XI INTERNATIONAL CONFERENCE ON AIDS

VANCOUVER, CANADA, 6 JULY 1996

SATELLITE SYMPOSIUM ON HIV PREVENTION

HIV PREVENTION: TEN VERITIES OF VANCOUVER

The Honourable Justice Michael Kirby AC CMG

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DEFEND IN ALL DANGER

We meet during the XI International Conference on AIDS. During the conference, most attention is likely to be focussed upon new therapies. For the first time in many years, there will be hope in news concerning treatment combinations which promise to arrest or retard the development of AIDS in those infected with HIV. Rightly, there will be great excitement about these developments. But this satellite symposium has helped to put them in proper context. So great are the costs involved, and

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so significant the difficulties of getting access to the new drugs, that most of the world will be left completely untouched by them. For the millions of people living with HIV throughout the world, but particularly in developing countries, the news of wonder therapies from Vancouver will leave a bitter taste. For most people in the world, prevention of infection is the only sure way to avoid the sad journey of HIV/AIDS. That is why this symposium has been, in many ways, the most important of the Vancouver conference. It is important to bring its message to the participants in the other sessions for there is insufficient attention to prevention in the conference programme. I have organised this report on our deliberations in terms of ten themes. They do not have the status of commandments. But they are verities which we can share with those in Vancouver, and those far away, who are addressing the vital problem of prevention.

I wondered why the task of summation had fallen to me, a judge, rather than to a medical or social scientist, or to someone with greater expertise about the epidemic. It occurred to me that a judge had been chosen because, for centuries before HIV/AIDS came along, judges have been locking up gays, drug users, sex workers, adulterers and fornicators in an attempt to prevent their activities and to secure behaviour modification. The attempt has only ever been partly successful. Laws and commandments tend to disappear into thin air at moments which are critical to an individual's pleasure-seeking or identification. Perhaps a judge was chosen out of a recognised need for

dispassion. HIV/AIDS enlivens passions because we see so much suffering and courage. Perhaps I was asked so that the summing up would be as to a jury. But here the jury speaks a thousand tongues and resides in hundreds of lands with different cultures, laws and customs. How can we devise an instruction that will be universally apt to preventing the spread of HIV/AIDS?

On my arrival in Vancouver I followed the course which I took ten years ago when I attended my first international conference on AIDS in Washington, DC. There, I went to the National Cathedral to join an ecumenical service to pray for early respite from the epidemic, the quick discovery of a vaccine and the speedy development of wonder drugs that would prevent the affliction spreading to unsuspecting populations on every continent. Alas, the prayers of a decade ago were not heeded. But still there is a need for prayer and meditation. The wellsprings of the motivation of all who are responding to HIV/AIDS is ultimately a spiritual concern for brothers and sisters in every land. So here, in Vancouver, I renewed my prayers. Close to this meeting place is the Cathedral Church of Christ Church. In many ways, it is a church more suitable for prayers in the face of AIDS. It is small and humble - no soaring Gothic turrets but a plain church, doubtless built by early settlers to thank God for their good fortune: living in a part of the world most richly blessed by nature.

As I sat in that quiet place thinking of precious friends whom I have known and who have been lost in this epidemic - faces and persons, not statistics - and reflecting on the valiant carers, struggling families, determined scientists and many brave friends, my eyes fell upon the *Book of Common Prayer*. I opened it at the section on the Visitation of the Sick. There could be found the strong and confident language of the English church reformers of the 16th century. Long before AIDS. The prayers were written at a time when plague and pestilence were a common experience of humanity and generally thought to be a message of an angry God, displeased with the sins of His people. As I read the prayers, I realised that the cadences and beauties of the language were suitable for all faiths - not specifically Christians. Sickness is a common experience of all humanity. The fear of death is universal. The first prayer on the Visitation of the Sick reads:

> *"God of all grace and power, behold, visit and relieve this thy servant. Look upon him/her with the eyes of thy mercy. Give him/her comfort and sure confidence in thee. Defend him/her in all danger and keep him/her in perpetual peace and safety."*

Keeping the billions of the world in peace and safety, free of the awful burden of living with HIV/AIDS, is what this satellite symposium is about. Whilst prayer and spiritual reflection are important, we must add to them practical action and energetic conduct. During this session ten principal lessons were

discerned. Doubtless there were many others. But let us reflect upon the ten.

TEN VERITIES

1. *Prevention is a vital part of the global strategy to address HIV/AIDS; yet it is neglected.*

The opening moderator, Dr Ronald Valdiserri of the National Center for HIV, STD and TB Prevention in CDC in the United States, identified the principal aim of the symposium. It was to assert and claim the part of prevention which the programme of the Vancouver Conference substantially neglected. Our task, he declared, was to draw to the attention of all participants in the international conference in Vancouver the vital importance of prevention as the only viable anti-HIV strategy available for most people in most countries of the world. Dr Tom Coates of the Center for AIDS Prevention Studies in the University of California, United States of America, was so upset at the neglect of prevention in the principal programme of the Conference, and at the large moneys being spent by drug companies on promoting their new therapies, that he called for revolution - a reverberation heard in a number of the workshops. He asked the delegates to march on the drug companies and their splendid receptions and to point out that the moneys being spent on pharmaceutical promotion at parties could be better

devoted to promoting prevention and saving lives in developing countries.

The neglect of prevention demands explanation. Is it because prevention is thought too problematical and unscientific? Is it because we despair of having real impact upon the mass of human behaviour in millions of unpredictable circumstances? Is it because we have become so accustomed to the magic of 20th century science that we thirst for the therapeutic breakthrough? Is it because there will be no Nobel prize for the patient, steady work of prevention? Is it because the media wants the "silver bullet" and quickly becomes bored with the unexciting and seemingly unheroic labours of prevention? Dr Jacob Gayle, Chief Global Division on HIV/AIDS of USAID, reported on the workshop on working with organisation and societal change. He emphasised the need to mobilise the mosaic of disciplines to sustain prevention work. But with so many disciplines involved, how can we ensure cooperation and coordination and the avoidance of territorialism? How can we guarantee that identified people take responsibility for leadership in the matter of prevention?

These are the quandaries that have assigned prevention to a low priority in the Vancouver conference. Yet for many in the watching world, prevention is all there is standing between them and infection with HIV.

2. *Prevention can never be totally effective.*

Dr Coates asked the blunt question in his plenary address. If prevention works, how come there are so many new infections?

The answer to this question he provided himself. No law and no prevention programme is ever totally successful. We must realise the imperfections of prevention strategies in order to appreciate where they work and where they break down. To adopt a criterion of total effectiveness is to engage in dangerous self-deception. Any behavioural science, studying the conduct of human beings, is necessarily imperfect, concerning as it does unpredictable conduct subject to countless variables.

All of this may be given. But Dr William Rowe, Director of the School of Social Work at McGill University in Canada cautioned that there is a tendency in society to hold behavioural scientists to unachievable results. It is not a failure of prevention strategy that a percentage of people continue to present with sero-conversion. Prevention strategy is concerned with opportunity costs. What are the opportunities that are lost by failing to adopt effective prevention strategies? This is the true measure of the neglect of effective prevention. The rapporteur for the workshop for prevention evaluation, Ms Ana Luisa Liguori, of the MacArthur Foundation in Mexico, gave us heart when she reported that although prevention strategies may not

be perfect they still do have an impact. Seemingly isolated efforts add up to national and global life-saving. These efforts must begin somewhere. This is not a time for despair but for resolution.

3. *Well targeted prevention does have an impact.*

This report leads naturally to the third conclusion. The utility of prevention measures can be demonstrated in many cases. Dr Coates showed how, in those parts of Uganda where prevention strategies have been prosecuted, sero-conversion rates are down. There is etched on our minds the graph of the rates of sero-conversion in Thai army recruits. It showed the rapid rise in the years prior to the adoption of concerted national strategies for AIDS education. And then an equally dramatic fall-off, apparently showing the impact of prevention strategies upon young men entering military service.

Dr Coates also reported on the success of the syringe exchange programme in Australia where sero-conversion amongst IV drug users is about 1%, much lower than that in other parts of the world where the strategies of prevention have been slower to arrive. Reports on sero-conversions amongst commercial sex workers ("CSWs") in Bombay show the impact of education combined with the wherewithal to afford empowerment and to provide protection.

Ms Noerine Kaleeba, Founder of the AIDS Service Organisation ("TASO") in Uganda, now of UNAIDS, stressed that effective prevention strategies have to be carried on in an environment of care and support. Cold educational messages and the provision of pamphlets which people can barely read, may make some feel that a useful initiative has been taken. But such strategies are unlikely to have a real impact.

Dr Rowe reported on the newly targeted groups in which strategies of prevention were being experimented with. Amongst those mentioned in his workshop were the strategies addressed to African American teenagers in Mississippi; to illegal substance users in Liverpool, England; and to groups exposed to risks in Ghana and Uganda. Dr Rowe emphasised the need to personalise the risks so that the subject of the instruction can see the utility of the information and identify personally with the problem of HIV infection. Ms Liguori reported on the study by Dr Kyung-Hee Choi (USA) on preventing sexual transmission amongst gay men in the United States. The variables in successful prevention include the intensity, duration and timing of the communications. Even simple things cannot be assumed. Detailed instruction in how to use a condom is necessary for effective strategies. Just giving out condoms, although a first step, may not succeed.

4. *Prevention deserves more funding.*

Given that the strategy of prevention is so much more cost-effective then any treatment currently on offer, Dr Coates lamented the pathetically small amounts being spent on prevention. This is not only true of the United States where the expenditure on prevention last year was $3 per person per year. In sub-Saharan Africa it amounts to no more than 3 cents per person per year. And in both the United States and sub-Saharan Africa the investment is declining. Dr Coates suggested that the 40,000 new infections in 1995 in the United States could have been reduced by at least a half had there been sufficient expenditure on effective prevention strategies. The cost to the national economy alone, not to say the suffering, distress and grief, of 20,000 unnecessary sero-conversions should be sufficient to convince political leaders of the need for effective prevention strategies. But these cost money and require bold political decisions. The point to be made is that not doing the vital work of prevention also costs money.

Ms Kaleeba described the increased condom use in Uganda and how this was having its impact. But how are condoms to be obtained and will they be appropriate to, and accepted by, the population to which they are supplied?

Mr Greg Williams, an economist of the Canadian AIDS Society, suggested the need for new ways to promote

prevention, eg by tax reforms designed to promote stable gay relationships and to recognition of these relationships for taxation and other purposes. Although such reforms may cost society a little in tax revenue, they could, in the long run, promote the environment in which the spread of the virus is diminished. Dr Rowe recorded reports in his workshop of the falling investment in prevention in San Francisco. It will be a dangerous message of the Vancouver conference if a general belief in the availability of effective therapies reduces the pressure to prevent the spread of the virus.

5. *Particular techniques of prevention need to be studied.*

An important message of this symposium concerns the variety of prevention techniques that have been used with effectiveness in different societies faced by HIV/AIDS. Amongst the strategies mentioned were:

(1) The involvement of couples in education about prevention. Dr Coates described how this had been tried successfully in Uganda. Ms Kaleeba said that 90% of people informed of their sero-conversion shared the knowledge with a partner or a friend. HIV/AIDS prevention needs to be community based and to involve all who are at risk and their loved ones.

(2) The special role of women in prevention and in HIV education was stressed by Ms Kaleeba. It is women who give most of the help to those who are infected, particularly when they are sick. The majority of carers are women. The empowerment of women is a constant theme of AIDS conferences. Women are the family educators. Good HIV prevention strategies will be targeted at them.

(3) Promotion of condom use is a major strategy being ventured in Uganda. Ms Kaleeba explained the "ABC" strategy adopted by TASO. The first rule is abstinence. The second is to be faithful to a single sexual partner. And the third rule is to use a condom if A and B fail. Simple messages of this kind, repeated often and targeted at particular groups may eventually succeed in effecting behaviour modification.

(v) Reducing other STDs which act as vectors for the spread of HIV is another strategy which has been adopted in developing, as well as developed, countries. HIV/AIDS must not be seen in isolation but as another sexually transmitted disease that requires a non-judgmental community approach if prevention is to be effective.

(5) Ensuring the safety of the blood supply seems an elementary requirement. In developed countries this is now largely taken for granted. But not so in developing

countries. The urgent priority of protecting the blood supply from HIV still needs vigilant attention and foreign assistance if this means of the spread of HIV is to be controlled.

(6) It is essential that people living with AIDS should participate in the design of strategies concerned with HIV prevention. This was emphasised by Dr Gayle reporting on his workshop. But it is also essential to involve commercial sex workers and drug users. Obtaining spokespersons for each of these groups is more difficult because of the stigma which society casts upon them, frequently reinforced by criminal sanctions. Yet if prevention strategies are to be effective, it is vital that those primarily at risk should be consulted and involved.

(7) Introducing instruction into the school curricula is a particular interest of Dr Rowe. Again this seems an elementary requirement. But it tends to run into conflict with certain notions of parental rights. Yet no parent has a right to prevent a child gaining information that might save the child's life. An interesting discovery in the survey of Mississippi teenagers was that, contrary to expectations, the overwhelming majority of parents consented to their children obtaining the necessary prevention information.

(8) It is imperative to tackle cultural and religious barriers that block prevention messages getting through to the targeted groups. Dr Rowe reported on investigations in Mexico which indicated the cultural and religious impediments there to the spread of information about HIV prevention. Those impediments exist in many lands. They must be addressed if realistic programs of prevention are to be set in place.

(9) Prevention strategies must tap into existing mechanisms of social support. Ms Marina Mahathir, President of the Malaysian AIDS Council, reporting on the workshop on working with communities, described the way in which clans and tribes in Uganda can be mobilised to reinforce HIV/AIDS prevention messages.

(10) Decriminalisation of homosexual conduct between consenting adults and of at least some personal drug use, was another suggestion that came from the same workshop. The available research suggests that the people involved in illegal drug use tend to be different from those involved in sexual transmission of HIV. Geno-type studies have suggested that there are, in fact, two global epidemics. (See *AIDS in the World II*, Boston, 1996, at 63-65). Whether this is so or not, the audiences appear to be different. The messages must equally differentiate

between those who are being addressed. One consequence of the strategies designed to prevent the supply of illegal drugs entering the world market has been the fall-off in opium smoking in the Yunan provinces of China and the increase in heroin injection, with its attendant risk of spreading HIV. (See *ibid*). The interaction of laws and drug strategies upon the cause of the HIV/AIDS epidemic is at last gaining attention in the international debate. One of the important themes of the Vancouver conference is the impact of drug use on the epidemic and the need for courageous, new strategies on drugs.

(11) There must be a multi-sectoral approach to HIV/AIDS prevention. Thus it is necessary to address a wide range of connected issues such as drug use, health rights, poverty, women's rights and homosexual rights. This was one of the points made by Ms Mahathir, reporting on her workshop.

(12) The messages must be culturally sensitive such as to convince the particular group being targeted. This was a point made by Dr Alex Wodak (Australia) to one of the workshops. The sensitivity called for is not only of an ethnic, religious or linguistic kind. It also includes sensitivity to the cultural norms of isolated and often

stigmatised and fearful groups, eg injecting drug users, rural patients; haemophiliacs, etc.

(13) Methadone treatment and equivalent strategies for dealing with the dependence of drug users must also be put in place. It is essential to make the point that drug users are citizens too. The basic problem in many cases is a medical one of addiction. Isolating, stigmatising and then punishing them can have counter-productive consequences for the spread of HIV. This is demonstrated by contrasting the rates of sero-conversion in those countries which have adopted a strategy of promoting HIV prevention amongst drug users (United Kingdom, the Netherlands, Australia and Switzerland) with those countries which have not (eg United States of America, Italy, France and Spain). The levels of sero-conversion amongst injecting drug users in the latter countries is substantially higher than in the former. This is proof-positive that well targeted, sensitive strategies of prevention can work. But it is also necessary to target political leaders. Some who accept that the strategies can work are unwilling to adopt them because of their anxiety about the consequences for the "war on drugs".

6. *Prevention at the micro-level adds up to global gains.*

Dr Coates emphasised in his plenary address that those who are involved in HIV prevention must continue with their efforts, realising that work at a local and community level adds up to a real impact on the global spread of HIV. He drew attention to the contribution thirty years ago by Hamilton Holmes at the University of Georgia in standing up for the rights of African American university students. The contribution of one or two students, supported by wise political decisions and courageous court judgments, turned the tide. So it can be with HIV/AIDS. We must focus upon saving individual lives whilst advocating the deeper changes which will have consequences for thousands and millions.

One of the dangers which faces communities and their political leaders in the field of HIV/AIDS is that statistics have no identity. In most areas of social change it is essential to put a face on the problem. That is why people living with AIDS (PLWAs) must always be involved in prevention strategies. They, their carers, families and loved ones bring home to all concerned the importance of this epidemic to individual human beings. When one reflects upon the changing direction demonstrated in the graph of HIV prevalence amongst Thai military recruits, the point must be made that the turn of the graph began somewhere. It commenced with individual instruction entering the consciousness of individual people.

Global trends depend upon action at the individual and community level. Whilst progress may sometimes seem to be slow, it can be achieved. It is certainly cost effective.

7. *Prevention is specially important in developing countries.*

It is this truth that lays emphasis on the importance of this symposium. Most people of the world live in developing countries. Most of the HIV/AIDS in the world is in developing countries. Most of the work of prevention must therefore be done in developing countries. The people of those countries will never be able to afford the drugs that are being reported with fanfares to the Vancouver conference. In all probability, at least for a time, they will be unable to afford the pioneering vaccines when they come on the market. Accordingly, the only effective strategy available to developing countries is prevention. Yet it is precisely in developing countries that much of the resistance to the promotion of knowledge and means of protection is to be found.

Ms Kaleeba stressed the importance of simple messages, often repeated: such as the ABC rule in Uganda. She also emphasised the need to balance the rights of individuals with the duty to the community and the duty to protect oneself. Many participants welcomed this expression of duties as well as rights. But care must be taken lest the talk of duty gives rise to proposals for ineffective criminal laws or to reinforcing punitive

attitudes which are counterproductive in preventing the spread of HIV/AIDS.

Ms Mahathir, reporting on her group, emphasised the need to work at the grass-roots and with individuals and organisations many of whom would not have a sophisticated understanding of the epidemic or of the virus. Tailoring strategies to be effective in the myriad of developing countries, operating in a context of social, religious and cultural sensitivities, presents an enormous challenge to those concerned with HIV prevention work. But the challenge must be accepted for otherwise the virus will spread unimpeded and cause personal and economic devastation.

8. *Prevention requires identification of particularly vulnerable groups.*

A number of the participants emphasised the need to identify and then target with effective prevention strategies, groups which are particularly vulnerable to the spread of HIV/AIDS. Dr Coates mentioned drug users and women as particular targets. But he also reported research on sexually abused children. Doubtless because of low self-esteem and other social conditions, much higher rates of sero-conversion are found amongst children who have been sexually abused than amongst those who have not. Ms Kaleeba emphasised the need to reach out to families with members living with AIDS. The

need to overcome stigma and to emphasise the worth and value of PLWAs was a repeated theme of her plenary address.

Mr Greg Williams emphasised the need to target indigenous peoples and also homosexual and bisexual men. Common amongst the target groups, according to Mr Williams, are features of disempowerment, economic disadvantage and the neglect of health needs. Often the vulnerable groups are the victims of economic restructuring which is a feature of developed countries at this time.

Amongst other vulnerable groups identified were haemophiliacs (Dr Gayle); refugees, immigrants and ethnic minorities (Ms Mahathir) and rural as well as urban populations (Ms Kaleeba). Within the specially vulnerable groups, subgroups are now being targeted by well-designed strategies. As Dr Rowe reported on his workshop, these include African American teenagers in Mississippi and illegal substance users in Liverpool, England. Giving information to these subgroups is not enough. To be effective they must be educated with skills that can sustain them and effectively promote behaviour modification.

Ms Liguori reported that it was a common theme of her workshop that strategies addressed to specially vulnerable individuals and groups must be based on sound ethical principles and informed by the basic rules concerning fundamental human rights.

9. *Prevention needs to be based on sound empirical data.*

Very early in this epidemic I learned from one of its heroes, Dr June Osborn (United States), of the imperative need to base all strategies upon sound scientific data. This remains a fundamental truth of the epidemic today. Ms Mahathir reported from her workshop on the repeated expression of the need for more empirical data upon the strategies that work and the variables that increase, or diminish, effectiveness of prevention programs. Dr Rowe emphasised that it was important to realise that some strategies will fail. We must learn from the successes; but also from the failures.

Adopting an approach to prevention strategies based upon sound empirical data, will help us to extrapolate and to see the connections of HIV penetration with other social disadvantages, such as poverty, homelessness, motor vehicle and other accidents, etc. A study of the empirical data will also illustrate the sub-epidemics which together make up the global AIDS pandemic: amongst men who have sex with men; intravenous drug users; heterosexual couples in sub-Sahahran Africa etc. In order to design prevention that works, it is essential to know, with precision, the target, and then to address that target with sustained and differentiated effort.

10. *Prevention also needs to convince political decision-makers.*

The final common theme of this symposium was the importance of breaking through to the political will, without which prevention strategies will only have a limited impact. Ms Mahathir reported that this was a strong message from her workshop. Dr Gayle lamented that, although politicians in the United States had received good advice and sound data, they continued to make poor decisions. Attention therefore switched to those countries where progress had been made in the field of prevention. What was the ingredient in Uganda, Thailand, Australia and Canada which helped promote sensible political policies? Giving information and even opportunities to Ministers was not enough. This was demonstrated in 1995 by the international HIV/AIDS conference held in Chiang Mai. Very few Health Ministers of the region attended. Some participants urged that the politicians who should be addressed were not always in the national or sub-national government. Sometimes they were at a local level as Mr Jonathan Derricott reported in the case of Liverpool, England. There, local politicians, police and pharmacists have cooperated in a thoroughly practical way to bring down the rates of sero-conversion amongst illegal substance users. Building trust and securing dialogue with national leaders is an urgent necessity but not one easy to obtain. There was a general consensus that this problem

requires more attention if prevention strategies are ever to obtain the political support and funding they deserve.

Ms Liguori reported that her group considered that one factor that might attract political interest and support was an explanation of the economic costs of *not* supporting prevention. Although the human rights and individual dignity arguments were vital, politicians and bureaucrats today all too frequently respond only to the siren call of economics. If this is so, workers in the field of HIV prevention must learn to speak the language of economics. The formula is simple. The costs of an infected citizen (including the opportunity costs of educational investment and productive labour foregone) outweigh many hundred-fold the costs of prevention that might reduce the rates of sero-conversion. Politicians, at least in democratic societies, seek to be popular. For them, HIV/AIDS presents a number of pitfalls and difficulties. Prevention strategists must give careful attention to the ways in which their lessons can be made more acceptable to political decision-making. This was a major message from several of the workshops of this symposium. It requires reflection.

CLOSING THEMES

Dr Valdiserri, at the outset, urged that humour was necessary to planning a conference, particularly one on HIV prevention. We had a little humour, but not much. The theme

of the symposium was intensely serious and many have suffered too long and too often for laughter.

Ms Kaleeba, in the opening plenary, mentioned the strategy of abstinence. She suggested that the participants had all "abstained" since they arrived in Vancouver. This drew nervous laughter from the participants which I found it hard to interpret.

Dr Gayle, after listing a savage attack on the suggested failures of the Congress of the United States of America to tackle prevention in that country more effectively, added, just a trifle too quickly "Remember, I'm just quoting". He was a faithful rapporteur for his group.

Dr Coates told of a conversation on a plane with an employment lawyer. Hearing of the suggested need for respect for sexual diversity, the lawyer exclaimed that he had never heard of that. "Honey, you're sitting beside it", was Dr Coates' disarming response.

Many were the memorable phrases that hang in the air at the end of this symposium. Dr Coates told us "AIDS is here to stay". But he urged "It's time for revolution. It is unconscionable that the majority of satellite meetings are sponsored by the drug companies". He invoked the words of Gor Vidal: "The solution to the problem of life is - more life". An aphorism apt for HIV prevention.

Ms Kaleeba began her address most memorably by inviting the spirits of those who had lived with, and died of, AIDS to join us in this symposium. When she mentioned the word "love" her rich voice dropped. I think the spirits responded. She reminded us that unless we restore togetherness in the struggle against HIV, we will be "devastated - even beyond the devastation of death".

Mr Williams dropped momentarily his clinical economist's facade and confessed that he never thought he would hear himself say that the time had come to recognise, in law, the legitimacy of gay marriage and tax reform to protect gay couples. Any nation which fails to invest in its health is a nation in decline.

Dr Rowe reminded us that "effective HIV prevention programmes can be infectious". That is the only kind of infection we need. And he quoted one patient whose words had left a mark on the participants of his workshop: "I went on thinking that it would all be over soon. A little medication is all that would be needed. We would all wake up and find ourselves at the end of this bad dream. I was good. I was good. I was good. I took my medication. But a certain time was reached when I realised I was not going to be a survivor". Millions are today facing that realisation. Most have absolutely no medication. That is why this meeting was so important.

Ms Mahathir reported on the success of some of the Australian strategies. For once the government really did convince the target groups. "We want you to live". For once, they believed the government and did not even think that its wishes were based on a need for their taxes. Other governments must have that conviction. They must convey it to the people whose conduct must be changed.

Dr Gayle talked of the way in which HIV had shown the "soft underbelly of prejudice". But he also acknowledged that it had brought out wonderful cases of compassion, courage and resolution. We need more of the latter and less prejudice. Ms Liguori urged that we must be open-minded enough to learn from our mistakes. And to acknowledge that not all prevention strategies work. We can learn from each other for in this problem we are all in the same global lifeboat.

The participants would wish to thank the Canadian Public Health Association for convening this symposium. Thanks must go to the other sponsors who joined CPHA in offering their support and in seeing its critical relevance to the global struggle against HIV/AIDS. To Ms Nancy Kotani, President of the Canadian Public Health Association and Chairperson of the National Advisory Committee on AIDS of Canada who opened the session. To Dr Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS who sent his greetings

and who attended, in a very busy schedule, the closing session. To the practical workers: the interpreters, the registration officers, the sound system technicians and others who made the symposium a success. But above all to the contributors and participants who told their tales and brought their wisdom and their feelings conveying a proper sense of compassion and urgency.

Now we go out to the Vancouver streets. In the distance, climbing majestically above the harbour, are the mountains which afford a silent backdrop to the international conference on AIDS. The sky is unbroken with clouds. Small white sails scurry around the waters. Up in the mountains we know there are glaciers, frozen lakes, countless fir trees and happy people enjoying their summer vacations. Down here in the city scientists and experts from all over the world, more than 15,000 of them, have gathered to address an awful problem which unexpectedly and all too rapidly has threatened humanity. So beautiful is the natural scenery that it appears a trifle unreal to be engaged in such serious business. But the signs of summer and the sights of happy people should galvanise us into resolution to do what we can to stop the spread of HIV/AIDS.

No trumpets sounded for this symposium. Alas, its messages will be muted in the exciting and admirable news of new, expensive therapies. But in all truth, the topic of this symposium is vital for the untold millions in lands far away and

close at hand. The cloud of HIV/AIDS is still above the world. It will not be blown away in the foreseeable future by drugs or vaccines. That is why prevention remains the centerpoint of effective global strategies against the spread of HIV/AIDS. It is the realisation of that simple truth that added legitimacy and urgency to our deliberations in Vancouver.