

Lecture 2

Learning objectives

- how it is transmitted
- how it functions once inside a body
- how to test for the virus and its impact on biological functions
- how to treat, manage, and limit its impact

Article: HIV transmission: a model for assessing risk

Categories of HIV transmission are

- no risk
- negligible risk
- low risk
- high risk

Conditions for HIV transmission

1. there must be a source of infection
relying on identification of a person not useful.. you cannot tell if a person is infected by looking at them. Consider source of infection as presence of HIV in certain body fluids such as blood, semen, vaginal fluid or breast milk.
2. there must be a means of transmission
 - sexual activity
 - sharing used, uncleaned needles or syringes, or other situations that involve piercing of the skin
 - mother to child transmission, in the uterus ,during childbirth (vertical transmission or through breast feeding
 - receiving transfusions of infected blood or blood products, transplanted organs or donated sperm (in Canada, all donated blood, organs and semen are scared for HIV antibodies)
3. there must be a host susceptible to infection
virus is harmless unless it finds a host or susceptible cells within the host's body. Every human being is considered to be a host susceptible to infection
4. there must be an appropriate route of entry to the target cells of the body
infected blood, semen, vaginal fluid or breast milk must reach the HIV-susceptible cells in the blood, usually through a break in the skin, absorption through mucosal membranes (mucosa) or through some disruption to the mucosa. Mucosa are the moist surfaces of the body which line most of the body cavities and hollow internal organs such as the vagina, rectum, mouth, urethra, nose and eyelids.
5. there must be a sufficient level of virus delivered to establish infection

because of a higher concentration or quantity of virus, some body fluids are efficient media for transmitting HIV, while others are not. Semen, vaginal fluid, blood and breast milk are of most concern in HIV transmission. Has also been isolated in urine, saliva and tears but is highly unlikely that it will present in sufficient concentrations for transmission to occur. Enzyme in saliva inhibits HIV. HIV does not thrive in exposed environments outside the body or inside

the body where there are high concentrations of acid, such as in the stomach or the bladder. HIV has been isolated in pre-ejaculatory fluid. Though the concentration is low, it cannot be discounted as a potential source of transmission. Viral load (the amount of HIV present in different body fluids and tissues) can also be a factor in transmission of HIV. the higher the viral load, the higher the risk of transmission through the exchange of these fluids.

Factors used to determine the level of risk

1. potential for transmission

consider whether or not the 5 conditions for transmission are met. Because it is impossible to prove an infection will never happen, is it important to consider the potential for transmission and weigh it against evidence of what is known to have actually occurred. “ we consider an activity to carry no risk only when there is no potential for transmission to occur.

2. evidence of transmission

Categories for assessing risk

1. no risk

no practices in this category have ever been demonstrated to lead to HIV infection. There is no potential for transmission since all of the basic conditions for viral transmission are not present.

potential/evidence for transmission = none

If you share food/ drinks, kissing, hugging, mutual masturbation, massages,

2. negligible risk

practices assigned to this risk level present a potential for HIV transmission because they involve an exchange of body fluids such as semen, vaginal fluid, blood or breast milk.

However, the amounts, conditions and media of exchange are such that the efficiency of HIV transmission appears to be greatly diminished. There are no confirmed reports of infection from these activities.

potential for transmission.... yes

evidence for transmission.... none

3. low risk

All of the practices assigned this risk level present a potential for HIV transmission because they involve an exchange of body fluids such as semen, vaginal fluid, blood or breast milk. there are also few reports of infections attributed to these activities

potential for transmission... yes
evidence for transmission... yes
(under certain conditions)

- * intercourse with a condom but it was used incorrectly... it broke, etc.
- * oral sex

4. high risk

all practices assigned to this risk level present a potential for HIV infection transmission because they involve an exchange of body fluids such as semen, vaginal fluid, blood or breast milk. In addition, a significant number of scientific studies have repeatedly associated the activities with HIV infection. Even when the exact mechanism of transmission is not completely clear, the results of such studies conclude that activities in this category are high risk

potential for transmission.... yes
evidence for transmission... yes

- sex without a condom
- without effective treatment/ anti HIV drugs

Transmission

what does HIV mean?

Human
Immunodeficiency
Virus

don't need to understand the virus/ all the parts in an in depth way*** it is TINY
also do not need to understand medical terms... just what it does.

How the virus enters the host?

- source of infection: semen, blood, vaginal fluid, rectal fluid, breast milk
means of transmission

- situation where virus can move into a host (any human)

+ an appropriate route of entry (way for virus to enter)

+ sufficient level of virus

Cannot get through healthy intact skin. Your skin is the best defence against it.

* unbroken skin is an absolute defence against infection

HIV does not live outside the host for any particular long period of time.

- if blood of someone who is HIV positive dries somewhere... the air alone will kill it within a minute or two of being exposed. You will not get HIV from sharing food or touching something that someone who is HIV positive has touched.

Infection is not always guaranteed... exposure might not be long enough, there are a number of factors.

What is HIV?

HIV is a virus that weakens your immune system, which is the internal system that defends your body against disease. Your immune system is supposed to protect you from infections, but HIV can sneak past it and then attack your body from the inside. If your immune system becomes weak enough, you can become sick from other infections.

What is AIDS?

- acquired immunodeficiency syndrome

If HI is not treated with anti-HIV drugs, your immune system generally becomes weaker over time. Eventually you can become sick with a life-threatening infections, at which point you are said to have aids.

With early diagnosis and proper treatment with anti-HIV drugs, people with HIV can avoid getting AIDS and stay healthy for a long time.

What is a virus?

Viruses are the very simplest and smallest of all living things — even smaller than bacteria or other germs. In fact, its hard to say whether viruses even count as living things at all since they cant reproduce on their own. To reproduce, viruses need to infect living cells and fool them into making more viruses. These newly formed viruses then go on to infect other cells. When describing how viruses like HIV reproduce, we use the term replicate.

HIV is a virus that can infect cells of the immune system, including CD4+ cells — the very cells that are supposed to fight off infections. Thats what makes HIV dangerous.

How do you know if you have HIV?

you have to take a blood test which is actually called an AIDS test which tests for hIV antibodies.

- antibodies produced by your body as a reaction to infection with HIV

- rapid HIV tests are starting to become available (20 min)

- since tests look for antibodies and not the virus

- current canadian HIV tests can detect infection in 50% of people by 18 days after infection, 95% of people 34 days after infection and 99% of people by one and a half months after infection.

- a positive test result means that you have been infected with HIV. you can transmit the virus to people if you have unprotected sex or share needles or other drug use equipment with them. A positive test does not mean that you have AIDS or that you will get it. It does not give you any additional information about the state of your health.

How your immune system works... (some germs are good)

- body first line of defence is the skin (acts as a physical barrier to germs)

- if there are breaks in your skin.. they can provide vulnerable spots where viruses and other germs can enter the body

- immune system is made up of chemicals, cells, tissues and organs.. most important elements are white blood cells.
- when you're fighting off the flu or other infection, you can feel swollen lymph nodes in your throat and groin. This is a sign that your immune system is actively fighting infection,

CD4+ CELLS

- different kinds of white blood cells work as a team to recognize and destroy germs..
- specialized white blood cells also search for any of your own cells that are already infected. They destroy these cells to prevent infection from spreading further
- CD4+ cells play a central role in the immune systems job of fighting off germs, they help recognize infection and co-ordinate all the other parts of the immune system to provide an organized response.
- destruction of CD4 cells prevents the immune system from working properly

How HIV can make you sick

- cd4+ cells are one of HIV's favourite targets. HIV attacks and destroys these cells, one of the most important parts of your immune system. Leaves your system weak and unable to defend you against serious illnesses.
- body fights back by constantly producing new immune cells however over time, the virus wins.
- immune system becomes less and less able to suppress HIV and other infections.
- also becomes less able to control the spread of certain types of cancer cells .. other infections and cancer become serious or deadly problems.

If you are not treated with anti-HIV drugs after being diagnosed, HIV moves or progresses through several distinct phases. Some people progress very quickly, while others live with HIV for years without developing a life-threatening infection.. with the treatment available now, most people who are diagnosed with HIV and treated with anti-hiv drugs remain healthy and do not go through these stages.

First stages of HIV infection

- most people are not aware they are infected and it is at this point that the virus multiplies rapidly.
- within 2-4 weeks after infection, you may experience flu-like symptoms such as fatigue, sore throat, swollen lymph nodes, headache, loss of appetite or skin rash. This illness usually lasts less than 2 weeks although can last up to 10.
- not everybody has these symptoms though, so they're not a reliable way to tell whether or not you have been infected.
- If you have these symptoms after unprotected sex or sharing of needles, etc. see a doctor immediately... the sooner you are diagnosed and begin treatment, the healthier your body is likely to remain.

During this period, the immune system is learning to recognize HIV. it has not developed antibodies to attack the virus in a significant way.

- the amount of virus in your body may be very high

- your CD4+ counts may drop until your body responds to the new infection
- standard HIV tests could show that you are not infected even though you actually are. this is because the tests look for HIV antibodies, which your body hasn't developed as this stage.
- you can still pass HIV on to someone else. You are more likely to pass the virus to others if you are newly infected and untreated because there's so much HIV in your body.

When your body develops antibodies to HIV.. it is known as seroconversion. This usually happens 1-3 months after infection. blood tests for HIV, which actually look for antibodies, not the virus itself, will only give positive results after seroconversion.

Next stages of HIV

- even if undiagnosed or untreated, you may feel perfectly well for a long time during the stage of HIV that follows seroconversion. Although your immune system hasn't limited the infection, it is able to more or less hold its own against it, meaning the virus and your body now co-exist in a kind of standoff. Your CD4+ cell counts and viral load will remain stable, although your viral load may go up if you're fighting off other infections such as the cold or flu. Many people have no symptoms of HIV disease which is why this stage is sometimes called asymptomatic infection.

- longest stage of HIV, in many people it can last 10 years or more while in other it may be a shorter time. During the asymptomatic infection phase, HIV is rapidly making copies of itself and infecting new CD4+ cells. Your body is trying to counterbalance this loss of CD4+ cells by creating new, healthy ones. As long as your body can replace those CD4+ cells which are infected by the virus with healthy ones, your immune system will remain strong. In most cases however, if left untreated, HIV eventually starts to win this battle.

- The strength of your immune system is measured by your CD4+ cell count.
- without anti-HIV treatment, the virus overburdens your immune system, your CD4+ cell count drops and you are at increased risk for developing symptoms of HIV infection (night sweats, fever, diarrhea, yeast infection, weight loss, fatigue) - all signs HIV is progressing.

AIDS

- if your HIV infection is not treated with anti-HIV drugs, you may progress to the state known as AIDS.
- before effective anti-HIV drugs were available, progressing to AIDS and eventually death was an inevitable outcome of HIV infection for most people. however, with the effective new drugs, HIV disease can be controlled and does not progress toward life threatening illnesses. Anti-HIV drugs can halt the progression toward AIDS in people with HIV who are healthy and it can also help people who have become sick with AIDS- related life threatening infections to get better and stay healthy.
- many people now refer to HIV disease or chronic HIV infection, reflecting that AIDS is now an uncommon outcome of HIV infection where anti-HIV drugs are available.

The viral life cycle and antiretroviral drugs

- HIV cannot multiply by itself, instead makes copies of itself (viral replication)
- up to 10 billion copies of HIV may be made every day by a person who is not on treatment

HIV is made of two strands of genetic material called RNA

- contains 3 enzymes
 1. reverse transcriptase
 2. integrase
 3. protease

these enzymes are the proteins that help the virus make copies of itself

step 1: HIV enters a cell

HIV virus has proteins on its surface that fit perfectly into the receptors on the surface of certain cells, including CD4 cells. Once HIV attaches these receptors, the virus can fuse with the cell. Then the contents of the virus are inserted into the cell. Before HIV can infect a cell, it has to bind to not just one but two receptors on the surface of the CD4 cells. One of these is called a CD4 receptor, the other is called co-receptor. There are different co-receptors, including two called CCR5 and CXCR4. Drugs are being developed to stop HIV from getting inside a cell. Drugs that stop HIV from joining to the CD4 receptor and fusing with the cell surface are called fusion inhibitors. Drugs that block HIV from using a cell's co-receptors are called receptor blockers.

step 2: reverse transcription — HIV takes control of cell

Once inside the cell, HIV takes control of the cell. Reverse transcriptase (RT) enzyme converts the genetic material of the virus into another kind of genetic material called DNA. Now the genetic material of the virus matches the genetic material of the “host” cell. A class of drugs called reverse transcriptase inhibitors slow down or stop the action of RT enzyme. (NRTIs or NNRTIs/ nukes or non-nukes) Nukes were the first drugs approved for the treatment of HIV. Used in pairs, nukes are the major part of most drug combinations. To make an effective drug combination, the two nuke backbone is paired with a drug from another class.

step 3: integration — HIV becomes part of the infected cell

Drugs that stop or inhibit HIV from integrating into human cells are called integrase inhibitors.

step 4&5: assembly and release — HIV tricks the infected cell into making copies of itself

- an HIV infected cell can remain inactive for a long time. If the infected CD4 cell becomes activated, it will start making and releasing new virus. When a new copy of HIV is produced, it starts out as a single long chain of viral protein. The protease enzyme then works like scissors to snip these protein chains into smaller pieces. These newly cut pieces are then assembled into new virus particles, which “bud” from the host cell and go on to infect other cells.

Protease inhibitors: are drugs that interfere with the action of HIVs' protease enzyme. They prevent protease from cutting long chains of new viral protein. When PI's are used, new viruses can still be formed but they are defective and cannot infect new cells.

Researchers are working to develop new and different classes of drugs that interfere with the final steps of the viral life cycle, including the final assembly of the virus particles and budding from the cell.

- screening test indicated you have HIV then a confirmatory test is performed.
- supplementary test may be a P24 antigen test or NAAT
- it can take up to one or two weeks for a person to receive their results if laboratory testing is conducted.

Rapid testing - tests that provide results within a few minutes.

- if it indicated that the person is infected this is not a final diagnoses, vial of blood must be taken and sent to a laboratory for confirmatory testing.

Home tests and self testing - not available in Canada.

1987 - first and only treatment was put on the market. AZT

AZT was first introduced in 1964 for cancer

— was rejected, too toxic. harsher than chemotherapy

— reintroduced March 1987 to stop HIV division

people had a hard time it's too harsh, and "the most expensive drug"

not a cure though it decreases short term mortality

1996 - second treatment called HAART - triple combination, cocktail of pills

highly active anti-retroviral therapy

— initially a complicated pill regimen requiring multiple pills at different points

during the day, each with specific instructions (empty stomach, morning, w food, etc)

— simplified into a simple pill taken once a day

1999- Zidovudine to limit vertical transmission (risk of transmitting through child birth)

2003- HAART is converted into a single pill form

2005- recommends delaying treatment

2010 - recommendation to start treatment early

2012- FDA approves Truvada (PrEP) - in Canada approval was only in 2016

Resistance — as implied, HIV mutates frequently: possibly that a mutation develops that resists the effects of particular medication

— those who don't take their doses as intended run the risk of developing resistance

— sometimes you have to change one or another element to ensure ongoing effectiveness

Adherence — how closely a drug regimen is followed, skipping days, allows multiplication to occur, and increases the possibility of drug mutations.

Anti-Retrovirals are not a cure..

- stop people from getting really really sick

types...

1. fusion inhibitors
2. CCR5 antagonists
3. nucleoside reverse transcriptase inhibitor (NRTI)
4. integrate inhibitors
5. protease inhibitors

Medications are aimed at slowing down, inhibiting, disrupting the life cycle of the virus

In Quebec - most medications are covered

medications are covered by either provincial or private insurance

provincial instance covers a large percentage of medication with a small amount paid by patient depending on regimen, age, income, etc. most people in Quebec would pay less then \$1000/year

Possible routes to a cure found in the viral reservoir

- Characterizing the viral reservoir
- what kind of cells are in the reservoir
- where are they located in the body
- developing tests to measure the resevoir, this is vital to be able to measure the success of attempts to reduce the size of the reservoir
- determining how the reservoir manages to persist

Lesson 4

Discourse: the one and the other; homosexual and heterosexual; guilty and innocent; perpetrator and victim; us and them; anus and vagina; sins of the parent and innocence of the child; love and death; knowledge and ignorance; doctor and patient; addiction and abstention; contamination and cleanliness; contagion and containment; life and death; injection and reception; instrument and receptacle; normal and abnormal; natural and alien; prostitute and paragon; whore and wife.

Discourse: a narrative, to “define, describe, delimit” what is possible to say about an event, object, action.

“Discourses attempt to persuade audiences to accept a particular version of reality over another... they define a system of abstract shared beliefs, images or concepts which give structure to everyday life and which assist individuals to make sense of their world”

Consider language as well as content.

Kim Bergales - first person with HIV to become some sort of public figure

Dentist removed 2 of her teeth and got infected.

Possible meanings of AIDS: (Treichler, Excerpted)

1. An irreversible, untreatable, and invariably fatal infections disease that threatens to wipe out the whole world.
2. A creation of the media, which has sensationalized a minor health problem for its own profit and pleasure
3. A creation of the state to legitimize widespread invasion of people’s lives and sexual practices
4. A creation of biomedical scientists and the centers for disease control to generate funding for their activities
5. An imperialist plot to destroy the third world
6. A fascist plot to destroy homosexuals
7. The perfect emblem of twentieth-century decadence, of fin-de-siècle decadence, of postmodern decadence
8. God’s punishment of our weaknesses

The point here is that no clear line can be drawn between the facticity of scientific and nonscientific (mis)conceptions. Ambiguity, homophobia, stereotyping, confusion, doublethink, them-versus-us, blame-the-victim, wishful thinking: none of these popular forms of semantic legerdemain about AIDS is absent from biomedical communication.

The Names Project: quilt panel

The U.S. in the 1980s

The 1970s and 1980s saw a revival of quilting from two very point of origin. Feminists and women's historians recovered the history of women's quilting work, while Regan-era cultural nostalgia brought a new interest in American traditions of domesticity. In a culture with rapidly shifting attitudes toward death, these developments were linked to changes in the use of cultural creativity in therapeutic and grieving situations. The off convergence of these trends, and not solely the accidental arrangement of placards on a wall, ensured that the most famous memorial to AIDS took the form of a patchwork quilt. Jones and his colleagues have always acknowledged this, and have often of the quilt's dialogue with American symbolism.

Lesson 5

Activism

"Health from below": those most affected by health problems and social issues are encouraged to organize in order to question and challenge the expertise exercised by health professionals and state officials. In doing so, they have demanded that health be treated not exclusively as a physiological condition, but as a social and political issue that must be addressed. (James Gillett)

The Denver principles: "expressed a fundamental truth: to be successful, the fight against the epidemic must include the people who have the disease as equal partners in the battle. That model empowered our community to create a massive AIDS service delivery system, from scratch, in a remarkably short period of time under difficult circumstances"

Milestones - mobilization

1982

- San Francisco AIDS Foundation
- Gay Men's Health Crisis

1983

- Denver Principles

1988

- AIDS ACTIONS NOW! Is founded in Toronto, published treatment information sheet.

Montreal 1989 Conference

every 2 years- early on it took place yearly

Talk/share about HIV

But people with actual HIV did not have a big part

“The hall was full of delegates waiting for then Prime Minister Brian Mulroney to open the conference. Instead they got a bunch of angry activists. We had no plan. As I was the spokesperson for AAN! - the largest AIDS activist group in Canada at the time - somebody passed me the microphone. So, I opened the conference “on behalf of people living with AIDS in Canada and around the world.” I denounced the government for its inaction on AIDS, and before we left the stage we read aloud the Montreal Manifesto, a declaration of the universal rights and needs of people with HIV/AIDS.” (Tim McCaskell)

“Protesters were visible daily, from the opening ceremonies to the last. They demonstrated in favor of anonymous testing. They appeared at plenary and specialty sessions, armed with questions and challenges. They booed... plans for mandatory reporting (HIV reporting) and contact tracing (previous partners and contact them).” (Slocum quoted in Gillett)

Randy Shilts - Closing ceremonies 1989

“For the first time in the history of medicine we have seen a political coalition form around a health issue. This coalition has proven the most crucial ally of AIDS science.... It is no longer the job of science to understand science. It is the job of science to understand the world and what the world expects of science.” (Gillett)

AIDS definition,

1. Presence of HIV
2. Presence of one of nearly three dozen associated opportunistic infections: caused by bacteria, viruses, fungi, and parasite that are normally controlled by the immune system:
 - Kaposi's sarcoma
 - Pneimocystic pneumonia
 - Tuberculosis
 - Toxoplasmosis
 - Candidiasis
3. CD4 cell count is <200.

Medical Research: what we learned

About drug testing:

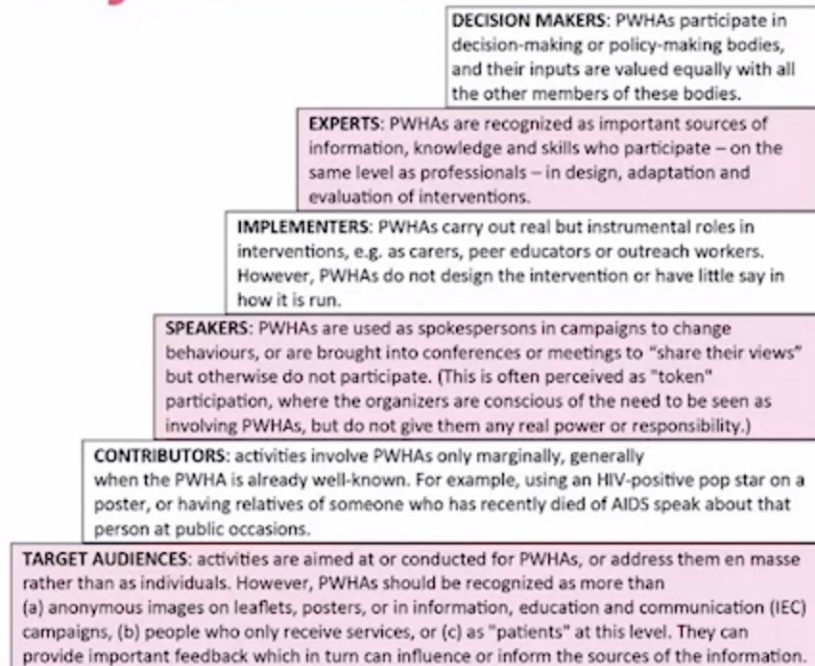
- Never on women
- Placebos
- Trails need to control for variables: no other medications

The initial definition of AIDS was based on early cases: primarily urban gay men (Definition expanded in 1993)

March 1989: Changing the definition

ACT UP starts a 4 year campaign against the centers for disease control (CDC) to change the definition of AIDS to include diseases specific to women and IV drug users.

Ontario ASO Pyramid of Involvement



GIPA Benefits

- Where successful GIPA implementation has occurred, there has been:
 - higher quality prevention and care programming
 - enhanced policy development
 - reduced stigma and isolation for PLWHA
 - increased feelings of personal empowerment
 - self-worth
 - enhanced credibility of AIDS service organizations
 - (ASO) as policy actors

Travers, R. et al.

GIPA Challenges

- GIPA implementation has been hindered by:
 - a lack of available leadership
 - the health status of PLWHA
 - lack of capacity
 - uncertainty over the value of PLWHA
- Participation
- Stigma

Stephens, 2004 in Travers, R., et al.

Greater Involvement of People Living with HIV/AIDS (GIPA)

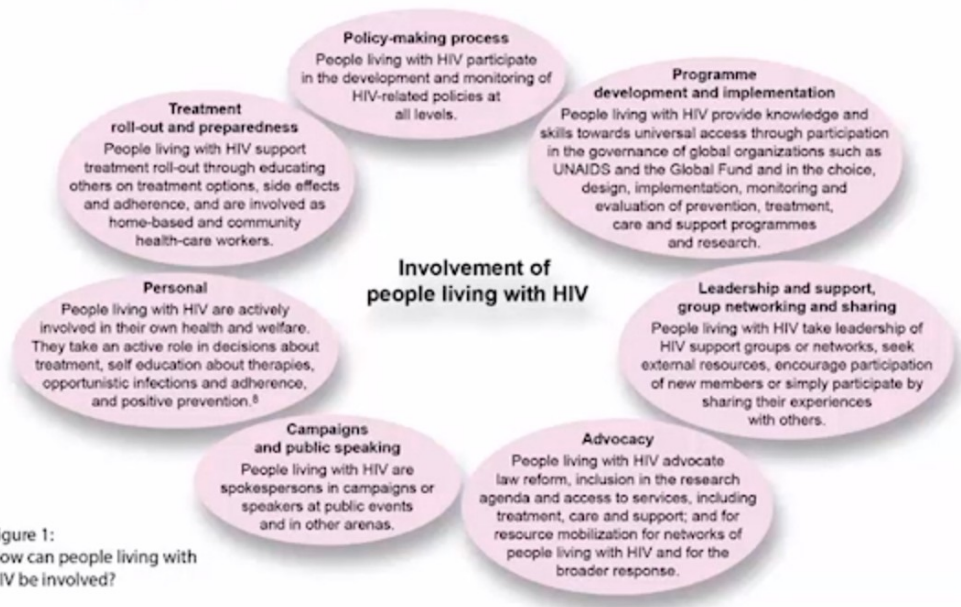


Figure 1:
How can people living with HIV be involved?

Lecture 5 (PLW HIV/AIDS)

What it was like in those early years for people living with HIV/AIDS

- are HIV+ people members of a community?
- how do you develop a positive identity from a stigmatized position

Yves video — became blind due to HIV

- Involved in prevention work, helps others on national levels deal
 - his husband is HIV negative (have been together 21 years)
 - prevention is possible
- “ AIDS is the problem, not the people living with it”

Activism

Those most affected by health problems and social issues are encouraged to organize in order to question and challenge the expertise exercised by health professionals and state officials. In doing so, they have demanded that health be treated not exclusively as a physiological condition but as a social political issue that must be addressed”

“Expressed a fundamental truth: to be successful, the fight against the epidemic must include the people who have the disease as equal partners in the battle. The model empowered out community to create a massive AIDS service delivery system, from scratch, in a remarkably short period of time under difficult circumstances”

Milestones — mobilization

1982 — San Francisco AIDS foundation

— Gay mens health crisis

(only 1 year after epidemic)

— recruited doctors within the community so they didn't have potential resistance/ bias within mainstream medicare

1983 — Denver principles

1988 — AIDS ACTION NOW! founded in Toronto

published treatment information sheet

distributed in a informal way — is now the CATIE website

How the Denver principles changed AIDS and health care forever. (1983)

— One year prior, AIDS became the fearful nameplate for the murderer of gay friends/lovers

— HIV has only been identified a few weeks earlier

— a group of activists met in Denver as part of a gay/lesbian health conference

— among them was a dozen men with AIDS

— asked to address attendees, was the bill of rights/ declaration of independence rolled into one, later would be know as the Denver principles

- they outlined 17 principles that covered everything from health care decisions to civil rights to sexual conduct

- demanded that physicians see their patients as whole people and provide accurate information

- asked all people to fight against AIDS discrimination in the workplace and in housing

- has influenced the doctor/patient relationship in every disease category, benefiting millions of patients

Power to the people

Early to mid-80's, igniting hope:

- early 80's nightmare of AIDS broke over gay communities in Canada's major cities
- young/healthy men were suddenly and inexplicably dying
- no one knew cause and even after identification of HIV in 1984, there was ongoing controversy over the role of the virus in the syndrome
- no cure existed and treatments were largely ineffective
- gay communities established organizations offering support and counselling, set up hospices to care for the dying and once HIV had been identified launched prevention campaigns urging safer sex
- with only marginalized groups —> gay men dying ... government efforts, what little there were, tended to be restricted to preventing the virus from spreading to the general population
- In 1987, impatience with government inaction and lack of research for treatments and a cure finally erupted in the u.s. The aids Coalition to Unleash Power in New York (act up ny) emerged, quickly leading to the formation of chapters across the u.s. Canadians soon followed
- That same year, Kevin Brown, a founder of the b.c. Persons With aids Society (bcpswa), began lobbying the federal government for speedy access to azt, which had just been approved as the first treatment for hiv infection in the u.s.
- A year later, after several false starts, there was still no national treatment registry in sight. Rather than wait on the government, activists decided to do it themselves. In February 1991, aan!'s tie project became the Community aids Treatment Information Exchange (catie). As an independent, charitable organization, catie would be able to raise funds to put in place a credible infra- structure to gather, evaluate and distribute treatment information, at least on a local level.

Montreal 1989 Conference

- this conference happens every 2 years, in different parts of the world
- primarily for researchers
- Montreal manifesto: declaration of the universal rights and needs of people living with HIV/AIDS
- people living with HIV were able to speak

“ protesters were visible daily, from the opening ceremonies to the last. They demonstrated in favour of anonymous testing. They appeared at plenary and specialty sessions, armed with questions and challengers. They boo'ed plans for mandatory reporting and contact tracing”

- mandatory reporting: required for people living with HIV living with government to declare themselves to the government
- contract tracing: write down all previous partners and contact them/ tell them to get tested
- a lot of effort in early years to make in mandatory
- if you just discovered you are HIV positive in 1989.... treatment is not super accessible and affordable and prognosis is not good.. probably not the best time to report this to other people who you may not speak to anymore, who might be angry with you, etc.

- long term social/individual impacts

Randy Shilts

“ for the first time in the history of medicine, we have seen a political coalition form around a health issue. This coalition has proven the most crucial ally of AIDS science. It is no longer the job of science to understand science. Is it the job of science to understand the world and what the world expects of science”

AIDS re-definition

- presence of HIV
- CD4 T cell count < 200 (per microliter of blood)
- presence of an opportunistic infection (30+) : caused by bacteria, viruses, fungi and parasites that are normally controlled by the immune system
 - * kaposi sarcoma
 - * pneumocystis pneumonia
 - * tuberculosis
 - * toxoplasmosis
 - * candidiasis

that combination of issues is important, range of symptoms together is a syndrome

- difference whether a person can access certain services/ insurance /benefits or not
- where researchers put their energy and resources

Medical research: what we learned

About drug testing

- never on women
- placebos
- trials need to control for variables: no other medications

The initial definition of AIDS was based on early cases: primarily urban gay men

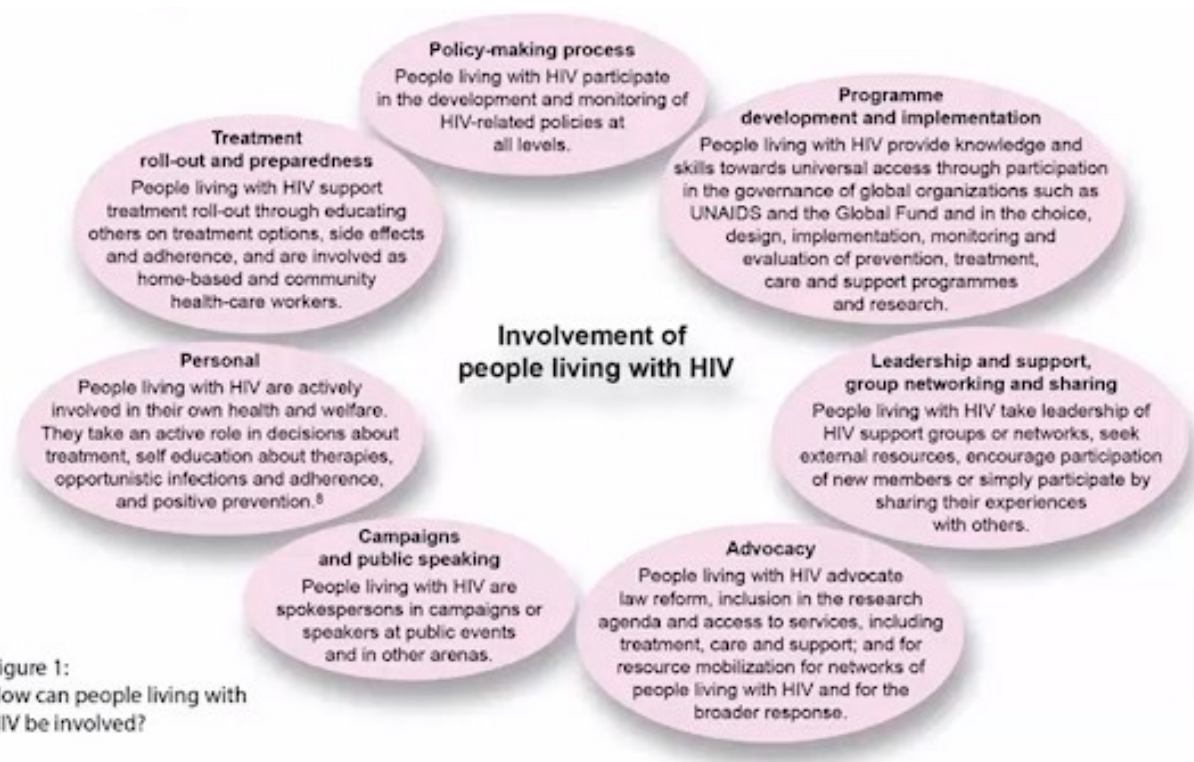
Changing the AIDS definition

The greater involvement of people living with HIV (GIPA)

- 40 million people around the world living with HIV
- in countries such as Botswana and Swaziland, people with HIV make up a quarter of the population
- people living with HIV are entitled to the same human rights as everyone else including access to appropriate services, gender equality, self-determination and participation in decisions affecting their quality of life, freedom from discrimination
- GIPA is critical to halting and reversing the epidemic which is also critical to reducing poverty
- GIPA not a project or program. Principle that aims to realize the rights and responsibilities of people living with HIV including their right to self-determination and participation in decision making processes that affect their lives.
- The benefits of GIPA are wide ranging. At the individual level, involvement can improve self-esteem and boost morale, decrease isolation and depression, and improve health through access

to better information about care and prevention. Within organizations, the participation of people living with HIV can change perceptions, as well as provide valuable experiences and knowledge. At the community and social levels, public involvement of people living with HIV can break down fear and prejudice by showing the faces of people living with HIV and demonstrating that they are productive members of, and contributors to, society.

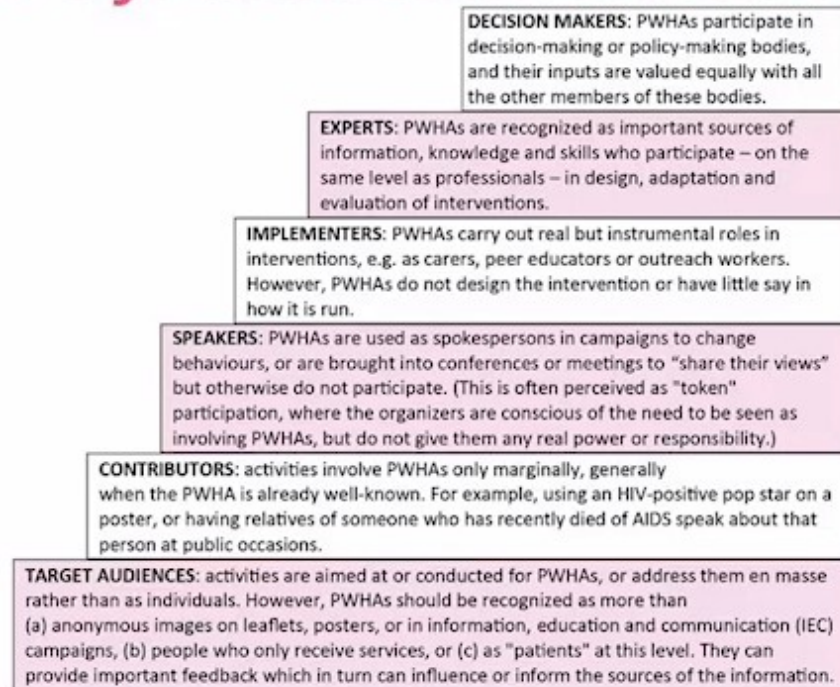
- GIPA does not require disclosing one's HIV status to the public
- People living with HIV often face stigma and discrimination, and this prevents them from accessing services, earning livelihoods and becoming involved, especially in organizations for people living with HIV or in high visibility roles
- Rejection by family, friends and the community, and discrimination by health service providers and in workplaces and schools is common. There are regular incidents of violence against people living with HIV. In some countries, traditional inheritance laws place an extra burden on women after the death of a partner as they have to leave their land and their homes. In many countries, anti-discrimination laws to protect people living with HIV and HIV workplace policies either do not exist or there is a failure to enforce them.



GIPA benefits and challenges

Meaningful involvement with people living with HIV/AIDS (MIPA)

Ontario ASO Pyramid of Involvement



GIPA benefits

where successful GIPA implementation has occurred, there has been:

- higher quality prevention and care programming
- enhanced policy development
- reduced stigma and isolation for PLWHA
- increased feelings of personal empowerment
- self-worth
 - enhanced credibility of AIDS service organization
 - (ASO) as policy actors

GIPA challenges

GIPA implementation has been hindered by:

- a lack of available leadership
- the health status of PLWHA
- lack of capacity
- uncertainty over the value of PLWHA

— participation

— stigma

— someone might not want to make their HIV/AIDS so public, it is time consuming, not everybody is made to be a leader/ spokesperson, etc.

The Brazilian campaign

- drop of HIV positive blood on the poster
- once dried it does not live outside the body
- not transmissible
- why did you kiss the poster “i felt love for this person i do not know”
- “ if prejudice is an illness, information is the cure”

Lesson 7

Three Decades of Trying to Stop the Pandemic

Why is Prevention So Difficult? □ According to Pierre Piot (responsible for UNAIDS response)

- First, HIV prevention, by nature, requires the engagement of many sectors (doctors/health practitioners vs. church leaders). Need a lot of different people in agreement at the table.
- Second, the solution required can challenge personal values (including the values held by implementers and those needed to champion prevention) or public image
- Third, as with prevention of any disease or illness, treatment of the acute crisis can produce immediate results, compared with prevention of the root cause, which achieves results over years and decades.

Herland:

- Because it's more abstract than a concrete change
- Because it involves a lot of people
- Because it often challenges peoples' belief systems
- It's very hard to make prevention work & work long-term

Prevention as Easy as ABC

- ABC starts with abstinence - perfect response to HIV infection was to remain abstinent
- Abstinence for youth, including the delay of sexual debut and abstinence until marriage
- Being tested for HIV and being faithful in marriage and monogamous relationships (not realistic)
- Correct and consistent use of condom for those who practice high-risk behaviour
- The primary message in a prevention campaign was to remain abstinent

The Grim Reaper

- Produced in Australia in 1987
- Prevention campaign
- "if you have sex only have one safe partner and always use condoms, always."
- Knocking down people with bowling balls
- Trying to make it scary

It's Never Just HIV

- New York City
- They make it sound like a scary movie trailer
- Almost feels like it can't be taken seriously

Early Prevention Efforts - Fear-Based Campaigns

Positive Impact of Fear-Based Campaigns

- Attract attention (with graphic imagery and simplistic language) □ they stick in your mind, leaves an impact
- Interventions are very memorable □ they stick in your head / leaves an impact
- Can lead to improved knowledge of precautionary behaviours □ because they stick in your head, you might retain the information

Unintended Consequences

- **Denial**: If people believe that the harmful consequence is unlikely, they may discount or deny the information
- **Othering**: The target audience thinks that the message is not directed at them. For example, older gay men may rationalize that the target audience is younger gay men
- **Ridiculing**: Occurs when a person thinks the message is absurd and, consequently, ignores it.
- **Minimizing**: Occurs when people think that the negative outcome is exaggerated and therefore do not respond to the message. For example, younger people are more likely to not have a sense of their own mortality.
- **Avoidance**: People may avoid the message altogether. People do not necessarily want their views challenged and may simply tune out.

- Fear based campaigns are usually seen as “over-the-top”, “unrealistic”. People will tend to disbelieve the message because it seems so exaggerated and unrealistic.
- The play on the emotions of people who is already at-risk or vulnerable, rather than people who believe they don't apply to the situation

Coming to Term with Complexity

“The need for strong and well directed leadership to keep HIV prevention at the forefront of social policy and action is especially crucial because of:

1. The many controversies associated with sex and drug use
2. The long time lag between HIV infection and the appearance of illness
3. The pressing need to provide treatment to those who live with HIV/AIDS

Pierre Piot

Types of Interventions

Behavioral Interventions

- Sex education
- Harm reduction education
- Peer education
- Mass communication messages through social media, press, advertising, campaigns, radio, etc.
- **Voluntary Counselling and Testing (VCT)**
- Stigma and discrimination reduction programs
- Cash transfer programs
- **Serosorting and Seroadapting** □ are choices and changes in behaviour individuals make based on their serostatus and the serostatus of their potential partner, and is usually in the context of sexual relationships. **Serosorting** is when people who are HIV+ choose to sleep with only others who are HIV+, and HIV- people sleep with HIV- people. **Seroadapting** is when you know the status of you and your partner, and you make choices about what sort of sexual activities or behaviours you will engage in based on that different serostatus. □ personal decision set of changes of behaviour, not an intervention in the classic sense.

Biomedical Interventions

- Male and female condoms
- Male circumcision
- **Voluntary Counselling Testing (VCT)** □ in behavioural & biomedical because the testing part is something that requires a medical establishment or medical approval to produce, take or prescribe
- Testing/treatment of Sexually Transmitted Infections (STIs)
- Needle Exchange Programs (NEP)
- Opioid Substitution Treatment (OST)
- Universal healthcare precautions
- Blood screening
- Antiretroviral drugs for vertical (mother to child) transmission; **Pre-exposure prophylaxis (PrEP)** (largely developed at St-Justine hospital in Montreal); **Post-exposure prophylaxis (PEP)** □(good for frontline – often offered in medical settings or work settings; where workers/jobs may put them at risk for expose to HIV (ex. in case of rupture of latex glove and stabbing of needle, etc. – exposed to bodily fluids with high concentration of HIV) – it’s usually a month-long set of medication; and Treatment as Prevention (TasP)
- Microbicides
- Vaccines

Structural Prevention

- Decriminalize sex work
- Decriminalize homosexuality
- Decriminalize drug use

- Law reform to protect people living with HIV
- Law reform to address gender inequalities
- Interventions that address poverty: ex. microfinance programs, programs for gender-based violence
- Addressing stigma and discrimination towards key populations

CDC Health Guideline 2014

- Suggested that all of these issues need to be taken into account (biomedical, behavioural, and the structural) for a prevention strategy to be effective, and that they're more likely to work and be sustainable long-term if these different levels are considered simultaneously and not "one solution for one population, and a different solution for a different population".
- "A prevention strategy that aims to increase access to effective biomedical, behavioural and structural interventions for the more than one million persons with HIV is more likely to decrease HIV transmission than a strategy that attempts to change sexual and drug-injection behaviours of the many millions of persons at risk for infection."

Combination Prevention Know Your Epidemic, Know Your Response (W.H.O)

Suggests that prevention methods should not only combine different strategies and different approaches, but they should also work to specifically be tailored in terms of vocabulary, priorities, issues raised or suggestions offered work directly with the population being addressed.

- A planning process that is inclusive and based on evidence: ensure the participation of all relevant stakeholders, including government officials, cultural leaders, civil society organizations, donors, and most importantly, individuals and communities affected by HIV and AIDS
- Identify modes of transmission and the most affected populations: Understand how HIV is spread in an epidemic, identify the most common modes of transmission, and the most affected populations
- Identify geographic variations in HIV prevalence: identify geographic differences in HIV prevalence (ex. Urban vs. Rural)
- Know the size of key affected populations: ensure the appropriate tools are available to collect, monitor and evaluate data about key populations
- Identify and understand structural factors that might fuel HIV prevalence: analyze social, legal, economic and cultural drivers of HIV prevalence (ex. punitive laws, gender imbalance, etc.)

Treatment as Prevention

- Thought to be the most effective type of prevention therapy
- Increasingly being adopted
- Public health experts estimate that 25% of Canadians living with HIV do not know they are HIV+

- “Test and Treat” is the most shorthand for encouraging everyone to take an HIV test and immediately starting treatment for those infected
 - This is intended to limit the potential damage caused by the virus
 - Since a recent study (the Partner Study, 2016) has proven that with a completely suppressed viral load PLWHIV do not transmit the virus – getting more people on treatment means limiting transmission
- As has been pointed out, Biomedical forms of prevention are the most easily adaptable since they do not challenge social, political or moral values. But does spending on increase treatment and care make sense?

The BC Centre for Excellence in HIV/AIDS Strongly Supports this Position

- Overall, out of every 100 people infected with HIV in 2011, 71 were diagnosed; of these people, 51 were consistently receiving treatment and 35 had an undetectable viral load for a sustained period.
- The cascade of care is referring to sort of the loss of people from one step to the other, for many number of reasons
- The more people that are diagnosed, the more suppressed viral load
- We have to keep testing people and get them onto medication, with that, we will limit transmission of HIV.

UNAIDS Treatment Target

- 90% diagnosed (vastly increasing testing) □ 90% of all people living with HIV will know their status
- 90% on treatment □ 90% of all people with diagnosed HIV infection will receive sustained ART □ 81%
- 90% virally suppressed □ 90% of all people receiving ART will have viral suppression (undetectable viral load) □ 73%

□ desired outcome in order to limit transmission (may not be realistic)

Pros & Cons of Test and Treat

Pros

- widespread effective antiretroviral may lower the community viral load
- more people would benefit from the treatment
- evidence shows that test and treat works
- test and treat would identify more HIV+ people
- the strategy would help mitigate health disparities
- when risk reduction counselling is included in HIV testing, it allows providers to discuss risk behaviours and harm reduction to both HIV+ persons as well as HIV- persons
- test and treat would enable monitoring and retention for people who start treatment
- test and treat would help link and retain people in care

- test and treat would present opportunities for prevention with patients' partners
- people would receive referrals to supportive services earlier in disease course
- sexually transmitted infection screening, treatment, and sexual health education would be facilitated

Cons

- widespread testing and treatment has large financial cost implications; as more people are engaged in test and treat, more resources will be needed
- many barriers to HIV testing remain
- modeling studies are flawed
- we may not be able to treat our way out of the epidemic
- demand for treatment exceeds supply
- behavioural disinhibition/risk compensation would compromise and decrease in incidence
- the current testing system makes capturing acute infections difficult
- viral suppression may not be possible for everyone
- current safety net resources should be used efficiently
- widespread treatment is unsustainable
- treatment initiation may take time. Unknown long term treatment toxicities
- stigma and discrimination continue to exist

San Francisco's Bold AIDS's Mission

- produced by PBS in the summer of 2016
- getting to zero by 2030
- how the model of Test and Treat is working in San Francisco
- PrEP □ Tuvada

Demystifying Pre-Exposure Prophylaxis (PrEP) □ YourekaScience

- PrEP is an HIV prevention strategy where an HIV- person takes a daily pill to reduce the risk of contracting HIV
- PrEP is not the same thing as PEP
- PEP is a month-long treatment regimen given to individuals within 72 hours after exposure to HIV to prevent infection to taking hold.
- The only currently approved PrEP regimen is Truvada, a two drug combi (Emtricitabine + Tenofovir) which blocks the enzyme called HIV reverse transcriptase (HIV relies on this enzyme to make new copies of itself), so Truvada prevents the HIV virus from multiplying, and establishing infection in the body
- PrEP works against HIV, does NOT prevent pregnancy or STIs □ therefore people taking PrEP should also be tested for HIV infection testing to make sure they haven't been recently infected, as well as STI testing & treatment if necessary.

- PrEP has been proven to reduce HIV infection in: gay/bisexual men, transgender women, heterosexual couples, IV drug users.
- PrEP does NOT treat HIV, it only PREVENTS it
- Myth #1: PrEP doesn't work. □ Major iPrEx study, researchers found an overall 42% reduction in HIV transmission. 4 pills per week, protection was approximately 96%. Those who took it daily saw 99% protection. FACT: PrEP works if taken as prescribed.
- Myth #2: PrEP causes bad side effects. □ Some people saw side effects such as nausea, headaches & weight loss. However, most of these side effects went away on their own, or when PrEP was stopped. But, the majority of people didn't have any side effects at all. Some people also saw a slight increase in serum creatinine, which reduces the kidney function, but the levels returned to normal after stopping the medication. Just to be safe, people taking PrEP should have regular monitoring for kidney health. Also slight loss in bone mineral density, although this bone loss did not worsen with long-term use.
- Myth #3: PrEP is impossible to get □ PrEP is available by prescription from doctors, nurse practitioners and physician's assistance, and most healthcare plans cover PrEP. Without insurance, PrEP can cost 1800\$/month. There are many medication assistance programs through Gilead Sciences that may be able to cover some or all the cost of PrEP.

From TasP to PrEP

- The strategies differ, in that TasP puts the burden of HIV prevention onto the person with HIV, while PrEP puts it onto the HIV negative person, but they share many similarities.
- Informed, motivated, voluntary uptake of TasP is an exercise in autonomy. However, lifelong adherence to medication is a huge commitment, particularly when started early. Unlike PrEP, the burden is unremitting once started, as taking breaks from the treatment has been shown to lead to drug resistance and failure.

Can Truvada Fix Everything? (VICE)

Lesson 8 Structural Strategies

Meet Jonathan Mann

- One of the first people responsible for addressing the HIV/AIDS pandemic. The first person made responsible for UNAIDS project to address AIDS.
- First encountered HIV in Africa
- He saw HIV in a different lens
- 4 phases:
 - 1) **Silent phase** (sometime in the mid-70s): When the AIDS virus was circulating around the world silently unnoticed and undetected.
 - 2) **Discovery** (1981-1985): Learn the virus, its name, how it spread and how it was a world problem.
 - 3) **Global Mobilization** (1985 - 1988): where we have seen a more rapid and more extensive, really unprecedented mobilization of global energy and resources to fight a disease that has never been seen before in history.
 - 4) **This period has no name** (early 1988)
- Explained AIDS to the world as a development problem, not just a medical problem.
- He said it was the most vulnerable and the most marginalized sectors in society that are affected the first by this epidemic, which is why we have to make sure that their rights are being protected and being strengthened.
- We have to do something about Human Rights
- Compassion is a major tool against AIDS, not discrimination.

From Behaviour to Structure

Universal Declaration of Human Rights Article 25:

- Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond

Chronology of Strategies

“The global response to HIV/AIDS clearly illustrates the maxim that how a problem is defined determines what we believe can be done about it, and from there what is actually done to address it.

The history of the response of HIV/AIDS has developed into four phases:

- From a danger to be alert about
- To a problem of individual behaviour
- To a societally contextualized behavioural issue

- To a human rights-linked challenge

Fear

- Early responses to HIV/AIDS were fear-based
- “A sense of urgency defined the problem, and the public information materials developed in this period often emphasized “danger” at the expense of clear information about prevention measures”

Late 80s

- defined HIV/AIDS in terms of individual risk behaviour.: an application of traditional epidemiological methodology which predetermined that risk factors would be identified as an individual level (ex. sex acts, number of partners, use of condoms), and the pervasive, unspoken acceptance within public health of:
 - o the individual-centered health belief model and its derivatives as the dominant approach to health-related behavior change
 - o specification of risk behaviours as the central concern led to the risk-reduction programs designed to change individual behaviours.

Agency Functions Within Structures

- First, there is understanding that the patterning of human sexual practices are deeply embedded in, and shaped by, underlying social, economic and legal-political structures.
- Single behavioural interventions cannot alter social structures that provide the environment in which patterns of risk practices are developed (sometimes over generations). Long-term, sustained alteration of these patterns instead requires a more comprehensive approach to structural change.
- A tailored, bottom-up direction through approaches that actively engage with the target populations’ reasons for their behaviours

Economic and Structural Context

- As the individual-behaviour based approach to prevention proceeded, questions inevitably arose about the social context in which individuals were “behaving”
- Disproportionally affecting people in developing countries and marginalized populations in industrialized countries.
- Recognizing the importance of societal context advanced painstakingly along disciplinary lines (economic, political, sociocultural)
- The ability to translate these insights into action lagged behind. For example, when poverty was identified as a central contextual issue, public health had difficulty going beyond pointing to poverty as a problem: concrete actions against poverty as an integral part of public health strategy did not result.

Jonathan Cohen: A Human Rights Approach Focuses on Accountability of Governments and Duty Bearers

- Produced in the mid 2000s to look at the importance of human rights in the context of public health generally and specifically in the context of HIV/AIDS
- What a Human Rights approach does is that it focuses on the accountability of governments and other duty bearers. It takes the science and the public health knowledge that we have and renders it into an obligation; because unless governments feel a duty to implement the best science, then it just remains a set of scientific findings that doesn't help people.

Structural Impacts

Understanding Structural Impacts

- The first body of work conceptualizes structural factors as those which fundamentally shape or influence patterns of risk behaviour – the drivers – whereas the second group conceptualizes structures as environmental factors which facilitate or hinder how people can specifically avoid HIV within a given context.
- Conceptualizing structural factors in these two ways (as drivers or as environmental barriers/facilitators) provides an important first step to guide locally tailored intervention strategies.

Structural Interventions

- Structural factors: the components other than individual knowledge or awareness which influence individual and group risk and vulnerability.
□ work to build (they are what shapes the individual)
- Structural risk drivers: a population-specific subset of structural factors empirically identified to influence individual and/or group risk practices
□ interrupt the pathway
- AIDS resilience: a situation in which individuals possess the capabilities to resist HIV in their given behavioural and risk setting.

Different Levels of Influence

An operational concept to guide implementing agencies to consider what areas are within their ability to influence. One can look for structural factors influencing the following:

- Micro: the individual or the household level
- Meso: the community or group level (neighborhood, social level)
- Macro: the broader environment or regional/national level (structural – the one individuals have the least control over in their day-to-day lives, but as we're seeing, have a very profound impact on the choices they make and the risk factors they may come up against.

Intersectional Responses

Intersectionality

- Intersectional dynamics are not static, but neither are they untethered from history, context, or social identity. As the many examples herein show, there are multiple ways in which the factors, conditions, institutions, structures, and politics contributing to mass incarceration might be said to intersect. At the same time that intersectionality transcends an exclusive focus on identity or mere categorization, the lived experiences of racially marginalized women and girls are shaped by a range of social and institutional practices that produce and sustain social categories and infuse them with social meanings.

Connections

- The ways in which marginalization impacts a trans person's life are interconnected; stigma and transphobia drive isolation, poverty, violence, lack of social and economic support systems, and compromised health outcomes. Each circumstance relates to and often exacerbates the other.

A process

- A structural approach to HIV can therefore be defined as the process undertaken to decide upon an appropriate set of structural HIV prevention interventions: a process because it is impossible to define in advance what activities to undertake; appropriate because HIV prevention must be tailored to local realities; and a set of activities because risk is typically shaped by multiple factors.
- In this way, a structural approach can be conceptualized as a decision tree approach

Addressing the Right to Health

The goal of combined HIV risk reduction and vulnerability reduction strategies is not to replace more traditional public health efforts with a purely human rights approach, but rather to add a human rights dimension, and thereby to create a modern public health.

Jonathan Mann briefly described four phases in the history of AIDS. Which of these phases pertains to early 1988 to present?

- There is no name to this period
- The Discovery Phase
- The Global Mobilization Phase
- The Silent Phase

Lesson 9 Sexuality / Morality

Global Perspectives on Sexuality

Global Influence

HIV is linked to globalization in a number of ways, including its transmission and the development of responses to the epidemic, which have been a major test of the United Nations system, of concepts of international solidarity and civil society, and the whole complex set of international agreements and regulations surrounding pharmaceutical patents and manufacture.

Global mobilization around the demands of a biomedical emergency has inevitably meant the further entrenchment of western concepts of disease, treatments, sexuality and the body. While I believe that the western scientific view of AIDS as resulting from infection by a retrovirus is correct, I also recognize that this particular understanding further undermines other and different ways of viewing medicine and the body.

- Altman

HIV Denialism

- After he assumed the Presidency, he appears to have articulated more clearly his understanding that poverty is a significant factor in the prevalence of AIDS and other health problems...Some speculate that the suspicion engendered by a life in exile and by the colonial domination and control of Africa led Mbeki to react against a portrayal of AIDS as another Western characterisation of Africans as promiscuous and Africa as a continent of disease and hopelessness

Criminalizing Same-Sex Relationships

- 78 countries make same-sex activity a criminal offence, with penalties ranging from whipping to execution
- Similarly, laws prohibiting – or interpreted by police or courts as prohibiting – gender nonconformity, defined vaguely and broadly, are often cruelly enforced.

Health, Safety, Tradition

- “Since the early days of the epidemic, there has been heated debate between those, often associated with gay communities and with international agencies, who argue that the proper response to fears of sexual transmission is safe(r) sex, against those, essentially supported by most religious institutions and conservative administrations, whether in the United States or Iran, who argue for abstinence and messages which reinforce taboos on non-marital sex”

- Altman

Using AIDS to Support Values

- There is a great deal of confusion in the discourses around HIV, with conservatives seizing upon the epidemic as “proof” that anything other than strict rules of exclusive heterosexuality, abstinence and monogamy will promote the epidemic. In one sense this is of course correct: a world without sex would clearly see a greatly diminished HIV epidemic. Yet the real consequences of these policies, and the denial of human desires and behaviours which accompanies it, is a greater danger for the spread of HIV than is “promiscuous” sexual behaviour. As social stability collapses, more young people find themselves living off their wits, forced to sell themselves to survive, and the failure of state services due in large part to policies promoted in the name of economic efficiency and rationalism further perpetuates this.

The Right to Sexuality

- Those groups who organize sex workers and drug users and homosexuals in many countries are often assailed as betraying national culture and tradition. Yet their claim for inclusion in the national culture is as legitimate as are those who would exclude them, and their insistence that human life takes precedence over religious or cultural taboos has itself strong ethical and religious support.

Modernization vs Tradition

- “Just as HIV/AIDS is found in both the richest and poorest parts of the world, so too its spread is associated both with “modernization” and industrialization on the one hand and the defence of “tradition” on the other. People are made vulnerable to HIV through rapid change and the disintegration of existing social mores and connections, but they are equally vulnerable because of denial and sometimes active persecution justified in the name of culture, religion and tradition.

We are Here - Excerpts from Documentary Film “Call Me Kuchu” Uganda’s Anti-Gay Bill

- Don’t recognize homosexuality as a Human Right

Sex Work

Community Dislocation

- The impact of civil war in countries such as Rwanda and Sierra Leone, and the vast disruptions to social life in countries which have experienced rapid social, economic and political transition, means greater rape, prostitution and transmission of STIs in environments where social supports and prevention programs are virtually non-existent. (Other untreated sexually transmissible diseases increase susceptibility to infection by HIV.)
- The growth of urbanization and economic “development” in many parts of the world means the collapse of “traditional” norms of sexual

behaviour and increased vulnerability, above all for young women, to infection by HIV. Under conditions of social dislocation, poverty and the absence of health services, HIV will spread much faster.

Sex/Money

- While it is often said that HIV is spread through prostitution (a formulation which repeats the usual demonization of the sex-worker while ignoring the client), the vast changes in sexual behaviours and attitudes across much of the world cannot be reduced to simple issues of prostitution and exploitation

Sex Work Legislation

- 116 countries and territories have punitive laws against sex work
- 80 countries and territories have some degree of protection in law for sex work
- 13 countries and territories have information available
- More than 100 countries criminalise some aspect of sex work. Cuba, China, Iran, Vietnam, South Africa and most of the US outlaw sex work entirely
- Laws in many countries deny sex workers fundamental civil entitlements, increasing their HIV vulnerability

How Structural Barriers Impact Human Rights

- The combination of criminalization and the failure to recognize sex work as work means that sex workers are cut off from state benefits and regulations that protect other workers' health and safety. Also, it often means that sex workers are more vulnerable to coercive state measures ranging from arbitrary arrest and detention to the testing of sex workers for sexually transmitted infections (STIs) against their will or without their knowledge, under the guise of public health protection

Sex Work as Contagion

Anti-STI Campaigns WWII

- "loose women are loaded"
- "She may be a bag of trouble"
- Sex workers are held responsible for HIV transmission
- "Death for sale"

Minority vs. Majority

- It is true that fighting HIV within a specific, affected population reduces overall HIV rates, and that everyone benefits. The problem comes when protecting the health of sex workers is secondary and supported merely as a means of saving other peoples' lives. Such an approach often leads to violations of the rights of sex workers in the name of promoting the public health of the "general population." - Anna-Louise Crago

Condoms as Evidence
Open Society Foundations

Lesson 10 HIV and the Law

Shereen El-Feki HIV: How to Fight an Epidemic of Bad Laws (video: TedTalks)

- Former chair on global commission of HIV and the Law
- The Kingdom's laws forbid entry of individuals with HIV □ Violation of International Human Rights
- Global Commission of HIV and the Law
- Harm reduction: offering clean needles, providing information, education, condoms, providing counselling, testing, etc. □ Harm reduction leads to HIV reduction
- Review legislation
 - Repeal laws that punish or discriminate
 - Reform police, judiciary
 - Raise awareness
 - Retool prisons
 - Redress through the court
 - Reinforce civil society
 - Reach out to community, religious and tribal leaders

Laws: the Good, the Bad, and the Ugly

Kinds of Laws:

- Laws/practices intended to limit transmission:
 - Criminalise transmission
 - Criminalize non-disclosure
 - Limit travel/mobility/freedom of PLWHIV/AIDs
- Laws which limit the freedom of people who may be vulnerable to the virus:
 - Automatic testing of expecting mothers
 - Sterilization of women living with HIV/AIDS
 - Laws intended to restrict/criminalize
 - Sex workers
 - Homosexual men
 - IV drug users
 - These laws may include limits to travel, decision-making, employment, access to health services, etc.
- Laws or policies which place conditions on funding/care/service delivery

When Prevention is Illegal

- Policies and interventions that focus on the individual assume that people have, and are able to exercise, sufficient autonomy to be able to make healthy choices as regards themselves and others, while structural interventions recognize that these choices are constrained -

and in some cases largely determined – by social structures. It is only by identifying and addressing the pathogenic effects of these structures that we can hope to achieve real change. – Weait

Matthew Weait

- Laws and their enforcement may, and do, have the potential to do good (for example in the context of antidiscrimination legislation, and those which secure access to testing, treatment and care); but those which elide ignorance, censure and populist moralism with a misguided belief in their capacity to influence behaviour and to protect the uninfected from infection do harm”

Weait Offers Two Ways to Evaluate Law:

- The first is whether the law in question does, or may, have the effect of impeding efforts at preventing the spread of HIV.
- The second is whether it does, or may, sustain HIV-related stigma and discrimination against people living with the virus, or otherwise diminishes their full enjoyment of the human rights to which we are all – irrespective of our HIV status – entitled

Does the Law Limit Care or Rights? Or Both?

- These may, of course, overlap - as when the denial of treatment (which would constitute a breach of the right to the highest attainable standard of health) results in heightened infectiousness (which may increase the risk of onward transmission)

Criminalization of Non-Disclosure

- Can be considered sexual assault in Canada

Use of Criminal Law

Concerns about:

- The rapid spread of HIV in many countries
- The failure of traditional HIV prevention efforts to stop the epidemic
- The particular vulnerability of women who are infected through sexual violence, or by partners who do not reveals their HIV status

HIV is Not a Crime (video)

- Nick Rhoades
 - o HIV+
 - o Had an undetectable viral load
 - o Used a condom
 - o Didn't pass on his HIV
 - o Sentenced to 25 years of jail
 - o Told he was a bad person
 - o Wears GPS & ankle bracelet

- Needs to be supervised when near a child
- Is marked as a sex offender
- The media demonizes HIV “HIV predator”
- “take the test and risk arrest” is what people fear from getting tested for HIV

The Canadian Context

Canadian Context

- In Canada, a person living with HIV (PHA) can be prosecuted for not disclosing their HIV-positive status before having sex
- People can be convicted even if HIV was not transmitted (criminalization of non-disclosure)
- The legal obligation to disclose was established by the Supreme Court of Canadian Currier in 1998
 - The law became more explicit in 2012

Very High Rate of Criminalisation

- 181 people have been charged to date (103 were men □ 90%) between 1989-2010

Power and Consent

- In HIV non-disclosure cases, both partners have consented to have sex. Lack of disclosure is usually not about asserting force over another person in order to gain sexual gratification, but rather the result of fear of violence or other harm, rejection or denial
- Arguably, by associating HIV non-disclosure with sexual assault, **the criminalization of HIV non-disclosure trivializes the offence of sexual assault and reinforces stigma against people living with HIV (HIV/AIDS Legal Network Fact Sheets)**

Which of the following is a false statement? In order for an individual to be convicted of sexual assault in regards to HIV, the Crown must prove, beyond a reasonable doubt that:

- The prosecuted was dishonest about their serostatus
- Had the compliant known the accused was HIV+, they would not have consented to sex
- The prosecuted did not use protection during the sexual act
- The sexual act threatened the life of the compliant

Lesson 11

Harm Reduction

Introduction

- Harm Reduction: An approach to transmission prevention or to health improvement to addressing some of the negative social determinants of health in a more holistic way that tries to bridge individual and structural prevention approaches.

IDU Stats & Context

HIV & IDUs Worldwide

- Eastern Europe and Latin America are the hardest hit currently
- Fairly important population in North America, and in South-East and East Asia
- When you live in a neighborhood with a higher prevalence of HIV, you are more likely to encounter it.

Some Statistics

- 16 million injection drug users around the world (estimated)
- One in five of them are HIV+
- Seven countries with 25% increase in HIV incidence in the past 15 years, largely due to injection drug use
- Estimates from 94 reporting low- and middle-income countries suggest that only 8% of people who inject drugs receive some type of HIV prevention service
- Central Asia and Eastern Europe, where nearly 83% of HIV cases are attributed to injecting drug use, former or current injecting drug users only represented 24% of the people on anti-retroviral treatment at the end of 2004.
- Five countries in particular (China, Malaysia, Russia, Ukraine, and Vietnam) are characterized as “mega-epidemics” in terms of people who inject drugs. Taken together, these countries account for an estimated 2 to 4 million cases of HIV infection and constitute the largest concentration of injecting drug users living with HIV worldwide.

2012 Report of the Global Commission on Drug Policy

- Fear of arrest drives persons who use drugs underground, away from HIV testing and HIV prevention services and into high risk environments
- Restrictions on provision of sterile syringes to drug users result in increased syringe sharing
- Prohibitions or restrictions on opioid substitution therapy and other evidence-based treatment result in untreated addiction and avoidable HIV risk behaviour
- Conditions and lack of HIV prevention measures in prison lead to HIV outbreaks among incarcerated drug users

- Disruptions of HIV antiretroviral therapy result in elevated HIV viral load and subsequent HIV transmission and increased antiretroviral resistance
- Limited public funds are wasted on harmful and ineffective drug law enforcement efforts instead of being invested in proven HIV prevention strategies
- Herland: It's the criminal context that is keeping people who inject drugs from accessing the services they need. Fear of arrest make people want to live underground and not be seen, not access services. As individuals they are forced to make a choice between their health and their freedom. To stay away from the justice system, they are avoiding access the healthcare.

Harm Reduction Defined

- "Harm Reduction" refers to policies, programs, and practices aimed at reducing drug-related risks and harms by advancing the health and human rights of people who use drugs
- As Harm Reduction International notes, "the defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs"
- This approach recognizes that "people unable or unwilling to abstain from drug use can still make positive choices to protect their own health in addition to the health of their families and communities"
- Access to health care should not be dependent on whether or not you use drugs.

Harm Reduction International

- "Human rights apply to everyone. People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment. Harm reduction opposes the deliberate hurts and harms inflicted on people who use drugs in the name of drug control and drug prevention, and promotes responses to drug use that respect and protect fundamental human rights."

Accept People Where They Are

- evidence-based □ already a lot of research/data demonstrating that it is effective
- We have already seen evidence previously that messages that aim to instill fear of infection may be counter-productive, as they make people feel helpless
- Easily understood by those it is intended to reach
- Implementable: in other words, people have to be willing and able to take the suggested precautions. To suggest that all sex is risky is to invite denial of any risk attached to sexual activity

- Persuasive, not punitive
- Not more disruptive than absolutely necessary
- Switching from a criminal focus to a health focus

Our Harm Reduction Stories (video)

- By Regent Park
- People involved in using or developing harm-reduction strategies
- Understanding the impact that harm-reduction has on individual lives
- “It’s extremely important not to judge, and the most important thing you can really do is just to listen”
- Honesty is at the core of the harm reduction approach. That can only be discussed if the communication is respectful, open and centered on the person’s needs.
- Harm Reduction = Honesty + Common Sense
- Harm reduction is truly just patient-centered care
- Harm reduction should include: access to information, tools (ex. safer substance use tools), has to have a place where it is welcoming and people feel comfortable to come and spend time that’s not judgemental.
- As soon as you start punishing people for using, they won’t want to come back
- When a harm-reduction worker, you must realize that at some point in time the user was traumatized. There’s a reason why they’re using (ex. abuse)
- Comprehensive harm reduction services should include a multitude of approaches and aspects, such as having access to safer harm-reduction tools, information and education, having a drop-in space where people can come in at any time would be helpful, referrals to resources (ex. housing, food access, income access, having access to healthcare and/or referrals to community health centres), having peer workers involved in service delivery.
- Be kind, respectful, open-minded & try to see the good in people.

User Involvement and Empowerment

Harm Reduction by a “User-Run” Organization: A Case Study of the Vancouver Area Network of Drug Users (VANDU)

- The International Journal of Drug Policy
- Thomas Kerr, Will Small, Wallace Peeace, David Douglas, Adam Pierre, Evan Wood

http://www.econcordia.com/my2/coursedocument.aspx?course=hiv_aids&document=L11_5_Involvement

User-Run Programs

Organizing Those with Little Structure

- “First, the organization tries to be inclusive of all current and former drug users. For instance, in placing volunteers into limited workspaces, priority is given to individuals who have never volunteered with VANDU. This strategy aims to prevent VANDU from becoming a small elite group distanced from those they seek to represent. Second, the organization is user-driven, and an elected board makes all organizational decisions. Third, VANDU employs a peer mentorship policy that involves pairing someone who has skills in a particular area with someone who is interested in acquiring those skills.”
- Herland: User-run centers like VANDU provide the opportunity for people who have experienced rejection, criminalization, marginalization within society to acquire skills to become articulate about their own needs, to support each other, and within that context, to be able to speak to healthcare providers and decision-makers about their own needs and to develop or work with others to develop programs that respond directly to their needs.

Strengths (and Weaknesses)

- “it is noteworthy that many of VANDU’s programs are initiated as responses to the immediate needs of local drug users, and are often implemented without funding or official support. By virtue of its method of peer consultation, VANDU has often operated a step ahead of local health authorities who aim to monitor and respond to priority health issues”.

Conclusion

- “Beyond the acquisition of skills, participants in VANDU can engender a sense of self-respect and purpose. Some participants also reported that VANDU has made a positive impact on local culture by fostering a sense of social responsibility and mutual caring among people who use drugs. VANDU has experienced its share of challenges over the years. Lapses in funding, police harassment, and the ongoing loss of members to overdoses, accidents, HIV/AIDS and other illnesses have weighed heavily on the organization.”

Harm Reduction Headway and Continuing Resistance

Harm Reduction Headway and Continuing Resistance: Insights from Safe Injection in the City of Vancouver

- The International Journal of Drug Policy
- Andrew D. Hathaway, Kirk I. Tousaw

http://www.econcordia.com/my2/coursedocument.aspx?course=hiv_aids&document=L11_7_Harm

From Needle Exchange to Safe Injection Sites

- The methods that are most practical and most effective in terms of reducing potential risks for injection drug users are also the ones that

create the greatest controversies and that are the hardest to implement.

Decline in HIV Among Injection Drug Users – British Columbia

- BC has been at the forefront of this type of harm reduction approach in Canada
- Early adopters in a global context
- 1996: methadone provision paired with highly active antiretroviral therapy begins
- 2002: syringe expansion
- 2003: supervised injection facilities open
- 2005: heroin prescription trial begins

Science, Not Morals

- Harm reduction's central theses espouse a neutral view of drug use and drug policy based on science, not ideology or morals.
- At the same time these declare support for rights and social justice – convictions that in no sense can be seen as “value neutral”. Harm reduction and enforcement may be reconciled, some argue, by making human rights the main foundation of drug policy.
- Possibly the most efficient way to transmit HIV is a tool that goes directly from blood stream to blood stream in a very short amount of time, which is what needle sharing is, is the most effective way of getting through the barrier skin, which as we know is the body's first and primary defense against any sort of infections or vulnerability. So anything that can be done to limit or to somehow reduce that possibility to having a needle go from one person to another person directly is going to improve that situation. But, a lot of people are concerned that in so doing, people who believe in current drug control policies for instance, argue that public health and harm reduction approaches to drug use weaken the deterrent power of drug control laws and ultimately would hurt, more than help, as the overall rate of drug use increases. They're concerned that by not making it a criminal penalty, latent offence is going to encourage more people to use drugs than are currently using drugs. □ Evidence shows no truth to this. There are a lot of people who are currently using drugs and accessibility does not seem to be a primary reason.

Advocacy and Public Order

- “respect for users' rights means recognising that drug users are the primary practitioners of substance harm reduction. This role is downplayed or neglected in harm reduction discourse that casts users as recipients or objects of intervention...The “right” to use drugs is provisional on showing oneself worthy as determined by health experts whose benevolent intentions and technologies in practice help justify repressive laws against the “underserving””.

Will Montreal Get A SIS (Safe Injection Site)?

- exchange a used needle for a clean one
- you only get the amount of needles you brought in □ seen as a way of limiting drug use
- A safe injection site is a space where somebody can inject the drugs that they own in a supervised, clean environment.
- Proved to be quite successful
- **Bill C-2, the “respect for community act”**, introduced by the Harper government. Makes it extremely difficult for safe injection sites, and supervised sites, where people can inject drugs in the context of healthcare professionals. It’s difficult to get approved by the Federal government, as they need to provide a long list of materials (letters from the city’s mayor & local police chief, crime statistics, information and data on the neighborhood where the site is going to be located, provide extensive background check on the potential employees, etc.)
- Coderre says he would like to open 4 different SIS, but is waiting for Federal government to approve that plan. Says he is making it a priority. It will probably be more possible with Trudeau in government, as Trudeau had said he would like to see this happen.

Percentages of Persons in Prison Ever Reporting a Positive HIV or HCV Test; Result by Sex and Aboriginal Self-Identification

- Hepatitis-C is much more prominent than HIV
- Aboriginal females are much more at risk for both
- Harm reduction becomes important in prison populations where there is a high prevalence.

Free Talk: Supervised Injection Site (video)

- Free talk Vancouver
- First supervised injection site in Canada: Vancouver
- Open since 2003
- Is SIS an enabler or a life saver?
- 3 million dollars per year
- In 2003 they had really high levels of HIV & HCV
- Half a dozen needle drop-off boxes around the East Side
- “People are gonna do drugs no matter what” - drug user
- “It’s really important as a healthcare clinic providing overdose response for people down here, preventing the spread of HIV, getting people treatment, and it’s also really important in helping building relationships with people who are really marginalized in our society. They don’t access healthcare easily. They go to emergency rooms, they go to clinics, and sometimes the experience isn’t very good. And what that does is makes them shy away from healthcare, but healthcare for people who are addicted is really, really important.
- “In-Site” helps keep you safe and alive

- The success rate of the program “on-site” is 43%
- “It’s in no way encouraging people to take drugs. It’s encouraging people to take care of themselves and to be a healthier, more functional human being.” “This is something that saves lives and helps your neighborhoods cleaner”.
- “The fact is addiction breeds in trauma, addiction breeds in chaos, addiction breeds in alienation and isolation. So if you want to increase addiction, keeps somebody out. Keep them outside, keep them in the alleys, keep them by the dumpster. If you want to help start to reduce addiction, bring them into in-site”.

Harm Reduction Behind Bars

- CATIE
- Prison-based Needle and Syringe Programs
- By Emily van der Meulen and Sandra Ka Hon Chu
- Rates of HIV in Canadian Federal prisons are at least 10 times higher than in the general population
- Rates of Hepatitis C are at least 30 times higher
- These rates are even higher among incarcerated Indigenous people and people who inject drugs
- More than 1 in 10 of indigenous women in federal institutions are reported to be living with HIV and almost 1 in 2 are living with Hepatitis C.
- Among people who inject drugs, almost three times as many are living with HIV relative to other prisoners upon admission to federal prisons

<http://www.catie.ca/en/pif/spring-2015/harm-reduction-behind-bars-prison-based-needle-and-syringe-programs>

What is Prison Like? (video)

- Prisoner’s HIV/AIDS Support Action Network
- Good Evidence Channel
- PASAN
- Their model is about empowerment
- Currently about 40% of the prison population is HCV+ and 10% of the prison population is HIV+
- A lot of times we don’t think of prisoner’s health as a human right’s issue, and it IS a human right’s issue.
- Hep C and HIV prevalence are going up in prison
- Staff is made up of people who are ex-prisoners, as well as people who are HIV+, which is important because these are individuals who know the system and its complexities
- Infection rates are higher inside prison due to lack of harm reduction resources

- PASAN has over 600 active clients who utilize services and programs offered such as the drop-in centre, in-prison harm reduction workshops and the women's program.

Which Bill, introduced by the Harper government, makes it very difficult to allow the opening of Safe Injection Sites in Canada?

- Bill C-4: The Respect for Users Act
- Bill C-2: The Respect for Community Act
- Bill C-4: The Safe Injection Site Act
- Bill C-2: Protection of the Community Act

Lesson 12

Neoliberalism: AIDS in a Time of Austerity

The Cost of Treatment

- May 2000: patented drugs: 10 000\$ US per person
- July 2000: Brazil decided to make treatment available to everyone within the country who needed it, to have it provided by the state; not have it on a "pay if you can" "as you can" basis. Brazil was able to do that because they were able to provide generic versions of the patented medications much more cheaply.
- Went from over 10000\$ per person, to under 300\$ per person.

Increased Need

- While overall prevalence rates have stabilized, the growing number of people on treatment, growing rate of resistance to first-line medications, growing populations and a continuing failure to reduce transmission mean that the response must expand just to stand still.
- Treatments have become, in the last couple of years (15-20), more accessible, less expensive, more available, there has been a growing demand for treatments, as more and more countries develop policies suggesting that treatments should start earlier.
- Treatment costs have gone steadily up. Even though it's less expensive to treat an individual person, more and more people are being treated.

Combined Impact - Sub-Saharan Africa

- Initial cost of ARVs meant many African countries in particular were encouraged by the World Bank to concentrate on prevention rather than treatment.
- In 2003, fewer than 100,000 people in Sub-Saharan Africa had access to such treatment
- A decade later, that figure had increased over 90-fold to 9.1 million in 2013.

- In Sub-Saharan Africa, the treatment was so expensive that they spent more on prevention rather than treatment, to try to limit the number of new cases, because it was less expensive to focus on prevention (to develop posters & campaigns), than it was to treat people who were getting infected. If you reduce transmission, it would be more cost-effective.

Framing AIDS in Times of Global Crisis

- "Wasting" Africa yet Again?
- Wiebe Nauta & Ludek Stavinoha

http://econcordia.com/my2/coursedocument.aspx?course=hiv_aids&document=L12_3_Framing

Neoliberalism and Funding

Building on Past Achievements: Funds Invested in AIDS Programs in Low- and Middle-Income Countries, 1986-2013

- The Global North has far more resources than the Global South
- HIV disproportionately hits those who are more marginalized and have less resources.
- Since the 2000s, a growing number of either private foundation (Bill & Melinda Gates foundations), or either combined government resources, either combined between governments and private enterprises.
- In the last few decades, there have been a variety of different bodies created to help increase the funds available to help fight against HIV.

Scarcity/Austerity

- "After some hope from the mid-2000s onwards, northern countries are reneging on their promises to fight the global pandemic, bowing to the ostensibly unassailable imperative of fiscal austerity due to a self-inflicted economic crisis" - Nauta
- Northern countries began to double back on their promises to fight the pandemic. Partly because of fiscal austerity and neo-liberal politics, partly because of the economic crisis. For any number of reasons, governments would promise funds and then not deliver, or deliver few funds than initially promised, citing the need to save or reallocate the resources elsewhere.

Global Funding

- In 2013, funding from donor governments actually fell to 8.07 billion - a 3% drop on 2012.
- This drop was primarily the result of declining annual commitments by the US government - the world's largest HIV donor. In 2012, 47% of all HIV spending was in sub-Saharan Africa, followed by Latin America (17%).
- Meanwhile:

- Over the last two decades, the private sector has emerged as the world's top source of financing and leadership in the fight against deadly diseases
- In 1970, these private contributions constituted a quarter of the WHO's budget. By 2008, they constituted nearly 80%.
- Philanthropies provided 636 million dollars for global HIV and AIDS programs in 2012. The majority of which comes from the US-based ones (467 million \$) followed by EU-based ones (147 million \$), and 38 million \$ comes from philanthropies elsewhere.
- Government funding decrease, private contribution increased.

The World Bank

- The World Bank was a leader in global HIV and AIDS spending in the early days of the epidemic. Since 1989, The World Bank has provided 4.6 billion \$ to HIV and AIDS programs worldwide.
- The World Bank remains a significant financier for HIV and AIDS - in 2013, its HIV budget was 1.5 billion \$. As well as financing HIV prevention treatment and care programs. The World Bank supports countries to do "better for less". Specifically, it provides technical assistance to increase the efficiency, effectiveness and sustainability of national responses to the epidemic.
- That money often comes with strings, it often comes with expectations, it often is focused on efficiency and sustainability, versus need and current status of any country vis-à-vis its ability to manage the pandemic within its borders.

Zambia

- Changes in global markets in the late 70s severely devalue its prime resource export - copper becomes reliant on IMF (International Monetary Fund) and The World Bank □ its main source of wealth was suddenly not nearly as valuable as it was when it needed resources. It's still paying off the debt of that change in global markets, that adversely affected its local economy.
- The trade-off is less control over policy in exchange for financial aid (priorities set elsewhere)
- "As late as 2004, when almost a fifth of adults were HIV positive, 62% of Zambia's budget was being devoted to debt servicing, compared to 12.6% to health" - Nauta
□ 62% is paid on World Bank repayments, at the great expense of resources being allocated to healthcare.
- This is how global economy / political economy, can have adverse effects in terms of something that we should take for granted, access to healthcare, which is a basic human right.

An Infrastructure is Created

- UNAIDS: a hybrid agency established in 1996 to inform, coordinate and mobilize the response across the UN system. □ by Jonathan Mann
- UNAIDS was thus expected both to provide information on HIV/AIDS and to act as an advocate for HIV/AIDS as a global policy priority, and acted as a crucial site for challenging widespread official indifference to HIV/AIDS epidemics outside the global north.

Global Fund to Fight AIDS, Tuberculosis & Malaria

- Founded in 2002 in order to: “This partnership between governments, civil society (institutions that are neither really public, nor really private. They tend to represent certain communities. Ex: religious institutions (Red Cross), non-governmental organizations, universities), the private sector and affected communities represents a new approach to international health financing”
- 2013:
 - Prevention (30%)
 - Treatment (29%)
 - Care & Support (8%)
 - TB/HIV Collaborative Activities (1%)
 - Health System Strengthening (14%)
 - Supportive Environment (18%)

PEPFAR: Introduction

PEPFAR – 2003

- The Global Fund donations are given with no strings attached. Because of objections related to harm reduction for users, and other programs that were considered as “endorsing” prostitution or abortion (all of which may be funded by the GFATM). George W. Bush announced the *President’s Emergency Plan for AIDS Relief* to fund programs that did not support such activity.
- It was announced as a 15-million-dollar financial project through the government, to help over 30 countries around the world. Initially, 15 countries were targeted (the ones most in need), including Haiti, Mozambique, Uganda, Zambia, Botswana. Over time, that increased to 30 □ This was seen as a huge lifesaver. Funds being made available to places that needed them.
- What’s not spoken about, is that the Global Fund offered money on a “no strings attached” sort of basis. However, George W. Bush’s government objected to concepts related to harm reduction for drug users, programs that were considered to endorse prostitution or abortion, by not ultimately banning or refusing to help people involved in such activities.

- Bush's funding was designed to have a whole lot of strings attached to it, in direct reaction to funds that were made available without those strings. □ it was a huge generous gift, that came at a high price.

PEPFAR Restrictions

- From 2006-2007, it was required that:
 - 55% of funding was spent on treatment
 - 15% on palliative care
 - 10% on orphans and vulnerable children
 - 33% on prevention funds were spent on promoting **abstinence** until marriage

PEPFAR

- between 2003 and 2013, US government funding to address the HIV/AIDS pandemic has been subject to anti-prostitution clause - colloquially known as "pledge" - that requires aid recipients to adopt an organizational policy opposing prostitution
- In essence, all who agreed to receive PEPFAR funds were required to state in writing that any and all activities supported by PEPFAR would not encourage or condone prostitution. From its inception, the pledge was accompanied by a second restriction forbidding the "promotion of prostitution".
- No funds - may be used to provide assistance to and group or organization that does not have a policy explicitly opposing prostitution and sex trafficking.

PEPFAR: The Problem (Taking the Pledge) - (video)

Just Sign on the Dotted Line: The Anti-Prostitution Loyalty Oath

- Produced by sex workers
- Brazil rejected the USAID funding
- Sangli India: Sex workers throughout India have marched in protest of the USAID restrictions. When SANGRAM (organization) refused USAID funding because of the restrictions, they were falsely accused of engaging in trafficking of persons.
- Thailand MAP organization also refused the policy. Their principle is to believe in human rights.
- "Policy should be based on demonstrated and measurable success in HIV prevention and treatment, as well as effective efforts to combat trafficking in persons. The inclusion of sex workers and their advocates is a crucial part of creating effective policies but U.S. funding restrictions prevent sex workers from helping to create responses to trafficking and prostitution. Unfortunately, current policies neglect the real needs of the people who are intended to be assisted by these program."

PEPFAR: The Impact

Brazil's Response

- Brazil was the only country that refuses to sign what came to be known as the “anti-prostitution pledge” in contractual agreements. In doing so, they rejected over 40 million \$ in funding for HIV prevention.
- Engagement with government offices is one of the hallmarks of the success of the civil society mobilization of sex workers. This advocacy is heavily focused on expanding labor rights and reducing stigma by seeking partnerships with institution that are not exclusively focused on HIV, such as the Ministry of Labor and the Ministry of Culture.

Current PEPFAR Policy

- Prostitution
 - o June 2013 marks the end of the funding restriction against organizations that do not explicitly state they oppose prostitution. Previously, PEPFAR refused support to organizations that would not denounce sex work.
- Abortion and Family Planning
 - o President Obama rescinded the Global Gag Rule after assuming office in January 2009, hopefully ending any confusion over whether organizations with particular abortion policies could receive PEPFAR funding.
- Needle and Syringe Exchange
 - o However, in July 2010, PEPFAR re-issued guidance for HIV prevention for injecting drug users (IDUs).

Recent Research

- “Those nations with epidemics concentrated among MSM or IDUs or among MSM, IDUs and heterosexuals received just 9.9 percent of the PEPFAR funding, despite their representing 26.4 percent of the people living with HIV in the nations and regions analyzed. In 2014, nations with generalized epidemics received 1.5 times more funding per person living with HIV than countries with epidemics concentrated among MSM or IDUs and 6.3 times more funding than nations with epidemics concentrated among MSM, IDUs and heterosexuals”.

Product Red: Tracking the (RED) Dollar

- RED was started in 2006 by Bonno and Bobby Shriver to support the Global Funds and AIDS programs in Africa
- RED is very simple, buy a red product by one of their many partner companies. Upon the sale of that product, a partner sends a portion of its profits to the Global Fund, and with no overhead at all, it's invested directly to an AIDS programs in Africa. □ Example: Apple, Beats by Dre, Belvedere
- The pills in Africa cost 40 cents per day.
- Little girl was given the pills, almost dying, and within 90 days she was a happy bouncy baby

Philanthrocapitalism

“Philanthrocapitalism”

- Tying capitalism, commercialism to a cause / charity / a philanthropic campaign

PRODUCT (RED)

- Established in 2006
- Its aim is to engage various commercial partners by getting them to theme some of their products with special global fund (RED) branding
- In return for the opportunity to increase revenue through the Product (RED) license, 50% of the profit gained by each partner is donated to the Global Fund. Corporate partners pay to participate, and that income is considered profit for Product (Red). This combined charity/corporate model is an example of “ethical consumerism”

How the Idea is Sold

- “Like it or not, people and companies find it easier to spend money on themselves than on charity. And Bono has found a way to combine the two” - Sunday Times
- “Elaborating on the topic, Bono said “philanthropy is like hippy music, holding hands. Red is more like punk rock, hip hop, this should feel like HARD commerce.” - BBC
- Unclear on how much of the percentage is donated.
- You’re partly paying the company, but you’re also partly spending on the licencing and advertisement. □ You’re told you’re contributing to a cause, but you’re not really given concrete information about what your contribution is.

Question:

In the year 2000, Brazil decided to make treatment available to everyone in the country who needed these treatments. How was this country able to afford this, if the United States’s treatment costed around 10 000\$ per person per year?

- The Global Fund to Fight AIDS, Tuberculosis and Malaria donated \$4.6 billion dollars to Brazil, which covered the costs of treatments to the HIV+ population.
 - Brazil provided their country with generic versions of the patented medications, which was much less costly than the one provided in the United States.
 - Brazil's treatments were less expensive as they were only 86% effective, whereas the United States provided HIV+ individuals with the utmost effective medications.
- The Brazilian government's laws and policies are based on human rights, which allows for free treatment to its population, no matter the price. The Brazilian government covers the full 10 000\$ cost.

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- “As late as 2004, when almost a fifth of adults were HIV positive, 62% of Zambia’s budget was being devoted to debt servicing, compared to 12.6% to health” - Nauta
□ 62% is paid on World Bank repayments, at the great expense of resources being allocated to healthcare.
- This is how global economy / political economy, can have adverse effects in terms of something that we should take for granted, access to healthcare, which is a basic human right.

An Infrastructure is Created

- UNAIDS: a hybrid agency established in 1996 to inform, coordinate and mobilize the response across the UN system. □ by Jonathan Mann
- UNAIDS was thus expected both to provide information on HIV/AIDS and to act as an advocate for HIV/AIDS as a global policy priority, and acted as a crucial site for challenging widespread official indifference to HIV/AIDS epidemics outside the global north.

Global Fund to Fight AIDS, Tuberculosis & Malaria

- Founded in 2002 in order to: “This partnership between governments, civil society (institutions that are neither really public, nor really private. They tend to represent certain communities. Ex: religious institutions (Red Cross), non-governmental organizations, universities),

the private sector and affected communities represents a new approach to international health financing”

- 2013:
 - o Prevention (30%)
 - o Treatment (29%)
 - o Care & Support (8%)
 - o TB/HIV Collaborative Activities (1%)
 - o Health System Strengthening (14%)
 - o Supportive Environment (18%)

PEPFAR: Introduction

PEPFAR - 2003

- The Global Fund donations are given with no strings attached. Because of objections related to harm reduction for users, and other programs that were considered as “endorsing” prostitution or abortion (all of which may be funded by the GFATM). George W. Bush announced the *President's Emergency Plan for AIDS Relief* to fund programs that did not support such activity.
- It was announced as a 15-million-dollar financial project through the government, to help over 30 countries around the world. Initially, 15 countries were targeted (the ones most in need), including Haiti, Mozambique, Uganda, Zambia, Botswana. Over time, that increased to 30 □ This was seen as a huge lifesaver. Funds being made available to places that needed them.
- What's not spoken about, is that the Global Fund offered money on a “no strings attached” sort of basis. However, George W. Bush's government objected to concepts related to harm reduction for drug users, programs that were considered to endorse prostitution or abortion, by not ultimately banning or refusing to help people involved in such activities.
- Bush's funding was designed to have a whole lot of strings attached to it, in direct reaction to funds that were made available without those strings. □ it was a huge generous gift, that came at a high price.

PEPFAR Restrictions

- From 2006-2007, it was required that:
 - o 55% of funding was spent on treatment
 - o 15% on palliative care
 - o 10% on orphans and vulnerable children
 - o 33% on prevention funds were spent on promoting **abstinence** until marriage

PEPFAR

- between 2003 and 2013, US government funding to address the HIV/AIDS pandemic has been subject to anti-prostitution clause – colloquially known as “pledge” – that requires aid recipients to adopt an organizational policy opposing prostitution
- In essence, all who agreed to receive PEPFAR funds were required to state in writing that any and all activities supported by PEPFAR would not encourage or condone prostitution. From its inception, the pledge was accompanied by a second restriction forbidding the “promotion of prostitution”.
- No funds – may be used to provide assistance to and group or organization that does not have a policy explicitly opposing prostitution and sex trafficking.

PEPFAR: The Problem (Taking the Pledge) - (video)

Just Sign on the Dotted Line: The Anti-Prostitution Loyalty Oath

- Produced by sex workers
- Brazil rejected the USAID funding
- Sangli India: Sex workers throughout India have marched in protest of the USAID restrictions. When SANGRAM (organization) refused USAID funding because of the restrictions, they were falsely accused of engaging in trafficking of persons.
- Thailand MAP organization also refused the policy. Their principle is to believe in human rights.
- “Policy should be based on demonstrated and measurable success in HIV prevention and treatment, as well as effective efforts to combat trafficking in persons. The inclusion of sex workers and their advocates is a crucial part of creating effective policies but U.S. funding restrictions prevent sex workers from helping to create responses to trafficking and prostitution. Unfortunately, current policies neglect the real needs of the people who are intended to be assisted by these program.”

PEPFAR: The Impact

Brazil’s Response

- Brazil was the only country that refuses to sign what came to be known as the “anti-prostitution pledge” in contractual agreements. In doing so, they rejected over 40 million \$ in funding for HIV prevention.
- Engagement with government offices is one of the hallmarks of the success of the civil society mobilization of sex workers. This advocacy is heavily focused on expanding labor rights and reducing stigma by seeking partnerships with institution that are not exclusively focused on HIV, such as the Ministry of Labor and the Ministry of Culture.

Current PEPFAR Policy

- Prostitution

- June 2013 marks the end of the funding restriction against organizations that do not explicitly state they oppose prostitution. Previously, PEPFAR refused support to organizations that would not denounce sex work.
- Abortion and Family Planning
 - President Obama rescinded the Global Gag Rule after assuming office in January 2009, hopefully ending any confusion over whether organizations with particular abortion policies could receive PEPFAR funding.
- Needle and Syringe Exchange
 - However, in July 2010, PEPFAR re-issued guidance for HIV prevention for injecting drug users (IDUs).

Recent Research

- “Those nations with epidemics concentrated among MSM or IDUs or among MSM, IDUs and heterosexuals received just 9.9 percent of the PEPFAR funding, despite their representing 26.4 percent of the people living with HIV in the nations and regions analyzed. In 2014, nations with generalized epidemics received 1.5 times more funding per person living with HIV than countries with epidemics concentrated among MSM or IDUs and 6.3 times more funding than nations with epidemics concentrated among MSM, IDUs and heterosexuals”.

Product Red: Tracking the (RED) Dollar

- RED was started in 2006 by Bonno and Bobby Shriver to support the Global Funds and AIDS programs in Africa
- RED is very simple, buy a red product by one of their many partner companies. Upon the sale of that product, a partner sends a portion of its profits to the Global Fund, and with no overhead at all, it's invested directly to an AIDS programs in Africa. □ Example: Apple, Beats by Dre, Belvedere
- The pills in Africa cost 40 cents per day.
- Little girl was given the pills, almost dying, and within 90 days she was a happy bouncy baby

Philanthrocapitalism

“Philanthrocapitalism”

- Tying capitalism, commercialism to a cause / charity / a philanthropic campaign

PRODUCT (RED)

- Established in 2006
- Its aim is to engage various commercial partners by getting them to theme some of their products with special global fund (RED) branding
- In return for the opportunity to increase revenue through the Product (RED) license, 50% of the profit gained by each partner is donated to

the Global Fund. Corporate partners pay to participate, and that income is considered profit for Product (Red). This combined charity/corporate model is an example of “ethical consumerism”

How the Idea is Sold

- “Like it or not, people and companies find it easier to spend money on themselves than on charity. And Bono has found a way to combine the two” – Sunday Times
- “Elaborating on the topic, Bono said “philanthropy is like hippy music, holding hands. Red is more like punk rock, hip hop, this should feel like HARD commerce.” – BBC
- Unclear on how much of the percentage is donated.
- You’re partly paying the company, but you’re also partly spending on the licencing and advertisement. □ You’re told you’re contributing to a cause, but you’re not really given concrete information about what your contribution is.

Question:

In the year 2000, Brazil decided to make treatment available to everyone in the country who needed these treatments. How was this country able to afford this, if the United States’s treatment costed around 10 000\$ per person per year?

- The Global Fund to Fight AIDS, Tuberculosis and Malaria donated \$4.6 billion dollars to Brazil, which covered the costs of treatments to the HIV+ population.
 - Brazil provided their country with generic versions of the patented medications, which was much less costly than the one provided in the United States.
 - Brazil’s treatments were less expensive as they were only 86% effective, whereas the United States provided HIV+ individuals with the utmost effective medications.
- The Brazilian government’s laws and policies are based on human rights, which allows for free treatment to its population, no matter the price. The Brazilian government covers the full 10 000\$ cost.