

UNAIDS OUTLOOK REPORT | 2010

OUTLOOK

SPECIAL SECTION:
STATE OF THE
AIDS RESPONSE

THE BENCHMARK
SURVEY

TREATMENT 2.0 }

A Day
with
Friends

THE LAST WORD
with Annie Lennox

AIDS OUT OF ISOLA TION



**NEW DATA SHOW FEWER
WOMEN ARE DYING EACH
YEAR DURING PREGNANCY
AND CHILDBIRTH.**

**UNAIDS SUPPORTS THE
CALL BY UN SECRETARY-
GENERAL BAN KI-MOON
FOR A MATERNAL AND
CHILD HEALTH MOVEMENT
TO SUPPORT MILLENNIUM
DEVELOPMENT GOALS
4 AND 5.**

OUTLOOK

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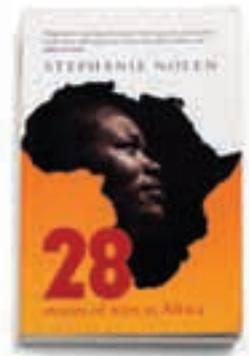
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ON THE WEB

unaids.org

@UNAIDS

Stay up to date on UNAIDS' activities through some of the most popular social media channels: check out Facebook (facebook.com/unaids) and Twitter (twitter.com/unaids) to access news and share with friends, and sign up to AIDSspace.org to connect with the global AIDS community.

State of the AIDS response

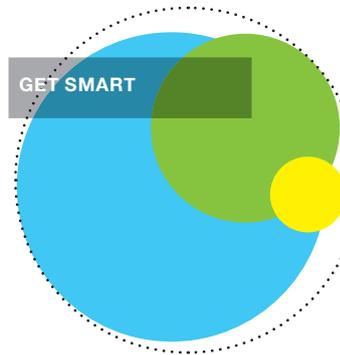
Download a copy of the OUTLOOK special section with the latest thinking on HIV prevention and treatment. Difficult economic times call for smarter, better and more creative solutions to how the world can collectively do more with less.

OUTLOOK report

Download the latest issue of UNAIDS' newest report. Prepared for the 2010 Vienna International AIDS Conference, OUTLOOK is filled with data, powerful testimonies and forward-looking assessments on the global AIDS response.

The benchmark

Get all the details of the new opinion survey, the methodology and how you and your organization can use this information in your advocacy efforts.



InBox



Send your letters to the UNAIDS OUTLOOK report. We want to know your thoughts about the new report and your opinion on the issues covered.

Write to us at:
outlook@unaids.org

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Invisible man

See how renowned artist Daniel Goldstein turned more than 800 syringes into a symphony of innovative design inspired by reflection, absence and hope.

The pitch

Take a closer look at three creative ideas for an international campaign to end HIV-related restrictions on entry, stay and residence. From a roll of red tape to a world that looks much smaller, three agencies hope to inspire you to make a difference today.

A day with friends— the 'making of' video

Take a behind-the-scenes look at the A Day with Friends photo story. Experience the photo shoot in a special 'making of' video in Rio de Janeiro, Brazil.

Art for AIDS

OUTLOOK partnered with MAKE ART/STOP AIDS for much of the art in this report. MAKE ART/STOP AIDS is an international network of scholars, artists and activists committed to ending the global AIDS epidemic. Artists are able to shape transformative insights and possibilities that literally redirect how people think and act.

Get smart

Let the data take you on a visual journey of discovery. OUTLOOK asks how we can better understand the AIDS epidemic and response through patterns, stories and connections. See the full set of Get Smart charts and sources.

GIPA principle: Support a greater involvement of people living with HIV/AIDS through an initiative to strengthen the capacity and coordination of networks of people living with HIV/AIDS and community-based organizations. By ensuring their full involvement in our common response to the pandemic at all national, regional and global levels, this initiative will, in particular, stimulate the creation of supportive political, legal and social environments.

What we are thinking

State of the AIDS response

On the eve of 30 years of the epidemic, UNAIDS is taking stock of where we are and where we are headed in the AIDS epidemic and response. In a special section we highlight the results of a sweeping new survey that finds that AIDS continues to rank high on the list of the most important issues facing the world.

OUTLOOK focuses on the emerging economies of the BRICS countries (Brazil, China, India, the Russian Federation and South Africa) and how they could stop the trajectory of the HIV epidemic. Looking at the economic elasticity of health, we ask if health is a necessity or a luxury.

Treatment 2.0

Can we revolutionize treatment and thereby revolutionize prevention? UNAIDS is exploring what tomorrow's treatment platform needs today. With 10 million people waiting for treatment the search is on for smarter, faster, lower cost and more effective solutions.

HIV and injecting drug use

Injecting drug use is the primary route of transmission of HIV in eastern Europe and central Asia, the only region where HIV prevalence is on the rise. And it's no wonder when a single act of exposure through injecting drug use has a 1% chance of causing HIV infection, compared with a 0.2% chance through unprotected heterosexual sex.

Rights here, right now

At the intersection of human rights and the AIDS epidemic are many issues. Often there are obstacles that can block the response, from travel restrictions to laws and regulations that discriminate against people living with HIV. OUTLOOK makes the case that the world cannot effectively respond to HIV without also addressing human rights.

Art for AIDS

Art has always been a powerful form of communication, and from the Keith Haring Foundation to art collector Jean Pigozzi, UNAIDS has been privileged to work with a number of renowned artists and collectors. OUTLOOK teams up with South African photographer Gideon Mendel to feature a new project: *Through Positive Eyes*. Illustrations from Australian artist Kat Macleod help highlight the issue of travel restrictions. And we work with Professor David Gere's Make Art/Stop AIDS programme to showcase art from Daniel Goldstein, Jiten Thukral and Sumir Tagra.

UNAIDS' new priority area

UNAIDS has added a new priority area focusing on empowering men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy. To highlight the issue, we look at what it means to be a member of the transgender community. And OUTLOOK asks: are you homophobic?

Some key statistics for 2008:

NEW INFECTIONS PER DAY

Children	1200
Young people (15–24)	2500
Adults (25+)	3700

NEW HIV INFECTIONS

Children	430 000
Young people (15–24)	920 000
Adults (25+)	1 340 000

PEOPLE LIVING WITH HIV

Children	2 100 000
Young people (15–24)	5 000 000
Adults (25+)	26 300 000

Get smart.

NEW WAYS OF LOOKING AT DATA

HIV is everywhere, but the intensity of the spread of the virus varies. South Africa's high HIV prevalence, combined with its population size, makes it the country with the most people living with HIV. India, on the other hand, has a much lower HIV prevalence, less than 1%, but with a billion-strong population has the second highest number of HIV-positive people. Swaziland has a population of 1.2 million, but one in four adults are infected with HIV.

ARE WE DOING ENOUGH?

In Australia an injecting drug user has access to about 200 needles and syringes each year. The same person in the Russian Federation, however, would only have access to two a year.

In Africa the majority of infections occur through heterosexual sex, but in 2008 each adult male had access to only four condoms. In Ghana more than 40% of infections occur through sex work, men having sex with men and injecting drug use, but only 0.24% of prevention spending went towards services for these populations.

In Uganda many clinics are waiting for people currently on treatment to die before they can provide treatment to new people. In parts of the Middle East, the blood supply is still not safe, while in the rest of the world there is near universal screening of blood before transfusion. Proportionally, more people are HIV-positive inside prisons than outside.

OUTLOOK takes a visual journey through some of these paradoxes of the HIV epidemic—its different faces, its spread and the response, its successes and failures. And asks again, are we doing enough?



Size of the AIDS epidemic

33.4 MILLION PEOPLE LIVING WITH HIV

2 MILLION
DEATHS
PER YEAR

2.7 MILLION
NEW INFECTIONS
PER YEAR

430 000
children

910 000 young people

ONLY ABOUT 40%
KNOW THEIR HIV STATUS

10 million are waiting for treatment

5 million people are on treatment

ASIA
4.7 MILLION

India 2.4 million

90% of infections are through heterosexual transmission

China
700 000

EASTERN EUROPE
1.5 MILLION

Russian Federation
940 000

MIDDLE EAST AND NORTH AFRICA
380 000

CARIBBEAN
240 000

OCEANIA
74 000

LATIN AMERICA
2 MILLION

Brazil
730 000

190 000 on treatment

NORTH AMERICA, WESTERN AND CENTRAL EUROPE
2.3 MILLION

United States of America
1.2 million

SUB-SAHARAN AFRICA
22.4 MILLION

Mozambique
2.4 million

Nigeria
2.6 million

Uganda
940 000

103 080 children

* Countries with high adult HIV prevalence (adult prevalence %)

Namibia*
200 000
(15.3%)

Lesotho*
270 000
(23.2%)

Swaziland*
190 000
(26.1%)

Botswana*
300 000
(23.9%)

857 455 require treatment

Ethiopia
980 000

South Africa*
5.7 million
(18.1%)

United Republic of Tanzania
1.4 million

Zimbabwe*
1.3 million
(15.3%)

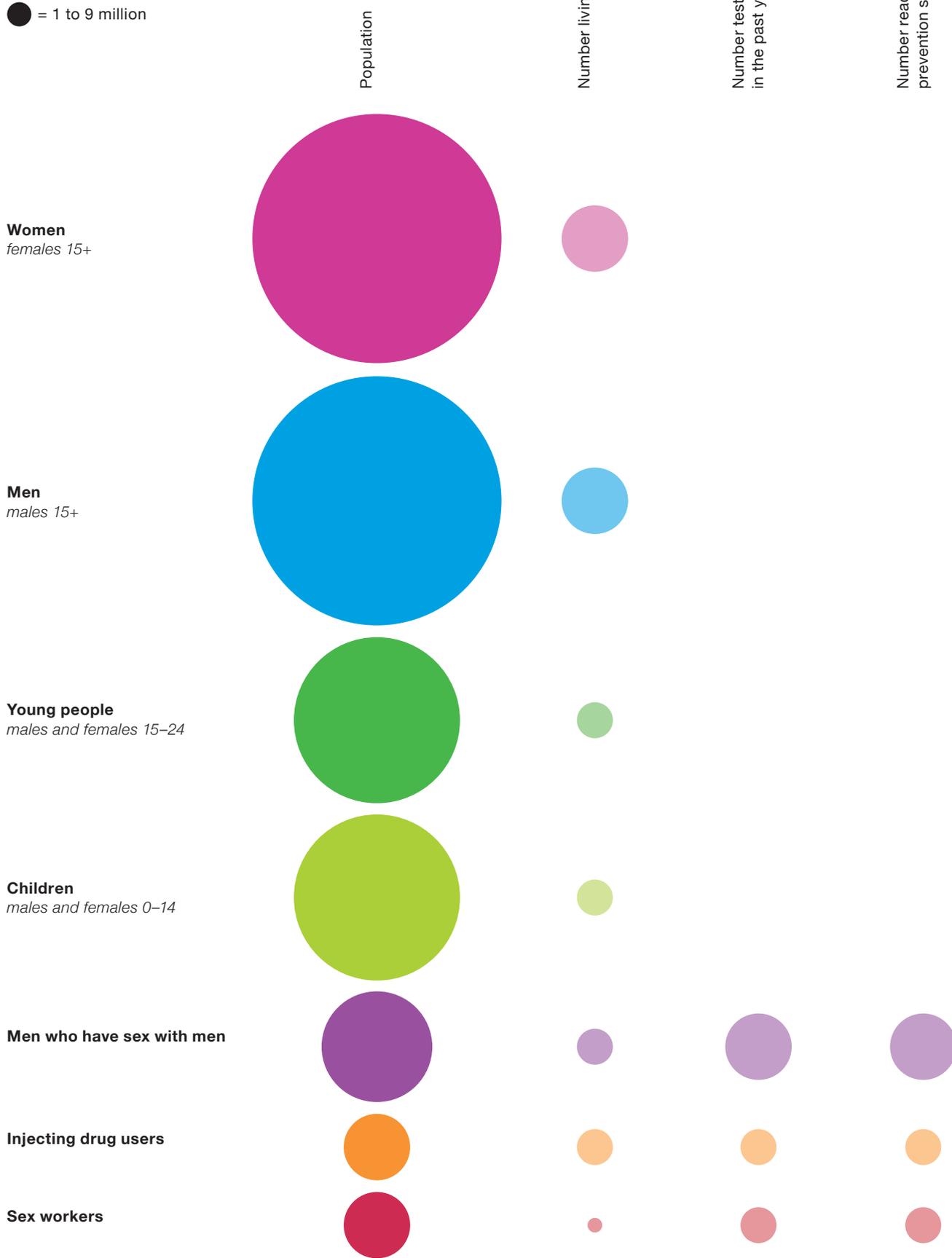
Zambia*
1.3 million
(15.2%)

:: 1500 new infections each day

1 million on treatment

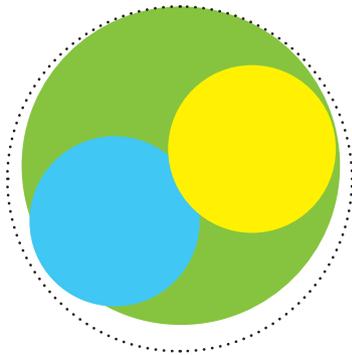
Global populations at risk

● = 1 to 9 million

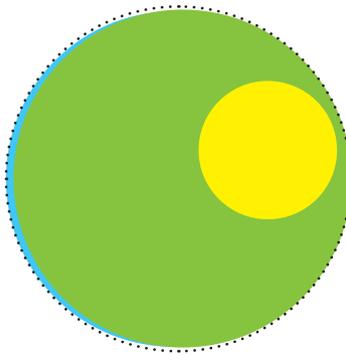


Source: UNGASS 2010 country progress reports, UNAIDS epidemic update 2009, Cacras 2006, Yamdepote 2006, Accijas 2006, Mathers 2008

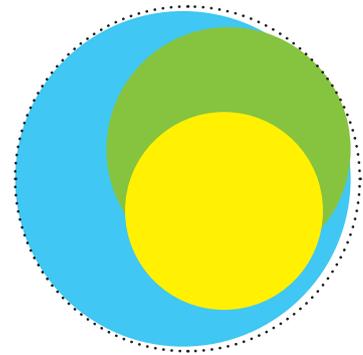
Making sex work safe



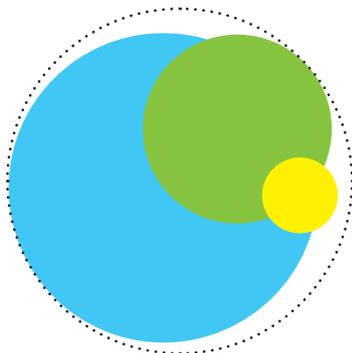
BENIN



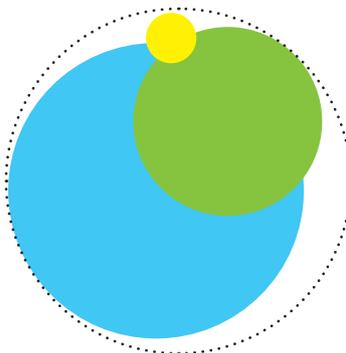
BURKINA FASO



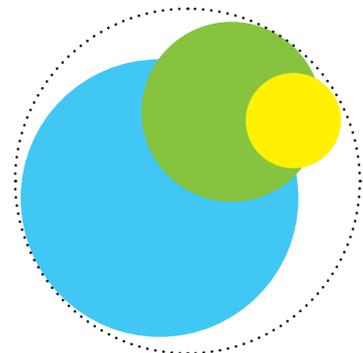
CÔTE D'IVOIRE



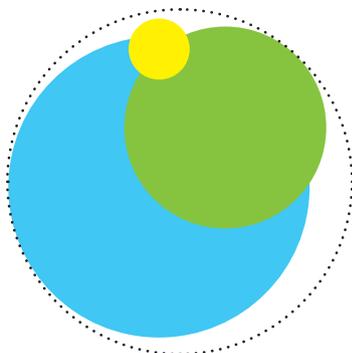
INDIA



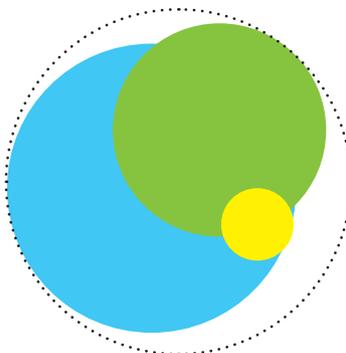
NEPAL



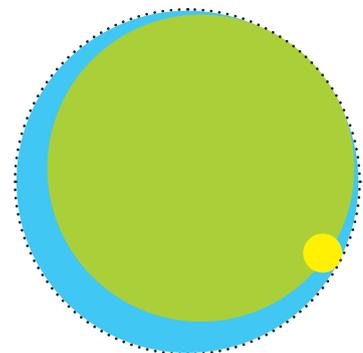
INDONESIA



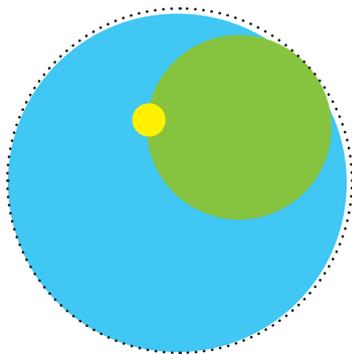
VIET NAM



RUSSIAN FEDERATION



KAZAKHSTAN



ROMANIA



All female sex workers in the country (100%)



Per cent HIV-positive



Per cent who received an HIV test in the last year and who know their results



Per cent who used a condom with their most recent client

Overlap of circles does not indicate an association between the proportion of HIV prevalence and the proportion of HIV testing or condom use, respectively

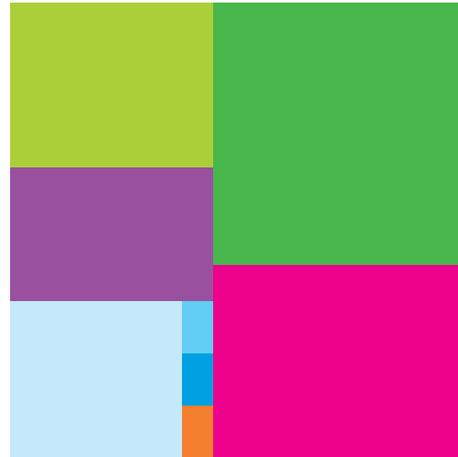
The last 100 HIV infections

Each square below represents the last 100 HIV infections that were contracted in the following countries. Each colour represents a different mode of transmission.

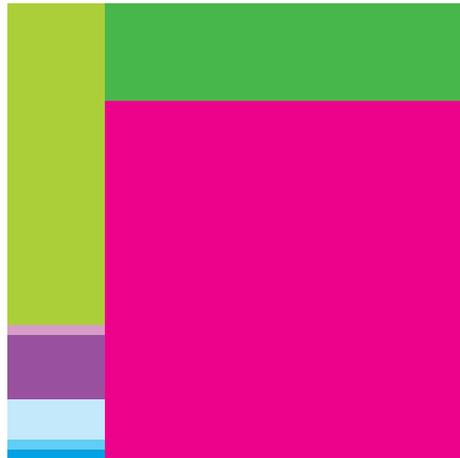
NIGERIA



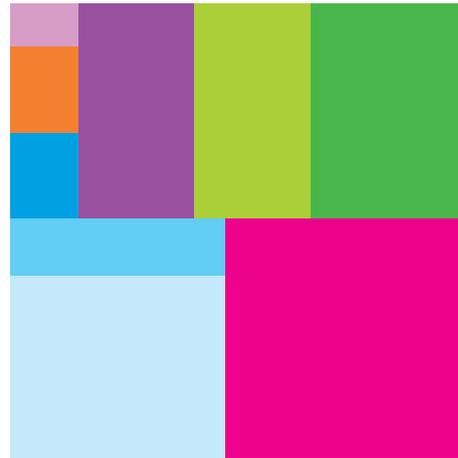
CÔTE D'IVOIRE



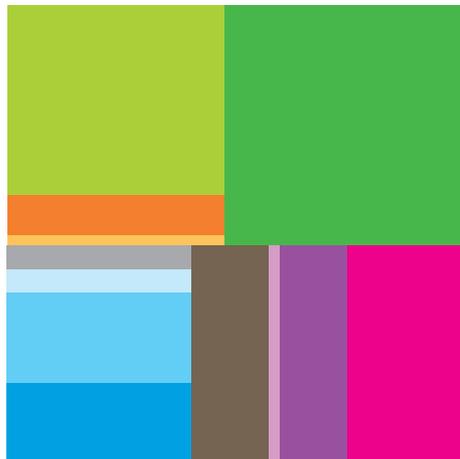
LESOTHO



GHANA



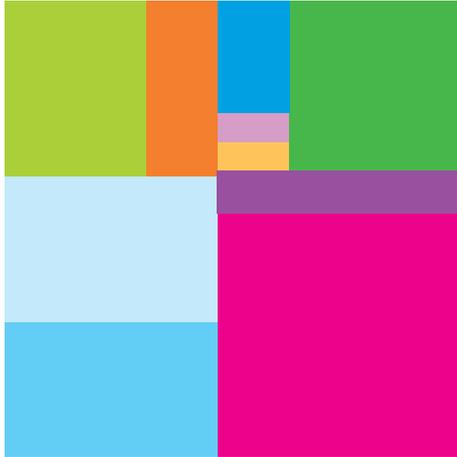
KENYA



ZAMBIA



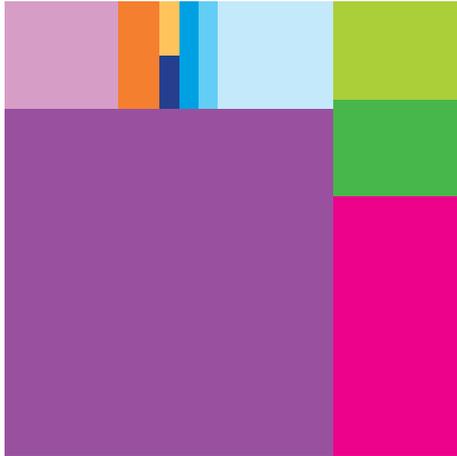
BENIN



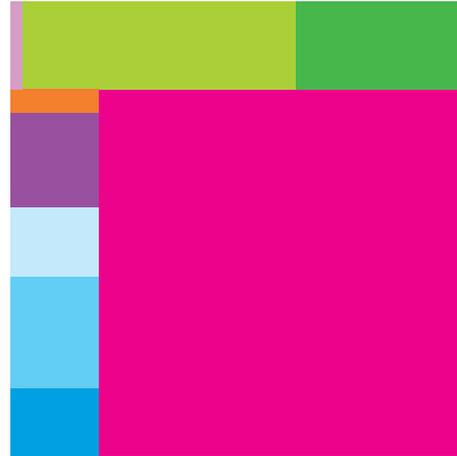
BURKINA FASO



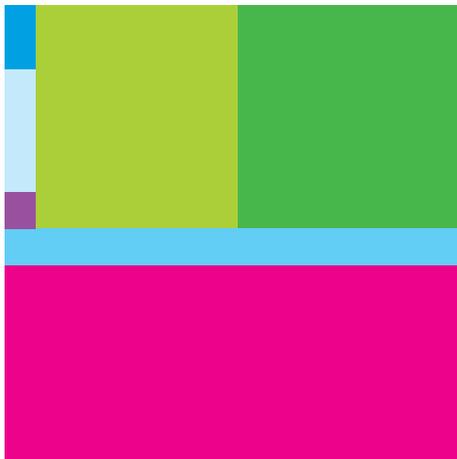
PERU



SWAZILAND



UGANDA



SENEGAL



Sources can be found at unaids.org

- Men who have sex with men
- Injecting drug users
- Prison population (only measured in Kenya)
- Female partners of men who have sex with men
- Partners of injecting drug users
- Other
- Blood transfusions
- Medical injections

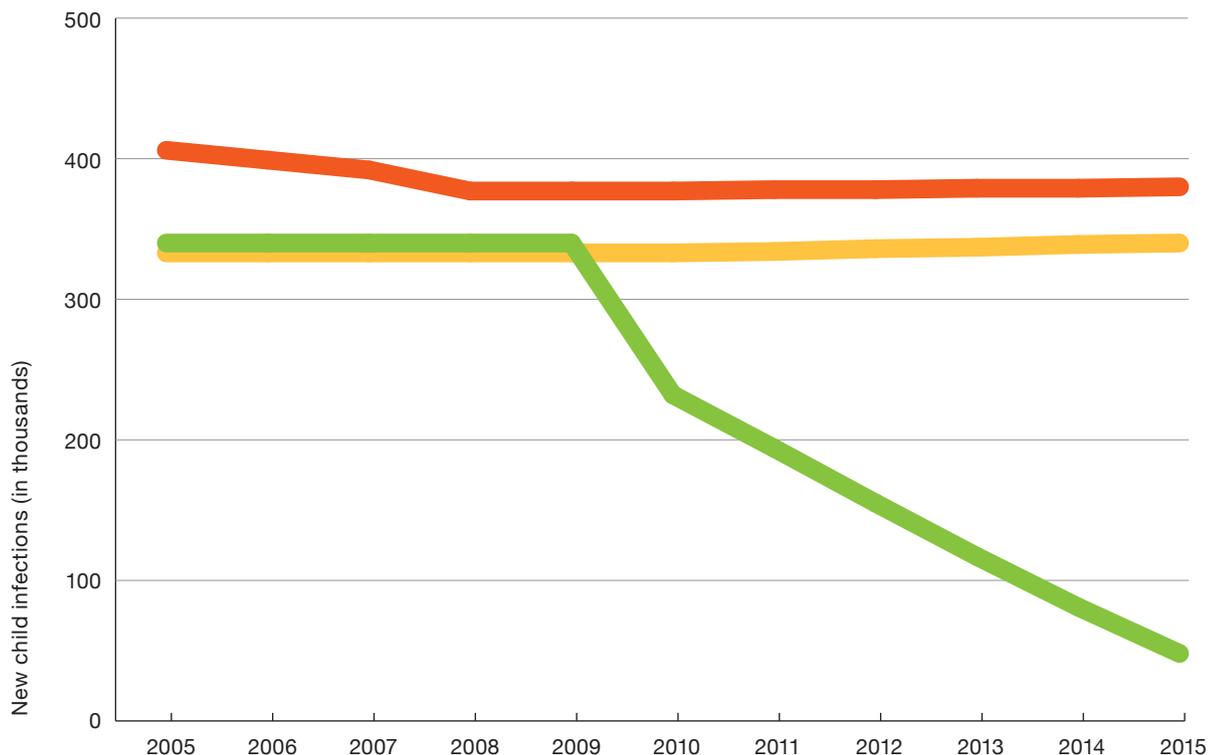
Virtual elimination of mother-to-child transmission of HIV is possible

In ideal conditions, the provision of antiretroviral prophylaxis and replacement feeding can reduce transmission from an estimated 30–35% with no intervention to 1–2%.



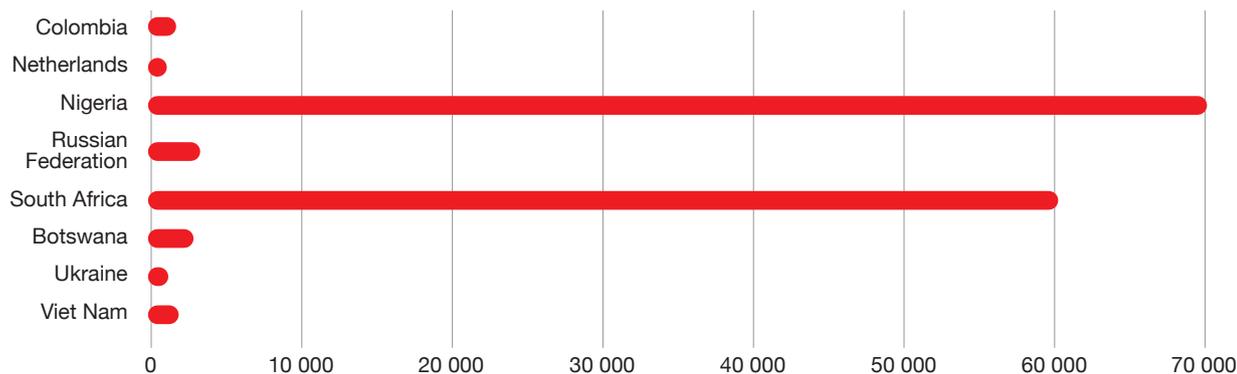
New child infections among 19 countries with the largest number of pregnant women living with HIV, 2005–2015

- If no prevention of mother-to-child transmission was available
- If we continued prevention of mother-to-child coverage at 2009 levels
- If we implemented four prongs*



* Implementing the four prongs would include reducing HIV incidence by 50%, reducing unmet needs for family planning by 100%, increasing antiretroviral prophylaxis (triple) to 95% coverage and ensuring that prophylaxis is continued throughout breastfeeding. Source: Country HIV estimates and projection files, UNAIDS

New infections among children (0–14) in 2008



Source: 2009 WHO/UNAIDS HIV estimates

More than half the sky

33.4 million people living with HIV globally

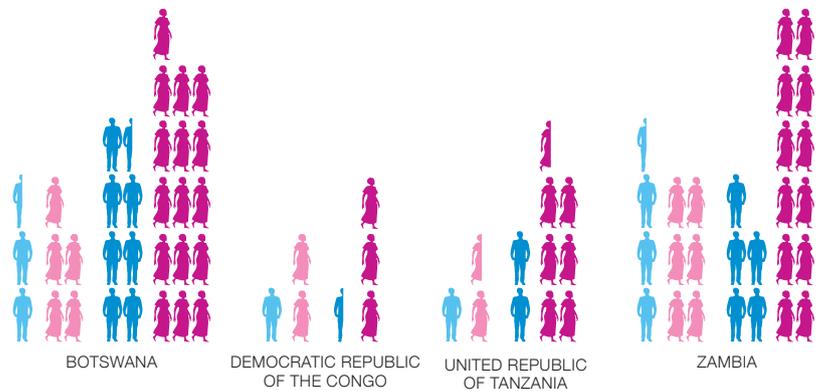
 2.4 MILLION CHILDREN

 15.3 MILLION MEN

 15.7 MILLION WOMEN

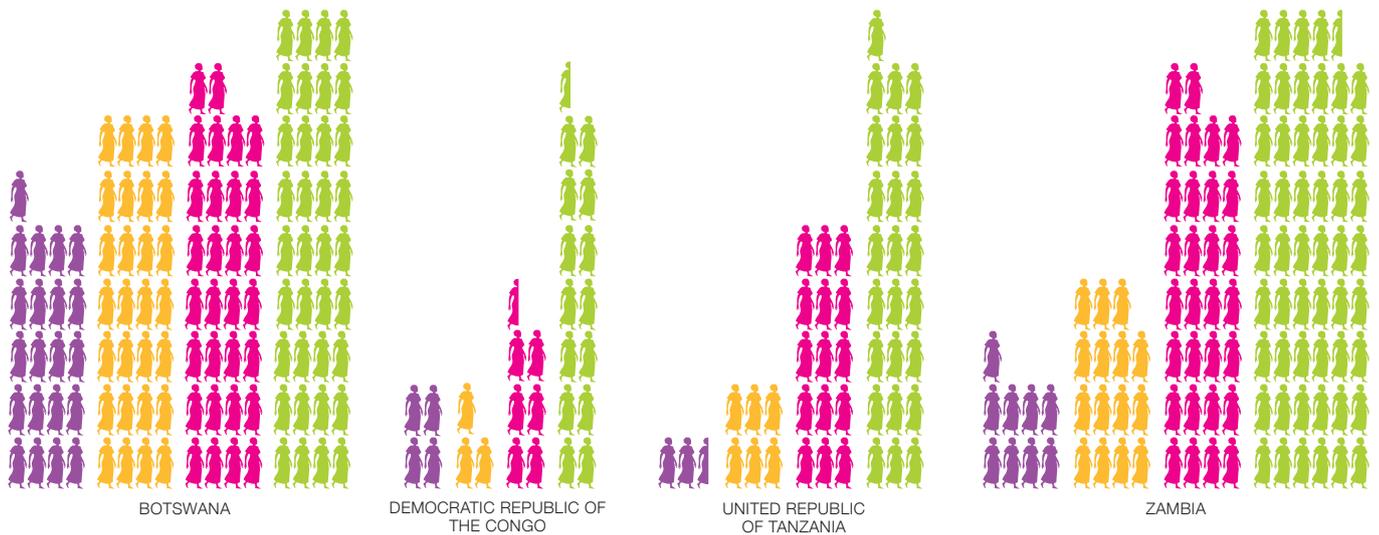
HIV prevalence among women is higher than men in sub-Saharan Africa

 = 1% of women 15-19 years  = 1% of women 20-24 years  = 1% of men 15-19 years  = 1% of men 20-24 years



HIV prevalence among women in sub-Saharan Africa by marital status

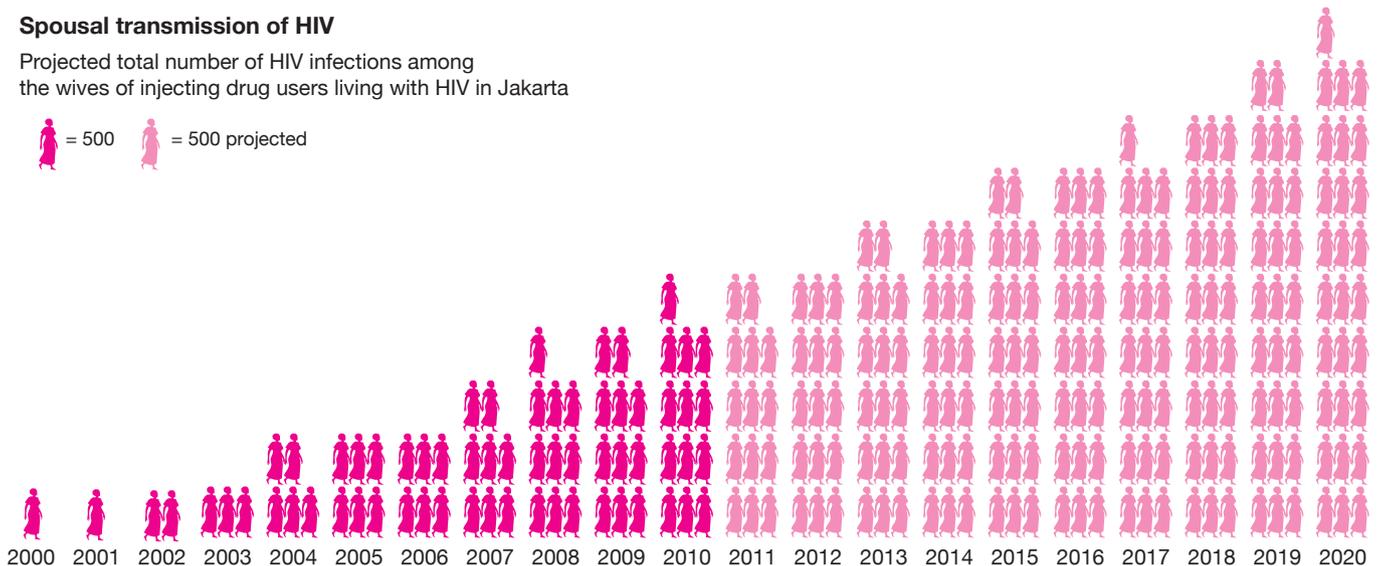
 = 1% of women never married  = 1% of women married/living with partner  = 1% of women divorced/separated  = 1% of women widowed



Spousal transmission of HIV

Projected total number of HIV infections among the wives of injecting drug users living with HIV in Jakarta

 = 500  = 500 projected



Source: Asian Epidemic Model projections using Jakarta data

Country policies and actions



Civil society

	Strategic plan Does the country have?			Human rights Does the country have non-discriminatory laws?				HIV prevention Majority of people in need have access to:				Treatment					
	Strategic plan	Clear targets and milestones	One national monitoring & evaluation plan	National action plan on orphans and children	Against discrimination	Sex work	Men who have sex with men	Injecting drug users	Prevention of mother-to-child transmission	Condom promotion	HIV testing and counselling	Harm reduction for injecting drug users	Risk reduction for men who have sex with men	Risk reduction for sex workers	Antiretroviral therapy	Paediatric AIDS treatment	HIV testing and counselling for tuberculosis patients
Brazil																	
Russian Federation																	
India																	
China																	
South Africa																	
Thailand																	
Cambodia																	
Papua New Guinea																	
Viet Nam																	
Indonesia																	
Haiti																	
Bahamas																	
Guyana																	
Dominican Republic																	
Ukraine																	
Estonia																	
Belarus																	
Uzbekistan																	
Swaziland																	
Botswana																	
Kenya																	
Mozambique																	
Panama																	
Suriname																	
Mexico																	
Colombia																	
Egypt																	
Morocco																	
Algeria																	
Switzerland																	
Spain																	
Central African Republic																	
Gabon																	
Nigeria																	
Cameroon																	

The countries selected for each region are those with the highest prevalence and/or number of people living with HIV (UNAIDS 2008). The information is from the National Composite Policy Index (NCPi) of the 2010 UNGASS country reports. Part A is completed by government officials and part B by representatives from civil society organizations, bilateral agencies and UN organizations. The final report is submitted by the government. Country specific information is already available online: the full data set will be published in November, please visit www.unaids.org for more information.

From the desk of

Note to readers: the comments are the reactions of the Executive Secretary upon receiving this memo from the Ministry of the Interior. And yes, the speech is based on real-life experiences.

Somewhere in the world

But the government has also signed up to comprehensive HIV prevention, including harm reduction!

Memo

To: Executive Secretary, National AIDS Authority
From: Permanent Secretary, Ministry of the Interior
CC: Readers of OUTLOOK
Date: July 2010
Re: Drug use and AIDS speech to be delivered at the upcoming conference

I wonder if the menace is the one using the word 'menace'!

Due to the bothersome volcanic ash cloud, the Honourable Vice-Minister will not be able to reach his destination in time to deliver the speech. As his back-up, I have read over the draft you sent and have felt the need to rewrite it.

We can learn from others. Many in our region are successfully working on this issue.

Ladies and Gentlemen

It gives me great pleasure to attend this important conference, which addresses one of our highest priorities, namely drug use and the spread of HIV.

Our government has always insisted on a **comprehensive ban on drugs**. In light of the HIV and drug epidemics in our country, we have formulated a national drug control strategy that has a dual purpose: getting rid of both drugs and HIV, twin **menaces** that afflict our nation.

We believe **our country is different so our solutions must be unique**. We are not blind to the fact that various elements would like us to have a soft approach in dealing with the control of drugs, but such a step would take this **nation backwards and our young people will be gripped by an affliction that is not only immoral but also life-threatening**.

Our policy is based on four pillars:

- Zero tolerance of drug use.
- ~~Det~~errence.
- Education.
- Rehabilitation.

Of course we don't want young people hooked on drugs, but we also don't want to discriminate against people who use drugs and are living with HIV.

People who inject drugs, like all people, are entitled to protection from arbitrary arrest, torture and killing.

These pillars will be implemented in pursuit of our goal to become drug free by 2015.

How about these five pillars instead:

1. Primary prevention before people start drug use.
2. Access to harm reduction.
3. Voluntary drug treatment.
4. Decriminalization of drug users.
5. Involvement of drug users in programme design and delivery.

You cannot force people to rehab clinics.

???

We can either aim for an ocean of fear or a sea of knowledge and tranquillity.

We need our children to stay away from drugs. We cannot tolerate our streets and entertainment centres becoming dens of drug use. To achieve this we must actively pursue the concept of zero tolerance, a centrepiece of the ruling party's manifesto—a promise that we now must fulfil.

Treatment, a job and support work better than scare tactics that will just drive people underground.

We have to put more police on the streets. Little drops of water make an ocean. If we can remove the visible parts of the drug trade off our streets, we can break the morale of the drug peddlers.

The second is deterrence. Our laws are clear. We warn the public about the dangers of drug use and we punish people who abuse the laws. We are also working together with the Medical Council to ensure that buying chemicals that can be used to make drugs and purchasing the associated paraphernalia are strictly regulated. Drugs are meant to save lives, not destroy them.

Respecting people's human rights does not mean we are making drugs fashionable.

Drug abuse increasingly appears to enjoy the image of a normal, even fashionable activity. But drug abuse is not a victimless crime. It corrodes society and adversely affects the health and welfare of individuals, families and communities. The health costs for someone on drugs are an estimated 80% higher than an average citizen in the same age group.

Let's help families and communities find local solutions.

Drug addicts are unable to make free decisions about their future. It is therefore not a policy option to throw up our hands and say "let's legalize".

Yes they can. Research shows that drug users on substitution therapy can go to work.

And finally let me talk about rehabilitation. I fully agree that drugs abusers must be rehabilitated into society once they are completely off drugs, not while on it. I am aware of several pilot programmes in our country that provide opioid substitutes as well as clean needles and syringes. Why are people advocating for the idea of putting more needles into the hands of drug users?

I don't think anyone here is saying legalize heroin.

We feel that this is ploy by the pharmaceutical industry to create a new market in the name of treating drug users. Our understanding is that by introducing these drugs we are opening ourselves to lifelong dependency. If methadone is not used in developed countries, why should we use it?

Good, he knows about methadone therapy. Now let's make sure he becomes a treatment advocate. Methadone is a WHO prequalified drug.

Ladies and Gentlemen

I would urge all of us to exercise caution and stay the course with tried and tested approaches. It is our duty to follow the law. This way, we can secure the future of our country and bring peace and stability to the region.

Distributing clean needles and syringes does not increase drug use, but does make the transmission of HIV and hepatitis C less likely.

Thank you

Where is the evidence for this?

That is why HIV prevalence has now risen to over 40% in the capital.

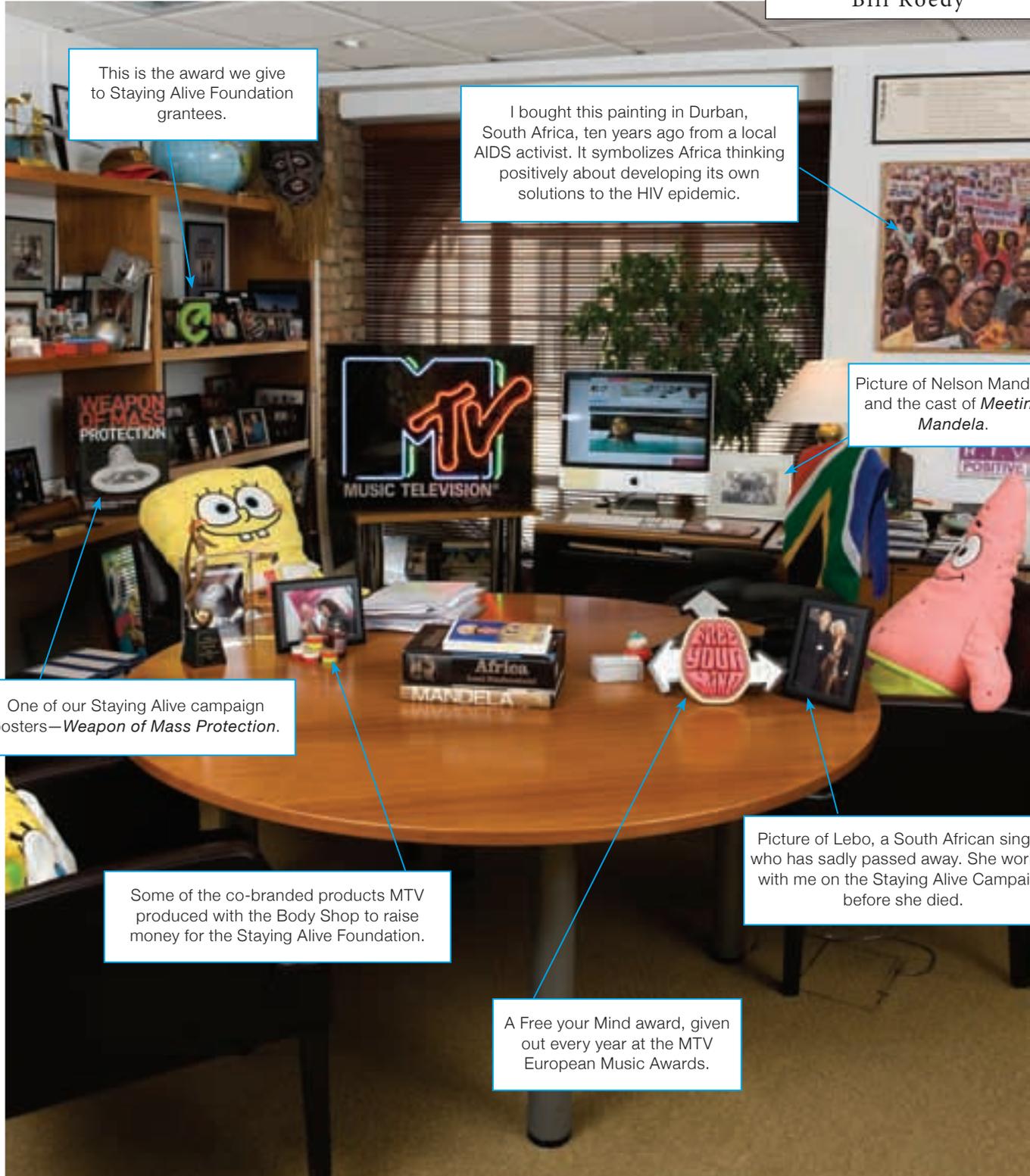
Harm reduction can help the law. Australia, Canada, the UK and the USA use methadone as substitution therapy. It doesn't contradict other valuable drug demand strategies.

Bill Roedy is Chairman and CEO of MTV Networks International and has been a dedicated AIDS activist since the 1980s. The first case of HIV was reported in the same year as MTV's launch and since then the media company has strived to creatively engage its audience by raising awareness about the epidemic. Through the MTV Staying Alive campaign, Mr Roedy leads the brand's global efforts to promote HIV education. The campaign has produced award-winning programmes, web sites and events that are broadcast on MTV's network of channels, reaching over 900 million households a year with vital HIV prevention information.

Mr Roedy also serves as the Chair of the Staying Alive Foundation, which was launched in 2005 to expand impact at the grassroots level. The Foundation awards small cash grants to HIV prevention projects across the globe, with more than 230 grants to young people in 56 countries awarded to date. Using the power of the media, Mr Roedy's focus is to empower young people to make a difference and to encourage positive social change. "Individuals moved by a shared dream and working together for a cause can change the world," says Mr Roedy.



THE OFFICE OF
Bill Roedy



This is the award we give to Staying Alive Foundation grantees.

I bought this painting in Durban, South Africa, ten years ago from a local AIDS activist. It symbolizes Africa thinking positively about developing its own solutions to the HIV epidemic.

Picture of Nelson Mandela and the cast of *Meeting Mandela*.

One of our Staying Alive campaign posters—*Weapon of Mass Protection*.

Some of the co-branded products MTV produced with the Body Shop to raise money for the Staying Alive Foundation.

Picture of Lebo, a South African singer, who has sadly passed away. She worked with me on the Staying Alive Campaign before she died.

A Free your Mind award, given out every year at the MTV European Music Awards.

The pitch

One issue. Three agencies. Lots of great ideas.

OUTLOOK asked three branding and communication agencies to give us their best thinking on a new global campaign to end HIV-related restrictions on entry, stay and residence—often summarized as ‘travel restrictions’.

Each agency has presented their ‘pitch’—a creative proposal that shows how an idea can be promoted.

THE BRIEF

Create a visual campaign aimed at travellers in an airport, for an in-flight magazine or for a web site.



Agency 1.

LEO BURNETT INDIA

Mumbai | leoburnett.com

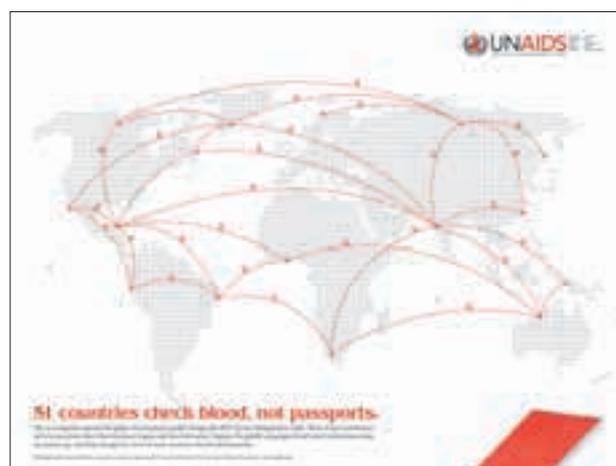
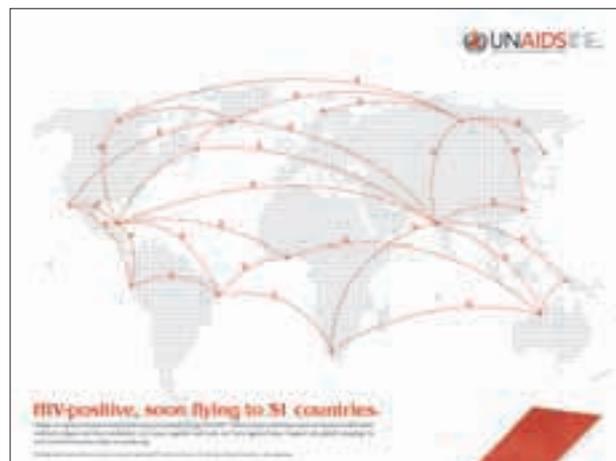
CONCEPT—The flight path

To explain the concept of travel restrictions we wanted a striking yet simple visual anchor to represent the impact of these restrictions. A global flight path map is a direct representation of travel. This creative communication was re-enforced by looping the flight paths into small AIDS ribbons—the most widely known visible cue of the global AIDS movement. With a visual that is direct, upfront and eye-catching, the large, bold headlines draw attention to the countries that restrict people living with HIV from entering. The tagline supports a call to action and encourages readers to find out more about the campaign.

Text: Today 51 countries impose travel restrictions on people living with HIV. These travel restrictions serve no purpose other than to reinforce stigma and discrimination. Let’s come together and raise our voice against them. Support the global campaign to end travel restrictions today at unaids.org.

About

Together with its partners, Leo Burnett India strives to put meaningful human purpose at the centre of its client’s brands, to transform the way people think, feel and ultimately behave. Leo Burnett is part of the Publicis Group, with 96 offices worldwide in 84 countries.





Agency 2.
MOVING BRANDS
London | movingbrands.com

CONCEPT—The red tape

Red tape has long been a powerful symbol of bureaucracy, petty mindedness and needless restriction across all aspects of political and normal, everyday life. We want to use this symbolism to bring awareness to the issue and to encourage and engage the public to help cut the restrictions against people living with HIV. The graphic approach uses a custom-made roll of adhesive tape that can be used in various situations and settings. It can be placed over billboards, magazine covers, web sites and out on the street. It will also translate as a graphic device across all print, digital and onscreen media. There will be two types of tape: one will have a list of countries with travel restrictions and the other will carry the campaign message.

Text: Help us cut the red tape: 51 countries impose needless travel restrictions on people living with HIV. For more information please visit unaids.org.

About

Moving Brands is an independent, award-winning branding company with creative studios in London, Zurich, Tokyo and San Francisco. Through its unique approach to brand strategy, brand identity and brand experience it creates powerful new ways for brands to connect with people, and people to connect with brands. Our aim is to redefine branding by setting new standards of creativity for a moving world.





Agency 3.
YOUNG & RUBICAM BRANDS

Geneva | yrbc.com

CONCEPT 1—It’s a different world

If you are HIV-positive and want to travel, it is truly a different world—it’s as if some countries just don’t exist. That’s what this idea brings to life with a simple graphic of the world with those countries that have travel restrictions. The world map is iconic and is something we all recognize. When you redraw it—as HIV travel restrictions have—the world looks like a very different place and somewhere we don’t recognize. That’s the idea behind this ad.

Text: 51 countries impose travel restrictions on HIV-positive people for no reason. Help us open the borders at unaids.org

CONCEPT 2—The ironic truth

Travel restrictions for people living with HIV have no grounds for existence. Yet there are still so many countries that impose them. Through a series of simple but powerful headlines we hammer home the truth that travel restrictions for people living with HIV are pointless, prejudicial and hurt rather than help. The idea is to use light wit and irony to make it impossible to avoid the conclusion that travel restrictions for people living with HIV are simply wrong!

Text: If you’re HIV-positive half the world doesn’t want to know you. 51 countries impose travel restrictions on HIV-positive people for no reason. Help us open the borders at unaids.org.

About

Young & Rubicam Brands Geneva is an integrated marketing agency that focuses on delivering to clients ‘ideas before advertising, ideas beyond advertising’. The office houses under one roof Group companies Y&R (advertising), Cohn & Wolfe (public relations), Wunderman (relationship marketing), Landor (branding and design) and Y&R Business Communications (B2B communications), as well as Y&R Business Consultants and media planning and buying through Mediaedge:CIA. Through an internal accounting philosophy and system that removes the need to promote a particular discipline, clients are assured of a marketing approach that provides the best possible return on their total marketing budget.



“Ladies & gentlemen, we wish you a pleasant trip and kindly remind you that for no apparent reason this is an HIV-negative flight.”

51 countries impose travel restrictions on people living with HIV for no reason. Help us open the borders at www.unaids.org



Apparently ignorance is more contagious than HIV.

51 countries impose travel restrictions on people living with HIV for no reason. Help us open the borders at www.unaids.org



Ideas lab



UNITED STATES

BANANAS AGAINST HIV?

Bananas may hold the key to new options to protect against HIV, according to researchers at the University of Michigan in the USA. In laboratory tests, scientists found that a lectin (sugar-binding protein) found in bananas could be as potent as two existing HIV treatment drugs. Michael D. Swanson, the lead author of the study said, "The problem with some HIV drugs is that the virus can mutate and become resistant, but that's much harder to do in the presence of lectins." The world's most popular fruit might one day help scientists in developing a lectin-based microbicide.



FRANCE

WEB SITE FOR THE FRANCOPHONE HIV-POSITIVE COMMUNITY

The web site of the French association against HIV, AIDES, aims to connect French-speaking people living with HIV worldwide, from sub-Saharan Africa to Quebec. Based on popular social networking sites such as Facebook and MySpace, Seronet.info offers users interactive tools to stay connected and exchange information. One of only a few French-language social networking sites for people living with HIV, Seronet.info provides forums, blogs, chat and a range of tip sheets geared specifically towards the community's needs (seronet.info).



UNITED KINGDOM

WWW.THEPLEASUREPROJECT.ORG

The Pleasure Project is an educational initiative that promotes safer sex that feels good. The Pleasure Project takes a positive and what it calls "sexy" approach to safer sex. The group provides innovative training, consultancy, research and publications to sexual health trainers and counsellors.

UGANDA

MOBILE PHONES—A LIFELINE FOR NEWBORN BABIES

Ten health centres in rural Uganda are using SMS to send the HIV results of babies born to HIV-positive mothers back to their doctors within three to five days. Before this pilot project began it could take up to ten weeks to get the test results. For a newborn, that can be a lifetime, delaying the baby being put on antiretroviral therapy and potentially putting him or her at risk. If the pilot project is a success, the system will be rolled out throughout Uganda and could significantly help to lower the country's high infant mortality rate.

SOMALIA

HIV EDUCATION GOES TO SCHOOL

According to the UN Educational, Scientific and Cultural Organization (UNESCO), policies to reduce the vulnerability of children and young people to HIV cannot be implemented without the full cooperation of the education sector. A new programme is targeting about 800 primary and junior high school students in north-western Somalia's self-declared republic of Somaliland with HIV messages for the first time.

ROMANIA

EARLY INTERVENTION IS EFFECTIVE

Romania is one of the few countries in central and eastern Europe that does not have a concentrated HIV epidemic among injecting drug users, even though it is believed to have a large injecting drug user population. The capital city of Bucharest has an estimated 16 000 people who inject drugs (0.9% of the city population), 95% of whom have been injecting for more than two years. However, HIV prevalence is lower, 1.0% in 2009, than in other cities with similar profiles.

Researchers believe consistent HIV prevention outreach programmes have been effective, in that 85% of drug users report using sterile equipment the last time they injected. Contributing to this was the expansion in accessing clean needles and syringes in pharmacies (38% of injecting drug users reported access to them from pharmacies in 2009, compared with 10% in 2005).



FAST FACT

WORLDWIDE, BANANAS ARE THE FOURTH LARGEST FRUIT CROP.

AUSTRALIA

NEW RAPID HIV TEST

A new application to improve the reading of HIV rapid test results will be developed in Australia. Victoria's Burnet Institute and Australian biomedical applications company Axxin Ltd have joined forces to develop a device that allows for the precise reading of rapid tests to determine if a patient needs antiretroviral therapy. Burnet Institute spokeswoman Tracy Routledge told the *Sydney Star Observer* that it was an important Australian innovation and would take the "human error" out of diagnosing if and when people living with HIV should start medication.



INDIA

FLIP FLOPS WITH A MESSAGE

In India, flip flops come with a message on how to use a condom. Pieces from the clothing line designed by artists Thukral and Tagra include HIV prevention messages. Jiten Thukral and Sumir Tagra work collaboratively in a wide variety of media, including painting, sculpture, installation, video, graphic and product design, web sites, music and fashion.



UNITED STATES

CLINICAL TRIAL OF FIRST FOUR-IN-ONE HIV DRUG

A phase III clinical trial by Gilead Sciences is under way to evaluate a four-in-one HIV drug (tenofovir + emtricitabine, plus a new compound, elvitegravir, that blocks an enzyme called integrase, which the virus needs to insert itself into a person's genes, and a booster medicine). In one study, the safety, efficacy and tolerability of the four-in-one pill will be compared with the company's current three-in-one pill for HIV (tenofovir + emtricitabine + efavirenz) over a 96-week period in the USA and Puerto Rico.

The second study will compare the four-in-one pill with another HIV treatment (ritonavir-boosted atazanavir and tenofovir + emtricitabine) over a 96-week period in more than 200 sites in North America, South America, Europe and Asia-Pacific. Initial results showed that the four-in-one pill reduced the virus to undetectable levels in 90% of patients after 24 weeks and had fewer side effects than its three-in-one pill.

MALAYSIA

ISLAM AND HARM REDUCTION

Following an in-depth study of the epidemiology of injecting drug use and the HIV epidemic in Islamic countries, researchers at the University of Malaysia have identified basic guidelines provided in the Koran and the Sunna (Prophetic traditions) that support needle exchange programmes and opioid substitution therapy.

Although drugs are 'haram' and therefore prohibited in Islam, illicit drug use is widespread in many Islamic countries throughout the world, which has helped lead to apparent concentrated HIV epidemics among injecting drug users. According to the study, when viewed through the Islamic principles of preservation and protection of the faith, life, intellect, progeny and wealth, harm reduction programmes are permissible and provide a practical solution to a problem that could result in far greater damage to society at large if left unaddressed.

MOZAMBIQUE

NEW TECHNOLOGIES IMPROVING THE HIV RESPONSE BY KAYAK

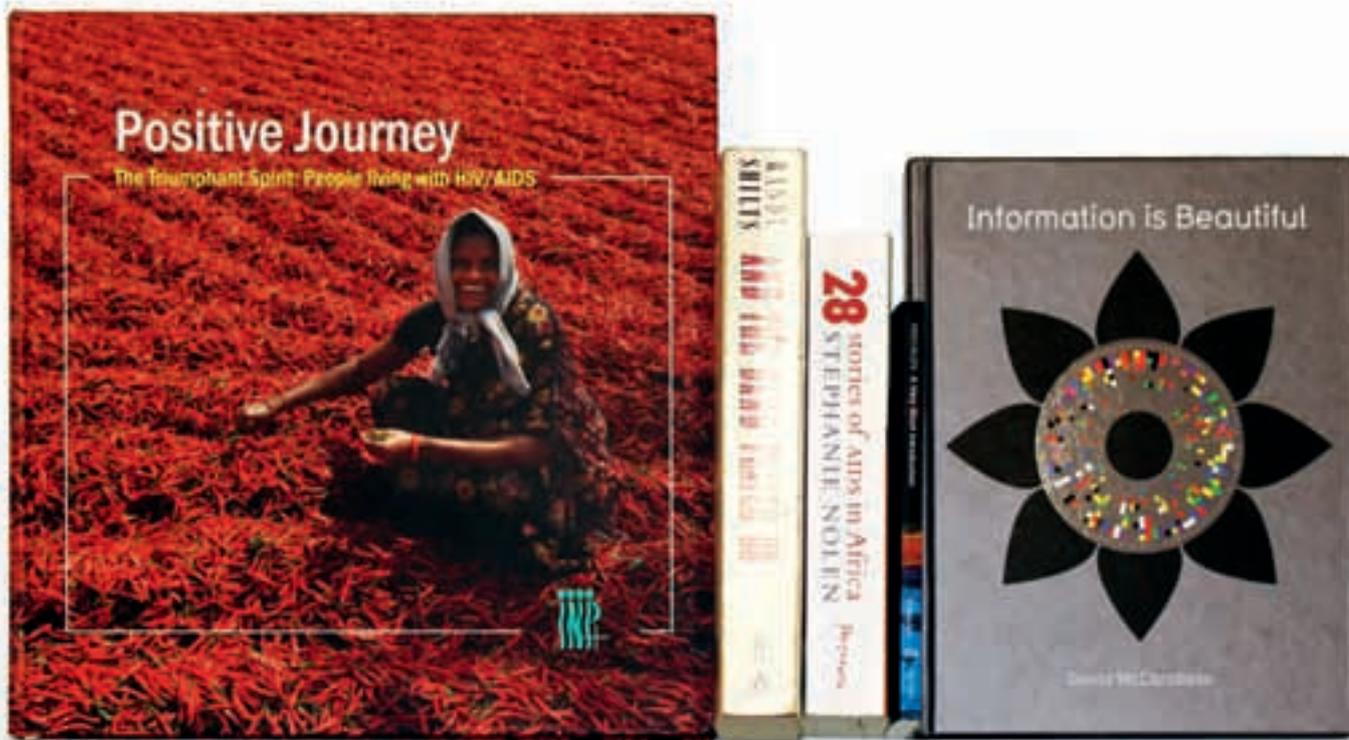
Timely delivery of HIV test results for infants who may have been exposed to the virus is critical to their health and survival. The National Institute of Health (INS) in Mozambique is using mobile phone text messages to transmit HIV test results in real time directly from laboratories to 260 health facilities across the country offering paediatric HIV treatment and care. In another project, INS is field-testing a device that provides patients with same-day CD4 test results, thereby reducing the number of visits to the health centre and improving treatment outcomes. In one northern region, the CD4 test device is transported by kayak to remote communities with no road access.



{ OUTLOOK }

Recommends

Books and a playlist not to be overlooked



Books

AIDS anthology

Partner to the poor

By Paul Farmer, 2010

For nearly 30 years, anthropologist and physician Paul Farmer has travelled to some of the most impoverished places to bring the best possible medical care to the poorest of the poor. In 1987, he and several colleagues founded Partners in Health to provide a preferential health-care option for the poor.

Partner to the poor collects his writings from 1988 to 2009, providing a broad overview of his work. A portion of the proceeds from the sale of the book will be donated to Partners in Health.



HIV/AIDS: a very short introduction

By Alan Whiteside, 2008

Alan Whiteside's introduction to HIV is an excellent resource for anyone wanting to gain a better understanding of the evolution of the HIV epidemic or to brush up on key developments in the global AIDS response. Packed with an epidemiological overview of the virus as well as statistics that help to map the progression of HIV, this pocket-sized book is a great resource to have on hand.

28 stories of AIDS in Africa

By Stephanie Nolen, 2008

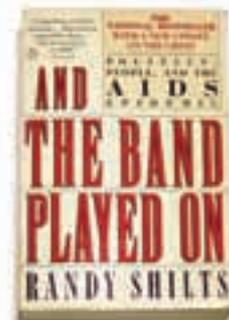
Renowned Canadian journalist Stephanie Nolen captured 28 stories of people living with and affected by HIV in 14 African countries. The stories put a human face to the epidemic and demonstrate the magnitude of HIV through individual lives. It articulates the despair, loss, grief—and, at times, love, hope and life—of the people the author met throughout her travels.

Classics

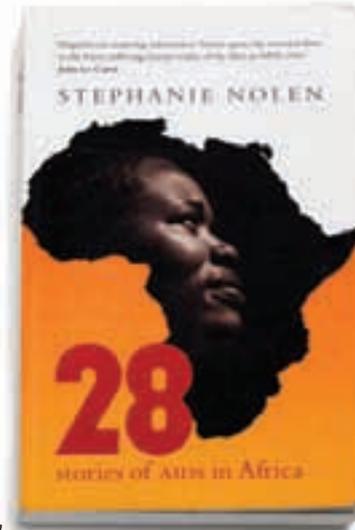
And the band played on: politics, people, and the AIDS epidemic

By Randy Shilts, 1987

One of a few reporters who delved into the subject at the beginning of the epidemic, Randy Shilts went beyond the headlines to investigate the social and scientific aspects of the disease. Openly gay, he refused to accept HIV as, what was then labelled, a 'gay disease', and through his work he demonstrated the effects of the inequities and stigma against people living with HIV. Twenty-three years on, his work serves as a reference of quality investigative journalism.



28 stories of AIDS in Africa
By Stephanie Nolen, 2008



Art

Information is beautiful

By David McCandless, 2010

Not your traditional tabletop book, it is about presenting information—surveys, timelines and other data—in a manner that is accessible to all. Readers will find themselves flipping through its pages, stopping to turn the book in various directions to take a better look at the graphs, circles and other clouds of ‘beautiful information’ presented.

Positive journey: the triumphant spirit—people living with HIV/AIDS

By the Indian Network of People Living with HIV (INP+), 2009

Indian photographer Shaju John spent several years capturing the lives of people living with HIV in six Indian states. A project of INP+, *Positive journey* intersperses powerful imagery with touching narratives. In the book’s preface, the photographer tells of the change he witnessed over the past several years, when people living with HIV would hide their faces while being photographed. This book is a testimony to that transformation.

Music

Inspirational

Universal Child

Annie Lennox, special release (2010)

Annie Lennox debuted this song on the US charity show *American Idol Gives Back* 2010. A long-time AIDS activist and newly appointed UNAIDS Goodwill Ambassador, she was inspired by Nelson Mandela’s call to action. She started the SING campaign to raise funds and awareness to bring about support and change for women and children living with and affected by HIV in South Africa.

Single Ladies (Put a Ring on it)

Beyoncé Knowles, from *I Am... Sasha Fierce* (2008)

The line “Put a ring on it”, from Beyoncé’s hit song, is being used as the tagline for a female condom public awareness campaign in the USA. The campaign teaches health professionals in the Chicago area how to use the female condom so they can pass the information along to patients.

Al-Vida

Salman Ahmad, special release (2005)

Pakistani rock star Salman Ahmad is the lead singer and founding member of one of South Asia’s biggest rock bands, Junoon. A UNAIDS Goodwill Ambassador since 2005, he has used his music to raise awareness on HIV. For World AIDS Day 2005, Salman Ahmad released *Al-Vida*, a song and music video dedicated to a woman’s struggle against the stigma, discrimination and ignorance directed towards people living with HIV.

Mutoto Kwanza

Angélique Kidjo, from *Oyaya!* (2004)

The title of this Salsa meets Ska infused dance song means “children first”—an expression the Beninese songstress heard from a group of children in the United Republic of Tanzania. In the country representing UNICEF as a Goodwill Ambassador, Angélique Kidjo was overwhelmed by the number of children orphaned by AIDS. Her experience there and hearing the children cry out “mutoto kwanza” led Kidjo to capture their plight—but in a way that is positive and that expresses hope.

Abre tu Corazón (el Sida)

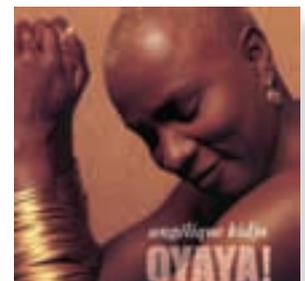
Marco Antonio Fernandez, from *Canciones Pendientes* (2003)

This passionate ballad from Chilean musician Marco Antonio Fernandez calls for unconditional love and acceptance. Open your Heart (AIDS), the title in English, encourages people to look beyond the syndrome and to overcome ignorance about HIV.

Kandjoura

Toumani Diabaté, from *Jarabi: the best of Toumani Diabaté* (2001)

Credited with introducing the kora—a traditional 21-string harp lute from West Africa—to audiences around the world, Toumani Diabaté was appointed a UNAIDS Goodwill Ambassador in December 2008. The first track on the album, *Kandjoura*, which speaks about love, courage, spirituality, tolerance and forgiveness, is the artist’s response to the AIDS epidemic.



Mutoto Kwanza
Angélique Kidjo, from *Oyaya!* (2004)

Mann Ke Manjeeré

Shubha Mudgal,

from *Mann Ke Manjeeré* (2001)

Empowering women to overcome violence and repression is the theme of this Hindi song by renowned singer Shubha Mudgal. The music video, featuring the popular Indian actress Mita Vashisht, has been viewed by 26 million households in India and has been credited with bringing the reality of domestic violence to the forefront—not just in India but throughout Asia. Loosely translated, ‘mann ke manjeeré’ means ‘the music of my mind’. The song’s title is also the name of a campaign on violence against women led by the Indian nongovernmental organization Breakthrough.

Together Again

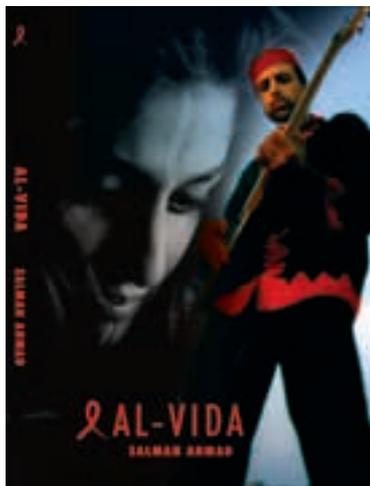
Janet Jackson, from *The Velvet Rope* (1997)

Together Again is Janet Jackson’s heartfelt yet upbeat tribute to friends she lost to AIDS. The second single off her hit album *The Velvet Rope*, Together Again was released just after World AIDS Day in 1997. The song became her eighth number one hit on the US Billboard Hot 100 Singles chart, selling nearly six million copies worldwide.

I’ll Stand by You

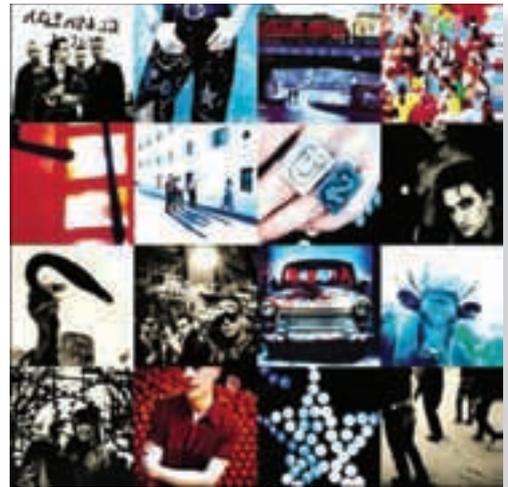
The Pretenders, from *Last of the Independents* (1994)

Penned by Chrissie Hynde with her songwriting team, the song was performed by Shakira on George Clooney’s and MTV’s Hope for Haiti telethon. The telethon raised millions of dollars to help rebuild the country—the most affected by HIV in the Caribbean—and its AIDS response after the devastating earthquake in January 2010.



Al-Vida

Salman Ahmad, special release (2005)



One

U2, from *Achtung Baby* (1991)

Streets of Philadelphia

Bruce Springsteen, from *Philadelphia: Music from the Motion Picture* (1994)

Bruce Springsteen wrote Streets of Philadelphia after being asked personally by the film’s director, Jonathan Demme. Philadelphia was one of the first mainstream Hollywood films to tackle HIV, homosexuality and homophobia. The success of Streets of Philadelphia drew attention to the film, reaching an audience that might not otherwise have seen it.

Everybody Wants

Remo Fernandes, from *Politicians Don’t Know How to Rock ‘n’ Roll* (1992)

The lyrics of Everybody Wants caused quite a stir when it was aired throughout India in 1992. With its chorus of “Everybody wants to oomph! Without the fear of AIDS,” the song was one of the first in the country to talk openly about sex and HIV.

One

U2, from *Achtung Baby* (1991)

This track is considered by many critics to be one of U2’s greatest songs. The song’s title shares the same name as the charitable organization of lead singer Bono. The ONE Campaign supports the Millennium Development Goals, with a special emphasis on ending extreme poverty and strengthening the AIDS response.

Together Again

Janet Jackson, from *The Velvet Rope* (1997)

(Something Inside) So Strong

Labi Siffre, from *So Strong* (1988)

British singer and songwriter Labi Siffre’s inspiration for this song came from a TV documentary portraying the violence of apartheid in South Africa. It has since become more than an anti-apartheid anthem, one that resonates for anyone who has experienced racism, repression, or stigma and discrimination. Many organizations have used the song in campaigns focused on women and children.

Feeling Good

Anthony Newley and Leslie Bricusse, for the musical *The Roar of the Greasepaint, the Smell of the Crowd* (1964)

This classic has been covered by everyone from Muse to Michael Bublé, but perhaps the best-known version is from the unforgettable Nina Simone. Why this song? The refrain says it all: “It’s a new dawn, it’s a new day, it’s a new life, for me, and I’m feeling good.” ●



STATE OF THE AIDS RESPONSE

OUTLOOK looks at HIV prevention and treatment as it explores the state of the AIDS response in 2010.

Difficult economic times call for smarter, better and more creative solutions.



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The future of AIDS starts today

Michel Sidibé
Executive Director of UNAIDS

A few months ago I sat in a clinic in Lagos, Nigeria, watching Jacob's father patiently listen to the doctor as she spoke to him about the treatment and care he should give to his son. As I listened to the heroic struggle of Jacob's family to stay alive, I knew there must have been a way for this son and father to have avoided becoming infected with HIV in the first place.

Can we prevent the 7400 HIV infections that occur each day? Yes. But it will require nothing short of a prevention revolution.

For three decades the evidence of what works and what does not has been debated in the UN General Assembly, parliaments, community forums, places of worship, scientific forums and conferences. We enter the fourth decade with the best possible knowledge on combination prevention and treatment options to help us realize our shared vision of zero new infections.

With new infections outpacing treatment uptake by 5:2, how can we work smarter and faster to outpace HIV?

More than 80% of HIV transmission is sexual. It is clear that preventing HIV transmission is not as simple as ABC—but each proven prevention method has a pivotal role to play.

An open dialogue on sexuality—based on current realities—should be encouraged in families and communities. HIV prevalence among females between the ages of 15 and 19 in South Africa and Kenya is three times higher than among males in the same age group. In other countries, such as Botswana and the United Republic of Tanzania, it is double. In many cases the cause of these startling differences is intergenerational sex. Recognizing and addressing the factors that drive young women and men to have sex with older people is paramount. The answers can be found in fundamental development issues—access to education, employment, social security and health. When basic necessities are not met, vulnerability increases.

Unsafe sex often becomes an entry point to survival.

Of course, not all sex is transactional. Sex is a biological and human need. Social norms such as forbidding premarital sex are not necessarily practical in an age when people are waiting longer to get married. Delaying the age of first sex is an important prevention option, but we cannot rely on this alone. Young people can be empowered to manage their sexual and reproductive health needs. We can allay parental and societal fears that sexual education will lead their children to start having sex earlier. A recent analysis of 83 studies by D.B. Kirby and colleagues found that sex education does not hasten or increase sexual behaviour, but rather can delay or decrease it or increase condom and contraceptive use.

Men's active engagement could unlock one of the main obstacles in the AIDS response. And adult male circumcision can provide the platform for change. It is heartening that the Zulu King, Goodwill Zwelithini, has revived the practice of male circumcision among young Zulu men in response to the evidence that circumcision provides a 60% protective effect. This is the power of communities.

Another entry point is to increase knowledge of HIV status among men. If men know their HIV status, they can begin conversations with their sexual partners about safe sex, pregnancy and treatment. A recent study in Malawi has shown that a home-based approach to HIV testing that provides instant test results can increase the uptake of HIV testing and counselling among all members of the family.

Outside of sub-Saharan Africa much HIV transmission takes place in the context of sex between men, sex work and drug use. Unfortunately, these behaviours are often criminalized and stigmatized. Being on the margins of society does not mean that people should have only marginal HIV prevention services. That is why I have called for the decriminalization of drug users and of adults engaged in consensual sexual behaviour. The benefits of such an approach are tremendous. The Avahan India AIDS initiative and government officials report that near universal coverage of HIV prevention services has been achieved for men who have sex with men. This is the prevention



revolution I speak of—where a narrow agenda is set aside for the greater good.

In Kolkata, India, sex workers are running cooperatives, managing health clinics and ensuring that underage girls do not enter the sex trade. They have also managed to keep HIV prevalence among sex workers low for the past two decades and are sharing their knowledge across the region.

Communities will mobilize if they have access to meaningful and effective HIV prevention and treatment services. Fewer than one in 100 injecting drug users in central Asia have access to opioid substitution therapy. We can do better. In sub-Saharan Africa only four condoms are available per year for each sexually active person. We can do better, as we are seeing in South Africa, where every person who comes forward and takes an HIV test will be offered 100 condoms.

I am still thrilled every time I hold a HIV-negative baby born to a mother living with HIV. We can virtually eliminate mother-to-child transmission and keep mothers alive. The AIDS response has a big role to play in reducing maternal mortality. It's why I have committed UNAIDS to support the call by the UN Secretary-General

Ban Ki-moon for a global maternal and child health movement to support Millennium Development Goals 4 and 5.

Just as antiretroviral therapy helps to ensure that pregnant women living with HIV don't pass on the virus during pregnancy or childbirth, exciting studies show that people on antiretroviral therapy are less likely to infect others when their viral load is low. The treatment-for-prevention approach provides a new platform for engaging people living with HIV to be at the forefront of the HIV prevention revolution.

The concept of 'positive health, dignity and prevention' begins with empowering people living with HIV to look after their own health and that of their loved ones.

The prevention revolution means putting into practice everything we have learned in the nearly 30 years of the HIV epidemic. It means redoubling our efforts and bringing them up to scale. It means leaving no stone unturned in finding new and innovative solutions. And, most importantly, it means respecting the rights and dignity of all people, regardless of their age, gender or sexual orientation, and empowering them to protect themselves from HIV.

The future of prevention— an incorrigible optimist's dream

We are in 2020, ten years from now.

We look back on the successes of the large-scale HIV testing campaigns of the 2010s. After South Africa showed the lead, many other countries followed. With the disappearance of social stigma, it is common place to know one's HIV status.

Staying HIV-negative has never been easier. Communication strategies, including social networking, have reinforced HIV prevention norms, with the result that over 95% of premarital first sexual encounters are condom protected.

Whether they are HIV-positive or HIV-negative, young people today have a range of choices to avoid sexual transmission of the virus. The fourth generation of female condoms has been a fantastic success: in 2019 female condoms out-sold male condoms for the first time.

Male circumcision has been another success story. Between 2010 and 2020, all adult and adolescent males desiring circumcision in high-prevalence countries were circumcised, and baby boys are being circumcised at birth.

An important development has been the use of antiretroviral therapy to reduce the amount of the virus that the immune system has to deal with and the world has seen the full benefits of treatment as prevention.

Microbicides have also been hugely successful. We now have several delivery mechanisms. The most popular is the combined contraception and microbicide ring, which can be worn internally for up to three months. The slow release of active ingredients protects against both unwanted pregnancies and HIV.

Technology has moved ahead faster than expected. The CD4 count is barely used any more for deciding when to start treatment and with new resistant-proof, low-toxicity drug therapy, maintenance is a breeze.

Research on vaccines received a boost back in 2009, when a trial in Thailand reported a modest 30% protective effect. Since then, several new trials have been launched. In each of them, the vaccine has been matched to the strain of virus that is prevalent locally.

One of the most important successes of the past ten years is that every country in the world completed a 'modes of transmission' analysis of its own HIV epidemic (knowing where the last 1000 infections occurred). Thanks to the adjustments that national programmes have made to address mismatches between local epidemics and the response early in the decade, countries around the world have seen the fruits of more tailored, effective combination HIV prevention programmes.

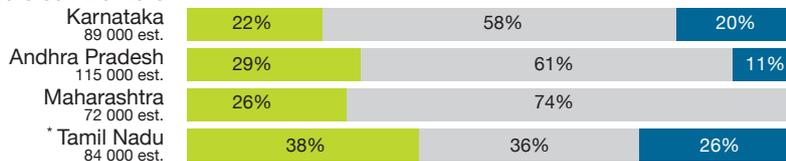
Thanks to unprecedented coordination efforts and knowledge transfer between countries, the global AIDS response is heralded as a model to tackle other challenges faced by humankind.

Saturating prevention coverage through complementary programming. Avahan has achieved a high coverage of focus populations (routine programme monitoring data).

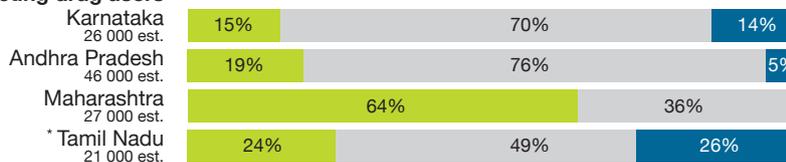
Injecting drug users



Female sex workers



Injecting drug users



 Government of India and others  Avahan  Uncovered

Percentages indicate intended coverage through establishment of services in specific geographic areas. * Includes districts with no intended coverage. Mapping and size estimation quality varies by state. Does not include rural areas. Source: Avahan and State AIDS Control Society programme data.

THE BENCHMARK

UNAIDS and the polling company Zogby International surveyed the world on what people think about the AIDS epidemic and response.

In this first of its kind global poll, AIDS continues to rank high on the list of the most important issues facing the world.

A sweeping new UNAIDS and Zogby International poll shows that nearly 30 years into the AIDS epidemic, region by region countries continue to rank AIDS high on the list of the most important issues facing the world.

Almost all people surveyed in sub-Saharan Africa, the Caribbean, South and South-East Asia, Latin America and East Asia say AIDS is important.

Eight out of ten people in the United States of America say it is important, and nearly nine out of ten in the Russian Federation say AIDS is important. In India about two thirds report that the AIDS epidemic is more important than other issues the world currently faces. In sub-Saharan Africa six in ten (57%) people say that the AIDS epidemic is just as important as other issues faced by the world.

Overall in the survey, AIDS leads public perception as the top health-care issue in the world, followed by safe drinking water.

Greatest achievement in the AIDS response

Public awareness about AIDS was considered the greatest achievement in the AIDS response by about one in three people (34%) overall. This was followed by implementation of other HIV prevention programmes (17.8%) and the development of new antiretroviral drugs (17.1%).

About 7.8% of respondents cited access to treatment as the greatest achievement and 7.2% say it was the prevention of mother-to-child transmission of HIV.

About 3.9% of people surveyed felt that abstinence education programmes worked. Just over 5% thought the world had been successful in distributing condoms or clean needles as part of prevention efforts.

Development of new antiretroviral treatment was seen as the greatest achievement in the USA, in eastern Europe and in central

Asia. Access to treatment was most often cited by people in Latin America (11%) and the Caribbean (12%).

Funding is a major obstacle

About 62% of people in Sweden think the availability of funding/resources or the availability of affordable health care (at 58%) is keeping the world from effectively responding to AIDS. Some 60% of people in the United Kingdom also felt that lack of funding was the main obstacle.

Is health a necessity or a luxury? Overwhelmingly the general public says governments have a role in ensuring treatment for people living with HIV.

Best way to describe the AIDS issue

'Hopeful' say 30% in South and South-East Asia and 25% in western Europe and the Caribbean. 'Manageable' say one in three (34%) in Latin America and Egypt, about 29% in East Asia and 15% in Australia.

'Tragic' is the term chosen by three in ten people in sub-Saharan Africa (30%), eastern Europe and central Asia (29%) and a third of people surveyed in Australia (33%).

'Getting worse' was chosen by people in sub-Saharan Africa (31%), eastern Europe and central Asia (28%) and East Asia (25%).

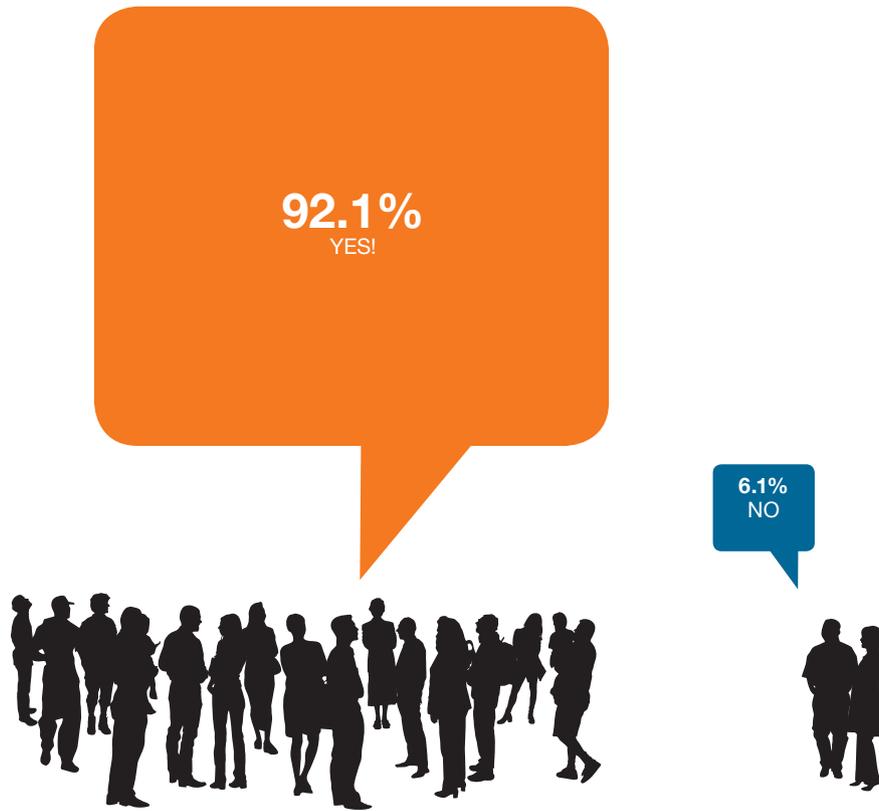
Is the world responding effectively to AIDS?

A resounding 'yes' was heard from the Caribbean (75%) and from South and South-East Asia (53%). About one in three in Latin America and just fewer than four in ten people in sub-Saharan Africa believed that the world was responding effectively to the issue.

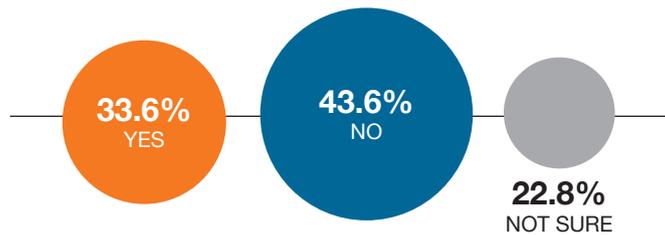
'No' was heard loudest in eastern Europe (61%), the USA (54%) and sub-Saharan Africa (50%).

Overall in the survey, AIDS leads public perception as the top health-care issue in the world, followed by safe drinking water.

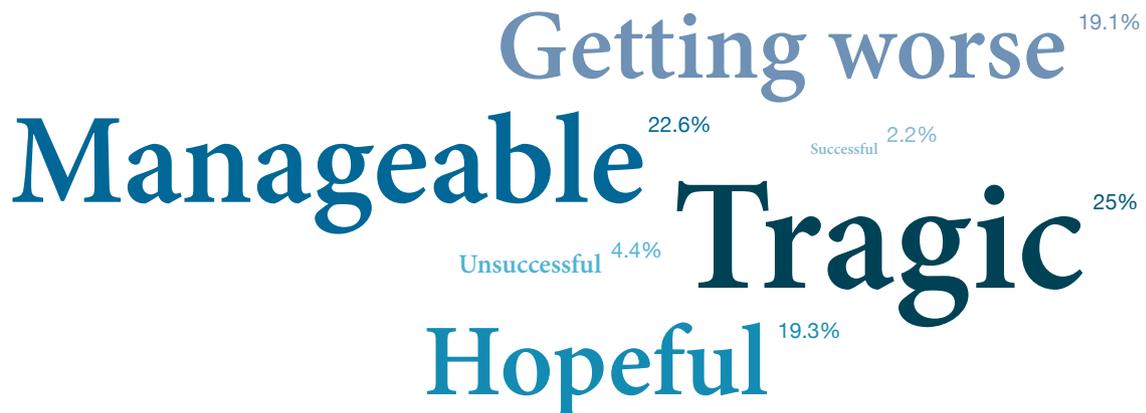
Is the AIDS epidemic important?



Is the world effectively responding to AIDS?



Which word best describes the AIDS issue?



About half in Latin America and eastern Europe want their government to subsidize treatment. Slightly fewer than half the respondents in the USA agree with subsidizing treatment for people living with HIV.

Is your country responding effectively to AIDS?

Opinion was equally divided. A little over 41% thought their country was effective against the AIDS epidemic. About 63% of the Caribbean respondents said ‘yes’, while 37% said ‘no’ compared with their view of the global response. A similar pattern was seen in Africa, Asia and eastern Europe.

A majority of respondents in the USA, Australia and countries in western and central Europe felt that their country was dealing effectively with the AIDS issue.

“Are communities responding to AIDS better?” ‘No’, seems to be the overall perception. Very few people surveyed say their own communities are doing better than their country’s overall response. In Japan, 8% of people thought their community was doing well, with 36.9% unsure about the issue.

In most regions, perceptions about community responses rank slightly lower than perceptions of country responses. The exceptions are South and South-East Asia and Egypt, where community responses ranked higher by a few percentage points.

Obstacles keeping the world from effectively responding to HIV

Despite considering raising awareness as the most successful aspect of the AIDS response, the lack of awareness and the availability of HIV prevention services was seen as the most important obstacle by more than half of the respondents.

Equally important was the availability of resources. For example, 78.7% surveyed in Uganda ranked availability of funding as the top obstacle.

Close to half of all respondents felt that stigma and discrimination towards people living with HIV and the availability and affordability of treatment were significant barriers. The lack of trained health workers was cited by nearly four out of ten people.

Similar trends were seen when asked the same question about their country or community. For example, in France 52.9% of respondents ranked the availability of resources as the biggest obstacle in their community.

Can the spread of HIV be stopped by 2015?

The Caribbean region is the most positive of all the regions, where 91% are optimistic that with proper use of resources the spread of HIV can be stopped. They are followed by South and South-East Asia (75%) and Latin America (63%). In sub-Saharan Africa four in ten (40%) were optimistic—for example,

in Senegal 48.7% were overall optimistic that HIV could be stopped by 2015.

Respondents from western Europe, Oceania and eastern and central Europe were equally divided, with a third of each either optimistic or pessimistic. Some 44% of people surveyed in the USA were most pessimistic, while 28% were optimistic and 24% neither optimistic nor pessimistic.

About half of all respondents said they would donate money to the AIDS response. The rest were either unsure or said ‘no’.

Contribution of the AIDS response towards other issues

Sex education tops the list, with an overall rating of six out of ten respondents (60.7%) saying the AIDS response had provided opportunities to respond to other issues. Latin America (77%) and sub-Saharan Africa (70%) thought so too. For example, in Mexico 76.8% said that the AIDS response has helped efforts in sex education.

Nearly four in ten (37.8–40.9%) respondents also said that sex work and injecting drug use issues had received a boost from the AIDS response. About three in ten (27%) felt that homophobia and sexual violence were on the agenda due to AIDS.

Importance of HIV services being linked to other health services

An overwhelming majority, more than seven out of ten (71%), agree that HIV prevention and treatment programmes should be linked to other health services such as tuberculosis and maternal health.

Nine out of ten in the Caribbean, and more than eight out of ten in sub-Saharan Africa, East Asia and Latin America agree with the concept of bringing AIDS out of isolation.

Who should pay for treatment?

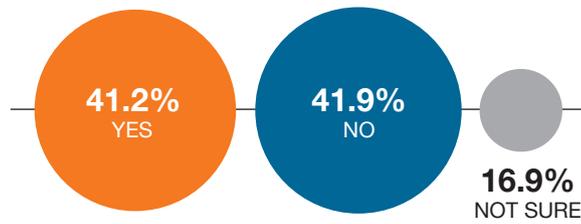
Overall about 58% of people surveyed agree that people living with HIV should receive subsidized treatment. This perception was strongest in the Caribbean, with 87% favouring subsidized treatment. Asia also agreed, with more than 70% approval of this issue.

About half in Latin America and eastern Europe want their government to subsidize treatment. Slightly fewer than half the respondents in the USA agree with subsidizing treatment for people living with HIV.

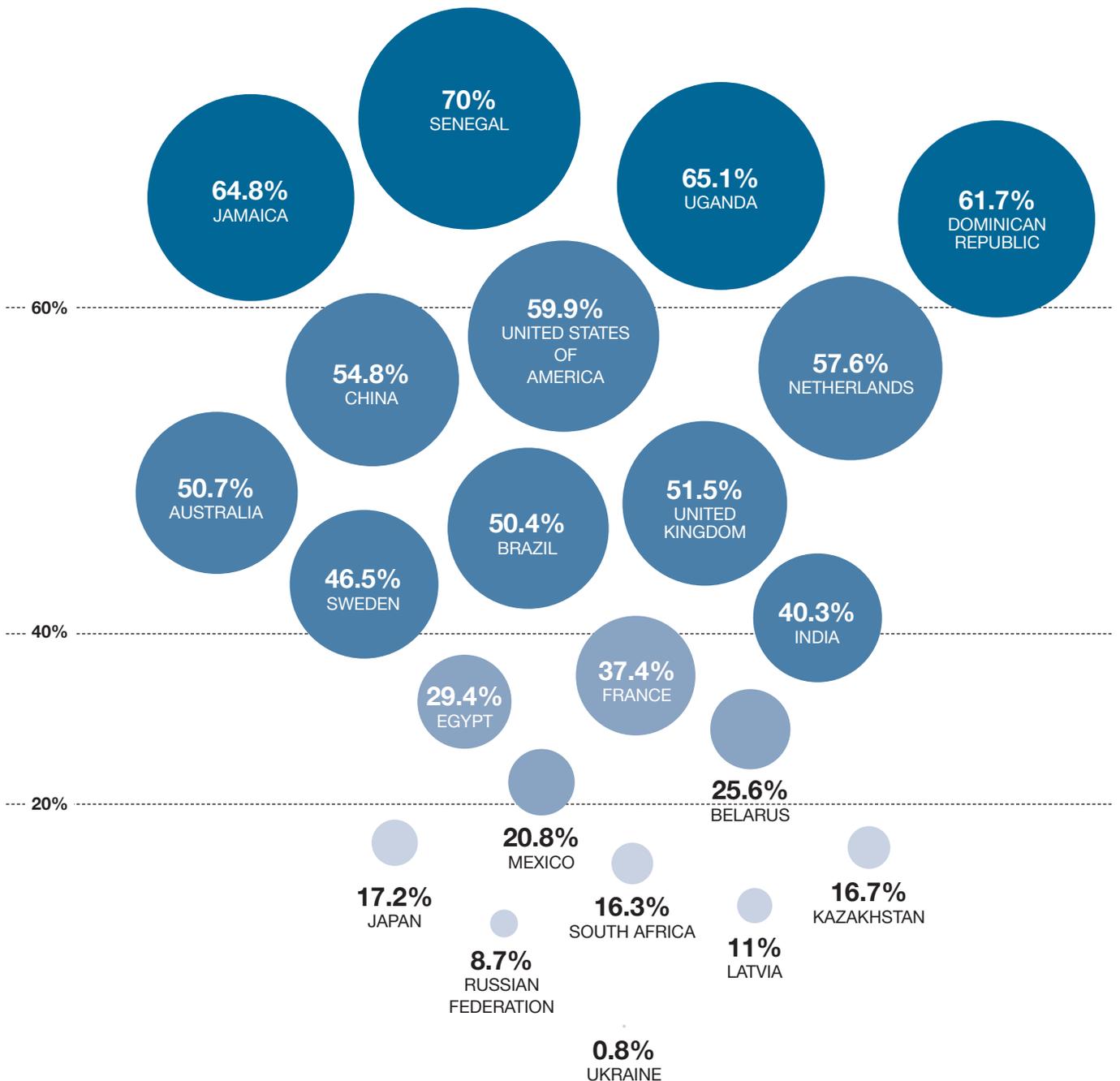
Where should the majority of the funding for HIV prevention focus?

Some 77% felt that sex workers and their clients, men who have sex with men (67%) and people who inject drugs (78%) are most at risk of HIV infection.

Is your country effectively responding to AIDS?



Is your country effectively responding to AIDS? (Per cent who responded 'yes' by country)



Almost everyone surveyed in sub-Saharan Africa said 'yes' AIDS was a problem for their country. In the Caribbean eight in ten agreed, while in Latin America, seven in ten said 'yes'.

However, when it came to funding priorities, people chose investments for young people and the general population over drug users, sex workers and men who have sex with men.

In eastern Europe and central Asia half of the people think that programmes should focus on people who inject drugs. In South and South-East Asia seven in ten, and in East Asia six in ten, say the majority of funding should focus on sex work. In the Caribbean, views are divided equally between sex work and injecting drug use.

Is AIDS a problem in your country and community?

Almost everyone surveyed in sub-Saharan Africa said 'yes' AIDS was a problem for their country. In the Caribbean eight in ten agreed, while in Latin America, seven in ten said 'yes'. The ratio of respondents in South and South-East Asia, as well as in eastern Europe, was six in ten who said AIDS was an issue in their country.

When asked if it was a problem in their community, the numbers dropped significantly. In the USA about one third (33%) felt that it was a problem in their community, while 70% thought it was a problem in their country. Similar trends were seen in most other regions of the world.

Do you worry about AIDS?

Three quarters of people surveyed in Latin America and the Caribbean and more than half in sub-Saharan Africa and South and South-East Asia are personally worried about AIDS.

Conversely, nine out of ten people in North America and nearly seven out of ten in western and central Europe do not personally worry about AIDS.

Risk of HIV infection

Aside from the Caribbean region, where six out of ten people felt they were personally at risk of acquiring HIV infection, more than three quarters of the people surveyed in other regions felt they were not at risk.

In sub-Saharan Africa 25% of people surveyed felt that they were at risk of HIV. A similar perception was held in Latin America and Egypt, as well as in eastern Europe and central Asia. People in Australia and the USA were the least worried about being at risk of acquiring HIV.

Can you protect yourself from HIV?

Individual confidence levels exceeded 75% in all the regions of the world. Nearly

all people in sub-Saharan Africa, North America, South and South-East Asia, Latin America, Oceania and the Caribbean were confident about protecting themselves from HIV. About 20% of the people surveyed in eastern Europe and central Asia as well as in East Asia were unsure about their ability to protect themselves.

Working and sharing a meal with someone living with HIV

Overall about 61% of the people asked would agree to work with someone living with HIV, while 20% would not. Acceptance of people living with HIV was highest in sub-Saharan Africa and the Caribbean, where eight in ten reported positive attitudes.

In sub-Saharan Africa and Latin America nine out of ten had no reservations about sharing a meal with a person living with HIV. In Egypt, 49% said 'no' and 30% said 'yes' they would knowingly eat with someone living with HIV.

Treatment, not jail

A majority of people (65.1%) responding said that people who inject drugs should receive treatment rather than be sent to jail. In Latin America nearly nine in ten (86%) favour this option. Similarly, two thirds (67%) in eastern Europe and central Asia as well as in South and South-East Asia and more than half in East Asia prefer treatment over incarceration.

Travel restrictions

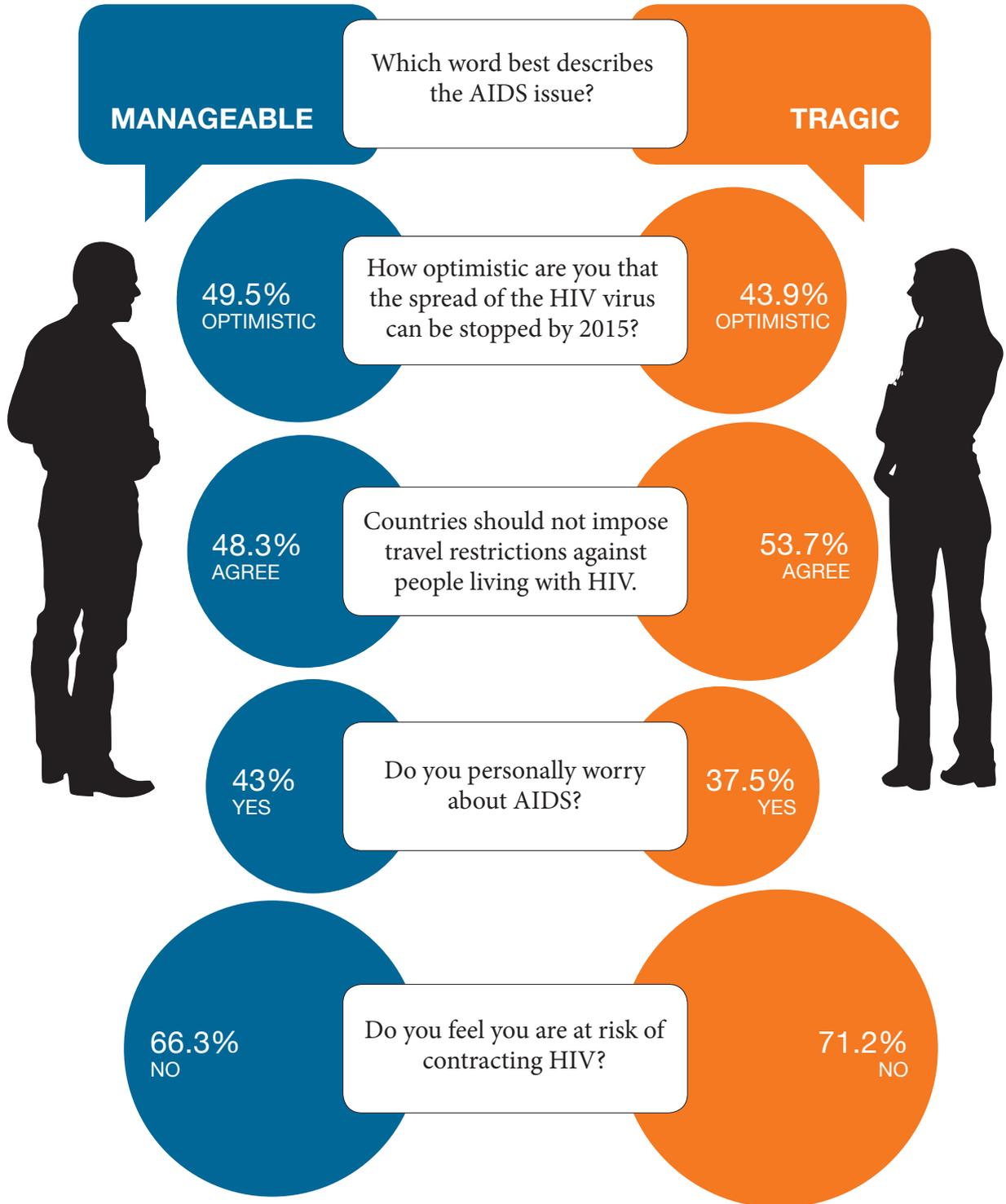
About half of all the people surveyed say there should not be travel restrictions for people living with HIV. Fewer than half of the respondents in western and central Europe, sub-Saharan Africa, South and South-East Asia and the USA said that there should be travel restrictions.

Information about the survey

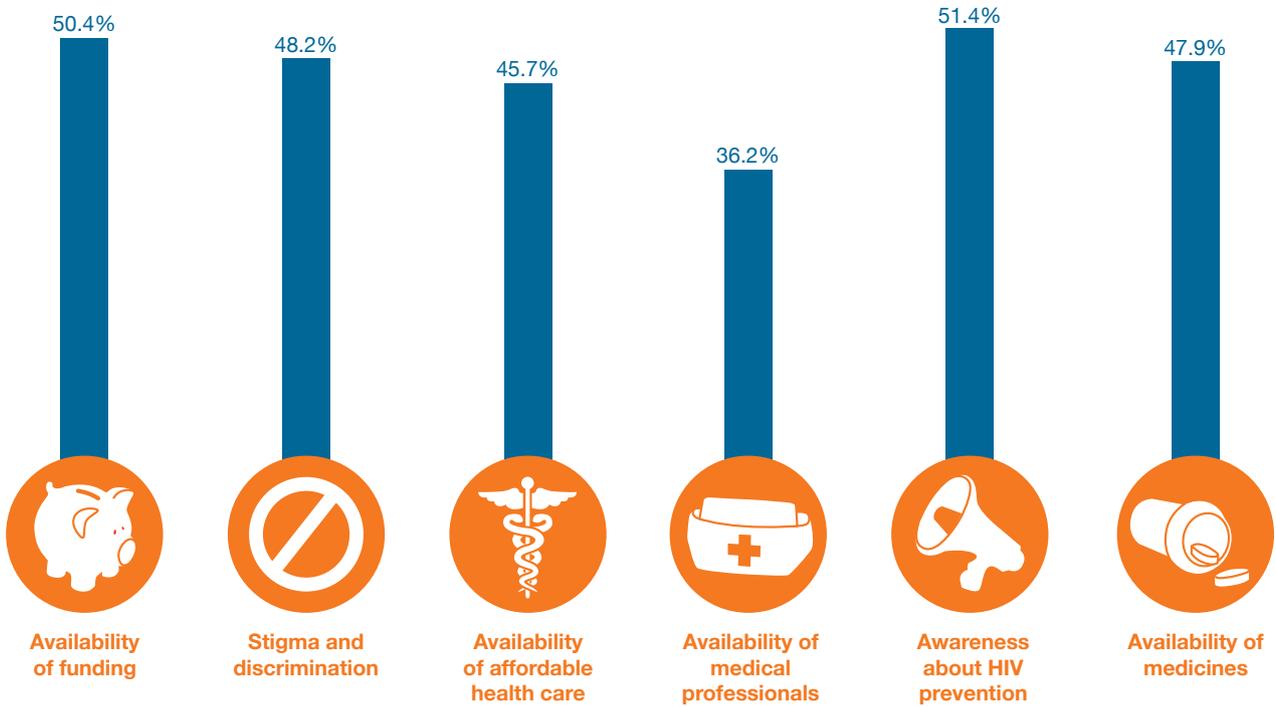
Zogby International was commissioned by UNAIDS to conduct an online survey of adults with Internet access in 25 countries. A total of 11 820 respondents participated in the study. A sample of Zogby International and its partner's online panel members was invited to participate. The study was conducted between 30 March 2010 and 21 May 2010. ●

The full report can be found online at unaids.org.

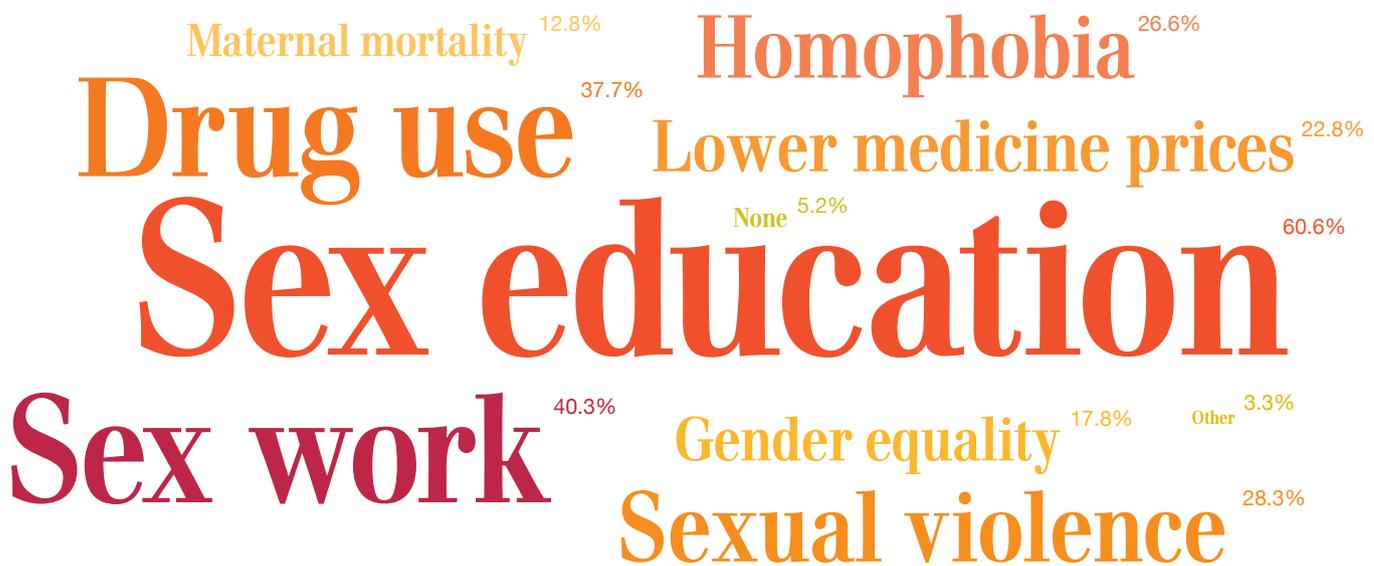
How differently do men and women feel about AIDS?



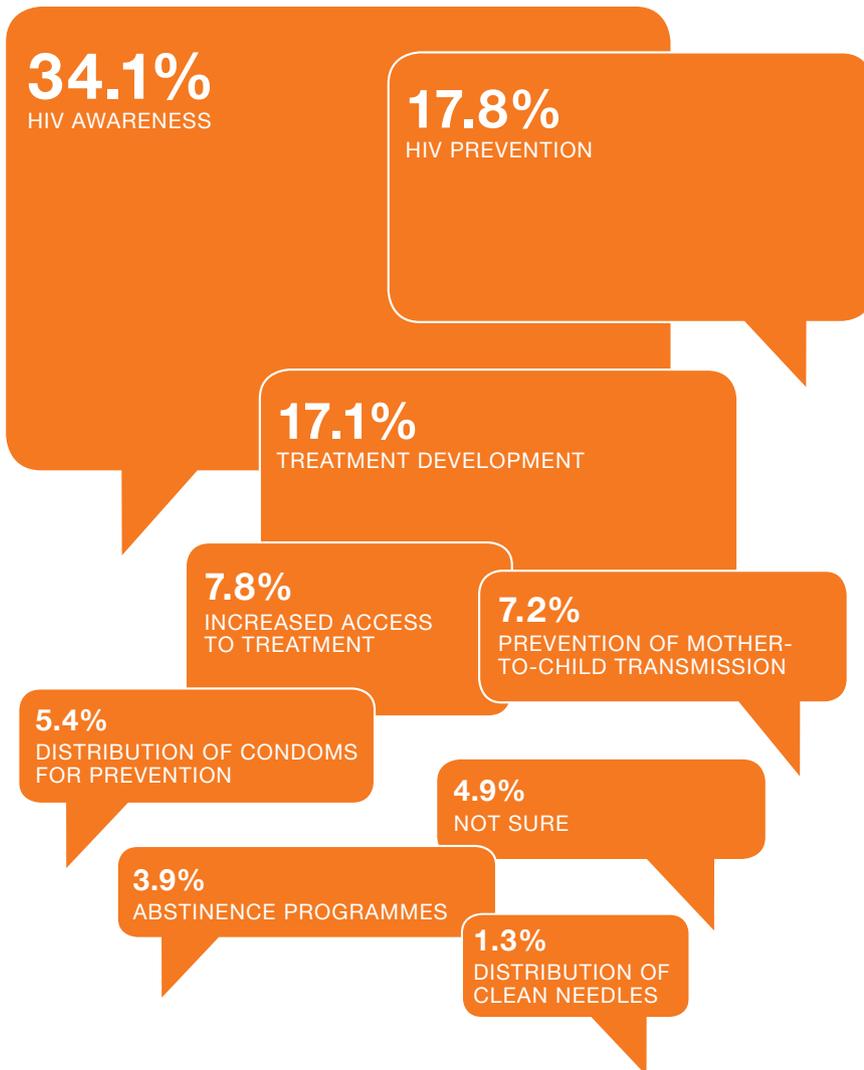
Which of the following obstacles are keeping the world from an effective AIDS response?



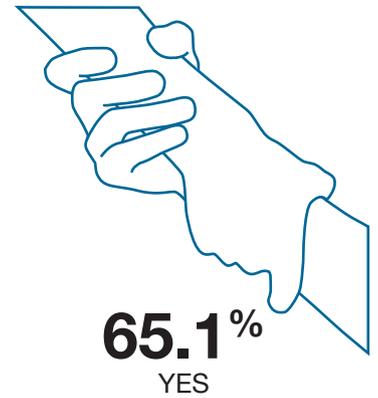
The AIDS response provides an opportunity to educate the public on other issues. Which from the following list, if any, do you think have been dealt with more effectively due to the AIDS response?



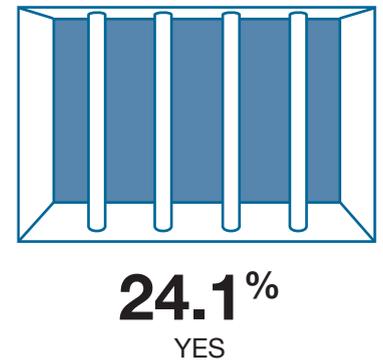
What has been the greatest achievement in the AIDS response so far?



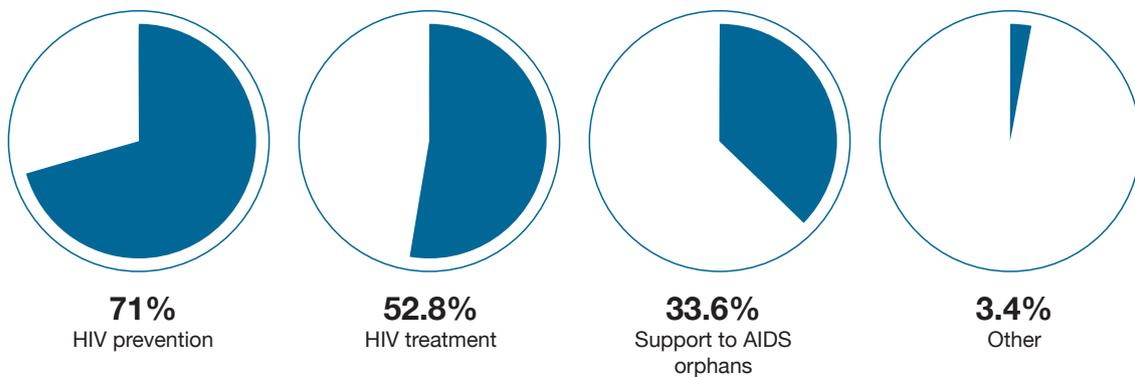
I believe people who inject drugs should receive treatment.

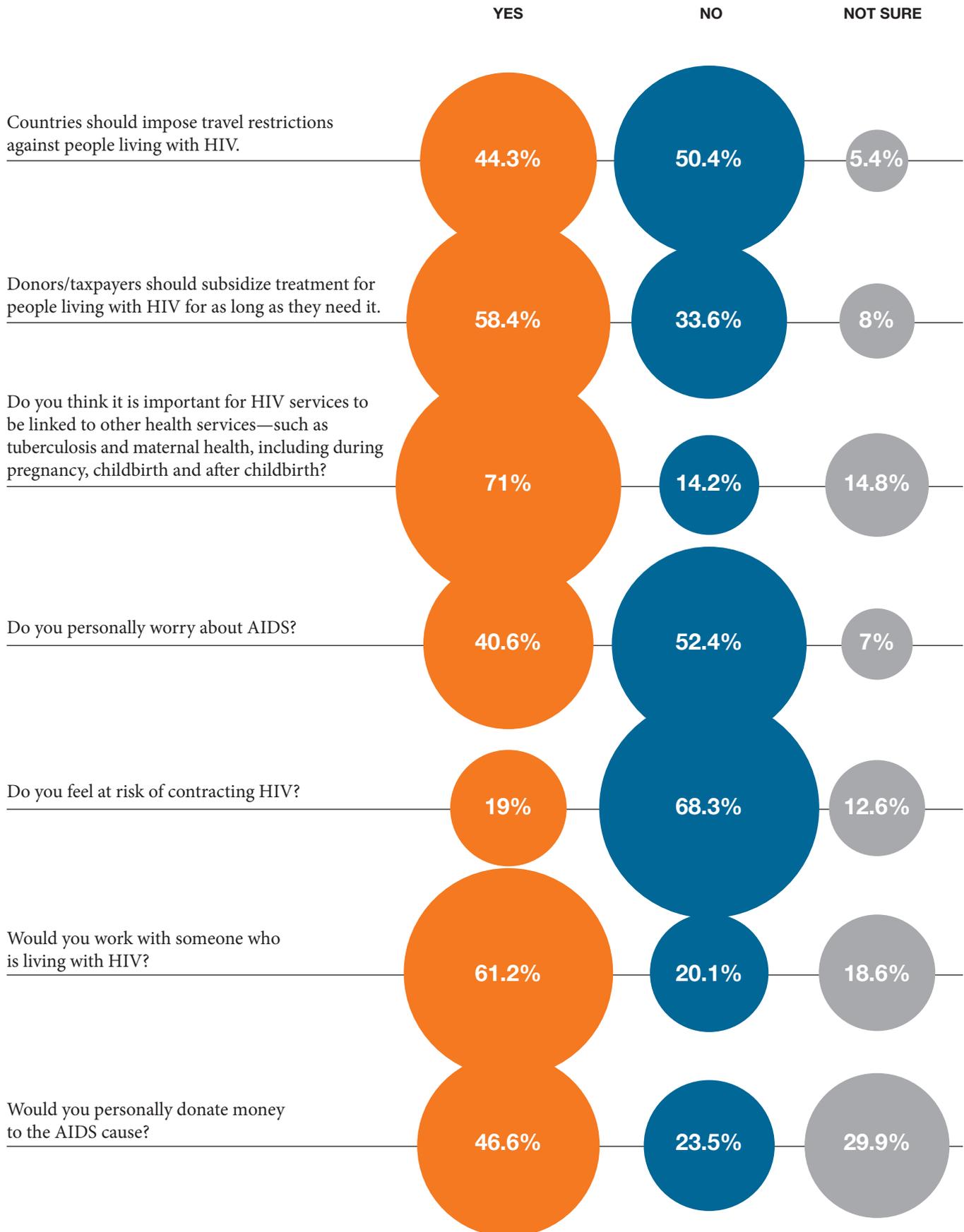


I believe people who inject drugs should be put in jail.



Where should resources for the AIDS response go?

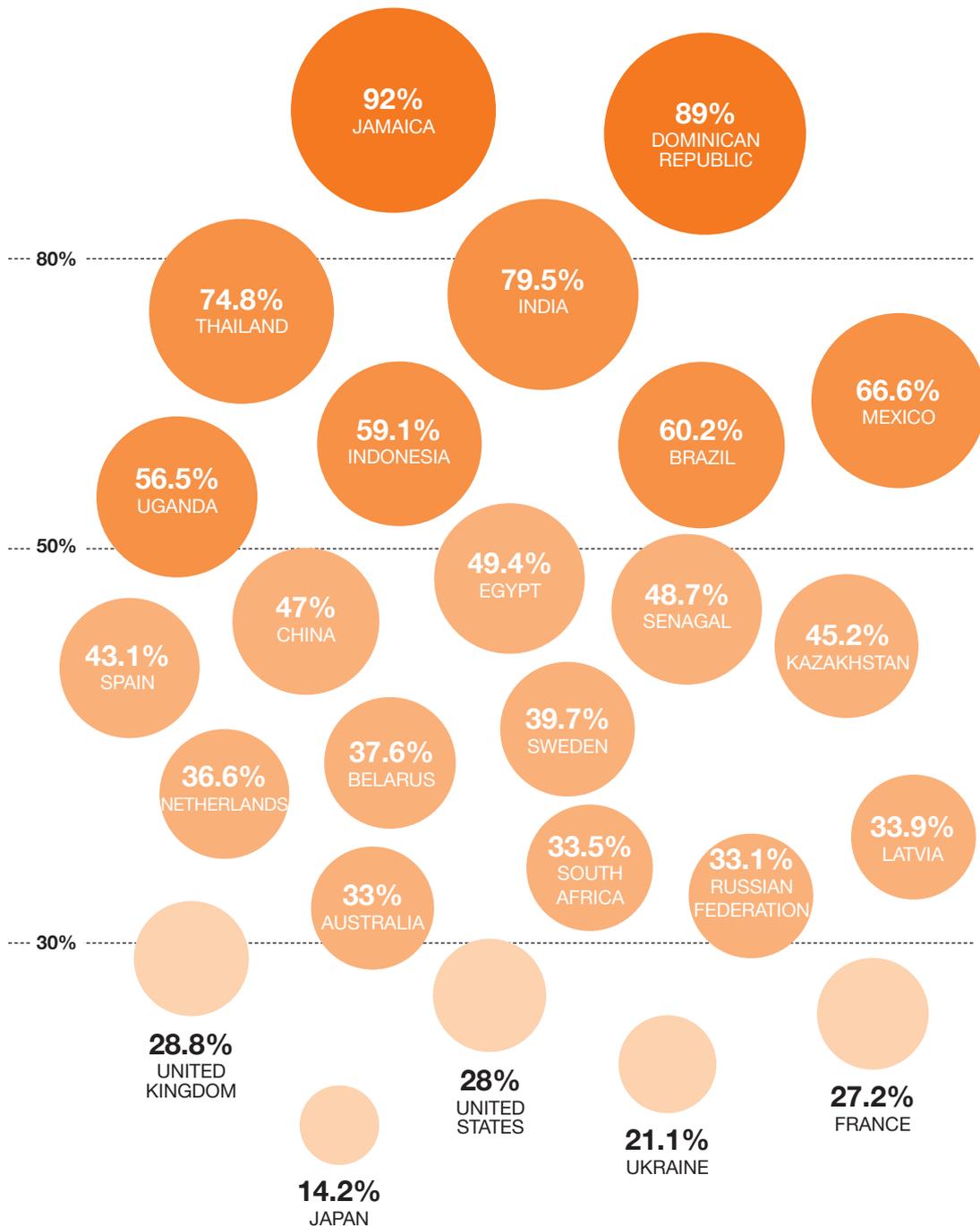




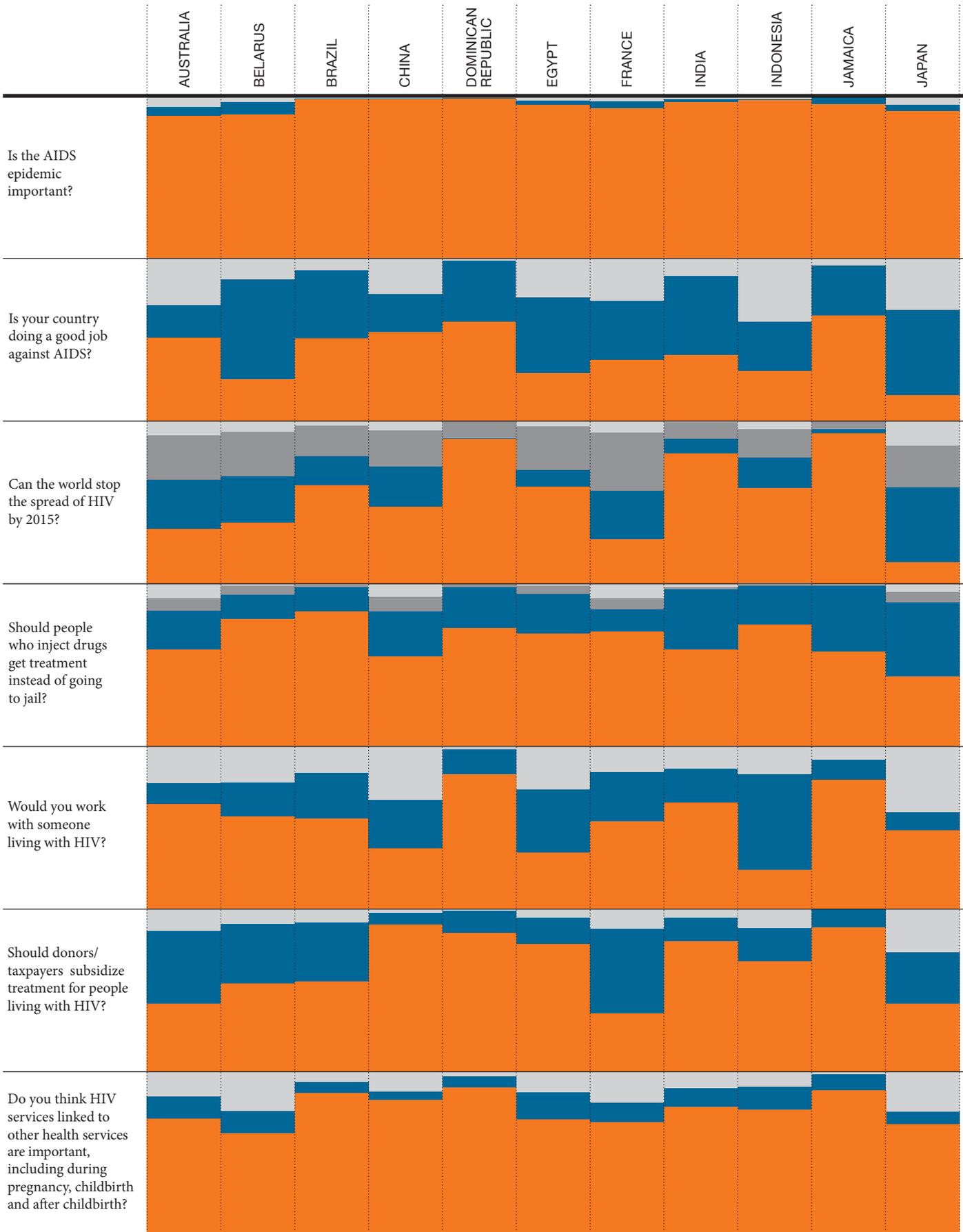
How optimistic or pessimistic are you that with the proper use of resources the spread of HIV can be stopped by 2015?



Can we stop the spread of HIV by 2015?
(Per cent who responded “optimistic” by country)



■ YES
 ■ NO
 ■ NEITHER/NEUTRAL
 ■ NOT SURE
 Each country rectangle equals 100%.



IS THIS THE FUTURE OF TREATMENT?



IMAGINE TREATMENT 2.0

A radically simplified treatment platform that's good for HIV prevention too!

Imagine an easy to use pill—low in toxicity and doesn't lead to drug resistance.

Then imagine a drastically reduced need for costly labs—monitoring can be done at home.

Now imagine no stock-outs—a low-cost supply chain and the community ensures that pills are there when you need them.

Finally imagine that treatment is contributing greatly to the prevention effort.

One third reduction of new HIV infections globally

The latest studies show that a reduction in new HIV infections of up to a third could be achieved globally if there is a radical overhaul of the way the world provides antiretroviral therapy and if global leaders meet their commitments of ensuring that all people in need of treatment are on it.

It's called treatment as prevention and it is one of the five pillars of the new Treatment 2.0 platform. In an effort to maximize the value of antiretroviral therapy, a radically simplified approach is needed. This includes the development of better combination treatment regimens, cheaper and simplified diagnostic tools, and a low-cost community-led approach to delivery.

Everyone wants to do things smarter, faster and better.

But the reality is that treatment today is complicated. From starting HIV treatment to maintenance, the treatment process works, but each step is cumbersome and expensive. Up to 80% of the cost of treatment isn't for the medication but for the systems to get it to a person and to keep him or her on it. Globally, only one third of people who need treatment are on it. HIV testing is underutilized—most people still find out that they are HIV-positive when they develop clinical symptoms of AIDS. Antiretroviral therapy is not homogenous in cost, effectiveness or tolerability. And resistance can build up, making it necessary to maintain costly labs to monitor each person on treatment.

To get smarter, faster and to save more lives, the world will need to shift resources and thinking

Today, an estimated 5 million people living with HIV in low- and middle-income countries are receiving treatment, up from about 400 000 in 2003—a more than 12-fold increase in six years.

Despite progress, the global coverage of antiretroviral therapy remains low. For every two people newly on treatment, five more become newly infected. A majority of people living with HIV are unaware of their HIV status. And although easily preventable, rates of mother-to-child transmission of HIV in many countries remain high.

In many settings, HIV prevention and treatment are provided through a sophisticated delivery system requiring specialist doctors who tend to focus on HIV only. This system is often overstretched, due to an increasing number of patients, a shortage of trained medical personnel and financial constraints. Many in need of treatment live in rural settings, far from specialized care.

With competing global priorities and an economic crisis, a longer-term sustainable solution is needed to ensure that world leaders can keep their commitments to achieve the goal of universal access to HIV prevention, treatment, care and support.

The most recent World Health Organization (WHO) guidelines for antiretroviral therapy call for earlier initiation of treatment and the use of simpler, better drug regimens—recommendations that will further decrease morbidity and mortality as well as vertical and horizontal transmission. However, there is still a long way to go.

Treatment 2.0 opens a new door...

PILLAR 1**Creating a better pill and diagnostics**

When treatment for HIV first came around in 1996, it was a tough pill to swallow—literally. It meant on average taking 18 pills a day, of varying shapes and sizes. Some were taken with food, others on an empty stomach, and rigorous monitoring of the time of day the pill was taken was needed in order to mitigate the risk of the virus becoming resistant to the drugs.

But it worked. People called it the Lazarus effect: people near death became healthy again.

Antiretroviral therapy works by suppressing the virus and stopping it from reproducing. If the active component of the drugs is not kept constant in the body, the virus can mutate, continue to multiply, and become resistant to the drug. By adhering to a treatment regimen—for most combinations this means taking the medication at a given time of day, two to three times a day—drug levels are kept even.

The more different types of pills a person takes, the more substances the body has to accustom itself to, the higher the risk of developing side-effects. Many people living with HIV who have been on treatment can testify to the side-effects—from depression and fever to lipoatrophy (the losing of fat from certain areas of the body).

Developing resistance to a regimen is a well-founded fear—once a regimen is no longer effective, people living with HIV may have to move to a second-line of treatment.

Access to second-line treatment is still rare in most low- and low-middle income countries due to the high cost of the pills and more complex monitoring systems and supply-chain management.

Improving effectiveness and ease of use, and lowering side-effects and resistance, need to be considered in the development of new treatment options.

Some regimens already exist as fixed-dose combinations, where multiple drugs are in one pill, but options that have fewer side-effects and have less potential for long-term toxicity (dose optimization, minimal requirements for laboratory monitoring) and that are more resilient and tolerant to

treatment interruptions (to minimize the development of drug resistance) are needed.

In an ideal scenario, having such a pill could do away with the current need for second- and third-line treatments.

At the same time, simpler diagnostic tools and technologies are in short supply. Pregnancy tests can be used at home. People who have diabetes can check their blood glucose level nearly anywhere. And if a mother is worried that her child has a fever she has many choices on how to check her child's temperature. All of these diagnostics are easy to use, usually without the need for a doctor or a lab.

The same cannot be said currently for checking HIV status or CD4 and viral load testing. While robust rapid tests are more and more used for the first HIV test, monitoring CD4 counts and viral load requires expensive and time-consuming lab-based tests.

Treatment monitoring that is closer to the patient can lead to better treatment results. It can facilitate early detection and treatment of HIV and can ensure appropriate and rapid response to drug resistance, improving outcomes for people on treatment and reducing the development and spread of drug-resistant strains of the virus.

Innovation is needed to develop inexpensive point-of-care diagnostic tools like simple dip-stick tests to measure CD4 cell counts, viral load or tuberculosis infection.

What is a CD4 count?

CD4 cells are a type of lymphocyte (white blood cell). These cells are an important part of the immune system and are sometimes called 'helper' cells. They lead the attack against infection. The CD4 cell count is a key measure of the strength of the immune system. Because HIV targets CD4 cells specifically, the lower the count, the greater the damage HIV has done.

PILLAR 2**Treatment as prevention**

Since 1991, the world has known that effective antiretroviral therapy can help to prevent HIV transmission. This has been the case for vertical transmission, for example ensuring that pregnant women living with HIV don't pass on the virus during pregnancy or childbirth.

Recently, however, the dramatic impact of treatment on other forms of HIV transmission has become better understood. Evidence clearly shows that successful viral suppression through treatment can substantially reduce the risk of vertical, sexual and blood-borne HIV transmission.

A recent study, supervised by the University of Washington and largely funded by the Bill & Melinda Gates Foundation looked at 3400 heterosexual couples—each with one HIV-positive and one HIV-negative person—from seven countries in sub-Saharan Africa. When the HIV-positive partner was on treatment, the researchers found the HIV transmission rate was 92% lower than among couples where the person living with HIV did not receive treatment.

This study also confirmed that a significant proportion of all HIV transmission happens during the phase when people living with HIV develop increasing immune impairment (which is marked with increasing viral load and decreasing levels of CD4 counts).

Treatment can become part of a combination prevention strategy. Optimizing treatment coverage will also result in other prevention benefits, including lower rates of tuberculosis.

Treating everyone in need of treatment according to current treatment guidelines could result in a one third reduction in new infections globally.

Further research is urgently needed in order to better understand the possibilities and role of antiretroviral therapy in earlier asymptomatic phases of HIV infection.

What it's like being on treatment

Rodrigo Pascal

Partnerships Officer, UNAIDS

I was diagnosed with HIV in 1996 while living in Santiago, Chile. At the time, there was only limited access in the country to low-quality antiretroviral regimens.

Doctors connected me with a support group for people living with HIV that met weekly at a hospital on the outskirts of Santiago. I remember at my first session feeling amazed by the helplessness of others in the group—they were in a terrible condition, wasting away, skinny, eyes wide with fear, waiting to die.

As a middle-class Chilean citizen, I could access treatment immediately. Most of the people in my support group were unable to afford the medications and had been placed on a hospital waiting list. I was angry and enraged at these blatant inequalities in access to health.

When I first started antiretroviral therapy in 1997, I took 12 to 14 pills a day. Throughout the years, I have moved from one regimen to another. In all of my years of treatment, I have never developed resistance to any one drug, but I've had some very strong side-effects.

When taking Sustiva, for example, which is a commonly-used antiretroviral drug, I had vivid dreams, nightmares and other psychological issues. At one time, my head became noticeably swollen and disfigured—an allergic reaction to the medication. I had to stop the drug, go back to the hospital and try a new regimen.

Another antiretroviral drug, a protease inhibitor, left me with lipodystrophy, which is a loss of fat in some parts of the body and an accumulation of fat in other areas. I could barely look at myself in the mirror; it was very bad for my self-esteem.

In 2006, after almost ten years of antiretroviral therapy, all of my coronaries were completely blocked. I had to have four bypass surgeries to survive. Given my underlying heart condition, I probably would have had

heart problems many years down the road—but not at the age of 50. I am actually taking more drugs now for my heart condition than for HIV.

My current antiretroviral regimen is pretty simple. I take three pills a day: one in the morning and two in the evening. I've had a few minor side-effects, but, on the whole, I feel good and the treatment is working.

Mrs Lineo Mafatle

(name has been changed)

Mother of two, Lesotho

I first found out I was HIV-positive back in 2001. I didn't know that my husband had tested positive for HIV, but I started noticing changes in his behaviour—he started staying out late, started drinking a lot. One day he told me he needed to tell me something that would hurt me a lot, something that might even kill me. Then he said: "I'm HIV-positive."

First, I was very upset. I screamed and shouted at him. After a while, I started preparing my mind that I have to accept my test result if I get tested, so that I could live longer. We started talking about it and agreed that we would be there for each other, and we were ready to support each other, no matter what my test result was.

My husband came with me when I went for a test, and I tested positive. This was in 2001 and back then I didn't even think about treatment. It was so expensive, I didn't even try to find out how much it cost, as knew I would not be able to afford it.

In 2003, when the first antiretroviral therapy centre opened in Lesotho we went together to the clinic and my husband was initiated on treatment. But my CD4 count was 250—that was the first time I had my CD4 count checked—so I did not have to start my treatment yet.

At the centre they told me I had to go for check-ups every three months, which I did. It was not until 2005, when my CD4 count dropped below 200, that I started taking antiretroviral drugs. Even though I did not have

any symptoms, I was what they called stage 1, I still started taking them.

In 2006, I experienced my first side-effect of one of the drugs, zidovudine. The fat on my body started redistributing itself and I got really thin on my backside, my legs and even my face. This meant I had to change one of the components of my treatment.

I take my three pills two times a day, every 12 hours. Apart from the fat distribution, I have also experienced a pain in my legs. I try to make sure that I massage them to make sure I don't feel it so much—I need to accept it as part of the treatment. I think at this point it is better for me to try to live through whatever minor side-effects, so I don't have to start on a second-line drug, which might have even worse side-effects than I am experiencing now.

The most difficult thing about being on treatment is adherence. Once you are on treatment and have been on treatment for some time, you get used to it, and you don't even remember if you have taken them or not, asking yourself "did I take them today?" Now I have a pill-minder where I put the pills for every day so I can check if I have taken them or not.

I think adherence is very challenging. But treatment has also given me hope. When I first found out I was HIV-positive I thought I was going to die, and that was very difficult. So for us to have antiretroviral drugs here in Lesotho, until we find a cure, treatment gives hope.

If I was allowed to dream of the future of treatment, for something like HIV where you have to take treatment for life, I think the main thing I would want would be for the number of doses to be reduced.

Pillar 3**Stop cost being an obstacle**

Despite drastic reductions in drug pricing over the past ten years, the costs of antiretroviral therapy programmes continue to rise.

The reported proportion of people on second-line regimens remains low. In 2008, a vast majority of adults (98%) and children (97%) surveyed in 43 high-burden countries were receiving first-line antiretroviral therapy regimens.

In low- and middle-income countries, the average annual cost of the most widely used first-line drug treatments was US\$ 143 per person in 2008, a price reduction of 48% since 2004. There was an even greater price reduction in paediatric formulations, from US\$ 436 per person per year in 2004 to US\$ 105 in 2008. This all helped to contribute to a wider availability of treatment. Second-line regimens continue to be more expensive.

Drugs can be even more affordable—however, potential gains are highest in the area of reducing the non-drug-related costs of providing treatment. Currently these costs significantly outweigh the cost of the drugs themselves.

Cost savings can be found in every step of the process. A better, single-dose pill with decreased toxicity and that was resistant-proof would have fewer needs for treatment monitoring. This would lead to a reduced number of interactions with health-care providers—less health-care time spent on monitoring people enrolled on antiretroviral therapy programmes frees up resources to be devoted to other pressing health issues.

A decreased frequency of interaction with health-care providers also lowers out-of-pocket costs, such as transport fees, for the care seeker.

Simplified treatment and diagnostic approaches would allow for the decentralization of services from specialized health systems to primary and community health-care providers, where antiretroviral therapy administration and monitoring moves from doctors to nurses and community health-care workers.

These simplified approaches will also ensure that investments in HIV treatment directly benefit the delivery of other health programmes, as they happen through the same health-care sites and with the same health-care workers. Infrastructure investments and training benefit more efficiently the delivery of broader health services.

Decentralizing HIV treatment in Malawi

According to government sources, nearly 200 000 people living with HIV in Malawi were accessing antiretroviral therapy in 2009, up from about 10 000 in 2004. Between 2003 and 2009, the number of sites in Malawi providing antiretroviral therapy increased from nine to 377. A decentralized approach to HIV treatment and care was critical to this national success in antiretroviral therapy scale-up.

Under Malawi's first national antiretroviral therapy guidelines of 2003, only doctors and clinical officers—based primarily at larger health facilities in urban settings—were empowered to start patients on antiretroviral therapy. Medical assistants and nurses could monitor and follow up on a patient's progress, but were not able to prescribe treatment.

With about 85% of the population in Malawi living in rural areas, treatment access became an important issue.

“Some people had to travel 100 kilometres to be assessed if they were eligible for antiretroviral therapy,” says Professor Anthony Harries, an adviser to the Malawian government's HIV programme from 2003 to 2008. “Though this was a free service, it meant time away from work. Those who did manage to access antiretroviral therapy had great difficulty continuing treatment because of the cost of transport.”

Malawi's new antiretroviral therapy scale-up plan (2006–2010) included a number of strategies to bring HIV treatment closer to the primary point of care, where the majority of the population lives. Under the new guidelines, medical assistants and nurses were empowered to initiate antiretroviral therapy—from 2006 and 2008, respectively.

In partnership with the Ministry of Health and district-level medical facilities, many community-based health centres were accredited as antiretroviral therapy delivery clinics. About 88 000 people started antiretroviral therapy in 2009 alone. Of the 377 sites in Malawi in which antiretroviral therapy is now offered, more than 50% are simple health centres.

“Through this decentralized approach, we were able to reach out into the communities, where people otherwise could not access treatment,” says Dr Frank Chimbwandira, Director of the HIV/AIDS Department in Malawi's Ministry of Health. “We were also able to improve treatment follow-up, as more people could come back and forth from the health centres to access their medication.”

Pillar 4

Improve uptake of HIV testing and linkage to care

The uptake of HIV testing and counseling and linkage to care will need to be improved drastically if the promise of treatment and treatment-centred HIV prevention approaches are to be realized.

Globally only about 40% of people living with HIV know their HIV status—the large majority of whom find out they have HIV by developing clinical AIDS, with their immune system already seriously weakened.

Stigma and discrimination remain as the foremost impediment to HIV testing utilization. For many people even seeking out HIV testing can lead to serious, even life-threatening, exposure to violence, legal action and loss of family, employment, and property. And where care, treatment and support services are unavailable, there is little incentive to take an HIV test.

However, progress is being made. South Africa is scheduled to reach 15 million people in two years. In the United Republic of Tanzania, three million people received HIV tests in six months; in Malawi 200 000 people took HIV tests in one week.

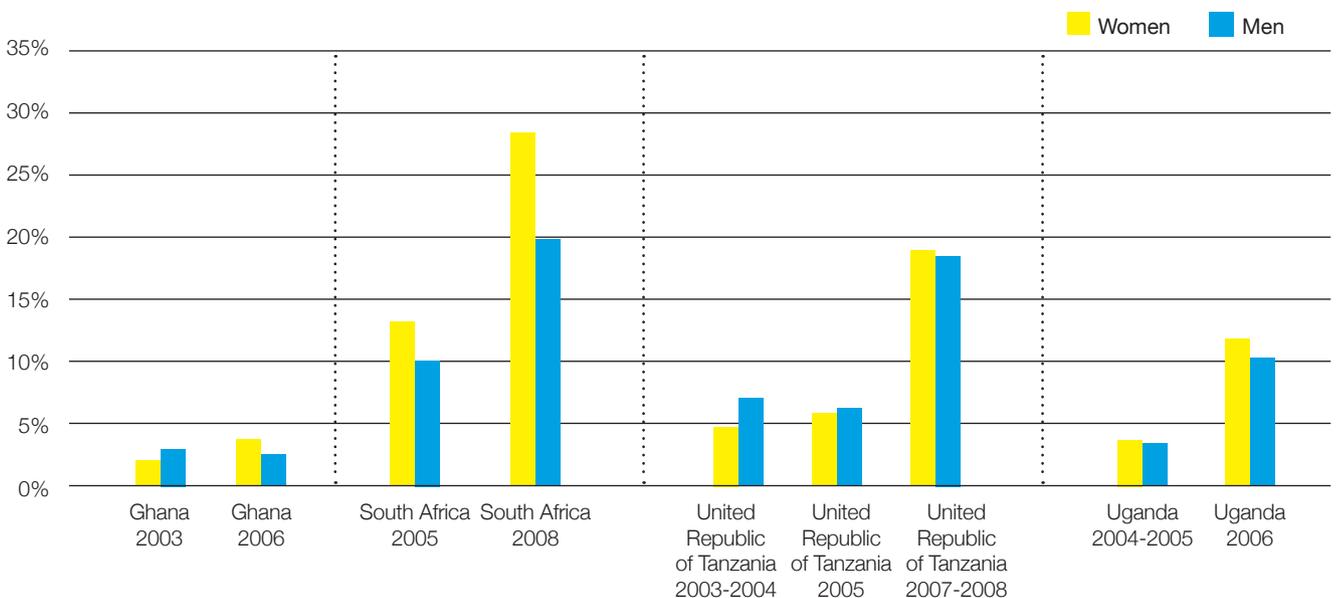
Community-based organizations, often led by people living with HIV, provide

an important and effective bridge into HIV testing and a link to treatment and prevention services. Peer-based services are often more trusted than government-led services, especially by populations at higher risk, which can be fearful of government-run health-care approaches.

The results of programmes from countries as diverse as Bolivia, Botswana, China, India, the Russian Federation, Rwanda and Uganda all show the positive impact that individual engagement with community-based services has on increased HIV testing rates and increased use of HIV prevention and treatment services, as well as improved treatment adherence and prevention practices and a reduction in stigma.

We need to learn from and scale up successful models of partnership between health service providers and community-based service providers to assist in stigma reduction and increased utilization of services in particular by populations at higher risk. Many examples exist in countries, including programmes that receive support from the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

Progress is possible: percentage receiving an HIV test and test results in the 12 months preceding the survey in countries with repeat population surveys, 2003–2008



Source: Demographic and Health Surveys

Pillar 5

Strengthen community mobilization

Drug users, men who have sex with men, sex workers and poor women often have little reason to trust government-provided health services. Fear of exposure of their HIV status keeps many people from seeking HIV testing and health services.

Community-based approaches to build trust, protect human rights and provide opportunities for socialization directly improve the ability of people to use HIV services and to benefit from antiretroviral therapy and prevent new infections. In fact, much of the success to date in the AIDS response is due to the unprecedented engagement of affected communities as advocates, educators and service providers.

In the late 1980s, TASO (the AIDS Support Organization) developed models for community-based support services in Uganda that were duplicated all over the world.

Grupo Pela Veda in Brazil successfully helped advocate for full antiretroviral therapy coverage in the country, which led to a 50% drop in AIDS-related deaths in one year.

Work by AIDS activists in the United States of America helped to cut the time

it takes to approve new drugs for life-threatening illnesses in half, leading to the early approval and availability of highly active antiretroviral therapy in 1996, saving millions of lives.

The All-Ukrainian Network of People Living with HIV managed a Global Fund grant to provide treatment access and prevention services in response to one of the world's fastest growing HIV epidemics.

The Treatment Action Campaign in South Africa successfully confronted a government that failed to address the most destructive HIV epidemic in the world, leading to the development of treatment access programmes throughout the country and an increased commitment to HIV testing and prevention.

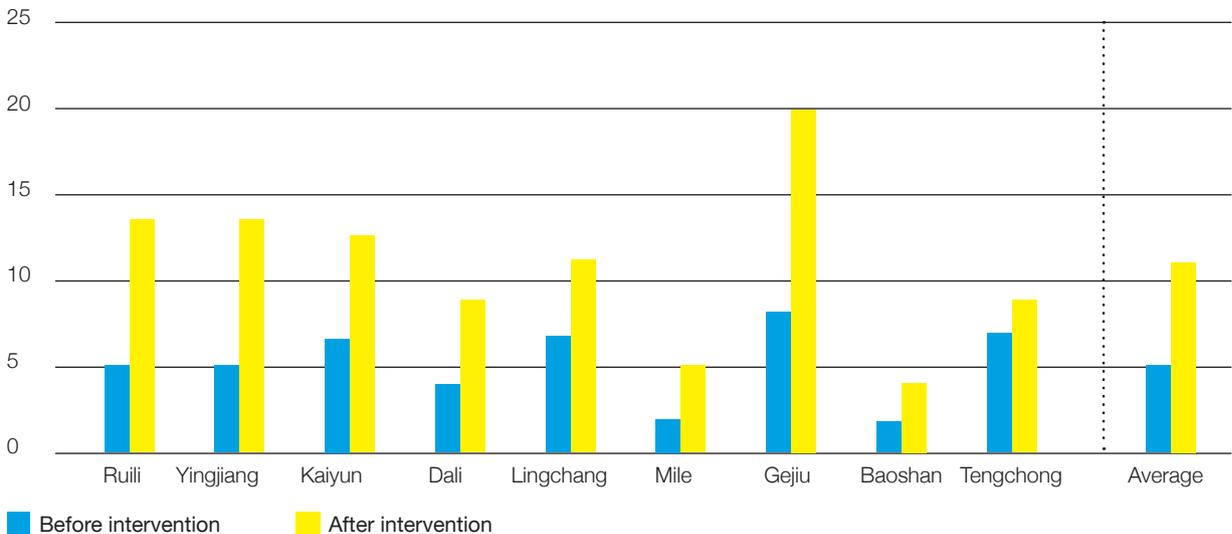
Simplified approaches to treatment offer unique opportunities to increase community-based delivery of outreach and support services, with direct positive effects for prevention and for lower-cost treatment.

For example, in Nepal the National Association of People Living with HIV has been supporting eight community-based organizations by providing counselling for discordant couples, condom promotion and referral for treatment, care and support services.

In China, an independent evaluation of 26 community-based organizations, all run by people living with HIV and supported

China: HIV treatment

More than doubling in enrollment after the introduction of community outreach



Source: AIDS Care China, 2009. Data for ten Yunnan sites in 2008.

by the International Treatment Preparedness Coalition (ITPC) HIV Collaborative Fund, showed that participation in support services provided by these organizations increased treatment adherence rates, brought more people into HIV testing and health services and increased CD4 cell responses to antiretroviral therapy.

A WHO evaluation of 186 community-based mobilization and service delivery projects in eastern Europe, South-East Asia and Latin America found that local-level community-based organizations led by people living with HIV are often best able to reach populations at higher risk of HIV and to get people to utilize health services effectively.

Community organizations can lead and manage access to HIV prevention, treatment, care and support, especially for populations at higher risk.

Strengthening community mobilization efforts to increase demand for HIV prevention, treatment and testing, ensure protection of human rights, advocate for equitable care, and provide community-based prevention and care support services. ●

Community buy-in

David Barr

Director of Development and Special Projects, International Treatment Preparedness Coalition and UNAIDS consultant

What is different?

This is a major shift in thinking. Up until now, treatment and prevention programmes have been relatively siloed. We used to think about treatment primarily as a way to reduce morbidity and mortality. Recognizing that treatment also prevents new infections provides us with new opportunities to better integrate prevention and care efforts. It requires that we recalculate the cost-effectiveness of providing treatment.

Why is community engagement critical to the success of a decentralized approach to HIV treatment and care?

Without the engagement of affected communities, it's impossible to get the people who are most at risk into care, and to get them to utilize care effectively. Global utilization of HIV testing and counselling is dismal. Without a greater investment in community mobilization, it will be impossible to improve uptake of HIV testing and prevention and care services. This is true across the board and most poignantly true for populations at higher risk, who experience severe discrimination when they seek out health services—the rural poor, men who have sex with men, drug users, sex workers. These groups have a very good reason not to trust public health officials and public health services that their governments run.

What are some of the risks of such an approach (human rights, quality of care, etc.)?

All HIV testing and care has to be provided within a framework of human rights protection. There's nothing in the Treatment 2.0 approach that changes that. The only way people can engage in these services is if they're not at risk of having their human rights violated. Treatment 2.0 will improve quality of care by bringing more people into the realm of care providers and making treatment and diagnostics easier to use.



Young people need access to information about HIV.

MAKING SENSE OF THE MONEY

*OUTLOOK makes
the case for the
necessities of life.*





IS HEALTH A NECESSITY OR A LUXURY?

Your gut reaction? A necessity.

People should have access to health care—right?

However, the answer, based on health-care spending behaviour, seems to indicate that people treat health care as a luxury. In most countries health spending increases at the same rate as the overall economy grows. In an economist's world, where necessity has an elasticity of 0 and luxury an elasticity of 1, health care has an income elasticity of close to 1 (see box).

So how can your gut reaction be made to mirror reality?

OUTLOOK looks at the possibilities.

More health investment

In good economic times, health care investments rise. Since health care has an elasticity of close to 1, a per-capita income increase of 1% would lead to an equal increase in demand for health. And the world has seen this happen.

However, relying on a growing economy is unlikely to work across the board. Not all economies are big enough to be able to raise the resources required to meet and sustain health needs. If it had been left solely to market forces, few people would be on HIV treatment today.

Worldwide health investment will continue to be made up of a combination of international assistance and domestic investment. Today health investments in low- and middle-income countries have reached almost US\$ 700 billion.

It could be said that what's been good for the AIDS response has also been good for global health in general. Funding for the AIDS response has ensured that more money has gone into tuberculosis and malaria programmes.

Spending on HIV amounted to nearly US\$ 15.6 billion in 2008. In countries where data exist, approximately 70% of the spending in low- and middle-

income countries comes in the form of international assistance. The remainder is funded by national revenues and out-of-pocket spending by individuals and families.

Understand the limits of domestic spending on HIV

The Abuja Declaration recommended that countries' spending on health should be about 15% of the government budget. But what does this really mean on the ground?

In 2008, the Democratic Republic of the Congo passed landmark legislation, declaring it a state responsibility to provide or facilitate access to HIV prevention, treatment, care and support for all of its people. UNAIDS estimates that the total resource needs for the country—where between 300 000 and 400 000 people are living with HIV—for 2010 are about US\$ 330 million, about 3.8% of the total economy.

DRC's overall economy might not be as vulnerable to economic shocks as other countries, according to World Bank indicators. The country's economy is estimated to be US\$ 9 billion. Of this, the government's share of revenue is

UNAIDS ESTIMATES THAT GOVERNMENTS SHOULD ALLOCATE BETWEEN 0.5% AND 3% OF GOVERNMENT REVENUE ON HIV, DEPENDING ON THE HIV PREVALENCE OF THE COUNTRY.

about 13%, and of this it spends about US\$ 3.8 million, or 0.3%, on HIV.

UNAIDS estimates that governments should allocate between 0.5% and 3% of government revenue on HIV, depending on the HIV prevalence of the country.

If the Democratic Republic of the Congo were to increase its national contribution to 0.6%, appropriate to its HIV prevalence levels, it would merely spend another US\$ 2.9 million. The country would still fall short by US\$ 323 million. To meet its constitutional obligations, the country has to either tax its people more or rely on international assistance.

At the end of 2008, international assistance provided about US\$ 91 million, or 96%, of the total spending on HIV in the country. If this were to be reduced, the country would have to make very difficult choices, including stopping its current treatment programme.

In 2008, domestic HIV spending in Africa was six times higher than in other parts of the world. Botswana leads the world in domestic spending on HIV as a proportion of its government revenue—over 4%. It is able to do so because the government's share of the economy is about 35% and its relatively strong economy is less vulnerable to shocks.

And the results are real. There is more than 80% coverage for people in need of treatment and 94% of pregnant women have access to services to prevent HIV transmission to their babies. But now the question is whether Botswana will be able to sustain the current investment levels over time.

Countries such as Mozambique and Uganda spend about 1% of their government revenue on HIV, although their share of the economy is only about 13%. Both countries have a high rate of HIV prevalence and a large number of people living with HIV. And their economies are fragile. Malawi is in a similar situation, spending about 2.5% of its government revenue on HIV.

Swaziland spent around 1.7% of its revenue on its AIDS response in 2007—this is expected to rise to about 3% in the medium term. The fiscal impact of

this level of HIV investment in the long term is not regarded as sustainable by the World Bank. In fact, some economists suggest that the net present values of its HIV investment far exceed what is sustainable in the long term.

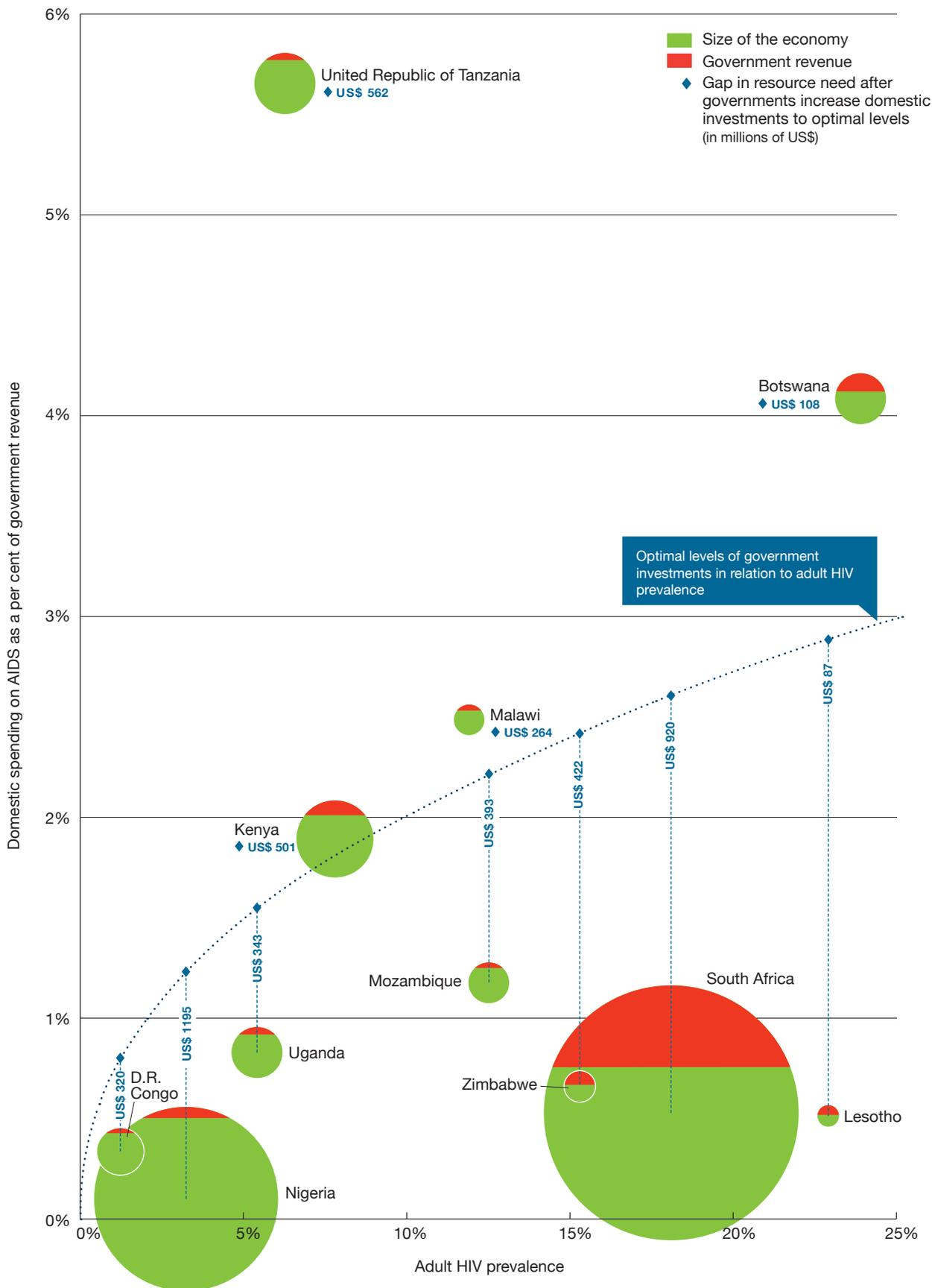
Is it fair to expect countries to spend more?

In some cases the answer is yes. Large emerging economies, such as those of China, India and South Africa, still have the ability to invest more. And in doing so could free up resources for countries that have greater needs and few avenues to raise resources domestically. Take the case of South Africa—the total resource needs for 2010 are about US\$ 3.2 billion, about 1.2% of its economy and 3.7% of its government revenue. In sheer size, the US\$ 1 billion investment by the country is the largest ever, but is still only one third of the total need, and less than the rate of spending in other countries with similar or lower prevalence levels. The good news is that its economy had been growing at a rate of about 5% until the recent global financial crisis. If growth returns to these levels, it will have the ability to expand its investments.

China and India currently receive over US\$ 245 million each year as official development assistance for HIV. Together, they account for 8% of the funds dispensed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). India has increased its health budget in recent years, riding on consistent economic growth. However, it still accesses international assistance for a significant part of its AIDS response.

Middle-income countries will need to shore up their domestic investments. Countries such as Brazil, China, India, Mexico, the Russian Federation, Ukraine and Viet Nam can fully finance their AIDS responses from domestic sources. Low-income countries too must increase their investments to levels proportionate to their revenue. Half of the global resource needs for low- and middle-income countries are in 68 countries that have a national need of less than 0.5%

Can governments meet the resource needs of the AIDS response from government revenue?



OUT-OF-POCKET EXPENDITURES PUSH THE BURDEN OF HEALTH CARE ONTO INDIVIDUALS AND FAMILIES, WHICH CAN IN TURN MAKE IT LOOK MORE LIKE A LUXURY THAN A NECESSITY. A SOCIAL HEALTH INSURANCE PROGRAMME THAT IS EQUITABLE CAN SOFTEN THE IMPACT, ESPECIALLY ON THE POOR.

of their gross national income. These countries could fund a significant part of their national AIDS response.

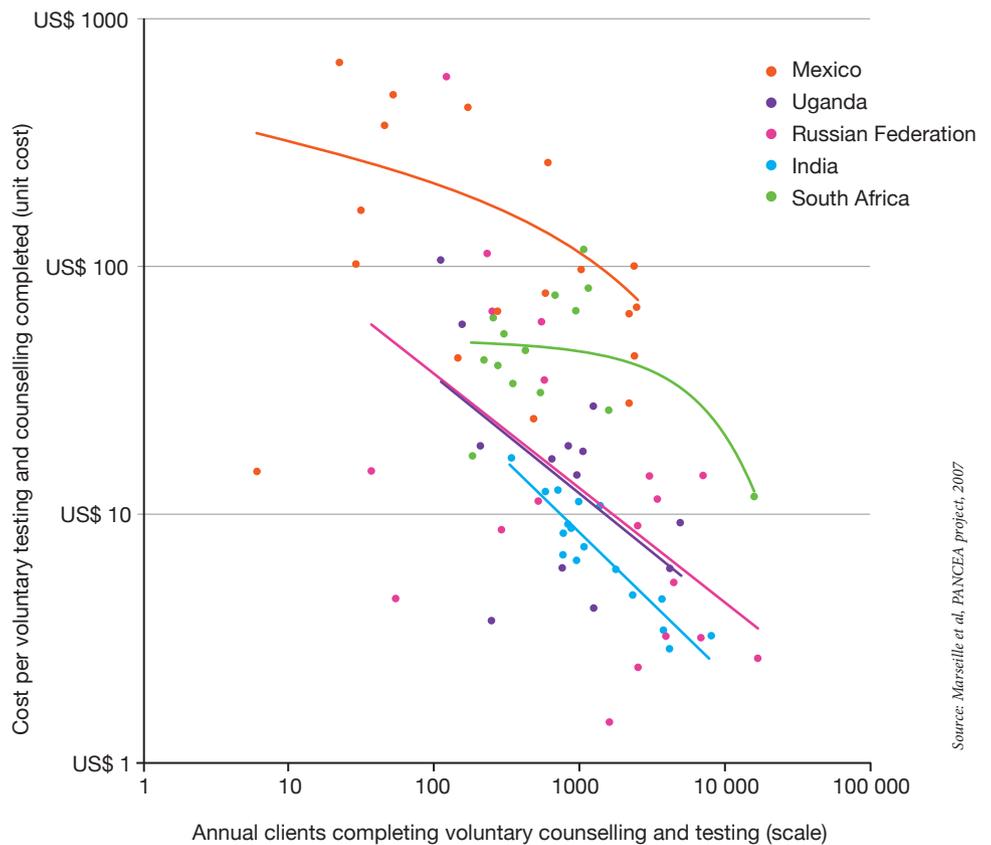
But protection must be given to marginalized populations in programmes funded by domestic sources. AIDS programmes must work with sex workers, people who inject drugs, men who have sex with men and transgender people—the populations are most likely to be left out from accessing social and health services, even in countries with stronger economies. This is of particular concern in countries that do not qualify for international assistance based on economic indicators and that do not have a strong tradition of supporting civil society organizations and community groups.

Innovation in health financing—reducing individual risk

Channelling out-of-pocket expenditures may be another option for increasing investments in health. Good data on how much people spend from their own incomes and savings is scarce, but various estimates place it globally at more than US\$ 1 billion. However, the high cost of health care can deter people from accessing it.

Out-of-pocket expenditures push the burden of health care onto individuals and families, which can in turn make it look more like a luxury than a necessity. A social health insurance programme that is equitable can soften the impact,

Enormous average cost variation for voluntary counselling and testing service delivery across multiple cities within countries



especially on the poor. By distributing risk equitably across the population, the resources generated can meet the needs of those who need it most. This is particularly attractive in countries where the government's share of the economy is not substantial.

Where the poor cannot pay for their share, the state can step in by providing coverage, either from its own resources or through international assistance. Rwanda has initiated such a scheme. Resources from the Global Fund were utilized to pay for premiums for the very poorest and for people living with HIV. Health outcomes were positive, not just for AIDS, tuberculosis and malaria, but across all health areas. Similar approaches have been attempted in Burkina Faso and Ghana.

Taxing luxury for social good

In recent years, several innovative schemes have been proposed to raise resources for HIV from indirect taxes. The MassiveGood project aims to raise money from the travel industry, while UNITAID gathers valuable funds from taxing airline passengers. There is talk of taxing high-value bank transactions, cell phone usage and money exchange.

Taxing petrol consumption has helped to build bridges and mass rapid transit systems. But while effective in raising money, in the end the capacity for such initiatives to succeed depends on long-term economic growth. There are limits to what society can expect to take from the economy and sustain it over time before public interest wanes.

Making the money work further

As international resources to respond to the AIDS epidemic grew in the early part of the last decade, there was a call to make the money work. In 2010, this has given way to a slightly modified call: make the money work further, better and smarter.

There are two ways to do this—by increasing the efficiency and the ef-

fectiveness of the HIV programmes. This means doing it better—knowing what to do, directing resources in the right direction and not wasting them, bringing down prices and containing costs.

A study conducted by the PANCEA project found that the unit cost of HIV testing varied sharply from one facility to another, even within the same country, in some countries more than tenfold. The cost of the delivery of services often differs, depending upon the source of the money. In India, for example, the basic unit cost associated with a programme for sex workers has been set by the government. Yet many organizations spend far above the set limit—these expenditures are often underwritten by external sources, whose predictability of sustaining the funding in the long term is uncertain.

Realizing that it spent more on purchasing antiretroviral drugs locally than abroad, South Africa recently changed its policies. Lowering costs is one piece of the African health-care puzzle.

And Africa cannot afford fragmented health regulatory authorities—a single pharmaceutical plan, currently being discussed by the African Union, can simplify the access and delivery of life-saving medicines for the continent as a whole. Pooling patents could help to bring to market more effective and cheaper medicines.

Many countries have utilized the flexibilities allowed under TRIPS to access less-expensive HIV medicines. However, in recent years there has been a trend to sign trade agreements that limit their ability to do, especially with the newer generation of drugs.

Many countries have conducted assessments to identify where the last 1000 infections occurred and triangulated them with investment patterns to ascertain if the money was directed at the right places. As a result the programme priorities are shifting. A modes of transmission study in Benin found that more than 30% of all new infections occur through sex work. Yet the resources that went towards sex work programmes

Elasticity

The income elasticity of demand for any good is a measure of the relationship between a percentage change in income and the percentage change in the demand for that good. A high value for the elasticity means that demand is sensitive to income; a low value means that it is not.

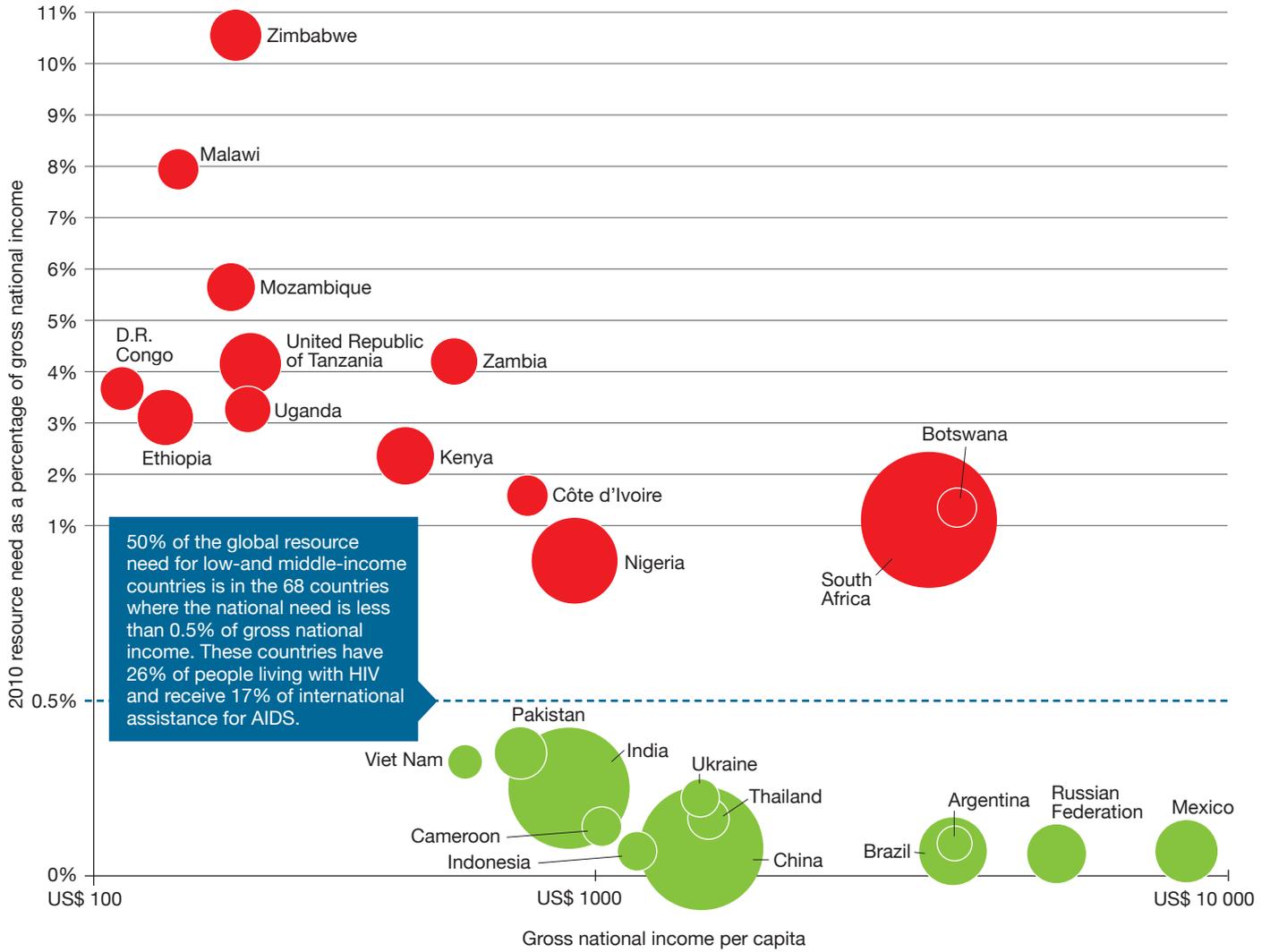
An income elasticity of less than 1 will mean that demand will change by less than the percentage change of income. This is normally associated with necessities, which people will try to consume regardless of their income. Poorer people will therefore spend a larger proportion of their income on necessities than more wealthy people do.

An income elasticity greater than 1 will mean that demand will change by more than the percentage change of income. This is normally associated with luxuries, for which poorer people will tend to use a smaller proportion of their income on than more wealthy people do.

An income elasticity of 1 for health means that the percentage change in demand for health will be the same as the percentage change of income in the country concerned. On average, populations will spend a fixed proportion of their income on health, averaging around 5% in low- and middle-income countries (including public as well as private spending).

Who can bear the resource burden of the AIDS response?

The 25 countries represented in this figure require 75% of the total resources needed for the AIDS response. Around 85% of people living with HIV reside in these countries. Together these countries generate 70% of the global gross national income in low- and middle-income countries.



- Countries that can meet a substantial proportions of their resource needs from domestic resources (public and private).
- Countries that cannot meet their resource needs from domestic resources (public and private) only.

The size of a country's circle represents their total resource need for the AIDS response in 2010 (UNAIDS estimates).

were only 3.5% of the total prevention spending. A similar pattern has for long been observed in Ghana. In many countries with low and concentrated epidemics, it is much easier to find resources to reach the general population or young people than for sex workers or adolescents at higher risk. Bangladesh has now found a healthy balance. The split between resources allocated to young people and populations at higher risk is nearly the same—around 40%.

Young people are not homogenous. In Asia it is estimated that 95% of infections among young people occur among adolescents at higher risk. But less than 10% of the resources spent on young people are directed towards this subset of the population.

In sub-Saharan Africa few programmes reach men and women in long-term relationships—they are perceived to be at low risk, even though a majority of infections occur in this group.

Is this acceptable? Can resources be directed more efficiently?

Another complex and much debated step is to review the efficiencies of the different programme approaches. Are HIV programmes evidence informed and the accountability for results clear?

Health-care delivery costs can be brought down through integration of tuberculosis and HIV services, bringing all mother and child care services under one roof, task shifting. Outreach to young people can become smarter and cheaper if we use social networking and SMS rather than the labour-intensive methods currently being used.

Making resource availability predictable

The most important lesson that the AIDS response has learnt in the current economic crisis is the issue of predictability. Countries cannot respond effectively to the epidemic on a fiscal-year basis. Efforts to finance AIDS programmes need to consider what is needed now

and what is needed over the longer term. The foundations for a comprehensive AIDS response must be strong enough to meet the needs not just in the next 12 months but over the next 10, 20 and 30 years.

In the past 12 months several countries have reported critical stock-outs of HIV medicines due to a lack of resources and managerial inefficiencies. Clinics are turning back people who need to start treatment because they have to focus on keeping existing programmes afloat. Most countries depend on external sources to meet their treatment bill. The Global Fund alone financed half of the 4 million people on treatment in 2008, while the US Government is another major source of investments in treatment programmes. If the Global Fund is not fully funded and the donor community does not fulfil its pledges or shifts its aid policies, the lifeline of millions could be in jeopardy.

The demand for access to HIV prevention, treatment, care and support has increased manifold in recent years. In the coming years, this is expected to further increase. This has to be converted into an opportunity to increase resources for global health. Strong economic growth requires a healthy and 'fit to work' population. To achieve this, health must become a necessity, not a luxury. ●

A skewed system

South Africa spends about 8% of its gross domestic product on health, which is slightly less than Sweden's 8.9%.

But the spending occurs in an unequal, two-tier system. Most of it is channelled into the private sector, which is where the bulk of resources are concentrated. The country was spending about 3.5% of its gross domestic product on its public health system in the mid-2000s—a smaller proportion than in considerably poorer countries, such as Honduras (4%), Lesotho (5.5%) or Colombia (6.7%).

Almost 60% of the health spend each year pays for the health care of about 7 million people, typically wealthier South Africans who belong to private medical schemes and who use the well-resourced, for-profit private health system.

Consequently, more than 23 million South Africans rely entirely on an overburdened and understaffed health system, while about 10 million people use the public sector, but occasionally pay out of their own pockets to use the private sector.

Some in South Africa are looking to a proposed national health insurance scheme as a quick way to improve health outcomes. The Health Minister believes that this has to go hand in hand with an overhaul of the public health system itself. A more equitable funding arrangement could help to speed up improvements.

Building BRICS*

**As power shifts from the G8 to the G20,
five countries stand out as being able
to change the course of the
global AIDS epidemic.**

**OUTLOOK explores how Brazil, India,
the Russian Federation, China and
South Africa could
finally break the trajectory.**

*Jim O'Neill of Goldman Sachs is largely credited for coining the term 'BRICs countries' in a 2001 paper entitled *The World Needs Better Economic BRICs*, about the economically-related nations of Brazil, the Russian Federation, India and China.

In 2010, a new BRICS term is used by UNAIDS to include South Africa as a part of five G20 countries that could have a profound effect on the trajectory of the global AIDS epidemic.



Brazil

Overview of HIV epidemic

Brazil has a concentrated HIV epidemic, with a 0.6% prevalence, that has remained relatively stable since 2000. Of the 630 000 people living with HIV in the country, 250 000 do not know their HIV status.

HIV is primarily spread in Brazil through injecting drug use and unprotected sex (between men, between transgender people and between sex workers and their clients). Studies carried out in ten Brazilian towns in 2008 and 2009 found HIV prevalence at 6% among injecting drug users, 13% among men who have sex with men and 5% among female sex workers.

The HIV epidemic varies considerably throughout the country, with new infections on the decline in the south-eastern and mid-west regions, but on the increase in the northern, north-eastern and southern regions between 2000 and 2008.

Free antiretroviral therapy has been available in Brazil since 1996. The government-funded programme currently has 190 000 people living with HIV enrolled, of which 35 000 were added in 2008. Around half of all HIV-positive pregnant women in the country received antiretroviral drugs to reduce the risk of HIV transmission to their babies in 2009.

In 2008, Brazil's AIDS-related spending totalled US\$ 623 million, of which 99% came



from domestic public sources. While 84% of funds were spent on HIV treatment and care programmes, HIV prevention only accounted for just under 7% of total spending.

The response

Brazil's HIV response is known for an approach based on human rights, an active civil society and the early provision of free access to antiretroviral therapy. When the first case of AIDS was identified in the

country, it coincided with a strong popular movement and public dialogue around citizenship and democracy. Calls were made for the state to be a provider of health care and education.

The close partnership between the government and civil society has been fundamental to ensuring the success in protecting and promoting human rights within the AIDS response.

Brazil showed early support for evidence-informed HIV prevention, with a non-stigmatizing attitude towards populations at higher risk, including injecting drug users, men who have sex with men, transgender people and sex workers. Free condom provision has also been one of the trademarks of the Brazilian AIDS response, and the female condom has been distributed since 1998. In 2009, 466 million male condoms and two million female condoms were distributed throughout the country—the largest distribution in Brazil's history. Despite having a condom distribution policy since the 1990s, a recent national survey has shown a decreasing use of condoms. This requires an appropriate and deep analysis in order to identify possible causes and to re-establish the observed trends over time.

The government's focus on both HIV prevention and free access to treatment undoubtedly played a key role in reducing the severity of the country's HIV epidemic.

Breaking the trajectory



With its record on treatment and its human rights approach, Brazil continues to broaden its leadership around the world.

With only 50% of HIV-positive pregnant women accessing services to prevent mother-to-child HIV transmission, Brazil has an opportunity to increase the coverage of HIV testing and counselling in antenatal care clinics. The number of maternity centres that effectively deliver prevention of mother-to-child HIV transmission services could also be increased, and particular attention should be given to remote areas, such as the Amazon region in the northern and north-eastern part of the country.

Given that one third of all new HIV cases were diagnosed in the late stages of infection between 2003 and 2008, scaling up HIV testing and counselling services to prevent late diagnosis can be a priority.

And Brazil should step up efforts to achieve the goal of universal access to HIV prevention, given that just under 7% of total AIDS spending goes on prevention.



Q&A

Dr Mariângela Batista Galvão Simão
Director of the National AIDS Programme

What are some recent key achievements in Brazil's AIDS response?

Brazil's National AIDS Strategic Plan focuses on populations at higher risk of HIV infection. The plan outlines clear goals and indicators on how to measure progress. The AIDS response is decentralized and engages all levels of the government—federal, state and municipal—and civil society organizations, which are seen as equal partners in the response, in the decision-making process. Finally, we have achieved success in increasing the uptake of HIV testing and counselling in different settings.

What are the greatest barriers to universal access in Brazil?

Although Brazil has had a policy of universal access to treatment since 1996, there are still some groups that cannot access health services—transgender people, sex workers and drug users. Stigma and discrimination remain key barriers for these populations. However, it is important to note that every person living with HIV in Brazil has the right to treatment and care free of charge through the national health system. There is no waiting list to receive treatment.

Looking ahead, what is the one thing that could make a real difference in preventing new HIV infections in Brazil?

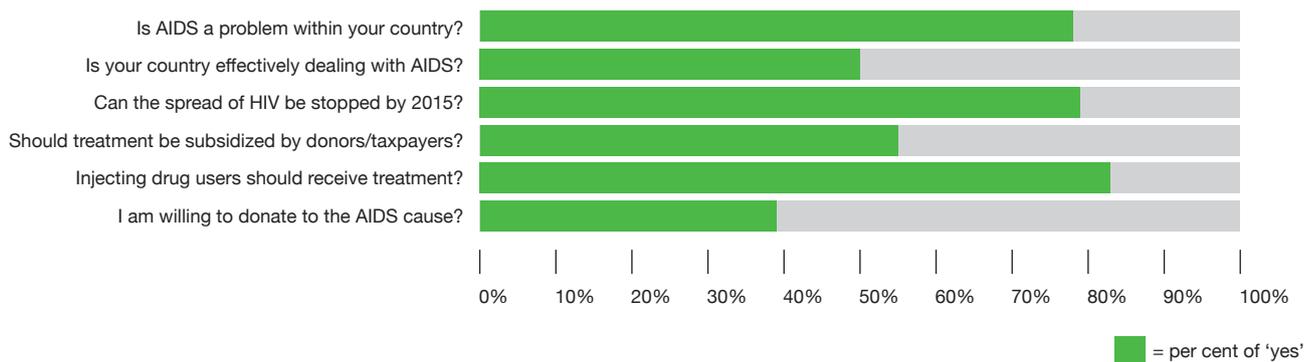
There is no simple answer to this question, as preventing new infections requires a broad range of integrated and combined prevention and treatment strategies, under the umbrella of the promotion of human rights. We are still missing data on HIV incidence in Brazil, which is key to ensuring that we deliver a more targeted response.

DID YOU KNOW?

In 2009, Brazil launched the National Plan to Promote the Citizenship and Human Rights of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals and the National Human Rights Plan to combat HIV-related stigma and discrimination.

Despite being known as a country in which sexual diversity is celebrated rather than stigmatized, Brazil still has hate crimes against the lesbian, gay, bisexual and transgender populations. In 2009 there were 180 documented cases of such crimes, according to a study by the organization Grupo Gay da Bahia.

UNAIDS benchmark survey results: Brazil





Russian Federation

Overview of HIV epidemic

The HIV epidemic in the Russian Federation is heavily concentrated among injecting drug users. According to government sources, 78% of people living with HIV in the country were infected through injecting drug use. However, sexual transmission is a growing source of infection, with some studies finding a high HIV prevalence among sex workers (6–39%) and men who have sex with men (1–9%) and the sexual partners of injecting drug users.

The number of new HIV cases continues to grow. In 2009, an estimated 58 400 new HIV infections—160 per day—were registered in the Russian Federation, up from about 44 800 in 2007.

Women in the country represent a growing share of those newly infected. In 2009, about 42% of new HIV infections were among women, up from 22% in 2001. And young people are badly hit—three quarters of all HIV infections in the Russian Federation occur among people under the age of 30.

While antiretroviral therapy access for HIV-positive people is improving—71 000 people received treatment in 2009, compared with 30 000 in 2007—these efforts are not keeping pace with the number of new infections. In 2009, for every four patients enrolled on treatment, eleven were newly infected with HIV. And with an estimated 400 000 HIV-positive people requiring antiretroviral



therapy by 2015, funding trends predict that there will be a shortfall in those accessing treatment.

The Russian Government is the primary contributor of the nearly US\$ 1.5 billion allocated for the country's AIDS response for 2006–2011.

The response

The country is leading the way in virtually eliminating mother-to-child transmission of HIV. Of the 14 000 HIV-positive women in the Russian Federation who became pregnant in 2008, more than 95% benefited from services to prevent HIV transmission to their babies.

Sex education in the country remains a sensitive issue, and while over 92% of schools in the country conducted HIV awareness sessions in 2009, knowledge about HIV among young people remains low.

Harm reduction programmes are no longer supported by the government, and opioid substitution therapy is illegal. Priority has instead shifted to the promotion of HIV awareness and of healthy lifestyles among the general population, with an emphasis on reduction of the demand for drugs.

As the Russian government did not provide any funding this year for HIV prevention activities aimed at populations at higher risk—including injecting drug users, sex workers and men who have sex with men—civil society organizations that implement prevention programmes are increasingly facing funding difficulties.

Efforts to reach men who have sex with men with prevention services are hampered by homophobia, and sexual minorities complain that their human rights are often violated.

Breaking the trajectory



With a growing HIV epidemic through injecting drug use, the Russian Federation has a huge opportunity to make a positive impact.

Urgent measures are needed to reduce HIV infection among the more than 1.5 million injecting drug users in the Russian Federation. These could include outreach to drug users, needle and syringe exchange programmes, condom distribution, provision of substitution therapy, and HIV treatment and rehabilitation programmes. Concentrating prevention services on populations at higher risk could have huge pay-offs.

The growing role of sexual transmission in the country's HIV epidemic, especially among spouses and partners of drug users, calls for a greater emphasis on prevention programmes for the general population.

The Russian Federation is a new donor country and an important scientific power. Because of its international leadership, the country could play a far greater role in promoting regional cooperation to address the HIV epidemic in eastern Europe and central Asia.



Q&A

Professor Vadim Pokrovsky

Head of the Federal AIDS Centre, Russian Federation

What are some recent key achievements in the AIDS response in the country?

All pregnant women in the country have access to HIV testing and to services for the prevention of mother-to-child transmission of HIV. As a result, the number of children born with HIV is declining. Overall, access to antiretroviral therapy in the country has grown sharply. The level of protection against HIV infection during blood transfusions is also very high.

What are the greatest barriers to universal access in the Russian Federation?

A very serious obstacle is insufficient access to information on HIV, mainly due to cuts in funding for HIV prevention activities aimed at populations at higher risk and the general population. As a result, we are seeing an increase in the number of new HIV infections.

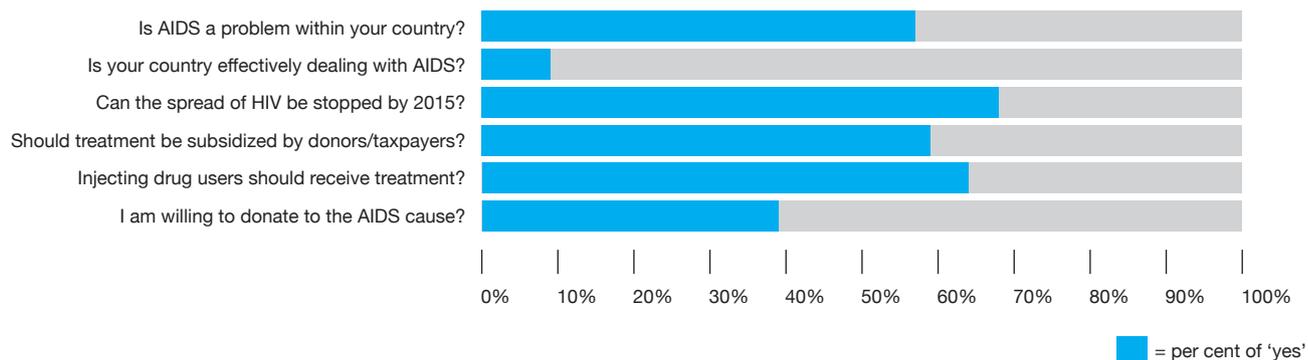
Looking ahead, what is the one thing that could make a real difference in preventing new HIV infections in the country?

It is necessary to considerably increase financing for primary prevention, public information and education on HIV.

DID YOU KNOW?

Despite growing rates of HIV infection among women, there has been a dramatic drop in HIV transmission from mothers to newborns—from 19% in 2000 to 6% in 2009.

UNAIDS benchmark survey results: Russian Federation





India

Overview of HIV epidemic

Although India is considered a low-prevalence country, with a 0.3% prevalence, it has the world's third largest HIV burden, behind South Africa and Nigeria. Sixty per cent of the 2.2 million people living with HIV in the country are concentrated in six high-prevalence states.

India's epidemic is largely driven by sexual transmission (sex work and unprotected sex between men). Given that condom use is not optimal or consistent, men who buy sex are the primary source of India's HIV epidemic. However, injecting drug use is the main mode of HIV transmission in the north-eastern part of the country.

The growth in HIV infections among women over the years is especially striking—Indian women accounted for close to 40% of people living with HIV in 2007.

Stigma and discrimination towards people living with HIV and populations at higher risk, both at the community level and within the health sector itself, continue to pose a significant barrier to accessing services.

Despite these trends, signs of progress have been seen on the prevention front. HIV prevalence has steadily declined among female sex workers due to targeted pro-



grammes. And in the most heavily affected Indian states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu, HIV prevalence among women aged 15 to 24 attending antenatal clinics declined by 54% between 2000 and 2007.

Progress is also being made on the treatment front. Access to antiretroviral therapy rose from 32% in 2008 to 45% in 2009. The percentage of HIV-positive pregnant mothers accessing treatment is on the rise, even if very slightly—from 16% in 2008 to 17% by the end of 2009.

The response

Over the past few years, India has strengthened its AIDS response by expanding prevention, treatment and care programmes for populations at higher risk, increasing services for HIV-positive pregnant mothers and scaling up HIV testing and counselling services.

India is committed to scaling up HIV prevention efforts, with 67% of the country's national AIDS budget earmarked for prevention. Over 245 million condoms have already been distributed. Prevention programmes have been most successful in reaching sex workers—prevention services now reach more than 80% of sex workers in four heavily affected states—and greater efforts are now needed for drug users, men who have sex with men and transgender people.

In July 2009, the High Court in Delhi made a landmark announcement by overturning the country's 150-year-old statute outlawing same-sex sexual behaviour. The High Court also determined that the sodomy law blocked access to HIV services by men who have sex with men—such oppressive laws drive people underground, making it much harder to reach them with HIV prevention, treatment and care services.

Breaking the trajectory



With its strong HIV prevention platform, India can lead the region in stopping new HIV infections.

India's declining HIV epidemic conceals the fact that HIV prevalence is on the rise among men who have sex with men, injecting drug users and transgender people. There is an opportunity to scale up prevention and treatment services for these populations in order to prevent HIV from spreading further into the general population through 'bridge' populations—sex worker clients, truckers and migrant workers.

An issue that generates little attention is HIV transmission among intimate partners, including spouses—a growing problem throughout the whole of Asia, including India. The largest number of new HIV infections in India occurs among married women, and more than 90% of women living with HIV became infected by their husbands or intimate sexual partners. Greater efforts in this area to identify discordant couples and to implement effective ways to reduce spousal transmission could garner big gains.



Q&A

Mr K. Chandramouli

*Director General,
National AIDS Control Organization, India*

What are the recent achievements in India's AIDS response?

We are moving well in the direction of achieving our overall goal, which is to halt and reverse the HIV epidemic. The most important among our prevention strategies are programmes that provide a package of prevention services for groups at higher risk of HIV infection. As of March 2010 the number of such programmes had increased to 1311, covering 78% of female sex workers, 76% of injecting drug users and 70% of the men who have sex with men and transgender populations. India's antiretroviral therapy programme has been increased to 270 centres; as of March 2010, more than 315 000 people were receiving free first-line treatment and more than 1100 were accessing second-line drug regimens. This has provided immense hope.

What are the barriers to universal access in India?

Tuberculosis is one of the most common opportunistic infections among people living with HIV. Only about 30% of people coinfecting with HIV and tuberculosis have been detected. Of the estimated 27 million women who become pregnant every year in India, only about 14% receive HIV testing. Of the 21 000 HIV-positive mothers detected last year, only 50% were given antiretroviral prophylaxis to prevent HIV transmission from mother to child.

Among populations at higher risk of HIV infection, few people are accessing HIV counselling and testing services.

Another important issue is the provision of life-long antiretroviral therapy for people living with HIV. Nearly 2–3% of people using first-line drug regimens may need to switch to second-line treatment after three to five years. However, as the antiretroviral therapy programme was started only in 2004–2005, and scaled up gradually, the number of people requiring second-line regimens, at present, is low.

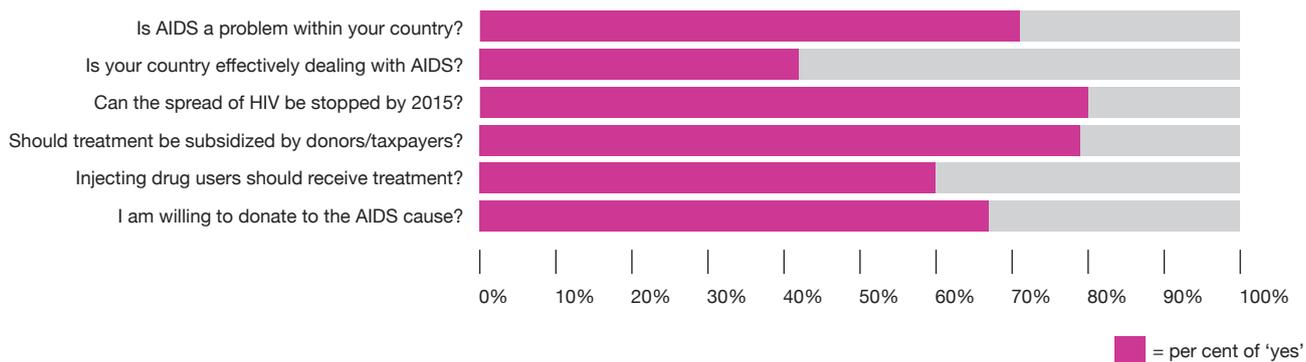
Looking ahead, what is the one thing that could make a difference in preventing new HIV infections in India?

The spread of the HIV epidemic in India is mainly due to unprotected sex with female sex workers, sex among men who have sex with men and injecting drug use. Many men who engage in high-risk behaviours in turn infect their partners. We have to target at-risk populations by creating awareness about HIV, promoting condom use, and controlling and preventing sexually transmitted infections.

DID YOU KNOW?

Launched in 2007, India's Red Ribbon Express is the region's largest mass mobilization effort against HIV. The train stops at 180 stations across the country each year and is expected to reach 6.2 million people in more than 50 000 villages with critical information on HIV prevention. HIV testing and general health check-ups are provided to the villagers. Six performing teams disembark the train on a fleet of bicycles to visit dozens of villages during each station stop, staging plays and skits about preventing HIV infection and fighting HIV-related stigma and discrimination.

UNAIDS benchmark survey results: India





China

Overview of HIV epidemic

Although China is estimated to have the world's largest population of injecting drug users, heterosexual transmission has replaced injecting drug use as the main mode of HIV transmission—and homosexual transmission is increasing rapidly.

At the end of 2009, 740 000 people were living with HIV in the country, just over 30% of whom were women.

Overall, China is still experiencing a low-prevalence epidemic, with a less than 0.1% prevalence, but some provinces are experiencing serious epidemics. Five provinces with the highest HIV prevalence account for 53% of total HIV infections, while the provinces with the lowest prevalence account for less than 1% of total infections.

Challenges remain in reversing the spread of HIV. HIV testing is low, and fewer than one in three people living with HIV know their status. The coverage of antiretroviral therapy and of services to prevent mother-to-child HIV transmission remains insufficient. And the implementation of China's Four Freed, One Care policy continues to be uneven across the country.

Despite these challenges, progress was made on various fronts in 2009. The number of pregnant women screened for HIV doubled, from just under 2 million to 4 million in 2009. And HIV prevention programmes for sex workers, men who have sex with men



and injecting drug users have significantly expanded in recent years.

China has also launched a major push to expand harm reduction programmes for drug users. In south-western China, the number of annual new HIV infections slowed down by two thirds as a result of such programmes.

The response

China's AIDS response has achieved significant results over the years. In 2003, China implemented the Four Freed, One Care policy (free HIV testing and counselling, free first-line antiretroviral therapy, free ser-

VICES for the prevention of mother-to-child HIV transmission, free education for AIDS orphans, and care for people living with HIV) to ensure a comprehensive response to HIV focusing on prevention, treatment and support.

With the roll-out of this policy in all 31 provinces, the number of HIV-positive adults receiving treatment has risen considerably. An estimated 65 000 people are currently on treatment in China, compared with 35 000 in 2007. However, in some provinces, more than 30% of patients on first-line regimens have experienced drug resistance.

During the past two years, China has acted against drug dealing, drug use and sex work, and has implemented a number of HIV prevention programmes for populations at higher risk, including condom promotion, methadone maintenance therapy and needle exchange.

China has also taken proactive steps to expand HIV testing. A nationwide free-of-charge HIV voluntary counselling and testing network has been put in place, with 7000 clinics set up throughout the country.

In April 2010, the Government of China lifted its long-standing travel ban for people living with HIV. This move is an important step in China's AIDS response and sends a signal that China's central government is serious about granting full rights to people living with HIV and addressing stigma and discrimination. President Hu Jintao's leadership on HIV over the years has been a catalyst in moving the AIDS response forward.

Breaking the trajectory



With its ability to scale up quickly, China is poised to make a big breakthrough—whether through a low-cost delivery and distribution system for treatment or new diagnostics, the world could benefit from innovations in the AIDS response.

China has taken bold steps in strengthening its AIDS response, but several actions are critically needed on both the prevention and treatment fronts to reverse the spread of HIV. These include increasing antiretroviral therapy for people living with HIV, expanding services to save mothers and ensure that babies are born HIV-free and scaling up HIV programmes for populations at higher risk, including injecting drug users, sex workers, men who have sex with men and migrants.

Civil society groups can also be strengthened to play a more active role in the response, especially in the area of delivering essential services to those most vulnerable to HIV infection.



Q&A

Dr Wu Zhunyou

Director of the National Center for AIDS/STD Prevention and Control, China CDC

What are some recent key achievements in China's AIDS response?

More than 260 000 drug users in China at 685 clinics are now accessing methadone maintenance therapy and about 115 000 drug users are benefiting from a range of comprehensive services, including drug treatment, HIV testing and counselling, syphilis and hepatitis C testing and treatment, CD4 cell count monitoring for HIV-infected individuals, and antiretroviral therapy for AIDS patients.

Free antiretroviral therapy has been extended to over 80 000 patients in China, with nearly 64 000 people retained on first-line treatment and about 2000 on second-line drug regimens.

Men who have sex with men in 61 cities are now accessing HIV testing and counselling. Services for preventing mother-to-child transmission of HIV have expanded to 453 counties, with more than 7.7 million pregnant women now accessing HIV testing.

China's sentinel surveillance programme has been further expanded to 1888 sites, covering eight sentinel groups.

What are the greatest barriers to universal access in China?

Stigma.

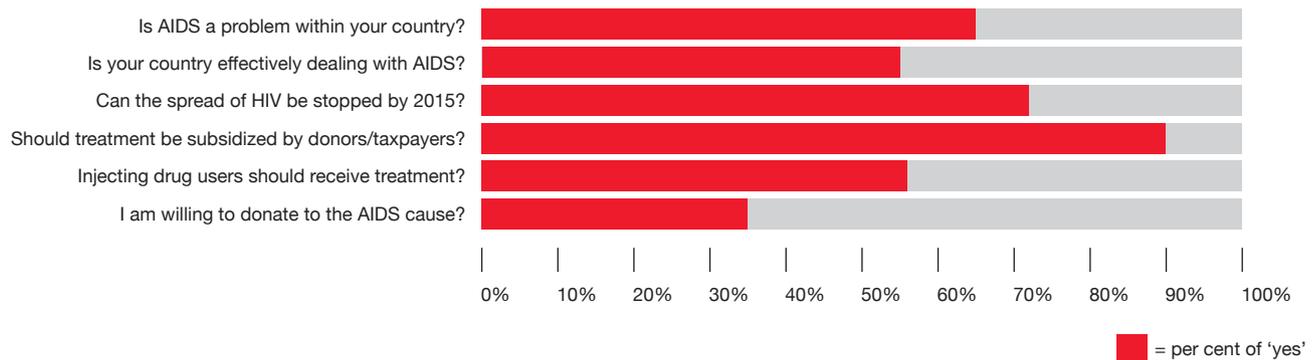
Looking ahead, what is the one thing that could make a real difference in preventing new HIV infections in China?

Encourage people to be tested for HIV as early as possible.

DID YOU KNOW?

According to the China stigma index survey, conducted among more than 2000 people living with HIV in 2009, 42% have faced severe HIV-related discrimination, 15% had been refused employment due to their HIV status and 32% said that their HIV status had been revealed to others without their permission.

UNAIDS benchmark survey results: China





South Africa

Overview of HIV epidemic

Nearly one in six people living with HIV in the world today lives in South Africa—18% of adults in the country are HIV-positive, or 5.7 million people.

According to recent national surveys, the HIV prevalence among young people (aged 15–24) in South Africa declined from just over 10% in 2005 to about 9% in 2008. However, prevalence remains disproportionately high among women—one in three women in the 25–29 age range is estimated to be infected with HIV. Prevalence among men is highest in the 30–34 age range, with about one in four HIV-positive.

With the largest antiretroviral therapy programme in the world, South Africa is experiencing substantial public health benefits associated with improved treatment access. In South Africa's Western Cape Province, six-month mortality rates among patients at an HIV treatment centre fell by roughly 50% between 2001, the start of the antiretroviral therapy programme, and 2005.

More than two thirds of South Africa's national AIDS response comes from domestic sources—the country committed US\$1 billion in 2010, a 30% increase over the previous year—with the rest coming from external partners, including the US President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the UK Department for



International Development (DFID) and the European Union.

The response

On 29 October 2009, the South African President, Jacob Zuma, called on national leaders to use evidence-informed approaches to address the country's HIV epidemic. In a landmark speech, President Zuma outlined ambitious targets in the country's AIDS response, including cutting the rate of new HIV infections in half and expanding treatment programmes to cover 80% of those in need by 2011.

"People must be armed with information," said President Zuma, in an address to the

National Council of Provinces. "Knowledge will help us to confront denialism and the stigma attached to the epidemic."

President Zuma's speech represented a fundamental break from the policies of his predecessor, Thabo Mbeki, who questioned the causal link between HIV and AIDS and the critical role of antiretroviral therapy in treating the disease.

In April 2010, President Zuma translated words into action, launching a historic campaign that could alter the face of the epidemic—in South Africa and globally. The campaign aims to test 15 million people for HIV by 2011, up from 2.5 million in 2009—a sixfold increase in just two years. Some 1.5 million people will receive antiretroviral therapy by June 2011, up from about 1 million in 2009.

During the campaign launch, many South African leaders were tested for HIV—including the President, government ministers and other senior government officials—which helped to inspire thousands of people across the country to take an HIV test. In no other country has national leadership led by example so openly.

HIV testing provides a critical entry point for conversations around a range of difficult issues, including sexuality, violence against women and intergenerational sex. During the campaign, each individual tested for HIV will receive 100 condoms, opening a new dialogue about HIV prevention and safer sex across communities.

Breaking the trajectory

It is investing significantly in the HIV prevention agenda by ensuring free and routine HIV counselling and testing for all South Africans. Through testing and counselling, consistent condom use will be promoted. Medical male circumcision is being expanded at the provincial level, starting with KwaZulu-Natal, which has the highest HIV prevalence in the country.

As more mothers learn their HIV status and have increased access to antiretroviral drugs, HIV transmission rates are expected to drop considerably. With more effective combinations of antiretroviral drugs, South Africa could move towards the virtual elimination of mother-to-child transmission.

The combination of prevention and treatment programmes on a national scale could have a positive impact on the HIV trajectory. The scale-up goal for antiretroviral therapy alone will try to reach at least 1.5 million people by June 2011.

Given that close to 50% of maternal deaths in South Africa are HIV-related, there is also an immediate need to integrate maternal child health and HIV programmes to save mothers and their babies.

On the global level, South Africa is a champion in the AIDS response. Momentum can continue to build as lessons learned in addressing the country's epidemic are shared regionally and globally.



Q&A

Mark Heywood

Deputy Chair of the South African National AIDS Council

What are some recent key achievements in South Africa's AIDS response?

On World AIDS Day 2009, President Zuma announced that South Africa would accelerate the national response to HIV by increasing HIV testing uptake and adopting new World Health Organization guidelines to reduce mother-to-child transmission of HIV, by mitigating the impact of concurrent HIV and tuberculosis infection and by improving the antiretroviral therapy regimen. The prevention agenda has been strengthened in order to reduce the number of people in need of treatment in the long term. South Africa already has the largest antiretroviral therapy programme in the world. The shift to HIV prevention and the target of voluntarily testing 15 million people by June 2011 is ambitious.

The budget allocation for health has been increased in order to support implementation and to complement political commitment. Private-public partnerships have been strengthened, with the largest pharmacy chain offering free HIV testing and counselling to the public. A truly multisectoral response is emerging that involves, among others, South Africa's prisons, the army, universities, civil society and the public service.

Each province has taken responsibility to scale up the HIV response and the testing campaign is now moving to the district level.

What are the greatest barriers to universal access in South Africa?

The greatest barriers are a low uptake of HIV counselling and testing, weak integration of tuberculosis-HIV services and poor access to antiretroviral therapy. More efficacious regimens to prevent mother-to-child transmission are also needed.

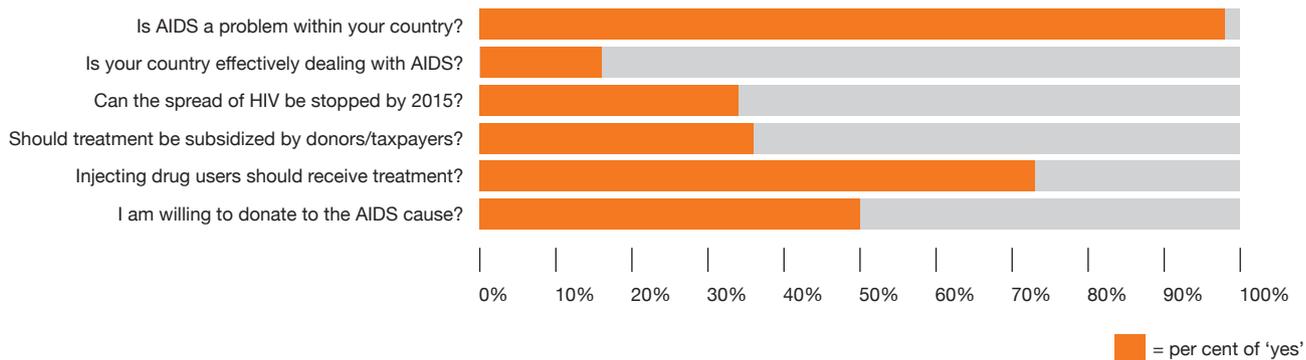
Looking ahead, what is the one thing that could make a real difference in preventing new HIV infections in South Africa?

HIV testing on a national scale—including counselling on risk reduction and lifestyle change—supported by community awareness and behaviour change should bring about a reduction in new infections. The majority of people will test HIV-negative and will be encouraged to stay negative through behaviour change. This combination of prevention activities and improved access to treatment is what will turn the tide for South Africa.

DID YOU KNOW?

According to a national survey of more than 7000 adults in South Africa, pervasive social norms encourage both concurrent partnerships and a rapid turnover of sexual partners, with little peer support for commitment to a single partner. Only 21% of survey respondents said "sticking to one partner and being faithful" could prevent HIV transmission and only 5% identified reducing the number of sexual partners as a sound HIV prevention strategy.

UNAIDS benchmark survey results: South Africa



SOUTH AFRICA'S TRANSFORMED AIDS RESPONSE

“It’s the first time one country has scaled up so quickly, to so many people,” says UNAIDS Executive Director Mr Michel Sidibé.

One of the most ambitious and quickest scale-ups of an AIDS response ever is finally under way in South Africa, a country where more than 5 million people are living with HIV. In March 2010, the country’s cabinet approved a plan to test one third of the population for HIV by the end of next year, to halve the rate of new HIV infections and to provide antiretroviral therapy to 80% of people who need the treatment.

“We asked for leadership from our government, and now we have it,” says one of the country’s most prominent figures living with HIV, Justice Edwin

Cameron of South Africa’s Constitutional Court.

The government has dramatically increased its funding for HIV. This year it will invest more than US\$ 1 billion in its AIDS response—a third more than ever before.

“It’s the first time one country has scaled up so quickly, to so many people,” says UNAIDS Executive Director Mr Michel Sidibé.

President Jacob Zuma’s government has also launched a massive male circumcision campaign. Studies in Kenya, South Africa and Uganda show that male circumcision can reduce men’s risk of HIV by up to 60%, and there are

Nozizwe Madlala-Routledge, believes the biggest challenge now is to build “a groundswell of sustained effort to prevent new infections”.

Going forward

These efforts are potentially huge steps towards curbing South Africa’s epidemic, which remains the world’s largest. Some 17% of all HIV-infected people in the world live in South Africa, a country with a mere 0.7% of the world’s population (see box).

In 2008, there were 5.7 million South Africans living with HIV. More than 250 000 South Africans died of AIDS-related diseases in the same year. And almost 2 million children have lost one or both parents to the epidemic.

In April, President Zuma became the first South African Head of State to publicly undergo an HIV test and disclose his status (he was HIV-negative). But most other South Africans still do not know their HIV status.

“It’s quite a shame that many of us don’t know our status,” Health Minister Aaron Mokoalele said in Johannesburg in April. “We have got our heads dug in the sand very deep.”

The aim is to test 15 million more South Africans by 2012, each of whom will also be given 100 condoms.

The government now follows a policy of routinely offering HIV tests to all people who use the public health system. Hundreds of pharmacies are also offering free tests, using government-supplied kits.

“This is a sea-change in our HIV/AIDS response,” says Dr Alan Whiteside, director of the Health, Economics and HIV/AIDS Research Division at the University of KwaZulu-Natal. “Sadly,” he adds, “time has been lost and resources will be limited—our choices will be tough.”

Beyond denial

The failure to prevent the epidemic’s rapid growth in the 1990s and delays in implementing a treatment programme in the early 2000s saw deaths in South Africa double between 1997 and 2005. Questioning of the link between HIV and AIDS by senior government officials in the past, and distrust of antiretroviral

Balancing the books

As people live longer on antiretroviral therapy, the total number of people living with HIV is likely to remain the same, even if new infections are drastically reduced.

“The present levels of daily infections are unsustainable,” says Justice Edwin Cameron, one of the country’s leading AIDS activists. “We cannot have 1000 new infections each day and keep putting everyone with HIV on antiretroviral drugs.”

Some health economists predict that as many as 50% more patients will need antiretroviral drugs by 2012, at a potentially huge cost to the state.

Yet studies show that earlier treatment would be cost-effective. It would reduce the burden on the health system in the medium term, as fewer AIDS patients would have to be hospitalized, and it could reduce new infections.

By 2012, an estimated 2.75 million South Africans will need antiretroviral drugs. If 50% of those eligible for treatment were diagnosed and started treatment, around 600 000 deaths could be averted (cutting the AIDS-related death rate by one third), and health spending would rise by a net US\$ 1.1 billion over five years.

In the event of 100% diagnosis and treatment, about 1.5 million deaths would be avoided at an additional cost of US\$ 1.5 billion over five years (an additional cost of about US\$ 1000 per patient).

Can South Africa afford such a programme?

With moderate economic growth over the next five years, and if public health spending increases from the current 3% to 5% of gross domestic product, an antiretroviral therapy programme with 80% coverage would absorb about the same share of the health budget as at present (12–14%).



signs that their female partners might also face reduced risks of infection. In the hardest-hit province, KwaZulu-Natal, the plan is to circumcise 2.5 million men. Last year, the Zulu king, Goodwill Zwelithini, declared that the tradition of circumcision (suspended in the nineteenth century) should be revived among his subjects.

“Let this be the start of an era of openness, of taking personal responsibility, and of working together in unity to prevent HIV infections and to deal with its impact,” President Zuma urged his compatriots on World AIDS Day last December.

Former Deputy Minister of Health,

drugs, stalled the HIV response in South Africa. “If we had acted more than a decade ago, we might not have been in this situation where we are,” says Minister Motsoaledi.

A 2008 Harvard University study estimated that some 330 000 premature deaths could have been prevented if the country had acted sooner to bring antiretroviral drugs to people with AIDS-related illnesses and to HIV-positive pregnant women.

In 2005–2006, more than 290 000 people were dying annually of AIDS-related diseases. The rising trend in deaths is slowly reversing, thanks to what has become the world’s largest antiretroviral drug programme.

Saving lives

When South Africa’s public antiretroviral therapy programme began in 2004, fewer than 30 000 South Africans were getting the drugs they needed—almost of them were in the private health system.

Within two years, some 230 000 people had started antiretroviral therapy, a number that more than doubled again by 2008. By then, the majority of those patients were being treated for free in the public health system.

Getting antiretroviral therapy to all who need it is a mammoth undertaking. The best estimate is that about 570 000 people were receiving antiretroviral therapy in 2008. About 1.5 million people needed treatment in that year, but the government says that it will provide antiretroviral therapy to 80% of those who need it in 2012.

Until early 2010, antiretroviral drugs were dispensed through only about 400 accredited health centres. The plan is to bring ten times as many public health clinics and centres into the antiretroviral therapy programme. In April alone, more than 500 additional health facilities began dispensing AIDS drugs.

Decentralizing the treatment programme also holds great promise. A recent study in townships in Cape Town and Johannesburg showed that handing more responsibility to nurses and other medical staff leads to treatment outcomes that are as good as when only

doctors manage drug provision.

The AIDS response got a further boost last December when President Zuma announced that tuberculosis and HIV would be treated under one roof. Patients with both conditions are to receive antiretroviral therapy if their CD4 counts are 350 or less.

Previously, patients referred from tuberculosis clinics often had to travel to distant health facilities authorized to dispense antiretroviral drugs. That system was weak, costly and time-consuming, and involved much duplication of testing and record-keeping.

The benefits of integration are clear. In 2007, only about 20% of patients on therapy in Cape Town’s Khayelitsha township, for example, had been referred from tuberculosis clinics; by late 2009, that figure had grown to almost 70%.

A big challenge now is to cope with the increasing numbers of patients being diagnosed with drug-resistant tuberculosis.

Retired health workers are being enlisted to help staff with these new initiatives. The Health Minister has sent appeals to thousands of non-practising doctors, nurses and pharmacists. By early April about 4000 retired staff had indicated that they wished to help out.

Keeping the momentum

Testing 15 million people in two years is a daunting target, but observers believe it can be done. In the United Republic of Tanzania, 3 million people received HIV tests in six months, while in Malawi 200 000 people were tested in one week. For the first time, the country’s rich array of civil society structures (from religious organizations to youth and sports clubs to social networks) are participating in the testing drive.

The campaign is using cell phone messages to direct people to their nearest HIV testing station. Some corporations are using raffle tickets, food and other incentives to encourage workers to take HIV tests.

The testing campaign will cost South Africa an estimated US\$ 200 million. But if it succeeds in helping to increase treatment uptake and reduce new infections, the long-term benefits would be huge.

The dramatic expansion of South Africa’s AIDS response has drawn great praise. But it is an open secret that the country’s health system currently functions poorly and is highly unequal.

“We are over the hump of denialism,” says Justice Cameron. “But ahead are the glum problems of capacity, resources, personnel and individual fears—all the problems that were there from the outset.”

Growth in South Africa’s antiretroviral therapy programme was rapid in 2008, but slowed significantly in 2009, says Mr Mark Heywood of the AIDS Law Project in Johannesburg. Hitches in budgeting and financial management were among the problems, along with weak monitoring and evaluation of treatment programmes.

National and provincial health ministries are under great pressure to keep up with the growing demand for antiretroviral therapy. In 2009, several provinces overran their health budgets and there were reports of stock-outs of antiretroviral and other drugs in seven of the country’s nine provinces.

“We are aware that the health system is not working well, we can’t hide it,” admits the Health Minister. “Some call it a collapse, others call it a crisis.” He lists “human resource capacity, and supply and logistical problems” among the priority challenges.

Management skills, monitoring and evaluation systems, as well as commodity supply and supply management systems, must be improved, says the head of the revitalized National AIDS Council, Dr Nono Simelela.

Also in short supply, she says, are “bottom-up approaches to planning” and stronger “community involvement and participation” in the AIDS response. The National AIDS Council is working to broaden community and civil society involvement, but it will take time to overcome the animosity and suspicions that, until quite recently, clouded relations with the government.

A long haul

For an epidemic as large as South Africa’s, a treatment programme that puts, and keeps, at least 80% of patients

in need on antiretroviral drugs can be sustained only if new HIV infections are drastically reduced and drug prices come down.

“At this rate, it’s not sustainable if we are going to increase the number of people who must be on antiretroviral drugs,” says Minister Motsoaledi. “Common sense should tell us that we need to prevent and stop this disease from spreading.”

There are glimmers of good news on that front.

Infection rates among young South Africans seem to be slowing. National HIV surveys show a substantial decrease between 2005 and 2008 in HIV incidence among teenagers. Unfortunately, the same is not evident among older South Africans.

Condom use, however, has increased dramatically. When surveyed in 2009, about 70% of South Africans said they used a condom the last time they had ‘casual’ sex, compared with between 30% and 40% in 2003.

Researchers have identified that having multiple sexual partners and unprotected sex between younger women and older men are major drivers of the HIV epidemic in South Africa and its neighbours, but it is proving tough to get that message across.

South Africa’s third national HIV survey found that the percentage of young women (aged 15 to 19 years) with partners at least five years older than them rose from 19% in 2005 to 28% in 2008. The percentage of young men (aged 15 to 24 years) with more than one sexual partner in the previous year rose from 27% to 31%.

Oddly, accurate knowledge about how HIV is transmitted seemed to be low in all age groups. Researchers say participants in the survey found it hard to grasp the link between multiple partners and higher HIV risk.

Protecting mothers and their babies

Breakthroughs are also expected in programmes to prevent HIV transmission from mothers to their newborn babies. Government policy now stipulates that all infants born to HIV-infected mothers must receive the anti-HIV drug nevi-

The epidemic in outline

Still the epicentre of the global AIDS epidemic, South Africa’s biggest challenge is to drastically reduce the rate of new infections.

Speaking last December, President Zuma compared the struggle against HIV with the struggle against apartheid.

“At another moment in our history, in another context, the liberation movement observed that the time comes in the life of any nation when there remain only two choices: submit or fight,” he said. “That time has now come in our struggle to overcome AIDS.”

The epidemic’s scale and intensity is startling. It is estimated that at least 350 000 adults and around 59 000 children were infected with HIV in 2009. Nearly 1000 South Africans die every day of AIDS-related diseases. An estimated 1.5 million adults and 106 000 children needed antiretroviral drugs in 2009.

HIV infection levels among pregnant women in 2006–2008 remained at 29%, indicating an epidemic that has stabilized, but at extraordinarily high levels. Overall, one in three women aged 20 to 34 years is HIV-positive, as is one in four men aged 25 to 49 years, according to the country’s most recent national HIV survey. Most of them do not know that they are infected.

The epidemic has spread unevenly across the country. The percentage of adults living with HIV is more than twice as high in KwaZulu-Natal Province than in Western Cape Province, for example, and disparities between districts are even wider. In some, upwards of 40% of pregnant women test HIV-positive, while in others HIV prevalence is as low as 5%.

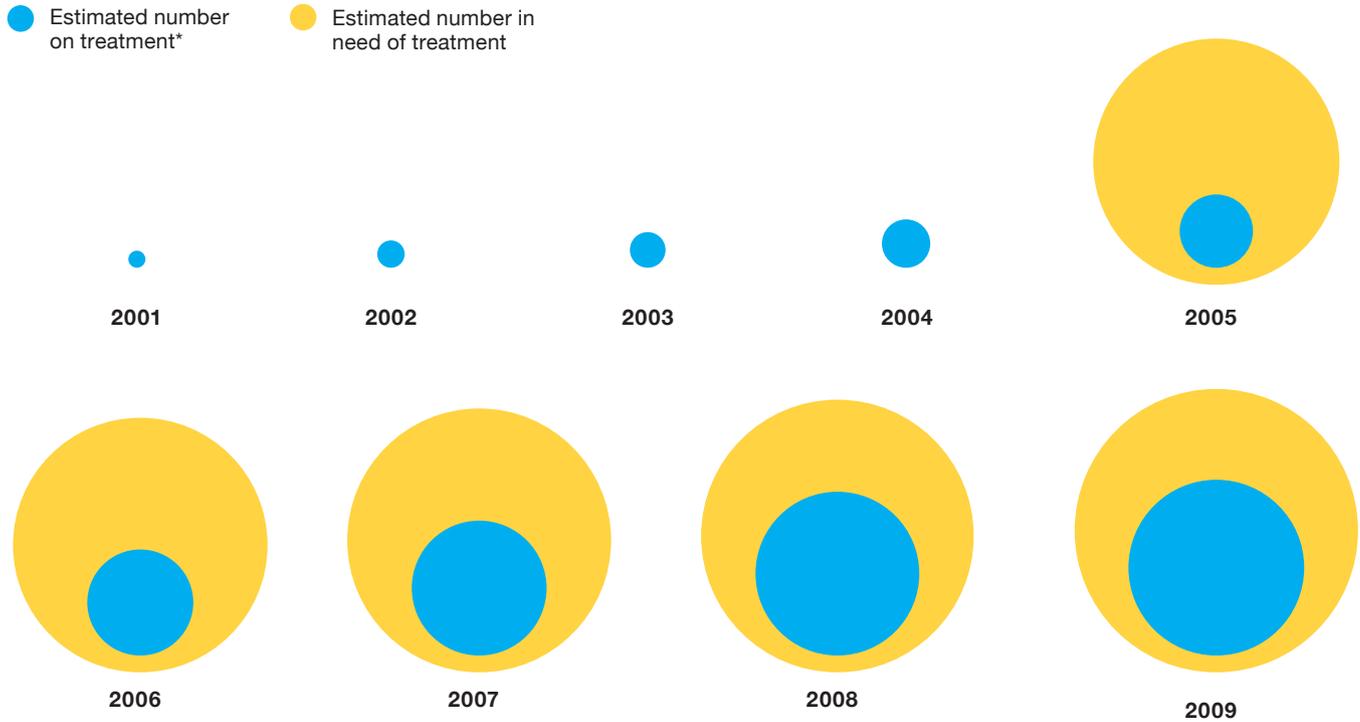
rapine from birth to six weeks (previously infants received AZT for one to four weeks). Treatment for HIV-positive pregnant women will start as soon as their CD4 counts drop below 350. Dr Hoosen Coovadia, professor of AIDS research at the University of KwaZulu-Natal, calls it a change in policy “just short of 360 degrees”.

The government also plans to treat all HIV-positive babies, a move that could improve the survival rates of children in South Africa, one of only 12 countries in the world where child mortality has worsened since the 1990s. All children younger than one year will now get treatment if they test HIV-positive.

Wider use of ‘dual therapy’ offers great promise. In KwaZulu-Natal Province, HIV transmission from mothers to their newborn babies was slashed by almost two thirds (to 7%) when dual therapy was used. (Dual therapy involves giving HIV-positive pregnant women AZT from 28 weeks into their pregnancy, as well as a single dose of nevirapine during labour.)

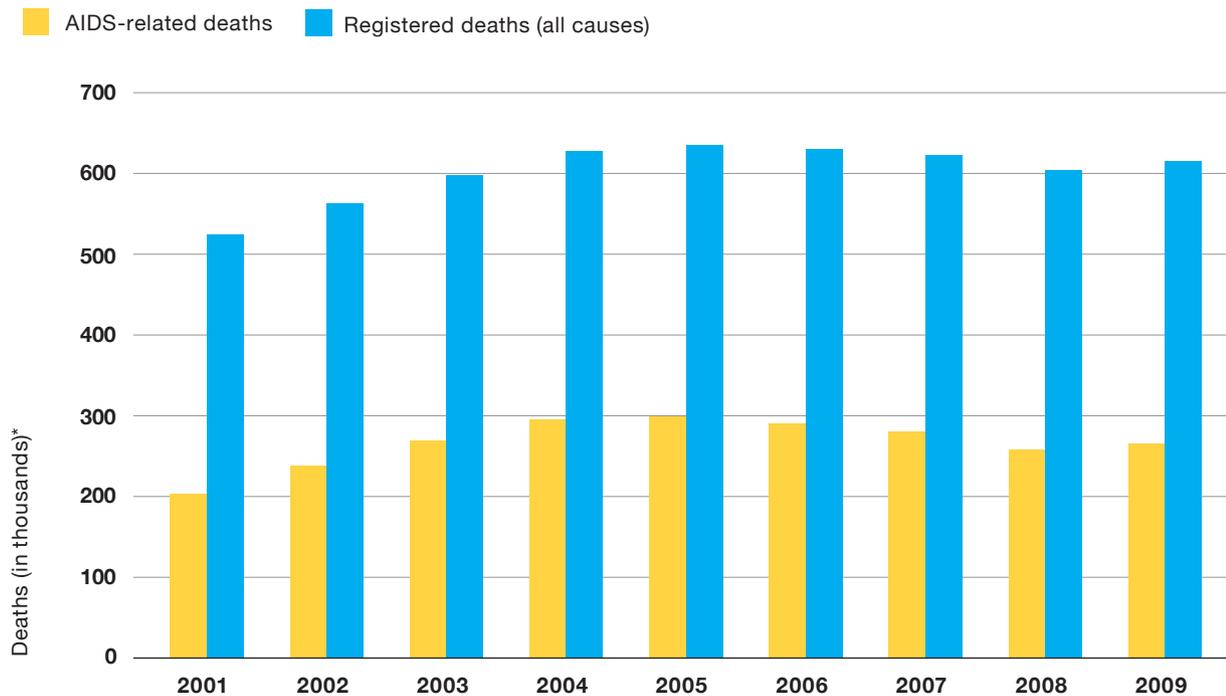
“The study has shown that an HIV-free generation is both achievable and within our reach,” says Ms Sibongile

Treatment vs need in South Africa



* This is the best available estimate of people on treatment in both the private and public sectors. The estimates for 2001–2004 reflect mostly people receiving antiretroviral drugs in the private health sector. The Dept. of Health periodically releases its own estimates, but these reflect people who at some point started treatment; it does not mean they are on treatment. Those estimates only reflect treatment roll-out in the public sector. Source: Adam, M. & Johnson, L. (2009) "Estimation of adult antiretroviral treatment coverage in South Africa", *South African Medical Journal*, Vol. 99 No. 9, September. 2009 data comes from South Africa UNGASS country progress report 2010.

Causes of death in South Africa



* Except for 2009, the total deaths reflect registered deaths. South Africa's death registration system is believed to be more than 90% complete. This means that actual total deaths are likely 10% more than indicated. The 2009 figures are projections, based on previous trends and death certificates received up to mid-year. Source: Statistics SA (2009) *Mid-year population estimates 2009, Statistical Release P0302, July*, Statistics SA, Pretoria. Available at <http://www.statssa.gov.za/publications/P0302/P03022009.pdf>.

Zungu, head of the province's health department.

But weaknesses in the current programme will have to be overcome to reap the full benefits. More than two thirds of women are only tested late in their pregnancies, often well after dual therapy should have started.

Paying the bills

This boosted response has major cost implications. Earlier treatment, for example, means that more people will need to take antiretroviral drugs, and for longer.

This year, the government is spending a third more on its response than in 2009. The increase came when President Zuma, shocked after being briefed on the latest HIV infection and AIDS-related death rates, expanded the budget to ensure that the AIDS response got sufficient funding.

But President Zuma believes more money and savings are needed to turn the epidemic around.

"The amount of resources dedicated to prevention, treatment and care has increased, but it is not enough. Much more needs to be done. We need extraordinary measures to reverse the trends we are seeing in the health profile of our people," he told South Africans on World AIDS Day last year.

There are opportunities for savings too. South Africa pays much more for antiretroviral drugs (up to 60% more in some cases) than do other African countries. "This is going to stop," the Health Minister vowed in April.

Most of the drugs are sourced from local pharmaceutical corporations. The government plans to open its next antiretroviral drug tender to global competition in an effort to force prices down. Officials believe that renewed efforts can secure the price reductions needed to enable affordable mass provision of anti-HIV drugs, including second-line drugs. Ms Madlala-Routledge believes that an "international effort to reduce the price of drugs" should be on the agenda again.

"We badly need the political will to enable compulsory licensing for the production of patented drugs, as allowed in the Doha and TRIPS agreements," says

Double-blow: tuberculosis and HIV

More than a quarter of all people with tuberculosis globally live in South Africa. High rates of drug resistance and HIV coinfection are aggravating the tuberculosis epidemic: nearly three in four (73%) new tuberculosis infections are among people who are also infected with HIV.

The tuberculosis epidemic dates back more than a century. It peaked in the 1960s, receded somewhat and then erupted again, this time alongside the HIV epidemic. Between 1986 and 2006, rates of tuberculosis case notifications quadrupled. According to the World Health Organization (WHO), annual tuberculosis incidence in South Africa in 2006 was in the region of 940 per 100 000 people.

New tuberculosis cases more than doubled between 2001 and 2007, when 382 000 cases were recorded. The tuberculosis epidemic is extraordinarily intense in parts of the country—notably KwaZulu-Natal, where case notification rates exceeded 1000 per 100 000 in 2006.

The introduction in the mid-1990s of the DOTS (directly observed treatment, short course) strategy made treatment potentially more effective. Implementation, though, fell short, while the AIDS epidemic also sabotaged potential gains.

Between 1997 and 2005, as the DOTS strategy was being implemented, the annual number of people dying of tuberculosis in South Africa increased by more than 300%. Renewed treatment efforts improved the tuberculosis cure rate to about 63% in 2006, which is still some way off WHO's 85% target.

Earlier poor implementation of tuberculosis control programmes and low cure rates have led to the spread of tuberculosis drug resistance, which is now a major handicap that also threatens to undermine the AIDS response. Outbreaks of extensively drug-resistant tuberculosis have been reported in each of the nine provinces since 2006, when 53 such cases were first detected at a rural KwaZulu-Natal hospital.

The AIDS epidemic is exacerbating these deadly complications, but the roots are in the poor management and implementation of tuberculosis control programmes over the years. Like the AIDS response, South Africa's tuberculosis programme offers huge opportunities for improvement.

the former Deputy Health Minister.

The commitment to bring the AIDS epidemic to an end has never been stronger in South Africa. But there is a lot of hard work ahead.

Procurement and supply management have to be strengthened further, for example, and back-up arrangements are needed to prevent drug stock-outs (see box). Referral and monitoring systems have to improve in order that treatment adherence and patient retention can be tracked more accurately. But the biggest challenge is to drastically slow the spread of HIV. The efforts to halve the rate of new infections over the next few years will test the mettle of this young democracy and its leaders. ●

South Africa: What do you think?

South Africa is at a historic junction in its AIDS response. With some 5.7 million people living with HIV, the government's political will is shifting. On 24 April, a nationwide HIV testing and counselling campaign was launched with the goal of testing 15 million people and of expanding antiretroviral therapy to ensure that 80% of those in need had access to it by 2011.

This move was celebrated around the world as a turning point not only for South Africa but for the whole southern African region.

OUTLOOK asks the people of Johannesburg whether they have seen a change in the attitude towards HIV in the past year in South Africa?



Mr Gqabi Njokweni

Film student

The government has invested a lot in trying to raise awareness about HIV. A lot more people know about HIV and how to prevent it. More people understand—unlike the older generations, who knew about it but didn't understand how to prevent or treat it. Information is more accessible today than before.



Ms Fikile Kunene

Receptionist

I don't think much has changed in the last year. There are still problems with ARV [antiretroviral drugs] stock-outs, especially in the rural areas. But the current government is trying; it seems they're doing something, certainly more than before.



Ms Nomahlubi Mthimkhulu

Street-stall owner

I think the response has improved, there are ARVs available now, people are more aware. Most people I know, know about HIV. But I have not seen any striking improvement, so things could still be better; for instance, there could be more about HIV in schools, like incorporating HIV in the curriculum at a younger age.



Ms Larissa Nathoo

Interior designer

I think the response to AIDS in South Africa has been stagnant. I think there needs to be more awareness of HIV, because a lot of people are getting infected every day.



Mr Bongani Julius Mavundla
Market research executive
 I think things are getting better. There are more condoms and ARVs available. There is more talking about HIV, even the President talks about it now!



Mr Boston Tshabuse
Security guard and president of a community development organization
 I think the response to AIDS involves everybody. I'm the president of a community development organization in Soweto and we educate people about HIV. I see more people getting involved at the community level. The more we speak about AIDS, the less people are afraid of it. Things are changing, slowly, but they're changing.



Ms Meme Mpuru
Designer
 People have become very de-sensitized to HIV. You see many campaigns and posters, but people just ignore them now. It has been drummed in too much. We need a fresh approach. Nothing new is happening in terms of the response to HIV.



Ms Annette Primo
Receptionist
 AIDS education is a movement from darkness to light. More needs to be done in schools to educate children; too many of our children are still affected by the pandemic. The reality of AIDS obliges people to think about sex as a possible death trap: your choices bear consequences. I think more has been done in terms of the response in the last year or so, there is more access to ARVs, there is more activism and the government is more serious about tackling AIDS. There is no more 'hiding' from the issue, there is more open debate.



Ms Henriette Lehman
Nutritionist
 AIDS affects different segments of society in different ways, but in South Africa poverty makes the situation worse. There has been a lot done in the past five years, even more in the past year in terms of educating people about AIDS. There are more campaigns, there is more activism. The key is to educate people, as this helps confront the AIDS epidemic.



Mr Yesheen Maharaj
Interior design student
 We need to make people more aware—there hasn't been sufficient awareness, and this is evident because lots of young people are having unprotected sex and getting infected.



Mr Pridepeter Malunga
Dog walker
 I think things are getting better, the government is giving more money to tackle AIDS, and they are asking people to get tested for HIV. They're trying hard to make things better.



[let's **PLAY** safe]



Evgeny Pisemsky

Thirty-two-year-old Evgeny Pisemsky is the founder and Executive Director of Phoenix Plus, a nongovernmental organization that he and his partner, Georgy, started up in 2005. Phoenix Plus—based in the city of Oryol, in the Russian Federation—provides care and support to people living with HIV in the country's central region. In 2008, Phoenix Plus was awarded a Red Ribbon Award in recognition of its work in improving the delivery of HIV services and in offering a range of support channels.

Evgeny has been living with HIV for ten years, contracting it through injecting drugs. He learned of his HIV status shortly after the death of his mother, and without her support and guidance Evgeny was unable to cope with the news. His life spiralled downwards, eventually resulting in him attempting to take his own life. Hitting rock bottom led him to seek help, which he found in meeting other people living with HIV. He joined a support group and there met a gay man for the first time. Evgeny soon acknowledged his own homosexuality and fell in love. Today, when looking back, he is proud of overcoming his own inner stigma about HIV and homosexuality.

8:00 WAKE UP

I am a night owl—I like to go to bed late and get up late. It is very difficult for me to wake up early in the morning. Georgy, my partner, is an early bird. He encourages me to get ready for my day.

8:20 COFFEE TIME

Breakfast is usually a cup of coffee or strong Chinese tea. I do not eat much in the morning, but when I do I usually have an apple, yogurt with muesli or a small sandwich. I take my treatment during breakfast. I have to take it once a day.

8:40 COMMUTE

I get on a shuttle bus and go to the regional AIDS centre. It takes me about 15 to 20 minutes, depending on the traffic. I use the time to check my e-mails and mark the most important ones to answer later.

9:00 WORK AT THE AIDS CENTRE

Three times a week I work as a peer counsellor in the AIDS centre. This is the favourite part of my work, as I deal with people—not paperwork and bureaucracy. I am there to help real people. Sometimes a lot of people come to the AIDS centre at the same time and they have to wait in line to see a physician or counsellor. The waiting room often turns into an ad hoc support group. This I like. I regularly stay at the centre until lunch.

13:00 LUNCH

It often gets so busy that I just grab a pastry and some milk. When I do have more time, I go to eat at the cafeteria in a nearby government building.

14:00 OFFICE

I start with keeping tabs on all the aspects that ensure Phoenix Plus runs smoothly. This means preparing and writing reports. Since I head a nongovernmental organization, I have to maintain good relations with the community. For the past year and a half, we have been funded by the regional department of one of the world's largest companies, so a well-managed house is important. I admit I do not like the piles of paperwork, but it is a rewarding process.

16:00 COUNSELLING TIME

I reserve two hours daily for individual counselling sessions, meetings with my staff and other consultations. We regularly use this time to have training, when the need or opportunity arises.

18:30 SPORTS

I need an outlet after a day jammed back to back with meeting people and tending to admin. I love sport and go to the gym on a regular basis. Outside of the gym, I enjoy cycling—I have two bikes. Georgy and I like to cycle together. I would like to cycle to work, but that would mean wearing my sports clothes to the office—I don't think that will happen anytime soon.

20:30 DINNER

I have a passion for cooking, although I don't often get the chance because of my schedule. I don't like store-bought, ready-made meals. Meal time can be a real dilemma—staying at work or shopping for fresh ingredients and cooking. When we pry ourselves away from work, we like to make sushi, fondue or fish or meat dishes.

21:30 WORK—ONE MORE TIME

In the evening I like to check in on my e-mails and create materials for a web site for HIV-positive men who have sex with men. Going to bed late gives me time to do this.

23:00 WINDING DOWN

Before bed, we like to watch movies. I like films that reflect society and the problems within it. I recently watched *Prayers for Bobby*. I cried like never before. I am an emotional person, but that film was something else.

“My idol is Harvey Milk, because he stood up for what he believed in and fought for equality. I want to create a nongovernmental organization focused on HIV-positive gay men so I can contribute to the human rights movement in the Russian Federation.”

— Evgeny Pisemsky





What's in his bag

1. "THE BAG"

I was with Georgy in one of St Petersburg's luxury shops when I first saw this leather bag. I immediately wanted it, but couldn't afford it, so I left the shop empty-handed. Georgy doesn't understand why people spend their money on expensive items, but, nevertheless, the next day he gave it to me as a present—he had returned to the shop when I was back at the hotel. I was very touched.

2. SUNGLASSES

To look good, of course.

3. PASSPORT

I always carry my passport. You never know when you will need it.

4. DIGITAL CAMERA

I like to document Phoenix Plus' projects—and catch my friends doing silly things.

5. PEN

I am always taking notes.

6. PILL BOX

I forgot my pill box recently when I left for a trip. Now I keep two—one at home, one in my bag.

7. AIRLINE BONUS CARD

I dream of collecting enough miles to go to New York. I am halfway there.

8. CONDOM

Safe sex always.

9. BUSINESS CARDS

Come in handy when I need to share my contact details.

10. FINGERNAIL CLIPPERS

Surprisingly useful on business trips.

11. BREATH FRESHENER

Fresh breath is so important.

12. LAPTOP

My computer is always with me. As a moderator of a discussion group on HIV for men who have sex with men, it is important to react to requests as soon as I can.

13. HEADPHONES

They drown out background noise when travelling.



3 things you need to know about Evgeny

1. His idol is Harvey Milk, because he stood up for what he believed in and fought for equality. He has plans to establish a new nongovernmental organization focused specifically on HIV-positive men who have sex with men. Evgeny wants to contribute to the human rights movement in his country and ensure that on issues such as homosexuality, bisexuality and transgender people, silence is overcome.
2. One of his happiest moments was receiving the Red Ribbon Award in 2008.
3. He plans on learning English next year.



HIV PREVALENCE AMONG INJECTING DRUG USERS

- Dhaka, Bangladesh
- Minsk region, Belarus
- St Petersburg, Russian Federation
- Guangdong Province, China
- Riga region, Tukums, Latvia
- Chandigarh, India
- Kiev region, Ukraine
- Hanoi, Viet Nam
- Tamil Nadu State, India
- Rio de Janeiro, Brazil
- Odessa, Ukraine
- Jakarta, Indonesia
- Bangkok, Thailand
- Kathmandu, Nepal
- Rangoon, Myanmar
- Manipur State, India
- Ho Chi Minh, Viet Nam
- Mandalay, Myanmar



Peaks and valleys

SCALING MOUNTAINS TO PREVENT HIV AMONG DRUG USERS

Geologists believe that the Himalayan peaks grew rapidly through the massive forces of tectonic plates colliding into each other. The shifting plates pushed rock to soaring heights, giving birth to the tallest peaks on earth.

The upsurge of HIV among injecting drug users can be likened to a mountain in silhouette—how high the peak is, and whether it stays at this high level once the epidemic saturates, depends on when, and whether, services for injecting drug users are scaled up.

In the foothills of the Himalayas lies the gateway city of Kathmandu, the capital of Nepal, which has witnessed its own Himalayan rise of HIV among drug users.

In 1991, HIV prevalence among injecting drug users was less than 1%. Health workers thought they had contained the epidemic by reaching drug users through needle exchange programmes. At the 1994 International AIDS Conference in Yokohama, Japan, Shiba Hari Maharjan and his colleagues reported that “clients of this harm reduction programme in Kathmandu have significantly modified their HIV risk behaviour in relation to drug use, from a starting point of high risk. The programme was instituted before HIV had spread, and seems to have achieved a sufficient level of behaviour change to have kept HIV prevalence low. Our indigenous model of HIV prevention through harm reduction in a developing country is proving effective, culturally appropriate and comparatively cost-effective.”

By 1999, HIV prevalence among injecting drug users, mostly young people, in Kathmandu had risen to about 50%. Similar rates were also found in other parts of the country.

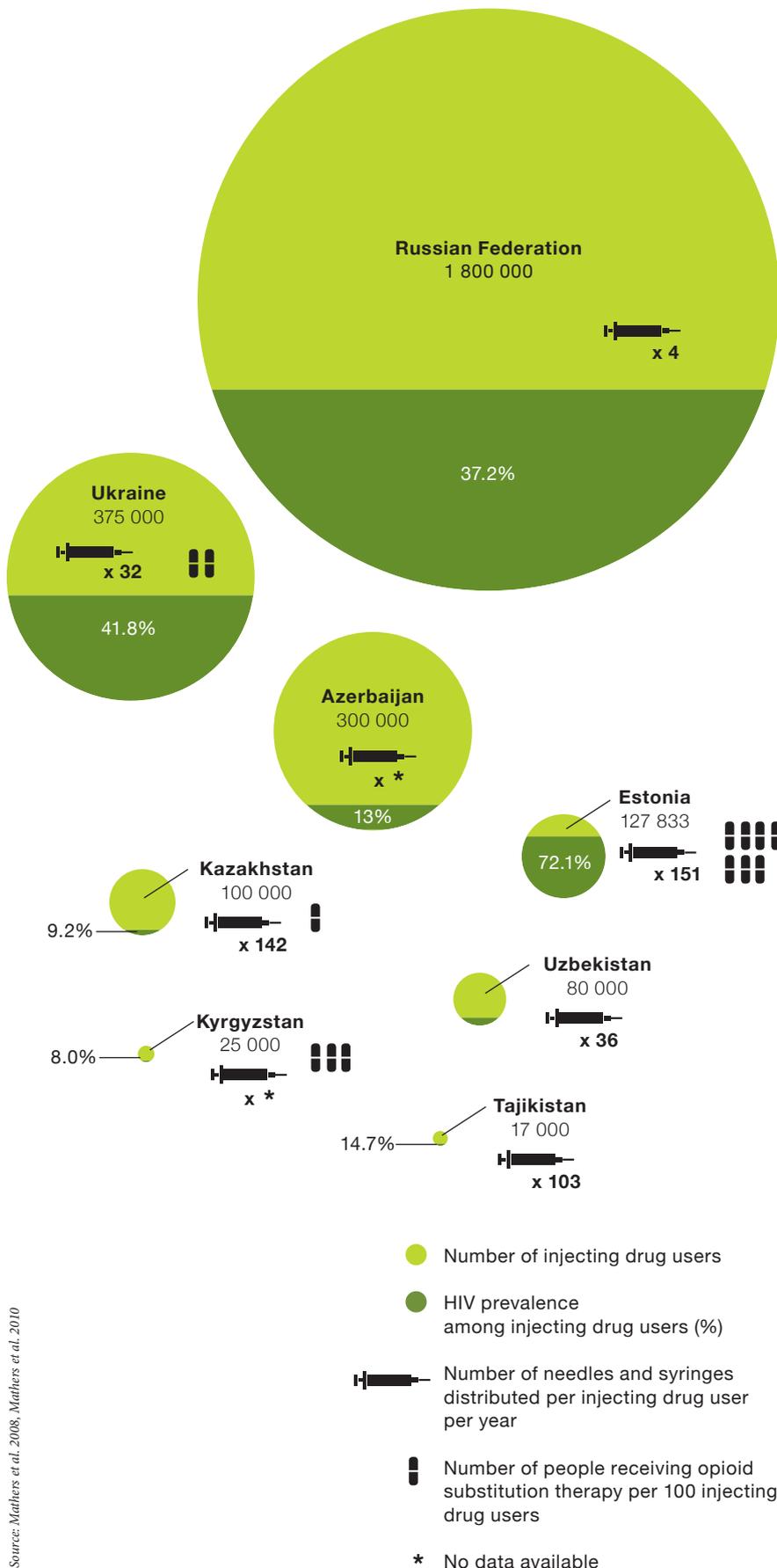
Further to the east, in the eastern Himalayas, lies Churachandpur, a town in Manipur State, India. In September 1989 researchers from the Indian Council of Medical Research set up camp to detect possible HIV infection in a region known for high drug use—there were an estimated 15 000 drug users in the town. The researchers found that none of the injecting drug users there were HIV-positive.



Source: US census bureau HIV database



INJECTING DRUG USE IN EASTERN EUROPE AND CENTRAL ASIA



Source: Mathers et al. 2008, Mathers et al. 2010

However, only six months later, they found that close to half were infected.

What went wrong?

HIV among injecting drug use peaks in a short period of time

The situation in Kathmandu and Chura-chandpur is not unique. In the early 1980s HIV rapidly spread among injecting drug users in Edinburgh, UK, skyrocketing from 5% to 55% within a period of two years, and similar trends have been seen in Bangkok, Hanoi, Kiev region, Minsk region, Jakarta and many other cities.

Transmission of HIV through injecting drug use is more efficient than through sex. A single act of exposure through injecting drug use has a 1% chance of causing HIV infection, compared with a 0.2% chance through unprotected heterosexual sex. Compounding the issue is the fact that there are new cohorts of first-time drug users emerging as existing drug users either die or stop taking drugs. This provides the conditions for continuing new HIV infections.

When drug users share contaminated equipment, needles or syringes, they receive a mini blood transfusion—injecting in their bodies, along with the drugs, left-over blood from previous users. Combine this with an interlinked network of drug users, mirroring the supply chain of illicit drugs, only one of whom needs to be HIV-positive, and the conditions for rapid transmission of HIV infection are ideal.

Web tools like Facebook show the nature of social networks: the mosaic of interactions and connections that bind people together. Injecting drug users form these networks, and, when HIV slips in, the network facilitates transmission.

Paras in Kathmandu became infected with HIV the very first time he used drugs, egged on by a friend. “I went to the house of a friend’s friend to spend some time. I had no idea that my friend was taking drugs or even that there would be drugs at this place. We were only five or six people in the house. A needle went around and I ended up sharing. There was no time to think, no time to ask for clean needles, no thought of HIV,” he said.

But why do drug users share needles? If each person used his or her own injecting equipment, HIV transmission would not take place. And if users can afford drugs, can they not afford to buy clean needles and syringes? Better still, can they not be taken off drugs? This is where idealism ends and social and political realities take over.

There are nearly 16 million injecting drug users worldwide. Nearly three million of them are living with HIV. And one third of all new HIV infections outside sub-Saharan

“Fear can lead drug users to inject quickly and furtively.”

Africa occur among injecting drug users. Between China, the Russian Federation and the USA, there are about six million people who inject drugs. The use of drugs is criminalized in all these countries and the majority of drug control efforts are spent on policing and imprisonment.

This provides a fertile ground for sharing. Costs of drugs are often high, so individuals are often involved in supporting their own drug use by selling small amounts to other drug users. The risks of being caught with needles and syringes weigh heavily on the minds of users, as many law enforcement officials use their possession as a proxy for drug use. Fear can lead drug users to inject quickly and furtively.

Choton navigates the busy streets of Dhaka, Bangladesh. An injecting drug user for many years, he does not carry his own needles and syringes, because of fear of getting caught. “I would rather use a dirty needle at an injecting site than carry my own and go to jail,” he says.

Bureaucracy doesn't help either. Pharmacies often do not sell needles without a prescription, or they ask too many questions. Where legal access is available, drug users seldom trust health officials to maintain confidentiality. Fear of discrimination and intimidation from employers and the police if they register as drug users is very real in many countries.

Mr Timur Islamov, Director of the Russian nongovernmental organization Development of Education, Health and HIV/AIDS Prevention, is a former drug user and has experienced this first-hand, “If you are registered as a drug user you cannot have a driver's licence and there are restrictions on certain types of work,” he says. “In addition, many organizations have security services that have access to databases of drug clinics. That means that this personal data can be used to not hire someone because of his/her past experience. One can be stopped at any time on the street and be forced to undertake a medical drug test. If the test is positive, the person can be imprisoned for three to 15 days.”

In Bangladesh, the authorities converted their extensive database of drug users into an anonymous one in order to avoid misuse by the police and other entities.

Dr Munir Ahmed, a former Team Leader for Operations of the HIV programme of CARE Bangladesh, led this process. “This helped restore confidence among drug users to access services from drop-in centres and meet with outreach workers without fear,” he says. “This system is now followed by all nongovernmental organizations working on harm reduction programmes with drug users in Bangladesh.”

Two authorities, one problem: getting public health and law enforcement on the same side

The relationship between health services and law enforcement agencies has sometimes been difficult. At times they have worked at cross-purposes. Breaking the vicious cycle of HIV and drug dependence demands that society build supportive relationships between people who use drugs, health authorities and law enforcement agencies. As Portugal has shown, civil tribunals that provide counselling and support can be a more effective response to drug offences than courts handing out custodial sentences. Alternatives to imprisonment and courts sensitive to the needs of drug-dependent people are appearing across the world.

The agreement at the annual meeting of the Commission on Narcotic Drugs that health solutions are better than criminal solutions is difficult for some drug enforcement officers—more comfortable with populist ‘zero tolerance’ campaigns—to accept. “This sends the wrong message” is the refrain that can be heard.

But where they have worked together they have been able to effectively balance the twin goals of drug control and HIV prevention.

Kyrgyzstan is a recent success story. There are approximately 26 000 drug users in the country. Mr Nurlan Shonkorov is one who has benefited from the introduction of harm reduction programmes there. “I have been on methadone for about three years and receiving antiretrovirals for more than three years,” he says. “I receive free condoms and some treatment for free. The treatment has been mainly arranged by the AIDS Centre's dispensary department.”

The country's harm reduction programme has backing from both law enforcement and public health officials. Opioid substitution therapy has been endorsed by both the national AIDS programme and the national counternarcotics programme. Methadone and buprenorphine have been included in the national essential medicines list. Civil society activists, drug treatment specialists and parliamentarians engage with people who oppose the strategy.

The results are promising. Increasing numbers of drug users have found employment. Self-reported quality of life increased by ten-fold after drug users went on methadone substitution therapy. A survey showed that casual sexual encounters went down by over half. Only 14.5% of drug users had injected drugs in the past three months and only 3.6% shared injecting equipment. Most importantly, crime dropped to zero.

“These programmes are effective both in terms of prevention and treatment. They help

drug users to come back from their previous drug-using life,” says Ms Oksana Katkalova, an expert working in Kyrgyzstan. “For harm reduction programmes, an injecting drug user should not only come and get syringes and needles, but also needs to be offered counselling.”

Working together requires building trust and a clarity of purpose on all sides. In southern Guangxi Province, China, the police supported the introduction of needle and syringe exchange programmes, but continued their crackdown on drug users, sending them to detoxification centres and labour camps. Outreach workers had difficulty distributing injecting equipment and the programme floundered. Some people still fear being forcibly tested for the use of drugs, as they have been previously identified as drug users. “When I talk to other people about the nightmare period I went through five years ago, I feel so full of regret and self reproach,” says Mr Wang Wen, a former injecting drug user.

“Because of that terrible experience, which I can’t bear to think back on, my life will never return to the relaxed, peaceful state I yearn for. Maybe in the future I will be forced to put a sign on my head saying ‘I have used drugs before. Please test my urine!’”

In Nepal, the home ministry and health ministry have come together alongside civil society organizations to oversee opioid substitution programmes, setting up a model for South Asia. HIV prevalence among drug injectors in Kathmandu has fallen to 21%, from a peak of 68% in 2005. Mr Anan Pun, President of Recovering Nepal, a network of people who use drugs and drug service organizations working with injecting drug users, feels that there has been a sea change in the approach since the early 1990s.

“Law enforcement authorities at the highest level are supportive of harm reduction, but drug users still face practical challenges from those who enforce law on the street,” says Mr Pun. “They are not the harm reduction agencies with a harm reduction agenda, but they can be agents for successful introduction of harm reduction programmes if a successful advocacy and education programme is tailored to change their beliefs and behaviours. Drug users are still harassed, as the drug laws still criminalize them, and it has not been changed yet, even though the policy has. Fear of punitive repression is preventing drug users from adequately accessing harm reduction and social services. It is an implementation challenge now.”

Australia has been a pioneer in adopting the harm reduction approach, adopting it in 1985, well before it was known that HIV was spreading among injecting drug users at an alarming rate. Since then over 30 million sterile needles and syringes have been



distributed each year and HIV prevalence has been kept at a low level. Several independent reviews have recommended continuing the approach.

“Harm reduction in Australia has been an extremely effective, safe and cost-effective way of controlling HIV among injecting drug users,” says Dr Alex Wodak, Director of the Alcohol and Drug Service at St Vincent’s Hospital in Sydney, Australia. The country is estimated to have saved over US\$ 1 billion in treatment and care costs as a result of this approach.

UNAIDS Executive Director Mr Michel Sidibé, in a speech to the Commission on Narcotic Drugs in April 2010 said, “But despite the success of these models, all too often today it is the police on the beat and the drug user in the street who are forced into a confrontation in the hand-to-hand combat of the war on drugs—and communities are the collateral damage. This endless and fruitless fighting must stop. We have alternatives, focusing our efforts in confronting the very real health problems of drug dependence and problematic drug use. Science, policy and governance must come together in this positive partnership.”

Decriminalizing drug users

HIV prevalence among prisoners in Ukraine is 15%, partly because of the large number of drug users incarcerated. HIV prevalence among prisoners with a history of drug use was nearly 31%, compared with just 5.9% among those who had never used drugs. And inside the prisons opioid substitution programmes are not available. Possession of small quantities of drugs for personal use is still subject to criminal prosecution. Such

“China now has more drug replacement clinics and needle and syringe programmes than any other country in Asia.”

laws make it difficult to scale up access to services for drug users.

This is one of the reasons why UNAIDS has called for the decriminalization of drug users. A recent Indonesian Supreme Court ruling that drug users need treatment, not prison, is welcome. In the UK, drug action teams refer drug users to health and social services. According to its National Treatment Agency for Substance Misuse, “Having successfully brought drug users into treatment, the system focuses on getting them better so they can leave, free of dependency. That process of recovery, in turn, can best be sustained by interventions that support drug users to assume a role as active citizens, take responsibility for their children, earn their own living, and keep a stable home.”

Bangladesh changed its narcotics law in the 1990s, encouraging the police to send drug users to treatment centres instead of jail. Ukraine was one of the first countries of the Commonwealth of Independent States to change and repeal all laws or policies that explicitly discriminate against populations at higher risk. It has removed explicit legal restrictions that impeded HIV prevention programmes and services.

United Nations Secretary-General Ban Ki-moon has called on Member States to ensure that people who are struggling with drug addiction be given equal access to health and social services, and asserted that “no one should be stigmatized or discriminated against because of their dependence on drugs.”

Scale matters

At the other end of the spectrum, the problem is that not enough is being done. As a rough guide, a regular drug user requires at least 150 needles and syringes each year. In Australia, an injecting drug user receives more than 200 needles and syringes a year. Few countries are able to match this. Estonia comes close, providing around 151 per person per year. But in the Russian Federation, only around four needles and syringes per person per year are distributed. In Ukraine the number is slightly better—32. Injecting drug users who receive fewer sterile needles and syringes are more likely to share equipment and put themselves and others at higher risk of contracting HIV.

Coverage for access to needle and syringe programmes or opioid substitution therapy is poor in most parts of the world. Recent strides in access to such programmes are simply not enough to push back the scale of new infections. According to a report in the *Lancet* by Bradley Mathers and colleagues, globally only 8% of all drug users have access to needle and syringe programmes. For every 100 drug users, only eight have access

to opioid substitution therapy. On average, only one in every one hundred injecting drug users in eastern Europe has access to opioid substitution therapy. And the number in central Asia is lower still.

Ms Batma Abibovna Estebesova leads Sotsium, one of the foremost nongovernmental organizations working on harm reduction in Kyrgyzstan. According to her, “There is a lack of resources to reach all injecting drug users and to provide them with psychosocial support. Unfortunately, many donors do not allocate funds for such activities. Because of this, we cannot support injecting drug users, who could become our partners in working with other drug users.”

The good news is that access to harm reduction programmes is clearly on the rise in most parts of the world.

China now has more drug replacement clinics and needle and syringe programmes than any other country in Asia. A groundbreaking methadone maintenance programme piloted in 2004 has grown to 680 clinics covering 24 provinces, and 1000 needle exchange centres reach 40 000 drug injectors every month. This is an astonishing turnaround that serves as a harm reduction model for other countries.

In Ukraine at the end of 2009 more than 5000 drug users were receiving substitution maintenance therapy at 102 health-care facilities in 26 regions, compared with just 10 centres serving less than 10% of the number of drug users just a few years ago.

Access to antiretroviral therapy

Injecting drug users living with HIV are not faring any better in accessing antiretroviral therapy. Globally, only four out every one hundred have access to treatment. In eastern Europe and South Asia the ratio is 1:100 and in central Asia 2:100, compared with 89:100 in western Europe. In countries such as Finland, Germany, the Netherlands and Spain, almost all injecting drug users living with HIV have access to treatment. However, in Brazil, Kenya, Pakistan, the Russian Federation and Uzbekistan less than one per hundred drug users have access to antiretroviral therapy. According to Ukraine’s 2010 country progress report on AIDS, the rate of treatment of active injecting drug users remains at only 7.5% of the total number of those receiving antiretroviral therapy, because of insufficient availability of substitution maintenance therapy—needed, since it has proven benefits in increasing adherence to antiretroviral therapy.

“Essentially, access to free medical treatment, rehabilitation and free legal assistance is non-existent at the state level,” says Ms Tetyana Semikop, of the Ministry of

Internal Affairs in Ukraine. “A repressive approach to injecting drug users, applied by narcology services, other medical institutions and law enforcement agencies, does not give an opportunity to provide efficient implementation of prevention programmes, including harm reduction programmes, rehabilitation and treatment of drug users and protection of their rights.”

Not enough is being spent

According to a new report by the International Harm Reduction Association, *Three cents a day is not enough: resourcing HIV-related harm reduction on a global basis*, global investments for harm reduction programmes for drug users are between US\$ 160 million and US\$ 180 million. In a world that prioritizes drug prohibition, political interest for funding such programmes has been limited.

One reason why there are only nine needles and syringes per injecting drug user in eastern Europe is because of the low investment in needle and syringe programmes. It is estimated that 76% of all resources spent in the region in this area come from international sources.

A full-scale comprehensive programme for drug users will cost US\$ 3 billion globally. Without the right investments, small-scale successful programme will simply be patchwork on a tattered quilt.

“Despite the fact that the state allocated substantial resources to combat HIV and drug use, we believe that it is not enough,” says Mr Evgeniy Petunin, Programme Director of ESVERO, the Russian Federation’s harm reduction network. “The main problem here is that neither programmes to combat HIV nor anti-drug programmes take into account the importance of working with vulnerable groups. Vulnerable groups still remain the driving force behind the epidemic—63% of HIV infections in 2008 and 2009 occurred among injecting drug users. There are no opportunities to develop specific and result-oriented programmes, particularly harm reduction projects.”

Another issue that confronts programmes is a lack of sustained funding and low service coverage and continuity of the programmes. Interruption in funding translates directly into interruption of front-line delivery of services for people who inject drugs. “Interruption in funding resulted in an explosive increase in sharing among injecting drug users in Kathmandu valley in the past. There is an urgent need to bring the service into scale and we need sustained funding”, says Mr Pun. A similar situation was observed in a cohort of drug users in Dhaka, Bangladesh. When programme



funding stopped briefly, needle lending and borrowing increased.

But it need not be.

What is going right?

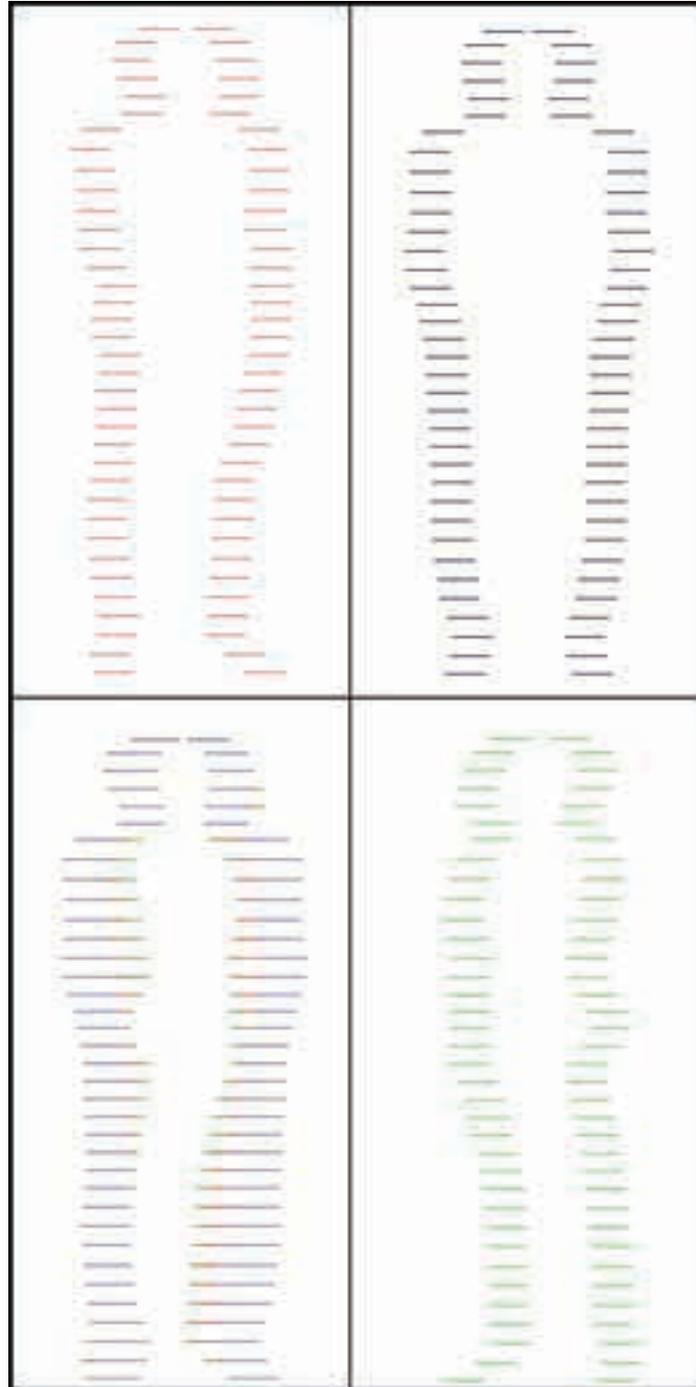
All countries should aspire to no new HIV infections among injecting drug users. New HIV infections among drug users have declined, even in countries that have had significant epidemics among drug users, such as Lithuania, the Netherlands, Spain and Switzerland. Portugal, which has western Europe’s largest epidemic among drug users, has halved new infections in this population since its overhaul of drug laws in 2001. The same trends are seen in Malaysia and Bangladesh.

Bangladesh applied lessons learned from Kathmandu and Churachandpur. It invested early in harm reduction programmes. Active community participation in outreach programmes was a key principle. Civil society organizations, local community leaders, drug control authorities and national AIDS programmes have worked together from the start. They have been able to keep HIV prevalence from skyrocketing, as it has elsewhere in the region. In 2009, HIV prevalence among drug users was just over 1%.

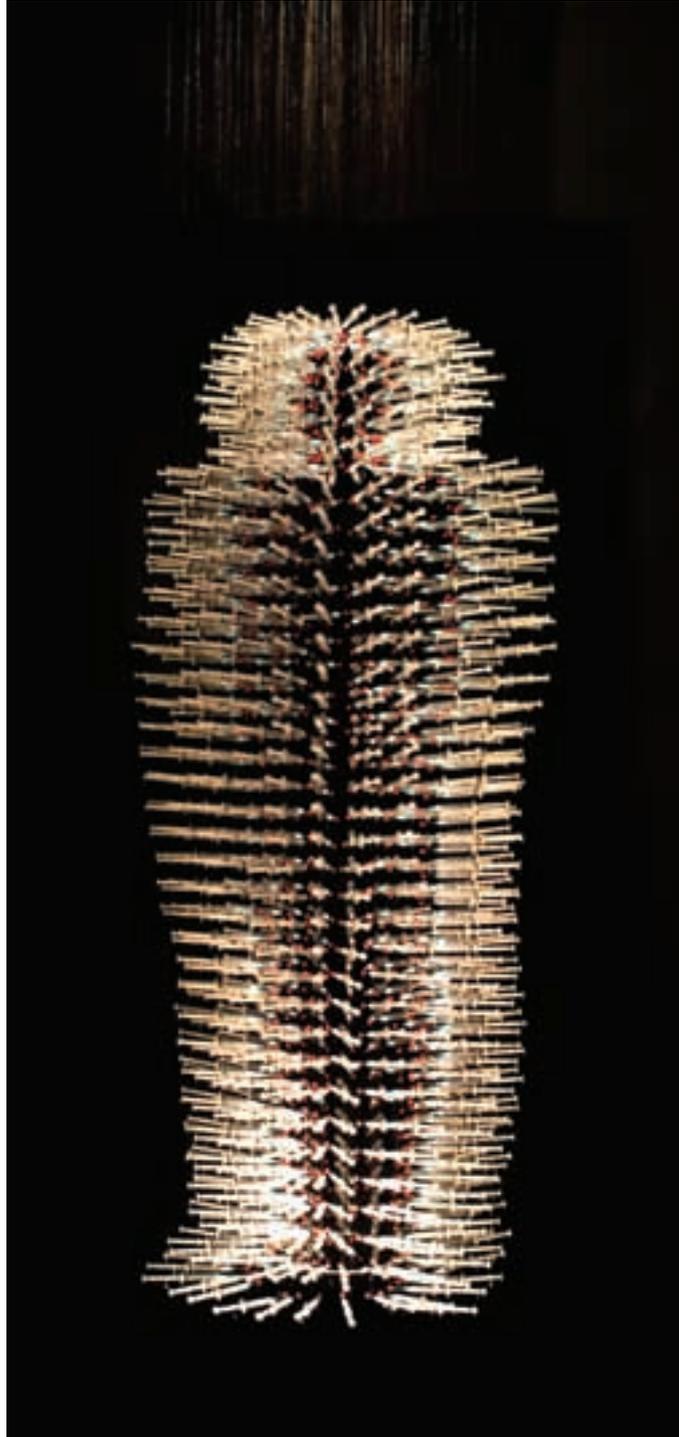
Central Dhaka boasts a 100% harm reduction reinforcement programme. It is estimated that there are about 100 injecting drug users living with HIV in the city. Six dedicated outreach workers ensure that they have daily contact with these individuals to provide them with clean needles and syringes. On average, a single outreach worker sees about 16 people a day. When they fail to reach someone, an alert system is activated, so that the services are not interrupted. Ensuring access literally on the doorstep has led to keeping new infection levels low.

Sanju is one of many outreach workers helping drug users in Bangladesh. A drug user himself, he joined CARE’s HIV prevention programme in 1998. His work has transformed his status among his family and friends. He has reduced his drug dosage, and performs well in his job. As Sanju proudly says, “This programme has given me a new life, physically and socially.” ●

Mr Daniel Goldstein *has been creating art, drawing on his experience of living with HIV, since the beginning of the AIDS epidemic. A well-known artist based in San Francisco, USA, he is a co-founder of Visual Aid, a non-profit group that helps artists living with HIV. His work has been exhibited in museums and galleries throughout the world. His large-scale mobiles can be found in numerous public buildings in the USA and Japan. The first showing of his Invisible Man exhibition will be at the International AIDS Conference in Vienna.*



The concept is a figure, similar in shape to the Medicine Men; however, it would actually be a void. Surrounding the void would be hundreds of syringes pointing inwards towards the body. The tips of the syringes would outline the body three dimensionally; in addition, they would be dipped in red rubber and have a red glass bead. The figure will be outlined by the red dots at the ends of the syringes. The syringes would also serve as a penumbra surrounding the figure—creating a larger figure. Lighting is crucial for this piece, as the syringes glow in the light.







MAKE ART/STOP AIDS is an initiative of the UCLA Art | Global Health Center: an international network of scholars, artists and activists committed to ending the global AIDS epidemic. Founded on the principle that artists are an essential part of the AIDS response, the coalition is shaping how people think and act. Funders have included UNESCO, the Andy Warhol Foundation, UC MEXUS, the World Bank and the Ford Foundation, among others. The initiative was started by David Gere, Associate Professor at the University of California, Los Angeles, in the USA.

HIV and the law

At the crossroads of human rights and the AIDS epidemic there often are laws and regulations that can discriminate against people living with HIV.



“When I got there, I felt so good. It was so good to be deployed. This is what I have been fighting for,” said Sgt Mthethwa.

For most soldiers, the army base at Kutum, northern Darfur, where temperatures reach 45–50°C, is hardly a plum posting. But for Sergeant Sipho Mthethwa, this dusty corner of the world is a dream come true.

The 39-year-old soldier is employed by the South African National Defence Force (SANDF), part of the African peacekeeping mission in Darfur. While his main job is keeping the peace, Sgt Mthethwa says that he has spent almost a decade fighting stigma and discrimination. Sgt Mthethwa is HIV-positive.

“When I first learnt I had HIV, I was in shock. At first I couldn’t believe it. I thought I hadn’t heard the doctor correctly,” said Sgt Mthethwa. “I thought I was going to die.”

After struggling to come to terms with this unexpected announcement, Sgt Mthethwa finally told a friend he was HIV-positive. And then he got another surprise.

“My friend said that it didn’t change

anything,” said Sgt Mthethwa. “My story is a very different story from other people living with HIV. When I went public with my status, nobody believed me. They never saw me as a sick person because I love to make jokes, they thought since I was always laughing it couldn’t be true.”

Although his friends rallied around, Sgt Mthethwa found that after he tested positive, in 2001, his army career stalled. His main job was to train SANDF soldiers for deployment out of the country, but he was never posted overseas, and was not promoted. In the past, SANDF stood behind its HIV policy—that people living with HIV were not suited physically or mentally to the stress of military life and could pose a risk to their fellow soldiers.

Sgt Mthethwa turned to the South African Security Forces Union (SASFU), which, with the AIDS Law Project, a human rights organization, filed

At issue was not whether testing for HIV in the military was discriminatory, but rather the consequences of the testing policy.

a complaint with the Pretoria High Court on behalf of the union and three HIV-positive soldiers. At issue was not whether testing for HIV in the military was discriminatory, but rather the consequences of the testing policy. The complaint objected to the blanket denial of employment, foreign deployment and promotion of people living with HIV in the SANDF and argued that an individual health assessment for each soldier should determine whether he or she was fit for work.

The case came before the court on 15 May 2008. After the close of the applicants’ oral argument on the first day of the hearing, the government withdrew its opposition. The parties reached an agreement, which was made into an ‘order of court’. The order declared that failing to employ, promote or deploy overseas soldiers solely on the basis of a positive HIV test was unconstitutional. As a result of this landmark court case, South Africa’s military amended its policy on health classifications to take into account the actual state of fitness of each SANDF employee.

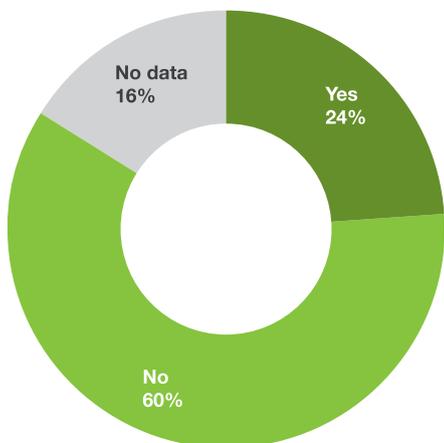
In October 2009, Sgt Mthethwa was deployed to Sudan, where he worked as an operations clerk. He refused a desk job and insisted that he would join other soldiers on long-distance patrols. “I run 4 kilometers a day. I don’t want to give the impression that I am different. You know you can do everything and anything. You are not powerless just because you are living with HIV,” said Sgt Mthethwa.

While some militaries are revising their HIV policies, there is a growing trend for countries to enact punitive laws aimed at people living with HIV and key populations at higher risk of HIV infection. More than 50 countries broadly criminalize HIV transmission. And nearly 80 countries have laws that criminalize men who have sex with men. UNAIDS has advocated that such punitive laws can create an environment of fear, often preventing men who have sex with men from finding out what they need to know to reduce their risk of HIV, to obtain and use condoms, or to access treatment if living with HIV.

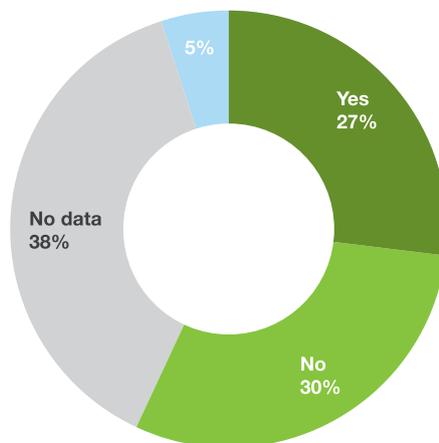
As Sgt Mthethwa’s case shows, courts have helped to improve the legal environment and to protect the rights of people living with or at higher risk of HIV. In July 2009, the Delhi High Court annulled a 150-year-old law criminalizing “carnal intercourse against the order of nature”, which banned sex between men in India. There are around 50 countries with travel restrictions on people living with HIV, although the USA and China removed such restrictions in 2010.

For women, being HIV-positive can be a double burden. A stark example of the kind of gender-specific human rights violation that women face is their forced sterilization if found to be HIV-positive. In Namibia, a study conducted in 2008 by the International Community of Women Living with HIV/AIDS and the Namibian Legal Assistance Centre found that nearly one fifth of the 230 HIV-positive women they interviewed

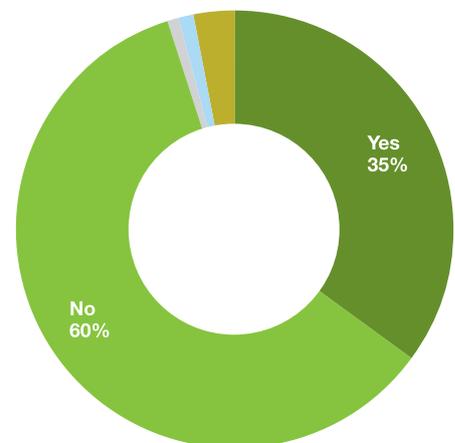
Percentage of countries that have HIV-specific restrictions on entry, stay or residence



Percentage of countries that have laws that specifically criminalize HIV transmission or exposure



Percentage of countries that have laws that criminalize same-sex activities between consenting adults



Legend: No data (grey), No (light green), Yes (dark green), Contradictory (light blue), Death penalty (yellow)



said that they had been forced to become sterilized. In Chile, the nongovernmental organization Vivo Positivo reported in a 2003 study that 50% of women in the country who had undergone surgical sterilization after learning about their HIV-positive status said they were pressured by health-care providers to do so, or that it was performed without their knowledge.

'F.S.', who has requested to remain anonymous, is a young Chilean woman. She says she continues to suffer the emotional scars of her sterilization, which she claims was forced. In 2002, she was excited to learn that she was pregnant, but when she went to her public rural hospital, she found out that she was HIV-positive. "I did not tell my family about the test result, but my husband was supportive so I was able to live with the news," said F.S. Her husband is also HIV-positive, and after learning of her status F.S. began antiretroviral therapy to prevent mother-to-child transmission.

In November of 2002 she was scheduled for a caesarean section. While F.S. was in surgery and under anaesthesia, the surgeon delivered her baby, but apparently also performed a tubal ligation. F.S. alleges that at no time during her pregnancy or stay in the hospital did she request to be sterilized, nor did she consent verbally or in writing to the life-changing procedure.

In Chile, traditional values and gender roles can be very strong, and motherhood is an intrinsic part of many women's identities.

"Being a mother is an extraordinary

experience. It's part of life. It's part of being a woman," said F.S. "I wanted to have at least two children, a boy and a girl. That was my dream, my ultimate goal in life."

F.S. gave birth to a healthy baby boy, who is HIV-negative, but she feels she was wrongfully denied the further happiness that comes with having another baby. In 2007, she filed a criminal complaint against the operating surgeon, alleging that the sterilization was forced and without consent. Chilean law requires that all sterilizations be authorized in writing, with the patient's fully informed consent. The surgical team has never contested the fact that no written authorization was ever provided for the procedure and has offered conflicting testimony regarding F.S.'s alleged oral consent.

The local court dismissed the case, and the appeal court upheld the dismissal. F.S. then filed a complaint with the Inter-American Commission on Human Rights in February 2009 in conjunction with the Center for Reproductive Rights and Vivo Positivo. The petition alleges that the Chilean state violated F.S.'s rights and seeks to compel the Chilean government to hold its doctors accountable for the rights violation. F.S. continues to wait for her case to be heard by the Commission.

Many human rights advocates say that one of the biggest challenges in the AIDS response is ensuring that people who believe their rights have been violated because of their HIV status can go to the courts and seek a fair hearing of their claim. Sgt Sipho Mthethwa's case shows that in some parts of the world this challenge is being overcome. ●

She says she continues to suffer the emotional scars of her sterilization, which she claims was forced.

Waiting for the world to change: Travel restrictions

The recent volcanic ash cloud over Europe gave stranded travellers a taste of what it's like—you want to go somewhere, but you can't. For many of the millions of people living with HIV around the world, travel restrictions are a daily reminder that they do not have the freedom to move internationally—or, even worse, that they may have to leave the place they call home.

Some 51 countries, territories and areas currently impose some form of travel restriction on the entry, stay and residence of people based on their HIV status.

When Mark Taylor,* a Canadian citizen working for a company in New York's financial sector, fell in love with his life in the Big Apple, he never gave it a second thought to apply for permanent residency in the United States of America. It was 1995 and he was thriving both professionally and personally.

"My new employer said it would sponsor my permanent residency, and we began the process of obtaining all of the required approvals," Mr Taylor said. In early 2002, with his residency paperwork completed, Mr Taylor was advised to have a medical exam in Canada to speed up the process.

"When I went to pick up the results, I was told that the HIV test had come back positive. As you might expect, I was devastated. I had been HIV-negative the last time I took the test in Canada. Not only did I have to worry about my health and well-being, but I was sure that I would be forced to leave New York, my job and all the friends I had there. I immediately sank into a deep depression, feeling hopeless and helpless."

For the 22 years the USA had a travel ban on people living with HIV.

Life stories like Mr Taylor's were not uncommon. It started in 1987, when the USA added HIV infection to a list of conditions making a person 'medically inadmissible', effectively banning people living with HIV from the country. It was a hardship imposed on many people.

"A huge range of frustrations and ridiculous restrictions weighed on people's abilities to visit the United States, to do business in the United States, to see family, to see friends and to go to weddings or funerals," said the Executive Director of Immigration Equality, Ms Rachel Tiven. Over the years her not-for-profit organization received an average of 1500 phone calls each year on its hotline, a quarter with questions about HIV travel restrictions.

"People called us to say," she said "I am at JFK Airport and they found my meds when I went through customs and they are telling me I have to get back on the plane—is that true?"

Too often it was true, people would have to get back on the airplane. For the United Nations General Assembly High-level Meeting on AIDS held in 2006 in New York a special waiver had to be sought for delegates living with HIV to

Illustrations: Kat Macleod for jaekywinter.com



125

countries, territories and areas have no HIV-specific restriction on entry, stay or residence.

51

countries, territories and areas impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status.

5

countries deny visas for even short-term stays.

Egypt
Iraq
Qatar
Singapore
Turks and Caicos Islands

5

countries require declaration of HIV status for entry or stay, resulting, for people living with HIV, in either a bar to entry/stay or the need for discretionary approval (including through granting waivers).

Brunei Darussalam
Oman
Sudan
United Arab Emirates
Yemen

22

countries deport individuals once their HIV-positive status is discovered.

Armenia	Qatar
Bahrain	Republic of Moldova
Brunei Darussalam	Russian Federation
Democratic People's Republic of Korea	Saudi Arabia
Egypt	Singapore
Iraq	Sudan
Jordan	Syrian Arab Republic
Kuwait	Taiwan, China
Malaysia	United Arab Emirates
Mongolia	Uzbekistan
Oman	Yemen

visit the country to participate. It's one of the reasons that the Executive Director of UNAIDS, Michel Sidibé, made lifting travel restrictions a priority.

"To not be able to participate in the very discussions about your future is not acceptable," he said. "Everyone should have equal freedom of global movement," he added.

Ms Tiven added, "It's simply not an effective way to limit the spread of the virus. We know that it is not just rhetoric, it is good public health practice for

people to know their status and to seek treatment, to be clear about their status with the

people they are intimate with, and to not make travel restrictions the reason people don't test to find out their status or not disclose their HIV status."

It's this very situation that Mr Taylor found himself in—he didn't take routine HIV tests in the USA and in the end feels

fortunate to have taken the test in Canada, where under the law his results could not be released to anyone without his consent. Mr Taylor put on hold his hope for permanent residency, but learned he could remain in the USA on his existing visa for an extended period of time. It was good news, but with a caveat.

"I could only remain in the USA if I was employed by my sponsoring com-

pany. During the turbulent times in the financial industry in the past eight years, I always feared that I was one round of layoffs away from having to leave the country," he said.

While Mr Taylor sought medical care and counselling, he believes his career suffered significantly. He tried to live as normal a life as possible, but always felt he was one misfortune away from having to leave the life he had established.

"I was reluctant to disagree or challenge colleagues on business matters.

The United Nations Human Rights Council adopted a resolution calling for the elimination of restrictions.

I always had the underlying fear that I could not do anything that might jeopardize my job," he added. "During this time I also became involved in a serious relationship, and the thought of being torn away from my partner was a source of even more anxiety."

Some 51 countries, territories and areas currently impose some form of travel restriction on the entry, stay or residence of people based on their HIV status. Five countries deny visas to people living with HIV for even short-term stays and 22 countries deport individuals once their HIV-positive status is discovered.

The International Guidelines on HIV/AIDS and Human Rights state that any restriction on liberty of movement or choice of residence based on suspected or real HIV status alone, including HIV screening of international travellers, is discriminatory.

International commitment to the issue is growing. In October 2009, the United Nations Human Rights Council adopted a resolution calling for the elimination of restrictions. The



Inter-Parliamentary Union at its 186th session in April 2010 adopted a statement to encourage “parliamentarians in countries with restrictions to play a leading role in their elimination, by reforming laws and by monitoring the regulations, policies and practices of relevant authorities in their countries. It urges parliamentarians to advocate for the right of their citizens living with HIV to have equal freedom of movement and to press senior officials in their governments to take up the issue with countries that have such restrictions.”

China is the most recent country to lift its travel ban on people living with HIV. The announcement came just days before the opening of the Expo 2010 Shanghai. Justice Edwin Cameron of the South African Constitutional Court, who is living with HIV, had travelled to China twice in the previous 18 months and met with government officials to discuss the travel ban.

“I am particularly delighted to hear of this decision, as the visa restrictions were illogical. They nearly led to the cancellation of my last trip to China because of a misunderstanding between government departments. I am relieved this will never happen again to anyone living with HIV,” he said.

In early 2009, with signs of movement towards regulatory changes in the USA, Mr Taylor decided to reactivate his application for permanent residency. It was a risky roll of the dice, as he was betting that new regulations would be in place by the time his application

made it through the system.

“Throughout the year, I followed the regulatory process closely. I would check the government web sites obsessively throughout the day for any new news,” he said.

The news came in late 2009—the USA lifted its entry, stay and residence ban, with President Barack Obama saying at the press conference, “If we want to be a global leader in combating HIV/AIDS, we need to act like it.”

It’s an announcement Mr Taylor remembers well, “I breathed a sigh of relief that had been pent up for over six years. A few weeks later, I received notification that my application had been approved, and a week later my permanent resident card appeared in the mail.”

And for organizations like Immigration Equality it means a shift towards outreach and to educating the public about the repeal. The organization will also monitor its implementation in the USA to ensure that all people living with HIV can enjoy the positive impact of the lifting of the ban.

And for Mr Taylor the announcement came just as he accepted a buy-out severance package from the company. He now has the freedom to think about what to do next in New York.

Mr Taylor added, “I finally feel like everyone else.” ●

* Some names have been changed.

China is the most recent country to lift its travel ban on people living with HIV.



FEATURE

A DAY WITH FRIENDS

OUTLOOK meets
Alessandra and
her new friends
in Rio de Janeiro.



One of the UNAIDS priority areas is to empower transgender people, so it was with excitement that OUTLOOK first spoke to Jacqueline Rocha Côrtes, of the UNAIDS office in Brazil, about the possibility of putting together A Day with Friends photo shoot. Even before the first question was asked, Jackie animatedly launched into a rundown of the differences between transsexuals, transgender people, transvestites and intersex people.

LOST IN TRANSGENDER

She quickly moved on to talking about how to communicate around issues relating to lesbian, gay, bisexual and transgender (LGBT) people. A new manual had been developed in Brazil that disentangles the differences between sexuality, sexual orientation and gender identity.

As Jackie spoke, it became apparent that there is much to clarify.

The communications guide makes it evident that the term ‘transgender’ relates not to sexual orientation but to gender identity. Still, it can be confusing, and some may wonder what is the difference between transgender people, transwomen, travestí (the Latin American term used for people who cross

genders) or, for example, hijra (the Indian institutionalized third gender)?

Navigating identity

Transgender people, the globally recognized umbrella term, was recently defined as describing “individuals whose gender identity and/or expression of their gender differ from social norms related to their gender of birth. The term transgender people describes a wide range of identities, roles and experiences, which can vary considerably from one culture to another.”

From talking to people within the community, it is clear that these broad brush strokes do not sit well with a plethora of individuals who self-identify as transsexuals, transvestites, transwomen, transgender people, transpeople, travestís, hijra or intersex people, with some terms preferred over others in different countries and continents. Taking into account that a transgender person may be gay, straight or bisexual, it can be complicated, for example, to talk about a male-to-female transgender person who is attracted to women.

“In Kenya, if a transsexual woman is attracted to women, she is called a lesbian, but she is not. It’s nothing against lesbians,” says Audrey Mbugua, who defines herself as an ‘out’ and politically active transsexual woman. “It’s the same as if you referred to a doctor as a carpenter—they wouldn’t like it. And it’s not because being a carpenter is bad.” Like this, Mbugua argues, the transcommunity is “denied [its] dignity and pride.”

Audrey Mbugua works for the civil society organization Transgender Education & Advocacy (TEA) in Kenya.

The three friends have coffee at *Cafecito* in the bohemian neighbourhood Santa Teresa.



Clothes

Brechoh Juisi by Licquor
Cervera
Forum
Neon
Lenny
Luiza Barcelos

Venues

Museu de Arte Moderna
Cafecito
Novo Desenho (museum shop)

“The transgender community has been active in the AIDS response since the early 1990s, but subsumed in the gay movement and boxed in the epidemiological term ‘men who have sex with men’.”

The organization opened its doors in December 2008 and has since worked to create awareness around transsexualism and intersexuality in Kenyan society. Audrey and others address and report on human rights violations of transgender and intersex Kenyans using a variety of different strategies, such as media campaigns, community mobilization and training for transgender people and their families.

In Kenya there is an increasing concern about criminalization of HIV transmission, as well as same-sex behavior, which makes it difficult to collect adequate data for HIV programming. According to Kenya’s 2010 UNGASS report, around 15% of new HIV infections are attributed to the group ‘men who have sex with men and prison populations’, but transgender people are not explicitly mentioned.

Mbugua describes the discrimination transgender people face in the country—being denied access to medical services, everyday violence, stigma and lack of access to education, but also battling with the female gender role: “patriarchy is an insidious part of our society. Assertive transsexual women are not the darlings of most men or even among sexual minorities,” she says.

A call to be heard

At the International AIDS Conference in Mexico in 2008, a call to action against the hidden HIV epidemic among transgender people was made. Globally, transgender people are more affected by HIV than the general population, including in generalized epidemics. Data show that one in four transgender people in three Latin American countries are living with HIV, and prevalence ranges from 10% to 42% in five Asian countries. Of these eight countries, only one has a general population HIV prevalence over 1%: Thailand, at 1.4%.

For this reason, advocates say that the voices of transgender people need to

be heard and counted.

According to the *UNAIDS action framework: universal access for men who have sex with men and transgender people*, little is known about access to appropriate HIV treatment, care and support for men who have sex with men and transgender people. It is reasonable to assume that stigma, discrimination and fear of public exposure means that, in many countries these two groups are less likely to access appropriate services than other groups.

Problems remain, two years down the line from the Mexico conference. Epidemiological data on transgender people are scarce, and the HIV epidemic among transgender people often becomes buried in the men who have sex with men reporting category.

According to Luis Zapeta Mazariegos, who works with OTRANS, a transgender organization in Guatemala, this is problematic, “The transgender community has been active in the AIDS response since the early 1990s, but subsumed in the gay movement and boxed in the epidemiological term ‘men who have sex with men.’”

“Even today they are still considered part of this group, when the practice, context and history tell us otherwise. They themselves even question the biological category ‘male!’” Luis Zapeta Mazariegos explains. The transgender population is not specifically addressed in the latest UNGASS report from Guatemala.

In contrast, a recent study in India concluded that “the ‘monolithic’ categorization [of men who have sex with men (MSM)] stands in the way of understanding high-risk behavioral outcome differentials within subgroups of the MSM population, which undermines effective interventions and research.” Compared with other self-identified men who have sex with men in the study, hijras had the highest prevalence of both HIV and syphilis. The study also showed that many hijras depend on sex



ALESSANDRA'S STORY

Brazilian sign language interpreter and translator, she is working to develop the first Portuguese sign language bilingual virtual dictionary.

work as their main source of income, and that they reported low levels of consistent condom use; this information would have been lost had the data not been disaggregated.

“All these sexualities are there and we have to understand them as they are,” says Laxmi Narayan Tripathi, an Indian hijra activist. “The whole perspective has to change. When you understand the priorities of the community, you will know how to deal with the higher-risk groups.”

And it is not only a problem from a data collection point of view. Both Tripathi and Mbugua agree that the merging of men who have sex with men and transgender people into one category can sometimes leave transgender people without representation in the decision-making process.

“Nowadays, every civil society organization in Kenya is talking about ‘LGBT’, but they only focus on the gay and lesbian communities,” said Audrey Mbugua. “Look at the involvement of trans- and intersex people in decision-making even in the LGBT organizations—it is practically nonexistent.”

Peru, which like many other Latin American countries has a concentrated epidemic, is taking steps towards diversifying the men who have sex with men category. In the UNGASS country report the group ‘men who have sex with men’ explicitly recognizes gay, bisexual and transgender populations and breaks down data accordingly.

With an HIV prevalence of 0.23% among antenatal clients in Peru and a national HIV prevalence among men who have sex with men of 13.9%, smaller studies conducted in Lima and the greater metropolitan area put HIV prevalence at 30–33% among transgender people. Its UNGASS country report clearly states that there is a series of subpopulations within the men who have sex with men category that have yet to be explored fully, and the authors call the transgender population the most vulnerable in the HIV epidemic of the country.

Not just HIV to worry about

Since transgender people often lack access to education and employment opportunities, many turn to sex work in an effort to survive. According to Jhoanna

Peru’s UNGASS country report clearly states that there is a series of subpopulations within the men who have sex with men category that have yet to be explored fully...

Castillo, Ombudsman’s Adviser, Human Rights Office Guatemala, transgender sex workers are often abused both verbally and physically, leaving them vulnerable to robbery, assault and rape. She is concerned about what she calls the “alarming situation” for transgender people and about the escalating transphobia in the country, listing a number of transgender people who have been tortured and killed over the past few years.

Johana Esmeralda Ramirez, a transperson from Guatemala City, testifies to these brutalities, “In November last year I was attacked—you can call it an attempt at my life—just for wanting to be me. I fear for my life on the streets, but I still work as a sex worker, because there is no other way for me to support myself.”

Zapeta Mazariegos, who works with OTRANS, counts an average of five transgender people allegedly killed each year between 1996 and 2006 in Guatemala, with another three transgender people killed in 2009, and one person missing since February 2010.



Zapeta Mazariegos says the situation for transgender people in Guatemala is one of “structural violence permeated with individual, communal, social, institutional and political transphobia.”

Moving ahead

The Election Commission in India for the first time allowed hijras to tick the box ‘other’ when declaring gender on ballot forms in November 2009. The country has also recently seen four hijras elected to public office in one state alone, Madhya Pradesh.

In Nepal a third gender has been accepted on identity cards, and Australia issued a birth certificate stating “sex not specified” to Norrie May-Webly, who wants to be considered as neither male nor female, in March 2010.

Peruvian Jana Villayzan, public health professional, travestí and living with HIV, wants to be part of the change, “When I was 42 I found out I was living with HIV. Now I am taking care of my CD4 count, to make sure I know when it’s time to start treatment. With this I hope to be able to show the transpopulation in Peru that HIV isn’t death, and that there is such a thing as positive

prevention, and even better, prevention before infection.”

In India, Tripathi reports a different kind of activism, “I was on a reality TV show with my family, and it was the first time that many people saw a hijra with her biological family. Many hijras are disowned by their families, but given a chance and family support things could be different.” After the show Laxmi received calls from other hijras saying that their parents had contacted them and wanted to talk to them again.

Beyond identity

As with many other issues relating to the HIV epidemic, discrimination against the transgender population leaves its mark, and for the community to dislocate itself from the social position offered often means moving mountains.

In India, hijras belong to a category recognized in society and are accepted in their traditional role “collecting alms and receiving payment of performance at weddings, births and festivals,” according to anthropologist Serena Nada. But as activist Laxmi argues, “Even though as hijras we are an integral part of society, it’s important that people realize that hijras

INDIANARA’S STORY

AIDS and LGBT activist since the 1990s, she’s proud of her own contribution to the way HIV prevention, treatment and research efforts have grown in Brazil.



Lazy summer afternoon
in the garden of the
Museum of Modern Art.



“All we want is to live with dignity. People should not only look at our sexual preferences, because we too are human beings.”

— Sudeep Chakarborty, India

are not only for begging, not only for sex work, they can be in fashion, they can be in make-up, they can act and perform.”

And here lies a tension between organizing a movement around an identity while at the same time striving to become an unnoticeable part of the social fabric.

In Peru, Giuseppe Campuzano, a philosopher, performer and travestí, has started a project called Museo Travestí del Perú. The initiative is a post-identitarian project, which aims to create awareness about the rich historical tradition of travestís in pre-Hispanic Peru, which Campuzano has traced through academic studies.



The project also investigates and presents contemporary travestí history (1966–1994) in local journalism and documents harassment and brutality, as well as resistance by the community. The Museo Travestí’s goal is to make visible this history to the travestí community itself and to the Peruvian general public.

The “Museo Travestí is a parallel platform for gender performance, research, activism and art,” says Campuzano, and it consists of a travelling exhibition of artwork and information pieces about travestís through history, up to the present.

Talking about the need for the project, Campuzano said, “In one hand I had a pre-Inca pottery replica depicting an important androgynous ritual mediating between the known and unknown, in the other several clippings about travestís assassinated or diseased and deceased with AIDS through the 1990s... and in between the necessity to articulate such historical events within one nation.”

But organizing people around a gender or sexual identity, such as a transgender movement, gay movement or women’s movement, can “lead to exclusion”, according to Campuzano. He gives the example of Peruvian HIV support groups that categorize members into male, female and travestí—where there might actually be a common denominator among them, for example sex work, which could facilitate exchange between these groups.

Campuzano also sees the building of exchange and solidarity between feminist and transgender activists as important, and Campuzano says that travestís, like women, need liberation from gender oppression.

“We aim to show that the attempt to categorize all humans as either male or female poses problems not just for travestís but for others too. We need to queer the binary structure of male and female.” In this way, a transformed society would offer a rainbow graduation of labels for gender and would respect the diversity of gender self-identification, Campuzano argues.

Sudeep Chakarborty, from India, perhaps best summarizes the hopes of transgender people, “All we want is to live with dignity. People should not only look at our sexual preferences, because we too are human beings.” ●

RHAYANA'S STORY

Hairstylist involved with HIV and human rights activism for the past ten years, she advocates for social inclusion for the LGBT community of Vale do Paríba.



Are you homophobic?*



* It's all in your head

He was a romantic poet who likened the full moon to his lover. Watching it alone, yearning for his lover to come. Unknown to him when his lover came to him—they were not alone.

In February 2010, unknown to him, a camera was installed in the house of Professor Ramachandra Srinivas Siras. It captured images of him having consensual sex with another adult male. His colleagues used the images to suspend him on charges of gross misconduct. He was thrown out of his campus housing, in the city of Aligarh, India.

For Professor Siras, a 64-year-old poet and academic in his final months of his teaching career, this shock was made worse because his accusers were the people he worked with and the students he taught. When asked about the suspension, the Vice Chancellor of the university said in an interview, “This university is an institution of international repute and its students go out with character. Homosexuality is not good for them and so such acts could not be allowed on campus.”

With support from the Lawyers Collective and Indian gay activists, Professor Siras appealed against the decision at the High Court of Allahabad. The court threw out the suspension, noting “the right of privacy is a fundamental right, needs to be protected and that unless the conduct of a person, even if he is a teacher, is going to affect and has substantial nexus with his employment, it may not be treated as misconduct.”

Professor Siras was discovered dead just days after winning the High Court judgement. Civil rights activists cried murder.

What drives institutions to these actions? “Fear of the unknown. Fear of difference. Fear of his own sexuality. Fear of God’s wrath,” says Mr Mark Clifford,

co-chair of the organization PRIDE in Action, in Jamaica.

“Homophobia is largely driven by society’s lack of understanding about gender, sexuality and homosexuality,” says Mr Shale Ahmed, Executive Director of the Bondhu Social Welfare Society, one of the oldest nongovernmental organizations working with men who have sex with men in Bangladesh.

What is homophobia? UNAIDS describes homophobia as intolerance and contempt for those who have identities and orientations other than heterosexual ones. It is an aversion, hatred, fear, prejudice or discrimination against homosexual men, bisexual people, transgender people, transvestites, lesbians and transsexuals. Homophobia confers a monopoly of normality on heterosexuality, thus generating and encouraging contempt for those who diverge from the reference model.

Homophobia can take place in various settings, in families, at work, in public services, in politics, in education, in social and sporting activities—in short, in differing forms within society as a whole.

INSTITUTIONAL HOMOPHOBIA

Some 80 countries currently criminalize same-sex behaviour. “In my opinion, I think that homophobia is driven by the present laws that are against homosexuals” opines Mr Craig R. Rijkaard, a research officer at the Directorate of Gender Affairs in Antigua and Barbuda. In many Caribbean countries the vestiges of colonialism still manifest themselves in the buggery laws introduced hundreds of years ago. “Jamaica needs to remove the buggery law from its book. Consenting adults should be allowed reasonable freedom of choice,” says Ms Carla Bingham-Ledgister, chair of the Civil Society Forum of Jamaica.

Changing laws doesn’t necessarily change attitudes and actions. For example, in the Russian Federation, when the criminal code outlawing homosexu-

“The right of privacy is a fundamental right, needs to be protected”

“Criminalization is increasing homophobia. It is also driving homosexual acts underground...”



ality was abolished there was little public discussion or explanation about the change and existing stereotypes continued. “The myths that have been in the Soviet era remain in modern society,” says Mr Vyacheslav Revin, director of a nongovernmental organization in the Russian Federation.

According to the Jamaica Youth Advocacy Network, acute expressions of homophobia continue because “there is little or no adjudication by the law and justice systems. There are hardly any sentences or punishment for an offender, as it is easy to say, for example, a gay man was making passes at you.”

In Fiji, despite the protection of sexual minority rights under the 1997 Constitution of Fiji, there has been a backlash from prominent churches, according to the Fiji MSM Network.

Many countries have found it difficult to strike down laws against homosexuality. “Policy-makers and legislators resort to scoring political points on the backs of the population to advance their political careers,” says Mr Caleb Orozco, a gay man from Belize. “Knowing that the laws do not recognize my relationship reinforces that, while I’m in a democratic society, I’m still marginalized by the laws, health policies and institutional attitudes that prevail,” he adds.

Mr Toni Reis, President of the Brazilian Lesbian, Gay, Bisexual and Transgender Association, feels that a culture that is still predominantly religious influences society and legislators. And in Africa there is a trend in some countries to introduce new laws that criminalize same-sex behaviour. Some 38 countries in Africa already have existing laws that criminalize same-sex relationships. Mr Frank Mugisha, Executive Director of Sexual Minorities of Uganda, has been at the receiving end of violence and discrimination. As an openly gay man living in Uganda he says that criminalization is increasing homophobia. It is also driving homosexual acts underground and making it risky for people to engage in safe sex. But what worries him most is that the absence of protection by the law makes it difficult for sexual minorities to access the kind of rights available to straight people. “When crimes are committed against gay men, such as rape, we cannot go to the police and report the case anywhere. We cannot go and get

treatment,” he adds.

Discrimination can be long-term and subtle. Mr Pallav Patankar, now a trustee of the Indian Humsafar Trust community organization, says that it is depressing to see open discrimination against his homosexuality at work. He says he hit a glass ceiling in his career because of his sexuality. “One then knows that confronting it is the only way. Others got promoted because senior management said they had wives and children to think of and I had no spouse or kids. But it was clear they were giving me a message. Finally I just quit and joined Humsafar. At least I know here that I will be judged on merit and not on my sexuality,” he said.

“It is extremely difficult to live pretending to be someone you are not in order to be allowed to study, to keep a job, to progress in life,” says Mr Leonardo Sanchez Marte, Executive Director of Amigos Siempre Amigos (a nongovernmental organization working with men who have sex with men in the Dominican Republic).

The ability to have a normal life, free of violence and stigma, can become a day-to-day challenge for gay men and women.

THE ROLE OF RELIGION AND CULTURE

Many members of the gay community are also people of faith. Across the world the impact of religious texts and beliefs on homophobia has been profound—both positive and negative. Faith continues to shape society’s views about sexual minorities. On the positive side, many faith-based groups have begun conversations with their members on the inclusion and acceptance of different sexual orientations. Openly gay men are being ordained as priests. “You are still my brother,” said an Imam in South Africa after hearing the story of a gay man. Archbishop Desmond Tutu has said “Homophobia is a crime against humanity and every bit unjust as apartheid.”

On the negative side, Ms Mayra Pichardo, Executive Director of Coalición Sida, in the Dominican Republic, feels that cultural patterns based on fundamentalist religious beliefs that have labelled and valued humans as good or bad based on their sexual practices affects women and men who are attracted

to people of the same sex.

“The underlying fear of religious institutions is their inability to control people’s sexuality. A control that is based on a relationship of power, punishment and submission between the church and its parishioners,” says Ms Mayra Pichardo.

“We need to separate religion from one’s sexual preference and allow God to be the judge and not man,” says Mr Rijkaard. “We need an open and committed discussion with the church,” adds Mr Tai Patai, Executive Secretary of the Te Tiare Association Incorporated (a Cook Islands network of men who have sex with men).

Many cultures regard same-sex relationships as unnatural, filthy and shameful. “Hatred is again derived from these ideas and actions such as violence, disownment and even murder are sometimes the result,” says Ms Miriam Edward, President of the Caribbean Sex Work Coalition, based in Guyana. “Some people also are afraid that if they show any compassion or love for homosexuals, they too will become homosexual. So because of this a lot of people choose to openly discriminate against homosexuals and therefore drive homophobia.”

IGNORANCE, MYTHS AND FEARS

Mr Joey Mataele founded the Tonga Leiti Association to support sexual diversity groups across the Pacific islands. One of the main issues it faced was ignorance.

“Homophobia is motivated and supported by ignorance first of all. Human nature is such that he or she cannot live in an information vacuum,” says Mr Mataele.

“The emptiness is gradually filled with a variety of incorrect information, myths and stereotypes. The most persistent myths are the ones that carry the greatest emotional message. In the case of homophobia that message is clearly negative.”

This notion is shared by Mr Radcliffe Williams, from Jamaica, who believes that ignorance is the major force behind homophobia; people fear what they don’t understand and hate what they fear. A web of prejudices and false beliefs is wired into people’s minds from an early age, handed down through the ages.

“There is a belief that homosexuals are able to ‘seduce’ the virtuous, are natural

to the devil, that homosexuals seduce children, and there is the idea that there is a homosexual mafia,” says Mr Andrei Beloglazov, Programme Director of the LaSky project, run by Population Services International in the Russian Federation.

“The underlying fear is that homosexuality is contagious, that we are all paedophiles and a set of people who cannot procreate,” says Ms Karlene Williams-Clarke, former chair of the organization Women for Women, who left Jamaica and sought asylum in Canada.

“There is a lack of sensitization among the general public on issues of homosexuality and there is a need to sensitize not only the community itself but others around us,” Mr Sherman De Rose, Executive Director of Companions on a Journey, a Sri Lankan civil society organization working with men who have sex with men. “We need more visibility in the community. Unfortunately, due to the high levels of stigma and discrimination, members of our community are reluctant to be open and come out.”

But Mr Clifford is unfazed. “Discrimination hurts, but I’m strong and will survive. I feel sorry for those who discriminate against me and others because they do so from a place of ignorance and so much energy invested in hate cannot be good for oneself,” he emphasizes.

SILENCE

For many years the US Army has allowed gay citizens to serve in the armed forces as long as they do not reveal their sexual orientation. The policy of ‘don’t ask, don’t tell’ helped gay men serve their country, but in silence. However, there appears to be a change of heart of the Army’s leaders. Testifying at the Senate Armed Services Committee on 2 February 2010, Admiral Mike Mullen, Chairman of the US Joint Chiefs of Staff said, “It is my personal belief that allowing gays and lesbians to serve openly would be the right thing to do. No matter how I look at this issue, I cannot escape being troubled by the fact that we have in place a policy which forces young men and women to lie about who they are in order to defend their fellow citizens.”

The adage that silence is golden does not help when it comes to standing up to stigma and discrimination. “The fear is if I don’t seem to be against homosexual

“I feel sorry for those who discriminate against me and others because they do so from a place of ignorance...”





“I am optimistic that a few years from now there won’t be any criminalization of homosexuality in Africa”

practices, I may be deemed as one and be forced to defend my sexuality,” says Ms Bingham-Ledgister. “It is also safe to say a lot of the homophobic display and outbursts are simply following a norm.”

Mr Joel Simpson from Guyana agrees, “Often men fear that if they accept these identities, it will reveal their own inherent same-sex tendencies—what researchers describe as internalized homophobia.”

“The notion of same-sex relations, feelings, lifestyle, challenges everyone, including gay people. Some people learn to embrace, tolerate or ‘let live’. Some are curious, some like my cousin have no interest in the subject as equally as she has no interest in space,” says Mr Morris Studdart, a gay man living in Jamaica. “But there will always be those who are hostile out of fear and self-doubt, because deep down they see something too terrible to acknowledge or accept. Why? Because they learn from the ‘normalization’ of other social behaviour that homosexuality is wrong,” he adds.

Most cultures promote the notion that a woman is made for the male and vice versa. This principle also defines macho culture. “Anything that might threaten macho culture is considered wrong and condemned,” says Mr Sanchez Marte. “There is also the fear of distorting the macho image or the fear of accepting that masculinity is not necessarily defined by being macho.”

“The fear comes from a perceived mythology that males become less male if they desire or sexually get attracted towards male sexuality. By desiring or

eroticizing another male one becomes more like a female, goes the logic,” says Mr Ashok Row Kavi, one of India’s most longstanding gay activists.

Silence can also come from members of the community. “The main underlying fears are being rejected by society and by one’s own family. A significant portion of homophobia can be internal for being fear of one’s own future,” says Dr K.A.M. Ariyaratne, Head of the Strategic Management Information Unit at the National STI and AIDS Control Programme in Sri Lanka.

“Being on guard 24 hours a day, seven days a week, is not good in maintaining peace of mind and a healthy relationship,” says Mr Orozco.

MEDIA: PROMOTING STEREOTYPES OR NORMALIZING?

Where does the media stand when it comes to defending homophobia? The manner in which the media talks and portrays gay issues has to some extent shaped the discourse in society.

Writing in the Express, a leading newspaper in the Caribbean, its former Special Publications Editor Ms Nazma Mulle says, “Because no media house has come out to advocate for equal rights and the removal of stigma, or even a discussion of the right to be gay, they are complicit in supporting homophobia.”

“It would seem that we just ignore the issue totally, unless a government official says something, as happened recently. But generally I can’t say there has ever been a proactive attempt to represent the views of gays or advocate decriminalization of

buggery by the newspaper,” she added.

“Every lead in to every other news story begins with stigmatizing the topic as ‘controversial’ (and by implication potentially illicit), rather than simply engaging in a rational, enlightening exploration,” says Mr Colin Robinson of Trinidad and Tobago’s Coalition Advocating for Inclusion of Sexual Orientation. “This serves to constantly stir the pot versus stilling the waters, in the sort of provocative ways the media has largely abandoned with questions of sexual infidelity and religious difference.”

“Gay people, rather than being humanized, are reduced to ‘controversies’, and the process of decolonization of homophobic thinking has been slow to follow the decolonization of our thinking about, for example, religious and expressive practices associated with Africa and poor people,” he adds.

“Changing and repealing homophobic laws can start a dialogue for reconciliation. We need to normalize gay people.”

Social transformation cannot happen in a vacuum. There are many ways for change to happen—a change in the law, an empathetic policeman or judge, a visionary leader, a sensitive journalist or an activist with a passion.

Mr Mugisha is one such activist. He has braved insults, beatings and the threat of being sent to jail. But he has begun a conversation. “When I was growing up, people said there were no homosexuals in Uganda. I thought I was most probably alone. I did not understand the feeling inside me. I did not think anyone understood me,” he said.

“But today, the conversations I am having with young people, gay and straight, show me that there is a very bright future. I am optimistic that a few years from now there won’t be any criminalization of homosexuality in Africa.” ●

What can be done to reduce homophobia?

OUTLOOK asked this question to people quoted in this story. Almost universally the response was education, especially for young people.

Mr Caleb Orozco, from Belize. “It becomes tiresome to hear children repeat the same homophobic remarks.”

Mr Ashok Row Kavi, from India. “The only way out is sex education. Sex education and more sensitization on sex, sexuality and gender should start from high school and continue as life skills education, so that males and females are made more aware of their bodies, sexuality and the bodies of the opposite and other genders.”

Mr Toni Reis, from Brazil. “Homophobia must be integrated into comprehensive sex education in the school curriculum and teachers must be duly trained to deal with this subject in the classroom.”

Miriam Edward, from Guyana. “I think education about the causes of homosexuality is much needed. A lot of people are ignorant of the fact that homosexuality is not predominantly a choice. The fact that there is a medical explanation is not widely known.”

Mr Shale Ahmed, from Bangladesh. “Families can be the first place of change. At the age of 15, my family members discriminated against me for my feminine gestures. Honestly, I felt devastated as a human being by their hatred about my feminine traits. They never tried to understand my sexual orientation. We also need to orient and train key homophobic stakeholders, like the media, law enforcers, lawyers, health workers and religious/political leaders, on gender, sexuality and homosexuality.”

Mr Morris Studdart, from Jamaica. “Conversations between and within communities on homophobia are rare. Changing and repealing homophobic laws can start a dialogue for reconciliation. We need to normalize gay people. It starts with a country showing respect for gays and lesbians by removing the buggery laws and enforcing laws relating to privacy and protection in the workplace—it would put front and centre in its citizen’s minds that homosexuals are no less deserving of consideration than any other human being.”

Mr Joey Mataele, from Tonga. “We need use our community mobilization skills to work closely with our community, especially here in Tonga. Our island kingdom is so rich in religion and culture, so if I have to tackle homophobia here in the kingdom I would have to work along with all the nongovernmental organizations, the community, stakeholders and also our government in a more peaceful way of doing things. I know I will face a lot of criticism, but I have done this for the past 18 years and I can say I can do just about anything now.”

Mr Vyacheslav Revin, from the Russian Federation. “Homosexuals are still invisible to society. Only homosexuals can solve the problem of homophobia by personal example, showing that they are real people and not cartoon images imposed by homophobes.”

MOTHER'S DAY EVERYDAY

As the saying goes—a mother's work is never done.





Keeping mothers and babies alive

Nee Olotu's laughter is infectious. Her 'just do it' attitude ensures that she survives the urban pressures of Lagos, Nigeria, a city that is bursting at its limits. Meeting her, it would be easy to assume that she actually has Lagos dancing to her tune.

She is about to give birth to her second child. Her first was born HIV-free, but ensuring that her second is born HIV-negative has not been easy. Nee Olotu's undetectable viral load led her doctor to suggest a vaginal delivery. But she is not sure how long her labour pain might last and whether in the end doctors will still have to perform a caesarean section.

While access to antiretroviral prophylaxis is free, she has to pay all other costs associated with hospitalization out of her own pocket. She has already been admitted to the hospital twice. The food costs alone are about US\$ 5 a day. When the child is born, she is considering breastfeeding her child, as infant formula costs have soared. Nee Olotu has difficult decisions everyday, but she is playing an important role in the goal of virtually eliminating mother-to-child transmission of HIV by 2015—a call first made by UNAIDS Executive Director Mr Michel Sidibé.

To make this goal a reality, programmes to stop babies from becoming infected with HIV have to take a comprehensive approach—the four Ps, as it is called by experts. Most attention has been given to the third P—prevention of HIV transmission from a woman living with HIV to her infant. However, new analyses and studies show that adding the three additional elements significantly increases the effectiveness of such programmes. OUTLOOK has there-

fore examined some key recommendations from scientific papers published in recent months on the four Ps and investigates how we can meet the goal by 2015.

Four Ps to stop HIV infections among babies

The first P—primary prevention of HIV among women of childbearing age—is common sense. If women are not infected with HIV in the first place, their children are automatically protected from being born with HIV.

Preventing unwanted pregnancies among women living with HIV

The second P—prevention of unintended pregnancies among women living with HIV—already averts around 170 000 new infections among children in sub-Saharan Africa every year, despite the region having low contraceptive access, according to a study conducted by H.W. Reynolds and colleagues. They also found that if all women in the region who did not wish to get pregnant accessed contraceptive services as many as an additional 160 000 HIV-positive births could be averted every year. In a separate study conducted by them, they assert that more than 120 000 child infections can be averted in South Africa alone if women living with HIV and not wanting to have children could access contraception.

J. Stover and colleagues in their 2003 paper *Costs and benefits of adding family planning to services to prevent mother-to-child transmission of HIV* have demonstrated that adding family planning to prevention of mother-to-child transmission services in high HIV prevalence countries could avert 71 000 child HIV

“Breastfeeding carries a risk of transmission of HIV, but this risk can be significantly reduced if women continue to take antiretroviral prophylaxis during their breastfeeding period.”

infections, compared with the 39 000 HIV-positive births averted with providing only antiretroviral prophylaxis.

A cross-sectional study in 2006 by D. Cooper and colleagues studied the fertility desires and corresponding health-care needs of 459 women and men (who were not partners of each other) living with HIV in Cape Town, South Africa. They found that an almost equal proportion of women (55%) and men (43%) living with HIV reported that they were not intending to have children as were open to the possibility of having children (45% and 57%, respectively). Overall, greater intentions to have children were associated with being male, having fewer children, living in an informal settlement and use of antiretroviral therapy. Women who were on antiretroviral therapy were more likely to want children than others not on treatment.

Interestingly, the study found that only 19% of women and 6% of men had consulted a doctor, nurse or counsellor in HIV care about their fertility intentions. Among women in HIV care, 11% had become pregnant since their HIV diagnosis, all unintentionally. Among women on antiretroviral therapy, 9% had become pregnant since starting treatment, with 30% of these pregnancies reportedly unintentional.

The study findings clearly indicated that integration of sexual and reproductive health services into HIV care settings is urgently required in order to create space for discussions with women and men about their fertility intentions. Most prevention of mother-to-child

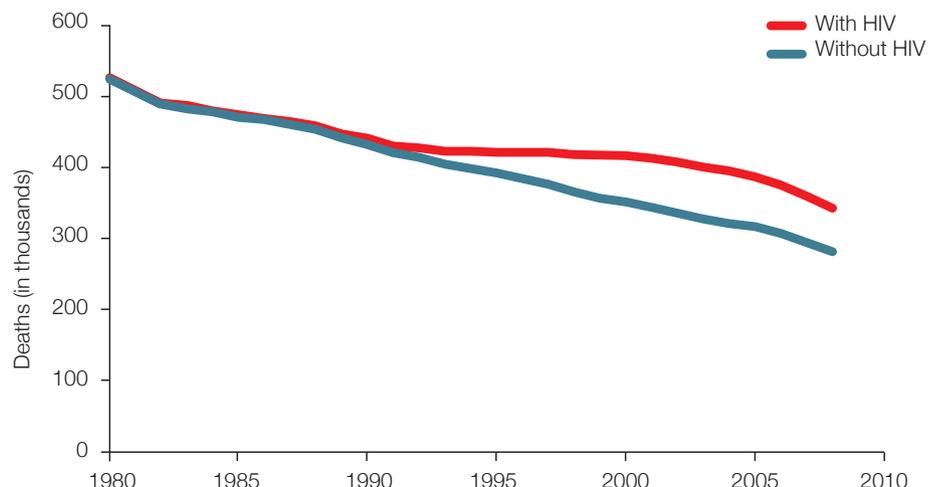
transmission programmes miss this opportunity, as they reach women only after they have become pregnant. Writing in the *Bulletin of the World Health Organization*, W. Rose and C. Willard say that separate, parallel funding mechanisms for sexual and reproductive health and HIV programmes and political resistance from major HIV funders and policy-makers to include sexual and reproductive health as an important HIV programme component are obstacles to HIV-positive women of childbearing age to stop unwanted pregnancies.

“Regardless of HIV status, increasing access to sexual and reproductive health services will not only offer women more control over their reproductive lives and help them safely achieve their desired fertility, but also will produce major public health benefits on maternal and infant morbidity and mortality. Voluntary contraceptive services, in particular, will benefit the health of women and infants in a variety of ways by delaying first births, lengthening birth intervals, reducing the total number of children born to one woman, preventing high-risk and unintended pregnancies, and reducing the need for unsafe abortion,” they say.

Preventing maternal mortality associated with HIV

HIV among pregnant women is now being understood as a major reason for continuing high rates of maternal mortality. A modelling study conducted by CAPRISA (the Centre for the AIDS

Global maternal deaths, 1980–2008



Source: Chris Murray et al. The *Lancet*, Vol 375, 8 May 2010

Programme of Research in South Africa) shows that HIV is now the leading cause of mortality among women of reproductive age, with HIV-related maternal mortality rates in sub-Saharan Africa increasing and surpassing other causes. The study showed that about half of all maternal deaths in Botswana and Lesotho were associated with HIV. In Nigeria there were nearly 10 000 such deaths. These findings were further corroborated in a paper published in the *Lancet* by C. Murray and colleagues, who on analysis of death registration records found that there would have been 61 400 fewer maternal deaths in the absence of HIV.

Providing antiretroviral prophylaxis to HIV-positive pregnant women

The third P—prevention of HIV transmission from a woman living with HIV to her infant through the provision of antiretroviral prophylaxis during pregnancy and breastfeeding—reduces the chance of transmission of the virus to as low as 1%. This rests on the premise that pregnant women are tested and counselled for HIV, but many women do not have access to such services before delivery.

Many studies have found that round-the-clock rapid testing and counselling services should be available for women in labour rooms. One of many such recommendations was made by N.P. Pai and colleagues, who say “in the wake of a paediatric HIV epidemic and the need for lifelong provision of antiretroviral therapy to infected children, a simple strategy for provision of round-the-clock rapid testing and counselling services in the labour rooms may be cost saving to the healthcare systems worldwide.”

Breastfeeding carries a risk of transmission of HIV, but this risk can be significantly reduced if women continue to take antiretroviral prophylaxis during their breastfeeding period. A study in the United Republic of Tanzania called Mitra-plus by C. Kilewo and colleagues found that providing maternal triple antiretroviral prophylaxis from as early as 14 weeks of pregnancy and continuing until one week after all exposure of the infant to breast milk ends, regardless of the mother’s own health needs, significantly reduces HIV transmission to infants.

Sexual reproductive health needs of women living with HIV

1. If a woman does not wish to become pregnant, she should be referred to or offered family planning services.
2. If she wishes to become pregnant, she should be informed about the local infertility and prenatal services, the types of chemoprophylaxis available to reduce the risks of transmission to her child and, if in a serodiscordant relationship, HIV prevention approaches to minimize the risk of infection transmission to a partner when trying to conceive.
3. If she is currently pregnant and wishes to continue with her pregnancy, she should be offered the opportunity to obtain antiretroviral therapy in order to reduce HIV transmission risks.
4. If she is currently pregnant but does not wish to continue with her pregnancy, she should be referred to safe abortion services. Postpartum contraception could be offered as an option for those who do not wish to become pregnant again.

Source: Wilcher R, Cates W. Reproductive choices for women with HIV. *Bulletin of the World Health Organization*, 2009, 87:833–839.

“Maternal antiretroviral therapy while breastfeeding could be a promising alternative strategy in resource-limited countries,” say C.A. Peltier and colleagues after they found that in Rwanda there was little difference in HIV transmission rates among women who chose not to breastfeed against those who opted to continue antiretroviral prophylaxis while breastfeeding their infants.

Such results have led to the World Health Organization issuing new guidelines on breastfeeding.

Keeping mothers alive

The fourth P—provision of appropriate treatment, care and support to women living with HIV and to their children and families—extends the benefits of keeping mothers and children alive long after the end of pregnancy.

Most women are asked to discontinue the use of antiretroviral drugs as prophylaxis once they stop breastfeeding, provided that their CD4 count is higher than the threshold for eligibility for treatment. However, J. Hargrove and J. Humphrey’s study in Zimbabwe found a higher risk of mortality for HIV-positive women in the 24 months following delivery across the entire CD4 cell count distribution spectrum compared

“Virtually eliminating HIV among babies will cost a little over US\$ 610 million each year in low- and middle-income countries. But the return on the investment is high. If programmes go to scale according to plan, the world could avert about 2.1 million child infections cumulatively between 2009 and 2015.”

with HIV-negative women. Although evidence suggests that pregnancy does not accelerate HIV disease progression beyond the passage of nine months of time, most of the data come from settings in developed countries. In contrast, these Zimbabwean findings suggest that serious consideration should be given to starting all pregnant women with HIV infection on antiretroviral therapy for life, regardless of CD4 count. “Early antiretroviral therapy initiation for all HIV-positive pregnant women may benefit individual mothers and infants, and simultaneously reduce population HIV incidence,” they concluded.

Mothers can now find out if their efforts at stopping their babies from becoming infected with HIV are successful shortly after giving birth if they have access to polymerase chain reaction, also known as PCR, tests. A new test, using dried blood spots, holds promise for the early detection of HIV among infants. R. Lazarus and colleagues found that mothers would like to wait as little as possible to know their test results, but go through significant stress during the period.

“The period before getting the results involved active mental preparation and was emotionally stressful. Most women accepted the results, but some had doubts about their reliability. Mothers of HIV-negative babies were relieved, but mothers of HIV-positive babies were generally very distressed and expressed a sense of responsibility and guilty,” they state.

This study, in the urban township of Soweto in Johannesburg, South Africa, supports the notion that HIV-positive mothers prefer learning their babies’ status early, rather than waiting for 12 or more months until maternal antibodies disappear. A recurring theme in the study is that most women said that their baby had been unplanned and they would not want to have another and that health-care workers concentrated on condoms as a means of reducing risk of transmission to partners, rather than as contraceptives, and some discouraged sterilization as a more permanent fertility control option.

Supporting babies born with HIV

Not all babies are lucky. In 2008 there were nearly 430 000 new infections

among children. Globally, the number of children under 15 years of age who received antiretroviral therapy rose from 198 000 in 2007 to 275 000 in 2008; however, a striking 62% of children in low- and middle-income countries who need antiretroviral therapy are not receiving it. All HIV-infected infants should start on therapy as soon as they are diagnosed, because of the very high mortality in the first year of life.

When children start antiretroviral therapy, it is important to monitor their clinical improvement to assess whether they are benefitting from it. M. Yotebieng and colleagues followed the lives of 1394 HIV-positive children in South Africa and developed HIV-specific weight gain reference curves that can be used by health workers in settings without CD4 percentage laboratory tests to identify which children on treatment are responding favourably to treatment and which ones are at higher risk of treatment failure and subsequent death.

In fact, there is good news about the prognosis of children starting on antiretroviral therapy in resource-poor settings. A.L. Ciaranello and colleagues, who conducted a systematic review and meta-analysis of the effectiveness of paediatric antiretroviral therapy, found that pooled estimates of the reported virologic and immunologic benefits after 12 months of antiretroviral therapy among HIV-infected children in resource-limited settings are comparable with those observed among children in developed settings.

Meeting the Millennium Development Goals is possible

Virtually eliminating HIV among babies will cost a little over US\$ 610 million each year in low- and middle-income countries. But the return on the investment is high. If programmes go to scale according to plan, the world could avert about 2.1 million child infections cumulatively between 2009 and 2015.

The year 2015 is five years away. The progress the world makes in stopping new HIV infections among mothers and their babies will directly determine if the goals of reducing maternal mortality and child mortality, as well reversing the AIDS epidemic, become a reality. ●

Prevention of mother-to-child transmission contributes directly to four of the Millennium Development Goals (MDGs) where HIV is currently holding back progress:

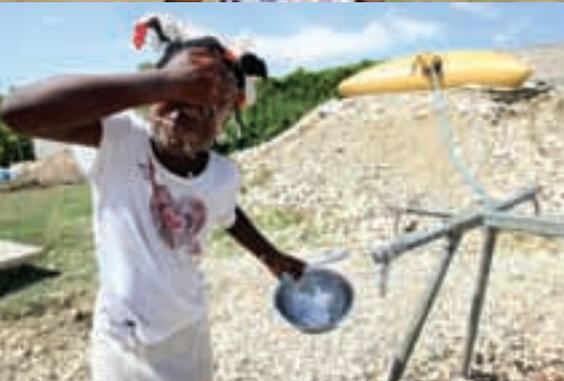
MDG 3: promote gender equality and empower women, by offering a channel to address gender equality issues, including ending gender-based violence, supporting women's reproductive rights, increasing access to information and sexual and reproductive health services, and engaging male partners.

MDG 4: reduce child mortality, by reducing the number of infants infected with HIV, providing treatment, care and support for uninfected as well as infected children born to mothers living with HIV and, indirectly, by improving maternal health and ensuring safer feeding practices.

MDG 5: improve maternal health, through primary prevention and family planning for women of child-bearing age, by ensuring care, treatment and support for mothers living with HIV.

MDG 6: combat HIV, malaria and other diseases, by preventing the spread of HIV through primary prevention among women of child-bearing age, preventing vertical transmission and treating both mothers and infants living with HIV.

Source: UNAIDS Outcome framework: prevention of mother-to-child transmission of HIV business case.



Haiti earthquake and HIV figures

- 230 000 deaths
- 300 000 injured
- 127 000 people living with HIV
- 2% HIV prevalence among men
- 2.3% HIV prevalence among women
- 2.2% overall HIV prevalence
- 11 320 new infections per year
- 8700 children living with HIV
- 24 400 people on antiretroviral therapy
- 109 000 children orphaned by AIDS
- 5600 will need prevention of mother-to-child transmission services in 2010
- 43 200 will need antiretroviral therapy in 2010

UN Photo/Sophia Paris

HAITI STILL HURTING

On 12 January 2010 an earthquake killed more than 200 000 people and left nearly 2 million people homeless in Haiti.

Following the devastating earthquake in Haiti, the Jean-Marie Vincent park became a refuge for families. Now nearly 50 000 people live there and the once peaceful park has become a vast temporary settlement, one of more than 1300 that have sprung up in the country.

Thousands of fragile dwellings—each two by two metres and generally no more than four wooden pillars covered with plastic—house entire families. UN armoured cars patrol the camp, while dozens of voluntary security personnel help to maintain a certain order. Families struggle daily to meet the basic needs of food, water, shelter and hygiene.

Massive and cramped, this city within a city can be dangerous. And for women doubly so, with the ever-present fear of sexual violence.

“I met ‘Gentile’ in an empty tent that had been left at the camp by one of the humanitarian groups, giving us at least a little privacy,” wrote Human Rights Watch’s Ms Liesl Gertholtz in the *Daily Beast*. “We sat in the oppressive heat, and she quietly described how, a few nights earlier, she had been grabbed by five men and taken into a nearby house. There she was raped, forced to perform oral sex, and brutally beaten. When she finally managed to escape, the men chased her and beat her in the street, where a man finally rescued her and took her to his home. Later that morning, she returned to the streets, as she literally has nowhere else to go.”

These are the daily realities. Unemployment, absence of privacy, loss of family, lack of economic independence, loss of belongings, anger and frustration all make it easy for violence to escalate. As officials and community workers try to reduce risk factors in the settlement, they also worry about vulnerability to HIV, especially women’s. Haiti has the highest number of people living with HIV in the Caribbean. There were more than 120 000 people living with HIV in Haiti before the earthquake—53% of whom were women.

Under two tents from Zanmi Lasante (‘Partners in Health’ in Haitian Creole), Dr Kobel Dubique and a team of ten doctors and a dozen nurses care for more than 500 people each day in sweltering conditions. Temperatures regularly soar to 35°C.

Around the makeshift clinic two smaller tents provide psychosocial support, but, says the Cuban-trained doctor, who also serves as the camp manager, few people attend, due to fear of stigma and discrimination.

“What strikes me the most is the quantity of positive HIV tests, around 15 a day, particularly among young people around 17–18 years old, and the rate of pregnancies among girls. Also, the quantity of cases with syphilis and vaginal infections,” says Dr Dubique.

With an estimate of nearly 2 million people displaced, the logistics of HIV prevention campaigns, condom distribution or voluntary counselling and testing have proved to be and will remain a challenge.

In these conditions, women and children are most vulnerable. Lack of income is seen as a major problem. As Ms Nadine Louis, the Director of Foundation Toya says, “Women and orphans need to survive and do not hesitate to have unsafe sex if it will allow them to feed themselves.” Ms Malia Jean, Coordinator of the Association des Femmes Haïtiennes Infectées et Affectées par le VIH/SIDA agrees, “Most women living with HIV do not have an income or a profession and therefore find it difficult to look after themselves or their children.”

With these issues at the forefront, people working on the HIV response have prevention at the top of their list, while acknowledging that the way forward is challenging. “Talking about sex is a taboo in Haiti,” said Dr Dubique. “And people are not educated in sexual and reproductive health. Therefore counselling and sexual education for parents and young people is a must, but practically nonexistent.”

In the same way that families have lost all privacy in their tents, health services cannot always offer privacy to patients. “One of our challenges is how to manage confidentiality of voluntary testing and counselling in camps when services are provided in tents and everyone knows each other,” added Dr Dubique.

He says many people refuse to get tested. “They know we will refer them to the health system, creating stigma and discrimination. And many refuse to meet with counsellors to talk about results for fear of being stigmatized.”

Support systems for people living with HIV were also shattered by the earthquake. The network of people living with HIV lost 40 people when its offices collapsed.

The government’s monitoring and evaluation abilities and coordination have been affected by the loss of data. The institutional memory stored on computers is gone—destroyed when the offices of the Programme National de Lutte contre le SIDA collapsed.

“Our biggest difficulty is to meet securely, as our offices were destroyed,” comments Ms Jean. Even so, there is optimism and some hope.

Asked about what had struck her most after the quake, Dr Joelle Daes, Director of the Plan National de Lutte contre le SIDA, talks of solidarity, “The solidarity of people and organizations, going to GHESKIO, for example, and seeing how they were caring for 6000 people when the centre was partially destroyed. Seeing how treatment was being delivered under tents. All of that gave me hope.”

Immediately after the earthquake makeshift pharmacies and clinics sprung up around the most devastated and HIV affected areas to try to reach people in need. Some 80% of people on treatment were quickly located and able to resume treatment.

As the rainy season approaches, life in makeshift camps and temporary settlements will become more difficult for families. Although many improvements have been made, living conditions and the long-term prospects are still uncertain. In these poverty conditions, food, water, shelter and jobs are the priority. “Why would someone spend money buying a condom when they have nothing to eat?” asks Ms Louis.

In looking to the future, Dr Antoine Augustin, President of the Fondation March, has a comment for the international community. “We are thankful for the outpouring generosity. But organizations should be thoughtful about what portion is spent on emergency relief and what on long-term development. The more than 1.5 million people in the camps hear the news about millions being donated, but do not perceive it in their everyday lives.” ●

AN INTERNATIONAL PHOTOGRAPHY PROJECT **THROUGH POSITIVE EYES** GIVES A VOICE TO PEOPLE LIVING WITH HIV. IN MARCH 2010, 17 PEOPLE LIVING WITH HIV FROM GAUTENG PROVINCE, SOUTH AFRICA, GATHERED IN JOHANNESBURG. AFTER TRAINING WITH PROFESSIONALS, INCLUDING THE PHOTOGRAPHER AND AIDS ACTIVIST GIDEON MENDEL, THE 17 EMERGING ARTISTS SET OUT ON THEIR OWN PERSONAL PHOTOGRAPHIC JOURNEYS, CAPTURING IMAGES OF THEIR DAILY LIVES. THE RESULTS DEMONSTRATE THE GROUP'S VISUAL CREATIVITY, INFORMED BY THEIR UNIQUE LIFE STORIES. THE INITIATIVE, WHICH RECEIVED FINANCIAL SUPPORT FROM THE US PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, WILL BE HELD IN SIX COUNTRIES AROUND THE WORLD OVER THE NEXT FEW YEARS. AN EXHIBITION OF THE PHOTOGRAPHS CAN BE SEEN AT THE INTERNATIONAL AIDS CONFERENCE IN VIENNA.



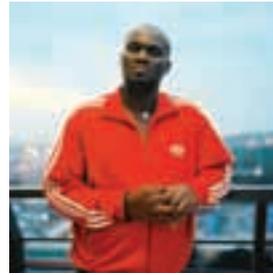
THESE ARE MY PHOTOGRAPHS. THIS IS MY STORY. THROUGH POSITIVE EYES



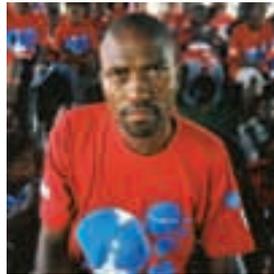
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MGLADZO



BHEKESISA



NONTYATYAMBO



NOMSA



THESE ARE MY PHOTOGRAPHS. THIS IS MY STORY. THROUGH POSITIVE EYES



BONGGI

“We are just two guys who are in love with each other.”



Gideon Mendel

I first realized I was gay in 1998, when I was doing my grade 10 at school. It was really difficult for me to accept this about myself. I tried to commit suicide. Then my mother and my stepfather took me to a pastor at church. I had to go through counselling sessions with him and he helped me understand and accept myself the way I am. Then, in 2003, I found out that I was HIV-positive.

It was really difficult for me to accept my HIV status. I told myself that maybe God had punished me because I'm gay. But then, after attending counselling sessions at the clinic, I accepted my status. We even have a support group at

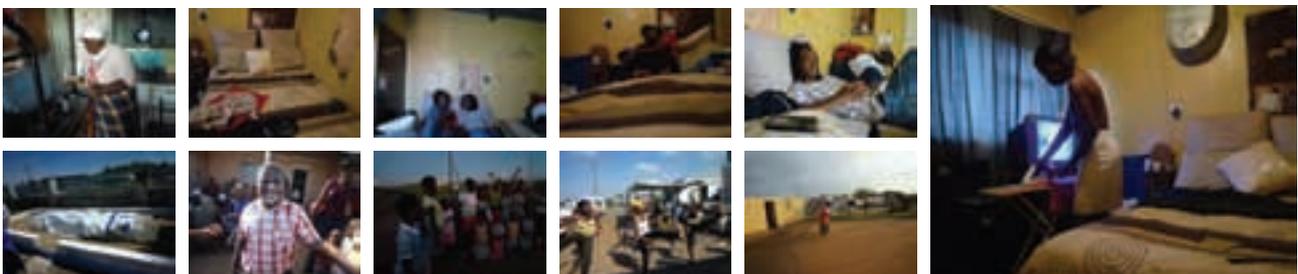
church for people who are living with HIV.

I disclosed my HIV-status to my parents in 2004. And again, my mother and my stepfather were so supportive. My mother is such a beautiful person—she's a prophet. She can tell you about your future. I love her a lot. If she weren't here, I think I would have died after finding out my status. She's the reason I'm living now.

Even though my family is there for me, support from the community is really hard to get. People will insult you, saying disgusting words: “Look at this gay person who has AIDS. You want to spread it. We are going to change you and make you a straight guy. But you

mustn't infect our girlfriends.” My motto in life is: What other people say or think about me is none of my business. In the end it's my life and I have to make the most of it.

I met my partner last year, and we have been together ever since. Our bed is very important to us. It's where we share memories, where we advise each other, where we fight, and where we pray. It's where our home is. He's HIV-negative, and he supports me. He loves me, and I love him. We live a normal life as heterosexual couples do—we even hold each others' hands when we walk in the street. We are just two guys who are in love with each other.





THESE ARE MY PHOTOGRAPHS. THIS IS MY STORY. THROUGH POSITIVE EYES



ZANDILE

"I try not to focus on it, but at times the fear will grip me anyway."



Gideon Mendel

My story begins when I met my baby's father. We were longtime friends, we dated for a short time, and before I knew it, I was pregnant. It wasn't planned. And then he left me for his ex-girlfriend. When I found out that I was pregnant, the doctor advised me to do the tests that all pregnant women do. And everything was negative, except for HIV. They told me then that I was HIV-positive. I was 23.

My son is HIV-negative. His name is Loyiso, which means victory. He conquered HIV. I love him, because if it weren't because I was pregnant, I wouldn't have gotten tested. I've

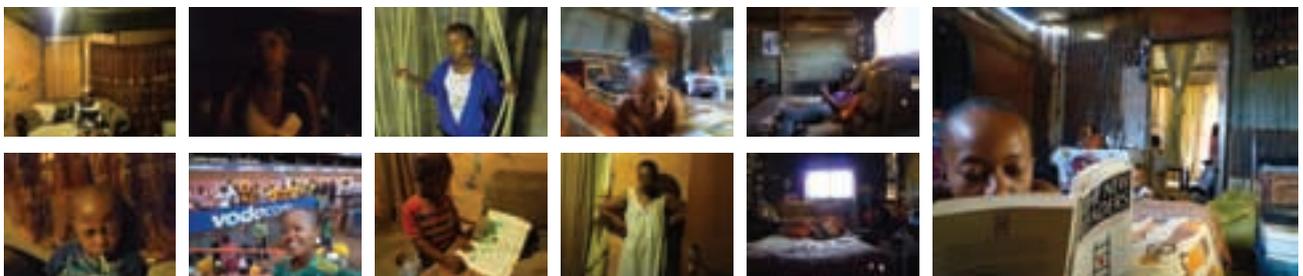
been on treatment for almost four years now. And I'm healthy. Though I'm HIV-positive, I'm healthier than most other people who are HIV-negative. I never even get sick.

I had a very tough childhood. My parents never knew, but as a child I was molested by one of my father's workers. So I've always had this fear that something bad would happen to me. So the dark place in my photos represents a child in me who's very scared, who went through a bad experience, at an early stage of life.

After I found out about my HIV status, I always hoped for a chance to share my story. I even saw myself doing this interview, taking pictures,

or making videos. The power of positive thinking, it's putting your faith to use, believing in what you want to receive as if it's already there.

For example, after I found out my HIV status I said, "You know what? Though I'm HIV-positive, I will never get sick. I won't change. In fact, I will even be more beautiful. I will grow. I will take care of myself. I will make sure I don't repeat all the wrongs I have done or have been done to me." I closed that chapter of my life, and I've moved on.



WIN-WIN

FOOTBALL AND THE AIDS RESPONSE



Captains and members of teams qualified to compete in the 2010 FIFA World Cup in South Africa, and football players, teams and fans worldwide, are joining together to help prevent mothers from dying and babies from becoming infected with HIV, especially in Africa.

— UNAIDS Goodwill Ambassador
Mr Michael Ballack, former Captain
of Germany

With more than 200 million people playing the game and billions more watching matches live and on television, football is the most popular sport in the world. The 2010 FIFA World Cup, held in South Africa from 11 June to 11 July, was therefore the ideal event to get AIDS-related information to a massive audience worldwide.

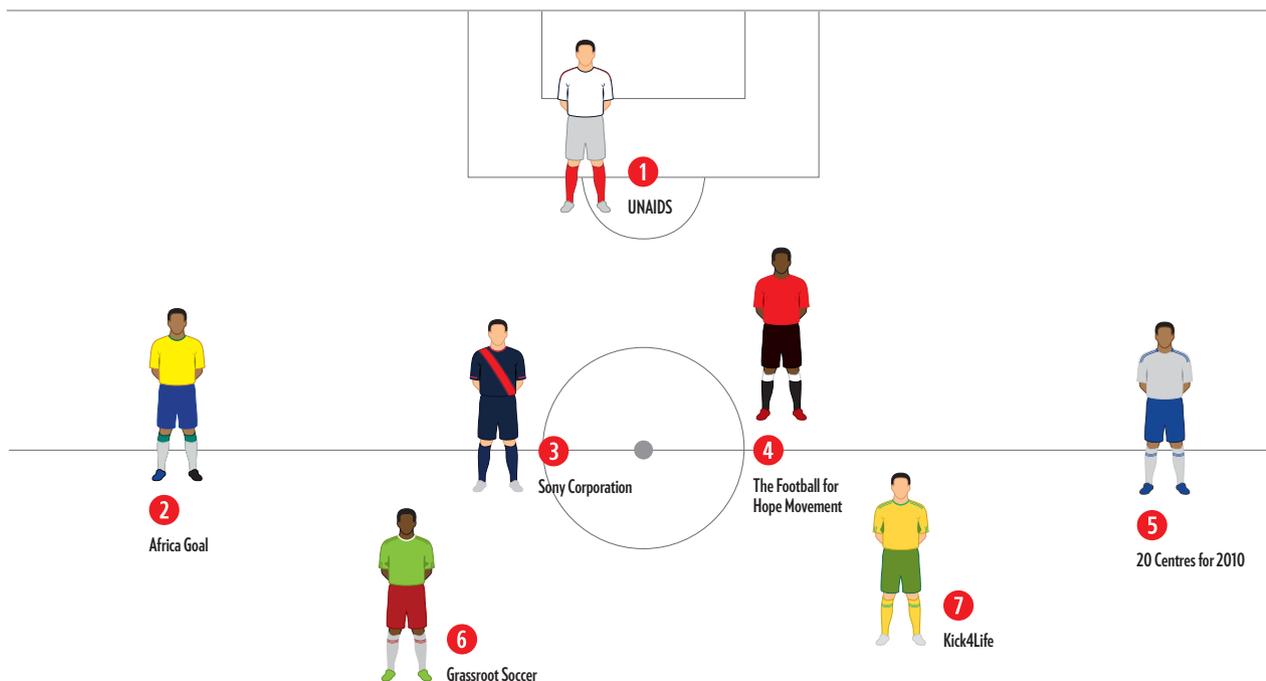
According to a survey conducted by FIFA published in 2001, over 240 million people in more than 200 countries regularly play football. Millions regularly go to stadiums to follow their favourite teams, while billions more watch the game on television.

In many parts of the world football stirs up great passion and plays an important role in the life of individual fans, local communities and even nations. It has helped to stop wars, such as Côte d'Ivoire's civil war in 2005. But it has also contributed to increasing tensions, such as when a match between Dinamo Zagreb and Red Star Belgrade descended into rioting in March 1990 at the beginning of the Yugoslav wars and in the events leading up to the Football War between Honduras and El Salvador in 1969. With such capacity to influence people's behaviour, a global event like the World Cup provided an invaluable opportunity to disseminate information about HIV to people the world over. A number of organizations took up the challenge by organizing projects

aimed at raising awareness about HIV in the lead up to and during the world's biggest football competition.

Football has long been followed with great enthusiasm and excitement in Africa, and pictures of leading footballers are displayed everywhere—in streets, in bars and in shops. Children play the sport wherever they can, sometimes with balls made out of whatever they can find, and people of all ages gather around television screens to watch the big matches. Significantly, this was the first time that the World Cup had been hosted in Africa, the region of the world most affected by the AIDS epidemic. This was therefore a tremendous opportunity to get the message about HIV across to the millions of fans in Africa and beyond.

At the pinnacle of the world's favourite game are the national teams, some of the members of which have become celebrities known worldwide and who are role models followed by men and women of all ages. These players personify the hopes and dreams of millions, and their actions and words resonate loudly among fans.



Many organizations and projects used the unprecedented opportunity that the World Cup presented to convey key messages on HIV prevention to audiences in South Africa, across the African continent and around the world.

1 UNAIDS UNAIDS mobilized football players, including captains of the 32 World Cup qualifying teams, to support a new initiative entitled *From Soweto to Rio, give AIDS the red card to prevent babies from becoming infected with HIV*. Through UNAIDS Goodwill Ambassadors Michael Ballack, former Captain of Germany, and Emmanuel Adebayor, international star from Togo, all the team captains were asked to support the campaign to prevent mothers from dying and babies from becoming infected with HIV. The initiative extends from the 2010 World Cup in South Africa to the 2014 World Cup in Brazil, following the UNAIDS Executive Director's call to end mother-to-child transmission of HIV by 2015.

2 Africa Goal This initiative, supported by UNAIDS, used the World Cup to bring HIV information to people in remote villages of east and southern Africa. A team of nine people travelled from Kenya to Johannesburg, showing live World Cup matches every evening for the duration of the football tournament, together with HIV information videos supplied by UNAIDS, SAFAIDS and, when possible, local nongovernmental organizations, to a diverse range of audiences. The Africa Goal project focused mainly on HIV prevention, including the promotion of the need to know one's status, the risks of having multiple concurrent partners and the reduction of stigma and discrimination, among other issues.

3 Sony Corporation UNAIDS Cosponsor the United Nations Development Programme (UNDP) partnered with the Sony Corporation and the Japan International Cooperation Agency (JICA) to bring health information, with a special focus on HIV, to vulnerable communities in Cameroon and Ghana. Sony set up large screens to show live approximately 20 World Cup matches. Throughout the games, UNDP, JICA and local partners also offered viewers HIV counselling and testing as well as advocacy materials as part of their HIV-awareness campaign called Public Viewing in Africa. Both countries' national football teams participated in the World Cup.

4 The Football for Hope Movement Established in 2007 by FIFA and streetfootballworld, the Football for Hope Movement aims to increase the impact of football as a tool for social development, peace and social change and to maximize the potential of football as a significant contributor towards the achievement of the Millennium Development Goals. The movement works through a global network of organizations that develop local projects with football as a central element. These organizations are clustered in five focus areas: health promotion, peacebuilding, children's rights and education, antidiscrimination and social integration, and the environment.

5 20 Centres for 2010 20 Centres for 2010 is the official campaign of the 2010 World Cup and hopes to build 20 Football for Hope Centres for public health, education and football across Africa, with the goal of achieving positive social change through football. The objective of the Centres is to promote social development within communities and to strengthen local organizations with vital infrastructure. The centres will provide a base from which to increase awareness about HIV, increase literacy, improve gender equality, integrate youngsters with learning disabilities and promote overall social development.

6 Grassroot Soccer Grassroot Soccer has been training professional African football players, coaches, teachers and peer educators in several countries to deliver an interactive HIV prevention and life skills curriculum to youth. Topics include making healthy decisions, avoiding risk, building support networks, reducing stigma and discrimination, increasing knowledge about testing and treatment, addressing gender issues and assessing values.

7 Kick4Life Kick4Life is an organization founded in 2005 that has been focusing its efforts in Lesotho, delivering a range of programmes to tackle HIV by providing sports-based health education, voluntary testing, life skills development and support for education and employment. Lesotho has the third highest HIV prevalence in the world and hundreds of thousands of children have been orphaned by AIDS.

@AIDS

How social media is shaping the way we communicate and what it means for the global AIDS movement.

Hours after the 12 January 2010 earthquake in Haiti, many of the world's leading news outlets were streaming live Twitter feeds. In 140 characters or less (the length of a Twitter message), viewers were getting instantaneous updates on the quake's devastating toll as the media told the stories that survivors were sharing on Twitter and other web sites.

This switch to social media for news demonstrates a shift in the recognition of these platforms—from what has often been described by many commentators as a 'passing trend' to a serious provider of information—so much so that CNN had staff monitoring Twitter to keep on top of the latest developments coming out of Haiti.

Beyond receiving news, the world responded through social media in an unprecedented way. The hashtag "#Haiti" was tagged on Twitter—together with SMS-based fundraising technology it helped the American Red Cross to raise US\$ 32 million for Haiti within one month of the quake. For the American Red Cross, and many other aid organizations, a new fundraising standard was set, and the value of social media to not only generate awareness but build support was demonstrated.

What can the global AIDS response learn from the Haiti example and the role of social media in communicating? Arguably a lot, and according to some social media experts organizations today have to embrace social media. Mr Erik Qualman, author of the book

Socialnomics: how social media transforms the way we live and do business, puts it this way, "We don't have a choice on whether we do social media, the question is how well we do it."

The social media landscape

Defining social media is not an easy task. There are different explanations, depending on who you ask. The entry for social media on Wikipedia states that the term "...is used to describe the type of media that is based on conversation and interaction between people online. Where media means digital words, sounds and pictures which are typically shared via the internet and the value can be cultural, societal or even financial."

Social media can refer to a range of web technologies, from blogs and wikis to social networking sites (e.g. Facebook) and media-sharing sites (i.e. YouTube). While it may be a challenge to capture one cohesive definition, it is difficult to dispute the argument that the world has gone social.

This point was backed by the Head of Strategy and Planning for Facebook's European, Middle East and Africa office at a social media conference in London in March 2010. In his presentation, Social Changes Everything, Mr Trevor Johnson shared some statistics that demonstrate social media's broad reach: Facebook alone has 400 million active users, who upload five billion pieces of content every week and two million photos per

second and spend six billion minutes online every day. In 2009, Facebook added 200 million new users, and if the site was a country and its members citizens, Facebook would be the world's third largest country—only behind China and India. Add in other sites, such as LinkedIn, Bebo, Orkut, Renren and a multitude of regional platforms, and it is clear that social media has attracted the interest of hundreds of million people worldwide.

Given the apparent popularity of social media, and the AIDS community's long history of engagement in people-centred campaigns and grassroots activism, many organizations are now looking at ways to bring their advocacy efforts online.

Some organizations are already leading the way. One example comes from the public-private partnership between (RED) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The (RED) campaign teams up with partner companies to produce (RED) products. When a product is sold, a percentage goes to the Global Fund, which, in turn, disperses the funds to support HIV programmes. Leveraging a network of celebrities as spokespeople, (RED) has been able to reach some 550 000 people on Facebook and a million followers on Twitter, providing supporters of (RED) an opportunity to keep track of the campaign and to share their individual experiences when buying a (RED) product.

Another illustration of social media's ability to spur greater awareness about HIV was demonstrated on World AIDS Day 2009, when Google, Twitter and Facebook 'turned red'. Twitter and Facebook encouraged its users to show solidarity for the AIDS movement by undertaking a series of red-themed modifications to their pages, and Google placed a red ribbon on its home page and had links to encourage its visitors to 'learn, act and support' the featured organizations working on HIV issues.

A grassroots initiative goes global

Before such larger, structured HIV awareness initiatives took hold, a group

“

when you see something that you feel you cannot keep your eyes closed to, you feel that you have to do something.

”

of individuals decided to leverage their own personal networks to show support and solidarity with the millions of people living with HIV.

On 5 November 2008, a Facebook group called World AIDS Day 2008: Wear A Red Ribbon on Facebook! was created with the simple premise of spreading awareness about HIV. The group encouraged Facebook users to post a red ribbon as a profile picture for World AIDS Day. In less than four weeks nearly a quarter of a million people had joined.

“It was amazing to see the sea of red ribbons rippling across Facebook, with people changing their profile pictures and telling their friends about the page,” said Mr Gilles Denizot, co-administrator of what is now the Red Ribbon Army fan page (<http://www.facebook.com/TheRedRibbonArmy>).

The group’s aim has since evolved, and they now want to share information on the global AIDS response with its 500 000 plus members. They see their Facebook page and presence on other social media sites as a way to share important information with their fans and followers, such as human rights abuses against people living with and affected by HIV. Mr Denizot, an AIDS activist since 1992, has moved from street-level action—handing out leaflets and organizing petitions—to the social media environment. “Back then, we did not have social media, so obviously it has changed the way people raise awareness and the way people learn about facts,” he said. “But when you see something that you feel you cannot keep your eyes closed to, you feel that you have to do something.”

Activism or slacktivism?

Nevertheless, Gilles Denizot admits social media has its downsides. He experienced this when posting a request to the Red Ribbon Army to sign a petition against the antihomosexuality bill in Uganda. Despite its 500 000 membership, only 7000 members rallied around the effort.

He said the petition shows the need to better understand how social media works and what makes people engage. He said he has yet to figure out the equation. “What makes a Facebook user go from passively being part of a group to actively signing a petition?” Gilles asks. For the sake of an argument, can it be said that online activism is nothing more than slacktivism? This term combines the words slacker and activism and

UNAIDS + social media

01 [@UNAIDS](https://twitter.com/UNAIDS)

02 slideshare.com/UNAIDS

03 facebook.com/UNAIDS

04 youtube.com/UNAIDS

05 flickr.com/UNAIDS

06 AIDSspace.org

posits that people who support a cause by performing simple measures are not truly engaged or devoted to making a change.

Mr Rupert Daniels, head of content for the 1 Goal education campaign, does not agree. “Interaction on social media leads to something. If you ask someone to contribute and they do—by signing a petition or retweeting a message—we can’t let those people down. We have to show results. They believe in it and so do we. Every contribution matters,” said Mr Daniels.

1 Goal aims to get global leaders to honour their promise of providing education to 72 million children by 2015—one of the eight Millennium Development Goals. Since the campaign’s launch, over 7 million people have signed a pledge on its web site and 50 000 people have joined the campaign’s Facebook fan page.

Mr Daniels underlines that success looks different, depending on the social media channel used—and, importantly, how it is used. Even though 1 Goal has around 6000 followers on Twitter, the campaign’s social media team has focused on building relationships with key influencers on Twitter.

“Our philosophy is not necessarily to get everybody to come onto our Twitter site or even our Facebook site. We like the fact that people like Shakira and Queen Rania [of Jordan] are talking about their engagement on the campaign on their own Twitter page,” said Mr Daniels. “When you add all these things up, it equates to a very large awareness of our campaign on the social networks.”

When asked how the 1 Goal campaign did it, Mr Daniels shares three pieces of advice for any organization, small or large, that wants to embark on a social media initiative.

First, leverage your own networks: if you are on Facebook and have friends, use your connection to your friends to engage your friend’s friends. Soon enough, by this first- and second-degree network, you will have thousands of people behind you. Second, collaboration is vital: find organizations with a similar mandate or goal and partner to

share resources and campaign messages. Third, keep your network informed: once you have a network established, share results and keep your fans and followers up to date on the campaign’s success. Especially important is highlighting how their contribution has helped the campaign to achieve its goals.

For small organizations, Mr Daniels concludes that social media is the most cost-effective approach to reach a wide audience.

What is in store for social media?

What is the next big thing for social media? In 2008, it was Facebook. Last year Twitter. While many industry experts prefer not to speculate, it appears that social media’s future is bright.

“Social media is in its infancy, and we will see a lot of development, especially in the integration of social features into a variety of products and platforms,” said Mr Matthias Graf, Head of Product and Engineering at Google’s Europe, Middle East and Africa office. The merging of mobile technology and social media is also an exciting development that Mr Graf believes will open up new communication opportunities.

For the global AIDS movement, the main challenge is to use social media tools in an effective way and to build opportunities to mobilize people interested and already engaged in the AIDS response.

As the Red Ribbon Army example highlights, an organic, low-cost approach to using social media can yield powerful results. And at the other end of the spectrum, a high-profile campaign, such as 1 Goal, demonstrates the possibilities of mass awareness of a single issue.

The AIDS community is at the early stages of taking its activism—and the vibrancy around it—to the online world. And while there appears to be no set formula for unlocking the potential of social media as a force for change, what is clear is that the possibilities for it are immense. ●



AIDSspace.org

Connecting the global AIDS response

AIDSspace.org is an online community for the 33.4 million people living with HIV and the millions who are part of the AIDS response. AIDSspace.org was created to expand both informal and established networks in order to help maximize resources for a stronger response to the epidemic.

The site is built on three key principles: connect, share and access. Through AIDSspace members can meet and connect with other members to: learn from their work; exchange ideas and discover new networks; post and share key policies, best practices, multimedia materials, reports and other essential resources; and access and post jobs, consultancies and requests for proposals and become a service provider.

When in Wien | The Vienna Doers' Guide



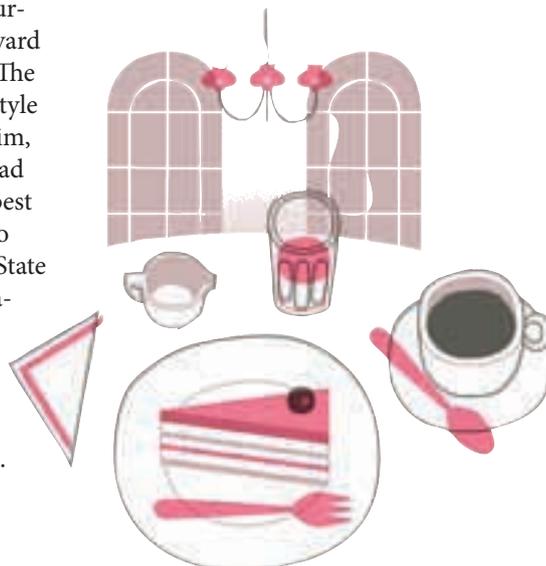
Vienna, the host city of the 2010 International AIDS Conference, has opened its welcoming arms even further to embrace the global AIDS community for the week-long conference. The city of Vienna has several activities themed around HIV and focused on getting participants to see as much of Vienna as possible.

Whether you are arriving a few days early, staying on after the closing ceremony or wanting to see a bit of Vienna in between satellite sessions, the OUTLOOK team has pulled together insights on some of the city's top attractions and locales to give a taste (literally and figuratively) of Vienna—from sipping a Viennese coffee to strolling through the Imperial Palace.

1 Take a ride on the Ring Tram
Vienna's old town (Innere Stadt) is surrounded by the Ring—a main boulevard with a parallel public transit circuit. The yellow Vienna Ring Tram, a classic-style 40-seat streetcar, known locally as a Bim, due to the bell used to warn other road users and pedestrians, provides the best vantage point (other than walking) to see the city's landmarks, such as the State Opera House, Imperial Palace, Parliament and City Hall. An onboard audiovisual system gives tourist information along the way. As stops are plenty, riders can 'walk on, walk off' and explore the old town by foot.

2 People watch while sipping a Wiener Kaffee

The coffee house is an institution in Vienna, so if there is only time to do one out-of-conference activity this is it—enjoy a legendary Viennese coffee and watch the city's 'who's who'. There are countless spots throughout the old town, but one of the best coffee houses to experience the full Wiener Kaffee culture is Demel (Kohlmarkt 14). Dating back to



the late nineteenth century, this bakery serves up some of Vienna's best pastries and handmade chocolates. A huge window offers visitors an observatory-style view on the master bakers as they prepare the day's treats. Open daily from 10:00 to 19:00. (demel.at/en)

3 Savour a Sachertorte or a Wiener Schnitzel

The Viennese claim that their Sachertorte is the best desert cake on the planet, and judging by the regular queues at Sacher Coniserie (Kärntner Strasse 38) there is probably a good amount of truth behind this. A simple but decadent chocolate cake with a thin layer of fruit jam, the Sachertorte is best served with a piping hot Wiener Melange (coffee with milk or whipped cream). A Sacher shop located at Vienna International Airport is a great place to grab a last-minute souvenir to take home. Open daily from 9:00 to 23:00. A trip to Vienna would not be complete without enjoying the (in)famous Wiener Schnitzel, a battered veal escalope often served with pommes frites (French fries). For a lighter take on the Schnitzel, head to the outdoor garden restaurant Glacis Beisl in the trendy MuseumsQuartier (Museumsplatz 1). Open daily from 11:00 to 02:00 (glacisbeisl.at).

4 Enjoy the music

Vienna is a city of classical music and first-class opera. Check out the programme at the Wiener Konzerthaus (Lothringerstrasse 20) to see if the renowned Vienna Mozart Orchestra, a group of musicians devoted entirely to Mozart's repertoire, is performing (konzerthaus.at). Modern sounds, from jazz to techno to progressive, can be heard at numerous venues throughout the city—often outdoors.

5 Tour the summer residence of Austria's former monarchy

Once home to the Habsburgs—Austria's imperial family—Schönbrunn Palace (Schönbrunner Schloßstrasse 47) is considered one of the most exquisite baroque palaces in Europe, and is a UNESCO world heritage site. A guided tour winds through the palace's meticulously restored rooms, such as the Mirrors Room, where Mozart gave his first concert at the age of six in front of Empress Maria Theresia. The palace grounds are equally impressive, featuring a maze, elaborate fountains and a botanical garden. Check the web site for opening times (schoenbrunn.at/en).

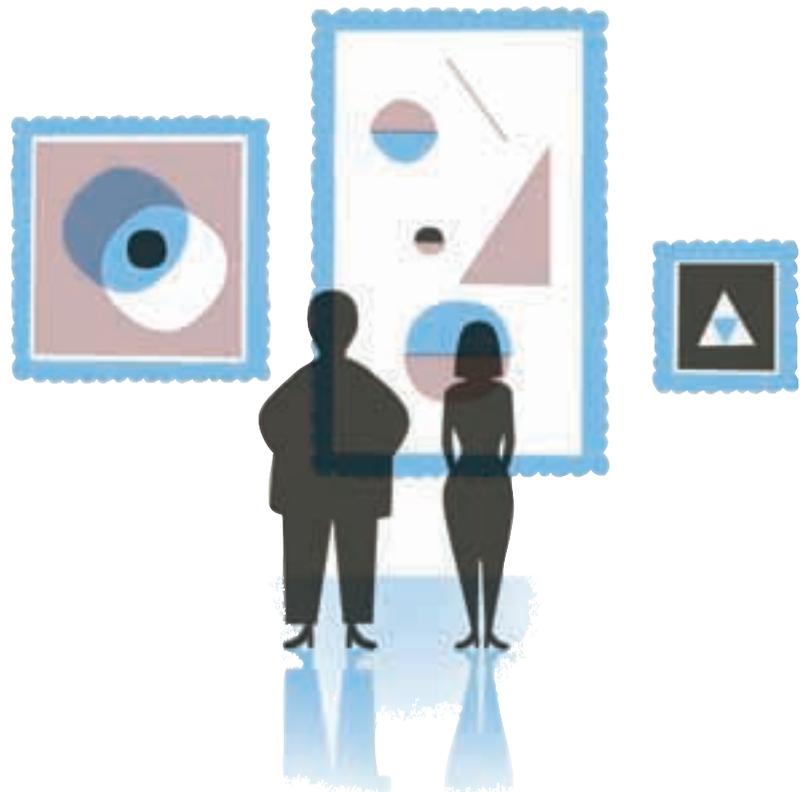
6 Get inspired

With over 100 museums, many visitors to Vienna may be hard-pressed to decide which collections and exhibitions to take in first. The Albertina (Albertinaplatz 1) features one of the largest graphical collections in the world, and its perma-

Vienna fast facts

- 1.7 million residents (2009).
- 10th largest city by population in the EU.
- Old town a UNESCO world heritage site.
- Composed of 23 districts (Bezirke), each with a distinct character.
- Home to the UN Office at Vienna, and headquarters of UNAIDS Cosponsor UNODC, the International Atomic Energy Agency (IAEA) and the seats of many other international organizations.

nent collection includes masterpieces by Klimt, Monet, Picasso and Baselitz. Aficionados of Austrian painter Egon Schiele should head straight to the MuseumsQuartier's Leopold Museum, which houses the largest collection of his work, including his self-portrait. Several of Gustav Klimt's masterpieces, including *Death and Life*, can also be viewed. The museum's upper floors offer a panorama of the old town. Also located within the MuseumsQuartier are the



Top sayings to help navigate Vienna

Hello/good day

Guten Tag/Grüss Gott [*Goo-tan Taag/Gruess Gott*]

How are you?

Wie gehts? [*Vee gates*]

Excuse me

Entschuldigen Sie bitte/Entschuldigung [*Ehnt-shool-dee-gan zee bit-eh/Ehnt-shool-dee-goong*]

I am lost. Where do I find...?

Ich habe mich verirrt Wo finde ich...? [*Ee-ch hab-eh mee-ch fair-eart...voh finn-deh ich?*]

Super/great

Leiwand (colloquial) [*lie-vaand*]

Yes

Ja [*yaa*]

No

Nein [*nine*]

Please

Bitte [*bit-eh*]

Thank you

Dankeschön/Vielen Dank [*Daan-keh-shun/Feel-in Daank*]

Where am I?

Getting from the conference to the city

The International AIDS Conference is held at the Reed Messe conference centre (Messeplatz 1) in a green belt area near the River Danube, some four kilometres from the city centre. Vienna has excellent public transport services, and the conference venue is connected by the underground (U-Bahn), tram and buses. The U2 underground line (the purple line) provides a direct connection to the city centre from two stations, Messe Prater and Krieau, which are accessible from both sides of the conference centre.

Museum of Modern Art (MUMOK) and the Kunsthalle. After getting inspired inside, stick around the lively Quartier to hear some impromptu bands perform at sunset (mqw.at).

7 Climb the steps of Stephansdom

Vienna's largest church, the Stephansdom (St Stephan's Cathedral) is hailed as the city's most visited landmark. Initially constructed in the mid-twelfth century, the cathedral survived the great fire of 1258 and the destruction of the Second World War. Largely built in gothic style, the cathedral's south tower—including its multicoloured tiled roof—dominates Vienna's old town skyline. Visitors can climb the 343 steps to the tower-keeper's room to catch a stunning view.

8 Cool down on the banks of the Danube

Head to Alte Donau (U-Bahn line U1, stop Alte Donau) to cool down and unwind after a long conference day. On a quiet area of the River Danube visitors can swim, rent a boat, take sailing lessons, grab a snack at one of the small restaurants or simply relax on the river's banks (alte-donau.info).

9 Stroll through the Naschmarkt

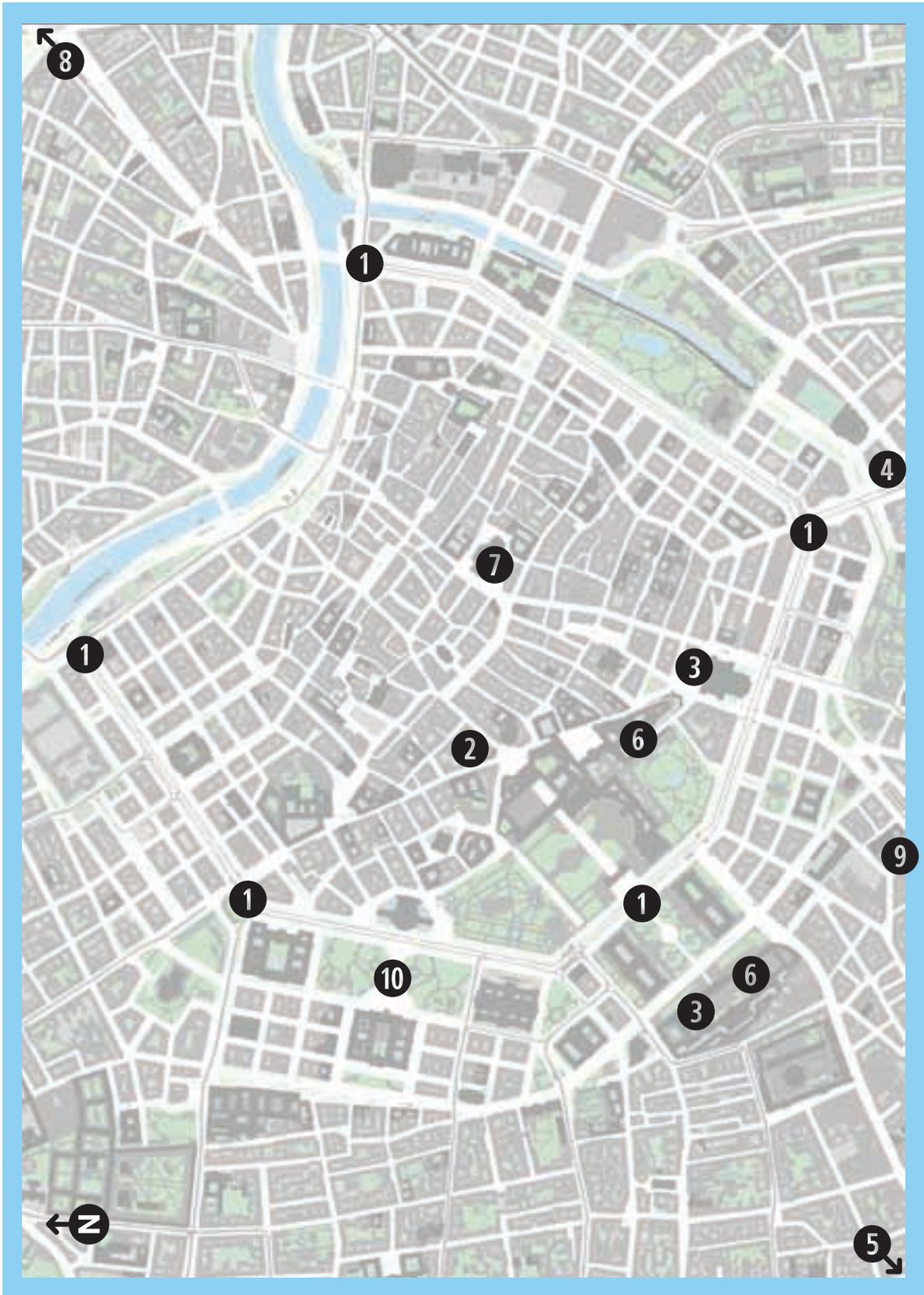
Vienna is a city of markets—26 to be exact. The Naschmarkt (between Karlsplatz and Kettenbrückengasse) is the city's largest open-air market and is considered to be one of best, featuring fresh food stalls selling food from Austria and beyond. On Saturdays, Vienna's bargain hunters, collectors and browsers flock to the adjacent flea market. Fans of the architectural and art movement Jugendstil (or Art Nouveau) will appreciate the high concentration of buildings in this style surrounding the market (wiener-naschmarkt.eu).

10 Catch an outdoor film at the Rathausplatz

Most city halls are not a popular place to hang out, but Vienna has made its Rathaus more than just a spot to do business. In the summer, the Platz (public square) in front of the City Hall turns into a lively open-air cinema, and during the conference there will be nightly screenings of HIV-themed films. Good weather permitting, this is an event not to be missed. Check the conference information booth for the schedule.



Vienna's inner city



THE LAST WORD

UNAIDS Goodwill Ambassador
Ms Annie Lennox



OUTLOOK gives the last word to UNAIDS Goodwill Ambassador Ms Annie Lennox.

What has inspired you to be such a passionate advocate?

Several years ago I was given the opportunity to visit people and places that have been devastated by the AIDS pandemic, and I started to understand that women and children are on the actual frontline of this issue. The scale of wipe-out is simply massive, yet the subject is more than often off the Western media's radar. As a woman and mother, I feel compelled to speak out, and try to raise awareness in the best way I can, to try to use my platform to do so.

As UNAIDS newest Goodwill Ambassador, what are your goals?

HIV is a complex issue, with many different facets that need to be addressed. Until there is a vaccine or a cure, the solutions are not straightforward. Up to this point in time my focus has been mainly on South Africa, a country with one of the highest HIV prevalences and where approximately one in three pregnant women are HIV-positive.

With the launch of the national strategic plan, which aims to halve the infection rate and double the roll-out of treatment, I'm hoping to see some kind of improvement; however, with the economic turndown, and the capping of donor budgets, I'm very concerned that these goals will not be reached, and additionally concerned as to what the coming future will look like, all over sub-Saharan Africa. My key objective lies with women and children, particularly with respect to access

to life-saving treatment, which ought to be a fundamental human right, but tragically for millions of people is out of reach.

I will take advice from UNAIDS and try to utilize my resources and platform to keep sending out that message and do whatever is in my power to make a difference.

What can we do to move the AIDS response forward?

Good question! I ask myself that every single day. I think the only answer is to stay committed, and not give way to despair.

So, we would like to ask you a few lighter questions...

Where did you live as a child?

I spent my first eight years living with my parents in a two-roomed tenement flat in Aberdeen in the north-east of Scotland, then we moved into one of the first high-rise council blocks to be built in the city, which felt very modern and luxurious at the time, because we had a 'proper' bathroom, with a bath inside the flat, hot running water from the tap, a telephone and my own bedroom!

How do you relax?

I go to bed! The best place to be when I need to recharge and unwind!

What is your favourite food?

I love all kinds of food. Japanese and Italian particularly.

Who is your hero?

Nelson Mandela.

What is your favourite piece of music?

That's an impossible question to answer really, because I love music in all its infinite forms. My taste is definitely eclectic. Perhaps the best way to answer this is to say that I love soul music. Go figure!

What is your favorite book?

Anything with pictures and a good cover!

What is your favorite film?

This is Spinal Tap.

What is your happiest memory?

Delivering both my daughters safely into the world.

What motivates you?

As a mother and woman I empathize and identify with my gender, especially with women in developing countries, who have so little in terms of emancipation, empowerment, human rights, access to education, medical treatment, reproductive rights, etc. I feel so grateful to have received these kinds of privileges in my life, and realizing that it is absolutely not a given for two thirds of the world's poorest people (women) I want to contribute and use my platform and resources to try to make a difference.

What human quality do you most admire?

Kindness.

What do you most value in your friends?

Whatever it is that drew us together in the first place. Rapport is almost indefinable and certainly unquantifiable.

If you could be granted one wish in life, what would you ask for?

To heal the planet of all its violent destruction and madness. Well, you did ask!

What do you want to be when you grow up?

Fully enlightened.

Where is your favourite place?

My bedroom.

What is your motto?

I don't have one... never joined the girl guides!

Getting to Zero.

Zero babies infected with HIV by 2015.

Uniting the world
against AIDS



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

Mr Michel Sidibé
Executive Director of UNAIDS
21 May 2009

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