COMBINATION PREVENTION
A WINNING APPROACH

PSI’S GUIDE TO IAC 2012
7 QUESTIONS
WITH TINDERBOX AUTHORS
DANIEL HALPERIN & CRAIG TIMBERG

SEN. BOOZMAN, REPS. LEE & MCDERMOTT
ON U.S. ACTION ON HIV AND AIDS
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PSI is a global non-profit organization dedicated to improving the health of people in the developing world by focusing on serious challenges like a lack of family planning, HIV and AIDS, barriers to maternal health and the greatest threats to children under five, including malaria, diarrhea, pneumonia and malnutrition.

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THE GLOBAL HIV AND AIDS EPIDEMIC AND

NEW HIV INFECTIONS & AIDS-RELATED DEATHS AT LOWEST LEVELS SINCE THE PEAK OF THE EPIDEMIC.

NEW HIV INFECTIONS reduced by 21% since 1997

Deaths from AIDS-related illnesses decreased by 21% since 2005

SNAPSHOT OF HIV AND AIDS EPIDEMIC OVER THE YEARS:

<table>
<thead>
<tr>
<th>Year</th>
<th>People living with HIV</th>
<th>New HIV infections</th>
<th>AIDS-related deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>28.6 million</td>
<td>3.15 million</td>
<td>1.85 million</td>
</tr>
<tr>
<td>2005</td>
<td>31.0 million</td>
<td>2.81 million</td>
<td>2.22 million</td>
</tr>
<tr>
<td>2009</td>
<td>32.9 million</td>
<td>2.72 million</td>
<td>1.89 million</td>
</tr>
<tr>
<td>2010</td>
<td>34 million</td>
<td>2.67 million</td>
<td>1.76 million</td>
</tr>
</tbody>
</table>

PEOPLE ACCESSING LIFE-SAVING ANTIRETROVIRAL THERAPY

2010: 6.6 million (that’s 47% of the estimated 14.2 million people eligible for treatment in low- and middle-income countries).

2009: 5.25 million since 2009.

Deaths averted by treatment since 1995 = 2.5 million

CENTRAL AMERICA COMBINATION PREVENTION

In 2010, with funding from USAID, PSI and its regional affiliates the Pan American Social Marketing Organization (PASMO), PSI/Mexico and PSI/Costa Rica, in collaboration with local and international partners, began the Combination Prevention Project. This program uses innovative, multi-level interventions and communications to increase access to HIV prevention interventions and reduce stigma and discrimination for female sex workers and their clients and partners, men who have sex with men, transgender persons, people living with HIV and their partners, and certain Caribbean populations in six countries in Central America and Mexico.

In South Africa, approximately 55 percent of Tuberculosis (TB) patients also test positive for HIV. Since TB is the leading cause of death for people living with HIV, PSI affiliate Society for Family Health (SFH) scaled up TB screening with all HIV counseling and testing services provided through its New Start franchise network. Since 2004, SFH has reached more than 800,000 people with non-medical TB screening services. In May 2012, SFH also started sputum collection from TB suspects. Once the sputum is analyzed, SFH follows up directly with the clients to help ensure diagnosis and treatment.

**NEW INFECTIONS AROUND THE GLOBE**

**Southern Africa**: ▼ Number of new infections dropped by 26% since 2007.

**Caribbean**: ▼ Number of new infections reduced by 33% from 2001.

**South and South-east Asia**: ▼ Number of new infections dropped by 40% between 1996 and 2010.

**Eastern Europe, Central Asia, Oceania, Middle-east and North Africa**: Number of new infections continues to rise. ▲

**THAILAND**

**PEOPLE WHO INJECT DRUGS**

At 38.7 percent, the HIV prevalence among people who inject drugs (PWIDs) in Thailand is almost 30 times higher than the general population. PSI/Thailand, in collaboration with civil society partners, is strengthening and scaling up comprehensive HIV prevention services among PWIDs. Using its network of more than 211 peer outreach workers and 19 drop-in centers nationwide, PSI and partners have distributed an estimated 368,369 condoms and 813,273 sterile needles and syringes to more than 6,191 PWIDs despite the absence of an enabling national policy environment.
What was the impetus for writing Tinderbox?
What do you hope readers will take away from the book?

DANIEL HALPERIN: Over the years I had published a number of more academic articles, but I thought it would be interesting to write for a more popular audience. One of the key motivations on my part was to dispel, expose or correct myths/misconceptions about the epidemic. Going back 15 or 20 years I have just had this burning sense that the story we are told about AIDS is incomplete or not totally accurately rendered. Also, a key motivation was to show some of the untold or under-told stories, especially of how some Africans themselves have responded to the epidemic.

CRAIG TIMBERG: For me, I had been a foreign correspondent in Africa during this horrendous epidemic, and I found that there were lots of things that I could see and sense that were hard to write at newspaper length. To tell the most important stories, I needed the broader canvas that a book has to offer. Even more profoundly, it was clear to me that the AIDS epidemic is poorly understood by the world, and that has consequences for the way that the global response works, given that most of the decisions are made by people who live thousands and thousands of miles away from where most of the victims are. The book is intentionally written for a more general audience. It is a little more science-y than I would write for your average Post readership, but more general than for your average Lancet readership. The idea was to bring the story back to as many readers as possible, without sacrificing its scientific rigor.

One of the premises of the book is that people and policies of the West, perhaps unwittingly, helped fuel the spread of HIV in Africa. How would you compare the West’s obligation to stem the tide with that of highly affected countries?

DH: Yes, I have been asked a number of times, ‘If Colonialism started the epidemic then what does that mean? What’s the implication of that?’ Some people have responded by thinking that if the West actually started this epidemic then it really has the main responsibility to fix it. But I hope that not too many people carry that conclusion away because that could, again, end up inadvertently causing more harm than good. (“The road to hell is paved with good intentions…”). One key point is that it’s like the Hippocratic Oath: at the very least, let’s try not to do harm. And it’s imperative that anybody, Westerners or not, who’s involved in this epidemic commit to disseminate the most accurate scientific information. We should continually seek to find and share the most accurate information on how the virus is spread and how it can be prevented. Certainly Westerners can and should help, but ultimately what will really turn the tide is when African societies, cultures and countries themselves take informed actions.
DH: Ironically, I think that in some ways the pendulum has swung from one extreme to the other. For years the World Health Organization, the Joint United Nations Programme on HIV and AIDS, and the Centers for Disease Control and Prevention and many others basically just ignored the issue and the few of us who talked about it were even ridiculed. The 2002 U.S. Agency for International Development conference, attended by some 150 experts, came to the conclusion that affordable MC services should be made available for men, not explicitly for HIV prevention, but essentially as a basic reproductive health service, for which men will want to avail themselves for a multitude of reasons. That is what I mainly still believe. But now the pendulum seems to have swung to the other extreme. So many international organizations are excited about MC and pushing quite hard for HIv prevention – sometimes too hard, I think.

CT: The model that I favor is one in which Western nations provide the best science and practices possible and some degree of funding, but also stop short of just taking over the national responses in these countries, even those that have very serious problems with HIV. In the end, I think if there is going to be less HIV in the world, it is much more likely the cause will be that the South Africans or the Swazis or the Kenyans are able to talk effectively to their own citizens about how to change sexual behavior or educate people on means of transmission. That conversation is automatically going to be more effective than something that is heavy-handed or prescriptive from the West.

The book strongly supports male circumcision (MC) for HIV prevention. More resources have been devoted to male circumcision in the past few years, but target countries are still quite far from hitting 80 percent coverage. What more needs to be done to get there?

CT: It is clear to me from my time reporting on it and talking to Africans in all kinds of settings, that the concurrency issue is real, and it seems quite obvious from any historical perspective that what you’re seeing is a legacy of polygamy as it evolved into new forms. But I also feel that this debate about concurrency has gotten unnecessarily academic, and Westerners are shooting bullets at each other in peer-reviewed journals about what exactly concurrency is, and what the methodology is, etc. It is cyclical. The world focuses on sexual behavior as a key element of sexually transmitted diseases and then talks its way out of it for a few years, and then rediscovers it. That has been, in the end, destructive and confusing for Africans who are mainly living with the epidemic itself. What I would like to see clearly established as an unchallengable principle of the response to HIV is that in the hardest places, it is spread by sex. I don’t know as a journalist exactly what levers NGOs can push in terms of bringing about changes in sexual behaviors, but I think that it is abundantly clear that when societies reduce the number of partners that people keep over time, then HIV goes down.

DOH: One good example of something that almost no one seems to be doing right is promotion of exclusive breastfeeding (or more to the point, warning communities about the dangers of mixed feeding). Organizations are basically counseling HIV-positive women in a narrow clinical context, saying ‘You should practice exclusive breastfeeding for six months.’ But why not encourage everybody in the community to exclusively breastfeed for the first six months? Why not have mass media help spread this message to all women in the community? This would affect not only HIV but also infant mortality rates and other health outcomes. It’s fundamental, low cost, and could have high impact.

DH: Of course, male circumcision really could have a large impact at the population level. It should be seen, from a policy perspective, as a kind of mass vaccine campaign. So MC should obviously be a huge focus, and this has already been won on the policy level; most of the big organizations and donors are in support of it, but, as I mentioned, I think the way it’s being implemented is not always optimal. But ultimately the most important thing should be a focus on behavior change. If you have a lung cancer epidemic, you have to focus on smoking behaviors; otherwise, it’s ludicrous. Behavior change communications was accepted as a key focus for some time, but we seem to be going backward on that, which is sad.

CT: Do you think moving away from stand-alone concurrency interventions is the right approach? How should countries and HIV programs deal with the issue of concurrency?

Advocates will fight resource cuts to HIV programs, but global budget pressures are real and likely to be sustained. What are the most innovative approaches you’ve seen in fighting HIV in a smarter, more cost-effective fashion?

CT: Don’t be scared from talking about sex and sexual behavior. If we lack the moral courage to focus on the key driver of this epidemic, the people who suffer are the victims of the epidemic, not us. We need to rouse ourselves to be brave and talk about these uncomfortable subjects if we are serious about trying to slow down the spread of this thing. I know it is sort of naturally slowing down on its own, and that will no doubt continue, but if we want to find a way to make a big dent in how rapidly HIV spreads through Africa in particular, we need to find a way to talk about sexual behavior.
A WINNING APPROACH

Fungai and Lovemore (middle) underwent couples HIV counseling and testing at PSI’s New Start center in Harare, Zimbabwe. Go to youtube.com/HealthyBehaviors to watch a video about the happy couple and their family.
From 2001 to 2009, HIV incidence decreased by more than 25 percent in 33 countries around the world, including 22 countries in sub-Saharan Africa. An estimated 6.6 million HIV-infected people in low- and middle-income countries now access antiretroviral treatment (ART)—while this reflects a 16-fold increase in access to ART between 2003 and 2010, another 9 million people continue to go without. And, while the overall number of new HIV infections is decreasing and access to treatment is increasing worldwide, there are two new HIV infections for every one HIV-infected person placed on treatment.
In this era of effective ART, treatment as prevention and pre-exposure prophylaxis (PrEP), primary HIV prevention and positive health, dignity, and prevention remain vitally important if we are to turn the tide on the HIV epidemic. Unless we reduce the number of new HIV infections, we will not have a meaningful impact on further reducing the burden of disease caused by HIV. Fortunately, we are at a point in the response where we now have a number of evidence-based interventions: behavioral risk reduction, male and female condoms, voluntary medical male circumcision (VMMC), needle and syringe exchange, knowledge of HIV serostatus, treatment of sexually transmitted infections (STIs), and use of antiretrovirals for both prevention and treatment.

How, then, might we employ this evidence to achieve a vision of zero new HIV infections? Current scientific knowledge and thinking suggests a combination approach to HIV programming is most effective. The aegis of a combination approach lies in the fact that, to date, no single HIV prevention intervention offers full protection against HIV. To have the greatest impact on reducing HIV incidence, evidence-based biomedical, behavioral and structural interventions need to be combined in mutually reinforcing intervention packages designed to address the epidemiological and social context of the epidemic within each country.

PSI, in collaboration with country governments, donors and partners, is working to deliver an appropriate package of HIV prevention services to address context-specific factors and risk behaviors. In doing so, we employ our deep experience in implementing behavioral and biomedical components of a comprehensive HIV prevention package while working closely with governments and partners to address structural factors. We place strong emphasis on understanding each epidemic to identify the best mix of evidence-based interventions, scale up these interventions in a coordinated and integrated manner in generalized epidemics, and appropriately target populations at highest risk for HIV in mixed and concentrated epidemics.

How does combination prevention work in practice? In eight sub-Saharan African countries with generalized HIV epidemics, PSI is scaling up VMMC services as part of a comprehensive package of services. Adolescent and adult male clients who access static or outreach VMMC services are offered voluntary HIV counseling and testing, screening for sexually transmitted infections (STIs), and are exposed to interpersonal behavior change messages which promote abstinence during the healing period, consistent and correct condom use, and reducing multiple and concurrent sexual partnerships. Where possible so that loss to follow up is minimal and early treatment initiation becomes easier, clients with a positive HIV test result are offered an on-site CD4 cell count, tuberculosis screening, and referral for treatment, care and support services. Female partners of sexually active clients are also reached with risk reduction messages and couples HIV counseling and testing. This model of combination prevention allows for multiple prevention interventions, as well as appropriate referrals and linkages, at a single point of contact.

HIV counseling and testing (HCT) is another example of combination prevention in addition to services integration. In 17 of 26 countries where PSI offers HCT services, we leverage this entry point into care and treatment not only to promote knowledge of clients’ own and his/her partner’s status, but also to offer clients access to family planning services and, for pregnant clients, referrals to antenatal care and prevention of mother-to-child transmission services. PSI promotes dual use of condoms plus one other modern contraceptive method for HIV-infected female clients and discordant couples who don’t intend to become pregnant, while striving to provide balanced and ethical counseling about fertility options. With significantly increased risk of cervical cancer among HIV-infected women compared to HIV-negative women, PSI is also scaling up cervical cancer screening, treatment and referral within existing HIV and family planning and reproductive health services.

In concentrated and mixed epidemics, PSI and its partners are advocating with governments and policy makers to create enabling environments for key populations (also known as most at-risk populations or MARPs), while providing services and products to meet the health needs of these marginalized populations. We work with and through peer educators who understand clients’ needs and link them to friendly services, and also engage local community leaders and key influencers to reduce stigma and discrimination. In Central America, PSI and its regional affiliates, the Pan American Social Marketing Organization (PASMO), PSI/Mexico and Proyectos en Salud Integral (PSI) Costa Rica, in collaboration and coordination with local Ministries of Health, local non-governmental organizations, and international partners, are working to increase access to HIV prevention services for key populations including MSM, female sex workers and their clients.
transgender persons, mobile populations, and people living with HIV. These populations are exposed to highly targeted communication interventions and are offered or referred to a core package of HIV services, including HIV counseling and testing, male and female condoms, and diagnosis and treatment of STIs.

Combination approaches offer the opportunity to thoughtfully tailor HIV prevention packages to address specific risk behaviors. A thoughtful and client-centered approach needs to be applied in selecting intervention packages and integrating non-HIV services – such packages shouldn’t overwhelm health personnel and thus health systems. Yet, there is also a need for a stronger evidence base. It is challenging enough to evaluate the impact of a stand-alone intervention; the methodological bar is considerably raised with combination prevention. The public health community will hopefully learn much from research supported under the National Institutes of Health-funded Methods of Prevention Package Program (MP3).

While the public health community seeks to understand what works and what doesn’t, a sense of urgency and practicability is needed. It is important to not ignore what we know already works to prevent taking another decade to move from evidence to implementation. Implementing agencies, such as PSI, can contribute to the evidence base by thoughtfully using existing evidence to design our combination prevention approaches, and documenting and sharing what we’re doing.

UNAIDS defines combination prevention programs as the following: “rights-based, evidence informed, and community-owned programs that use a mix of biomedical, behavioral, and structural interventions, prioritized to meet the current HIV prevention needs of a particular individuals and communities so as to have the greatest sustained impact on reducing new infections.” (UNAIDS Prevention Reference Group, 2009).

**WHAT IS COMBINATION PREVENTION?**

UNAIDS defines combination prevention programs as the following: “rights-based, evidence informed, and community-owned programs that use a mix of biomedical, behavioral, and structural interventions, prioritized to meet the current HIV prevention needs of a particular individuals and communities so as to have the greatest sustained impact on reducing new infections.” (UNAIDS Prevention Reference Group, 2009).

**PSI’S APPROACH TO COMBINATION PREVENTION**

**BIOMEDICAL INTERVENTIONS**
- Male and Female Condom Sales and Distribution
- Voluntary Medical Male Circumcision
- Prevention Mother-to-Child Transmission
- Antiretroviral Treatment
- Counseling and Testing
- Sexually Transmitted Infections Testing and Treatment
- Integration: Family Planning, TB, WASH

**BEHAVIORAL INTERVENTIONS**
- Demand Creation for Products and Services
- Harm Reduction for People who Inject Drugs

**STRUCTURAL**
- Eliminate stigma and discrimination for key populations at risk.
- Improve access to services and information for women and girls

In Cambodia, peer educators promote the use of condoms for prevention of HIV and sexually transmitted infections.
WHAT IRENE TAUGHT ME ABOUT HIV

BY DEBRA MESSING, PSI AMBASSADOR

For many of the people I met in Zambia, HIV had led them to death's doorstep; their families and communities abandoned them. But when I boarded the plane to come home, I felt hope – not despair.

As an ambassador for PSI's HIV programs, I traveled to Zambia to learn how PSI’s “combination prevention” approach to HIV is providing hope for millions by fighting the disease from every angle. It’s a common-sense approach – use multiple interventions that prevent HIV in tandem and the likelihood of HIV transmission is greatly reduced.

On the first day of my trip, I met with a support group for people newly diagnosed with HIV. It was the fourth of five meetings meant to give them the tools they need to manage their disease.

I walked into a bright, one-room structure that sits behind a Catholic church at the end of a long dirt road. There were about 25 people in all – men, women, some young, some old, some with children.

To break the ice, I shared why I got involved as an HIV activist. I lost a very dear friend many years ago.

After I spoke, Irene stood up to share her story. She had a strong face, but underneath I could tell there was a story of hardship and struggle. She had a baby on her back and another at her feet.

The path that led her here had not been easy.

Some time ago she started to develop painful sores on her hands and all over her body, and didn't understand why. She could barely lift herself out of bed. But the physical pain wasn't the worst part. Irene was a greeter at her church – something she loved to do. When she started getting visibly sick, people wouldn't go near her. The pastor told her she had AIDS and that she was going to die, and asked her to leave the church.

It wasn't until a friend insisted that Irene get tested for HIV that she learned of her status and started treatment. When she told her son, instead of offering support, he spat on her and told her she was as good as dead. He tossed money at her and told her to go to another village to die.

She refused to leave. She had no other family. Her husband passed away years ago, and everyone she cared about was abandoning her.

As she spoke, I was surprised to see relief come across her face. The fact that she was able to share her story and that people in the group were listening and relating to her somehow lessened her pain. Clearly she needed to be heard, and like all of us, she just needed some compassion.

At the end of the meeting, I walked over and hugged her. We held each other for quite some time. I looked at her and she was smiling – she proudly introduced me to her two beautiful children. We played and laughed together. It started a chain reaction of hugs that turned into the most beautiful singing that then turned into dancing.

I left the support group full of emotion and with a greater appreciation for the impact these programs have for people like Irene. Irene came to the group to learn how to live with HIV – instead, she’s learning to thrive.
NGHIMUNYA'S STORY

I started feeling sick in 2003. Back then there were no free antiretrovirals, so my sister decided to take me to the traditional healer in the village. The healer said I had crocodile demons and told me I needed to dance to be healed. But dancing didn’t heal me, and I became very sick – so bad I couldn’t walk or talk.

I didn’t know where to go for care. My grandfather was old and said he couldn’t manage to care for me. So he prepared for my death. He sent three boys to borrow shovels and dig my grave for when I died. He told me he would bury me next to my father. The boys cleaned the burial yard and tied the goat for my funeral. Then they left the tools in my room. I cried for six days.

I decided to leave the village without telling my grandfather. My sister asked the bus driver to please take care of me. We got stopped by the police too, and they pointed to me and asked the driver, “Why are you carrying that dead body?” The driver paid them money to let us keep going.

I was very angry. But I couldn’t talk. When we reached Lusaka, the bus driver took me to my sister’s place and explained everything. She paid him back.

My sister welcomed me and took me to the clinic, where I started my tuberculosis treatment. In 2004, I decided to go for voluntary counseling and testing and found out that I was HIV-positive. My CD4 count was 40, so I started my antiretrovirals and started feeling better.

Nghimunya is now a happy, healthy member of an HIV support group in Kanyama township, supported by the Center for Infectious Disease Research in Zambia. She is the lead member of a choir her group formed that uses music to educate communities about HIV prevention and how to live positively with it.
While in Zambia, I met a woman named Connie who inspired me with her story and incredible passion to help others. She lost her first three children to AIDS complications because she did not know her status. After a long and very difficult struggle to regain her physical and mental health, Connie became a formidable figure in Zambia, fighting to educate anyone who would listen about HIV, and giving her support to those affected. How does Connie’s story exemplify Alere’s motivation to design a campaign that fights the stigma and discrimination around HIV and AIDS?

RON ZWANZIGER: After hearing Connie’s story, I was so impressed that even though she faced so much tragedy early in life, she still had the courage after testing positive to see that she had her whole life before her and inspire others to get tested. Connie and the work she’s done at the Kanyama Clinic to build a network of individuals committed to getting people tested, helping them make healthy decisions, and supporting them as they return to a normal way of life is exactly what More Positive is all about.

DM: When I was in Zambia to promote the Make (+) More Positive campaign, it was amazing to see people open up and express their stories and feelings through art. How does Alere plan to use this art to fuel the campaign?

RZ: Art is such a powerful tool for people to communicate thoughts and feelings that can’t always be conveyed with just words. We encourage everyone, no matter what their HIV status may be, to design a plus symbol on morepositive.com that illustrates what living positively means to them. For every symbol received, Alere will donate one HIV test, up to 1 million.

DM: I hope Impact readers will go to the campaign website and Facebook page to learn more and stay up to date. But what would you ask that people do to join and stay engaged with the Make (+) More Positive community?

RZ: We want people to share their stories. Make (+) More Positive is about making sure people understand that knowing your status can do a lot to prevent the spread of the virus. We also want people to know that it is entirely possible to be diagnosed as positive and live a healthy life. Devices like the AlereTM CD4 Analyzer help to ensure that people, no matter where they are, can get the therapy they need, but we need to get the message out that there is hope.

FOR EVERY SYMBOL RECEIVED, ALERE WILL DONATE ONE HIV TEST, UP TO 1 MILLION.
TURNING THE TIDE TOGETHER
IAC 2012: PSI SATELLITE SESSIONS

SUNDAY, JULY 22

Women, HIV and Non-Communicable Disease: Making the Links and Moving to Action

To ensure that women living with HIV have their full health needs met, we must work together to understand the links between HIV and cancer, diabetes, heart disease and chronic respiratory illnesses. This satellite will review the latest epidemiologic trends, highlight programmatic experiences and open discussion on how best to integrate services effectively and quickly. Members of the Task force on NCDs and Women’s Health will launch a policy brief developed by the Task force.

DETAILS: 11:15am-1:15pm • Mini Room 7

SPEAKERS: Laurie Garrett, Council on Foreign Relations (moderator) • Peter Piot, London School of Hygiene & Tropical Medicine • Sally Cowal, PSI • Peter Lamptey, FHI 360 • Peter Drobac, Partners in Health Rwanda

HOSTS: PSI, NCDs and Women’s Health Task Force: American Cancer Society, FHI 360, IPPF, Jhpiego, GTF.CCC, Family Care International, Partners In Health, PATH, The Partnership for Maternal, Newborn & Child Health, Women Deliver, World Heart Federation, UICC

SUNDAY, JULY 22

Public Private Partnerships – A New Way Forward

Private/public partnerships have become an increasingly important channel of funding, institutional development and capacity building for NGOs in the fight against HIV. At this session, private sector partners will speak about the programs in which they are investing and explain the win-win opportunities they represent for the HIV and global communities. Panelists will highlight their ongoing programs and discuss opportunities for expansion into new issue areas with new partners.

DETAILS: 1:30pm-3:30pm • Session Room 2

SPEAKERS: Paul Hempel, Alere, Inc. • Sharon D’Agostino • Johnson & Johnson • Melissa Janis, Pfizer, Inc. • Dr. Greg Allgood, Procter & Gamble • Sally Cowal, PSI

HOSTS: International Planned Parenthood Federation

MONDAY, JULY 23

Voluntary Medical Male Circumcision: Call for Action for Maximum Public Health Impact

If voluntary medical male circumcision (VMMC) is scaled up to 80% of adult men within five years, it has the potential to avert more than 3.4 million new HIV infections and save an estimated U.S. $16.5 billion in care and treatment costs. This satellite session will focus on the critical role that communication and advocacy play in accelerating the scale up of VMMC. African political and traditional leaders will join key figures in the international HIV response to discuss challenges, lessons learned and the road ahead.

DETAILS: 8:30pm-9:30pm • Session Room 8

SPEAKERS: Dr. Oburu Odinga, Ministry of Finance, Kenya • Prof. Peter Anyang’ Nyong’o, Ministry of Medical Services, Kenya • Mr. Blessing Chebungo, Zimbabwean Parliament • His Royal Highness Chief Mumena XI, Zambia • Dr. Bernhard Schwartländer, UNAIDS • Dr. Jean-Baptiste Rongou, WHO • Angelo Kaggyva, AVAC • Hendrica Okondo, Young Women’s Christian Association

HOSTS: PEPFAR, UNAIDS, WHO, AVAC, Champions for an HIV-Free Generation

SUNDAY, JULY 22

The Politics of Condoms: Cock-ups, Controversies, and Cucumbers

Speakers will discuss the many aspects of the current controversies and challenges that impede effective condom programming around the world. The session aims to re-energize the collective attention to condoms and advocate for a much needed ‘back-to-basics’ approach for renewed focus on comprehensive condom programming.

DETAILS: 3:45pm-5:45pm • Mini Room 3

SPEAKERS: Dr. Krishna Jafa, PSI • Susan Timberlake, UNAIDS • Jon O’Brien, Catholics for Free Choice • IPPF • UNFPA

HOSTS: International Planned Parenthood Federation

SUNDAY, JULY 22

From Stigma to Strength: Strategies for Men Who Have Sex With Men, Transgender People and Allies in a Shifting AIDS Landscape

Amid rapid changes in the global AIDS response, the AIDS 2012 Pre-Conference event will highlight issues for men who have sex with men (MSM) and transgender people. The full day event will host more than 600 of the world’s leading experts in HIV among MSM and transgender people and will focus on implications of gender people and will highlight programmatic experiences and open discussion on how best to integrate services effectively and quickly. Members of the Task force on NCDs and Women’s Health will launch a policy brief developed by the Task force.

DETAILS: 9:00am-5:00pm • 1825 Connecticut Ave. NW

SPEAKERS: U.S. Rep. Barbara Lee • The Honorable Michael Kirby, Former High Court Judge, Australia • Dr. Kevin Fenton, CDC • Dr. Tonya Nyagiro, Global Fund to Fight AIDS, Tuberculosis and Malaria • Rafael Mazin, WHO

HOSTS: PSI, MSM Global Forum

**TUESDAY, JULY 24**

**Innovations to Facilitate Acceleration of Voluntary Medical Male Circumcision Scale Up: Potential Role of Medical Devices**

This session will provide an introduction to devices and their potential to accelerate voluntary medical male circumcision (VMMC) scale up, current stage of device research, and approval processes, as well as provide a closer look at clinical profiles and acceptability of devices. It will also address thinking ahead of device rollout, including costing, global access, logistics, and training considerations, as well as leveraging the characteristics of devices to generate demand for VMMC. A panel discussion with device experts will follow.

**DETAILS:** 7:00am-8:30am • Mini Room 5

**SPEAKERS:** Jason Reed, OGAC • David Sokal, FHI 360 • Emmanuel Njeuhmeli, USAID • Lynda Bardfield, FHI 360 • Renee Rldzon, Bill & Melinda Gates Foundation • Prof. Tshimanga, Zimbabwe Ministry of Health and Child Welfare • Vincent Mutabazi, Rwanda Ministry of Health • Karin Hatzold, PSI • Tigistu Adamu, Jhpiego • Mark Barone, EngenderHealth

**HOST:** PEPFAR with PSI, FHI 360, Jhpiego and EngenderHealth

**TUESDAY, JULY 24**

**Why WASH? Integrating WASH into HIV Programs**

People living with HIV are more susceptible to the impacts of poor water, sanitation and hygiene (WASH). In this session, HIV and household water treatment experts will take a critical look at the integration of programs targeting these health issues – highlighting the need, strengths and challenges of program implementation, cost effectiveness and policy orientation in charting the way forward. Keynote speaker Debra Messing, PSI global ambassador, will share experiences from her trip to Zambia to raise awareness about HIV counseling and testing and de-stigmatizing HIV and AIDS.

**DETAILS:** 6:30pm-8:30pm • Mini Room 4

**SPEAKERS:** Greg Allgood, P&G (moderator) • Debra Messing, PSI • Rachel Peletz, London School of Hygiene and Tropical Medicine • Joe Brown, London School of Tropical Medicine and Hygiene • Beth Barr, CDC Malawi • Thomas Kisimbi, Clinton Health Access Initiative • Dr. Mike Cohen, UNC • Roy Dhlamini, PSI • Katharine McHugh, PSI • Dr. Charles Holmes, PEPFAR

**HOST:** PSI

**WEDNESDAY, JULY 25**

**Scaling up HIV/TB Collaborative Activities: Turning the Tide through Integrated Services**

This session will highlight experiences and successes in the integration of HIV and TB service delivery. The session will bring together scientific experts, programmers, policy makers and donors to share their experiences working with HIV and TB integration in diverse and most affected settings around the world. Topics to be discussed include: intensive case finding, community based efforts to support HIV and TB integration, private public mix (PPM), use of new diagnostics and the promotion of effective treatment and support. Participants will be provided with practical guidance to support the scale-up of integrated HIV and TB services at the local, national, and global levels.

**DETAILS:** 6:30pm-8:30pm • Mini Room 2

**SPEAKERS:** Dr. David Wilson, World Bank • Lucica Ditu, Stop TB Partnership • Dr. Anthony Harries, International Union Against Tuberculosis and Lung Disease • Dr. Charlotte Colvin, PATH • Dr. Phyu Phyu Swe, PSI/Myanmar • Ms. Carol Nawina Nyirenda, Community Initiative for TB, HIV/AIDS & Malaria, Zambia • Dr. Owen Mugurungi, Ministry of Health & Child Welfare, Zimbabwe

**HOSTS:** PATH and PSI

**THURSDAY, JULY 26**

**HIV in Haiti in the Time of Reconstruction: Epidemiology, Achievements, Challenges, and Perspectives**

In Haiti, interventions against HIV have been hampered by numerous political, natural and medical disasters. Where is the Haitian HIV epidemic now? What are the main achievements and obstacles? Where should we go from here? A panel of experts will attempt to answer these questions in an interactive multimedia session.

**DETAILS:** 6:30pm-8:30pm • Session Room 2

**SPEAKERS:** Haiti National AIDS Control Program • PSI • National Alliance of State and Territorial AIDS Directors • Ministry of Public Health & Population • Haitian Group for the Study of Kaposi’s Sarcoma and Opportunistic Infection

**HOSTS:** PSI and Haitian National AIDS Control Program
IAC 2012: PSI PRESENTATIONS

HIV Counseling & Testing (HCT)
- Attitudes about Pediatric HIV Testing in Rural Zimbabwe
  Poster # MOPe441 • July 23 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- Retesting and HIV Sero-conversion among Previously Negative Clients Attending PSI Rwanda’s HCT Services, 2009–2010
  Poster # MOPe150 • July 23 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- Increase in VCT Uptake Among Most-at-risk Populations Exposed to Chan Trei Moi Social Marketing Campaigns, Vietnam
  Poster # TUPE294 • July 24 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Voluntary Medical Male Circumcision (VMMC)
- Reasons for Not Getting Circumcised and Willingness to Get Circumcised (Botswana)
  Poster # THPE282 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- VMMC as an Entry Point for other Reproductive Health Services
  Poster # WEPE248 • July 25 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Male and Female Condoms
- Analysis of Male Condom Availability and Quality of Coverage in High-risk Areas for HIV Transmission in El Salvador
  Poster # THPE353 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- I have things under control! A demonstration of the female condom intervention in Cameroon
  All week • Global Village
- Feel Pleasured, Feel Empowered and Feel Protected: The Triple Benefits of Female Condoms
  Poster # THPE527 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Concurrent Sexual Partnerships
- Evaluation of a Behaviour Change Communication Program Targeted to Reduce Concurrent Sexual Partnerships in Botswana
  Poster # WEPC072 • July 25 • 1:00pm-2:00pm • Mini Room 7
- Contextual Analysis of the Risk of Marriage as a Driver of HIV Epidemic in Uganda: Interconnection or Patterns of HIV Prevalence in Uganda
  Poster # TUPE633 • July 24 • 12:30pm-2:30pm • Exhibition Hall, Level 2

People Who Inject Drugs
- Development of Comprehensive HIV Prevention Programs for People Who Inject Drugs Through Government and Civil Society Collaboration in Russia
  Poster # Mope596 • July 23 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Female Sex Workers and Clients of Female Sex Workers
- Factors Associated with condom use among female sex workers aged 15-29 in the ABMS/PSI intervention areas in Benin
  Poster # THPE199 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Men Who Have Sex With Men (MSM)
- An application of pervasive gaming to HIV prevention with MSM in Romania
  Poster # THPE210 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- Promoting HIV Testing Among Men who have Sex with Men in Mexico: Struggling with Stigma and Miss-conceptions
  Poster # TUPE479 • July 24 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- A profile of men who have sex with men (MSM) in Lome and Aného cities, Togo: Challenges and opportunities for programming
  Poster # TUPE563 • July 24 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Other Populations at Risk
- Analysis of Youth Behaviors (15-24 years) surrounding Unplanned Pregnancies and HIV Risk Behaviors in El Salvador
  Poster # TUPE586 • July 24 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- Evidence-Based Approach to Preventing HIV/AIDS among Vendors, Plantation Workers and the Fishing Community in Malawi
  Poster # TUPE319 • July 24 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Factors Associated with condom use among Commercial Sex Workers in the city of Bukuku (Democratic Republic of Congo)
- Poster # WEPE6781 • July 25 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- Factors Associated with Consistent Condom Use among Female Sex Workers in Burundi
  Poster # TUPE328 • July 24 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Women and Real Men* (Las Mujeres y los Hombres de Verdad) – What Women Think about “Real Men” in Six Countries of Central America
- Poster # LBPE38 • July 24 • 12:30pm-2:30pm • Level Three (next to Session Rooms 2, 3, 4)

People Living with HIV and Preventing Mother-to-Child Transmission (PMTCT)
- Exploring the Determinant of Stigma and Discrimination in Cameroon
  Poster # THPE454 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- Should measurement of HIV-related Stigma and Discrimination Be Redefined?
  Poster # THPE481 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2

Health Financing
- Catalysing Policy Change: Lessons from Advocating Mainstreaming HIV in Health Insurance in India
  Poster # MOPE585 • July 23 • 12:30pm-2:30pm • Exhibition Hall, Level 2
- Study on Government Funding of the HIV National Response in Nigeria
  Poster # THPE377 • July 26 • 12:30pm-2:30pm • Exhibition Hall, Level 2
In 2007, the World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) recommended that voluntary medical male circumcision (VMMC) be used as an HIV prevention intervention in 13 countries in sub-Saharan Africa with generalized HIV epidemics and low male circumcision prevalence.

An ambitious goal was set to perform 20 million circumcisions in those 13 countries by 2015 – 80 percent coverage of men and adolescents aged 15-49 years. Such a scale-up would avert 3.36 million new HIV infections through 2025.

Less than five years later and despite supply and demand challenges, we have seen significant progress in some countries. Kenya, for example, has achieved 61.5 percent of the 80 percent coverage target. Yet, progress lags in most other countries. More than 550,000 VMMCs were performed between 2008 and 2010 – which represents approximately 3 percent of the 80 percent target coverage level in priority countries.

Countries struggle with several issues: a shortage of qualified health professionals, national policies that restrict who can perform circumcisions, and weak health infrastructures. Increasing demand also remains a major challenge. The main reasons men typically opt out of circumcision are because they’re concerned about pain or complications from the surgery, they can’t miss work or they can’t easily access services.

Newer devices put health goals in closer reach

As the 2015 deadline looms large, devices like the Shang Ring, developed and manufactured in China, and the PrePex™ device, manufactured in Israel, have great potential to put the 80 percent goal within reach. These devices are not silver bullets, but they could accelerate scale-up by making the procedure faster, simpler and performable by non-physician providers.

Who and UNAIDS indicate that universal VMMC in sub-Saharan Africa could prevent more than 3 million new HIV infections and 386,000 AIDS deaths by 2025.

The Shang Ring device, which consists of two nested plastic rings with silicon gasket in between, requires a sterile setting with surgical cleansing, local anesthesia and excision of the foreskin at time of application. The device is removed after seven days. The PrePex™ device works on a different mechanism. The foreskin

CONTINUED ON PAGE 18 ➔
is not removed at the time of device placement, but after seven days, when the tissue to be excised has become hardened or necrotic. The device can be applied in a short procedure without anesthetic injection and with no cutting or bleeding at the time of application.

WHO has developed a framework for the clinical evaluation of adult VMMC devices, which includes three stages of studies. Case and comparison studies so far have shown low adverse events for both devices and high acceptability among clients and providers.

The Bill & Melinda Gates Foundation is currently funding one PrePex™ field study in Zimbabwe and two Shang Ring field studies in Zambia and Kenya with PSI and FHI360, respectively. If the Shang Ring and PrePex™ field studies deliver positive outcomes, WHO could recommend their use in the 13 countries for VMMC scale-up by the beginning of 2013. More countries in Southern and Eastern Africa where PSI provides technical assistance are interested in conducting pilot implementation studies using the devices. These studies would provide insight into clinical outcomes, staff utilization, models of service delivery and cost-effectiveness at high- and low-volume circumcision sites, as well as guide countries in the integration of devices to increase scale-up of VMMC once their use has been approved.

Devices like the Shang Ring and PrePex™ have the ability to increase volume and efficiency of service delivery and improve the surgical aspect of VMMC. However, these devices are only part of what’s needed. Much more thought needs to be given to increasing demand for VMMC, which remains a major obstacle to scaling up most national male circumcision programs.

Increased staffing will be required as comprehensive VMMC programs include HIV testing and counseling, screening for STIs, advice on safer sexual practices and condom promotion. As countries work to resolve complex issues like demand creation around this incredibly effective intervention, medical devices could serve as a reliable solution and bring us one step closer to our 2015 health impact goals.

PSI Author: Karin Hatzold, Deputy Director, Sexual, Reproductive Health and TB, PSI/ Washington, based in Harare, Zimbabwe.
On June 26, 2011, Jabu Qwabe and Thokozani Mndzebele celebrated the birth of their new baby boy, Sihlelelwe, at a small hospital outside of Mankayane, Swaziland. Like all new parents, they dream for Sihlelelwe to live a healthy life – which is why before leaving the hospital, Jabu and Thokozani made the decision to have him circumcised.

As parents of a child in Swaziland – the nation with the world’s highest adult HIV prevalence, at 25.9 percent – their decision could very well save Sihlelelwe’s life. Voluntary medical male circumcision has been found to reduce the risk of sexual transmission of HIV from women to men by as much as 60 percent.

In 2008, Swaziland initiated its adult/adolescent male circumcision program for HIV prevention – a program that continues to expand across the country. While reaching adult/adolescent circumcision targets remains the priority, Swaziland launched a parallel early infant male circumcision (EIMC) program one year later in an effort to invest in and implement a long-term HIV prevention strategy. The impact of Swaziland’s approach has demonstrated the value and sustainability of infant circumcision programs for health systems in developing nations, and represents an important step forward in the worldwide effort to achieve an HIV-free generation.

**WHY INFANT CIRCUMCISION?**

The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommend adult circumcision in high HIV prevalence countries like Swaziland to reduce the spread of HIV. Both organizations, along with the United Nations Children’s Fund (UNICEF), advise that infant circumcision be implemented in tandem with adult programs. Infant circumcision takes place long before a child becomes sexually active and can be more easily integrated into existing maternal and child health interventions. The procedure is quicker and simpler than adult circumcision, results in fewer surgical adverse events and post-operative complications, and is more cost-effective.

In 2009, Swaziland’s Ministry of Health launched a nationwide infant circumcision program with assistance from the U.S. Agency for International Development (USAID), UNICEF, the President’s Emergency Plan for AIDS Relief (PEPFAR), PSI and Jhpiego. In less than three years, the program has provided 1,300 voluntary circumcisions to boys in Swaziland. The procedure is now offered in four health facilities in two of the four regions of the country. Three additional facilities began providing EIMC during the first half of 2012, with more to be added during the latter half of the year. Ultimately, this network will have the capacity to serve the entire country and the approximately 20,000 male infants born each year.

“EIMC is a game-changing HIV intervention for Swaziland,” said Futhi dlamini, EIMC coordinator for PSI/Swaziland. “It offers sustainability of services by being integrated in maternal and child health services. This program will be even more effective as parents become more accepting of EIMC and when nurses are allowed to perform the procedure.”

**THE EDUCATION QUESTION**

Swaziland is traditionally a non-circumcising country. Therefore, the introduction of EIMC requires intensive community awareness and sensitization, training and buy-in of health-care workers, and patience as the country begins to accept a new HIV intervention whose benefits are seen in the long term.

Parents are introduced to EIMC at antenatal care clinics and child welfare clinics, as well as in the maternity units (including post-natal ward) of health facilities. They are approached by nurses, midwives and patient educators who are all trained on the basic facts of EIMC. One parent – either the mother or father – needs to sign the consent form for the procedure.

To spread the word about the procedure to expectant parents and others in the country, USAID, PSI and partners created the Lugotjwa Lusemanti campaign, which loosely translates to “bend the reed while it’s still wet.” Through posters, brochures and media outlets, parents and the general public learn about the health benefits of circumcision and about why the ideal time for the procedure is soon after a boy is born, while he is still in a health facility.

**AN HIV-FREE GENERATION IN SWAZILAND**

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I love the rain. I joke that the rains were the trumpet announcing my birth – I was born right after the rainy season, when the earth is full of life. On that beautiful Monday in April, on the 16th in 1979, that sweet scented sign of life saw me into this world.

I'm 33 years old – too young by most accounts to be writing my life story. But like many gay men growing up in Africa, I have collected far too many experiences for my age. I have a degree in microbiology from the University of Zambia. I am a scientist, but I chose the path of a human rights activist for gay people in my country.

The first family member I came out to was my father Anderson Kambela Mazoka, a true gentleman who sought only my safety and happiness. He had an illustrious political career that was cut short by death. Without his protection, my family accused me of being demon possessed and arranged an exorcism. Of course, it didn’t work. That’s when the horror began.

On the first day, two traditional healers held me in a small room, and with a sharp blade, one of them made 200 lacerations on my body and smeared ashes from an old Kwacha note (currency of Zambia) and a concoction of dried powdered herbs into them while the other talked to the spirits through the night.

On the second day, I was held captive for more chanting and cutting. The cuts across my body burned; I was bleeding, sore and tired. When the sun was in our eyes, I was led into the bush barefoot and shirtless with streaks of dried blood staining my body. With freshly strewn bark rope I was tied to a tree at the feet and the waist. My hands were bound, back to the sun. Alone, bound, bleeding and scared, I listened to the sounds of the night and just before dawn returned, the men I had come to hate for this torture came for me again; they untied the bark rope, burned it, and motioned me to follow them.

As we walked back, I couldn’t help but wonder how the world could be oblivious to my suffering. The men were staying at a lodge not more than 300 meters from the Kalulushi Police Station, and I kept wondering if I should make a run for it. But, then what?

While I lay on the cold tiled floor, the last of the lacerations were made – 512 cuts, some through the same ones that were starting to clot.

The morning and the afternoon went by – chants interrupted only by cutting and rubbing of herbs and ash. As the sun went down, I was led to my mother’s house where a waist-deep rectangular hole had been dug into the ground near her garden. My mother had been instructed to buy white linen in which I was wrapped. I was put into the hole with my feet turned towards the setting sun and my head towards where it rises. The men piled earth on me, leaving only my head exposed. I was buried for six hours, unable to move.

At midnight, they dug me out and gave me a bucket of herbed water to bathe myself. I remember being glad to be home. In all this, the hardest thing to bear was the agony and confusion my family went through not knowing how to deal with my sexuality.

That day, I decided to devote my life to teaching so no one would suffer as I did because of ignorance. My mission was simple – set up a community center that would be a safe space for gay people. It would not be as easy as I thought. Three days of torture were hard, but I have since learned what people mean when they speak of battles.

I converted my living room into a space where we could learn and share knowledge about HIV/AIDS, discuss the law and other
practical things that could enrich—and for many of us—save our lives. It was humble, but it was what I could afford.

I managed to secure meager funding for basic counseling and testing, psycho-social support, condoms and lube, and to pay a small staff. In 2010, we lost that funding. For the next year I ran the program from personal savings until they too were gone.

Many men had come out of the closet, and they were counting on our services. For one such young man, the center has been a lifeline. Orphaned, living with a relative who repeatedly threatens him, he has tried to take his life five times. So to shatter their hopes by folding up and moving on would have been a crime against all good and right things.

In just two years, we made progress. We were able to include men who have sex with men in the National AIDS Strategic Framework for 2011-2015. And just last month, Debra Messing, ambassador for PSI, and Will Chase visited my home and offered to help share my story.

Today, my organization Friends of Rainka is living day-to-day. Without funding, we will close.

Recently, I gave a talk about homosexuality in Zambia—not an easy topic to discuss. I have stood in public often to address the needs of men who have sex with men in Zambia.

I spoke to the group after lunch—the graveyard shift, as I fondly refer to that time of day. I joked about people being heavy with lunch, so I did my best to wake the unfriendly audience.

What they didn’t know was that I was not heavy with lunch. That day, I had not eaten breakfast or lunch. I had nothing for dinner the night before, and I had no idea where my next meal would come from.

I took a deep breath and started my talk with this: “Everyone is entitled to their own opinion, but not their own facts.”

Author: Lundu Mazoka, Executive Director, Friends of Rainka, Lusaka, Zambia

By Steven Chapman, Ph.D.
Chief Technical Officer, PSI

**COURAGEOUS LEADERSHIP WILL SAVE LIVES**

President Barack Obama’s announcement in May that same-sex couples should be able to marry, and surveys showing a steady upward trend in the proportion of Americans who agree with him, were powerful signals that the remaining stigmatizing and discriminatory policies against lesbians, gay, bisexual and transgender people in the U.S. are unlikely to last.

In Africa, there was, until recently, no such hope—particularly for men who have sex with men, among whom HIV prevalence is four times higher than the general population. Male-to-male sex is illegal in 31 sub-Saharan African countries and can result in the death penalty in four countries. Social hostility against homosexuality is widespread and, in certain countries, it is becoming even more intense, as evidenced by Lundu’s story.

International and local organizations have found it impossible and sometimes dangerous to develop effective and sustained HIV interventions through raising funds; conducting research; tailoring messages, products and services for men who have sex with men; and sharing lessons. PSI, like many international agencies, must strike a delicate balance between serving men who have sex with men and being a trusted partner to local governments. International and local organizations have made recent moves that could signal the environment for developing and delivering tailored HIV interventions for men who have sex with men could be improving.

Most notably, the availability of data about HIV prevalence and the behavior of men who have sex with men, funding and government responses have improved, despite falling far short of what is required to design effective interventions. The epidemiological studies that exist demonstrate the presence of men who have sex with men in all African populations, consistently higher HIV infection among these men, and that men who have sex with men are also engaged in concurrent or recent sexual partnerships with women.

Meanwhile, through the rise of mobile telephones and social media, local organizations representing the interests of men who have sex with men and increased exposure of local populations to the increasingly fair and equitable treatment of lesbian, gay, bisexual and transgender communities outside of Africa are slowly creating the conditions for national HIV program responses.

International agencies are becoming increasingly aware that funding for programs for men who have sex with men is too low given HIV rates. As a result, dialogue with national programs, however delicate in many settings, is trumping the mismatch between government aspirations for controlling HIV and intervention priorities. Working against this, however, is the very important limitation that these same international agencies are facing funding shortages, resulting in their looking to local governments to increase their contributions to HIV programs.

Improving access to and availability of HIV programs for men who have sex with men requires fundamental shifts in perceptions among individuals and partners, in addition to shifts in supporting conditions in families, communities and nations. Stigma and discrimination in official policies and communities create enormous obstacles to HIV prevention and treatment. Access to appropriate health services, products and information is, for them—possibly more so than for any other group in Africa today—in need of courageous leaders and changing public opinion. Today, HIV agencies that devise evidence-based programs must include men who have sex with men among target populations. Until then, an AIDS-free generation is impossible to attain.

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Facebook is thriving among young people in Benin’s urban areas. There were more than 142,600 Facebook users in Benin at the end of June, nearly half of whom are 18-24 years old. Recent research of young people in Benin’s four largest cities – Bohicon, Cotonou, Djougou and Parakou – found that youth prefer Facebook as a way to communicate with each other.

But Facebook goes beyond a simple social network. ABMS – Association Beninoise de Marketing Social, PSI’s affiliate in Benin – is using it with great success to engage youth on topics related to sexual and reproductive health, HIV and other issues such as exams, fashion and sports.

In 2010, ABMS launched the Amour & Vie club to reach in-school and out-of-school 10-24 year olds. The club’s main goals are to increase the use of contraceptives and access to reproductive health services among young people; encourage them to wait to have sex; educate them so they can protect themselves against HIV and sexually transmitted infections; and reduce unwanted and teenage pregnancy.

**HEALTH RISKS FACING YOUTH**

Modern family planning usage among 20-24 year olds is 4.7 percent and even less among 15-19 year olds. On top of that, the percentage of adolescents who have begun childbearing increases rapidly from 5 percent at age 15 to 44 percent at age 19.

While HIV prevalence in Benin is relatively low at 2 percent (UNAIDS, 2011), it is estimated that half of all new HIV infections occur among young people. Girls 20-24 years old are four times more likely to be affected than boys. Cross-generational sex and concurrent sexual partnerships play a big role in the epidemic; most girls have their first sexual encounter with older partners who also have multiple sexual partners.

The Amour & Vie program relies on young people to help design and implement activities. A group of 12 young volunteers helps ABMS to reach out and respond to youth who might be in risky situations or just need answers. “I’m ready to have sex. How do I properly use a condom without being embarrassed?” was one of the questions posted on the club’s Facebook page. At the end of June, more than 3,000 young people had joined Amour & Vie, and 705 youth ‘Liked’ the club on Facebook. On average, they send 43 direct messages and make 253 posts per month.

Amour & Vie engages youth offline as well through its bi-monthly magazine, a popular weekly radio show on 12 radio stations, TV campaigns, peer education activities in 80 school clubs around the country, a hotline to answer questions and direct youth to services, mobile video unit activities; community activities with Peace Corps volunteers; and an internship offered each year by ABMS.

Research conducted by PSI shows that more youth ages 15-24 report using a condom the last time they had sex in the areas where Amour & Vie is active. Results show condom usage is up from 29.7 percent to 49 percent among males and from 29 percent to 36.5 percent among females. Among out-of-school youth, condom use at last intercourse increased from 33 percent to 43 percent among males and from 21.3 percent to 38.4 percent among females (p<0.05).

Amour & Vie continues to look for ways to reach and engage youth via a multi-channel approach, and is particularly focused on improving the integration of different communication mediums. The program is also looking at ways to increase youth-friendly services in targeted areas.

**PSI Author:** Mandy McAnally, Communications Manager, Washington, D.C. Hugues Setho, ABMS/ Benin, and Nene Fofana, Sexual & Reproductive Health & TB, Washington, D.C., contributed to this article.
UP CLOSE WITH NYARADZAYI GUMBONZVANDA
GENERAL SECRETARY OF THE WORLD YOUNG WOMEN’S CHRISTIAN ASSOCIATION

NYARADZAYI GUMBONZVANDA, a Zimbabwean, is a trained human rights lawyer. Active in the women’s movement, she has focused on intergenerational leadership, women’s rights and peace through her roles at the United Nations and in civil service in Zimbabwe. In 2007, Ms. Gumbonzvanda became General Secretary of the World YWCA, a global network of 25 million women and young women leading social and economic change in 125 countries. In her role, Ms. Gumbonzvanda’s has focused on: (1) championing young women’s leadership; (2) advancing women’s sexual and reproductive health and rights including in HIV response; (3) advocating for an end to violence against women and for peace and justice; and (4) supporting movement building to promote gender equality and women’s empowerment.

IMPACT: The World YWCA is a leading advocate for stronger sexual and reproductive health and rights (SRHR) for women. How are you mobilizing new female leaders in this area?

NYARADZAYI GUMBONZVANDA: Women and young women need to have opportunities and capabilities to make informed choices about their sexual and reproductive health. This is important in terms of who is a leader, because leaders have been defined more in hierarchical terms of authority, power and influence. For us, leadership is also about the capability to make decisions on issues that affect your life. This year, we will run a series of regional trainings and intergenerational dialogues on skill building and empowerment of young women around SRHR in Jordan, Nepal and the Czech Republic. We take a very systematic approach to creating opportunities for dialogue among young women, led by young women. We feel that change does not happen unless we have the crucial conversations. At this moment, the crucial conversation is to explore the issues of culture, faith and women’s rights.

IMPACT: Tell us about a World YWCA program or campaign that is working to protect women’s sexual and reproductive rights?

NYARADZAYI GUMBONZVANDA: The World YWCA Africa program in eight countries on young women as advocates and champions of SRHR is a good example of a success story. We are robustly contributing to the efforts to reduce teenage pregnancy and eliminate early marriage. The World YWCA is a member of the Girls Not Brides Global Partnership on ending early marriage. We are currently engaged in a campaign with The Elders, an independent group of global leaders who work together for peace and human rights, to end this practice. We know that when a girl is 14 years old and is married off without her consent, her rights are being violated. This campaign provides opportunities to empower young women to say no to child marriage, whilst raising global awareness about the implications on women and children’s health (such as increased risk of HIV), education and lifelong impact that early marriage has on a woman. This program has enabled us to see the inter-linkages of issues such as right to education and economic empowerment for women and girls; violence against women, SRHR and women’s participation in decision-making. The strategic partnerships with organizations like the David and Lucile Packard Foundation, Norwegian Church Aid and German Church Development Service (Evangelischer Entwicklungsdienst) on such critical and sensitive issues have enabled us to make an impact in communities globally.

IMPACT: What are your thoughts on HIV treatment as prevention, particularly for women?

NYARADZAYI GUMBONZVANDA: More than 33 million people living with HIV and AIDS are in sub-Saharan Africa, and more than 67 percent are women and girls. Women’s ability to negotiate protection against HIV is a critical issue. Therefore it is important for women to have access to treatment, and access to other female-controlled and gender-sensitive prevention options, including quality information and commodities. This includes family planning for women living with HIV. We have had so many discussions around the male condom and how much control women have over this. The female condom also needs to be available, accessible and affordable. We don’t understand why we can find male condoms in every kiosk across the world, but you will rarely find the female condom. We will also continue to advocate for investment in microbicide research. The issue of access to treatment for women is very important, including for prevention of mother-to-child transmission. The right to treatment must continue to be enforced; governments need to put forth full access to treatment for people with HIV. The UNAIDS policy commitments of “Getting to Zero” is a positive step toward galvanizing greater commitments and actions on issues of gender equality and women’s rights in the AIDS response.

IMPACT: Where do you see positive reform to improve women’s health, protect women against violence and keep girls in school?

NYARADZAYI GUMBONZVANDA: Tanzania has played a significant role in the Every Woman, Every Child United Nations Commission on Information and Accountability on Women and Children’s Health, in which President Jakaya Kikwete was a co-chair, and I served as a commissioner. This was evidenced by some of the significant work that is ongoing in the country, in which the YWCA of Tanzania is involved, around young women and their sexual health. This includes meetings on human rights, faith and culture that created space for crucial conversations for the chief justice, the bishops and the women in communities.

I have also been monitoring the progress in Zimbabwe where there has been a strong push on condom use, one of the documented best practice countries. Zimbabwe has launched the national campaign on maternal mortality, part of implementing the condom campaign, to make a pledge for Every Woman, Every Child. Despite the economic and political crisis in the country, there has been a commitment to sexual and reproductive health and HIV response that has maintained political will and global partnerships and support.

Norway provides the perspective of a developed country’s commitment, providing significant support to women and children’s health. I have had the pleasure of being invited to the launch of the country’s policy paper on Global Health and Human Security, and I’ve also been engaged in a number of their health, women’s rights and peace initiatives. It has been interesting to see the inter-linkage between the work of Norway, the political will of Tanzania and investment in maternal health in a fragile country like Zimbabwe. Ultimately, real sustainable change and impact are derived from greater involvement of women and girls, protection of their human rights and advancement of gender equality.
BREAKING THE DEADLY LINK BETWEEN HIV AND TUBERCULOSIS

In 1990, Zimbabwe had one of the lowest incidence rates of tuberculosis (TB) in Southern Africa. By 2005, however, the rate had increased sevenfold, placing Zimbabwe among the 22 countries with the highest TB burdens in the world.

Why? The answer is rooted in the epidemic that began its assault on families and health systems in Zimbabwe during the 1990s: HIV and AIDS.

TB is the most common and most serious opportunistic infection associated with HIV and AIDS. Approximately one-third of all people living with HIV worldwide are co-infected with TB, and undiagnosed TB is the most frequent cause of death among people living with HIV and AIDS. In Zimbabwe, where 15 percent of the adult population is HIV-positive, the link between the two illnesses is palpable. Today, eight of 10 TB patients in the country are also infected with HIV.

Fortunately, when diagnosed early, TB is manageable and curable. Moreover, early detection can dramatically reduce the risk of TB transmission to others.

ACTIVE DIAGNOSIS

The World Health Organization (WHO) recommends a strategy of “active tuberculosis case finding” – or actively looking for TB cases in communities as opposed to passive detection, where health facilities wait for people to report with symptoms – to achieve the international community’s target of identifying 70 percent of all TB cases. Most countries currently fall far below that target. In Zimbabwe, for example, only 45 percent of all estimated TB cases are identified.

To support countries with active TB case finding, the WHO/Stop TB Partnership has set up the TB Reach program, under which implementers can apply for funding. TB Reach supports innovative and effective techniques of finding TB cases quickly, avert deaths, stop TB from spreading, and halt the development of drug-resistant strains.

HIV-TB INTEGRATION

In 2004, PSI/Zimbabwe began integrating TB symptom screening into its HIV counseling and testing network, New Start, which tests approximately 400,000 people for HIV each year.

Today, all clients accessing HIV testing are asked questions to detect TB symptoms using a standardised questionnaire. With this simple tool, PSI/Zimbabwe has been able to identify and refer thousands of men and women with suspected TB to clinics for diagnosis and treatment when the disease is confirmed. A majority of these individuals would have otherwise gone undiagnosed and untreated for long periods of time, suffering from the disease and infecting others.

In October 2011, PSI/Zimbabwe received support from TB Reach to take this integrated approach to scale. PSI/Zimbabwe has improved its TB laboratory capacity with fluorescence microscopy and GenXpert technology – a new fully automated system that allows for TB detection in sputum using a molecular technique, which is more sensitive than microscopy.

At the same time, PSI/Zimbabwe has strengthened its outreach program, using community promoters to distribute leaflets and brochures that explain TB symptoms and to refer people with symptoms to the TB/HIV outreach team or to the New Start center for testing. In the past six months, PSI/Zimbabwe screened more than 100,000 people for the disease, tested 2,500 sputum samples, and identified and began treatment for 422 cases.

As PSI works with local governments and other partners to take similar TB programs to scale around the world, the goal of reversing the disease’s trajectory will become a reality.

PSI Authors: Karin Hatzold, Deputy Director, Sexual & Reproductive Health & TB, based in Harare, Zimbabwe; Stephano Gudukeya, TB/HIV Manager, Harare, Zimbabwe; and Scott Thompson, Associate Communications Manager, Washington, D.C.

2 www.stoptb.org/global/awards/tbreach/default.asp.
In July, world leaders, experts and advocates will gather in Washington for the 2012 International AIDS Conference, hosted in D.C. for the first time ever. This landmark moment presents an opportunity to highlight the successes that U.S. foreign aid has achieved over the past decades, notably its leadership in addressing HIV and AIDS globally through the President’s Emergency Plan for AIDS Relief (PEPFAR).

Last year in recognition of the 30th anniversary of the first diagnosis of AIDS in the U.S., a bipartisan group of members of Congress launched the Congressional HIV/AIDS Caucus. The Caucus examines methods by which the U.S. can maintain global leadership in response to the epidemic – both in the U.S. and around the world – demonstrating an impressive show of cooperation across the aisle. In this month’s U.S. Policy Matters, members of the HIV/AIDS Caucus speak to the successes of past years and the future of U.S. advocacy on the fight against HIV/AIDS globally. Get Congressional HIV/AIDS Caucus updates on Facebook at www.facebook.com/AIDSCaucus.

Annie Toro is PSI’s Governmental Affairs Manager in Washington, D.C.

**LANDMARK MOMENT**

WASHINGTON, D.C., HOSTS THE INTERNATIONAL AIDS CONFERENCE

**GOING FOR GOLD – AN END TO AIDS**

BY REP. BARBARA LEE (D-CA)

This month, the world’s eyes turn to London for the 2012 Summer Olympics. As Americans around the country cheer for our athletes and share in the joys of gold medals and amazing accomplishments, I urge us to treat the XIX International AIDS Conference (IAC) the same way – to consider it the Olympics of Health.

Americans should be proud. For the first time in 20 years, the IAC will be in the United States, and we – leaders in the global HIV and AIDS fight – will be able to showcase our incredible efforts and successes on our own soil developing new solutions to address the ongoing challenges posed by HIV and AIDS throughout the world, and even in our own country. Through a bipartisan effort begun by Congress and President George W. Bush and completed by President Obama, people living with HIV and AIDS are finally able to travel to our country to share in the invaluable learning and networking that comes from this global conference. At no other time in history has the U.S.’s global leadership been more important than it is today, in large part sustained by the bipartisan Congressional HIV/AIDS Caucus – co-chaired by Representatives Trent Franks, Jim Mc Dermott and myself – and by U.S.-led efforts like the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Today we have the tools, knowledge and science to finally say with certainty that ending AIDS globally is within our reach.

As we applaud new world records in London this year, let us remember to applaud the collaboration, bipartisanship and brave U.S. leadership that is essential to breaking the trend of HIV and AIDS. We must change history against this deadly disease once and for all.

REP. BARBARA LEE (D-CA) is a social worker by profession and a senior member of the House Appropriations Committee. She has represented California’s 9th Congressional District since 1988 and Co-Chairs the Congressional HIV/AIDS Caucus.

Follow Rep. Lee on Twitter @RepBarbaraLee.
RISING TO THE CHALLENGE
BY SENATOR JOHN BOOZMAN (R-AR)

The American people have always risen to the challenge to help our global neighbors. We recognize that we have a moral responsibility to respect the dignity of all human beings no matter what country they call home, and that is why I am an advocate of global health initiatives. When it comes to global diseases like HIV/AIDS we can be proud of our efforts to provide resources for the prevention, treatment and research aimed at ultimately curing this global disease.

Bipartisan efforts in Congress have enabled us to provide tools to combat HIV/AIDS. As a supporter of the President’s Emergency Plan for AIDS Relief (PEPFAR) legislation, we have worked together for a common-sense solution to tackle this growing problem. This initiative allows us to further develop HIV/AIDS research and treatments while helping countries all over the world cultivate sustainable national health programs to target this disease.

While the government has an influential role to play, faith-based organizations are making a difference in the battle as well. As a former member of the House of Representatives Foreign Affairs Subcommittee on Africa, we examined how federal funds can help public-private partnerships and reach populations of rural Africans to improve the health and education of this epidemic. I am proud of our combined efforts and remain involved and committed to continuing Congress’ efforts to fight HIV/AIDS.

SENATOR JOHN BOOZMAN (R-AR), a businessman and member of the HIV/AIDS Caucus is serving his first term as a U.S. Senator. Sen. Boozman sits on four Senate committees: Agriculture, Nutrition and Forestry; Environment and Public Works; Commerce, Science and Transportation; and Veteran’s Affairs.

➤ Follow Sen. Boozman on Twitter at @JohnBoozman.

COMBINATION PREVENTION CAN MEAN AN AIDS-FREE GENERATION
BY REP. MCDERMOTT (D-WA)

As a physician in the Congo during the 1980s, I witnessed the devastating effect of AIDS. I saw adults die and watched women pass HIV to their newborns – all because we had no comprehensive response to the disease. Today, an end to global HIV is within reach.

I am proud to say because of PEPFAR – the largest public health program of its kind – millions who would be near death now enjoy productive lives. PEPFAR uses resources effectively by embracing combination prevention: a mix of biomedical, behavioral and structural interventions that together can stop the spread of HIV.

We now have many tools to fight the spread of HIV: biomedical interventions like antiretroviral drugs and male circumcision; behavioral interventions like condom-distribution programs and encouraging monogamy; and structural interventions like needle-exchange programs and outlawing discrimination against gays and lesbians. Together they can lead to an AIDS-free generation. By helping countries design and implement combination-prevention programs, PEPFAR can help direct its resources according to the needs of a given population.

I was heartened by Republican colleague and Chairwoman Kay Granger’s release of an appropriations bill for fiscal year 2013 with no reductions to PEPFAR, which the full House Appropriations committee maintained. This bipartisan commitment, including the new HIV/AIDS Caucus I co-founded, demonstrates that both parties have common ground to fight HIV. The United States can backslide if we do not continue to support PEPFAR and domestic efforts to end HIV. Let us build on our progress and seize this moment toward defeating HIV/AIDS for good.

REP. MCDERMOTT (D-WA) is a senior member of the House Ways and Means Committee. He is in his 12th term serving the people of the 7th Congressional District of Washington State. Rep. McDermott is Co-Chair of the bipartisan Congressional HIV/AIDS Caucus.

➤ Follow Rep. McDermott on Twitter @repjimmcdermott.
THE NOTABLE NORDICS

Our Nordic neighbors (Denmark, Finland, Norway and Sweden) are known for their generosity, consistently ranking among the most generous contributors of official development assistance (ODA) in the world – especially when expressed as a percentage of their gross national income (GNI). A significant share of their respective assistance is earmarked for mitigating the HIV epidemic, as well as for promoting activities involving sexual and reproductive health (SRH).

From 2007 to 2009, Sweden ranked fifth among donors supporting HIV and SRH programs, giving US$305 million (or 6.7 percent of its ODA); Norway was seventh on the list, contributing US $250 million (or 6.12 percent of its ODA).1 Also close to the top were Denmark, ranking ninth with US $162 million (5.78 percent of its ODA) and Finland, coming in at twelfth with US $71 million (or 5.51 percent of its ODA). While Finland is still working toward the ODA target of 0.7 percent of GNI, it can boast one of the largest increases in population assistance from 2007 to 2009. These Nordic countries stack up respectably against established leaders in development assistance. As a comparison, the Netherlands earmarked 9.16 percent of its ODA for population assistance and the U.K. earmarked 6.35 percent.

Against the gloomy backdrop of the ongoing European debt crisis, all four Nordic states are exhibiting resilience greater than many of their southern neighbors. Denmark, Finland and Sweden are members of the European Union (EU), but only Finland circulates the euro. Norway is not an EU member and is Europe’s largest producer of oil (and the world’s fourth-richest country, in per-capita terms). The three Nordic states affiliated with the EU are going through some economic contractions due to their reliance on the other European countries. However, even with the current economic uncertainty, there is very little indication of appreciable declines in the Nordic level of ODA. For now, it seems that Denmark, Finland, Norway and Sweden will continue to play a very visible role in contributing to HIV and SRH programs around the world.


UK GOVERNMENT, BILL & MELINDA GATES FOUNDATION HOST SUMMIT ON FAMILY PLANNING

The U.K. Government and the Bill & Melinda Gates Foundation hosted the London Summit on Family Planning on July 11. The unprecedented event brought together world leaders to catalyze political and financial commitments to reach the needs of an additional 120 million women who lack access to modern, voluntary family planning methods. Just ahead of the Summit, LSE Health – the health research center of the London School of Economics (LSE) – and PSI co-hosted a public discussion at the school. The discussion looked at the Summit’s relevance to health, economic and environmental challenges facing every country – and why everyone has a critical role to play. Dr. Sara Seims, visiting Fellow at LSE and a Senior Adviser to the Packard Foundation, chaired the discussion. The panel included Ashley Judd, PSI Board Member, actress and humanitarian; Karl Hofmann, PSI President and CEO; Nina Muita, Master’s student at LSE; Ernestina Coast, Deputy Director of LSE Health; and Dr. Gary Darmstadt, Director of Family Health Division at the Bill & Melinda Gates Foundation.

NORDIC DONORS SUPPORTING HIV AND AIDS, AND SEXUAL AND REPRODUCTIVE HEALTH (IN US$)

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<tr>
<th>Country</th>
<th>Amount (in US$)</th>
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<tr>
<td>Sweden</td>
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<td>Norway</td>
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<td>Denmark</td>
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COUNCIL OF EUROPE WRITTEN DECLARATION ON FAMILY PLANNING SUMMIT

The Council of Europe has issued a written declaration on the July Family Planning Summit in support of voluntary family planning for women. The Council includes Parliamentarians from the major political parties across Europe. In the declaration, 20 signees urge the Council of Europe donor governments to mobilize new and secure existing financial commitments to support the rights of an additional 120 million women and girls in the world to use contraceptive information, services and supplies, without coercion or discrimination, by 2020.

Michael Chommie is Director of PSI Europe.
WE STILL HAVE WORK TO DO

When I first moved to Africa as a young Foreign Service officer, my introduction to the continent was two years in Kigali, Rwanda, 1985-87. In the West, we were still just learning about the HIV epidemic. How was it transmitted? Why was it so heavily concentrated (as it then was) in the Great Lakes region of Africa, where I was headed? My attention was focused on these questions.

In Rwanda in 1986, I would learn that 25 percent of blood tests among pregnant women at Kigali's central hospital showed seropositive results. Rwanda's paper-thin health infrastructure was already under tremendous stress. The viral wave would rise, crest and eventually recede in this region, but the ignorance, fear and helplessness made for stormy navigating as Rwanda, and the world, tried to come to grips with the HIV epidemic.

Fast forward 15 years, I found myself in Lome, as U.S. Ambassador to the Republic of Togo. I made HIV advocacy my top priority. President Eyadema told me HIV was spread because populations were forced to move when pressures for political change turned violent – democracy was the cause of HIV. I told him that I would use my office to talk about the virus, break down stigma, and bring HIV into the light of day. Still, in 2000, with no treatment options in sight for the average Togolese, what could I offer to the brave people who were willing to talk openly about their positive status, outside of moral support and solidarity?

One of the most courageous HIV-positive people I met was Mademoiselle Gouna. She was bright-eyed, frail and soft-voiced. The disease left her looking hollow. Mademoiselle Gouna was organizing an HIV-positive support group. The discrimination was brutal, borne of ignorance and fear. I did what I could to help, but resources were scarce. Mademoiselle Gouna didn't seem like she had long in this world when I first met her. Like many Togolese, she had the spirit of a survivor, but I didn't hold out hope that I would see her again when I left Togo.

Time passed and Mademoiselle Gouna was often on my mind. I wondered about her fate and wished there was more I could have done for her.

When I returned years later to Togo, now as President of PSI, I planned to visit her grave. I was surprised to learn that she was alive and was very glad to see her again, strong from antiretroviral treatment, still advocating for the life and dignity of Togo's HIV-positive citizens.

PSI has played an energetic role in this fight, over many years. We are part of a wider spectrum of advocates, implementers, researchers, policy-makers, funders, survivors – all engaged in one of the great public health efforts of this generation.

We know our role: implementing the most cost-effective, innovative and comprehensive HIV-prevention programming possible, based on what hard evidence tells us works. So long as the virus keeps outrunning the world's ability to relegate it to the footnotes of our global health progress, we know we have work to do.
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