– AIDSLink #52 –
Treatment & antiretrovirals

"Love others as well as you love yourself" (Mt 22:39 The Message)

September 2006

Issue #52 focuses on treatment and antiretroviral therapy (ART). This will be particularly useful for health care workers and others giving recommendation on child bearing. What are the implications and challenges in your HIV & AIDS ministry of the current scale-up for universal access to treatment by 2010? What lessons are you learning? Please take a moment to share your valuable experiences and thinking through AIDSLink – email me at international.aids-consultant@sim.org

CONTENT
1. ART: Loving your neighbour as yourself?
2. Scaling up access to treatment: globally, Zambia & India
3. HIV & AIDS, children and treatment
4. Child bearing and ART – 2006 guidelines
5. International recognition of innovation – coffee drinking ceremonies
6. Making it known – Christian AIDS Resource and Information Service (CARIS)
7. Tip of the Month – Life lines

1. ART: Loving your neighbour as yourself?

Jesus said, "Love others as well as you love yourself" (Mt 22:39 The Message), that is "love your neighbour as yourself. All the other commandments … are based on these two commandments" (Mt 22:39,40 NLT). Some of us reading these words here, if we develop symptoms of AIDS would automatically receive ART and quality medical diagnosis and treatment when needed through our nation's medical system, perhaps even at no cost. Others of us could access treatment if we found the financial resources. But some of us would have no opportunity of receiving ART. ART gives time to those with AIDS, their families and their communities; to put our affairs in order, to prepare our children for an uncertain future, to get right with God.

In the midst of the harsh reality that the vast majority of those struggling with AIDS do not receive ART, is the hopeful sign that in the last few years the numbers able to access ART has increased dramatically (see below), including women. This has been due in the past to those who have spoken up on behalf of the voiceless, pressuring the international community, government at all levels, and those in the pharmaceutical business.

For Discussion:

1. How do you respond as a Christian to:
   a. the reality of the "majority" without access to ART?
   b. improved access for those in need brought about by advocacy?
2. What do Paul's words in Gal 6:10 "Let us work for the benefit of all" say to us about widening access to ART?
3. What is your team doing to fulfill Jesus' words in Mt 29:39 with respect to ART in your community?

2. Scaling up access to treatment

Access to ART began to increase significantly in 2003. According to the joint UNAIDS/WHO fact sheet released for the XVI International AIDS Conference, scaling up has been most dramatic in sub-Saharan Africa with over one million people now receiving treatment representing a 10-fold increase in 3 years. Coverage has risen to 23% of those requiring ART. In East, South and South East Asia, 235,000 people are now on treatment representing a greater than a 3-fold increase. In Latin America and the Caribbean the coverage is 75%. Data suggest no systematic bias against women with the proportion of ART recipients who are women, corresponding closely to the proportion of infected. However scaling up is leaving children behind. Children account for 14% of

AIDS deaths – 90% of children with HIV are African. Prevention of mother-to-child transmission is completely inadequate with less than one in ten HIV infected women in low and middle income countries benefiting from antiretroviral prophylaxis. For further information see:

1. *Progress in scaling up access to HIV treatment in low and middle-income countries, June 2006* (493KB) is available at: www.who.int/hiv/toronto2006/FS_Treatment_en.pdf

2. *Rapid scale-up of Antiretroviral Therapy at Primary Care Sites in Zambia.* JAMA. 2006; 296:782-793, abstract available at http://jama.ama-assn.org/cgi/content/abstract/296/7/782 This reports on a nation-wide scale-up of ART in 18 primary care facilities using mostly non-physician clinicians. The program enrolled 21,755 adults over a 19 month period ending November 2005. Some of the major findings:

- 73% of patients were WHO stage III or IV (of those with documented staging)
- mean CD4 count at entry: 143
- 75% of all patients were started on ART
- mortality rate within 90 days of starting ART: 26 per 100 patient-years;
- mortality rate after 90 days of starting ART: 5 per 100 patient-years
- mortality risk was predicted by commonly measured clinical and immunologic factors (CD4 count, stage, body mass index, anemia, poor adherence)

The study concludes that massive scale-up of HIV and AIDS treatment services with good clinical outcomes is feasible in primary care settings in sub-Saharan Africa. Most mortality occurs early, suggesting that earlier diagnosis and treatment may improve outcomes.

3. *Supporting safe and effective ARV treatment in India: building treatment friendly communities* 2006 is available (264KB) at:
http://synkronweb.aidsalliance.org/graphics/secretariat/publications/Supporting_safe_ARV_treatment.pdf
This is a rapid situation assessment from the International HIV/AIDS Alliance by Panda, Kaul, Dhaliwal, Rohini, & Nembiaklum. It explores the psychological, social and material needs of those on ART in Manipur and Andhra Pradesh, challenges faced by people on ART, and the quality of existing services.

3. HIV & AIDS, children and treatment

According to WHO, the most efficient and cost-effective way to tackle pediatric HIV globally is to reduce mother-to-child transmission (MTCT). Sadly, every day there are nearly 1500 new HIV infections in children under 15 years of age. HIV-infected infants frequently present with clinical symptoms in the first year of life, and by one year of age an estimated one-third of infected infants will have died, and about half by 2 years of age.

It is critical that children are diagnosed early and provided with ART as early as possible, as the course of HIV infection is faster and more aggressive in children. Many of the obstacles associated with treatment of pediatric HIV have to do with lack of simple and affordable diagnostic technologies and insufficient understanding of the life-saving effects of ART in children. WHO has now revised and updated the previous ART guidelines for infants and children, taking into account the realities and limitations of resource-limited settings. These guidelines include how to establish diagnosis of HIV in infants and children, when to commence ART, ART drug toxicity, strategies when first- and second-line treatments fail, considerations for nutrition/malnutrition, ART clinical and laboratory monitoring, and ART adherence and drug resistance problems.

Antiretroviral therapy of HIV infection in infants and children in resource-limited settings: towards universal access: Recommendations for a public health approach. 2006 (1.54MB) is available at
www.who.int/hiv/pub/guidelines/WHOpaediatric.pdf

For a resources on HIV in infants and children see www.who.int/hiv/paediatric/en/index.html

Global AIDS Alliance's summary of the major advances and significant remaining gaps in efforts to scale up global pediatric HIV treatment and prevention since July 2005 is available at:
:www.globalaidsalliance.org/Children_Left_Out.cfm

4. Childbearing and HIV – 2006 Guidelines

The recommendations for those living with HIV and considering child bearing has undergone a change in the light of access to treatment – ART.

Dr Gisela Schneider, Head Of Training department Infectious Diseases Institute, Makere University and International Medical Advisor WEC International contributes the following:

> "Up to the present child bearing has generally been considered unwise, at best, by many of us advising and caring for couples. The main reasons for that view have been the chance of passing HIV to the baby if the mother is infected, and in discordant couples the chance of the one partner infecting the other during unprotected sex. This recommendation (voluntary infertility) is burdensome for many couples in Africa and elsewhere" (Dr Mike Blyth MD, Evangel Hospital, Jos, Nigeria).

Nearly three million children are living with HIV and annually WHO estimates about ½ MIO deaths among children under 15 years. 90% of these children get infected through pregnancy, childbirth or breastfeeding. The chance of infection varies between 25%-45% (1) depending on breastfeeding and without any prevention of mother to child transmission (PMTCT). There are many challenges in treating children living with HIV effectively. A lack of trained staff, difficulties in access to antiretroviral drugs for children, difficulties with paediatric drug formulations, long-term toxicities and the challenges of disclosure of HIV status to children and adolescents are well known hurdles in treating children and adolescents for HIV. Therefore it is important that we prevent mother to child transmission as far as possible. Unfortunately many mothers still do not have access to such preventive services. It is important that all our health centres and mission clinics have trained staff who can deal with this situation and have access to effective preventive measures as described in the WHO guidelines that are revised since Toronto 2006. (2)

On the other hand, many women and men living with HIV who are on ART are getting back to their normal life. They are back at work and they are reproductive and may want to have children. Often enough women are pregnant and come to us for advice. Some women even consider terminations, others really want to have healthy children. As health workers we now have to weigh risks and benefits very carefully and counsel PLWHA well so that they can make an informed choice for family planning and if they really want to have children, to have children safely and build families wisely. Therefore we need a proactive reproductive health approach for all our patients living with HIV but especially those on ART. This includes information on the benefits of family planning using dual protection for infected women, but also informed counselling for a safe pregnancy for couples who wish to have children.

For women living with HIV that are pregnant and are not eligible for ART according to WHO or national guidelines, it is possible to reduce the risk of HIV transmission by using a three step approach (revised guidelines):

> For the mother:
> - AZT starting at 28 weeks single dose
> - SD NVP at birth together with Combivir
> - Combivir (AZT/3TC) for 7 days
>
> For the infant:
> - SD NVP followed by one week of CBV

Women who qualify for ART, will need triple therapy whenever they are diagnosed during pregnancy. The new WHO guidelines suggest that women with a CD4 count of 200 – 350 can already be considered for ART. The aim with ART is full immune reconstitution and undetectable viral loads. This can be achieved with complete adherence to a triple therapy. Detectable viral loads increase the risk of transmission to partners and to the unborn child. But with an undetectable viral load the risk of MTCT is small. Therefore ART should be considered for women in this group.

On the other hand, we now have women come for advice because they want to get pregnant. A planned pregnancy for women on ART would best be considered for a couple that has full shared confidentiality, with both partners well and undetectable viral loads. A woman who gets pregnant at that stage would be monitored throughout pregnancy and continuously take her ART regimen (that should NOT include Efavirenz) and be delivered safely, depending on the situation keeping with WHO regulation on safe delivery for HIV infected women.

Postnatally the children born to HIV positive mothers will receive SD-NVP and one week of Combivir (WHO). The child will need close monitoring. Where available a qualitiative PCR test after 6 weeks or repeated HIV tests at 6, 9 and 18 months may be used to determine the child's HIV status. Cotrimoxazol prophylaxis will be started at 6 weeks until there is evidence that the child is NOT HIV infected.

Overall prevention is paramount. As health workers we need to realize that we face a new paradigm where PLHWA now are well again and in turn will become reproductive and therefore we should create an environment of trust and good counseling whereby women and men living with HIV will be able to protect themselves, their partners and children and come to an informed choice on the best way for them in terms of reproductive health.

(1) De Cock Km et al. Prevention of mother to child transmission in resource limited settings: translating research into policy. JAMA, 2000, 283: 1175-1182
(2) Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource limited settings. WHO 2006 (2.35MB) Available at: www.who.int/hiv/pub/guidelines/WHOPMTCT.pdf

Related 2006 WHO publications include the revised WHO clinical staging for adults and children, treatment guidelines for adults guidelines on the use of co-trimoxazole preventive therapy (CPT), and *Sexual and reproductive health of women living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children on RLS* (1.5MB). These are available at: www.who.int/hiv/pub/guidelines/en/

For further information on childbearing and HIV contact:
Dr Gisela Schneider: gisschneider@gmx.net
Dr Mike Blyth: mike.blyth@sim.org www.ecwaevangel.org facilitates an email newsgroup for people interested in issues of antiretroviral programs in faith-based organizations in Africa, to facilitate sharing ideas, problems, and news. To subscribe write to: arv-fbo-owner@yahoogroups.com

5. International recognition of innovation – coffee drinking ceremonies

Congratulations to the Kale Heywet Church (KHC), Health and HIV/AIDS Department, Ethiopia whose Awassa project was one of 25 community finalists recognized for outstanding leadership in the Red Ribbon Award at the recent International AIDS Conference in Toronto.

By focusing on community behavior and attitudes towards HIV/AIDS as well as the consequences of the epidemic, KHC has changed not only the way people act but also the way people think about HIV/AIDS. The Church has dedicated itself to reducing stigma, and this improved community feeling has enabled them to mobilize many new volunteers. KHC has been innovative in its approach, incorporating the important Ethiopian cultural ritual of “Bunna Tettu” into their program in all 6 sites. Bunna Tettu is a coffee drinking ceremony which involves friends and neighbors discussing local issues while drinking coffee. It has proven itself to be a valuable forum in which to educate the Ethiopian people about HIV and AIDS. For further information contact:
- Timotewos Genebo (Coordinator Medan Acts Programs) genebogaga@yahoo.com
- Sr Tewabech Tesfayleng (Awassa Project Manager) medanact@ethionet.et
- MulugetaAbuye (Program Officer for Awassa,Dilla and Soddo Projects) medanact@ethionet.et

“The Red Ribbon Award provides a unique opportunity to support and publicize the most outstanding and least recognized actors in the effort to stop this global epidemic - the communities who are finding innovative and effective ways to address HIV and AIDS and secure livelihoods around the world. It aims to become an important vehicle for ensuring that voices from communities from developing countries are honoured and heard at International Conferences.” For more information in English, French & Spanish at: www.redribbonaward.org

6. Making it known

Lyn van Rooyden from CARIS, South Africa writes: I would like to introduce our organization, the Christian AIDS Bureau for Southern Africa and specifically the project I manage, the Christian AIDS Resource and Information Service (CARIS). CARIS tries to make the huge amount of information available on HIV accessible to Christians, Churches and Christian organizations involved in HIV. We encourage networking, and are busy with a mapping process of Christian programmes and projects. Visit our website www.cabsa.co.za and explore the HIV database.

7. Tip of the Month – Life lines

Lifelines show events in peoples' lives that they feel are particularly important. Some may be very positive events – such as meeting a loved one or starting a new job or sad such as the break up of a relationship or the death of a friend or family member.   Lifelines can be used with communities to look at how past experiences affect their vulnerability to HIV infection and what lessons can be learned for the future, and to identify community trends or differences across community members such as generational, gender or economic status.

1. Draw a horizontal line and mark it off in years, or decades, from their birth to the present. This may be done on paper, on the ground, or any other variation appropriate for your context!
2. Draw a vertical line down the left hand side so that it meets the horizontal line. Mark the top of it "happy" and the bottom of it "sad."
3. Think back over your life and mark the events at different ages that made you happy or sad. For example, if an event made you very "happy", draw a symbol to represent this event very high. Be creative.
4. Join these events of your life with a line to show the ups and downs
5. Encourage participants to share their lifelines, either in pairs or with the whole group. Discuss the things that affect people's levels of happiness and sadness, and how these might relate to vulnerability to HIV infection. Remember that lifelines focus on feelings so be sensitive to the needs of participants as this activity may bring back some painful memories.

For an example of a life line see *Project Cycle Management CBO Training Toolkit* (p70) developed by the International HIV/AIDS Alliance and CARE for capacity building work in Malawi, May 2006. www.coreinitiative.org/Resources/Publications/ProjectCycleManagementToolkit.pdf

Co-worker with you,

Diane Marshall, Consultant for HIV/AIDS
Email: international.aids-consultant@sim.org
Mail: Morling College, 120 Herring Rd, Eastwood NSW 2122. Australia
Tel: (61-2) 9870 8208

Championing HIV & AIDS ministries and helping partners respond more effectively to growing epidemics in Africa, Asia, and South America

AIDSLink is a publication of SIM International's AIDS Related Ministries and HOPE for AIDS. This edition is freely available through ICMDA and Right to Dignity and Health. The opinions and views expressed in AIDSLink do not necessarily reflect the views of these organizations. Technical information in AIDSLink is crosschecked as thoroughly as possible however we cannot accept responsibility should problems occur.