25 Years of AIDS Candlelight Memorial Parallels History of AIDS Epidemic

FIGHTING FOR OUR LIVES

AN AIDS CANDLELIGHT MARCH
A personal expression to honor the dead and support the living.

SAN FRANCISCO
7:30 P.M.
FROM CASTRO & MARKET
TO U.N. PLAZA/CIVIC CENTER
BRING CANDLE
INFO / AIDS & KS FOUNDATION
(415) 864-4376

NEW YORK
8:00 P.M.
FROM SHERIDAN SQUARE
TO FEDERAL BUILDING
BRING CANDLE AND WEAR
BLACK ARMBAND WITH
PINK TRIANGLE
INFO / GMHC HOTLINE
(212) 685-4952

MONDAY, MAY 2, 1983

Illustration by David Enfelter / Graphic Design by Enfelter Moske Associates
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TO OUR READERS:
Global AIDSLink editorial pages are a forum for opinions and views on the many issues and controversies raised by HIV/AIDS challenges. We invite you to join in the discussion with short letters to the editor commenting on the articles you have read: What do you think about what you’ve read? What do you agree or disagree with? We also welcome op/ed pieces with a strong voice and/or new take on current HIV/AIDS-related issues; these run from 500-700 words and should be bold, well-researched and original.

International in scope, Global AIDSLink includes HIV/AIDS related conferences and other events as well as new publications and diverse forms of resources. Please send us those as well.

Thank you for your interest in Global AIDSLink.
Sara Ann Friedman, Managing Editor
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This special issue of Global AIDSLink commemorates the 25th anniversary of the International AIDS Candlelight Memorial — the oldest organized movement for HIV/AIDS awareness in the world and a program of the Global Health Council.

Researching this issue of the newspaper showed us with perfect clarity how the Candlelight Memorial parallels the history of the epidemic, from a “gay” disease in the United States in the early 1980s to its current unchecked spread throughout the world.

This feature focuses stories about that first courageous Candlelight march, May 2, 1983, and its follow-up event. Current Candlelight coordinators recall their first memorial experiences and others tell us about the astonishing work they do right now as advocates and service providers in their “day job” outside the volunteer Candlelight work. Their stories range from youth advocacy in Nigeria to community-based care of orphans and vulnerable children in Kenya, to innovative support for drug users in Estonian prisons, and to a perspective on men having sex with men in Trinidad and Tobago that strips down stereotypes. These stories starkly parallel a timeline of the history of the disease and its response worldwide. (See pp 12-13)

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“We have to do something,” was the call of five young men in San Francisco. Bobbi Campbell, Bobby Reynolds, Gary Walsh, Mark Feldman and Dan Turner were in the prime of life, irrepressible, creative, advocates and admittedly excess in their displays of sexual liberation so recently won by the gay community. In the face of their own unresolved grief, fear, anger and isolation, they were hell-bent to put a public face on their community. In the face of their own unresolved grief, fear, anger and isolation, they were hell-bent to put a public face on.

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A consummate act of courage and defiance, the first Candlelight laid the groundwork for the many thousands of such acts over the next 25 years. Facing stigma, loss of jobs, abandonment by families, and violence, men and women have gathered strength from the safety of the Candlelight to publicly acknowledge their HIV status. As the first Candlelight 25 years ago fought back against the double stigma of being gay and having AIDS, the marginalization comes full circle. As AIDS explodes today among the growing populations of men who have sex with men (both gay and not), in Asia and elsewhere, the Candlelight Memorial is an inextinguishable reminder of continuity, connection and courage.

Although Candlelight preparation occurs over several months, the Memorial is still a one-day-a-year event. To expand local ownership and broaden the program’s scope, the Global Health Council has received a Ford Foundation grant to strengthen the program and to create a new initiative, the Candlelight Advocacy Network, that will work throughout the year on regional and national AIDS advocacy issues. National and regional coordinators have been selected to organize the Candlelight Memorial program in their areas and an international advisory board of regional coordinators will contribute to the strategic planning for both the May Memorial and the new Advocacy Network.

(AIDSLink would like to acknowledge the many sources whose recollections helped to give shape to this issue: Ron Macinia, director of policy and programme at the International AIDS Society, who started us on the trail; Hank Wilson, (See p. 7); Paul Boneberg, executive director, GLBT Historical Society, (See p. 8); Clave Jones, creator in 1985 of the AIDS quilt; Mike Sbraver, from MAA who managed Candlelight 1993-1996; Paul Kawata, executive director, National Minority AIDS Council; Dr. Steve Morin, director, Center for AIDS Prevention Studies (CAPS) and AIDSLink Policy Research Center, UCSF; photographers Rink Foto and Harley Shapiro. We also pay tribute to several books of the times: Randy Shultz’ “And the Band Played On,” Rink Foto and Harley Shapiro. We also pay tribute to several books of the times: Randy Shultz’ “And the Band Played On,” Rink Foto and Harley Shapiro. We also pay tribute to several books of the times: Randy Shultz’ “And the Band Played On,” Rink Foto and Harley Shapiro. We also pay tribute to several books of the times: Randy Shultz’ “And the Band Played On,” Rink Foto and Harley Shapiro. We also pay tribute to several books of the times: Randy Shultz’ “And the Band Played On.”) For more information on the Candlelight Memorial go to: www.candlelightmemorial.org

The Woodrow Wilson International Center for Scholars has received a $350,000 grant from the Bill & Melinda Gates Foundation to fund publication and dissemination of a UN-commissioned report on HIV/AIDS and governance in Africa. The grant will be used to publish and disseminate a two-volume report, “Securing Our Future,” which compiles and analyses data on the impact of HIV/AIDS on state structures and economic development, and will assist governments in consolidating the design and implementation of policies and programs that can help to govern the epidemic.

The Bill & Melinda Gates Foundation announced 11 new grants available for distribution, totaling $280 million, to help fight tuberculosis. The grants will speed research and development on promising vaccines, diagnostic tests, and treatments to help reduce the global TB burden. They focus on three key areas: the Aeros Global Foundation to conduct clinical trials of up to six TB vaccine candidates; Foundation for Innovative New Diagnostics (FIND) to develop TB tests that are more accurate and simpler to use; and nine grants to identify new TB treatments to combat drug resistance.

The United Nations Children’s Fund (UNICEF) and Family Health International (FHI) have joined forces to help women and children in five countries combat AIDS. At first, the joint venture will be implemented in Goyana, India, Malawi, Nigeria and Zambia. FHI Chairman Albert Siemens, Executive Director of the United Nations Children’s Fund (UNICEF) to develop TB tests that are more accurate and simpler to use; and nine grants to identify new TB treatments to combat drug resistance.

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Bristol-Myers Squibb announced a new approach to expand its SECURE THE FUTURE through replicating its most successful HIV treatment support programs in partnership with governments, community groups and other funders. The initiative will provide a practical, step-by-step guide to create effective HIV treatment support programs based on methods proven successful even in the poorest, most remote areas of Africa. The aim is to enable others to take advantage of the lessons learned by SECURE THE FUTURE from eight years of work fighting HIV/AIDS in some of the most resource-constrained areas of Africa. Closely monitored and rigorously evaluated, the program paired medical care and treatment with a variety of community support programs including home-based care, targeted and broad-based community mobilization and education.

Pathfinder International announced the appointment of Caroline Crosbie to the position of senior vice president. In this post, Crosbie will oversee headquarters and field program operations, with an emphasis on strategic action. She has played an integral role in the strategic management and design of Pathfinder International’s programs since her promotion to vice president of programs in 2000. Prior to returning to Pathfinder’s headquarters where her career started, Crosbie was the country representative for Pathfinder in both Peru and Haiti. She received her undergraduate degree at Mount Holyoke College in Massachusetts and her MBA from the University of Texas Graduate School of Business.

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May 2, 1983. San Francisco, California “We had no idea if anyone would show up, but starting down the route from Castro Street to City Hall, our small core group was slowly joined by more and more people appearing out of nowhere, until the streets were full.”

— Hank Wilson, the only surviving organizer of the first Candlelight March, remembers.

Walking behind the banner, “Fighting for our Lives,” thousands of young men – and a few women – were marching in what would become the first of 25 years of worldwide candlelight marches and memorials – now in 119 countries.

They were marching to put a human face on this new and still mysterious disease ravaging the gay communities in the cities of San Francisco, New York and Los Angeles. Two years had passed since the first cases of ‘gay cancer’ were reported in the Morbidity and Mortality Weekly Report and it would be still another year until scientists isolated the infectious agent believed to cause AIDS and named it HTLV-III (or HIV).

Active young men in their 20s and 30s were developing unexplained purple sores on their bodies, *pneumocystis pneumonia*, and infections that killed cats and sheep, but not people – until now, or illnesses unknown to anyone under 50. Because an antibody test had not yet been developed, the appearance of symptoms signified late stage AIDS and usually meant death in as few as nine months from diagnosis. On the day of the march,
This is a statement from me to the community and the government that I am a person and not a statistic.

— Bobby Reynolds

the Centers for Disease Control released its weekly figures, showing a fast and exponential rise to 1,366 cases of this new disease in the United States. Five hundred, or one-third of those diagnosed so far, had died.

For much of the gay community responses ranged from not knowing, to not wanting to know, to not wanting others to know. Recently emerging out of the collective closet, gay men in San Francisco were protective of their hard-won rights and their sexual liberation. The media’s initial indifference kept many in the dark, others in denial – afraid to know that they were facing a rapidly progressing and fatal disease – and provided temporary relief from the threat that publicity would bring to gay businesses.

But there were those whose anger and fear moved them to action. They wanted to know and to warn others. Psychologist Gary Walsh was the 16th person in San Francisco to be diagnosed, and as the disease weakened his body and wreaked havoc with his immune system, he was already riding the AIDS roller coaster alternately thinking of suicide and clinging to false hopes.

During the middle of a meeting at the Harvey Milk Democratic Club, Walsh raised his hand. “I think we have to do something,” he said. “My friends are getting sick and some have already died.” But the club president answered by closing the meeting. Hank Wilson remembers that he approached Walsh and told him: “We don’t need to do it through the club.” Wilson and Walsh called together a group of activists and brainstormed a street action that would rally the community and capture the media’s attention.

Bobbi Campbell, Bobby Reynolds, Dan Turner and Mark Feldman, who all had seen their friends and lovers die, were already sick with AIDS. They too were angry at the inaction of the government, the indifference of the media, a hostile and homophobic public, and denial, silence and dread among much of the gay community itself. Only the National Institutes of Health and a handful of other agencies, as well as gay physicians, realized the grave situation and pleaded for both more funding and public warnings. The irony of AIDS breaking out in San Francisco, the epicenter of the gay movement in America, was not lost on them. Reynolds likened the experience of coming out with AIDS to coming out as a homosexual – with all the fear, courage and stigma it brought.

The people who have died from AIDS, those still alive who have AIDS, and those who do not have AIDS but are working to combat it, are my family.

— Bobbi Campbell

Putting a Public Face on AIDS

Bobbi Campbell was the best known of the small group of core organizers. A registered nurse and member of the satirical drag group called the Sisters of the Perpetual Indulgence, he went by the name: ‘Sister Florence Nightmare.’ Diagnosed in 1981, Campbell was the first AIDS victim to come out publicly and was known as the Poster Boy for Kaposi Sarcoma. In part to bring public attention to the disease and encourage others who hid their status, he made a poster showing his lesions and placed it in the window of a local pharmacy. Later that year, his face would grace the cover of Newsweek magazine. But he also endured the stigma of homophobia and anyone with AIDS. When he was interviewed by CBS news anchor, Dan Rather, he was instructed to sit in a glass booth, where technicians did not have to touch him in order to place the microphones.

Neither the choice of the route from Castro and Market Streets to City Hall, nor the choice of the candles was an accident. Gay men in San Francisco had been marching since 1978 when the openly gay city supervisor Harvey Milk and human rights champion mayor George Moscone were brutally murdered because of their role as gay rights advocates. The spontaneous “White Knight” riot protesting the light sentence of their murderer became only the first of many marches, demonstrations and protests down the path from Castro Street to City Hall. The candles were a conscious choice to attract media.

Calls went out and signs went up everywhere – on street poles, bars, bathhouses and businesses. As the only organizer who didn’t have AIDS, Wilson describes himself as “the energy person” who would “do all of the running around and getting the word out.”

On the night of May 2, 1983, candles flickered for a mile as the crowd proceeded somberly down the route. There were men dressed as nuns and others holding hands, carrying flowers, candles and signs. Some brought snapshots of friends who had died, while others carried signs that read like gravestones:

Brandon Marx
Born July 20 1948
Died November 30 1982

Thousands of people stood in front of UN Plaza in San Francisco near the City Hall dome listening to speeches by people with AIDS. Only people with AIDS were permitted to speak and carry the banner. They spoke about their loss and the loss of the community with a strength and passion that belied their frail bodies. The speakers called for attention to AIDS and rallied against the U.S. government for its inaction. Mark Feldman who would die before the end of the month, told the crowd: “Our President doesn’t even seem to know that AIDS exists. He is spending more money on paints to put the American flag on his nuclear missiles than on spending for AIDS research. That is sick,” he added.

These men single-handedly changed the face of the epidemic with little more than a banner, some speeches and an unbelievable sense of pride and visibility. As the storm approached, these gay men with AIDS were putting into motion policy, programs, funding and activities that they would not live to benefit from.

— Mike Shriver, Mobilization against AIDS and CLM organizer

That same night, candlelight marches were held in New York, Boston, Chicago, Dallas, Houston and other cities, as the pictures flashed across the country sparking some of the first local media coverage.
The first event a city holds puts a face on the local people with AIDS; it is profoundly personal, profoundly spiritual, and if done correctly changes the entire community.

— Paul Boneberg, Executive Director, Mobilization Against AIDS (MAA), 1985-1992

Among the many hundreds of community members taking part were young children wearing headbands reading “Stop AIDS,” and holding candles or handing out emotional IEC materials. Considering that the Georgian community is quite conservative and reluctant to openly speak about sexuality, STIs and HIV, I was delighted.

— Mzia Tabatadze, Georgia, coordinator 2004-2007

The Candlelight Marches On

May 23, 1983 Bobby Reynolds, Bobbi Campbell and Dan Turner carried the banner to a meeting in Denver where gay people from around the country drafted a manifesto of rights and recommendations, known as the Denver Principles. It was at this historic gathering that Bobbi Campbell passed along the plea of Mark Feldman to reject the term ‘patient’ or ‘victim’ and replace it with ‘People living with AIDS’ (or PLA) a term that became the opening salvo of the national and worldwide movement of people living with HIV/AIDS.

But then 1984 came and went, without a candlelight memorial. Many people, though, remembered that organizing for the Democratic National Convention held in San Francisco that year burned up all the organizing energy. In fact, according to Paul Boneberg, who would take up the Candlelight the following year, there had been no discussion of continuing it.

Near the end of 1984, a new organization called Mobilization Against AIDS (MAA) was formed as the very first direct AIDS organizing group. Bobbi Campbell, Dan Turner and Bobby Reynolds, leaders who would take up the Candlelight the following year, were right. May 1985 would mark the date of what we regard as the International AIDS Candlelight Memorial.

The memorial began in earnest operating out of Boneberg’s apartment. The first year it reached 40 cities worldwide with London taking the lead. From then on, the International AIDS Candlelight Memorial continued to grow every year. “But some cities would fall away,” said Boneberg. “It was our strategy that it was more important to get new cities than to keep the old ones.” The first time is a seminal event where a city acknowledges that there are people with HIV. “So we target small cities small towns and places outside the U.S. – and we do that the entire time I’m there.” Although Boneberg left MAA in 1992, the organization ran the Candlelight until 2000, when the Global Health Council took it over.

The Present & Future of the Candlelight Memorial

Today, the International AIDS Candlelight Memorial program continues to thrive. Since its beginnings in San Francisco in 1983, the memorial has expanded to every continent, reaching hundreds of thousands of people. In 2007, some 2,000 memorials took place in 119 countries, exposing the memorial to new communities and repeating, year after year, the brave first steps toward awareness in those communities as the founders once took 25 years earlier. Candlelight coordinators include leaders from corporations, academia, faith-based organizations and government.

Much has changed since Paul Boneberg operated the memorial with few resources from his apartment in the 1980s. The Global Health Council now manages the International AIDS Candlelight Memorial program from its offices in Washington, D.C., in the United States, working with international partners to recruit and guide coordinators, and to develop the program into an effective awareness-raising intervention. Recently, the Council initiated plans to create leadership opportunities for coordinators and to work with them year-round to advocate for advancing global AIDS policy.

The Candlelight Memorial has a bright future. In the coming years, the Global Health Council is planning to support greater leadership opportunities for the Candlelight coordinators and expand the program to new communities. This is already happening with the selection of national coordinators, and the formation of the International Advisory Board, a body of regional coordinators who will help guide the memorial’s path. The Council also plans to create a year-round advocacy network to advance national and global AIDS policies.

While the faces of the memorial are new, the mission is still the same: Remember the lost. Make others aware of this terrible disease. Urge leaders to make a difference. And break down the stigma and discrimination that are just as infectious, just as perilous. From Haiti to Spain to Nigeria and India, the International AIDS Candlelight Memorial remains civil society’s effort to change the course of the epidemic and honor the souls it has displaced. It is a testament to the power of light, the insistence of hope, and the impenetrable bond of a global community.
When Gary Walsh proclaimed “we need to do something” near the end of a packed meeting at the San Francisco Gay Democratic Club in 1983, the club president abruptly adjourned the meeting.

I approached Gary and suggested that he call a meeting of people with AIDS. About a dozen guys showed up. Some were pretty weak. Every one had stories about their own, their partners’, roommates’ and friends’ shaky health. I was welcomed because I was healthy; they needed my energy and valued my activist experience. I wasn’t diagnosed yet but I assumed I had IT, too. We still didn’t know what caused it; we still didn’t have an antibody test and people who had symptoms were already in the relatively late stages of AIDS.

There was little coverage in the mainstream media. One gay paper reported new deaths each week and provided community updates. Another carried no news about the spiraling epidemic because the editor didn’t want to hurt gay businesses. Was it safe to share utensils, toilet seats? Was it safe to kiss? There were many questions, few answers, and lots of rumors, theories and escalating fear.

We heard about mysterious illnesses and infections popping up. We were confronted with a new language and words we could barely pronounce: Kaposi’s sarcoma, pneumocystis pneumonia, cytomegalovirus, toxoplasmosis, cryptococcal meningitis, lymphadenopathy.

There was confusion, uncertainty and endless questions. Do all lesions ooze? Are they contagious? Do they keep growing and spread to different parts of your body? What did a swollen lymph node mean? What should you do and how much time did you have? Everyone worried about time.

Bobbi Campbell debuted as the first public person with AIDS at a Stonewall Democratic Club/community meeting where he allowed more than 60 attendees to view the lesion on his foot. At the rival Alice B. Toklas Democratic Club meeting, Mark Feldman opened his mouth as wide as he could as dozens waited in line to see the Kaposi’s sarcoma lesion inside. My friend, Eric Moore, had cytomegalovirus and was going blind at home. He dictated an article for the gay paper about how a newly formed support group was helping him. Most of us didn’t know what a “support group” was, but we knew we needed them.

We remembered the pink triangle and what happened in Germany. How would the community react? Would people with lesions lose their jobs? Would customers shy away from gay businesses?

We wanted a street action with large numbers of people, something dramatic that would magnetize the media. We knew that San Francisco officials remembered the 1979 White Night rioting where 13 police cars were burned after the murderer of gay supervisor Harvey Milk was convicted of only manslaughter. A huge turnout could leverage funding for needed services and prod community leaders to confront AIDS discrimination.

We wanted to both honor the dead and support the living. We prioritized putting a face on AIDS, so that it would be your son, your neighbor, your co-worker, your uncle, your brother, your dad. Not just numbers of dead, numbers hospitalized, t-cell counts, or exotic infections. At that time in the United States, AIDS was visible in only gay men. Later marches would broaden the face of AIDS to include women, hemophiliacs and children.

We decided to welcome community leaders and elected officials but relegated them to march behind us. All the speakers and everyone on the front line holding the banner had to be people with AIDS. We brainstormed about a theme for the event and instantly agreed on “Fighting for Our Lives.” It was how we felt.

With AIDS deaths spiraling in New York and Los Angeles, we wanted our action to be bigger than San Francisco. With only two weeks until the march, I called both Larry Kramer, a founder of Gay Men’s Health Crisis (GHMC) in New York City and Paul Popham, the current president of the board of directors of GMHC, and told them what we were planning. I figured one of them would see the potential in joining us. They both did. We suggested using GMHC’s upcoming Madison Square Garden concert, which was already sold out, to announce the Candlelight March. They could turn out the lights, light a candle, and announce the AIDS Candlelight March. We sent them the posters and figured they would tailor the event to their community. Someone also reached out to Los Angeles.

Our media committee outreached to the press. Coming UP, an LGBT (lesbian, gay, bi-sexual and transgender) monthly newspaper, surprised us by dedicating their whole front and back page to the march. That was a life saver because the Bay Area Reporter, another major gay newspaper, didn’t give us any publicity. Not a word, not a phrase, not a sentence.

Bobbie Campbell and I met with the editor. He wanted to downplay AIDS, afraid that it would harm gay businesses. We were in crisis mode after the Bay Area Reporter blanked us out, so poster distribution and street signs became a priority. Delivering a poster to Walt Whitman Bookstore, the local gay bookstore, I was shocked when the owner refused to allow us to post it. I activated a phone tree and, by day’s end, he relented and requested that we deliver a poster, ASAP. He got over his fear and the poster was featured on the front door.

Our other strategy was to blanket the Castro, Polk and Folsom neighborhoods with street signs taped to telephone poles, and to make sure there were posters or signs in every gay bar, gym and bath house. No one could claim that they didn’t know about the march.

The march was scheduled for 7:30 pm on May 2. We arrived a little early and finding hardly anyone there, freaked. “This is really going to be depressing if nobody comes. Maybe we shouldn’t have done this.” By 8 pm, people starting coming from every direction and eventually thousands appeared. Possibly, people weren’t sure if anyone else was going, so they came with some hesitation.

When three nurses came up the escalator together in their white uniforms and white hats, I realized we weren’t going to be alone, it wasn’t just us gay guys, we had allies. Incredible numbers of women showed up; the lesbian community turned out en masse. I remember thinking that however many people die, we’ll be okay as a community because we rallied to support and take care of each other.

People in wheelchairs stood out and monitors assured their participation. The sprinkling of weak and sick guys reminded everyone of the crisis we were facing.

You could hear a pin drop for each speaker. Bobbi Campbell exuded a sense of confidence and pride, and shamelessly expressed his expectations of how the richest country in the world should prioritize health services for everyone; Mark Feldman, who was noticeably weak and sick, moved us to tears revealing his fears, his awareness that he was dying, his love for our community, and his anger at a homophobic and unresponsive government. He shared his sense of humor and got us laughing some between our tears. Bobby Reynolds led a visualization, sharing his visions for the future and his appreciations for the community support that was manifesting.

Photographers were everywhere – the candlelight effect making everyone a star. TV crews filmed from the sides, the middle, and from every vantage point. Cheers went up when it was announced that the New York march had drawn thousands and much coverage. We cheered again when it was announced that Los Angeles and Houston had also put a face on AIDS.

Finally, everyone raised their candles in unison and you could feel the sadness, but also the hope, and a strong and powerful sense of community. We were now people “Fighting for Our Lives” TOGETHER.
Paul Boneberg was executive director of Mobilization Against AIDS, founded in San Francisco in 1984. MAA was the first activist organization focused specifically on AIDS. Boneberg managed the Candlelight Memorial from 1985 to 1993. Although he left the organization in 1993, MAA managed the Candlelight until 2000 when the Global Health Council took it over. Boneberg is currently the executive director of the LGBT Historical Society in San Francisco.

A conversation between Boneberg and AIDSLink follows.

**Q.** Was there any thought of continuing the Candlelight after 1983?

I don’t believe the ’83 organizers looked beyond Candlelight as anything more than a one-time local event in three cities. Remember the life expectancy of people with AIDS at that time was about nine months – so these are really, really sick people trying to put something together. As they were proceeding, whole bunches of people were dying. By a year later, many of them were dead and many were very sick. So in 1984, there was no Candlelight Memorial and I think they looked back and thought, “We should try to continue this.”

**How did it happen?**

At that time, all activism was done through the gay Democratic and Republican clubs – there was no specific AIDS organization yet. At the end of 1984, a group called Mobilization Against AIDS was formed with Bobbi Campbell, Dan Turner, Bobby Reynolds and those guys who were well enough to be at the meeting in the leadership. They argued that the Candlelight Memorial needed to be revived and made into a national and international event.

Initially, I opposed the idea. They were crazy dreamers – activist visionaries and not a highly practical group of folks. It was far more, “We want to do our vision and we’ll figure it out along the way.” I said, “You have no money, no staff, and now you want to organize international Candlelight Memorials!” I was arguing for lobbying and protesting as the exclusive focus of the organization while they were arguing for a broader cultural focus. And they turned out to be right!!!

People were dying at a very rapid pace. We’re talking 30,000 in the Castro who died within 10 years and maybe 10 or 15 people dying a week. What that means is if you didn’t see someone on the street, you assumed they were dead. If you walked into every store, every business, someone was sick, someone was dead. At the end of ’85 when Mobilization called people to renew their membership for ’86, 10 percent of them were dead. So the organizing wasn’t practical; it was “How fast can we go? How many things can we do?”

**So when and how did the Candlelight Memorial become international?**

Mobilization had lots of committees – research, education, civil rights and the Candlelight committee, which was divided into two arms. Richard Rector did the international piece and other folks did the local piece. It was all done out of my apartment and Richard’s apartment by phone and by fax – and with no money. Richard paid for all the long distance calls himself. The whole time I was there, Mobilization never had a budget above $200,000. We took money from the political piece of the program, from membership, and funded the Candlelight. We could never convince UNAIDS, or the United States, or anyone to give us any money to do it. We were seen as too grassroots and it was a polarized time.

After ’85 we continued to build the Candlelight. I think we doubled it every year for a number of years. And some cities would fall away. Now, having done the Candlelight for 10 years, I found that the first time a city puts a face on the local people with AIDS, it is profoundly personal, profoundly spiritual, and if done correctly, changes the entire community. The San Francisco event did that for San Francisco. I later heard from those guys saying, “We put out a call, but we didn’t know if anyone would show up.” They were stunned that 10,000 people came. Maybe it was even the biggest Candlelight that was ever done here.

**What was your reflection on the first Candlelight?**

The ’83 Candlelight, as I saw it, was mostly a way to put a face on AIDS, partly a way to ask for support, and partly a last hurrah, a goodbye from activists who didn’t expect to be alive in a few months. This is a very different context from later because there was no test in ’83. People with AIDS at the time were, by definition, late-stage people with the disease.

**Could you talk a little about the context of the years ’85-’90? What was going in terms of AIDS and responses?**

The AIDS community grew from ’81 to the mid-’90s because every year more people died, more people became sick, more people became involved with AIDS.
There was just this pure fear that people can be healthy on Friday and dead by Monday. You didn’t even know who was infected. In the face of that great fear, you got the Candlelight.

Then you got the horrible treatments in the late ’80s which was basically mild therapy and AZT, with its little delays and horrible side effects that only made people die a year and a half later than they would have anyway. In the United States, you also got the Ronald Reagan response: “Don’t mention the word AIDS,” and you got new discriminatory immigration laws, calls for everything from tattooing people with AIDS to quarantines, forced registration and mandatory testing. Ryan White was being kicked out of school.

The American government did very poorly by its citizens and allowed the climate of civil rights attacks. It was not beyond the pale for them to lose their jobs or be locked up for having HIV. First, deaths; second, the government didn’t do anything; and third, those who always hated gay people used it as an avenue to attack them. That was a reality up until the late 1980s and early ’90s. Only in the mid-’90s you started to see some improvement with the breakthrough of the cocktails.

**How did the Candlelight Memorial evolve over the time you were there and what was your role?**

One of the things that the early ’85 organizers introduced was the calling out of names. They did the process of reciprocal chants with the crowd where people would call out the names of people who had died and the crowd would call out, “We remember,” or “We won’t forget.” When that’s successful, you see hundreds of people for the first time call out the name of somebody and it will be their lover, their son, or their brother and the whole crowd will call out, “We remember.” So you were hearing dozens and hundreds of names being called out. Although it didn’t directly translate into political action, it took them past being alone in their grief into a community effort. It just changed their world. That to me was Candlelight at its most powerful.

In ’85, I played a support role and then, as executive director, played a more leading role. The organization had three staff members so everybody was doing everything. We produced all the materials, contacted the old cities, reached out to new cities, tried to get the materials translated, organized the local event, and dealt with the media because the whole point of the event is visibility. We just kept adding more dots and more cities. We would have a map of the world with hundreds of dots on it. We just kept adding more dots and more cities. We would have a map of the world with hundreds of dots on it.

We had a map of the world with hundreds of dots on it. We just kept adding more dots and more cities. We would try to identify the organization and a specific person and we’d send them a tube of posters; in the tube would also come a little bit of information about an organizing kit with some instructions about what type of event it was – that is, a people-with-AIDS event. It wasn’t where people with AIDS sit in the audience and politicians speak…. That seems to be an issue following the Candlelight up to the present.

I remember back in ’85 or ’86 when the organizers wanted to only have the speakers be people with HIV, but they didn’t know how to tell elected officials, whom they were lobbying, that they couldn’t speak. So I proposed this solution – that there be no speakers, but awards instead. We gave out AIDS Hero Awards and, coincidentally, the awardees were all people with AIDS who were allowed to make an acceptance speech, and the politicians were just told there were no speakers.

Ultimately, we told them to do what worked. Some cities changed the date. Some cities didn’t use candles. I remember in India, some used oil lamps.

By the time I left Mobilization at the end of ’92, we had become a quarter of a million to half million dollar organization. We were no longer missing payroll, no longer asking for people to work for free. In effect, we were saying, we can actually pay you. It may have been $30,000 a year but we could actually make payroll.

**What kept you going all those years when you could have just dropped it?**

AIDS is one of the great moral challenges of our time – what slavery was in 1840, AIDS is in our time. But, I was also living through it. If I walked down the street in the Castro, people would stop me all along the way saying, “What about this?” and many of them would be sick or know people who were sick, saying, “What about the breakthroughs? What about research? What about drugs?” I remember one conversation where someone stopped me and said: “I’m at the end of my chemical rope. What’s coming?” So that was the environment that I and all AIDS activists were living in until the 1990s.

Mobilization felt that we had a moral commitment to the people with AIDS who handed Candlelight to us in trust and who were all dead by the end of the ’80s. It crossed our minds to give it to other organizations, which is how it found its way to the Global Health Council in 2000, but it never crossed our minds to not do it. By the time the cocktail arrived in ’96, 40 or 50 percent of those infected in the first wave were still alive. The activism of the ’80s halved the people who were infected when AIDS hit San Francisco in ’81. Half of them died, but half didn’t. They actually got medicine and made it through until the cocktail came, and some of those people are still alive, which is frankly beyond what anyone would have expected. So the activism as a whole was a success and the Candlelight was a piece of that.

I remember one other thing. During the late ’80s, people would come by the Mobilization office because they viewed us as this giant American group organizing things all over the world. They were shocked at these small offices and how grassroots it was. One of the visitors was a group of nuns from the Philippines who brought pictures of their Candlelight and told us about the event in Manila. They ran a rehabilitation training program for sex workers and trained them to do dress-making or cosmetics, something in the fashion industry, working with a man who was teaching them how to design clothes. This man was gay and died so the women in the program wanted to do the Candlelight Memorials organized by the Sisters. (See story on page 10)

**How do you see the future of the Candlelight?**

I think it needs to keep going. Candlelight reminds us that there are still people with AIDS in most communities. It gives them a voice and to some degree shame the people in political leadership into supporting them. So, yes, I think it should continue and hope very much that it does not become a government top-down event, and that it remains an indigenous event led by people with HIV.

I think there are places we don’t even know about where it’s tremendously needed. I urge you to continue the event and keep empowering the people with AIDS to fight on.
What does a Sister have to do with AIDS and prostitutes? That is a question asked of me time and time again.

Incongruous? Contradictory? Absolutely not! Just steep yourself in the Gospel and you will know what it is to care for and serve the derelict, the despicable, the downtrodden. To follow Christ, you just have to do what he did – love Mary of Magdala, respect the Samaritan woman, canonize Lazarus.

My first call came in 1980 to pick up the challenge of Japanese media women who begged me to do something about the phenomenon of sex tourism from Japan. I thought that writing one letter would suffice. But since that Human Rights Day, Dec. 10, 1980, I have taken a thousand steps in pursuit of a solution through international policy advocacy and through a compassionate service to those caught in the sex trade. So I answered that call by organizing a series of protests in Southeast Asia during the visit of Japan’s prime minister in early January 1981. This resulted in what is now known as the Third World Movement Against the Exploitation of Women (TW-MAe-W).

In 1987 when I was stricken with rheumatoid arthritis, I began the direct services for those in prostitution. Although I have professional training, I drew the methodology not just from my various academic courses but mainly from the attitude and approach of Christ as seen in the Gospel stories. Thus, I called the drop-in centers “Belen” because at his birth in Bethlehem, Jesus showed his preference for the marginalized by inviting the social outcasts of his day, the shepherds, to be his first guests in the stable. The first TW-MAe-W shelter is called “Nazareth Growth Home” because those who have decided to leave prostitution come there for healing and renewal and, in the process, they also grow in “grace, age and wisdom” as Christ did in Nazareth.

Plunging into the AIDS Epidemic

True to the pattern in my life of somehow being “chosen” to advocate for an issue way ahead of the time before it becomes the “in” thing, I was plunged into the new world of the AIDS pandemic in the late 1980s.

The World Health Organization was looking for regional representatives to invite to Geneva to discuss “the epidemiology of HIV-AIDS and prostitution.” Because of my involvement in ministering to prostitutes, the WHO contacts pointed to me. And thus, I served as a temporary adviser for WHO. No less than the late Jonathan Mann, human rights champion and head of the global AIDS program, made sure that I stayed involved. He told his staff, “Invite Sister Sol to the conference in Cameroon.” And a chain of international invitations followed—Melbourne, Berlin, Paris, Yokohama, among others.

Meanwhile back in the Philippines, the TW-MAe-W went into full swing from information dissemination to counseling, voluntary testing of women in prostitution, considered a high risk group, and the actual care of those living with HIV/AIDS. We were pioneers in this regard.

The AIDS Candlelight Memorial and Mobilization

Perhaps because I was known in international circles, I was requested by Mobilization Against AIDS in San Francisco to organize the first celebration in the Philippines of the International AIDS Candlelight Memorial and Mobilization. This took place in the Quezon Circle on May 17, 1992. Because the Philippines is a Catholic country, it was natural that we hold a Eucharistic celebration in honor of those who died of AIDS. We succeeded in gathering a huge crowd at this public park.

The previous year, the first AIDS person TW-MAe-W cared for, Nonoy Robles, died. He had been a couturier in Spain for 10 years who came back to the Philippines to spend his last days. Nonoy, a homosexual, was referred to me and when he came to Nazareth Growth Home, he got excited when he saw our sewing machine. He offered to teach sewing to our women in the home in Quezon City and in the drop-in center in the red light district of Manila. Knowing his days were numbered, I wanted him to sew his own quilt. But too weak to do so, he just described his design. He wanted a beach scene with a red car under a palm tree. “I like a red car because I’ve always wanted to own a car,” he told us. And the message would be “Life is beautiful!” This was the first AIDS quilt in the Philippines. The quilt was strikingly beautiful. I made a big sacrifice of donating it to the San Francisco group but I felt consoled because it gets exhibited in many places. Nonoy belongs to the world!

Of course one cannot forget the first of Philippine celebrations in 1992. Held as the sun was setting, the Memorial began with prayer and evoked responses from a huge crowd. The people were invited to light vigil candles that spelled out Nonoy’s dying message, “Life is beautiful!” The ethnic music of an indigenous flute and the meaningful songs of Joey Ayala created the proper ambience. Sisters of Nonoy Robles presented their testimony.

The following year, Lolita Ramos, one of our very own women, had tested positive and bravely decided to come out in the open that May. This had never been done before. Millions must have viewed that AIDS Memorial that was being held out in the open that May. This had never been done before.

A Personal Investment

My AIDS involvement stems from the gut level. My special ministry to the sexually exploited and abused has given me the opportunity to understand and accept the marginalized groups, including those with different sexual orientations. I started with those who have been prostituted, then came to know and befriend the gay crowd. One of the best articles about me was written by one of them. Entitled “The Gentle Activism of Sister Sol,” it was published in METRO, a slick magazine.

But more than any one else, it was a winsome American boy named Michael Christopher who engraved his memory deeply. He came to our shelter when he was two years old and I cared for him for six years. He had been living with HIV because of perinatal transmission. In 2001 I brought him with me to the UN General Assembly Special Session on Children in New York. He became a favorite of the AIDS section of UNICEF which sponsored our participation. Sadly, an accidental fall at the UN park caused a lesion in his brain and hastened his death at age 8 ½. Michael died near Lourdes in France on our way back to the Philippines on May 31, 2001.

Each time I see the UNICEF advertisement on TV about children dying of AIDS, the pain of separation stabs my heart once again. I have more to say but that will have to wait till I get time to write a book.

Sister Sol was recently selected as a regional coordinator and member of the International AIDS Candlelight Memorial’s new international advisory board. For further information contact: soledadperpinan@yahoo.com
I was diagnosed as HIV positive in 1986 when I was 27 years old. Some years later I learned about the NAMES Project Quilt and in 1993, founded the Spanish NAMES Project in Barcelona with the help of Michael Meulbroek (my partner who is also HIV positive) and a couple of friends. In May 1994, we organized Spain’s first Candlelight Memorial (CLM) in Barcelona. The conjunction of the AIDS Quilt and the CLM made a powerful combination to raise awareness and visibility about HIV and AIDS. Facing the ignorance and indifference of society, thousands of people in Spain were dying from AIDS. Celebrating the CLM over the years in Cathedral Square, the center of Barcelona where thousands of people ramble around, made them familiar with the big problem that my country was facing. Since that very first year, the CLM is covered widely by the media and has become very popular. Over the years, politicians, actors and other key social actors joined the celebration making of the CLM the most important social event related to AIDS in Spain, even more than World AIDS Day on Dec. 1.

The Candlelight Memorial makes people confront death and loss in a healing way. There is a very moving and special moment at the end of every Memorial that still impresses everybody and leaves no one indifferent. It is the moment when thousands join with candles and read the names of those left behind. The minutes of silence observed after the reading are probably the most effective campaign against AIDS.

During the celebration of CLM in 1998, we organized an international European display of the AIDS quilt. Hundreds of quilt panels were shown and representatives of 12 European countries gathered in Barcelona. I remember the impact that made among the general public with the quilt panels dedicated to Romanian children. Another very special and moving CLM was the one we organized in May 2002. It was the first official community activity of the International AIDS Conference that took place in Barcelona in July of that year. The following year, we created and inaugurated the first permanent Spanish AIDS Memorial grove in Barcelona. Since 2003, part of the activities of the annual CLM has taken place at the Montjuïc Park (the biggest and most significant park in Barcelona where the AIDS memorial grove is located).

**CLM is More than a Memorial**

Barcelona’s CLM is attended every year by the most important political authorities: the city’s mayor, the minister of public health, and others. They are totally aware of the political power of the Candlelight, which yearly constitutes an unavoidable confrontation with AIDS. Every year, more than 50 Spanish AIDS NGOs gather in Barcelona. Without doubt, the award of the medal of Barcelona to the NAMES Project Spain in 2005 was a political decision.

More and more people get infected by HIV every day. In Spain, HIV is still spreading among the most vulnerable populations. The prevalence among gay men is estimated to be above 20 percent. At the same time the CLM raises awareness about AIDS as a global problem and shows its worldwide devastation.

I have continued my advocacy work in AIDS with the opening in January 2006 of the first checkpoint for gay men in Spain (BCN Checkpoint) where people can be tested free and anonymously for HIV and other sexually transmitted diseases in a comfortable and safe environment. I counsel people living with HIV/AIDS, and I am involved in treatment activism at a national level through my work in the Spanish Federation of AIDS.

Thinking that I’ve been promoting and organizing the CLM during the last 14 years without a break, and forming part of an international movement, is something that really empowers me at the hardest moments – especially when I feel tired.

Ferran Pujol has been a Candlelight coordinator since 1994. For further information contact: fpujol@hispanosida.com

*Spain’s Candlelight Memorial has been held in Barcelona’s famous Cathedral Square since 1994. It is widely covered by the media and the most popular AIDS-related event in Spain with political clout and close attention of the Mayor and many ministers.*
U.S. Centers for Disease Control reports first cases of rare pneumonia in five young gay men

U.S. CDC formally establishes the term Acquired Immune Deficiency Syndrome (AIDS): which refers to four identified ‘risk factors’ of male homosexuality, intravenous drug abuse, Haitian origin, and Hemophilia A

First AIDS cases reported in Africa

The first Candlelight Memorial is held in San Francisco, California

The Human Immunodeficiency Virus (HIV) is identified by Luc Montagnier at Louis Pasteur Institute and Robert Gallo at the National Cancer Institute

30 million people living with AIDS worldwide

UNAIDS established to advocate for global action on the epidemic and to coordinate HIV/AIDS across the UN system

Brazil begins national ARV distribution, the first developing country to do so

AIDS is leading cause of death for all Americans between ages of 25 and 44

AIDS is the number one killer in Africa

13th International AIDS Conference (Breaking the Silence) is held in Durban, South Africa, and first to be held in a developing country

The Global Health Council takes over the International AIDS Candlelight Memorial

UN Secretary-General Kofi Annan, called for a ‘global fund,’ a ‘war chest’ to fight AIDS

UNAIDS convenes its first special session on AIDS – UNGASS

HIV leading cause of death worldwide among those aged 15-49

Global Fund begins operations; approves first round of grants
3,000 participants attend the first International AIDS Conference held in Atlanta, Georgia

First HIV test licensed by U.S. Food and Drug Administration to detect antibodies to HIV

Indiana teenager with AIDS, Ryan White, is barred from middle school

Mobilization Against AIDS takes over Candlelight Memorial; First International Memorial held

The first case of AIDS is reported in China

Cleve Jones created the AIDS quilt

President Reagan first mentions the word AIDS in a public address

First AIDS cases reported in Russia and India

First antiretroviral drug – Zidovudine or AZT is approved by U.S. Food and Drug Administration

AIDS reported in 127 countries

Women are named the fastest growing group of PWAs

FDA licenses first rapid HIV test, which provides results in as little as 10 minutes

Barbara Bush lights a candle in the window of the White House

Decision to move 1992 International AIDS Conference from Boston to Amsterdam because of U.S. travel ban to all people living with AIDS

8 million HIV cases have been reported worldwide

Congress passes the Ryan White Care Act, named for Ryan White who dies of AIDS at 18

Candlelight Memorials are held in 180 cities in 32 countries, including those in Asia, the Middle East and Eastern Europe for the first time

U.S. President announces PEPFAR, a $15 billion, five-year initiative to address HIV, TB and malaria in the hardest hit countries.

UNAIDS estimates about 39.5 million people living with HIV

UNAIDS estimates between $24 and $36 billion is needed to reach universal access by 2010

Candlelight Memorial events held in 119 countries

Sources:
- Global Health Council
  www.globalhealth.org
- Kaiser Timeline
  www.kff.org/hivaidstimeline/hivtimeline.cfm
- PBS
  www.pbs.org/wgbh/pages/frontline/aids/cron/
- UNAIDS
Prayers to God and intense discussions with my family led to a most difficult decision. I would leave my job as a personnel administrator for the British America Tobacco Company and my family in Nairobi and relocate to an area where the needs of orphans were dire.
t all began with the death of my sister Rita and the wishes of my young nephew Ferdinand. In 1993, when Rita, her husband and two daughters had all perished from AIDS, I was left with the care of seven-year-old Ferdinand, who was HIV positive. My house in Nairobi became his new home, where he lived for the next eight years, and my family became his family.

Those eight years were heartening for Ferdinand and for me; he attended school, played with his cousins and recovered psychologically from the grieving of his losses.

But as he weakened and incurred a new TB infection, and the cost of his care increased, my thoughts went to the many orphans who were HIV positive and had no one to take care of them. Prayers to God and intense discussions with my family led to a most difficult decision. I would leave my job as a personnel administrator for the British America Tobacco Company and my family in Nairobi and relocate to an area where the needs of orphans were dire. It meant tight adjustments for my family at a time when our children were still attending college. But oddly, it was choosing the name of the new venture that took the longest. It was Ferdinand, who asked for a chance to help, proposed the name of the new venture that took the longest. It was Ferdinand, who asked for a chance to help, proposed his late mother’s name. And so it became: St. Rita Community Based Orphan Care.

Making the Move
On Sept. 17, 1998, I left my formal employment and moved to Kisumu, a remote poverty-stricken fishing village on the shores of Lake Victoria, to talk with the community about the benefits of support for orphans and vulnerable children through community based care. I relocated to Nyalwenda “B” West Kolwa, for two reasons: First, this was the childhood home of my husband and where we were married; and second, the HIV/AIDS prevalence in this lake region was very high with many children orphaned as a consequence.

Our plan was to set up a community care system with guardians taking children into their homes, as well as an official membership organization of community members who would contribute whatever they could in time or money. But our first efforts to find guardians, or people who would take children into their homes, were disappointing as most appeared more interested in what they could get than what they could give. In addition, several members found it difficult to maintain their contributions and dropped out of the program.

Starting again, we sought only guardians who were affected by AIDS, either infected themselves or their families; they understood the consequences and what children were going through. We also did training, involved the guardians in decision making and trained them to train others. Many of our orphans have since grown into healthy youth and now serve as members and guardians.

How it Works
From the start we believed that children should live with families and not in orphanages. We wanted them to lead as normal lives as possible and be part of a village community. Originally, we arranged for orphans to be distributed to their relatives. This meant that each time a community member died, leaving behind an average of five children, five relatives would be sought to choose at least one orphan each. At first it was most difficult because most of the villagers were so poor they could not afford to take in any more children. But as we persevered and were able to provide support, people were now willing to take in a family so that the children grow up together, sharing the joys and vicissitudes of life.

When houses are too small, we support new construction; in many cases we support the children to stay in their own homes with an elder sibling to head the activities and a relative to oversee them. This arrangement has made it possible for many orphans to keep their property, which used to be sold by relatives as soon as the children left home. Pro-bono legal services from lawyers in Kisumu have helped to protect the orphan’s property.

Today, St. Rita’s has 93 orphans living in 52 households. All of them are in school including 20 in secondary school. (Six girls and six boys in Form I reduced to two boys and no girls in form IV.)

In addition to pro-bono legal support, financial support to the St. Rita CBO relies on individual donations from friends. This includes support from Kenya’s National AIDS Control Council, a training grant from AMREF, and an award from the World Children Prize for the Rights of the Child. In addition, we have received individual support from friends in the U.S. and from Calgary, Canada – adding up to approximately $20,000, which nearly covers our current annual costs for school fees, supplies, lunch program, water and salaries of security guard, gardener, farm worker and office staff.

But the lion’s share of support lies in the community commitment, managing to stretch its meager resources beyond anything thought possible. Initially, we didn’t know what to do because we had no money. A few of us started baking bread and cakes that we sold in town. Others grew vegetables to sell. After a while, we earned enough to buy a cow and started selling milk.

Our membership is now 11, including seven guardians and four youths representing youth and HIV-positive and affected children. Members meet every month, contributing their subscription, and the youths make beads to raise the $33 per month needed.

I am still constantly going to offices in town begging for food and money for our children. I approach charities, authorities, companies and the well-off. I didn’t like begging at first but as the children really need all the help they can get, I don’t mind it now. I can rarely afford to take the bus or taxi so I usually walk. I also bake cakes that Seraphine, who is typical of the committed volunteers, sells at her work place.

Sarah Mbeka and Wendy Were manage the office, cook, serve lunch, and every afternoon, go round the village visiting the children we take care of.

Ninety-three orphans ranging from two children to ten are placed in 52 households. Eighteen volunteers from the community carry out visits every Saturday at 2 pm, reporting key issues to the office. For example, if an orphan is sick, the guardian or the child will report to the office and receive a letter of referral to the hospital. If the medicine is not available, St. Rita CBO will buy it from the pharmacy.

Working very long hours, chasing very limited resources on behalf of the orphans can be frustrating and demoralizing. Children expecting material things when often their guardians cannot even buy a pencil, can deplete the energy of a volunteer.

In spite of these difficulties, we have made a huge impact, changing the life of 93 orphans and vulnerable children. In addition, I have been instrumental in opening and providing training in three outreach units in other districts of Nyanza Province. They are all reaching out for more orphans who are infected and affected by HIV/AIDS. Depending on availability of resources, we hope to open more outreach units and soon enroll up to 1,000 orphans. It is this hope, the children we have seen grow into healthy and purposeful youth, the growing commitment of the community – and, of course, the continuing need – that keeps us going.

Bernadette Otieno was recently selected as a regional coordinator and member of the International AIDS Candlelight Memorial’s new international advisory board. For more information contact: strita42@hotmail.com

Initially, we didn’t know what to do because we had no money. A few of us started baking bread and cakes that we sold in town. Others grew vegetables to sell. After a while, we earned enough to buy a cow and started selling milk.
MSM:

Beware of Dangerous Labels and Stereotypes

By O’Leo Lokai, Project Coordinator
RED Initiatives
Trinidad and Tobago

HIV/AIDS is a social disease. It has no barriers and does not discriminate when it comes to sex, race, class, location, education or sexual orientation. In the Caribbean, we are reported as having the second highest per capita rate of transmission globally.

In Trinidad and Tobago, due to this high rate of infection, one of the many taboos used to promote awareness is: “What’s your position? The ABC’s of prevention”

However, due to many years of cultural conditioning, behavior change is still a serious obstacle toward reducing transmission. HIV and AIDS targets the vulnerable and is attached to many other social ills, including domestic abuse, violence, incest, infidelity and sexual irresponsibility. In our tropical paradise where sex is merged with everything under the sun, many ‘high risk’ groups develop all-encompassing acronyms like CSW (commercial sex workers) and MSM (men who have sex with men).

When I first became involved in prevention work five years ago, I began to hear about this group ‘MSM’ – the fastest growing sexual group. When I first heard the term, it made me think of the candy that melts in your mouth not your hands (M&M’s). I then made the common assumption that MSM were all homosexual men in denial about their sexual proclivities. However, more research and work with this population showed me I was wrong – on both counts.

MSM as an Unfortunate Label

I came to discover that MSM is only a generic name or unfortunate label for many different kinds of men. Some are, of course, homosexual men, both in and out of the closet. But they are also bisexual men, curious men with homoerotic tendencies, and male sex workers who tend to the needs of other men.

MSM are also men who follow the standard of a heterosexual life style with a wife or a girlfriend but indulge in a sexual experience with men from time to time. Simply put, they do not see having sex with a man as ‘gay’ because they are not, and stay away from the term as far as their testosterone can keep them again – that these groups are all homosexual or gay men. Having sex with other men is far more complex, and compressing MSM into one defined group would be much like labeling MSW (men who have sex with women). We need to address this complexity and these differences if we are going to solve the problem of HIV.

Faithfulness and Denial

For a variety of reasons, condom use is not part of their reality. For example, men who are in secure relationships with their wives and girlfriends often practice ‘being faithful’ as a way of prevention. So the option of carrying condoms in their wallet is taboo and does not go along with the image of the perfect couple next door. They do not view their casual sex with other men as breaking those vows.

This is also the result of the ‘skin on skin’ culture when it comes to sex of any kind in the Caribbean. Couples, in general, equate trust and commitment with no condom use. They are sometimes used at the beginning of the relationship and thrown away after ‘trust’ is gained in a couple months. So why should they consider precautions when condoms represent an acknowledgement of risky sexual activity – something they ‘don’t engage in.’

This leads to liaisons that may include cruising areas other MSM frequent, posting an ad on a website for another DISCREET MALE, or carrying a friendship a bit further with another straight ‘willing’ guy. This increase in proactive sexual behavior can also be associated with the introduction of globalization – cable television, cell phones and the Internet – anonymous easy access to other men who may share the same inclinations. One-night stands or casual encounters are seen as just an erotic activity. They never acknowledge the names or the sex because anything resembling an expression of gay sex is seen to them as alien. And the shame due to years of conditioning by the church in a third world country has solidifies their fears.

Sex and sexuality are as widespread and diverse throughout the Caribbean as mangoes in a bowl, but some activities are hidden away due to the stigma created by the church and legal status. The ban against homosexuality is a relaxed law in Trinidad and Tobago, but still a law. Despite all the sensual bliss of island life, carnival and other cultural aphrodisiacs, men indulging in same-sex experiences are still taboo and highly shamed.

Moreover, the consequences of HIV transmission cannot be contained within a group. MSM, who engage in unprotected sex and acquire HIV, do the injustice of transferring the infection to their other relationships. This may be their wives, girlfriends and other male partners, thus creating an entire line of infection that will be hard to trace or identify in time and may lead to other social problems, including orphaned children. But who is to bear the burden when it comes to growing up in a society that drives your feelings underground and makes your attraction an all-but-criminal activity?

HIV is Everyone’s Business

How then can men who do not acknowledge that they have sex with other men be expected to acknowledge safe sex responsibilities? We in HIV/STI prevention have the challenge of mapping and reducing transmission in a prevalent sexual group that remains sexually incognito. Risk reduction intervention is the key to prevent infection and save lives for men who are gay, straight, bisexual, male CSW, and undetermined. But the challenges are not about addressing the identity of the sexual group but rather with the health issue of prevention. Too much time is wasted on getting people to acknowledge what we ourselves can’t pigeon hole.

Rather than excluding them by constricting behavior to something that is shameful and taboo, we should be broadening the outlines so that for everyone it is ‘just sex.’ Sexuality is fluid and cannot be contained in jars and shelved. When I speak to men or run focus groups, I do not address their sexual preference but ask them to look at what they are doing to protect their own lives and that of their families. Speaking to men is just that, not trying to get them to choose a side or a lifestyle that they do not have.

HIV and STI prevention is the same for all men. This includes proper condom use every time, negotiating condom use with a sexual partner, risk reduction, relationship mitigation, getting tested, and self-esteem development. This means getting men to access condoms and use them when they have ‘sex’ with whomever they choose.

As this hurricane of sexuality sweeps across the Caribbean culture, it carries in its wake HIV and STI transmission, not only to men who have sex with each other, but also to all the relationships that surround them. This calls to mind a slogan we use frequently in Trinidad and Tobago: ‘HIV is everyone’s business,’ confirming that that we all are vulnerable to infection no matter what sex we choose to be identified with.

Sex is part of who we are in the Caribbean. It is a part of us, but it does not define us. Being responsible, tolerant and knowledgeable will.

O’Leo recently has been selected to serve as a regional coordinator and member of the international advisory board of the International AIDS Candlelight Memorial.

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The epidemic in Estonia is a relatively new phenomenon. That is why, above all, it is necessary, before it gets out of hand, to create partner forums that unite people living with HIV with governmental and non-governmental partners. A young organization, the Estonian Network of People Living with AIDS is doing just that; it is bringing together important non-governmental organizations with one another and with the government represented by the institute of health, the ministry of social affairs, and prison officials.

Challenges of HIV in Estonia’s Prisons

Conditions in Estonian prisons (as in other countries) are well-suited for the transmission of HIV. These include crowded cells, quick turnover of drug users, frequent use of drugs and of non-sterile injecting equipment, tattooing, and sexual contacts between men. The first HIV-infected prisoners were thought to be Russian-speaking residents from the northeastern parts of Estonia, who had no access to education and did not speak Estonian. They were often convicted for drug-motivated petty robberies or thefts. In 2001, test results already showed high HIV rates in Estonian prisons.

Over the next two years, more than 600 HIV-positive cases were diagnosed with all infections occurring before entry into prison. In response, prison officials initiated a drug-prevention program that replaced the more punitive approach of confiscating drugs entering prison and of punishing drug dealers with greater attention to counseling drug-addicted prisoners.

The first challenge for the prison administration was figuring out where and how to care for these individuals. They had to contend with the absence of medical and social support in post-Soviet prisons and to provide basic knowledge of health and hygiene. Even more importantly, they had to combat the negative attitudes of other prisoners and prison officials.

Prison officials discovered many cases of unwillingness to share a cell with an HIV-positive prisoner. Once HIV diagnosis was disclosed, certain prisoners became outcasts, and beds in isolated parts of prisons were discovered. In the words of one prisoner: I learned that I was HIV positive when I took the test in prison. I was ready for the result and was not shocked. But I was shocked by the attitudes of other prisoners toward HIV-positive individuals. I thought it was time to hang a bell round my neck, just as lepers had to do in the past.

Tea, Talk and Testing

I work for the non-governmental organization Convictus Eesti (www.convictus.ee). In December 2002, we received a permit to work in one of the oldest and largest prisons in Estonia – Murru Vangla, where HIV-positive prisoners were housed in special isolated units. We managed to set up three support groups on the prison grounds and went to sections where prisoners were known to be intolerant about HIV. We spoke, listened, discussed, and examined their points of view. We identified their level of knowledge on HIV/AIDS and their level of discrimination. More than half considered HIV infection not a crime but a disease. Others however suggested that HIV positive prisoners should be "moved to an island."

One prisoner told us: There are those who are even afraid to say hello to us. I regard it as a lack of education. I do not want to thrust my opinions on anybody, because anything can happen in life. I want to lead a healthy life, not to spread the infection and to keep in touch with people who support me psychologically.

These statements show the difficulty of those first steps – working in a complex setting where prisoners did not understand our role and denied their own situation. However, we kept at it, holding group meetings with drug-dependent prisoners and conducted lectures and presentations for prisoners on health issues in prison. We conducted campaigns that promoted voluntary HIV testing in co-operation with medical personnel and in a cozy and informal atmosphere. We offered clients a cup of tea, while our staff members provided pre-test counseling. Materials, brochures and posters were presented (including some that the prisoners made themselves), as well as books and films about drug use. Continued on page 22
The epidemic in Nigeria is complex and varies widely by region. In some states, it is more concentrated and driven by high-risk groups, while others have more generalized epidemics sustained primarily by multiple sexual partners in the general population.

Currently, the total HIV infections in Nigeria are about 4 million, with more than 200,000 new AIDS cases and 184,000 AIDS deaths already recorded in 2007. Nigeria has about 1.8 million children orphaned by AIDS.

Youth and young adults in Nigeria are particularly vulnerable to HIV. Although information about the number and percentage of youths who have died of AIDS is not available, 2005 estimates from the National HIV/Syphilis Sero prevalence Sentinel Survey by the Federal Ministry of Health indicate an HIV prevalence rate ranging from 3.6 percent to 4.9 percent among people, aged 15-35.

**Nigeria Slow to Respond**

Since the onset of the epidemic in 1985, Nigeria has been slow to respond. The nearly 30 years of military rule and its legacy – a slow transition to democracy, a weak civil society and a private sector uninterested in rule and its legacy – a slow transition to democracy, a weak civil society and a private sector uninterested in rule and its legacy has contributed. Today, the amount spent on AIDS alone could reach 35 to 45 percent of the health budget.

**Young Adults at the Center**

Our generation (15-40 years) is being described as the AIDS generation, since we young people have never had a world without the epidemic. It is members of this age group, who are at their most productive age and constitute the major work force in Nigeria. And it is this age group that suffers a major impact, including loss of jobs, denial of admission into some universities, marriage breakdowns, and denial of participation in politics and other social activities.

The case of Jegede-Ekpe, a nurse, is a typical example. When she publicly declared her HIV status, members of her choir asked her to stop singing with them. The principal of her nursing school tried to expel her and her fellow students shunned her. Another example was the compulsory HIV and pregnancy tests initiated by the Covenant University, Ota in Nigeria, although this recently has been resolved following government and civil society action.

The impact of HIV infection among young girls is the worst. They are not given in marriage. They drop out of schools, and are allowed to die as a way of punishing them for their 'promiscuity.' Where one family member dies of AIDS, another is left with the burden of providing for the needs of the children alone, with little or no assistance from relations because they know the cause of death and fear infection.

Young people face not only the normal challenges of growing into adulthood but peer pressures as well, which may lead them into risky behaviors such as drug and alcohol use, sexual promiscuity, cultism, etc, which indirectly fuel the spread of HIV.

Despite their high level of awareness about HIV/AIDS in Nigeria, new infections continue to rise among youth, indicating that knowledge does not translate into action or behavior change. The physical, psychological and social attributes of young people make them particularly vulnerable to HIV and other STIs. Most of the time, they are not able to comprehend fully the extent of their exposure to risk.

Our society further compounds this risk by making it difficult for them to learn about HIV/AIDS and sexual reproductive health. Many youths are socially inexperienced and, therefore, depend on others. Peer pressures easily influence them, often in ways that increase their risks to HIV infection.

Moreover, the epidemic among us has remained largely invisible to our political leaders and to ourselves. HIV infection is invisible to youths because they often carry the virus for years without knowing they are infected. As young people, we are yet to come to terms with the fact that “HIV no dey show for face!” Some of us still incorrectly measure one’s HIV status on the physical appearance and freshness of the body. The fear of testing for HIV scares some of us and when tested positive, we hide the results out of shame and fear of discrimination.

For young people to gain critical prevention skills, they need to be at the forefront of every HIV prevention effort – that is to be actively engaged in the design and planning of behavior change communications. But the involvement of youth in HIV prevention efforts is minimal in Nigeria. Youth are not policy makers, nor do they contribute to making policies that affect their lives. They are only at the receiving end.

The consequence of this lack of involvement is the design and implementation of HIV and other health programs that are unfriendly to youth, who are worst hit by the epidemic.

The earlier youth are seen as critical stakeholders and engaged in the planning and execution of efforts directed toward them, the better for all of us. If they are properly guided and their synergies harnessed, youth groups all over the world will make the greatest impact in the struggle to stop HIV infections.

**Youth Takes the Lead**

The African Youth Development Foundation (AFRYDEF) is a Nigerian NGO established in 1999 to cost-effectively empower young people, women and children to choose a better future for themselves in a society that enables positive changes through facilitating sustainable youth and rural development initiatives in Africa. We in AFRYDEF envision such a society where youths, women and children are viewed as assets and encouraged to develop their potentials.

Continued on page 22

The National Press Foundation (NPF) has launched the NPF Helpdesk, a free online resource for journalists around the world covering HIV/AIDS. Every Monday, veteran journalist Ruth Pollard of the Sydney Morning Herald (with the occasional assistance of NPF’s Bob Meyers and Philip Javellana), will share HIV/AIDS online resources and answer questions regarding the challenges in HIV/AIDS reporting. The site may be accessed at www.npfhelpdesk.org.

The International HIV/AIDS Alliance released a new French adaptation of the Building Block Africa-wide briefing note on Young children and HIV, which provides practical guidance on meeting the developmental needs of young children affected by HIV and their care and treatment needs. Focusing on children under eight years of age, it aims to help local organizations and service providers to strengthen family and community support. The first section describes the impact of HIV on the intellectual, emotional, psychological and social development of all young children and what organizations can do to help families and communities to meet children’s developmental needs. The second section describes the impact of HIV infection on young children. A PDF version can be downloaded at www.aidsalliance.org/custom.asp/publications/view.asp/publication_id266&languagefr.

The International Center for Research on Women released a new paper on Gender and PEPFAR, which focuses primarily on steps that the Office of the Global AIDS Coordinator can take to increase its priority to women and girls, as well as broader gender relations. This paper provides a brief overview of PEPFAR’s record on gender and offers five recommendations to help the Office of the AIDS Coordinator (OGAC) make gender central to its policies and programs. The paper can be found at www.icrw.org/docs/press/2007/PEPFAR_white_paper_sept07.pdf.

The Woodrow Wilson International Center for Scholars released a new policy brief on the public and private provision of health care in Africa. The publication includes a list of conclusions and next steps reached by the participants of a workshop held last year on health imperatives for Africa. In addition, it includes summaries of the three papers commissioned for the meeting: Africa health trends, improving health efficiencies, expanding public-private sector partnerships (PPPs), African health-care systems facing daunting challenges; African dependency on public health services that are hobbled by inadequate budgets, underinvestment in physical infrastructure, and insufficient numbers of trained health care providers. The policy brief, webcasts of the paper presentations, and the unabridged papers, are available now at www.wilsoncenter.org/globalhealth.

The Gender, Institutions and Development Data Base (GID-DB) represents a new tool for researchers and policy-makers to determine and analyze obstacles to women’s economic development. It covers 161 countries and 60 indicators on gender discrimination. The data base has been compiled from various sources and combines current empirical evidence on the socio-economic status of women. Information on cultural and traditional practices that impact on women’s economic development is coded so as to measure the level of discrimination. It can be viewed at www.occld.org/document/23/0,3343, en2649_33935_36225815_1,1_11,0,00.html.

EngenderHealth and the International Community of Women Living with HIV/AIDS released Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: Manual for Trainers and Program Managers. It is now available in five languages: English, French, Portuguese, Russian and Spanish. This manual meets a critical need addressing the sexual and reproductive health, rights, and needs of HIV-positive women and adolescent girls worldwide. The manual provides information and a structure for a four-day training and a two-day planning workshop. These will program managers and health workers to provide comprehensive, nonjudgmental, and high-quality sexual and reproductive health care and support to HIV-positive women and adolescent girls. It was field-tested in Brazil, Ethiopia and Ukraine. To order the CD-ROM, download a PDF, or order a hard copy in English, go to www.engenderhealth.org/ress/offic/hiv/women/index.html.

Transcending Boundaries to Improve the Food Security of HIV-affected Household in Rural Uganda is a new case study released by New Horizons. Conducted in Tororo, Uganda, the case study found that a partnership between TASO, an AIDS service NGO and agricultural extension was successful in helping HIV-affected communities take steps to improve food security. Horizons is a global operations research initiative designed to identify and test strategies to improve HIV/AIDS prevention, treatment, and care programs, as well as to disseminate research findings and promote their utilization with the aim of replicating and scaling up successful interventions. The report is available for download at www.popcouncil.org/pdfs/horizons/UgandaFoodSecurity.pdf.

The New Gender and Sexuality Toolkit from the International HIV/AIDS Alliance aims at enabling individuals and organizations working on HIV and AIDS issues to address gender and sexuality effectively. The toolkit contains participatory activities which enable groups of men and women of different ages to explore how gender and sexuality affect their lives and identify changes which they wish to make to improve their relationships and sexual health. The tools involve community members using techniques such as role-play, making diagrams using local resources such as the ground, sticks and everyday objects to generate discussion. Contents include sections on gender sexuality and vulnerability, sex and relationships and sexual violence working together making an action plan. A PDF version can be downloaded from the Alliance website at www.aidsalliance.org.

The Interagency Youth Working Group (IYWG) released Youth InfoNet 38. This issue of the monthly e-newsletter on youth reproductive health and HIV prevention features nine new program resources with Web links, as well as 15 summaries of published research studies conducted in Bangladesh, Burkina Faso, Ethiopia, Ghana, Iran, Malawi, Nepal, Nigeria, the Philippines, Romania, Uganda, the United States, and Zambia. You can read the issue at www.fhi.org/en/Youth/YouthNet/Publications/YouthInfoNet/38.htm.
**AFRICA**

**Zimbabwe Shifts to Provider-Initiated Testing**

Zimbabwe has shifted from a voluntary HIV testing system to a provider-initiated system in which medical professionals incorporate HIV testing into routine medical exams with the permission of their patients. Provider-initiated counseling and testing aims to strengthen HIV service programs. Under the new system, HIV screening will be provided as part of routine hospital services and patients can opt out of tests. The new system would preserve consent, counseling and confidentiality requirements outlined by the World Health Organization and UNAIDS. According to ministry of health officials, changes in Zimbabwe’s HIV testing policies will not lead to mandatory testing.

– The Herald, Oct. 27

**Researchers Warn Vaccine Volunteers About Increased Risk of HIV**

HIV/AIDS researchers in South Africa began warning 801 volunteers who participated in a trial of Merck’s experimental HIV vaccine about a possible increased risk of HIV. Merck announced that it had ended its Phase II trial after its experimental vaccine failed to prevent HIV infection in participants or prove effective in delaying the progression of the virus to AIDS. Researchers said that the vaccine will not cause infection with HIV but could cause changes in the immune system that might make HIV transmission easier during later exposure to the virus. Researchers plan to tell the roughly 50 percent of volunteers who received the vaccine that they might have an increased risk of contracting HIV. In addition, researchers are counseling all trial volunteers that the vaccine might lead to a possible increased risk of HIV.

– Washington Post, Oct. 25

**Uganda Implements Five-Year Program to Reduce HIV**

The Uganda AIDS Commission plans to implement a five-year strategy aimed at reducing the spread of HIV by more than 40 percent. The strategy will focus on boosting the ABC approach to HIV prevention and on providing access and treatment to people living with HIV/AIDS. The plan aims to provide antiretroviral drugs to 80 percent of HIV-positive people in the country. The terms of the program were agreed upon at the United Nations General Assembly in June 2006.

– New Vision/AllAfrica.com, Oct. 24

**Ugandan Children Not Adequately Covered Under ARV Program**

Children living with HIV/AIDS in Uganda have not been adequately covered by the country’s antiretroviral treatment program, officials from the ministry of health said. According to statistics from Uganda’s ministry of health and UNAIDS, about 110,000 children are living with HIV/AIDS in the country. Out of these, about 50,000 children need access to antiretroviral therapy, but only 10,000 receive it. Mother-to-child transmission of the virus is the second most common mode of transmission in Uganda, accounting for 21 percent of all new HIV cases in the country.

– Daily Monitor, Oct. 18

**Shock at Archbishop Condom Claim**

The head of the Catholic Church in Mozambique said he believes some European-made condoms are infected deliberately with HIV. Maputo Archbishop Francisco Chimoio claimed some antiretroviral drugs were also infected in order to purposely kill the African people. The Catholic Church formally opposes any use of condoms, advising fidelity within marriage or sexual abstinence. AIDS activists in the country have been shocked by the archbishop’s comments.

– BBC, Sept 26

**Low Quality Condoms Flood Malawi**

Efforts to contain an upsurge in HIV infection rates in Malawi face a serious new setback with reports emerging that low-quality porous condoms have flooded the country’s contraceptive market. The development has raised fears that the fight against HIV could be set back as the use of condoms as a preventative tool has been widely promoted in Malawi. Officials said calls for the government to buy condom-testing machines had produced no results, leaving experts struggling to address the situation. A variety of NGOs have promoted the use of condoms in Malawi, including PSI and Banja La Mtsogolo (BLM), which have both carried out social marketing programs to help make condoms more accessible. The ministry of health also distributes free condoms through various health centers but local markets are flooded with imported condoms that come with no quality guarantees.

– HDN, Aug 17

**ASIA**

**Southeast Asia Attempts to Stop Drug Use Undermining HIV Control Efforts**

Efforts by police to stop injection drug use are undermining attempts to curb the spread of HIV among injection drug users in Southeast Asia, law enforcement and health experts said. IDUs are often forced to use dirty needles because they are harassed or arrested at needle-exchange centers and drug treatment clinics. Police in Thailand often confuse IDUs and people who sell drugs, hindering efforts to provide treatment to IDUs. According to experts, it has become more difficult to determine the number of IDUs in Southeast Asia because police have caused them to go underground. Some experts say that as many as 50 percent of IDUs in the region are HIV-positive.


**AIDS Prevention among MSM in China Remains a Challenge**

Preventing the spread of HIV among men who have sex with men remains a challenge for the government, said officials at the Chinese Center for Disease Control and Prevention. The United Nations and the Asian Development Bank recently reported that the number of HIV cases in China is rising faster than the average number in most Asia-Pacific countries despite efforts by the government. More than half of the new HIV cases reported in the country as of June this year were among MSM and commercial sex workers. Officials said it is difficult to reach MSM because of stigma.

– China Daily, Oct. 18

**Majority of Thai Youth Lack Knowledge about HIV/AIDS**

About 77 percent of young people in Thailand have limited knowledge about HIV/AIDS, the ministry of public health said. A surveillance report found that about 321,650 people in the country are living with HIV/AIDS and that half of them are between ages 25 and 34. According to the report, most people living with HIV contracted the virus during adolescence and began to show symptoms when they reached adulthood. About 23 percent of young men and 26 percent of young women in Thailand fully understand the development and seriousness of HIV/AIDS, according to a survey on HIV/AIDS knowledge among youth. Changes in the social environment in Thailand have increased concerns about HIV transmission among adolescents.

– TNA/MCOT News, Oct. 24

**UNHCR Launches AIDS Campaign among High-Risk Groups in Nepal**

The United Nations High Commissioner for Refugees launched a six-month HIV/AIDS awareness campaign among high-risk groups in six districts of Nepal. The campaign, which received funding from the United Kingdom’s Department for International Development, will be channelled through UNAIDS and implemented in the districts. UNHCR also is launching a condom promotion program in 15 districts in Nepal.

– Xinhua/People’s Daily, Oct. 16
**WHO to Launch Nutrition Campaign for HIV-Positive People in Asia**

The World Health Organization will soon launch a campaign in South and Southeast Asia aimed at making nutrition programs a central part of HIV/AIDS treatment in the region. This is the first time the region has been targeted to improve nutrition as part of its effort to fight HIV/AIDS. The campaign follows a similar WHO initiative in sub-Saharan Africa that was launched after the approval of a resolution that formally recognized the link between nutrition and HIV/AIDS at the 2006 World Health Assembly in Geneva, Switzerland. HIV-positive people who are malnourished are at an increased risk of malaria and other diseases. HIV-positive people taking antiretroviral drugs might be unable to handle the medication without proper nutrition. Some argue that low-income populations without proper nutrition also might sell antiretrovirals for money to purchase food.

– Inter Press Service, Oct. 14

**People Living With AIDS Higher in Rural Areas of Japan**

The percentage of people in Japan who have already progressed to AIDS when they are newly diagnosed as being HIV-positive is higher in rural areas than in urban areas, a finding that highlights the discrepancies in the country's HIV/AIDS control. Although HIV testing systems in urban areas are inadequate, local governments in rural areas are even less prepared to administer HIV tests. The ministry called on them to create HIV testing programs that take a person's privacy into consideration.

In urban areas in the Aichi region, 22.6 percent of new HIV diagnoses were among people who had progressed to AIDS, compared with 42.3 percent in rural areas.


**EUROPE**

**Ireland to Provide Life Insurance to People with HIV**

The Irish government launched a program to provide life insurance, mortgage protection and travel insurance to people who contracted HIV or hepatitis C through contaminated blood products. In the mid-1980s, about half of Ireland's 500 hemophiliacs contracted HIV or hepatitis C from the nation's blood supply. About 3,300 people in Ireland have initiated claims against the government related to infections from contaminated blood products. People who enroll in the new insurance plan – which is expected to cost about 1.1 billion pounds, or about $2.2 billion – will pay the average premium for an HIV-negative person of the same age and gender, and the government will cover additional costs. Applications for mortgage protection and life insurance will be subject to restrictions after 12 months. The program is the first of its kind worldwide.

– Evening Echo, Sept 27

**European Commission Approves Pfizer’s CCR5 Inhibitor Maraviroc**

Pfizer announced that the European Commission has approved its antiretroviral drug Celsentri, known generically as maraviroc, for sale and marketing in the European Union. Maraviroc belongs to a new class of antiretrovirals that could provide an alternative to HIV-positive people who have developed resistance to multiple drugs. The treatment works by blocking a protein, called CCR5, on human immune system cells that HIV uses as a portal to enter and infect the cell. Pfizer has proposed using the drug to treat people with advanced HIV or AIDS who have not responded to other medications. The European Commission approved maraviroc based on 48-week data from two ongoing clinical trials. The data showed that nearly three times as many HIV-positive people who took maraviroc in combination with a traditional treatment regimen achieved undetectable levels of HIV, compared with those receiving only the traditional regimen. Pfizer said the side effects recorded among participants who took maraviroc resembled those experienced by participants who received only the traditional regimen. The most common side effects reported included diarrhea, nausea, fatigue and headache.

– Pfizer release, Oct 24

**LATIN AMERICA**

**Guyana Launches Project Aimed at HIV in Prison Inmates**

Guyana’s ministry of home affairs recently launched a new project aimed at decreasing the spread of HIV among prison inmates and reintegrating HIV-positive inmates into society at the end of their sentences. The project has also allowed the purchase of equipment to establish voluntary HIV counseling and testing in prisons, as well as programs aimed at training prison officers to provide HIV care and counseling. The ministry is concerned about the increasing number of inmates entering the prison with HIV or other diseases and is working to integrate and promote safer behaviors among inmates. Three inmates have been trained to provide support to medical staff providing care to HIV-positive inmates. In addition, about 122 people and 131 prison officers were recruited to participate in training on HIV/AIDS prevention. The ministry, with funding from the World Bank, recently opened a high-dependency care unit at Lusignan Prison to facilitate care and management of inmates living with HIV/AIDS and other infectious diseases.

– Stabroek News, Oct. 29

**Catholic Church’s Opposition to Condom Helps the Spread of HIV**

The Roman Catholic Church’s opposition to condom use is contributing to the spread of HIV in Latin America, said a UNAIDS coordinator in Honduras. In addition, evidence indicates that promoting abstinence is not working. About half of the 1.1 billion Catholics worldwide live in Latin America, and the Roman Catholic Church holds sway in the region. About 1.7 million people in Latin America are living with HIV/AIDS. The number of new HIV cases in the region increased to 410,000 in 2006 from 320,000 in 2004, according to UNAIDS.

– Reuters, Oct. 23

**NORTH AMERICA**

**Ohio Not Applying for Federal Funds to Prevent HIV among Teenagers**

Officials at the Ohio Department of Education are not applying for a $1.25 million, five-year grant from the CDC intended to prevent the spread of HIV among teenagers. The state has no existing program to support the grant and developing one would require the legislature to approve changes in the state’s health education policies. Ohio received the grant for 12 years but dropped out in 2000 after some state lawmakers disagreed with some language and condom-promotion aspects of a teacher-training program. Some advocates of HIV/AIDS education in Ohio schools said that they do not understand why the state will not apply for the grant. Utah is the only other state that does not apply for the federal grant.

– Cleveland Plain Dealer, Oct. 30

**Experts Call for Broadened Approach to AIDS Relief**

A panel of public health experts stressed the need for added emphasis on HIV/AIDS prevention before a House Foreign Affairs Committee hearing on the reauthorization of PEPFAR. Dr. Nils Daulaire, president and CEO of the Global Health Council, likened current PEPFAR efforts to getting an emergency room up and running. The challenge now, he said, will be to establish measures that will prevent people from having to go to that emergency room. CARE CEO Gayle said it was imperative that PEPFAR shift to an “ABC-plus” model, which would focus aid on factors beyond the scope of the current PEPFAR ABC approach: abstinence, be faithful, and correct and consistent Condom use. Gayle said the program must address the social, cultural, and economic factors that affect young girls’ vulnerability. The abstinence and be faithful approach, meanwhile, is ineffective for many women who have little or no choice when it comes to sexual practices.

– CQ Health News, Sept. 26
Young people have always been the primary target of our projects, be it in peace building, conflict resolution, poverty reduction or HIV/AIDS programming. As future leaders of society, young people need to be fully informed and empowered before that responsibility falls on them. As upcoming leaders, they are already faced with enormous life challenges, which if not properly met may cause long-lasting negative consequences.

In the past, we launched a “Testing 4 Life” campaign, which sensitized young people to the importance of testing. This campaign was predicated on the importance of early detection in HIV/AIDS treatment and care. We encouraged and provided young people with voluntary HIV counseling and testing and referred HIV-positive youths to the Network of People Living with HIV/AIDS for easy access to ARV drugs and other care services.

This year, we also celebrated the Global Week of Action on AIDS in Owerri from May 20-27. Coincidentally, the weeklong event was kicked off with the Candlelight Memorial on May 20. To mark the week, we organized a street rally, held street interviews, conducted poster campaigns, and the week was wrapped up with a press briefing where we presented the Nigerian Charter of Demands to the state government officials.

The Charter of Demands was jointly prepared by a Coalition of NGOs formed and supported by ActionAid International, Abuja, Nigeria. The document contained demands to the government at all levels to guarantee Nigerians universal access to HIV/AIDS treatment, care and support by 2010. It also reminded the government of its Abuja declaration – a promise to allocate 15 percent of the national budget to the health sector.

The week was a success possibly because we utilized the “street rally” strategy, of mobilizing our audience – which is attractive to young people. We would not have succeeded if we had organized what I call a “closed program,” where the adverts for the programs are only aired on radio and television. In Nigeria, if you really want to reach your target audience, you need to go on the street.

**Voices that Care!** was a follow up to the 2007 International AIDS Candlelight Memorial and the Global Week of Action to get the support of political and religious leaders and to ask the government officials to be committed and respond to the critical issues raised during the two events.

**Voices that Care!** was held in a university environment and was strategically designed to educate young people about HIV prevention, treatment, care and support using entertainment. In particular, the project used the power of art, drama and music in delivering HIV/AIDS prevention messages to students. HIV/AIDS prevention messages such as condom use, sexual activity and risk-taking were built into drama and songs and then presented to the audience. We used this strategy because important messages are youth-friendly and easily communicated to them.

The target audience, youths themselves participated in every aspect of the program, from planning to execution. AFRYDEF provided the technical and logistical supports

Where used, it is clear that involving young people in peer education and the design and planning of behavior change communication programs is the best, if not the only way to empower them. When youths take part in developing social and group norms that protect against HIV infection, they serve as positive role models for their peers. To better serve youth, health-care providers must do more to make them feel comfortable. Services, including STI treatment, VCT and referrals should be provided confidentially. Even small declines in HIV/AIDS prevalence among youth that are showing up in some countries are the best evidence to support the conviction that they must be at the center of all strategies and programs targeting them.

For further information contact: afrydef@yahoo.com

AIDS in Estonia, the Baltic region, and the world.

**Seminars for All Social Actors**

On Dec. 1, 2003 (World AIDS Day), Convictus Eesti organized a campaign: We formed and lit the ribbon of tolerance in the prison yard; it was a copy of the red ribbon that symbolizes the fight against HIV infection. For many of our clients participation in the campaign was an achievement; those who lit the ribbon did so out of self-respect and dignity, not to challenge others.

The following month with the financial help of the Global Fund, we began activity in seven prisons in Estonia, setting up 21 support groups divided by different needs: drug-dependent men; drug-dependent prisoners, who experienced discrimination; men, who have sexual relations with men; women, who were or would become mothers; HIV-infected adolescent girls; minors, who were dependent on illegal drugs. Each group had its own goals, tasks and members, allowing us to deal with the complexity of HIV/AIDS – which was our main goal and mission.

We conducted the first seminar in Murru Vanga on “Life with HIV infection: support groups in Estonian prisons.” All participants received beautiful certificates as souvenirs of a day full of communication. One social worker noted that “during the discussion, the convicts were freer in their opinions than we were.”

The group has since held seminars in four prisons. Participants represent a wide variety of professional and social groups, including doctors and nurses; prison social workers and those who help former convicts adapt to life outside the prison; ministry of justice workers; journalists; and representatives of non-governmental organizations dealing with the problems of the prophylactics of drug addiction and HIV.

In a way, the seminars were the culmination of the work done by the 21 support groups. Anyone could join whether or not they were HIV-infected or a drug addict themselves. At first, it consisted of those who simply wanted to drink tea and talk. Yet slowly a circle formed of those for whom a profound discussion was more important than tea and sweets. It appeared that not only HIV-positive people were interested, but also those who had such friends and acquaintances, as well as those who did not personally know such people and wanted to know how to protect themselves and their close ones.

The seminars were important not only for those who try to solve problems of HIV and drug use in prisons, but for those who tackle the problem without direct prisoner contact. My colleagues and I went behind the barbed wires in order to show people how they can regain and keep their dignity. If even two or three out of dozens of prisoners leave the realm of anger and helplessness, we would regard it as a success.

**Enter Harm Reduction**

Today, we are very optimistic about our activity, but realize that harm reduction is necessary for the program to achieve ultimate success. The wide sharing of needles is only spreading the disease and can undermine our efforts.

On the one hand, prisons are a high-risk environment for the spread of infectious diseases; the population inside the prisons tends to come from the higher social risk groups and prison conditions fuel the behavior. On the other hand, in prison, the members of these groups are more easily reached than in free society where they are hard to contact and treat. Therefore, it is essential to pay special attention to sharing correct information about diseases and to prevent high-risk behavior in prison.

It is often forgotten that prisoners are an inseparable part of society and one day will return to that society as free men and women. They are entitled to the same level of medical services.

From October 2003 until the end of September 2007, the prison support groups, run by Convictus Eesti and the Estonian Network of PLHWA, were financed with the help of the Global Fund. In September 2007, the Global Fund cut the funding. But only a month ago, the two organizations signed a contract with the ministry of justice to continue the work. It looks as if our hard work is paying off and that the government has taken up its responsibility to all its citizens – even those in prisons.

For more information contact: aljev@gmail.com
December 2007

Dec. 12–15
International Symposium on Tropical Medicine and Hygiene
Location: Sindh, Pakistan
Organized by: Aga Khan University/RSTMH/IDSP
The symposium will highlight important issues of relevance to tropical medicine, clinical and public health practice in Pakistan and the developing world. Visit www.aku.edu/news/seminars/rstmh/ for greater detail.

January 2008

Jan. 7–9
National Annual Conference of the Indian Association of Clinical Psychologists
Location: West Bengal, India
Organized by: Indian Association of Clinical Psychologists/University of Calcutta
This is the biggest conference for clinical psychologists in India. It will have symposiums, panel discussions, workshops, scientific papers and poster presentations. Contact Prasanta Roy at naciapc2008@gmail.com for details.

Jan. 27–29
International Conference on Opportunistic Pathogens in AIDS
Location: New Delhi, India
Organized by: All India Institute of Medical Sciences
The conference will focus on new trends of the HIV epidemic, treatment guidelines and vaccine development. Visit www.icopa-india.org for more information.

February 2008

Feb. 24–27
Microbicides 2008
Location: New Delhi, India
Organized by: Indian Council of Medical Research
The conference intends to provide updates on the current state of the art and the likely future scenario of ongoing research and development efforts in the area of microbicides in different parts of the world. Visit the website at www.microbicides2008.com for details.

March 2008

March 27–April 1
HIV Vaccines: Progress and Prospects
Location: Alberta, Canada
Organized by: Keystone Symposia Global Health Series
In this keynote symposia meeting, leading experts in the field will discuss recent advances in novel vaccine approaches, humoral and cellular immunity, immune correlates of protection, and early and late phase clinical trials. This event is supported by the Bill & Melinda Gates Foundation and sponsored by Wyeth Vaccines Research. For more details, visit the website at www.keystone-symposia.org.

April 2008

April 2–5
Australasian Society for Infectious Diseases, Annual Scientific Meeting
Location: Sunshine Coast, Queensland, Australia
Organized by: Australasian Society for Infectious Diseases & Australasian Society for HIV Medicine
The ASID conference is a highly regarded event in the sector and is a major forum for presentations of ground-breaking basic science and clinical research in the area of infectious disease. E-mail Daliah Frank at conferenceinfo@ashm.org.au for more details.

April 23–25
AIDS Scenarios Workshop
Location: London, UK
Organized by: LSE and Scenario Development
The objective is to provide introductory insights and hands-on opportunities for understanding scenarios, learn the essential elements and interact with professional practitioners and network with your peers. Visit www.scenario-development.com/AIDS_Scenarios for details.

April 23–27
43rd Annual Meeting of the European Association for the Study of the Liver (EASL)
Location: Milan, Italy
Organized by: European Association for the Study of the Liver (EASL)
EASL is a leading Association of clinicians and scientists involved in the fight against liver diseases. For details, visit the website at www.easl.ch/liver-meeting.

May 2008

May 18
25th Annual International AIDS Candlelight Memorial
Location: Worldwide
Organized by: Global Health Council
The annual International AIDS Candlelight Memorial, a program of the Global Health Council, is one of the largest and oldest grassroots mobilization campaigns for HIV/AIDS awareness in the world. The Candlelight is meant to honor all those who have been affected by the AIDS pandemic. For more information, visit the website at www.candlelightmemorial.org/ for details.

May 27–31
Global Health Council International Conference
Location: Washington, D.C.
Organized by: Global Health Council
The Global Health Council’s 35th Annual International Conference will focus on community health, exploring the cycle of community health issues. What are the problems and the solutions? Did the solutions have an impact? Join us as we celebrate 35 years as the premier annual event in global health. For information visit www.globalhealth.org/conference/.

August 2008

Aug. 3–8
20th Australasian Society for HIV Medicine (ASHM) Conference
Location: Perth, Australia
Organized by: Australasian Society for HIV Medicine

September 2008

Sept. 17–20
6th Australasian Viral Hepatitis Conference
Location: Brisbane, Australia
Organized by: Australasian Society for HIV Medicine
This conference will cover Hepatitis B and C for the subject areas basic science, clinical medicine, community responses, epidemiology, public health and prevention and social research. Visit www.hepatitis.org.au/ for greater detail.

November 2008

Nov. 2–5
Pan Pacific HIV+ Peoples Conference 2008
Location: Auckland, New Zealand
Organized by: Body Positive Inc.
This conference is specifically for HIV+ people in the Pacific region. Visit website at www.bodypositive.org.nz/PanPacific08/ for more details.

December 2008

Dec. 8–11
15th International Conference on AIDS and Sexually Transmitted Infections in Africa
Location: Dakar, Senegal
Organized by: The Society for AIDS in Africa
For information about the conference, visit the SAA website at www.safrica.org.
Sunday, May 18, 2008
Be a part of the movement
www.candlelightmemorial.org