GLOBAL

AIDSLink

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U.S. Judge Strikes Down Anti-Prostitution Policy.....Page 3

Civil Society Monitors Governments ....Page 6

Fighting Homophobia in Latin America..................Page 12

Five Years Later

Contents

3 **U.S. Judge Strikes Down Anti-Prostitution Policy**

4 **How Far We've Come; How Far to Go**
An Interview with Peter Piot, UNAIDS Executive Director
By Sara Ann Friedman, Global Health Council

6 **Civil Society Monitors Governments' Progress**
By Rachel Guglielmo, Public Health Watch/Open Society Institute

8 **Best Kept Secret in PMTCT**
Contraception to Avert Unintended Pregnancies
By Heidi W. Reynolds and Rose Wilcher, Family Health International

7 **U.S. Provides Conference Waiver for HIV-positive Participants**
Travel Ban Remains Solidly in Place
By Alina Oswald

9 **The Long Arm of the U.S. Government Aniti-Prostitution Policy**
By Meena Saraswathi Seshu, SANGRAM

10 **Letter from the President**
By Dr. Nils Daulaire, Global Health Council

11 **The Global Fund to Fight AIDS, Tuberculosis and Malaria**
The Biggest Achievement of The UNGASS Declaration To Date
By Hélène Rossert, Vice Chair Emeritus of the GFATM

12 **Changing Social Norms in Latin America**
Five mass media campaigns to combat homophobia
By Paulo Lyra, Pan America Health Organization

14 **The UNGASS Agenda**
Donors and Ministries Ignore Acute Teacher Loss to HIV
By Helen Cornman, World Learning

18 **Resources**

19 **Timeline**

20 **Global Updates**

23 **Maladi pa tonbe sou pyebwa, se sou moun li tombe**
This sickness does not fall on trees
By Denizard Wilson,Thomonde, Haiti

TO OUR READERS:

Global AIDSLink editorial pages are a forum for opinions and views on the many issues and controversies raised by HIV/AIDS challenges. We invite you to join in the discussion with short letters to the editor commenting on the articles you have read: What do you think about what you've read? What do you agree or disagree with? We also welcome op/ed pieces with a strong voice and/or new take on current HIV/AIDS-related issues; these run from 500-700 words and should be bold, well-researched and original.

International in scope, *Global AIDSLink* includes HIV/AIDS related conferences and other events as well as new publications and diverse forms of resources. Please send us those as well.

Thank you for your interest in *Global AIDSLink*.
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COVER PHOTO
UN BUILDING WITH AIDS RIBBON
PHOTO COURTESY OF UNAIDS

U.S. Federal Court Rules
Anti-Prostitution Policy Violates First Amendment

A U.S. federal judge ruled May 9 that a sweeping restriction on the privately funded speech of groups participating in the federal government's international HIV/AIDS program violates the First Amendment.

At issue in the case is a requirement that public health groups receiving U.S. funds pledge their "opposition to prostitution" in order to continue their life-saving HIV prevention work. Under this "pledge requirement," recipients of U.S. funds are forced to censor even their privately funded speech regarding the most effective ways to engage high-risk groups in HIV prevention.

In his opinion, Judge Victor Marrero of the U.S. District Court for the Southern District of New York ruled that the requirement violated the First Amendment rights of two plaintiff organizations, Alliance for Open Society International (AOSI) and Pathfinder International. "The Supreme Court has repeatedly found that speech, or an agreement not to speak, cannot be compelled or coerced as a condition of participation in a government program," wrote Judge Marrero. The plaintiffs are represented by the Brennan Center for Justice at NYU School of Law.

While none of the relief organizations receiving funds "supports prostitution," it is essential that they maintain their ability to engage in proven, effective HIV prevention methods with at-risk populations.

"We're delighted that the court recognized the pledge requirement as unconstitutional and overreaching," said Ricardo Castro, a board member of the Alliance for Open Society International, one of the plaintiffs. "The provision not only violates the First Amendment, but also hampers organizations on the front lines of the AIDS epidemic working to save lives through proven prevention methods. We believe that public health policy should be based on science – not ideology."

Rebekah Diller, associate counsel at the Brennan Center, attorney for the plaintiffs, said: "It's wrong for the government to force public health organizations to make ideological pledges on unrelated issues in order to do their work of preventing HIV/AIDS. This decision has wider implications. As nonprofit organizations partner with government to address social problems, it should be clear that what counts is whether they do the work, not whether they are willing to espouse ideological positions."

The Long Arm of the Anti-Prostitution Policy (See Related story, page 9)

The plaintiffs are among a chorus of voices that have objected to a requirement that interferes with proven HIV prevention approaches. In July 2005, Brazil declined tens of millions of dollars in U.S. funds for its work fighting HIV/AIDS. In February 2005, 13 charitable organizations, including the International Rescue Committee, Save the Children and CARE, criticized the pledge requirement, saying that it "greatly undermines" AIDS prevention efforts.

In his ruling today, Judge Marrero determined that a preliminary injunction against the enforcement of the pledge requirement was necessary to prevent AOSI and Pathfinder from suffering irreparable harm. While the court's decision applies directly only to AOSI and Pathfinder, it could have a broad impact on the many other public health organizations also forced to sacrifice their privately funded speech in order to receive government funds.

It is important to note that while the judge's ruling technically only applies to the plaintiffs in this case, it does provide a precedent for other organizations receiving U.S. HIV/AIDS funds if they choose to explore their legal options. It is also important to note that foreign organizations must still comply with the anti-prostitution loyalty oath as a condition of receiving U.S. HIV/AIDS assistance.

A ruling is also being awaited in a similar lawsuit filed by DKT International in U.S. District Court for the District of Columbia challenging the pledge requirement. The attorneys for DKT report that the timing of the judge's ruling in their case is still uncertain.

The full decision is available at www.brennancenter.org/programs/pov/osi_court_documents.html

InsideTrack

Richard Feachem, the British-born University of California San Francisco professor who has run the Global Fund to Fight AIDS, Tuberculosis and Malaria almost since its inception in 2002, is stepping down as executive director when his latest term ends in July. Feachem's four years mark an extraordinary acceleration of international spending for diseases in poor countries. Global Fund programs have put 384,000 people on AIDS drugs, most of them low-cost generics.

Asia Russell, director of International Policy for Health GAP, has been appointed to the board of the Global Fund for HIV/AIDS, Tuberculosis and Malaria. Russell has extensive experience in the Global Fund's formal structures, processes and policies; proficiency in collaboration with community organizations; and, commitment to represent interests of people living with the diseases and their communities. She is representing the delegation at the Policy and Strategy Committee (PSC) of the Fund's board.

The U.S. Senate approved the nomination of **Randall L. Tobias**, to head the U.S. Agency for International Development (USAID). Tobias was previously the U.S. global AIDS coordinator, overseeing about $3 billion a year in funding for international treatment and prevention programs. As administrator of the agency, Tobias will also serve as the first director of foreign assistance, a new position created by the Bush administration to coordinate international aid programs. The job was created as part of Secretary of State Condoleezza Rice's restructuring of the State Department in January.

The president of Family Health International (FHI), **Ward Cates**, has been appointed to the program board of amfAR, the Foundation for AIDS Research, one of the world's leading nonprofit organizations that supports AIDS research, prevention, treatment and advocacy.

The Elizabeth Glaser Pediatric AIDS Foundation has announced the appointment of **Pamela Barnes** as its new president and CEO. Barnes has been chief operating officer of the foundation since November 2004 and has been interim CEO since November 2005.

De Beers Consolidated Mines and the Soul City: Institute for Health and Development Communication (IHDC) have announced a partnership worth $1.25 million over the next three years. Soul City IHDC is a South African NGO that promotes health and development through the use of mass media. De Beers will be supporting the master trainers' program that aims to contribute to positive behavior change in targeted populations. Some 70 percent of this year's funding will be used for training in areas targeted by Soul City at a national level while the remaining 30 percent will support training in communities around De Beers' mines in South Africa. The board of De Beers made a decision last year to initiate a more targeted and proactive approach beyond the workplace and has committed a total of $1.7 million a year for the next three years to community-based HIV and IDS programs.

Global Health Council board member **Allan Rosenfield**, MD, dean of Columbia University's Mailman School of Public Health, received the highest honor in the reproductive rights movement – Planned Parenthood Federation of America's Margaret Sanger Award. Created in 1966, the award recognizes a global leader who best embodies the values of Margaret Sanger, the pioneer in women's reproductive rights. Dr. Rosenfield joins the distinguished company of the Rev. Martin Luther King Jr., Sarah Weddington, Bella Abzug, Gloria Steinem and Supreme Court Justice Harry Blackmun.

How Far We've Come, How Far to Go

PHOTO BY UNAIDS

UNAIDS Executive Director Dr. Peter Piot, right, in India, where he participated in several events involving civil society groups, the business sector, government.

An Interview with

Peter Piot

Executive Director, UNAIDS

By Sara Ann Friedman, Global Health Council

Q.

What do you see as the biggest successes and failures since the 2001 UNGASS?

I see many failures, but I also see enormous progress. One of the UNGASS targets for 2005 was a decline by 25 percent of new infections among 15-24 year olds in the worst affected countries. UNAIDS has just issued a report that we have reached that target – with the urban population in East Africa. Before that we could only say, "There's Uganda and there's Thailand and that's it." Now we can say there are far more countries where we see a decline in new infections in that population.

Secondly, in 2001, we were at an all-time low with regard to accessing antiretrovirals, at least in developing countries, where there was basically no interest, including from AIDS activists in the North. But we have gone from a few tens of thousands on treatment to nearly 1.5 million. Although this is not enough, as six million people need treatment, it's been quite spectacular progress in the last couple of years. In the end, it depends on the message we want to give: we have failed to meet our goals or we are making progress.

And failures?
I would say that there is little progress in the overall area of prevention. We've known for many years what to do. There's no new technology. We are not reaching those most at risk – injecting drug users, sex workers and their clients, men who have sex with men.

Our biggest failure though is prevention of mother-to-child HIV transmission. Here we've got something that is a straightforward medical intervention, uncontroversial – everyone wants to save babies, the drug therapy is freely available, and we can measure it. Yet the coverage is around 10 percent worldwide when it should be 80 percent. The lesson for me is that it's not enough to have the medical intervention, the right technology, the right evidence. You also need a strong commitment and mobilization that goes back to tackling stigma. Women do not want to come forward for testing for fear of being stigmatized and discriminated against.

So what are we facing at the UNGASS review?
The big problem now – and it was identified in basically every country consultation – is universal access. It is still an issue of political commitment, but we are also paying the price for decades of lack of investment in public health services, education and other public services, especially in Africa by both African governments and donors.

Another major issue is tackling the continuing drivers of the epidemic – stigma and discrimination, homophobia, and gender inequality. Some of the worst affected countries are also the weakest states with low levels of accountability and organized civil society. And this unfortunately is not going to change automatically because there is money for AIDS.

> There is little progress in the overall area of prevention. We've known for many years what to do. There's no new technology. We are not reaching those most at risk – injecting drug users, sex workers and their clients, men who have sex with men.

It looks as if you are talking about AIDS as a development issue – health systems, education, stigma and discrimination, the role of women.
I very much agree, but that also puts us into a kind of bind. On the one hand, it is the exceptionality of AIDS that made possible a number of things, such as the mobilization of money. The Global Fund to Fight AIDS, TB and Malaria was not created because of TB and Malaria – it was AIDS and AIDS activism. The exceptions made for generic drugs in the (World Trade Organization) TRIPS (Trade Related Aspects of Intellectual Property Rights) agreement were because of AIDS. But to deliver the goods we have to link with health systems, poverty and discrimination. When I was in Tanzania in February, people living with HIV in the community told me, "Ok, we have access to antiretrovirals, but we don't have the few shillings we need to take a bus to the health center to get them." They're hungry, they have no work, and women have to ask their husbands' permission to go to the clinic. I know we can't solve all the problems in the world to stop AIDS but they are inextricably linked.

And the bind?
AIDS is not only a health issue, it is also a development crisis. If we say that fighting AIDS has to be part of regular health care, it might disappear from the political agenda and people will continue to die from AIDS. At the same time, we know for sure that bringing AIDS under control is absolutely essential to achieving the Millennium Development Goals (MDGs), and achieving many of these goals will help defeat AIDS. So AIDS must be tackled in the broader development context if we are going to make any headway in reversing the epidemic.

Along those lines, sometimes I think that there's a positive irony here as well. Maybe the spotlight that AIDS casts on these longstanding problems of human rights, of women's roles, and other negative social norms will bring concrete changes.
I've been thinking that more and more. Look at the way the AIDS epidemic has definitely contributed to gay emancipation. The more I travel in Africa, the more I start thinking that AIDS is going to be useful to strengthen the position of women. What strikes me so often is their leadership around AIDS. Not as presidents yet, there's still only one, but many of the national AIDS directors are women, and then in the communities of people living with HIV and AIDS, it's the women who speak out. All the issues you mentioned in relation to the position of women and social justice have become so blatant, so fatal, that there's no turning back, no standing still. So, yes, this may help the position of women in very concrete ways from female-controlled contraception, to economic rights, to access to education, to sexuality, which of course will be the most difficult one to change.

Are you prepared to set treatment targets for the next five or 10 years?
It is essential that each country set very ambitious targets. One has to start with national targets because that's the only way that governments are held accountable. It has not happened through global targets.

But civil society is pushing for global targets as well.
I am not denying that a global target such as "3 by 5" has generated real momentum, but there is less and less enthusiasm for global targets because a country can then say, "If all countries do their best, then we don't have to do anything because the global target will be met." We first have to really fight for ambitious national targets and then we can aggregate them later on into regional targets, so that it is clear what the norm is. This too was a large consensus coming out of the more than 100 national consultations. Over and over again people tell me – including people living with HIV – "we need to start here, not in New York or Geneva."

What about money? Are you willing to set targets there? The latest estimates seem to say that $18 billion is needed for 2007 alone.
Yes, we in UNAIDS have said that the 2007 need in developing countries is $18 billion indeed, which means there is a serious funding gap. However, last year we spent $8.4 billion on fighting AIDS in developing countries, compared to only $1 billion five years ago. That is progress. Will it continue? That will depend on the mobilization of funds, but it must come not only from rich countries – developing, particularly middle-income countries, need to come through. A large number of Latin American and Asian countries can fund the response. It's a matter of political priorities around resource allocation. But it won't happen without struggle and advocacy.

Going back to prevention and our lack of progress. Do you see that there is too much focus on abstinence only, and earmarks for abstinence in U.S. global AIDS funding which has just been criticized by the recent Government Accountability Report.
For prevention policy, anything that has the word "only" in it doesn't work for AIDS. About 10 years ago, I had a debate with USAID experts who thought that we could fix this epidemic by first marketing condoms. Today, some think abstinence only can work, which has no scientific ground. We need a truly comprehensive approach. But this debate on prevention policy is happening far more in the U.S than anywhere else.

I don't think so. So much money comes from the U.S. that it has a definite impact on the ground.
Fair enough, but I look at the U.S. as a major shareholder in the AIDS fight. When it comes to prevention strategies, though, we do have differences of opinion. While the U.S. is spending enormous sums on abstinence only programs, it also remains the number one provider of condoms for HIV prevention in the world – ahead of all other countries combined. Fighting AIDS doesn't mean agreeing on every issue across the board. Since 1982, I've done nothing else but work on AIDS. Political and technical debates have been the hallmark of the fight against AIDS since day one.

Looking down the road, one year, five years, ten years what do you see in your crystal ball?
That we have to see AIDS as a marathon, not a sprint. That means no longer thinking about it in years, but in decades. We have to make sure, not only that we scale up significantly the number of people on treatment now, but also be able to support them 20-30 years from now when they still will need ARVs. In 2001, there were hardly any people on ARVs so their future was not an issue. HIV prevention, too, is for life and we need to invest much more in prevention. However, it is better to have today's problems and challenges compared to what we had in 2001 when despair was the prevailing sentiment.

Civil Society

Monitors Governments' Progress

By Rachel Guglielmo, Project Director
Public Health Watch/Open Society Institute

In 2001, 189 governments adopted the Declaration of Commitment (DoC) at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). In doing so, they acknowledged the crucial role of civil society and particularly of people living with HIV/AIDS, in the design, planning, implementation and evaluation of HIV/AIDS policies and programs. They also committed to undertake regular public reviews of their performance, with the participation of civil society, in achieving the goals and targets set forth in the DoC, including those related to prevention, treatment, care and support, human rights, and support for vulnerable groups.

In preparation for the UNGASS 2006 high-level review, governments were requested to submit official progress reports. A group of eight civil society organizations* joined in a coordinated effort to support independent assessments of DoC implementation in 37 countries. Starting in mid-2005, country partners prepared in-depth 'shadow reports' to feed into and complement the official government reports. Shadow reports present a civil society perspective both on the progress report-preparation process (i.e. the extent to which civil society was able to participate) and on the achievements and shortcomings of government HIV/AIDS policies and programs. More than 25 shadow reports were presented to governments as input for official progress reports and to UNAIDS as input for its "Global Progress Report." They are available at www.ungasshiv.org.

This article presents some of the most common themes and findings that emerged from these monitoring efforts and shadow reports.

Government Cooperation with Civil Society is Uneven

A number of governments consulted with civil society groups in preparing their progress reports. Some gathered civil society input during discussions or workshops, as in Bangladesh, Kenya and Malawi, while others reflected input from the shadow reports in the final document. Canada and the Netherlands involved NGOs directly in preparing their official reports, and Brazil presented the entire NGO shadow report to UNAIDS together with its official report.

By and large, however, civil society faces significant barriers to "full and active participation" in HIV/AIDS policy-making. Some governments, such as that of the U.S., failed to provide opportunities for contributions, public review and comment on draft reports before submission. In other countries, such as Cameroon, awareness of UNGASS and the DoC was low among both civil society groups and government officials, and officials were reluctant to provide information for the shadow report.

Many National Plans are Fragmented

Several countries lacked comprehensive national policies on HIV/AIDS that covered a continuum of prevention, treatment and support services. Monitors found national plans to be largely fragmented, narrowly targeted and restricted to the health sector. In some countries, such as Bangladesh, HIV/AIDS policies have been developed by external consultants, with only token participation of key national stakeholders, including people living with HIV/AIDS.

Domestic Contributions to AIDS are Insufficient

Many governments failed to ensure sufficient funding for their national HIV/AIDS policies, stemming from poor budgetary planning, lack of transparency in budgetary allocations, and expenditures, significant budget shortfalls, and failure to prioritize health in general and HIV/AIDS in particular. Argentina, Brazil, Chile, Paraguay and Uruguay have special HIV/AIDS budgets within overall health budgets, but, with the exception of Brazil, lack disaggregated data to track and assess the impact of actual spending.

Depending almost exclusively on international donors, many governments have not committed sufficient domestic resources to fighting the epidemic. For example, in Malawi, government funding comprised just 2.4 percent of the 2005 HIV/AIDS budget. Even some middle-income countries, such as Argentina, cut back on domestic HIV/AIDS spending when Global Fund money became available. Reliance on external funding often limits national "ownership" of HIV/AIDS policy, and makes it difficult for some governments to manage the relationship between their own priorities and donor requirements. Although achieving 100 percent access to safe injecting supplies is a priority for Vietnam, the U.S. President's Emergency Program for AIDS Relief (PEPFAR) – a key donor – limits use of funding for harm reduction activities.

Donor funding is often expended on time-limited projects rather than incorporated into a comprehensive national strategy. This approach favors large well-established NGOs who can meet bureaucratic reporting requirements over community-based organizations. Shadow reports also noted limited capacity to process large amounts of donor assistance in many countries, including Bangladesh, Ethiopia, Malawi, Ukraine and Zambia.

Governments Fail to Meet the Needs of Most Vulnerable Groups

Many shadow reports cited a failure by governments to use available evidence as the basis for policy, thus undermining the effectiveness of HIV prevention efforts, especially among those most vulnerable to HIV infection. Lack of targeted services, stigma and discrimination, and repressive policies and laws limit access to services for some of these groups.

Data in the Ukraine, for example, shows widespread infection among injection drug users, yet national prevention programs reach only an estimated 10 percent of this group. In Jamaica, targeted prevention efforts reach only 10 percent of women, men who have sex with men, prisoners and sex workers, and refugees and injection drug users are not even mentioned in the national strategy.

In donor countries as well, domestic prevention policy often does not reflect the evidence of what works. For example, many at at elevated risk of HIV infection in the U.S. do not have access to a full range of proven-effective prevention tools. Institutional policies in Canadian prisons prohibit access to clean needles and in some cases condoms, though these prevention tools are made available and accessible to the general population.

Legal regulations and discriminatory policies often discourage some of the most vulnerable groups from seeking prevention and treatment services. For example, fear of criminal prosecution make Latvian drug users and sex workers reluctant to access existing prevention services. In Jamaica, sex workers face both legal prohibitions and public opprobrium, leading to fear of disclosure and a high potential for exploitation, particularly among adolescents. In both the Ukraine and Vietnam, repressive policies raise obstacles for injection drug users to access medical services, including ARV treatment. In many cities in Argentina, young people are required by law to be accompanied by a "responsible adult" to access public health services; many young people simply do not access HIV preventive services as a result.

Inequitable access to services is also a common problem in many countries. In Nicaragua and Senegal, for example, HIV/AIDS services are available mainly in urban areas, and are not reaching rural communities effectively. In Zambia, the national AIDS policy does not address the demonstrated vulnerability of women and girls. And although prevention services are theoretically widely available in Canada, access for vulnerable populations, including youth, aboriginal communities, refugees and trafficked women, is very spotty in practice.

Legal regulations and discriminatory policies often discourage some of the most vulnerable groups from accessing prevention and treatment services. For example, fear of criminal prosecution makes drug users and sex workers reluctant to access existing prevention services; legal prohibitions and public shame often create a fear of disclosure among sex workers and a high potential for exploitation (especially for adolescents). In both the Ukraine and Vietnam, repressive policies towards drug users create obstacles for injection drug users wishing to access medical services, including ARV treatment.

Researchers documented stigmatizing or discriminatory practices in more than a dozen countries from Pakistan to Haiti, including segregation in hospitals, hostile attitudes by health workers, refusal of medical staff to provide elective treatment and stigmatizing language in the media. In Sri Lanka, people living with HIV reported that they do not access treatment even when available because they are treated unkindly and unprofessionally. And in Jamaica, shame and stigma attached to personal financial status reportedly deters some people living with AIDS from accessing free drugs.

ARV Access and Collaborative TB-HIV Services are Limited

Even where governments have pledged the provision of universal access to ARVs, lack of funding often prevents them from delivering on this promise. In several countries, ARV access is largely limited to those living in the capital, and in Paraguay, Honduras and Pakistan very few people can access ARVs anywhere in the country.

There has been insufficient progress in ensuring collaborative HIV and tuberculosis (TB) policies and services, even where high-level officials have acknowledged the seriousness of the co-epidemic. Very few people living with AIDS in Ethiopia, for example, are receiving prophylaxis with co-trimoxazole, despite its known effectiveness and low cost. Some hospitals in Vietnam reportedly test patients for HIV without asking for their consent (or even informing them), charging patients for the tests, and thus potentially discouraging people without sufficient resources from seeking TB treatment.

Care and Support is Lagging Behind Treatment

Care and support for people living with HIV/AIDS is largely provided through faith-based organizations and NGOs. However, there are many instances where inadequate resources severely compromise the quality of care. A lack of home-based care kits and food in Malawi reinforces the impression that "governments sometimes use these programs as dumping grounds for people living with AIDS," and in Ethiopia, coverage of services is largely concentrated in major cities. In Latvia, people living with HIV/AIDS expressed concern about the absence of psychosocial support services, particularly for injection drug users who confront a range of social issues.

Conclusion

Civil society organizations,organizations and people living with HIV/AIDS, in particular, are among those best positioned to provide independent, critical feedback on the quality of public HIV/AIDS policies and services. Without this feedback, it is more difficult for governments to design and implement effective programming that meets the needs of the populations it is intended to serve and achieves the long-term desired result: a large-scale reduction in HIV transmission and AIDS mortality.

In the interest of achieving this result, UN member states, including the U.S., should commit to ensuring greater involvement of civil society – especially people living with HIV/AIDS – at all levels of national and donor decision-making. This includes: funding allocation decisions; policy-setting; determining programmatic priorities; and substantive participation in the design, implementation, and periodic monitoring and evaluation of HIV/AIDS policies and programs.

For further information contact: phwinfo@sorosny.org.

*This article was drawn from country/shadow reports by: CARE International, Gestos, the International Council of AIDS Service Organizations (ICASO), the Latin American Council of AIDS Service Organizations (LACCASO), Panos, Public Health Watch/Open Society Institute and the World AIDS Campaign.

U.S. Provides Conference Waiver for HIV-Positive Participants

Travel Ban Remains Solidly in Place

By Alina Oswald

Viewing HIV-positive people as a health risk, U.S. federal law bans visitors with this status from traveling to or through the U.S. According to a law enacted in 1993 to exclude Haitian refugees from the U.S., immigration authorities may refuse entry to any non-citizen who is HIV positive. The law lists HIV/AIDS and highly communicable diseases, such as active tuberculosis, as reasons for exclusion.

This travel ban has made it extremely difficult to hold international HIV/AIDS conferences in the U.S. Visitors must complete entry documentation stating their status, and their luggage may be searched for antiretroviral medications.

To attend U.S. conferences generally, HIV-positive delegates must obtain a waiver from the U.S. The application involves a $100 fee, a doctor's letter attesting to the individual's good health, confirmation that the person is employed in her home country, and documentation of a conference invitation, hotel reservation and return flight. The U.S. has in three instances provided a blanket waiver to allow HIV-positive visitors to enter the U.S. Attendees to UNGASS on May 31 to June 2, 2006, and participants to the August Chicago 2006 Gay Games may apply for a waiver at their local U.S. consulates and enter the U.S. without further complications. In addition, the U.S. has provided a blanket waiver to HIV-positive attendees to the Toronto International AIDS Conference in August, allowing them to transit through the U.S. to Canada.

Although a waiver would permit an HIV-positive visitor to enter the U.S. for a specific purpose, the waiver process generally requires disclosure to the U.S. government of the visitor's HIV status. This information then becomes a matter of government record, and a known HIV-positive individual may be barred from future entries into the U.S. Moreover, there is strong opposition to the ban itself, and the waiver "does nothing to deter us from working together to overturn the ban so that making sure there is no need for waivers," said Ronald Johnson, assistant executive director of the Gay Men's Health Crisis. "Overturning the travel ban would require an act of legislation signed by the president. It's an uphill battle all the way, but one that we need to wage," said Johnson.

Both the travel ban and the waiver process violate privacy rights by requiring disclosure of health information to U.S. authorities. In addition, the travel ban infringes on visitors' rights to travel protected by international law, such as the International Covenant of Civil and Political Rights (ICCPR), which the U.S. has ratified.

In 1985 the World Health Assembly said, "No country bound by the regulations may refuse entry into its territory to a person who fails to provide a medical certificate stating that he or she is not carrying the AIDS virus." The U.S. is a member of the World Health Assembly.

For further information, please contact beri@icw.org.

BEST KEPT SECRET IN PMTCT

Contraception to Avert Unintended Pregnancies

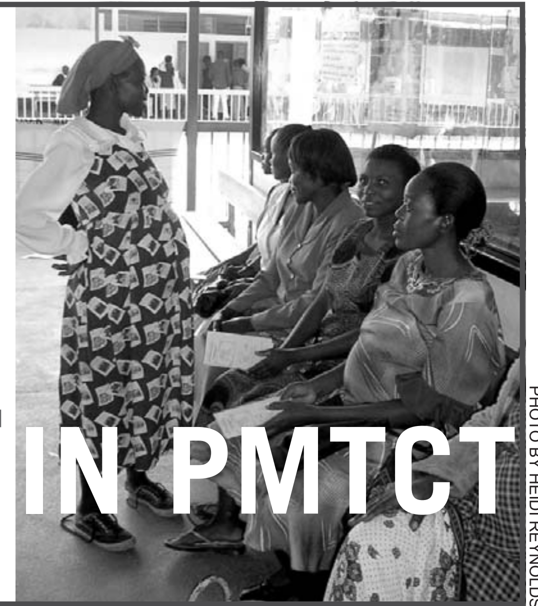


PHOTO BY HEIDI REYNOLDS

Antenatal care clients waiting for PMTCT services in a district hospital in Kenya.

By Heidi W. Reynolds, PhD, MPH, Scientist
and Rose Wilcher, MPH, Senior Program Officer
Family Health International

With prevention of mother-to-child transmission (PMTCT) a top priority on the UNGASS agenda, agencies have recommended a four-part strategy that includes: preventing primary HIV infection in women; preventing unintended pregnancies in HIV-positive women; preventing mother-to-child transmission with antiretroviral (ARV) prophylaxis; and, providing care, treatment and support for HIV-infected women, their infants, and their families.

There is broad international consensus that all four elements of the strategy are required to reach the UNGASS goal of reducing by 50 percent infant HIV infections by 2010. Yet, the majority of resources and attention are targeted to PMTCT with ARVs, such as the two-dose nevirapine regimen for HIV-positive pregnant women and their newborns. Consequently, the prevention of unintended pregnancies in these same women is an undervalued and little-used strategy. As women of childbearing age account for nearly half the people living with HIV worldwide, mounting evidence indicates that improving access to contraception for HIV-infected women who do not wish to get pregnant is an important and cost-effective way to prevent HIV-positive births. By extension, such a strategy will also reduce abortions and the number of children orphaned by AIDS.

Protecting the Health and Human Rights of Women

Protecting the health and human rights of women by enabling them to prevent unintended pregnancies is a long-established goal that remains unrealized in many parts of the world. Family planning services, particularly contraception, benefit the health of women and infants in a variety of ways. It can delay first births, lengthen birth intervals, reduce the total number of children born to one woman, prevent high-risk and unintended pregnancies, and reduce the need for unsafe abortion. On the other hand, the focus on providing ARVs to HIV-positive pregnant women and their newborns benefits infants while largely neglecting the mother's needs.

Enabling women to prevent unintended pregnancies is consistent with the right of all women "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights," a clear principle of the Convention on the Elimination of All Discrimination against Women (CEDAW). Not all HIV-infected women want to postpone childbearing, but they have a right to appropriate counseling in order to make informed reproductive choices.

Research Supports the Value of Contraception in Fighting HIV

Evidence confirms the important contribution that preventing unintended pregnancies can make to reducing new HIV infections. Moderate decreases in the number of pregnancies to HIV-infected women, ranging from 5.6 percent to 34.8 percent, depending on the country, result in numbers of averted HIV-positive births equivalent to those averted by ARVs (see Sweat et al., AIDS 2004; 18(12): 1661-71). Evidence also shows that pregnancies of HIV-positive women are often unintended. In South Africa, one study of three PMTCT programs documented that 84 percent were unplanned (see Rochat et al., JAMA 2006:295:1376-8). Another study in Côte d'Ivoire followed 149 HIV-positive women and found that of the 37 subsequent pregnancies, 51 percent were unintended (see Desgrées-du-Loû et al., Int J STD AIDS 2002;13:462-468).

Going one step further, many clients seeking HIV services express an explicit desire to prevent pregnancies. In Kenya, for example, HIV-positive clients in traditional PMTCT programs were 2 1/2 times more likely than HIV-negative women to be planning not to have more children. And regardless of HIV status, the great majority of pregnant women indicated an intention to use contraception after they delivered (see Baek & Rutenberg, Horizons Research Update, 2005). Evidence suggests that adding family planning services to traditional PMTCT services could nearly double the infant HIV infections averted compared to ARVs alone (see Stover et al., 2004).

The desire to prevent pregnancies among women in voluntary counseling and testing (VCT) services is also clear. Across four countries, more than half the women accessing these services did not want to become pregnant in the next two years; yet the majority in three countries were not using a contraceptive method, see Table 1:

Table 1. Fertility desires and contraceptive method use of female VCT clients, client interview data

	Kenya*	Zimbabwe*	Haiti*	Tanzania*
N=	211	40	158	154
Does not want a/another baby in next 2 years	59%	77%†	92%	66%
Not currently using a method to prevent pregnancy	60%	62%	56%	37%

**Among women ages 15 and older in Kenya, women ages 18 and older in Zimbabwe, youth ages 15-24 in Haiti, youth ages 16-24 in Tanzania*
† Zimbabwe: time period for next birth is not specified
Source: FHI unpublished data, 2006

Strengthening traditional family planning programs is another way to prevent unintended pregnancies in all women, including HIV-infected women. In fact, this strategy has shown that dollar for dollar such programs have the potential to prevent nearly a third more new infections than PMTCT programs that provide ARV prophylaxis (see Reynolds et al., Sex Transm Dis 2006; published ahead of print). Current levels of contraceptive use in sub-Saharan Africa are already preventing 22 percent (or 173,000) of HIV-positive births annually, despite the relatively low level of contraceptive use (see Reynolds et al., Sex Transm Inf. 2005;81:184). Increased access to high-quality family planning services is needed in sub-Saharan Africa, where the widespread unmet need

Continued on page 16

PHOTO COURTESY OF SANGRAM

Sex workers from Sangli district marching in protest to show their displeasure with the raids.

The Long Arm of the U.S. Government Anti-Prostitution Policy

"United States funding for activities carried out by your organization, SANGRAM, was terminated by mutual consent of the Avert Society and SANGRAM. United States government funding was not removed from SANGRAM for trafficking in persons."

— David Kennedy, spokesman, U.S. Embassy, New Delhi, Oct. 6, 2005

U.S. JUDGE STRIKES DOWN ANTI-PROSTITUTION PLEDGE
Page 3

By Meena Saraswathi Seshu
Director, SANGRAM

Over the last 15 years, the Sampada Grameen Mahila Sanstha (SANGRAM) has received worldwide recognition for its pioneering work in preventing HIV/AIDS in six districts in Maharashtra and northern Karnataka, India. SANGRAM started its work in the early 1990s in Sangli district, which has the highest incidence of HIV in Maharashtra. Today, its 120 peer educators – mostly women in prostitution – distribute 350,000 condoms to 5,500 women in prostitution each month, an intervention that has reduced sexually-transmitted diseases, unwanted pregnancies, and HIV infection.

Our work, which UNAIDS has called a "best practice" in reducing HIV/AIDS, began with the simple yet powerful understanding that women in prostitution are not deviants who spread HIV – but are human beings who can be transformed into agents of change to protect themselves and their clients from HIV. These peer educators educate other women in prostitution about STDs and HIV, counsel them to enforce condom use with their clients, and support those infected by the virus. This rights-based model is now globally recognized, and because of this decade-long work, I am one of the 17 members of UNAIDS' Global Reference Group on HIV/AIDS and Human Rights.

In 2002, the Avert Society – a joint project of the government of India, the National AIDS Control Organization (NACO), and the United States Agency for International Development (USAID) – started funding a part of this intervention. In May 2003, the U.S. government passed a law that prevents any U.S. funds from being used overseas "to promote or advocate for the legalization or practice of prostitution or sex trafficking." It also required U.S.-aided HIV programs to have policies "explicitly opposing prostitution and sex trafficking."

This policy is deeply problematic and has hindered the HIV-prevention efforts of many organizations, including SANGRAM. We work to promote the health and human rights of those in prostitution – this does not mean we promote prostitution – just as we fight against HIV, not against people with HIV. NACO, the apex HIV-prevention body in India, explicitly recognizes empowering sex workers as a key strategy to prevent HIV; this is the strategy we follow. Are we now supposed to undo a decade of result-oriented community-based work just because the U.S. can't understand the difference between promoting health and human rights and promoting prostitution? Or between prostitution and sex trafficking, which are two different things, based on whether or not coercion is involved?

By linking trafficking to prostitution, this policy links a criminal offense to a moral one, thus making the criminal offence a soft option. Not all women who are trafficked are into prostitution and vice versa. Multiple sex partnerships within a commercial context is a moral issue.

Countries like Brazil, which are recognized as having model anti-HIV programs, have refused to follow such a policy. This year, Brazil turned away $40 million in U.S. funding rather than comply; in August 2005, the organization, DKT International filed a suit against USAID in Washington, D.C., after a grant for its Vietnam program was defunded. Far away in remote Sangli, it was hard to believe that giant global policies made in Washington, D.C.,

Continued on page 16

Time to Go Beyond the Debate to Common Ground

Nils Daulaire
Global Health Council

In 2001, the United Nations hosted for the first time in its history a special session of the General Assembly dedicated to addressing a disease ravaging humankind. The UNGASS on AIDS set a new standard for dialogue between governments, multilateral institutions, and civil society, out of which grew the Global Fund, a massive increase in resources dedicated to fighting HIV/AIDS, and the start of a real voice for persons living with the disease.

Now, the five-year review of UNGASS is convening to review progress and challenges. The meeting revolves around the broad theme of "universal access," covering treatment, care, prevention and information. And as speeches are made, the global community today has the opportunity to reflect on the commitments kept, the promises ignored, and the distance yet to travel.

Five years ago, the very idea of widespread affordable and accessible ARV treatment for AIDS seemed a fantasy. Today, it is very real for more than a million people, and those affected are rightfully challenging governments and international agencies to do more, faster. By 2010, an estimated 10 million people will be in need of ARV treatment, with more added each year as the disease progresses in those more recently infected. We have a long way to go to reach universal access for treatment, but today that is a serious practical conversation rather than a fantasy.

We have seen the evolution of better and more precise ways of measuring the spread of the pandemic and its impacts, human and economic, on those affected. With greater precision have come revisions in earlier crude estimates, and predictable attacks on the motives of those who made those estimates based on limited data points. This is the normal advance of science. We are all grateful that the extent to which the virus has penetrated various societies now appears to be somewhat less than earlier projections; that does not change the very serious challenge posed by the ongoing spread of HIV globally, nor does it change the grim realities faced by tens of millions already infected.

We know that since 2001, the pandemic has taken root in "second wave" countries such as Russia, China, India and Nigeria, which together make up one-third of the world's population. And AIDS has more clearly showed its multitude of faces as its spread in many of these newer arenas has been driven largely by high-risk marginalized and excluded populations such as sex workers, injecting drug users, and men who have sex with men. Caring about "the innocent" has little relevance to protecting the world from a killer virus.

This, in turn, has reinforced the reality that one size does *not* fit all when it comes to AIDS prevention and mitigation. As a recent report of the U.S. Government Accountability Office (GAO) makes clear, workable prevention programs must be built on realities on the ground and evidence of effectiveness, and not on political and ideological dictates from Washington pushed by budget earmark requirements. It is time to go beyond the sterile debates of which letter in ABC to emphasize, and find common ground in comprehensive programs, education and the search for meaningful qualitative outcomes.

Passive recipients and inappropriately designed programs will not do the job of reversing the tide of HIV. Because those whom this disease has hit hardest are so often among powerless, marginalized, excluded and already-stigmatized groups, it is more vital than ever that we assure their voice through vibrant mechanisms to bring civil society's presence to bear on the design, implementation and evaluation of programs.

AIDS is no longer seen as a health issue alone. Its spread exposes and exacerbates harmful conditions that existed long before the disease appeared on the scene, and highlights the need to change those conditions and create new social norms. In Africa, as AIDS has hit girls and women the hardest of all, ideas ranging from female-controlled methods of prevention to inheritance and property laws that empower women no longer fall on deaf ears.

This UNGASS review also marks an opportunity to revisit the critical role of prevention. In the pendulum of response, first there was only prevention in the absence of feasible treatment possibility; then there was treatment as the principal goal. Yet we recognize that bailing a leaky boat will never be a lasting response, and that only prevention tied integrally to meaningful treatment and care programs will ultimately plug the inflow of new infections. So universal access to a full range of effective prevention options is fully as important as treatment of current cases.

The world has come a long way in the past five years. But with more than 40 million people living with HIV, and close to 5 million new infections each year, we are perhaps in the position of Winston Churchill when he said, "This is not the end. It is not even the beginning of the end. But it is perhaps the end of the beginning."

The Biggest *Achievement of The UNGASS Declaration to Date*

The Global Fund to Fight AIDS,Tuberculosis and Malaria

By Hélène Rossert
Director General / AIDES France
Vice Chair Emeritus of the GFATM

Launched in January 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) came into being as a new and unique financial mechanism to fund the fights against these three diseases, the major killer epidemics of the developing world. Often cited as a major outcome of the UNGASS 2001 Declaration, the GFATM, in fact, benefits from many illustrious origins – the Okinawa G8 meeting (2000), demonstrations during the Durban international AIDS conference (2000), the CIA report on world instability (1999), the Abuja declaration (March 2001), the UNGASS declaration in June 2001, and the Genoa G8 meeting (July 2001) among others.

Rooted in Four Principles

The GFATM is rooted in four basic principles that remain more or less respected five years later. First, is a demand-driven process that relies on country ownership rather than on external donors. The second principle is the call for a projects scheme called "rounds of projects." Since its inception, the GFATM has already launched five rounds and funded more than 300 projects in 130 countries. The third principle is the creation of a country coordinating mechanism (CCM), a multisectoral body in each country that decides how the funding will be spent. Representing the widest and best expertise, CCMs were created to force national stakeholders – public systems, private entrepreneurs, NGOs, people living with the diseases and the academic world – to work together. This same kind of representation also takes place at the board level, balancing the donor and recipient communities.

Genuine transparency and flexibility constitute the fourth principle that make the GFATM unique, keeping it afloat these five years and allowing adjustments in a highly changing environment. There has been no institution as assessed as the Global Fund since its inception and while it has been the subject of never-ending and often-valid criticism, the insistence on transparency has lead to dynamic change and a fantastic opportunity to keep getting better.

A Diverse Board

Unlike most funding mechanisms, the composition of the GFATM board helped all stakeholders to make the most constructive compromises between the real experiences of people living with the diseases and the more removed and results-oriented donor requirements and constraints. Three NGO representatives vote on a board of 18 and can submit or amend proposals. Thanks to this governance process, the role of communities of people living with the diseases grew from observer status to decision-makers, new rounds were launched against initial donor opposition and CCMs have been reformed against initial opposition from recipient governments. In these ways, the GFATM is an ideal mirror of the spirit of the UNGASS declaration – inclusive of all stakeholders and comprehensive in its approach. From now on, civil society will be an equal decision-making partner and can never revert to the status of other institutions.

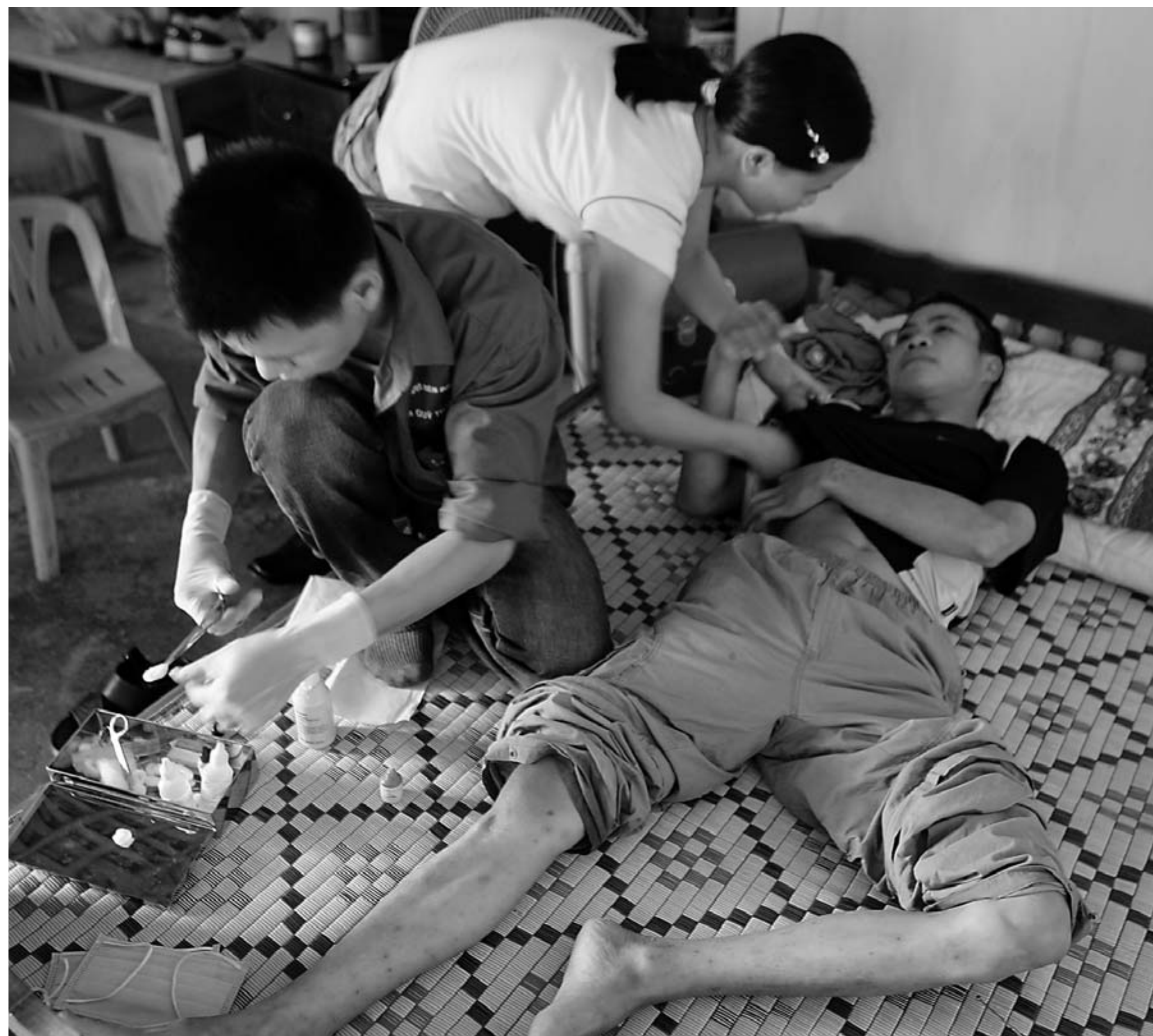
The Global Fund Faces Many Challenges

Because of its uniqueness, the GFATM also faces a unique set of challenges. As AIDS has inexorably morphed into a development issue, it faces the age-old struggle between

Continued on page 17

PHOTOS BY THE GLOBAL FUND/JOHN RAE

Both photos are of the HIV Club for a Brighter Future, Vietnam, with Global Fund support. Above: Conducting awareness raising workshops; Below: Providing basic medical services to PLWA.



CHANGING SOCIAL NORMS

FIVE MASS MEDIA CAMPAIGNS TO COMBAT HOMOPHOBIA

By Paulo Lyra
Communications Advisor with the HIV/AIDS Unit
Pan America Health Organization

"My son doesn't want to see you ever again," shouts the angry father, before slamming the front door. Clearly agitated, he paces through the house, but regains his composure as he approaches the room where his wife and son are waiting. "He is gone," the father assures his son. The mother hugs and comforts the boy: "Don't worry my son. You are still going to find a young man that deserves you."

As the scene closes, the reason for the break-up becomes clear – unprotected sex.

Brazilians love soap operas. So this 30-second TV spot asking people not to discriminate against homosexual men was well-placed in the middle of a popular 8 pm soap on a June evening in 2002. Its tag line: "Respecting differences is as important as using a condom." The message was followed by a sign-off from the ministry of health, and caught the eyes of 40 million people already glued to the screen.

The Brazilian spot used a family setting to break into unfamiliar territory. But that was just the beginning. Over the next three years, unprecedented, high-profile, mass-media campaigns, using top-rated radio slots, prime-time television, and prominent billboards, sprung up across the continent in countries as far apart as Argentina, Mexico, Chile and Colombia. This public discussion about homophobia surprised many, upset quite a few, and generated a heated public debate that may change forever the landscape for HIV prevention in the region.

The campaign organizers knew they would be controversial. They did not know just how good such controversy could be.

While Latin America is best known for machismo, homophobia is a deeply-rooted and closely-associated phenomenon. "Latin America has more homophobic crimes than any other region," says Brazilian sociologist Luiz Mott. People point fingers, shout names, and throw dirty water at gays in public places. Homosexual men are fired from jobs, expelled from clubs, and barred from churches. A worrying number of cases end in violence. In June 2004, Octavio Acuña Rubio, a psychologist and well-known human rights activist, was stabbed to death in his office in Queretaro, Mexico. In Brazil, it is estimated that 1,960 homosexuals were murdered between 1980 and 2000.

This environment couldn't be better for the propagation of HIV. Stigma, discrimination and violence lead to low self-esteem and self-efficacy (one's judgment of ones capabilities, for instance, to negotiate condom use), which leads to HIV. And HIV leads, of course, to more stigma and discrimination.

Latin America has one of the most "masculine" HIV epidemics. For every 10 young men aged 15-24 with the virus, there are six HIV-positive females in the region, 15 worldwide and almost 30 in sub-Saharan Africa. Of the AIDS cases registered from 1983 to 2005 in Mexico, 83 percent were men. Among them, men who have sex with men (MSM) are at particular risk. In Brazil, the chances of gay, transgender or straight-looking homosexuals having HIV are 11 times greater than that of heterosexual men.

Several countries adopted anti-discriminatory constitutions, as part of the democratization process that swept the region in the 1980s. Other initiatives like distributing condoms and leaflets in gay bars helped to raise awareness, protect MSM, and strengthen their communities. But compared with reduction of prevalence in similar groups in the developed world, the overall results were disappointing.

In April 2005, Mexico was launched its campaign with two radio spots in the 12 "most homophobic" states. It took them six months to get the right approach and to reach a consensus within the government and civil society. Just like the Brazilian campaign, the family was the setting for the radio spot, "Dinner Time:"

Mother: You seem to be very much in love, my son.
Son: That's right, mom.
Mother: How long have you been going out?
Son: Five months already.
Mother: Are you happy we are having dinner together?
Son: Very much. I will prepare a nice dessert.
Mother: I just hope both of you like what I will cook. What is his name again?
Son: Oscar, mom. I already told you. His name is Oscar!
Background voice: Does this seem unusual to you? Homophobia is the intolerance to homosexuality. Equality begins when we recognize that all of us have the right to be different.

What is so "unusual" about these campaigns? That they break a taboo subject? Yes. Their daring tone? Yes. Their most remarkable feature, however, was the effort to change the social norm. For the first time, ministries of health across the region, working together with civil society, moved away from individual behavior change campaigns and focused instead on changing society as a whole, in this case, its centuries-old attitude towards homosexual men. For the first time in MSM prevention initiatives, the general public was the target audience, while the gays were the protagonists. For the first time, homophobia was portrayed in the mass media as a public health problem.

PHOTO BY MINISTRY OF SOCIAL PROMOTION, COLOMBIA

In Colombia and Chile, the anti-homophobic component was part of a broader condom promotion campaign targeting different audiences. Colombia used a subtle approach, depicting a very normal, urban, middle-class, young, male couple that aimed to confront existing attitudes without aggravating the viewers. In each spot, the couple wore different clothing, hinting at a stable relationship contrary to the stereotype that gay men are promiscuous. They were "normal," successful and they used condoms. The Chilean campaign also used two young homosexual men to promote condom use. Asked by the campaign tagline: "What is your position?" The two reply: "With love and without prejudice."

Argentine Campaign Creates Uproar

By contrast, the Argentine campaign was inadvertently audacious. "There are more things that don't transmit HIV than do" portrayed a series of daily-life situations that cause no risk of HIV infection – donating blood, safe pregnancy, using condoms, hugging and kissing – illustrated by different population groups like couples, mothers and young people. For the message, "Hugging does not transmit HIV," the ad agency suggested the photo of a homosexual couple. They were indeed hugging, but above all they were kissing each other passionately on the mouth.

Latin Americans tolerate effeminate depictions of homosexual men, but public displays of affection are soundly rejected. Not long after the kissing-hug

IN LATIN AMERICA

picture was displayed in Buenos Aires bus stops, several billboards were covered with protesting messages such as "I don't want my money spent on this" and "We don't want our children to see this."

It took several weeks and huge damage control for the campaign organizers, the Argentine Country Coordinating Mechanism (CCM), to rectify the damage. Yet, the overall result was surprisingly positive. The CCM received congratulatory messages from different parts of the country and abroad. Newspapers picked up the issue, initially focusing on the controversy, but soon moved to investigate why homophobia is still so prevalent in Argentina. TV shows organized debates around the theme. What started as a smaller component of a larger campaign took on a life of its own and brought homophobia to the center of the country's public agenda.

In Mexico, the controversy played out in a similar way. One bishop told the media it would lead to the "degradation of the human being and of the Mexican society." Some state governments tried to prevent the broadcast. Yet, the huge public debate that followed galvanized remarkable support. A group of mothers and fathers for sexual diversity went to newspapers to support the choices of their sons and daughters. Intellectuals and artists expressed solidarity. Another set of state governments provided funds for extra broadcasts in the local media. To reach this outcome, the national AIDS commission CONASIDA relied on two main strategies: quoting extensively the international commitments subscribed to by the country, and the candid and authoritative support to the campaign by the Secretary (minister) of Health, Julio Frenk.

The Brazilian campaign was the most wide-ranging and the most expensive. Because of the complexity and scale, Brazil took two years to develop the campaign. For each possible criticism they had a ready-made reply and an outside spokesperson, such as a university professor or a civil society representative. Journalists knew months in advance about the campaign, and why it was so important to address homophobia straightforwardly. A web site was created to allow supporters and protesters to share their opinions. The supporting postings were quite touching. One young man said: "For the first time in my life I felt I was a citizen. Thank you so much."

In Chile, a country that spent six years without a mass-media campaign on HIV because of the opposition from conservative groups and the church, there was much debate about the depiction of a gay couple. But it took a back seat to the promotion of condoms which remained the focus of the disagreement. In Colombia, somehow disappointingly, neither the couple, nor the condoms provoked reaction. "We knew it could be contentious," said Ricardo Luque, the manager of the national AIDS program involved in producing the TV spots. A defense for each possible attack was in place. But they did not come. "Sometimes I wonder if we did something wrong," he jokes.

Because of the cultural and geographic proximity, it is logical to assume a domino effect from the campaigns. Apparently this did not happen. Each of the campaign developers had little or no information about the parallel processes in neighboring countries. In spite of the months or years it took them to be launched, most of the processes were internal and confidential, as a leak could easily preempt the whole effort. It seems that the coincidence in the dates of the campaigns was the result of the simultaneous maturity in the region. "The campaigns were the natural outcome of the search for more effective mechanisms to prevent HIV/AIDS in homosexual men," said the national AIDS manager of Brazil, Mariângela Simão.

The Global Fund financed the Argentine campaign and part of the Chilean. PAHO provided supplementary funds to Mexico. The bulk of the money, however, came from governments. The five campaigns cost US$ 6 million. A small sum for breaking such a taboo subject in countries that account for 70 percent of the population of Latin America.

Were the campaigns successful? As with most communication initiatives, little time and effort was allocated to measure the impact. Only Brazil made a formal evaluation, and that was limited to a recall survey. We don't know how the campaigns will affect the social attitude towards homosexual men in the years to come. Homophobia is a complex and deeply rooted problem in the region. But anecdotal evidence of success is unequivocal, chiefly lodged in the public debate that accompanied the campaigns and the visible empowerment of the homosexual community. These achievements suggest that Latin homophobia may now be more of a stereotype than an irreversible mindset.

The PAHO report, "Mass media campaigns against homophobia in Latin America," will be available June 2006. For further information, contact lyrapaul@paho.org.

PHOTO BY MINISTRY OF SOCIAL PROMOTION, COLOMBIA

Public messages in Brazil, Argentina and Mexico stating that homophobia, not homosexuality is the problem. Center: Billboard covered with protesting messages, such as "I don't want my money spent on this."

PHOTOS BY WORLD LEARNING

THE UNGASS AGENDA

DONORS AND MINISTRIES IGNORE ACUTE TEACHER LOSS TO HIV

By Helen Cornman
HIV/AIDS Specialist, World Learning

As loud calls reverberate at UNGASS to revitalize the AIDS-decimated health-care sector, a similar and worsening crisis in education is hearing only whispers.

Education and HIV prevention are linked almost to the point of cliché. International energies have been mobilized for decades around basic quality education with special attention to gender disparity. Education has been called a 'social vaccine' and long acknowledged not only as a human right in itself, but the major link to all other rights. The education of girls has a considerable bearing on the economic health of nations and campaigns to eliminate school fees, increase attendance and completion, continue unabated.

The recent announcement by the UK of a 10-year $15 billion pledge to basic education holds a more-than-welcome promise. Education is vital in preventing the further spread of HIV/AIDS, said UK Chancellor Gordon Brown in a challenge to the G8 meeting the following week. "Women who have had schooling are thought to be three times better able to protect themselves against HIV/AIDS than those with no education." He further stated that in Swaziland, two-thirds of teenage girls in school are free from HIV, while two-thirds of girls out of school have the virus.

The powerful impact of education on the HIV/AIDS epidemic is no secret. According to international HIV and education experts a completed quality primary education alone can halve the risk of infection for young people – as many as 700,000 cases of HIV each year. Thirty-one of the poorest 55 countries most likely to miss the Millennium Development Goal (MDG) of universal primary education (UPE) by 2015 are also among the 36 worst affected by HIV/AIDS. A desperate shortage of teachers in developing countries due to misplaced priorities of governments and global economic pressures from international donors is noted. According to a recent report by UNESCO, sub-Saharan Africa will have to recruit 1.8 million teachers or increase its teacher workforce by 68 percent over the next decade.

There is still, however, a disturbing disconnect between these issues and the serious HIV-related teacher loss that is wreaking havoc on the education systems in many countries.

Rates of Teacher Attrition Continue to Climb

Despite some stabilization at the secondary and university level, countries in sub-Saharan Africa and south Asia are experiencing a climbing rate of teacher attrition from AIDS-related death, illness, bereavement leave and withdrawal. In some countries, where education is the largest public sector, 50 percent of public sector deaths are due to HIV/AIDS. Although very little is published about teacher attrition, there is more than enough data to cause alarm.

- In South Africa, nearly 13 percent of the teacher workforce – about 45,000 people are HIV-positive and more than 4,000 teachers died of HIV/AIDS-related complications in 2004. (Human Sciences Research Council).
- In Swaziland, approximately 80-85 percent of teacher deaths were AIDS-related.
- An average of 2,880 Tanzanian teachers die of HIV/AIDS-related complications annually (Tanzania's Education Minister, Joseph Mungai.)
- In Namibia, there is a need for two teachers for every post due to absenteeism, sick and bereavement leave.
- In Kenya, in 2004, four to six teachers a day or more than 1,000 died of AIDS-related illnesses (Permanent Secretary, Ministry of Education).

Rural postings of teachers, already a challenge, are becoming even scarcer as teachers who know they are HIV-positive prefer to be near mostly urban health facilities to access specialized medical treatment. Teachers are also leaving the teaching profession – to care for family members affected by HIV/AIDS or taking up employment in other areas where HIV/AIDS has created vacancies in the public and private sector, and some teachers are emigrating for employment.

HIV-positive teachers are subjected to repeated stigma, intensified because of their societal role as mentors and guardians. As a result, their lack of confidence in the institutional response to stigma and confidentiality further inhibits their desire and willingness to be tested. According to an official in Uganda's ministry of education, many teachers have withdrawn from teaching because of abuse and stigma. "We have an uphill task of convincing those who have not yet gone for testing, to do so," he said.

Teacher attrition of this magnitude threatens the workforce and erodes the overall systemic capacity. It goes without saying that left unchecked, the ripple effect will lead to increased HIV among students, especially girls, increased poverty accompanied by decreased female economic independence, and further barriers to reaching the MDG of universal primary education by 2015. The consequences will be dire for present and future generations.

'Deadly Inertia' Strikes Ministries of Education

So, what are we doing about it? A thorough search of the literature for a better grasp of the problem in order to develop programs and policy for World Learning produced very little overall. It did uncover one excoriating and well-researched survey-report by the Global Campaign for Education, (a conglomerate of NGOs and teachers' unions in more than 150 countries). The report, entitled "Deadly Inertia," documents across-the board "paralysis" of responses by ministries of education in 18 high, medium and low prevalence countries in Latin America, sub-Saharan Africa and south Asia. Although the survey results varied according to region and prevalence, the report paints a grim picture. Low prevalence countries in Asia and Latin America reported that they had no strategic HIV/education plans due to the common belief that the epidemic is insufficient to warrant serious attention. HIV was perceived as the responsibility of ministries of health and unrelated to education.

Aside from some programs for orphans and vulnerable children (OVCs) and single HIV advisors, among even the high-prevalence countries, only Tanzania had both finalized and started implementing a strategic HIV/AIDS plan. Those that developed programs have not seen them implemented. In Ghana, a draft is still being revised after two years, and, in Kenya, the process stalled altogether while the cabinet considered and reconsidered the plan.

With the exception of Zambia, none of the 18 countries have adequately implemented anti-stigma campaigns or non-discrimination policies for HIV-positive teachers. Only the ministry in Zambia had identified

Run-down and overcrowded classrooms in Eithiopia due to teacher loss from HIV/AIDS have a dire and long-term impact on students. Bottom: Many children stand outside a small tin-roofed village schoolroom.

address the issue of teacher attrition or to work collaboratively with teacher unions and HIV/AIDS networks.

Civil society has contributed to education and HIV through anti-AIDS education in the schools. A few innovative programs support HIV-positive teachers, such as the teachers' union in South Africa that is training 75,600 peer educators and providing antiretroviral treatment to 2,300 teachers and their spouses. Save the Children in Malawi trains teachers to become peer counselors who provide guidance and support to other teachers to access voluntary counseling and testing and psychosocial support. Donors should support more of these proven methods and recognize the overall importance of such interventions.

AIDS-related teacher shortages, developed a policy of non-discrimination, and appointed an HIV/AIDS-in-the-workplace technical advisor.

Reliable data on human resources is an unequivocal essential in determining needs, policies and programs that address the impact of HIV on education resources and infrastructures. Only a handful of countries reported any ministry-led research on the topic. In some countries, the ministry of health had collected information with little or no feedback into the education system. Zimbabwe and Kenya reported the collection of some data for HIV-sensitive indicators, such as numbers of HIV-infected OVCs or teacher mortality. Few countries are in the process of, or even considering, training new teachers to make up the losses, and even fewer have reviewed or amended their human resources polices to address those losses.

One of the main problems that emerged in the surveys was the overall and across-the-board isolation and lack of coordination. HIV/AIDS is treated as a stand-alone issue in nearly all 18 countries; strategic plans carry no links to budgetary or policy processes within the ministry of education and their programs are not mainstreamed into the overarching education plans, such as Education for All or the Poverty Reduction Strategy Papers. Cooperation and coordination between ministries of education and other sectors are rare. HIV/AIDS coordinators within the ministries are often funded by outside donors and often there is only one person working on a parallel track to HIV units in other ministries. HIV/AIDS continues to be perceived by many as the responsibility of the ministry of health.

Donors and Civil Society

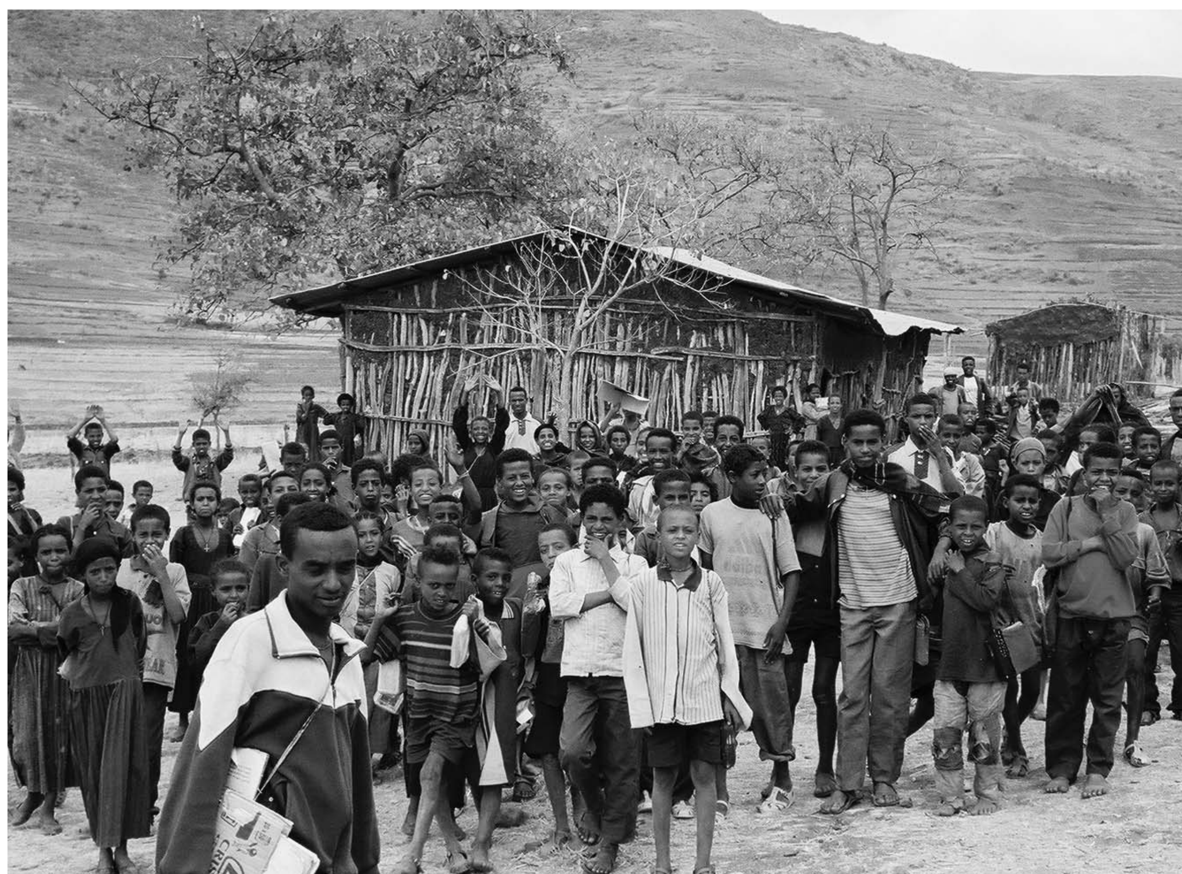
Similar to the responses of the ministries, donors and civil society have narrowly targeted their responses without an overall policy perspective. For example, donors support one-off projects such as school bursaries, give direct or indirect support to OVCs, and provide HIV/AIDS education in the schools. But they lack vision and bold leadership to support HIV-positive teachers or provide substantial resources to training a new teacher workforce that will replace what is being decimated by the epidemic.

There is also a serious lack of coordination between ministries of education and civil society with responsibility falling on both sides. On the one hand, most ministries surveyed acknowledged their failure to effectively and systematically engage civil society in the design of HIV/AIDS policies to address teacher attrition and stigma. Interviews with NGOs, however, also reveal that even their own excellent programs often tend be piecemeal without coordination between HIV and education. HIV-focused NGOs typically respond to the epidemic in only one of two ways – through HIV/AIDS education in schools or support for OVCs. Education NGOs, for their part, are often ill-informed about the epidemic and fail to

What this report is telling us accentuates several underlying and important realities. First, that HIV/AIDS has for too long been pigeonholed as a public heath problem alone when it is also highlighting many longstanding development problems such as weakened structures and human resources. Second, we will fail in meeting our interdependent goals of preventing HIV/AIDS and achieving universal primary education unless we work in a comprehensive and multi-sectoral way – something everybody talks about but is still minimally achieved. If we don't bring this message to UNGASS, the G8, the UK and other donors, we will have failed our teachers, our children and ourselves. The impact of this failure will reverberate at all levels, weakening our educational systems to the point of breaking and reverse the years of gains for many generations.

The above information is drawn from the report, "Deadly Inertia," by the Global Campaign for Education published in November 2005 and carried out in coordination with the first-ever UN Education Sector Global HIV/AIDS Readiness Report, a questionnaire-based exercise that collected information from 71 Ministries of Education. The 18 countries surveyed were: Bolivia, Burundi, El Salvador, Gambia, Ghana, Haiti, India, Kenya, Mali, Nepal, Nigeria, Senegal, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

For further information: contact Helen.cornman@ worldlearning.org.



FHI— Continued from page 8

leads many women, regardless of HIV status, to have more children than they desire or to resort to unsafe abortions.

Barriers to Expanding Access to Contraception

Why then are family planning services not given greater priority among HIV prevention efforts? Part of the answer lies with funders. Funding from initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight TB and Malaria (GFATM) is largely focused on HIV care and treatment. Moreover, none of these funders include contraceptive use as an indicator of programmatic success.

Even as resources increase for HIV priorities, traditional family planning programs are losing ground. After years of no growth in funding, the U.S. 2007 budget proposes 18 percent cuts in international family planning programs. Even as the number of people desiring to use contraception continued to rise, UNFPA reports that support for family planning services in developing countries decreased by 36 percent from 1995 to 2003.

While separate funding mechanisms keep priorities separate, structural obstacles also prevent important linkages between HIV and family planning. Health ministries and heath service facilities are typically organized and delivered vertically, meaning that clients see a different provider for each health concern. This situation also means that providers may lack the skills or incentives to meet clients' dual needs.

Integrating HIV and Family Planning Services

Integrating HIV and existing reproductive health services, specifically family planning, has the potential to draw on the strengths and resources of both programs in order to help women learn their HIV status and to make better-informed contraceptive choices. HIV prevention and care programs, such as PMTCT, VCT, treatment with antiretroviral therapy, home-based care programs, and services for orphans and vulnerable children, are all rapidly expanding. Integrating family planning services into these programs can increase access to contraceptive methods and dramatically enhance the public health impact of the HIV programs. HIV prevention and care activities could also be mainstreamed into the existing reproductive health infrastructure, which may both increase access to and destigmatize HIV services while strengthening traditional family planning programs.

Meeting the contraceptive needs of HIV-infected and at-risk women requires providers who are adequately trained to seek out and understand client desires and to counsel them effectively on their reproductive choices. As in traditional family planning programs, informed-choice counseling must be the cornerstone of contraceptive services in HIV-service delivery settings. HIV-infected women, like all women, have the right to make reproductive choices for themselves, and care must be taken to ensure that they are not coerced into a particular reproductive decision. For those women who do not wish to become pregnant, providers must be able to discuss feasible, safe and effective contraceptive options.

In addition, as resources and attention are increasingly diverted to the HIV epidemic, renewed political commitment and financial support for family planning is essential. Efforts to reduce unmet need will not only produce concrete gains against the HIV epidemic, but improve overall maternal and child health.

Despite abundant evidence of the positive public health impact of family planning on the HIV epidemic, contraception remains an undervalued and underutilized intervention. Increasing access to voluntary contraceptive services needs to be an integral component of HIV prevention efforts if the UNGASS goal of reducing infections in infants is to be met and if the right of women to decide the number and spacing of their children is to be realized.

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Sangram— Continued from page 9

would affect our tiny lives. But when they did, we too started cementing our position. Last year, when our three-year Avert Society-funded project drew to a close and renewal talks were going on, both SANGRAM and Avert agreed not to renew such conditional funding. We decided to look for alternate funding and assumed the matter had ended there.

But no! In May 2005, the police started raiding brothels in Sangli – at the behest of an international NGO called Restore International. The raids, which were conducted with missionary zeal and thug-like brutality, spared no one: two school girls visiting their families were picked up as part of the 35 women and girls who were arrested. According to the law, only minors in prostitution may be rescued, not adult women. An initial medical report showed that only four out of the 35 were minors. Based on this, when SANGRAM intervened to secure the release of adult women in prostitution and the two school children, we were accused of 'thwarting the raids.' A canard was spread that USAID had cut SANGRAM's funding for impeding the rescue of minors.

Child prostitution is a criminal offense – I see it as a form of child sexual abuse. The issue though is how to stop it. Brothels have been raided since time immemorial, but more and more children are being brought into prostitution. So how have these raids helped? Every brothel in Sangli had a minor when we started work in 1990; today, very few do. This has happened through time, trust and community involvement — not through police raids, indiscriminate arrests, and physical violence. Raids only drive marginalized communities further underground while long-term above-board community work is what is needed.

The truth is that Restore International and its allies `thwart' organizations like SANGRAM that have painstakingly created spaces for stigmatized women in prostitution to collectively find their own solutions to their own problems.

It has taken the Indian government a long time to come around to empowering and supporting the rights of women in prostitution as a means of protecting their health, but this support is still fragile and could easily be corroded by such a policy coming from the U.S. with whom it has close political and economic ties.

Women in prostitution still are seen in many places as deviants rather than human beings, and when organizations working with them are tagged as 'promoting prostitution,' this only undermines all the progress we have made. But until we start working with women in prostitution (rather than against them), until we start having trust and confidence in them (instead of blaming them), until we believe that they are capable of changing the lives they lead (instead of thinking we have to save them from themselves), we will only be running in place and out of time.

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the need for setting realistic long-term goals and donor pressure to deliver rapid results. AIDS creates a special challenge because no one knows how to implement sustainable delivery of lifelong treatments for a communicable disease in resource poor settings while respecting human rights. How could the GFATM, for example, be accountable for reaching 3x5 targets by rushing to deliver development responses that other institutions have been failing for two decades?

The Global Fund is now confronting extremely weak health-care systems, which AIDS did not cause, but exposed and exacerbated. If the international community is serious about tackling the three epidemics, rebuilding these systems in poor countries – especially in sub Saharan Africa – is urgent. But, since the World Bank and the World Health Organization (WHO) as implementing agencies have failed so far to reinforce health systems, how can the GFTAM, as a small multi-lateral, multi-sectoral financial mechanism, dependent on outside sources make a dent in the problem? In the 2005 launch of Round 5, while the Global Fund allowed proposals to include a health system strengthening component, WHO and the World Bank have been protesting against this extended role of the GFTAM.

The Struggle for Funding

Civil society in both the developing and developed world has pointed to the badly-needed continuous funding as a major life-threatening obstacle to the Global Fund. The early funding enthusiasm in 2002 faded quickly and since Round 4 in November 2003, has fallen short of the need; today there is not enough money to launch Round 6 and currently the bulk of GFTAM money is coming from developed country governments with very little from the private sector .

Both donor and recipient governments are culpable. Rich countries, while funding the Global Fund did not increase their commitment for health development issues, and at the same time developing countries took advantage of GFTAM grants to decrease other commitments for AIDS. This is unacceptable. At the same time, a few countries such as France and the UK are striving to find innovative ways to find continuous funding. The airline solidarity contribution, or tax, to be implemented in July 2006 in France from any airline ticket bought in the country is predicted to bring 200 million euros per year. The principle is easy to implement and politically neutral. Communities living with the diseases like it so much that they want to launch a campaign during summer 2006 at Charles de Gaulle airport called 'You fly, I live!" Advocates from all over the world should push for other countries to join this effort.

Program Quality At Risk

The quality of programs is also being questioned at the developing country level. Since program evaluation and follow up to Phase 1 (the first two years of a grant) rely essentially on quantitative indicators, there is a high risk of pushing quality to the side in favor of better performance on numbers. For example, some programs have been shifting from a comprehensive approach toward treatment-only programs because prevention is more difficult to capture through quantitative indicators.

Conflict of Interest

Phase 1 of the grants benefits from an independent scientific review, but programs ready to move to Phase 2 (the three last years of a five-year grant) are subject to grant-by-grant board approval. Because some board members lack the required technical knowledge to evaluate a program, their own personal and political bias may put a fair evaluation in jeopardy.

The CCM composition has also been at risk of conflict of interest in the grant management process. When grants were first implemented, the CCM chair and principal recipient came from the same institution (usually the ministry of health). But 2005 grants entering Phase 2 also face potential conflict of interest from board constituencies since countries receiving grants will vote through their representative on the GF board.

Weak Southern Voices

Another major road block to long-term success is the weakness of NGO voices from the South at both the board and country levels. Seeing the opportunity to capture big money, many governments of the South erected a wall between them and the NGOs, unwilling to use or learn from their on-the-ground experience and expertise. Depriving NGOs of information and the means to influence national response creates a tremendous waste of social capital.

Looking to the Future

As an international institution, the GFATM has already changed the paradigm for health development, developing country-driven programs and program accountability leading to results. Much more remains to be done in this area.

The Global Fund must shift toward funding successful programs without further burdening recipient countries. The system of rounds is heavy on monitoring and linking quantitative indicators to disbursement every three months. Accountability will need to be assessed differently, and more emphasis is needed on program quality with different kind of indicators and evaluation. In order to be effective and sustainable, the GFATM will have to rely on additional funding both from North and South that is targeted at the rebuilding of public health care systems, a heavy task indeed.

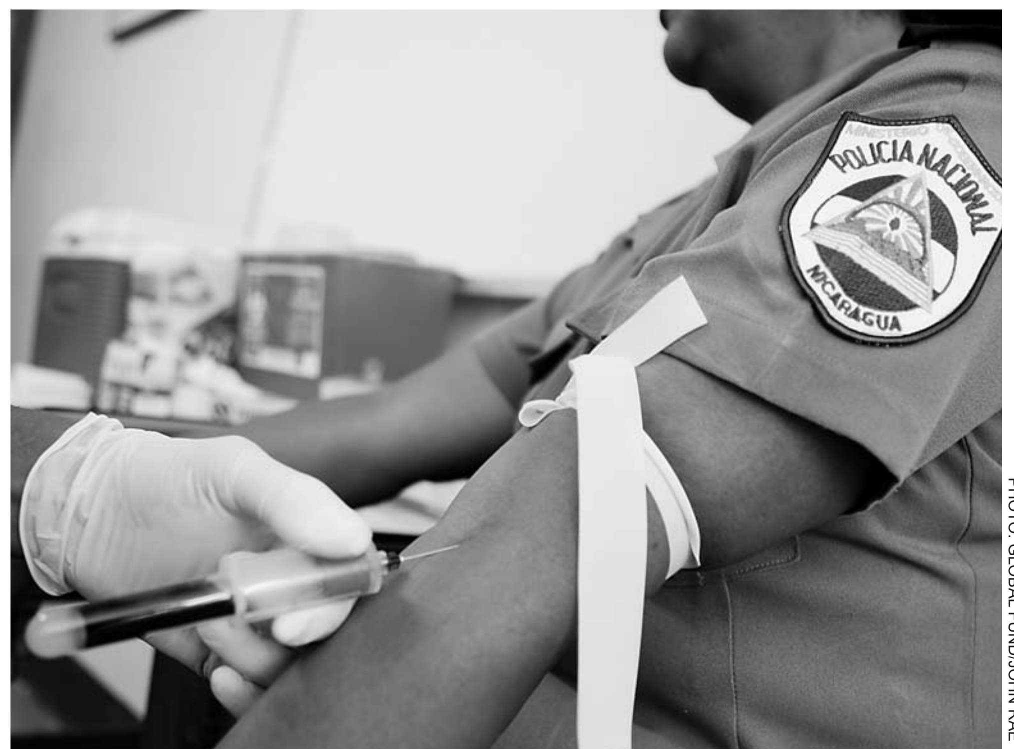

PHOTO: GLOBAL FUND/JOHN RAE

Voluntary HIV testing for national police officers in Nicaragua with Global Fund Support.

With serious questions about funding for Round 6 hovering over the last few months, the board at its April 28-29 meeting launched the new round. That is exciting news and it is now incumbent on donors to come up with the money. New rounds are estimated at $1 billion and current available resources are significantly short of that. It is still up to all of us as activists, advocates and taxpayers to push our governments who signed the 2001 UNGASS declaration to fund this round and continue to transform an international declaration into a long-term achievement. We can do it, we have to do it.

For further information, contact: helenerossert@yahoo.fr.

Resources

PEPFAR Watch is a new web resource intended to inform and spur action on U.S. global HIV/AIDS policies and related issues in which U.S. policy and funding are of concern, including reproductive and sexual health, access to treatment and health-care systems. A joint effort of the **Center for Health and Gender Equity (CHANGE) and Health GAP (Global Access Project), PEPFAR Watch** aims to promote the accountability of U.S. global AIDS policies to ensure health and human rights. Visit the website at www.pepfarwatch.org.

The Global Campaign for Microbicides has released several new facts sheets. They include: Fact Sheet No. 12 Microbicide Messaging: Themes to emphasize and avoid; Fact Sheet No. 18: Addressing Questions and Common Misperceptions about Microbicide Clinical Trials; and Fact Sheet No. 19 Managing Expectations Around Microbicides. The fact sheets can be found at www.global-campaign.org.

CROI (Conference on Retroviruses and Opportunistic Infections) has released two studies showing that single-dose nevirapine prevents HIV transmission in consecutive pregnancies. According to the studies, women who have used single-dose nevirapine to prevent mother to child transmission of HIV can use it with equal or greater success during a second delivery. Go to www.aidsmap.com/en/news/077B2D16-12AA-4B3E-A944-E3B0D2B0265A.asp?type=preview to find more information about the two studies.

YouthNet, a program of **Family Health International**, has released several new resources including a youth peer education curriculum toolkit called the *Training of Trainers Manual*. It uses participatory techniques based on a variety of theoretical frameworks to ensure that future trainers are skilled and confident in their abilities to train peer educators and serve as informed resources for their peers. *The Training of Trainers Manual* can be viewed online at www.fhi.org/en/Youth/YouthNet/Publications/peeredtoolkit/index.htm. Summaries of the other resources include current research abstracts and program resources are featured on the YouthNet's online publication and can be viewed at www.fhi.org/en/Youth/YouthNet/Publications/YouthInfoNet/index.htm.

A newly revised book *HIV, Health and Your Community – A Guide for Action* looks at community-based care of HIV/AIDS in areas with few medical resources. Written by Reuben Granich, MD, MPH and Jonathan Mermin MD, MPH, this comprehensive manual is accessible to people without technical knowledge or prior training in HIV prevention care of people with HIV/AIDS. Topics include biology of HIV, prevention strategies, counseling and testing, low-cost care for people with HIV and their families, and guidelines for using ART and treating opportunistic infections. Preview and download this book at www.hesperian.org/publications_download.php#hiv.

The British Medical Journal published an article entitled *Barriers to Better Care for People with AIDS in Developing Countries*. The article examines the challenges faced in the World Health Organization's "3 by 5" initiative. It highlights the belief that the focus on delivering ARVs distracts resources and attention from a broader model of health care. The authors argue that the initiative must develop a chronic disease model of care through a strengthened public health infrastructure. They also point out the exclusionary power of stigma and outline the need for training programs for health-care workers on medical ethics and human rights. Link to the article at www.eldis.org/cf/search/disp/docdisplay.cfm?doc=DOC16885&resource=f1.

The video *What Can I Do? Strategies for Hope* is now available in English, French, Portuguese, Swahili and Spanish. Featuring the Rev. Canon Gideon Byamugisha from Uganda – the first African priest to disclose his HIV-positive status – the video addresses HIV-related stigma, shame, discrimination and denial. Part of the video can be viewed at the **Strategies for Hope** website at www.stratshope.org. To order the video, go to www.talcuk.org or send an e-mail to info@talcuk.org.

The latest issue of the **Horizons Report** responds to a growing call for a renewed focus on HIV prevention by highlighting practical findings from research studies in Kenya and South Africa with important program and policy implications for moving the HIV prevention agenda forward. Among the features of the Kenya study are: *"Prevention for Positives,"* also addressing men who have sex with men; "ABCs: Not as Simple as They Sound;" and how adults and youth interpret key messages. The South African study focuses on a mining community and the importance of understanding sexual networks. Another Horizon study asks *Does Being Treated With HAART Affect The Sexual Risk Behavior of People Living With HIV/AIDS?* This report highlights findings from a study comparing the sexual risk behavior of HIV-positive individuals on HAART with those on treatment for opportunistic infections. Both reports are available at www.popcouncil.org/pdfs/horizons.

A national survey of HIV/AIDS health-care delivery in Kenya was conducted by the **National Coordinating Agency of Population and Development** through the MEASURE DHS project. The first national survey of HIV/AIDS health-care delivery in Kenya, the *2004 Service Provision Assessment (SPA) on HIV/AIDS services* included a representative sample of 440 facilities throughout Kenya including those managed by government, NGOs, private for-profit and faith-based organizations. The SPA provides baseline information on the capacity of the formal health sector to provide both basic and advanced level HIV/AIDS services, on record-keeping, and on internationally recognized components for quality services.
For the full report go to www.measuredhs.com/pubs/pdftoc.cfm?ID=562.

A **World Bank** report, *Repositioning Nutrition as Central to Development* warns that malnutrition is costing poor countries up to 3 percent of their yearly GDP, while malnourished children are at risk of losing more than 10 percent of their lifetime earnings potential. The report also says malnutrition may increase the risks of HIV infection, while reducing the numbers of children and mothers who survive malaria. For more information go to http://tinyurl.com/foeul.

Connecting Wants and Haves in the field of HIV/AIDS is the theme of **HIV ATLAS-INDIA** a new site that is part of a worldwide initiative of **HIV ATLAS**. The site includes: a clearing house for goods and services; e-forums and community space; job listings and resumes; events, opinions and blogs. A work in progress, the site is asking for suggestions at india@hivatlas.org,in or e-mail jharsh@gmail.com.

The **Synergy HIV/AIDS Online Resource Center** contains 4,374 searchable online documents relevant to HIV/AIDS project management, research and reproductive health issues. New additions are constantly being added. For questions or inquiries, e-mail SynergyInfo@s-3.com.

Timeline

June 2006

June 15-16
1st Annual African HIV/AIDS Update Conference
Organized by: Valley AIDS Council
Location: Nairobi, Kenya
This conference will facilitate an international exchange of information and ideas about the latest development in the field of HIV/AIDS and the discussion of culturally competent treatment strategies. A disease without borders demands a partnership in spite of borders. For more information, visit www.valleyaids.org.

June 15-18
12th International Congress for Infectious Diseases (ICID)
Organized by: Merck, Sharpe & Dohme Ltd.
Location: Lisbon, Portugal
This conference will bring world-renowned speakers to address issues of emerging infectious diseases and advances in diagnostic techniques. Visit www.isid.org/12th_icid for further details.

June 14-18
PLWHIV/AIDS Forum and Canadian AIDS Society Annual General Meeting
Organized by: Canadian AIDS Society
Location: Ottawa, Ontario, Canada
The PLWHIV/AIDS Forum is an excellent opportunity to network with other people living with HIV and AIDS from across Canada, to set priorities for the community-based AIDS movement, and to participate in the general business of the society. For details, see www.cdnaids.ca; contact name, Darren Fisher.

July 2006

July 17-Aug.11
10th Research Model Course in Sexual and Reproductive Health and HIV
Organized by: The Population Council
Location: Johannesburg, South Africa
Training course provides opportunities for discussion and interaction with international, regional and local facilitators who have Africa-based research experience. Visit: www.rhru.co.za/site/methods.htm or contact Sandra McIntosh at s.mcintosh@rhru-jhb.co.za for more information.

August 2006

Aug. 13-19
XVI International AIDS Conference
Organized by: International AIDS Society
Location: Toronto, Ontario, Canada
AIDS2006 Toronto brings more than 20,000 delegates to share current knowledge on a full spectrum of issues about the global HIV/AIDS epidemic. See www.aids2006.org or contact Bryan Hobson at info@aids2006.org for details.

Aug. 29-31
Pan African Health 2006 Congress Explores Accessing and Managing Funding
Organized by: Pan African Health
Location: Johannesburg, South Africa
Pan African Health is the premier African health-care congress – incorporating a conference, exhibition and the first Health-Care Award for Excellence and Innovation. The theme of the 2006 congress is Accessing and Managing Funding for Health-Care Initiatives in Africa. This will include sharing of information and experiences, reinforcing existing relationships, and staying abreast of developments in the health-care and health-care funding arenas.Visit www.panafrican-health.com for more information.

September 2006

Sept. 14-17
HIV/AIDS Sustainable Developments between North and South: Bridging the Divide
Organized by: Light of Africa NRW e.V
Location: Mettmann, North Rhine Westfalia, Germany (near Duesseldorf)
The first international conference will create fora to exchange information and ideas and to foster collaboration between social and medical health personnel with a view to strengthening and improving contributions to health development between the North and South. Go to www.bridging-hiv.de for details; contact name: Elizabeth Horlemann.

Sept. 25-26
Decade of HAART: Historical Perspectives and Future Directions
Organized by: IAPAC
Location: San Francisco, CA
On the decade anniversary of highly active anti-retroviral therapy, IAPAC is hosting a two-day historic conference where the clinical and social dimensions of HAART delivery are explored and future projections are made. Visit www.iapac.org for details; contact name: Aimee Clark.

October 2006

Oct. 1-14
18th Annual Conference of the Australasian Society for HIV Medicine (ASHM)
Organized by: Australasian Society for HIV Medicine
Location: Melbourne, NSW, Australia
The ASHM conference brings together the range of disciplines involved in HIV and hepatitis management including: basic science, clinical medicine, community programs, education, epidemiology, indigenous health, international and regional issues. For details, visit www.ashm.org; contact name: Nicole Robertson.

Oct.12-13
IAPAC European Sessions 2006
Organized by IAPAC & EACS
Location: Budapest, Hungary
The annual IAPAC European Sessions is a unique symposium that allows HIV-treating health-care professionals to learn from each other while advancing HIV/AIDS medicine toward solutions to on-going clinical questions. Visit www.iapac.org; Contact name: Aimee Clark

Oct. 25
14th Annual HIV/AIDS Update and Border Health Summit
Organized by: Valley AIDS Council, Texas
Location: South Padre Island, TX
An exchange of ideas providing a rich opportunity to gain the latest information regarding the care and treatment of HIV/AIDS. Contact: crsmith.vac@tachc.org or visit www.valleyaids.org for details.

Oct. 26-29
Scaling the Heights of HIV/AIDS Nursing
Organized by: Association of Nurses in AIDS Care
Location: Las Vegas, NV
This conference will feature the latest information on care and treatment, critical policy issues, health disparities of vulnerable populations, etc.
Visit www.anacnet.org for details; contact name: Kathy Reihl.

November 2006

Nov. 12-15
Eighth International Congress on Drug Therapy in HIV Infection
Location: Glasgow, UK
This congress is now firmly established as one of the major meetings in the international medical congress calendar, addressing current therapeutic strategies and clinical trials, and discussing future research and innovations in HIV infection. Visit www.hiv8.com for details.

Nov. 15-30
Disease State Mgmt and HIV/AIDS
Organized by: Continuing Education, Inc
Cruise from Sidney, Australia
Visit: http://www.continuingeducation.ne; contact name: Sandra Barnhart.

GlobalUpdates

AFRICA

Global Fund Suspends Grants to Nigeria

The Global Fund to Fight AIDS, Tuberculosis and Malaria suspended about $50 million in grants to help Nigeria control the spread of HIV/AIDS because the country failed to meet targets on drug access and "transparency." In a letter dated November 2005, the Global Fund pointed out inconsistencies in data provided by NACA, including the number of people taking antiretroviral drugs. At that time, NACA spokesperson Sam Archibong said the committee had made changes to its management in response to the letter. The Global Fund's board in April voted to halt two five-year grants after two years because not enough people were receiving antiretroviral drugs and there were concerns over data accuracy. According to government statistics, Nigeria's HIV prevalence decreased to 4.4 percent in 2005 from 5.0 percent in 2003.

— Reuters South Africa, April 28

African Bishop Advocates for Condom Access

South African Catholic Bishop Kevin Dowling supports the use of condom access to prevent the spread of HIV/AIDS. Dowling, who is the only one of the 30-member South African Council of Bishops to favor condom access, works in the slums of Rustenberg, South Africa. "I don't underestimate the veracity of abstinence before marriage and loyalty among couples," Dowling said, "but what about the vulnerable women who don't have that option? What about realizing that the official church in circumstances of human living does not respond to that reality?" Dowling said that he is encouraged by recent statements by some Catholic cardinals and the book "Catholic Ethicists on HIV/AIDS Prevention," which says that the church should have relaxed its ban on condoms 20 years ago.

—*The Washington Post*, April 26

Inflation Hinders ARV Access in Zimbabwe

Toronto's *Globe and Mail* examined access to antiretroviral therapy in Zimbabwe, where inflation of at least 700 percent and foreign-exchange shortages have increased the price of antiretrovirals so that even "well-educated, gainfully employed people" cannot afford to start or stay on the drugs." Interrupting ARV therapy "is not only a death sentence," but "raises the specter of a spread of a drug-resistant strain of HIV across the region," according to the paper's editorial. Tests needed to measure CD4+ T cell counts have become too expensive, and some laboratories cannot pay for imported testing chemicals. Of the 320,000 HIV-positive Zimbabweans who need immediate access to antiretrovirals, about 20,000 receive them – an estimated 15,000 of whom receive the drugs at no cost from the government. It is unclear how long the government will continue to supply the drugs at no cost. In addition, sanctions against the government of President Robert Mugabe, puts annual aid at $8 per person living with HIV, compared with $184 per person in neighboring Zambia.

— *Globe and Mail*, April 3

Religious Group Replaces ABC

The African Network of Religious Leaders Living With or Personally Affected by HIV and AIDS has developed a new strategy that aims to fight HIV comprehensively and curb stigma and discrimination. The strategy uses the acronym SAVE: Safer practices, available medications, voluntary counseling and testing, and empowerment through education and aims to replace the HIV prevention method ABC. The London-based group Christian Aid said that ABC "is not well suited to the complexities of human life," and "fuels stigma and precludes safer sexual practices" by placing people in one of the three categories.

— Catholic Information Service for Africa/AllAfrica.com, March 24

Catholic Weddings for Tested Couples Only

Burundi's Roman Catholic Church will conduct marriage ceremonies only for couples who take HIV tests and can present certificates showing the result, although the test results will not affect whether the couples can marry. "We do not demand that the fiancés show us the test results, but we demand the proof that they have taken the test and told the truth," Father Gelase Mugerowimana said. Burundi's National Association of People With HIV/AIDS criticized the announcement, saying the requirement "violates the right of the individual and threatens to counter the fight against the disease." ANSS head Jeanne Gapiya said, "The Catholic Church should play its moral role in society, but to play the police by giving orders is prejudicial to the fight against AIDS." The country had an adult HIV-prevalence rate of 6 percent in 2003.

— *Reuters Health*, March 23

ASIA

India's Goa to Require Tests to Wed

The government of the Indian state of Goa plans to require couples registering for marriage to undergo HIV tests. If either or both test positive, the couple then can decide whether to proceed with the marriage. The measure already had sparked debate among advocacy groups, who say that compulsory HIV testing cannot be imposed, and UNAIDS country director for India Denis Broun urged Goa not to require couples to be screened for HIV, saying that although 90 percent of HIV-positive people do not know their status, mandatory testing is not productive. The legislation would not require HIV tests for couples who have signed a consent form indicating that they do not want the test performed, he said.

— *Hindu*, April 1

Taboos About Sex Fuel Epidemic

The region must quell cultural taboos about sex and halt discrimination if it is to curb the HIV/AIDS epidemic, said AIDS Society of Asia and the Pacific President Myung-Hwan Cho. He said that cultural factors make preventing new HIV cases in the region particularly difficult. "Talking about sex is taboo," he said. "But we need to educate young people." Fifty percent of all people infected in Asia last year were aged between 14 and 24. He called on attorneys general and human rights commissions in the region to advocate for laws to make refusal of employment, health care and education for children based on HIV status illegal.

— Reuters UK, March 22

HIV/AIDS Increases among MSM

Although the majority of new HIV cases in recent years across the Asia-Pacific region have been reported among commercial sex workers and injection drug users, new data indicate that new cases among men who have sex with men (MSM) also are increasing. A study conducted by CDC and the Thai government finds that the prevalence of HIV among MSM in Bangkok increased from 2003 to 2005, and data from the Monitoring the AIDS Pandemic Network indicate that HIV prevalence among MSM in Mumbai, India, is 18.8 percent and 12.8 percent in Phnom Penh, Cambodia. According to HIV/AIDS advocates, some countries have disregarded HIV among MSM while others ban homosexual activities preventing them from accessing HIV prevention messages and condoms.

— *AP/Mainichi Daily News*, March 22

HIV-Positive Woman Candidate in India Denied Nomination

An HIV-positive woman, Jahnabi Goswami, who heads the Assam Network of Positive People and applied to run for the Assam state assembly said that she was denied the Congress Party nomination because of stigma and discrimination. She said that the Congress Party decided to give the nomination to the

wife of a former member of the assembly because 12 other candidates "joined hands to spread the propaganda that AIDS was an airborne disease and sitting and talking with an AIDS patient would mean transmission." Goswami said that she will take up the matter with Congress Party President Sonia Gandhi, who also chairs India's parliamentary AIDS committee.

—*Times of India*, March 21

CENTRAL AND EASTERN EUROPE

Russia to Spend $175M on Programs

Russian President Vladimir Putin asked officials to increase HIV/AIDS awareness in the country as the government announced it will allocate $175 million this year for HIV/AIDS programs. Although official figures place the number of HIV-positive Russians at more than 342,000, "some experts think it is much higher," Putin said, adding that most infections are in people under age 30. "We need to constantly explain to people the danger of catching HIV," he said. "Above all, it is important to work with high-risk groups. So far we do not have a common strategy for this." The $175 million in HIV/AIDS funding is a more than 30-fold increase over last year's allocation, and the government plans to increase the amount to about $284.9 million next year.

—*Globe and Mail*, April 24

Politicians React to Western Aid for Prevention

A group of legislators has drafted an appeal requesting Russian president Vladimir Putin to limit the activities of international HIV/AIDS groups in Russia, saying that safer-sex HIV prevention methods advocated by Western groups promote immorality. "We're buying AIDS prevention programs from countries we were at war with a few years ago," said Vadim Pokrovsky, head of the federal center on preventing and fighting AIDS. "This money would be better used to set up real structures in Russia and deal with this problem on our own." According to Mikhail Rukavishnikov, head of a private organization that supports people living with HIV/AIDS, Russian authorities see such groups as rivals. "We urge the use of condoms, while they swear abstinence is the only way to prevent AIDS," he said. Funding provided by international organizations such as the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria dwarfs that of the Russian government.

— Agence France-Presse, April 23

Ukraine Hopes To Resume World Bank Project

Ukraine hopes to resume a program funded by a $60 million grant from the World Bank aimed at fighting HIV/AIDS and tuberculosis, said health minister Yuri Polyachenko. The Bank suspended the project in April because of the government's failure to launch the program and distribute funds. The government to date has spent only 2 percent of the $60 million allocated in January 2004 to be dispersed over a four-year period. The program, targeted at high-risk groups, was to provide funds for medicines, training for health-care workers and other prevention measures. "Unfortunately these funds have not been used for the most urgent needs," Polyachenko said. "They went to buy office furniture, cars and computers." He also said that an agreement to restart the project might be reached within one month.

— Reuters, April 14

MIDDLE EAST AND NORTH AFRICA

Injection Drug Use Fuels HIV/AIDS in Iran

The growing number of injection drug users in Iran is fueling an increase in the number of new HIV cases, said Mohammed Mehdi Gooya, of the ministry of health. The country is taking steps to address HIV and injection drug use by distributing clean syringes and providing methadone treatment to heroin users under government-sponsored programs. In Tehran, the local administration is providing needles to hundreds of inmates who formerly shared syringes. According to the ministry, there are 70,000 people in Iran living with HIV and 137,000 injection drug users. The ministry also says that about 64 percent of HIV cases occurred through injection drug use, and the rate of drug use is increasing by about 8 percent annually.

— *AFP/Yahoo! News*, April 17

NORTH AMERICA

U.S. Bi-Lateral Trade Agreements Threaten Generic Access

Bi-lateral FTAs between the U.S. and developing countries are, according to some government officials and public health experts in different countries, an attempt by the Bush administration to "coax developing nations to barter away their patent-breaking rights," which allow the nations to produce low-cost, generic versions of the drugs, "in exchange for lucrative trade benefits." Under the WTO TRIPS agreement, governments can approve the domestic production of generic versions of patented drugs during emergency public health situations if they fail to reach an agreement with the patent holder. "If you prevent countries from using generic drugs, you are promoting genocide, because you're killing people," said Pedro Chequer, head of Brazil's national AIDS program. However, U.S. officials have said the intellectual property policies in the FTAs are aimed at diseases other than HIV/AIDS and that there is enough flexibility in our free trade agreements to allow our partners to do what they need to do."

— *International Herald Tribune*, April 19

California Creates Names-Based HIV Reporting

California Governor, Arnold Schwarzenegger signed a bill that implements a confidential names-based reporting system for new HIV cases in the state. The new reporting system will ensure that California does not lose about $50 million in federal funds annually for HIV/AIDS treatment. New provisions under the Ryan White CARE Act mean that states reporting new HIV cases using codes will not receive federal funds beginning Oct. 1, 2006.

— *The Los Angeles Times*, April 18

Immigration Bill Harms Africa

A little-noticed provision that addresses the shortage of nurses in the U.S. "stands to produce lasting damage" to sub-Saharan Africa, said Isabella Mbai, head of the nursing sciences department at Moi University in Eldoret, Kenya, and Eric Friedman, HIV/AIDS policy analyst for Physicians for Human Rights. Mbai and Friedman wrote that the provision would remove the limit on the number of foreign nurses allowed to immigrate to the U.S. , "accelerating the flow of nurses" out of African countries where they are desperately needed. Rather than offering Africa's health workers incentives to leave, the U.S. and other developed countries "have an obligation to help bolster wages and improve working conditions" in Africa, Mbai and Friedman write.

— *The Washington Post*, March 23

WESTERN EUROPE

France and Brazil Launch Funding Facility

Officials from France and Brazil hope to have the International Finance Facility — aiming to fund global health and development programs through an airline ticket tax and other sources — operating on an initial $300 million annual budget by September. The facility would help Africa meet the MDGs by frontloading purchase of international bonds. France and Brazil are among 13 countries agreeing to impose such a tax to fund HIV/AIDS, TB and malaria programs. The French parliament in January passed a measure that will add a tax of up to $47 on tickets for travelers departing from French airports. The other 11 countries are the UK, Chile, Congo, Cyprus, Ivory Coast, Jordan, Luxembourg, Madagascar, Mauritius, Nicaragua and Norway. The facility initially will focus on pediatric HIV/AIDS medications, prevention of vertical HIV transmission, and the costs of second-line HIV/AIDS drugs and malaria medicines.

— *Financial Times*, April 22

HEALTH AND CHILD SURVIVAL FELLOWS PROGRAM

Health and Child Survival Fellows Program (HCSFP), Johns Hopkins University Institute for International Programs, prepares junior and mid-career health professionals for careers in international health and child survival. Candidates for specific assignments are selected from a pool of applicants. All HCSFP assignments require U.S. citizenship.

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Global Health Action

In response to the HIV/AIDS pandemic in Africa, Global Health Action (GHA) provides courses to meet the specific needs of HIV/AIDS community-based organization program managers. The course provides planning and implementation tools and skills that are necessary to efficiently design, manage and evaluate HIV/AIDS prevention, care and support projects to ensure the greatest impact in their communities.

The course is divided into two parts. In the initial one-week course participants learn Communication, Human Resources, Leadership and Management, Needs Assessment, Strategic Planning, Program Design, Monitoring and Evaluation skills. Six months later, GHA conducts a 4-day follow-up course where participants discuss specific topics they have requested. This second training also gives participants the opportunity to collaborate and learn about the progress of each project as well as problem solve together.

GHA is a private, nonprofit 501(c)(3) organization headquartered in Decatur, Georgia. For 33 years, GHA has served the health needs of individuals, communities and countries through five programmatic initiatives: : Leadership and Management Training, HIV/AIDS, Women's Health and Reproductive Health, Primary Health Care and Second Generation Organizations. To date, GHA has trained more than 6,800 health and community leaders in the United States and 88 countries worldwide.

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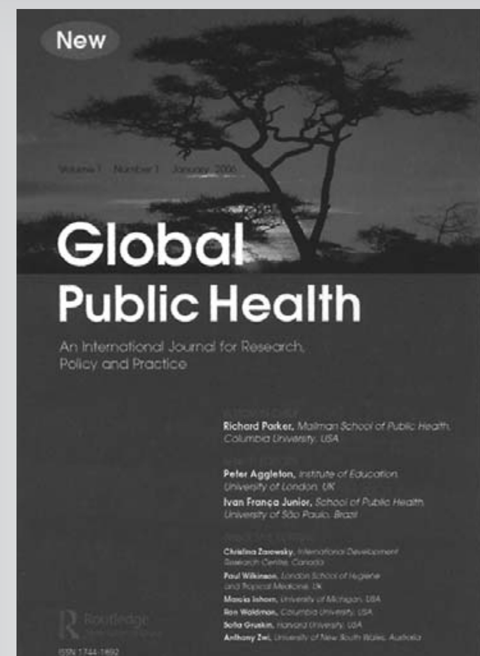

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Maladi pa tonbe sou pyebwa, se sou moun li tombe
This sickness does not fall on trees

PHOTO BY ELIZABETH WHELAR

Denizard Wilson and his wife who is HIV-positive. Both their children are infection free.

By Denizard Wilson
Thomonde, Haiti
(Interview facilitated and translated from Haitian Creole to English by Elizabeth Whelan, edited by Louise Ivers)

I was on a bus on my way to Port au Prince when I heard a woman talking badly about AIDS, spreading rumors. I could not let her say those things anymore, so I said to her, "I am infected."
She didn't believe me. "Liar," she said.
So I took my medications from my bag and held them out in my hand for her to see. Because I have this virus in my blood, I take medicine every day. I have a community health worker, who brings my medication to me every morning. Before I plan to travel anywhere, I tell my community health worker and my doctor, and they give me the pills to take with me. I explained all of this to her and the rest of the people on the bus.
"Are you lying to me?" she asked.
I replied, "You will not find one single human being who would choose to be infected by this disease. Why would I lie about this?"

Apart from the kidnapping and the political problems that we have in Haiti, there is a terrible epidemic that is sweeping through our country. Wherever I go, I try to spread this message: AIDS can touch anyone anywhere.

I am a motorcycle messenger for Partners In Health. I work in a village called Thomonde at one of their seven hospitals in Haiti's Central Plateau. I carry patient blood samples over dirt roads, and doctors send me to find patients who stop coming in for appointments, or patients who think that an HIV positive diagnosis means their life is over. I have a message for these patients, and for my family, and for everyone, infected or not: as long as we are alive and have access to drugs, there is hope.

On Oct. 4, 1993, I was diagnosed with AIDS. I had a job in an office in Port au Prince. I was making some money and advancing in my job. I started getting weak, though, and I kept getting admitted to the city hospital. I had health insurance, but it was not covering my medical expenses. Every time I began to recover my strength, I would fall ill again. At first I tried to hide my sickness from my boss. I was afraid he would fire me if he knew that I was HIV positive. But this sickness does not know how to hide.

There came a point when I had spent all my money and could not bear this virus anymore. I finally told one of my directors that I was infected. He told me about Partners In Health – that they had a good hospital in the Central Plateau with free health care. So I moved back to Thomonde, the place I was born, to be closer to the hospital. For the 13 years that I have been with Partners In Health, I have never been sick again – not the kind of sickness I had known.

My wife is also infected. We thought that my seven year old was HIV positive when she was born. At that time, there was no program to prevent mothers from giving the virus to their babies. Thanks to God, though, we know now that she is HIV negative. By the time my wife was pregnant with my second daughter, though, Partners In Health had started a program to prevent the AIDS virus from being passed from mother to child. The hospital gives us infant formula every month so that she will not be infected by her mother's breast milk. Now she is four months old, and we are waiting for the test result to see if she is infected.

There are scientists and researchers searching for drugs, and I know they will find a cure for us. That day is not far away. My community health worker used to give me three different drugs. I do not know what the medicines are called, but I know that I used to take one big pill and two small pills. Now, I only have two pills, and someday those two pills will become one. Finally, there will come a day when I will not have to take any pills at all. I know that. I feel that.

Medications have slowed the virus down, but there is no cure yet. I have a message for all the youth who are uninfected: Go to school before you enter into sexual relations. It is your right to wait until you are the appropriate age to be intimate with a partner. Do not give your body to just anybody. Before you give your body to someone, ask yourself, 'Do I know this person?

And to those of you who are infected, protect your partner. The AIDS virus is like a poison, and to give it to someone else is like a crime. I do not want to make anyone die before it is their time. Remember to keep your promise, the 2005 World AIDS Day theme. I keep my promise to my wife because I do not want to make anyone else sick. Every time you enter into sexual relations with someone, even with a condom, you are taking a chance. One decision that you make now can affect your children and their children for generations to come.

Maladi pa tonbe sou pyebwa, se sou moun li tombe. This sickness does not fall on trees, as the Haitian expression goes, but on people. I would not like for even one single living creature to become infected with this disease – not an animal, not even an insect, let alone a human being. I want to ask all the people and organizations that are supporting Partners In Health to keep helping them so that they can give more people a chance at life, like me. I ask all the drug companies to lower the price of the medications because there are thousands and thousands of people who still do not have the chance to take medicine because they cannot even afford to buy food.

On that October day when I first learned that I was infected, there is something I had not yet realized: When a person is infected, that does not have to mean that life is over. Dr. Almazor, one of my doctors, would always encourage me when I felt depressed. He would tell me that even though I am infected, right now there is someone else who is dying. There is someone else who is being buried at this moment. But me, I still have work to do. Thanks to Partners In Health and the medication they give me every day, I am alive. I have a different life, but it is life, nevertheless, and I will protect the rest of the days I have been given, thanks to God, and thanks to Partners In Health. The only way I would be scared would be if Partners In Health did not exist. As long as they are here, I am alive. And as long as I am alive, I will have hope, and as long as I have hope, I will continue to spread this message.

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