Male Circumcision
Warnings and Way Forward
by Cindra Feuer

Pending the rollout of medical male circumcision (MMC) for HIV prevention, women in affected communities are speaking out about the challenges it will pose to their safety and eventual benefit. They identified the potential for increased rates of infection from newly circumcised partners who do not abstain prior to wound healing as well as from a possible increase in men's risk behaviours. Women have also expressed concern that spending on women-focused prevention might decrease and that greater stigma and blame could be directed at HIV-positive women. In recognising the need to amplify women's concerns and inform MMC scale-up to ensure that the intervention is beneficial to men and women, a coalition of women advocates across East and Southern Africa documented barriers and put forth recommendations to overcome the challenges.

Background
Three large-scale clinical trials were conducted in Kenya, Uganda, and South Africa from 2005–2007 to determine the effects of MMC for HIV prevention in men1. The participants who received circumcision plus the prevention package were estimated to have 50 to 60% fewer infections than those in the control group (who received the prevention package alone). This led researchers to conclude that circumcision provided risk reduction beyond that provided by standard prevention such as STI treatment, condoms, and counseling2. MMC reduces heterosexual men’s risk of HIV transmission from female partners. Benefits to women could be seen in the longer term, if MMC coverage increases to where it reduces the number of positive men. Thus far, there is no conclusive answer as to why MMC reduces men’s risk of HIV infection.

What Women Think
There is general support from women for the implementation of medical male circumcision (MMC) as an HIV prevention strategy

- In general, women lack detailed factual knowledge of the benefits and risks of MMC for HIV prevention
- Many women believe erroneously that they would be directly protected against HIV if their partners were medically circumcised
- There is a perceived belief among women that traditional male circumcision (which has not been evaluated for its HIV prevention benefits) might afford the same protection as MMC for HIV prevention
- Women from some communities reported a conflation of female genital mutilation and medical male circumcision, including the perception that both would reduce the risk of HIV infection
- For women to access and act on information related to MMC and HIV, the information needs to be tailored to women. Also, the socio-cultural context and the realities of women, particularly in traditional male circumcising communities, need to be taken into account.


Continued on page 4
Hope springs eternal...

The second decade of the 21st century is looking like an interesting mix of the hopeful and the downright terrifying in HIV matters.

On the hopeful side, we have ‘The Berlin patient’ - the lucky man who developed leukaemia whilst on ARV treatment. His own immune cells were destroyed by chemotherapy in an attempt to wipe out the leukaemia, and his immune system was reconstituted with cells that lacked CCR5 the part of the T cell that HIV needs in order to enter the cells. The man stopped antiretroviral therapy, and three years later researchers are unable to find any trace of HIV. This shows that it is possible to clear the ‘reservoirs’ of HIV in the body and achieve a ‘cure’.

Science to the fore
HIV uses two different surface co-receptors – CCR5 and CXCR4 – to enter CD4 T-cells. If the co-receptors are blocked or disrupted, the virus is unable to enter the cell. Other novel science using this approach has just been announced at the 18th Conference on Retroviruses and Opportunistic Infections (CROI), held from 27th February to 2nd March 2011 in Boston in the USA. Gene therapy, using zinc finger nuclease technology to disable the gene responsible for producing the CCR5 co-receptor on T-cells, has been successfully used to protect T-cells from HIV infection. This represents a potential first step toward achieving a “functional cure” that is a little more practical than the ‘Berlin Patient’s’ stem cell transplant.

That’s the positive news – and not surprisingly, it is immediately relevant only to those in the developed world, where such expensive treatment may at some point be offered. The picture in Africa is grimmer.

Tight money reduces access to ARVs
With the economic recession hitting donors and aid agencies where it hurts, the funding shortage is cascading rather than trickling down to small AIDS Service Organisations (ASOs) and Community Based Organisations (CBOs) on the ground. The funding shortage is impacting on the idea of ‘treatment for life’ which now seems to be a debateable issue. We can only hope that the people responsible for decision-making come to their senses before we see an upsurge in drug resistant HIV and an ever steeper climb in the incidence of TB.

Now that money is so tight, countries with generalised epidemics need to be using it to purchase the most cost-effective and cheapest drugs – Indian generics have been the lifeline that underpins access to treatment in many African and developing countries. Implementing the new WHO guidelines to initiate treatment at CD4 counts of 350 and above and to remove Stavudine as the drug of choice are already problematic for many sub-Saharan African countries - the new first line drugs are many times more expensive and those for second line treatment are all under patent protection; when developing countries try to apply compulsory licensing they are frequently targeted for doing so, viz Thailand and India’s brushes with Big Pharma over the last few years.

Countries like Zimbabwe, trying to fund their own ARV needs, are being forced to introduce the new WHO guidelines over a period of years because of unavailability of funding to acquire the new drugs to replace Stavudine.

Data exclusivity – Big Pharma’s latest attack on generics
Despite all this, the EU is currently involved in a bid to seal a trade deal with the Indian Government that could stop the flow of cheap life-saving drugs. It is likely that Big Pharma stands behind the EU’s negotiations.

3 A lifeline to treatment: the role of Indian generic manufacturers in supplying antiretroviral medicines to developing countries. Waning B, Diedrichsen E, Moon S. Journal of the International AIDS Society 2010
India, sometimes called the pharmacy of the world, appears to be close to signing the deal, which has been on the cards for some time and which will prevent India’s generic pharmaceutical companies from making cheap copies of expensive drugs. Global pharmaceutical giants claim data exclusivity is essential for their future investments and research on developing country needs.

Hard won exemptions to patent protection (compulsory licensing) are about to be disabled by the new trade agreement, which requests “data exclusivity” on drugs, for between five and ten years. This means that generic manufacturers will have to carry out their own trials before they release a new generic. Michelle Childs of MSF says, “Indian patent laws have been shown to work to stop unnecessary patents on HIV medicines. Data exclusivity would undermine the benefits by giving a monopoly to stop production even when the patents have been removed”.

To their credit, the Indian government is trying to hold out, but the stakes are no doubt high. If the world allows this to happen it will be goodbye to cheap generics and to universal access in southern Africa.

UNGASS 2011 upcoming
In June the agreed to review the commitments in the Declaration of Commitment (2001) and the Political Declaration (2006) to universal access in 2011. While there are many disappointments with regard to UNGASS, its successes are undeniable – it created a scientific basis for the reporting of key indicators of the epidemic – and succeeded in getting many countries to submit their statistics to UNAIDS. It was UNGASS that gave us the very idea of ‘Universal Access’ and the idea that such a thing was possible. By 2010, commitments had been made to reduce HIV infection in people aged 15-24 years by 25%, and to reduce mother-to-child transmission by 50%. UNGASS has become a tangible basis on which to build donor commitments and given UNAIDS a clear mandate for work with governments. It is one of the few international bodies to build civil society into Government reporting commitments. In latter years, CSOs have prepared country-specific shadow reports on government implementation and increased their watchdog role. But despite these increasing successes, this may be the final UNGASS. It is proposed that it be replaced with a merging of the 2001 Declaration, the Political Declaration (2006) and the MDGs. Obviously this will mean a weakening of the emphasis on HIV and a shift towards general health indicators as in the MDGs. Progress or regression? Only time will tell.
Male Circumcision: Warnings and Way Forward

Possible explanations include that the foreskin of the penis has many cells of a type that are vulnerable to HIV infection, and circumcision removes these cells, and also makes the penile skin more durable, which might also reduce the risk of HIV infection. Furthermore, MMC reduces the rate of genital ulcer disease; genital ulcers can increase the risk of HIV infection.

Based on the trial findings, WHO and UNAIDS concluded in 2007 that male circumcision should be a priority HIV prevention service in countries with high HIV prevalence rates and low prevalence of male circumcision. Since then, steps have been taken at country level to develop policy frameworks, programmes and services to introduce and rollout medical male circumcision for HIV prevention in 13 targeted sub-Saharan countries.

A WHO/UNAIDS document, New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications (2007), provides guidance for decision-makers and programme planners, as well as for health service providers, regarding the human rights, legal and ethical obligations and duties when offering or conducting MMC for HIV prevention.

The protection and promotion of human rights focuses on the need for accessible services within a framework of informed consent, and the provision of comprehensive HIV prevention education and counselling that emphasizes the partially protective effects of medical male circumcision.

Access to accurate information for all forms a central guiding principal for the rollout of MMC for HIV prevention. The document also recognises the gender implications in the context of male circumcision. The potential harms of MMC for HIV prevention are outlined as unsafe sex, sexual violence, and the conflation of male circumcision with female genital mutilation. The guideline calls for medical male circumcision services to actively link with other programmes that address gender norms and masculinity, as well as providing other male sexual health services.

Women Safeguarding the Scale-up of MMC

The Women’s HIV Prevention Tracking Project (WHIPT) was created in 2009, to inform policies and programmes related to male circumcision. WHIPT country teams were formed in Kenya, Namibia, South Africa, Swaziland and Uganda, out of networks of women living with HIV who work predominantly at the community level. Each team developed a work-plan tailored to their context and trained women in qualitative data collection to capture local women’s impressions of male circumcision. WHIPT teams developed a standard interview questionnaire and focus-group template to be adapted to local contexts. Teams met to evaluate data across countries for common and context-specific themes. An advocacy agenda was shaped according to the data and implemented at a global, country and local level.

The WHIPT findings are documented in the report, Making Medical Male Circumcision Work for Women, released in December 2010. The findings and recommendations are one component of ongoing civil society work in countries to elevate women’s concerns, and to ensure that the rollout of MMC as an HIV prevention strategy is beneficial and safe for women. Throughout this year, WHIPT teams will execute advocacy plans based on their documented findings.

In total, 494 women completed the questionnaire-led interviews across the five countries and almost 40 focus groups were convened. In each country, the research was carried out in diverse locales, selected to reflect a diversity of practices, including traditionally circumcising and non-circumcising communities, as well as those practicing female genital mutilation.

Making Medical Male Circumcision Work for Women

Women’s support

WHIPT’s unprecedented qualitative community research confirms the potential negative implications listed in WHO’s New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications. Findings show that women are indeed worried that MMC will increase unsafe sex, sexual violence, and the conflation of male circumcision with female genital mutilation.
genital mutilation, among others. Though these primary concerns exist, for the majority of the women interviewed across the five countries there is general support for the implementation of MMC as an HIV prevention strategy in their communities if safeguards are put in place.

In general, a majority of the women from the five countries had heard about MMC. When probed, they had varying levels of knowledge. Findings show that 40% of women talk to their sexual partners about MMC; 74% would want to be involved in the process of their partner’s MMC, and 36% of women perceive themselves as potentially involved in the decision-making process around MMC.

Given the gap between women’s interest in engaging with male circumcision for HIV prevention, and their reported lack of involvement, there is an urgent need to ensure that MMC programmes and policies actively create opportunities for women to engage with and inform MMC implementation.

**Understanding protection**

A total of 46% of the women interviewed believe that MMC is protective for them. Out of these, some believe correctly that they would be indirectly protected over time once a critical mass of men in the population are circumcised; others incorrectly think they’d be directly protected. Others did not specify how they might be protected. There were also reported misconceptions that medically circumcised men are by definition HIV-negative.

Clear and correct messages must be provided to men and women and the media must be trained with factual information, highlighting risks and benefits of MMC for HIV prevention overall and the specific implications for women—including the lack of a direct HIV risk-reduction benefit for women with circumcised partners. Also, MMC should be emphasized as a complementary HIV prevention method, rather than as a stand-alone method.

**Implications for sexual decision-making and gender-based violence**

Of the respondents, 64% believe MMC would change ideas around HIV risk, either negatively, or for the better. These perceptions range from concerns that men would increase risk behaviours and blame of women for HIV transmission, to the hope that information and education for men during MMC would decrease men’s risk behaviours—including condom use and decreasing sexual partners.

The majority of WHiPT participants perceive that MMC might lead to an increase in gender-based violence (GBV) and heightened stigma for women living with HIV. This would be a result of circumcised men’s misperceptions that they are not HIV-positive and/or cannot transmit the virus. Thus sex and/or safer sex would be less negotiable than before circumcision, putting women at greater risk of GBV. Seventy-four percent of women reported existing GBV in their communities and 54% of respondents say MMC could increase GBV.

To safeguard against an increase in stigma and violence, national MMC plans should ensure that MMC programmes are implemented as part of comprehensive HIV prevention programmes that also integrate female condom access and empower women to be involved in sexual decision-making. Implementers must offer comprehensive MMC packages that will integrate sexual and reproductive health services for men, including condom counselling and gender equality education. Implementers must include gender indicators in MMC rollout monitoring and evaluation efforts. Advocates must monitor that resources allocated for MMC rollout are not diverted from HIV prevention programmes and research for women.

**Conflation of Medical Male Circumcision and Female Genital Mutilation (FGM)**

Women, particularly those from regions of Kenya and Uganda where female genital mutilation (FGM) is practiced, report a conflation of FGM and MMC, including the assumption that both reduce risk of HIV infection: 23% surveyed incorrectly think FGM could protect women from HIV; 25% believe that the promotion of MMC might also promote FGM among girls and women.

Implementers must clearly distinguish MMC from FGM in all programme literature and communications in relation to its benefits for HIV prevention. Advocates must monitor efforts to clarify the distinction between MMC and FGM, and all stakeholders must ensure that the rollout of MMC does not lead to an increase in FGM.
Many women participating in the research indicated that they have heard about MMC for HIV prevention. However, when discussed further, responses also indicated some level of confusion between traditional and medical male circumcision. Traditional MMC is practiced in a variety of ways and has not been studied for HIV prevention efficacy in a randomised clinical trial. Governments, implementers and advocates must distinguish clearly between traditional and medical male circumcision in all programme literature, communications and counselling in regions where traditional male circumcision is practiced.

**A Cautious Nod to the Cut**

Women interviewed in communities, including women living with HIV, raise serious concerns about the impact that the partially effective intervention might have on risk compensation (increased numbers of partners for men and decreased use of condoms by men), sexual negotiation, GBV, stigma, FGM, and resource allocation away from comprehensive HIV prevention, particularly from women-controlled and -initiated prevention tools.

**findings underscore the need to increase women’s participation in all aspects of MMC policy and programme development so that these policies and programmes address women’s concerns in operationalising the rollout of safe MMC**

Over the next year, WHIPT teams will execute advocacy plans based on their findings. Actions include linking women’s organisations and networks to WHO MMC country delegations; working with MMC implementers on women-specific MMC communications materials; ensuring implementers include gender indicators in MMC rollout monitoring and evaluation efforts; developing a collaborative research literacy curriculum aimed at women in affected communities; monitoring resources allocated to MMC; further investigating the conflations of MMC and FGM and how an increase in FGM may be mitigated; and investigating the benefits and disadvantages of infant male circumcision. A scorecard rating country MMC programmes’ attention to women’s issues will be available on the Male Circumcision Clearinghouse website www.malecircumcision.org as early as April. Finally, the WHIPT team findings underscore the need to increase women’s participation in all aspects of MMC policy and programme development so that these policies and programmes address women’s concerns in operationalising the rollout of safe MMC—making the hailed intervention beneficial for men and ultimately women.

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Copies of Making Medical Male Circumcision Work for Women can be downloaded at www.avac.org/whipt. To order hard copies go to avac.org/orderpublications.
Self-forming patient groups in Mozambique successfully distribute ARVs, monitor treatment

By Carole Leach-Lemens

Self-forming groups of patients who distribute antiretroviral medicines to those on treatment have proved highly successful in retaining patients in care in Mozambique, and have drastically reduced the need for patients to travel to health facilities. This is according to Tom Decroo and colleagues in a study reported in the advance online edition of the Journal of Acquired Immune Deficiency Syndromes.

Responding to patient-identified barriers to care, Médecins sans Frontières (MSF), together with patients, created a community antiretroviral group (CAG) model. For patients who are stable on antiretroviral treatment (ART), this model reduced transport costs and provided an incentive for patients to take greater responsibility for their own health and to be active partners in healthcare delivery. It helped build and strengthen social networks and peer support; important factors in ensuring adherence to treatment. A four-fold decrease in consultations among patients in CAGs was reported by staff at healthcare facilities. The authors note that the initial findings suggested a viable approach to supporting long-term ART management.

As the numbers of people on treatment and awaiting treatment in low-income countries continues to increase, there is growing concern about how to get and keep people on treatment and in care. Reports show that as many as a third are lost to follow-up within two years of starting ART.

In Mozambique, as in other high-prevalence countries, the health needs outstrip available resources, and an estimated seven-fold increase in health personnel is needed to meet the health needs of the population, note the authors.

The authors highlight that the long-term success of ART delivery requires models of care that separate those functions needing trained healthcare workers from those that do not (such as giving out medicines). New models also need to address barriers to access and retention in care. HIV, as a chronic disease and not an acute one, must focus on self-management of the disease outside of the clinic setting, they add.
Tete Province is in central Mozambique where approximately 85% of the population live in rural areas. Adult HIV prevalence is estimated to be 13%. Since 2002 MSF has been supporting the health authorities in Tete. In spite of progress in increasing access to ART services through decentralisation and task-shifting, approximately one in five people on ART are lost to follow-up, note the authors.

Group discussions between patients and counsellors at MSF-supported facilities identified transport costs; perceived stigmatisation at health facilities; and time lost waiting in long queues, as the main barriers to retention and care. The Ministry of Health guidelines recommend that patients stable on ART need a clinical consultation every six months; but medication can only be given out on a monthly basis.

The community ART group was developed so that patients using existing social networks and the pooling of resources could reduce their individual need to travel and queue, as well as provide mutual support for adherence and social needs.

Community ART groups (CAGs) were established in twelve health facilities in six districts of Tete Province. Those patients stable on ART for at least six months were told about the model and invited to form groups. The key functions of the group members included:

- Facilitating monthly ART distribution to other group members in the community
- Providing adherence and social support
- Monitoring outcomes, and Ensuring each group member has a clinical consultation at least once every six months

Group members visit the health centre on a rotational basis so that each member has contact with the health delivery services every six months.

Of the 1,384 members enrolled in 291 groups from February 2008 to May 31, 2010, 83 (6%) transferred to another conventional care or treatment centre, because of a change in residence. Of the remaining 1,301 patients in community groups, 1,269 (97.5%) were still in care, 30 (3%) had died and two (0.2%) were lost to follow-up. The latter two were due to change of residence or for social reasons and not related to CAGs or their care.

Future challenges for this model, according to the authors, include supporting health services across the treatment spectrum and amongst vulnerable sub-groups (children, adolescents, pregnant women, sex workers and HIV/TB co-infected patients).

The authors conclude that these initial findings support the establishment of community-based out-of-clinic solutions, notably for patients stable on ART, as key in the long-term management of ART in resource-poor settings.

Reference X2/3
Reprinted courtesy of AIDSMap
Experiencing antiretroviral adherence
helping healthcare staff better understand adherence to paediatric antiretrovirals

Authors: Benjamin R Phelps, Sarah J Hathcock, Jennifer Werdenberg and Gordon E Schutze

Abstract

**Background:** Lack of adherence to antiretroviral medications is one of the key challenges for paediatric HIV care and treatment programmes. There are few hands-on opportunities for healthcare workers to gain awareness of the psychosocial and logistic challenges that caregivers face when administering daily antiretroviral therapy to children. This article describes an educational activity that allows healthcare workers to simulate this caregiver role.

**Methods:** Paediatric formulations of several antiretroviral medications were dispensed to a convenience sample of staff at the Baylor College of Medicine-Bristol-Myers Squibb Children’s Clinical Center of Excellence in Mbabane, Swaziland. The amounts of the medications remaining were collected and measured one week later. Adherence rates were calculated. Following the exercise, a brief questionnaire was administered to all staff participants.

**Results:** The 27 clinic staff involved in the exercise had varying and low adherence rates over the week during which the exercise was conducted. Leading perceived barriers to adherence included: “family and friends don’t help me remember or they tell me I shouldn’t take it” and “forgot”. Participants reported that the exercise was useful as it allowed them to better address the challenges faced by paediatric patients and caregivers.

**Conclusions:** Promoting good adherence practices among caregivers of children on antiretrovirals is challenging but essential in the treatment of paediatric HIV. Participants in this exercise achieved poor adherence rates, but identified with many of the barriers commonly reported by caregivers. Simulations such as this have the potential to promote awareness of paediatric ARV adherence issues among healthcare staff and ultimately improve adherence support and patient outcomes.

http://www.jiasociety.org/content/13/1/48/abstract

A bi-regional survey and review of first-line treatment failure and second-line paediatric antiretroviral access and use in Asia and southern Africa

Author: TREAT Asia Pediatric HIV Observational Database (TApHOD) and The International Epidemiologic Databases to Evaluate AIDS (IeDEA) Southern Africa Paediatric Group

**Abstract (provisional)**

**Background:** To better understand the need for paediatric second-line antiretroviral therapy (ART), an ART management survey and a cross-sectional analysis of second-line ART use were conducted in the TREAT Asia Paediatric HIV Observational Database and the IeDEA Southern Africa (International Epidemiologic Databases to Evaluate AIDS) regional cohorts.

**Methods:** Surveys were conducted in April 2009. Analysis data from the Asia cohort were collected in March 2009 from 12 centres in Cambodia, India, Indonesia, Malaysia, and Thailand. Data from the IeDEA Southern Africa cohort were finalised in February 2008, from 10 centres in Malawi, Mozambique, South Africa and Zimbabwe.

**Results:** Survey responses reflected inter-regional variations in drug access and national guidelines. A total of 1,301 children in the TREAT Asia and 4,561 children in the IeDEA Southern Africa cohorts met inclusion criteria for the cross-sectional analysis. In Asia, 10% of children and
3.3% of African children were on second-line ART at the time of data transfer. Median age (interquartile range) in months at second-line initiation was 120 (78-145) months in the Asian cohort and 66 (29-112) months in the southern African cohort. Regimens varied, and the then current World Health Organization-recommended nucleoside reverse transcriptase combination of abacavir and didanosine was used in less than 5% of children in each region.

Conclusions: In order to provide life-long ART for children, better use of current first-line regimens and broader access to heat-stable, paediatric second-line and salvage formulations, are needed. There will be limited benefit to earlier diagnosis of treatment failure unless providers and patients have access to appropriate drugs for children to switch to.

A lifeline to treatment: the role of Indian generic manufacturers in supplying antiretroviral medicines to developing countries.


Abstract

Background: Indian manufacturers of generic antiretroviral (ARV) medicines facilitated the rapid scale-up of HIV and AIDS treatment in developing countries though provision of low-priced, quality-assured medicines. The legal framework in India that facilitated such production, however, is changing with implementation of the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights, and intellectual property measures being discussed in regional and bilateral free trade agreement negotiations. Reliable quantitative estimates of the Indian role in generic global ARV supply are needed to understand potential impacts of such measures on HIV treatment in developing countries.

Methods: We utilised transactional data containing 17,646 donor-funded purchases of ARV tablets made by 115 low- and middle-income countries from 2003 to 2008 to measure market share, purchase trends and prices of Indian-produced generic ARVs compared with those of non-Indian generic and brand ARVs.

Results: Indian generic manufacturers dominate the ARV market, accounting for more than 80% of annual purchase volumes. Among paediatric ARV and adult nucleoside and non-nucleoside reverse transcriptase inhibitor markets, Indian-produced generics accounted for 91% and 89% of 2008 global purchase volumes respectively. From 2003 to 2008, the number of Indian generic manufacturers supplying ARVs increased from four to 10 while the number of Indian-manufactured generic products increased from 14 to 53. Ninety-six of 100 countries purchased Indian generic ARVs in 2008, including high HIV-burden sub-Saharan African countries. Indian-produced generic ARVs used in first-line regimens were consistently and considerably less expensive than non-Indian generic and innovator ARVs. Key ARVs newly recommended by the World Health Organization are three to four times more expensive than older regimens.

Conclusions: Indian generic producers supply the majority of ARVs in developing countries. Future scale-up using newly recommended ARVs will likely be hampered until Indian generic producers can provide the dramatic price reductions and improved formulations observed in the past. Rather than agreeing to inappropriate intellectual property obligations through free trade agreements, India and its trade partners - plus international organisations, donors, civil society and pharmaceutical manufacturers - should ensure that there is sufficient policy space for Indian pharmaceutical manufacturers to continue their central role in supplying developing countries with low-priced, quality-assured generic medicines.


There will be limited benefit to earlier diagnosis of treatment failure unless providers and patients have access to appropriate drugs for children to switch to.
Imprisoned and imperilled: access to HIV and TB prevention and treatment, and denial of human rights in Zambian prisons


Abstract (provisional)
Background: Although HIV and tuberculosis (TB) prevalence are high in prisons throughout sub-Saharan Africa, little research has been conducted on factors related to prevention, testing and treatment services.

Methods: To better understand the relationship between prison conditions, the criminal justice system, and HIV and TB in Zambian prisons, we conducted a mixed-method study, including: facility assessments and in-depth interviews with 246 prisoners and 30 prison officers at six Zambian prisons; a review of Zambian legislation and policy governing prisons and the criminal justice system; and 46 key informant interviews with government and non-governmental organisation officials and representatives of international agencies and donors.

Results: The facility assessments, in-depth interviews and key informant interviews found serious barriers to HIV and TB prevention and treatment, among them extended pre-trial detention that contributed to overcrowded conditions. Disparities both between prisons and among different categories of prisoners within prisons were noted, with juveniles, women, pre-trial detainees and immigration detainees significantly less likely to access health services.

Conclusions: Current conditions and the lack of available medical care in Zambia’s prisons violate human rights protections and threaten prisoners’ health. In order to protect the health of prisoners, prison-based health services, linkages to community-based health care, general prison conditions and failures of the criminal justice system that exacerbate overcrowding must be immediately improved. International donors should work with the Zambian government to support prison and justice system reform and ensure that their provision of funding in such areas as health services respect human rights standards, including non-discrimination. Human rights protections against torture and cruel, inhuman or degrading treatment, and criminal justice system rights are essential to curbing the spread of HIV and TB in Zambian prisons, and to achieving broader goals to reduce HIV and TB in Zambia.

Protecting HIV information in countries scaling up HIV services: a baseline study


Abstract (provisional)
Background: Individual level data are needed to optimise clinical care and monitor and evaluate HIV services. Confidentiality and security of such data must be safeguarded to avoid stigmatisation and discrimination of people living with HIV. We set out to assess the extent to which countries scaling up HIV services have developed and implemented guidelines to protect the confidentiality and security of HIV information.

Methods: Questionnaires were sent to UNAIDS field staff in 98 middle- and lower-income countries, some reportedly with guidelines (G-countries) and others intending to develop them (NG-countries). Responses were scored, aggregated and weighted to produce standard scores for six categories: information governance, country policies, data collection, data storage, data transfer and data access. Responses were analysed using regression analyses for associations with national HIV prevalence, gross national income per capita, OECD income, receiving US PEPFAR funding, and being a G- or NG-country. Differences between G- and NG-countries were investigated using non-parametric methods.

Results: Higher information governance scores were observed for G-countries compared with NG-countries; no differences were observed between country policies or data collection categories. However, for data storage, data transfer and data access, G-countries had lower scores compared with NG-countries. No significant associations were observed between country score and HIV prevalence, per capita gross national income, OECD economic category, and whether countries had received PEPFAR funding.

Conclusions: Few countries, including G-countries, had developed comprehensive guidelines on protecting the confidentiality and security of HIV information. Countries must develop their own guidelines, using established frameworks to guide their efforts, and may require assistance in adapting, adopting and implementing them.
Absent Fathers Fuelling the HIV Epidemic

As the challenge of HIV continues, is the ‘Absent Father’ a major point of concern?

By Diana K. Opolot

A documentary on the ‘American Al Qaeda’, revealed a young American man – Bryant Neal Vinas – who ended up in terrorist activities after failing to cope with the fact that his father had moved out of home. It is also reported that in later years, many girls end up in intergenerational relationships with much older men, in an effort to make up for the father they never saw, or had around as they grew up. Some studies in New Zealand and the US (Bruce Ellis et al, 2003; Carol W. Metzler, et. al, 1994) have revealed that teenage pregnancy is associated with absent fathers – that girls reach puberty younger, become sexually active earlier (David M. Fergusson et. al, 1944) and are more likely to get pregnant in their teens if their father was absent from the home from when they were young.

Increasingly, men are making minimal contributions in their role as parents. This is irrespective of socio-economic status and is progressively more common in many parts of the world. As a result, more and more women are taking on the roles of two parents. This is not to say that there are no absent mothers, but the phenomenon of absent fathers is far more common.

The traditional roles of the family have changed over the years. Women are becoming more educated and getting better paid jobs. With this, their male counterparts might imagine that women on their own would effectively and without any strain, take care of the family. However, children’s needs are both economic and social and require the presence and contribution of fathers.

Some categories of absent fathers that come to my mind include:

- those who previously provided social and economic support but have now stopped;
- fathers providing very minimal financial support yet they have the means;
- those providing some economic support but who are living away from their families;
- fathers who are away for work, and who have the means to enable their families to stay together with them out there, but who have chosen not to;
- fathers who have totally denied fathering their children.

The list goes on…

“The human father has to be confronted and recognised as a human, as a man who created a child and then, by his absence, left the child fatherless and then Godless”.

Anais Nin -
Here we are not referring to those being away for work, or for other justifiable causes or reasons beyond one’s control, like serving a prison sentence. We are also not referring to those fathers whose relationships have gone sour, where the female partner makes it impossible for the fathers to remain in touch with or provide for their children. We are referring to those men who actively participate in making babies, and then neglect the obligations that come with it.

Absent fathers generate several negative effects on their families. These are social repercussions that include reproduction of generations without family values and people who will never appreciate the importance of children growing up together with both parents. Other social consequences include nurturing generations of disgruntled young people who grow up to become disgruntled adults making violence, including gender-based violence, crime, or even terrorism, inevitable.

Children in single-parent families are more likely to be victims of physical and sexual abuse than children who live with both biological parents. This also increases such children’s vulnerability to HIV infection. Some fathers have been absent from birth; children in this situation are subjected to a lot of social pressures. Here is an example of six-year old Tom; last year his teacher reported that another child said to him, “Where is your dad? You haven’t got one, have you?”. Tom had the strength of mind to reply, “I have got a dad, but he went away when I was in mummy’s tummy and didn’t come back, but I have a brilliant mum!” How many children face such difficult questions daily from peers and others? Luckily Tom is empowered to respond the way he did, but most children faced with such questions feel confused, lost and rejected.

Absence fathers generate several negative effects on their families. These are social repercussions that include reproduction of generations without family values and people who will never appreciate the importance of children growing up together with both parents.

In relation to sexual and reproductive health and rights (SRHRs), women are more likely to be faithful to absent partners for moral, health or other reasons. As a result they may miss out on the opportunity to have more children should they desire to, as well as their right to sexual pleasure. Other possible consequences may include mothers (or worse, a girl child) becoming involved in sex work in order to supplement the family income and being exposed to HIV infection. From another perspective, if the women or girls are already living with HIV, sexual interaction with various males accelerates the spread of HIV.

As revealed by research (outside Africa) early sexual debut for girls whose fathers were absent during childhood and the greater likelihood of intergenerational relationships with older men, increases these young women and girls’ risk of HIV infection.

Studies in the US have also associated child sexual abuse with absent fathers. According to Beverly Gomes-Schwartz et.al, 2007, “...27% of the abused children lived with a stepfather or the mother’s boyfriend”. While according to Sedlak, A. and Diane Broadhurst (1996), children in single-parent families are more likely to be victims of physical and sexual abuse than children who live with both biological parents. This also increases such children’s vulnerability to HIV infection.

Other studies have revealed that children from fatherless families are 32 times more likely to run away from home. In the context of street children, they may face extreme life challenges that include increased vulnerability to acquiring HIV.

Some of the implications of absent fathers are economic, such as stretching the limited resources available to run more than one home. Children growing up in single income families are more likely to experience poverty and related problems. An additional income, however humble, certainly makes a difference.

The absenteeism of fathers is also tantamount to the violation of their children’s human rights,
such as the right to education, health etc. Many children in our communities have had second-rate education or at worst, dropped out of school, as a result of absent or negligent fathers. Research, again in the US, has also demonstrated that:

- Children raised by single parents do not do as well as others in school and have more behavioural problems such as drug abuse. (William Galston & Elaine Kamarck, 1993; Deane Scott Berman, 1995).
- Children living without a stepfather or without contact with their biological father are twice as likely to drop out of high school (US Dept. of Health and Services, 1993).
- “Father hunger” often badly affects boys aged one to two, whose fathers are suddenly and permanently absent. These children experience sleep disturbances such as trouble falling asleep, nightmares and night terrors, which frequently begin one to three months after the father leaves home (Alfred A. Messer, 1989).

Boys from families with absent fathers are at higher risk for violent behaviour than boys from intact families; for example, 72% of adolescent murderers grew up without fathers. Sixty-two percent of adults who kill or harm others in school and have more behavioural problems such as drug abuse.

President Obama, sharing his own experience on absent fathers as both a son and as a father, in his address to commemorate Fathers’ Day on 22nd June 2010, reminded the gathering that his own father left the family when Obama was just two years old.

America’s rapists grew up in the same way (D. Cornell et al., 1987; N. Davidson, 1990; J.L. Sheline et al., 1994; N. Vaden-Keirman et al., 1995). As demonstrated by this research, being a rapist is strongly associated with boys whose fathers were absent when they were children. This certainly has HIV-related implications. If a rapist has HIV, he is likely to infect his victims, while if the rapist is uninfected, he also runs the risk of being infected.

Behaviours associated with drug use have been shown to be among some of the most prominent and robust drivers of HIV transmission. Drug use also affects judgment about sexual risk, thereby increasing the likelihood of transmitting or acquiring HIV through unprotected sex. With children in single parent families being more likely to develop behavioural problems including drug abuse, they have an additional risk factor to acquiring HIV.

Also, in the context of HIV, many women are striving single-handedly to ensure the well-being of their HIV positive children. This may result in poor quality of life, violating the child’s right to health care as well as the right to life.

You may be familiar with the term ‘OVC’, which stands for orphans and vulnerable children. You might imagine this term does not relate to you or your children, but if you are an absent father, it does. Your children may not be orphans in the literal sense because you are alive, but as absent fathers, your children have been denied social protection and therefore become vulnerable to many practical challenges in life. The UNICEF definition of an orphan is a child lacking either parent. Is this what YOUR children deserve? For parents who provide economic support but live apart from their families, this is not enough. Children need their father’s physical presence, to experience his daily love, care and guidance. They need a role model.

What can be done to help fathers, to fulfil their obligations as key duty bearers in children’s lives? Something needs to be done to support and improve fathers’ participation in their children’s upbringing - fathers are not merely sperm donors; those few moments of pleasure are not the end, but the beginning of a vital role as parents who nurture their children. What should mothers do, or do better to help improve the situation? This will not only benefit the fathers greatly, but their families as well.

President Obama, sharing his own experience on absent fathers as both a son and as a father, in his address to commemorate Fathers’ Day on 22nd June 2010, reminded the gathering that his own father left the family when Obama was just two years old. Though his mother and grandparents “poured everything they had into me and my sister”, he said, “I still felt the weight of that absence. It’s something that leaves a hole in a child’s life that no government can fill”. President Obama advised that absent fathers re-engage in their children’s lives. I would add, “re-evaluate yourselves and save your children from the consequences of a fatherless childhood”.

As Steven Kalas writes, “Faithful fatherhood shapes men into the wholeness of manhood”. I am sure all men treasure their manhood. A childhood is lived once - let’s not deny our children the precious presence of their father.

Research is needed to establish the impact of absent fathers on the HIV epidemic in Africa. This will allow the design of appropriate interventions to address this important issue.

The writer is a Social Scientist who is interested in productive partnerships that can help take this issue to the next level, either through research, publication or any form of dissemination. Feedback will also be appreciated. Email: dkopolot@gmail.com
Launch of the UNAIDS 2010 Report on the global AIDS epidemic


The report features the latest global, regional and country estimates on HIV and new trends in the epidemic’s evolution. In addition to the latest epidemiological data, the 2010 edition includes country-by-country scorecards on key issues facing the AIDS response.

Materials

The report will be accompanied by a full press kit which includes:

- Press release
- Scorecard Overview
- Global and chapter fact sheets
- Epidemiology slides
- HIV prevalence trend map

Most of the support materials will be available in English, French, Spanish and Russian. The full report and support materials are accessible on the UNAIDS RST ESA website at www.unaidsrstesa.org

Materials for broadcasters

In addition to the report and press kits UNAIDS has produced a video package for broadcasters which includes footage from sub-Saharan Africa, Central Asia, Asia and Latin America. If you are interested in receiving this material please contact Chiara Frisone ahead of the launch date.

Interviews

Senior experts from UNAIDS and co-sponsoring UN agencies will be available for interviews on 23 November at 14:00 at the press launch venue. If you are interested in lining up an interview with one of our speakers please contact Chiara Frisone.

Contact: UNAIDS RST ESA | Chiara Frisone | tel. +27 82 8804 729 or +27 11 519 69 15 | frisonec@unaids.org

UNAIDS, the Joint United Nations Program on HIV/AIDS, is an innovative United Nations partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support. Learn more at unaids.org.
Why it is Important for Business to be Involved in Supporting HIV Programmes.

By Dr Edmore Munongo (MBChB)

Southern Africa is home to two thirds of people living with HIV according to the World Health Organization. Recent statistics from global HIV epidemics indicate that the number of new HIV infections continues to increase, showing the need for more innovative prevention tools. Despite the effort of funders, researchers and communities, there have been both encouraging and equally discouraging results in this respect (Hiller SL, 2009).

The most common mode of transmission in sub-Saharan Africa is unprotected heterosexual sex with an infected partner (Dickinson D, 2007). According to UNAIDS people who are infected generally become sick within eight to ten years if they do not receive treatment. Interventions in the workplace, for instance those implemented by companies such as Eskom in South Africa and Debswana in Botswana have managed to reduce the cost of health services to their employees while also reducing the impact of the disease at the workplace and in communities at both the macro and micro-economic levels (du Toit J, 2010).

The Debswana experience has taught us some very important considerations when implementing a social responsibility programme around HIV in the workplace, taking into consideration as they do issues of vulnerability and susceptibility for both the employees and...
the organisation itself. Susceptibility describes those aspects of an organisation or employment that make workers more or less likely to become infected with HIV. For example, instance migrant workers are more susceptible to infection with HIV due to their high mobility, lack of access to HIV prevention information and education. (Debswana-Global benchmark du Toit J, 2010). Vulnerability refers to unequal opportunities, unemployment, or precarious employment and other social, cultural, political, and economic factors that make an individual more susceptible to HIV infection and to developing AIDS. The factors that underly vulnerability may reduce the individual’s ability to avoid HIV risk and include lack of the knowledge and skills required to protect oneself, accessibility, quality and coverage of services; as well as societal factors such as practices, beliefs, and laws that stigmatise and disempower certain populations and limit their ability to access HIV prevention, treatment, care, and support services.

Organisational vulnerability refers to those aspects of an organisation that increase the susceptibility and vulnerability of the employees thus increasing the likelihood that it will experience unusual levels of illness or death that negatively impact on the operations of the company. For example, a company that employs specialist engineers who must visit far-away sites and spend long periods living away from their families, is vulnerable to the illness and loss of highly skilled employees who are not easy to replace. Therefore interventions that modify vulnerability and susceptibility will make a significant impact on the epidemic both on the business and in the society at large.

Thus, investing in HIV and AIDS workplace programmes as part of corporate social responsibility is beneficial to both the community and the company itself. This discussion will focus on the justification for businesses to implement and participate in HIV and AIDS programmes from a corporate social responsibility point of view.

**Impact of HIV and AIDS on business**

HIV is not only a health issue. It is also an issue that goes to the core of business practices. (UNAIDS, 2005). The effect of the epidemic is evident at two levels; at the individual company level and at the macro-economic level.

It is important for business to identify the impact of HIV on markets, savings, investment, services and education. The impact of HIV and AIDS on people’s health affects their productivity and increases household expenditure on health, reducing families’ savings and investments and consequently reducing business markets, especially for services outside food, housing and energy. This affects overall economic growth. The United Nations estimates that the economic growth rate for a country with an HIV prevalence of 10% will be reduced by one third. There is also the impact on investor perception; if HIV is not controlled in the sub-Saharan Africa region investment is likely to be reduced, compromising the growth of economies in the region. The involvement of businesses in corporate social responsibility on HIV will help counter this.

Involvement in corporate social responsibility may be at employee level as well as at community level. If the company has an HIV policy in place which it is implementing, this will assist its workers in dealing with the disease. In 2006, Eskom reported that new infections were projected to cost the company four to six times the annual salary per individual, while the cost of existing infections from 2006 – 2010 would average 7% of the total payroll. By contrast, in 2002, Anglo American in South Africa announced that it was going to provide antiretroviral medicines (ARVs) to those workers who required them because it was cost effective for them to do so (Dickson D, 2007). Debswana in Botswana did the same. This demonstrates that if a company appreciates the impact, sees the need for corporate social responsibility and makes an intervention it can make a significant difference.

Increased absenteeism is one of the leading drivers of reduced productivity. It is visible in the disruption of the production cycle, underutilisation of equipment and the use of temporary staff and can lead to a company failing to meet its supply obligations and losing market confidence.
use of temporary staff. Studies done in East African businesses have shown that absenteeism accounts for between 25% to 56% of the cost of production (UNAIDS, 2005). This absenteeism is mainly due to employees becoming ill with HIV related opportunistic infections.

Company interventions thus make savings both financially and in working hours lost by reducing absenteeism due to hospitalisation and sick leave. Because HIV infection is largely transmitted through heterosexual sex in the region, it is also a family and community problem. Workers with sick family members will take time off to care for them and to attend funerals. Therefore it makes sense for business to extend its corporate social responsibility to the families of its workers in order to maximise the benefits.

Thus, businesses need to extend their social responsibility to the communities in which they are located. Poverty in the general community has been seen to be a driver of the infection. If the business community assists the community by uplifting the standard of living, and building hospitals and schools and ensuring that orphans are cared for, this also impacts on the spread of the disease and business benefits again.

**Impact on human resources**

HIV mainly affects the sexually active members of the society, who are also the most productive members of the community, from whom business derives its human resources. Another impact on human resources is the loss of skills, resulting in businesses spending more resources on training and recruiting. Thus, if the HIV epidemic is not controlled by direct investment into prevention and treatment programmes, labour resources will shrink. Investing in education as corporate social responsibility also creates a bigger skills base that may be available to replace the skills that are lost as a result of illnesses and death due to HIV and AIDS. Company investment in the surrounding communities further uplifts the standards of living, while at the same time creating markets.

In the Eskom programme employees, suppliers and customers were considered important to the programme, requiring intervention at all levels of the business chain. Companies also need to invest in empowering women and reducing their abuse, both in the workplace and in the community. This also reduces HIV transmission.

**Social stability**

UNDP has reported that migrant workers are usually at higher risk of infection due to several reasons, including the breakdown of their family lives, abuses experienced in the foreign country and general poverty. Businesses that employ migrant workers must therefore make a deliberate effort to create social responsibility programmes that assist migrants who provide them with cheaper labour. Protection of the rights of immigrants also needs to be included, as well as programmes aimed at confronting stigma and discrimination.

Access to health and prevention services is also vital and ensures early treatment and healthier lives. The provision of health services needs to be seen as an investment rather than as a cost; prevention of and limiting sickness and related absenteeism means controlling workforce health risks. Business must also invest in food security, which will assist in the reduction of the numbers of people engaging in risky behaviours in search of food and better nutrition.

Similarly, investment in sanitation facilities such as running water and toilets improves the quality of life of community members, and will reduce incidences of opportunistic infections and the spread of HIV.

One of the biggest challenges in the era of AIDS is the massive increase in the numbers of orphans. Orphans and vulnerable children create another potential driver of infection if they are not assisted with food and education. Investment in looking after these children, as is being done by Econet in Zimbabwe, has shown that such initiatives are important for both empowering orphans and reducing their involvement in antisocial activities such as theft and sex work. Sponsoring sporting activities like soccer helps keep youth away from crime and from engaging in risk taking behaviour, giving them a focus in life, while also assisting in reducing their vulnerability to HIV.

**Other reasons**

The corporate world must also at times just be involved in charity without asking too deeply why good causes exist. It makes good moral sense to invest in the communities from which the business makes its profit. At times it also makes good business sense. It helps companies improve their public image and raises the morale of the workforce, who feel protected.
Their families also feel protected and thus every person in the community becomes proud to work for a company that looks after kith and kin. For example, at one time in Zimbabwe, it became the wish of everyone to work for Mimosa Mine because it provided food for its workers and for the local hospital at the height of the economic difficulties and food shortages. Everyone wanted to be identified with the company.

According to UNAIDS, the challenge to business is clear. Given the impact of HIV on communities, business has to respond. These responses have initially been in addressing and safeguarding business’s core activities, by protecting its own workers. However they soon realised that there was a need extend their responses to wider preventive and educational collaborative initiatives. Their motives are both philanthropic and business oriented with a local, national and international scope.

Conclusion
The above is just a brief review of the impact that the HIV epidemic has on business and the justifications for business to get involved in it from the corporate social investment and philanthropic viewpoints. Business is affected both at the individual business level and at the macroeconomic level. First, the business has to take care of its own workers, but this is less effective, since the disease impacts along the whole supply chain, from the source of raw materials to the consumer. As a result business needs to make a paradigm shift and start appreciating the importance of investing in corporate social responsibility involving all communities as a way of sustaining their own businesses and in order to boost their image.

At the macroeconomic level it is obvious that it is difficult for businesses to thrive in a failing economy. The economic fundamentals are affected by the individual failure to be productive and eventually the gross domestic product of the whole country is affected. At times the social fibre of a whole region may be disrupted, as is happening currently with Zimbabwe. There have been reports of Zimbabweans crossing illegally into Zambia for CD4 counts tests because business and Government have failed to invest in the necessary equipment (Herald, 6 Sep.10). This has an obvious disruptive effect on business due to absent workers who will need days to go to Zambia and back to assure their treatment is effective.

Corporate social responsibility programmes should not be run as independent charities, but rather should be integrated into broader corporate and national HIV strategy so that companies achieve tangible returns, such as increased productivity, employee retention or improved brand equity.

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Hungry HIV-positive mothers wary of exclusive breastfeeding

Nutrition experts recommend that HIV-positive mothers exclusively breastfeed their babies for the first six months to reduce the risk of HIV transmission, but food-insecure Kenyan mothers worry they have insufficient milk to keep their babies full and healthy.

“As much as you would want to do it [breastfeed exclusively], it is hard because I don’t have enough food so I just think the milk coming from my breast isn’t enough for the child,” said Rose Otieno, a 35-year-old mother of six in Nyando District in Kenya’s western Nyanza Province.

According to Oscar Kambona, the provincial nutritionist in Nyanza Province, women needed educating on the links between their own food security and their capacity to produce breast milk.

“Mothers need adequate food to stay healthy, but the amount of food one takes has no bearing at all on the amount of breast milk and this is what most mothers don’t understand,” he said.

Experts say the nutritional status of a lactating mother has little effect on her ability to breastfeed, and only in extremely malnourished women is the energy and protein content of breast milk significantly affected. However, they recommend that malnourished mothers increase their food intake during breastfeeding so that they do not compromise their own nutritional status and health.

Drought and poverty
Kenya has been severely affected by a drought sweeping through East Africa; an estimated five million Kenyans require food assistance. While Nyanza is a traditionally fertile and food-secure region, extreme poverty means sufficient food is not always guaranteed. Benta Akoth, another HIV-positive mother in Nyanza, says if it were not for her husband, she would not have been able to exclusively breastfeed her last two children until they were six months old. “I have given breast milk without any food for six months... my husband has made it his duty to look for food,” she said. “I have many friends who start children on porridge at just three months because there is no food.”

According to a 2011 study conducted among 148 women in Kenya’s Rift Valley province, women in households affected by food insecurity had significantly greater odds of believing breast milk would be insufficient for six months.
I have many friends who start children on porridge at just three months because there is no food."

continue breastfeeding for the first 12 months of life. It adds that breastfeeding should only stop once a nutritionally adequate and safe diet can be provided.

**Education, support**

Charles Okal, the Nyanza Province AIDS and Sexually Transmitted Infections Control Coordinator, told IRIN that HIV-positive mothers needed psychosocial and nutritional support in order to exclusively breastfeed.

“There should be a way of involving the community so that they are able to offer support to mothers who come from food-insecure households so that exclusive breastfeeding as an HIV-prevention method becomes effective,” he said. “Maybe even a health facility-based feeding programme would be useful.”

But Kambona said a health facility-based feeding programme was not the solution. “If you give a woman food at the facility every time she comes, she won’t eat while her children go hungry [she will give the food to her children], so it is not only unsustainable, it doesn’t solve the problem at all,” he said.

“The only solution is for the Government to try [to] make households food-secure,” he added.


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ACHAP’s support to Botswana’s national antiretroviral (ARV) treatment programme

Authors: Innocent Chingombe, Themba L Moeti, Charles Olenja, Lesego Busang, Panganai Makadzange, Segolame Lekoko Ramotlhwa, Tendani Gaolathe and Godfrey Musuka

The African Comprehensive HIV & AIDS Partnerships (ACHAP) was established in 2000, as a country-led, public-private development partnership between the Government of Botswana (GoB) and the two funding foundations: Bill & Melinda Gates Foundation and Merck & Co. Inc. / The Merck Company Foundation. Its operations in Botswana commenced in early 2001 with a major focus on supporting the national ARV treatment programme.

ACHAP provided financial and technical support to the programme through GoB line ministries, as well as the civil society sector. This support has seen Botswana ranked as one of the top African countries with a successful ARV treatment programme. It currently boasts having 94% of its population in need of services having access to the treatment. Such a success story has motivated the authors to tell the story in form of this paper. The paper aims to highlight the main contributions made by ACHAP to the national ARV treatment programme between 2001 and 2009. Some notable outcomes of the national treatment programme are discussed, as well the new direction ACHAP is taking, going forward.

The birth of the Masa programme.

In 2001, the ‘latent demand’ for ARV therapy was about 110,000 people (de Korte, Mazonde and Darkoh, 2004). This number was expected to grow in a linear way to 260,000 by the year 2005, driven by the dynamics of the HIV epidemic, and assuming that all patients would be treated as soon as they become clinically eligible (McKinsey Consultancy Report, 2001). Contrary to this high demand for ARV treatment services, by the end of 2001, less than 5% of patients who needed ARVs were accessing them.

In realising such a gap in March 2001, the president made a declaration that the Government, with support from development partners, shall implement a national treatment programme before the end of that year (ACHAP, 2004).

This declaration gave birth to a national antiretroviral therapy programme now well known as the ‘Masa programme’, Masa being the Setswana word for “new dawn”. With the necessary arrangements in place, the government received the first batch of funding from Bill & Melinda Gates Foundation and Merck & Co. Inc. / The Merck Company Foundation through ACHAP. This support saw the first antiretroviral drugs provided at the Princess Marina Hospital in Gaborone, in January 2002. Three other centres in Francistown, Maun and Serowe were rolled out later the same year.

By June 2004, more than 1,700 doctors, medical officers, pharmacy staff, nurses and laboratory staff were trained to run the ARV treatment programme.

By the end of 2009, over 7,000 health care workers had been trained.
The Masa programme was pivoted on four major assumptions: (de Korte, Mazonde and Dakorh, 2004).

- Humanitarian: Treatment is essential for those already infected, since the vast majority of them will die without it.

- Prevention: Treatment is necessary to optimise prevention efforts. Access to treatment can be an incentive for an individual to take an HIV test, enabling primary prevention for those uninfected and antiretroviral treatment for those infected. Effective antiretroviral therapy lowers the viral load and reduces the likelihood of HIV transmission to others.

- To save children and the fabric of society: With more adults dying, the number of orphans will increase, resulting in a demographic shift that may contribute to increased societal political instability and violence.

- Economic development: Without treatment, many adults will die in the prime of their working lives taking with them the skills and knowledge-base that are essential for human and economic development.

ACHAP's contribution to the success of the Masa programme
ACHAP's support to the national ARV treatment programme was as follows:

Infrastructural development support
The introduction of the Masa programme called for the commitment of large resources to put in place the facilities required for treatment. Additional space was needed in existing health facilities to cater for the unexpectedly high numbers of patients. This resulted in the infrastructural development of Infectious Disease Care Clinics (IDCC). Lack of space led to ARV treatment services initially being rolled-out from only four sites, namely, Princess Marina, Francistown, Maun and Serowe. However, these four sites were unable to cope with the demand for ARV treatment services in 2002.

Out of this dire need, Botswana's President requested ACHAP's support in building the necessary IDCCs to expand the ARV programme. In health facilities with no existing space to meet the ARV programme needs, new space had to be constructed. ACHAP followed standard government procedures, liaising with several civil service departments in the construction process; and spending US$5.2 million on the construction, renovation and furnishing of 35 ARV treatment facilities for the Masa programme, including upgrading the ARV infrastructure for the Central medical Stores (CMS).

Drug donations
In addition to the funds dedicated to the project, Merck & Co., Inc. donated two antiretroviral medicines, Stocrin® (Efavirenz) and Crixivan® (Indinavir sulphate). In late 2008, Merck provided a further two medicines - Isentress® and Atripla® - available through ACHAP. The total monetary value of drugs donated between 2001 and 2009 is estimated at US$66.9 million.

Training of health care workers
Despite the willingness of the country's health care workers to play a role in the ARV treatment programme, the majority lacked training and experience with ARV medicines. In response to this gap, the Botswana Ministry of Health (MoH), working together with the Harvard AIDS Institute and ACHAP, developed a basic training curriculum for the training programme called KITSO, an acronym for Knowledge Innovation, Training Shall Overcome AIDS.

By June 2004, more than 1,700 health care workers, among them doctors, medical officers, pharmacy staff, nurses and laboratory staff, had undergone the modular HIV clinical management programme. By the end of 2009, it had trained more than 7,000 health care workers. Training of key health workers required to launch the Masa Project at each site was fully funded by ACHAP.

While the KITSO modules present health care workers with the theoretical aspects of HIV treatment, a complementary health care worker training programme known as the Clinical Preceptorship Programme (CPP) was launched in 2002, by the MoH, in collaboration with ACHAP. It sought to provide
health care workers with knowledge on the practical aspects of HIV treatment. The goal was to raise the level and quality of HIV and AIDS care and improve clinical expertise within the overburdened Botswana public health system. The programme brought HIV treatment-experienced physicians and nurses, mainly from developed countries, to come and work in Botswana’s introductory ARV treatment programme sites.

Using the Botswana National HIV Treatment guidelines, the experienced physicians, known as Clinical Preceptors (CPs) mentored local staff with no ARV management experience and provided operational and managerial support at the sites where they were stationed. Clinical Preceptors were assigned to each site for periods ranging from three to six months, and were generally seconded to their assigned treatment sites before the enrolment of the first cohort of ARV patients.

From 2005 to 2006, the CP programme expanded in direct relation to the phased roll-out of the national ARVT programme, starting in the country’s four pilot treatment sites in 2002, and expanding to all 32 treatment sites by the end of 2004. Through this programme, on average, each doctor CP trained more than 10 medical officers through hands-on training, while nurse CPs trained 32 registered nurses through hands-on training.

ACHAP sponsored a total of 51 HIV clinical specialists (36 doctors and 15 nurses) for training.
Overall Outcomes from the ARV Treatment Programme

Botswana's ARV treatment programme has been a success story resulting in several benefits for the Batswana. Overall, through its PMTCT and treatment programmes, it has achieved significant results in preventing new child infections, as well as deaths among adults and children.

Specifically, the programme helped to expand the coverage of ARV services to the whole country, while also improving access to services by those in need, in the public sector, representing approximately 90% of the ARV treatment-eligible population. This is a massive achievement for the Masa, when one considers that prior to the establishment of the programme, the same statistic was under 5%. This impressive performance led to Botswana becoming one of the very few countries that was able to achieve the WHO 3 by 5 targets (Stover et al, 2008).

The extensive coverage of the ARV treatment programme has also played a very significant role in helping avert deaths due to AIDS-related complications. Stover et al (2008), estimated that with ACHAP’s support, between 2001 and 2007 Masa has helped prevent the deaths of more than 53,000 Batswana, making it possible for thousands to return to productive lives. Through the prevention of mother-to-child transmission (PMTCT) programme, it has also played a very significant role in reducing the transmission of HIV from infected mothers to their babies. The number of new child infections has declined from 4,600 in 1999, to about 890 (810–980) in 2008, due to nearly total coverage of an effective PMTCT programme (Stover et al, 2008).

Going forward

It has, however, become clear that antiretroviral treatment alone cannot solve Botswana’s devastating HIV and AIDS epidemic; hence going forward, ACHAP intends to direct its support more towards HIV prevention, in line with Botswana’s vision of zero infections by 2016. This calls for the implementation of new and innovative approaches like safe male circumcision.

References

New AWiSA Network provides information and a space for the discussion of HIV in the World of Work

By Angela Kurth and Lisa Mildes

Workplace programmes for the automotive sector in South Africa

For countries in sub-Saharan Africa HIV is not simply a health issue but a huge socio-economic challenge. The epidemic imposes a heavy burden on families and communities as well as economies.8

UNAIDS estimated that 3.4 million persons were HIV-positive worldwide in 2009, of these, almost 25 million were workers between the ages of 15 and 49 years old - people in their most productive years.9

Due to the fact that the most productive age group is at such high risk of getting infected with HIV, it is evident that the HIV epidemic has an enormous impact on national productivity and earnings. HIV thus has to be considered as a significant threat as the epidemic imposes huge costs on enterprises through falling productivity, increased labour costs and the loss of skills and experience.10

An AIDS Prevention and Health Promotion Workplace Programme – known as AWiSA – was implemented at AIDC in Eastern Cape in 2007 and in Gauteng in 2009, with three Technical Advisors from the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) supporting management in the various companies with the implementation and co-ordination of the programme.

AWiSA was launched in 2003 and is currently working in Malawi, Mozambique, South Africa and Zambia. The objective of the AWiSA Programme is to support companies and organisations in addressing HIV and AIDS in a strategic way, as well as to implement comprehensive and tailor-made HIV prevention and health promotion workplace programmes in southern Africa.

In cooperation with a broad number of partners and under various conditions, a lot of experience, expertise as well as practical knowledge and tools have been gained and developed over the years – focussing on addressing HIV and AIDS in the workplace. Permanent development and allocation of knowledge and expertise is becoming more and more important.

In order to make all this available on a regional level - following the principles of sustainability and partner orientation - the idea of an online Community of Practice came up. The AWiSA Network gives stakeholders and organisations the opportunity to exchange and share information, experience and knowledge about HIV in the workplace.

- Research on the South African Automotive Industry shows that the supplier industry is largely unaware of the consequences of the epidemic and its effect on their business. The study was conducted by the Automotive Industry Development Centre (AIDC) at over 100 component manufacturing companies in five provinces in South Africa. The AIDC survey shows that the automotive sector has taken the fight against HIV with most respondent companies stating that they have HIV policies and programmes. However, most of the companies do not have enough understanding, as well as knowledge of how employees are infected and how many carry the burden of infected family members.

- Only 38% of companies with a turnover higher than R50 million a year have implemented an HIV policy. But the thought of having “some type of policy” in place does not necessarily mean that the issue of HIV is effectively and sufficiently addressed. The research found that 19% of large companies and 20% of medium-sized companies feel that HIV has no impact on their organisation while smaller companies face challenges in responding to the epidemic due to the fact that they do not have budgets for HIV programmes. In addition, 34% of the sector believes that there is no support, or companies rely on community based NGOs for support. In the case of multinational companies this support comes from parent companies.

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8 UNAIDS (2010): Global Report
New Resources

Report providing the current implementation status on each of the MDGs in Zimbabwe. The report indicates trends over the last decade in terms of the progress attained in socio-economic development. It notes significant strides that have been made in a number of key areas of development such as attaining universal primary education, halting and reversing the spread of HIV, and attaining gender parity in primary school enrolment.

A book exploring the role culture plays in child development and learning. The authors note that young children experience the most rapid period of growth and change during the human lifespan, in terms of their maturing bodies and nervous systems, increasing mobility, communication skills and intellectual capacities, and rapid shifts in their interests and abilities. Young children make sense of the physical, social and cultural dimensions of the world they inhabit, learning progressively from their activities and their interactions with others. Young children's experiences of growth are powerfully shaped by cultural beliefs about their needs and proper treatment, and about their active role in family and community.

Report assessing the progress made since 2006 towards the implementation of the Global Plan to stop TB. The highlights achievements, challenges and areas requiring new or more intensified effort.

An HIV training handbook for churches. The handbook presents set of practical, action-oriented training programme on HIV issues for churches and their communities especially in sub-Saharan Africa. The handbook is designed to enable pastors, priests, religious sisters and brothers, lay church leaders and their congregations and communities to reflect on and understand the spiritual, theological, ethical, health, social and practical implications of the AIDS epidemic and the Christian call to respond with compassion.

Guidelines and activities for a unified approach to sexuality, gender, HIV and human rights education. The book presents a bank of 54 sample classroom activities. The activities are designed for adolescents and children over the age of 10 years.

Guidelines and activities for a unified approach to sexuality, gender, HIV and human rights education. The book supports the use of participatory, learner centred teaching methods. The guidelines enables educators and policy makers to address not only the individual determinants of young people's sexual and reproductive health, but also the social determinants of their health and well-being. It focuses attention on the real world in which young people live their lives.

A training manual for use either as a training tool at workshops to develop workplace programmes, or for workplace policy development. The manual provides the required steps in establishing workplace HIV policy and programmes. It also provides guidance on how to involve various stakeholders in programming and how to create strategic partnerships in a workplace setting. The manual also gives guidance on how to monitor and evaluate workplace programmes.

National orphan care policy for Zimbabwe. The document gives guidelines on basic orphan care and protection especially for children orphaned by HIV. It outlines the basic principles in orphan care and the strategies and interventions to be employed in caring for orphans. It also sets out the operational modalities in caring for orphans in the country as well as the role of the Child Welfare Forum.

Booklet providing national statistics on TB and HIV in Zimbabwe. These include national estimates, historical trends in HIV, trends in HIV prevalence in young women, incidence for the years 2007 to 2009, children and treatment, AIDS related death recorded from 2007 to 2009 as well as TB and HIV co-infection.
NOWHERE TO TURN

Blackmail and Extortion of LGBT People in Sub-Saharan Africa

Published by: INTERNATIONAL GAY AND LESBIAN HUMAN RIGHTS COMMISSION
Edited by Ryan Thoreson and Sam Cook, Printed by Minuteman Press, Brooklyn, NY, 2011,

Reviewed by: Samuel Matsikure

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his book is a must read for people working in the fields of HIV and Human Rights as well as for policy makers and those working in the Justice System. It can be used as a tool to curb this social phenomenon which is the most prevalent but least talked about violation of the rights of lesbian, gay, bisexual and transgender persons (LGBT). The book explores the psychological, financial and physical trauma that blackmail and extortion have on the victims.

Homosexuality is criminalised in at least 38 countries across Africa; violence and discrimination are regularly unleashed on LGBT people because of their sexual orientation and identity but the prevalence of blackmail and extortion against them is less well documented. These crimes, and the factors that contribute to them were the window the International Gay and Lesbian Human Rights Commission (IGLHC) used to draft this study, which also looks at strategies that can be used to mitigate their impact and prevent victimisation.

The book includes studies from five African countries; Cameroon, Ghana, Malawi, Nigeria, and Zimbabwe. Among men who have sex with men (MSM) in Malawi, Namibia and Botswana, blackmail was the most prevalent human rights abuse they faced, with 18% of MSM in Malawi, 21.3% Namibia, and 26.5% in Botswana having experienced some form of blackmail.

While the definitions of blackmail and extortion differ across jurisdictions, the authors define them as follows; Extortion is defined as the use of threats to exploitive influence, or blackmail, to secure payments. Threats to disclosure information the person wishes to keep private is blackmail. Extortion differ across jurisdictions, the book provides an overview of the range of the human rights frame work shows how.

HIV aggravates the situation, as blackmailers falsely accuse LGBT of infecting them with HIV or other sexually transmitted infections and use that threat to extort from their victims repeatedly. Many LGBT people are sidelines by HIV bodies and thus denied life saving information on protection against HIV, according to CDEP in Malawi. Lack of access to information and knowledge about HIV transmission and STI testing among MSM, along with the failure to practise safe sex, may later be used by a blackmailer.

The emotional and psychological damage that results from living in a homophobic environment creates insecurity and allows blackmailers and extortionists to prosper, reinforcing secrecy and invisibility and putting people at greater risk of HIV. The existence of penal codes against homosexuality, some of which carry severe sentences as high as fourteen years, are a significant deterrent against exposing the blackmailer or extortionist. Police often concentrate more on their being homosexual, than on the crime reported. In countries where Sharia law is practised, homosexuality carries the death sentence.

Victims’ response to blackmail and extortion varies across the continent. The majority fear losing their reputation - especially those also in heterosexual relations or with reputable positions - and will part with the few resources they have. A few are brave enough to challenge their attackers and blackmailers and extortionists left them alone, while others consider leaving their countries for more tolerant and liberal states.

The book provides some tactics on how to deal with blackmailers and extortionists using the legal system and the police, based on the experience of Zimbabwean lawyer Derek Matyszak who has experience in such cases through working with GALZ in Zimbabwe. While these may not be applicable to other countries, they nonetheless provide useful references and precedents. It also offers useful references and footnotes on some of the cases to allow one to do further reading.

The human rights frame work shows how the rights to dignity, privacy, and autonomy of LGBT are violated, and how perpetrators are allowed to target them with impunity, while inequality denies them legal redress. The authors offer an overview of the range of the socio-legal contexts in which the problems arise and emphasize the need to understand how the legal and justice systems in different countries can be encouraged to respect the universality of rights and protect all citizens.

In their conclusion, the authors return to the challenges and difficulties of dealing with blackmail and extortion and the need to address the root cause of the problem. As long the victims lack recourse in law, they remain vulnerable to those who seek to take advantage of them. States need to take action by decriminalizing same sex activity and strengthening laws that protect the victims of crimes. Training of the police and the judiciary to ensure that they perform their functions of protecting citizens, is essential. NGOs can also make efforts to curb stigma by raising awareness around these issues.

While the book is a very useful contribution to the rights needs of LGBT in Africa, it would be strengthened by further research into state organs such as the police and the justice system to determine their opinions, position and reactions to crimes against LGBT, when they are required to protect all citizens, as well as helping to solve these crimes.

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