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.... men of Issachar, who understood the times and knew what Israel should do.
1 Chron 12:32

TRENDS in the HIV&AIDS EPIDEMIC

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A core value of SIM is to be responsive to our times. We want to respond with creativity and courage to evolving needs and opportunities under the guidance of the Holy Spirit. To be effective and relevant, ongoing evaluation and adaptation must be an integral part of our ministries, priorities and structures. What changes in the epidemic have you observed at your local and regional level? AIDSLink 87 summarizes the latest evidence of trends in the AIDS epidemic. AIDSLink 88 will take a closer look at the drivers of the epidemic. Share your reflections with colleagues and friends by sending your contribution to AIDSLink at: international.aids-consultant@sim.org

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1. BIBLICAL FOUNDATIONS – TRENDS

Change brings challenges. We have a natural tendency to find comfort in familiarity rather than stepping out into uncharted new territory. In the leadership transition at the time of King David's coronation, mighty men throughout the kingdom came with undivided loyalty and determination to declare their goal (1 Chron 11&12, esp. 12:38). David as leader was radically committed to God and his team, and they were committed to him. There were differences in their abilities; some came from outside the Israelite community (1 Chron 11:39, 41-46). The men of Issachar were valuable members of David's team, given special mention for their ability to understand the times and the practical implications (1 Chron 12:32). It seems they had God-given perception and penetrating analysis.

How this contrasts with the religious leaders of Jesus' time who were strongly rebuked for their inability to discern the times (Matt 16:2-3)! In Chronicles, the author is encouraging men and women after the exile who needed to live out God's purpose in community, and to strengthen the nation in difficult days. Despite successes in HIV&AIDS – decoding the genetic structure of HIV-1, fewer people becoming newly infected, increased access to treatment, and people living longer – much remains to be done with five new people becoming infected for every two put on antiretroviral therapy. HIV prevention is most effective when we understand the populations at higher risk, address contextual factors, make high burden areas a priority, and invest strongly over the long term. This demands courageous leadership, and discerning the times.

As Christians we take refuge in a God who never changes. At the same time we must simultaneously remain alert to the changing world in which we live and keep firmly fixed on the goal (Hebrews 12:2). Fruitful workers have one eye on eternal concerns and the other on the temporal needs in their community. They respond in culturally appropriate ways, demonstrating values of the kingdom such as respect, love and compassion.

For reflection and discussion:

1. To what extent do you see modeled in your team people with the ability of Issachar's men to understand the times and to know what to do?
2. What are key social, political, economic and spiritual trends in your context to which you and your team need to be alert?
3. How does HIV&AIDS intersect with some of these key trends? How could you respond?

2. AIDS EPIDEMIC UPDATE – KEY THEMES

AIDS continues to be a major global health priority. Despite significant achievements in preventing new infections, the number of people living with HIV continues to increase due to lowering AIDS related deaths. This is highlighted in the *AIDS Epidemic Update, (Dec 2009)* available (2.9MB) at: http://data.unaids.org:80/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf and the *UNAIDS Outlook Report 2010* available (3.7MB) at: http://data.unaids.org:80/pub/Report/2009/JC1796_Outlook_en.pdf

Themes noted below from these documents have important implications for how we respond strategically to HIV&AIDS within our local context, regionally and globally. To what extent are you constantly evaluating your response and taking into account the following considerations?

- Large geographic variations exist between and within countries and regions. This underscores both the need to tailor prevention strategies to local needs and the importance of decentralizing AIDS responses.
- The epidemic is evolving and pattern are changing, eg. parts of Asia's epidemic are increasingly characterized by significant transmission among heterosexual couples.
- Evidence of success in prevention, eg. a drop in new infections among children, and falling HIV prevalence among young people in many countries.
- Increased evidence of risk-taking among key populations of injecting drug users and men who have sex with men (MSM).
- Clinical trials confirming results from observational epidemiology that male circumcision significantly reduces transmission of HIV.
- Improved access to treatment having an impact. Antiretroviral therapy is lowering AIDS related deaths and contributing to increases in prevalence in multiple countries. Globally 4 million people are receiving treatment.

Gaps In Prevention

Gaps are evident in basic prevention approaches in hyper-endemic settings. Although the largest share of new infections in many Sub-Saharan African countries is occurring among older heterosexual couples, relatively few prevention programs have specifically focused on older adults. Sero-discordant couples account for a substantial percentage of new infections in some African countries, however HIV testing and counselling programs are seldom geared specifically for sero-discordant couples. Many programs focusing on young people fail to address some of the key determinants of vulnerability, such as the high prevalence of intergenerational partnerships. UNAIDS recommends urgent efforts to involve people living with HIV in the planning, implementation and monitoring of prevention efforts.

Application:

What barriers impede HIV prevention efforts among older heterosexual couples in your setting?

How might healthy marriage and family life be strengthened in the life of your church and community?

Access to Treatment

We are seeing an unprecedented increase in access to HIV treatment in resource-limited settings where antiretroviral medications were previously unavailable. Between 2003 and 2008, access to antiretroviral drugs in low- and middle-income countries rose 10-fold. Improved access to antiretroviral therapy is helping to drive a decline in HIV-related mortality. It is suggested that improved treatment access will help to lower HIV incidence by reducing the viral load at the individual and community levels. In ideal conditions, the provision of antiretroviral prophylaxis and replacement feeding can reduce mother-to-child transmission from an estimated 30-35% with no intervention to around 1-2%. There are strategies for the virtual elimination of mother-to-child transmission by 2015.

Funding

Most of the international assistance is channelled bilaterally from one government directly to another. An estimated 69% of funding is given as bilateral assistance by member countries of the Development Assistance Committee of the Organisation for Economic Co-operation and Development. Another 23% is disbursed through multilateral agencies. Private funding from the philanthropic sector accounts for 7% of the international assistance.



Sub-Saharan Africa

In 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults and 91% of new infections in children. Although it remains the region most heavily affected by HIV, studies of new infections by mode of transmission show that the epidemic is more complicated than once thought. As epidemics have matured, the proportion of new infections among people in stable, so-called 'low-risk', partnerships is often high, eg. In Uganda, people in sero-discordant monogamous relationships were estimated to account for 43% of incident infections in 2008. This underscores the need to ensure prevention efforts are also targeted towards people in marriages and long-term relationships.

Women and girls continue to be affected disproportionately by HIV in sub-Saharan Africa with women accounting for approximately 60% of HIV infections. This stems from their greater physiological susceptibility and the severe social, legal and economic disadvantages they often confront. Individuals who are divorced, separated or widowed tend to have significantly higher HIV prevalence than those who are single, married or cohabitating, with divorced or widowed women experiencing especially high prevalence.

Application:

Social factors making women particularly vulnerable to HIV are amenable to change.

What changes are needed and how can these be brought about in your context?

Consistent with the generalized nature of the region's epidemic, HIV affects all social and economic groups in sub-Saharan Africa. Surveys have detected a wide variation in the relationship between HIV, income and epidemiological patterns. Where household surveys have been conducted, HIV prevalence is higher in urban areas (except in Senegal). The most pronounced difference in HIV prevalence is in Ethiopia, where urban dwellers are eight times more likely to be HIV-infected than people living in rural areas. The circumstances associated with mobility and migration have been shown to increase vulnerability to HIV infection. A small percentage of prevalent HIV infections in sub-Saharan Africa is estimated to stem from unsafe injections in medical settings.

Application:

It what ways should HIV prevention in urban areas differ from that in rural areas? Why?

To what extent are these considerations taken into account in the planning and implementing of prevention programs in your context?

What steps could you take to more effectively tailor your response?

Asia

Asia, home to 60% of the world's population, is second only to sub-Saharan Africa in the number of people living with HIV. India accounts for roughly half of Asia's HIV prevalence. A wide variation in epidemiological patterns between different Asian settings is apparent. Although long concentrated in specific populations – injecting drug users, sex workers and their clients, and MSM – the epidemic in many parts of Asia is steadily expanding into lower-risk populations, such as to the sexual partners of those most at risk.

Transmission among sex workers and their clients is driving a much broader epidemic of heterosexually acquired HIV, resulting in extensive transmission among individuals who engage in low levels of risk behaviour. In China, where the epidemic was previously driven by injecting drug use, heterosexual transmission has become the predominant mode of HIV transmission.

Latin America

National epidemics in Latin America remain stable. Although they are heavily concentrated among MSM, injecting drug users and sex workers, only a small fraction of HIV prevention spending in the region supports prevention programs specifically targeting these populations. Many MSM in Latin America do not identify themselves as homosexual. Individuals with lower educational levels in Latin America especially tend toward early initiation of sexual activity, which potentially increases their risk of HIV acquisition. According to WHO and UNAIDS, antiretroviral coverage in Latin America (at 54% in 2008) is above the global average.

High Income Countries

Progress in reducing the number of new HIV infections has stalled in high-income countries. Between 2000 and 2007, the rate of newly reported cases of HIV infection in Europe nearly doubled. The resurgence in HIV among MSM in high-income countries is tied to an increase in sexual risk behaviours. Epidemiological data in high-income countries continue to reflect the extraordinary benefits of antiretroviral therapy.

3. MAKING IT KNOWN – CONFERENCES, COURSES & AWARDS

1. 18th International AIDS Conference

This will be held in Vienna, Austria from 18 to 23 July 2010 on the theme: More Rights. Right Now. Online abstract submissions will be accepted until 10 February 2010. www.aids2010.org

2. Red Ribbon Award

Nominations are open for the 2010 Red Ribbon Award. Twenty five organizations that have shown outstanding community leadership and action on AIDS will receive an award: all will receive a monetary prize of US\$ 5,000 and five of the awardees will receive special recognition and an additional US\$ 15,000 award. Nominations close 28 February 2010. Information can be found on www.redribbonaward.org or by contacting redribbonaward@undp.org.

2. Short Course on Antiretroviral Therapy

The Institute of Tropical Medicine in Antwerp is an internationally recognized centre for research, training and patient management in the field of HIV&AIDS. Places are available in their *Short Course on Antiretroviral Therapy, (SCART 2010)* in English for those with a medical degree involved in HIV clinical care programs in resource poor settings. The 2010-2011 course overview and application forms are available from: www.itg.be/itg/GeneralSite/Generalpage.asp A limited number of scholarships are available and selected on a competitive basis. All required documents for a scholarship must be sent by post. The application deadline is 31 Jan 2010. This is course is recommended by Dr Adamu Addissie of Ethiopia.

4. TIPS IN DOCUMENTATION & COMMUNICATION – PLANNING

Why a plan for documentation and communication? A well-written plan for your project, program or organization that is conscientiously implemented will:

- Improve efficiency, quantity and quality of documentation and communication
- Enhance your professional image
- Increase awareness by staff of budgeting and fundraising requirements and the value of documentation and communication activities
- improve understanding amongst staff of their roles and responsibilities
- Make it easier to meet deadlines
- Improve monitoring and evaluation
- Enable the program to receive and respond to feedback

Consider how your program, project or organization plans to document and communicate its activities over the coming year. Identify:

- Why are we documenting this? What information/programming gap is being closed? – need
- Who are we developing this for? – target
- What are we developing? Are they print, audiovisual, web based, etc? – type of products
- Who will do what in the process? – the people responsible
- When? – timelines
- How? How will they be secured? – resources needed (human, financial, equipment)
- Who will use it and how? – the document's usefulness/appropriateness

Reference: Building Skills in HIV&AIDS Documentation & Communication: A Reference Manual, Jan 2008. (2.1MB) www.saf aids.net/files/u1/DocComRefMan.pdf



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