Report

of

INTERNATIONAL STUDENTS' SEMINARS ON CURRENT ISSUES:

"HIV/AIDS in My Country"

At

Aashirwad, Bangalore

on

20th December 2006

INSTITUTE OF SOCIAL STUDIES TRUST

BANGALORE

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REPORT ON INTERNATIONAL STUDENTS' SEMINAR ON HIV/AIDS ISSUES
HIV and AIDS In My Country – Challenges and Responses
20th December, 2006

INTRODUCTION

On the 20th of December ISST held the second in its series of seminars for international students in Bangalore on the topic 'HIV/AIDS In My Country' – Challenges and Responses'.

The international student community in Bangalore represents a diverse mix of countries from Africa, the Middle East, former Soviet republics and India's neighbours. The seminars are organised around issues proposed by the students themselves. The idea behind the seminars is to build solidarity and understanding about the common problems that face our countries and benefit from the sharing of varied experiences.

The topic of HIV and AIDS was particularly relevant for the students because it is the 15-24 age group that is at the highest risk of the disease. Over 50% of new infections occur in the under 25 age-group – a breakdown of 6000 youth infected every day and one every 15 seconds.

The seminar was preceded by a half-day workshop for the presenters on HIV and AIDS held at the ISST office by Dr. Meera Pillai. The workshop sought to discern levels of knowledge and discrimination among the presenters and ensure that prejudices were revealed as such and sensitivities heightened.

The findings of the workshop were interesting...

The schedule for the seminar included 7 presentations by international students from Afghanistan, Sri Lanka, Turkey, Sudan, Fiji, Uganda and Bahrain, one presentation on India by Ms. Asha Ramaiah, a prominent AIDS activist, and a presentation by Ms. Sonia Kandathil, an AIDS scholar and consultant with amfAR (the Foundation for AIDS Research), on New Technologies for HIV and AIDS Prevention.

SESSION 1

The first session of presentations featured presenters from Afghanistan, Sri Lanka, Turkey, India and Sudan, and was chaired by Sonya Thimmaiah, Programme Associate, ISST.

Presentation 1: **Jawed Nader – Afghanistan**

Jawed Nader's presentation was a sobering narrative that showed how conditions in a war-torn, conflict-ridden state make it extremely difficult to mount a significant effort to combat AIDS. Jawed began his presentation with a poignant quote by a young prostitute in Kabul, evoking the similarity between death and the kind of life she leads. A pertinent quote by a Senior Planning Officer, stating that when Afghanistan has the highest maternal and infant mortality rates in the world, poor basic health facilities and a chronically malnourished population, AIDS is not a big priority, indicated the stand of the current government. Jawed explained that although the prevalence of HIV and AIDS is still low in his country, Afghanistan has several factors that make it high-risk in terms of HIV and AIDS, such as low literacy levels, drug use, lack of women's rights and a basic health system. He said that the government has taken some steps towards combating HIV and AIDS by putting together 5 year and annual AIDS action plans, and they will hopefully be implemented and AIDS will not add to Afghanistan's critical concerns. Another striking statistic Jawed presented just prior to his presentation coming to a close was that 80% of the health facilities in Afghanistan were currently being provided by NGOs, underlining the fact that donor agencies have a special responsibility to Afghanistan.

Presentation 2: **Nizla Naizer – Sri Lanka**

Nizla Naizer's presentation on Sri Lanka revealed that the country has a very low prevalence of HIV and AIDS. This coupled with the high literacy rate puts the country in an advantageous position to combat the spread of the disease. However, it was interesting that despite the high literacy rate, awareness levels of HIV and AIDS were low. Nizla elaborated on several risk factors that needed to be addressed, chief among these being low condom use, the ongoing ethnic conflict and commercial sex tourism, specifically the 'beach boy' phenomenon. She then talked about the government response which had been and continues to be proactive – with the institution of national programmes on HIV and AIDS prevention and national campaigns to spread awareness about the disease. She revealed that NGO work in HIV and AIDS had been very limited and largely uncoordinated. She ended by providing the audience with a glimpse of a prominent HIV and AIDS spokeswoman, Dr. Kamalika Abeyratne, who had recently passed away, with a quote by Princess Diana decrying ignorance of AIDS, and with an exhortation to 'Spread Prevention and Stop AIDS!'.

Presentation 3: **İlker Çakin – Turkey**

İlker Çakin's presentation on Turkey, the only European country that was represented on the day, illustrated the advantages that a good health care and education system can make to combating HIV and AIDS. Although only a small percentage of the population has contracted the virus (3700 people out of a population of more than 71 million), levels of awareness are extremely high, with over 99% of women who have been to high school and higher aware of HIV and AIDS. He mentioned that the government has also initiated a coding system to protect patients' identities while reporting infections. A National AIDS Commission was established in 1996 and a National AIDS Programme adopted in 1997. Another interesting fact that emerged from his presentation was that close to a quarter of all patients with advanced HIV infection received antiretroviral combination therapy – an indication of Turkey's advanced nation status. İlker went on to say that Turkey being a candidate country for the EU had given a fillip to its fight against AIDS as neglecting the disease would negatively affect its candidature. The government spends around 78 million dollars annually on AIDS monitoring and prevention programmes. İlker ended by saying that Turkey cannot afford to be complacent as there are some risk factors that cannot be ignored, such as the rise of injecting drug users and the liberalisation of socio-cultural norms with increasing tourism.

Presentation 4: **Asha Ramaiah – India**

Asha Ramaiah's presentation focused on improving the quality of life for people living with HIV and AIDS in India, drawing from her background as founder of the Karnataka Network of Positive People and her current role as a National Advocacy Officer for the Indian Network of Positive People. She started by saying that she is HIV positive and has been for over 10 years, and has not contracted AIDS despite not taking ARVs or treatment of any sort. She talked about the countrywide representation of INP+ and the different groups that made up the network. She detailed the issues that the members of the network faced on a social, legal and political level. She made powerful point that a lot of people are dying not from HIV and AIDS but from stigma and discrimination. She specifically mentioned the medical community as being discriminatory and lacking sensitivity and awareness with regard to HIV and AIDS. She advocated integration as an answer to the discrimination faced by HIV and AIDS affected people. She ended by outlining some the broad strategies the network has formulated to combat these issues – advocacy, network building and service delivery – and the initiatives under each of these strategies that are currently being implemented.

Presentation 5: **Hani Mohamed Qasim – Sudan**

Hani Mohamed's presentation reflected the general sentiment prevailing as a result of the conflict in Sudan and was titled 'The Dark Future of Sudan'. Sudan has the highest rates of HIV and AIDS prevalence in North Africa and the Middle East, and this is compounded by extremely high levels of social stigma and discrimination. A critical point Hani highlighted in the battle against HIV and AIDS was that although close to 85% of the population in a certain region of Sudan had some knowledge of the disease and the virus, most had misconceptions. He said that the current impact of the epidemic was unclear and that although figures exist, most come with caveats. Another exacerbating factor in the spread of AIDS and HIV has been the conflict in Darfur which has seen rape and sexual assault become widespread, and it is believed that a commercial sex network has sprung up around the African Union peacekeeping force. Hani cautioned that with Sudan emerging ravaged from two decades of civil war, the AIDS and HIV threat has the potential to be even more devastating than the civil war. He said that the government had taken some steps towards combating the spread of HIV and AIDS, such as the establishment of non-medical programmes through targeted awareness campaigns that work with community groups, religious leaders and local officials, but the war was the priority – nothing else. He ended with some statistics of HIV and AIDS prevalence in Sudan.

SESSION TWO

The second session of presentations featured presenters from Fiji, Uganda and The Persian Gulf, and was chaired by Dr. Meera Pillai, Senior Consultant, ISST.

Presentation 1: **Torika Nyanga – Fiji**

Torika Nyanga's presentation revealed that the prevalence of HIV and AIDS in Fiji is not high. The country has a population of under one million people and WHO/UNAIDS estimate that there are around 5000 people living HIV and AIDS. Torika went on to say that while the number may be small, there are several risk factors that could precipitate an HIV and AIDS epidemic if attitudes and policies are relaxed. These range from high incidences of other STIs and teenage pregnancies, cultural behaviour that includes considerable extra marital sex, especially by men, and sexual violence to a large tourism industry and high incidences of drug and substance abuse. She went on to say that the national response has been good, with the government instituting a strategic plan for HIV and AIDS, launching treatment options and opportunities for PLWHA, and that, in general, there was high level support from political, traditional and religious leaders. She ended with an invocation of the World Aids Campaign slogan, 'Stop AIDS – Keep the Promise'.

Presentation 2: **Byomuhangi Kay Pontian – Uganda**

Byomuhangi Kay's started his presentation with a look at the history of the disease in Uganda, a country that has had remarkable success in combating HIV and AIDS. He said that Uganda's highest recorded prevalence was 18.5% in 1992 – a number that has since dropped to 6.4%. Kay spoke about the magnitude of the epidemic in Uganda saying that it had claimed over half a million lives and that there were currently over 1.4 million people living with HIV. He moved on to the impact of HIV and AIDS on the country – on the health sector, civil services, agriculture sector and at the household level. He discussed the reasons for Uganda's success in bringing down rates of prevalence, chief among them being President Yoweri Museveni's commitment and support. He went on to detail major interventions through vigorous pursuit of the ABC mode of HIV and AIDS prevention, including the establishment of the Uganda AIDS Commission to coordinate a multi-sectoral approach to prevention and control. Kay proceeded to list some of the achievements of Uganda's approach, from an increase in condom use (from 7% in 1989 to 42% in 1995 in urban areas in the high-risk 15-24 age group) to engendering behaviour change by increasing the mean age of first sex contact from 14 to 16 years. He then talked about current

shortcomings in the fight against HIV and AIDS, and reactions to America's tied-to-funding emphasis on Abstinence-only programmes, which led to a national shortage of condoms in 2005. He warned against complacency and said that recent statistics show that rates of prevalence of HIV and AIDS may be climbing again. He ended by proposing the way forward which included multiple approaches and focused interventions for high-risk groups, and the need for new strategies to address new challenges.

Presentation 3: **Haithem Ali Saleh – Persian Gulf**

Haithem Ali's presentation began with an introduction to the regions that comprise the Persian Gulf – Bahrain, Kuwait, Qatar, Saudi Arabia, Oman and the U.A.E. He said that when the first case of AIDS was reported in 1989 the reaction was one of finger pointing and condemnation. He used a quote by an influential religious leader to illustrate this reaction that claims that AIDS is Allah's way of punishing the immoral. He said that some of the implications of such a reaction were increased secrecy, the creation of a national fear and a lack of focus on the important issues regarding HIV and AIDS. To illustrate how taboo sex is in this region, he said that the first time he saw a box of condoms was when he came to India. One promising aspect of the fight against the disease in the Persian Gulf is the robust health system accessible to the majority of the population. He outlined innovative regional initiatives like the inclusion of sex education in school curricula and the involvement of religious leaders in the HIV and AIDS battle. Societal responses ranged from organising marches and workshops to spread awareness and insistence on blood testing for STIs before marriage. He captured the HIV and AIDS prevention efforts in a series of slides with snapshots of awareness and prevention activities. He stressed that a conceptual change was needed for these efforts to truly be successful and that efforts needed to be focused in this direction. He ended his presentation with a promising quote by a prominent religious leader exhorting people to learn from the mistakes of those who have contracted HIV and AIDS and be compassionate to them.

The second session was followed by a question and answer session during which questions were posed to presenters of both the first and second sessions...

SESSION 3
Lecture: **Sonia Kandathil – Research and Programme Analyst**
amFAR – The Foundation for AIDS Research

Sonia Kandathil's lecture presented an overview of effective and promising new prevention technologies to combat HIV/AIDS. She started by stating that the goal of behavioural interventions is to initiate behavioural change in terms of sexual activity as well as drug use. She talked about the different types of interventions and said that meta-analyses have shown these interventions to result in an up to 40% reduction in risk behaviours associated with the spread of HIV and AIDS. She briefly explained the ABC approach and the shortcomings of an abstinence-only emphasis. She said that studies had shown that girls who had taken virginity pledges were actually indulging in riskier sexual behaviour than girls who weren't. Sonia moved on to detailing the methods of prevention, beginning with male and female condoms, which are currently estimated to be the most effective means of protection against HIV and AIDS, and it was striking to hear that the latter are actually marginally more effective. She spoke about methadone maintenance as a strategy that's proved effective for drug users. She then proceeded to talk about bio-medical interventions like STI Management, the use of ARTs, Post Exposure Prophylaxis, Pre-Exposure Prophylaxis and male circumcision, and revealed that the last intervention can actually reduce the risk of HIV by more than 50%.

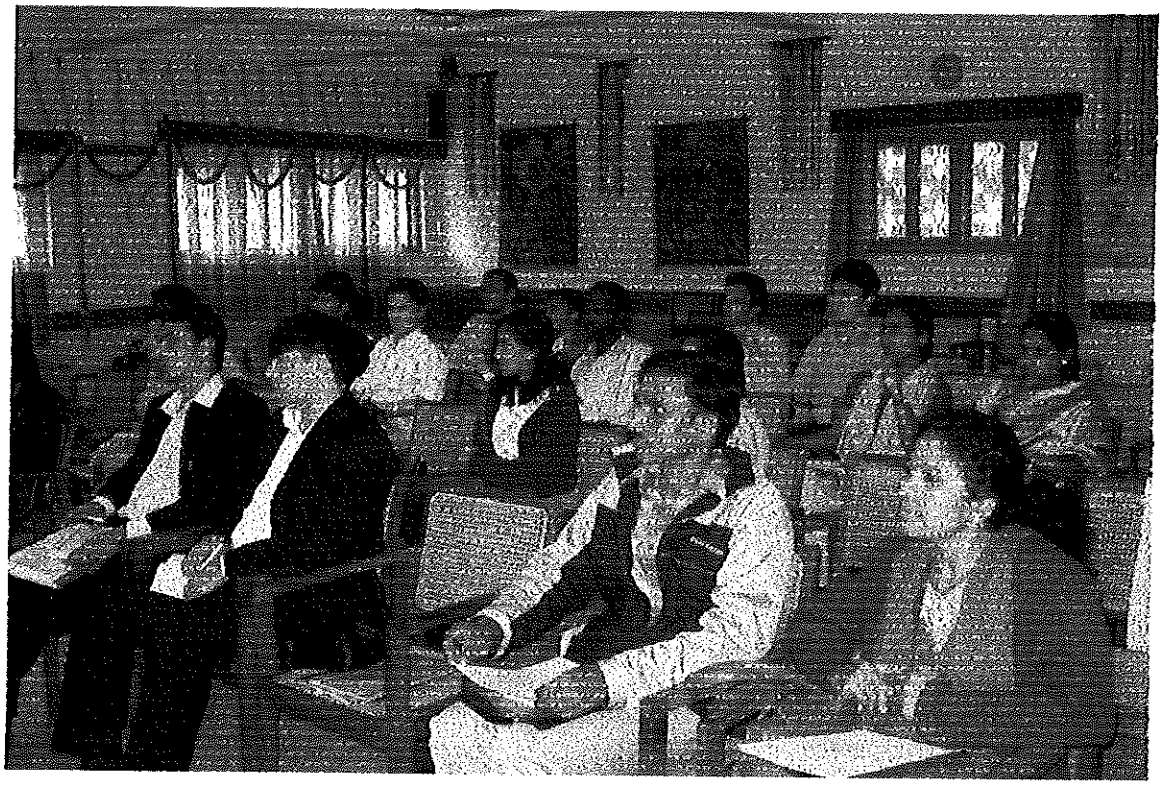
The other interventions that Sonia explained were vaccine, microbicide and social/structural interventions. As an example of a social intervention at the policy level, she elaborated on the hugely successful Thai 100% Condom Use programme, which was able to effect a decline in the

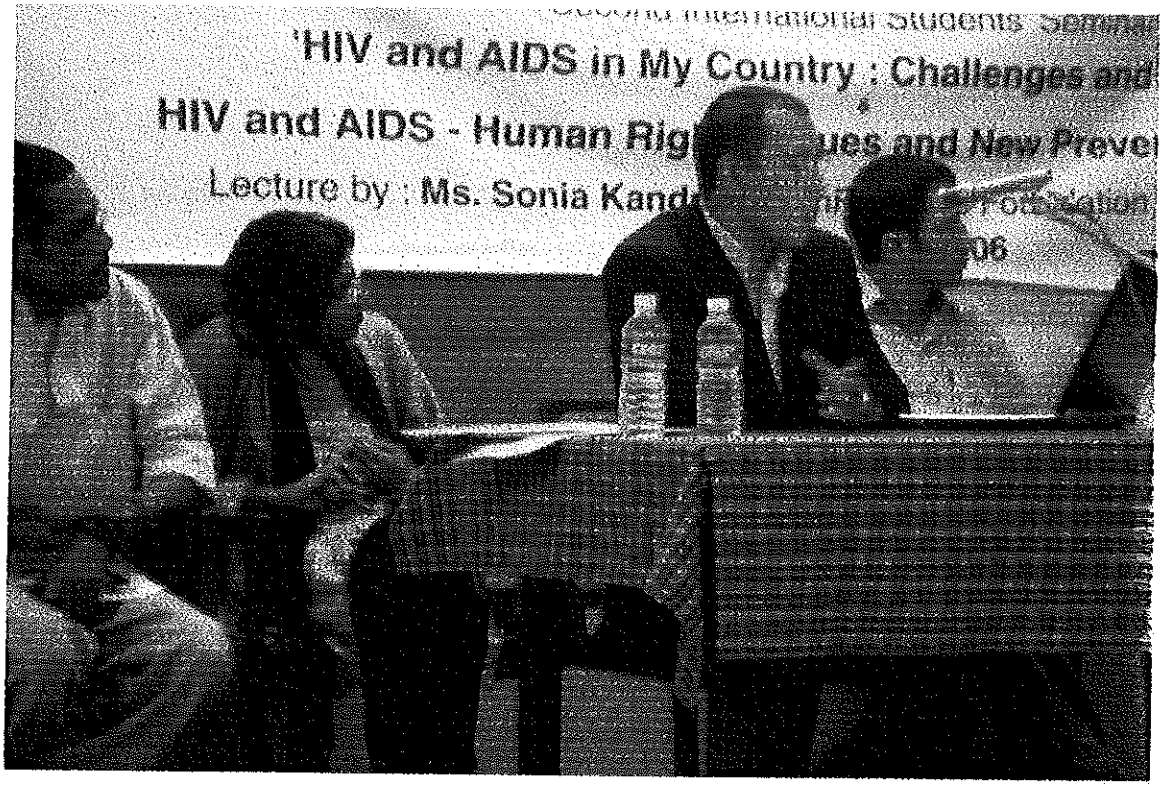
HIV incidence rate from 3/100 person-years in 1991 to 0.3/100 person-years in 1993 and an increase in condom use with sex workers by 32% between 1991 and 1995. She also talked about syringe exchange programmes which have been shown to be very effective without increasing drug use, contrary to popular misconceptions, and mentioned economic empowerment of women as an indirect intervention.

In conclusion, Sonia stressed the point that all of these interventions when used in combination are likely to produce the best results. She followed this with some statistics on the estimates of access to effective interventions for at-risk populations and the numbers showed that there was a lot of work to be done in terms of scaling up as only very small percentages even had access to these programmes. She also stressed the need to increase and education to combat stigma and discrimination. She ended on a positive note by saying that as she had detailed, there was a great deal of evidence for prevention efficacy and that an integrated, comprehensive approach reflecting local solutions was a promising way forward.

The third session ended with participants breaking for tea. The participants reconvened post-tea and a question and answer session followed...

Ms. Grace Fernandez from ISST delivered the Vote of Thanks that brought the seminar to a close.

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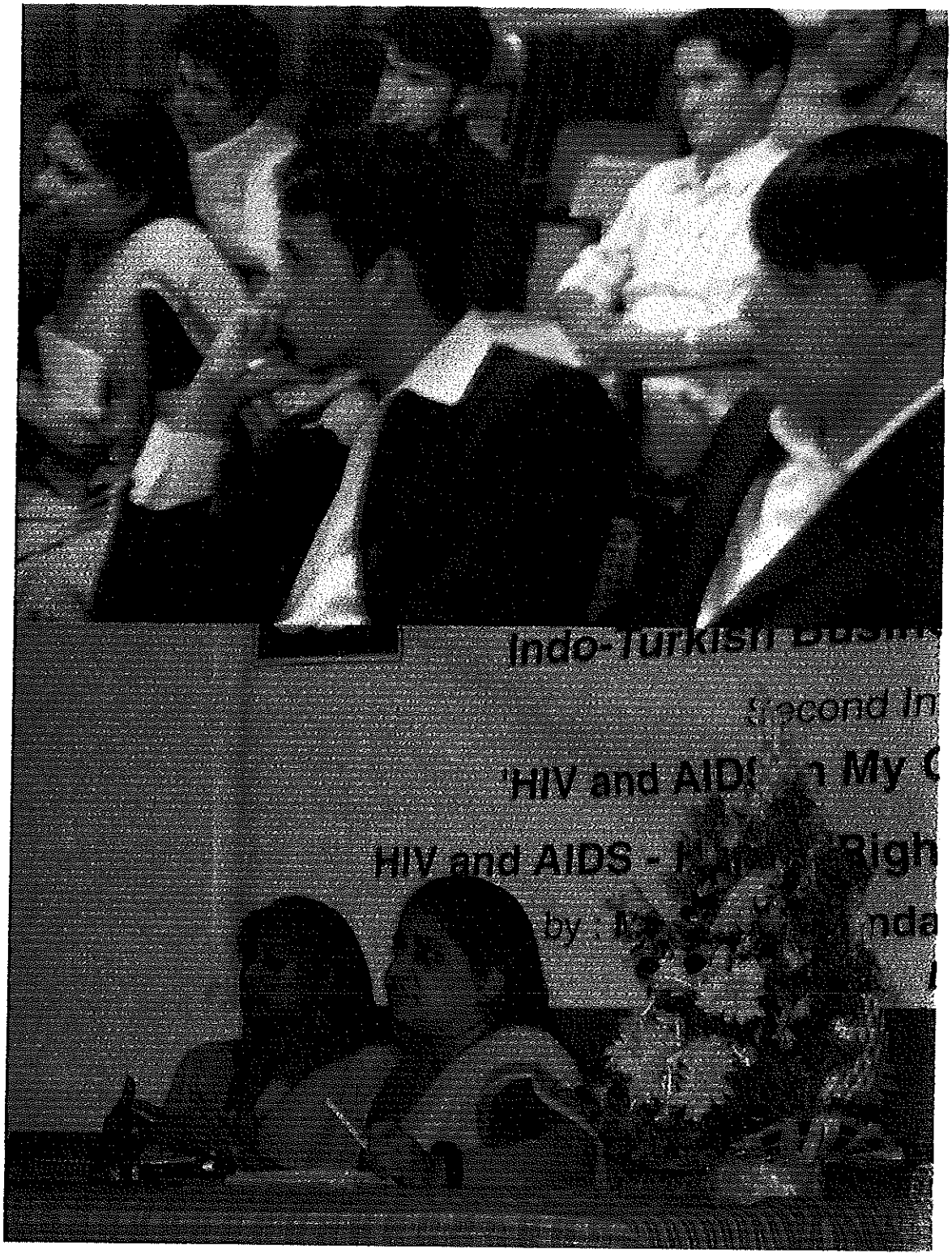
HIV and AIDS - Human Rig ues and New Preve
Lecture by : Ms. Sonia Kand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ISST


ISST
Institute of Social Studies Trust, Bangalore
Consulate of the United States, Chennai
Indo-Turkish Business Association
'HIV and AIDS in My Country : Challenges and Responses

INTERNATIONAL STUDENTS' SEMINARS ON CURRENT ISSUES:
A CONCEPT NOTE

In recent years, Bangalore has seen more and more international students, many of them from other developing countries and the independent republics carved from the former Soviet Union, who come here to take advantage of the numerous educational institutions in the city. Among the countries which have sent students to Bangalore are Thailand, Vietnam, Indonesia, Sri Lanka, Yemen, Iran, Morocco, Uganda, Kenya, Kyrgyzstan, Uzbekistan and Tajikistan. Almost all these young people are extremely motivated and committed, apart from being very bright. Many of them are here on scholarships and fellowships.

These students constitute a potentially rich set of resources on which our community can draw, adding more vibrant skeins to Bangalore's already vivid multicultural tapestry. It would be good to explore in what ways we can share and enjoy the information, skills and strengths these young people can bring into our community, while simultaneously building relationships with them that would make their experiences as students in India more valuable to them.

As one effort in this larger endeavour of proactively appreciating this group of international students in our community, the Institute of Social Studies Trust (ISST) is organising a series of panel presentations which highlights common issues affecting our respective countries. These presentations would also simultaneously showcase the skills, resources and opinions of this diverse student body, and introduce them in a positive way to the larger Bangalore community.

The Institute of Social Studies Trust is a non-profit organization involved in several inter-related issues of research. It is headquartered in Delhi with an office in Bangalore. Our research projects are geared to working closely with grassroots groups (particularly women's groups) in identifying information gaps, conducting research, and using these strategies to bridge the gaps between research, action and policy debates. In particular, we have focused on studies relating to public health, recognising women's work and making women's contributions to the economy visible, strengthening local governance, and training grassroots practitioners in governance.

The themes for the series of seminars we are organizing are on issues which are currently of importance to several of the countries, particularly developing countries, represented by this student body. Having such presentations would, we feel, build solidarity and understanding about the common problems that face our countries, the differences related to these problems from country to country, our differing responses to these problems, etc.

The benefits to international students from participating in this venture are:

- Doing basic independent/assisted research on a topic of interest
- Honing presentation skills
- Working on a collaborative project with highly motivated and exceptional students from other academic institutions

- Exposure to the larger community through these presentations
- A piece of work that the student can use towards the building of his/her resume

ISST also issues certificates of participation to students, which might help further their educational and career goals.

The first seminar in the series was held on March 18, 2006, and as a follow up to International Women's Day, the theme was "The Status of Women in My Country". Nine international students made presentations, at the end of which there was a lively question and answer session.

The second seminar in the series will be held on **December 20, 2006** as a follow up to World AIDS Day, on the theme of **'HIV/AIDS In My Country: Challenges and Responses'**.

The seminar will be followed by a lecture on 'HIV and AIDS – Human Rights Issues and New Prevention Technologies' by **Ms. Sonia Kandathil, Research and Policy Analyst, amFAR – the Foundation for AIDS Research**.

ISST would like to thank the **Indo-Turkish Business Association** and the **Consulate of the United States, Chennai,** for supporting us in organising this seminar and lecture.

For further information:
(between Monday through Friday, 10:30 a.m. to 5 p.m.)
Ms. Sonya Thimmaiah/Mrs. Grace Fernandez
ISST, Bangalore
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sonya.thimmaiah@gmail.com

'HIV/AIDS In My Country: Challenges and Responses'
20th December 2006
Aashirvad, Bangalore

Schedule for the Day

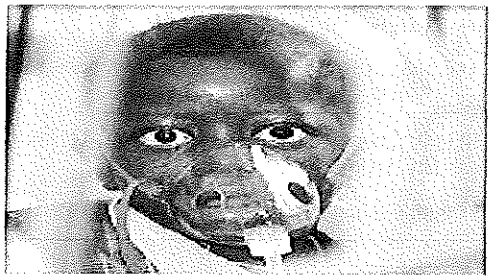
SESSION	TIME	DETAILS
Registration & Coffee	11–11.30 a.m.	Registration of participants
1st Session of Presentations	11.30 a.m. – 1 p.m.	**Mr. Jawed Nader** – Afghanistan **Mr. Hani Mohamed Qasim** – Sudan **Ms. Nizla Naizer** – Sri Lanka **Mr. Ilker Çakın** – Turkey **Ms. Asha Ramaiah** – National Advocacy Officer, Indian Network of People Living with HIV/AIDS
Question Time	1– 1 .30 p.m.	**Clarifications and Discussion**
LUNCH – 1.30-2 p.m.		
2nd Session of presentations	2 – 3.00 p.m.	**Ms. Torika Nyanga** – Fiji **Mr. Byomuhangi Kay Pontian** – Uganda **Mr. Haithem Ali Saleh** – Bahrain, presenting on the countries of the Persian Gulf
Question Time	3.00 – 3:15 p.m.	**Clarifications and Discussion**
Guest Lecture	3.15 – 3:45 p.m.	**Ms. Sonia Kandathil** (amFAR, The Foundation for AIDS Research) - **HIV and AIDS: Human Rights Issues and New Prevention Technologies,**
Question Time	3:45 – 4.00 p.m.	**Clarifications and Discussion**
TEA – 4-4.15 p.m.		
Distribution of Certificates	4.15 – 4.30 p.m.	**Mr. Ozkan Soycan** (Indo-Turkish Business Association) & **Ms. Sonia Kandathil** (amFAR, The Foundation for AIDS Research)
Vote of Thanks	4.30 – 4.35 p.m.	**Grace Fernandez**, Administrator, ISST

The Dark future of SUDAN

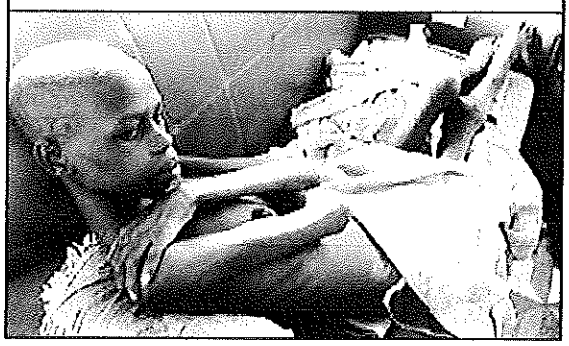
The facts

- Sudan is the largest country in Africa and tenth in the world by area.
- 40,187,486: population of Sudan (July 2005 EST.).
- Like many African countries, Sudan is passing through a period of crises and civil war.
- Sudan has the highest rate of HIV infection in north Africa and the Middle East. (U.N EST)

- 7 years old child tested HIV/AIDS positive



- A women rescued from a town southern Sudan.



Awareness about HIV/AIDS in Sudan

- In Sudan's primarily Muslim north those infected with HIV complain that they face enormous social stigma and have a difficult time getting jobs.
- Although 85 percent of those questioned in the eastern areas of Red Sea were aware of HIV/AIDS, most had misconceptions about it.

- Sudan's western region of Darfur, home to about 3 million people, was plunged into crisis in February 2003.
- Three years of fighting has caused the death of more than 200,000 people and forced another 2.5 million people from their homes.

- Rape and sexual assault are widespread in Darfur, and it is thought commercial sex networks have been established around the 7,000 African Union peacekeeping force, a development that could fuel the spread of HIV/AIDS.

- almost 20 years of conflict in southern Sudan, an emerging HIV/AIDS epidemic could prove to be even more devastating than the civil war.

Solutions

- The Government has established a non-medical project aims to combat the growth of HIV/AIDS through targeted awareness campaigns that work with community groups, religious leaders and local officials to increase awareness.

- **350, 00:** Estimated number of people living with HIV/AIDS
- **1.6%:** Estimated percentage of adults (ages 15-49) living with HIV/AIDS.
- **180,000:** Estimated number of women (ages 15-49) living with HIV/AIDS
- **30,000:** Estimated number of children (0-14) living with HIV/AIDS
- **34,000:** Estimated number of deaths due to AIDS

Fiji The Way The World Should Be

- Location: Oceania Island group in the South Pacific Ocean about two third's of the way from Hawaii to New Zealand
- Languages: English (Official) , Fijian , Hindustani
- Religions: Christian (52%),Hindu (38%),Muslim(8%),Others(2%)
- Ethnic Groups:Fijian (51%),Indians(44%),European-other Pacific islanders, overseas Chinese (2%)
- Population: 0.8 (million)

Fiji has 229 confirmed AIDS cases as of September this year

The WHO/UNAIDS estimate that there could be over 5000 people infected in the country

The main route of Infection is heterosexual activity, there has been only one known case of Intravenous transmission

HIV/AIDS Estimates

Figures	Value	Year
Estimated number of HIV cases (Adults and Children)	1000	2005
Adults (15 - 49 Years)	1000	2005
Women (15 - 49 Years)	500	2005
Children	-	-
Estimated number of Deaths Due to AIDS	100	2005
Estimated number of AIDS orphan	-	-

Risk Factors For Fast Growing HIV Epidemic in Fiji

- The high incidence of other sexually transmitted infections
- The high incidence of teenage pregnancies
- The high incidence of drug and substance abuse
- The mobile population
- Large Tourism industry
- Cultural behavior that includes a considerable amount of extra marital sex particularly by men
- Sexual violence
- Lack of training for health workers in the area of STI HIV/AIDS coupled with the negative attitude towards condom distribution

The National Response

- The National Strategic plan for HIV/AIDS for 2004 – 2008 amongst other strategies, was expected to strengthen policies and legislations on confidentiality and anti-discrimination in the care administered to people living with HIV/AIDS
- Fiji has launched treatment options and opportunity for PLWHA
- The HIV antiretroviral drug treatment is another multi agency initiative which is expected to be strengthened over time
- Fiji is the only country in the region that has provided specific budget lines for HIV/AIDS and 100% increase from $150,000 in 2003 $300,000 in 2004 and $500,000 in 2006 to combat HIV
- High level support from political, traditional and religious leaders

STOP AIDS KEEP THE PROMISE

If we die, what does it matter? If I live, what does it all mean?" Laila, a 26-year old Prostitute in Kabul

HIV/AIDS in Afghanistan

By: Jawed Nader

Outline

- Country Profile
- Important Factors
- State of the Epidemic
- Risk Factors
- National Response

Country Profile

- **Location:** Central Asia, Landlocked and surrounded by Iran, Pakistan, China, Tajikistan, Turkmenistan and Uzbekistan
- **Religions:** Islam 99 %, Sikh and Hindu 1%
- **Population:** 25 Million
- **Ethnicities:** Pashton 34 %, Tajik 28 %, Hazara 24 %, Uzbek 7 %, Turkmen 3, % and 15 other small minorities (Blooch, Nooristani, Pashaye)
- **Government:** Islamic Republic
- **Languages:** Persian (Dari), Pashto, Turk Languages (Uzbeki and Turkmeni) other more than 30 minor languages (Bloochi, Pashaye)
- **Administrative Divisions:** 34 Provinces

Special Factors

- A devastated country by almost 3 decades of armed conflict since 1978
- One of the Poorest countries in the world
- Suppression of women's rights for several years

Special Factors

- Over 2 million internally displaced persons since 1978
- 2 million Afghan refugees in Pakistan and more than 1.5 million in Iran

Special Factors

- It has a Human Development Index ranking of 0.346
- Lack of social and health infrastructure
- One of the lowest life expectancies in the world
- In 2004 Afghanistan became the 191st signatory to the Millennium Declaration

State of the Epidemic

- Reliable data on HIV prevalence in Afghanistan is sparse

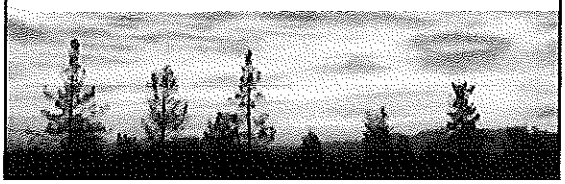
Figures	Value	Year
Estimated Number of HIV cases (Adults and children)	>1000	2005
Adults (15-49 years)	>500	2005
Women (15-49)	>100	2005
Estimated number of deaths due to AIDS	>100	2005

Risk Factors

- **High Numbers of Refugees and Displaced People**
  - 3.4 million Afghans outside the country
  - Central and western parts of the country host nearly 200,000 IDP
- **High Levels of Illiteracy**
  - 19 % of population able to read and write
  - Setting fire to Schools
- **Competing Health Priorities**
  - 15,000 Afghan women dying every year from pregnancy-related causes
  - One in four children dies before its fifth birthday
  - Early response to HIV and AIDS risks get lost

Risk Factors

"We have the highest maternal mortality rate in the world; the highest infant mortality rates in the world; we have unsafe drinking water and poor hygiene. Sixty percent of the population suffer from chronic malnutrition. AIDS is just in the early stages, and we are doing what we can. But we have to focus on our bigger priorities." Dr. Hedayatullah Stanekzai, Senior Planning Officer



Risk Factors

- **Injecting Drug Users**
  - 50,000 heroin users and about 15% of male users injects the drug
- **Low Status of Women**
  - Gender Development Index among the lowest
  - Extremely low access to health, education, employment, legal and political rights
  - forced into sex work to support their families
- **Lack of a Health System**
  - Acute shortage of health facilities and trained staff, particularly female
  - Only half of the 44 medical facilities that transfuse blood are able to screen the blood for HIV infection

Priority Areas

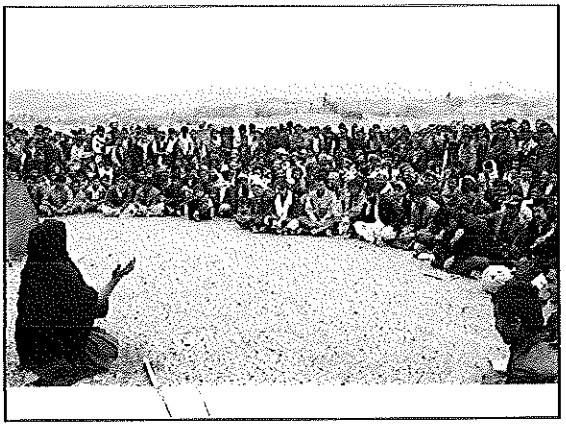
- Rebuild the Primary Health Care System
- Gather Data for Planning and Action
- Implement a Multi-Sector Response
- Address High-Risk Groups

National Response

Government

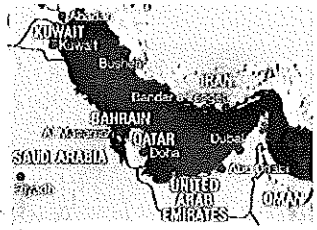
- National HIV/AIDS/STI-control Campaign
- Incorporation of HIV/AIDS awareness materials in the school curricula

- **NGOs**
  - 50 International NGOs and about 100 national NGOs
- **Key Donors**
  - UNICEF, UNFPA, WHO, USAID, World Bank



AIDS – Keep the promise

AIDS – The Arabian Gulf
INTRODUCTION

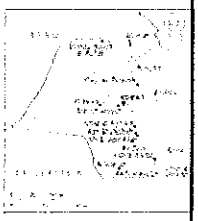


Aggregate Population: 37 Million Persons

Aggregate Population Density: 14 persons per sq km

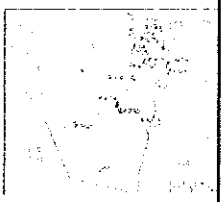
Aggregate GDP: 590 Billion USD

AIDS – The Arabian Gulf
Kuwait



- Size of Nagaland
- Population of Mizoram
- Holds 10% of the oil reserves of the world

AIDS – The Arabian Gulf
United Arab Emirates

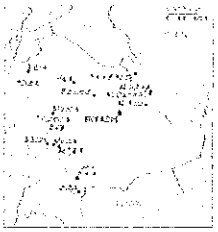


- Half the size of karnataka
- one-tenth Population of Himachal Pradesh
- 25% of population - nationals

AIDS – The Arabian Gulf
Oman

- The size of Maharashtra
- one-tenth Population of Himachal Pradesh
- 250 airports – seven in each city

AIDS – The Arabian Gulf
Saudi Arabia



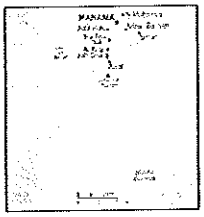
- Two-thirds the size of India
- Population of Kerala
- 63% of oil reserves in the world

AIDS – The Arabian Gulf
Qatar


- The size of Andaman and Nicobar Islands
- Population of pondicherry
- Top natural gas exporter in the world

AIDS – The Arabian Gulf
Bahrain





- A little bigger than Pondicherry
- Population of Sikkim
- The least taxed country in the world

AIDS – The Arabian Gulf

HIV-AIDS Situation

Estimated number of adults and children living with HIV/AIDS, end of 2003

Country	Adults	Children	Women	Deaths	Orphans	Percentage
Bahrain	400	600	1000	400	n/a	0.35%
Qatar	350	150	400	n/a	n/a	0.09%
Kuwait	500	200	1500	600	n/a	0.12%
Saudi Arabia	Estimated 27,000 persons					0.01%
Oman	1300	500	1000	400	300	0.18%
UAE	Estimated 2,400 persons					0.17%

AIDS – The Arabian Gulf

HIV-AIDS Situation

Men-women AIDS Ratio

Country	Men/Women Ratio	Adult/Children estimate
Bahrain	2:3 Ratio	7:3 Ratio
Qatar	7:3 Ratio	5:1 Ratio
Kuwait	5:2 Ratio	10:1 Ratio
Saudi Arabia	n/a	
Oman	13:5 Ratio	23:5 ratio
UAE	n/a	

AIDS – The Arabian Gulf

FIRST INCIDEN



AIDS – The Arabian Gulf

First Incident reported – Bahraini Male - 1989

Public Outraged – Made to believe it's a punishment from God

Awakening of the governments of all gulf countries to the problem

Blame on foreign construction and Maid workers

AIDS – The Arabian Gulf
Initial Reactions

AIDS – The Arabian Gulf
Initial Reactions

" People sin so Allah punishes them for their sins, If these villains (HIV Patients) were devout Muslims, they would have been spared but it is because of their imitation of the west and disregard to Islamic good life that god decided to speed them to his hell. So if Allah doesn't want them on earth why should we ?"

Sheikh Abu-mesab wahabi. Saudi Arabia

AIDS – The Arabian Gulf
Implications

- Creation of a national fear regarding even discussion of AIDS
- Increase in unreported cases and more secrecy
- Less focus on the important issues regarding AIDS
- No efforts driven towards the betterment of the lives of the current patients

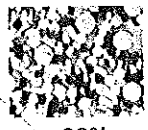
AIDS – The Arabian Gulf
Health Care

- Health care for all
- Comprehensive Health services
- Technical and Financial burden government sponsored
- Free and highly accessible
- 40 Doctors per 10,000 population
- 600 Hospitals with 325,000 Hospital beds

AIDS – The Arabian Gulf

HIV-AIDS Situation

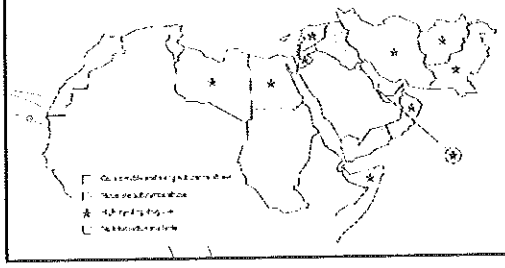
<u>Causes and Reasons for spread of Aids</u> - GCC

MAL-NUTRITION	DRUGS	IMPROPER HEALTH CARE	UNSAFE SEX
			
0%	62%	0%	33%

AIDS – The Arabian Gulf

<u>Causes and Reasons for spread of Aids</u> - GCC

62%



AIDS – The Arabian Gulf

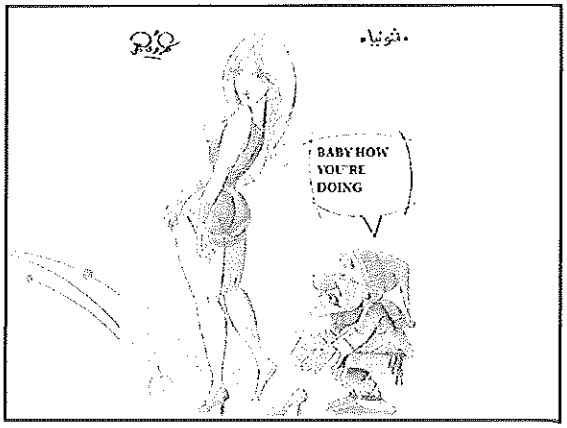
Causes and Reasons for spread of Aids - GCC

33%

PEOPLE SELL THESE ?!

I AM FINE. WHAT ARE THE CHANCES !!!

CONDOMS !!!! WHAT CONDOMS ?



Innovative Regional Initiatives

- Specialized treatment facilities opened in certain cities like Jeddah, Muscat etc
- Sex Education included in school curriculum at the PUC level
- Prevention through Life skills education Eg. Oman
- Harm reduction strategies- needle exchange, methadone treatment
- Triangular clinics
- Involvement of Religious leaders

Societal Responses

- Organizing of marches and workshops to spread the issue amongst schools and Rotary clubs
- Collection of Donations towards the United Nations AIDS foundations
- Establishment of NGOs for helping the AIDS patients
- Blood testing before marriage for STDs

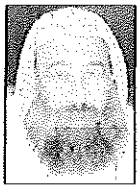
AIDS – The Arabian Gulf

Picture speak

United Arab Emirates and Bahrain pledge millions in survey projects and awareness programs through public ads and notice boards

AIDS – The Arabian Gulf

Picture speak



Religious leaders asked to talk about AIDS in Friday gatherings and preach mercy towards HIV patients

AIDS – The Arabian Gulf

Picture speak

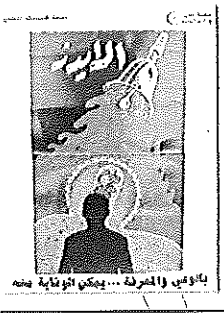
Volunteer shows a foreign worker in Qatar on how to use a condom

Workshops conducted in various parts of the GCC to spread awareness

An AIDS helpdesk established in Dubai Shopping festival targeting youth in malls

AIDS – The Arabian Gulf

Picture speak



Publications issued in Arabic for free. This one says "AIDS – Through awareness and protection we can prevent it"

AIDS – The Arabian Gulf

Picture speak

Orphaned HIV children – visited and taken to special trips on Eid

Conceptual change

- Massive drive regarding public awareness
- Development of public health service facilities for HIV Patients
- Tolerance of and Sympathy towards HIV Patients
- Donations towards finding a cure
- Support of regionally most affected areas like Egypt
- Less Finger pointing and more constructive action

" The beauty of being human is that we make mistakes and learn from them. An HIV patient is most often a human who didn't get a second chance. So while they are here with us, let us learn from their mistakes and make life worthwhile for them "

HIV/AIDS IN UGANDA

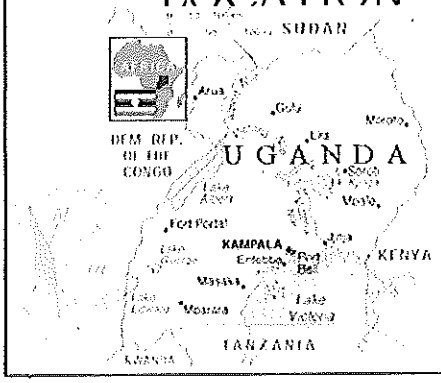
CHALLENGES & RESPONSES

Byomuhangi Kay
CMR IMS

SUMMARY

- Location/introduction
- History of HIV/AIDS in Uganda
- Routes of transmission
- Magnitude of the epidemic
- Demographic indicators
- Impact
- What brought down the rates
- Major interventions
- Achievements
- Shortcomings
- Reactions
- Way forward

LOCATION



INTRODUCTION

- **Land locked country**
- **Population:** 28,195,754
- **Age structure:**
  0-14 years: 50%
  15-64 years: 47.8%
  65 years and over: 2.2% (2006 est.)
- **Religions:** Roman Catholic 33%, Protestant 33%, Muslim 16%, indigenous beliefs 18%
- ***Literacy:*** age 15 and over can read and write
  total population: 69.9%
  male: 79.5%
  female: 60.4% (2003 est.)
- **GDP per capita $1,800**

HISTORY OF HIV IN UGANDA

1982 First 2 cases of Slim disease were reported

1983 17 more cases of Slim disease were reported

1984 Slim disease was confirmed as AIDS.

-The epidemic spread from major towns to rural population in Uganda.

-To date all districts have reported AIDS.

HISTORY OF HIV IN UGANDA CONT'D

- 1989, Prominent Ugandan musician, Philly Lutaya declared publicly that he had AIDS (1st African)
- Uganda's highest recorded prevalence was 18.5% in 1992, and 30.5% among pregnant women, especially in urban areas.
- These have both fallen to 6.4%

Routes of HIV Transmission in Uganda.

- Heterosexual transmission accounts for 84%
- Mother to child transmission accounts for 14%
- Contaminated blood/blood products
- Use of unsterilised needles and syringes — 2%
- Use of unsterilsed instruments.

Magnitude of the Epidemic

- 1.9 million cumulative HIV infections have been reported since the epidemic started.
- Of these 1.4 million are living with HIV.
- About 500,000 have died of AIDS.
- 120,000 are living with AIDS.
- Around 6.5% of the adult population in Uganda is HIV infected.

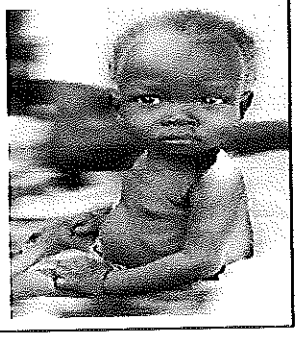
Demographic Indicators with and without AIDS in Uganda

- Population growth rate with AIDS 2.8% and without AIDS 3.5%
- Life expectancy with AIDS 42.6 years and without AIDS 54.1 years.
- Crude death rates with AIDS 19.0% and without AIDS 12.5%.
- Infant mortality rates with AIDS 92.9% and without AIDS 81.3%.

Impact of the HIV/AIDS in Uganda

(a) Burden on Health Sector

- Bed occupancy in hospitals by AIDS patients rose from 50% to 70%.
- 60% of TB patients are HIV co-infected.
- Increase in infant and young child morbidity and mortality.
- Increase in drug purchase for treatment of opportunistic infections and other related illnesses.
- Increase in work load for few health workers.



Impact of the HIV/AIDS in Uganda (Cont'd)

(b) Burden on Civil Services

- Labor and human capital is severely affected.
- Reduction of life expectancy (54.1 to 42.6)
- Increase in expenses to meet funeral expenses burial, coffins, transport)
- Time lost by civil servants to care for the sick with AIDS, attend funeral ceremonies.
- Increased number of orphans.
- No productivity in terms of labor, poor output, poor income and poor GDP.

Impact of the HIV/AIDS in Uganda (Cont'd)

(c) Burden on Agriculture

- Reduction in farm labor, reduction in agricultural production.
- Reduction in yields, no sales.
- Risks of reduced food security.

(d) Burden at the Household Level

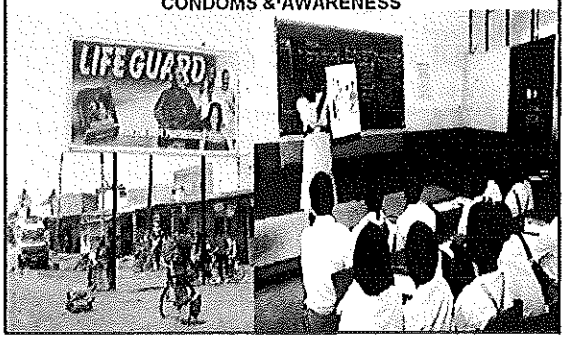
- Increased poverty at household level.
- Economic losses at the households level arising from increased expenditure on the sick.

What brought down the rates?

- Top Political commitment from President Yoweri Museveni and support has been strongly demonstrated.
- Openness about the epidemic
- Vigorous pursuit of the ABC mode of HIV prevention, decentralization, international resources.
- Involvement of women and youth in governance, and activism by people living with HIV/AIDS.
- Establishment of Uganda AIDS Commission (1992) to coordinate multisectoral approach to HIV/AIDS prevention and control through:-
  - i Joint Planning
  - ii Joint monitoring and evaluation
  - iii Information sharing

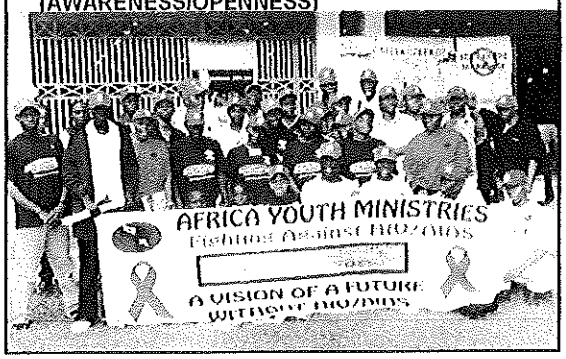
What has been done?

(PICTORIAL)
CONDOMS & AWARENESS



What has been done?

(AWARENESS/OPENNESS)



Major Interventions:

(A) IEC initially focusing on Awareness but now has strong elements of behavior change.

- Social mobilization of the political and administrative system.
- Mass campaign at the grassroots.
- Establishment of Health Education Network (HEN) in all the districts in Uganda.

Major Interventions: (Cont'd)

- Peer education in post primary and tertiary institutions.
- Material development
- Training module development on the behavior change process.
- Condom Promotion.
- Establishment of Networks of PLWAHs.

Major Interventions: (Cont'd)

(B) Improved Laboratory and Blood transfusion Services.

(C) Care and Support

- Establishment of continuum of comprehensive care.
- Availability of drugs for treating opportunistic infections.
- The introduction of the UNAIDS Drug Access Initiative and the MCTC of HIV prevention intervention.

Achievements

(a) General

- Capacity of the Uganda Virus Research Institute (UVRI), National Blood Transfusion (NBTS), Joint Clinical Research Centre (JCRC) have been built and strengthened.

(b) Declining trends in selected antenatal clinics in Uganda.

Achievements (Cont'd)

(c) Decline in HIV prevalence amongst STD clinics.

(d) Behavior Change indicators:

- Mean age at first sex contact rose from 14 years to 16 years.
- Reduction of sex with non regular sexual partners from 52.7% to 14.1%.
- Knowledge of at least 2 methods of HIV prevention is between 70%-80%

Achievements (Cont'd)

(e) Increase in Condom use: From 7% in 1989 to 42% in (1995) for most urban areas among the young age group (15-24 years). And increase in condom use with casual partners by men to 84% in 2002.

(f) Involvement in research e.g. The vaccine trial.

(g) Introduction of Voluntary Counseling and Testing (VCT) Services

Out Standing Shortcomings:

1. Limited studies on the culture of communities and on behavior change.
2. Remote areas not effectively reached by radio transmission in addition to the limited access to health facilities.
3. Inability to avail ARVs to AIDS patients.
4. An estimated $600m is required for treatment and prevention of HIV/AIDS in Uganda over the next five years. However, experts are worried over the source of funding.

REACTIONS

- In 2005 Critics accused the US of encouraging a shift in Uganda's HIV prevention policy towards promoting abstinence only, and away from promoting condoms. A severe national condom shortage was reported.
- Some workers, activists and scholars agree, saying the abstinence approach pushed into law by U.S. religious conservatives has translated poorly to Africa. The Christian doctrine of abstinence, they say, is a concept that doesn't always resonate in traditional African cultures and is therefore stalling efforts to save lives.
- But ABC advocates point to Uganda where, beginning in the early 1990s, President Yoweri Museveni launched a society-wide offensive on the epidemic, which at that time infected 15 percent of adults. Ten years later and with ABC programming firmly entrenched, the infection rate dropped to 5 percent.

What has happened? Why are the earlier strategies not working now?

- RECENT reports have indicated that HIV infection levels could be rising in Uganda. Yet Uganda is one of the few countries that registered significant declines of HIV infection rates in the past.
- There has emerged a problem of complacency in the AIDS programme as well as among Ugandans. We have taken the progress so far achieved for granted.
- It is also believed that it is more difficult to reduce infection rates when they are lower. This means Uganda needs more efforts and resources now more than ever before.

The way forward

- Condoms work and they need to be promoted alongside other approaches.
- We need focused interventions for the vulnerable and high risk groups like the youth, women, internally displaced people and prostitutes.
- The 2005 HIV survey by the Ministry of Health shows that the current drivers of the epidemic are in Uganda. For instance, married couples and rich women were found to be at high risk. New strategies are needed to address these new challenges.

HIV / AIDS in Turkey

The challenges, responses…

The first time to meet with HIV/AIDS in Turkey

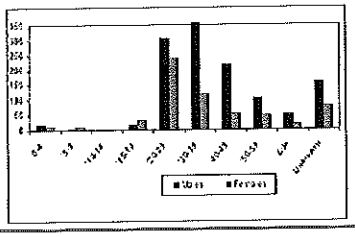
The first case of HIV infection was reported in 1985, and by the end of 2004, a total of 922 cases had been identified. The rate of increase for the reported number of HIV/AIDS cases has been more or less constant over the last three years (about 490 reported new cases annually) and the estimated prevalence is 3,700 cases out of a population of over 70 million.

Fast facts about HIV/AIDS in Turkey…

- According to the statistics provided by the Ministry of Health (MOH), the main route of transmission is through heterosexual sex (over 50%) followed by men having sex with men (MSM) at 8% and iv drug users (IDU) at 6%
- Sex work can be considered as a major driver for the epidemic and sex workers form a significant portion of the vulnerable populations
- Since 1994, a coding system has been utilized to keep the patient's identity anonymous while reporting the HIV infections in Turkey.

Fast facts about HIV/AIDS in Turkey…

- As reported by the MOH, 317 cases were in the 15-24 age group, **611 were 25-34 age group**, 497 in the 35-49 age group, and less than 50 in the 0-14 age group
- Among the reported HIV-positive and AIDS cases, males between 15 and 39 years of age appear to be at highest risk. In 2004, roughly 1/3 of reported infections were in women



The history of HIV / AIDS related issues in TURKEY

Since 1994, a coding system has been utilized to keep the patient's identity anonymous while reporting the HIV infections in Turkey

The National AIDS Commission (NAC), a multi- sectoral body was established in 1996

In 1997 NAC adopted a National AIDS Program

The third Strategic National Action Plan, for 2006-2010, is under preparation by NAC

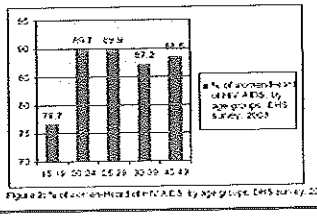
What about the awareness of Turkish people?

•88% of ever-married women have heard about HIV/AIDS and two-thirds of the women believe that there is a way to avoid HIV/AIDS

•The proportion knowing about HIV/AIDS is less than 80% only for the youngest age group of ever-married women (77%), for all other age groups, knowledge of HIV/AIDS is close to 90%.

•Ever-married women living in urban areas are more knowledgeable about HIV/AIDS than their rural counterparts

•Half of the women living in rural areas do not believe that there is a way to avoid HIV/AIDS



HIV / AIDS in TURKEY

The challenges, responses...

The general information, fast facts

Name: Republic of Turkey (Türkiye Cumhuriyeti)

Foundation: 1923

Population: 71,700,000

Official Language: Turkish

Government Type: Republican parliamentary democracy

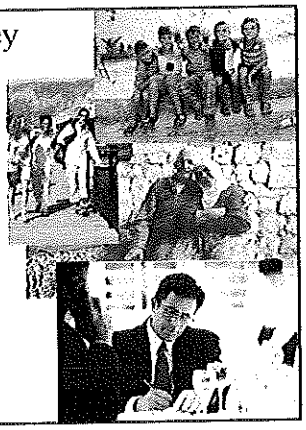
People in Turkey

Population 71,700,000

Population Growth Rate 1.13%

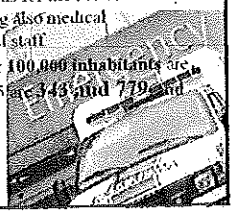
Religions 99% Muslim 1% Others

Median Age 27.3 years

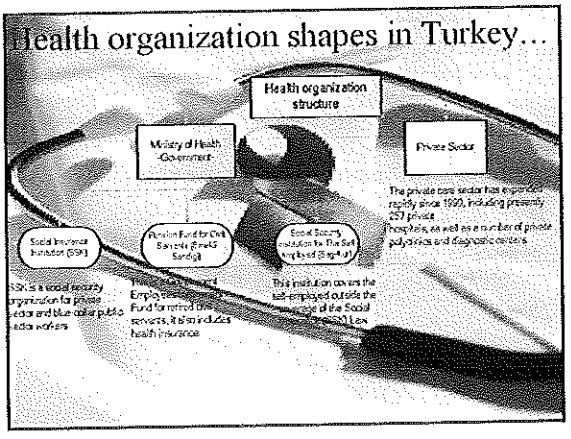


Health Organizations in Turkey...

- Turkey spends 6.6 % of GDP on health, while the EU15 spend 8.8 %. Total government expenditure on health accounts for 13 % of the total government expenditure, while it represented 17 % of EU15.
- The health care service in Turkey is provided by public, quasi-public, private and philanthropic organizations
- The Ministry of Defense owns 42 hospitals for the use of military personnel and their dependants, providing also medical postgraduate training for military medical staff.
- The number of physicians and nurses per 100,000 inhabitants are 137 and 235 respectively, while on EU25 are 343 and 779 and on EU15 were 356 and 818



Health organization shapes in Turkey...



What about the awareness of Turkish people?

The level of education is closely related to knowledge of HIV/AIDS. Almost all ever married women with secondary or higher education have heard of HIV/AIDS, while this figure declines to 63% for women with less than primary education

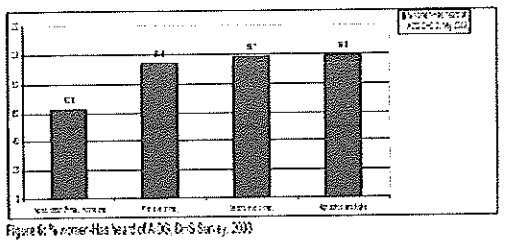
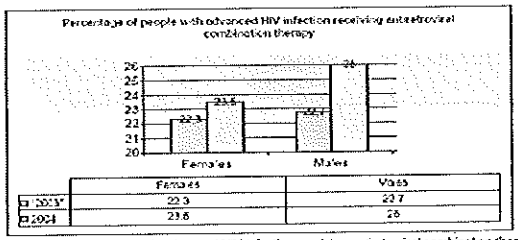


Figure 6: % ever-married women who have heard of AIDS, by education, DHS Survey, 2003

What about the awareness of Turkish people?

Percentage of people with advanced HIV infection receiving antiretroviral combination therapy has increased from 22,3% in 2003 to 23,5% in 2004 for females and from 22,7% in 2003 to 26% in 2004 for males



	Females	Males
2003	22,3	22,7
2004	23,5	26

Figure 10: % of people with advanced HIV infection receiving antiretroviral combination therapy
Source: MOH

The NGO's combating against this disease in Turkey

- The EU and the Global Fund are the main donors for HIV activities in Turkey
- Unicef
- Aiesec, providing young generation an international platform to discuss and be aware of this disease
- UNAIDS

AIESEC

GBC

Koç

Young Turkish generation & AIDS...

- Women and young people are not given the appropriate knowledge to protect themselves from HIV
- Some of the factors that contribute to the increase of HIV/AIDS in Turkey include a young population, many of whom are also sexually active, inadequate knowledge about sexually transmitted diseases makes them more vulnerable to HIV infection
- But the young generation is luckier than the previous ones due to accessing the necessary and vitally important information about AIDS. With the help of globalization, they are affected in a good way from European countries who are striving to educate the candidate countries for EU

The precautions the government and NGO's is taking

- IDUs [Individual drug users] have been identified as target groups in HIV/AIDS prevention programmes that will be implemented between 2005-2007 in Turkey.
- STD/AIDS control programme in Turkey monitors HIV infection through 81 Provincial Health Directorates (PHD) country-wide that are geographically distributed to represent all parts of the country
- A new strategic action plan is being developed for the years 2006-2010 emphasizing more on the millennium development goals
- Amount of national funds disbursed by governments is around $78,000,000 annually.
- Moreover, HIV and AIDS research protocols involving human subjects are reviewed and approved by ethical review committee of MOH or related health centers' ethical committees.

The threats for Turkey about the disease...

- Despite preventive efforts, the number of HIV/AIDS cases is on the rise and HIV/AIDS is becoming challenge for Turkey
- Injecting drug use is also on the rise
- Socio cultural norms are being increasingly liberalized because of tourism in Turkey.
- Also, many Turkish people work outside of Turkey
- Annually, Turkey receives approximately 24 million foreign visitors. Of these, roughly ¼ come from Eastern Europe and Newly Independent States (NIS) countries, a number of them with concentrated HIV/AIDS epidemics

Major challenges faced in Turkey about HIV/ AIDS

a) Because of the young structure of the population there is a need to intensify on prevention among young people

b) Recognition and appreciation of the need for effective strategies among high risk groups such as commercial sex workers, men having sex with men, IDUs and street children

c) Support and care mechanisms for PLWH are insufficient

d) There is a need to establish a strategic national monitoring and evaluation mechanism to oversee the national response

e) There is a need to a national AIDS account available to track the funds for HIV

f) Ensuring balance in the distribution of health personnel is a challenge

The Conclusion; Still hopeful...

Despite the fact that, there are some inevitable results may happen in society about AIDS, however it's still enhancing our hopes that, we have a government which is striving to create a whole necessities from the treatments to law processes, and we will have a well educated young generation who will be the AIDS patients' foe the [illegible]

Institute of Social Studies Trust and Office of Public Affairs U.S. Consulate General

present

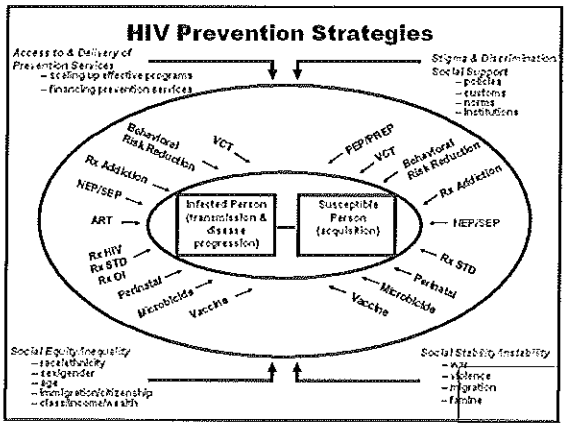
HIV/AIDS and Prevention: What is the Evidence?

Overview of Effective and Promising HIV Prevention Interventions

Sonia M. Kandathil, MPH

HIV/AIDS and Women
December 20, 2006

HIV Prevention Strategies



Behavioral Interventions

Goal:

- **To change behaviors to reduce risk of HIV infection by delaying onset of intercourse, reducing number of sex partners, increasing condom use, reducing or eliminating drug injection and/or sharing drug use equipment.**

Behavioral Interventions

Types:

- **Individual, couple, small group counseling**
- **Information and skills-building programs**
- **Peer and network interventions to change social norms**
- **Social marketing & mass communications campaigns**

Behavioral Interventions

Findings:

- **Meta-analyses have found that such interventions have resulted in 0% to 40% reductions in risk behaviors associated with HIV transmission and acquisition among different population groups and exposure categories** ***(See JAIDS, 2002, Vol. 30 S).***

HIV Prevention Paradigms: Science vs. Ideology

Public Health Science		*Ideology*
•Delay onset of sexual intercourse	⇨	• Abstain from intercourse until heterosexual marriage
•Reduce number of sex partners	⇨	• Be "faithful" within heterosexual marriage
•Use condoms consistently	⇨	• Use Condoms as last resort

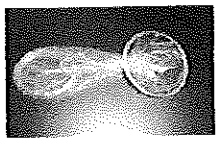
What's Wrong With Abstinence-Only?

- **Not evidence based; has no proven effectiveness**
- **May be harmful**
- **Stigmatizes and dehumanizes LGBT**

(D Kirby 2001; M Galiant & E Maticka-Tyndale 2004; N Kim et al. 1997; J Santelli et al. 2006)

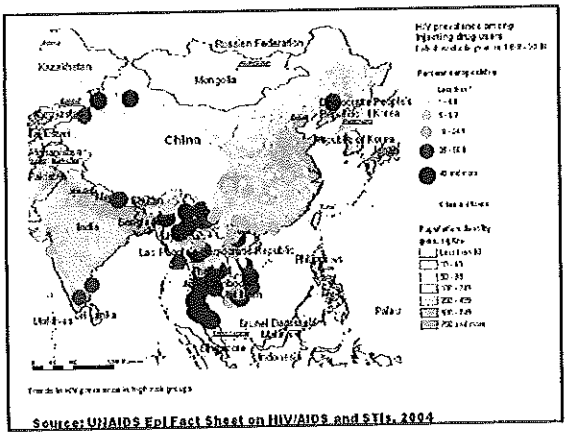
Condoms

- Male, latex condoms are 80% to 95% effective in reducing the risk of HIV transmission when used consistently and correctly *(NIH, 2001; Hearst & Chen 2003; Weller & Davis 2004; Holmes, et al. 2004).*
- Female condoms are estimated to be between 94% and 97% effective in reducing risk of STI, including HIV, transmission when used consistently and correctly *(Trussel, et al. 1994).*



Voluntary Counseling & Testing

- **Data are mixed on whether VCT reduces risk behavior and HIV infection** *(Weinhardt et al. 1999).*
  - VCT may be effective in reducing risk among sero-discordant couples.
  - VCT may be effective in reducing the number of non-primary partners (Merson et al. 2000).
- **But, VCT utilization remains low in high prevalence communities.**



Source: UNAIDS Epi Fact Sheet on HIV/AIDS and STIs, 2004

Drug Addiction Treatment

- **Methadone maintenance can be an effective HIV prevention strategy.**
  - One study found that IDUs in methadone treatment program were 6 times less likely to acquire HIV infection than IDUs not in treatment (3.5% seroconversion vs. 22%) *(Metzger, et al. 1993).*
  - Another study found at 36 months, 8% of IDUs in treatment and 30% of IDUs not-in-treatment became HIV infected. *(McLellan et al., 1996)*

Biomedical Interventions: Evaluating Technologies

Goal:

- **To moderate the influence of biological or physiological factors that may increase infectiousness or susceptibility to HIV or to prevent infection from progressing after actual exposure.**

STI Management

- **Three trials of syndromic and mass STI management have demonstrated mixed results in HIV prevention (Mwanza--38% reduction in HIV incidence; Rakai--3% reduction; Masaka--0% reduction)** *(Grosskurth, et al. 1995; Wawer, et al 1999; Kamali, et al 2003).*
- **STI management and control for HIV prevention is likely to be most effective in populations with early and concentrated sexually transmitted HIV epidemics and in populations with high prevalence of STIs and sexual risk behaviors** *(Korenromp et al. 2005).*

STI Management

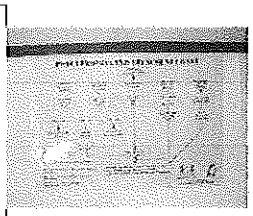
- **Prevalent HSV-2 infection is associated with as much as a 3-fold increase in risk of HIV acquisition among both women and men** *(Freeman et al, 2006).*
- **HSV-2 also appears to increase infectiousness of HIV+.**
- **Based on observational data, a number of Phase III trials are underway to measure effects of episodic or suppressive antiviral therapy on HIV acquisition or transmission** (Nagot 2006; Celum 2004).

Using ART for HIV Prevention

- **Preventing Mother-to-Child Transmission**
- **Post-Exposure Prophylaxis**
- **Pre-Exposure Prophylaxis**

Preventing Mother-to-Child Transmission

- **Long- and short-course AZT and single-dose nevirapine are effective in reducing MTCT by 44% to 66%** *(Brocklehurst 2004).*
- **Breast-milk substitutes have been shown to significantly reduce infection among infants.**
- **The number of children who acquired HIV perinatally decreased by 89% between 1992 and 2001** *(Cooper, et al. 2002).*



Post-Exposure Prophylaxis (PEP)

- **Evidence suggests that a short course of ART administered within 72 hours of occupational or non-occupational exposure is effective in preventing HIV infection** *(Cardo, et al. 1997; Wulfsohn 2003; Mayer 2003).*
  - **Retrospective study of occupational PEP concluded AZT monotherapy administered within 24 hours of exposure and over 28 days reduced HIV transmission by 81%** *(Cardo, et al. 1997).*

Pre-Exposure Prophylaxis (PrEP)

- *Goal*: To prevent infection from taking hold by administering ART before exposure.
- *Rationale*:
  - VL associated with HIV transmission
  - Animal studies
  - PEP and PMTCT data
  - Observational data, e.g., Taiwan

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Male Circumcision

- Two meta-analyses of observational studies found the risk of HIV among circumcised men was about half that of uncircumcised men *(Weiss, et al. 2000; Siegfried, et al. 2004)*.
- RCT in South Africa (N = 3,000) showed 70% protective effect of circumcision (Auvert, et al. 2005).
- Other trials are in process (in Kenya and Uganda) to see if results are replicated.

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Vaccines

Goals:

- Prevent HIV Infection
- Prevent Disease Progression (therapeutic vaccine)

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Vaccine Accomplishments

- >30 products or combinations tested in over 50 phase I & II trials with >4000 volunteers
- New vaccine designs developed; 10-12 to enter phase I clinical trials within 2 years
- First multigene, multiclade Phase I trial launched by NIH Vaccine Research Center
- One Phase III trial completed in U.S. & Netherlands (no efficacy); one Phase III trial in process in Thailand.

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Microbicides

Goal:

- Block sexual transmission of HIV infection by:
  - Killing or inactivating the virus
  - Preventing the virus from crossing mucosal barrier
  - Interrupting the viral life cycle

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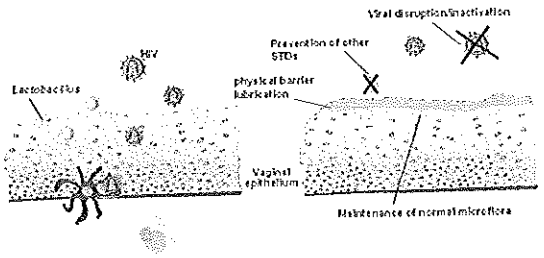
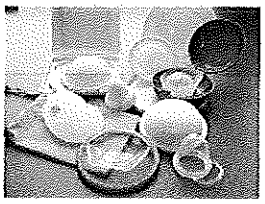
How Might Microbicides Work



Efficacy Trials of Topical Microbicides

Sponsors	Product	No. Women Seen	No. Women to Enroll	Status	Complete
NIAID	BufferGel, PRO 2000	9000	3200	Ongoing	2007
Pop Council	Carraguard	12,540	6300	Ongoing	2005
FHI/USAID	Savvy	10,000	4284	Ongoing	2005
FHI/USAID	Cellulose sulfate	5000	2160	Ongoing	2006
CONRAD/ USAID	Cellulose sulfate	5000	2574	Ongoing	2008
MDP/MRC	PRO 2000	20,000	12,000	To begin	2008

Cervical Barrier Methods



- Basic and clinical studies suggest cervix may be particularly vulnerable to HIV and STI transmission.
- Observational studies indicate diaphragm used with spermicide may protect against some STIs and associated sequelae.
- Seven clinical trials underway to examine effectiveness of diaphragm in preventing STIs including HIV.

Social/Structural Interventions

Goal:

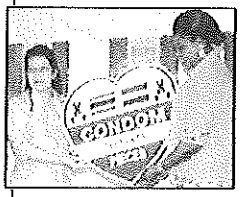
- **To modify social arrangements and/or affect social conditions that facilitate health promotion and risk reduction**

Social/Structural Interventions

- **Policy Interventions**
  - Thai 100% Condom Use Program
  - Syringe Access
- **Economic Empowerment for Women**
  - Microfinance
  - Property & Inheritance Rights

Thai 100% Condom Use Program

- Made condom use mandatory in all brothels, even while prostitution remained illegal.
- Promotion of condom use coupled with emphasis on decreasing visits to sex workers.
- Program included mass media, community mobilization, NGO engagement, political commitment

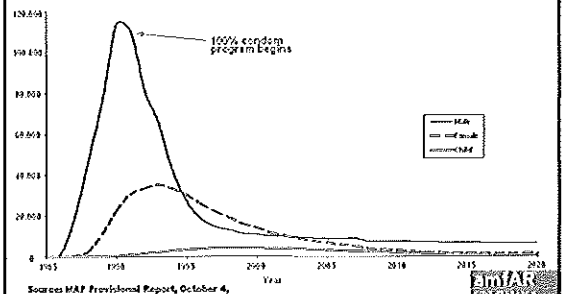


Thai 100% Condom Use Program

Results:

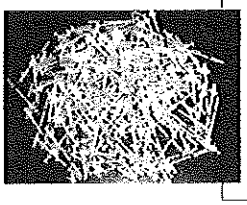
- Among military recruits, visits to sex workers decreased 34% and condom use with sex workers increased 32% between 1991 and 1995.
- HIV incidence rate declined from 3/100 person-years to 0.3/100 person years between 1991 and 1993.
- Program replicated in other Asian countries.

Modeled new HIV infections in men, women and children in Thailand, 1985 - 2020



Source: MAP Provisional Report, October 4, 2005

Syringe/Needle Exchange Programs



- Syringe exchange programs have been shown to reduce the risk of HIV transmission among IDUs without increasing drug use.
  - In NYC, HIV incidence among IDU declined by over 40% between 1991 and 1996, in great part due to access to clean needles *(Des Jarlais, et al. 1998)*.
  - Study of 99 cities concluded that HIV prevalence decreased by 18.6% per year in cities with SEP, and increased by 8.1% in cities without SEP *(MacDonald, et al. 2003)*.

Economic Empowerment for Women

- **Property & Inheritance Rights**
  - Limited empirical evidence for impact on HIV incidence.
- **Microfinance**
  - One RCT showed no effect on HIV incidence or risky sexual behavior, but did show reduction in physical and sexual abuse among intervention participants.

Cross-Cutting Issues

- **Recruitment & retention in studies**
- **Adherence to prevention protocol**
- **Behavioral disinhibition/risk compensation**
- **Partial effectiveness**
- **Engaging communities in research**

Summary

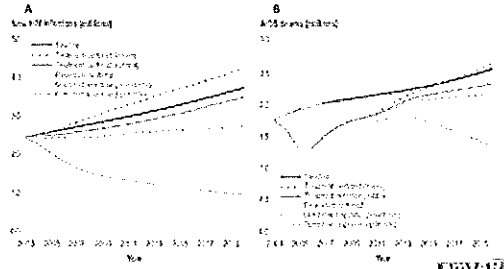
- Great deal of evidence for efficacy/effectiveness of a number of HIV prevention interventions.
- Risk reduction and declining HIV incidence can be achieved through behavioral, biomedical, and social strategies, especially in combination.
- No intervention will be 100% effective.
- We must not confuse lack of implementation with lack of effectiveness.

Estimates of Access to Effective Interventions for At-risk Populations, 2005

- 9% of MSM received prevention services
- <20% of IDUs received prevention services
  - <10% in Eastern Europe & Central Asia
- 9% of pregnant women were provided PMTCT services

(UNAIDS 2006)

HIV incidence & AIDS mortality among adults in Sub-Saharan Africa, 2003-2020 under different intervention scenarios *(Salomon, et al. 2005)*



Conclusions & Way Forward

- Acknowledge great deal of evidence for prevention efficacy
- Recognize human behavior is difficult, but not impossible to change
- Understand HIV is transmitted through human relationships that occur in social, cultural and physical contexts
- Increase education and outreach to eliminate stigma and discrimination
- Accept that there is no single best, nor perfect prevention strategy
- Integrated, comprehensive approach reflecting local solutions is necessary

Caucus for Evidence-Based Prevention

Caucus for Evidence-Based Prevention

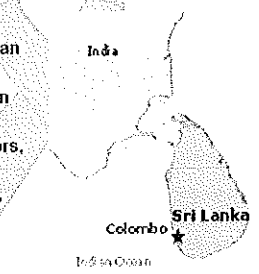
http://caucus.hiv-prevention.org

AIDS IN SRI LANKA

- NIZLA NAIZER

SRI LANKA

- **Location:** Southern Asia, island in the Indian Ocean, south of India
- **Population :** 20 million
- **Ethnic Groups:** Sinhalese, Tamil, Moors, Burghers and Malays
- **Religions:** Buddhism, Hinduism, Islam and Christianity



General Health in Sri Lanka

- Good health parameters
- High (90%) literacy rate
- Low prevalence of HIV/AIDS
- Immunization coverage of children against potentially life threatening childhood diseases
- Ethnic conflict 1985, volatility in northern and eastern regions which have been at the heart of the conflict

HIV in Sri Lanka

- First reported case of AIDS in 1986
- Total reported HIV cases – 614 (2004)
- HIV-positive men to women in Sri Lanka is reportedly 1.4 to 1
- Methods of transmission:
  - 86% through heterosexual transmission
  - Homosexual and bisexual behavior
  - Injected drug users
  - Mother to child transmission
  - Infected blood transmission

Status In Sri Lanka

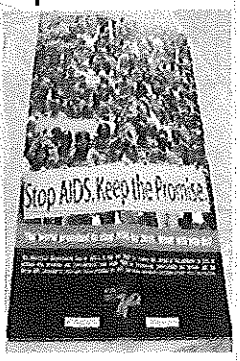
Figures	Value	Year
Estimated number of HIV/AIDS (women and children)	5000	2005
Adults (15-49 years)	5000	2005
Women (15-49)	< 1000	2005
Estimated Number of deaths due to AIDS	131	2004
Estimated Number of AIDS orphans	< 500	2005

Risk Factors

- Low condom use
- Commercial sex – women and beach boys
- Sexually Transmitted Infections (STI)
- High mobility
- Injecting Drug Users
- Low level of awareness among the poor
- Military groups

National Responses

- National STD and AIDS Control Programme (NSACP) under the Ministry of Health.
- Management Information System established currently linking all STI clinics to the central NSACP based on a Monitoring and Evaluation Framework for HIV.
- Blood screening since 1987.
- Care and treatment through the national HIV Prevention Program.
- As signatory to UN's Millennium Development Goals, Sri Lanka is committed to halt and reverse of the spread of HIV / AIDS by 2015.



Government Priorities

- Disseminating accurate information on STIs and HIV/AIDS among young people
- Provide information on youth friendly services
- Advocacy to empower the groups at risk to better protect themselves and demand better prevention and care services
- Standardise STI treatment by training of general practitioners in syndromic management
- Put in place a strong programme for comprehensive care and treatment for HIV infected people
- Establish a programme for prevention of mother-to-child transmission of HIV

NGOs & the World Bank

- NGO work in the area of HIV/AIDS prevention in Sri Lanka has been limited & largely uncoordinated.
- Its program coverage of high-risk sub-populations is estimated to be less than 10 percent.
- World Bank provided about US$1 million each year to Sri Lanka's HIV/STD program through the Health Services Project.
- In December 2002, the Bank's International Development Association (IDA) provided a $12.6 million grant to help finance the National HIV/AIDS prevention project.

AIDS Awareness Campaigns

Stigma and discrimination abound

- Reducing the stigma by involving civil society organizations, businesses, the entertainment industry, religious leaders, and the medical community.
- Training police to reduce harassment of vulnerable groups and engage HIV-positive groups.

A Portrait of Greatness

- Dr. Kamalika Abeyratne
- Infected by HIV after a car accident through blood transfusion in 1995
- Spokeswoman for AIDS awareness
- Succumbed to the disease in Dec, 2004

"It's bad enough that people are dying of AIDS, but no one should die of ignorance."
- Princess Diana

Spread Prevention
Stop AIDS!!!

WELCOME

Indian Network for People Living with HIV/AIDS (INP+)

Ms. Asha Ramaiah
National Advocacy Officer
INP+

Our Goal...

- To improve the Quality of Life of People Living with HIV/AIDS in India

Structure...

INP+ (National Level Network)

↓

23 State Level Networks

↓

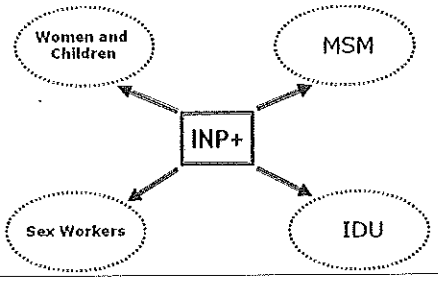
140 District Level Networks

↓

Blocks/Taluk Level Networks

(More than 45000 membership)

Working Groups...



Issues...

- Stigma discrimination in the health care settings, work place and community
- There is no proper diagnostic facilities at PHC level
- There is no second line ARV medicine
- Slow legal process
- Lack of Ministries commitment
- Lack of regional language IEC materials
- Indian women are more vulnerable (Blame, lack of education, early marriage, no decision power, violation of rights, cultural factors, etc.)

Strategies...

- Advocacy
- Network building
- Service delivery

Key Areas of Advocacy...

- Improved access to treatment
- Reduced stigma and discrimination
- GIPA

Service Delivery....

- Care and Support
  - Peer education
  - Access to Treatment preparedness
  - Support for diagnostic
  - Nutrition support
  - Livelihood
  - Protection of rights
- Prevention
  - Education on prevention
  - Positive prevention
  - Creating enabling environment

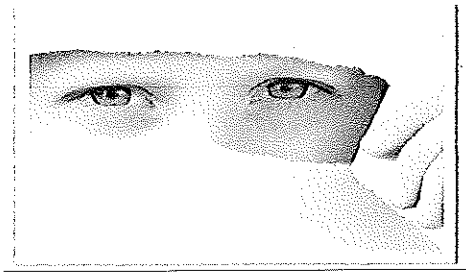
Network Building...

- Increased membership for peer support
- Improve governance and leadership
- Skill building
- System strengthening (MIS, finance and administrative)

Government services (NACO/SACS)...

- ICTC established in district level
- Around 107 ART centers established through out India
- November 14th on children day occasion - Pediatric ARV centers established at state level
- Financial support (NGO for prevention Program, PLHA network for creating enabling environment)
- NACO accepted GIPA policy paper
- Developing IEC materials
- Mainstreaming the HIV/AIDS issues in all the sector

Thank You...



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