Bangkok: a watershed event?

"Like Durban, Bangkok could be a watershed event," Dr Joep Lange, President of the International AIDS Society, told delegates at the Opening Ceremony of the XV International AIDS Conference last night.

The occasion held its fair share of promises, hopes and encouragement. The Thai Minister of Public Health, Ms Sudarat Keyuraphan, reminded delegates that the country had provided free antiretroviral therapy (ARV) since October 2003. She added that this conference would be the first Conference to offer a "leadership programme," although some sessions had been cancelled for security reasons.

The Thai Prime Minister, Dr Thaksin Shinawatra, went on to further boast of the country's progress in stemming the tide of HIV infection through its “100% Condom” campaign. While describing a new national harm-reduction programme, he faced a barrage of placard-wielding demonstrators seated throughout the arena.

From the presentations, it would be easy to presume that real advances have been made, and that a new level of awareness had been reached. There is clear evidence of increased condom use by sex workers - from low percentages in the early 1990s, to a steady 95% today. There had also been a dramatic reduction - from 30% to 3% - in the number of Thai babies infected through transmission of HIV from an infected mother.

But problems still exist. Mr Paisan Sawannawong of the Thai Drug Users Network spoke of the continuing power of social stigma associated with drug use. Over the past few years, more than 50,000 drugs users have been convicted - often through confessions forced by police - only to face the additional stigma of being an ex-convict. Social isolation drove many to return to drug use. Mr Sawannawong challenged the seriousness of the government's commitment to harm reduction. He asked: "do they really mean harm reduction, or harm production?"

Stigma and discrimination featured in other ceremony presentations. Many speakers described the importance of holding, hugging or kissing a person infected with HIV. As the Prime Minister stated, people infected with HIV should have the opportunity to be members of society, "just like you and me."

Another theme that seemed to resonate with delegates was the importance of a gender focus. In a moving address supported by sustained applause, Kofi Annan, Secretary-General of the United Nations, was the only speaker to stress that women are an increasing proportion of people newly infected with HIV. He added that all countries needed to empower women and girls to develop the ability and confidence to negotiate sexual practices safely. He also stressed the importance of challenging men's behaviour, attitudes and stereotypes.

In certain aspects, this conference does promise to be as groundbreaking as the Vancouver Conference in 1996. At that conference, delegates questioned the success of medical treatment in improving the quality of life of people living with HIV. In Bangkok, the focus may be on a fresh commitment to address the social and cultural factors that contribute towards HIV. Given the momentum to focus on developing world realities instilled during the Durban conference in 2000, this is a possibility.

The most disappointing aspect of the ceremony was the number of delegates who left during the video about youth, two hours into the event. By the end of the ceremony, probably only a hundred delegates heard the final address.

Given its location in Asia, where in some countries drug use is the main route of HIV transmission, this conference seems set to witness the breakthrough of harm reduction approaches into the mainstream of the HIV/AIDS response.
A turning point for Thai drug users?

Interview with Paisan Suwannawong of the Thai Drug Users Network

At the opening ceremony of the XV International AIDS Conference, Thai Prime Minister Thaksin Shinawatra made a public commitment to increasing efforts to provide healthcare to HIV positive drug users. We talked earlier with an AIDS activist about his own experience on the ground.

"Drugs are everywhere," he says. "But drugs is just another political issue. Government policies are ineffective."

Mr Suwannawong believes the reason is that there is no real political leadership. "There have been changes in funding, but the amount invested in health care hasn’t changed." In fact, as he points out, the crisis is so acute that many NGOs won’t work with drug users, "because they know they won’t get government funding."

"The Prime Minister and government need to take the lead," he says, mentioning that to force the issue the network had recently met with Prime Minister Thaksin Shinawatra for the first time in the run up to the XV International AIDS Conference.

Hopes are high for the Conference, and Mr Suwannawong wants it to be a real turning point in focusing the right kind of attention on drug use and HIV/AIDS issues for the country and the region.

In Thailand in particular, he feels, the Conference can encourage reflection on realistic means of tackling drug-use related HIV. "I hope things won’t be just the same after everyone leaves," he says. "I hope it is not just talk."

The shift in Thailand’s HIV epidemic towards high incidence among injection drug users has been recognised and emphasised in many forums, including the 2004 UNAIDS report. The global overview of the disease identifies transmission among injection drug users as responsible for the world’s fastest spread of HIV in recent years.

But it also points to proven prevention activities, including "making treatment available to users, providing appropriate substitution therapies and making sure clean needles and condoms are available". Mr Suwannawong points out that there is no real commitment to needle exchange programmes in his country, and that methodone access is not national. Even in Bangkok there are probably only "five hospitals that would supply free methadone, in the rest of Thailand you pay."

Governments traditionally shy away from needle exchange programmes because they fear appearing to condone drug use, or worse, appearing to encourage it.

This is one reason why the network also delivers services, implementing programmes that aim to reduce the dangers associated with drug use, and providing information to prevent the spread of HIV among drug users. In the absence of state provision, they have established programmes to make clean needles and syringes available, and covered costs related to prevention, care and treatment for drug users under the national health care plan.

Unsurprisingly, Mr Suwannawong’s group is also active addressing stigma and discrimination against drug users.

But the sad truth is that whatever the official line on needle exchange, cultural stigma means that most drug users are so afraid to make their HIV positive status public that they end up closing due to lack of demand. This irony isn’t lost on Mr Suwannawong, whose personal disclosure and public visibility are particularly significant.


"I’m not afraid any more," he says. "I have nothing to lose. A long time ago when I used drugs I was afraid. I think about it but what can I do." And his personal inspiration? "My friends died without treatment and help, that inspired me," he says.

Despite all his different efforts to help HIV positive drug users, Mr Suwannawong ultimately still sees a change in the way his fellow Thai view drug users as the only long-term solution. "The public image of the typical drug user is someone who is selfish and doesn’t care, but they can contribute to society."

"The capitalist world doesn’t care about marginalised groups - especially drug users..."

"I’d like to see politicians involving civil society more – you can’t let governments do things alone."

"The Correspondent Your key to the Conference"

Welcome to the first issue of The Correspondent – the on-site newspaper of the XVth International AIDS Conference. Whether you are at the conference in person or are one of the thousands more who cannot be here, getting the most from an event of this scale is a challenge. The Correspondent will help you keep track of some of the main issues that arise during the next five days. We hope that, beyond that, our coverage will provide you with a reminder of discussions, of what was promised and of what has been learned.

Our team of Key Correspondents includes doctors, social scientists, lawyers, journalists, community workers and counsellors – people living and dealing with the epidemic on a daily basis. They are encouraged to bring local, national and personal perspectives into their reports, allowing them to interpret what they hear as you might. As a result, and while we strive to ensure the accuracy of our reports, some subjective comment is inevitable – and we hope appreciated.

"Leadership means daring to do things differently, because you recognise that AIDS is a different kind of disease"

Kofi Annan, Secretary-General, United Nations
HIV/AIDS in Thailand

As the XV International AIDS Conference unfolds in Thailand this week, delegates will have the opportunity to learn from experiences in the host country that have been praised for its response to HIV/AIDS. At the same time, information is also being shared about new HIV-related challenges. Thailand could very well be a crossroads, with current decisions having the potential to either extend or undermine the achievements of the last several years.

Thailand, a country of 65 million people, has an estimated adult HIV prevalence rate of 3.5%. According to a recent United Nations Development Programme (UNDP) report, there have been an estimated 460,000 AIDS-related deaths since the beginning of the epidemic.

The AIDS epidemic arrived in Southeast Asia later than in some other regions, with the first cases of HIV not appearing until the mid-1980s. HIV began to spread rapidly a few years later, and surveillance was showing high prevalence among injecting drug users and female sex workers by the late 1980s. The diffusion of HIV through the population followed a common route, with the clients of female sex workers transmitting the virus to other sexual partners, and a wave of perinatal transmissions following.

The Thai government acted quickly and decisively, launching large-scale HIV prevention initiatives, and civil society also mounted a vigorous response. Probably the best known component of Thailand’s massive prevention effort, the “100% condom program,” was implemented nationwide in 1992. The focus was on the commercial sex industry, with government officials working with police, brothel owners and sex workers to make condom use a widespread and widely accepted practice. The campaign brought about a major increase in condom use among clients of sex workers.

According to the UNDP report, new HIV infections in Thailand peaked at 143,000 in 1991, and has been falling ever since. There were an estimated 19,000 new infections in 2003, reflecting a remarkable decline over a 12-year period.

At the same time, there are ominous signs that much work remains to be done. UNAIDS, in its “2004 Report on the Global AIDS Epidemic”, states: “Despite Thailand’s indisputable success, coverage of prevention activities is inadequate. This is especially the case among men who have sex with men, and injecting drug users; their infection levels remain high.”

A new report by Human Rights Watch underscores the concern about the latter group. The report says that, “in stark contrast to other groups at risk of HIV, such as sex workers and military recruits, HIV prevalence among Thailand’s injection drug users remains high.”

The UNDP report also calls attention to the needs of injecting drug users, saying: “About one quarter of all new HIV infections are occurring through unsafe injecting drug use. . . Yet very little of the prevention budget is being deployed on this front.”

Shifting the Paradigm on Zero Tolerance

We are in Bangkok, epicenter of “zero tolerance” for drug use, for the one-day satellite conference “Human Rights at the Margins: HIV/AIDS, Prisoners, Drug Users and the Law”. The satellite was organized by the Canadian HIV/AIDS Legal Network, the Lawyers Committee of the HIV/AIDS Unit, India, the International Harm Reduction Development and the Thai Drug Users’ Network.

This satellite was essentially about the continued marginalisation of drug users and prisoners. The sessions underlined that there seems to be “equity” in the uniform and consistent marginalisation of drug users and prisoners all over the world. With that marginalisation comes the marginalisation of their human rights.

To understand this, the sessions were designed to provide information and critical analysis of the consequences of that marginalisation, and of the international and local legal setting that at worst perpetuates it and at best does little to prevent it.

The discussions were assisted by two excellent background papers, which were presented in draft form. The first was “Regime Change: Drug Control, Users’ Human Rights and Harm Reduction in the Age of AIDS,” which provided an overview of the state of the drug-related HIV/AIDS epidemic worldwide, as well as of responses to the epidemic, and a review of the key human rights, legal and ethical issues. The second, “Prisoners’ Health and Human Rights in the HIV/AIDS Epidemic,” provided a very comprehensive overview of the response to HIV/AIDS in prisons and of the key human rights, legal and ethical issues.

The root problem lies in prohibitionist drug policies, both in international conventions and domestic law. These policies fail drug users because governments rely on them to justify their failure to provide the full range of harm reduction measures to people who inject drugs, including education, voluntary counselling and testing, clean needle programmes, substitution therapy etc. These policies have fueled the HIV/AIDS among injecting drug users in many countries.

The consequences are clear to see in that prevalence of HIV/AIDS is higher within the inmate population than outside. This is particularly so where HIV infection in the general community is pervasive among injecting drug-users, who are dramatically over-represented in correctional institutions.

The satellite also had a rich presentation of regional overviews of research and community insights on the work in progress, challenges, gaps and opportunities. The workshops, however, had limited space for discussion, as time was very limited.

I come back to the title of this article: we must focus on zero tolerance to HIV/AIDS. We have to make sure drug users and prisoners do not get HIV/AIDS. And if they do, then we must ensure best available treatment, care and support in the context of our own communities. If we protect them we also protect our broader communities. It does not hurt to emphasize that protecting prisoners will also protect prison staff.

The draft documents mentioned above are still evolving. The workshops provided some feedback into the draft document and more feedback is welcome. The documents are available on http://www.aidslaw.org/bangkok2004/e-bangkok2004.htm

Welcome from the Conference Chair and Co-Chair

On behalf of all the organisers, welcome to the XV International AIDS Conference in Thailand. It is fitting for this meeting to be held in a country that is so committed to tackling the AIDS epidemic, and we are delighted to be hosting the meeting in Southeast Asia for the first time.

With Access for All as our overarching theme, we are pleased to present a diverse, exciting and informative program. The Conference this year will include speakers from across the full spectrum of the global HIV/AIDS community, including those living with HIV/AIDS, world leaders and experts from research and science backgrounds, as well as those working in the field.

Each year, our knowledge of HIV/AIDS and our experience in managing the epidemic grows, and this year is no exception. As the growing need for information, each day of the Conference will have an overarching idea related to an aspect of access, so that information can be delivered in a logical way, for delegates to get the most from their attendance.

There are five specialised tracks that have abstract presentations selected from over 10,000 original submissions. These will be supplemented with further educational training and debate sessions, where attendees will have the opportunity to share information.

New at the XV International AIDS Conference and Symposia is our Leadership Program, which will bring together leaders from all walks of life, who are committed to fighting the global AIDS epidemic. The Leadership Program has become an integral part of the International AIDS Conference. We are delighted these leaders are able to join us, to share their knowledge and to motivate world action in gaining Access for All.

This Conference will help us all move forward to create Access for All in all aspects of HIV/AIDS prevention and care.

It is critical for us to work together as a global community if we are to win the battle against AIDS. This Conference will help us all move forward to create Access for All in all aspects of HIV/AIDS prevention and care.

We wish you the very best for what we hope will be the most informative and successful International AIDS Conference to date.

Dr Vallop Thaineu - Conference Chair
Dr Joep Ma Lange - Conference Co-Chair
ปัญหาเอชไอวี/เอดส์ในประเทศไทย

การระบาดของโรคติดเชื้อเอชไอวีและเอดส์ในประเทศไทยเริ่มต้นในปี 2534 โดยสาเหตุที่เชื้อไวรัสเอชไอวีได้แพร่กระจายไปยังกลุ่มบุคคลที่มีความเสี่ยงสูง ซึ่งประกอบด้วยกลุ่มบุคคลที่มีเพศสัมพันธ์กันในกลุ่มเดียวกัน รวมทั้งผู้ชายที่มีเพศสัมพันธ์กันและผู้หญิงที่มีเพศสัมพันธ์กัน ซึ่งมีการแพร่กระจายทั่วไปในประเทศ

ด้านการควบคุมการระบาด การควบคุมการระบาดของโรคติดเชื้อเอชไอวีและเอดส์ในประเทศไทยได้รับการให้ความสำคัญเรื่อยมา ซึ่งมีการจัดทำแผนการกำหนดนโยบายและแผนปฏิบัติการในการแพร่ระบาดอย่างต่อเนื่อง

การดำเนินการควบคุมการระบาดในประเทศไทย ได้รับการดำเนินการอย่างต่อเนื่องและมีผลอย่างต่อเนื่อง การมีการจัดทำแผนการควบคุมการระบาดของโรคติดเชื้อเอชไอวีและเอดส์ในประเทศไทย ซึ่งมีการจัดทำแผนการควบคุมการระบาดอย่างต่อเนื่อง

ตลอดจนการดำเนินการในสถานที่บริการจะจัดให้ได้ตามความต้องการ และที่สุดท้าย สำนักงานปลัดกระทรวงการคลัง ได้กำหนดนโยบายและแผนปฏิบัติการในการจัดการและควบคุมการระบาดของโรคติดเชื้อเอชไอวีและเอดส์ในประเทศไทย ซึ่งมีการจัดทำแผนการควบคุมการระบาดอย่างต่อเนื่อง

*สำนักงานปลัดกระทรวงการคลัง ณ ปี 2544
กลุ่มสหภาพทางการแพทย์ในการขับเคลื่อนทั้งด้านเอดส์ และบริการการตรวจเลือดเชิงบางร้ายการติดเชื้อ

วันนี้กลุ่มสหภาพทางการแพทย์ประมาณ 50 ได้ร่วมกันอั้น เพื่อเรื่องศักยภาพในการขับเคลื่อน
บริการการตรวจเลือดเชิงบางร้ายการติดเชื้อ ที่มีจุดมุ่งหมายของกลุ่มสหภาพทางการแพทย์

จากการสืบค้นกลุ่มสหภาพทางการแพทย์ได้สัมภาษณ์ทางการแพทย์ พบว่า พวกเขามีความตื่นตระหนก
ที่จะมีการขับเคลื่อนที่มีประสิทธิภาพในการขับเคลื่อนทั้งด้านเอดส์ และบริการการตรวจเลือดเชิงบางร้ายการติดเชื้อ

ความจำเป็นของกลุ่มสหภาพทางการแพทย์ในการขับเคลื่อนทั้งด้านเอดส์ และบริการการตรวจเลือดเชิงบางร้ายการติดเชื้อ

ขอขอบคุณที่สำคัญในเรื่องนี้เพื่อให้กลุ่มสหภาพทางการแพทย์มีการตื่นตระหนก และมีการวิเคราะห์ข้อมูลที่มีประสิทธิภาพในการขับเคลื่อนทั้งด้านเอดส์ และบริการการตรวจเลือดเชิงบางร้ายการติดเชื้อ
FEATURE

The Global AIDS Epidemic

The global summary, while not surprising to those who have been following the epidemic, still makes for sober reading.

Evidence suggesting that conditions might favour the rapid spread of HIV in some countries, including China and India, the two most populous countries in the world.

Asia

According to UNAIDS: “Epidemics in this region remain largely concentrated among injecting drug users, men who have sex with men, sex workers, clients of sex workers and their sexual partners.” This observation may seem inconsistent with urgent warnings about the scale of the threat that HIV poses in Asia, but it’s not. The widespread alarm is based on evidence suggesting that conditions might favour the rapid spread of HIV in some countries, including China and India, the two most populous countries in the world.

Cambodia currently has the highest adult HIV prevalence rate in Asia, at more than 2.5%. Thailand’s rate of 1.5% is the next-highest. Although prevalence is well below 1% in Vietnam and Indonesia, those monitoring the situation have expressed concern about high HIV infection rates among some groups of injecting drug users and sex workers in both countries.

Evidence suggesting that conditions might favour the rapid spread of HIV in some countries, including China and India, the two most populous countries in the world.

Oceania

UNAIDS says that with an overall estimated adult rate of 0.6%, Papua New Guinea has the highest HIV prevalence in Oceania, which also includes Australia, Fiji and New Zealand.

Although a smaller proportion of its residents are infected, Australia also provides some troubling data. “Following a long-term decline,” the global report says, “the annual number of new HIV diagnoses has gradually increased over a five-year period, from around 650 cases in 1998 to around 800 in 2002.” The primary mode of transmission in both Australia and New Zealand is sexual contact between men.

Sub-Saharan Africa

With great variations between and among countries, the data from Sub-Saharan Africa present an intricate jigsaw puzzle. When country figures are totalled, the numbers for the entire region are staggering: 25 million people living with HIV, three million new infections in 2003 and 2.2 million AIDS-related deaths during the same year.

In six countries – Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe – adult HIV prevalence is above 20%. The Central African Republic, Malawi, Mozambique and Zambia all have prevalence rates of 10% or more. Southern Africa “remains the worst affected region in the world,” says the report.

It can be difficult to look past such shocking figures to consider what is happening in the 34 other Sub-Saharan countries. But it is important to do so because their epidemics, while small by the continent’s standards, are still enormous. Côte d’Ivoire, for example, has a 7% adult prevalence rate, and in Nigeria – the ninth most populous country in the world – the figure is 5.4%. Uganda, which is widely hailed as an HIV prevention success story because of the dramatic reduction in transmission that has been achieved there, still has an adult prevalence rate of 4.1%.

Heterosexual sex accounts for the vast majority of cases of HIV transmission in Sub-Saharan Africa, and today women living with HIV outnumber men by a ratio of 13 to 10. UNAIDS notes that “African women are being infected at an earlier age than men, and the gap in HIV prevalence between them continues to grow.” The report adds that the disparity is even greater in women aged 15 to 24.

“Chinese women being infected at an earlier age than men, and the gap in HIV prevalence between them continues to grow.”

North Africa and the Middle East

Tracking the course of HIV in this part of the world is problematic because of the lack of systematic surveillance in most countries. Also, UNAIDS warns that “inadequate monitoring of HIV prevalence among sex workers, injecting drug users and men who have sex with men,” potential epidemics in these populations are being overlooked.

With an estimated adult rate of more than 2%, the country thought to have the highest HIV prevalence is Sudan. Heterosexual transmission accounts for most cases, and the virus is spreading more rapidly among women than men. Libya, Bahrain and Oman have seen “substantial transmission” through injecting drug use, but there are not enough data to draw more conclusions. In the region overall, widespread stigmatisation and criminalisation of male-to-male sexual behaviour present a considerable obstacle to learning about HIV prevalence in that segment of the population.

Eastern Europe and Central Asia

Injecting drug use is “the main driving force” for the spread of HIV in this part of the world. At the same time, UNAIDS emphasises the diversity of the epidemics taking place there. For example, in Russia, where most drug users are male, the proportion of female HIV infections shot from one in four to one in three over the course of a single year, and observers suspect that “sexual intercourse has been playing an increasing role in transmission.” Meanwhile, the Czech Republic, Hungary, Slovenia and the Slovak Republic are all hosts to epidemics driven primarily by male-to-male sexual transmission.

Estonia, the Russian Federation and Ukraine have adult HIV prevalence rates above 1%, Ukraine’s being the highest, at 1.4%.

Latin America

Drug injection and male-to-male sexual behaviour are the primary modes of HIV transmission in most of South America, where UNAIDS suggests that “low national prevalence is disguising some very serious epidemics”. Brazil, for example, has an estimated overall adult prevalence rate of only

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Estimated number of people living with HIV

<table>
<thead>
<tr>
<th>Region</th>
<th>Adults and children, end 2003</th>
<th>Adults (15-49), end 2003</th>
<th>Adults (15-49) rate (%) end 2003</th>
<th>Women (15-49), end 2003</th>
<th>Children (0-14), end 2003</th>
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<tr>
<td>Sub-Saharan Africa</td>
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<td>17,000,000</td>
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</table>

0.7%, while cohorts of injecting drug users in some Brazilian cities have prevalence rates above 60%. Furthermore, since Brazil is the fifth most populous country in the world, even low prevalence translates into enormous healthcare challenges.

In Central America, “sex between men is the predominant mode of transmission in several countries, notably Colombia and Peru. However, conditions appear ripe for the virus to spread more widely, as large numbers of men who have sex with men also have sex with women.”

The Caribbean

Six of the seven Caribbean countries have adult HIV prevalence rates above 1%. The hardest-hit country is Haiti, at 5.6%, followed by Trinidad and Tobago and the Bahamas, with rates of 3.2 and 3.0% respectively. Prevention efforts have led to a decline in HIV prevalence in the Dominican Republic, where 1.7% of the adult population is now estimated to be infected. UNAIDS states that “the Caribbean epidemic is predominantly heterosexual, and is concentrated among sex workers in many places. But the virus is also spreading in the general population.”

High-income countries

There are an estimated 1.6 million HIV-infected people living in the high-income countries of the world. Sexual transmission between men accounts for many of these cases, and is the most common form of transmission in Australia, Canada, Denmark, Germany, Greece, New Zealand and the United States. At the same time, heterosexual transmission has “sharply” increased in high-income countries in recent years. Also, injecting drug use led to more than 10% of all reported cases of HIV infection in Western Europe in 2002, and is thought to account for about 25% of cases in Canada and the United States.


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**Activists on the march**
Perhaps more than any other medical challenge, HIV has transformed how we think about society’s response to the illnesses of individuals. The International AIDS Conferences, held since 1985, provide a window onto the unique social history of this epidemic.

The first International AIDS Conference took place in Atlanta, home of the US Centers for Disease Control. Treatment and prevention were both on the agenda, along with basic science. Following a similar meeting in 1986 in Paris, the tenor of the Conferences began changing from 1987.

Attendance nearly tripled, with more than 7,000 delegates gathering in Washington, DC, and protestors turned out to contribute in their own ways. One of their major complaints was the length of time needed for experimental treatments to go through the clinical trials system. The conference itself included a “living with AIDS” panel discussion in which HIV-infected people shared their experiences.

The San Francisco Conference was the last to be held in the United States. The 1992 Conference was scheduled for Boston, but the refusal of the US Government to allow people with HIV from other countries to enter the US tied the organizers to cancel the Conference and move it to Amsterdam. Since then Conferences have been held in Vancouver (1996) and Toronto (2006) to allow AIDS workers from the US to attend Conferences at reasonable cost.

The 1994 Conference was again characterized by an absence of major treatment breakthroughs, but it was significant for other reasons. This was the first time the event was held in Asia, with more than 11,000 delegates gathering in Yokohama, Japan. And the International AIDS Society was restructured so that it could assume greater responsibility for future conferences. Yokohama was the last annual conference, and since then the event has taken place every two years.

At more recent conferences, organisers have sought to amplify the calls for a unified global response to AIDS. The official theme in Vancouver in 1996 was “one world, one hope”, and that theme in Geneva in 1998 was “bridging the gap”. The research updates in Vancouver did appear to finally offer true hope: this was the year when data began to confirm that combining drugs from multiple classes could produce sustained clinical benefits. But it looked like the first treatments with real potential to stave off immune system breakdowns would only be affordable for a relatively wealthy minority.

Hence the focus on “bridging the gap” in Geneva. More than 3,000 people from developing countries were reported to be among the conference’s 12,700 delegates. Community representatives played an unprecedented role in helping to plan the event. But the scale of the global healthcare gap led some delegates and their allies to conclude in the wake of the Geneva conference that far more needed to be done. Their frustration and in some cases outrage was channelled into activities surrounding the historic conference in Durban, South Africa, two years later.

The Durban conference represents a turning point in the global effort to mobilise a response to AIDS.

People with HIV again had a presence the following year in Stockholm, expressing their views in a series of conferences sessions. The event was held in the US in 1992 and again attended by thousands of panels for individuals who died from HIV-related causes. At the policy level, the World Health Organization published the conference proceedings with a display from the AIDS Memorial Quilt, which is made up of thousands of panels for individuals who died from HIV-related causes. The conference also featured a display from the AIDS Memorial Quilt, which is made up of thousands of panels for individuals who died from HIV-related causes.

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Memorable quotes from Barcelona 2002 and Durban 2000

Two years ago in Barcelona:

“In its first round of proposal review, the Global Fund approved the financing of programmes that will expand ART treatment to over 220,000 people living with HIV over five years, doubling the current number of people who now have access to these medicines in developing countries.”

(Global Fund press release)

“We are aiming for 3 million people worldwide to able to access ARVs by 2005.”

Dr Gro-Harlem Brundtland, Director-General, WHO

“When this conference gathers again in Bangkok we will know who has delivered on the first UNAIDS promises, due to be achieved in 2003. Bangkok will be a time of accountability.”

(Peter Piot, Executive Director, UNAIDS)

“Let this be the conference where expectations start to be really translated into actions”

(Stefano Vella, President, International AIDS Society)

Four years ago in Durban:

“When all is said and done, when the drums are silent, when the media has packed up and gone, when the hotels are less full and the streets less busy, when the singing and chanting have stopped, and when the marches are just a memory, I assure you all that we will still be here.”

(Dr Manto Tshabalala-Msimang, Minister of Health, South Africa)

“But much more needs to be done to bridge the health equity gap between the world’s havens and have-nots, to ensure in Nelson Mandela’s words, that the poorest of the poor do not have to wait 10 to 15 years for and AIDS vaccine to trickle down to them.”

(Bill Gates)

“TB is the leading infectious cause of death in adults worldwide. It is also the most common cause of suffering and death in people with HIV infection. Therefore it is critical that we educate patients and health care providers about the link between these two diseases.”

(Dr Kenneth Castro, Director of CDC Division of TB Elimination)

And actions taken by each of us this week can help to determine how our remarkable coalition continues to evolve.
The Abuja Declaration - ActionAid Report

T he Abuja Summit in April 2001 brought African leaders together in the Nigerian capital for an unprecedented dialogue on the continent’s response to HIV/AIDS. The product of this two-day event, the Abuja Declaration, announced the goal of reducing HIV, tuberculosis (TB) and other related infectious diseases. It also established a broad set of objectives for moving forward.

In a new report, ActionAid International takes up the question of how well the commitments made in Abuja have been honoured in four countries with high numbers of HIV infections: Kenya, Malawi, Nigeria and Zimbabwe. The report provides valuable insights into these countries’ performances. It also indirectly illustrates, through its unavoidable limitations, just how difficult it can be to hold policy-makers accountable for their promises.

Before considering the different components of the “action framework” that accompanied the Abuja Declaration, the ActionAid report begins by observing that commitments were expressed in very general terms. “The lack of specificity in targets and indicators . . . means that assessment is often more qualitative than quantitative.”

With this caveat, the report goes on to consider 12 priority areas, including leadership, human rights, access to treatment, care and support, health systems development, resource mobilisation, partnership, and prevention of HIV, TB and other related infectious diseases. In discussing each country’s progress in these areas, the report synthesises many observations on a wide range of issues.

For example, the section on human rights notes that Malawi has drafted a workplace HIV/AIDS policy for the public and private sectors, that Kenya has no legislation to prevent discrimination against people with HIV/AIDS; and that in Zimbabwe there are only scattered efforts to enact HIV-related legislation addressing specific situations.

In the section on disease prevention, we learn that 54% of Zimbabwean hospitals had facilities delivering mother-to-child transmission prevention by the end of 2002, that more than three times as many men in Malawi than in Nigeria report using condoms; that distribution of male condoms in Zimbabwe has been hampered by fuel shortages; and that “Kenya, Nigeria and Zimbabwe don’t mention TB in their prevention programmes”.

The report also highlights the conundrum of trying to build capacity in the face of an epidemic that disproportionately strikes people at the most productive stage of life. The situation in Malawi provides a striking example: “The impact of HIV/AIDS on the skilled workforce has had a devastating effect on government capacity to formulate and manage national programmes. Total public sector mortality rates increased from 3 percent in 1990 to 16 percent in 2000,” say ActionAid.

Information like this calls to mind the troubling metaphor of trying to erect complex structures on a foundation of quicksand – and provides at least part of the explanation for why the HIV/AIDS responses of many African countries lag so far behind people’s needs.

ActionAid International (2004), Responding to HIV/AIDS in Africa: A Comparative Analysis of Responses to the Abuja Declaration in Kenya, Malawi, Nigeria and Zimbabwe is available during the conference from any of the ActionAid International Team or the ActionAid stand, number 227.

In brief

Why the Thai approach is working: HIV issues and needs in Asia

• Asia-Pacific is home to 60% of the world’s population and 19% of the men, women and children living with HIV/AIDS in 2004.
• Despite low prevalence rates, large populations mean large absolute numbers of infected people: 5.2 million men, 2 million women and over 150,000 children.
• Themes of risk behaviours for HIV in Asia are:
  - The buying and selling of sex.
  - Injecting drug use.
  - Male-male sex.
• Commercial sex remains the most common risk behaviour in Asia.
• Household surveys suggest that it is not uncommon for between 5% to 10% of men to report having bought sex in the preceding year.
• In several places where condom use in commercial sex is high, HIV prevalence has started to drop.
• In many settings, needle- and syringe-sharing are very common; high levels of HIV infection among injection drug users is consequently also common.
• While many Asian countries ignore male-male sex, this behaviour is spreading HIV.
• Male-male sex is a common means of transmission; a 2003 survey in Bangkok found 13% of men who have sex with other men were infected.
• Throughout the region, multiple risk behaviours are carrying HIV into different parts of the population.
• Asia’s HIV prevention successes:
  - Provide specific services to reduce the risk of specific risk behaviours.
  - Provide access to information and to services on a scale large enough to make an impact on HIV transmission.
  - Ensure the social, political and security environment supports the provision of appropriate HIV prevention services to those most at risk.

Source: MAP (2004), AIDS in Asia: Fact the Facts, A comprehensive analysis of the AIDS epidemics in Asia, Monitoring the AIDS Pandemic (MAP) network.

Available on-line at www.mapnetwork.org/reports/aids_in_aia.html

“Power of Partnerships”

Public-private partnerships mean increasing the chances of progress in the battle against HIV/AIDS. A united front will bring about real answers to a complex problem like HIV/AIDS.

One such partnership, addressing training, treatment and prevention is The Infectious Diseases Institute (IDI) at Makerere University in Kampala, Uganda.

Now that resources, including funds and medicines, are beginning to reach people in countries hardest-hit by the pandemic, building capacity among local healthcare providers is of paramount importance to ensure that people living with HIV/AIDS receive the best care and treatment possible.

The IDI brings together leading academic physicians from Africa and North America to strengthen medical infrastructure to meet the unique challenges of the pandemic. Collaborating institutions include the Academic Alliance for AIDS Care and Prevention in Africa, the San Francisco AIDS Foundation, Pangaea Global AIDS Foundation, Pfizer Inc, the Infectious Diseases Society of America, and The AIDS Support Organization.

Each partner brings unique expertise to the program, whether in the areas of patient care, training, prevention, access to medicines, monitoring, counselling or project management.

The Institute now provides care for approximately 500 patients per week, and treats 3,000 HIV infected patients. When the facility is fully operational it will have the capacity to care for 50,000 patients each year.

QUOTED TODAY

“I will never cease my commitment to universal access to antiretroviral drugs for people living with HIV/AIDS.”

Thaksin Shinawatra, Prime Minister, Thailand
First Global Fund Partnership Forum convenes

Established in January 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria is a financing mechanism that gives large sums of money to programmes fighting these diseases. In the first 30 months of its existence, the Fund has disbursed US$3.1 billion to 296 projects in 129 countries, and will release another US$1 billion to 200 programmes by the end of 2004. It has pledged another US$5 billion through 2008 through four rounds of funding. As the Fund says: "These sums represent a substantial increase in the overall resources for these three diseases, more than doubling 2002 funding for malaria alone."

The Partnership Forum is a mandated part of the Fund’s governance, and will meet every two years to give global stakeholders a formal voice and an opportunity to review progress, to discuss and debate issues and to submit recommendations to the board for consideration. The first Partnership Forum met in Bangkok on 7 and 8 July 2004, for consideration. The first Partnership Forum was and is experimental. Hopefully, the framework within which the Partnership Forum operates will coalesce and strengthen in future years.

Global fund speak – some definitions

Board: A 23-member board of directors, recipient governments, NGOs, private sector and affected communities governs the Fund and approves grants.

Secretariat: An 80-person staff based in Geneva that manages grants and reports on Fund activities to the public.

Technical Review Panel (TRP): An independent panel of health and development experts that reviews proposals for technical merit.

Principal Recipient (PR): A public or private body legally responsible for implementation of a grant. Sub-recipients (SRs) are organisations sub-contracted by a PR to deliver programme-related services.

Country Co-ordination Mechanism (CCM): A country-level public-private partnership that develops and submits grant proposals to the Fund in accordance with Fund guidelines. CCMs also oversee project implementation and review reports from PRs.

Local Fund Agents (LFA): Experts that act in lieu of Fund country-level presence, providing financial oversight.
Asian People's Charter on HIV/AIDS

The Asian People's Charter on HIV/AIDS is a consensus charter—a campaign document that provides a people's perspective on HIV/AIDS and related issues like access, rights and equality.

It aims to help create a world in which people are placed above profits and politics, and those living with and affected by HIV/AIDS are given the appropriate medical, social and political responses.

The Charter was developed at a grassroots level, taking in Asia, Africa, Europe and the Americas, and was written after consultations held in the lead up to XV International AIDS Conference by HIV-positive people's networks, NGOs, trade unions and other associations, media and communication strategists, and UN agencies and government representatives.

Support for people-oriented actions on HIV/AIDS contained within the Charter is under the banner of the Asian People's Alliance for Combating HIV/AIDS.

The writing process was led by the People’s Health Movement—a movement with a presence in more than 100 countries.

HIV/AIDS crisis is a public health issue, the Charter notes. The Charter argues that poverty, hunger, ill-health and other factors contributing to the spread of the disease are increasing, assisted by neo-liberal economic policies, lack of respect for health and human rights and a breakdown of nation states due to conflict, war and disaster.

While endorsing concern over the HIV/AIDS epidemic, the Charter demands increased emphasis on primary healthcare and the strengthening of health systems to address other communicable and non-communicable diseases in an integrated way.

Some delegates attending the XV International AIDS Conference who have been involved with the consultation process feel that the Charter should focus on improving access to primary health care, since this is a proven means of improving people’s quality of life and combating HIV/AIDS.

There will be two sessions on the People’s Charter on Health during the conference. The first is on Monday 12 July in IM Pact Room G, from 20:15 to 22:15, the second on Tuesday 13 July in Global Village Room 2, from 10:30 to 12:30.

The Charter calls for action at various levels. Civil society is asked to:

- Continue campaigns for the rights of people in poor countries to receive antiretroviral treatment, delivered through comprehensive primary healthcare services.
- Draw attention to the links between the spread of HIV/AIDS and underlying societal determinants such as poverty, war and displacement.
- Participate in efforts to redress these injustices.

Governments are asked to:

- Provide education on sexual and reproductive health rights.
- Oppose stigma and promote respect of and care for people living with HIV/AIDS.
- Increase access to basic services for people living with HIV.
- Allocate more resources for primary healthcare in general and communicable diseases in particular.
- Reduce budgets for factors that amplify public health and HIV/AIDS crises, such as the military.
- Place people above profits and politics, and thus focus on policies that improve people’s lives in general, and the lives of people infected, affected, suffering from and living with HIV/AIDS particularly.
- Develop a transparent, scientific and human way to conduct clinical trials through an informed consent approach.

The WHO is asked to:

- Commit funds to improve health systems, particularly for primary healthcare, and to provide drugs, general health services and information in the long term.
- Enhance involvement of lay people, especially affected communities and civil society, in its own planning, implementation and evaluation.

Peter Piot: What is HIV/AIDS leadership?

**Q & A**

**OPINION**

**Q** Why is leadership important? How do you define leadership in HIV/AIDS?

**A** Leadership is key in the response to AIDS. At the end of the day, how do you define leadership? It's in money and in policies—from harm reduction for injecting drug users to making it possible for condoms to be advertised on TV in prime time. These are leadership issues. They are not popular issues, and that's why they need leadership. Without strong leadership, you can't do it.

Leadership in this sense is still very disappointing. But my belief is that in many countries we will see progress over the next two years. Why is that? The funding started increasing since Barcelona 2002. A lot of investments have been made in training, in the community, capacity building and all that. When it comes to treatment I think a lot of the investments have been made.

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In Asia, in terms of leadership there are only three countries spending more than 20% of the resource needs on AIDS, including Thailand. All other Asian countries could spend a lot more - so that reflects weak leadership. Globally, the lowest leadership of all is in Eastern Europe and in Latin America. It’s pretty high in Africa, and in the Caribbean and in Asia it’s mixed—emerging, but not bold enough.

**Q** One last thing—the “Three by Five”, are we going to make it?

**A** I’m convinced that there will be enormous progress, and I am not only thinking of Three by Five. But even with three million on treatments by 2005 people it’s still not enough. Antiretroviral therapy is still a rare commodity, and it will be for some time. The result of that is always higher price, and also higher price in terms of power. Who has access to it, and who comes first? It’s a terrible issue. And that’s why it will be necessary to have affirmative action for women. If it’s first-come-first-served, or who pushes hardest, they will fall out of the boat.
The XV International AIDS Conference is organised by the International AIDS Society (IAS) and the Thai Ministry of Public Health as the Local Host. The co-organisers of the conference are UNAIDS, three international community networks (the International Community of Women Living with HIV/AIDS (ICW), the International Council of AIDS Service Organisations (ICASO) and the Global Network of People Living with HIV/AIDS (GNP+)), and the Thai NGO Coalition on AIDS (TNCA), a coalition of Thai AIDS NGOs.

The International AIDS Society is a professional society for scientists, health care and public-health workers, and others engaged in HIV/AIDS prevention, control and care. IAS is a non-profit organisation founded in 1988 and has more than 6,000 members from over 130 countries, and 16 affiliated national and regional societies representing yet another 6,000 members. The IAS is the custodian of the International AIDS Conferences.


As the main advocate for global action on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response to the epidemic aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

Representatives from the organisations and co-organisers form the basis of the Conference Organising Committee (COC). The Chairs of the conference represent the IAS and the Local Host. The COC in turn appoints two chairs each for the Scientific Program Committee (SPC), Community Program Committee (CPC) and Leadership Program Committee. The Committee Chairs serve on the COC. All three committees are composed of leading representatives from a variety of fields bringing diverse expertise to the conference planning process.

IAS Freedom of expression statement
The following statement was released by the International AIDS Society on 6 July 2004

The International AIDS Society has endorsed freedom of expression as an essential principle in the fight against HIV/AIDS. Activism and advocacy contribute to advancing commitment, policy and practice aimed at ending the epidemic.

The IAS does not condone the destruction of property or the use of force by any party during the XV International AIDS Conference.

We have worked closely with the co-organisers, the Local Host, activists, security services and other partners to encourage a vibrant, dynamic conference where the voices of all presenters and delegates can be heard.

We ask all participants to respect these principles, in the interests of a peaceful and successful Conference.