

# Taboos and denial in government responses

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Stopping the spread of HIV should be easy. Indeed, someone looking back in a hundred years' time at the rapid spread of HIV may well be most struck by the discrepancy between the ease with which the epidemic could have been significantly slowed and the obstacles put in the way of doing so.

Those obstacles range from deliberate denial of the potential of the epidemic to spread, to wilful ignorance and a desire to maintain particular cultural and religious values and policies, irrespective of their impact on the epidemic. Just as Thai officials were accused of minimizing the impact of the tsunami on Thailand at the end of 2004 because of fears it would discourage tourists, so a number of governments have played down the threat of HIV for similar reasons. The denial is both of the epidemic itself, and of the specific means by which it is spread. In retrospect it seems extraordinary that Nelson Mandela's willingness to acknowledge that one of his sons died from AIDS in 2005 was seen as an act of moral courage. By that stage South Africa's HIV rate was among the highest in the world, and almost everyone in the country was intimately aware of and affected by the epidemic.

The taboos around dealing with HIV stem from the history of the epidemic, the means of its spread and the fear of recognizing its potential consequences. HIV was originally associated both with stigmatized populations (especially homosexual men and drug users) and also with foreigners: while many in western countries saw it as an African disease, the reaction in parts of Asia was to brand it as an American import and to ban foreigners from places such as bars and nightclubs. Niko Besnier noted: '[It] is widely and believed in Tonga [that] AIDS is divine retribution for transgressions of selected Biblical injunctions, as well as a foreign threat.'<sup>1</sup> Similar comments underlay the vituperative comments about AIDS as an imported disease of western degeneracy in some

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<sup>1</sup> Niko Besnier, 'Sluts and superwomen', *Ethnos* 62: 1-2, 1997, p. 27.

African countries, or Indian claims that AIDS was not a threat because it stemmed from behaviours that were alien to Indian culture.

As treatments for HIV/AIDS have become more effective, there has been a major international debate about the global inequalities that effectively deny these developments to the great majority of those infected. That debate is crucial, but it must not be allowed to distract attention from the current and pressing issue of preventing transmission of HIV. Effective prevention is possible, but it requires a willingness to accept a range of sexual and injecting behaviours that are often stigmatized, criminalized or simply denied. The ways in which HIV is spread, combined with its slow incubation period, which means the great majority of people who are infected do not know they are, has created extraordinary dilemmas for community groups, governments and international agencies seeking to implement prevention strategies.

### **AIDS and sexuality**

It is impossible to divorce a discussion of HIV/AIDS from a broader discussion of the social and political regulation of sexuality. There is no doubt that the pressures to control the epidemic have led to a dramatic increase in knowledge about and discussion of sexuality. (Measuring changes in behaviours is more difficult, but the evidence suggests that behavioural changes have taken place, albeit unevenly across the world.) Research into sexual behaviour, and publicly funded campaigns that accept at least some of the realities of sexual behaviour, are constantly expanding in ways unimaginable without the imperatives of the HIV/AIDS pandemic. No longer is it possible for governments to ignore the issues of sexual health, or the immediate health consequences that the control of sexual behaviour has.

These changes can be seen as both liberating and repressive. A number of countries, most notably Thailand, have sought to ensure that sex work involves 'safe sex', as in the Thai '100% condom' campaign, which has had a pronounced impact on the organized sex trade of that country. Inevitably such campaigns increase government surveillance and regulation, and may mean greater interference in areas sometimes thought of as private. (Sex worker groups have criticized a number of such programmes on these grounds.) Yet such campaigns also open up space for the assertion of new identities and rights, so that homosexuals attacked in Egypt or campaigners for women's rights in Bangladesh can call upon international support for anti-HIV programmes and an underlying language of human rights to bolster their positions.

These developments are both uneven and highly contentious. At the Special Session of the United Nations General Assembly (UNGASS) held in July 2001 the most disputed issue was whether or not to name particular populations, including sex workers and 'men who have sex with men', as particularly affected by and vulnerable to HIV. Increasingly, conservative governments and religious leaders have joined together to block attempts to promote gender

equality, in particular any significant measures to give women greater power in negotiating sexual relations.

Even without AIDS, questions of change in the understanding and regulation of sexuality would be increasingly significant in a globalizing world. The vast shifts in everyday life that accompany rapid industrialization, urbanization and civil warfare inevitably disrupt gender and sexual relations, breaking and remaking family structures and often forcing people to rely upon the sale of sex as their only means of survival. Changes in marriage patterns, increasing teenage sex, rising numbers of single parents and new forms of family structure are occurring across both rich and poor countries in response to dramatic shifts in the nature of the economy. The vast underworld of exploited and marginalized prostitutes in nineteenth-century European cities is matched today in cities across the globe, and sex work is often a major factor in population movements, as hundreds of thousands of people, crossing frontiers in search of a better life (or, in many cases, transported across frontiers against their will), become part of the international sex industry. Advertisements for brothels in Bangkok and Tokyo feature men and women from every continent, and streetwalkers from Rio, Lagos and Calcutta can be found in any large European city.<sup>2</sup>

At the same time the growing affluence available to at least some people in formerly poor countries allows for new choices in sexual matters, as it becomes economically and socially possible for women to establish themselves independent of either father or husband, and to make choices unimaginable to the vast majority of the world's women. In an oversimplified contrast this is demonstrated by the shift from the world of teenage marriage arranged between families to the 'freedom' to choose relationships depicted in television programmes such as *Friends* or *Sex in the City*; and while the latter might seem a mirage to most women, more and more can at least imagine it as cultural images are increasingly dispersed through the reach of global media.

But AIDS has made the sexual possibilities opened up by social and economic change more central to public policy, and concentrated political attention on the 'breakdown' of traditional cultural and social structures, whether these be the idealized nuclear family in the West or more traditional extended families in many non-western societies. One reaction to these changes is a fundamentalist movement to restore the imagined security of tradition, in the various forms of crusades for family values in the United States and movements to impose Islamic law in countries stretching across Africa and Asia. Another is the creation of new identities and communities based upon sexuality and lifestyle, often linking people across national frontiers through the use of modern technology, above all the internet.

Particularly significant in terms of HIV is the rapid growth of homosexuality as the basis for identity and community outside the western world. It is not only in rich countries that gay community organizations helped shape the

<sup>2</sup> I have developed this analysis at length in my book *Global sex* (Chicago: University of Chicago Press, 2001).

original responses to the epidemic. It was organizations based among gay men (and, often, lesbians) in countries as dissimilar as Nicaragua, Malaysia and Hungary that first pushed reluctant governments into taking the new epidemic seriously. Gay communities in various countries invented the term 'safe(r) sex', which first appeared in literature produced by gay AIDS prevention groups in San Francisco and Houston in 1982. Similar groups quickly followed across the western world: early in the epidemic the new messages were dramatized through groups such as the Safe Sex Sluts in Melbourne and the Safe Sex Corps in Toronto. Similar messages are now being disseminated through prevention programmes targeting a broader public across the world, often through imaginative use of theatre, puppetry and cartoons.

Recognition of the vulnerability of men to infection through homosexual contact has meant that international agencies and donors have funded HIV prevention programmes for 'men who have sex with men' (a generic phrase coined to avoid the problem of deterring or excluding men who do not identify themselves as homosexual or gay). Such programmes in turn have assisted the emergence of a larger gay and lesbian movement, which is now found in many countries whose official ideologues claim homosexuality does not exist within their countries. Often there is an uncomfortable balance between those using universal terms of sexual identity and those whose sense of self grows out of more 'traditional' ways of organizing gender and sexuality, as for example the 'kathoey' (trans-gendered men) in Thailand depicted in the film *Iron Ladies*.

Equally, it was the threat of HIV that ended taboos on advertising condoms on television in countries such as Australia and France, if not yet the United States. In other countries, such as Mexico and the Philippines, condom advertising has been a bitterly contested issue, bringing Church and state into direct conflict. Condoms are now regularly used in pornographic films, thus both normalizing and perhaps eroticizing them. In the same way HIV has been a major factor in promoting organization among sex workers, though the great majority of people who sell sex do so without much sense of sharing this identity. Even so, the growth of sex worker organizations in both rich and poor countries is a significant step towards breaking down the worst abuses faced by people who live from selling their bodies.

As it became clear that HIV was spread through sexual contact and needle use, discussion of the epidemic was hampered by an apparently universal squeamishness about discussing such behaviours openly. Yet beyond sexual squeamishness, the desire to deny the threat of HIV seemed in part to grow from a repressed knowledge of just what an escalating epidemic could mean to countries that were already socially and economically fragile. The threat of the epidemic seemed most poignant in South Africa, where the explosion of HIV appeared to coincide with the end of apartheid, leading to a sorry history of denial, evasion and scapegoating by government officials who were unable to imagine and act upon the sort of massive mobilization of resources, human as

much as financial, that HIV demanded. Only a psychocultural explanation can make sense of President Mbeki's bizarre statements about AIDS, and his determination to disprove the existence of HIV as the cause,<sup>3</sup> or of the growing irrationality of Mugabe's regime in Zimbabwe, a country with one of the world's highest infection rates.

The stigma associated with HIV/AIDS has made it extremely difficult for the most effective prevention methods to be employed. The behaviours associated with the spread of the disease embarrass many authorities, who would rather deny the existence of HIV than admit that such stigmatized activities exist within their countries.<sup>4</sup> While epidemiological figures support the argument that HIV is largely spread through heterosexual intercourse, and that young women are increasingly vulnerable in many parts of the world, this is only one part of the overall pattern. The constant stress on HIV/AIDS as a disease of women and children allows governments to pass over realities they find less acceptable: injecting drug use, commercial sex and homosexuality. In a sense we have gone full circle: when the epidemic first emerged in western countries in the 1980s there was concern that depicting it as 'a gay disease' would both foster homophobia and obscure other forms of transmission. Today the emphasis on heterosexual spread means that those most likely to be ignored in prevention programmes are men who have sex with men, who are often not mentioned at all in official programmes and policies.

In the same way, the emphasis on heterosexual transmission, with its politically attractive message that women and children are most at risk, ignores the links between HIV and needle use in some countries that are experiencing the fastest growth of the epidemic, particularly the former Soviet Union. The temptation to apply the most obvious patterns of spread in Africa to other parts of the world leads to inadequate prevention messages and distorted use of resources, with little funding made available to those groups who may be the most vulnerable.

The hypocrisies of official discourse give rise to confused and misleading messages about HIV (governments that refuse to acknowledge homosexuality may convey the message that it does not involve any risk of HIV). In countries as different as Singapore, Chile and Kenya, governments have put limits on prevention campaigns in the name of 'tradition', 'morality' and 'religion', and recent attempts by some African Catholic bishops to soften the Church's total prohibition of condoms were rejected by Rome. At the time of writing there is little reason to expect a change during the incumbency of the current Pope.

<sup>3</sup> See Debora Posel, 'Sex, death and the fate of the nation', *Agenda* (Durban) 62, 2004; Hein Marais, 'To the edge', *AIDS Review 2000* (University of Pretoria, 2000); Liz Walker, Graeme Reid and Morna Cornell, *Waiting to happen* (Boulder, CO: Lynne Rienner, 2004).

<sup>4</sup> See e.g. Michael Blackwell, 'HIV/AIDS in Romania', in M.-L. Foller and H. Thorn, eds, *No name fever* (Gothenberg Studentlitteratur, 2005), pp. 227–55; Michael Specter, 'The devastation', *New Yorker*, 11 Oct. 2004, pp. 57–69.

## Prevention and its discontents

For almost twenty years we have known how HIV is spread and have possessed the techniques to prevent transmission. While treatments are expensive and demand considerable infrastructure, primarily trained personnel, the basic means of prevention are reasonably simple. Use of infected blood in transfusions and mother-to-child transmission are partial exceptions, because they require medical rather than behavioural interventions. But there is little doubt that the major routes of infection are sexual intercourse and needle use. Even if one accepts that slip-ups are inevitable, as the result of human or technical failures, the consistent use of condoms and clean needles would be sufficient to slow the spread of HIV greatly.

Studies of HIV prevention can be divided into those that stress the success of such technologies of control, and those that emphasize the social and cultural barriers that make consistent use of condoms and clean needles very difficult to implement. Even among gay communities in rich countries there is growing evidence of a slow decline in the normalization of 'safe sex', and demands for more authoritarian measures.<sup>5</sup> In more generalized epidemics there are increasingly arguments for what Alex de Waal has termed 'assertive means' and Allen and Heald refer to as 'social constraint'.<sup>6</sup> To prevent infection, such authors argue, we may need to abandon some of the concerns with individual rights and informed consent before testing that characterize the international norms on 'best practice'.

Under conservative political pressure, the earlier emphasis of anti-HIV programmes on condoms and needles has been replaced by what is known as the 'ABC' approach, namely: 'Abstain; Be faithful/reduce partners; use Condoms'. A statement by a group of American experts at the end of 2004 argued that

All three elements of this approach are essential to reducing HIV incidence, although the emphasis placed on individual elements needs to vary according to the target population. Although the overall programmatic mix should include an appropriate balance of A, B and C interventions, it is not essential that every organization promote all three elements; each can focus on the part(s) they are most comfortable supporting.<sup>7</sup>

In practice this position would seem to support moves by the United States such as deleting references on the Centres for Disease Control (CDC) website to studies showing that condom promotion does not lead to increased sexual activity, and that it is highly effective in preventing HIV transmission.

<sup>5</sup> See e.g. Andrew Jacobs, 'Gays debate radical steps to curb unsafe sex', *New York Times*, 15 Feb. 2005.

<sup>6</sup> Alex de Waal, 'Human rights organizations and the political imagination', *Journal of Human Rights* 2: 4, Dec. 2003, p. 490; T. Allen and S. Heald, 'HIV/AIDS policies in Africa: what has worked in Uganda and what has failed in Botswana?', *Journal of International Development* 16, 2004, p. 1152.

<sup>7</sup> David Halperin et al., 'The time has come for common ground on preventing sexual transmission of HIV', *Lancet*, 27 Nov. 2004, pp. 1913-15.

The dangers of simultaneously sending apparently conflicting messages through the 'ABC' model are summed up by Shanti Parikh as follows: 'Uganda's internationally lauded ABC campaign is often interpreted by youth in unintended ways, as they translate the message in ways that position monogamy and condoms as two mutually exclusive options for safer sex.'<sup>8</sup> Ironically, both those who want to promote abstinence *and* those who want to promote safe(r) sex are able to point out the inherent contradictions of the 'ABC' model. But just as many teenagers are unlikely to adopt the first measure, so it is not likely that they will take much heed of the other, or will have sufficient knowledge of the sexual history of their partners to be sure that they can dispense with condoms. Equally, sexually faithful wives are often particularly vulnerable to infection because their husbands have sex with other partners but are unwilling to acknowledge this. The '100% condom' programme in Thailand has struggled to persuade people that use of condoms is necessary in sexual relationships other than with sex workers.

Increasingly, international debate on HIV prevention has moved from the idea of 'safe(r) sex', with its acceptance that large numbers of people will engage in sexual intercourse with more than one partner, which will make them vulnerable to infection, to a stress on the 'traditional' model of restricting sex to intercourse within heterosexual marriage. This is a position that is promoted strenuously by the Catholic Church, the Bush administration and the President of Uganda, and recalls the precepts of school texts from the 1950s.<sup>9</sup> (It also ignores certain customary practices, such as the expectation in some African societies that a widow will have sex with a relative of her dead husband for ritual 'cleansing' purposes.) At the same time, American pressure has also led to a move away from promoting clean needles and replacing this message with one of total prohibition on injecting drug use.

Despite a considerable amount of evidence that 'harm minimization', including the provision of safe injecting equipment, has been remarkably successful in slowing transmission of HIV, this approach has been strongly opposed by American conservatives. In late 2004 the executive director of the United Nations Office of Drugs and Crime (UNODC), Antonio Maria Costa, met with the US Assistant Secretary of State Robert Charles, following which he issued a statement in which he said: 'Under the guise of "harm reduction", there are people working disingenuously to alter the world's opposition to drugs.'<sup>10</sup> Despite winning UNODC over to supporting the expert consensus on harm minimization as a weapon against HIV, the United States has so far been unable to convince the Programme Coordinating Board of UNAIDS, and the first half of 2005 saw serious moves in Malaysia and China, both regarded as hard-line in their approach to drug users, to adopt the principles of

<sup>8</sup> Shanti Parikh, 'Sex, lies and love letters: rethinking condoms and female agency in Uganda', *Agenda* (Durban) 62, 2004, p. 12.

<sup>9</sup> See Mary Crewe, 'A pep-talk too far—reflections on the power of AIDS education', plenary address at the International AIDS Conference, Bangkok, 14 July 2004.

<sup>10</sup> Martin Bright, 'US cash threat to Aids war', *Observer*, 6 Feb. 2005.

harm minimization because of the fear of a growing HIV epidemic. In 2005 the health minister of Malaysia, Chua Soi Lek, was strongly attacked by religious leaders for proposing distribution of condoms and clean needles.<sup>11</sup>

Clearly, abstinence from both sex outside marriage and needle use would, if universal, be the two most effective means of stopping the spread of HIV. The real question is how meaningful such advice is for most people in a world where the realities of choosing to 'just say no' are not straightforward. There is some evidence from Uganda—and Uganda is almost the only country ever cited—that it is possible to reduce the number of sexual partners and raise the age of sexual initiation. It is not likely, however, that abstinence and fidelity alone are effective as long-term strategies, and indeed this has been argued specifically in the case of one study in Uganda's Rakai district.<sup>12</sup> Helen Epstein points out that the 'zero grazing' campaigns addressed to Ugandan men in the 1990s recognized that many men were likely to have multiple partners, and that it was more practical to concentrate on reducing casual encounters, especially those involving young girls. This is rather different from claims now being made by the President's wife that Uganda's success is based upon policies of 'abstinence'.<sup>13</sup>

Other than Uganda, almost every reported 'success' in slowing HIV transmission, whether among homosexual men in the western world or among 'general' populations in other countries, has been based on the widespread adoption of condoms. Knowledge of how HIV is transmitted and access to condoms are of course vital, but even where both of these are present HIV continues to be spread sexually. It is true that condoms can break, can be used without proper lubrication, or can become ineffective through age or exposure to heat and light. But it is also true that, properly used, they remain the single most important tool in preventing the spread of HIV, and the prohibition of their use by religious leaders is directly responsible for thousands of new infections a year. As Norman Hearst and Sanny Chen conclude in their remarkably balanced overview of the evidence: 'Avoiding overstatements about the effectiveness of condoms may go a long way toward eliminating any possible conflicts between condom promotion and other strategies to reduce sexual risk. Presenting people with accurate information about the advantages of condom use is not impossible. Family planning programmes around the world have achieved a similar balance in promoting contraception.'<sup>14</sup>

To rely on abstinence and monogamy is to ignore the messy realities of human life, and the degree to which people will engage in a variety of sexual relations under a complex set of social, economic and ideological pressures.

<sup>11</sup> Jonathan Kent, 'Malaysia HIV measures under fire', BBC News, 14 June 2005.

<sup>12</sup> Bob Roehr, 'Abstinence programmes do not reduce HIV prevalence in Uganda', *British Medical Journal* 330, 5 March 2005, p. 496. See also S. Singh, J. Darroch and A. Bankole, *A, B and C in Uganda: the roles of abstinence, monogamy and condom use in HIV decline* (New York: Alan Guttmacher Institute, 2003).

<sup>13</sup> Helen Epstein, 'God and the fight against AIDS', *New York Review of Books*, 28 April 2005, pp. 47–51.

<sup>14</sup> Norman Hearst and Sanny Chen, 'Condom promotion for AIDS prevention in the developing world: is it working?', *Studies in Family Planning* 35: 1, March 2004, p. 45.

Even advocates of abstinence before and fidelity within marriage need to acknowledge that a great deal of sexual behaviour takes place without full consent. Given gender and economic inequalities, there will be huge power differentials in the ability of people to opt for abstinence, or to insist on the use of condoms in all sexual encounters. Equally, drug use is a matter of complex supply/demand questions: most people who shoot up live in environments where free choice is doubtful.

Imagine a child living on the streets in the slums of Rio or Dhaka or Lagos or Kiev, forced to survive through prostitution and petty crime, often turning to drugs to numb the pain, the fear and the hunger of everyday survival. Telling such a child to use condoms or not to share needles to ward off an illness that may strike many years hence is meaningless. Imagine a young woman, forced by family and community pressure to marry at thirteen and have sexual relations with a man who is older than her father and whom she has never properly met, and assess the possibility of her insisting on his using a condom—if, indeed, she even knows the dangers of unprotected intercourse. Imagine a young man forced into an army or militia, having to flee his family and home to survive, perhaps in prison or a makeshift camp, introduced to drugs as a means of escape; and then imagine the chances that he will have the means or the incentive to reject the short-term euphoria of a hit because the needle may not be clean.

Yet in many parts of the world there are considerable obstacles to providing people with the information and the means to protect themselves through these relatively simple means, and infections continue to rise. These obstacles stem largely from the ways in which sexuality is socially imagined, controlled and surveyed, and the fact that sexual acts, usually regarded as private and intimate, do not take place outside larger social, economic and political structures. There is an economic factor in access to condoms, just as there is to clean needles; but more significant are the complex and multiple taboos that surround attempts to create effective HIV prevention programmes.

There has been a significant shift in United States policy in the last couple of years, as the Bush administration has decided both to increase unilateral assistance for HIV work and to attach a number of moral guidelines to the prevention component of this assistance. A few years ago, the then US Secretary of State Colin Powell was attacked for endorsing the use of condoms by the sexually active. He was attacked not because there is evidence that condoms are ineffective—such claims have been effectively disproved—but because he seemed to be speaking against the position of the moral right, who have subsequently been able to attach most of their assertions to official American policies on HIV and family planning. Currently there is a savage, if not always public, debate between those advocates of a harm minimization approach (who tend to echo the ‘best practice’ consensus developed by UNAIDS) and those who argue for restricting and if possible eliminating behaviours seen as ‘high risk’. In practice the argument becomes one between

those who would emphasize protecting people from infection irrespective of what behaviours they engage in versus those who would proscribe and limit the behaviours themselves.

In those areas of the world—parts of the former Soviet Union and some Asian countries such as Burma and Vietnam—where needle infection is the primary route of transmission, government policies often stigmatize users to the point where any attempt to promote safe injecting is itself criminalized. Even in developed countries that pride themselves on their public health achievements there are remarkable lacunae in areas such as prisons, where transmission by both needle and sexual contact is common. Indeed, in both Russia and the United States one of the single most effective measures to prevent the spread of HIV would be to discharge the great majority of prisoners, who are at far greater risk in gaol than they pose to anyone outside. (There is an unknown percentage of HIV transmission that is caused by the use of unclean needles in health care, particularly in the injection of antibiotics etc., but except in a few countries this is unlikely to be as significant as needle use for illicit drugs.) There are some interesting examples of effective prevention in prisons, often from unexpected countries such as Portugal and Iran. (In the case of Iran, however, there appears to be a much more pragmatic approach to needle use than to sex work or homosexuality.)

### **What makes for successful prevention?**

There is no one formula for successful prevention against HIV, but there is a combination of factors that appears to be somewhat effective: information, choice, and access to basic prevention technologies, including those which women can control. (I am assuming that a vaccine is not a realistic prospect in the near future.) For these to be present requires both government leadership and community mobilization, both of which are more dependent on human capital than on massive development aid. We badly need comparative studies of prevention programmes in, say, Brazil, Senegal, Thailand, Cambodia and Uganda, all of which are sometimes touted as ‘success stories’, before we can be sure what has been the most effective method.

HIV prevention that is not tied to larger social and political agendas will not succeed, and will certainly not be sustainable. As Alex de Waal points out:

In Uganda it was the creation of local democracy and affirmative action for women; in Ethiopia it was the preservation of the army as a functioning institution—drawing on the army’s history as a liberation movement. In these cases, those implementing policies have not shirked from using assertive means to enact behavioural change, including where necessary coercing the minority that is unwilling to behave in a responsible manner. At their core has been the project of giving people something to believe in.<sup>15</sup>

<sup>15</sup> Alex de Waal, ‘Human rights organizations and the political imagination: how the West and Africa have diverged’, *Journal of Human Rights* 2: 4, Dec. 2003, p. 490.

Thus access to treatments for those already infected is an important component of prevention programmes, a principle that underlies the Brazilian response.<sup>16</sup>

For people struggling to survive in the midst of chaos, economic insecurity and threatened or actual violence, the messages of prevention are unlikely to be very successful. People need both to believe they have the capacity to prevent transmission and some incentive to do so that outweighs the immediate desire or need for sex or drugs. While there is some fatigue with the language of empowerment and community capacity, it is only when people are directly engaged with the issues that prevention programmes will succeed. This may mean restrictions on the age of first intercourse, or on commercial sex, but it may equally mean far more direct sex education in schools and large-scale condom distribution. Governments may not always be able to manage such programmes, but they need at a minimum not to work against them. If there is one vital barrier to be overcome, it is the view of many in authority that preserving traditional norms and social arrangements is more important than saving lives.

From the mid-1980s AIDS entered the global imagination, conveyed by powerful images such as the gaunt face of the dying Rock Hudson, the red ribbon and Memorial Quilt, the devastating images of a whole generation dying in African villages and the appearance of the twelve-year-old Nkozi Johnson at the 2000 International AIDS Conference in Durban. Alongside the epidemic we have seen large shifts in our understandings of sexuality, and both greater acceptance of diversity and new cases of stigma and discrimination. Effective mobilization against HIV requires specific and frank programmes that target different forms of behaviour, alongside a broader commitment to challenging those forces that seek to restrict sexual behaviour and discussion in the name of preserving culture and morality, and in so doing only promote greater suffering and death.

For the last 20 years we have known both the technical means for preventing the spread of HIV and the larger social contexts within which they will work. There is nothing new about calling for greater political commitment, more resources, support for community-based action, and the breaking down of stigma, ignorance and denial. Yet after 20 years we still regularly hear stories such as this, from a pioneer of HIV and gay rights activism in India:

A young drop-in at Humsafar [Mumbai] tells of visiting the G.T. Hospital [one of Bombay's bigger teaching hospitals], where a doctor asked him politely how he got infected by HIV. When the kid told him the truth [i.e. though anal intercourse] the doctor says—after the sonography—what's the use of guys like you coming here? You deserve to die!<sup>17</sup>

<sup>16</sup> See Tim Brown, 'Integration of prevention and care', plenary session, 7th International Congress on AIDS in Asia and the Pacific, Kobe, 5 July 2005; Stephen McNally, *Prevention and treatment: you can't have one without the other*, occasional paper (Melbourne: AIDS Society of Asia and the Pacific, 2004).

<sup>17</sup> Personal communication from Ashok Row Kavi, 5 Aug. 2005.

Twenty years into the epidemic, such attitudes reveal how far we still have to go. What might once have been excused as ignorance is no more than prejudice and deep intolerance, and in a world of growing fundamentalism and declining respect for diversity these are shaping up as the greatest barriers to a successful effort against HIV. Terrorism, and the war against it, are likely to create a world in which HIV will spread unchecked in ways we failed to foresee even a decade ago.