

MALE SPEAKER 2: Ms. Paula Akugizibwe will now deliver the third presentation on the state of epidemic.

PAULA AKUGIZIBWE: Good evening. [Applause] Thank you.

[Audio played]

PAULA AKUGIZIBWE: I want to start off by emphasizing that the message that opened the conference this evening is possibly the most important message that you will hear over the next few days, regardless of what specific issues we are addressing. We need to see accountability, broken promises killed in regards to funding, to quality of evidence based interventions, we need to keep the promises that we have made and we need to keep funding universal access. [Applause]

Ten years ago, the German declaration at the AIDS Conference in South Africa ended with the statement that by working together, we have the power to reverse the tide of this epidemic. Science will one day triumph over AIDS, just as it did over small pox.

Curbing the spread of HIV, HIV will be the first step, and until then, reason, solidarity, political will, and courage

must be our partners. So here we are 10 years later, the year that we're supposed to be celebrating universal access.

But I still have to stage die-ins after the national AIDS conference to draw attention to the fact that already, despite the fact that we're less than halfway to realizing this triumph over AIDS, the political world, the courage, the solidarity that we had thought would be necessary and had fought to see through to the end have already begun to wane.

So here we have about 20, 25,000 participants from about 100 countries around the world. And if we make a conservative estimate of about \$2,000 per participant including travel accommodation, registration, and so on, which we can all agree is a very conservative estimate, and work out the total of this costs, it's 20-percent of the total of money that was given by the Global Fund in 2009 to the Southern African region for all three diseases in seven countries in Southern Africa.
[Applause]

Not just that, but as has been stated in all of the Austrian Government sites, 2010 is also of great important to Vienna as a conference center. The current prognosis for the conference to contribute a total of \$45 million Euro to Austria's gross domestic product. What's the moral of the story? We'll come back to that later.

Let's start off by establishing the common ground that we all have here this evening. We're all here because we have

a shared vision, namely gathered around related goal six, which is to curb the spread of HIV, TB, and other infectious diseases and to realizing universal access, although the precise definition of that may be debatable and needs to be clarified, but it is to realize universal access to HIV prevention treatment and care for all of those who need it.

This is not an unattainable goal, as has been said by Ban-Ki-Moon in this year's development goal report. Yes, we can achieve this goal. He says the world possesses the resources and the knowledge to ensure that even the poorest countries and others held back by disease, geographic isolation or civil strife can be empowered to achieve the MDGs.

So even in the worst circumstances that one could imagine these goals, are attainable. So what's going wrong? Development and implementation of successful interventions requires the resources and knowledge that I referred to in the statement. But additionally, especially when it comes to the context of HIV and human right, go out to HIV, the make or break at the end of the day is not just about collective knowledge and collective resources.

The make or break ultimately comes down to individual level decisions. The decision to use a condom when having sex, the decision to get tested, the decision to initiate treatment and to adhere to it. The decision to travel 200 km or however

far it is to get to the nearest facility where you can your CD4 monitored.

These are all the decisions that make or break the HIV epidemic on a daily basis. But it's important for us to realize that because of the context, the social and legal, cultural economic context within which these interventions are being implemented, often these decisions are not just a matter of one person involved, because we're dealing with human beings.

And ultimately the HIV response is not about microbes, it's about humans who live in human realities. And these realities come with social dimensions, cultural, economic, and political dimensions, and ultimately because of failing to address this, we have put people within a limited frame work that chooses for them what decisions they can make, what access to services they can have and yet at the same time, we claim to be committed to universal access.

And so we walk into the International AIDS conference because too long we have seen a false divide between human rights and science. We've seen allegations that human rights holds back progress and scientific innovations, but at the end of the day, we're all working towards the same thing, we know what we want to achieve.

So the question that we all need to agree on now is how do we get there? If science is the engine of the human rights

response, then the engine of the HIV response, then Human rights are the vehicle that take us forward. Resources are the fuel and the accountability is the driver. And we need all of these together in order for us to make progress.

If anyone is missing, then we're going nowhere. And so here we are in 2010, a critical year and you are making or breaking. As you can see from the new stories over the past few months, many of the challenges that we are facing in 2010 with making the best possible use of the tools that we already have are not already fundamentally scientific challenges.

Yes, absolutely, we need more research and all like to see the day when there's a cure for HIV or a vaccine for HIV, but right now with what we do have, we could be doing a lot more. And the reason why we're not doing as much as we could, fundamentally, politically, or social, economic, or cultural problems.

So today, I'm going to speak about how human rights have shaped the state of the epidemic. And I'll speak in three main areas. First the ability to reach and engage people where they are. Secondly, our ability to nurture and sustain a sense of shared responsibility for the HIV response, and thirdly, accountability, both in regards in funding as well as the implementation of evidence based approaches.

Let's start at the foundation, the right to health. I wanted to ask by show of hands how many people sitting here in

the room today believe that health is a human right. It seems like just about everyone does. And yet if you look at the policies, the constitutions of many of the governments around the world, they do not reflect this belief.

It's interesting to note that the global HIV response was originally written in a recognition to health. It was unprecedented in the history of public health for so many governments and people around the world to mobilize, billions of dollars in terms of lateral initiatives such as the global fund, to respond to a global disease. And this happened because millions of people around the world mobilized around the right to health and how it related to the right to life.

But unfortunately, this has not happened so much at the national level, and because of the absence of legally enforceable revisions of the national level, our ability to sustain this energy is flimsy and it is not predictable.

Last year the World Ranking UNAIDS did a survey to see which of the countries believed that the HIV response would be under threat in the coming year because of economic crisis. And they found that national recognition of the Right to Health was one of the key three predictors of sustainability for HIV treatment programs at a time of economic crisis.

So, lack of recognition of the Right to Health doesn't only create an unpredictability in our response. But, it also creates hierarchies of axes where governments can decide based

on their own subjective political whim who is more entitled to the right to health and thus, who is more entitled to the right to move and through this we end up seeing groups of people who are most needing of particular interventions but are systematically excluded from receiving them.

If we talk about universal access it has to be universal. And, we'll never manage to get anywhere the indications we're trying to reach as long as we have specific people being left out in a systematic way.

So, let's look at ways, in which, human rights have worked for us. Access to essential medicines trips flexibilities. The whole rationale behind this was that people's rights, human rights, the right to people who need access to medicines need to be prioritized over the profit rights of pharmaceutical companies. And, as a result, we've seeing remarkable gains in reductions in ARV prices over the past ten years.

We do see almost a hundred fold in some cases. Meaning that many people who would never had access to life-saving medicine were able to afford it. But, because of lack of this principle at the national level, lack of an understanding of the importance to ensure the rights to health and access to health services, we're seeing that many of these gains are threatened at the regional international level. Some examples

being some of the intellectual property of Neimans
[misspelled?].

Economic partisan agreements that are being set up with European Union and other countries. I was interested to hear the European Commissioner for Health saying that HIV treatment was being universally available and accessible because we're seeing concerns in the past year with this very treatment being confiscated and held here in this very continent. One that's on its way to meet people who need it in order to stay alive. [Applause] It doesn't seem to be much consistency in that.

Within countries that need access to medicines, as well, we've seen challenges with regional laws, such as the anti-counterfeit bill in Kenya that threatened access to generic medicines, which in itself is not a bad law, but somehow, intentionally, otherwise groups generics medicines as part of counterfeit medicine.

And, my best threat accessing feature. People living with HIV have taken the government to court based on the human right to health and the human right to life. And, so far the rulings in favor and we call in the Kenyan government to ensure that when the final decision is handed down it is not for delay the right to people living with HIV to access generic medicines. [Applause]

Same contrast to seeing rights in action and the positive impact that we've had a result, we also have many more

examples of rights inaction and the devastating impact that this has. And one of the most talked examples is that of prisons. In most cases in the world if you are sentenced to spend time in prison today, you're also sentenced to disease.

A sentence to HIV and TB and very little chance of actually seeing testing treatment and care. And one has to wonder how prison is being subjected to a series of human rights violations expected to be rehabilitated within these systems. We see gross lack of HIV, TB prevention, testing and treatment measures in prisons.

Lack of condoms, although we know it is a reality that sex happens in prisons and that it happens because many cases it happens because other rights are being violated. Because there's overcrowding, because people don't have access to food or water and as a result they have to have sex as a transactional way of getting access to these essential things that they need to stay alive.

It's been estimated that 27-percent of the U.S. inmates experience sexual violence and across the wall, we see that the challenges faced by prisons overlap with other rights challenges and they each have a response such as injecting drug use.

On HIV, UNAIDS and UNODC [misspelled?] say that we haven't sufficient knowledge but what we do know is alarming. And rates in prisons could be up fifty times general population

rates. TB incidence could be 10 to 100 times the general population. Every year, 30 million people go through the prison system and at any given time there are only several million people who are actually in prison.

So, all of the rest of these people are coming through the system where they are exposed to these high risks and then coming back into the communities, which is why prisons have often been described as epidemiological pans or reservoirs of disease.

It is a human rights violation but from a public health perspective it's also completely irrational. We also see challenges with migrants and I asked a few activists from the Southern African region. If they had one story and one message that they would like to send to this National AIDS Conference what would it be?

This story came from Botswana of a man called Isaac whose been in a long-term relationship with this Zimbabwean woman who was unable to access PMTCT because she is not a citizen of Botswana.

As a result, when they had their son, Othelea [misspelled?] in 2007, he was born with HIV in a country that has one of the most advanced HIV treatment programs on the African continent. He did not inherit Botswana citizenship for whatever reason and therefore, he, himself was unable to access ART.

When he fell sick, Isaac could not watch his only son die and he started sharing his ARVs with his child. Eventually, the child died and Isaac has now developed drug resistant HIV.

And, Cindy says the last time we spoke to Isaac he said I can't believe my own government that I voted into power that's cremated my own flesh and blood. How much could it have cost to save my child's life? What could have become of my child's life?

She goes on to say that as long as African governments fail to make their goodwill commitments and as long as donors continue to scale back on their commitments to funding universal access, organizations such as hers, Bonella in Botswana [misspelled?] will not be able to challenge these discriminations because ultimately it comes down to priorities with our national resource allocation.

So, systematic marginalization precludes universal access. As long as we have elation of rights that are entrenched in punitive laws, we'll have access virus for key populations.

And, you can see here that many countries around the world reportedly do have laws that precludes access for drug users, for men having sex with men, for sex workers and even this reporting, you can see, is not quite up to scratch because if you look at the African region, we know that many more

countries have laws that prohibit same-sex relationships and now effected in this graph.

And while we welcome the increase recognition of the need for interventions for these groups, such as the establishment of a global fund and reserve around ten for most adverse populations, we also need to recognize that this is not just the part of public health approach Avilelei , that the risk in prevalence that these groups face are not inevitable but that the results of political, social, cultural frameworks. And, until we can address these from a human rights based perspective a public health interventions will have limited reach.

The fundamental principle of rights is that of equality and this includes equal protection of the right to have regardless of subjective opinions on morality. And this is not just the human rights angle but it is also supported by public health rationale. As we can see here drug users, MSM and sex workers contribute a large part of the prevalence in many regions of the world.

Next, talk about drug use in Eastern Europe. We've all heard about the Vienna Declaration in the previous speakers which opens with the statement that the criminalization of illicit drug users is fueling the HIV epidemic. And has now resulted in overwhelmingly negative health and social consequences. A full policy orientation is needed.

We have the fastest growing epidemic in the world here, 66 prevalent increased over the past few years and we have a huge amount of incidence being related to drug use. And yet, drug users often don't receive prevention intervention such as clean needles. And not only that, but they are least likely to access ART.

Although, there's no evidence to support the prejudiced assumption that are acting [inaudible] resistance because of the fact that they won't adhere to treatment. Research has shown that this is not the case.

So, the rights-based approach calls for harm reduction which includes needle exchange, as well as, opiate substitution programs. Scientifically, it's very sound. This graph shows that we can reduce incidence by 50-percent if we scaled up old period programs by 50-percent but politically, unfortunately, we find that it is too unpalatable.

Let's talk about Human Rights and LGBTI. At least six countries around the world criminalize same sex relationships. And this is not just a matter of law and policy, as many people tend to think. It's actually an epidemic of societal homophobia based on pseudo-religious and cultural arguments and I won't get into those now.

You're welcome to visit the ARASA toll if you'd like to know more about how attempting to respond to this. But, ultimately these arguments though are designed to explain why

people ongoing engaging consensual same-sex relationships should not have the equal rights that the rest of us enjoy.

Has dramatic indications, first before the ability to engage in healthy relationships for the experiences of homophobia and the way that this impacts the sexual relationships. Sexual violences, we've heard of correctional rape being implemented in some countries but people who are in same-sex relationships are raped as a way of attempting to desensitize them to these practices. It makes no sense in the spread HIV.

And, finally, decreased access to HIV services because of the stigma that they face. As a result, we see prevalence levels are much higher among social minorities. Particularly in the MSM sub-Saharan African region. But, in many other groups there is very little known about transmission because these groups are not prioritized.

Here's another story of someone from Kallaroo, and who was arrested and spent a year in prison because the law prohibits same-sex relationships where HIV prevention and treatment are not readily available. Ten days after his release from prison and he died of AIDS related complications and the message from Chief Willy [misspelled?] from the International Gay and Lesbian Human Rights Commission is that homophobics stigma and denial have pushed the issue of same-sex HIV transmission firmly into the closet.

The needs of African same-sex practicing people are off the map that governments and civil society have drawn to guide national and regional HIV strategies. Political and colorful resistance technology, African homosexualities and the resulting invisibilization of same-sex practicing people are contributing to wide spread human rights abusers and increasing vulnerability to HIV.

Let's talk about sex workers which we've heard very little about so far. UNAIDS has said the rights based approach calls for recognition of agency over ones body and choices. And this includes the choice of work because sex-work is work. It's just that the work it involves is sex, much like some marriages some might say without the paperwork. [Laughter]

So, there's no logical reason why we should criminalize against this particular group apart from our own prejudice notions of what morality is. Criminalization renders sex workers vulnerable to violence, it compromises their ability to negotiate companies, and it ostracizes them from access to health and justice.

And, as a result, prevalence rates are about 75-percent in some populations because of this criminalization and despite the fact that they have such high prevalence rates, sex work and HIV receives less than 1-percent of the global resources. There is no rationality in this.

In countries that have taken the courageous steps, such as New Zealand, after criminalizing sex what the impacts have been astonishing. Both with regards to increased condom use as well as the perception of the right to refuse sex which in many countries the sex work is criminalized, is not a right that's recognized. And, finally it expands opportunities for sex workers to consider other professions if they should choose to do so in the future because it doesn't come with a criminal record.

Human rights in gender, we've heard a lot about, so, I want to talk about this at length. But, we need to emphasize the challenges we see with HIV among women and especially sub-Saharan African region but we need many other regions across the world need to be placed within the broader context of structural inequalities of sexual violence, economic dependency and an equal access to medicine.

And HIV response cannot divorce itself from these realities and not cannot it continue if it only pays them lip service. As has been said in the MDG report, gender equality and the empowerment of woman are the heart of the MDGs and are preconditions for overcoming poverty, hunger and disease.

But progress has been sluggish on all fronts from education to access to political decision-making. As we can see by this diagram, showing how many woman are in positions of decision-making power in countries around the world.

We also need to recognize that this course in gender creates cultural tensions and that we need to find ways of engagement that are not didactic but actually creates safe spaces for people to talk.

And additionally, the divisionism that we see now as part of the backlash in HIV funding which states that we need to take money away from HIV in order to focus on maternal health and a child health is really a forced dichotomy and a very dangerous one.

Because maternal mortality in many regions in the world could be significantly reduced by ensuring that universal coverage of HIV services available to all woman. But, unfortunately, this is not the case. PMTCT has scaled up at a very slow rate, particularly in the African region but in many other regions as well. Reproductive rights were under threat in the early days of HIV epidemic but continue to be under threat.

And initially, the pretext though was given for this was that these were risk of vertical transmission. PMTCT has result this dilemma but there's been a delay in scaling it up and as a result we still see that 1,200 children are born with HIV daily that access to maternal health and entinatal care remains very low. And we continue to see social stigmatization of pregnant woman living with HIV which in itself presents a deterrent to access.

Recently in the media we're seeing that even where there is considerable scale up of PMTCT the extreme end is to curtail the reproductive rights such as forced sterilization of woman who reports to hospitals needing care and in order for them to receive the care are forced to consent to sterilization to prevent them from having children in future because they are living with HIV. How do we expect people to be drawn to services when this subtle stigma that we are offering them in return?

Ending with [inaudible] transmission. The course of approach is have a place. I would just like to emphasize here that getting people to test, getting pregnant woman to test for HIV which sometimes they have chosen to do a mandatory fashion is only the first step of a multiple step journey. And that if you ostracize and antagonize people at this step, we break down the system every other point of the way. As this systematic review showed, the main reasons for people not engaging with PMTCT right through to this conclusion of poor understanding, patient denial, and fewer stigma.

We cannot adopt public health approaches that ignore these realities and Jonathon Mann, the former head of HIV of the WHO spoke with the prophetic insight when he said in 1987 that the epidemic of stigma discrimination and denial is essential to the global AIDS challenge as the disease itself. We need to start learning these lessons.

We cannot control HIV TB through coercive approaches, we cannot force people to get tested for public health rationale because ultimately this pushes people away from the services to which we are attempting to draw them.

But, unfortunately, the examples in the region Lesotho, Swaziland, and South Africa and although the evidence has suggested that this happens in the context of universal testing campaigns often because health care workers don't receive adequate training and sensitization leaves no rationality in forcibly entering people into a program when at the end-of-the-day they're not going to be able to see through the life-long commitment that one needs to enjoy the positive benefits of HIV services because of the fact that their rights have been violated. [Applause]

Criminalization is becoming more popular in countries around the world. [Inaudible] is meant to encourage disclosure, it's meant to protect woman, but often, it has the opposite effect. It reinforces stigma, it particularly affects woman because they themselves are often at risk because they cannot negotiate safe-sex because of fear of violence or they cannot disclose the HIV stages because of fear of violence.

So, the very objectives the way using to defend the stance often have the precise opposite outcome when you look at what happens in reality. Criminal law, as was said a couple of years ago, cannot draw reasonable and forceable lines between

criminal and non-criminal behavior. Nor can it protect individuals of society from HIV transmission. In the protection of woman it is a poor substitute for policies that go to the roots of subordination and gender-based violence.

The use of criminal law to address HIV is inappropriate, except in rare cases. And, similarly, the use of criminal law to control TB is inappropriate. And this is something that has been recognized by the WHO in the most recent guidelines.

We know that TB HIV are essentially called epidemics, particularly, in Southern Africa which is where I am based. And we started to see governments attempting to clamp down on transmission of TB by forcibly assuming people in facilities.

In some parts of the world, like Ukraine, a lot of TB patients, not as drug resistant TB patients are kept in isolation facilities. Many models around the world have shown that community-based care has preferable outcomes.

Not only from human rights but also from a public health perspective and yet we still practicing mandatory isolation regardless of infrastructural capacity, which is a lot more costly than treating people in the communities in the homes in a manner that respects their rights. There is no rationality in this and there's no rationality in a continued refusal of many national HIV programs.

To address the socio-economic context in which HIV interventions are being implemented. Why is it that the systematic review shows two years after initiation of people in NRT in sub-Saharan Africa? We have an average of 60-percent retention in NRV programs.

Simply getting people services is one thing but in order to retain them within these services we need to make sure that we address the challenges that they face such as food insecurity, distance to health care facilities, stigma and discrimination, these are things that come up repeatedly but still somehow have not found their way to the center of the way in which we design our responses.

In thought, we are hearing a lot about bold and radical new strategies. We are entering brave new world of treatment 2.0. Many have a need by medical approaches said yes, are welcoming and necessary but the question from the human rights perspective is what is happened to the same old problems that we have been facing.

How can we focus on bold new interventions before we have addressed a lot of these very fundamental social economic and political challenges that have really been the fundamental shortcomings and the response to HIV. This is a staggering and a costly rationality and would do well to heed the words of Marcos Espinal who said earlier this year that TB is not a medical problem.

It's a development issue, it's an economic problem, and it's a human rights situation. The same thing could apply to HIV.

And in closing, I just want to bring us back to our original, to where we started on the issue of funding and rationalities and rights. I'm not an economist, so I borrowed – time's up. Okay. Excuse me, I'm just going to be a few more minutes.

I think it is very important this message gets emphasized. We are making decisions to cut back on funding that is now is going to violate people's rights, people's access to health but ultimately going to be very foolish economic decisions, as is evidence by the statements from African heads of state and from the World Bank.

The global economic crisis is not the thing that is threatening the fight against AIDS, it's a global priorities crisis that is threatening the fight against all MDGs.

[Applause] The issue is one that HIV is overfunded, the issue is that health is underfunded and it's underfunded because we do not prioritize it. Because we would rather prioritize competing political interests.

And these are some of the things that we seem to have a lot of funding for, political luxury vehicles, for military expenditure, for politician's pay, for World Cup Stadiums and

when it comes to health we have to beg for one's till. There's very little rationality in that. [Applause]

In closing, I want us to just consider this situation, where you have a government that instructs implementing countries that they should not enlong people on HIV lifesaving treatment unless other people have died to create gaps in programs for them.

You have a government that's just a few weeks before they host International AIDS Conference ripe for the global fund to say that health is not a thematic priority of the Austrian development Corporation and therefore they cannot make any contributions to the global fund over the next few years, although, they will be making 45 Million Euro from this conference.

You have a government that has tolling billions of dollars from health donors and are yet to pay half of this money back and then you have activists who visit the World Economic Forum to deliver the mirandum emphasizing that health is wealth.

You have the Iranian doctors who have medical integrity, the courage and the humanity to provide treatment to people in a country that's stigmatizes HIV at the highest levels. And the question that I ask you as intelligent, rationale and humane human beings which I seen that all of us in this room are, is who are the criminals in this context?

I'll give you a clue, it's those ones circled in red. And the point of this, the moral of this story is that something is going very wrong in accountability, in the way that we approach the HIV response and we need to start looking as we call for more funding, we need to start looking what we do much more quickly.

We need to remember that the theme of this conference human rights is not just about having all these rights face interventions but ultimately that the human rights based approach calls on all of us as human beings to accept our own individual sense of responsibility. Not as bureaucrats, not as commissions, not as researchers, as humans.

And, therefore, whatever we discuss over the next few days cannot end here. We each have an individual responsibility to take it back through where we came from and if you all believe in the rights you have is a human right then we need to go back to our countries and we need to make sure that the resources, types of interventions that are implemented over the next few years recognize this right. Apologies of going over time. Thank you. [Applause]