EDITORIAL/REDAKSIONEEL

AIDS 2000 – A CONFERENCE FOR CHILDREN

'This was a conference to bring your children to.' These were the words of Dr Stefano Vella, secretary of the International Aids Society at the closing ceremony of the AIDS 2000 conference. Unusual words for a conference concerned with a sexually transmitted infection. But then HIV is much more than a sexually transmitted disease and this was no usual conference.

Although the opening ceremony officially launched the meeting on Sunday 9th July, the beginnings of the Durban conference dated back some years. The two previous International AIDS meetings in Vancouver and Geneva coined 'One world one hope,' and 'Bridge the gap' as conferences themes. These messages were intended to inspire and mend the inequities and disparities between North and South, but these objectives were not achieved and the meetings were punctuated by demonstrations and controversy. The decision to stage the millennium conference in South Africa was strongly contested and not without opposition. Why was there such resistance?

Some believed that Africa simply could not host a meeting which was technically demanding and on such a scale. Other reasons, however, were lurking in the shadows. The world's dominant countries and scientists would relinquish control of the intellectual and political agendas in the HIV/AIDS world. What would hold centre stage? The implementation challenges and cultural complexities of the epidemic in the developing world, or the pharmacological opportunities of highly active antiretroviral drug therapies for a select minority in the highly industrialised countries of the North? There were threats of a boycott, not only as a response to these contentions, but also in protest against the S. African government's ambivalent position on HIV. In the end 12 473 delegates attended. 3 000 each travelled from Europe and North America, about 4 500 came from the African continent and 2 000 from the rest of the world. 1 400 scholarships were given, mainly to African delegates, to attend the meeting. But the proof was in the pudding! Dr Vella concluded his passionate account of the conference with the simple statement that "they were wrong". The critics and sceptics with their noses out of joint had missed a landmark meeting which consolidated knowledge and inspired those with flagging energy to rededicate themselves to finding solutions to this most awful disease.

The scientific programme was organised into 5 tracks: a) basic science; b) clinical science; c) epidemiology, prevention and public health; d) social science; and e) rights, politics, commitment and action. In addition, a community programme was included for the first time which consisted of a two-day community forum, symposia, skills-building sessions and debates. The number of presentations precluded attendance at more than one or two themes and hence I will focus on the two areas of personal interest: mother to child transmission (MTCT) of HIV, and voluntary counselling and testing.

The therapeutic possibilities to reduce MTCT have been dogged by problems of implementation and the theoretical *vs* real cost implications. The conference did not add much new knowledge to either of these discussions, but consolidated the considerable data that are known and clarified the challenges for the future. There are several drug interventions, most notably the short course zidovudine (AZT) and nevirapine regimens reported in the Thailand and Uganda studies respectively, which are clinically beneficial and are cost effective. In trial settings both

interventions can reduce MTCT by 50-60% and in theoretical modelling are cost effective for implementation at programme level in developing countries. The practical difficulties of applying even these simple regimens, however, were illustrated by reports from pilot programmes in several sub-Saharan countries: the failure of health care staff at government clinics to provide antenatal HIV testing because of heavy workloads; the reluctance of pregnant women to accept testing or to return for results out of fear of the personal consequences; the resistance of HIV-infected women to use formula feeds, even when supplied free of charge, because of the risk of disclosure by adopting a practice which is not socially or culturally normal; and the hesitation of governments to act decisively because of insufficient data on long-term therapeutic effectiveness and affordability. In spite of these obstacles the message was clear. Effective interventions are available and cheap. The difficulties of implementation are not to be belittled. These, however, are not an excuse for inaction. The detailed answers will be provided in the process of moving forward and not by further debate on the height and breadth of the hurdles ahead.

The ethical and practical quandary of offering voluntary counselling and testing (VCT) for HIV has brought clinical and social scientists together in an unprecedented way. Without knowledge of HIV status therapeutic interventions lie idle. Without access to effective interventions there is little perceived benefit for an individual to seek knowledge of their status. VCT has, to date, been considered by most clinical scientists, if not other programmers, as simply the doorway to other interventions. Unfortunately, there were few new offerings at the conference. Innovative models for offering VCT to rural communities and to pregnant women at antenatal clinics were sadly lacking. The use of rapid HIV testing and immediate return of results was perhaps the most creative development, but this was more a logical step rather than a new concept. But if there were disappointments around new ideas, there were also enlightenments that were significant. VCT came of age when it was presented as an effective intervention in its own right with the realisation that knowledge of HIV-infected status produced changes in respect of sexual behaviour and family planning. This awareness and also the availability of affordable interventions particularly for MTCT must renew the vigour to develop effective models of counselling that acknowledge the workload of health care workers and the dynamics of small rural communities.

While the scientific programme was comprehensive and in some respects plotted the course ahead, it was the plenary sessions which most roused the emotions and stirred the hearts of those listening. In his address entitled 'Breaking the deadly silence,' Judge Edwin Cameron berated the institutional and individual indifference that permits prejudices to continue and gives an unimpeded course to the stigma around HIV/AIDS. He articulated his own experience following disclosure of being HIV-infected and the injustice of preferential access to antiretroviral treatment and care in sub-Saharan Africa. He likened the silence surrounding HIV/AIDS to that around the holocaust in Europe, the genocide in Rwanda and the ethnic cleansing in Kosovo. His words cut through the pretence and respectability of international economics and humbled the most informed observer. Gita Gupta presented a paper on the dangerous confusion which hovers around gender roles, culture, underlying values and practice. She described how it is easy to misunderstand the practices as representing the values which underpin a culture, when in fact they may be quite distorted representations. Men have more frequently than not been depicted as the culprits of the HIV epidemic. Gupta argued not so much in defence of men but that we need a better understanding of the roles that are being acted out and to appeal to the formative values of communities most affected by the epidemic.

So, what future was predicted for HIV and the respective role players? HIV has a healthy future in the short to medium term. Governments, both North and South, need to be confronted with their responsibilities: unequivocal support for and commitment to preventive programmes is needed in the countries most affected. Economic responsibility and action are needed from the countries with the resources to do so. Geoffrey Sacks (Harvard) reported that the New York stock exchange had realised gains of 20 trillion dollars since 1996. A fraction of this would make a substantial difference to the epidemic. The motivation to commit such resources, however, is not simple philanthropy, but fiscal necessity and investment prudence on a global level. Drug companies need to be reined in and trade and marketing regulations adjusted to serve the needs of the greater community.

What were the lighter and special moments of the conference? Seeing the staff of Futhi's Fast Food stall dancing on the tarmac in their chef's aprons and hats must rate as one of the most fun events; observing people living with HIV/AIDS 'wearing' their status (t-shirts) in the company of thousands without fear of being shunned or rejected was perhaps the most poignant; listening to an Isicathamiya choir sing their way into the hearts of delegates from behind a fence and raise their school fees was the most entrepreneurial; hearing Nelson Mandela's plea for rhetoric to become action was the most inspiring. Durban looked fabulous. The International Conference Centre was outstanding. It was a success for the city.

While the programme had the appearance of a standard offering, everything else around the conference set it apart from the other HIV meetings each year. That it was set in Africa undoubtedly bestowed upon it an unparalleled focus and relevance. That sense of timing and opportunity slowly but surely seized the heart and soul of this conference. While unbridled zeal will not change the world, some of the elements needed to spur change and action around this global threat were unquestionably present. Even if there were not many children at this conference, the well-being of future generations was certainly well served and the challenges were squarely set before all those who were present and who had chosen to be absent.

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