OPEN SOCIETY NEWS

SOROS FOUNDATIONS NETWORK NEWS
SPRING – SUMMER | 2004

Shedding Light on the Fight against HIV/AIDS and TB

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SOROS FOUNDATIONS NETWORK

The Open Society Institute, a private operating and grantmaking foundation based in New York City, aims to shape public policy to promote democratic governance, human rights and economic, legal and social reform. On a local level, OSI implements a range of initiatives to support the rule of law, education, public health, and independent media. At the same time, OSI works to build alliances across borders and continents on issues such as combating corruption and rights abuses.

OSI was created in 1993 by investor and philanthropist George Soros to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help countries make the transition from communism. OSI has expanded the activities of the Soros foundations network to other areas of the world where the transition to democracy is of particular concern. The Soros foundations network encompasses more than 60 countries, including the United States.

Open Society News, published by the Open Society Institute in New York, reports on programs and issues critical to advancing open society throughout the network and the world.

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EDITOR'S NOTE

It has been more than two decades since HIV was clinically identified as the cause of AIDS. Since then, HIV/AIDS has mushroomed into a global epidemic—often working in tandem with other devastating diseases such as tuberculosis, now the biggest killer of those who develop AIDS. The epidemic has wreaked havoc in Africa, caused hundreds of thousands of deaths in North and South America, and is now spreading at an alarming rate in Southeast Asia, Russia, and other parts of the former Soviet Union.

This issue of *Open Society News* describes the challenges and evolving approaches to providing care and compassion, not punishment and isolation, to those living with HIV/AIDS and members of marginalized groups at risk for HIV infection such as prisoners and drug users. One story examines the soaring HIV and TB infection rates in Russian prisons and how prisons incubate these diseases. The clear but often overlooked conclusion is that improving inmate health and prison conditions is crucial to public health. Other stories examine injecting drug use, a major cause for the spread of HIV in many countries, and challenge policies that punish drug users and regard them as incapable of adhering to antiretroviral treatment regimens. Another article cautions against relying on simplistic, universalized formulas that ignore the varied forms of oppression that make many women vulnerable to HIV infection.

As these and other stories in this issue demonstrate, the multiple problems created by HIV/AIDS and TB will never be solved by shunning or ignoring certain groups or parts of the world. Rather, they are challenges that demand a coordinated global response that includes input and cooperation from those who are at risk for HIV infection; that prioritizes the provision of affordable TB and HIV drugs; and that aggressively seeks to alleviate the burdens faced by developing countries struggling with HIV/AIDS and TB epidemics.

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(ABOVE) **HIV-positive woman educating others about safe sex practices and AIDS, Botswana**
(RIGHT) **Mother and child waiting for counseling at Médecins Sans Frontières AIDS clinic, Zambia**

Nina Schwalbe, OSI Senior Fellow in International Health and former director of OSI's Network Public Health Programs, describes the Soros foundations network's efforts to address HIV/AIDS and TB and the threats that such health crises pose to development and democratic, open societies.

NINA SCHWALBE

Every day 14,000 people around the world become infected with HIV. Over half of them are below the age of 25 and less than 1 percent have access to treatment. In South Africa, 600 people per day die of AIDS. In Botswana, life expectancy has fallen from 72 to 38 years. The devastation is not limited to Africa. In Eastern Europe and the former Soviet Union, diagnosed HIV infections surged from 30,000 in 1995 to 1.3 million by the end of 2003. And in the United States, 40,000 people are infected with HIV every year.

HIV/AIDS has also caused a resurgence of tuberculosis worldwide. Many of the countries with AIDS epidemics have seen a 500-fold increase in TB rates since the mid-1980s. Up to 50 percent of people with HIV or AIDS develop active TB, yet in most of East and Southern Africa, fewer than one-third of patients have access to appropriate drugs.

With over 30 million dead and 40 million currently living with HIV/AIDS, the virus must be considered both a global public health crisis and a major obstacle to economic and political development.

The HIV/AIDS and TB co-epidemics are hindering the development of democratic societies as they deplete and divert resources, kill present and future generations that could contribute to change, and foster hatred and intolerance. Instead of receiving care and compassion, those perceived as members of high risk groups—such as drug users, sex workers, and gay and bisexual men—often face prejudice and denial of treatment.

The Open Society Institute began to address the wide-ranging impact of HIV/AIDS and TB by supporting harm reduction programs in Central and Eastern Europe and the former Soviet Union in 1994 and TB programs in Russia in 1997. Since then, OSI and the Soros foundations network have supported efforts ranging from treatment information to legal protection programs to the introduction of palliative care services.

OSI has also made advocacy a key part of its agenda and has supported the Global Fund to Fight AIDS, TB and Malaria, the UNAIDS Global Coalition on Women and AIDS, and the Clinton Foundation's initiatives on lowering the costs of drugs and diagnostics.

OSI's activities have contributed to a growing number of successful efforts in helping communities and governments provide HIV/AIDS and TB treatment and prevention services to people in places ranging from struggling South African townships to overcrowded Russian prisons.

Yet we still need a better understanding about why the same intervention may work in one setting and not another. Scaling up treatment programs will require greater knowledge of local political and social environments. Ensuring efficiency and access will require strong economic, political, and public health institutions. We need prevention programs that address drug use and sex. We need new drugs, diagnostics, and vaccines for both HIV and TB. Supporting gender equity is also a key to controlling both epidemics. And we need substantially increased resources for the Global Fund and bilateral technical assistance programs.

Most importantly, individuals, organizations, and governments concerned about HIV/AIDS and TB must address the co-epidemics as a "chronic emergency" that poses both an immediate public health crisis and a long-term development challenge.

FOR MORE INFORMATION

To learn more about the Soros foundations network responses to HIV/AIDS and TB, visit www.soros.org/initiatives/health and www.soros.org/initiatives/ihrd.

Prison hospital ward, Russia

Tuberculosis in Prisons: Deadly Breeding Ground

Paul Farmer, M.D., Ph.D., and Alice Yang of Partners In Health and Harvard Medical School analyze how tuberculosis in prisons can affect public health beyond prison walls and offer a model for fighting TB infection among prisoners and in the general public.

PAUL FARMER AND ALICE YANG

> In 2001, the case fatality rate of prisoners from TB was 144 per 100,000 prisoners in Tomsk Oblast. Since implementing directly observed therapy and introducing critical second-line drugs, this number has dropped to zero.

Tuberculosis has long been associated with prisons. Complex mathematical formulas describe the transmission of this airborne disease, but a visit to an overcrowded prison provides the simplest explanation: herding together hundreds of people in poor health under substandard conditions with little or no ventilation makes the outbreak and spread of TB all but inevitable.

Tuberculosis rates for prisoners in many countries are 5 to 10 times the national average; outbreaks can rapidly push that closer to 100 times the rate outside jail. In some former Soviet countries, including Russia, prison TB can exceed 25 percent of all cases nationwide.

Most people would not give much thought to TB if it stayed safely confined behind bars. However, there is increasing recognition that the high rate of tuberculosis in prisons poses a threat to society at large: prisons act as a reservoir for TB, pumping the disease into the civilian community through staff, visitors, and inadequately treated former inmates.

To stem the tuberculosis epidemic, policymakers and public health experts must take into account underlying social forces such as poverty and inequality. A disproportionate number of prisoners come from socioeconomically disadvantaged populations where the burden of disease may already be high and access to medical care limited. When they enter prison, they are more susceptible to infection and, if they are already infected, progression to active TB. Prison conditions further fan the spread of disease through overcrowding, poor ventilation, weak nutrition, and inadequate or inaccessible medical care. The combination of incomplete, interrupted, and inadequate treatment often leads to drug resistance; the combination of delayed diagnosis, insufficient treatment, and drug resistance results in high case fatality. The presence of HIV/AIDS, which suppresses immune systems and inhibits the body's ability to fight TB, also increases the likelihood that new infections will progress to active and contagious TB, further amplifying outbreaks and driving up mortality.

This cycle of infection is particularly pronounced in Russia. In the aftermath of the collapse of the Soviet Union, Russian prisons have become a breeding ground for TB. During the country's ongoing transition, poverty and illness have skyrocketed, and an increase in petty crimes has led to an explosion in the prison population: Russia's incarceration rate, 606 per 100,000 population, is second only to that of the United States. In addition, Russia's once internationally renowned system of TB care and control crumbled as funding disappeared, and rates of tuberculosis and multidrug-resistant tuberculosis (MDRTB) climbed rapidly across the former Soviet Union. In Russia's prisons, approximately one out of every 10 inmates is infected with active tuberculosis, with more than 20 percent of sick inmates affected by drug-resistant strains. In some prisons, tuberculosis is reported to account for up to 80 percent of inmate deaths. HIV infection rates in Russian prisons are also increasing: In 1995, there were 7 HIV-positive prisoners; in 2002, there were over 33,000.

A number of international organizations and NGOs have started to respond to the resurgence of TB in the former Soviet Union. Partners In Health (PIH), one of the first organizations to recognize the problem of MDRTB, pioneered a successful community-based treatment model in Peru.

Since 1998, PIH has collaborated with a group of NGOs, government bureaus, and international public health agencies to extend its MDRTB treatment model to Russia. PIH's work in Russia ranges from direct patient care to advocating for federal-level policy changes, both in the prisons and in the civilian sector.

In 2001, with support from the Open Society Institute and other organizations, PIH assumed primary clinical responsibility for a comprehensive MDRTB treatment project in Tomsk Oblast, Siberia, that includes training health care workers, equipping laboratories, providing social support to patients and providers, and conducting clinical and operational research.

The initial results of the project are encouraging, especially in the prisons. In 2001, the TB fatality rate was 144 per 100,000 prisoners in Tomsk Oblast. Since implementing directly observed therapy and introducing critical second-line drugs to treat MDRTB, this number has dropped to zero. The decrease in infection and mortality rates in the prison sector is in part attributable to the stable population, which facilitated direct observation of treatment, complete coverage, and health education.

The need for more TB programs that focus on the health of both prisoners and the general public is critical in Russia and other high TB prevalence countries. In fact, the conditions found in prisons offer an ideal setting in which to pilot effective control and treatment programs that may lead to improved tuberculosis services at the national level. Prison-based programs that draw attention and resources to the problem of TB are also likely to lead to an overall improvement in prison conditions, the health of inmates, and human rights.

The TB and HIV epidemics in Russia are on a collision course. The growing rates of MDRTB and HIV in Russian prisons suggest that without comprehensive programs for TB as well as HIV/AIDS, prisons will continue to be "hot spots" for the transmission of both epidemics.

FOR MORE INFORMATION

To find out more about TB, prisons, and public health, visit Partners In Health at www.pih.org and OSI Public Health Programs at www.soros.org/initiatives/health.

Women's Rights and HIV/AIDS:

Not as Simple as A

Women and children in South African township

Throughout the world, women are increasingly at risk of HIV infection. Joanne Csete, director of the HIV/AIDS program at Human Rights Watch, examines the HIV risks for women and reveals that popular, simplistic formulas will not provide women with effective protection against HIV.

JOANNE CSETE

Is combating the global AIDS epidemic as simple as ABC? Many policymakers have concluded that a good guide to fighting AIDS is to follow the Bush administration's "ABC" message: Abstain from sex if you are not married, Be faithful, use Condoms. Based on their interpretation of the success of ABC in Uganda as part of the national AIDS response, many in the Bush administration have focused on abstinence and fidelity as the keys to reducing HIV infection.

ABC is simple and catchy, but given the diverse situations faced by many at-risk groups, particularly women, is ABC really enough?

> "The gender disparity in HIV infection is strongly related to factors such as women's and girls' second-class status in the household, in society, and in the law. This is a recipe for HIV transmission, and it certainly is no help in these circumstances to tell women to 'be faithful.'"

The epidemiologic pattern of AIDS over its more than 20-year history has generally been to affect first people who are at high risk such as injection drug users, sex workers, and gay and bisexual men, and then, if not contained, spread to the "general population." In country after country, it has become clear that in the general population, women and girls are at greater risk of HIV than men and boys.

According to the UN, women make up almost 50 percent of all people living with HIV worldwide. Among people under the age of 24, girls and young women comprise two-thirds of all new infections. In many parts of sub-Saharan Africa, teenage girls are five times more likely than boys to become infected with HIV.

There are physiological reasons for this greater risk, but they do not fully explain the higher rates of infection among women, especially in places like sub-Saharan Africa where the epidemic is mature. In these regions, the gender disparity in HIV infection is strongly related to factors such as women's and girls' second-class status in the household, in society, and in the law. Men often face no social barriers to having sex partners outside marriage, but married women face violence and abuse when they refuse sex or demand condom use of their husbands, even if the men have been unfaithful. This is a recipe for HIV transmission, and it certainly is no help in these circumstances to tell women to "Be faithful."

In addition, discrimination against women—a human rights violation—is written into law in many countries in the form of property, inheritance, and divorce laws that deflate women's economic potential and make them economically dependent on marriages that may be unsafe in terms of exposure to HIV as well as physical violence.

"My husband hated condom use. He never allowed it. He would beat me often when I refused to sleep with him," said Sara K., a Ugandan woman who spoke to Human Rights Watch in 2003. "My husband said, 'We are married, how can we use a condom?' When I knew about his girlfriends, I feared that I would get infected with HIV. I tried to insist on using a condom but he refused. So I gave in because I really feared [him]."

While unaware of her own HIV status, Sara K. did learn that her husband was HIV-positive and she eventually left him because of the abuse. But, as Sara noted, many women have nowhere to go.

As for the "A" of ABC, for many unmarried women, the option to abstain from sex is not something completely under their control. Human Rights Watch has interviewed thousands of young women across the world who have faced exceptional HIV risk because of rape or because they have been in situations where the only way to survive was to trade sex for food or money.

"I tried to do anything to keep us going," said 22-year-old Claire S. from Kenya, who became the head of her household at 17 when her mother died of AIDS. "I made and sold food, I washed cars, and now I'm working for a woman with a small kiosk, but I don't think it's going to last. I may have to go into prostitution, and then I know I will get HIV. I would rather have a real business, but it is not easy."

Human Rights Watch has also encountered hundreds of girls orphaned by AIDS who reported sexual abuse by their "guardians," a particularly heinous crime. For all these girls, having someone preach to them about abstinence is a cruel joke.

The good news is that subordination of women, sexual abuse, and even "survival sex" are increasingly recognized as important factors in many analyses of the causes of HIV/AIDS. The bad news is that so little is done about it, including by many of those best placed to act.

There are many reasons for this inaction. Since the beginning of the AIDS epidemic, politicians have found it easy to reduce AIDS to a problem of "bad behavior" such as drug use and sex outside marriage. For the Bush administration, there has been great political benefit in ABC because it appeals to Bush's conservative constituency, particularly when the emphasis is on "A" and "B."

Yet if the U.S. policymakers and others who support the government's current HIV/AIDS policies were really serious about fighting the epidemic, they would look beyond ABC and make protection of the human rights of women and girls a central element of HIV/AIDS policies.

Action is urgently needed in three areas: basic protections against sexual violence, including marital violence and rape, and increased prosecution of offenders; improving women's economic potential by removing all discrimination against women in property, inheritance, and divorce laws; and ensuring equal access to education and health services for girls and women.

Until the basic human rights of women are taken as seriously as ABC, and are established and secured, particularly in countries devastated by HIV/AIDS, women and girls will face unduly high risk of HIV, and the epidemic will continue to have the upper hand.

FOR MORE INFORMATION

To learn more about the impact of HIV/AIDS on women and human rights, visit www.hrw.org/women/aids.html and www.hrw.org/reports/2003/africa1203/.

Thailand's Dirty Little AIDS Secret: Death and

Karyn Kaplan of the Thai AIDS Treatment Action Group describes why the Thai government's abuse and neglect of drug users is no way to fight HIV/AIDS.

KARYN KAPLAN

One of the strongest undercurrents accompanying the 15th International AIDS Conference, hosted by the Thai government in July 2004, was the frustration of drug user activists in Bangkok about the lack of attention to their issues.

"With more than 2,500 people murdered over the past year in a violent government-sponsored drug crackdown, did Thailand deserve to host what is arguably the world's most important conference on HIV?" asked Paisan Suwannawong, director of the Thai AIDS Treatment Action Group (TTAG) and founding member of the Thai Drug Users' Network (TDN).

The crackdown took place in early 2003 as part of an ill-conceived effort to end all drug sales in Thailand within three months. Government claims that most of the deaths came from drug dealers killing each other have been dismissed by the international community. Instead, Amnesty International, Human Rights Watch, the United Nations, and even the U.S. State Department—a frequent defender of the Thai government—were unanimous in their concern about "shoot first, ask questions later" policies that made anyone suspected of being involved with drugs fair targets for violence and abuse.

Prime Minister Thaksin Shinawatra's war on drugs and nationwide campaigns depicting drug users as a threat to security and family values have created a climate of fear and ignorance in Thailand that works against sensible harm reduction and HIV/AIDS prevention policies.

"Drug users are described as 'scum' by the current administration, and so it is no wonder that HIV prevention for this group is hardly a priority," said Paisan, who noted that HIV prevalence among injectors in Thailand has raged at 50 percent since the late 1980s and shows no sign of abating. Globally, one in three new HIV infections outside of Africa is related to injection drug use.

At the same time it has harassed and refused to treat drug users, the government has done a laudable job of providing HIV prevention and treatment to other high prevalence groups, such as the sex workers active in Thailand's lucrative sex-tourism industry. Government policies have helped lower sexually transmitted HIV infections from 143,000 to 29,000 in just a decade. A "100 Percent Condom Use" project to reduce HIV infection among sex workers and their clients was documented by UNAIDS as a prevention "best practice."

This year, the government boldly announced its intention to provide antiretroviral therapy to "all who need it" by using a grant from the Global Fund to Fight AIDS, TB and Malaria. The government is also producing cheap HIV/AIDS drugs. A dynamic network of people living with HIV/AIDS and allied NGOs has conducted persistent and often successful lobbying efforts to achieve these advances in prevention and treatment.

For injection drug users, however, these policies have meant little. The government only recently ended its policies of denying antiretroviral therapy to "high risk behavior" groups, i.e., drug users. Most doctors still refuse to treat active drug users out of a belief that they are unable to adhere to treatment regimens—even though there is no evidence to support that assumption.

"This problem is just the tip of the iceberg. Drug users historically avoid health care services because of well-founded fears of discrimination and arrest," said Piyabutr Nacaphiew, coordinator of the Thai Drug Users' Network. "Prime Minister Thaksin's war on drugs only exacerbated what was already an unaddressed public health crisis, where even outreach workers trying to provide support services felt intimidated and unsafe doing their work."

In addition to intimidating drug users and HIV/AIDS prevention groups, the Thai government's policies fly in the face of universal principles about access to health care and equal rights language contained in Thailand's constitution.

The Thai Drug Users' Network has been one of the only groups in Thailand publicly speaking out against the government's egregious violations of drug users' rights to health care, confidentiality, due process, and freedom from abuse and violence. TDN has used a combination of direct action demonstrations and advocacy through government channels to address the gaps in Thailand's HIV/AIDS prevention and treatment plans.

"We need comprehensive harm reduction services with national coverage—yet we still face resistance from the government, which claims these scientifically proven interventions are inappropriate for our culture," said Paisan. "Thailand's popular antidrug campaign has increased stigmatization of users. This is a recipe for disaster for the future health of drug users and the general population. HIV does not stay in a little

Neglect for Drug Users

> "Prime Minister Thaksin's war on drugs only exacerbated what was already an unaddressed public health crisis."

Thai police displaying confiscated drugs

'reservoir' of infection. If it is ignored in some populations, you'll never fully confront AIDS successfully."

In the past, drug user issues have been notoriously underrepresented at international HIV/AIDS conferences. TTAG Director Paisan did participate in the Bangkok conference's opening ceremony, but by the time he gave his address, top UN officials and half of the audience had left. Determined activists made sure Paisan was invited back to speak at the closing ceremony. TDN did receive the Award for Action on AIDS and Human Rights from Human Rights Watch and the Canadian HIV/AIDS Legal Network, and some progress was made in Bangkok on drug user issues, yet more work needs to be done to focus attention and concern on the discrimination faced by drug users.

The true test of the conference's success will be what kind of concrete policies and programs emerge to meet the immediate and long-term needs of all those affected by HIV/AIDS. Thai drug users' groups intend on using their growing momentum to make themselves heard. "We cannot stand by and watch more of our friends die while those with the power to change this are not held accountable," Piyabutr said.

FOR MORE INFORMATION

To find out more about Thailand's drug war and its responses to drug users and HIV/AIDS, visit http://web.amnesty.org/library/Index/ENGASA390082003?open&of=ENG-THA, and www.ahrn.net/member/document/ razak2003.pdf.

HIV Treatment for Drug Users: A Realistic Goal

OSI's International Harm Reduction Development Program (IHRD) has long been at the forefront of efforts worldwide to provide prevention and treatment services to populations particularly vulnerable to HIV/AIDS, including injection drug users (IDUs). During the 15th International AIDS Conference in Bangkok, Thailand, in July 2004, IHRD helped organize a satellite meeting, "HIV Treatment for Drug Users: A Realistic Goal," at which participants called for greater inclusion of drug users in HIV treatment efforts.

Other organizations involved included the Central and Eastern European Harm Reduction Network, the European AIDS Treatment Group, Gay Men's Health Crisis, the Thai Drug Users' Network, and the Thai AIDS Treatment Action Group.

The meeting had experts such as Jim Kim, M.D., director of the World Health Organization's HIV/AIDS program, present substantial evidence showing that drug users can receive the same benefits of treatment as other people with HIV. Kim warned that failure to offer HIV treatment to drug users compromises an effective response to the epidemic.

The meeting also marked the official release of IHRD's new report, *Breaking Down Barriers: Lessons on Providing HIV Treatment to Injection Drug Users*, which categorically refutes negative assumptions about IDUs' ability and desire to be treated for HIV infection. It also presents examples of innovative HIV treatment programs for drug users in a wide variety of countries.

FOR MORE INFORMATION

To find out more about IHRD's activities, the Bangkok conference, and obtain a copy of *Breaking Down Barriers*, visit www.soros.org/initiatives/ihrd and www.ceehrn.org/ARV4IDUs.

Thai Sex Workers:

Facing Discrimination But Gaining Confidence Every Day

In June 2004, Andrew Hunter from the Asia Pacific Network of Sex Workers spoke to a group of sex workers from Chiang Mai in northern Thailand about the impact of HIV/AIDS on their lives and work. The discussion was organized by Empower, a Thai NGO that works to promote fair treatment and income for Thai sex workers and provides HIV/AIDS prevention and treatment services. The following is an edited summary of the group's responses.

How are sex workers with HIV treated by the community?

Discrimination is alive and well in Chiang Mai. Bar owners won't employ sex workers rumored to be HIV-positive. Brothel owners won't allow a woman to work if she becomes thin or has skin problems. The general public in Chiang Mai discriminates against sex workers and people with HIV. One friend, who died last month, was routinely refused public transport and evicted from various guest houses and hostels. She also was unable to find a hairdresser and Thai massage salons refused to serve her. We think this is because public campaigns for tolerance and living together have stopped.

Have attitudes toward HIV-positive sex workers changed in the last 10 years?

Ten years ago sex workers were targeted as the "spreaders of HIV." This portrayal came from the media and some academics. However, a decade of statistics *[transmission of HIV/AIDS by men to others is much easier than transmission by women]* and advocacy *[for example, campaigns to get men to wear condoms]* have largely dismantled this myth though sex work is still seen as very high risk for HIV. It is still less of a stigma to be HIV-positive than to be a sex worker.

Are sex workers who get sick able to go home to their families?

Many sex workers have spent their lives as the family bread winners. They are independent, proud women who don't want to be a burden or bring shame on their families. Generally, most women wait until just days before they die to travel home. For migrant sex workers from Burma the question of going home is complicated by illegal travel and the length of the journey. Also, because of forced relocations in Burma, many women have lost track of where the government has moved their families.

Do sex workers get access to good medical treatment?

Most sex workers do not reveal their work to the health services. This means that they receive the same health care as other citizens. The exception is the government sexually transmitted infections (STI) clinic, which has special sex worker services. The STI service in Chiang Mai is currently very respectful and cooperative toward sex workers.

Are sex workers discriminated against in medical treatment—including access to antiretroviral drugs (ARVs)?

If their sex worker status is known, then they are at risk to be regarded and treated badly. Most people in Thailand applying for ARVs are very ill already and are no longer working.

What issues do migrant sex workers face?

Migrant sex workers generally work in brothels when they first arrive or have worked in them in the past. These brothels require that you have sex 5 to 10 times a day. The customers have an estimated HIV rate of 12 percent. Condoms offer 90 percent HIV protection in perfect use. These three factors combine to put women in brothels at an extreme risk of infection. All the women we know who have died from HIV have worked in a brothel sometime in their lives. Sex workers from Burma are malnourished, have had no previous or primary health care, and they are in high stress situations. When they get HIV, their immune systems fold quite quickly, giving them a life span of maybe two years.

How does Empower help sex workers deal with HIV/AIDS issues?

The program gives sex workers practical things like access to condoms, language and negotiation skills, and less tangible skills like self-confidence and community support. The health program plays an important role in individual counseling, referral, and care. Empower also joins with others to ensure access to prevention, care, and treatment, and helps provide care for sex workers with AIDS. Things are still quite bad for sex workers, yet support from each other and groups like Empower helps us get noisier and stronger each day.

Helping Those with HIV/AIDS in South Africa:

A Question of Political Will

Zackie Achmat's advocacy efforts on behalf of the millions of South Africans living with HIV/AIDS have made him one of the world's most visible HIV treatment activists. In 1998, he cofounded Treatment Action Campaign (TAC), a South African nongovernmental organization that works to increase access to HIV treatment and raise awareness about HIV throughout the country.

Achmat was diagnosed with HIV in 1990. Later that decade he generated much public attention and discussion by refusing antiretroviral (ARV) drugs until the South African government made them available through the country's public health system. The government finally promised to do so in 2003 and Achmat began HIV treatment in August of that year.

In June 2004, Achmat spoke to *Open Society News* about the state of the HIV/AIDS epidemic in South Africa and what priorities he and TAC have identified for future action.

> "Change will only come through political mobilization. There's not a single black African family that doesn't know someone who has died of AIDS."

Zackie Achmat speaking at a TAC event

Last year the government pledged to begin providing ARV therapy through the public health system, with an initial goal of reaching 53,000 HIV-positive patients by the end of March 2004. Has the roll-out been successful so far?

The government missed that target by a long shot. Patients in fewer than half of South Africa's 11 provinces are currently receiving drugs. It's not that the demand isn't there. In one hospital an average of 180 patients a day are registering to get treatment. But the hospital is only equipped to take 100 a month. And a consistent drug supply for even that number has been impossible to ensure.

I believe the program will take off. There isn't a shortage of money to treat the 500,000 people who need ARV now, but there is a shortage of political support. For example, KwaZulu/Natal province has the highest HIV rate in the country, yet the province is still waiting for the national ministry to approve its treatment plan.

You say that adequate funding isn't the issue. But what about South Africa's health infrastructure? Is it developed enough to provide treatment to hundreds of thousands of people?

South Africa has a fantastic infrastructure that could be utilized—but again, it's a question of political will. The private health sector needs to be more involved. One idea would be to ask private sector health providers to work one day a week in public hospitals.

This would likely not be as hard to arrange as it sounds. Health workers recognize the severity of the epidemic, after all. There's been a hemorrhaging of nurses and doctors, the frontline health workers, from the public sector to the private sector, in part because of their frustration with being unable to help people with AIDS.

Attracting doctors and nurses back to the public sector can be done. We need to remunerate doctors and nurses properly and give them the appropriate tools, such as antiretrovirals, and we need to pursue broader structural reform of the health care system.

You have clashed numerous times with Health Minister Manto Tshabalala-Msimang and President Thabo Mbeki over what you consider their unconscionable—even criminal—inattention to South Africa's HIV/AIDS epidemic. What are your thoughts in the wake of Mbeki's reelection in April and his decision to reappoint Tshabalala-Msimang?

We wanted to give the health minister the benefit of the doubt—the opportunity to change policies after five years of delays and obstruction. TAC and others in the HIV community have made efforts to reestablish a working relationship with her, but nothing has changed. The minister is at war with the entire health system, public and private. The head of the AIDS program and other key staff have recently resigned because they can't work with the minister. Each province is left to its own devices, and many cautious politicians at the provincial level are placing their personal political lives over the lives of people with HIV.

An estimated 20 percent of all South Africans between the ages of 15 and 49 are currently infected with HIV. Treating them is a primary goal, but what about prevention?

TAC has always stressed that it's impossible to separate prevention from treatment, and prevention and education efforts are currently not adequate either. A recent study of young South Africans' sexual behavior showed that more than 10 percent of 15- to 24-year-olds were infected with HIV. More than 70 percent of HIV-negative individuals in this age group perceived themselves to be at no risk or only a small risk for contracting the virus, and 62 percent of those *already* HIV-positive felt they weren't at risk.

We also need to do a better job of making condoms available. But even when they're available, talking about sex and condoms remains taboo in South Africa. Widespread migrant work, high unemployment, and economic dislocation have helped make sex a commodity. Ultimately, we need to give women greater economic independence and a greater say over their own bodies.

At the international level, religious and politically conservative institutions and leaders ranging from the Vatican to the Bush administration have emphasized abstinence and refuse to consider realistic means of prevention. The "Abstinence, Be faithful, use Condoms" prevention model touted by Bush doesn't work. Encouraging a woman to "be faithful" does little good if her migrant-worker partner isn't when he is away. "Be faithful" by itself is a death sentence for such women.

Given the mixed results of these policies and programs, what should South Africa do to adequately address the HIV/AIDS epidemic?

Change will only come through political mobilization. There's not a single black African family that doesn't know someone who has died of AIDS. People are beginning to realize how desperate the situation is and that they can—and must—take action.

Médecins Sans Frontières recently set up a pilot program in a poor rural area in Eastern Cape province. The program distributes 100,000 condoms a month and has at least 140 people in treatment. Such efforts create treatment-literate patients, a key part of a potentially effective global AIDS strategy.

But to roll out a program like this nationally in South Africa requires the government. The private sector and NGOs can't do it alone. The state must be involved in fighting HIV and AIDS.

FOR MORE INFORMATION

To learn more about TAC's work in South Africa and its international advocacy efforts, visit www.tac.org.za.

Living with HIV and Fighting for Change

Believe Dhliwayo recounts his experience of being diagnosed HIV-positive and giving up his life as an engineer to become coordinator of Zimbabwe Activists on HIV/AIDS.

Believe Dhliwayo during a group risk awareness and confidence building activity for HIV-positive people at the nonprofit Zimbabwe Activists on HIV/AIDS

BELIEVE DHLIWAYO

When I received my HIV-positive diagnosis in 1999 at age 28, I decided to empower myself and my family. I left the plumbing and water engineering profession to address HIV in my country.

I was among the first professional men to be open about having HIV and I helped organize the Post Test Club, Zimbabwe's first support group for people living with HIV. The club is also open to people who are HIV-negative but feel concerned enough to get tested. The reaction to my efforts and the club has been mixed: other professional men called me a coward who couldn't face HIV/AIDS like others. This reflects the strong cultural pressure in many parts of Zimbabwe for HIV-positive men to accept their fate and die quietly.

Getting involved with HIV issues and living with HIV has altered my life in ways I never could have known. As a result of HIV-related illnesses, I went through a very traumatizing divorce. Initially, the stress of illness gave me severe acne. My face changed from being smooth to being covered with pimples that my cousins referred to as "small anthills." The acne cleared up with time.

In 2001, I could no longer stand seeing my fellow group members dying from easily treatable opportunistic infections and I gave money allocated for meetings to pay for their medical treatment. The organization that provided the money interpreted this as stealing and I was put in jail for three days. At the time, most NGOs and AIDS service organizations in the country ignored treatment and concentrated on prevention of new infections. This angers me because lessons around the world show that prevention can't work on its own without treatment, especially treatment for opportunistic infections.

Seeing people living with HIV/AIDS being denied affordable medical treatment makes me consider HIV/AIDS primarily as a human rights issue. This really dawned on me in Namibia when I had an opportunity to participate in a human rights regional conference. I realized for the first time that people living with HIV/AIDS have rights, and I keep UNAIDS' international guidelines near me like a small blue bible.

Unfortunately, people like me who are living with HIV/AIDS have no rights in Zimbabwe, and very limited capacity to make our concerns clear. We have a health minister who focuses only on prevention and has little interest in treatment. He has refused to include any treatment activities in Zimbabwe's first round Global Fund proposal.

There are restrictive laws under the Public Order Security Act that can punish you if you talk against the government. Newspapers, tightly controlled by the government, always include glowing reports that do not accurately and truthfully depict what is really happening.

If we raise our voices, the government quickly targets us as an opposition political party that must be crushed. But how can we be a political party when we are simply talking about the life and death of people from AIDS?

Our nonviolent advocacy requires us to be patient, focused, and organized, qualities that remain a challenge to Zimbabwe's community of people living with HIV/AIDS.

While some international organizations have been willing to work with needy communities in Zimbabwe, local NGOs insist on holding workshops and conferences, and pay little attention to the needs of poor rural women and children.

It is because of this that Zimbabwe Activists on HIV/AIDS was born in January 2003. Our mission is to ensure universal, unconditional access to treatment and information for people living with HIV/AIDS. We pursue legal and political advocacy and promote holistic treatment for opportunistic infections, antiretroviral therapy, and alternative treatments to improve the lives of people living with HIV/AIDS.

I have HIV but I still have a passion for life due to my spirituality, alternative therapies, and good nutrition. My CD4 count is decreasing, down to 249 as of May 2004.

I know I need antiretroviral drugs, but as Zackie Achmat in South Africa did, I will refuse them until treatment opportunities expand for most Zimbabweans. If I die before this can happen, I know I have at least empowered my family members to take legal action against the ministry of health for causing needless deaths by failing to provide treatment.

Central Asia:
Ailing Public Health Systems
Limit Effective Harm Reduction Efforts

The continued failure to build comprehensive public health infrastructures is severely hampering efforts to address growing drug use and HIV/AIDS crises in Central Asia. OSI consultant and public health policy analyst Richard Elovich examines some of the reasons for this failure and provides ideas for more effective drug and HIV/AIDS policies in the region.

RICHARD ELOVICH

Central Asia is heading toward a major public health crisis. Yet governments in the region are unprepared for problems that could soon devastate the lives of tens of thousands of citizens and derail political and economic development.

The looming drug use and HIV/AIDS epidemics in the region could overwhelm public health infrastructures that have deteriorated or been neglected in the wake of the breakup of the Soviet Union. These systems are struggling just to provide minimal services for the public at large. An estimated 80 percent of the region's HIV cases can be traced to injecting drug use. And Afghanistan continues to flood Central Asian neighbors like Tajikistan and Uzbekistan with high-grade heroin. Drug use and the spread of HIV, first among drug users, then among the larger public, are not likely to go away any time soon.

Harm reduction measures—including needle exchange, methadone substitution therapy, and comprehensive social support services—can provide Central Asia with critical tools for effectively reducing the transmission of HIV and other blood-borne diseases among drug users. But harm reduction programs cannot be implemented in a vacuum, without support from and integration with viable public health and social service structures.

Increased emphasis on epidemiology, the social context of health problems, and transparency are crucial to any efforts by Central Asian countries to improve their public health responses to drug use and HIV/AIDS.

Medical and narcological personnel must be allowed to step back from their growing caseloads of patients and discern the patterns of exposure and health problems across the population. This analysis can then help them deploy resources to prevent the spread of diseases and to engage people earlier in treatment and targeted harm reduction. Epidemiology is invaluable to public health structures because it clarifies causes and effects and promotes responses that are timely, feasible, cost-effective, and consistent with social values.

Epidemiology independent of state interests is critical. For example, Eric Klinenberg's book, *Heat Wave: A Social Autopsy of Disaster in Chicago*, about deaths in Chicago during a 1996 heat wave, challenged government and media accounts of "natural" heat-related fatalities. Klinenberg used social epidemiology to show that the disproportionate number of fatalities among elderly black residents was far from natural and more due to social isolation, changes in housing policy, lack of access to safe public spaces, and the privatization of social services. This critique, in turn, was a call for public policy change.

HIV and SARS have demonstrated that there are serious health repercussions if governments are unable to analyze and study data about epidemics, or if they produce accounts about how they are responding that are not transparent and open to scrutiny and discussion.

The Chinese government, for instance, has been roundly criticized for failing to disclose in-depth and accurate information about its HIV epidemic, a policy that has limited its ability to adopt HIV prevention and treatment standards that have proven effective elsewhere. The government's similarly secretive response to SARS in 2003 was also blamed for allowing the epidemic to spiral out of control for a time; China's health minister and the Beijing mayor were later fired due to the outcry.

In Central Asia, accurate data and discussion on heroin use or HIV prevalence is severely lacking. For example, in Uzbekistan and Tajikistan, the only consistently available measure is "registered addicts"—drug users who have been arrested or admitted to a hospital and subjected to compulsory detoxification. However, government officials, narcologists, and independent observers generally agree that these registered users comprise as few as 10 percent of the total number of heroin users in each country. Similarly, little to no data exists in either country distinguishing occasional heroin users from drug-dependent individuals.

There is little transparency about how Central Asian governments use tax revenue for public health, since there are few independent

Drug user turning in used syringes at needle exchange program, Kyrgyzstan

> "Letting 'heroic' individual volunteers deal with the problem is not a substitute for a collective, systematic public health response."

"budget watch" organizations to monitor and hold governments accountable. Corruption is often endemic and revenues that could be used for public health are frequently reserved for the military or questionable macroeconomic projects.

In Uzbekistan, international funding on health dwarfs government funding. However, international funding is often time-limited because donors seek to have a large impact on a specific problem in a short time. Not many donors have been involved in long-term projects such as developing an educated and reasonably paid health sector workforce and service-delivery infrastructure that would increase local capacity to respond to emerging health problems.

Effective responses to the drug use and HIV epidemics rely heavily on a commitment to community health with well-designed harm reduction services that are integrated within neighborhoods and among local populations. Community health experts also recognize that prevention is just one plank in a comprehensive HIV policy. In countries where HIV is concentrated among the impoverished, prevention programs have been most effective when they are coupled with treatment efforts. In Brazil, for example, experience has shown that if people who are infected receive ongoing health services and feel cared for, they are far more likely to care for others and be involved in efforts to disseminate prevention and treatment information in their communities and beyond.

In an economy of scarcity and joblessness, harm reduction programs in Central Asia are sometimes staffed by people who are interested primarily in having jobs and focus more on filling ledgers with questionable needle counts than on engaging drug users in meaningful education and mobilization. Too many officials and citizens in Central Asia allow stigma, stereotypes, and indifference to ignore calls from drug users, their families, and people living with HIV/AIDS for comprehensive public health policies. Letting "heroic" individual volunteers, mostly former or active drug users or their relatives, deal with the problem is not a substitute for a collective, systematic public health response.

By continuing to turn their backs on the problem and not prioritizing the revitalization of their ailing public health systems, citizens and officials in Central Asia are missing a rapidly closing window of opportunity to address public health problems that may soon overwhelm them.

Tuberculosis Resurging with Help from a Deadly Ally: HIV

Joia S. Mukherjee, M.D., medical director of Partners In Health and faculty member at Harvard Medical School, describes the global health threat emerging from the synergy between tuberculosis and HIV/AIDS and how the international community is responding.

JOIA S. MUKHERJEE

> Global Fund support for integrating TB and HIV services indicates a growing consensus that global health is a responsibility of all countries rather than an effort sustained by the world's poorest and most heavily TB- and AIDS-burdened countries.

The pairing of tuberculosis (TB), an airborne, infectious bacteria, with HIV, a blood-borne virus that destroys the body's immune system, is one of the deadliest biological weapons that nature has ever unleashed.

HIV-positive persons are 100 times more likely than HIV-negative individuals to develop active tuberculosis once they are infected because HIV attacks the CD4 cell, the primary conductor of the immune system, thus limiting the body's ability to fight TB. And once an HIV-positive person has active TB, he or she is more likely to die from the disease.

In fact, TB is the most common cause of death among HIV-positive persons worldwide. In countries with high burdens of TB like Botswana and Malawi, TB accounts for up to 50 percent of mortality among HIV-positive persons.

The synergy between HIV and tuberculosis is also having a catastrophic effect on tuberculosis control in countries like Botswana that were doing a good job managing TB prior to the explosion of HIV in the 1990s. Currently, Botswana has one of the highest HIV infection rates in the world and its TB rates have tripled within the last 10 years. Over 79 percent of adults diagnosed with TB are also infected with HIV.

The establishment of the Global Fund to Fight AIDS, TB and Malaria in 2001 marked the international community's first substantial step to address the noxious synergy between the epidemics of tuberculosis and HIV. One of the Fund's goals is to develop a variety of models for integrating TB and HIV treatment and services in regions marked by high rates of coinfection such as Africa, Asia, Latin America and the Caribbean, and the former Soviet Union.

The global nonprofit Partners In Health (PIH) is working with the fund on several of its TB-related efforts. In 2002, the PIH team in Haiti, Zanmi Lasante (Creole for "Partners In Health"), implemented a "four pillars" approach to scaling up TB and HIV treatment in a rural, high burden area. Using four key screening points—voluntary counseling for HIV; prevention of mother to child transmission; TB detection, treatment, and diagnosis; and treatment of sexually transmitted diseases—HIV and TB diagnosis and treatment are fully integrated into primary health care.

The team performed a needs assessment for the town of Lascahobas in southeastern Haiti, where the public clinic that served the town's 55,000 residents lacked medications and diagnostic tools and its demoralized staff often left by noon. As a result of these service inadequacies, the clinic saw fewer than 10 people per day, only 9 cases of TB had been diagnosed, and HIV testing was not offered.

Using the four pillars approach, the team strengthened primary care provision, introduced 30 new essential drugs, established a small laboratory, and trained and paid public and community health workers. Soon 200–400 patients were seen each day and hundreds of people living with HIV came forward for evaluation and care. Within a year, more than 200 patients were newly diagnosed and treated for tuberculosis. Two thousand people were screened for HIV, of whom 120 started antiretroviral therapy.

Global Fund support for such flexible approaches to integrating TB and HIV services indicates a growing international consensus that global health is a responsibility of all countries rather than an effort sustained by the world's poorest and most heavily TB- and AIDS-burdened countries. Despite being underfunded, the Global Fund has managed to disburse $320 million in 79 countries since it began giving grants in 2002.

Some countries such as the United States, however, have been slow to recognize the global dimensions and deadly interaction of TB and HIV. The U.S. bilateral plan, known as the President's Emergency Plan for AIDS Relief, neglects the synergy of tuberculosis with HIV. Elements of the plan, such as President Bush's promise to earmark one-third of the AIDS money for "abstinence only" education, also inappropriately impose the agenda of conservative American groups on programs trying to meet the needs of diverse populations in Asia, Africa, Latin America and the Caribbean, and the former Soviet Union.

TB and HIV remain major challenges requiring investments that develop the public health infrastructure of resource-poor countries and address other factors that inhibit human development such as poverty and lack of basic health services.

If the international community can sustain and expand the Global Fund, and powerful countries like the United States can do more to address both TB and HIV, infection rates can be reversed and many lives saved.

FOR MORE INFORMATION

To find out more about efforts to address TB and HIV/AIDS, visit Partners In Health at www.pih.org.

Residents receiving lab results at clinic, Lascahobas, Haiti

Politics Hampering UN Response to Drugs and HIV/AIDS

OSI consultant and Columbia University public health scholar Daniel Wolfe examines the politics behind UN efforts to address the intertwined problems of HIV/AIDS and drug use.

DANIEL WOLFE

UN General Assembly in session

The 15th International AIDS Conference, the world's most important gathering of AIDS caregivers, policymakers, and activists, was held this July in Bangkok. The location was chosen not only because Asia is expected to be the epicenter of the next big wave of HIV infections, but because Thailand has been praised by international experts and UN Secretary General Kofi Annan as one of the few developing countries that has made progress in stemming the spread of the epidemic.

Conference organizers and UN officials alike, however, seemed to forget that for drug users—a group at high risk for HIV across Asia—Thailand's approach looks less like innovative HIV prevention than old-fashioned, barrel-of-the-gun repression. In February 2003, the governing Thais Love Thais party launched an all-out war on drugs that has included forced urine testing at nightclubs and bars, blacklists, arrest quotas, and mass roundups of more than 43,000 alleged "drug traffickers." Even more ominously, more than 2,500 men, women, and children have been gunned down during the crackdown in what human rights observers say are extrajudicial executions.

Wholesale assaults on drug users have become an increasingly common part of the political landscape across Asia and the former Soviet Union, particularly since heroin and methamphetamine are among the "goods" circulating with increasing speed across the newly opened borders and free-trade zones characteristic of post-Cold War economies. The approach that offers drug users prison or forced abstinence, while demonstrating little or no effect in reducing drug use, is clearly exacerbating HIV infections.

"Call it the mixing bowl effect," said Chris Beyrer, a Johns Hopkins epidemiologist whose work has traced the ways that HIV outbreaks follow punitive drug policies and drug trafficking patterns. "Force uninfected and infected people together in institutions where drug use and sex continue, make condoms and sterile injection equipment impossible to obtain, and release those who are newly infected back into a society that punishes admission of drug use with stigmatization and reincarceration."

Indeed, outside Africa, national and international policy toward drug users will play a critical role in determining the course of the HIV epidemic. In China, the government acknowledges that 1 million Chinese are infected with HIV, more than 60 percent of them injection drug users. In Russia, 1 million people are estimated to have HIV, and at least 80 percent contracted the virus through injecting drug use. Drug users account for the majority of HIV cases in Afghanistan, Iran,

> "The United States has had great success in pushing UN drug-control agencies toward punitive approaches that do little to address drug use and the spread of HIV/AIDS."

Nepal, Pakistan, Ukraine, all of Central Asia, and much of Southeast Asia including Indonesia, Malaysia, and Vietnam.

In the face of such a global crisis, one might expect coordinated, emergency action at the organization spearheading international control of both drugs and HIV: the United Nations. UN entities such as UNAIDS and WHO regularly affirm the importance of HIV prevention strategies, including needle exchange and methadone programs. Yet UN entities have been extremely slow in working with national governments or international donors to bring a harm reduction program to national scale in countries where injectors are the majority of those with HIV.

Meanwhile, the UN measures that carry the force of law remain the drug control protocols of 1961, 1971, and 1988. In theory these conventions, which do not specify penalties for drug use, are flexible. But the United States and its allies have had great success in pushing the UN drug control agencies toward approaches that emphasize punitive law enforcement measures over the public health practices proven to reduce the spread of HIV/AIDS.

A recent UN survey noted that many Asian governments do not permit methadone substitution because they believe that to do so would contravene the UN conventions. In Russia, authorities have regularly cited the UN conventions to justify policies that have meant that nearly 20 percent of those imprisoned are there for petty drug offenses. For many, imprisonment includes risk of infection with the deadly, multidrug-resistant tuberculosis now rampant in the Russian penal system, as well as continued exposure to drugs and HIV.

Not all the news is bad: A handful of Russian provincial and municipal governments have put programs in place to offer education on safer injection and safer sex, and the Russian Duma recently approved legislative revisions to reduce mandatory prison penalties for those in possession of only small amounts of illicit drugs. At the same time, however, Moscow Duma members recently complained to the U.S. government about support of "harm reduction" efforts such as condom distribution, saying "If a policy is not acceptable in America, please do not export it to us." Russian drug control authorities have begun to advocate criminal prosecution of harm reduction programs, and are said to be working to overturn the new, more liberal laws on drug sentencing.

The most lasting changes in global drug policy may come as a dividend of geopolitics. In a rebuke observers suspect had less to do with drugs than with the Bush administration's unilateralism, U.S. representatives were voted off both the UN Commission on Human Rights and the International Narcotics Control Board (INCB) in 2001. The United States countered by increasing its pledges to UN drug control by 45 percent, and successfully fielded a candidate to replace a departing INCB delegate from Peru.

Growing impatience with American strong-arm tactics, however, especially in Europe, may edge the UN from "just say no" toward more effective, evidence-based approaches to deal with illicit drugs. The question is how long reform, if it happens, will take to change conditions for drug users in the countries where the AIDS epidemic is growing fastest.

FOR MORE INFORMATION

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HIV/AIDS activists demonstrating in South Africa

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