Reading 1, South Africa:
Text Messages Are New Tool for AIDS Education in South Africa

A mobile health project in South Africa is using cell phone text messages to reach people in even the most remote areas of the country to encourage them to get information and counseling on HIV/AIDS.

Project Masiluleke, part of the burgeoning field of mobile health technology, delivers about 1 million HIV/AIDS and tuberculosis texts each day to personal cell phones providing the number for the national AIDS helpline along with messages like: "Frequently sick, tired, losing weight and scared that you might be HIV positive? Please call AIDS Helpline."

Since the program began in fall of 2008, the messages have increased calls to the center from about 1,000 a day to between 3,000 and 4,000 a day, according to Gustav Praekelt of the Praekelt Foundation, which designed the technology behind the project.

"Increasingly in Africa we find that the mobile phone is the prime resource for finding information," Praekelt said. "I think people often underestimate the penetration of these devices in Africa and what a difference it makes to a lot of people's lives."
Callers to the national helpline can ask questions about HIV, get information about where to get tested and receive counseling.

The project takes advantage of a popular form of texting across Africa, called a "please call me" message, that can be sent for free from a phone even if it is out of pre-paid minutes. The empty characters on the free text are used to convey the health message.

Future phases of the project will allow users to text health questions, if they prefer not to call the line, and will provide an internet portal of information accessible by cell phone for people to learn about HIV. The ultimate goal, says the group, would be to provide free home HIV testing kits that would be supported by mobile counseling, so that people who aren't willing to visit a clinic can find out their status.

Zinny Thabethe, an HIV positive South African and co-founder of the HIV/AIDS education organization iTeach, helped create the program for Project Masiluleke. She said opening a dialogue about HIV/AIDS is so important because the stigma surrounding HIV/AIDS in South Africa is still very strong.

An estimated 18 percent of South Africans between the ages of 15 and 49 are HIV positive, according to the World Health Organization.

When the South African government announced it would increase access to AIDS medications in 2003, there was new hope for the infected, but the stigma did not go away said Thabethe.
"In the community people don't want to talk about it," she said. "If you go to funerals ... nobody is talking about it, they are making excuses as to why people are dying."

In the feedback the program has received, Thabethe said some callers have reacted defensively, asking why they received the message and who knew their HIV status. But most expressed the need for a confidential way to ask their questions about HIV and AIDS.

"They felt uncomfortable because in the clinics there are people from the community," Thabethe said. "But because [the helpline] is confidential and anonymous they can phone in and talk to someone who doesn't know them, who is in another province, who can help them with their questions and they can be able to be honest."

South Africa has 13 official languages, and the project sends messages in the major vernaculars. The team has observed a higher yield of callers from messages sent out in Zulu than in English. While all calls are confidential, anecdotal evidence from the project has shown that the majority of the callers are male and many are from rural areas, two populations that are traditionally very hard to reach with health information, Thabethe said.

The project is a case study for a new area of mobile technology based health efforts, termed "mhealth." The United Nations Foundation released a report on the topic in February, citing its potential to cast a wider net for health programs and health training.
Aside from initiatives for health outreach and education like Project Masiluleke, there are also pilot programs around the world working on monitoring patients and reminding them to take medications, using mobile technology to quickly collect data about outbreaks so that proper medical response can be deployed faster, and using mobile technology to connect health workers with the training and support they need.

Claire Thwaites, who heads the U.N. Foundation's work on mHealth, said the mobile phone technology is already in the hands of 64 percent of people in the developing world, and that number continues to grow.

Networks for cell phone service are relatively easy to expand into rural areas, whereas computers are often limited to urban areas that have reliable access to electricity and Internet. By 2012, 50 percent of all individuals in remote areas of the world are expected to have mobile phones.

But, said Thwaites, the field of mhealth technology needs to be strengthened by rigorous data collection about results before programs can be expanded.

"To be very frank, it is very early days in terms of proper monitoring and evaluation of the technology," said Thwaites.

The two indicators that will be crucial to the success of smaller programs will be finding ways to scale the project up, and sustain the project through government interest and business collaborations. Thwaites is optimistic that applications can be developed into business models that will provide investors the incentive they need to get involved.

The penetration of cell phones into the developing world "happened without government intervention and without regulation, it's happened because of market forces," Thwaites said.
"There is no reason why market forces shouldn't bring around mhealth next."

--By Talea Miller, Online NewsHour
http://www.pbs.org/newshour/updates/health/jan-june09/projectm_0309.html

Reading 2, South Africa:
Reporter's Notebook: Cultural Taboos Around Sex Feed AIDS Epidemic

In his final reporter's notebook from South Africa, Ray Suarez reflects on the entanglement of sex and death in the HIV/AIDS epidemic and the challenges of confronting the issues that no one wants to discuss.

For a very long time, South Africa was a very conservative place. In this corner, Calvinist Afrikaners, gravely frowning at revealing clothing, too much drink, depictions of sexual material in popular culture. Over here, the British Government and its established Church of England, which discouraged all but the most conventional sexual mores. And most numerous of all, black Africans and the wide array of Protestant denominations they professed, many native-born churches supporting a very buttoned-down brand of Christianity.

Even during the resistance to apartheid, leaders who spent long years in exile could easily be considered straitlaced. Sophisticated and well-travelled, spending big chunks of their adult lives in the Eastern Bloc and the decadent West, many were still mission school kids who learned their lessons well and frowned upon multiple partners, divorce, homosexuality, and pornography.

As in so many parts of South African life, the country has had to come a long way in a short time. In the final analysis it may not matter all that much whether the country comes willingly or is dragged kicking and screaming.

The lives of millions are threatened by a disease very efficiently transmitted by sex. This year, more than a thousand South Africans a day will contract the HIV virus.

Sex has been decoupled from love in a fundamental way. Worst of all, the discussion of sex has been decoupled from death, which daily makes the problem worse.

All the way from South Africa's minister of health in a beautifully appointed executive suite in the Parliament buildings in Cape Town, to a married woman in her thirties on a garbage strewn produce market in the teeming Soweto township, the message was often the same, even if the elements were presented in a different order:

Men want sex from women.
Men don't want to use condoms.
Men refuse to check their HIV status.
Women can't refuse to provide sex to men on whom they rely.

Both men and women commonly have multiple sex partners, either inside long-term relationships or in transactional sex (for money, food, protection).

See number two. When women told me the men in their lives refused to be tested, and refused to wear condoms, I often followed up with the very simple question, "Even if it means he ends up dying and killing you too?" Their answer, just as simple: "Yes."

Policymakers high up on the country's organizational chart struggle to find a message that strips the discussion of AIDS of shame, judgment and guilt. They openly strive for HIV status to become an unremarkable medical fact as easily produced as a cholesterol level or blood pressure.

The early messages about HIV and AIDS tried to scare people into doing the right thing to stay safe, and since there was no cure instead found the strategy had backfired. Sexual behavior didn't change, and people avoided finding out their HIV status because it might only mean sure death with no recourse and no options for treatment.

You might see the wisdom in that strategy. Stop making AIDS scary. Make HIV status a thing somebody might want to know in hopes they could get on retroviral drugs and save their own lives along with those they have sex with. But while pursuing the goal of detaching HIV and AIDS from moral conclusions about decision-making and behavior, they might have also thrown out something unintended: love.

The people of South Africa have been bombarded for 20 years with public health messages on the radio, TV, billboards and in print about every facet of the HIV virus. The spread of the virus, its trading among sexual partners and its passage out to radiating memberships in wider sexual networks, the particular threat to pregnant women and newborns are all old hat.

Even the presidential terms of Thabo Mbeki, who questioned whether HIV causes AIDS, didn't slow down private sector and non-governmental efforts to get the word out.

All this has happened at a time when hundreds of thousands of people were dying of AIDS without ever even having a diagnosis, and while South Africa was becoming the country with the single largest HIV-positive population on earth. Yet, men still seek out multiple partners. Women still concede to unprotected sex with men whose viral status is unknown. Men still condemn their own consequent children to short lives of suffering and death.

That people are capable of callous disregard for others is not new. That men are capable of cruelty to their own wives and children is not new. I guess it's the scale that's puzzling. The existence of so many people who are willing to roll the viral dice, repeatedly, and each time hope everything turns out OK.

That's why you've got to remove the stigma, I was told. A man who offers to wear a condom will immediately be suspected of HIV infection and found unsuitable as a sex partner. A woman who demands her partner wear one will be seen as making an accusation of infidelity, or making an admission of infidelity, and neither is a palatable choice. So millions carry on doing what they've been doing, with predictable and disastrous consequences.

Some have placed their hopes in treatment, rather than prevention. Getting people to change their behavior hasn't worked, they reason, and now that antiretrovirals make HIV infection something other than a death sentence, let's show the country models of living and thriving with HIV. There's an appealing logic there: Build down the stigma, build down the fear, encourage testing and then put the HIV-positive population on the drugs that will save their own lives and make them less contagious at the same time.

Not everyone's so sure. The medical director for a large employer told me you're never going to medicate your way out of this crisis, and that changing behavior was the only way to defeat HIV in the long run. Both approaches make sense, but in different time frames. One school of thought says the house is on fire and we don't have time to sit down and have a family meeting about how to throw water on it and get out alive. The other says unless we stop doing the same things we may get today's fire out, but the next place we move is going to burn down and so is the one after that.

For our upcoming series on AIDS and tuberculosis in South Africa we interviewed John Molefe, producer of one of the longest-running dramatic series in South African television, "Soul City." The show deals with the realities of black daily life in South Africa, and is guided to a remarkable degree by polling and social science research in crafting its themes and story lines.

Recently Molefe decided to throw the weight of the show behind the One Love campaign, a national multi-media effort to encourage having a single sex partner.

Molefe said it isn't charity, and though he believes in One Love's goals, the alliance isn't entirely altruistic. The tension around the sexual behavior among his countrymen is driving conversation and debate among audience members and confronting his country with life or death choices about the

future. For one of the creative minds behind a hit show, being at the center of controversy is both the right thing to do and an extension of the way the show has positioned itself since its debut in the late nineties.

Across the country from the leafy Johannesburg park where Molefe and I sat down for a talk, Rebecca Hodes of the Treatment Action Campaign predicted One Love won't work. As much as she found its goals admirable, Hodes said simply telling people something over and over again won't make them stop as long as campaigns like One Love don't address twin truths about the spread of HIV in the country. One problem is the heavy promiscuity among the young who believe they will be the exception rather than the rule in their unsafe sex practices. Another is that teenagers and young adults are among the most economically **disadvantaged** and powerless of all South Africans, and any campaign that ignored the transactional nature of sex in poor communities would not change anyone's behavior.

On the one hand. On the other hand. What people do is making them die. On the other hand we can't get them to stop doing it. We are very afraid of the spread of a disease, so we tell people how to protect themselves. On the other hand, if they don't protect themselves we'll give them medicines to keep them alive. Male dominance in South African society undermines women's ability to protect themselves from the HIV-positive men in their lives. On the other hand, a traditional source of male power-their children-have their lives put in jeopardy by paternal irresponsibility. Sex and death are now intertwined in South Africa to create a hellish problem. One Saturday morning at Soweto's main cemetery, watching families bury people in their 20s and 30s is enough to break even the hardest heart. Wouldn't you do what you could to avoid ... this?

What several people told me over two weeks of reporting was that life has been appallingly hard for a very large number of people in South Africa. When you are short of money, short of food, short of work, and short of education year after year, taking new steps to protect your life and make it a long one just doesn't seem the same kind of priority it was in the 80s and 90s, when AIDS burst upon the scene in Europe and North America. Is that really it? Are South Africans unwilling to do what it takes to save their lives because they've figured their lives really aren't that valuable? Please watch my upcoming series of reports on the NewsHour, starting in March. And watch the Online NewsHour for more material from the recently completed reporting trip.

---- By Ray Suarez, NewsHour Senior Correspondent
http://www.pbs.org/newshour/updates/health/jan-june09/sa_0223.html

Reading 3, Ethiopia:
AIDS responses in action in rural Ethiopia
22 April 2009

UNAIDS Executive Director Michel Sidibé joins a village "community conversation" in the Tigray Region of Ethiopia, 800kms from Addis Ababa, 22 April 2009.

Across Ethiopia, community initiatives and local government are coming together to make a difference in the AIDS response. During his official travel to the country, UNAIDS Executive Director Michel Sidibé visited some of the programmes and projects putting into action the goals of universal access to HIV prevention, treatment, care and support services.

Adegude Health Center
At the heart of health service delivery in Ethiopia are the government-run local health centres which deliver primary health services such as family health, communicable disease prevention and control, including HIV, and health education.

Michel Sidibé was invited to visit the Adegude Health Center, one of five local health centres in Hintalowagrit District, which provides voluntary HIV counseling and testing services, as well as prevention of mother to child transmission and HIV treatment. Staff working at the centre gave an overview of the HIV services that they deliver in this rural area of Ethiopia to Mr Sidibé and shared their achievements as well as the challenges they face. District health office officials also shared experience of coordinating the multi-sectoral AIDS response, implementation of HIV programmes and service delivery.

Community conversations
Mr Sidibé also had an opportunity to observe one of the "community conversations" in Hiwane Kebele where a cross-section of people—women and men, old and young, people living with HIV, representatives from women's associations and youth groups join local religious and traditional leaders who have the ability to influence and bring change—regularly come together.

"Community conversations" are taking place across rural Ethiopia and studies show that they can be agents of change in the AIDS response. Once a week or fortnight in villages, or "Kebeles", up to 70 people gather for a couple of hours with trained local facilitators to exchange their views on a range of social topics.

The village gatherings enable taboos to be aired and misunderstandings about sex and AIDS to be clarified. Traditional practices that may be factors in the spread of HIV are also discussed.
The "conversations" have changed opinion and even translated into action. For example, in some localities groups have condemned early marriage and committed to protecting school girls from discontinuing their education. Others decided to stop female genital cutting in their areas or some participants reached a consensus to avoid practices like widow inheritance. The importance of leveraging AIDS responses to deliver broader development results including gender equality and human rights is a point often emphasized by Mr Sidibé.

The local events also enable issues—such as stigma—to be explored collectively and can be a forum from which community actions are initiated such as HIV prevention, home based care, support for orphans, and increased take up of voluntary counselling and testing.

Facilitators explained how community conversations were first developed by UNDP and piloted from 2003 to 2004 in Ethiopia. The pilot was more successful than expected and federal authorities have since made community conversations a priority strategy for community mobilization across the country.

“The local community conversation I have witnessed is an inspiration. Governments, people living with HIV, civil society leaders, and partners—we all need creative platforms to join in open discussion of the issues and identify ways to move forward together in the AIDS response,” said Mr Sidibé.

People living with HIV in the region

The Executive Director also met with the Chairman and Board Members of the “Save the Generation Association Tigray” umbrella network of people living with HIV in Tigray National Regional State. The Network promotes the rights of its members, fight stigma and assists regional efforts to scale up HIV prevention, treatment, care and support services. According to the Federal Ministry of Health an estimated 62,000 people are living with HIV in the region and 63% of those in need of HIV treatment have access to it.

Care and support of vulnerable children

Around 650,000 children have been orphaned by AIDS in Ethiopia. Mr Sidibé visited a care and support project for orphans and vulnerable children and affected families in Mekelle. The project, run by Human Being Association of Brotherhood, began in 2001 to support orphans and vulnerable children and families under difficult circumstances and today provides basic and educational support to over 1000 families caring for orphans and vulnerable children. It also provides vocational training, equipment and seed money to street children and child sex workers to enable them to have their own income and continue their education. Other support services include reuniting street children with extended families and legal support for children to inherit property and pensions of their families who died of AIDS-related illnesses.

The Ethiopian Minister of Health Dr Tedros Adhanom accompanied Mr Sidibé on these site visits.

The government of Ethiopia has set ambitious targets to achieve universal access to HIV prevention, treatment, care and support and developed a multi-sectoral Plan of Action for 2007 to 2010. This was developed in consultation with a broad range of stakeholders, who shared lessons learned during implementation of the AIDS response. The plan includes detailed activities, targets, cost estimations and a financial gap analysis and represents a major step towards the realization of the ‘Three Ones’ principles.

UNAIDS

http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090421_rural_Ethiopia.asp

Reading 4, Zimbabwe:
Empowering women to protect themselves: Promoting the female condom in Zimbabwe
29 October 2009

When AIDS first emerged in the 1980s, it mainly affected men. Today, according to UNAIDS figures, women account for about half of the 33 million people living with HIV worldwide, and 60 per cent of those infected in sub-Saharan Africa. Most of these women acquired the virus through heterosexual intercourse, often through unprotected sex with their husbands or long-term primary partners.
"Women think marriage is a safe haven," says Beauty Nyamwanza of Zimbabwe's National AIDS Council. "They think that when you're married, you don't have to worry about HIV."
But what the AIDS-prevention team in the country found out is that marriage can actually increase the risk of HIV among young women. According to research carried out in Kenya and Zambia in 2004 , marriage increases the frequency of sex and hinders a woman's ability to negotiate condom use or abstain from sex. Married women are often afraid to ask their husbands to use a condom – or to use one themselves – since this implies that they suspect their husbands of infidelity.
Thanks to the efforts of Ms Nyamwanza and others, Zimbabwe is one of a handful of countries that has taken advantage of the female condom and made major inroads in promoting its use. The latest device, the FC2, is a strong, flexible, nitrile sheath, about 17 centimetres (6.7 inches) long, with a flexible ring at each end. The closed end is inserted into the woman's body, and the open end remains outside during intercourse. Like the male condom, it offers dual protection against unintended pregnancy and sexually transmitted infections, including HIV. But it has one critical advantage: it is the only available technology for HIV prevention that women can initiate and control.
Condom promoters in Zimbabwe suggest that married women can present the female condom as a means of child spacing. In this way, the issue of a woman appearing to accuse her husband of having other partners and putting her at risk need not arise.

Building support
Zimbabwe introduced the female condom in 1997, but acceptance was slow. Eventually, the Government requested support from the United Nations Population Fund (UNFPA) to scale up promotion of both male and female condoms through the public sector. Beyond training condom promoters, highly creative ways to educate the public about condom use were employed. Billboards, radio spots and TV commercials helped break down taboos against talking about condoms, and thus helped overcome the stigma sometimes associated with them. In the process of implementing the strategy, the team – which included the Ministry of Health and Child Welfare, the Zimbabwe National Family Planning Council, the National AIDS Council and Population Services International (PSI) – discovered that the female condom can be a tool for empowerment, enabling women and adolescent girls to take the initiative in protecting their own reproductive health and that of their partners.
From 2005, when the strategy was launched, to 2008, female condom distribution by the public sector in Zimbabwe increased five-fold, from about 400,000 to more than two million. Sales of female condoms through social marketing rose from some 900,000 to more than 3 million, and sales of male condoms also increased.

Involving men
One person who has seen the change coming is Langton Ziromba. He owns a small, outdoor barbershop in the Budirio section of Harare. In addition to haircuts, shaves and chats about football and women, Mr

Ziromba provides another service to his male customers: information about female condoms, how they are used, and the advantages to both partners. He is one of about 70 barbers and 2,000 hairdressers in Zimbabwe who have been trained to promote the female condom. He sells Zimbabwe's most popular brand, called Care, and makes a small commission on the highly subsidised price.
"Our research shows that for this product to be accepted and used by women, we also need to involve men," says Margaret Butau of the National Family Planning Council. "We customise the benefits of the female condom according to the target group we are addressing." Specific points highlighted for men include the fact that the female condom is not constricting like the male condom, it is even less prone to breakage, its use does not require an erection and it can enhance pleasure for both partners. Moreover, it is not necessary to withdraw immediately after ejaculation. And, finally, it could be seen as the woman's responsibility. "When we point all this out, we find that men become curious about having their partners try the product."

Providing a model for other countries
The Zimbabwe campaign created by PSI that uses hairdressers to market condoms has served as a model for a similar programme in Malawi. Some 2,400 Malawian hairdressers now sell, and serve as advocates for, the female condom in the country. Their numbers are growing as word spreads. Sandra Mapemba, a national programme officer in the UNFPA office in Malawi, says the impact has been dramatic. "The female condom is actually empowering women to become more assertive and to stand up for their own health issues," she says. "That's the most exciting thing for me. Women who are in discordant relationships or women who are HIV-positive come and tell me that now they can actually insist on condom use. Before, their partners would refuse."
The response has been so positive that UNFPA Malawi is now providing training in condom programming to some 35 international and local NGOs working on HIV-prevention in the country. Over the course of three years, female condom distribution through the public sector alone in Malawi increased from 124,000 in 2004-2005 to nearly a million in 2008.

Programming challenges persist
The success of UNFPA and its partners in promoting the female condom in Zimbabwe, Malawi and also in Zambia has prompted other countries to seek similar assistance. Though global distribution of female condoms nearly tripled from 2004 to 2008 – to a total of 33 million in 90 countries – they still represent only 0.2 per cent of condom use worldwide. Key barriers are cost and availability. Not only are female condoms more expensive than male condoms – they cost as much as $1 per unit in some countries – they are still far less widely available. Through an initiative called comprehensive condom programming, UNFPA is helping countries address these and other issues. The programme is also a platform from which other female-initiated prevention technologies still in development, including cervical caps and microbicides, will be launched.
"Giving women the power to protect themselves could turn the tide of the AIDS epidemic," says Bidia Deperthes, who leads the comprehensive condom programming initiative for UNFPA. "But we still have a long way to go." The largest obstacle, in her view, is funding for programming. While the majority of donors willingly contribute essential commodities, including male and female condoms, little money is allocated to laying the groundwork needed to create awareness and demand, and to train women to use condoms correctly and consistently. "It's all part of one comprehensive package." UDAIDS: http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20091021_UNFPA.asp

Reading 5, Vietnam:
Exiled From School, H.I.V.-Infected Orphans Learn a Bitter Lesson
By Seth Mydans
October 14, 2009

AN NHON TAY, Vietnam — The first day of school was a special one last month for the 15 children from the Mai Hoa orphanage here. They are infected with H.I.V., the virus that causes AIDS, and for the first time they would be allowed to attend the local primary school.
"The children were so excited," said Sister Nguyen Thi Bao, who runs the orphanage and had been lobbying for three years to enroll them in the government school. "They had been wishing for this day to come."

But when they arrived, they found an uprising by the parents of the other students, who refused to let their children enter the school together with the infected orphans. Some of the parents hastily backed away when the orphans walked past.

After a short standoff, the principal, who had agreed to accept the orphans, told Sister Bao that their papers were not in order and that they could not stay.

The children returned to the orphanage, just a short walk down a country road, where they continue to study in small classrooms, still exiled from the uninfected world.

"I was so happy to go to the school," said a 12-year-old fourth grader for whom Sister Bao insisted on anonymity to keep her from the spotlight. "But then I saw that some parents wouldn't let their children go to school with me because they are scared of my disease."

The girl said she understood their reaction.

"If I were a normal child, I would be afraid, too, because I wouldn't understand," she said. "I would feel the same way. But I wouldn't have acted the way they did."

Sister Bao and officials of the district and the school, the An Nhon Dong Elementary School, have met with the parents since then, but they remain adamant.

"I don't want my child to be with the AIDS children," Nguyen Thi Thuy, 36, said the other day as she brought her 8-year-old son to school. "He could be injured, and it's easy to transmit the disease through blood. And once you're sick, it's difficult to become a normal person again."
One after another, parents who arrived with their children on small motorbikes raised their voices in agreement. If the orphans came back, said a man who gave his name only as Tam, he would pull his son out again.

The story is not surprising, said Eamonn Murphy, Vietnam director for Unaids, the United Nations' AIDS-fighting agency.

“You go to any rural environment in Asia, and you are going to have similar reactions,” he said. “The general lack of understanding leads to this inappropriate reaction and fear.”
Most of the parents here are farmers with little education, but the prejudice seemed to extend to city folk as well.

“I don’t know why we don’t isolate people with AIDS,” said a civil servant in Ho Chi Minh City, about 20 miles southeast of the village. “Even with swine flu we isolate people, and this disease is much more dangerous.”

There is no truth to these fears, Mr. Murphy said.

“H.I.V. is not contagious from community contact, even if you are sharing cups and saucers and eating from a communal plate. You can’t get H.I.V. from that.”
In recent years, Vietnam’s prevention and treatment programs have been improving, Mr. Murphy said, although so far only 30 percent of people who need life-saving antiretroviral drugs receive them.

About 290,000 people in Vietnam, a country of 86 million, carry H.I.V. today, and Mr. Murphy said that although the rate of increase was slowing, the infection was spreading outside high-risk groups.

Among those infected, the government estimates that 5,100 are children. Although the law requires equal treatment, almost none of them have been accepted in schools because of the fears of other children’s parents, Nguyen Vinh Hien, the deputy minister of education, said last month.
He said the ministry would try to enroll at least half of these children in government schools by next year, but the experience of the Mai Hoa orphans suggests that this will not be easy.
Frightened and angry on that first day, some of the parents seemed heartless, Sister Bao said.
“They were saying the children were going to die anyway, so there’s no need for them to study,” she said. “ ‘If they are going to study, let them do it in the orphanage, and not put our children in danger.’ ”

The Mai Hoa AIDS Center, with its green and quiet grounds, was founded by a Roman Catholic order in 2003 as a hospice for patients in the final stages of the disease. It added the orphanage to care for children of people who died there.

The children are infected as well, Sister Bao said, but are receiving antiretroviral medication.
The buildings behind the classrooms are still a hospice, where a dozen emaciated patients lie on cots.
Altogether, 250 people have died, Sister Bao said, including 90 whose unclaimed ashes are stored behind the hospice buildings. Some of those are the remains of the children’s parents.
So the orphans of Mai Hoa live suspended between the death that fills the space behind their classrooms and the life of a world, just down the road, that still will not accept them.
“The children say they want to go to the other school because they want to have friends,” Sister Bao said. But the 12-year-old fourth-grader seemed to have changed her mind.
“I don’t want to go to that school,” she said. “I already have enough friends here.”

http://www.nytimes.com/2009/10/14/world/asia/14orphans.html?_r=1

Reading 6, Russia:
Russia Is Urged to Switch Its Approach to Curbing Spread of H.I.V.
By THE ASSOCIATED PRESS
Published: October 28, 2009

MOSCOW (AP) — AIDS experts urged Russian officials on Wednesday to scrap their abstinence-based strategy for curbing the spread of H.I.V., saying the country's fast-growing epidemic could be entering a dangerous new phase.

Specialists meeting here at a regional AIDS conference said Russia must adopt successful strategies, citing needle exchange programs and heroin substitutes like methadone for drug addicts. The number of Russians infected with H.I.V. has doubled in the past eight years, and there is evidence that the virus is increasingly being spread by heterosexual sex.

The rapid growth of the epidemic in Russia is in contrast to sub-Saharan Africa and South and Southeast Asia, where prevalence of the virus fell during the same eight-year period, according to UNAIDS, the United Nations AIDS agency.

Russia's chief public health officer, Gennadi G. Onishchenko, told the conference that Russia was "emphatically against" the use of drug replacement therapy. He also criticized programs that exchange clean needles for used ones, saying they may promote illicit drug sales and H.I.V. transmission.

Both types of programs are part of a so-called harm reduction strategy, in contrast to programs that urge abstinence from drugs and risky sex. Russian health officials say they are committed over all to a "healthy lifestyles" focus to improving public health.

Critics say the approach falls short. "International studies show that an abstinence-based message on drug use or sex simply doesn't work," said Robin Gorna, executive director of the International AIDS Society. She said it appeared that in Russia, "ideology is getting in the way of public health care policy."

Since 2006, Russia has increased by 33 times its spending on AIDS programs, part of an ambitious new national health care strategy. It has expanded drug treatment drastically for AIDS patients and is among the leaders worldwide in reducing the incidence of transmission of the disease between mothers and their babies.

But many Russian officials view harm reduction efforts as encouraging criminal or shameful behavior. The position has left the country increasingly isolated, as China recently embraced such programs, foreign AIDS experts here said.

Russia has some highly successful needle exchange programs and free condom programs, several experts said, but many have been paid for through grants from the Global Fund to Fight AIDS, TB and Malaria, an international public-private partnership. Now those grants are being terminated under Global Fund rules, the specialists said, because Russia is too wealthy to qualify for them.

Russian civic groups and other nongovernmental organizations that have distributed millions of free condoms in Russia also lost their Global Fund grants in August, because of the eligibility issue, Ms. Gorna of the International AIDS Society said.

She said she was unable to determine Wednesday whether the Russian government has continued those programs.

Chris Beyrer, a professor at the Johns Hopkins Bloomberg School of Public Health, said Russian officials had "never really embraced" free condom distribution and other harm reduction techniques.

http://www.nytimes.com/2009/10/29/health/policy/29russia.html?scp=1&sq=Russia%20HIV&st=cse

Reading 7, United Kingdom:
Rise in UK HIV numbers continues
Health protection experts estimate there are now 77,400 people with HIV in the UK.

There were more than 7,000 new diagnoses last year - a rise of 6% on the previous year.
Almost a third of people are diagnosed late - meaning they are missing the benefits of early treatment.
Gay men accounted for 41% of new cases, but the Health Protection Agency said heterosexual transmission is steadily increasing too.

The estimated number of people infected through heterosexual contact within the UK has nearly doubled from 540 new diagnoses in 2003 to 960 in 2007. The bulk of the 4,260 new heterosexual cases were acquired abroad.
The overall figure included an estimated 20,000-plus people in the UK who have HIV, but do not know it.

The estimated numbers of infections acquired through injecting drug use and mother-to-child transmission remained low - 180 and 110 respectively in 2007.

Experts said access to testing must be made easier.

Dr Valerie Delpech, head of HIV surveillance at the HPA's Centre for Infections, said uptake of testing offered in genitourinary and antenatal clinics was good - over a million were carried out last year.

Wider testing
But she said more needed to be done to pick up cases of HIV in the community.
Dr Delpech said: "We need to improve availability of HIV testing in a number of healthcare settings, including general practice, to improve diagnosis of this infection. Without this we will not see the reduction in transmission that we need to see, or a further fall in serious disease."
New testing guidelines, backed by the Department of Health, recommend all men and women between the ages of 15 and 59 in some "high risk" areas of England should be offered a HIV test by their GP.

These areas include 25 primary care trust areas inside London and parts of the South coast, the Midlands, Manchester and Blackpool.

And men who have sex with men - a particularly high-risk group - should be tested annually.

HIV HOT SPOTS
- 25 areas of London, including Lambeth, Southwark and Islington
- Brighton
- Luton
- Manchester
- Berkshire
- Blackpool

Based on primary care trusts where the prevalence of diagnosed HIV infection exceeded two adults per 1,000 population

Lisa Power, of the HIV charity Terrence Higgins Trust, said the fact that so many people were unaware that they were infected with HIV posed a serious threat to public health.

She said: "Not only is this dangerous to their own health, but they are more likely to pass the virus on than someone who has been diagnosed."

"Gay men and African people are most likely to have undiagnosed HIV in the UK so we would urge people in those groups in particular to recognise their level of risk and get tested for HIV regularly."

Overall, 31% of people diagnosed last year were diagnosed very late - perhaps years after infection.

Deborah Jack, chief executive of the National AIDS Trust, said the number of people who should be on HIV treatment but who in fact are not was deeply worrying.

"Treatment for HIV has revolutionised the condition and people with HIV can now expect a good life expectancy if they are diagnosed early and take their medication as advised."
Liberal Democrat health spokesperson, Sandra Gidley, said: "These figures are very worrying but not surprising. They are the legacy of a government which has left sexual health services to languish by the wayside.

"It is crucial that we ensure future generations are not now put at risk."

Shadow Health Minister Anne Milton, said: "These figures are of huge concern. They are indicative of a generation that was not exposed to the effective tombstone campaigns of the late 1980s.

"These figures are another example of why we in the Conservative Party think it is so important to commit to prioritise public health spending, so that short-term pressures do not compromise the health of the nation in the long-term."

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