar has put a focus on the prevention of new infections among children. One quarter of all pregnant women living with HIV in Senegal receive HIV treatment and care in Dakar.

### WHY THIS CITY IS MAKING A DIFFERENCE

Dakar has all the country's referral care facilities. Of the 25 hospitals in the country, just under half are located in Dakar. The city administration is the principal source of funding for these facilities and covers almost all of the administrative costs.

All public health facilities in Dakar offer HIV counselling and testing services at all levels, including counselling centres for adolescents that render services for young people and pregnant women.



### MAYOR OF DAKAR

“Among our key achievements, communication for behavior change and participatory approaches to prevention interventions, have been focused on and integrated into education programmes. The implementation of the prevention of sexual transmission programme has contributed to a significant reduction in new infections. But workplace and targeted programmes for mobile populations have not adequately reached the required scale. Participation of the private

sector remains limited and stigma at treatment centres persists. We hope that by 2015 the incidence of HIV will decrease by 50% and its impact on individuals, families and communities will be reduced. We also hope that the vision of the 2014–2017 national strategic plan will end the AIDS epidemic by 2030 with the Dakar Mayor's Office central in its implementation.”

*Khalifa Ababacar Sall, Mayor*

### DID YOU KNOW?

Dakar has the best-equipped network of health facilities in Senegal. However, more needs to be done with respect to social support for impoverished and vulnerable populations.



## eThekweni (Durban)




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**The city is focusing on changing sexual behaviour as means for reducing HIV incidence.**

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*Changing sexual behaviour is seen as one of the most effective ways to reduce new HIV infections in the busy South African port city.*

#### OVERVIEW OF THE HIV EPIDEMIC

**A** national survey in 2012, among pregnant women who went for antenatal care services, estimated HIV prevalence in eThekweni at 39%, the third highest in South Africa. In the same year, the national population-based survey showed that adults living in informal settlements were more likely to be HIV-positive than people living in formal areas. The survey also estimated that, of the adults who had sex in the preceding 12 months, 15% had multiple sexual partners. The city is also characterized by a high tuberculosis burden with a 70% tuberculosis/HIV co-infection rate. HIV prevalence among men who have sex with men in eThekweni is particularly high at 48%.

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eThekweni aims to reduce new HIV infections to less than 1% and to reduce AIDS-related morbidity and mortality by 2016.

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## eThekwini (Durban)



### THE AIDS RESPONSE

eThekwini is working to ensure that HIV treatment and services are accessible in the areas with the highest HIV burden. The city is committed to eliminate new HIV infections among children and do more to reach key populations including sex workers, taxi drivers, truckers and men who have sex with men. Services are provided via fixed and mobile clinics.

The city is also focused on young people in schools and universities. HIV prevention initiatives such as First things First and Graduate Alive, offer voluntary medical male circumcision, condom distribution, family planning and HIV treatment. Condom distribution is an integral part of the city's HIV prevention strategy; in 2013, 18 million male condoms and 3.2 million female condoms were distributed.

As in the rest of the province, the city runs Operation Sukuma Sakhe programme, which means 'stand up and build'. This programme tackles a range of problems, including: food security; disease and infection, most notably HIV and tuberculosis; disempowerment of women and youth; poverty; violence against women and girls; teenage pregnancy; substance abuse; crime; and motor vehicle accidents. eThekwini is part of the South African Cities Network (SACN) that

encourages the exchange of information, experience and best practices on urban development and city management to enhance good governance. eThekwini's mayor signed the Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICALL), reflecting the importance of locally led, multisectoral action that complements supportive national policies.

### WHY THIS CITY IS MAKING A DIFFERENCE

eThekwini has made strong advances in several aspects of its HIV and tuberculosis response. Condom distribution doubled between 2012 and 2014. At the end of March 2014, 271 000 people were receiving antiretroviral therapy (ART) which is 32% of all ART provided in KwaZulu-Natal province.

According to the eThekwini District Health Barometer, tuberculosis incidence decreased from 1155 per 100 000 in 2012 to 1032 in 2013. However, it was still the fourth highest in the country. The tuberculosis treatment success rate (all tuberculosis) increased annually from 63.1% in 2009 to 78.3% in 2012. This is lower than the national target of 85%. Of the tuberculosis patients who started tuberculosis treatment in 2013, HIV status was known in 83%. Some 56% of the HIV-positive tuberculosis patients were recorded to be accessing ART.



### MAYOR OF ETHEKWINI

"Providing access to antiretroviral therapy for women living with HIV has significantly reduced mother-to-child transmission, which currently stands at less than 1%. This means virtual elimination is a reality for our city. Progress has been dramatic in scaling up access to antiretroviral treatment."

*James Nxumalo,  
Mayor, eThekwini*

### DID YOU KNOW?

eThekwini is the second most populous city in South Africa after the Greater Johannesburg metropolitan area and the largest city in KwaZulu-Natal. Some 50% of the city area is used for subsistence farming and only 2% for urban settlement. The city's population of about 3.44 million is predominantly young, with 66% under the age of 35.

After Johannesburg, eThekwini is the second most important manufacturing hub in South Africa, and its harbour is Africa's busiest port. Manufacturing, tourism, finance and transport are the four largest economic sectors.

Well-established circular migration patterns have contributed to population growth. The largest source of migrants to eThekwini is from outside the country, with 15% of these migrants living in informal settlements. The proportion of the population living in informal settlements is estimated at 33%.



# Kingston



The city's public campaigns are helping to prevent new HIV infections.

Kingston has 10 out of 21 treatment sites in Jamaica and plays an essential role in treating and caring for people living with HIV.

*Challenges remain but the city is determined to engage, inform and empower its citizens to reduce new HIV infections.*

## OVERVIEW OF THE HIV EPIDEMIC

Kingston has come a long way since the first AIDS-related death was recorded in 1982. One third of the country's 30 265 people living with HIV were diagnosed in the Kingston metropolitan area, although only 7500 are estimated to reside in the capital. In Kingston, the majority of people newly diagnosed with HIV have an HIV-related illness or disease, indicating late diagnosis.

According to Ministry of Health estimates, in 2013 HIV prevalence among the homeless and people who inject drugs was at 4% and among prison inmates was at 9%. Data for female sex workers and men who have sex with men is incomplete but it is estimated to stand at 4% and 32% respectively.

The government's financial contribution is increasing but the response effort remains under-resourced and highly dependent on funding from external sources.

# Kingston



## THE AIDS RESPONSE

Since 2005, when a national HIV policy was developed, Kingston has provided political leadership to address gender equality and human rights, charting the course for an enabling environment and greater involvement of people living with HIV.

Investment in the HIV response is aligned with the geographic burden of the epidemic. However this has not necessarily focused on the most affected population groups. This is changing as more data has been gathered.

The Justice for All Programme, led by the Sexual Health Agency, aims to address stigma, discrimination and legal reform through consultations and engagement with parliamentarians, faith-based organizations and young people. A unit working for the greater involvement of people living with HIV is also aiming to reduce stigma and discrimination in the workplace.

## WHY THIS CITY IS MAKING A DIFFERENCE

The national HIV programme utilizes an evidence-based approach. Consequently, there is greater investment of resources in the city and other parishes with the highest HIV burden. Additionally, HIV programmes are primarily coordinated from Kingston, where the support of nongovernmental organizations and international partners is strongest. Kingston has 10 out of 21 treatment sites in Jamaica and plays an essential role in treating and caring for people with HIV. The city has hosted multiple discussions on human rights, including parliamentary hearings on the Sexual Offences Act, and provided leadership in the Caribbean region for a dialogue on HIV and human rights with conservative faith-based communities.



## MAYOR OF KINGSTON

“Key challenges include the relative low rate of economic growth, high unemployment levels, early sexual debut of young girls and stigma, including self-stigma. In some communities, a macho culture reinforces negative behaviour choices. Jamaicans are also uncomfortable speaking openly about sex and sexual health. Our youth are not sufficiently informed and empowered to articulate their position, negotiate for self-protection or to provide peer education. The more young adults and adolescents are involved, our public campaigns will lead to a reduction in [incidence] of HIV for generations to come. Educated citizens are enabled to make more rational decisions about the importance of protecting themselves and their partners. I am hopeful we will soon see a society that will not perceive HIV as a reason to discriminate, but a reason to embrace and give care. We are working assiduously in partnership for a society that is empowered, educated and healthy. The change is on the horizon.”

*Angela Brown Burke, Mayor and Senator Councillor*

## DID YOU KNOW?

Jamaica’s dancehall culture, sports, drama and faith-based activities have been used to support radio, TV and print campaigns to disseminate key messages on HIV and increase condom usage. Campaigns—such as ‘Smart Women Always Buy, Carry and Use Condoms’ and ‘Hold On, Hold Off’ foster local and national discussions about HIV.

# Melbourne



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The impact has been clear: globally, Australia has one of the lowest transmission rates of HIV among people who inject drugs.

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## The city is a pioneer in harm reduction in the AIDS response

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*Progressive strategies that include needle and syringe programmes and opioid substitution therapy have led to one of the world's lowest HIV transmission rates among people who inject drugs.*

### OVERVIEW OF THE HIV EPIDEMIC

**O**f the 307 HIV case notifications in the 12 months prior to July 2014 in the state of Victoria, 75% were men who have sex with men and 2.6% were injecting drug users. More than half of the estimated people living with HIV in Victoria live in the inner city of the state capital, Melbourne.

# Melbourne



## THE AIDS RESPONSE

Australia's health care system is funded and administered by several levels of government (national, state/territory and local) and is supported by private health insurance arrangements. Australia's national public health insurance scheme, Medicare, is funded and administered by the Australian Government with States. The Australian and state/territory governments fund and deliver a range of other health services including population health programmes, community health services, health and medical research, Aboriginal and Torres Strait Islander health services, mental health services, health workforce and health infrastructure.

Strategic HIV policy is determined by government agencies in close consultation with community, research and clinical stakeholders. The Victorian AIDS Council is the primary organization responsible for implementing the national AIDS strategy in Melbourne and the wider state territory.

The Melbourne Sexual Health Centre offers sexual and reproductive health services, provides testing, HIV treatment and education. It also offers focused services via a gay-friendly clinic that operates specifically for men

who have sex with men. The centre works closely with communities, researchers and community-based organizations to design appropriate programmes, provide services and community education. In Victoria, 50% of all HIV cases are diagnosed through these focused services.

Melbourne is at the forefront of treatment as prevention, with the Victorian pre-exposure prophylaxis demonstration project researching the use of daily antiretroviral medication by HIV-negative people at high risk of infection.

## WHY THIS CITY IS MAKING A DIFFERENCE

Australia has been a global leader in harm-reduction strategies, particularly in the way it has established and expanded needle exchange and safe disposal programmes. Melbourne and Sydney have been at the forefront of these pioneering efforts, negotiating ways around national laws to open safe injecting rooms. The impact has been clear: globally, Australia has one of the lowest transmission rates of HIV among people who inject drugs. These strategies have also led to low rates of prison-related transmission.



## MAYOR OF MELBOURNE

“The city of Melbourne prides itself on being diverse and inclusive in all ways. On behalf of people living with HIV and those at risk of acquiring HIV, it is everyone's responsibility to reduce HIV-related stigma and discrimination and to be a leader in the elimination of HIV.”

*Robert Doyle, Lord Mayor of Melbourne*

## DID YOU KNOW?

Melbourne's scientists have been pivotal in developing some of the world's most innovative biotechnology, including flu treatment and the bionic ear. Most recently, Melbourne hosted the 20th International AIDS Conference, AIDS 2014, bringing together more than 16 000 delegates from around the world.



# Mumbai




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**The city sees public-private partnerships as key to expanding HIV programmes.**

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The Maharashtra State Commission for Women, a statutory body constituted to improve the status and dignity of women, now has a policy dedicated to support female sex workers and transgender people

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*Nongovernmental organizations are leading the city's response to HIV with innovative solutions to the problems of a rapidly changing sex work environment in an environment of stigma and taboo.*

## OVERVIEW OF THE HIV EPIDEMIC

**D**reams of a better life bring people from all over India to Mumbai. With more than 18 million inhabitants, Mumbai is the most populous city in India. It has one of the highest levels of HIV prevalence in the country. Mumbai has witnessed a decline in HIV infections among key populations, though rates for these groups remain substantially higher than the national averages. The biggest change in HIV prevalence was among female sex workers in a period of 8 years—from 54% in 2003 to less than 10% in 2011.

# Mumbai



## THE AIDS RESPONSE

Partnership between the public and private sector is one of the key features of the city's HIV programme. The Mumbai District AIDS Control Society reaches out to people at greatest risk, providing prevention of mother-to-child transmission services, workplace programmes and services for HIV and tuberculosis co-infections. With policy-makers committed to evidence-based planning, hospitals, pharmacies, and health and maternity clinics are providing services for HIV prevention, treatment, care and support.

## WHY THIS CITY IS MAKING A DIFFERENCE

Actions by health and social rights advocates, community stakeholders and people living with HIV have been key to overturning legal barriers and stigma associated with HIV. The Maharashtra State Commission for Women, a statutory body constituted to improve the status and dignity of women, now has a policy dedicated to support female sex workers and transgender people. Medical insurance, biometric smart cards, women's collectives and wellness clinics for sex workers are some of the civil society innovations supporting Mumbai's key populations at highest risk.

Evidence indicates these efforts are delivering positive results, demonstrated by the decline in HIV prevalence in women attending antenatal care clinics. Seroprevalence trends show that while more women are being tested, the number of positive cases has decreased.



## MAYOR OF MUMBAI

“Health care is a fundamental necessity: not only for preventing disease and minimizing its effect, but most importantly as a central step to improve a person's well-being and contribution to society. We are committed to further improve comprehensive health care and secure universal coverage and access to HIV prevention, treatment and care services. Our focus is on the vulnerable and socially marginalized, including women, children and young people.”

*Snehla Ambekar, Mayor*

## DID YOU KNOW?

The constant struggle for living space is one of the biggest social challenges facing Mumbai. However, from this adversity a strong housing rights movement has emerged. Various social protection programmes are available to people living with HIV, including pension programmes, travel concessions and free medical aid for low-income families. Nutritional and educational support is also provided in collaboration with community-based and nongovernmental organizations.



# Nairobi



**Focusing on location and population, the city is able to reach people most affected by the AIDS epidemic.**

Steep declines in AIDS-related deaths, especially among women, indicate the programme is making headway in addressing some HIV-related gender inequities.

*A diverse range of community partnerships are helping the sprawling metropolis meet its complex HIV challenges.*

## OVERVIEW OF THE HIV EPIDEMIC

Nairobi City has the highest burden of HIV in Kenya, with about 180 000 residents living with HIV. In 2013, Nairobi county had more than 3000 new HIV infections. HIV prevalence in the capital is higher than the national average, with about 8.4% of adult women in the city living with HIV and 5.3% of adult men. HIV infection levels are highest in the city's slum areas, with women most affected. Girls and young women aged 15–24 years living in the poorest areas are nearly four times more likely to acquire HIV compared with their peers in other parts of the city. Key populations also have a high risk of HIV infection. Nationally, almost one in five men who have sex with men and people who inject drugs are living with HIV, as are almost 30% of female sex workers.



## Nairobi

### THE AIDS RESPONSE

Nairobi has taken important steps to control its epidemic. The city is mapping the areas where HIV infections are reported and at the same time developing estimates on the sizes of key populations. This data is helping to make it possible to focus HIV efforts and bring HIV services closer to the most affected communities. Nairobi is also part of a major voluntary medical male circumcision campaign. The wider Nairobi county has expanded access to HIV treatment to 92% of adults compared with the 79% national coverage, while treatment for children is relatively high (74%) compared to 42% national average coverage. Projects to empower women economically and provide cash transfers for orphans and other at-risk children aim to reduce people's vulnerability to HIV.

A diverse range of community partnerships complement government efforts: the Oxfam/Concern Worldwide Nairobi Urban Social Protection Programme supports food and livelihood security in slums by providing cash transfers and skills training to more than 5 000 households; the Mathare Youth Sports Association links sport with HIV through its Football for Hope programme; and young representatives from Nairobi's 10 slums meet monthly as part of the Nairobi Slum Leaders Assembly to discuss issues of concern and to formulate community-based responses.

The changing character of Nairobi and its mobile population provide a complex setting for the urban HIV epidemic. A successful response requires close cooperation among stakeholders across traditional city administrative boundaries and a strong understanding of a changing HIV epidemic and dynamic environment.

### WHY THIS CITY IS MAKING A DIFFERENCE

Nairobi has developed strong capacity to undertake research and provide HIV services by building high-level collaboration between international and local institutions. There has been a special focus in the Kenyan capital on strengthening HIV programme leadership and management. Quality and sustainable HIV services have been linked with programmes for preventing and treating tuberculosis, and with reproductive health and family planning. Although health-care services are limited in the slum areas, residents have benefited from the scale-up of HIV treatment. Steep declines of AIDS-related deaths among women can be seen as an indicator that the programme is addressing HIV-related gender inequities. Evidence-based programmes, combined with the capacity to deliver HIV services to key population groups, make Nairobi's AIDS response a strong one.



### GOVERNOR OF NAIROBI

“We are proud of the progress we have made in Nairobi but we are also aware of the long way ahead—in getting everyone to know their HIV status, and link people who are HIV-positive to the care and treatment they need, and for people who test HIV-negative to come back again and be empowered to lead a healthy life. We are committed to learn from what has worked, in reaching people, but also in ensuring people's rights, especially those living with HIV, women and young girls and those most vulnerable. As a city, we respond to the HIV epidemic to support our citizens, but we also use the response to HIV to drive change on gender inequality, human rights, and economic growth. Kenya has achieved significant milestones since the first cases of HIV were diagnosed. We have witnessed our response saving many lives, from as high as 700 people dying daily due to AIDS-related complications, to fewer than 150 AIDS-related deaths today. The AIDS response has delivered and strengthened health services to the residents. Today, we know that a lot more can be achieved if we provide political leadership and commitment to technical solutions.”

*Evans Kidero, Governor,  
Nairobi City County*

### DID YOU KNOW?

Nairobi is an expanding city that is seen by many as the economic and cultural centre of East Africa. With a population of 4 million, Nairobi generates about 60% of Kenya's total economic output. At the same time, the city is divided by conspicuous inequalities. Nairobi has two of Africa's three largest slum areas, Kibera and Mathare, where only a minority of residents have access to safe drinking water and sanitation. Nairobi's population is strikingly diverse. It includes internal and international migrants, as well as refugees from neighbouring countries. Nairobi is increasingly sprawling towards nearby towns and villages, effectively forming a city-region that encompasses smaller neighbours, such as the urban areas of Thika, Athi River, Machakos and Kiambu.

# New York




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**The city has committed to “Bend the Curve” and move to end the AIDS epidemic in New York State by 2020.**

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In 2014, Governor Andrew Cuomo announced a three-point plan called “Bending the Curve”, which aims to bring HIV rates in New York State and City below epidemic levels by 2020.

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*Since 1981 New York City has been at the centre of the United States HIV epidemic. New York has also been a leader in the AIDS response.*

## OVERVIEW OF THE HIV EPIDEMIC

It is estimated that nearly 3000 residents of New York City will newly acquire HIV in 2014, which is significantly lower than the 14 000 new HIV infections the city faced in 1993. In 2012 an estimated 114 926 people were living with HIV in New York with more than half accessing antiretroviral therapy. From the efforts of stakeholders as diverse as activists, health care professionals, human rights groups, city and state officials, New York has created the nation’s most far-reaching and comprehensive safety net for people with HIV and become a model for responding to the epidemic.

## New York



### THE AIDS RESPONSE

New York remains a leader in the AIDS response. The early mobilization of the lesbian, gay, bisexual and transgender communities and allies, mobilized an unprecedented response. It included support groups, community-based care and support programmes, risk assessments for HIV transmission and guidelines for safer sex, and the first treatments for opportunistic infections. The city was also a pioneer in the development and availability of antiretroviral therapy, from community-based trials to buyers' clubs to import medication and treatments from other countries.

Activist coalitions developed a sense of urgency in the city and government officials, and pharmaceutical manufacturers were forced to respond to the needs of people living with and at risk for HIV. Advocates also mobilized support for funding, innovations in research, and approval processes to deliver early access to experimental treatments. New Yorkers fought for the protection of the human rights of people living with HIV, and pushed for anti-discrimination laws to prevent evictions, employment harassment, and personal attacks.

In 2014, Governor Andrew Cuomo announced a three-point plan called "Bending the Curve", which aims to bring HIV rates in New York State and City below epidemic levels by 2020.

The goal is to reduce the number of new HIV infections each year to 750 (from the currently estimated 3000 per year) by 2020. The three-point plan includes: promoting HIV testing; linking and retaining people living with HIV in care; and facilitating access to pre-exposure prophylaxis (PrEP).

### WHY THIS CITY IS MAKING A DIFFERENCE

While challenges remain, New York's HIV response is effective. Multiple factors contribute to HIV transmission in a large, diverse city and disparities in access to information, to testing and access to healthcare persist. Prevention of HIV transmission is difficult and stigma related to HIV and at risk behaviors and lifestyles further complicate New York's HIV response. Scaling-up HIV services to provide 100% access to treatment, care and support, as well as effectively addressing the social drivers of the epidemic, will be a substantial and complicated undertaking.



### MAYOR OF NEW YORK

"This [AIDS] crisis continues and we have more to do...I'm very proud to work with Governor Cuomo to provide some measure of security to people struggling with the debilitating effects of HIV-AIDS. We are committed to lifting up the most vulnerable among us. This is the mark of a compassionate city."

*Bill de Blasio,  
Mayor of New York*

### DID YOU KNOW?

In the United States, New York has the highest number of people living with HIV and of people at significant risk of acquiring HIV. The city is well-equipped to address the epidemic because of its large network of committed professionals, talented providers and organized advocates. Also with established community planning processes, there is an extensive social safety net that specifically aims to reduce structural barriers and provide care and treatment for people living with HIV.



# Paris




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More than 50 000 people receive medical care and 500 000 people benefit from action focused on HIV prevention, awareness and testing.

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## The city's HIV response has not been limited to city limits.

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*Paris has been at the forefront of the response to HIV since the beginning of the epidemic, through the work of service organizations, activists, political leaders and scientists.*

### OVERVIEW OF THE HIV EPIDEMIC

Paris is the French city most affected by HIV. The prevalence of people living with HIV in the capital is much higher than the national average, according to the latest statistics from the Institut de Veille Sanitaire. In recent years (2009-2013), approximately 1200 Parisians annually have been diagnosed with HIV, that figure has remained stable with no significant increases. Among people living with HIV in Paris, 78% are aged 25 to 49 years, 9% are under 25 years and 13% are 50 years or older. Women represent one-third of all people living with HIV in Paris and almost all contracted HIV through heterosexual sex. Most males (65%) who contracted HIV in Paris are men who have sex with men.

# Paris



## THE AIDS RESPONSE

Paris operates information centres for the testing and diagnosis of sexually transmitted infections. These centres make it possible for everyone to know their HIV and hepatitis serostatus. The City of Paris plans to develop sexual health centres offering holistic care, from health promotion to patient monitoring. The new centres will also provide information services, testing and initial treatment, in particular for key populations. Studies in the city have confirmed the need for more effective HIV prevention programmes for men who have sex with men.

## WHY THIS CITY IS MAKING A DIFFERENCE

The response of Paris to the AIDS epidemic is not limited to the city but includes support for projects in countries with high rates of HIV prevalence. Since 2001, more than 22 million Euros have been allocated to French associations, civil societies and non-governmental organizations for HIV work. More than 50 000 people receive medical care and 500 000 people benefit from action focused on HIV prevention, awareness and testing.



## MAYOR OF PARIS

"The economic crisis worsens the vulnerability and insecurity of people affected by HIV and causes difficulties in access to care. The City of Paris wants to make every effort to fight against social inequalities in health. At the global level, elected officials can be key players in the response to HIV, towards further stabilizing the epidemic and ultimately eradicating the disease permanently. Paris has made ambitious political commitments endorsed by the Paris Declaration on AIDS. So long as the response to HIV needs to continue, we have no right to let our political will falter!"

*Anne Hidalgo, Mayor of Paris*

## DID YOU KNOW?

Paris relies on a highly developed network of associations that work with populations at higher risk and are based in areas close to people most affected by HIV. The dedicated associations are a source for innovation for more efficient responses to HIV. The networks operate across the health-care spectrum, from HIV prevention to patient monitoring, including testing and initial treatment, in coordination with the City of Paris and hospital services. This work is a key leverage point for successfully achieving the ambitious goal to end the AIDS epidemic in Paris.



# Quezon City



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**The city is focusing on local investment and innovation for a successful AIDS response.**

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The 2011 Quezon City Investment Plan for AIDS lays out a five-year plan, which aims to reach 80–90% of key populations with prevention coverage annually by 2015.

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*After-hours health clinics and a peer education drive have led to an impressive increase in the uptake of HIV services.*

## OVERVIEW OF THE HIV EPIDEMIC

**Q**uezon City, with a population of 2.76 million, accounts for a significant proportion of the HIV epidemic in the Philippines, with a total population of about 95 million. Since 2007 there has been an upwards trend of HIV infections among men who have sex with men. HIV prevalence in this group increased from under 1% to nearly 7%.

## Quezon City



### THE AIDS RESPONSE

Quezon City has taken strong and bold action to understand and respond to its epidemic. Advocacy linked to strategic information has led to increasing local investment, with city administrators leading and funding the HIV response. The 2011 Quezon City Investment Plan for AIDS aims to reach 80–90% of key populations with HIV prevention coverage annually by 2015.

The Sundown Clinic is perhaps the city's most innovative programme. In response to a significant increase in HIV infections among men who have sex with men, the city established a community clinic that operates from the afternoon until late at night to enable people to attend after work. The clinic, Kilinka Bernardo, is a comprehensive sexual health-care clinic that provides testing, counselling and treatment for HIV and sexually transmitted infections.

To localize its peer education programme, the city has hired 20 educators who work at night providing outreach, counselling and testing. Access to HIV related information is now offered online, enabling people to access information in private and on their own

terms. Of the people tested by peer educators in the field, fewer than 50% go back to the facilities for treatment; to counter this, satellite treatment hubs are being established.

### WHY THIS CITY IS MAKING A DIFFERENCE

In response to the evidence presented in the Integrated HIV Behavioural and Serological Surveillance (IHBSS), Quezon City is taking intensive action to scale up its HIV response for key populations. A local investment planning was undertaken with stakeholders, including international partners.

The response is being rolled-out and it is already showing an increase in the uptake of services. More than double the number of men who have sex with men are being reached.



### MAYOR OF QUEZON CITY

“Quezon City is unrelenting in its effort to pursue and sustain its programme of zero new infections, zero discrimination and zero AIDS-related deaths. Our governance mantra is to respond and invest in programmes to address this health issue rather than turn a blind eye to this stark reality. We remain committed to providing preventive intervention, treatment, care and counselling to ensure our patients receive a better quality of life.”

*Herbert M Bautista,  
Mayor of Quezon City*

### DID YOU KNOW?

Under the leadership of its mayor Herbert Bautista, the Quezon City government has worked with local landowners and the private sector to undertake an ambitious housing programme. The government purchased land and managed the building of affordable, decent housing for informal settlers and poorer residents. In the third stage of the programme, more than 1000 housing units have been built.

In recognition of its achievements in the response to HIV, the Quezon City government received the Philippines' Galing Pook award for outstanding local governance in 2014 for its socialized housing programmes and the pioneering sundown clinic.



# San Francisco



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**The city is on track to end its AIDS epidemic by 2030.**

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The city was a pioneer of the test-and-treat strategy and has set up a programme to help people access treatment on the day of diagnosis.

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*During the 1980s HIV took a particularly heavy toll on San Francisco. But the city has come back even stronger by investing in HIV treatment, research, education and community support.*

## OVERVIEW OF THE HIV EPIDEMIC

In the early 1980s San Francisco was at the centre of the HIV epidemic in the United States. HIV affected its large gay community, with studies suggesting that up to 51% of gay men were living with HIV. At that time, life expectancy of people admitted to the hospital with AIDS-related illness was measured in months. There were few treatment options and family, friends and clinicians often watched helplessly as young men and women died from pneumonia, encephalitis and other AIDS-related illnesses. As of 2010, more than 19 000 had died from AIDS-related causes and thousands more are living with HIV.



# San Francisco

## THE AIDS RESPONSE

San Francisco today is almost unrecognizable to people who lived through the HIV epidemic during the 1980s and early 1990s. Through an aggressive home-grown response, citizens developed what is known as the 'San Francisco model', a comprehensive grass-roots response, where a variety of HIV services were often found under one roof. When antiretroviral therapy became available, San Francisco embraced it as a life-saving intervention. Clinicians, researchers, public health officials and the community led efforts to improve HIV treatment and prevention in the city and beyond. They worked together to establish a continuum of care, from diagnosis to successful treatment for the estimated 16 000 people living with HIV in 2013, many of whom are aged 50 years and older. Through the many testing centres and clinics set up throughout the city by the government, HIV is consistently detected in its earlier stages. This makes it more treatable, keeps people healthier and significantly reduces transmission. The city was a pioneer of the 'test-and-treat' strategy and has set up a programme to help people access treatment on the day of HIV diagnosis.



## WHY THIS CITY IS MAKING A DIFFERENCE

Through these efforts, San Francisco halved the number of new infections between 2004 and 2011, and now reports about 350 new cases per year. The city hopes to trim that number by a further 25% this year. It has set its sights on becoming the first city to end AIDS in which diagnosis, treatment and outreach services, such as housing, substance abuse counselling and mental health counselling, are integrated under one umbrella of care.

## MAYOR OF SAN FRANCISCO

"Building upon the tremendous leadership of [US House of Representatives Minority Leader] Nancy Pelosi in Congress on the reauthorization of the Ryan White Care Act, San Francisco will continue to sustain investments in HIV and AIDS care and treatment. Despite continued historic budget challenges, we remain committed to funding critical care services for those living with HIV in San Francisco."

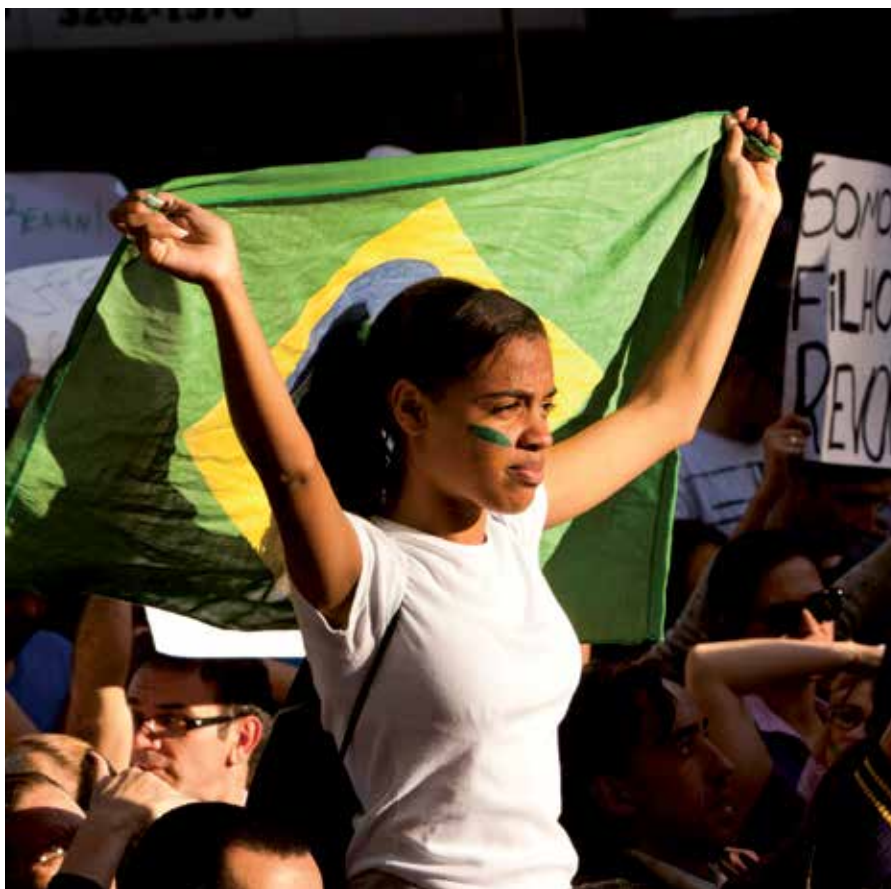
*Edwin M Lee,  
Mayor of San Francisco*

## DID YOU KNOW?

"We are in a new era in the HIV epidemic. We are moving towards the end of the AIDS epidemic," said Diane Havlir, MD, Professor of Medicine at the University of California and chief of HIV at San Francisco General Hospital. "We're talking about San Francisco reducing new HIV infections by 90% in 2020."



## São Paulo




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### Working in partnerships the city aims to ensure stigma-free access to healthcare.

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São Paulo boasts one of the first clinics for transgender people in Brazil, providing holistic and stigma-free health care.

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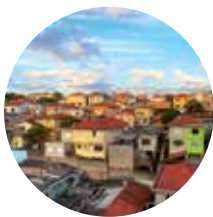
*Latin America's largest city responds to HIV with innovative collaborations at national, state and municipal levels.*

#### OVERVIEW OF THE HIV EPIDEMIC

São Paulo, the centre of the HIV epidemic in Brazil, had the first case in the country identified in 1980. From 1980 to 2013 there were 89 270 HIV cases reported, almost 20% of all cases in the country.

In São Paulo, the rate of HIV diagnosis declined to 24.1 cases per 100 000 inhabitants in 2012 from 35.5 per 100 000 in 2000. The number of AIDS-related deaths also declined, from 1379 deaths in 2000 to 796 in 2012. As is the case throughout Brazil, key populations are the most affected by the epidemic. HIV prevalence among men who have sex with men was estimated at 15% in 2012.

## São Paulo



### THE AIDS RESPONSE

Brazil's first local AIDS programme was launched in São Paulo in 1984. Since then, several actions have been taken in response to the epidemic, leading to a reduction in new cases of AIDS as well as in AIDS-related mortality. These successes are the result of the combined efforts of the national, state and local governments in strong partnership with civil society organizations, particularly from within the gay community.

### WHY THIS CITY IS MAKING A DIFFERENCE

São Paulo boasts one of the first clinics for transgender people in Brazil, providing holistic and stigma-free health care. The clinic supports the use of hormones and offers psychosocial and legal help, and referrals for surgical procedures funded by the public health system. The clinic has more than 1500 enrolled clients.

Since 2011, São Paulo adopted a strategy to increase HIV testing uptake by gay and transgender persons and men who have sex with men via a mobile unit placed at cruising sites in the city centre. The Quero Fazer programme (I want to do it), conducted in partnership with a local nongovernmental organization, tested more than 4500 people. Among them, 233 new HIV cases were diagnosed, with almost half of those the result of first-time testing.

Recently, the AIDS programme started providing free condoms. By the end of 2014, it expects to place condoms at every bus stop. In the first three days after the pilot was launched, 15 000 condoms were taken by people passing by.



### MAYOR OF SÃO PAULO

“We have expanded free access to condoms and trained over a thousand health workers to use HIV rapid diagnostic tests. We offer free antiretroviral treatment to all people living with HIV and have established strong partnerships with civil society to increase services for key populations. But to advance the AIDS response we must also reduce access barriers—stigma and discrimination have created major obstacles to health services. Pioneers in Brazil, we created the “Open Arms” Programme—a human rights-centred programme that provides jobs, opportunities, housing and health care, including HIV prevention and treatment, to people who use crack-cocaine and live on the streets of the city.”

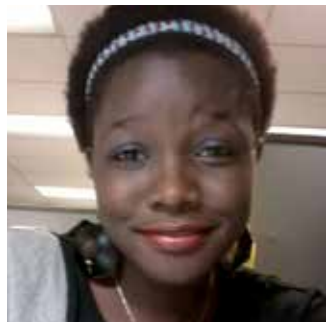
*Fernando Haddad,  
Mayor of São Paulo*

### DID YOU KNOW?

With almost 12 million inhabitants, São Paulo is the largest city in the Americas and the world's 12th most populous city. As such, it shares common problems with other cities in Brazil and elsewhere, including widespread use of crack cocaine. São Paulo is dealing with the problem using a revolutionary strategy for the country. The harm reduction programme De Braços Abertos (Open Arms) offers job opportunities within the municipality to regular drug users. Together with the prospect of work, there is a package of benefits, including support for housing and food, and help to access health care.



# YOUNG LEADERS TO WATCH



## 01

**Lorraine Anyango**  
United States

*Public Policy Fellow at AIDS  
United in Washington DC,  
North American Youth  
Representative to the UNAIDS  
Youth Advisory Forum*

Over the last six years, I have worked on a number of domestic and global programmes that are improving the lives of, and opportunities for, young people around the world. Through a number of roles, I have directly supported and advocated for young people living with HIV, to ensure their needs are met and that their voices are included in decision-making processes. As a Peer Mentor at Next Step, I helped design and deliver HIV education and sexual and reproductive health programmes for youth in five counties across Massachusetts. I advocate for young people living with HIV as a representative of the Massachusetts Integrated Prevention Planning Committee, the Statewide Advisory Board for the Massachusetts Department

of Public Health's Office of HIV/AIDS, and on Next Step's Youth Task Force.

I recently held community dialogues as part of the ACT! 2015 initiative to advance SRHR and HIV in the post-2015 agenda. Now I am working with various grassroots, national and international organizations to promote ACT! 2015 at the country level.



## 02

**Fatima Zahra Benyahia**  
Algeria

*Executive Director, AIDS  
Algérie NGO*

I joined the fight against AIDS six years ago with the hope of helping develop a national and regional youth movement that aims to break the social and cultural barriers and taboos that surround HIV—particularly in the Middle East and North Africa. Since then, this has been my ambition, awake and asleep.

I belong to a movement of young women who defeat drivers of vulnerability daily, and

seek to create opportunities of empowerment in all fields. Upholding our human rights means ensuring that young girls must not face stigma, discrimination, violence or submission. We must also be able to exercise our sexual and reproductive health rights, including accessing HIV services.

In Algeria, we are building a spirit of solidarity and leadership with youth and civil society to ensure we are part of every single policy and strategy on HIV and sexual and reproductive health. We defend our needs under the post-2015 agenda through a process of dialogue with government and stakeholders



## 03

**Sara Vida Coumans**  
Netherlands

*Advocacy Officer at dance4life*

While sexuality is something to be celebrated, young people's sexuality is often approached with fear. The idea that young people have sexual and reproductive rights is (still) not something that is internationally acknowledged.

“Today, I advocate for integrated HIV and sexual and reproductive health services that meet the needs of young key populations in my community.”

This sparked my motivation to join the [youth] movement when I was 16-years-old. I began in my community, but continued at the international level where I advocate for the rights of young people. While doing this work, I always keep in mind that policies should reflect the diversity of young people.

At dance4life we provide peer-led comprehensive sexuality education in 20 countries, and aim to build the leadership and advocacy skills of young people, so that they can make a difference at the local, regional, national and international levels.

Over the years, I have noticed a gap between what policy-makers say in international negotiations and the realities young people face in their countries. At dance4life we want to bridge this gap, by supporting young people’s meaningful participation in policy-making processes to ensure that policies better reflect their needs and realities.



04

**Musah Lumumba**  
Busia, a border town shared between Uganda and Kenya  
*Lead on HIV treatment at Y+*

When I was 16, I was forced to undergo an HIV test because my brother had died of an AIDS-related illness. I tested positive. My once rising popularity suddenly declined due to the widespread HIV-related stigma and discrimination within my school environment.

To cope up with the situation, I founded a straight talk club in 2004. As “prezo” or president I was able to regain the respect of my peers and become a leader once again. I was a peer mobilizer and educator facing the realities of growing up with HIV.

Witnessing the HIV epidemic first hand, and the inability of so many of my peers to access HIV treatment and services, inspired me to study clinical medicine after high school. Today, I advocate for integrated HIV and sexual and reproductive health services that meet the needs of young key populations

in my community. I am a strong opponent to the HIV Prevention and Control Act, which criminalizes HIV transmission in Uganda, and recently led the organization of the first Youth Pre-Conference, which was held before the National Paediatric AIDS Conferences in Uganda.



05

**Jaime Luna**  
Panama  
*Member of Genesis+ Panama, the HIV-Positive Youth Network of Panama (Y+Pty)*

For five years I have lived with HIV and for more than three years I have been working to support people living with HIV, especially young people and key populations. I am part of a new generation, developing brand new ideas and prioritizing prevention, strengthening the global HIV response and representing the best of Latin American positive youth.

We are training new leaders to use evidence, inform government officials and participate in decision-making to create

policies in each of our countries that benefit and improve the HIV response across Latin America.

Right now we are focused on negotiating with our government on implementing policies to protect and promote the sexual and reproductive health and rights of women, youth and the lesbian, gay, bisexual, transgender and intersexed (LGBTI) population. With the right policies and programmes, we hope to empower people to lead healthy sexual lives.



06

**Lebohang Masango**  
Johannesburg  
*ZAZI ambassador, City of Johannesburg*

Ambassador for Zazi (“Know your strength”), a campaign aimed at young women and girls in South Africa.

I came to Zazi from an understanding of feminist politics—that young women aren’t safe in our country, with an epidemic of gender-based violence, and that we need to empower ourselves in whatever way we can. Zazi has helped me

# YOUNG LEADERS TO WATCH

to understand that, as young women, in intimate relationships we need to assert ourselves, put our health first and not allow anyone else to determine our health status.

Young people in Johannesburg need ‘cool’ role models to normalize the use of condoms and communicate messages about HIV that speak to them as young people. I travel to university campuses with Zonke, a female musician and a female house DJ, DJ Zinhle, who are also Zazi ambassadors. There we give young people messages on HIV and family planning through entertainment. The message that I want to leave young women with is, “Your life is yours.”

## 07

**Peter Mladenov**  
Bulgaria  
*International Coordinator of Y-PEER*



I have been lucky to have access to comprehensive sex education since I was 14-years-old. This has helped me to become the leader I am today but furthermore it showed me how important it is for a young person to be able to make informed decisions about his/her sexuality. I have had the opportunity to work with so many young passionate activists, and they share one goal: to gain the skills and knowledge necessary to have a dignified, self-determined, healthy and meaningful life.

One of my biggest priorities is to gain better access for young people in terms of decision-making and the design of sexual and reproductive health and rights (SRHR) policies and programmes. I am proud that as a result of the joint efforts of different organizations, Bulgaria is on the way to have a law that supports universal access to comprehensive sex education for all young people.

Half of the world’s population is under the age of 25. Young people must be able to fully participate in the design of the next [Sustainable Development Goals] agenda. I am often guided by what a fellow youth activist once told me, “We should not forget the future is in our hands and we are the ones who have the power to design the way we want it to be!”



## 08

**Jaevion Nelson**  
Jamaica  
*Programme and Advocacy Manager, J-FLAG*

In 2007, I began volunteering with the Jamaica Youth Advocacy Network (JYAN). It was an excellent opportunity for me to not only advocate for the sexual and reproductive health rights (SRHR) of young people, especially those who are most vulnerable, but to understand, appreciate and accept my own sexuality.

I later headed JYAN’s SRHR and HIV portfolio where I designed and implemented a sex education project for schools where the Health Family Life and Education Curriculum was not being implemented, and an online youth resource project for LGBT.

Since 2010, I have been working at J-FLAG—the foremost organization in Jamaica advocating for the rights of LGBT people. With J-FLAG I designed the “Fight the Hate” project which

**“We can all be agents of change to ensure young women with HIV live with dignity, free from stigma and discrimination.”**

successfully launched a bold video campaign as well as a 10-module sensitization training programme for public health workers in collaboration with Jamaica’s Ministry of Health and National Family Planning Board. Together we seek to ensure access to quality healthcare, free from stigma and discrimination, for all Jamaicans.



09

**Ayu Oktariani**  
Indonesia

*Public campaigner, Indonesia AIDS Coalition and Youth LEAD Focal Point for young women living with HIV*

I am a 27-year-old mother living with HIV from Jakarta, Indonesia. I work for the Indonesia AIDS Coalition (IAC), a national NGO. IAC focuses on advocacy issues and promotes transparency, accountability and civil participation in the national AIDS response. Given that 75 million people in the country use the Internet on a daily basis, I have embraced the opportunity to be a public and online campaigner for the IAC, in hopes of reaching both key populations and the

general public with messages on living positively with HIV.

My personal experience and struggles can be an inspiration to other young women living with HIV in Indonesia. We can all be agents of change to ensure young women with HIV live with dignity, free from stigma and discrimination.

10

**Serge Douomong Yotta**  
Cameroon

*Executive Director of Affirmative Action Cameroon, Member of the UNAIDS Youth Advisory Forum*



I have dedicated more than five years to working on human rights, including lesbian, gay, bisexual and transgender (LGBT) and youth issues in the AIDS response. I am committed to supporting the Global Fund’s implementation of rights-based programmes throughout the world. With the help of several partners, I recently organized a series of national consultations with key populations, including

LGBT, sex workers, people who inject drugs, young people, people living with disabilities and people living with HIV to identify their priorities and ensure that they are addressed through the Global Fund’s New Funding Model.

My team is currently working on an exciting project called "Light on Live" which aims to provide temporary shelter for young LGBT who face rejection or have recently been imprisoned because of their sexual orientation. We hope to offer young people a safe space as well as impress upon the government the need to open a national debate on homosexuality in Cameroon and demonstrate the harmful impact of homophobic laws on the sexual health of young people.

# ART POSTERS

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**Words and images in posters can change the way people think about HIV, challenge attitudes towards people living with and affected by HIV and mobilize the world to action.**

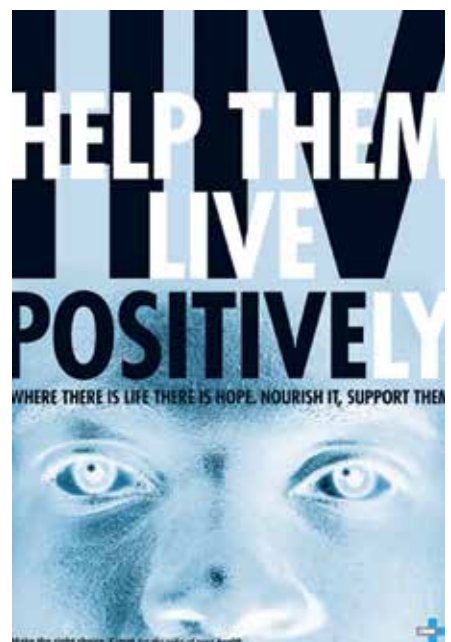
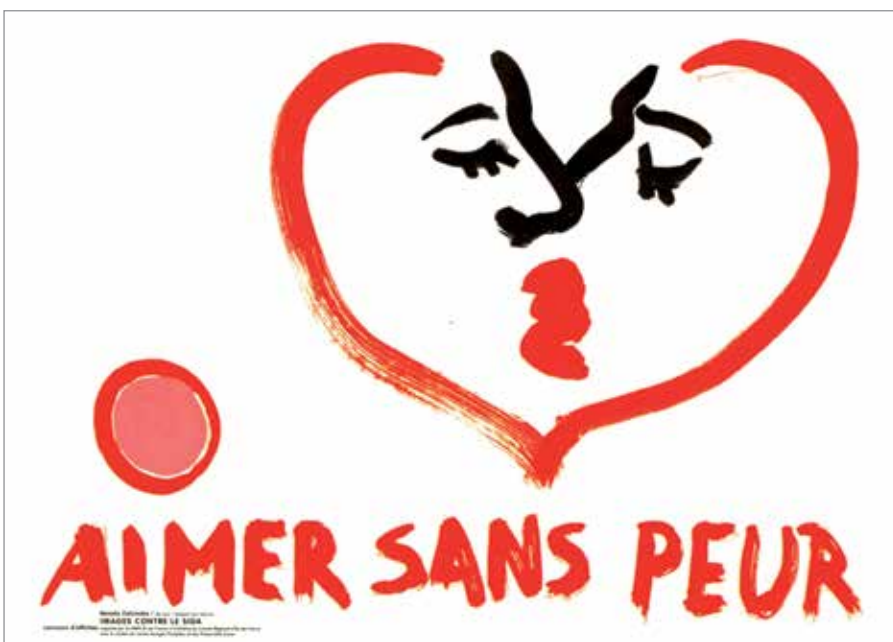
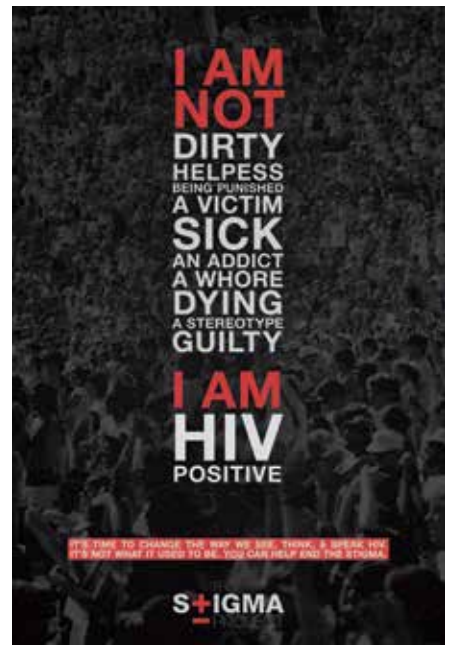
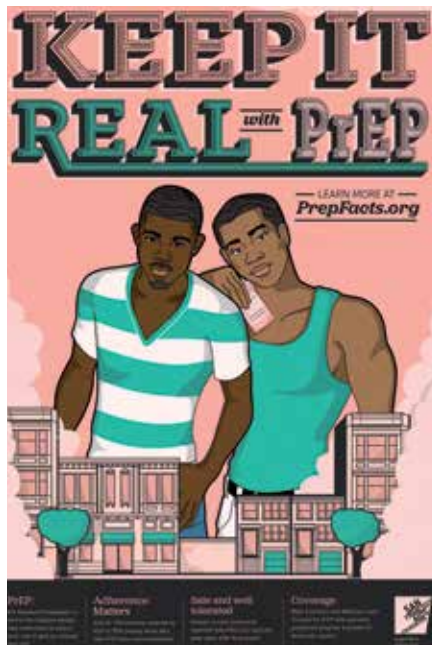
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**B**ig, small, provocative or simple—HIV advocacy posters continue to play a critical role in the response to HIV. Posters inform and reach people in a way that traditional messages cannot. Renowned artists such as Keith Haring used poster and street art to make their messages known.

New generations are learning about HIV and messages are still needed to explain how HIV is transmitted, prevention options, how to stop stigma and how to manage HIV treatment. More complex messages are also needed to challenge misperceptions and myths about HIV. Posters can help translate complex messages and speak on sensitive issues on sex and sexuality, drug use, illness, family relationships and economic disparities.

While posters today are more likely to show up on a virtual wall than on a street corner—the goal is the same: to grab attention, provide information and inspire action.





# action-packed cities

**AROUND THE WORLD**

*cities are working to end the AIDS  
epidemic in creative and innovative ways*



## Buenos Aires, Argentina

### Buenos Aires building a more inclusive society by embracing sexual diversity

#### Introducing Buenos Aires

*Argentina is among the most legally progressive countries in the world in terms of protecting and promoting equality and the human rights of lesbian, gay, bisexual and transgender (LGBT) populations. In its capital, Buenos Aires, law prohibits discrimination on the basis of sexual orientation.*

#### The city in action

While the legal framework in Buenos Aires provides an enabling environment—stigma, prejudice and discrimination against LGBT populations persist. In hopes of creating a more inclusive urban society, the City of Buenos Aires has undertaken a range of actions to move from legal equality for the LGBT population towards the realization of equality in everyday life. These progressive steps are closely aligned with the Plan for LGBT Citizens, a set of recommended public policies for *LGBT citizenship* developed by the Argentine Federation of Lesbians, Gays, Bisexuals and Transgender.

With the objective of eliminating stigma and discrimination experienced by LGBT populations and enabling equal access to opportunity and resources, the city has implemented a host of programmes, services

and policy changes across a number of sectors. Such actions include:

- Extension of same-sex marriage rights and benefits to foreigners, the registration of children born by surrogate mothers to same-sex parents and the legal recognition of the identity of transgender children.
- Activities led by the Sub-Secretariat of Human Rights and civil society organizations that promote a culture of diversity and non-discrimination, including Buenos Aires Diversity Days.
- Legislative reform to eliminate discrimination in the context of blood donations and to accept donations from LGBT individuals.
- The creation of legal and psychological support services, provided by the Minister of Social Development of the City.
- Offering LGBT-specific HIV counselling and testing services.
- Ensuring integration of transgender men and women into the city's public workforce.
- Supporting various cultural activities, such as the musical *Diversa Sinfonia*.

#### Impact

These actions, among others, have helped “normalize” sexual diversity in the hearts and minds of porteños (inhabitants of Buenos Aires) and have helped reduce discrimination towards LGBT people in everyday life.

#### Looking forward

City leaders recognize the need to continue to strive for change across many sectors of society in order to achieve real equality for LGBT populations in all areas of life including health, education, work, social services and political participation. The main challenges ahead are to achieve a more inclusive and non-stereotypical representation of lesbians, gays, bisexual and transgender people in the media and to increase acceptance of sexual diversity in the family environment and in schools.



## Chengdu, China

### Chengdu mobilizing community resources to reach men who have sex with men

#### Introducing Chengdu

*Home to more than 14 million people, the city of Chengdu is the economic, cultural and educational centre of southwestern China. While HIV prevalence is low among the general population, the growing epidemic among men who have sex with men has garnered increased political attention and resources. In the city of Chengdu, more than 10% of the population of men who have sex with men is living with HIV.*

#### The city in action

Chengdu was one of the cities participating in a multi-city initiative, which laid the groundwork for the founding of the Urban Health and Justice Initiative. The six cities include Bangkok, Thailand; Chengdu, China; Ho Chi Minh City, Viet Nam; Yangon, Myanmar; Manila, Philippines; and Jakarta, Indonesia.

Following a meeting that brought these six cities together, in 2011 the government of Chengdu developed a city AIDS strategy aimed at dramatically reducing new HIV infections and AIDS-related deaths among men who have sex with men.

The strategy seeks to usher in sustained political

leadership, mobilize city-specific resources, and focus on where the epidemic is localized.

“By working to build a strong, multi-sectoral response in Chengdu, with meaningful community participation, we can scale up coverage of prevention, treatment and care services among MSM and halt the spread of HIV in our city,” said Mr Yang Xiaoguang, Director of Chengdu Health Bureau. To effectively reach this traditionally stigmatized population, the strategy has embraced a novel partnership between the local government, health service providers and community-based organizations which has enabled various innovations, such as:

- The roll-out of venue-based programmes such as at bars and bathhouses.
- The use of online social networking tools to build awareness and reach people at risk.
- Ensuring community-based services are available when people do test positive and take medication, including psychosocial and adherence support. The strategy has also taken the progressive step of providing treatment to people as soon as they test positive, regardless of CD4 count.

#### Impact

Data shows that in just one year, between 2009 and 2010, consistent condom use increased from 8 to 40%. Access to HIV treatment among men who have sex

with men increased to 57% in 2010—an increase of 15% over the previous year, while a remarkable 89% of all people who tested positive began antiretroviral therapy. The recent implementation of couples counselling and testing for male couples has also served to create a safe environment for results disclosure, facilitate cooperation for behavioral risk reduction, and encourage planning for treatment and care.

#### Looking forward

The city of Chengdu continues to adapt its response in the face of ongoing and emerging challenges to ensure that interventions remain effective and relevant to the various populations they seek to address. The heavy burden of the epidemic on young people is of particular concern—six out of ten people living with HIV are under 30-years-old. Accelerating the roll out of the city’s strategic plan will require implementing youth-friendly and youth-relevant interventions, as well as enhancing the financial, technical and human resource capacity of civil society and grassroots organizations that are central to the response.



## Harare, Zimbabwe

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### Harare decentralizing new diagnostics for tuberculosis

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#### Introducing Harare

*One of the biggest challenges in responding to tuberculosis is early detection. Many people with tuberculosis are either not detected or detected too late, leading to increased mortality and continued transmission of the disease to others. In Zimbabwe, only four out of every ten people who get sick with tuberculosis are diagnosed and started on treatment. An estimated 70% of tuberculosis patients also have HIV, requiring an integrated response.*

*The capital, Harare, holds only 10% of the country's population, yet 20% of all tuberculosis patients in Zimbabwe are diagnosed and treated in the city.*

#### The city in action

The City of Harare Health Department wanted to improve tuberculosis detection and treatment by decentralizing tuberculosis testing and care services. All testing for tuberculosis was previously done in one centralized laboratory and treatment was initiated at just two hospitals. With support from Tuberculosis REACH, which provides grant funding for innovative projects to improve tuberculosis detection and treatment, the initiative was able to establish numerous microscopy laboratories. The city was also able to introduce a

new molecular tuberculosis diagnostic test that reduces the time it takes to diagnose tuberculosis cases from weeks down to hours. “The project afforded tuberculosis patients convenience, patients didn’t need to wait for two weeks to be started on treatment,” said Dr Clemence Duri, Director of Harare City Tuberculosis Programme. “Instead people were getting results within 24 hours.”

The programme greatly improved access, accuracy and time to treatment for people with tuberculosis through eight different laboratories around the city. Together, these clinics saw thousands of outpatients a day.

#### Impact

Time to treatment initiation was reduced from two to three weeks to 24 hours, thereby cutting transmission in the community. After implementing the new molecular test, there was a 40% increase in the number of people with confirmed tuberculosis. These people would have been missed in prior years and many would have died while waiting for a diagnosis. The benefit of the intervention was even more acutely felt among people living with HIV, as the new molecular test can double the number of tuberculosis/HIV co-infected people identified, compared to conventional methods.

#### Looking forward

Harare City continues to improve the facilities used to diagnose tuberculosis, especially among people with HIV, and is engaging new donors such as the Global Fund to support the highly successful project. The model that Harare has provided is now being considered in other cities in Zimbabwe to improve decentralization and access to tuberculosis and HIV services.



## Kigali, Rwanda

### Kigali focusing efforts on key populations in a single city-wide strategy

#### Introducing Kigali

*Kigali has long been the economic, cultural and transport hub of Rwanda. It is also home to one-third of the country's people living with HIV. City officials consider the response to HIV among the top priorities. The prevalence of HIV in the City of Kigali is 7.3%, more than three times the average in rural areas (2.3%). The epidemic burden among key populations is particularly high—recent evidence indicates HIV prevalence is as high as 56% among the city's sex workers.*

#### The city in action

A 2010/2011 review of the city's HIV response found that while there was considerable political commitment and leadership in coordinating the HIV response across the various districts of the city, there was an urgent need for stronger coordination of efforts. The review called for a single, common plan that clearly outlined the short and medium-term goals of the city's response. Kigali city officials took action and launched the Strategic Plan for HIV and AIDS Response in the City of Kigali, 2013-2016.

“As leaders it is important that we learn from evidence. We need to know the nature of the epidemic that we face and therefore work on translating evidence into

actions,” said Ndayisaba Fidèle, the mayor of Kigali. “We are all concerned by the epidemic and are all invited to take actions to prevent new HIV infections, reduce AIDS-related deaths and address stigma and discrimination.”

The HIV plan is focused on both the populations and geographic locations most affected by the epidemic with multisectoral solutions. The city also looked at how issues affect access to services such as: urban poverty, informal settlements, work in the informal sector, mobility and migration, and norms and institutionalized practices that reinforce discrimination on the basis of gender, class, age and ethnicity.

#### Impact

The city is at the forefront of the national response to HIV, and has achieved universal access to HIV treatment with more than 80% of people living with HIV accessing antiretroviral therapy in mid-2014. Under the city's new Strategic Plan for HIV, city officials, community-based organizations (CBOs) and their partners in the response have demonstrated even greater commitment to ensuring evidence guides the development of results-oriented programmes.

To reach those key populations that continue to be left behind, the city of Kigali is ramping up investments and partnerships with CBOs. In order to strengthen civil society capacity to implement programmes to reach female

sex workers, for instance, the city sponsored the engagement of several CBOs in regional events such as the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) 2013 in South Africa and the global meeting of municipalities held in Rabat, Morocco during the United Cities and Local Governments Forum of 2013.

#### Looking forward

Kigali recognizes that the capacity of CBOs to meaningfully and effectively participate in the governance of the response is greatly limited—particularly among those organizations that represent key populations. Inadequate financial and human resources keep these organizations from being able to make direct contribution to the city's HIV response. This limitation is considered a major challenge to developing a stronger and more inclusive response — and one that city leaders are committed to overcoming.



## Rabat, Morocco

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### Rabat mobilizing for migrants' access to health services and HIV programmes

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#### Introducing Rabat

*Located on the Atlantic Ocean at the mouth of the river Bouregreg, Rabat is both the capital of Morocco and of the Rabat-Salé-Zemmour-Zaer Region. With a population of approximately one million, it forms the second largest city in the country after Casablanca. Due to Morocco's central geographic position, the country has become a popular transit location, while its economic and social stability has also encouraged a growing number of migrants.*

#### The city in action

Over the past several years, a number of non-governmental organizations (NGOs) have begun to implement programmes to promote HIV prevention among migrants and to increase access to health services and to promote human rights.

Following the guidance of His Majesty the King Mohammed VI, in September 2013, Morocco started implementation of a new immigration policy, including the promotion of migrants' access to social benefits including health services and equal rights that are afforded to Moroccan nationals.

“Morocco has become a sustainable homeland for migrants, economic and cultural enrichment sources

but also of preoccupations and new challenges, particularly to guarantee their access to treatment and care,” said El Houssaine Louardi, Minister of Health of Morocco.

In this context, the Ministry of Health with support from UNAIDS launched a community health programme focused on improving migrants' access to care. A study shed light on living conditions and specific health challenges. A mapping of HIV programmes was also undertaken. The data provided strategic information to inform the development of an integrated action plan focused on strengthening HIV prevention activities and care for migrants.

#### Impact

With the support of the Ministry of Health, the ability of NGOs to provide relevant, accessible health services to migrants in Rabat has markedly improved. A full package of services is now available to migrants. Moreover, migrants in irregular administrative situations benefit from free services covered by national health programmes. In 2013, 10 500 migrants benefited from outreach HIV prevention programmes. Antiretroviral treatment and care for migrants living with HIV are provided by the Ibn Sina Hospital.

#### Looking forward

As part of the new integrated national strategy on immigration developed by the government, the city of Rabat will continue to

adapt its response to current and emerging challenges to ensure that interventions remain effective and relevant to migrants. Proponents are hopeful that the regularisation of the administrative situation of many migrants will continue to ease and encourage access to HIV services in Rabat.



## Vancouver, Canada

### Vancouver prioritizing public health over punishment

#### Introducing Vancouver

*The Canadian city of Vancouver is often voted among the world's best places to live. However, deep in the city's downtown area, one neighbourhood struggled for decades with the influx of illegal drugs—which had effectively made the area an epicentre for heroin use. Estimates of HIV prevalence among people who inject drugs in Vancouver range from 17-30%.*

#### The city in action

Determined to curb its concentrated but growing HIV epidemic, and in response to community demands, city officials in Vancouver opted for health-focused policies over the federal law enforcement approach. Major pressure derived from the scientific and medical community in Vancouver, with significant support mobilized by leading international HIV specialist Dr Julio Montaner of the British Columbia Centre for Excellence in HIV/AIDS. In 2003, Vancouver's health authority successfully applied to the federal government for a legal operating exemption to pilot North America's first medically supervised injection facility (SIF), called 'Insite'. Legal exemption was granted on the condition that the programme be subjected to rigorous scientific evaluation. Today, Insite provides a safe, health-focused centre where

people can safely inject drugs and connect to health care services—from primary care to treat disease and infection, to addiction counselling and treatment and housing and community support.

#### Impact

To date, more than 30 peer-reviewed studies have been published describing the programme's impacts. These publications indicate that Insite provides a range of benefits to its clients and the greater community. A recently released report summarizing 15 years of data on the drug situation in Vancouver provides clear evidence that harm reduction programmes have helped reduce illicit drug use and improve public health. Fewer people are injecting drugs; more are accessing addiction treatment and HIV and hepatitis C transmission related to injecting drug use has plummeted. In 1996, almost 40% of drug users in Vancouver reported sharing needles; by 2011, needle sharing had dropped to 1.7% while the proportion of people who injecting drugs accessing methadone treatment rose from 12% in 1996 to 54.5% in 2008.

A large and growing body of scientific evidence demonstrates that harm reduction programmes, such as needle exchanges, are effective in reducing the harm associated with illicit drug use. One cost-benefit analysis published in the *International Journal of Drug Policy* in 2010 determined that the site prevents 35 cases of HIV and about 3 deaths per year, indicating a yearly

net-societal benefit of more than CAD \$6 million.

#### Looking forward

Despite supportive scientific evidence and strong local support, Insite continues to face intense scrutiny and controversy. In 2010, the site faced closure by the federal government although Canada's Supreme Court ruled in 2011 that it remain open. In their ruling, the Supreme Court noted "the experiment has proven successful. While Insite remains open, resistance from the federal government has limited the expansion of the pilot project. Proponents in cities such as Toronto and Ottawa remain hopeful, however, that policy change will one day enable the establishment of more safe injection sites as a powerful component of a strong city HIV prevention strategy.





## Cities in Western Europe

### Five cities across Western Europe reducing open drug scenes

#### The issue

*“Open drug scenes” are gatherings of people who consume and deal illegal drugs publicly. Five cities across Western Europe—Amsterdam, Frankfurt, Lisbon, Vienna and Zurich—have explored a variety of measures to reduce open drug scenes in a constructive and sustainable way. These cities have demonstrated that combining prevention, harm reduction and treatment services with law enforcement and ensuring close collaboration between police, health care and social services can bring about real change.*

#### Cities in action

In the past, city officials in Amsterdam, Frankfurt, Lisbon, Vienna and Zurich had confronted growing public drug scenes with an oftentimes conflicted approach between liberal and conservative policies. In Zurich, for example, political controversies and shifting decisions obstructed effective action for several years despite a growing epidemic of public injecting drug use.

A recent study reviewing the experience of these five cities found that only when the cities developed a comprehensive policy that integrated treatment and helping measures with control measures were they able to successfully alleviate

their situation. City officials were able to overcome controversies between prohibitionist and harm reduction ideologies in favour of a balance between providing opioid maintenance treatment combined with outreach social work and effective policing.

A common feature across all five cities is that harm reduction has been adopted as a central strategy. There were differences in how this strategy was implemented but the common features were a free-of-charge, low threshold public health service, often at city service level. Critically, experiences in low-threshold methadone, needle exchange and heroin-assisted therapy have yielded evidence of both crime reduction and significant HIV prevention.

All five cities have also developed specific strategies to contact and attract “hard to reach” users, through outreach services in cooperation with police officers. A shared element has been the provision of easily available contact and crisis centres that offer a range of social services, often incorporating needle dispensing, and in some cities, user rooms.

#### Impact

In the last several years, across all five cities, there have been no noticeable open drug scenes. The combination of a harm reduction strategy and systematic prevention of public nuisance appears to have been effective in

keeping public drug use to tolerable levels.

#### Looking forward

The lessons learned through the experience of these five cities resonate across a range of contested and controversial urban challenges. For years, ongoing political and ideological conflicts prevented these cities from being able to pursue effective measures until political compromise could be wrought. The cities are actively pursuing sustainable solutions, recognizing that there will be no “quick fixes” to the issue of public drug gatherings.

# the last word

**Teresia Njoki Otieno**

*Eastern Africa Representative, International Steering Committee of The International Community of Women Living with HIV (ICW)*

## How has the AIDS response in your city changed your life?

Access to information, treatment and care has really improved and the integration of services is making life easier for me and for other women. As a woman living with HIV, it is important for me to have an opportunity to influence policies and programmes that affect me and others like me. It is also important for me to have services provided to communities. Our world is changing so quickly, with new ways of communicating, new medicines, new expectations of young people. Life is greatly improving for many people, but there are also many people and populations who remain unable to access HIV services and a better life.

## How have you changed the response?

We have succeeded where people came together, bound in their fierce belief of their own value and dignity, and courageously confronted forces in our societies that arise from misunderstanding, stigma, greed and indifference. That is the source of power in the AIDS response—the hearts and souls of people living with and affected by HIV. We have struggled and continue to struggle to overcome stigma and discrimination, rejection by our families, fear in our communities and unjust criminalization by our state. I joined other women to call for a human rights framework in responding to HIV and gender inequalities, and for respect for sexual and reproductive health and rights.

## What is the most important thing we can do for our communities?

Neither social nor legal barriers should keep anyone from embracing their own power to define the outcome of their community—that is everyone's right. Conversely, as members of our communities (local communities, countries and increasingly as global citizens) we must also participate in planning our common future—that is our obligation. We must become change agents, focus-



ing on the young generation as we focus on ending AIDS. We need to empower and support vulnerable populations, and we need to tap into the experience and expertise of women living with HIV.

## What can each of us do for World AIDS Day and every day?

Each of us has an unmatched ability to form meaningful engagement and partnerships with people living with HIV, to understand our own epidemic and to be able to provide the right kind of services on the very city corners where they are needed. We need to be flexible and fast moving with regard to policy change and service delivery, while maintaining a steadfast commitment to the human rights of all people and populations.

## Where did you grow up?

I grew up in Nairobi. I see change for the better every day. And it is up to me, you—all of us—to continue to push for more just policies and laws; for better programmes and services for and with the people who need them most; for social norms that are accommodating; and respect for diversity and women's human rights.

## What is your happiest memory?

Giving birth to healthy children—despite my HIV status.

## Who is your hero?

Women leaders who, living with HIV, have endured stigma, shame and degrading inhuman treatment because of their HIV status. Women who stood by other women to encourage, support, educate, fight for and mentor them for a better tomorrow.

## What motivates you?

I desire an end to the AIDS epidemic; to see all children born free from the virus; to see women empowered in making informed decisions and bridging the gap for the less privileged in society.

## What's next?

What I have learned from the AIDS response is that, as citizens and inhabitants of cities in the 21st century, we all face basic social responsibilities to treat women living with HIV with the respect and dignity they deserve, to uphold community rights and community obligations and most importantly to ensure the next generation does not have to do this all over again.

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**ENDING THE AIDS EPIDEMIC**  
*in cities by 2030*





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