

**Reflections on  
the XVI International AIDS Conference  
Toronto, Canada  
August 2006**

**With Emphasis on the Themes of  
Equity, Leadership, Accountability, and  
Partnerships**

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## INTRODUCTION

The Ford Foundation created *The Global HIV/AIDS Initiative 2006-2010*, under the direction of Deputy Vice President Dr. Jacob Gayle. This initiative provides the opportunity to build upon the strong base of impressive work at the Ford Foundation and to develop a program for the next 5 years that will take this work even further.

One of the goals of this initiative is to enable the Ford Foundation to bring its own highly respected voice to advocate for greater action on fighting the HIV/AIDS epidemic. It is important that a strong voice be given to Ford's unique values and contributions related to human rights and social justice, social protection, gender equity, asset and community development, self-determination, and cultures of compassion.

The Ford Global HIV/AIDS Initiative 2006-2010 has four broad goals:

- Bring greater public **accountability** (to leaders and to global programs) for implementation of best practices in preventing and treating HIV/AIDS;
- Create deeper talent pools of professional and community **leaders** knowledgeable about best practices for preventing and treating HIV/AIDS; encourage leadership from developing countries;
- Ensure **equity** in access to services without jeopardizing human rights; and
- Encourage **partnerships** to solve key problems in the epidemic.

This effort has to take place within the context of an ever-changing epidemic. Specifically, the epidemic has become feminized and pauperized. As well, new prevention technologies are becoming available, and these may change the nature of prevention. Further, ARVs are increasingly available in the developing world, which creates new prevention challenges and increases demands for equity in access to life-extending treatments.

The XVI International AIDS Conference in Toronto was a historic event, attracting between 20,000 and 30,000 people from all over the world, with presentations by and dialogues with major leaders such as Bill and Melinda Gates, former President Clinton, and others. It is difficult to understand and assimilate all of the deliberations and discussions from such a large, diverse conference. Therefore, we asked a number of experts from UCLA and Columbia University to cover different parts of the conference, by topic and by region.

We prepared this report to identify some key HIV/AIDS issues relevant to the themes of Accountability, Leadership, Equity and Partnerships, as well as information that might assist with thinking about needed AIDS policy development. This report is not intended to be comprehensive, but rather a 'snapshot' of the conference focused on the Ford Global HIV/AIDS priority areas. Clearly, some important issues that were discussed or presented may have been missed, but it was not possible to cover or include everything.

We look forward to your response to this report, and would like to hear from you about issues that we failed to cover, or issues that we covered but may have failed to cover from all perspectives.

We can treat this as a blog if you like. If you send us your responses, comments, concerns, and criticisms, we will update our report and add additional perspectives. Send all comments to Tom Coates at [tcoates@mednet.ucla.edu](mailto:tcoates@mednet.ucla.edu). Thank you.

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## EXECUTIVE SUMMARY

One of the dominant stories of the XVI International AIDS Conference in Toronto was the work of foundations such as the Bill and Melinda Gates Foundation, the William J. Clinton Foundation, and the Stephen Lewis Foundation. The resources, leadership, and visibility brought to the issue of AIDS by these prominent individuals and their foundations is essential and inestimable.

Nonetheless, such a presence also reinforced the need to maintain a diversity of voices working in a variety of areas to ensure a broad and comprehensive response to HIV/AIDS. An important and historical opportunity will have been lost if technological solutions are effective at curtailing the epidemic, but the social and cultural drivers of HIV/AIDS have not been solved. The work of the Ford Foundation and others in this regard is essential and must continue.

Major issues for consideration identified by the UCLA and Columbia writing groups included the following:

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## A. ISSUES RELATED TO EQUITY

### A1. Implications of the Revival of the ‘Innocence Discourse’

Melinda Gates’ remarks at the opening ceremony placed the importance of female-initiated methods of HIV/STI prevention (and especially microbicides) on center stage. Gates’ comments were important and useful, and it was refreshing to see major leaders talking about equity, prevention, female-controlled methods, and condoms. Her willingness to advocate for condom use was important and remarkable, and the Gates’ commitment to the development of new prevention technologies, especially microbicides, is crucial.

Nonetheless, the comments regarding condoms foreshadowed several days of presentations that linked gender inequality and HIV/AIDS risks.

Gates’ choice of words revived a familiar and important discourse that was not critically examined deeply enough at the conference. The resurgence of an individualist innocence discourse brought to the fore the need to advance rights-based approaches to HIV prevention and care without falling into the trap of morality, judgment, and blame. In her appeal for politicians to support HIV prevention services for sex workers, she framed the argument around the need to protect “the faithful mother of four” whose husband visits a sex worker.

This innocence discourse, long used to set apart babies, hemophiliacs, faithful wives, and orphaned children as deserving of protection and health services, might be a way to make condoms palatable to politicians and others. However, such discourse may perpetuate stigma, minimize structural factors that affect both women’s and men’s HIV risks, does not deal with issues of marginalized populations (eg, MSM, commercial sex workers, IDU), may not address the needs of adolescents, and may do little to advance the rights of those infected, affected, and at-risk for HIV. Including these very populations, especially those living with HIV in the discourse and practice of the response to HIV/AIDS, is essential in order to frame the discussion with equity and dignity.

***How do we advance rights-based approaches to HIV prevention and care without falling into an individualized discourse of morality, judgment, and blame? How do we make people aware of the tendency to revert to the latter at the expense of rights?***

***How do we reinvigorate a discourse of individual accountability, and focus on issues like prevention for positives, without stigmatizing or blaming?***

***The impact of a reliance on technologies for women, such as microbicides, may produce the view that women are responsible for minimizing HIV/AIDS risks. The issue of how we might merge technologies with social scientific understandings of behavior remained under-examined. At the same time, there are clear opportunities to support efforts that merge the need for technologies with the need for men’s widespread participation in HIV prevention.***

***There is a need to focus on funding the ‘gap’—ie, addressing the gaps left by Gates, PEPFAR, and the Global Fund; making sure that the end of the epidemic sees a changed world as well as new technologies.***

## **A2. Women's Rights, Gender Relations, and Discourse Regarding Men**

There were new and important emphases at the conference placed on structural inequities facing women and how to adequately respond with new interventions at this level (eg, educational and economic interventions, property rights, continued legal reform). But most sessions referred to gender as a women's issue, and there were few sessions on gender relations, men, and masculinity. Even fewer sessions examined the role of racism in the exacerbation of the epidemic. Some of the discourse and research framed "problems" related to the epidemic as the fault of individual men instead of examining a system of interlocking race, class (or caste), age, and gender relations. Overall, particularly strong vilification of African men occurred throughout the conference.

Improving gender equality may go a long way toward resolving some of the most powerful dynamics of HIV transmission. It will remain important to examine the disenfranchisement that both women and men face, and to develop programs to fight structural inequities. Vigilance will be required in order to avoid the trap of individualizing problems/solutions that pit men and women against one another. A rights-based agenda can advance women's status and reduce their HIV/AIDS risks, and hence a women's empowerment agenda needs to be advanced.

However, it also remains vital that discourse and research find a more accurate way to describe men and masculinities, particularly as these intersect with race, class/or caste, sexuality, and nation, in order to take a comprehensive gender relations agenda forward. One writer for *The Toronto Globe and Mail* said, "...changing the behaviour of African men is probably hopeless." These kinds of stereotypes of men serve to entrench common modes of thought about gender instead of advancing the discussion. Men are being portrayed as vectors, unconcerned about others and spreading disease along with violence and neglect for families. Young men in particular were a neglected constituency, yet research from Instituto Promundo and others underscored that rigorously implemented interventions with young men can be effective.

The same complexity should be added to an analysis of women, where dramatic differences in their experiences are seen depending on race, class/caste, sexuality, age, and nationality.

***The issue is nuance and balance, without losing the momentum on the linkages that are being made between HIV/AIDS and the women's rights' movement (or, in South Africa, the development of "AIDS feminism"). There is a need to move toward a discussion of gender relations and masculinity.***

## **A3. The Nexus of Sexual Behaviors, Racism, and Discrimination**

Lurking just below the surface in many presentations is the belief or perception that people in certain countries or regions are more promiscuous, more callous, less empathic, or

less moral. For numerous reasons, some are framed as more damaged from their pasts and present environments than others. All too quickly, this can slide into discussions of morality, “excessiveness,” or personal responsibility. The ensuing conversations about sexuality may be too individualized (or group-based) and become a justification for racism and inequitable judgments on populations from the Global South (or inner cities of the North). Also lurking below the surface is the attitude and expectation that people living with HIV should abstain or minimize sexual activity and refrain from pursuing a full sex life, including procreation.

Therefore, the need remains to better understand sexual behaviors and sexuality in diverse populations as well as the needs of sexual minorities, especially in places where discrimination, stigma, and legal sanctions are practiced. For example, MSM are still left out of surveillance categories in several locations, epidemics are often framed as “heterosexualized” and “gendered” while numerous men are MSM or MSMW. Where epidemics are “heterosexualized,” we lose sight of the meanings of men’s behavior, lose sight of constraints and enablers on men, and drift into discussions of “excessive” sexuality. There needs to be a renewed focus on adolescent sexuality and prevention that moves beyond current areas of polarization (eg, abstinence, comprehensive sex education, dangers or fears about sex, how to be sex positive). Attention is needed to examine decriminalizing sex work and injecting drug use. We also need to more fully understand desires and intimacy needs among people living with HIV.

#### **A4. The Need for Concrete Programs on Stigma and Discrimination**

The words “stigma and discrimination” were used with great frequency at this year’s event, but there was little clarity about how to specifically describe, operationalize, and change stigma and discrimination--particularly beyond the individual level. It remained clear that much work will need to be carried out in order to scale-up and accelerate the reduction of stigma and discrimination at the community and national levels. Much of the work lacked specificity on how to identify these trends, how to break them into recognizable features of social systems, and what, precisely, to do about culturally specific trends.

***Considerable work remains to be done to de-link sexual behavior with promiscuity, to put forward a discourse of sexual behavior that is less laden with morality, and to accurately depict various risk factors for HIV.***

***Not enough work was presented on men’s sexual and reproductive health needs, anti-domestic violence work in these settings, or men’s sexual and reproductive health (SRH) or HIV/AIDS prevention needs at refugee sites.***

***Further, stigma and discrimination are felt by many and are real. Nonetheless, discourse about them is often very general and non-specific, and solutions to address them are lacking. The links between stigma and discrimination and sexuality, and a general inability to address sexuality, should be addressed.***

## **A5. Addressing Structural Inequalities to Alleviate Gender Inequality, Poverty, and HIV/AIDS**

The feminization of poverty and the feminization of HIV/AIDS have converged globally; the face of HIV/AIDS is now that of a woman from the Global South. Numerous presentations featured the ways in which women's cultural and institutional inequalities are entrenched, relative to men. Hence, institutional approaches that improve women's "empowerment" were emphasized as an avenue for solutions, such as access to education and income-generation activities. At the same time, several presentations underscored that access to an institution does not mean equality within it. For example, if girls gain access to schools, are they safe within these environments or do they receive harassment, intimidation, or face pressures to have sex in order to cover their school fees? Several presentations showed that both situations (lack of access and inequality within a system once accessed) are occurring.

The conference did little to resolve these basic tensions. At the same time, very few sessions focused on men at all, and a gender-relations perspective was often not fleshed out. Little work has been done on:

- a) men's over-conformity to narrow definitions of masculinity that may hurt both men and women (referred to as "costs of masculinity"),
- b) men's structural marginalization or destabilization, and
- c) linking these to HIV/AIDS (are there, for example, structural interventions for men?)

Numerous talks addressed how women's lower levels of education, disproportionate responsibility for household labor, child care, and in-home health care, coupled with a disproportionate experience of poverty and economic dependence, leads to gender-based power differentials that make safer-sex negotiations difficult. This is exacerbated by high levels of violence against women, one of the variables found to be strongly associated with high rates of HIV. Almost no work discussed the complex "root causes" of gender-based violence.

Young women are disproportionately affected by HIV/AIDS—several presentations emphasized that girls from numerous countries have older male sex partners who help them to pay for school fees, clothing, food, or who may work on their families' homes. At the same time, men in their thirties were particularly at risk.

Cultural norms about masculinity and femininity are not insurmountable and can certainly be changed. Forty years ago, almost no men attended the birth of their children, whereas now this has become normative in many settings. The few sessions offered on men mostly featured men as violent, sexually aggressive, abusive, and disinterested in their families. At times, men were also framed as gatekeepers who would "let" women make certain decisions or as those who stopped women from seeking treatment. Examples from sessions also included men who beat their wives or partners when women said no to sex, or men who were viewed as authorized to abandon wives if they didn't follow male authority. Men were only marginally discussed as being involved in the care of sick children or orphans or involved in the protection of children, families, and partners. While links between masculinity, violence, and authority may be real, the concept of masculinity was presented only as a singular form and without consideration for masculinities in the plural. Furthermore, few works attempted to understand

male sexuality and respond to men's economic and social destabilization while simultaneously seeking an agenda of gender equality.

***The IMAGE program (Intervention for Microfinance, AIDS, and Gender Equity) is highly innovative. It integrates income-generation activities with antiviolence work and gender-equality work more broadly. This is the first randomized controlled trial that seeks to shape women's empowerment on multiple structural variables that shape HIV/AIDS vulnerability. The program appears to have significantly lowered domestic violence rates and led to numerous anti-violence protests, but the impact on reductions in HIV/AIDS rates or safer sex is not yet known as the main publication is still under review. This program is in Limpopo Province, South Africa and is a collaboration between RADAR (Rural Aids Development and Action Research) Wits, the London School, and SEF (Small Enterprise Foundation).***

***It is important to note that cultural norms about sexuality can be changed—and we need to continue to press forward to change cultural norms of masculinity and femininity.***

***Mainstreaming gender equality and women's human rights into the "3 ones" is being emphasized now, particularly by UNIFEM, UNAIDS, and others. How this can be merged with accountability and leadership will remain to be seen.***

Actionaid and the Association for Women's Rights in Development (AWID) point out in reports released at the conference that funding to promote gender equality is extremely scarce. In their study "Where is the money for women's rights?" AWID reports that, "gender equality goals tend to be represented in overall legal and policy frameworks but 'evaporate' at the level of budgetary allocations, implementation, evaluation and measuring of impact". The authors point out that funding for gender equality represents only 3.5% of all development aid distributed in 2003, and that more than half the organizations that participated in the study receive less funding than they did five years ago—and this in the midst of an HIV&AIDS epidemic driven in significant part by gender inequalities.

***Structural inequities are pervasive and real, yet also difficult to change. Promising interventions on education, income-generation, and property rights need further development. Implementing and evaluating programs designed to redress these structural inequities and others (race, economic contexts, migration movements, and war) are also needed.***

## **A6. Integrating Sexual and Reproductive Health (SRH) with HIV/AIDS**

Several sessions began with a personal narrative of an individual who is HIV-positive, has children, has further fertility desires, goes to a clinic to pick up their ARVs for treatment at one location, has to travel to another location for family planning services, and has to find

another separate service area for children's needs. Hence, there are two clear tasks: 1) integrate HIV/AIDS prevention, care, and treatment into SRH and 2) integrate SRH into HIV/AIDS prevention, care, and treatment.

The intensification of linkages between SRH and HIV/AIDS is not simply a service issue but is at the core a policy and program issue as well. These linkages are complex and involve family planning, maternal and infant health, management of STIs, and management of other SRH-related issues on the one hand, and HIV/AIDS prevention, treatment, care, and support on the other. Areas where key linkages need to be made include VCT, the promotion of safer sex, STI management, tending to the SRH of PLWH/A, tending to the primary health care of PLWH/A, integrating HIV/AIDS prevention and care into maternal and reproductive health, examining SRH and safer sex between discordant couples, and optimizing other connections between HIV/AIDS and SRH (eg, gender-based violence, female condoms).

***While stronger linkages are thought to automatically lead to public health benefits, it is difficult to ascertain which linkages will have the most impact or how to best strengthen linkages that are being attempted. Nonetheless, the needs of key populations should be kept at the center.***

***The example of the health care system telling HIV-positive women not to have children, while local communities and families pressure women to have children in order to be "real women", reveals a very real clash between institutional and familial/societal values.***

There are numerous areas of contention when examining the intersections between SRH and HIV/AIDS. Some of these include:

- 1) Should testing or disclosure be mandatory?
- 2) Rights of marginalized groups to have a safe and satisfying sex life, whether HIV positive or negative
- 3) The rights of PLWH/A or other marginalized groups to have children
- 4) Decriminalization of sex work
- 5) The fact that there is less than 10% coverage of ARVs for mother-to-child transmission
- 6) Some on the sexual and reproductive health side of the continuum were angered by a lack of funding (which HIV seems to so readily receive)
- 7) Some on the HIV side of the continuum felt that SRH has not been comfortable enough addressing violence against women, female condoms, economic empowerment of women, and other issues that are common to both sides, and now funds have to be "shared." Clearly, there are both substantive and resource issues involved and the resulting synergies should continue to be explored.

In addition to the above policy and program issues, there was also a research framework presented on integrations between SRH and HIV. Dimensions of "unmet needs" (macro-human rights) (micro-services), "supply and availability of services," and "service use" were examined on one axis while "types of research available" and "types of research needed" were on the other. It was argued that there is a "hidden evidence base" already available as to how effective it would be to integrate SRH and HIV (eg, integrating VCT into SRH, or family planning use into the PMTCT programs or family planning integrations with VCT programs). Even where there is evidence for benefits, this may not be enough given the resistance of some to this agenda. The

implications of furthering this research agenda are important, since this involves issues such as identifying key efficiencies in this integration; examining the barriers and facilitators to a successful integration; and examining short- and long-term health outcomes, costs, and voices of client satisfaction. Policy reports can be developed that could assist institutional and national level plans.

**Innovations and policy implications within this theme were numerous, for example:**

***Support for legal and policy reform to remove barriers to young people's access to forms of HIV testing and counseling***

***Develop policies and programs that support dual protection***

***Advocate for the investment in STI management as a strategy to reduce HIV transmission***

***Develop policies to provide HIV/AIDS care and treatment for numerous groups***

***Leverage reproductive health and HIV/AIDS work at the national policy level with the help of the law***

***Ask ministries of health to work more closely with national AIDS control groups to assure that these important integrations receive support***

***Support policy development on comprehensive safer sex services for young men and women, PLWH/A, and other populations***

***Ensure that programs and national-level plans for integrations have meaningful participation of PLWH/A***

***Health care workers could ask, "Do you have sex with men, women, or both" (speakers underscored how this would also not be terribly disruptive to heteronormativity). This could help to avoid alienation of individuals entering the health care system who fear stigma or discrimination and who need services. At the same time, the protection of rights and sensitivity/care are needed given the stigma/discrimination associated with revealing such information.***

***Ministries of Health are being asked to collaborate at the intersection of SRH and HIV in a variety of ways. In Kenya and Colombia, the MOH is now offering ARVs to family planning clinics***

## **A7. Macroeconomics and the Consequences for HIV/AIDS**

Researchers, NGO leaders, and IMF representatives found themselves in an unusual position when they appeared on the same panels at this conference; hence, heated exchanges

occurred. Structural adjustment programs were largely framed as being dictated from the North to the South, with considerable implications for the status of recipient populations, the economic health of recipient countries, and the physical health of their populations. The IMF felt that the “macroeconomic health” of economies would be put at risk if enough care was not put into thinking about the long-term, while trying to address the short-term needs of the epidemic.

Researchers explained that when governments spent much of their money repaying IMF and World Bank loans, governments were constrained into cutting back on their educational, health care, and other systems. Wages in the public sector were cut, and public service employees tended to flee this sector from burnout and in search of higher wages that they could earn elsewhere.

Gender inequality was described as often (although not always) worsening when countries shift from more to less resources; this is what many countries experienced when HIV became a significant problem.

The IMF and World Bank have struggled to address the need for economic reforms while also responding to the worst pandemic in history. Economists in the audience pointed out that the IMF and World Bank use assumptions of full employment, wellness, and greater capacity in systems (for example health care) when making economic policies, and that these are not necessarily relevant to countries that are facing different circumstances.

***Several argued that the IMF needs to be challenged. Do the standards that come from the North and are imposed on the South (eg, what level of inflation is acceptable? where should money be spent? etc) seem reasonable when the epidemic is raging, the health care infrastructure has collapsed, people are fleeing the country to find higher wages, the age structures are changing (eg, life expectancies), and the populace is not able to adequately tend to its citizens?***

***Poverty and AIDS advocates need to work in concert with one another in order to adequately and creatively engage powerful institutions like the IMF and the World Bank. Development plans must be integrated with HIV planning. Importantly, governments’ adherence to international standards and guidelines should be monitored.***

***Can the IMF or the World Bank become more flexible in their frameworks to inject new funds into the fight against AIDS? NGOs asked if HIV could be viewed as not only something that affects the “social sector,” but something that affects the “productive sector”, such that resources can be allocated differently to the fight against HIV?***

***Why has debt forgiveness proceeded so slowly in structural adjustment and retrenchment programs? This could potentially help countries allocate resources where they are most needed.***

## **A8. Rights-Based Approaches to Reducing Social Inequity for Marginalized Populations**

Many sessions centered on how numerous groups face criminalization, feared or actual stigma, discrimination, harassment, and poor treatment in or lack of access to health care systems. Many sessions underscored how the health care system either refused or delayed

access to health care, prevention, treatment, or reproductive health information or services. Simply put, those who are HIV-infected often stand at the intersection of multiple social locations (eg, drug user, poor, woman, sex worker, transgendered, MSM, MSMW) that are viewed as “undesirable,” and there are frequent violations of the health and human rights of the above groups.

Forced drug detoxifications, forced sterilizations, police harassment, abuse, and even torture were examined within marginalized groups that included:

- HIV-infected persons
- HIV-infected women who are pregnant
- Women
- Children and orphans
- Youth and adolescents
- IDU
- MSM
- Sex workers
- Mobile populations and displaced refugees
- (Racialized rights and heterosexual men not often mentioned)

**Sex Work.** Sessions powerfully underscored that prevention work can serve to increase stigma without emphasizing rights. The infamous example of Thailand’s “100% condom-use” structural intervention reveals how sex workers’ voices were not featured at all in what is widely hailed as a successful prevention intervention. Presentations featured sex workers as mobilizing for themselves instead of being framed as a public health threat that has to be monitored and controlled.

***Mobilization of sex workers from a rights-based perspective was a strong theme at the conference. This is a much needed emphasis, given that sex work stands at the intersection of state apathy, stringent immigration policies, abuse on the job, the right to sex work, and an allowance to use oppressive arms of the state to raid and use forcible detention.***

India was highlighted for how some of its NGOs are working with sex workers, third gender groups, and men who have sex with men in a way that is much more involved with communities than government approaches. These efforts remain smaller in scope and are the minority of the groups trying to do this work. One example of “what works” was from Astha (FHI program, funded by Gates) that works with female and transgender sex workers in Mumbai. They have developed, promoted, and distributed a condom-based prevention effort based on the feedback of the sex workers themselves.

***Government efforts would be greatly improved if they worked with advocacy and activist groups, incorporating the ideas and needs of these groups into programs instead of attempting to intervene with these populations from the top-down.***

Commercial sex workers in China and Vietnam are sent to rehabilitation programs that are about “re-education,” which is often under-girded by individual or societal morals. There were examples mentioned of sex workers (mostly female) who were mixed into rehabilitation camps with male drug users (albeit separately but they reportedly find one another). Such situations—when high seroprevalence groups have contact and are then released into the general population—can fuel an emerging epidemic. Community groups were described as racing (and creatively attempting) to reach these groups upon release. U.S. anti-prostitution policies are likely exacerbating the problem, as they prevent funds from being used to assist these groups.

**War, Refugees, and Displaced Populations.** There are more than 37 million people who have been displaced by war, and many of these displaced persons either reside in refugee camps in their own countries or are end up in neighboring countries (eg, those from southern Sudan are in Kenya and Ethiopia). Women and children constitute 65% of all displaced persons worldwide. In addition to needs for food, shelter, and health care, there are numerous sexual, reproductive health, and HIV/AIDS prevention, care, and treatment issues that need to be tended to in these settings. HIV can thrive in these areas, but paradoxically, some researchers reported that conflict can sometimes be protective, given that it can keep people sequestered in lower-risk settings. Depending on geography, however, conflict can also lead to a situation where individuals from a higher seroprevalence area become refugees without access to condoms, and then return home to exacerbate an epidemic in a lower seroprevalence area.

There were many reports of an escalation of violence against women in refugee camps, rape as a tool of war, the need for emergency contraception, and low condom availability.

***While NGOs have made some progress on providing a basic HIV/AIDS prevention toolkit in several locations, and good progress had been made on starting to reduce rates of maternal mortality in certain refugee camps, much work remains on this front.***

***Simple governmental modifications can help mobile populations. Currently in several countries, internal migrants can register in only one province to receive health care; when they migrate they lose access to the health care system. More flexible registration procedures are needed within and across regions.***

***In refugee settings, minimum service packages were put forward in several locations for sexual and reproductive health, but these need to be better merged with HIV/AIDS prevention, treatment, and care. The minimums covered were 1) coordination plans to prevent patchy access to services, 2) decrease excesses in maternal and neonatal mortality, 3) minimize HIV/AIDS risks, 4) attempts to prevent sexual violence, and 5) planning for more comprehensive services as the situation permits***

***Governments need to press for more fair and just immigration policies, and not discriminate against HIV-infected persons***

**Orphans and Other Children Infected and Affected by HIV.** Children have tangible rights based on the Convention on Child Rights signed in 1989 and the 1947 Universal Declaration of Human Rights. There are approximately two million children who are infected

with HIV/AIDS and 90% of all children with HIV live in Africa. There are approximately 15,000 new HIV infections among children every day. Children with HIV have rapid disease progression and early death. The issue of orphans and children who are infected and affected by HIV is one that is truly overwhelming in scope and magnitude. By 2010, approximately 20 million children may be left as orphans in Africa alone and Africa is the only region in the world where orphans and vulnerable children (OVC) are increasing. Overall, the estimated number of OVC worldwide is 39 million. Only around one quarter of these children are receiving *any* form of support services. Even though Africa has been hardest hit, Latin America, Asia, former Soviet republics, and the United States also have large numbers of children whose parents have died from HIV/AIDS. The conference offered vital research, policy, and practice implications.

The mental health, social, and economic impact on children when they lose a parent is significant, and sessions highlighted the following consequences: economic hardship, psychological distress, stigma and discrimination, withdrawal from school, lack of love and affection, increased risks of HIV infection and other illnesses, and loss of inheritance money or property. At the same time, many countries still have no national policy to face the growing needs of children and orphans

***Children should be treated at higher standard because they need adult assistance to survive. There is also a need for increased funding to go to child-related organizations.***

***Various international agencies have responded to meet the needs of OVC and have devoted significant resources to strengthen the capacities of communities and families. However, not enough of these programs are community based, most are relatively new, and little attention is given to orphans and children in development agendas and donor programs.***

***Little is known about how efficacious current programs are, and many are not set up to face the longevity and scope of this crisis. Community-based programs have produced literally thousands of possibilities, but there little opportunity for scale-up.***

***Some future goals include: 1) extending the lives of parents, 2) strengthening families and communities, and helping them mobilize in order to protect and care for orphans and other children affected by HIV/AIDS, 3) keeping children in school, helping families economically, and protecting children from abuse, 4) reinforcing the need for government to protect the human rights of children and to improve access to services, and 5) reconsidering the tendency to view work with orphans as mitigation, and consider HIV prevention, survival skills, and skill-development for young people and adolescents.***

**Children with HIV and Access to Care.** Pediatric ART coverage was <3% in 2003, and now ranges from 1%-28% (highest rates of coverage are in Côte d'Ivoire, Namibia, Sudan, and Ghana). Prevention of mother-to-child transmission (PMTCT) coverage is <10%. ART expenditure estimates are \$200/child to provide services. Generally (for adults and children), ART "pay" programs are associated with nonadherence, and free ART access is associated with better adherence, higher probability of sustained viral suppression, and lower mortality. The data on the efficacy of treatment in children is very good. Observational data thus far (many examples were presented at the conference) show excellent immune recovery with ART, and mortality in children after the initiation of ART is generally much lower than what is seen after the initiation of ART in adults (Botswana-Baylor experience is 7% mortality in the first three months and 1% thereafter. The Thai experience revealed a 95% survival at 6 months with high

hospitalization rates early in treatment). Issues of pediatric adherence were also examined. One African study showed 19% of children had serious nonadherence and one-third of providers reported missing doses of ART in their child dependents. Reasons for nonadherence were numerous and were related to conflicts between parents or caregivers, multiple caregivers, child-headed households, and poverty.

***Incorporating family-based VCT into primary health clinics and VCT sites can be an important strategy that can identify women and children with HIV. Joint partner testing and education could be a way to identify “families” with HIV—perhaps shared testing and notification could help to prevent partner violence and stigma and improve within-family support, particularly in the immediate post-test period.***

**Men Who Have Sex with Men (MSM).** In the face of the overwhelming HIV epidemic in Africa and other parts of Asia, it is easy to forget that MSM are the majority of infections in many parts of the developed world, as well as Latin America and other regions. There are significant unmet needs for MSM in parts of Asia such as China and Thailand, as well as MSM commercial sex workers.

In the area of HIV prevention there are numerous challenges in addressing the wide range of needs experienced by vulnerable populations, particularly when there are significant structural and societal barriers to being able to work with these groups. One example includes the HIV prevention challenges facing MSM. Innovative strategies and partnering have shown some success in developing much needed prevention programs in this setting. Significant barriers to effective prevention outreach include a lack of inclusion in surveillance categories, the “criminalization” or marginalization of MSM, transgender, gay, lesbian, bisexual and culturally-specific categories (eg, *hijiras* in South Asia), the broad lack of awareness of HIV issues, lack of condom availability and normative use, police harassment, assumptions that WSW are not at risk, homophobic violence, and lack of protection under the law.

***One of the strongest approaches in dealing with sexual minorities like MSM is the support of regional or global partnerships. Solidarity across borders and continents can often strengthen movement and change. See the section on Partnerships (D6) for more on this issue.***

***Vigilance also needs to be maintained regarding legal and other reforms essential to protecting MSM and MSMW (men who have sex with men and with women).***

**Injecting Drug Users.** Needle exchange is evidence-based prevention and irrefutably helps IDU avoid blood-borne pathogens. Yet many nations do not offer or allow needle exchange or methadone programs. In the Russian Federation, IDU do not even receive post-test counseling. ARVs are not freely available to IDU. As the youth IDU plenary speaker eloquently said, “Drug users have a right to live. They need methadone.” Ending the criminalization of drug users and seeking their meaningful participation in programs and policies are high priorities.

People with HIV need considerable legal assistance in determining what their rights are in terms of access to care, treatment, government disability support, and government income support. Groups that helped individuals to do this in Canada remarked that people are not often aware of what they can even expect to fight for. Similarly, other sessions featured “community justice workers”, community members who inform their constituents about their legal rights under the constitution and the availability of access to care and treatment. Issues such as HIV/AIDS are not isolated and are often linked to requests for assistance with domestic violence and other concerns.

Marginalized groups do not simply experience stigma, discrimination, and oppression, but also internalize it. Changing group consciousness will remain important to shaping the will to resist, fight, live, organize, and seek one’s rights. This is consistent with work that will be mentioned below in the accountability section (and above, in examining the mobilization of groups for rights) that examined the concept of *conscientização* (put forward at a 2005 Nairobi think tank where GIPA principles were discussed): it is the process of achieving a deeper awareness of sociocultural forces that can result in action and change.

***Rights-based approaches to prevention, treatment, care, and support are vitally needed. Governments could be better advised to either decriminalize sex work or reconsider sending individuals to rehab (particularly without drug or HIV treatment) with few alternatives for income generation, alternative employment, and survival.***

***As stigma and discrimination (actual or perceived) are real for people living with HIV, equal rights in all domains of society must be front and center in all prevention and care initiatives, including the right to full sexual expression and family planning.***

***ABC movements (“Abstinence, Be faithful, use Condoms”) may be undermining progress that has been made, particularly in HIV prevention and rights for women, sex workers, and youth. Policy analyses and accountability for unintended consequences of programs is needed.***

***Fighting gender-based violence, including violence against transgender populations.***

## B. ISSUES RELATED TO LEADERSHIP

### B1. Sustaining the Leadership Response: De-Exceptionalize but Re-Politicize

Dr. Peter Piot underscored the need to de-exceptionalize yet re-politicize HIV in order to maintain its status as an international health and human rights priority and to ensure a commitment to planning and allocating resources for the next 25 years of the epidemic. He advocated for sustained resources for universal access to treatment and global commitment to funding evidence-based prevention services. Thus, he emphasized the need to re-politicize, and rejuvenate meaningful political leadership and commitment to the fight against AIDS. The imperative is to move from crisis mode to one of sustainability.

***The discussion on de-exceptionalizing HIV (as is planned in South Africa) needs to be advanced with regard to opt-in vs. opt-out VCT. An empirical study on this has also started in Uganda.***

***How to re-politicize? What will engage politicians at this stage of the epidemic? This relates to the following point about accountability.***

***Funding and Human Rights (Equity and also Accountability): Funding for interventions and programs that already work, including putting what works into the hands of those that need them (ARVs, female condoms, male condoms, education, VCT, etc); ensuring the human rights framework for prevention addresses the human rights violations involved in denying access to prevention and treatment services.***

### B2. Universities Need To Take Leadership

The role of universities, especially in sub-Saharan Africa and other countries where HIV is highly endemic, can be bolstered so as to mount effective prevention and care programs that will protect the next generation of leadership within these countries. Universities are the source of leadership for government and business. Two issues are paramount—the first is that students are given maximal protection against HIV while at university; the second is that they learn about HIV from economic, business, government, medical, and international perspectives.

### B3. Religion: Unites and Divides

The role of religion and communities of faith in the fight against HIV/AIDS remains a fertile area of development. The emphasis in some sessions was placed on how religion can bring people together, produce communities of compassion, care, and service, rather than judge or separate. Religious leaders and the role of religion in influencing HIV norms, stigma, and discrimination were discussed at length.

The reliance on the concepts of moral right and wrong, which can intersect with systems of inequality, were somewhat predictable, however the strengths of religion were also discussed

—how faith-based and religious groups can be quite adept at accepting ‘sinners’ and showing compassion. The need to add nuance to the discussion of religion and to reframe the arguments about religion without falling into an innocence/blame discourse were both clear.

#### **B4. Business Needs to Step Up Where Government Does Not or Cannot**

The need for various civil sectors, and especially business, to step into leadership roles to continue to push the response was resoundingly clear. Business involvement in HIV/AIDS activities can occur at several levels. Industries and businesses can adopt policies and recommendations regarding HIV/AIDS in the workplace. They can spearhead treatment initiatives and routinely offer prevention and diagnostic services, such as voluntary counseling and testing, in the workplace and in communities. They can examine policy, economic, and structural barriers and facilitators to prevention and care, and engage in structural changes to produce better health outcomes. They can act as leaders in advocating for similar businesses or their suppliers to adopt workplaces policies and programs. They can engage in philanthropy that might stimulate and support government programs, provide pilot grants to initiate programs and research, build facilities and structures, or promote programs that governments or other funders might avoid. Many have argued that business should be encouraged to:

- a. Take leadership and join with advocacy groups in moving government toward effective testing, prevention, and care services;
- b. Convene to explore “corporate social opportunity”, and learn from organizations that have used HIV/AIDS in this way;
- c. Develop, export, and sell products, skills and services that will provide more efficient testing, prevention, and treatment;
- d. Lead the way in teaching public sector workplaces how to devise, implement, and evaluate testing, prevention, and treatment programs;
- e. Implement supply-chain strategies to encourage HIV/AIDS programs among suppliers.

***How do we engage African universities to lead the way in protecting the next generation of leadership in their countries?***

***How can religion unite, not only providing compassion for the sick but also prevent infection?***

***How can business be more engaged to lead the way in providing solutions and resources?***

***Is there a role for religion or business to help fight structural inequalities and not only work in the realm of values and services?***

#### **B5. Where is the Implementation Leadership?**

The conference was characterized by the omnipresence of very high-profile celebrities and former political leaders, most prominently Bill Clinton and Bill and Melinda Gates, and also

Stephen Lewis. Bill Gates' priorities were centered on researching and developing new technologies such as microbicides, oral chemoprophylaxis, and vaccines.

Striking in his discussion was the startling lack of attention to the behaviors and social context within which these behaviors will occur, as well as HIV prevention technology and methodologies which are known to work, yet remain unavailable to the vast majority of those who need them – VCT, prevention of mother-to-child transmission, male and female condoms, needle exchange, drug substitution therapies, and universal access to ARVs. Evidence abounds for the effectiveness of these interventions, yet these remain largely unfunded, out of reach, and orphaned by unapologetic funders for a wide variety of reasons (politically unsavory, logistically difficult, or perceived to be the remit of national governments, who may or may not have the resources to implement them). The Bill and Melinda Gates Foundation's commitment to HIV is undoubtedly the largest private funding source in the area, but questions remain about the foundation's accountability and ability to critique and receive criticism of its own work. The chief concern is of a leader in the sphere of HIV/AIDS who is answerable to no one.

## **B6. Who is Preparing the Next Generation of Activists?**

Grooming the next cadre of leaders from the community of PLWH/A, activists, and youth was an important concern, and youth voices were heard at plenaries and sessions on sexual and injecting harm reduction. However, the need to invest in and focus on youth could not be overstated. In particular, the need for mentorship and capacity building of youth to become the leaders in the sustained response to HIV is great. Youth in many settings face the highest incidence of HIV, thus their participation and leadership is essential.

***How do we ensure that leadership is as focused on implementation as it is on innovation?***

***Foundations (eg, Clinton, Gates, Ford, and others) have emerged as the leaders in HIV/AIDS innovation in many different spheres—science and technology, drug engineering and patent rights, drug distribution, prevention, as well as gender, human rights, legal advances, and the rights and needs of minorities. How do we ensure that foundations are working together? How do we guarantee that innovation continues? How do we make sure to include the voices of community and countries among these giants?***

***How do we ensure that a new generation of AIDS activists are stimulated and educated in the most effective strategies of AIDS activism? How can activists from around the world be linked and learn from each other?***

There should be a concerted effort to document the history of PLWH/A activism and involvement in civil society. Such a history can serve to inform and help to develop new leadership from among PLWH/A, which is a priority.

## C. ISSUES RELATED TO ACCOUNTABILITY

***There is the need for an overall system of accountability, scale-up of evidence-based prevention programs, promotion of youth involvement, and a re-focus on drivers of the epidemic, such as poverty, gender inequality, war and conflict, migration movements, and others.***

### **C1. The International AIDS Conference: A Missed Opportunity to Address Accountability?**

Lawrence Altman, MD, writing in *The New York Times* on September 12, 2006, quoted Dr. Richard Horton, editor of *The Lancet* in saying that, “The organizers [of the AIDS conference] wasted a superb opportunity...to create a tool to chart success and to identify catalysts of change or obstacles underlying failure.” Dr. Altman writes that, “The conference was the first major AIDS meeting since June, when United Nations member countries, in a General Assembly meeting, committed themselves to providing universal access to comprehensive prevention programs, treatment, care and support by 2010.” He quotes Dr. Horton further, “But the opportunity to produce a roadmap to reach the 2010 target of universal access was squandered. Rarely has there been a meeting that felt so disengaged from a global predicament of such historical proportions.”

“AIDS conferences should become a global accountability mechanism to monitor country progress, to hold all parties accountable for the part they play in defeating AIDS, and to set specific measurable objectives for discussion at future meetings.”

***Altman and Horton make a compelling point. What are potential global accountability mechanisms? How can we work with IAS to explore this plan? How should this idea or other accountability ideas be taken forward?***

***Accountability of hegemonic funding bodies and programs; accountability of governments and businesses, as well as international agencies that gain credibility and good will from implementing programs; need for inclusiveness and transparency.***

***There is a need for accountability to and by affected communities and civil society.***

***Regulatory reforms regarding access to medications and diagnostics need to continue.***

### **C2. Accountability to a Commitment to Protect Self, Partner(s), Family, and Community**

***At the Bangkok AIDS Conference, Kofi Annan called for personal responsibility. This language frames the discussion in too much of an individualistic framework, and can***

***inadvertently reinforce stigma and discrimination. We propose changing the framework from one of personal responsibility to one of a discussion of accountability—to a commitment to protect self, partner, family, and community.***

### **C3. Donor and Recipient Governments Both Need to be Accountable**

Governments that receive large flows of public and private international resources to support HIV/AIDS programming are finding themselves somewhat, if not completely, relieved of responsibility and accountability for long-term commitments for HIV prevention and care.

In parallel, in *The Lancet* “Red” issue, Jim Yong Kim reviewed Alex de Waal’s book *AIDS and Power*, and related it to the importance of the WHO ‘3 by 5’ initiative. Despite many governments failing to meet the explicit target, the mere existence of the target “jolted many of them into action when faced with an outcome that would be measured and reported for all the world to see.” The accountability to the target, irrespective of its unfeasibility for many ministries of health to attain, meant that “3 by 5 was the first time that anyone had held them accountable for an HIV-related outcome. Governments had become very good at HIV-related process, such as high-level meetings and declarations of commitment.”

***While the greater involvement of big business, billionaires, and politicians is to be applauded, how can we ensure that this does not give government the opportunity to say that it can lessen its role?***

***How can we ensure that bigger government, business, and philanthropic involvement does not diminish the need for individuals’ commitment to themselves, partners, families, and communities?***

### **C4. Accountability for Resources and Their Disbursement**

As Peter Piot repeated, targets, timeframes, and accountability are the lynchpins of success. Monitoring across sectors will help to ensure that resources and activities are coordinated with common goals and objectives, and that contributions made by sectors can be measured and documented. The need for accountability for resources, and the way they are spent, requires rapid scale-up of monitoring and evaluation (M&E) and must be results-oriented with indicators specific to HIV/AIDS in order for them to be relevant and useful. Scale-up of effective interventions and programs depends on the ability to quantify and measure their components and results. In addition, HIV/AIDS monitoring and evaluation should be integrated into existing M&E frameworks, which may be challenging in practice.

In many cases, HIV resource needs are expressed as a proportion of countries’ GDP. For example, in Malawi HIV resource needs are estimated to be 15% of GDP. In Liberia, HIV

treatment would theoretically consume 100% of the health budget, as compared to 10-40% in many sub-Saharan African countries. There are unquestionably very difficult decisions to be made with regard to HIV/AIDS-related spending. For example, there is a trade-off in the potential for inflation from macro-economic policies supporting fully funded HIV programs, as opposed to the devastating consequences of an unchecked epidemic. At the same time, changes to the assumptions that undergird current macroeconomic policies and modifications in these policies can be made (see section on Equity).

Many speakers acknowledged the tremendous impact that President Bush's PEPFAR initiative has had on increasing access to treatment. At the same time, the ideologically driven restrictions, regulations, and proscribed "ABC" approach of the Bush administration's PEPFAR initiative have long engendered resentment and frustrations amongst AIDS activists. Stephen Lewis, UN special envoy on AIDS, was one of many who gave voice to this frustration, saying in the closing plenary, "Abstinence-only programs don't work. Ideological rigidity almost never works when applied to the human condition. Moreover, it's an antiquated throwback to the conditionality of yesteryear to tell any government how to allocate its money for prevention. That approach has a name: it's called neo-colonialism." Well-known Ugandan HIV-positive activist Beatrice Were from The AIDS Support Organization (TASO) spoke with a similar sense of outrage in a plenary session, arguing that abstinence-only programs fuel stigma and silence.

PEPFAR's 'prostitution loyalty oath', which prohibits recipients of PEPFAR funds to advocate for the legalization of prostitution, was also frequently cited as an example of ideology undermining the integrity of prevention. Despite being ruled unconstitutional by the U.S. courts, the prostitution pledge persists in PEPFAR policy. This example highlights the frequent mismatch between recipient and donor countries – communication and compromise should be goals, but in some instances compromises are impossible or undesirable, and all the more challenging given that evidence-based practice does not inform the PEPFAR funding mechanism. With PEPFAR, the accountability is to the U.S. government and tax-paying public, nonetheless. Country Operational Plans (COPs) remain secret and are lacking in transparency, unlike the Global Fund mechanisms.

***There is an imperative to make disaggregated data more widely available, as often it is either unavailable or cost-prohibitive to obtain. AIDS-related objectives, and the indicators used to measure them, should both reflect and enrich national strategic plans and the M&E systems in place to evaluate them. It is clear that M&E capacity urgently needs to be strengthened.***

***The priorities for a sustained response include increasing funding stability, diversifying funding sources, and committing to operationalize universal access to treatment, prevention, and care. Long-term strategic plans for HIV/AIDS must be evidence-based and prioritized as such. Ultimately, it is the responsibility of governments, civil society, and the communities to which government is accountable to make the difficult decisions and set macroeconomic priorities.***

## **C5. PEPFAR Restrictions and Other Donor-Country Accountability to Use Evidence-Based Approaches**

The real consequences of donor-country restrictions need to be documented, not only in terms of what they do to HIV/AIDS programs, but also in terms of their societal and legal consequences. The restrictions and regulations surrounding PEPFAR resources, for example the “prostitution loyalty oath”, undermine the integrity of prevention efforts and may actually serve to increase the stigma of people with HIV. Despite being ruled unconstitutional by the U.S. courts, the prostitution pledge persists in PEPFAR policy. This example highlights the frequent mismatch between recipient and donor countries. Communication and compromise should be goals, but in some instances compromises are impossible or undesirable, and all the more challenging given that evidence-based practice does not inform the PEPFAR funding mechanism. With the example of PEPFAR, accountability is to the U.S. government and tax-paying public, nonetheless Country Operational Plans (COPs) remain secret and are lacking in transparency, unlike the Global Fund mechanisms.

## **C6. Ensuring That Programs are Accountable to Affected Communities and Civil Society**

Gregg Gonsalves’ talk in the special session entitled “25 years of AIDS--Reflecting Back and Looking Forward” highlighted three important points.

First, “the largely unaccountable, self-justifying infrastructure [which has come about in response to AIDS] privileging the policy preoccupations of the major industrialized countries, privileging generalized, international responsibility instead of specific local political accountability, privileging technical skill and experience over local knowledge; promoting ‘development’ or assistance instead of social change.”

Second, he stated, “...facing the structural and environmental factors that are the fuel for this great fire of an epidemic and watch the flames grow higher because to act on these issues moves beyond charity and far too close for comfort to them to politics.”

Third, he called for the “...need to re-politicize AIDS. The calls to de-exceptionalize AIDS and return it to its proper medical context can easily become calls to turn us back into patients and victims, passive actors in this epidemic--no doctor likes patients who talk back and neither do their governments...”

“AIDS is essentially a crisis of governance, of what governments do and do not do to and for their people. We have the drugs to treat HIV infection, we have the tools to confront the risks that drive HIV transmission and prevent infection itself. What we don’t have is national political will necessary to scale up our response. We have demanded too little from our leaders, excused far too much.”

These remarks echo Peter Piot’s comments about re-politicizing AIDS, and resonate with AIDS activists’ demands and reflections about governments’ will and commitment.

In a session on the UNGASS process, the challenge to accountability focused on resources disbursed rather than outcomes, particularly with respect to PEPFAR (and in contrast to the Global Fund principles). The UNGASS declaration for civil society was an important tool

in moving governments and civil society in partnership toward reaching shared goals, and UNGASS was effective at raising the discourse on HIV from the level of ministries of health to that of heads of state.

***Can governments be made more accountable for where money is going even when debt cancellations are being granted?***

***For example, the Zambian government detailed how they integrate development and HIV plans. They also detailed what they consider their successes: political leadership, National Aids Councils, multi-sectoral leadership, provincial task forces, community groups, and free ARVs. These areas were cited as those that have helped Zambia dramatically. Reductions in stigma and scale-up of ARVs remain challenges.***

***There is a need for 'shadow reports' to supplement government reports. Commonly used by human rights groups, these shadow reports may be useful to HIV/AIDS efforts and provide greater perspective on achievements and challenges from PLWH/A.***

***All mechanisms that improve inclusiveness and transparency in the relationship between civil society and government are important and should be promoted. In addition, linkages among grassroots, country, and global networks should be a priority.***

## **C7. Accountability of the Pharmaceutical Industry and Governments to Communities in Developing Countries with Regard to Drug Access, Pricing, and Trade Issues**

Drug companies, including “big pharma” and generic manufacturers, must be accountable to populations in developing countries. In this regard, civil society can force progress on HIV medicines, as people must not wait for governments to take the lead on trade and intellectual property issues. Despite many international agreements supporting the concept of “health before trade”, in practice this is difficult for developing countries to insist on. Many developing countries have made provisions for compulsory licensing, by which patented drugs can be produced off patent in public health emergencies. Countries are free to define emergencies for themselves, but the provision begs the questions of whether AIDS is already a public health or national emergency in many countries.

***Regulatory reform with regard to medicines, trade, and intellectual property is urgently needed. While this is particularly pertinent to the HIV/AIDS sphere, it applies far more broadly. In the future, it may be wise to advocate for medicines to be exempted from international agreements on property rights, despite the difficulties involved in such negotiations. Generic manufacturers should be urgently incentivized and encouraged to produce pediatric formulations, fixed-dose combination formulations, and off-patent drugs that are currently only produced by a sole manufacturer.***

## **C8. Ensuring that Legal Processes are Accountable with Regard to the Human Rights of People Infected with and Affected by HIV**

There is a long history of laws governing HIV and AIDS, including criminalization of transmission, sodomy, drug use, and sex work; quarantine, notification, stigma and discrimination. Criminalizing people and their sexual or drug-use behavior makes it more difficult for them to care for themselves and prevent transmission to others, and can render the behaviors more dangerous by driving them underground.

In addition to supporting fundamental human rights, antidiscrimination and other progressive HIV/AIDS legislation can advance the right to health. In effect, there is often quite a wide gap between what is enshrined in law and what is actually practiced, ie, customary law. A salient example of this exists in Kenya, where inheritance and property rights for women are protected by the constitution, however in practice women's rights are abrogated by customary and traditional practice. The legal frameworks developing and developed around HIV/AIDS can be an opportunity to question whether customary laws reinforce or contradict prevailing legislation and human rights agendas.

***Community members may be trained as paralegals in order to build legal capacity to address HIV issues.***

***Parliaments and other government bodies should be held accountable to review laws with the goal of eliminating HIV and other discrimination, mobilizing resources to fight HIV/AIDS, and to enact laws to improve the lives of PLWH/A.***

***Governments should be pressed to engage with civil society groups on all aspects of law formation, reform, and enforcement.***

***A consultative process should ensure that communities inform and guide law, not merely passively receive it.***

***Governments' adherence to international standards, conventions and guidelines should be monitored and reported.***

## D. ISSUES RELATED TO PARTNERSHIPS

The concept of “partnerships” was emphasized throughout the conference in a wide range of contexts and settings. Given the enormity of the HIV pandemic and all of the biological, social, and public health factors associated with prevention, treatment, and care, many kinds of partnerships are necessary to provide an adequate and sustainable response to the multiple needs of populations affected. Human capacity and infrastructure constraints impact the rollout of lifesaving ARVs to vulnerable populations. Thus, any large-scale approach must address these issues in innovative ways. Partnerships can leverage resources for treatment and care in resource-constrained settings. Public-private partnerships can reach their objectives more quickly, cheaply, and more efficiently by leveraging technology, maximizing existing resources, and using systems thinking and approaches.

***In one session, a famous case in Peru (1996, Mestanza v Peru) was examined. In this case, a woman was threatened with criminal sanctions until she consented to (forced) sterilization. She received little medical follow up and died from complications within nine days. The Latin American and Caribbean Committee for the Defense of Women’s Rights (CLADEM) and two other Peruvian human rights group filed a petition with the Inter-American Commission on Human Rights (IACHR) in 1999 and were later joined by the Center for Justice and International Law (CEJIL). In 2002, the Peruvian government agreed to settle the case. An agreement was signed in 2003 in which the Peruvian government acknowledged international legal responsibility, agreed to compensate Mestanza’s surviving husband and children, and agreed to modify and implement recommendations made by Peru’s Human Rights Ombudsman concerning sterilization procedures in Peru’s government facilities.***

***It is important to note that this success was accomplished through collaborations across several local and international legal organizations that transferred their methods and expertise across teams. The case dramatically raised the level of international awareness surrounding abuse and violations of HIV-positive women’s reproductive rights.***

### D1. Developed Countries Dominate: Moving Leadership to Developing Countries

Dr. Altman commented in his *New York Times* piece that the principal talks at the conference were given by people in the developed world, who were speaking—albeit eloquently and passionately—for the people in the developing world. Unfortunately, the President of Liberia cancelled because of the failure of the Prime Minister of Canada to appear at the conference. She would have been the only major African leader to speak at the conference. Much mention was made of the failure of South Africa’s government to address the epidemic seriously and with commitment, probably the first time that a developing country government was taken to task in this way. In terms of developing countries, China’s advances in HIV prevention and care were lauded, but activists also raised concerns about China’s human rights record and whether or not China’s response is fully respectful of human rights.

On a positive note, the AIDS pandemic has brought together people from all over the world with common causes. It has brought together women interested in advancing women’s

rights. It has brought together people interested in sexuality and sexual rights, with a special focus on the needs of adolescents. Scientists from around the world now have relationships that they once did not have, and capacity is being built through significant scientific relationships. Journalists are learning from each other, and the networks to advance the coverage of HIV in the media are having impact.

***What partnerships need to be fostered and formed to continue to unite people around common action? Further, how can people and organizations from the developing world lead such partnerships? What kinds of capacity building are necessary in order to ensure developing-country leadership?***

## **D2. Health Care Personnel Are In Short Supply**

An important issue highlighted in several conference venues was the paucity of skilled health care personnel and the lack of proper medical training. Skilled, trained health care personnel are desperately needed to accommodate treatment needs in the context of wide-scale distribution of ARVs and appropriate follow-up treatment and care, particularly in the context of more widespread HIV testing scale up. In some contexts, many health workers received their medical training prior to the emergence of HIV, and therefore have little or no knowledge of the diagnosis and treatment of HIV and HIV-related illnesses. For some who received training after the onset of the epidemic, but prior to the availability of ARVs in their region, many still believe that HIV/AIDS is an invariably terminal and unmanageable condition. Those aware of these medications may lack the knowledge to administer them properly. In other contexts, community-based workers who may be lacking “formal” health-care training are delivering the highest standard of care. Volunteers have played important roles in counseling and care, but investment is needed to bridge the gap and maintain consistency in quality of care for the long term, since they are subject to burnout. There are several examples of innovative partnerships from different regions of Africa, Latin America, and the Caribbean that are addressing gaps in sustained health care delivery systems. These include the utilization of home-based care (HBC) providers (professional and para-professional) to work with centrally located medical providers, and the mobilization of traditional healers and PLWH/A to be recruited and trained as support partners and to dispense treatment.

***Presentations and discussions highlighted both local and national partnerships to address needs, and strong partnerships were shown as a way to stronger and better-informed communities.***

## **D3. Global Partnerships for Legal Reform: Brazil’s Leadership**

Brazil occupies a unique position as an HIV/AIDS policy leader. As a mid-developed country, Brazil has both an HIV epidemiological character and technical capacity that resembles both developing and developed countries. Brazil’s long standing aggressive governmental

position on prevention and treatment, its extensive capacity for research, and capabilities for off-patent manufacturing, coupled with its considerable leverage with the biotechnology/pharmaceutical industries and global policy stakeholders has uniquely positioned it to mentor developing countries regarding best practices and to facilitate South-South bilateral cooperation.

The Brazilian response to its AIDS epidemic has been characterized by the participation of an organized social movement, reflecting the mobilization of social groups that are, historically, among the most active in the society. The increasing relationship between AIDS and poverty in Brazil demanded the inclusion of disenfranchised social groups with little or no access to social rights and citizenship. The fight against AIDS has been seen as a mobilization factor, stimulating a social organization that must continue to be strengthened.

A vivid example of the role of civil society in political articulation in the fight against AIDS in Brazil is the AIDS/NGO forum of Rio de Janeiro State. Since 1996, the movement in the fight against AIDS was organized through the AIDS/NGO Forum and represents NGO/AIDS of Rio de Janeiro State in national commissions, committees, and networks. With 120 organization members involved, it presents a diverse gathering of different organizations focused on political activism in inter-correlated fields, sexual education, production of knowledge and prevention activities, support to those living with AIDS, and technical cooperation. The activities of the Forum are based on a participatory internal statute and facilitate the following: exchange of experiences, information, and resources that strengthen technical and political capabilities of organizations; coordinate proposal writing that strengthen NGOs, allowing them to discuss, reflect, and write proposals for public policies in health and prevention and assistance to STD/AIDS; and promote articulation and collaboration among NGO/AIDS at city, state, national, and international levels. Collectively, they denounce all forms of omission, transgression, and violation of human, civil, political, and social rights. The Forum participates in all levels of decisions on AIDS policies, permanently in articulation with governmental offices and voicing the movement's deliberations through elected leaderships and commissions. It also maintains an active system of information dissemination through the Internet. The outcomes obtained by collective mobilization, also present in other Brazilian states and national articulation, demonstrates the potential of the network of a collective political organization with the participation of civil society.

The Technical Cooperation Network for HIV/AIDS (Ford Funded) was established with the initial objectives of enhancing each of the eight member-countries' capacity to acquire, manufacture, and supply ARVs/generics; the acquisition of laboratory testing kits (rapid tests, CD4+ cell counting, genotyping, etc); and the advancement of universal access to care for PLWH/A. In establishing the network, initial membership requires both a governmental commitment and a basic capacity for acquisition and development of materials required for manufacturing ARVs. The Brazilian Ministry of Health acts as a coordinating partner of the eight member countries—Argentina, Brazil, China, Cuba, Nigeria, Russia, Thailand, and Ukraine. Primary objectives of the network are to: 1) broaden access to medicines and other pharmaceutical products used for diagnosing, preventing, and treating HIV/AIDS, 2) to strengthen the technical capabilities for manufacturing antiretrovirals, and 3) to make effective use of the TRIPS (trade-related aspects of intellectual property rights) allowances for off-patent manufacturing. Particularly noteworthy is the networks' explicit mission to maximize allowances granted in respect to international intellectual property rights and to facilitate the use of these allowances by member countries.

In a separate project, international clinical training and ARV provision is also part of Brazil's bilateral cooperation. Brazil's International Cooperation Program for HIV Control and Prevention Activities for Developing Countries focuses on establishing sustainable national responses by training medical professionals in the early diagnosis of HIV, the care of PLWH/A, and the provision of antiretrovirals produced in Brazil. The program's Latin American and Caribbean partners include Bolivia, Columbia, the Dominican Republic, El Salvador, and Paraguay. It also involves the Portuguese-speaking countries of Cape Verde, East Timor, Guinea-Bissau, Mozambique, and São Tome and Príncipe.

Finally, one of the most promising South-South networks led by Brazil is the International Center for Technical Cooperation on HIV/AIDS (ICTC/AIDS). The ICTC is a joint venture between UNAIDS and the Brazilian Ministry of Health intended to maximize developing countries' ability to effectively access and utilize available global resources in the context of establishing sustainable national responses. While increased availability of multilateral and bilateral global funding resources like the Global Fund to Fight AIDS, Tuberculosis and Malaria constitutes a substantial movement in a positive direction, these resources are often underutilized due to the limited human resources and technical capabilities of recipient countries.

The ICTC was established to address these deficiencies in the framework of horizontal cooperation in which "peer" countries may benefit from other countries that have similar social and epidemiological situations. The goal is to draw upon Brazil's programmatic experience and technical resources to strengthen national responses in developing countries. The horizontal model assumes that local governments and organizations, with assistance from the ICTC, will administer programs. The ICTC was launched in 2005 to identify and promote areas of the Brazilian response which other countries may benefit; to conduct needs assessments and establish horizontal programs with partner countries; to disseminate technical materials and best practices based; to coordinate and monitor activities of these programs; and to facilitate and coordinate access to UNAIDS programs and bilateral donors in technical cooperation.

In addition to technical leadership and biomedical research, Brazil has remained at the forefront of behavioral research on sexual and reproductive health. Vera Paiva, from the University of Sao Paulo Institute of Psychology, reported her findings regarding the reproductive desires of PLWH/A in Brazil. Dr. Paiva highlighted that the differences in reproductive desires of PLWH/A in the well-developed countries are dramatically different than those in the global South. She reports that in Brazil, reproductive desires are considerably stronger among heterosexual and bisexual men than women (50% of surveyed HIV-positive men vs. 19% of HIV-positive women). Despite the finding that desire for more children was associated with being younger, being less than 34 years of age, and being male—consistent with data from Asia, Africa, and Latin America—parenthood is integrated as a female issue in most health services. Framing women as central to the programming of SRH services may be from assumptions made in models from developed economies of North America and Europe. It is necessary to have access to moral-free objective information about reproductive options and rights that integrate male involvement and are responsive to local epidemiology and cultural mores rather than models that are imported from other regions.

#### **D4. Care, Support, Treatment, and Prevention Can Be Integrated**

There is now growing evidence that integrating care, support, and treatment programs reduces stigma and discrimination and enables capacity building of the healthcare work force. In Vietnam, district-level health facilities have increased access to comprehensive services. Experiences in India and Zambia have shown that partnerships of allied health programs are critical for treatment scale-up.

The challenge of increasing local capacity for HIV/AIDS programs can be addressed through private, public, and civil sector partnerships. Effective partnerships can strengthen the human rights-based response to HIV/AIDS and thus contribute to the building of an enabling environment for universal access at both national and regional levels. Further, it requires equal partnerships between civil societies, which take the pulse of communities on changing epidemics, and governments, which use the information to formulate responsive actions, to achieve universal access and scaling up of responses. Strengthening community institutional capacity through partnership and networking has proved effective in addressing HIV/AIDS treatment, care, and prevention efforts.

#### **D5. Public-Private Partnerships: Making Them Work**

The Broad Reach Program is funded by PEPFAR and aims to provide thousands of patients with immediate access to free ARVs in underserved areas throughout South Africa. The program uses a unique public-private partnership that matches an existing network of community-based doctors with patients from existing community-based support organizations (CSOs) and government ARV sites that are at capacity (eg, by removing patients from waiting lists and down-referrals). The model uses technology and telemedicine to task-shift and tap into the capacity of 5,000 community-based general practitioners. It does this by leveraging the expertise of a few HIV/AIDS clinicians to monitor and to provide real-time training. Preliminary results estimate that the doctors can take on 500,000 patients in five years. Implementation occurred using a replicable yet adaptable methodology with training manuals, standard operating procedures, work plans, and toolkits. In the pilot phase, this approach allowed the program to expand to 16 communities in five provinces, reaching over 2,000 people in six months.

For example, Eskom's (the major energy supplier for much of South Africa) major partners include the Foundation for Professional Development (FPD) and the South African HIV and AIDS Clinicians Society (SAHCS). Together, these three form the African AIDS Training Partnership (AATP), which has jointly developed the ambitious HIV Clinical Management Course. The course covers prevention, diagnosis, and clinical treatment of infected individuals. With the growing population of infected patients in sub-Saharan Africa, it is very common for caregivers and health workers to see HIV and AIDS patients on a daily basis. Eskom and its partners' program covers basic science, epidemiology and prevention, health care planning and management, clinical aspects, therapy and social response--all practical, well-defined issues that are relevant to local areas within sub-Saharan Africa. The partnership has built a sustainable infrastructure that reinforces further training as a principle whilst actively supporting practicing clinicians. To date over 8,000 medical workers and caregivers have undergone this training, adding to the growing community of well-informed medical workers.

The Russian Parliamentary Working Group on AIDS (PWG) is a coalition of State Duma deputies, representing various legislative committees and political parties working to strengthen

HIV/AIDS strategy, expand public-private partnerships, improve HIV/AIDS legislation and funding, and promote collaboration between Russian and international organizations. PWG serves as a bridge to other sectors, including business, media, the scientific community, and people living with HIV/AIDS. It has developed as an essential tool for comprehensive policy dialogue in Russia, safeguarding the interests of various sectors and communities, including vulnerable groups. PWG has also emerged as an international model for effective partnership on HIV/AIDS. Advocacy efforts have raised HIV/AIDS awareness among Russian parliamentarians, resulting in breakthrough policy initiatives including, most notably a review of national HIV/AIDS policies at a meeting of Russian State Council, chaired by President Putin, and a joint initiative with the UK All-Party Parliamentary Group on AIDS to focus the attention of parliamentarians from the G8, China, India, and CIS on the growing challenges presented by HIV/AIDS.

A large-scale national response necessitates neutrally led coalitions that include all stakeholders working within nationally agreed implementation, monitoring, and evaluation frameworks. An HIV/AIDS Partnership in Uganda comprised of 12 groups commonly referred to as Self Coordinating Entities (SCEs), namely Parliament, Ministries of Government, AIDS development partners (donors and the UN), local authorities, PLWH/A, private sector, national and international NGOs, faith-based institutions, research academia and science, young people (10-24 yrs), media, arts, and culture. The Partnership provides a regular forum and opportunity for policy and program review and revision, has promoted information sharing in planning, resource mobilization, and advocacy to garner commitment from development partners, government, and civil society to address national priorities.

#### **D6. Strengthening Local Response Through Global Partnerships of PLWH, MSM, and Women's Organizations**

A network of Nigerian PLWH/A, women's organizations, and international partners, including CIDA, UNIFEM, and UNFPA, successfully overcame substantial institutional resistance to including women's voices in HIV/AIDS policy making in Nigeria. The network played a critical role in enabling women's voices to be heard and incorporated in the 2005 National Action Committee on AIDS' (NACA) review of the national response to HIV/AIDS in Nigeria, and in the development of a strongly engendered National Strategic Framework (NSF). Responding to stakeholders' advocacy, and recognizing that gender inequality is a key factor in the spread and control of HIV/AIDS, NACA established the Gender Technical Committee (GTC) to promote a deeper understanding of, and support and commitment to, gender mainstreaming processes in the NSF. This underscores the importance of strategic partnerships in programming and its implications for policy.

In the area of HIV prevention there are numerous challenges in addressing the wide range of needs experienced by vulnerable populations when there are significant structural and societal barriers to being able to work with these groups. One specific example includes the HIV prevention challenges facing MSM in the Middle East and North Africa. Innovative strategies and partnering have shown some success in developing much needed prevention programs in this setting. Significant barriers to effective prevention outreach included the "criminalization" of MSM behavior, the broad lack of awareness of HIV issues, lack of condom availability and normative use, police harassment, and homophobic violence. A small group of gay advocates forged discreet networks at the outset in order to plan and develop strategies. Through growing

partnerships, they were able to conduct meaningful advocacy with journalists, judges, lawyers, and ultimately the police and the Ministry of Health to develop trust through the collaborative process. With financial support from the Global Fund and continued strong advocacy for human rights, they utilized media communication and brought about significant changes in policy and law, increased availability of condoms, scale-up of HIV VCT, and access to treatment and care for MSM in this region of the world.

## **D7. Partnerships with Other Disease Groups**

HIV/AIDS, TB, and malaria-affected communities (HTMCs) are organizing around Global Fund processes, and are rising to the challenges of addressing these serious, inter-related diseases. The Global Fund Board has worked to bring HTMCs together. HTMC delegates to the Board were invited to the 2006 international conference on the airline solidarity contribution (ASC) and international drug purchase facility (IDPF) proposals in Paris. Community delegates then partnered with the French PLWH/A group Act Up-Paris for joint advocacy about the proposals and how these respond to grassroots needs.

***By forming partnerships with CBOs from other countries and other diseases, HIV/AIDS advocates can successfully deal with politicians' bias against bundling the three pandemics, ensuring the response is comprehensive and representative from a grassroots perspective without losing the necessary specificity for each of the diseases.***

Hope for African Child Initiative (HACI) is a unique pan-African partnership of PLAN, WCRP, SAVE, SWAA, NAP+, World Vision, and CARE working with over ten donors and more than 1,000 community-based organization, over the last five years to scale up the orphans & vulnerable children (OVC response). HACI has supported over 1.5 million children in nine countries (Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Senegal, Uganda, and Zambia) to deal with the challenges of caring for their ailing parents or coping with loss to HIV/AIDS.

## **D8. Sexual and Reproductive Health and AIDS Partnerships**

A strengthening of U.S. health and education agency partnerships to improve HIV, STD, and unintended teen pregnancy prevention in schools was carried out. In January 2005, the Association of Maternal and Child Health Programs (AMCHP), National Alliance of State and Territorial AIDS Directors (NASTAD), National Coalition of STD Directors (NCSD), and Society of State Directors of Health, Physical Education and Recreation (SSDPHER) (referred to as the National Partners), conducted national stakeholders meetings for nine state teams with the goal of strengthening collaboration between state health agencies and education agencies to support the integration of HIV, STD, and UTP prevention in schools. Participating teams drafted action plans to articulate a shared vision and were provided technical assistance at the second and sixth month after participation. Since 2003, 24 state teams have participated in NSM, which are supported with funding from the CDC's Division of Adolescent and School Health.

## **D9. Country and Regional Partnerships**

Partnerships at country and regional levels are being built between national AIDS programs, clinicians, and local NGOs, supported by Partnerships in Health, an international NGO with Sida funding in the western Balkans. This involves capacity building for primary and secondary health providers and 16 local NGOs, while advocating greater involvement of PLWH/A. The program enables local NGOs to establish community-based VCT, help providers to overcome discrimination and provide quality care, and reach out to marginalized populations, including PLWH/A , IDU, CSW, MSM, and ethnic minorities, including Roma.

***The Brazilian experience was, since the beginning of the epidemic, focused on the promotion of human rights through the recognition and support to community-based initiatives. Civil society participated in the establishment of public policies.***

***The Brazilian Government, with AIDS-related nongovernmental and community-based organizations, opted to establish two action modalities: (1) technical and financial support of projects, and (2) the creation of forums, which are formal channels for participation and decision-making. The first partnership was established through technical and financial support to initiatives conducted by community organizations. Between 1998 and 2002, there were 2,958 projects financed at 600 nongovernmental organizations, with a total budget of US\$33 million.***

***The second partnership modality was constituted through dialogue channels between the Brazilian National AIDS Program, People Living With HIV/AIDS, and of the most vulnerable groups, including sex workers, drug users, homosexuals, and women. Currently all work groups of the Brazilian National AIDS Program include members representing civil society. This strategy has resulted in a strong and efficient social and community mobilization.***

## **E. SUMMARY COUNTRY REPORTS**

These brief country reports were compiled by members of UCLA's Program in Global Health. The summary reports raise issues related to the themes of accountability, leadership, equity and partnership development as they were articulated at the conference.

### **E1. CHINA**

China and Chinese speakers were conspicuous for their absence at this conference. There were some important speakers present and talks given, but there was a relative dearth of sessions on China compared to other Asian and South Asian countries. This was compounded by a high no-show rate—several Chinese speakers scheduled to participate on panels or present talk and posters were not able to attend.

Much of what was presented from China was a positive portrayal of efforts to address the epidemic. Zunyou Wu's presentation was representative of this—his optimistic reportage left one wondering what the real situation is on the ground. A few presenters, with Wan Yanhai being the best example, discussed the discrepancy between official policy and actual practice.

Essentially, China seems to be making a lot of progress in addressing HIV, but it is not a fully open player in the international field. There seemed to be few genuinely grassroots leaders. Questions were brought up about equity, but nothing that explored the issue in-depth. There was essentially nothing that addressed accountability.

### **E2. SOUTH ASIA (India, Pakistan, Nepal, Sri Lanka)**

There are substantial equity issues in India due to extreme poverty and inequity in the distribution of wealth and power. The most marginalized groups are sex workers, men who have sex with men, transgender persons (including transgender sex workers and *hijra*), and injecting drug users.

The government's efforts would be improved if they worked with advocacy and activist groups, incorporating their ideas and needs into the programs instead of attempting to intervene with these populations from the top down. Additionally, the epidemic among injecting drug users seems to be ignored by the government, the only interventions in evidence were being implemented by NGOs and universities.

India has several powerful and successful examples of partnerships between NGOs, the government, university research groups, CBOs, and activist organizations. There are also projects that have been successfully scaled up within a state that could be scaled up over a larger area, for which additional partnerships should be established.

India has several powerful international NGOs, as well as local NGOs and CBOs that are strong both in their leadership capacity and in their ability to train and sustain leadership in advocacy and activism. Many of these NGOs have good track records but are not able to reach the large numbers of people needing education or other interventions. This is properly the responsibility of the Indian government which seems open to working with vulnerable populations such as sex workers, but seems to ignore injecting drug users, prisoners, and men who have

sex with men. There is a clear need for the Indian government to play a more proactive role and to scale up its response.

According to the South Asian activists and community groups represented at the conference, it has been difficult for civil society to hold national government accountable due to the regional heterogeneity of the epidemic. Also, they point out that civil society remains largely uninterested in HIV/AIDS and has not been 'activated.' Activists also pointed to the need to hold private sector providers accountable. Studies related to quality of care and use of ARVs have revealed poor provider understanding of HIV management and dangerous misuse of therapies amongst private providers who represent a sizable percentage of providers in the region. Similarly, within the private sector and across the medical system in general, activists reported intense stigmatization of HIV positive patients and a refusal to treat PLWH/As.

Women's rights activists in India recently secured passage of the Domestic Violence Act—the first recognition of domestic violence in the penal code. Activists indicated concern though about whether the rights of HIV-positive or unmarried women facing violence will be protected and urged civil society groups to hold government accountable.

On the issues of equity and access to treatment, activists noted that government and WHO efforts to scale up access to treatment have not reported on the utilization of services by highly stigmatized groups such as MSM and CSWs. AIDS activists in India fear that these groups have had disproportionately low access to therapy due to stigma and other factors. Activists have requested greater involvement of PLWH/As in the planning of ARV rollout in the country.

According to activists from India, their government's recent signing of the Trade-Related Aspects of International Property Rights (TRIPS) may have a devastating effect on access to treatment. TRIPS has changed patent law in India, forcing legislation to now include protection of product patents. The loophole left in the legislation that enables generic manufacturers to continue producing ARVs is that the product patents are not allowed for new uses of existing known compounds. Thus, the argument has been made for many of the ARVs that the active compounds have been known for a long time and are being used for a new purpose, and thus not eligible for patent protection. The constitutionality of this provision has now been challenged by Novartis through the Chennai courts (litigation papers filed August 2006). If this loophole is closed, the supply of generic ARVs in India may be outlawed.

In dealing with hard-to-reach and vulnerable groups, two examples of leadership and innovation stood out from amongst presentations from the region—work with injecting drug users in remote rural areas and with adolescent and child laborers. Providing harm reduction services to injecting drug users in the mountainous regions of the northeast has proven difficult. An innovative strategy used has been to involve IDUs in identifying appropriate 'secondary distributors' of clean needles. Distributors include teachers, vegetable vendors, retailers, etc. Over 6 years, secondary distributors have been successful in accessing socially marginalized IDUs. With regards to reducing the vulnerabilities of adolescent/child labor in India, a grassroots NGO has established 2 interventions to address the sexual risks of youth labor in the printing and textile industries in Tamil Nadu. This NGO has created a 'child's rights committee' composed of local elected representatives, traditional healers, and parents, that acts as a watchdog and conducts educational sessions on HIV/AIDS. The second intervention is the creation of a "Children's Parliament" for adolescent laborers 13-16 years of age. The purpose of the parliament is to teach youth about participatory government, decision making, recognizing individual risk based on group deliberation, etc. This program has been in place for 5 years.

### **E3. MEXICO**

Mexico ranks 22nd (of 27 countries) in the Americas/Caribbean in terms of HIV prevalence in the adult population. Transmission is primarily sexual, and HIV prevalence is concentrated in men who have sex with men (15%), commercial sex workers (12.2%), and IDUs (6%); general population prevalence is 0.3%. The ratio of AIDS cases for men:women is approximately 5:1, and the states of highest prevalence border the U.S. (eg, Baja California) or the Caribbean (Yucatan), as well as the state containing Mexico City (Distrito Federal).

When surveying the full range of oral presentations and posters that made any reference to Mexico, clear themes emerged (numbered in rank order, 1 = most prevalent):

1. Migration/border issues
2. Stigma and discrimination
3. Injecting drug use
4. Men who have sex with men
5. Commercial sex workers
6. Advocacy

Due to the fact that Mexico will host the next International AIDS Conference, a number of Mexican AIDS officials enjoyed prominence throughout the conference and seem well connected and committed.

Equity was a major issue in Mexico's presentations and cut across all themes. Although there is universal access to ARVs in Mexico, prevention appears to have received insufficient attention. Stigma and discrimination were presented as major impediments to prevention efforts amongst high-prevalence group—particularly homophobia, machismo, sexism, and anti-indigenous racism, which continue to shape access to and delivery of services. Though not a major presence, in two presentations the issues of access to care, services, prevention, etc for indigenous persons was raised.

Multiple factors explain the increased prevalence in border areas such as Tijuana. These include poverty, lack of adequate education about HIV and ignorance about modes of transmission, drug use, fear of getting tested because of stigma related to HIV, fear of being labeled as gay, increased commercial sex work; high mobility, lack of housing, and incarceration.

Several partnerships were noted in various sessions throughout the conference, in particular between Mexico and U.S. universities near the border (such as UCSF or UCSD), or with international organizations like USAID, Constella Futures, and International HIV/AIDS Alliance. Given the concentration of HIV in the border states, cross-border collaborations should be examined more closely.

### **E4. MIDDLE EAST/NORTH AFRICA (MENA) REGION**

#### **MENA Region Countries:**

Algeria | Bahrain | Djibouti | Egypt | Iran | Iraq | Israel | Jordan | Kuwait | Lebanon | Libya | Malta | Morocco | Oman | Qatar | Saudi Arabia | Syria | Tunisia | United Arab Emirates | West Bank and Gaza | Yemen |

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The MENA region has the highest number of refugees in the world and is characterized by wide socioeconomic disparities in all MENA countries, migration from rural to densely populated urban centers, high unemployment, inequalities in access to public participation, changing practices among youth and a shift toward injecting drug use. There are an estimated 400,000 injecting drug users in MENA, and IDUs are fueling epidemics in Libya and Iran (in 2005, 61.5% of new HIV cases in Iran attributed to IDU).

The limited response to HIV/AIDS in the MENA region reflects the perception of low regional prevalence rates. The latest prevalence estimates indicate 67,000 new infections in 2005 and 510,000 people living with HIV. Estimated adult and child deaths attributed to AIDS in 2005 are 58,000. HIV surveillance remains weak in this region. Region-wide prevalence is estimated at 0.2%, but wide local variance exists with areas as high as 2.9%, and others as low as 0.01%.

Access to services remains a major issue. VCT and prevention education are limited and less than 5% of people needing ARVs have access. As elsewhere, stigma remains a problem. However, UNAIDS reports that 16 country programs are in place across the region.

The weak structural capacity and reach of existing surveillance programs combined with low governmental priority and high stigma suggests that although limited data exist, there are pockets of high localized prevalence among work and migratory routes and within regions of higher injecting drug use. The main mode of HIV transmission in this region is unprotected sexual contact, although injecting drug use, which has steadily increased over the last 5 years, is becoming an increasingly important factor. Based on available data, Sudan is the most heavily impacted area, with the highest incidence rates in southern Sudan. Evidence also points to steadily increasing HIV incidence rates, particularly among youth, in Algeria, Libya, and Morocco.

**Migratory Trends:**

- High migratory trends are attributed to people seeking work and safety from conflicts.
- Mobility in Gulf countries includes domestic workers from South and Southeast Asia.

**Limitations:**

- Lack of rigorous multidisciplinary research that includes both epidemiological and behavioral studies
- Limited research on the social dynamic of the epidemic.
- Urgent need for programmatic evaluation to assess ongoing interventions.
- Disparity between growing body of reproductive health and research on HIV/AIDS
- Government/State obstacles to NGOs/civil society asking key questions and self-censorship (by investigators) of research.
- Little or no baseline data, lack of mapping, and measurement of change among vulnerable populations.

- Tendency to borrow notion of vulnerable groups from international experience that are not contextualized sufficiently to the region (eg, “Egyptian summer marriages” – wealthy travelers marry young poor Egyptian women and divorce at end of the summer).

**MSM:**

- HIV prevention challenges face MSM in MENA states. Male homosexuality is taboo, homosexuality is illegal, homophobia widespread.
- Male sex workers report 1 to 30 partners per week, anal sex 97%, low condom use, and considerable violence.
- Psychological and social support provided, with outreach workers distributing condoms, lubricant, and safer sex educational materials.
- In Morocco, MSM in many cities also report high rates of unsafe sex; interventions to reach these groups have only recently been funded, but remain restricted by cultural and legal constraints.

Throughout sessions, speakers consistently cited the lack of governmental accountability and cooperation with NGOs and civil society in the MENA region. Examples cited included extensive governmental resistance, artificial hurdles, arbitrary and shifting local policies, difficulty in communication with government stakeholders, and extensive delays in response time. MENA researchers believe multiple factors contribute to this bottleneck, but there is a general consensus that the major factors include: 1) perceived low prevalence leading to low governmental priority, 2) stigma associated with both HIV/AIDS and public discourse about sexual practices, and 3) insufficient reproductive health education (and where it does exist it is not integrated with HIV/AIDS education). Recommendations from MENA advocates included seed grants to agencies that would develop, standardize, and/or facilitate a HIV/AIDS and reproductive health communication pipeline among MENA governmental stakeholders, NGOs, and civil society.

Panelists spoke of an urgent need for a paradigm shift in reproductive health and HIV/AIDS education. The lack of basic rights for women in public participation combined with silence about sexual practices and contraception was described as exacerbating the vulnerability of women. For example, women’s ability to utilize proposed prevention technologies, such as microbicides or PrEP, is currently compromised by women’s subordination, disempowerment, and limited legal and cultural rights. Recommendations from panelists included support for programs that emphasize and facilitate the role of women in reproductive health that has integrated STD education and that encourage women’s leadership, promotion gender equality, and encouraging greater openness about sexuality.

Panelists also spoke of the need for fiscal support for youth-focused programs. The MENA region has an increasing population in the 10-24 age group (approx 1/3 pop.) and a growing population of single men and women in their 30s. In other regions, these age groups are among the highest at risk. There is limited or nonexistent youth-specific messaging, particularly about reproductive health. Recommendations included: context-specific youth-focused sexual and reproductive health programs that are not simply imported from other regions.