

Malevolent friends: Malaria and HIV

by SafAIDS Staff



Source: www.AVERT.org ©AVERT

Malaria has long been a serious public health problem in sub-Saharan Africa. Yet with the advent of HIV, malaria prophylaxis and treatment has taken a somewhat back seat. Both diseases independently cause complications for maternal and child health, but recent studies in Africa demonstrate that the dangers are compounded when both HIV and malaria occur together.

Dual infection in pregnant women is associated with an increased risk of maternal, perinatal, and early infant death compared to either disease alone; HIV-infected pregnant women have an increased incidence and severity of clinical malaria, while in children with HIV and malaria, anaemia is common and associated with increased mortality. Immunosuppression also reduces the effectiveness of malaria treatments, while parasitemia is often more dense in HIV infected individuals.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) AIDS epidemic update (2006) states that "An estimated 40 million people are infected with HIV in Africa,

resulting in an annual mortality of over 3 million, while over 500 million clinical malaria infections occur every year with more than a million malaria-associated deaths." Although there is a significant geographic overlap between the two diseases there has, up until now, been little clear evidence of the pathological interactions between them.

Now, the epidemiological modelling exercise by Abu-Raddad, Patnaik and Kublin which we mentioned briefly in our last issue, suggests that malaria/ HIV interaction is one more independent explanatory variable for the high incidence and rapid spread of HIV in southern Africa. This represents another significant challenge for the already stretched

public health systems in the region.

HIV destroys CD4 cells, the same immune cells that are involved in the development of antimalarial immunity and HIV infection appears to double the risk of malaria parasitemia and the development of clinical malaria. In turn, transient episodes of malaria are known to increase the viral load of those with HIV, raising the possibility of increased sexual transmission of HIV. Research in Kenya has shown that treatment of uncompromised malaria with sulphadoxine-pyrimethamine is significantly more likely to be unsuccessful in HIV-positive adults with CD4 cell counts below 200 cells/mm. Successful treatment depends on the co-activity of the antimalarial drugs which clear drug-sensitive parasites, and the immunity of the host.

The Kenya study found that malaria in HIV-infected people with a low CD4 cell count resulted in significantly higher parasite density, prevalence of fever and prevalence of anaemia, than those with a high CD4 cell count or those who were HIV negative. They also had lower levels of haemoglobin and a higher incidence of overall treatment failure and reinfection. It is clear from this data that HIV infected individuals are at much greater risk of other developing other harmful conditions when they are co-infected with malaria – a common occurrence in southern Africa.

For reasons of both ethics and logistics, it has not been possible to ascertain whether malaria promotes HIV transmission and whether high HIV prevalence might extend the borders of malaria endemicity. Now, the modelling exercise has shown that malaria is fuelling HIV transmission on a large scale, and that high HIV prevalence can also increase the spread of malaria as a result of reduced immunity in the population at large.

Continued on page 3

In This Issue

- From Mother to Mother: A peer mentor programme to prevent mother-to-child transmission of HIV in South Africa offers much needed support
- Voluntary Counselling and Testing for HIV and Masculinity in South Africa
- Genital herpes implicated in up to half of all HIV infections in some African countries
- Novartis loses Indian Patent case: good news for ARV access
- Donors and NGOs working hand in hand to address HIV and AIDS in the workplace
- AIDS Vaccine Advocacy Coalition Voices Disappointment in Trial Result
- FHI in Bold New Initiative to Reduce Orphaning in HIV-Affected Communities
- My Mum has HIV: Innovative IEC programme in Zambia

Editorial

Another Year, Another Chance

The Band plays on

Another year, another World AIDS day over and still the number of new infections continues to rise. It is no accident that the themes for World AIDS Day have for several years revolved around aspects of leadership. If ever there was a need for genuine leadership at all levels (and if ever there was a greater lack) it is in the response to the AIDS pandemic. The G8 continue to make commitments which they fail to keep, while the majority of countries in Africa have still to meet the commitments of the Abuja Declaration. Are we not dying? It has been pointed out that the number of deaths per week in Africa was the equivalent of three '9/11s', and still the band plays on.

The Global Fund has proven to be an effective way of allocating money that finds its way directly to where it is needed, but nonetheless there is need for some revisions in the way the system works. CCMs are too often ineffective in getting money spent and in providing the necessary information for calls for proposals for the next funding rounds. There is obviously a serious problem when some countries have still not managed to spend Round One money, yet we are about to begin Round Eight. The fact too, that countries - with both a severe epidemic and difficult economic conditions - lose out on funding, suggests the need for civil society to be capacitated, so that the people on the ground no longer have to carry the weight of civil servants' ineptitude.

TB Anywhere is TB Everywhere

This year, appropriately, Cape Town hosted the 38th World Lung conference - southern Africa has the largest dual epidemic of TB and HIV co-infection and South Africa itself holds the distinction of raising the alarm about XDR TB. TB continues to be the largest single killer of people living with HIV worldwide, yet it is both preventable and curable. TB and HIV services must be integrated without delay and will surely help reduce the strain on the limited health care resources and personnel available.

Those involved in TB treatment and diagnosis need to take several leaves out of the books of HIV treatment activists; by adopting 'treatment buddies'; pushing

urgently for better and faster diagnostic tools; for treatment regimens that are easier to adhere to; and the launch of popular campaigns for health education on TB control. Let's hope that this time around, the rich world will not deceive itself that TB is not their problem. TB anywhere is TB everywhere. If southern Africa becomes a reservoir for MDR and XDR TB because of the extent of its HIV epidemic, then the whole world is at risk. HIV and TB must be seen as twins and tackled together as a matter of urgency.

The roll-out of universal access to treatment, care and support must continue in the coming year with renewed urgency - keeping immune systems strong with ARVs and prophylactic isoniazid therapy where necessary, is one of the best ways of reducing the incidence of TB.

More people on treatment must also be seen as another aspect of prevention - more people on ARVs also means less HIV transmission. But the search for ever new ways of pushing

prevention of new infections must be the strongest arrow in our quiver. Reports from countries where ARV treatment is readily available suggest that our prevention messages are missing the mark and as yet we have failed to find messages and methods that produce real and meaningful behaviour change. This must be our target for this coming year.

Its all about fear

Increasingly we are finding that HIV is a key that allows us to open up and explore ever more complex aspects of how we relate to our bodies to each other and to the societies around us. The stigma that prevents us from speaking openly about sex, about

gender based violence, child abuse, HIV, illness and dying is surely rooted in fear. Uncovering what we are afraid of allows to find ways to combat the fear and to take action. This issue's article from EngenderHealth explores the complexities of behaviour and gives new insights to work with in our prevention programming. EngenderHealth investigated why it is that South African men will not go for HIV testing. The obvious answer is that they are afraid. But afraid of what?

Fears are complex emotions and the fear uncovered is ironically not so much fear of the results, as fear of seeming less

of a man. Their research shows how gender roles compromise men's reproductive health by encouraging risky behaviours while simultaneously discouraging the use of VCT and other health seeking behaviours. We need more innovative programmes like this to challenge our deepest feelings of inadequacy and broaden communities' awareness of TB and HIV treatment

programmes. The position of women in society is an important part of Africa's enduring difficulties in improving the continent's health and programmes like this need to be expanded into the rest of the southern Africa region.

Another year

As we also highlight in this issue, other preventable diseases continue to fuel the HIV epidemic in Africa, among them malaria and genital herpes. These diseases must also be targeted as part of a multi-pronged prevention programme.

Another year, another chance for us to get some things right and stop AIDS in its tracks. ■

Those involved in TB treatment and diagnosis need to take several leaves out of the books of HIV treatment activists

Malevolent friends: Malaria and HIV

Continued from page 1

The modelling exercise was carried out using data from a survey in Kisumu district, in Kenya, an area of high HIV prevalence and endemic malaria and it shows that "Co-infection leads to an increase in viral load in chronic-stage HIV-infected patients during febrile malaria episodes and HIV infection substantially increases susceptibility to malaria infection and the development of clinical malaria". Thus, malaria in HIV-positive people represents an important risk factor for HIV transmission both to sexual partners and to unborn babies.

The model incorporated a range of core assumptions, among them: the rate of HIV transmission per sexual act; the increase in viral load during malaria attacks of varying severity; HIV-mediated susceptibility to malaria as a function of the stage of HIV progression; the duration of viral load increments sure to malaria; sexual activity during clinical and non-clinical malaria; the proportion of HIV-negative and HIV-positive people developing clinical malaria; and HIV mortality in dually infected patients in areas of stable and unstable malaria.

According to the model, the HIV epidemic peak in Kisumu was 8% higher and the malaria peak 13% higher, than they would have been were there no interaction between the infections. Between 1990 and 2005, HIV prevalence was 25% in Kisumu and almost 5% of HIV infections were attributable to malaria, while malaria promoted by HIV stood at almost 10%. "In the absence of malaria intervention, the disease interaction was responsible for 8,500 excess HIV infections and 980,000 excess malaria episodes since 1980" say the authors.

The effect of the interaction between the two diseases is negligible in areas where the incidence of both is high. However, where one disease is prevalent, co-infection was found to increase the prevalence of the other. In a setting with 1% malaria and 37.8% HIV prevalence at baseline, co-infection increased malaria prevalence to 9.2% but HIV prevalence was barely changed, at 38.5%. This demonstrates a significant risk of malaria spread in areas of southern Africa where HIV prevalence is already high and where malaria can be supported.

The model also allows calculation of the impact of interventions in dual infected individuals, such as malaria prevention and treatment and sexual abstinence or condom use, and indicates that relatively small interventions could have a significant impact on the incidence of both diseases. Raddad et al suggest that emphasis on malaria treatment and protection against mosquitoes, such as insecticide treated bed nets for HIV infected people, will be beneficial and that malaria treatment and control services should be combined with HIV services and treatment.

There are many other compelling studies to indicate the advantages of joint services for those with co-infection, especially in the realm of maternity care. Malaria increases the likelihood of mother to child transmission of HIV and the effect of dual infection is greater in patients with advanced HIV disease and suppressed immune function. Given the

frequency of this combination, interventions here are likely to have a significant public health impact.

In endemic malaria areas, most individuals have developed some immunity by the age of five. However it seems possible that HIV infection impairs the immune response to *P. falciparum* and that women may lose this acquired immunity during pregnancy. This may then result in a woman contracting a severe case of malaria that can lead to a preterm delivery, low birth weight, growth retardation, or even the death of the infant or herself. A Kenyan study of HIV and malaria co-infection, reported that dual infection was associated with low birth weights, preterm deliveries, and slow gestational development.

A study in Zimbabwe found that both infections were independently associated with an increased risk of stillbirth and preterm delivery, low birth weight and foetal growth restriction. However, infants born to co-infected women were much more likely to die. The risk of death for infants born to women affected by malaria was 18%, 40% for those with HIV, and as high as 73% for mothers with dual infection. Similarly, women with HIV are more likely to present with clinical malaria during pregnancy, and dual infection increases their risk of death.

Malaria infection in HIV-positive pregnant women may increase the risk of mother to-child transmission of HIV, and this concern was echoed by a study in Uganda which looked at the effect of placental malaria on mother-to-child transmission (MTCT) of HIV. The study found that placental malaria was more common in HIV-positive than HIV-negative women and 13% had placental malaria, compared with 8% of HIV-negative mothers. In the study overall, the rate of MTCT was 20%: for those with placental malaria it rose to 40% while it was 15% in those without malaria. There was a significant association between MTCT, maternal viral load and placental malaria infection.

On the whole, international funders and public health systems in Africa have been slow to adopt appropriate policies for the care of people with HIV in respect of malarial co-infection, but we now have the evidence that relatively cheap and easy interventions can make a significant difference to co-morbidity from these two infections.

As an example of how simple and cost-effective such interventions can be, a study in children in Mali found that cotrimoxazole - already recommended by UNAIDS as a prophylaxis for people living with HIV in resource-limited settings - provides almost 100% protection against malaria and does not cause resistance to the anti-malarial drug sulfadoxine-pyrimethamine. Previous studies in Zambia and Malawi have confirmed this effect, but there were concerns that cotrimoxazole might reduce the treatment efficacy of sulfadoxine-pyrimethamine. The primary aim of the study was to test the theory that prophylaxis with cotrimoxazole decreases the efficacy of sulfadoxine-pyrimethamine treatment for malaria, while

the secondary objective was to see if treatment with cotrimoxazole promoted the emergence of malaria parasites with resistance.

These fears were not confirmed; instead the study found that the prophylactic efficacy of cotrimoxazole against uncomplicated malaria was over 99%, with a 97% efficacy against asymptomatic malaria, but there were other unanticipated benefits. Children in the treatment arm had fewer gastrointestinal illnesses and needed fewer prescription medicines than children in the control group. Cotrimoxazole prophylaxis also seems to increase levels of haemoglobin resulting in a lower incidence of anaemia in those treated.

Clearly there is a need for further field studies to confirm the Abu-Raddad et al's epidemiological modelling, but there is now sufficient evidence to suggest that malaria prevention and prophylaxis are a cheap and cost-effective option that will save lives and reduce morbidity, as well as hopefully, prevent the further spread of endemic malaria, while reducing the rate of HIV transmission.

If the millennium development goals that target HIV and malaria as impediments to socio-economic development in Africa are to



be met, then major investments in this are warranted. The Global Fund, which funds almost 70% of malaria control financing, needs to ensure that the evidence from these studies is put into practice as a matter of urgency and allow greater access to Long Lasting Insecticide Treated Nets, Indoor Residual Spraying and to effective drugs to stop unnecessary deaths from dual infections in the region. ■

References

- Ayisi JG et al. *The effect of dual infection with HIV and malaria on pregnancy outcome in western Kenya.* AIDS. 17: 585-594, 2003.
- Brahmbhatta H et al. *The effects of placental malaria on mother-to-child HIV transmission in Rakai, Uganda.* AIDS 17: 2540-254
- Laith J, Abu-Raddad, Padmaja Patnaik and James G. Kublin. *Dual infection with HIV and malaria fuels the spread of both diseases in sub-Saharan Africa.* Science 314: 1603-1606, 2006
- Michael Carter *Cotrimoxazole prophylaxis is highly effective against malaria.* AIDS MAP.com
- Shah SN et al. *HIV-1 immunosuppression and antimalarial efficacy: sulfadoxine-pyrimethamine for the treatment of uncomplicated malaria in HIV-infected adults in Siaya, Kenya.* Journal of Infectious Diseases 194: 1519-1528, 2006.
- Theo Smart *HIV/malaria co-infection increases morbidity and mother to child HIV transmission.* AIDS MAP.com
- Thera MA et al. *Impact of trimethoprim-sulfamethoxazole prophylaxis on falciparum malaria infection and disease.* J Infect Dis 192: 1823 - 1829, 2005.
- Ticconi C et al. *Effect of maternal HIV and malaria infection on pregnancy and perinatal outcome in Zimbabwe.* Journal of Acquired Immune Deficiency Syndromes 34: 289-294, 2003.

TSF Southern Africa First External Review

Countries in the region and beyond have recently committed themselves and set ambitious targets to achieve universal access to HIV prevention, care and support programmes. To help achieve these targets UNAIDS after extensive consultations, set up the Technical Support Facilities (TSF) to provide country partners with timely and quality assured technical support in HIV strategic planning, programme implementations, monitoring and evaluation and to build local capacity using local and regional expertise.

Five TSFs have so far been established; three in sub-Saharan Africa (Southern Africa, Eastern Africa and Western and Central Africa) and one in South East Asia and South America.

In May, after 18 months of existence, the Southern African TSF underwent an external review to assess its effectiveness, efficiency and relevance. The review

included document reviews, interviews and questionnaire surveys with key stakeholders including UNAIDS Country Coordinators, RST-ESA staff, representatives of National AIDS Commissions, Ministries of Health, NGOs, bilateral and UN agencies and consultants.

The review concluded that the TSF Southern Africa works well and is an effective model and system for delivering short term technical assistance. It has gained momentum and is well positioned to play a larger role in the region. At the time of the review, it had provided 2,000 days of technical support in 13 countries and had established a database of more than 1,000 consultants. The review also found that:

- The TSF has a good reputation for being a valuable and credible technical support delivery mechanism – both in-country and at regional level, and to stakeholders

such as UN agencies, NACS, NGOs and consultants

- Clients perceive services to be useful, timely, reliable, client-friendly and largely meeting their quality definitions
- Consultants find the contracting, back-stopping and information services useful and relevant

The TSF for Southern Africa is managed by a consortium led by Health and Development Africa (HDA), based in Johannesburg. It services 14 countries; Angola, Botswana, Comoros, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Zambia and Zimbabwe.

For more information contact Susan O'Leary, UNAIDS RST-ESA Regional Adviser, Technical Support, OLEarys@unaids.org

New Online HIV Prevention Database

UNAIDS Regional Support Team for Eastern and Southern Africa (UNAIDS RST-ESA), the UN Working Group on HIV Prevention and UNAIDS Technical Support Facility (TSF) are pleased to announce the availability of a new online database of HIV Prevention Consultants:

www.hivpreventionexperts.org

The database managed by the TSF for Southern Africa, is intended to help users identify skilled HIV prevention consultants based in Africa. The consultants will support the development, implementation, monitoring and evaluation of HIV prevention strategies and programmes.

Consultants are available for Behaviour Change Communication and IEC, condom

programming, gender, male circumcision, policy co-ordination, PMTCT, programming for high risk populations, STI diagnosis and treatment and more.

HIV and AIDS Focal Points from UN agencies, UNAIDS Country Offices, National AIDS Councils, government ministries, development partners and NGOs will find the database invaluable in locating country and regionally based consultants.

Users are able to search from an extensive pool of consultants by a combination of:

- Area of technical expertise
- Country of residence
- Language- English, French, Portuguese and Spanish
- Name of Consultant

The database has a special focus on consultants for eastern and southern Africa-countries with concentrated HIV epidemics. In addition, the TSF has established a training programme to further develop the capacities of the consultants.

To locate a consultant:

www.hivpreventionexperts.org/search.php

To register as a consultant:

www.hivpreventionexperts.org/consultants.php

For more information contact: TSF Southern Africa

Telephone: +27 (0)11 484 8217/8

Fax: +27-11-484-6782/8238

Email: info@hivpreventionexperts.org

Website: www.hivpreventionexperts.org

Establishing Joint UN Teams and Programmes of Support on AIDS: A Status Report

As part of ongoing efforts to improve the co-ordination of UN support to national AIDS responses, Resident Co-ordinators with support from UNAIDS and co-sponsors at the regional level are at the directive of the UN Secretary General, overseeing the establishment of a Joint United Nations Team on AIDS with a Joint Programme of Support.

A survey completed by UNAIDS RST-ESA in April 2007 revealed overall

progress in the establishment of Joint Teams in eastern and southern Africa. Of 18 countries surveyed, 15 had teams in place or had made advanced preparations. Progress in establishing a joint programme of support, however, lags behind; only eight countries had a joint programme or had made advanced preparations.

The Joint Team is considered established when four elements are met.

These include:

1. nomination of team members by the Resident Co-ordinator or Head of Agency,
2. domestication of the division of labour,
3. designation of technical support leaders
4. approval of joint team managements or accountability mechanisms.

Of the four elements, the nomination of the team members of the division of labour are the most advanced in the countries

Continued on page 5

Continued from page 4

surveyed. The designation of technical support leaders and management arrangements require more work. Most teams have created working groups on HIV prevention, treatment, care and support. Significantly less countries have working groups on orphans and vulnerable children, mainstreaming and monitoring and evaluation. More analysis will be undertaken on the number of staff working on HIV and AIDS and their actual capacity to make the groups work.

The Joint Programme of Support consists of five elements, namely the production of a strategic framework, an annual rolling work plan, a technical support plan, an AIDS team monitoring and evaluation plan and co-ordination and implementation arrangements. In the countries surveyed, the development and endorsement of a multi-year strategic framework aligned to the UN Development Assistance Framework (UNDAF) and annual rolling work plan are most advanced. More work remains in developing a technical support

plan, reaching agreement on co-ordination and implementation arrangements and a monitoring and evaluation plan for the AIDS Team.

UNAIDS RST-ESA and the co-sponsors will continue to support countries through the complex progress of establishing Joint Teams. It will, before the end of the year, convene a meeting of the Resident Co-ordinators, to reflect on experiences, lessons learnt and implications for the future.

For more information visit or contact Dominique Mathiot, UNAIDS RST-ESA at MathiotD@unaids.org

Update on Universal Access Target Setting in Eastern and Southern Africa

UNAIDS RST-ESA undertook a second rapid review in April, to establish progress made by countries in the region in setting universal access targets. The target setting process follows on the 2006 Brazzaville Declaration on Universal Access adopted by African Member States and the Political Declaration on HIV and AIDS adopted by the United Nations General Assembly, where countries committed themselves to set ambitious national targets to ensure universal access to HIV prevention, treatment, care and support by 2010.

The review showed that 17 out of 20 countries, or 85%, had draft or final targets that were decided through a consultative process that included civil society. This is significant progress compared to the first review in September 2006, when only eight

countries had finalised their targets, and another six were in the process.

Target setting is however incomplete in that no country has all seven core indicators relating to antiretroviral access, OVC support, PMTCT, HIV testing, condom distribution, age of sexual debut and national resource commitment. Countries are generally stronger on treatment targets, and weaker on prevention and national resource commitment. Sixteen countries have treatment targets as opposed to 14 with prevention and only eight have resource commitment targets.

Common challenges faced by countries include a weak evidence base from which to set targets, delayed member state follow up on international commitments and

insecure funding to realise ambitious targets.

Seven out of 20 countries have incorporated universal access targets into their National Strategic Framework and six of these have costed the frameworks. Three countries have costed their frameworks but are still to incorporate the targets.

UNAIDS will continue to support the countries to ensure completeness and consistency of the core indicators. A priority will be to address weaknesses in prevention and national commitment targets. Other required support includes brokering technical and financial support for action planning, costing and monitoring and evaluation.

For more information contact Masauso Nzima, M&E Advisor UNAIDS, nzimam@unaids.org

UN Directory of Regional Advisors on HIV for Eastern and Southern Africa

The directory assists individuals and organisations to identify and contact appropriate advisors within the United Nations System, for their HIV related strategies and activities. It provides information on the UN Regional HIV and AIDS Teams, the Team for Eastern and Southern Africa (RHAT) and the 16 UN entities involved in the AIDS response.

*Date: 2007
Availability: Publication
Website: www.unaidsrstea.org
Keywords: Directory, RHAT, Regional Advisers
To Order: UNAIDS RST ESA,
Tel+ +27 11 517 1519,
Email: KnowledgeDeskRSTESA@unaids.org*

Male Circumcision: Africa's Unprecedented Opportunity

The document reviews the evidence that male circumcision reduces the risk of HIV transmission in men by 60% and what African leaders and governments are doing and can do to make the procedure widely available.

*Date: August 2007
Availability: publication, website
Keywords: Male Circumcision, HIV Prevention, Advocacy,
To Order: UNAIDS RST ESA,
Tel+ +27 11 517 1519,
Email: KnowledgeDeskRSTESA@unaids.org*

Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access

The report presents practical guidelines for policy makers and planners to tailor their national HIV prevention response to the epidemic dynamics and social context of the most vulnerable and at risk populations.

*Date: 2007
Availability: Publication
website: www.unaids.org
Keywords: HIV Prevention, guidelines, Universal Access
To Order: UNAIDS, Tel: + 41 22 791 36 66,
Email: distribution@unaids.org, Website: www.unaids.org*

2006 UNAIDS Document Library

The searchable CD-ROM contains all UNAIDS documents in English, French, Spanish, available by February 2007. It contains corporate publications and documents produced under the best practice collection. It indicates documents that are available off the web. *For updates and new releases: www.unaids.org/en/publications or email: distribution@unaids.org*

These articles were sponsored by UNAIDS

From Mother to Mother: A peer mentor programme to prevent mother-to-child transmission of HIV in South Africa offers much needed support

by Hena Khan, Carolyn Baek, Vuyiswa Mathambo, Sibongile Mkhizge, Irwin Friedman, Louis Apicella and Naomi Rutenberg.

Nokukhanya is filled with excitement and hope as she discovers she is pregnant for the first time. Determined to give her baby the best care she can, she visits the local antenatal clinic in Kwazulu-Natal, South Africa. But there she receives the crushing news: she is HIV-positive and could potentially pass the infection to her unborn child.

As the counselor explains steps she can take to protect her baby—things like taking medicine while she is pregnant and giving them to her newborn—Nokukhanya's head spins and her thoughts race. All she can focus on is how much she wants to be around to watch her baby grow, how desperately she wants her baby to be healthy, and how frightened she is of the diagnosis, of telling her husband, and of her neighbors finding out about her status.

To help the thousands of mothers like Nokukhanya, the **mothers2mothers (m2m)** programme was created in South Africa in 2001. The idea behind it was simple: to provide much needed psychosocial support for women who have learned they are HIV-positive so they can both accept their HIV status and adhere to medical recommendations for the prevention of mother-to-child transmission (PMTCT).

In South Africa most PMTCT services are offered through government-supported health facilities that provide rapid HIV testing at the first prenatal care visit and Nevirapine for women in labour and for infants after delivery. The facilities are now scaling up to provide dual treatment with AZT and

Nevirapine for pregnant women and infant testing for HIV at six weeks of age using HIV DNA PCR tests. However, despite the availability of services, the reality is that for many women, adhering to the recommendations is hindered by fear of stigma, lack of information, and little time for overworked health providers to offer counselling and support services. In addition, there is weak follow-up during the postpartum period, which means many women and children do not get all the services they need.

other mothers, **m2m** trains and employs new mothers, who have themselves benefited from PMTCT services. These “mentor mothers” participate in two weeks of training that covers basic medical knowledge about HIV infection and antiretroviral therapy (ART), behaviours that help prevent mother-to-child transmission, safer feeding options for infants, strategies for helping women disclose their status and negotiate safer sexual practices, and nutritional guidelines for women living with HIV.

“The program recognises that mothers are a community's single greatest resource,” said Dr. Mitchell Besser, founder of **m2m**. “Mentor mothers, who have gone through PMTCT services themselves, are recruited locally and paid a stipend for the work they do, making them professional members of the health care team.”

The **m2m** programme exists in partnership with provincial, district, and municipal initiatives to support the delivery of antenatal care (ANC), HIV testing and

counselling, and treatment services in order to prevent mother-to-child transmission of HIV. Programme activities include health talks conducted in waiting rooms to introduce new mothers to **m2m**, individual and group education, and regular support group meetings that include nutritious lunches. Mentor mothers also conduct community outreach to assist women at home with disclosure, support women in their choice of infant feeding method, promote safer sex and family planning, and encourage mothers to return for wellness HIV care or treatment and to bring their baby back to the clinic for HIV testing and care.



While anecdotal information suggested that **m2m** fills an important gap in service provision, the programme had not been formally evaluated until now. To determine whether it improved the psychosocial well-being and behaviours of women living with HIV, and increased the uptake of PMTCT services, the Horizons Programme, in collaboration with Health Systems Trust, conducted an evaluation of the programme in 2006.

The Programme

Based on the concept that peer support is an effective model for education and social empowerment, and that mothers themselves are the best vehicles to provide support to

The Evaluation

The study was conducted in KwaZulu-Natal, South Africa's most populous province and with the highest HIV prevalence among pregnant women (approximately 39%). Prior to the introduction of **m2m** in three health facilities in the province, the research team used a structured survey to collect baseline data from a cross-section of 361 HIV-positive pregnant (6–9 months) and postpartum women (12 weeks or less), ages 18–49, accessing services from September to November 2005. The researchers collected data from a second cross-sectional sample of 695 HIV-positive pregnant and postpartum women after the program had been in place for approximately one year (August–October 2006).

To determine the effects of the programme, the investigators compared data from the baseline and follow-up surveys and between participants and non-

“The programme recognises that mothers are a community’s single greatest resource.”

From: **Khan, Hena** and **Ellen Weiss (eds.)**, 2007. "PMTCT," Horizons Report, June. Washington, DC: Population Council.

participants in the **m2m** programme at follow-up. The outcomes included PMTCT knowledge, disclosure of HIV status, receipt and ingestion of Nevirapine, infant feeding intentions and practice, family planning intentions and practice, referral and follow-up for care, and psychosocial well-being.

Exposure to the Programme

The programme achieved substantial coverage at the three evaluation sites, with high rates of programme participation by both pregnant and postpartum women. Two-thirds of the HIV-positive women

interviewed at follow-up (n = 695) reported that they had heard about a program called “**mothers2mothers**.” Among the 345 HIV-positive pregnant women who were interviewed at follow-up, 6 out of 10 women reported that a mentor mother had talked to them. Of the 350 HIV-positive postpartum women, over half reported that a mentor mother spoke to them during their most recent pregnancy, and 39% reported that this occurred after delivery. Among the postpartum women who established contact with a mentor mother, the median number of contacts was four during pregnancy and two after delivery.

For the purpose of this study, respondents were considered programme participants if they spoke to a mentor mother two or more times. Using that definition, 42% of the 345 pregnant women and 49% of the 350 postpartum women interviewed were considered programme participants at follow-up. For clarity in presenting the study results and for understanding the potential impact of the programme, data from women who had only one contact (16% of pregnant women and 9% of postpartum women) were removed from the analyses.

Are Mentor Mothers Making a Difference?

It is an explicit goal of **m2m** to encourage HIV-positive women to disclose to at least one person, as this facilitates adherence to PMTCT recommendations. For this reason, the women interviewed were asked whether or not they had disclosed their status to anyone, as well as when and how many people they had told.

The evaluation found that postpartum women who had two or more contacts with **m2m** were significantly more likely to have disclosed to someone than non-participants (97% vs. 85%; $p < .01$). Among those who disclosed, programme participants were more likely to have disclosed prior to delivery than non-participants (91% vs. 81%; $p < .05$). Programme participants also reported disclosure to more people than non-participants (median of 3 vs. 2).

The study also found important changes among postpartum women in the area of Nevirapine use. Postpartum programme participants were significantly more likely to have received Nevirapine to prevent mother-to-child transmission of HIV during their pregnancy in comparison to non-participants (95% vs. 86%, $p < .05$). In addition, the women who had two or more contacts with mentor mothers were significantly more likely to have ingested the drug and to have received the infant dose of Nevirapine within three days of delivery.

In the words of a mentor mother

“As a mentor mother I encourage women to take care of themselves and tell them that when you have this disease it’s not the end of the world. I also give them support on different kinds of problems and try and come up with solutions to the problems that they have.

When I advise a person who has just tested and found out that she is positive, the first thing that I tell that person is that finding out that you are positive does not mean that it is written on your body—I am also positive but you cannot tell. What you need to do is cry, and I know that it is difficult in the beginning to deal with finding out about your status. The only thing that you need to do is to accept it. I encourage that person to come to the support group all the times so that she can learn from other members until she is used to it.

When I found out I was positive [and there was no **m2m** programme] I thought that it was the end of the world and I was going to die and leave my child behind. I thought that maybe it had been a long time since I had this disease. I blamed my partner for infecting me.

The programme has helped me because I know about my status and about the CD4 count. They also advised me about the kinds of food that I have to eat. I now visit the doctor regularly. I am able to help other people and I am no longer scared. I share the knowledge that I get from the **mothers2mothers** programme with my family so that they know what is happening and how to help me when I am sick.

I am now able to support my child and my family and I can take care of myself—as you can see I look beautiful. By working in the mothers programme, I can say that I have received skills for the food of the soul, to be able to advise people whenever they have a problem.”

25-year-old mentor mother with one child

Continued on page 8

... CD4 count is a key marker for determining eligibility for ARV treatment and having the test done is an important first step in accessing HIV care ...

In accordance with WHO recommendations, **m2m** does not advocate either breast or formula feeding but rather educates women about the importance of selecting an exclusive feeding method, ideally during pregnancy, and then supports women's decisions and helps them maintain their choice post delivery. The evaluation found that postpartum programme

Postpartum programme participants were significantly more likely to have received Nevirapine during their pregnancy

participants were more likely to report practicing an exclusive method of feeding (89% vs. 76% ; $p < .01$), with most feeding their child infant formula without giving breastmilk.

This result of greater adherence to recommended feeding practices is supported

by postpartum programme participants being more likely than non-participants to have decided on a feeding method before delivery (87% vs. 71%; $p < .01$). Among those who decided on a feeding method before delivery, 9 out of 10 postpartum women (both programme participants and non-participants) indicated that they were feeding their infant the method they had previously selected, suggesting that in this study population almost all women are able to execute their plans if they made a decision prior to delivery.

CD4 count is a key marker for determining eligibility for ARV treatment and having the test done is an important first step in accessing HIV care. Study results indicate that significantly more postpartum program participants underwent CD4 testing during their last pregnancy than non-participants (79% vs. 57% ; $p < .01$). Logistic regression analysis further supported this relationship, as postpartum programme participants were 3.3 times more likely to have undergone CD4 testing during their last pregnancy compared to non-participants (adjusted odds ratio: 3.3; 95% ; CI 1.9–5.9; $p < .01$).

Finally, **m2m** programme participants reported a significantly greater sense of well-being than their counterparts on several measures. More than 9 out of 10 pregnant programme participants felt that they could do things to help themselves, cope with caring for their infants, and live positively. Fewer postpartum programme participants than non-participants reported having negative feelings such as feeling alone in the world, overwhelmed by problems, and hopeless about the future.

Conclusions

Overall, the evaluation findings indicate that **m2m** plays a positive role in complementing PMTCT services by providing psychosocial support and a continuum of care for HIV-positive women

and their infants. The study, which was conducted in a real world setting, provides valuable quantitative data which suggest that **m2m** helps women utilise PMTCT services and follow PMTCT recommendations. But limitations of the study are its lack of randomised samples and biological markers, such as PCR testing. Thus the findings from this evaluation are proxy measures for reducing vertical transmission and further research that directly assesses whether participation in **m2m** contributes to lower HIV transmission rates among infants born to HIV-positive mothers will be important.

This evaluation found that postpartum women who participated in the programme acted to a greater extent on PMTCT recommendations than pregnant women; this may be due to the fact that they had more contacts with **m2m** staff than pregnant women, and also had more time to come to terms with living with HIV. "The findings among postpartum women are encouraging and suggest that there is a dose effect, and that more contacts and time with the programme may lead to greater impact for more women," explained Carolyn Baek of Horizons/Population Council, principal investigator for the study. ■

Results from the **m2m** evaluation are being widely disseminated in the United States; South Africa; and among researchers, donors, and stakeholders. A final report is available at:
www.popcouncil.org/m2mFinalReport.

More information about the **m2m** programme can be found at www.m2m.org

Louis Apicella and Naomi Rutenberg, Carolyn Baek - Horizons/Population Council; Vuyiswa Mathambo, Sibongile Mkbize, and Irwin Friedman of Health Systems Trust

For more information on this study, contact Carolyn Baek at cbaek@popcouncil.org

This article was sponsored by Horizons.

The Horizons Program of Population Council is supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through the US Agency for International Development (USAID).

THE FEAR FACTOR: Voluntary Counselling and Testing for HIV and Masculinity in South Africa

by Andrew Levack, Kent Klindera, and Dumisani Rebombo – (Engender Health & MAP)

Clarence's male cousin recently died from HIV. Clarence had never really thought of his own status, because HIV had never really hit so close to home. It was a disease of 'them' not 'us.' In his day, Clarence certainly had numerous partners. Even today, although he has a girlfriend, he also occasionally has sex with other women. He knows he is safe because his girlfriend was recently tested and told him she was negative. As long as she continues to test negative, Clarence is not afraid.

Michelle had been dating Sipho for over three years – never being tested for HIV. They had been trying to get pregnant for many months and finally it happened. Upon Michelle's first anti-natal visit, she was informed that she was positive for HIV and should consider enrolling in a PMTCT programme. When she arrived home in deep despair to inform Sipho of her status, Sipho would not believe her story and accused her of infidelity. He subsequently moved out of the house and claims the child can not be his since Michelle has HIV. Sipho is now refusing to test himself for HIV.

The above scenarios are common in South Africa. Clarence's case is known as "proxy testing" whereby one partner (typically male) sends their sexual partner (typically female) to be tested for HIV. In Michelle's case, men are abandoning responsibility because of female partner's HIV status. Why are these scenarios happening? What causes men to not seek voluntary counselling and testing (VCT) services? This article will explore various factors involved in men's lack of utilisation of VCT services, and explore strategies to get more men to take responsibility, get tested for HIV and to seek additional HIV and AIDS-related services when appropriate.

Men and VCT

Examining most data on voluntary testing and counselling (VCT) in South Africa, men are much less likely to be testing for HIV. With an adult HIV-prevalence of close to 20%¹ South Africa's AIDS epidemic is one of the most severe in the world. In 2002, it was estimated that there were 6.5 million people in South Africa living with HIV and AIDS². It is clear that men play a key role in fueling South Africa's high rates of HIV infection. Over the past several years, numerous governmental and non-governmental organizations in South Africa have adopted large-scale national programmes that target men for HIV prevention. Although efforts to reach men with prevention messages have been established, men's participation in voluntary



counselling and testing (VCT) services continues to be extremely low. Recent national studies in South Africa found that only one in five South Africans aware of VCT have been tested³, and that men accounted for only 21% of all clients receiving VCT⁴.

Men's utilisation of HIV testing is of great importance. Research conducted in developed and developing countries has shown that VCT can reduce high risk sexual practices, decrease rates of sexually transmitted infections, and reduce HIV transmission^{8,9}. Men's participation in VCT has also been associated with increased support and involvement in prevention of mother-to-child transmission (PMTCT) programmes. A study in Nairobi found that

HIV-infected women, whose partners came to the antenatal clinic for VCT, were more likely to receive nevirapine during follow-up, avoid breastfeeding their infant, and report condom use¹⁰. Men's utilisation of VCT also has implications for uptake of antiretroviral treatment. A study in Johannesburg conducted between April and June of 2004 reported that women accessing antiretroviral medication outnumbered men by a ratio of 2 to 1¹¹. The same study reported that women's CD4 count at initiation of treatment was significantly higher than men's, which suggests that men's reluctance to know their status often leads them to seek treatment only when they become ill.

There have been several studies in South Africa and the region that looked at factors associated with VCT utilisation. A study in a township in Cape Town found that compared to people who had been tested, individuals who were not tested demonstrated significantly greater AIDS related stigma¹². Such stigma included negative beliefs about people living with HIV and AIDS, shamefulness of the behavior of people with HIV and AIDS, and the endorsement of social sanctions against people with HIV and AIDS¹². A study of mineworkers in South Africa found that the major identified barriers to VCT were fear of testing positive and potential consequences such as stigmatization, disease and death¹³. The same study also found that only 14% of men would be more likely to access VCT if antiretroviral therapy became available. Focus groups with factory workers in Zimbabwe found reasons for not wanting to test included confidentiality concerns, fear of death, and stigmatisation. Men who wanted to know their test results cited concern over past risk, desiring peace of mind, and wanting to plan their family's future¹⁴.

EngenderHealth - Men and VCT Study¹⁵

In 2005, EngenderHealth conducted a study in Soweto, South Africa to determine causes of the imbalance between men's and women's utilisation of VCT. Five focus

Continued on page 10

groups were carried out with same-sex groups of men and women living in Soweto. Male focus group participants also completed a short survey to determine their HIV testing history and preference for HIV service delivery. Six individual interviews were carried out with men living in Soweto who had previously tested for HIV. Seven individual interviews were also carried out with women who have participated in PMTCT programmes.

Results from this study cited the reasons for men not testing fell into three realms: individual factors, societal factors and institutional factors. In terms of *individual* factors, the data included that fear of one's HIV status was the leading factor inhibiting men from seeking VCT. Additional *individual* factors including assuming that a partner's HIV status is one's own, no value seen in knowing one's status, and no sense of vulnerability to HIV. *Societal* factors that contributed to men not utilising VCT included stigma and men's gender socialisation. *Institutional* factors included poor treatment by nurses and confidentiality concerns.

Examining the lead individual factor of fear of one's results (which is related to the societal factor of stigma) various issues linked heavily to issues of gender. These fears include fear of the stigma associated with HIV and AIDS, fear of death, as well as the fear of being seen as weak. Indeed, traditional gender roles portray men as strong and as risk takers. Men and boys are told not to cry; not to share their emotions; and not to show they are in pain. Thus, if a man is suffering from an illness, he is perceived to be less of a man; more like a

to be strong and come up with various excuses to not seek care, such as the clinics and hospitals are not "male-friendly." In fact, it is often argued that the clinics are not "human friendly", yet women continue to utilise these services.

EngenderHealth/Men as Partners (MAP) Response

Clearly, a new form of masculinity is needed. As mentioned above, traditional gender roles limit men's involvement in HIV and AIDS efforts, but clearly men need to be involved. To address these discrepancies, EngenderHealth implements the MAP programme. MAP is a global initiative designed to work with men on HIV and AIDS and reproductive health issues within a gender framework. MAP is based on the realization that current gender roles give men the power to influence women's reproductive health, that these roles put men at risk by associating risky health practices with manhood, and that men have a positive role to play in improving their own health and that of their families. It also addresses factors that inhibit men's health themselves.

MAP began in South Africa in 1998 through a collaboration between EngenderHealth and the Planned Parenthood Association of South Africa (PPASA). The programme involves running workshops with men, training male "transformation agents" (e.g. peer educators), raising community awareness related to gender and sexual and reproductive health (SRH), mobilising communities to take action, and working to modify and establish just policies that work to support MAP goals.

compromising their sexual and reproductive health, including increasing their vulnerability to HIV and AIDS and placing the burden of care and support for people living with AIDS squarely on women's shoulders. In the service of promoting gender equality and protecting women from HIV and AIDS, MAP draws the connections between sexism and racism and other forms of oppression, and strives to get men to see the ways in which gender equality is a fundamental human right, of comparable importance to those fought for during the anti-apartheid years. This approach connects gender equality to South Africa's rich tradition of social justice activism, and situates it squarely within human rights discourses and traditions embraced by most South African men. Many MAP educators come from activist backgrounds and apply their expertise to devising strategies that get men to take a proactive stand for gender equality and against women's oppression.

Specifically related to HIV and AIDS, MAP recognises that contemporary gender roles can compromise men's reproductive health by encouraging men to equate a range of risky behaviours – the use of violence, alcohol and substance use, the pursuit of multiple sexual partners, the domination of women – with being manly, while simultaneously encouraging men to view health-seeking behaviours as a sign of weakness. A number of studies demonstrate clearly that such gender roles leave men especially vulnerable to HIV infection, decrease the likelihood that they will seek HIV testing, and increase the likelihood of contributing to actions and situations that could spread the virus. Noar and Morokoff have documented the effects of "masculinity ideology" on condom usage and sexual and reproductive health in general, and indicate that traditional men's gender roles lead to "more negative condom attitudes and less consistent condom use", and promote "beliefs that sexual relationships are adversarial."¹⁶ Similarly, a recent study of anti-retrovirals treatment in Johannesburg, conducted between April and June of 2004, reported that women accessing ARVs "outnumbered men by a ratio of 2 to 1". This same study reported that women's CD4 count at initiation of treatment was also significantly higher than men's (100 cells/ml in women and 85 cells/ml in men) and concluded by saying "The observation that two thirds of patients were female, with 23% of women referred from prevention of mother to child transmission programmes, underscore the need for programmes that target HIV-infected men."¹⁷ These findings were similar to those reported on in a study of VCT uptake in the Khayelitsha clinic

... thus, testing for HIV would be a sign of weakness, especially if a man is to be open about his status...

weak woman. Thus, testing for HIV would be a sign of weakness, especially if a man is to be open about his status. As is quite common, men who are living with HIV and AIDS often wait too long to seek treatment (often too late), as they fear being emasculated. During this waiting period, or should it be called a "hiding period", most men hide their fears. These men pretend

MAP uses a human rights framework to enable men to recognise the ways in which contemporary gender roles mirror the oppressive relations of power characteristic of Apartheid. This oppression has devastating health consequences for women, placing them at risk of violence, limiting their ability to negotiate the terms and conditions of sex, and severely

Continued on page 11

outside Cape Town, South Africa, where fully 70% were women. ¹⁸

Behaviour Change Community Strategies / Picture Story Cards

MAP integrated behaviour change communication strategies into its efforts to assist men in redefining masculinity. A key aspect of behaviour change is motivation. Thus, MAP focuses on methods to motivate men to take action for change. Specifically

Similarly, EngenderHealth/MAP in partnership with the United Nations Development Fund is employing an additional strategy utilising “picture story cards”. These cards detail personal stories of men and women dealing with issues of HIV and AIDS and gender-based violence. The cards are based on true stories, and work to motivate men to be more responsible. They are based on the reality that men are suppose to be brave and strong – thus they should be able to face their fears and get tested for HIV; or stop harassing women. The cards work to motivate men (and women) to take action related to HIV and AIDS (including VCT) and gender-based violence. Based on the MAP methodology, the cards utilise social learning theory to motivate men to redefine masculinity – with emphasis placed on achieving gender equality. Cards address issues of confronting fears related to getting tested for HIV; sharing housework with partners; reducing sexual harassment and child sexual abuse;

related to VCT, EngenderHealth is focusing on the fear factor to convince men to not be afraid – and to overcome the fear factor. Thus, one campaign MAP has utilised is the concept of “strength,” with the tag line of “My Strength is not for Hurting.” Working in partnership with the Western Cape Office of the Premier and a US-based NGO Men can Stop Rape, EngenderHealth/MAP has a poster campaign to encourage men to show their strength by getting tested.



accepting gay and lesbian people; among other issues.

EngenderHealth and its MAP programme partners will continue to address the fear factor related to men and VCT. For too long, men have left themselves behind in the gender movement. It is time that men take more action to limit the spread and impact of HIV and AIDS and gender-based violence. One way to act is to get tested and take responsibility. Hopefully, men like Clarence and Sipho, mentioned above, have read this article and are reconsidering their actions. Please help us in spreading the message. ■



Kent Klindera is the Senior Technical Advisor on Gender Youth at EngenderHealth/ South Africa (kklindera@engenderhealth.org), Dumisani Rebombo is the Multi-sectoral Programme Officer at EngenderHealth/ South Africa (drebombo@engenderhealth.org) and Andrew Levack is the Men as Partners Programme Global Director (alevack@engenderhealth.org) and lead investigator for the VCT study. For more information call +27.011.833.0504 or check www.engenderhealth.org.

References

- UNAIDS 2006. *AIDS Epidemic Update*. Geneva: UNAIDS; 2006.
- Dorrington R, Bradshaw D, Budlender D. *HIV and AIDS profile of the provinces of South Africa - Indicators for 2002*. Cape Town: Centre for Actuarial Research, Medical Research Council and the Actuarial Society of South Africa; 2002.
- Shisana O, Simbayi L. *Nelson Mandela/HSRC study of HIV and AIDS: South African national HIV prevalence, behavioral risks, and mass media household survey 2002*. Cape Town, South Africa: Human Sciences Research Council; 2002.
- Magongo B, Magwaza S, Mathambo V, Makhanya N. *National Report on the Assessment of the Public Sector's Voluntary Counselling and Testing programme*. Durban, South Africa: Health Systems Trust; 2002.
- Chege J. *Baseline survey on gender dynamics in intimate relationships for evaluation of Men As Partners Program in Soweto*. In: *Frontiers/Population Council*; 2005.
- City of Johannesburg Region 10 Health Service. *VCT Quarterly Data Input: July-Sept 2004*. In: *Unpublished Data*; 2004.
- Perinatal HIV Research Unit. *Personal Communication*. In: *Levack A, editor*. Soweto, South Africa; 2005.
- Kamb A, Fishbein M, Douglas J, Rhodes F, et al. *Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases*. *JAMA* 1998;280(13):1161-1167.
- Voluntary HIV-1 Counseling and Testing Efficacy Study Group. *Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial*. *Lancet* 2000;356:103-112.
- Farquhar C, Kiarie J, Richardson B, Kabura M, et al. *Antenatal Couple Counseling Increases Uptake of Interventions to Prevent HIV-1 Transmission*. *Journal of Acquired Immune Deficiency Syndrome* 2004;37(5):1620-1626.
- Hudspeth J, Venter WDF, Van Rie A, Wing J, Feldman C. *Access and early outcomes of a public South Africa adult antiretroviral clinic*. *The Southern African Journal of Epidemiology and Infection* 2004;19(2):48-51.
- Kalichman S, Simbayi L. *HIV testing attitudes, AIDS stigma, and voluntary HIV counselling in a black township in Cape Town, South Africa*. *Sexually Transmitted Infections* 2003;79:442-447.
- Doy JH, Miyamura K, Grant AD, Leetow A, Mumsamy J, Baggaley R, et al. *Attitudes to HIV voluntary counselling and testing among mineworkers in South Africa: will availability of antiretroviral therapy encourage testing?* *AIDS Care* 2003;5:665-672.
- Macbekano R, McFarland W, Bassett M, Mandel J. *Views and attitudes towards HIV voluntary counseling and testing among urban men: Harare, Zimbabwe*. In: *XIII International AIDS Conference*. Durban, South Africa; 2000.
- B Andrew Levack. *Understanding Men's Low Utilization of HIV Voluntary Counseling and Testing and Men's Role in Efforts to Prevent Mother-to-Child HIV Transmission in Soweto, South Africa*; Thesis submitted for Masters in Public Health, University of Washington, Seattle, USA. 2005.
- Noar, S.M. & Morokoff, P.J. (2001) *The Relationship between Masculinity Ideology, Condom Attitudes, and Condom Use Stage of Change: A Structural Equation Modeling Approach*. *International Journal of Men's Health*, 1(1), 2001
- Personal correspondence with Dr. F. Venter, University of Witwatersrand, October 11, 2004 based on unpublished data of a retrospective medical file review of all adult patients on ARV treatment during the first 10 weeks of a public antiretroviral clinic in Johannesburg, South Africa, focusing on demographics, clinical presentation, and response to antiretroviral treatment.
- Coetzee D, Hildebrand K, Boule A et al *Outcomes after two years of providing antiretroviral treatment in Khayelitsha, South Africa*. *AIDS*. 2004 Apr 9;18(6):887-95

One Family's Story – Opening the Doors for Leadership in responding to HIV

by Penelope Mutambirwa and SAfAIDS staff

“If YOU care, YOU CAN BE A LEADER”, was the SAfAIDS message for World AIDS Day this year. World AIDS Day celebrations this year revolved around the many and varied aspects of leadership, yet often, in the case of HIV, it seems that true leadership comes from the community rather than the top-down phenomenon many expect.

In a departure from our usual kind of article, here we describe a very personal and sincere demonstration of leadership by the family of a SAfAIDS staff member, who recently held a memorial service for the eldest child in their family, Pam, who died of HIV-related meningitis, earlier this year.

In an all-too-rare departure (diversion) from the traditional silence that surrounds tragic premature deaths of such a nature, Pam's family decided to make the memorial a public educational statement about HIV and AIDS and in the process, uncovered a huge, unmet need for openness and HIV education and testing. Pam's father's determination, to ensure that his extended family and the community at large benefited from his daughter's death, illustrates the practicability of male role modeling in responding to HIV.

This is one rural African community's story, narrated by Pam's sister Penelope:

“Pam had been living with HIV for more than five years. My parents never kept it a secret that Pam was living with HIV; they were not public about it, but certainly did not lie about it when asked. She (Pam) preferred it that way.

As a family we always took Pam's status as a serious and sensitive issue, but mostly one that needed our support. So at her funeral, there were no hushed whispers of ‘I am sure it was AIDS’ because everyone KNEW she had succumbed to it. One or two relatives came out and admitted they were also in the ‘same boat’ and another asked for Pam's ARVs so they could take them. It made me realise that knowledge around antiretroviral treatment is still limited, because some people believe that taking ARVs is like taking a painkiller when you have a

headache; they don't realise that once you start, you have to take them consistently for life, whether you feel good or not.

information with others, but that did not happen - because she died. What I would like to see in this community is a decrease in the number of AIDS-



When we were preparing for her memorial, and in discussion with my parents, we agreed to find a way of educating our extended family and friends as much as we could, in the forum that had presented itself. For us it was a celebration of her life that she had lived openly and confidently with HIV; that was the main theme. We agreed that we would also include critical themes that have links with HIV and AIDS, such as domestic violence, stigma and positive living, all presented in the most common and inoffensive forum of a church set-up.

To set the pace, my Dad gave his eulogy and bravely shared the facts: “My daughter died of AIDS, and it should not be a secret. She had access to information and wanted to share that

related deaths. If there were 10 people dying a month, let that number come down to 2, and that can happen if people have access to information and people know their status – and are offered the necessary support by their families and the community. I don't mind using my own home as a place where people can access information on HIV and AIDS”.

The occasion proved that what I have learnt, and shared within my family, has been well received – and you will agree that the family context is often the most difficult to seriously and honestly discuss HIV and AIDS, especially your immediate family. It's not easy breaking the cultural barriers that make it challenging to discuss HIV and AIDS with your parents or siblings, because

HIV is mostly viewed in a sexual context. I give out condoms to everyone who makes a claim to be my relative – and they all know it! I challenged myself that if I can talk to a stranger whom I do not know and may never see again, about the dangers of putting oneself at risk of HIV infection, then why can't I tell my own family, whom I love and care for and live with everyday.

We had the usual kind of memorial service, where the preacher reminded us in a very brutal manner that we shall all die, but with no mention of what caused the death of my sister. Encouragingly, the preacher was the first one to approach me with such enthusiasm on his face, saying he was going to share this experience. I hope that means the church will adopt ways of addressing issues around HIV and AIDS – particularly stigma and discrimination, even when there is no death involved.

We also had a great performance by PATSIME, an HIV and AIDS edutainment company. It was set in a church context but touched on all the areas of ordinary family life and brought out the themes we wanted, linked to HIV and AIDS.

You never really expect people to personalise performances like that, but immediately after it, I was inundated by people who decided to 'come out' and reveal their HIV status – those who already knew, and those who thought they knew. There was a hunger for more information on how to eat right and how to live positively. A lot of people who do not know their HIV status were somehow encouraged to get tested, and I think this had to do with the way we, as a family, took a stand to admit that HIV is there, AIDS can kill – and it can be prevented. Anyone can become infected with HIV, but you do not have to die because of ignorance. The fact that my dad, as a man, and culturally the head of the home, chose to be open, I think is what made it a serious yet manageable issue and allowed other men to relate, because men rarely enter the forefront of HIV responses, and when it comes to taking care of an ill person, you hardly find a man cooking or taking care of a patient. My father's openness about Pam's HIV status broke many barriers and was a unique leadership stand.

An aunt of mine confided in me that she felt 'liberated' from the gossip and whispers of family members concerning her son's health. Her son shows visible signs of HIV infection, and she said she felt encouraged to take on the same positive and open stance regarding her son's status, in terms of providing the right kinds of food for him and giving him all the support he needs to live positively. She herself is HIV infected, although she does not have any visible signs, but she is upset that her husband lives in denial and will not get tested. She said she felt much better about her status now because HIV had been discussed in her family, and there was now no need for her to feel excluded or ashamed. Several women wanted the issue of condom use and practicing safe sex to be driven home to their male partners, but because this was a family event the issue of condoms had to be veiled behind the statement 'protecting oneself'.

My eyes were opened to the fact that people in my home area know about HIV and AIDS and they also know that treatment is not readily available, yet what they are desperate for is to know how to live with HIV, because that is the reality.

The menu we planned for lunch deliberately emphasised cultural foods and they were prepared in the traditional way, so people actually appreciated what they can do with what they have in their garden and home. An uncle of mine commented that he cannot afford to buy pure fruit juice since fizzy drinks are not good. I handed him a cup of mahewu (a traditional, non-alcoholic fermented maize drink) that is both nutritious and refreshing.

A local councilor was present at the memorial and a plea was made to him to advocate for scaling-up access to information on HIV and AIDS treatment and positive living for the community members in the area.

A week after the memorial there are over 100 people from the community who want to be tested and know their HIV status. They have organised themselves into sections and they are hungry for information. No one asked them to do that – we were just celebrating the life of one of our own...”

This story illustrates that community members remain desperate for knowledge to facilitate openness about HIV infection, living positively and seeking support when they need it. It needs only a few brave people to take a stand and conquer the stigma related to living with HIV: once the silence is broken, whole communities can be liberated to admit the challenge in their midst and allow community members to collectively identify ways of alleviating their difficulties.

This kind of leadership can fuel genuine behaviour change so that in time, an AIDS-free generation will become a reality. This kind of leadership can and should be provided by anyone and everyone. The Mutambirwa family has demonstrated that leadership in HIV and AIDS is not about political leaders nor is it about celebrities; it is about people in the community who are driven by care and concern for fellow human beings taking it upon themselves to do something.

Postscript: PSI's mobile testing and counseling unit visited the community on Dec 5th, using the Mutambirwa homestead as their base and turning leadership into action. Fifty people took the test in front of the other members of the community, starting with Pam's parents and Pam's sister. This is what community initiated and driven responses can do. This community and family needs the support of AIDS Service Organisations to continue the social mobilisation they have initiated. ■

The menu we planned for lunch deliberately emphasised cultural foods and they were prepared in the traditional way, so people actually appreciated what they can do with what they have in their garden and home.

The Village of Hope: An Innovative and Holistic Model

by Laura Maynard

As a result of the 1994 genocide, Rwanda was left with a large number of widows and orphans, many of whom had suffered the worst inhumanities ranging from rape to torture. In the aftermath of the genocide women constituted approximately 70% of the adult population and 50% were widows. For these survivors their social and psychological scars were aggravated by having no financial support in their new roles as heads of households, often caring for a number of orphans in addition to their own children. With limited or no technical skills, education or access to financial resources, despair and depression became dominant forces in their lives. Coupled with this was the culture of silence and stigma directed towards these vulnerable groups. The gross denial of their rights that occurred during the genocide was often perpetuated later, as many women experienced property grabbing and disinheritance.

The Village of Hope (VoH) is a project of Rwanda Women's Network that takes a holistic approach in serving vulnerable women and youth, including victims of rape and other violent crimes, widows, orphans and people living with HIV and AIDS. The Village of Hope is a unique and innovative project because of its holistic approach in improving the health and welfare of identified vulnerable groups in Rwanda, especially those of women who were victims of Gender Based Sexual Violence (GBSV) and as a result, are often living with HIV and AIDS. The Village of Hope's approach recognises that the healing of a women subjected to GBSV is a long term process that must include, not only basic medical health care, but also psychosocial support, counselling and opportunities to foster socio-economic empowerment. The programme works towards the end goal of healing the wounds of the 1994 genocide and supporting peace and reconciliation. One of the greatest accomplishments of the VoH is that it has created a space where women who were widowed by the genocide and/or victims of GBSV can freely share their experiences and find strength and solace in the stigma-free and empowered community that exists in the village.

The project is addressing the vulnerability of those widowed by the genocide through the provision of housing, which in the short term reduces the level of poverty felt by these individuals. The village is made up of 20 housing units each accommodating 20 families with approximately six persons per family, making the total number of direct beneficiaries 120 people. The Village of Hope (VoH) also has a centre which provides a variety of services, such as trauma counselling, skills training, and education and awareness programs on HIV and AIDS and human/legal rights, to the residents of the village and the surrounding community. Presently the VoH has over 4,000 women members and 800 youth. Thus in the long term, the village is alleviating poverty by building the capacity of its members through skills training and knowledge dissemination.

Women who have participated in activities at the Village of Hope have gained a new sense of empowerment and many now contribute to helping and educating others. For example, a Home Based Care Alliance was formed, as well as groups called 'Focal Points', who work to educate fellow women on their rights and help them in legal battles. During this process of peer learning the members of the Village of Hope have found strength and purpose through the solidarity fostered between women of different ethnicities, ages and religion.

The main pillar on which the programme stands is the provision of a space for free interaction and dialogue. The Village of Hope is a replication of the Rwanda Women's Network project Polyclinic of Hope (PoH), in that the beneficiaries of the PoH identified those amongst them who were most in need of shelter. The management of the centre includes members of the community it serves, women and youth. Beneficiaries are involved in all activities of the centre, from conceptualisation to evaluation. The weekly meetings facilitated by community mobilisers at the VoH are held by and for the women and youths to share their problems, needs, visions and current issues; they prioritise and identify issues as well as contribute towards the solutions.

The women and youth at the VoH are empowered to take action and responsibility

so that they: decide on the best times to implement programmes like training sessions, make contributions to solve some of the problems they identify, such as; providing packages for visiting sick counterparts; deciding on who to assist first, in case what is available can not reach everyone; leading advocacy campaigns; providing information about themselves / case studies; training others in the knowledge gained from trainings, such as human / legal rights, HIV and AIDS, counselling, Home-based care; program implementation , monitoring and reporting on some programmes such as home (based) care, mobilisation and sensitisation, advocacy and income generation.

The members of the Village of Hope have shown a substantial increase in capacity and demonstrate a strong desire to learn new skills, as well as to share what they have learned with other women. Many women who benefited from the Home Based Care Alliance felt compelled to join the group in order to help care for others, as they had been cared for. Many women comment that as home based care volunteers they feel they have gained a new sense of respect, both from their communities and for themselves.

The programme's major achievements include; the village itself; the construction of the centre that provides support to over 4,000 women and 800 youths; the construction of a youth centre to house their activities; provision of school fees to 70 secondary school children and 100 primary students; provision of medical services; psychosocial/trauma/HIV and AIDS counselling and mobilisation, as well as sensitisation sessions on different issues that affect women.

The VoH has provided skills training in seven areas and the cumulative membership in each group is as follows; Cultivating – 2,018, Bead work - 902, Bedcover making - 502, Knitting sweaters - 595, Cultural dance, games and drama club - 99, Cards – 124 and Tailoring – 284. As a result of these achievements and the impact that project has had on the lives of both direct and indirect beneficiaries, the Village of Hope was given a Red Ribbon Award for Providing Access to Care, Treatment and Support for People Living with HIV and AIDS in 2006, at the 16th International AIDS Conference

held in Toronto, Canada. The Village of Hope is also the recipient of the 2006 Dubai International Award for Best Practice to Improve the Living Environment.

The Village of Hope has proven to be a unique, replicable and a sustainable model due to its integrated people based approach. The VoH is a sustainable programme in that it is community centred and involves the beneficiaries in all activities. The program, as much as possible, gives capacity to people within the community by employing them, so that they can take on the responsibility when the time comes. For instance three among the five people employed at the centre are beneficiaries of the VoH program. The Village of Hope's spirit of solidarity building, sharing and

supporting each other can be sustainably spread throughout the community without any financial costs. Members of the Village of Hope continue to improve their capacity to support their immediate families and those whom they identify as vulnerable in their community. The capacity gained in income generating areas are essential for the sustainability of the program, but also the feeling of worth, value and empowerment gained by members of the VoH will benefit themselves far into the future.

After the genocide many women could not return to their villages as their houses were illegally occupied and often those who committed acts of genocide continued to live freely in the village, acting as constant

reminder of the horrors these women lived through. The Village of Hope has achieved its goal of establishing a village where women who were raped or widowed in the genocide can live without fear of discrimination, stigma or further violence, and can live with HIV and cope with the impact of AIDS. Further more, the VoH has achieved its goal of creating a space where village members and women from the surrounding community can access a variety of services that are essential in the holistic approach to healing. ■

Laura Maynard works for the Rwanda Women's Network



Agonising Choices in Africa: Who will live, and who will die?

This statement was made on behalf of Sir Elton John, Chairman of The Elton John Aids Foundation

When I set up the Elton John AIDS Foundation 14 years ago, AIDS was a death sentence. During the 1990s the Foundation provided palliative care, information, emotional and financial support to thousands....and prayed for a cure.

Today, life saving antiretroviral treatment is available, affordable and entirely viable in the developing world. I have met wonderful, courageous HIV positive Africans who are thriving because my Foundation, like many other organisations, has grasped the chance to use these medicines in groundbreaking programmes.

Yet about 70% of Africans who need treatment to survive are still not receiving it. Ultimately, it takes the will of the richest governments on earth to close that gap. In June the G8 pledged to do just that - to provide access to HIV/AIDS treatment for all those who need it by 2010. At the present rate, we are barely on track to meet half that target. So, are we saying that by 2010 we will save only half of those dying from AIDS? And, if so, how will we decide who should be spared?

Back in June, the G8 decided that one way to get treatment to all those who need it would be to triple the size of the Global Fund to Fight AIDS, Tuberculosis and

Malaria. This means that by 2010 it could provide US \$6-8 billion to fund programmes delivering medical treatment. Next week in Berlin, members of the G8 will attend a meeting of the Fund to deliver on that promise.

I believe Gordon Brown's leadership and vision on this issue is urgently needed, right now. After all, he helped found the Fund and played a central role in bringing world leaders to commit to universal treatment access. If the UK were to provide £700m over three years, tripling its annual contribution by 2010, it would challenge the rest of the world to follow suit.

I am not alone in this view. The Stop AIDS Campaign, a coalition of over 80 organisations working on HIV/AIDS in the developing world, feels the same. So do leaders in Parliament, not least the Chairs of 3 All Party Parliamentary Groups responding to AIDS, TB and Malaria, who represent all sides of the political divide. A bold pledge like this from the UK would encourage other countries, such as Canada, France, Germany, Japan and the US, to do their part too.

I am not a politician. I see this problem through the lens of my Foundation's work, which has no favoured ways of getting the job done. For us, it's about who is being effective, transparent, and keeping money flowing to benefit people living with HIV/AIDS, rather than invent more structures or processes. We expect no less from the Global Fund. But I know that in many areas the Fund has had impact where

other, less innovative mechanisms have failed. Over 1 million people with HIV/AIDS in Africa, Asia and Latin America have already received antiretroviral medication, and 2.8 million people suffering from TB, the biggest killer of people living with HIV/AIDS, have been treated thanks to the Global Fund's resources.

In many parts of the world governments are hostile or reluctant to provide services for the most marginalized groups: men who have sex with men, injecting drug users and prisoners generally have appallingly little access to basic HIV services. In responding to this need, my Foundation is guided by what is effective in fighting HIV/AIDS rather than what is politically expedient. Through this work I have met brave activists who face threats and harassment in order to help marginalised groups access basic services. This is another area where the Fund is crucial. It has the flexibility to channel funds directly to civil society organizations without toeing a particular political line.

At the United Nations this July, Prime Minister Gordon Brown showed integrity and leadership when he said "We did not make the commitment to the Millennium Development Goals only for us to be remembered as the generation that betrayed promises rather than honoured them and undermined trust that promises can ever be kept."

These decisions directly affect whether people live or die, I urge the British Government to take a lead in ensuring these promises are kept. Honour the pledge. ■

AIDS Vaccine Advocacy Coalition Voices Disappointment in Trial Result Applauds Merck's Leadership and Calls for Reinvigorated Effort to Design and Test AIDS Vaccines

This statement was issued by The AIDS Vaccine Advocacy Coalition (AVAC) following the announcement that vaccinations have been discontinued in the STEP Study, a test-of-concept trial of the MRK-Ad5 AIDS vaccine candidate developed by the Merck Research Laboratories:

"Today's announcement about the STEP Study is a deep disappointment and a scientific setback for the AIDS vaccine field. However, it must be seen for what it is: the failure of a product to show efficacy in a specific trial. Clinical testing of AIDS vaccines is a scientific process and, while this is a disappointment, it is in no way the end of the search for an AIDS vaccine.

"These data are certainly not the ones that we had hoped for. The entire HIV vaccine field, including AVAC, had been looking to STEP and its companion Phambili trial in South Africa, to provide initial evidence of vaccine-related benefits. Even as the data disappoint, we also note the success of the STEP Study trial design in providing a swift answer to the critical question of whether or not the vaccine provided any benefits. A successful clinical trial is one that produces a scientifically accurate result. It may not be the result you had hoped for, but it answers questions that help the field move forward.

"We applaud Merck's tremendous leadership on HIV vaccine research. The

company has set an example for the field, taking on one of the most important health technology challenges of our time. Merck and its collaborator, the US NIH-funded HIV Vaccine Trials Network, have been committed, strategic and willing to take risks at every stage of evaluating MRK-Ad5, and they must be commended for this. AVAC also recognizes the contributions of the thousands of volunteers in these trials. Their altruistic involvement makes HIV vaccine research possible. It is essential to build on what has been learned here and proceed with further research as rapidly as possible. Millions of lives are at stake.



Source: www.AVERT.org © Alison Napjte

"In the next weeks and months the AIDS vaccine field will need to make carefully-considered decisions about whether to move forward with planned trials of related vaccine strategies, and how to proceed with the Phambili trial, which has paused immunizations and enrollment. AVAC is committed to working with many other stakeholders in the AIDS vaccine field and in other areas of AIDS prevention research to ensure that these discussions are thoughtful, transparent, and clearly communicated to global audiences.

"These results do not change our fundamental view. Developing an AIDS vaccine will require a series of large-scale human trials in many different countries

over a number of years. These trials need to be designed to produce clear results and to design better candidates in the future. This research must be complemented by ongoing studies of other new biomedical prevention strategies, and by full-scale, fully-funded implementation of proven prevention and treatment strategies."

About the STEP Study
An interim analysis of data from the study, involving over 3,000 people testing an adenovirus-based vaccine (MRK-Ad5) developed by the Merck Research Laboratories, showed no efficacy in protecting against new infections or in reducing viral load in people who received the vaccine and went on to become infected. The study was scheduled to end in 2009. Periodic reviews of data by an independent monitoring board are part of the clinical trials process, and the study was halted on the recommendation of the STEP Study monitoring board after a regularly-scheduled review.

There have been two previous efficacy trials of an AIDS vaccine candidate, called AIDSVAX. Both of these studies took more than five years from launch to announcement of the finding—that the candidate did not protect against infection. The STEP Study enrolled its first participant in December 2004, and we have a definitive answer less than three years later. Getting swift, precise answers about candidates is crucial for the field. In this sense, the STEP Study fulfilled its purpose—as disappointing as the results may be.

One reason for this efficiency is that both STEP and its companion trial Phambili, which tested the candidate in South Africa, were designed as "test-of-concept" trials, to give an initial answer about vaccine benefits in a relatively abbreviated timeframe. The STEP Study met its enrollment targets and its endpoint goals within the timeframe specified by the trial planners. ■

Please send any questions or comments to avac@avac.org.

*Warren Mitchell : Email: mitchell@avac.org
Website: / / avac.org/pr_step_study.htm*

... A successful clinical trial is one that produces a scientifically accurate result. It may not be the result you had hoped for, but it answers questions that help the field move forward...

HIV Prevalence among 15-19 year olds in Botswana: Secondary data analysis of trends

Rolang G. Majelantle¹; Kenabetsho Bainame¹;
Lesego Busang²; Themba L. Moeti² and
Godfrey Musuka²

¹University of Botswana, Department of
Population Studies, ²African Comprehensive
HIV and AIDS Partnerships (ACHAP)

1. Introduction and background

In many countries the HIV and AIDS epidemic presents one of the most serious health, economic and social problems in recent history resulting in thousands of HIV-related deaths and cases of orphan-hood. In 2005, there were an estimated 270,000 people living with HIV, and around 160,000 orphaned children living in Botswana, of whom more than three quarters had lost a parent to AIDS (United Nations, 2004). In Botswana the ANC HIV-prevalence rates for the years 2003 and 2005 for women aged 15–19 years were (N=1150) 22.8% and (N=1127) 17.8% respectively (ANC reports 2003 & 2005), demonstrating a decline of 22% in HIV prevalence among this population sub-group. The prevalence among women aged 15-19 years was 9.8%, vis-à-vis 3.1% of men of the same age (CSO, 2004). It would appear that the epidemic is gender biased, as shown by a higher number of females who are HIV infected compared to males.

HIV and AIDS has a serious impact on the socio economic and political development of the country and contributes to the deepening poverty situation. The health facilities of Botswana are overburdened by people sick with AIDS-related diseases. Around 50–70% of hospital bed occupancy in Botswana is HIV related (Nair, 2004). The health sector is also likely to suffer from fatigue, and this may compromise the quality of health and other services (NACA, 2003). In terms of the economy, AIDS contributes to absenteeism, illness and death among workers, resulting in a reduction in the size of the effective labour supply in terms of both quality and quantity (Nair, 2004). Depletion of skilled labour also increases the cost of turnover and replacement. The impacts of AIDS continue to be felt as a new generation of HIV-infected youth enters the labour force.

The Government of Botswana (GoB) and its partners have implemented programmes to prevent the spread of HIV. These include:

- Public education and awareness through bill boards, and a radio drama called Makgabaneng
- Education for young people
- Condom distribution and education
- IEC to promote behaviour change to reduce the risk of HIV and AIDS in youth
- Prevention of mother to child transmission of HIV (PMTCT)
- Voluntary counseling and testing
- Introduction of routine HIV testing in 2004
- IEC/DCC Campaigns
- Promotion of behaviour change to reduce the risk of HIV and AIDS in youth
- Supporting of Total Community Mobilisation (TCM).

In order to monitor the trends and levels of HIV and AIDS in the country and the impact of the national response to HIV prevention and mitigation, the GoB commissioned nationally representative population surveys referred to as the Botswana AIDS Impact Surveys (BAIS). To date, two such surveys have been conducted, namely, BAIS I and II. BAIS I conducted in 2001 provided baseline data, and BAIS II, 2004 provided data that can help assess the effectiveness of the programmes implemented in positively shifting key HIV and AIDS indicators. Another HIV surveillance tool conducted on an annual basis through GoB support is the Antenatal Care (ANC) Sentinel Surveillance. The ANC sentinel surveillance surveys assess HIV prevalence levels among pregnant women receiving antenatal care services from selected health delivery points. It is increasingly important to know whether these programmes have further reduced spread of HIV. There is therefore a need to assess the level and trends in HIV and AIDS prevalence among young people aged 15-19 years (This is the age group in which more than half of young people start sexual activity).

In Uganda HIV infection rates peaked at around 15% in the early 1990's and significantly declined to 5% by 2001 (UNAIDS). HIV prevalence fell most steeply at young ages: by 23% among men aged 17 to 29 years and by 49% among women aged 15 to 24 years (www.sciencemag.org). The Abstinence, Be faithful, Condomise approach has been associated with the decline, however there have been controversies about the distribution of

condoms between government and religious groups, who would like sexual abstinence to be the central pillar of the fight against HIV. In addition, Uganda had high-level political support in the fight against HIV and AIDS. Decentralised planning and implementation for behaviour change communication reached both general populations and key target groups, and was focused on face-to-face interaction (i.e. non-electronic means) and was culturally appropriate. Religious leaders and faith-based organisations were very active in the intervention, with their efforts focused mainly on abstinence and being faithful to one partner. Uganda also introduced confidential voluntary counseling and testing (VCT) services around the country.

Zimbabwe has also experienced a decline in HIV prevalence over the period 2000 – 2004. This decline is largely attributed to changes in Sexual behaviours. In, particular, condom use with non-regular partners and faithfulness increased during the same period (UNAIDS 2005).

Our analysis found that in Botswana HIV prevalence fell most steeply at young ages, with a drop in prevalence of 49% for women aged between 15 and 24, and a 23% drop in men aged 17 to 29. These declines are attributed to people delaying their sexual debut and having fewer casual partners. The study found that among 17 to 19 year old men, only 27% had commenced sexual activity in the 2002 survey, compared with 45% in the 1992 survey. For women aged 15 to 17, the percentage reporting sexual experience dropped from 21% to 9%. At the same time, the proportions of men and women reporting a recent casual sexual partner fell by 49% and 22% respectively.

2. Analytical techniques

This study recognises that estimates for HIV prevalence in Botswana are derived from data generated by a variety of sources. The Antenatal Care surveillance survey of HIV among pregnant women receiving antenatal care, VCT data and data from population-based surveys are at once complementary and contradictory sources of data. They are complementary because they allow us to gauge HIV prevalence in different populations, and because their biases are in different directions, allowing us to triangulate the true prevalence rate decline suggested by different sources. They can be contradictory in that each has its own patterns of non-response and representativeness, thus the subpopulations surveyed by each are often distinct.

Notwithstanding that, in assessing HIV prevalence in young people aged 15-19 years, there is need to establish to what extent the data obtained reflect whether there was a true HIV prevalence decline among young people aged 15 to 19 years attending ANC clinics and those who voluntarily tested for HIV at VCT sites/clinics.

2.1 Methods

The study first obtained and compared HIV prevalence rates from the ANC surveillance system and VCT routine data. Data generated by surveillance systems that focus on pregnant women aged 15-19 years attending antenatal clinics, were used to arrive at estimates in HIV prevalence in the general population aged 15-19 years. The study attempts to verify if the perceived decline in HIV prevalence observed in the ANC Sentinel Surveillance data is reflected in the VCT data.

3. Findings

3.1 Findings from ANC Surveillance survey

One of the aims of this study is to establish whether there is a significant difference in the decline in HIV prevalence rates obtained from ANC data in the years 2003 and 2005. From this data HIV prevalence among young females aged 15-19 years in 2003 was estimated at 22.8% and 17.8% in 2005.

In testing whether there are any differences in two proportions from independent samples there is a need to establish the confidence interval and then test the hypothesis about differences in proportions. In so doing it was found that the confidence interval for the difference in the proportions of HIV positive women 15-19 years for the two periods was (0.02 to 0.08) or (1.7% to 8.3%) with a 95% confidence level. These are read with the assumption that for large samples the proportion is (approximately) normally distributed and the two samples are independent random samples. In this case both assumptions are satisfied.

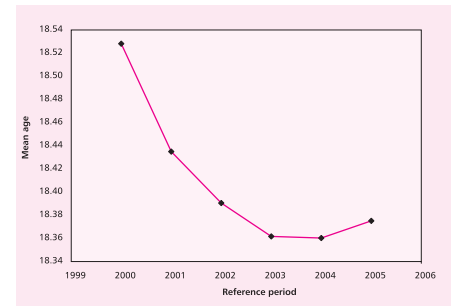
Furthermore in testing the hypothesis that the HIV prevalence among pregnant women aged 15-19 years in 2003 is greater than of women of the same age in 2005, we find that since the observed value of $z=2.96$ is greater than the critical value of 1.96, there is therefore sufficient evidence at $\alpha = 0.05$ level to conclude that HIV prevalence among pregnant women aged 15-19 years has decreased over the 2003-2005 period.

3.2 Findings from VCT data

In this section we first make an assessment of whether the decline in HIV prevalence rates among young persons aged 15-19 years in the period 2000 to 2005 could be due to the change in the average age of women who test at VCT. This is premised on the concerns that the HIV epidemic may lead to a delay in the first sexual experience and greater condom use. This will inadvertently change the average age of pregnant women over this period, making them older and less comparable with earlier populations. VCT data show that among clients who submitted for HIV testing in the period there has been a significant change (with $p < 0.001$) in the

average age of persons who test. In this population group the mean age changed from 29.2 years in 2000 to 31.3 years in 2005. This shows an increase in the mean age of clients who visit VCT centres. However, the mean age among young persons aged 15-19 years who visit VCT centres has decreased overtime, and this change has been significant with a p value of 0.005 (Figure 1 below shows trends in mean ages for the period 2000 to 2005).

Figure 1: Mean age distribution of VCT clients for the period 2000-05



One other diagnostic tool used to assess comparability of data from the VCT sites was to establish whether there was an association between HIV positive status and the proportion of young people in the total population visiting the site. Table 1 presents a percentage of population in the age group 15-19 testing for HIV, and their HIV prevalence. Furthermore, the data shows that in 2001 and 2002 when the proportion of young people testing was highest, HIV prevalence in that age group was lowest. We also observe that the proportions of those testing out of the total population are lowest for the reference year 2003, 2004 and 2005. These figures are accompanied by high, though declining, HIV prevalence. In establishing whether HIV prevalence varied by reasons for visiting the VCT centre, we find that reasons why clients visited the facility varied overtime. In the period 2000 and 2001, about 46% of clients reported that family planning was the most important reason for visiting the VCT centre. In 2004, 30.3% reported to have been exposed to a risky behaviour, while in 2005, 33.7% reported that their partner had died (see table 2). In 2003 when HIV prevalence rate was highest, 28% provided "other" reasons for visiting the VCT centre. In the same period another 25% reported having been exposed to risky sexual behaviour as the reason they were visiting the facility. It is clear that reasons for visiting the sites varied between the periods. This together with the shifts in the mean age, demonstrates changes in the characteristics of the population under study. The issues raised above may possibly result in methodological challenges, since the statistics could be less comparable with earlier age groups and with data from previous survey periods.

In addition the percentage of young people accessing VCT centres for HIV testing has significantly increased over the period.

One of the possible explanations for this phenomena could be that young people have been more receptive to campaign messages on HIV testing, and because of their first initiation in sexual activity, young people in the age group 15-19 years may perceive themselves to have been exposed to HIV infection, hence the need for testing. This is likely to have had an effect on prevalence.

These observations are less likely to influence the variations and levels in HIV prevalence. The following section proceeds on the assumption that these have had no effect on HIV prevalence overtime.

Table 1: Percentage of young testing for HIV out of the total population testing

Reference period	Percent of young people testing of total who tested	HIV positive
2000	6.11	6.96
2001	9.33	5.53
2002	9.55	5.50
2003	5.22	8.99
2004	4.33	7.67
2005	5.55	6.50
Correlation coefficient	-0.81626	
r-squared	0.666279	
T-test	0.867295	

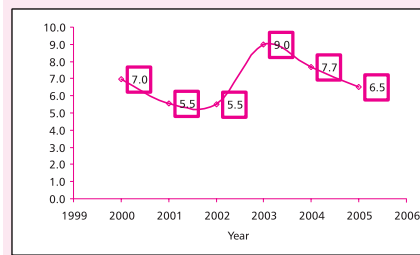
Table 2: Reasons for visiting VCT site by reference period

Most important reason here today	2000	2001	2002	2003	2004	2005
Client behaviour risky	18.5	21.0	25.0	30.3	0.0	
Client had risk	2.9	2.1	1.8	1.3		
Partner behaviour risky	0.6	1.0	0.7	0.4	14.7	
Partner had risk	7.1	11.7	16.7	14.2		
Partner HIV positive	2.8	1.5	2.1	1.8		
Feel ill with symptoms	1.9	1.3	0.9	0.6	1.7	
Partner with symptoms	3.1	3.3	3.2	2.0	9.0	
Partner dead	0.5	0.4	13.9	16.0	33.7	
Marriage	0.1	0.4	0.1	0.1		
Family planning	45.8	15.6	4.5	2.8	19.4	
Second test	11.7	1.3	1.6	1.8	2.8	
Needs counseling	0.1	2.8	0.2	0.2		
PMTCT	0.4	0.2	1.3	0.9		
Access to care and treatment	0.6	1.2			13.9	
Other	4.5	27.5	28.0	27.7	4.8	
Total	100.0	100.0	100.0	100.0	100.0	

3.2.1 Trends and patterns in HIV prevalence among 15-19 years olds submitting for HIV testing at VCT centres

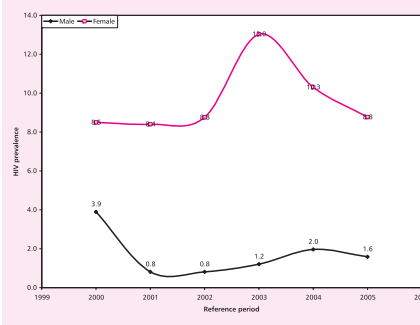
The data obtained from the VCT centres throughout Botswana for the year 2000 to 2005 show varying levels of HIV prevalence over the period. In the year 2000, of the 230 VCT clients aged 15-19 years who visited the VCT sites for HIV testing, 7% turn out positive. The total number of clients in the age group 15-19 years who enrolled for testing at VCT centres increased to 1,301 in 2001, and the corresponding prevalence was 5.5%. Figure 2 presents HIV prevalence among VCT clients aged 15 to 19 years. From this, it is worth noting that the year 2003 experienced the highest prevalence among young people in the age group 15 to 19 years. This prevalence figure coincides with the rollout of the ARV programme, which would have encouraged people who perceived themselves to have been at risk of being infected, to test for HIV. This is likely to have introduced a selectivity bias. Note that the statistics show that in this period, of the 2,424 who submitted for HIV testing, 9% were HIV positive. In subsequent periods (2004 and 2005) prevalence declined, though there were no significant differences in the rates for the period 2003 and 2004. This is notwithstanding that in 2005, there was a significant difference in prevalence between the year 2003 and 2005. The observed percentage difference of 2.49 is highly significant at p value 0.0000.

Figure 2: VCT HIV prevalence among 15 to 19 year olds



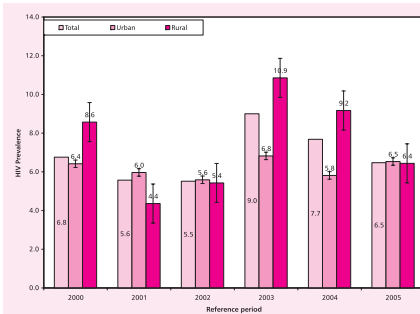
The differences in HIV prevalence between males and females in this age group are well pronounced, with very few males in the age group 15-19 years presenting with positive results. From the VCT data we also observe that in this age group the percentage of females (83.2%) who have ever had sex is higher than that of males (74.2%), thereby showing young females more susceptible to HIV infection. HIV prevalence by gender is presented in figure 3 for visual detail.

Figure 3: VCT HIV prevalence among 15 to 19 by gender



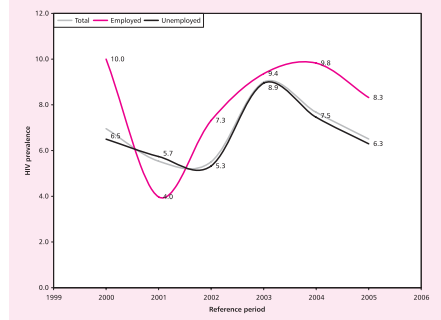
Variations in HIV prevalence between urban and rural residents aged 15-19 years are depicted in figure 4. In this figure HIV prevalence is high for the periods 2000, 2003 and 2004 among rural residents. The differences in HIV prevalence in the aforementioned periods are statistically significant. Figure 4 demonstrates this by the use of error bars which show that the confidence intervals do not overlap. It is also critical to note that in the periods where prevalence was generally low, the difference in prevalence between urban and rural areas was statistically insignificant.

Figure 4: VCT HIV prevalence among 15 to 19 by residence



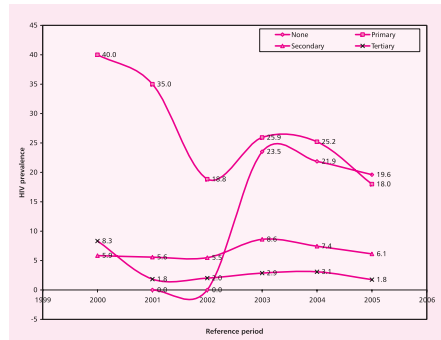
It would also appear that HIV prevalence is high among young people who are employed. The differences in HIV prevalence by employment status vary from one period to the next. For instance HIV prevalence among young persons who were employed at the time of testing was highest in 2004. Test statistics show that indeed there are differences in the proportions of HIV positive clients over time by employment status. Figure 5 shows that despite the high prevalence over the period, there are indications that it may be declining (see details in Figure 6).

Figure 5: VCT HIV prevalence among 15 to 19 by whether client is employed



On the levels of education and HIV prevalence, the data show that prevalence for clients with no education fluctuate considerably. This may be accounted for by the fact that access to education in Botswana is universal, therefore the numbers submitting for HIV testing would consequently be small (the numbers range between 0 and 122 for the period 2000 to 2005). Among those with primary education only, prevalence is highest, though declining (prevalence in this category ranges between 18 and 40% for the period 2000 to 2005 - see figure 6). HIV prevalence in young people aged 15-19 years with secondary and tertiary education is relatively low, with the rates ranging between 5.5 and 8.6% among young people with secondary education. The rates among young people with tertiary education ranged between 1.8 and 3.3%. This information is detailed in Figure 6 below.

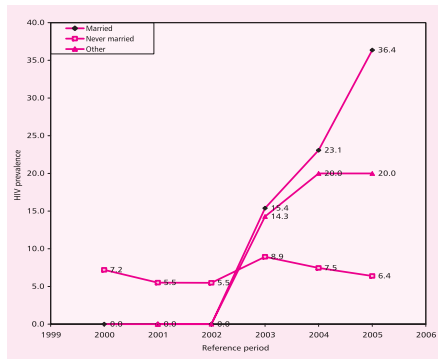
Figure 6: VCT HIV prevalence among 15 to 19 by level of education



The data on marital status, particularly on the numbers that are married, are very erratic and are likely to produce unreliable results. Notwithstanding that the percentage

of HIV positive clients who have never been married is gradually declining. However, the picture presented for other marital categories is disturbing, with the prevalence increasing overtime (see Figure 7).

Figure 7: VCT HIV prevalence among 15 to 19 by marital status



The rates among 15-19 years who have ever had sex decline from a high of 10.5 in 2003 to a low of 7.7 in 2005 (Figure 8). Although the VCT data show that among 15-19 year olds who have never had sex, 50 tested positive, there is no information on how this population group could have possibly contracted the virus. However, further analysis on reasons for HIV testing show that 23 who had never had sex and were HIV positive, presented for an HIV test because their partner had been at risk, 10 presented for other reasons, 5 did so for family planning, 3 had risky behaviour, while 2 needed to access care and treatment. The remainder presented for varied reasons including counselling, PMTCT, partner dead, partner had symptoms, and client had

symptoms or was unwell. This obviously throws some doubt on the reliability of the responses obtained, such that these results are thought to be unreliable and the statistics should be read with caution.

Figure 9 also demonstrates that the decline in HIV prevalence has been drastic over the period. The data on HIV prevalence were also analysed for each age in the age

Figure 8: VCT HIV prevalence among 15 to 19 by ever had sex

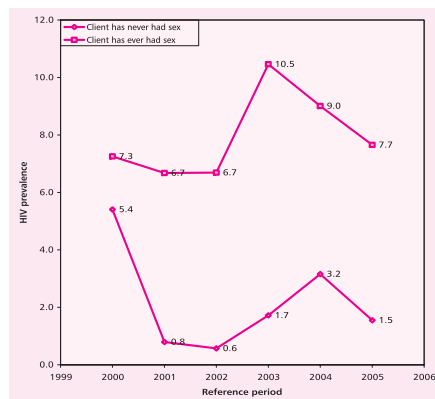
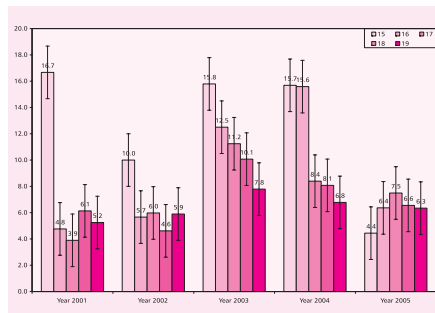


Figure 9: VCT HIV prevalence among 15 to 19 for the periods 2000-2006



bracket 15-19 years for the period 2000 to 2005. The data as shown in figure 10, point out that in 2003 the prevalence rates among 15 year olds was 15.8% compared with 15.7% in 2004 and only 4.4% in 2005. The rates also decline in other age groups. This provides sufficient evidence that HIV prevalence has significantly declined among 15-19 year olds.

The data from VCT over the 5 year period suggest that although in early 2000, HIV prevalence fluctuated, from the year 2003 there has been a marked decline in HIV prevalence among young people 15-19 years. Some of the behavioural factors that could account for these decline are; the number of young people who enter into sexual unions, condom use and number of partners. In the period between 2000 and 2003 we observe an increase in HIV prevalence among clients who reported one steady partner at the time the client visited the VCT centre for testing. Despite this there is a general decline in HIV prevalence among clients with no partners and among those with one partner.

4. Conclusion

This study utilised aggregated data from ANC and data from VCT records to establish whether there is any evidence of a decline in HIV prevalence among 15 to 19 years olds in Botswana for the period 2000 to 2005.

HIV prevalence among pregnant women aged 15-19 and in the population group 15-19 as a whole, appears to have declined during the period 2003 to 2005. There is need for more data to be analysed for the period 2006-2007 in order to verify this apparent trend. ■

... Some of the behavioural factors that could account for these decline are; the number of young people who enter into sexual unions, condom use and number of partners...

Bibliography

Boerma, J. T. Holt, E. Black, R. Measurement of Biomarkers in Surveys in developing countries: opportunities and problems. *Popul Dev Rev.* 2001; 27: 303-14.

Boerma, J.T. Peter D. Ghys, Neff Walker. Estimates of HIV-1 prevalence from national population-based surveys as a new gold standard. *The Lancet.* 2003. 362: 1929-31.

Kwesigabo G, Killewo, J.Z.J. Urassa, W. et al. Monitoring of HIV-1 infection prevalence and trends in the general population using pregnant women as sentinel population: 9 years experience from the Kagera region of Tanzania. *J. Acquired Immune Deficiency Syndrome.* 2000. 23: 410-17.

Glynn, J.R. Buve, A. Carael, M. et al. Factors influencing the difference in HIV prevalence between antenatal clinic and general population in sub-Saharan Africa. *AIDS.* 2001; 15: 1717-25.

Gregson, S. Terceira, N. Kakowa, M. et al. Study of bias in antenatal clinic HIV-1 surveillance data in a high contraceptive prevalence population in sub-Saharan Africa. *AIDS.* 2002; 16: 643-52.

Swartlander, B. Stanecki, K. A. Brown et al. Country Specific estimates and models of HIV and AIDS: Methods and Limitations. *AIDS* 1999; 13: 2445-58.

<http://www.avert.org> The "ABCs" of HIV Prevention: Report of a USAID Technical Meeting on Behaviour Change Approaches to Primary Prevention of HIV/AIDS. United Nations, 2004.

UNAIDS 2005. Evidence for HIV prevalence in Zimbabwe a comprehensive review of the epidemiological data.

USAID 2000. What happened in Uganda? Declining HIV prevalence Behaviour change and the National Response.

Botswana National Strategic Framework 2003 – 2009.

Kgosidialwa, M.C (2003) the economic impact of HIV/AIDS on industrial firms in Botswana, Research paper

NACA, 2004 Botswana HIV/AIDS Impact Survey II. Statistical Report.

SAVE ~ the New Comprehensive Approach to HIV Prevention

By Dr. Rachel Baggaley
Head of HIV Unit, Christian Aid
With Rev. James Matarazzo
Sr. Advisor, HIV Unit, Christian Aid

Christian Aid (CA) and its partner ANERELA+ (African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS) have been aware for some time of limitations implicit in the ABC (Abstain, Be faithful, use Condoms) approach to combating HIV. Some messages used to slow the spread of HIV have had the unfortunate consequence of adding to the stigma surrounding it. ABC is sometimes one such message.

In a recent conference of CA HIV partner organisations from around the world, the degree to which these problems are a real barrier to our partners' work – in high- and low-prevalence settings – became apparent. As a result, CA has adopted a new doctrine as the basis for a comprehensive approach to HIV – under the acronym **SAVE**:

- Safer practices
- Available medications
- Voluntary counselling and testing (VCT)
- Empowerment.

SAVE was originally developed by ANERELA+ in order to expand upon and improve the ABC model. Recently, ANERELA+ founded a new global network, INERELA+ (International Network;), which will be formally launched in Mexico City at the International AIDS Conference in August 2008.

The SAVE message can be simplified into slogan format along the lines of the ABC message by rendering the meaning of the acronym in this way:

- Be Safer
- Get what's Available
- Get tested Voluntarily
- Get Educated

The anti-stigma motto of ANERELA+ is that **HIV is a virus, not a moral issue**. The response to HIV must be based on public health measures and human rights principles. ABC as a theory is not well-suited to the complexities of human life. If you or your partner have been tested positive for HIV and still have unprotected sexual intercourse, then this puts the other person at risk of HIV infection. Whilst abstinence may be appropriate at some stages of life,

faithfulness is for many people the preferred choice. Unfortunately, it is not a guarantee against HIV infection. ANERELA+ reports that approximately 60 per cent of HIV-positive African women believed they were in a monogamous and faithful relationship.

According to these definitions, the use of a condom automatically puts a person in the category of one who cannot be faithful, or does not want to abstain. This can fuel stigma, and precludes safer sexual practices.

Many faith-based organisations use HIV as a way to reinforce traditional views of sex and sin. CA's faith-based partners feel religious organisations can best protect people from HIV, and help those living with it, by extending Christian values of care and support and promoting safer lifestyles.

Following the launch of our SAVE document, we have had many responses from partners, staff, CA supporters, and the general public. Although the vast majority has been positive, a minority thought that, by adopting SAVE, we had somehow 'abandoned' abstinence. It is important to be very clear here; the adoption of SAVE **does not** imply the abandonment of abstinence. The "S", for "safer practices", includes abstinence as a very important option, alongside a wide range of evidence-based HIV prevention interventions.

methods for penetrative sexual intercourse; and sterile needles for injecting. Abstinence remains the most reliable method of avoiding exposure to sexually transmitted infections (STIs), but it must not be taught in isolation.

A refers to available medications. Antiretroviral Therapy (ART) is by no means the only medical intervention needed by people living with HIV (PLHIV). Long before it may be necessary, or desirable, for a person to commence ARV therapy, some HIV-associated infections will have to be treated. These interventions result in better quality of life, better health, and longer term survival. Every person needs adequate good nutrition and clean water, and this is doubly true for PLHIV.

V refers to voluntary counselling and testing. Individuals who know their HIV status are in a better position to protect themselves from infection, and – if they are HIV-positive – from infecting others.

E refers to empowerment. It is not possible to make informed decisions about any aspect of HIV or sexual behaviour without access to all the relevant facts on "S", "A", and "V". Inaccurate information and ignorance are two of the greatest factors driving HIV-related stigma and discrimination. Education also includes information on good nutrition, stress management, and the need for physical exercise.

Correct, non-judgmental information

- Safer practices
- Available medications
- Voluntary counselling and testing (VCT)
- Empowerment.

Additionally, HIV prevention cannot be effective without a care component. The SAVE model combines prevention and care components, as well as providing messages to counter stigma:

S refers to safer practices covering all the different modes of HIV transmission. For example: safe blood transfusions; barrier

must be disseminated to all. This can only assist people to live positively – whatever their HIV status – and help to break down the barriers that HIV has erected between people and within communities. After all, we must not forget that HIV is just a virus; stigma has no place in an urgent matter of public health. ■

Genital herpes implicated in up to half of all HIV infections in some African countries

by Keith Alcorn

Up to half of all HIV infections in some African countries with long-standing HIV epidemics may be due to the presence of genital herpes and its cause, HSV-2, in HIV-positive people or their partners, epidemiologists from the London School of Hygiene and Tropical Medicine estimate.

Their projections, published this month in a supplement to the journal *Sexually Transmitted Infections*, are drawn from data accumulated during the Four Cities study, which compared trends in HIV prevalence in four African cities in different regions, and from local trends data from each city.

A previous meta-analysis of published studies carried out by the same research group estimated that 38-60% of new HIV infections in African women and 8-49% of new infections in African men could be attributed to HSV-2, depending on HSV-2 prevalences that ranged from 29% to 71% in women and 5% to 53% in men.

The investigators wanted to model the interactions between HIV transmission and sexually transmitted infections over time in order to pinpoint when interventions against HSV-2 and curable sexually transmitted infections would have the greatest relative impact.

They used data on HSV-2, chancroid, syphilis, gonorrhoea and chlamydia infections, as well as modelling HIV incidence. However the main focus was the interaction between HSV-2 and HIV.

Assumptions in the model

- Primary ulceration lasts three weeks and ulcers recur every two and half to three months for the first two years, and every six to eight months during the following ten years. After the primary infection, ulceration lasts for one week.
- The per-contact probability of transmission from men to women was 0.30 during the primary infection and

0.20 during later infection if an ulcer was present, with a much lower per-contact probability associated with HSV-2 shedding during latent infection (0.01 per contact during the first two years, and 0.005 subsequently).

- HIV infection increases ulcer duration and recurrence fourfold.
- Presence of primary herpetic and chancroid lesions increased the per contact risk of HIV transmission 25-fold
- Since recurrent ulcers were assumed to last for a shorter period, they were assumed to account for a tenfold increase in the per contact risk of transmission.
- Syphilis increased the per contact risk of HIV transmission sevenfold, gonorrhoea and chlamydia threefold.

Results

The study found that over time, in each city, the proportion of HIV infections attributable to genital herpes rose, and the proportion attributable to other sexually transmitted infections (including chancroid) fell.

Five years after the introduction of HIV, HSV-2 was implicated in between 8% and 30% of infections varying by city. Fifteen years into the epidemic, the proportion had grown to between 35% and 48% of HIV infections varying by city. The highest proportion of infections due to HSV-2 was seen in Cotonou in Benin, where the rate of other STIs fell markedly over time due to intensive STI treatment in commercial sex workers.

In Yaoundé, Cameroon, the proportion of infections attributable to HSV-2 levelled off around 37% after ten years, due in part to strong uptake of condoms in the early 1990s.

Chancroid's role in amplifying HIV transmission declined; while it had an important role in establishing the HIV epidemic in three of the four cities, its influence declined as syndromic treatment of STIs became established during the 1990s.

The authors observe that, according to their model, "at the current stage of the HIV epidemics, and given the current level of condom use and provision of STI treatment services, further strengthening of

treatment services for curable STIs may be expected to produce little additional gain. However, withdrawing those services would most likely result in increased prevalence of curable STIs and increased HIV transmission."

HSV-2 infection appears to drive up HIV incidence over time, and become responsible for a larger proportion of HIV infections at a population level, the authors suggest, more because of its effect on infectivity, rather than because it makes HIV-negative people more susceptible to HIV infection.

The increased infectivity is more important, they think, because individuals with HSV-2 and HIV may have multiple partners and may have increased levels of HIV in their genital fluids for long periods as a result of HSV-2 infection, whereas genital herpes lesions in an HIV-negative person only make that person vulnerable while the lesions are present.

The authors also point out that trials of HSV-2 interventions need to be designed and interpreted in the light of these findings, since the stage of the HIV epidemic in a location and variables such as condom use and incidence of other sexually transmitted infections clearly modulate the interaction between HIV and HSV-2 and could affect the results of trials.

Recently reported studies of HSV-2 interventions have found that treatment with valaciclovir, a drug that suppresses HSV-2, reduced HIV shedding in HIV-positive women, but the effect of aciclovir (a similar drug) appeared modest in two studies in HIV-positive women. All these studies followed women for a relatively short time.

The only study to look at HIV incidence, in HIV-negative women with HSV-2 infection, found that daily aciclovir therapy did not reduce the risk of HIV infection, possibly due to poor adherence. ■

Reference

Freeman EE et al. Proportion of new HIV infections attributable to herpes simplex 2 increases over time: simulations of the changing role sexually transmitted infections in sub-Saharan African HIV epidemics. *Sex Transm Infect* 83 (suppl 1): i17-i24, 2007. Courtesy of AIDSMAP.com <http://www.aidsmap.com/en/news/236EC846-5173-4FD3-B78C-110D40.A76658.asp>

... over time, ... proportion of HIV infections attributable to genital herpes rose, and the proportion attributable to other sexually transmitted infections fell...

Novartis loses Indian Patent case: good news for ARV access



Source: www.AVERT.org ©AVERT

News of the Indian High Court's ruling against Swiss pharmaceutical giant, Novartis has been welcomed by AIDS activists in the developing world.

Novartis had challenged an Indian law that allows the country to refuse a patent for a medicine that is a modified version of an existing drug and not truly innovative.

According to Dr Marta Darder, of the South African office of international medical humanitarian organisation, Médecins Sans Frontières (MSF), patenting new versions of old drugs is a strategy used by the pharmaceutical industry to prolong monopolies that keep the prices of essential medicines out of reach of people in the developing world.

A ruling in favour of Novartis would have stifled competition among India's generic drug manufacturers, which have played a vital role in driving down the prices of antiretroviral (ARV) drugs over the last decade. "This is exceptional news for the future of access to affordable medicines in resource-constrained settings," said Darder.

India has become known as the 'pharmacy of the developing world' because of its huge generic drug manufacturing

industry, which exports two-thirds of its production to developing countries at a fraction of the cost of patented medicines.

After being forced to comply with World Trade Organisation (WTO) rules governing patents in 2005, India designed its patent law to take advantage of safeguards provided in the WTO's Trade Related Aspects of Intellectual Property Rights (TRIPS), which allow intellectual property rights to be balanced against public health priorities.

"In many ways, India's patent law is very progressive," commented Jonathan Berger, a senior researcher at the AIDS Law Project, an organisation that fights for the rights of people living with HIV/AIDS in South Africa. "It is the only country that has taken advantage of flexibilities in TRIPS; the real question is, why haven't other countries done the same?"

The ruling will mean that a drug like the new version of the second-line ARV, Kaletra, which has been modified so that it no longer requires refrigeration, will still not be patentable in India and can therefore be produced in cheaper, generic forms and exported to other countries.

Indian Health Minister Anbumani

Ramadoss, Archbishop Desmond Tutu, members of the European Parliament and the US Congress were among nearly 500,000 people worldwide who signed an MSF-led petition protesting Novartis' legal action and highlighting the negative impact it could have on access to essential medicines such as ARVs.

Berger hoped the landmark decision by India's High Court would help build a stronger case for other developing countries to act against patent barriers.

"The fact that India has been able to protect this [patent] provision under incredible pressure does provide some encouragement to other countries to use similar provisions, or else to amend their laws to take advantage of the flexibilities and safeguards under TRIPS." ■

© IRIN. This item comes to you from PlusNews, part of IRIN, the humanitarian news and analysis service of the UN Office for the Coordination of Humanitarian Affairs.

The opinions expressed do not necessarily reflect those of the United Nations or its Member States. <http://www.irinnews.org/>

Donors and NGOs working hand in hand to address HIV and AIDS in the workplace

STOP AIDS NOW

Managing HIV and AIDS in the Workplace

International NGOs, like many international businesses, have recently woken up to the need for workplace policies on HIV and AIDS. Policies like these help to reduce the impact of HIV and AIDS, ultimately maintaining the performance and effectiveness of the organisation. The positive effects are worth much more than the extra costs involved, yet many organisations - especially local NGOs - still don't have an HIV and AIDS workplace policy.

Ignoring difficult realities, a costly habit in the case of HIV and AIDS

Local NGOs do recognise that it makes sense to invest in managing HIV and AIDS, including providing treatment for HIV-positive employees and their families, in order to reduce the effect that AIDS has on their work. However they are facing some difficulties to actually define a strategy. Common obstacles are the fear to be open about the ways in which AIDS is affecting the performance. Many donors remain silent, an attitude that doesn't stimulate their local partners to take this matter on. As a result, the local NGOs, their staff and their work are more vulnerable to the impact of HIV and AIDS than they need to be.

Breaking the silence

In many partnerships between Northern and Southern NGOs, HIV and AIDS is not discussed, or is discussed only in terms of the effects at community level. STOP AIDS NOW! has conducted a baseline survey (May, 2006) on managing HIV and AIDS in the workplace among NGOs in Uganda, which showed that only 4 out of the sampled 52 NGOs had a functional comprehensive HIV and AIDS workplace policy. STOP AIDS NOW! aims to actively open up the dialogue and provide support to our partners, rather than being 'concerned bystanders' who are doing little to assist.

Working with local NGOs and Donors at the same time

The overarching aim of the "Managing HIV and AIDS in the workplace" project is: supporting our partners to reduce the impact that HIV and AIDS has on their work, thus safeguarding performance and effectiveness.

To reach this aim we work at different levels, with local NGOs and with Donors.

Local NGOs

Through the project, STOP AIDS NOW! stimulates and supports its local partners in the development and implementation of a comprehensive HIV and AIDS workplace policy. This workplace policy includes a stigma reduction strategy.

Donors

STOP AIDS NOW! wants to set a good example, to re-think "business as usual". We have defined our position as a donor, in the process of managing the organisational impact of HIV and AIDS of our local partners. We aim to motivate other donor organisations to go through a similar process. This part of the project is called: Good Donorship in times of AIDS.

Good Donorship Guidelines

During the process of defining our position as a donor STOP AIDS NOW! has developed the guidelines "Good Donorship in times of AIDS". These guidelines explain why donors working with local NGOs, should support them to implement a HIV and AIDS workplace policy in order to manage the impact of HIV and AIDS. Crucially, the guidelines do not only present reasons, ideas and information, but also clearly set out our principles and the

commitments which we as donors are making to our partners.

The guidelines are short and written in plain language, and include sections on:

- how a workplace policy addressing HIV/AIDS can benefit local NGOs;
- the key principles for a workplace policy;
- the components of an ideal workplace policy;
- adapting the ideal workplace policy to the partner's context;
- the process of developing and implementing a policy;
- covering the cost of the policy.

Most critically, the guidelines are not just talk; throughout they present clearly stated **principles and commitments** from the members of STOP AIDS NOW!, including what financial and other support will be given to our partners. By being very clear and precise, both local NGOs and donor staff knows what support is offered, why, and within what limits. For example, STOP AIDS NOW! commitment to fund the costs of workplace policies up to a maximum of 4% of the total staff costs.

Does your organisation, or your partner, want to tackle the issue of HIV and AIDS in the workplace? Congratulations! One of the challenges you will face is budgeting. STOP AIDS NOW! has designed a tool to help local NGO staff who do the budgeting, "What's it likely to cost?"

Pilot countries

For a period of three years the guidelines are implemented in the pilot countries Uganda and India. During this period continues capacity building activities take place. These activities are organised at the local level.

Maximise learning

To maximise learning, a phased applied research component is added to the project. The main objective of this research is to identify and analyse the factors which influence successful development and implementation of HIV and AIDS workplace policies. Good practices that will enable the development of better strategies — in other settings too — are identified



Yvette Fleming

and documented during the process.

The applied research consists of three phases, each with a different focus:

- Phase 1 – *development* of workplace policies
- Phase 2 – *implementation* of workplace policies
- Phase 3 – *effects* and impact of workplace policies

Check our website for the results of the applied research phase 1:
http://www.stopaidsnow.org/our_work_article/workplace_results_more2

Successes from Uganda

In the pilot projects we are bringing partners together to learn about workplace policies, take part in capacity building exercises, share experiences, and to develop strategies. Since we introduced the Good Donorship Guidelines in March 2006 along with support at country level on sensitization, peer education, and policy formulation 46 out of 76) have developed and formulated draft policies in Uganda.

In a very short time local NGOs have been stimulated and motivated to take action and now consider an HIV and AIDS workplace policy to be an effective strategy to reduce the impact of HIV and AIDS on

back and are in the process of incorporating feed-back etc

- **3** are responding to HIV and AIDS in the workplace without a formal policy
- **30** are not yet responding due to various reasons, but main reason is ignorance and lack of commitment from management

Some outcomes of a survey conducted among 62 participating organisations, during the first phase of the project :

- **Need for information:** 98% expressed the for more information on HIV and AIDS. Main topics (multiple response): ART (83%), fighting stigma and discrimination (76.2%), PMTCT (60.8%) and how HIV and AIDS affect the body (59.6%).
- **Perceived workplace-related risk:** 32.3% have ever felt at risk at the workplace or during duty travel; relatively more management (40.7%) and technical staff (33.3%). Reasons for feeling at risk: during duty travel being exposed to temptations in sexually attractive company (42.6%), fear of having been contaminated through working with PLHIV or through (medical) accidents (31.7%).

(45.1%) and reduced performance (13.2%) and increased absenteeism due to personal illness (12.1%) than women. The younger respondents (57%), women (58.3%) and volunteers (58.3%) were less likely to report any impact compared to the others.

Relatively more support staff reported reduced performance due to weakness (20.6%) and absence due to personal illness (15.9%) than staff in other job categories.

- **Managing HIV and AIDS in the workplace:** 28% reported their organisation does something to respond to the needs of staff living with HIV or AIDS. Of those, the activities: actively fighting stigmatisation and discrimination (58.3%), pay for treatment of opportunistic infections (44.7%), access to ARVs (42.7%), HIV positive being redeployed to suitable positions (15.5%), food supplements (6.8%).

Commitments of our partners

SAN! partners (Oxfam Novib, Cordaid, HIVOS and ICCO) integrated mainstreaming HIV and AIDS in their business plans 2007-2010 for most of their partners worldwide.

What can you do?

We would like you to “rethink business as usual”. Ask yourself the question what the impact of HIV and AIDS is on your organisation, and what you can do about it. We invite you to open up the dialogue on HIV and AIDS in the work place. Break the silence and talk about the issue with your local partners, donors, contractors, employers and employees. You can get some inspiration from our Good Donorship Guidelines. The Guidelines are available in English, French, Portuguese and Spanish, you can download them from our website: www.stopaidsnow.org/our_work_article/workplace_results ■

More information

The fight against AIDS is closely related with the fight against poverty. Based on this idea the Aids Fonds and four Dutch development organisations, Hivos, ICCO, Cordaid and Oxfam Novib, decided to join forces and found STOP AIDS NOW! in 2000. Through the partnership Hivos, ICCO and Oxfam Novib are strengthened to further mainstream HIV and AIDS within their activities. On the other hand they concentrate on AIDS-specific activities, such as increasing access to treatment.

*For more information on STOP AIDS NOW! and the “Managing HIV and AIDS in the workplace” project please visit our web-site
http://www.stopaidsnow.org/our_work_article/workplace .*

Contact details

Local Project Coordinator Uganda: spencer@acord.or.ug
Project Coordinator Netherlands: Yvette Fleming .



their organisations. The local NGOs claim that the support at country level in combination with the clearly defined position of their donors has made the project so successful. It has helped to convince directors, board members, management and staff to define workplace policies.

Project facts & figures

There are 76 NGOs involved in the project, of which:

- **5** are implementing with funding from donors and 3 are partially implementing without donor funding
- **8** have submitted their WPP to their respective SAN! donor and waiting for a response
- **27** are drafting and received feed-

- **Effect of HIV and AIDS on workers:** 70.8% have been personally affected. Effects (multiple response): attending burials (56%), taking care of a sick family member (33.4%), caring for bereaved (32%), increased medical bills (21.4%), reduced personal health (5.7%).
- **Effect on the workplace:** 48% reported affect of HIV and AIDS on their work: (multiple response) increased absenteeism due to illness of family members and/or burials (38.4%), increased workload due to illness of other staff (17.3%), reduced performance due to weakness (10.2%), and increased absenteeism due to personal ill health (9.9%). Men relatively more report absenteeism due to illness of family members



Source: www.AVERT.org ©ACHAP

Family Health International in Bold New Initiative to Reduce Orphaning in HIV-Affected Communities and Reclaim Generation Lost

At a time when only 15% of all children globally who need antiretroviral treatment (ART) have access to it, Family Health International (FHI) is launching a bold new HIV initiative to improve the lives of children and families affected by HIV and AIDS.

The comprehensive programme, announced today at the Clinton Global Initiative in New York, will provide ART, the lifesaving HIV and AIDS drug regimen, to 20,000 additional children and their

link between HIV among children and the growing orphan crisis.

“We are failing the world’s children,” says Albert Siemens, chief executive officer of FHI, which operates research and public health programmes in about 70 developing countries. “HIV-related orphaning is creating a desperate situation where, in many cases, children are caring for children. This is a massive tragedy.”

Indeed, one quarter to one third of untreated HIV-infected children die before their first birthday, half or more by their second birthday, and four-fifths by age five, according to the United Nations Children’s Fund (UNICEF). By the year 2010, the number of children orphaned by AIDS is expected to more than double to 25 million or more globally – equal to the number of people who have died of AIDS since HIV was first recognised 25 years ago.

“This initiative has the potential to profoundly change the lives of children and families in developing countries. By addressing the complex needs of HIV-positive children and HIV-affected families, this initiative can help reclaim a generation lost to AIDS,” says Deepak Verma, chief executive officer of the Clinton

Foundation HIV/AIDS Initiative, which has been assisting countries in implementing large-scale, integrated care, treatment and prevention programmes since 2002. The Foundation partners with governments in more than 25 countries and provides limited support to an

additional 12 countries to assist their pediatric care and treatment capacity, in Africa, the Caribbean, Eastern Europe and Asia by providing technical assistance, mobilising human and financial resources and facilitating the sharing of best practices.

This new initiative builds upon FHI’s HIV treatment successes and is further shaped by two FHI projects that address the complexities of orphaning. The first programme, Nuru Ya Jamii (“Light of the Family” in Swahili), has prevented hundreds of Kenya children from becoming orphaned. The second, LifeWorks, an East African regional project, is addressing the root causes of illness, such as poverty and joblessness. By rapidly expanding the core elements of these programmes, we not only extend life, but increase a community’s vitality.

“We envision a world where every child has a healthy family and a place to call home. The challenge is great and we must all work together to make it a reality,” Siemens says.

The non-profit FHI has been at the forefront of public health research, prevention, care and treatment in the developing world since 1971. FHI delivers services and conducts research in HIV/AIDS, other infectious diseases and reproductive health to improve the lives and well-being of some of the world’s most vulnerable people. ■

Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709 USA
www.fhi.org
 Email: DHock@fhi.org
 Courtesy of AF-AIDS eForum 2007:
af-aids@eforums.healthdev.org

...The plan will triple delivery of treatment to HIV-positive children and prolong parents’ health so fewer children are orphaned...

families in 10 countries. Families enrolled in the programme will also gain access to a safety net of other essential services, skills and opportunities that will improve their living situation and reduce the likelihood of their children becoming AIDS orphans. This holistic response recognises the tragic

TB and HIV: Time to Balance the Cure and Treatment Scale

By Dr Nyasha Madzvingira

With approximately 9 million new cases and nearly 2 million deaths every year, tuberculosis (TB) remains a disease of concern in many countries. It has also become the primary killer of people living with HIV (PLHIV), with 15% of deaths related to TB. HIV increases the risk of developing active TB by 50%. Of the 14 million people co-infected with TB and HIV, 10 million reside in Africa. A number of factors including poverty, ignorance and stigma continue to compound the challenges communities face in dealing with TB and HIV co-infection.

TB is spread from person to person through the air, when free-floating particles that contain TB bacilli are inhaled. Not all persons exposed to TB become infected. Unlike diseases such as measles or smallpox, which are highly contagious and carry an almost 100% chance of infection, exposure to TB does not guarantee TB infection. Other factors increase or decrease the probability of transmission.

These include; risk of infection because of close contact with the source or index case; the age of the contact (infants, young children and older adults are at increased risk) and immune status (HIV-positive individuals are at increased risk). The environment - for example, the size of a room or space, the duration of exposure, ventilation (air exchanges or air flow) and the presence or lack of sunlight or artificial ultraviolet light - also influences transmission.

Southern Africa, the epicentre of the HIV and AIDS epidemic, is currently experiencing an increased burden of TB cases and especially co-infection with TB and HIV. The table below indicates the HIV prevalence and TB incidence in some southern African countries.

Why TB Screening is Necessary for PLHIV

Most people affected by TB mycobacteria will not develop active TB because their immune system response works to keep the disease dormant. But as a person's immune system weakens, which is typical with HIV infection, the TB infection reactivates. An estimated one third of the 40 million people living with HIV worldwide are co-infected with TB. Despite being curable, TB is the

leading cause of death amongst PLHIV, so screening of PLHIV for active TB will identify many individuals in need of treatment for previously undiagnosed TB. There is also need to ensure that PLHIV

The marked increase in HIV-associated TB globally, and especially in Africa, demands rethinking the TB control strategy along with a more aggressive approach to case finding. Directly observed therapy (DOTS),

HIV Prevalence and TB Incidence in Southern Africa

Country	Population	HIV Prevalence (%)	TB Incidence (per 100 000)
Botswana	1,893,526	24.1	654
Lesotho	2,513,076	23.2	696
Malawi	11,553,163	14.1	409
Mozambique	20,356,242	16.1	447
Namibia	2,083,405	19.6	697
South Africa	49,660,502	18.8	600
Swaziland	1,173,758	33.4	1262
Zambia	11,486,812	17.0	600
Zimbabwe	12,398,897	18.1	601

Source: <http://www.internetworldstats.com/africa.htm>

who have symptoms suggestive of TB have access to diagnosis and treatment. The risk of active TB rises steadily with decreasing CD4 count, especially with CD4 counts below 200.

The risk of active TB rises steadily with decreasing CD4 count, especially with CD4 counts below 200.

introduced by WHO in 1993, resulted in a dramatic improvement in treatment of TB cases. However, the DOTS approach is limited since it focuses on TB in the lung and is reliant on passive case finding, seeking the presence of bacilli in the sputum in patients who present with coughs lasting more than three weeks and are given a clinical exam and sputum smear microscopy.

This handicap is aggravated by the fact that HIV positive people tend to have fewer bacilli in their sputum and are also more likely to have extra pulmonary TB. Consistent detection of TB in HIV positive people, therefore, cannot be effectively accomplished by the present, most commonly used tests.



Symptoms for pulmonary TB

- Persistent cough
- Shortness of breath
- Chest pain
- Weight loss
- Fever
- Night sweats

Continued on page 24

TB bacilli are NOT spread through...

- Blood or bodily fluids
- Food or liquids
- Eating utensils
- Social contact (hugging or shaking hands)
- Sex
- Dust, dirt, vehicle fumes

The most common TB diagnostic method (smear microscopy) is 125 years old and routinely fails to identify nearly 50% of TB cases. Furthermore, it does not detect extra pulmonary TB. The Mantoux Test or the Purified Protein Derivative (PPD) test, which detects TB by analysing a skin reaction can be used, but it takes time (the patient must return for the test to be assessed) and the results can be difficult for health workers without special training to determine.

The most common TB diagnostic method (smear microscopy) is 125 years old and routinely fails to identify nearly 50% of TB cases.

For PPD positive individuals living in high TB burden settings, Isoniazid Preventive Therapy (IPT) will reduce the short-term risk of developing TB by 40-64%. In people living with HIV who live in high TB burden settings, who have a positive PPD test, IPT will reduce the risk of developing active TB disease in the short-term by 64% even though the benefit may only last a couple of years, in settings where people are frequently re-exposed to TB. IPT is one of the key interventions recommended by WHO to reduce the burden of TB in

Isoniazid Preventive Therapy (IPT) is used to prevent development of TB infection into TB disease for people who have been diagnosed with LTBI (and confirmed PPD positive) :

- The usual adult dosage for IPT is 300 mg daily for 9 months.
- For those who cannot take isoniazid, (INH), two to three months of rifampicin (R) and pyrazinamide (Z) or 2RZ is recommended.
- TB could be prevented in millions of people with both HIV and TB through the use of IPT.

PLHIV and yet the pace of implementation has been very low. Only 25,000 PLHIV worldwide were reported to have received it in 2005. IPT should be a routine part of the package of care delivered by HIV and TB service providers for PLHIV and their families.

Secondary prevention strategies for HIV infection include early use of ART, before a person develops clinical symptoms, and opportunistic infection (OI) such as prophylaxis with cotrimoxazole. For TB, IPT for latent TB infection (LTBI) or nine months of isoniazid (INH) preventive therapy (IPT), reduce the subsequent risk of developing active TB disease. The beneficial impact of this therapy appears to level off around nine months, although there is still need to verify the best duration of therapy for HIV positive people.

The Need for HIV testing for all TB Cases

Without concomitant HIV testing and counseling for all TB cases, countries will never recognise the true scale of the burden of HIV and TB co-infection, which will consequently remain untreated. For TB and HIV scale-up to be successful, provider initiated HIV testing and counseling must be encouraged. Communities need to be educated to understand that HIV infection promotes the progression from latent TB infection to active TB disease - the risk increases from 1 in 10 per lifetime to 1 in 10 per year. HIV also increases the rate of TB recurrence. HIV infected people have greater proportions of smear negative (24-61%) and extra-pulmonary (4-40%) TB, which means that TB is often undiagnosed in PLHIV.

Unfortunately, HIV also impacts on the care delivered to HIV negative people with

TB, and the stigma attached to HIV-associated TB may affect the health seeking behaviour of TB suspects, regardless of their HIV status. Testing for HIV can therefore improve health-seeking behaviour

where a TB suspect is negative, as well as improve disease management for those found to be HIV positive.

Secondary Prevention Strategies HIV infection :

Early use of ART, before clinical symptoms develop plus OI prophylaxis with cotrimoxazole.

TB infection : IPT for latent TB infection or nine months of IPT reduce the subsequent risk of developing active TB disease.

Challenges to rapid and effective TB diagnostics

There are many challenges to the development of effective TB diagnostics. These include:

- Self medication with some antibiotics may mask TB symptoms or affect test results
- Failure to attend regular hospital appointments causes delays in proper diagnostic investigation
- Most HIV treatment centres do not have onsite diagnostic units and depend on referrals, thus delaying diagnosis
- Too few personnel are trained in TB diagnostics
- Where tools are available, diagnosis is slow, taking between 6 and 16 days
- There is lack of community involvement in TB Programmes
- There is a high default rate in TB treatment due to intolerance to medication, stigma associated with TB, loss to follow up and inefficiencies in the DOTS system
- In resource-poor countries there are no tools for the diagnosis of MDR-TB and XDR-TB

What needs to be done?

Diagnostic Tools

There is need for simple, rapid and accurate TB diagnostics and effective drugs now. HIV/TB activists have a vital role to play in ensuring that new the research and development of new TB tools addresses communities' priorities and is done efficiently. There is need also to demonstrate how Isoniazid treatment for LTBI can be effectively rolled out taking account of the current limitations on diagnostics.

Laboratory Capacity Development

There is need to build laboratory capacity (equipment, staff, laboratory infrastructure, training and supervision) for TB diagnostics.

Infection control

Some simple but effective interventions are not being encouraged, for example;

- Administrative protocols for coughers, at general outpatient clinics, to reduce spread of infection
- Enhanced training and distribution of N95 (Non-oil resistant particulate aerosol with a filter efficiency of 95%) masks for treatment supporters.
- Active screening of household contacts to curb the spread of TB bacteria.
- Prevention of transmission between patients can be improved through ventilation systems and use of isolation wards.
- Protection of hospital health workers (HIV screening, N95 masks, universal precautions) needs to be undertaken. Ideally health workers who are HIV positive should not work on medical wards where TB may be present. If this is not possible they should be offered IPT

Many of these items need to be undertaken as a matter of urgency.

Community-based care

There is need to introduce TB treatment supporters by integration with HIV and AIDS programmes. TB patients also need support with food packages, transportation to health centres, psychosocial support and temporary housing should be provided for patients living in very isolated areas.

Treatment literacy (Cover your Cough)

Treatment literacy in HIV has proved to be very effective and has changed the landscape of medicine. The same route should be followed with TB. Clients need to understand the disease (prevention, transmission and treatment), the drugs (how they work, their benefits and side effects), the need for treatment adherence and that TB compromises not only their own health, but that of their families and community members. Simple messages such as 'Cover your Cough' can protect many community members from TB.

Integrated TB and HIV health delivery systems

Where TB and HIV services are integrated, TB cure rates have gone up, with high levels of adherence to treatment. Dual facilities are vital for people who come for TB tests and treatment to be encouraged to test for HIV and vice versa. It is also possible to have a strong base of peers at the facility to give support to TB clients, as well as to help trace those who default.

Implementation of this strategy will help

reduce chances of TB patients developing drug resistance. For integration to be successful, TB and HIV programmes need to be financially supported through well-channelled funding streams.

Political commitment for health

Governments need to demonstrate the political will necessary to curb TB, as has been the case with HIV. They need to support the development of policies, guidelines and supporting materials, as well as the training of health professionals at all levels (national, provincial, district). ■

References

Challenges in TB Diagnostics in Secondary and Local Government Health Institutions in Ibadan, Nigeria. *Ayinde, B.O. and Oladapo, O.O. 2007: Paper presentation at a One day Symposium on TB field Diagnostics. City Hall, Cape Town - 7 November 2007.*

XDR TB: Lessons from Rural Tugela Ferry. *Gandhi, Neel. 2007. Paper presentation at a one day satellite workshop on MDR- and XDR-TB in the Context of HIV Infection. Cape Sun, Cape Town - November 6, 2007.*

Tuberculosis Fact Sheet. *MSF. 2007.*

It's time to integrate TB/HIV care on a national scale. *NAM. 2007.*

Poverty vis-à-vis TB diagnostics - A crisis for People Living with HIV and AIDS in Africa: Rethinking the Strategy for TB Control. *Okello, F. L. 2007. Paper presentation at a One day Symposium on TB field Diagnostics. City Hall, Cape Town - 7 November 2007.*

How can countries/sites increase the success of their Green Line Committee Applications. *Satti, Hind E. 2007. Paper presentation at a one day satellite workshop on MDR- and XDR-TB in the Context of HIV Infection. Cape Sun, Cape Town - November 6, 2007*

Community-based treatment support and case detection strategies and how they can prevent and address DR-TB *Seti, B. 2007. Paper presentation at a one day satellite workshop on MDR- and Isoniazid Preventive Therapy (IPT) for People Living with HIV.*

XDR-TB in the Context of HIV Infection. *Cape Sun, Cape Town - November 6, 2007. The Global TB Working Group. 2007.*

Dual facilities are vital for people who come for TB tests and treatment to be encouraged to test for HIV and vice versa. It is also possible to have a strong base of peers at the facility to give support to TB clients, as well as to help trace those who default.

My Mum has HIV: Innovative IEC programme in Zambia



“Let’s print some brochures and some t-shirts.” This could be the most quoted line in Zambia when it comes time to focus on HIV communication in Zambia. It seems that brochures, posters and t-shirts have become a common information, education and communication (IEC) solution for every project.

But are all of these brochures and t-shirts really having an impact? IEC materials, are supposed to inform and educate the community and ultimately to support positive behaviour change.

And yet, despite the overwhelming number of materials being printed and produced, is there a noticeable change in behaviours on the ground?

Recognising the need for innovative use of IEC materials, the Treatment Advocacy & Literacy Campaign TALC has launched a storybook called *My mum has HIV*.

What makes this IEC material different is that it responds directly to the social needs of the community and that it was produced by that same community. *My mum has HIV* is essentially the product of meaningful involvement of people living with HIV.

The book is a fictional story about a young girl, Mulenga, and her family, who live in urban Lusaka. When Mulenga’s uncle comes to visit she overhears him talking to her mother about his HIV-positive status and the fear he has of disclosing to his children.

Through the story Mulenga remembers back to the time her mother told Mulenga and her brothers that she, their mother, was HIV-positive. Mulenga recalls her feelings at the time and recognises that the disclosure was actually a positive experience that had brought the family closer together and ensured her mother was receiving love, care and support in the home.

While the story is fictional it is based firmly on fact, weaving into the narrative the personal experiences and anecdotes of more than 20 HIV-positive parents and their children. The parents are all members of TALC – an organisation formed to lobby for proper access to HIV treatment, care and support for all Zambians living with HIV.

The parents themselves were the inspiration for the book, as they struggled with telling their children about their status. One of those parents is Carol Maimbolwa. For many years she told her children the ARVs she was taking everyday were for cancer. She was scared about how her

children might respond to news that she was HIV positive.

“I’d hear my kids and their friend’s talking negatively about people living with HIV, and that worried me, I wondered how they’d react when I told them I have HIV. I think partly I was scared they would stop loving me, they’d hate me and maybe reject me and think I’m contagious.

“Somehow I realised my daughter was suspicious, she’d read some brochures about HIV. And I encouraged them to read a lot, especially about how ARV’s prolong life, so that they’d know when I told them that I wouldn’t be dying tomorrow.”

“I also wasn’t ready for a long time. I was in denial, but then I realised I had to tell them – what if I fell sick. I wanted them to hear it from me, and not from someone else after I got sick.”

“I’d like to encourage people who are positive to make use of this book, because then they are not struggling, and disclosing really lifts a weight off your shoulder. Keeping it to yourself makes it worse, you feel like you have to hide and you have to run to take your medication.”

“And once you disclose your family can help you, they can act as your buddies to remind you when to take your medicine, and they also keep you in check. For me, I used to enjoy wine, maybe a bit too much, and if it wasn’t for telling my kids I’d still do that, but I know that would make my kids upset, so they keep me in check.”

My mum has HIV is being distributed with support from SAfAIDS and US Government organisations, CIDRZ and ZPCT, who are working directly with the Ministry of Health through district clinics.

Other community-based organisations, including the Network of Zambian people living with HIV (NZP+) are also sharing the book through support groups and community networks.

TALC hopes the book will signal the potential for using IEC materials in more appropriate ways that actually meet the needs of the community.

TALC programmes manager Felix Mwanza says: “A t-shirt or a simple brochure could not have carried the same punch as this book. This book is different and interesting, it is a book written by HIV-positive parents for HIV-positive parents, and as a result it contains a great depth of information and feeling that we really believe will help promote disclosure.”

My mum has HIV follows on from other innovative TALC information, education and communication programmes, such as *TALCing about HIV in the Church*.

“Like *My mum has HIV* our *TALCing about HIV in the Church* programme was developed by people living with HIV. We decided to take a fresh look at our IEC work and realised that while newsletters and brochures can have their place, they are not the only way to communicate effectively,” Felix said.

“By working through a process of identifying our key messages, our target audiences and the best channels to communicate those messages to our audience we developed an innovative programme.

“Our members told us we needed to inform the general community, including young people, men and women about the need for HIV testing, with VCT rates around 10% in Zambia.

“Our members also told us that promoting HIV-positive role models, who could talk from experience about VCT and testing positive, was a good way to encourage behaviour change.

“Looking at our messages and the target audience we realised that the church, or religious organisations, could provide the perfect vehicle for communicating our messages. As a Christian nation, the majority of Zambians attend church services regularly and congregations include young people, men and women.

“Church services also provided an opportunity for people to listen to testimonies of HIV-positive people, and with often high levels of stigma in churches it seemed the best channel for sharing our message. And so *TALCing about HIV in the Church* was born.”

The response from the community to both the *My mum has HIV* and the *TALCing about HIV in the Church* projects has been overwhelmingly positive.

“We believe this shows a new way forward in the HIV response for Zambia. A way forward that involves working with the community to produce information that is relevant, useful and packaged in a way that compels people to take action.” ■

‘My mum has HIV’ is available to view at www.xilef.net/mymbasbiv and organisations can access copies to share in their communities through the Joint HIV Resource Centre, run by Afya Mzuri, SAfAIDS and TALC, in Lusaka. Enquiries should be made to the TALC resource centre officer, William Chilufya, on wchilufya@afyamzuri.com

New publications at SAfAIDS Resource Centre

1. Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS. 2007. Geneva, UNAIDS.

A set of guidelines designed to provide policy makers and planners with practical guidance to tailor their national HIV prevention response so that they respond to the epidemic dynamics of country populations who remain most vulnerable to HIV.

2. Coordinating With Communities: Guidelines on the Involvement of the Community Sector in the Coordination of National AIDS Responses. Sarah Middleton – Lee. 2007. Toronto, International Council of AIDS Service Organizations (ICASO).

These guidelines aim to increase and improve the active and meaningful involvement of the community sector in the development, implementation and monitoring of coordinated national AIDS responses. They also promote universal principles such as human rights and gender equity.

www.icaso.org

3. Managing HIV and AIDS in the World of Work: Experiences from Southern Africa. SAfAIDS & HIVOS Harare. 2007. SAfAIDS & HIVOS

A book which covers diverse topics including employment rights, an overview of policies and legislation within Southern Africa and the experiences of businesses and organisations which have successfully implemented workplace policies and programmes.

4. What Is a Good School: Imagining Beyond the Limits of Today to Create a Better Tomorrow. Dipak Naker. 2007. Kampala, Raising Voices.

A publication which emphasises the need to extend focus beyond creating access to education. It contributes ideas and perspectives on what the characteristics of a good school are and how good schools can be collectively created in society.

5. Voices of Violence. Raising Voices. 2007 Kampala, Raising Voices.

This video draws on the experiences of children who face violence in their day-to-day lives. It creates space for children and adults to ask three basic questions: What is violence against children? How does it make children feel? What can we do to prevent it?

www.raisingvoices.org

6. Educational Responses to HIV and AIDS for Refugees and Internally Displaced Persons: Discussion Papers for Decision-Makers. UNESCO & UNHCR. 2007. Paris, UNESCO.

This discussion paper examines the current situation with regard to conflict, displacement and HIV and notes the protection risks faced by refugees and Internationally Displaced Persons (IDPs). It also addresses the policy and programmatic measures required to address the prevention, treatment, care and support of these individuals.

7. Bringing HIV Prevention to Scale: An Urgent Global Priority. Global HIV Prevention Workgroup. 2007. Johannesburg, Global HIV Prevention Working Group.

A report offering a new analysis that examines the future course of the HIV epidemic with greatly scaled up prevention responses, surveys the latest evidence on HIV prevention access and reviews the experiences in countries where such barriers have been overcome.

8. CRS Success Palliative Care: Nutritional Supplementation Targeted Evaluation. Kari Egge & James Campbell et al. 2007. Baltimore, Catholic Relief Services.

This is a targeted evaluation of nutritional supplementation. The project aimed to investigate the impact of nutritional supplements on HIV positive home-based care (HBC) clients not taking ARVs. The study was conducted over a six month period.

9. Growing Up in a time of AIDS. Zisiwe Educational Trust & Child Institute. 2007. Cape Town, Children's Institute.

A CD ROM designed to contribute to developing public awareness and appropriate responses from children in the context of poverty and the HIV pandemic, by giving children themselves the chance to depict their lives, interests and concerns to a wider audience.

10. Accelerating Action: A Technical Support Guide to Develop Capacity and to benefit from Global Health Financing. Backup Initiative. 2007. Eschborn, Deutsche Gesellschaft für Technische.

A technical support guide which gives direction on how to plan for technical support, human resource development for health, societal empowerment, accessing financial resources as well as monitoring and evaluation.

11. Strengthening People's Power for Health: 14th National Conference. CWGH. 2007. Harare, Community Working Group on Health (CWGH).

This report summarises the proceedings of the Community Working Group on Health (CWGH) 14th National Conference meeting. A number of key issues affecting Zimbabweans were tackled in discussions, namely treatment literacy access, child and youth participation for development, as well as the Domestic Violence Act and its health implications. An assessment was also done on Mental Health.

12. Missing the Target # 4: Time is Running Out to End AIDS - Treatment and Prevention for All! ITCP. 2007. Cape Town.

A global research study by the International Treatment Preparedness Coalition (ITPC), which was undertaken by community-based HIV treatment activists and educators from over 60 countries. The Missing the Target series is also part of the Treatment Monitoring Advocacy Project (TMAP).





Book Review

Africa AIDS Education Series.

ISBN - 1-919910-01-8

Published by Awareness Publishing Group (Pty) Ltd. P. O. Box 453, Kelvin. 2054, South Africa
by Gloria Ganyanya

HIV and AIDS does not discriminate. It affects everyone regardless of colour, age or creed and this useful set of educational books for children fills an important gap. Children, long left out of HIV and AIDS interventions, are increasingly affected by the epidemic and need to be equipped with information so that they can make informed decisions. Although the series is set in South Africa, it is relevant to the southern African region as a whole.

The *Africa AIDS Education Series* is a set of eight durable and colourful children's books on HIV and AIDS. Seven of the books were written by Cecile Mather and one by the late child HIV and AIDS activist Nkosi Johnson, is a testimony of his life.

The books are targeted at children and aimed at informing and educating them on HIV and AIDS issues. The author uses a lot of illustrations and examples as well as testimonies to help readers identify with the stories. Each page is accompanied by a picture to assist children to visualise and understand the messages – the pictures alone tell a thousand words.

The language used is simplified and difficult words and concepts are defined to help children to understand. A glossary of terms at the end of each book allows children to look up words they may not have understood.

The first book, *What are HIV and AIDS*, explains how HIV is spread and clearly shows children that HIV is related to AIDS but that the two are different. It emphasises the importance of knowing facts about HIV and AIDS so that people are better able to protect themselves.

AIDS in Africa, the second book in the series, informs children that the only way people can find out their status is through an HIV test and highlights the importance of eating well to help the body fight against illnesses. It also explains how HIV and AIDS have impacted on the lives of many children in Africa with many orphaned, some staying in care centres, while others are being cared for by their grand parents, or by older siblings, themselves barely out of childhood.

The third book, *Children and AIDS* alerts children to the fact that they can be infected with HIV by vertical or paediatric transmission.

Mather encourages children to talk about HIV and AIDS with parents, teachers or doctors so that they understand the disease better and need not be afraid of playing with children who are infected.

Care For Us and Accept Us was written by the late Nkosi Johnson who was born with HIV and died at the age of twelve in 2001. He tells how he fought to make people aware of HIV and AIDS and the struggle he went through to get a place at school because he was HIV positive. Nkosi's testimony is powerful and inspiring and he appeals for mothers to be helped so that they do not transmit HIV to their babies. He calls on people to care for and accept people living with HIV. 'We are all human beings, we are

normal, we have hands, we have feet, we can walk, we can talk and we have needs like everyone else'.

The fifth book in the series, *Rights and AIDS* informs children about their rights to information, protection and a safe environment, as well as the rights of people living with HIV and AIDS. The book highlights the fact that knowing one's rights enables people to protect themselves, their friends and families.

Masakhane **Working Together to Stop AIDS** highlights what people have done to draw attention to HIV and AIDS, such as the memorial quilt made in South Africa in 1999, and painting murals about AIDS on walls. Masakhane encourages support of people with HIV and AIDS and highlights how some people are taking their time to teach people in schools about HIV and AIDS and healthy living.

Living with AIDS traces the history of HIV and AIDS to the 1980s when it was first identified in the United States and provides general information on what happens when a person is HIV positive and the illnesses they are likely to suffer from. It encourages people to get tested and highlights the idea that disclosing one's status is one way of coping with the infection and reducing stigma.

The final book in the series, *The Truth About AIDS*, importantly sets about dispelling myths about HIV and AIDS and how it is acquired. Mather emphasises that anyone can get AIDS regardless of their age, race, culture or religion. Some people get the virus because they don't know the facts, some don't believe the facts and some just don't take care to protect themselves.

The *Africa AIDS Education Series* informs and educates children about HIV and AIDS and encourages them to get more information about their rights and how to protect themselves, as well as to care for people affected and infected by HIV and AIDS, and is a useful addition for any school library or institutions that educate or care for children. ■

Tell us what you think!

SaFAIDS would like your feedback on the content of SaFAIDS News. What do you like about it? What do you dislike? Are there areas you would like us to include that are not already covered?

Please take some time to think about these questions and tell us what you think. Your feedback is invaluable in making sure the magazine

continues to be responsive to your needs in terms of HIV and AIDS information in the southern African region

Please send your comments to:

editor@safaids.org.zw or by post to The Editor, SaFAIDS, P O Box A509, Avondale, Harare, Zimbabwe.

SaFAIDS News is published quarterly by the southern Africa HIV and AIDS Information Dissemination Service, SaFAIDS. Articles may be photocopied, reprinted or abbreviated provided this is not for profit and that full acknowledgement is made to SaFAIDS and to the original source or author (where applicable). SaFAIDS requests a copy of any used material.

Subscriptions: A two-year subscription is Z\$800,000 (for 8 issues) to Zimbabwean-based subscribers, US\$60 for Africa only; elsewhere, US\$80. Money orders or cheques should be made payable to SaFAIDS. Local organisations or individuals in Africa who cannot pay may ask for complimentary mail or subsidy. SaFAIDS News is available free on our website.

SaFAIDS contact details: PO Box A509, Avondale, Harare, Zimbabwe. Physical address: 17 Beveridge Road, Avondale, Harare, Zimbabwe; Tel: + 263 4 336193/4 307898; Fax: + 263 4 336195; E-mail: info@safaids.org.zw, Website: www.safaids.org.zw

The Editor welcomes views, comments and any other helpful feedback that will make SaFAIDS News a better publication.