



Swiss Tropical Institute
Institut Tropical Suisse
Schweizerisches Tropeninstitut

Swiss Centre for
International Health

HIV/AIDS update 1/2002

Mai 2002

Claudia Kessler Bodiang, MD, MPH
Karin Wiedenmayer, MSc, PharmD

**A commissioned product established in the context of the mandate
No. 7F-03874.14 of the Swiss Agency for Development and Co-operation (SDC)**



TABLE OF CONTENTS

LIST OF ABBREVIATIONS	3
Executive summary	4
Introduction	4
Choosing interventions	6
The role of religious leaders and faith-based organisations	9
Imams as allies of health workers in the fight against STD/HIV/AIDS in Senegal	9
Buddhist Principles to Cope with AIDS	10
Christian Churches start to form alliances to fight AIDS	10
The right OF children affected by HIV/AIDS to childhood	12
Masiye Camp, Zimbabwe	13
HUMULIZA, Tanzania	13
Regional Psycho-social support initiative for Eastern and Southern Africa (REPSSI)	14
ACCESS TO HIV/AIDS DRUGS in developing countries	15
Background	15
Milestones: declarations, appeals, initiatives and conferences	17
FEexamples of pilot activities and actions taken	18
Best practice	20
SELECTED LINKS ON HIV/AIDS	22
ANNEX: Matrix OF strategies for different epidemics	23
ANNEX: User Evaluation sheet	24

Contacts

Swiss Agency for Development and Cooperation

Daniel Mäusezahl
Daniel.Maeusezahl@deza.admin.ch
Sandra Bernasconi
Sandra.Bernasconi@deza.admin.ch

Swiss Centre for International Health Swiss Tropical Institute

Claudia Kessler-Bodiang
Socinstrasse 57, Basel
Telefon +41 61 284 81 87
E-Mail: claudia.kessler@unibas.ch

Disclaimer

This paper was commissioned by the Swiss Agency for Development and Cooperation (SDC). The views and ideas expressed herein are those of the authors and do not necessarily imply or reflect the opinion of the Agency.

List of Abbreviations

ART	Antiretroviral Therapy
ARV	Antiretroviral
CBS	Community Based Services
CCIH	Christian Connections for International Health
CSW	Commercial Sex Workers
DOT	Directly Observed Treatment
FBO	Faith Based Organisation
GDP	Gross Domestic Product
GTZ	German Technical Cooperation
HAART	Highly Active Antiretroviral Therapy
HEKS	Swiss Protestant Aid Organisation
HIPC	Highly Indebted Poor Countries Debt Initiative
IDUs	Intravenous Drug Users
IEC	Information Education Communication
IMAU	Islamic Medical Association (Uganda)
MSM	Men who have sex with men
MSF	Médecins Sans Frontières
NGO	Non Governmental Organisation
OIs	Opportunistic Infections
PLWHA	Persons living with HIV/AIDS
PRSP	Poverty Reduction strategy Paper
SDC	Swiss Agency for Development and Cooperation
STD/STI	Sexually Transmitted Disease/Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
TRIPS	Trade Related Aspects of Intellectual Property Rights
UNGASS	UN General Assembly Session on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WTO	World Trade Organisation

Executive summary

In order to help SDC (the **Swiss Agency for Development and Cooperation**) and its collaborators make a significant contribution to fighting the global epidemic, this document will **present some current issues** that should be of relevance for those working for or in the concerned countries. Twice a year important issues will be selected and the essential aspects briefly presented in order to allow the reader to focus his /her reading time in a field which daily produces an amount of printed materials that no individual can easily digest anymore.

This HIV/AIDS update will include sections on the following topics:

- **which strategies and interventions to chose in a given context**
- **the role of religious opinion leaders**
- **children affected by HIV/AIDS**
- **latest developments in access to antiretroviral drug therapy in developing countries**

An increasing international consensus exists, not only on the necessity to massively increase funding for the fight against HIV/AIDS, but also on **priority strategies and interventions** for various types of epidemics. **Evidence based approaches**, based on lessons learned and best practice continue to be documented and should guide anybody in charge of choosing interventions.

Faith based organisations (FBOs) and churches have so far often played a doubtful role in the fight against the epidemic. Increasingly, the dramatic situation in the countries forces them to play a stronger role in not only care but also prevention of HIV. Experiences where early and successful involvement of religious leaders and faith- based organisations made an important impact on the epidemic do exist and are presented in the document.

One of the most vulnerable groups exposed to the epidemic are **children affected by HIV/AIDS**. Their needs are manifold. While the focus has been so far on meeting their physical needs, their psychosocial needs and the needs of the families and communities of which they are part have often been neglected. Some best practices are presented.

Substantial progress has been made over the past years in promoting and facilitating **access to affordable care**, including Anti Retroviral Therapy. The drug costs have dropped significantly and negotiations are continuing to further improve the situation for the poorest. Pilot interventions are shown and some of the key lessons learned listed.

Introduction

At the International Conference of Financing for Development, held in March 2002 in Mexico, the UNAIDS Director of Social Mobilisation and Strategic Information, Mrs Fahlen, stated that **“AIDS is on track to single-handedly wipe out 50 years of development gains in the most affected countries”**. Countries lose many of their young and most productive people to the epidemic and poverty and inequality deepen as a result of HIV/AIDS. The economic and social consequences of the epidemic are profound. One of the examples given is Botswana, where it is estimated that the government will lose twenty percent of public tax

revenue by 2010 due to the economic impact of AIDS. Various Caribbean countries are expected to face a 5% loss in GDP (Gross Domestic Product) by 2005 as a result of AIDS. And a recent study in **Burkina Faso, Rwanda and Uganda has calculated that AIDS will increase the percentage of people living in extreme poverty** from 45% in 2000 to 51% in 2015¹.

Confronted with this global emergency, the international community is speeding up its response. Increased financial commitments of bilateral and multilateral donors, debt relief programmes and the Global Fund to fight AIDS, Tuberculosis and Malaria are some of the efforts currently underway at the international level, that provide some reason for hope. But the **funding gap** will still remain important and in the end, what matters, will be the way, this money will be invested and used to make a difference.

In order to help SDC and its collaborators make a significant contribution to fighting the global epidemic, this document will present some current issues that should be of relevance for those working for or in the concerned countries. **Lessons learned (highlighted in yellow boxes)** and best practices will be the “Leitfaden” throughout the various chapters of this update. Only a selection of topics could be elaborated on. This update builds on three previous key issue papers that were produced for SDC in 2001 (*HIV/AIDS control options in developing countries*; *The multisectoral approach to HIV/AIDS*; *Access to care in developing countries*²). These papers were geographically focussed on the situation in Sub Saharan Africa, as they were produced in the forefront of a workshop of SDC’s South and East Africa Section (SOSA). An HIV/AIDS update similar to this one shall be produced in the second half of 2002. It will allow developing some of the issues not covered in this update.

Readers are encouraged to **fill in an evaluation sheet** (*see sheet in the annex*) for this document in order to help improve future updates. They are also **welcome to propose further topics** relevant for their work to be included in the next HIV/AIDS update. **Possible topics for the next update** could be:

- Mother to child transmission (MTCT)
- Social marketing for condoms
- Homebased care and other community based approaches
- Stigma and AIDS
- etc

Please send your feed back and suggestions to SDC headquarters, SoDev (sandra.bernasconi@deza.admin.ch) . The topics most asked for will then be included in the following document. You should also be informed, that SDC will issue this year a key issue paper specifically dealing with the HIV/AIDS situation in Eastern Europe and Central Asia. This explains why this update does not include information on that region.

¹ UNAIDS Press release, 19.3.2002: HIV/AIDS is wiping out fifty years of investment in development, UNAIDS says.

² They can be ordered from: sandra.bernasconi@deza.admin.ch

Choosing interventions

Both UNAIDS (*The Global Strategy Framework on HIV/AIDS, June 2001*) and the World Bank have worked on providing frameworks for decision-making as to what interventions should be targeted in a specific country or region. A brief summary of key recommendations is given in this chapter.

According to UNAIDS:

- The most effective responses to the epidemic have **integrated education, prevention and care strategies**. Care approaches which have voluntary counselling and testing as their entry point constitute effective prevention strategies.
- **Successful responses to the epidemic have their roots in communities** and local actors. They need to be empowered to determine their priorities for action and enabled through access to proper information.
- At every level, **people living with HIV/AIDS³ (PLWHA)** have to become greater involved as they **are central to the response**.
- UNAIDS propagates an “**Expanded Response to the Epidemic**”, which is one that simultaneously acts on reducing:
 - ✓ **risk** (including behaviour, where there is a risk of HIV infection- such as unprotected sex- as well as situations, where there is a risk of infection- such as needing a blood transfusion in a setting where there is no blood safety),
 - ✓ **vulnerability** (measure of an individual’s or community’s inability to control their risk of infection) and
 - ✓ **impact** (physical, mental, social, economic, cultural and political impact)

Examples of interventions to influence each of the three dimensions are given in the strategy framework.

It is increasingly recognised that the **global epidemic is composed of multiple epidemics**, each with its own particular dynamic and each asking for a different and specific response. In both low and high endemic settings, **reducing the vulnerability of young people** to HIV infection is of central importance when trying to influence the future spread of the epidemic. In **low endemic settings**, strategies that address the needs of the so-called “populations with the highest risks for infection” (depending on the context i.e.: sex workers and their clients, injecting drug users and their partners, men who have sex with men, those with high rates of sexually transmitted diseases, transit and migrant workers and the military) should receive the highest priority. Many members of these groups belong to the most vulnerable segments in a population and they are often suffering of multiple stigmatisation, which is worsened by the stigma attached to AIDS. Preventive actions are clearly most important. However, care and support strategies create incentives for early detection and reducing stigma, and thus reinforce

³ At every level, from community to national to international, the benefits of a greater involvement of people living with HIV/AIDS have been shown. Stigma and discrimination towards PLWHA has been reduced by their visibility and involvement in organisations at various levels. Their participation in policy, programme design and implementation has been instrumental in reorienting priorities, ensuring relevance and effectiveness, challenging a human face and voice to the epidemic, challenging complacency and denial, strengthening the call for urgency in the response and moving governments and their leader to action. (*source: The Global Strategy Framework on HIV/AIDS, UNAIDS June 2001*)

prevention efforts. In **high risk endemic settings**, where the epidemic has become generalised (more than 5% of the general population infected), preventive activities have to target the general population. At the same time impact reduction, care and support become more important. The **matrix in the annex** outlines various strategies to be applied in different stages of the epidemic.

The **World Bank**'s position is similar to that of UNAIDS. In addition to what has been said before, they define a

core set of prevention interventions that have proved most effective in reducing the spread of infection:

- Changing behaviour through **communication**
- Making **condoms** and **treatment** of sexually transmitted infections (**STIs**) and voluntary counselling and testing (**VCT**) widely available and affordable
- Ensuring a **safe blood supply**
- Preventing parent- to child transmission (**PTCT**)
- Harm minimisation among injecting drug users (**IDUs**)

A **core set of treatment, care and mitigation activities** for countries that are heavily affected would be:

- Provide access to **treatment of opportunistic infections** and **palliative care**
- Improve **capacity of the health system** at all levels to deliver care to HIV-infected patients
- Provide alternatives to hospital care, including **community-based and home-based care**
- Strengthen the **safety net for poor households affected** by AIDS, including **AIDS orphans**
- Provide **counselling and prevention services for PLWHAs (persons living with HIV/AIDS) and their families**
- Evaluate roles of concerned stakeholders in providing **HAART (Highly Active Antiretroviral Therapy)**

Choosing interventions should be based on the following criteria:

1. Specific **epidemiology** of HIV, including who are at risk and the stage⁴ of the epidemic
2. Identified **best practices**; what has/has not worked (*see www.unaids.org/bestpractice/digest/index.html for a selection of best practices by topic*)
3. **Level of resources available**
4. **Implementation capacity**

A special concern of the World Bank is the **link between poverty and AIDS**. The Poverty Reduction Strategy Papers (PRSP) currently prepared on request of the Bank by many aid recipient countries have to date not been fully successful in capturing the seriousness of the HIV/AIDS threat. In December 2001 the World Bank held a seminar in Washington on

⁴ low prevalence (less than 5% prevalence in any high-risk group), concentrated epidemic (prevalence of over 5% in a high-risk group, but less than 5% in the general population), generalised epidemic (population prevalence over 5%)

Prevalence is here defined as the percentage of the adult population (in this case either general population or high risk group) infected at a given moment in time.

“AIDS and the PRSP- marrying key parts of the development agenda” (<http://www.worldbank.org/poverty/strategies/review/semseries/aids.htm>) that evaluated lessons learned and issued recommendations to consolidate the AIDS/PRSP link. Some lessons learned discussed at that meeting are listed below.

Lessons learned on AIDS and the PRSP

- Poverty-AIDS analysis is stronger where **socio-economic impact research** is underway (Uganda), but this is no guarantee (Kenya)
- A well-articulated and publicised **AIDS plan** creates a strong basis for a strong AIDS strategy in the PRSP (**Mozambique**)
- Key actions, indicators, and targets in the national AIDS plan set the stage for the PRSP
- National AIDS body must lobby for its place in the PRSP process (Uganda, Guinea) – and donors can support the process
- Efforts to **include AIDS in the TOR for the PRSP** are important but not sufficient (Malawi)
- **Donors can make a difference** (UNICEF in Uganda) but vigilance is low or inefficient in many places (**Burkina**).

In 2001 the World Bank also published in collaboration with UNAIDS a very useful resource called “AIDS, Poverty Reduction and Debt Relief: a toolkit for mainstreaming HIV/AIDS Programmes into Development Instruments”. According to that document, **PRSPs and Highly Indebted Poor Countries Debt Initiative (HIPC) documents should include the following aspects:**

- HIV/AIDS as a **cause of poverty**, plus a discussion of poverty and income inequalities, and their contributions to conditions that make persons **vulnerable to HIV infection** and less able to cope with the **consequences** of being infected;
- The main strategies in the national **HIV/AIDS plan as a central part** of the overall national poverty reduction programme, justified and costed;
- Medium-term **goals** and poverty monitoring **indicators derived from the national HIV/AIDS plan;**
- **Short-run actions** for successful implementation of the national HIV/AIDS plan, with specific and monitorable targets that form agreements for debt relief.

References:

- *The Global Strategy Framework on HIV/AIDS*, UNAIDS June 2001, <http://www.unaids.org/publications/documents/care/general/JC637-GlobalFramew-E.pdf>
- *The UNAIDS best practice collection:* www.unaids.org/bestpractice/digest/index.html
- World Bank position: see under <http://wbln0018.worldbank.org/hdnet/hddocs.nsf/c840b59b6982d2498525670c004def60/0560436b70e56de385256a4800524119?OpenDocument>
- *AIDS, Poverty Reduction and Debt Relief: a Toolkit for Mainstreaming HIV/AIDS Programmes into Development Instruments*. UNAIDS, World Bank. UNAIDS Best Practice Collection, March 2001. <http://www.worldbank.org/poverty/strategies/chapters/health/aids.pdf>

Can religious leaders and faith-based organisations play a positive role in the fight against HIV/AIDS?

Faith-based organisations are important stakeholders in the field of development cooperation and can be found amongst the **partners and leading agencies of SDC** at both Swiss and local level. In addition, many SDC collaborators may be actively involved in churches and have direct contacts with and means of influencing religious opinion leaders. Currently, many such faith-based organisations are looking for orientation on how to approach the topic of HIV/AIDS in the framework of their work. It is important for them to know, that throughout the world, experiences are known, where **religious leaders and FBOs (faith-based organisations) contributed in a very constructive way to the fight against AIDS.**

Depending on the religious context one is working in, the influence of religious leaders on the HIV/AIDS work can be more or less strongly felt. In **the past, their role has been often obstructive**, linking HIV infection to immoral behaviour and thus deepening the stigma, discrimination and exclusion of infected and affected persons. AIDS has been portrayed as a disease sent by God to punish the evil. The use of condoms has been an issue of hot debate within many religions and churches. The official position of the **catholic church, banning their members from the use of any modern method of contraception, including condoms**, influenced catholic bishops and priests all over the world and led to acts such as the public burning of condoms in Kenya. In March 2002 more than 70 representatives of various religious organisations declared at a meeting in Dar es Salaam, Tanzania, that “all holy books” across the world were against the use of condoms (The Guardian). Some Islamic leaders, as well, have declared the use of condoms to be of evil. In most of sub-Saharan Africa, **churches have stood quietly by** as AIDS has decimated whole communities. The reluctance to get involved is explained by the fact that issues touching sexuality, sexual relations and the use of condoms have never been easy for the churches to address. This is now starting to change as the situation is getting out of hands.

Several **best practices of examples where religious leaders have played a very positive role** will be presented in order to stimulate discussions around how to give religious leaders a more important role in combating HIV/AIDS.

Imams as principal allies of health workers in the fight against STD/HIV/AIDS in Senegal

An example, where Islamic religious leaders play a key role in a behaviour change campaign is that of a GTZ (German Technical Cooperation) supported project in southern Senegal, the “FANKANTA” project, in which the author of this report worked during 4 years. After winning the head of the Imams of the region of Kolda for collaboration, workshops were held with several hundred religious leaders from the most remote villages of the region. They discussed in depth the position of the Koran to questions such as infidelity, sexual health, gender roles and relations. Many of the Koranic principles were found to be useful in promoting safe sexual behaviour and keeping the family healthy. From then, the Imams accompanied health workers while doing outreach sensitisation work and talked about Islam and the principles of abstinence, fidelity and delayed age at first intercourse for young people⁵.

⁵ what Green calls „primary behaviour change“ and „the comparative advantage of FBOs“ in his speech „The Impact of Religious Organisations in Promoting HIV/AIDS Prevention“

They then invited the health worker to speak about “medical aspects” which came down to talking about the use of condoms. Being present while the health worker demonstrated the use of condoms made their attitude visible to the population: if you cannot restrain yourself from engaging in unsafe sex, it is the smaller evil to use a condom in order to protect yourself and your family. With the support of the FANKANTA project, the Imam Ratib produced an audio cassette on “Islam and HIV/AIDS and family planning” in the local languages (Pulaar and Mandingue), which was broadcast on the local radio and listened to in most rural villages. It was used extensively by the CBS (community based services) volunteers to stimulate discussion amongst the very traditional and illiterate population of the Kolda region.

In the same country, a meeting on AIDS prevention in 1996 reunited all bishops and ended in their consensus that AIDS prevention was an important national priority (at a time, when the official HIV prevalence rate was still “only” around 1%). Senegal also hosted the First International Colloquium on AIDS and Religion, held in Dakar in late 1997. **It is widely believed that in Senegal the early and active involvement of religious leaders contributed much to keeping the HIV prevalence rates at a comparatively low level over time.**

Similar experience exists from **Uganda**, where the Islamic Medical Association declared a **spiritual Jihad on AIDS**. Imams and Islamic religious leaders are very much involved in HIV prevention activities using similar approaches as the ones described above.

Buddhist Principles to Cope with AIDS

(source: HIV/AIDS and Communication for Behaviour and Social Change. June 2001, UNAIDS)

Spiritual care is an integral part of the Sanpatong Home- Based Care project in Thailand (<http://www.unaids.org/bestpractice/collection/subject/responses/sanpatong.html>), where **Buddhist principles** of kindness, compassion, altruistic joy and equanimity **help the afflicted to cope with AIDS**. Those suffering from HIV/AIDS often spend week-long retreats at Buddhist temples where they meditate, re-examine their spiritual beliefs and benefit from a regimen of healthy diet and exercise. Discourses cover how to come to terms with one’s mortality, or that of loved ones. Buddhist principles forbid to take lives (i.e. do not infect others) or the consumption of substances to alter the natural body state (i.e. do not consume alcohol or inject intravenous drugs), thus provide an effective **spiritual platform to address high-risk behaviour**.

Traditionally, Christian churches and NGOs have been involved in care activities (especially home based care and the issue of AIDS orphans). But Christian churches are also key in shaping people’s moral decisions (e.g. religious leaders in South Africa have campaigned for affordable AIDS drugs and challenged the Vatican’s stance on condoms) and - through missionary hospitals and clinics - they are the **most important private provider for health care in Sub Sahara Africa**.

Christian Churches start to form alliances to fight AIDS

In the year 2000, the **Ecumenical Advocacy Alliance** was founded in Geneva. Over 40 representatives of the **World Council of Churches** from all continents decided to declare the issues of “Global Trade” and “HIV/AIDS” the two priority topics that the new Alliance should concentrate on. Since, a Coordination Office was opened in Geneva, a plan of action elaborated and various initiatives have been started.

The **Christian Connections for International Health** (CCIH, *see: <http://ccih.org/harp/harp-toc.htm>*) have a mandate to promote international health and wholeness with a Christian perspective. At their May 2001 Conference “Challenges for the Church: AIDS, Malaria and Tuberculosis” various presentations concentrated on the comparative advantage and the role FBOs can and should play (*see: www.ccih.org/forum/0110-03.htm*). It was said, that “an important direction of Christian HIV/AIDS work will be the continued **promotion of open, active and on- going inter-faith dialogue** and the promotion of active listening to collaboratively address HIV/AIDS prevention.”

Currently, **Swiss Faith Based Organisations** with development cooperation activities overseas also start to **engage in joint reflections** concerning their contribution to combating HIV/AIDS. Individual agencies such as “HEKS”, CARITAS or “DM Echange et Mission” support projects which include HIV/AIDS components in some of their partner countries. HEKS is elaborating AIDS guidelines that should also include workplace policy issues. The “Mission 21” (former “Basler Mission”, Christian awareness in partnership, protestant mission in Basel) has created a 50% position for an HIV/AIDS Project Coordinator and is initiating a working group of Protestant FBOs in Switzerland around HIV/AIDS and Development Cooperation. This group could later integrate in the planned **Swiss platform on HIV/AIDS and Development**, which is a project currently under elaboration⁶.

Lessons learned:

- Faith-based organisations and religious leaders do need to play a **more important role in not only HIV/AIDS care but also in prevention efforts**
- There is **evidence** (Uganda, Senegal, etc) that **early active involvement of religious leaders** contributes to a successful anti HIV/AIDS campaign
- Their **comparative advantage** is in promoting fidelity, abstinence and delayed age at first sexual intercourse, but they also need to overcome their reluctance in promoting the use of condoms. **Collaboration with health workers** allows delegating sensitive messages to the health professionals while sanctioning the message.
- Religious leaders at all levels **need information and training** to be competent partners in the fight against AIDS. The FBOs need **networks** and fora for exchange to help them define their positions and exchange best practices.

References:

- *HIV/AIDS and Communication for Behaviour and Social Change*. June 2001, UNAIDS, page 23-25. <http://www.unaids.org/publications/documents/supporting/communications/JC627-KM117-E.pdf>
- Green E.C. „The Impact of Religious Organisations in Promoting HIV/AIDS Prevention“, March 2002, communication during CCIH Conference, www.ccih.org/forum/0110-02.htm

⁶ So far there was no coordination mechanism of Swiss development agencies involved in HIV/AIDS work abroad. This lack has been identified during a needs assessment initiated by Medicus Mundi Switzerland. A working group is now elaborating a project proposal to create a Swiss platform/network on HIV/AIDS and development. The platform should be an instrument for exchange, coordination and creation of synergies.

Do children affected by HIV/AIDS have the right to a childhood?

The devastating effect the AIDS epidemic has on children in the most affected countries is becoming increasingly obvious. UNAIDS estimates that by 2010, **one third of all the African children will be orphaned**. These children undergo recurrent and continuous trauma, starting well before the death of their parent: cycles of poverty, sexual abuse and exploitation, as well as lack of access to education, health care and adequate nutrition.

Initial responses

The early days of the orphan crisis in Africa saw a rush by well meaning NGOs and church organisations to build **orphanages**. This response proved quickly to be **ineffective**. Not only was the sheer number of children in need outweighing grossly the places available in institutions and the financial resources to create and maintain them. It was also realised that institutionalisation was yet another trauma for many affected children, alienating them from their extended families and culture, and putting at risk their integration into the society.

Other attempts, again being initiated mainly by church organisations and NGOs were to try and **meet the physical and material needs of these children**. Providing school fees and clothes as well as other necessary items helps to mitigate the material consequences on HIV/AIDS affected orphans and children. However, these interventions raise ethical questions. From which moment is a child entitled to this assistance: is it only after the death of the parent? What about the child who cares for his or her terminally ill mother or father? What about the “sisters” and “brothers” of the caretaker family, that has taken on the orphan, whose parents may have been impoverished as a consequence of their act of solidarity? And are such external inputs of resources sustainable? What will happen the day the assistance dries up? And until what age are children entitled to such kind of assistance?

The psychosocial dimension

At the same time- looking beyond superficial first requests for material assistance- what many orphans and HIV/AIDS affected children suffer most of is the loss of love and care, the stigma they are exposed to and the new roles and responsibilities they have to come up to. Many of the girls and boys are responsible for feeding and clothing their younger siblings. In order to be able to do so they leave school or sell sexual services. The community, which they relieve of their obligation of support and assistance to these children, however, does not value their contribution and pushes them even further into social isolation.

Children living under such **circumstances need therefore another dimension of support, which is of psychosocial nature**. Their self- esteem needs to be re-established and their life skills strengthened. At the same time, offering psychosocial support also allows to integrate preventive approaches for targeting this extremely vulnerable group. Clearly, a gender specific approach, both to psychosocial support and prevention related to HIV/AIDS of AIDS affected children is of crucial importance. Especially girls are at risk of having to leave school, of sexual exploitation and having to offer sexual services for income generation to feed their orphaned siblings.

In addition to the support to the individual child, a **systemic approach** needs to consider the context, the needs of the **caretakers and communities** and enable them to be more supportive and understanding of the children’s’ problems and needs. It has been recognised that the **extended family, with the support of the surrounding community, is the best way of caring for orphans and probably the only viable and sustainable solution to the problem of mass orphanhood**. Community based programmes designed to strengthen families’ and

communities' capacity to provide care are known from several countries and have shown to be effective.

Children, whose parents have died of AIDS, whether they are infected themselves or not, are often referred to as "AIDS orphans". This term tends to label and stigmatise. It also excludes children whose parent(s) are infected with HIV but are still alive. It is therefore **suggested to refer to children as either orphans or children affected by HIV/AIDS**.

Two approaches to psychosocial support for children affected by HIV/AIDS will be briefly presented. Both projects are presented in more detail in the UNAIDS Best Practice Collection, published in 2001.

Masiye Camp, Zimbabwe:

The Masiye Camp in Zimbabwe is an example of **life skills education** through play and adventure based learning for orphans, started in 1998 by the Salvation Army. Owing to their responsibilities and pressures at home, orphans do not have time to play. The camp offers a 10-day experience based on the principles of Outward Bound, which encourage trust and team building through adventure learning. The camps focus on child-headed households and children living with ill parents and are for many the first opportunity to relax and express themselves to someone who listens. The counsellors and facilitators are volunteers, most of them orphans themselves, which enables the children to develop viable, personal solutions. The adventure activities offered represent life: they look almost impossible, they challenge the mind and the body, but once the children overcome their fears they can conquer the obstacle and face the challenge feeling confident and strong. Each activity offered is facilitated and followed by a debriefing. Aerobics and running emphasises fitness and discipline. Traditional dancing and drama promotes self-confidence. Building a raft inspires problem-solving skills. Craft making provides the children with a skill they can take with them. In addition, they participate in sessions on health promotion and education (on topics as HIV/AIDS, drugs, alcohol, hygiene, etc). The camp emphasises spirituality to build up a defence mechanism for the children through the belief that they are never alone because of God. Of course, the experience during the camp can help boost a child's self esteem and life skills, but **follow up care is needed** in order for a child to stay empowered. For this purpose the Masiye Camp co-operates with various community organisations and Youth clubs who provide **ongoing support for the children once they are back in their communities**.

HUMULIZA, Tanzania:

HUMULIZA exists as a pilot project since 1997 and is based in Nshamba. It is supported by **Terre des Hommes Switzerland** and funded amongst others by the Swiss Agency for Development and Cooperation (SDC) and the **Novartis Foundation**. Estimations project that by the year 2010 there will be 4.2 million orphans living in the United Republic of Tanzania. Facing this worrying perspective, the project felt the need to provide support that goes beyond material assistance. Several components have been developed out of listening to the concerns and needs of the children themselves.

After the loss of one or both parents, the **teachers' role in providing guidance and emotional assistance becomes increasingly important** in the life of a child. The project trains teachers to be more aware of the specific needs of such children and to provide them with support beyond the classroom. The teachers are encouraged to visit students in their homes and follow up with caregivers. In school based counselling sessions, the students learn to express their emotions and problems and how to deal with them in a constructive way. They are led to realise their own strengths and resources which they already apply in coping with the difficult situation. By sharing their experience they learn that they are not alone with

such problems and hear about coping mechanisms, which have worked for other children. The approaches focus on **problem solving skills and boosting self-esteem**. They also learn to support each other. Out of this developed the creation of a Youth organisation (VSI, Vijana Simama Imara “adolescents stand firm”) providing a **network for orphans**. VSI receives financial support from HUMULIZA but is entirely youth run. Members of the organisation are older and serve as a resource for the younger orphans in the area. Through this network of solidarity and self-help, affected children can find some substitute for the lost feeling of family at the same time as emotional assistance in times of distress and practical help for specific problems they face. The organisation has also started **income generating activities** with small credits and saving accounts and a model farm has been set up to prevent loss in farming skills and traditional knowledge which so often follows the spread of the epidemic in farming areas.

While appreciating the achievement of these projects, UNAIDS rightly points out that more efforts have to be made in order not to create dependency on the generosity of outside sources. “In the process of helping communities, AIDS organisations now dominate the situation, which has allowed others to relax in their responsibility to the situation and has created dependency on the continued support of the AIDS organisations.” **Sustainability and responsibility** are two important key concerns and can be worked towards by **involving to the greatest possible extent the communities** themselves in planning and implementing, as well as monitoring all efforts. Assistance to the children needs to be constant and therefore supporting organisations must be sustainable.

It may be of interest in this context that a **network** has been created to accelerate learning through sharing experiences and information, including in the field of psychosocial support. The **ANNEA (AIDS NGO Network of East Africa, annea@habari.co.tz)** is a consortium of NGOs in Kenya, Uganda and the United Republic of Tanzania working in the field of HIV/AIDS, established in 1994. It gives priority to children’s issues and held recently a workshop on psychosocial support for children affected by HIV/AIDS in Kampala, Uganda.

Another example of a regional network to be created is the REPSSI initiative, supported by SDC and described in the following paragraph.

The Regional Psycho-social Support Initiative (REPSSI) for East and Southern Africa:

This Initiative is a very large regional programme, planned to start in mid 2002 and last until December 2004. REPSSI is a unique regional programme that will create a network of partnerships to **scale up current successful community-based NGO programmes**, and rapidly expand the programme coverage from currently 10'000 children per year to over 250'000 children per year by 2004. REPSSI will also contribute to supportive environments in which children can grieve, express themselves and begin to heal.

REPSSI was established to improve psycho-social assistance and opportunities for children affected throughout East and Southern Africa. This growing network is an opportunity to react fast and professionally to the needs in the worst hit region. The programme will be implemented by a partner consortium of organisations experienced in dealing with HIV/AIDS world-wide, represented by the "Salvation Army Africa Regional Team". It will initially run over a period of five years and is closely cooperating with **Terre des Hommes Switzerland**, Pact Inc., and the International HIV/AIDS Alliance representing various other organisations. **SDC SOSA section** (South and East Africa) plans to support this project with a multi million Swiss Francs **financial contribution**.

In conclusion, the following lessons learned about addressing the needs of AIDS affected children can be formulated:

Lessons learned:

- The term “**AIDS orphans**” is **inappropriate**, as it contributes to further stigmatising the children and excludes children whose parents are sick but have not died. It should better be replaced by “orphans” or “**children affected by HIV/AIDS**”.
- The problem of AIDS affected children **cannot be solved by setting up more orphanages**
- Apart from taking care for their material, financial and educational needs, it is crucial to **address in a professional way the psycho- social needs** of children affected by HIV/AIDS, to teach them life-skills and to empower them.
- Community based approaches which address the needs of the children in **the context of their extended family and the community** while strengthening the available local resources are most promising
- Any project or programme engaging in care and support to children affected by HIV/AIDS has to be particularly sensitive about not creating new dependency. Approaches need to be **sustainable, locally owned and have a long- term perspective.**

References:

- Matshalaga N.R, Powell G.: *Mass orphanhood in the era of HIV/AIDS*; BMJ 2002; 324:185-186, 26.January
- *Investing in Our Future: Psychosocial Support for Children Affected by HIV/AIDS; A Case Study in Zimbabwe and the United Republic of Tanzania.* UNAIDS Case Study, July 2001. UNAIDS/01.47E
- *Children and young people in a world of AIDS*, UNAIDS/01.56 E, August 2001, <http://www.unaids.org/youngpeople/>

Contacts:

- HUMULIZA, P.O.Box 158, Muleba-Kagera, Tanzania. K.madoerin@terredeshommes.ch
- Masiye Camp, Ezekiel Mafusire, The Salvation Army, Box AC 800, Bulawayo, Zimbabwe. Info@masiye.com, www.masiye.com
- ANNEA , Secretariat, Rebman House, Old Moshi Road, PO Box 6187, Arusha, Tanzania; annea@habari.co.tz

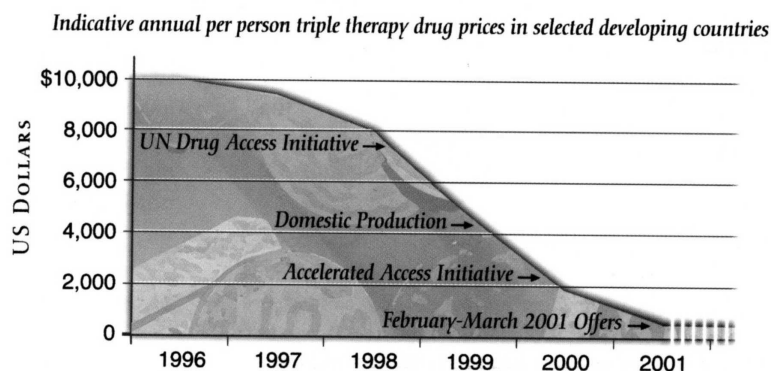
Access to HIV/AIDS drugs in developing countries

The question of access to antiretroviral (ARV) drugs is the field, which probably evolves the fastest compared to other HIV/AIDS related topics. News stories of yesterday are often outdated today. This explains also the difficulty of capturing the status quo in such a news update. A new version could be written almost daily and the field is so vast, that only a few selected issues can be highlighted. The current update tries to concentrate mainly on major developments that took place in 2001. Certain topics, such as Mother to Child Transmission (MTCT), take such an important place in these discussions, that we suggest to reserve them a chapter apart in the upcoming news update 2/2002.

Background

Since the International AIDS Conference in Durban in July 2000 and the United Nations General Assembly Special Session (UNGASS) in June 2001, the world is mobilised as never before to address the issue of HIV/AIDS in developing countries. In addition to continuing efforts to step up preventive efforts, access to HIV medications must now be ensured for the millions of infected persons in the developing world within the broader context of appropriate care, prevention and support. There is much that can be done to increase the life span and improve quality of life of HIV infected individuals. Treatment is not just a moral necessity and an essential human right but a necessary component of economic stabilisation and an ultimate return to economic development in high prevalence parts of the world. **Treatment programs** should always be designed in a way to **leverage prevention efforts as well**. Funding for treatment should only be offered together with active prevention programs. The availability of drugs will greatly increase the number of individuals coming forward for **voluntary counselling and testing (VCT)**. It is estimated that only 5 percent of HIV-infected Africans currently know their status (*Sachs et al*).

Compared to only a few years ago, treatment has become more affordable, with **significant reductions in the prices** of the necessary drugs, as shows the following graph (*in: Differential Pricing and Financing of Essential Drugs*).



Source: Presentation by Dr. J. Quick

Total annual costs per patient, including drugs and medical services, are **now around \$500 to 1000\$ a year in sub-Saharan Africa**, probably about the same as the average annual income of the workers being struck by the disease. This makes such treatment cost-effective in economic terms but still unaffordable by the individuals themselves (*Sachs et al*). ARV's for the prevention of **mother-to-child transmission of HIV** (treatment only around delivery and not lifelong) and **prophylaxis** for opportunistic infections are recognized to be **cost-effective**. Reduced drug prices and new financing mechanisms are critically important for access to therapy. Affordability of drugs is an intrinsic part of a comprehensive health care strategy for HIV/Aids. **Equity Pricing**⁷ and **Differential Pricing**⁸ are two strategies proposed to increase access of the poor to Antiretroviral Therapy.

⁷ **Equity pricing:** policies that ensure that from the point of view of the community and the individual, the price of a drug is fair, equitable and affordable, even for the poor population and /or health system Strategies that lead to equity pricing include measures to increase generic competition, differential pricing, global/regional procurement and distribution, local production through compulsory or voluntary licences and technology transfer (*e-drug, Tue 15 may 2001*).⁷ **Differential pricing:** is also called preferential or tiered pricing are commercial terms describing lower prices for low-income populations. It is the adaptation of prices by the seller to the purchasing power of governments and households in different countries. It may lead to equitable access to drugs but does not necessarily mean that even the lowest prices charged will be affordable.

Milestones: declarations, appeals, initiatives and conferences

Access to antiretroviral drugs (ARV's) continues to be high on the international agenda. The fear of developing countries and others concerning the impact of international trade agreements on drug prices and accessibility have been expressed in a series of recent statements in different international fora. Importantly, access to Aids drugs is no longer an issue just for health professionals and government officials alone, it has become headline news. A much wider constituency is now engaged- with all its complexity that it brings in terms of new possibilities and public expectations⁹.

Below is a **selection of some important meetings, proposals and conclusions of 2001** that concentrated on the issue of improving access to ARV.

Differential Pricing and Financing of Essential Drugs: WHO/WTO Workshop, April 2001

This high level workshop has moved the agenda of affordable drugs forward. More than 80 experts from 21 industrialised and developing countries met to exchange views on how to respond to the current crisis. The objective was to explore the complex questions concerning access to drugs at prices affordable in poor countries and adequate financing for this purpose, while providing adequate incentives for research and development (R&D) into new drugs.

Give due priority to funding of ARV: the Ouagadougou Appeal¹⁰, November 2001

At the international Conference on Aids and STD's in Africa, in November 2001 in Burkina Faso, several thousand people signed the Ouagadougou Appeal urging the Global Fund against Aids, Tuberculosis and Malaria to give due priority to HIV treatment access.

The Ouagadougou Appeal states that **access to antiretroviral drugs should be a priority of the Global Fund to Fight Aids, TB and Malaria.**

The conflict of interest between trade and public health :Declaration on the TRIPS Agreement and Public Health at Doha¹¹, November 2001

The 142 countries of the World Trade Organisation meeting in Doha, Qatar, issued a declaration stating that the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement should be interpreted and implemented so as to **support protection of public health** and to **promote access to medicines for all**. This declaration is being hailed as a major and **historic breakthrough** by the main actors involved in promoting equity in health. The only critical issue remaining is how countries without manufacturing capacity can make use of compulsory licences. This will be discussed during the TRIPS council in 2002.

Towards concerted and coordinated action: Declaration for a framework for action¹² December 2001

This document is the product of a yearlong consultative process involving 155 experts from 27 countries and 57 national and international organisations. It is the consensus of the

⁹ [e-drug] Brundtland speeches in Norway meeting, Fri, 13 April 2001

¹⁰ [e-drug] Ouagadougou Appeal, Sat, 12 April 2002

¹¹ [e-drug] Joint press statement on Doha outcome, Thu, 15 November 2001

¹² Declaration for a framework for action: Improving access to HIV/Aids care in developing countries
www.remed.org/declaration/html/en.html,

participants who convened in Paris at the invitation of the French Ministry of Foreign Affairs, UNAIDS and WHO. The purpose of this document is two-fold. The first is to set forth a clear **framework for improving and accelerating access to care** for HIV-infected women and men in the developing world. In particular, the document highlights the most critical areas which require resources in order to scale up the most effective programs for access to care, such as VCT, MTCT prevention, opportunistic infection prophylactics and treatment, access to ARV therapy and psychosocial support. The second purpose is to serve as a start for **mobilising organisations and people to an ongoing, progressive, sustainable action plan** that will help to make the UNGASS declaration become a reality.

The lessons learned from the various meetings and workshops can be summarised as follows:

- The price of drugs matters
- **Effective health systems** including appropriately trained and salaried staff, effective supply management, information systems, infrastructure and supervision **are a prerequisite** for delivering ARV programmes
- **Protection of intellectual property** is needed for stimulating new research but needs to be **combined with protection of public health**
- International trade agreements need to strike a **balance between the rights of patent holders and the rights of patients**
- To increase access to drugs, multiple solutions must be sought with a mix of mutually supportive strategies. Single solutions cannot be relied on. **Reduction of prices must be complementary to investments in health systems.**
- **Differential pricing** is feasible and it can result in prices that are between 1% and 10% of those charged in high-income markets.
- Availability and affordability of drugs needs to be backed by effective distribution systems, public-private partnerships and agreements between governments and donors.
- **Co-ordinated and concerted action** between the various actors are more effective and are needed to **follow up on declarations and consensus opinions reached with sustainable action.**

Some examples of pilot activities and actions taken

All declarations, appeals and wordy conferences are futile if not followed by action, implementing proposals into practice. A number of national and smaller pilot programs in middle-income (Argentina, Brazil, Chile, Thailand, etc.) and low-income (Côte d'Ivoire, Senegal, Uganda, etc) countries have demonstrated a comparable feasibility, efficacy and compliance¹³ with antiretroviral treatment to those obtained in high-income countries. The Brazilian experience, which ensures universal access and promotes domestic drug production, shows that ARV's can be cost-saving for the health care system: extra costs of drugs are offset by savings due to reduced hospitalisations due to opportunistic infections. One innovative model for providing care is "**Association-Based Treatment**" (e.g. Burundi, Zimbabwe, Venezuela). In this model, financial and material treatment resources are managed by the associations of people living with HIV/AIDS, together with doctors and other providers. This allows direct involvement in the decision making process and organisation of HIV care.

¹³ compliance: patients taking the correct amount of the prescribed medicine at the proper time and complying also otherwise with the proposed treatment

Below presented are some other recent examples of initiatives and activities having the aim to increase access to AIDS drugs and care.

*Decentralised initiatives in defiance of the instructions of the South African government*¹⁴

In January 2002 members of the Treatment Action Campaign (TAC) returned to South Africa from **Brazil** carrying **generic drugs manufactured for use in an AIDS treatment programme in Khayelitsha**. At a press conference, **TAC and Médecins Sans Frontières (MSF)** explained that 50 people were already taking the Brazilian medicines in Khayelitsha. To guarantee the quality of these drugs, an authorisation from the Medicines Control Council, the South African drug regulatory authority, was obtained prior to their use. Despite the national government's refusal to provide antiretroviral treatment, three clinics run by MSF within the government primary health care centres offer a comprehensive package of services to people living with HIV/AIDS, including antiretroviral therapy. This project is part of an **agreement between MSF and the government of the Western Cape**, signed two years ago. The clinics in Khayelitsha, a township of 500,000 people outside Cape Town, have provided treatment for opportunistic infections for over 2,300 people living with HIV/AIDS.

This initiative shows the power that pressure and advocacy groups and NGOs can have in pushing the issue of access to ARV therapy. In other cases, as well, provincial governments of South Africa have started to implement treatment programmes which were not in line with the views of the national Ministry of health, widely criticised for its reluctance.

*Will generic ARV drugs soon be produced locally in South Africa?*¹⁵

South Africa's first locally produced generic HIV/AIDS drugs could soon bring relief to thousands of people infected with the HI virus. Aspen Pharmacare CEO told in January that a cheaper, generic version of AZT could be produced by the company. The **daily dosage of the drug would cost US \$0.87 a day while a triple therapy combination could cost \$1.30 a day**. The local company was last year granted **voluntary licences by GlaxoSmithKline and Bristol-Myers Squibb** to produce generic versions of their antiretroviral drugs in South Africa. The company intended to submit the drugs to the government's Medical Research Council for final regulatory approval. According to Aspen Pharmacare, the international humanitarian organisation Medecines sans Frontieres had already expressed an interest in purchasing the drugs, and the company was also negotiating with other NGOs.

Brazil and India have shown how the production of generic ARV drugs in developing countries can make a huge difference to the question of access to care. If such a production could be established on the African continent, another milestone would certainly be reached in the fight against the epidemic.

Community –based treatment of advanced HIV disease: introducing DOT-HAART in Haiti

(source: Farmer et al)

A group of researchers from Harvard and local collaborators in Haiti studied a novel approach to Highly active anti retroviral (HAART) treatment in a small community based-treatment program in Haiti based on experience and lessons learnt in Tuberculosis control. With the collaboration of Haitian community health workers experienced in the delivery of home-based

¹⁴ [e-drug] TAC and MSF import generic ARV's into South Africa, Tue, 29 January 2002

¹⁵ South Africa: Local generic drugs available soon, IRINnews, Wed, 16 January 2002

and directly observed treatment of TB, an Aids prevention project was expanded to deliver HAART. The study concluded that directly observed therapy (DOT) with HAART, DOT-HAART, can be effectively delivered in poor settings provided there is an regular supply of high quality ARV drugs.

This approach is interesting, but still raises a number of questions regarding the necessity for lifelong non-curative treatment with HAART, compliance, mortality and the cost of such a programme.

Best practice

Finally, two guidelines of the World Health Organisation will be presented which can help in setting up and running antiretroviral treatment programmes. The first guideline addresses the question on a more public health level, whereas the second- published only some weeks ago- is meant for clinicians in charge of such treatment programmes.

The WHO has established **guidelines for the safe and effective use of ARV treatment in resource limited settings** that also deal with the question:

WHAT SHOULD BE IN PLACE BEFORE INITIATING ART (ARV therapy) PROGRAMMES?

The following conditions are essential prerequisites to the introduction of (ART)

- Assured access to voluntary HIV counselling and testing (VCT) and institution of follow up counselling services for ART to ensure continued psychosocial support and to enhance compliance to treatment.
- Capacity to recognise and appropriately **manage common HIV related illnesses and opportunistic infections.**
- **Reliable laboratory** monitoring services including routine haematological and biochemical tests for the detection of drug toxicity as well as access to facilities for monitoring the immunologic and virologic parameters of HIV infection.
- Assurance of an **adequate supply of quality drugs**, including drugs for the treatment of opportunistic infections and other HIV related illnesses.
- Identification of **sufficient resources to pay for treatments on a long-term basis.**
- Information and **training** on safe and effective use of antiretroviral drugs for health professionals in a position to prescribe ART.
- Establishment of reliable **regulatory mechanisms** against misuse and misappropriation of antiretroviral drugs.

In addition, the World Health Organisation has just published (April 2002) the first treatment guidelines for HIV/AIDS in poor settings. **“Scaling up antiretroviral therapy in resource-limited settings: guidelines for a public health approach”**.¹⁶

¹⁶ A summary is available under

http://www.who.int/HIV_AIDS/HIV_AIDS_Care/Executive%20sum-April22v3.pdf

whereas a 115 pages draft version of the full guidelines can be downloaded under

http://www.who.int/HIV_AIDS/HIV_AIDS_Care/ARV_Draft_April_2002.pdf.

These guidelines **answer practical questions of a clinician based in a developing country**, such as:

- When to start ARV therapy
- Recommended first-line and second line treatment regimens
- Reasons for changing ARV therapy
- Considerations for specific subgroups of patients

According to WHO the new guidelines propose a practical, standardised and simplified combination of ARV therapy. They provide guidance on more rational use of ARV treatments resulting in fewer side effects, less resistance and better tolerance of the medicines. The guidelines will also make it easier to **train health workers and make ARVs simpler to use**.

Parallel to the announcement of the guidelines, WHO has endorsed the **inclusion of AIDS medicines in its Essential Medicines List**. The decision of introducing ARVs in the “2002 WHO Model List of Essential Drugs” is based on a careful analysis of current evidence of ARV efficacy in developing countries, which shows that these medicines can be used effectively and safely in poor settings. The Model Lists are regularly updated and aim to provide an example for countries to develop their own essential medicines lists, according to their priority health needs. For further details see: <http://www.who.int/inf/en/pr-2002-28.html>

In conclusion, some **lessons learned from recent developments** in the field of improving access to antiretroviral therapy are:

- **Care, treatment, and prevention of HIV/AIDS are strongly linked.**
- **Care** constitutes an **entry point** and a key element for effective **prevention**.
- **Strengthening the health system is an essential prerequisite** to offering effective ARV therapy and VTC.
- In low and middle income countries a wide array of life-prolonging care and treatment interventions are feasible and cost-effective today. The sharp **drop in the prices** of antiretroviral drugs in these countries has dramatically **improved their cost-effectiveness**.
- Several nationwide and smaller ARV programs (such as Brazil and Senegal) have shown **compliance levels and efficacy outcomes of therapy that are similar** to those in the developed world.
- Governments, the private and not-for profit sector, and the international community must now **commit the required financial resources** commensurate with the need as identified by the UNGASS declaration.

References and links on access to drugs

- Sachs et al, Macroeconomics and Health: Investing in health for economic development, WHO, 2001. www.cid.harvard.edu
- Differential pricing & financing of essential drugs. A WHO/WTO secretariat workshop, 2001. www.who.int/medicines/library/edm_general/who-wto-hosbjor/who-wto-hosbjor.html
- Declaration for a framework for action: Improving access to HIV/Aids care in developing countries www.remed.org/declaration/html/en.html
- Farmer et al, Community-based treatment of advanced HIV disease: introducing DOT-HAART, Bulletin of the WHO, 2001,79: 1145
- WHO/HIS: Section three: Guide to ART in resource limited settings. www.who.int/HIV_AIDS/WHO_HIS_200.04_1.04/003.htm
- the last issue of the Medicus Mundi Switzerland newsletter also deals with the question of access to pharmaceutical drugs <http://www.medicusmundi.org/E/news.htm>,

Selected Links on HIV/AIDS, general:

- **UNAIDS;** www.unaids.org, most comprehensive source of information on HIV/AIDS. Information by topic, epidemiological information globally and by country, news, guidelines, etc.
- **HIV sero-prevalence Database, United States Census Bureau**
The HIV/AIDS Surveillance Data Base was developed and is maintained by the Health Studies Branch, International Programs Center (IPC), Population Division, U.S. Bureau of the Census. It is a compilation of information from those studies appearing in the medical and scientific literature, presented at international conferences, and appearing in the press. Available information for population groups in a selected country can be easily retrieved and displayed on the computer screen, printed in tabular format, or saved to an ASCII or Lotus file.
<http://www.census.gov/ftp/pub/ipc/www/hivaidsw.html>
- **AIDS Organisations Worldwide**
This directory lists contact details and service profiles of key organisations throughout the world working in the field of AIDS and HIV. Information is presented in four languages: English, French, Spanish and Portuguese. International, national and major regional organisations are listed, as well as international networks, key specialist agencies and research units linked to community-based projects. e-mail: info@nam.org.uk <http://www.aidsmap.com>
- **Aids Info Docu Switzerland**
Offers information and materials about AIDS prevention and the social, legal, political, and ethical questions involved. e-mail: info@aids-info-docu.ch <http://www.aidsnet.ch>
- **International Council of AIDS Service Organisation (ICASO)**
<http://www.icaso.org> Publications, details of International AIDS Conferences and the work of partner NGOs
- **WHO ASD (AIDS and STD control programme)**
http://www.who.ch/programmes/asd/asd_home.htm

Annex: Matrix showing strategies for different epidemics

(source: „DFID HIV/AIDS Strategy, May 2001*“, *based on matrix developed by Kate Butcher, JSI, UK)

Prevalence	Low prevalence/nascent	Concentrated epidemic	Generalised epidemic
Intervention Targeting Approach	Targeting to most vulnerable groups (e.g. CSW, IDUs, MSM, transport workers and migrant workers) and their partners	Targeting to most vulnerable groups and their partners	Targeting to most vulnerable groups and their partners and to general population
Prevention strategies	<ul style="list-style-type: none"> • Political leadership mobilisation • Stigma reduction • Functional national HIV strategy in place • Effective surveillance system in operation • Data about activities/epidemic collated and available • Population aware of STI's and HIV and how to avoid them , especially sub-populations with high incidences • Condoms available, affordable and accessible • Blood screening • HIV and sexual health integrated into school curricula • Operations research to understand transmission patterns and impact of interventions • STI treatments and diagnosis available and accessible for women and men • Private sector involved through social marketing • Infection prevention and Quality Assurance guidelines in place and observed • Capacity building of NGO's • All projects to assess impact of HIV 	<p>Same package as low prevalence /nascent, with:</p> <ul style="list-style-type: none"> • Effective outreach for at risk sub-populations • All DFID projects to include HIV/AIDS considerations and/or prevention interventions • Expanded training of health care workers 	<p>Same package as concentrated epidemic, with</p> <ul style="list-style-type: none"> • Expanded commodity security and distribution • Expanded involvement of youth • IEC campaign to address national epidemic
Care strategies	<ul style="list-style-type: none"> • Planning for VCT • Basic health care delivery for OIs 	<p>Same package as low prevalence /nascent, with:</p> <ul style="list-style-type: none"> • Implementation of VCT • Health systems development to support care • Expanded training of health care workers 	<p>Same package as concentrated epidemic, with:</p> <ul style="list-style-type: none"> • Voluntary testing and counselling • Syndromic treatment and diagnosis of STIs • Antiretrovirals for pregnant women • Effective care and support strategies • Health systems development to support care
Mitigation strategies	<ul style="list-style-type: none"> • NONE 	<ul style="list-style-type: none"> • Planning for expanded social service delivery • Economic impact of HIV/AIDS assessment • Planning for the impact of HIV/AIDS on all sectors 	<p>Same package as concentrated epidemic, with:</p> <ul style="list-style-type: none"> • Interventions to care for increased number of orphans • Expanded business and labour sector involvement • Active multisectoral involvement • Increased legal protections • Coping strategies for families and communities

User Evaluation: HIV/AIDS update 1/2002

of services/products provided within the framework of the Backstopping Mandate Swiss Tropical Institute (STI)/SDC SoDev-Health

In order to allow STI to produce services tailored to the needs of the potential users in SDC we would greatly appreciate if you could take the few minutes needed to fill in this questionnaire. Please fill in your name and feel free to express your opinion openly in order to help us to improve the quality of our services. Space is provided for three users to fill in their feedback on the same sheet.

User 1 (Name, function, place of work):.....

User 2 (Name, function, place of work):.....

User 3 (Name, function, place of work):.....

How do you rate the utility of the service/product/event provided in relation to:
Please circle one rating (1=poor, 2= fair, 3=neutral, 4=good, 5=excellent)

	<i>User 1</i>	<i>User 2</i>	<i>User 3</i>
➤ <i>choice of information</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>
➤ <i>service provided access to new information</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>
➤ <i>relevance to your work</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>
➤ <i>level/language appropriate</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>
➤ <i>presentation</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>
➤ <i>overall rating</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>	<i>1-2-3-4-5</i>

Other comments and suggestions (please continue on the back of the form if needed):

Please send this form back to BNN in headquarters. We thank you for your collaboration and for feedback on how to improve the evaluation form.