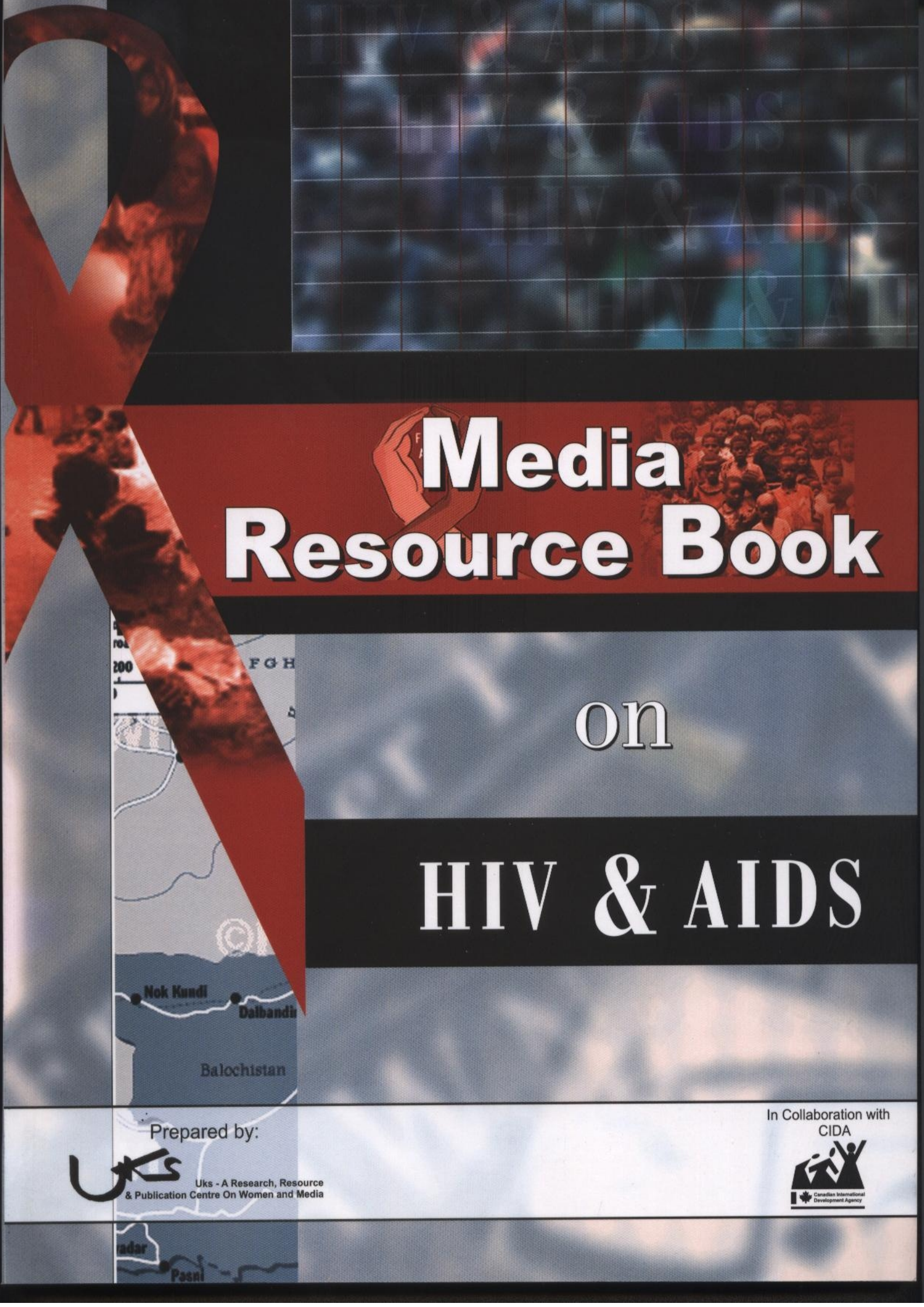

Prepared by:

Uks - A Research, Resource & Publication Centre On Women and Media

In Collaboration with CIDA

Canadian International Development Agency

Abbreviations & Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral
CEDAW	Convention on the Elimination of Discrimination against Women
CPEA	Child Protection and Empowerment of Adolescents Programme
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
ILO	International Labour Organization
IDUs	Injecting Drug Users
MCHC	Maternal and Child Health Care Programme
MSM	Male to Male Sexual Behaviour
MTPS	Mid Term Plans
NSP	National Strategic Plan
PEP	Post-Exposure Prophylaxis
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNIFEM	United Nations Development Fund for Women.
VAW	Violence against women
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Contents

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Tasneem Ahmar

Director Uks

Introduction

"Networking and Advocating for HIV and AIDS Awareness amongst Indigenous Media in Pakistan" is a three-year project undertaken by Uks, a research, resource and publication center for women and media. It is supported by the Canadian International Development Agency (CIDA). This book is an integral part of the project and a resource for media and communication professionals. It is an attempt to impart a full understanding of the epidemic through updated and accurate information and to sensitize media and communication professionals on the cultural context of the disease. This handbook can also be useful for a range of people working on HIV and AIDS.

According to UNAIDS, Pakistan's estimated number of HIV and AIDS cases is 70,000 to 80,000 persons. This may however not be reflective of the actual number of cases in Pakistan due to underreporting, social stigma associated with the disease, lack of awareness and testing. Although the rate of 0.1% of the adult population in Pakistan is relatively low, the threat is significant because of the prevalence of risk factors. Thus this is an opportune time for the media to play its role in containing the spread of HIV and AIDS and mitigating its impact.

HIV and AIDS is not only a medical issue; it is a complex social and cultural phenomenon. It reflects the limit and politics of how and how not to disseminate information on this complex issue. In many countries, including Pakistan, lack of awareness and misreporting are the contributing factors in its spread. Being a complex and multifaceted issue, it warrants a response that is multi-sectoral with the involvement of all stakeholders; media, government, civil society, HIV infected individuals, health practitioners, international agencies and development partners to address the potential threat of a full-blown epidemic with all its economic and social implications.

Media can either hinder or help attempts towards this. Its role is two-fold, firstly to create awareness among the masses regarding high-risk behaviour, vulnerabilities and transmission sources of the disease and secondly to redress the misinformation and strengthening of stereotypes that are propagated by it. Although, the past decade has seen some shift in these stereotypes, but misperceptions, information gaps and ignorance of the disease still exist among media professionals.

A sustained effort on the part of the media is thus imperative. Media interest in HIV and AIDS remains sporadic. The issue is covered only on special occasions such as the World AIDS Day, some regional or country specific event or while reporting a new case. Media must therefore have a sustained and informed debate on the subject and regularly report on the problems encountered by HIV infected individuals.

While addressing the issue, media professionals must be cognizant of the fact that Pakistani women are at a greater risk of infection especially in certain vulnerable groups such as commercial sex workers, spouses of returning migrant workers (four million workers travel overseas for work annually), truck drivers and intravenous drug users (half a million heroin users who share needles and visit sex workers). At the root of this lies women's unequal social and economic status and the gender disparities and sexual stereotypes that are culturally reinforced. Women typically have limited access to reproductive health services and are often ignorant about HIV, its spread, prevention and treatment. Any discourse on HIV and

AIDS must therefore be gender sensitive catering to the specific needs of women and acknowledging its cultural context. This is vital since women identify media campaigns as the single source of information on HIV and AIDS.

A few words about the content of this document are in order. A huge amount of literature is available on this topic but due to the nature and complexity of the disease, it is difficult to remain current since the epidemic is constantly evolving. The first part of the book deals with the history of the virus, its prevention and treatment. The second section deals with the current global and national situation as well as the socio-cultural factors affecting the disease.

We hope that this handbook will be a useful reference for those reporting on HIV and AIDS and will not only foster a more adequate response to the disease but motivate media personnel to report on the subject frequently and accurately.

I

FACTS ABOUT HIV AND AIDS

What does HIV mean?

HIV stands for Human Immunodeficiency Virus. HIV is the virus that can cause AIDS.

What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is not a single disease. It is a condition of the human body in which the immune system of the patient is seriously damaged because of the persistent attack of the HIV virus.

How does HIV become AIDS?

HIV is the virus that can cause AIDS. A person infected with HIV does not necessarily have AIDS but all people with AIDS have HIV. HIV causes AIDS by directly killing or interfering with the normal function of CD4+T cells which are an integral part of the body's immune system. These cells are commonly called white blood cells and are responsible for the body's immune response. The virus multiplies within these cells and destroys them in the process. A person who is HIV positive may look or feel well for a period of time which may extend between 5-15 years. During this time the virus multiplies and overtakes the body's immune system making it vulnerable to other infections and diseases.

HIV infection typically follows the following course:

▪Initial infection, usually going unrecognized or marked by mild flu-like symptoms:

At this early stage the body tries to fight the AIDS virus but eventually the virus multiplies and overpowers the body's immune system. Often this decline is evident in laboratory tests (e.g. CD4 cell counts, HIV viral load) even though the individual may appear well.

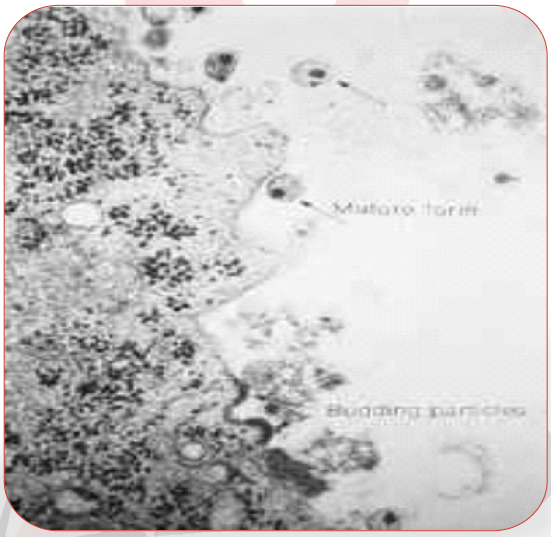
▪With moderate immune deficiency:

The body becomes more prone to illnesses. These can usually be simply diagnosed and treated through which the immune status improves and the person returns to reasonable health again.

▪Severe immune deficiency;

This results in the development of opportunistic infections and some cancers and represents the major cause of death in AIDS patients. These can often be treated if detected at an early stage but the outcome depends on the health of the immune system.

A vast majority of people who get the HIV virus eventually die of AIDS. There is no known cure of AIDS. However, in the industrialized world, the affordability of certain drugs to inhibit the virus have made the disease manageable and like a chronic condition.



Opportunist Infections

People with AIDS die from sickness, termed as "opportunist infections" because they take advantage of the weakened immune system. Many of these infections can be cured through drugs, but most drugs are expensive and protected through patent laws. This makes managing these opportunist infections difficult for the AIDS patient. These diseases can also happen to people who are HIV negative, but they are far more common and dangerous for an HIV positive person. If these people do not receive timely and appropriate treatment their condition worsens and they are likely to die.

Common opportunist infections include:

Tuberculosis (TB) - This is the most common life threatening opportunist infection in people with HIV in Africa.

Candidiasis (thrush)- a fungal infection that affects the mucus membranes around

. AIDS is not a single disease. It is a condition of the human body in which the immune system of the patient is seriously damaged because of the persistent attack of the HIV virus.

the mouth, vagina, oesophagus and skin

Gastrointestinal infections that cause chronic diarrhea

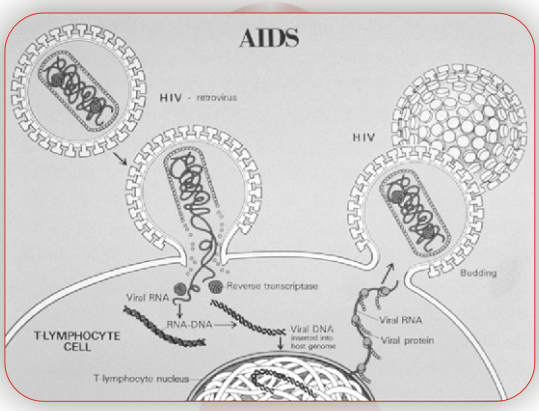
Cryptococcal Meningitis- a fungal infection of the membrane that surrounds the brain.

Pneumocystis Carinii Pneumonia (PCP) - a lung infection characterized by

HIV causes AIDS by directly killing or interfering with the normal function of CD4+T cells which are an integral part of the body's immune system.

coughing, high fever and difficulty in Breathing.

Cytomegalovirus (CMV)- a viral infection that affects the eyes, oesophagus and intestine.



Herpes and Shingles- viral infections

Cancers such as Kaposi's sarcoma may also develop. Other cancers such as cervical cancer in women and rectal cancer in men may develop in immune-suppressed people. Also, a number of diseases such as Kaposi's sarcoma are virtually unknown in people with adequate immune systems.

Source: A Resource for Journalists: Soul City Institute for Health and Development Communication

Origin and History of HIV and AIDS

The origin of the disease has been much debated since it was first discovered in 1981. However, it is generally accepted that HIV is a descendent of Simian (monkey) Immunodeficiency Virus (SIV) which transmitted from animals to humans through a process called zoonosis. Research indicates that this particular virus may have crossed over from chimpanzee to human when the animal was killed and eaten. Other theories suggest that it was transferred iatrogenically i.e. via medical experiments. Another popular theory is that polio vaccine called Chat may have played a role in the transfer. The Chat vaccine may have been grown in chimp kidney cells in the Congo, the Wistar Institute and Belgium. This could have resulted in the contamination of the vaccine with chimp SIV. This vaccine was administered to about 1 million people in the Belgian Congo, Ruanda and Burundi in the late 1950s. However, in February 2000, this theory was refuted. In January 2000, the results of a new study presented at the seventh Conference on Retroviruses and Opportunist Infections, suggested that the first case of HIV infection occurred in 1930 (with a 20 year margin for error in West Africa. This estimate is based on a complicated computer model of HIV's evolution.

First case of HIV infection occurred in 1930 (with a 20 year margin for error in West Africa. This estimate is based on a complicated computer model of HIV's evolution.

During the 1970s and 1980s, homo bisexual men in New York City, Los Angeles and San Francisco reported an increased incidence of white infections of the mouth as well as diffused enlarged lymph glands, the cause of which was non-specific. Subsequently, in 1980-81 a rare form of cancer; Kaposi's Sarcoma and a form of pneumonia was detected in bisexual men from these areas. This rare form of disease was characteristic of cancer and transplant patients and severely malnourished children. The Centres for Disease Control published a study based on these new trends and shortly afterwards, the term AIDS was coined. Within two to three years, the HIV virus was identified.

HIV was first isolated in Paris in 1983 by Dr. Luc Montagnier. Antibodies to HIV were first detected in blood samples in 1959. In 1981, the US Centers for Disease Control published the first scientific paper on the epidemic in a rare cancer, Kaposi's sarcoma detected in a small number of homosexuals. The virus was initially named Human T Cell Lymphotopic Virus Type 3 (HTLV 3). Subsequently it came to be known as the HIV virus and this has been its worldwide usage since then.

After HIV was discovered, an antibody test was developed, initially to screen the blood supply. This test was conducted on a number of people in the high-risk category (bisexual men, female sex workers, drug users, etc) and results showed that a large number of these healthy-appearing individuals were infected with the HIV virus. Test results further indicated that these asymptomatic individuals had the virus in their blood and sexual fluids and hence were sexually contagious. To understand the entire scope of the disease, we must appreciate that people infected with AIDS only represents a small dimension of the problem, beneath this there is the category of people with AIDS-related conditions such as oral thrush, lymphodenopathy etc. and then there is a large segment of people who are asymptomatic infected individuals.

Source: Positive Times, Issue 3 , March 2005

Advent of the Disease in Pakistan

The first officially reported case of AIDS in Pakistan was reported in December 1986. The patient was an African sailor who died of high fever within a week of the diagnosis. Another case of AIDS was that of a woman who was infected by the virus in 1982 through blood transfusion during delivery in Dubai. The blood had been imported from USA. The virus was detected in 1986 during her second pregnancy.

In the initial phases, a majority of AIDS cases were identified in Karachi, mostly among foreign nationals. Generally this was perceived as a disease of foreigners only. This view was challenged in 1988 when a Pakistani family of three; husband, wife and child were diagnosed as HIV positive and two other Pakistani's who received blood transfusions from paid donors.

In the 90's many Pakistani men living abroad became infected through their high-risk behaviour. Lack of awareness regarding modes of transmission was a contributory factor. These men in turn infected their wives and in some cases the children also got infected as a consequence. The first reported case of transmission of HIV through breast feeding was reported in 1993.

How is it transmitted?

HIV virus has a very limited ability to live outside the human body compared to other diseases therefore its transmission is not very easy. Although communicable, it is not contagious like air-borne diseases and cannot be transmitted through coughing, sneezing, shaking hands, hugging or sharing utensils or even through food or insect vectors/mosquitoes.

Following are the main modes of transmission:

Sexual Interaction

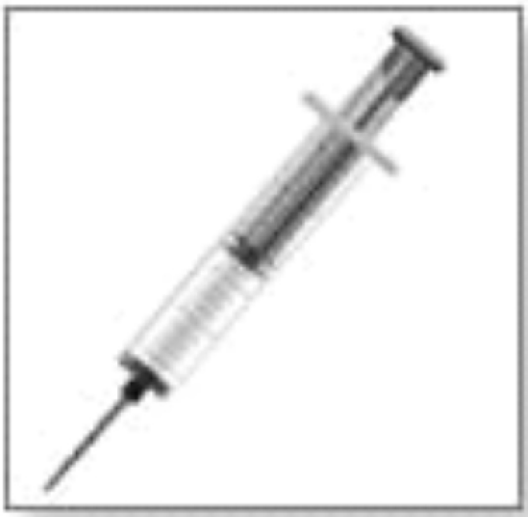
Between male and female or male to male (MSM, an umbrella term used for men engaging in male to male sexual behaviour, regardless of the sexual identity they adopt) where one partner is infected and sexual activity is unprotected and penetrative. During intercourse the virus can be transmitted through mucosal linings of the vagina, vulva, penis or rectum. It can only be transmitted through saliva only if there are open sores or cuts in the mouth since the saliva contains chemicals that kill the HIV virus. If the vaginal fluids, semen etc do not come in direct contact with the internal membranes of the partner through the use of condoms, for example, the risk is greatly minimized.

The presence of untreated Sexually Transmitted Diseases (STDs) increases the vulnerability of women since through STDs the immune cells present at the site of infection facilitate the entry of the HIV virus into the body. Generally STDs in women are symptom less thus putting them at greater risk of infection.

Blood Borne Transmission

Intravenous Drugs

Intravenous drug users who share infected needles and syringes (since there is always some blood left in the syringe after usage)



and the simultaneous consumption of drugs and alcohol are also causes of infection.

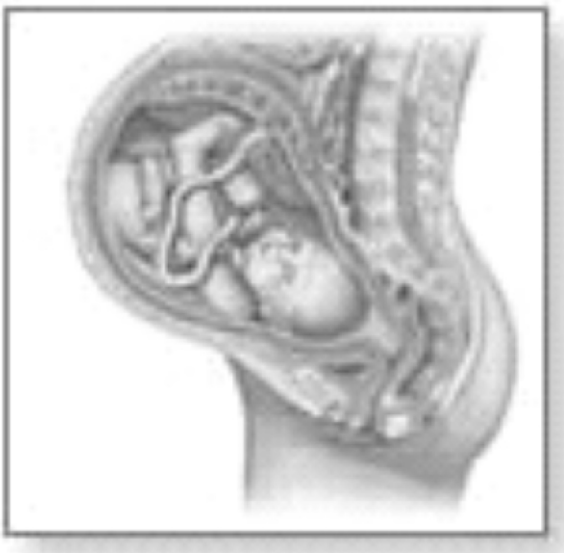
Transfusion of Contaminated Blood

HIV can also be transmitted through infected blood transfusion. It can also occur through:

- sharing of surgical and other instruments used for circumcision, tattooing or skin piercing
- during sexual intercourse when the reproductive organs of one partner are bleeding
- or in rare cases the health professional who acquires the virus by being pricked by a contaminated needle known as needle stick injury

From Mother to Child

There are two main routes of transmission between the mother and child. First is the called the "perinatal" infection where an infected mother transmits the virus either to the fetus during pregnancy, or delivery. The other mode of transmission is through breast feeding. This practice is often maintained since alternatives to breast milk are either unhygienic or unaffordable.



Addressing the Myths

The Myths associated with HIV and AIDS presents a major impediment in dealing with the epidemic. Other than the social stigma associated with it (this will be discussed later) people in general are seriously misinformed about the disease. Certain stereo-types are perpetuated by the media which make AIDS a disease exclusively for foreigners or homosexuals. The truth is that any individual can potentially get the disease. The facts are that HIV is not transmitted:

- Via airborne, droplet or food or insect vectors/mosquitoes
- Through close non-sexual physical contact (such as hugging, touching etc.)with an infected person
- By swimming in the same pool as an infected person
- Via sweat, saliva or tears, the only bodily fluids which can transmit are sexual fluids, blood or breast milk
- Through the protective barrier of skin if it is not cut, it protects the body against infection from blood or sexual fluids
- Through the secretions commonly found in public toilets-urine and feces

It is important to note that the HIV virus dies within seconds once it is outside the body. For transmission, infected blood or semen has to be in contact with the non-infected person within seconds

Factors that Increase Vulnerability to AIDS

Who should be tested for AIDS?

Those who have:

- sexual relations with more than one or multiple sex partners
- bisexual contact (heterosexual man to woman, heterosexual woman to man, lesbian contact and gay/bisexual man to man)
- been exposed to violent sexual intercourse
- practice/d prostitution
- received blood transfusion
- received blood transfusion in a foreign country prior to 1985
- drug addiction
- shared a used syringe with a drug addict
- suffered any sexually transmitted disease
- HIV infected mothers

Pakistan's Risk and Vulnerability to HIV and AIDS

Certain stereo-types are perpetuated by the media which make AIDS a disease exclusively for foreigners or homosexuals. The truth is that any individual can potentially get the disease.

There are serious risk factors that put Pakistan in danger of facing a widespread epidemic if immediate and vigorous action is not taken:

•*Injecting Drug Users (IDUs):* The number of drug dependents in Pakistan is currently estimated to be about 500,000, of whom an estimated 60,000 inject drugs. An outbreak of HIV was discovered among injecting drug users in Larkana, Sindh, where out of 170 people tested, more than 20 were found HIV positive. This represents the first documented epidemic of HIV in a well defined vulnerable population in Pakistan. It serves as a confirmation of the threat that HIV poses to Pakistan and validates the basic premise of the country's recent enhanced HIV AND AIDS programme While Pakistan is a low prevalence country, it has many risk factors that can lead to a rapid development of an epidemic.

•*Commercial Sex:* commercial sex is prevalent among the major cities and truck routes. Commercial Sex Workers (CSWs) and their clients report very low condom use and have insufficient access to information about HIV and STDs. Behavioural and mapping studies in three large cities found a CSW population of 100,000 with limited understanding of safe sexual practices. Furthermore, sex workers often lack the power to negotiate safe sex or seek Treatment for STDs

Inadequate Blood Transfusion Screening and High Level of Professional Donors: It is estimated that 40% of the 1.5 million annual blood transfusions in Pakistan are not screened for HIV. In 1998, the AIDS Surveillance Center in Karachi conducted a study of professional blood donors-people who are typically very poor, often drug users, who give blood for money. The study found that 20% were infected with Hepatitis C, 10% with Hepatitis B, and 1% with HIV. About 20% of the blood transfused comes from professional donors.

Restrictions on women's and girl's mobility limits access to information and preventive and support services. Young people are vulnerable to influence by peers, unemployment frustrations, and the availability of drugs.

•*Migration and Refugees:* Large number of workers leave their villages to seek work in larger cities, in armed forces or on industrial sites. A significant number (around 4 million) are employed overseas. Away from their homes for extended periods of time, they become vulnerable to high-risk behaviours, such as having unprotected sex.

•*Unsafe Medical Injection Practices:* Pakistan has a high rate of medical injections; around 4.5 per capita per year.

Large number of workers leave their villages to seek work in larger cities, in armed forces or on industrial sites. A significant number (around 4 million) are employed overseas.

Studies indicate that 94% of injections are administered with used injection equipment. Use of un-sterilized needles at medical facilities is also widespread. According to WHO estimates , unsafe injections around 62% of Hepatitis B, 84% of Hepatitis C, and 3% of new HIV cases.

•*Low Levels of Literacy and Education:* Efforts to increase awareness about HIV among the general population are hampered by low literacy rates and cultural influences. In 2001, the illiteracy rate of Pakistani women over 15 years old was 71%

•*Vulnerability Due to Social and Economic*: Restrictions on women's and girl's mobility limits access to information and preventive and support services. Young people are vulnerable to influence by peers, unemployment frustrations, and the availability of drugs. In addition some groups of young men are especially vulnerable due to the sexual services they provide, notably in the transport sector. Both men and women from impoverished households may be forced into the sex industry for income.

Source: World Bank Issue Brief-HIV AND AIDS Prevention Project for Pakistan: http://www.worldbank.org/pk

Treatment

HIV treatment usually takes one of the following approaches:

- Drugs that target HIV itself called antivirals
- Drugs to treat manage and prevent the onset of opportunistic infections-these may include antibiotics, antifungal or chemotherapy
- Treatments that aim to repair or restore any damage to the immune system called immune-based therapies

In the last few years, HIV antiviral treatments have become much more sophisticated. There is now a range of drugs treating HIV i.e. ARVs. The first and most famous of this drug was called AZT. In 1996, the World's Aid Conference in Vancouver made headlines because of the discovery of a new kind of antiviral drug called Protease Inhibitor. This inhibits the development of the protease enzyme, which the virus needs in order to replicate.

There are now three classes of antiviral drugs used to treat infections:

- Nucleoside analogues
- Non-nucleoside reverse transcriptase inhibitors
- Protease inhibitors

Each of these drugs works in a different way to inhibit the replication of the HIV virus in the body. The accepted standard is to use a combination of these drugs and this is known as Highly Active Antiretroviral Therapy (HAART).

Vaccines

Vaccines are substances that teach the body to recognize and defend itself against bacteria and viruses that cause disease. . It thus creates an immune response to the invading virus and is a form of prevention and not cure. HIV positive individuals will only be able to reduce the progression of HIV through treatment. Developing a vaccine must be part of an overall integrated strategy that includes prevention, treatment care and support.

Microbicides

The word "microbicides" refers to a range of different products that share one common characteristic: the ability to prevent the sexual transmission of HIV and other sexually transmitted infections (STIs) when applied topically. A microbicide could be produced in many forms, including gels, creams, suppositories, films, or as a sponge or ring that releases the active ingredient over time.

Scientists are currently testing many substances to see whether they help protect against HIV and/or other STIs, but no safe and effective microbicide is currently available to the public. However, scientists are seriously pursuing more than 30 product leads, including 10 that have proven safe and effective in animals and are now being tested in people. If one of these leads proves successful and investment is sufficient, a microbicide could be available by the end of the decade in a handful of settings in high prevalence countries.

Microbicides would fill an important gap in our ability to prevent HIV and STIs as today's prevention options --condoms, mutual monogamy, and STI treatment-- are not feasible for millions of people around the world, especially women. Many women do not have the social or economic power necessary to insist on condom use and fidelity or to abandon partnerships that put them at risk. Because microbicides would not require a partner's cooperation, they would put the power to protect into women's hands. Additionally, some of the microbicides being investigated prevent pregnancy and some do not. It is important to have both non-contraceptive microbicides as well as "dual-action" microbicides that prevent pregnancy and infection, so that women and couples can protect their health and still have children.

Source: The HIV AND AIDS Media Guide, Second Edition: 2000 Australian Federation of AIDS Organization INC. (AFAO), ANCHARD

Source: global campaign for Microbicides; www.global.campaign.org

Difficulty in Developing a Vaccine

It is extremely important to recognize that thus far HIV has not been cured or eradicated by any available drug. Those who use these drugs remain HIV positive.

The reason is that HIV is not an easy candidate for vaccine development. The HI virus incorporates its own genetic material into the immune system, which is the very system designed to fight off viruses. It is therefore difficult to eliminate or neutralize the virus without destroying the immune system itself.

HIV also mutates very fast and is prone to genetic changes as it replicates. AVTs are designed to attack the virus at specific stages. Sometimes, during the process of replication, a change occurs in the genetic make-up of the virus and this results in affecting the specific stage of the virus and thus the drugs become ineffective If this happens the virus continues to make more copies of itself thus beyond the control of these drugs. This may eventually lead to the multiplication of the drug resistant virus and the immune system may be rapidly affected despite the administration of drugs, just as untreated HIV virus will do. It is not uncommon for HIV positive people to have a virus which is resistant to the available drugs thus limiting treatment options.

It has subtypes that vary between geographical areas, from person to person or even with the same person over a period of time. One vaccine may not work against all the sub-types. Currently, there are ten different Clades (subtypes) of the main subgroup HIV 1.Even when a vaccine is developed and tested to be safe and effective, it may take from five to seven years to be available to the general public.

Generally speaking most research on vaccines targets Clade B which is commonly found in developing countries. Funding for research on Clade C, most common in developing countries has been limited.

An HIV positive person has an inherent right to proper health care to combat and postpone the advent of the disease. He must have access to a full range of care, treatment, support and prevention.

An HIV positive person can get different kinds of treatments both for:

The illness caused by HIV

- An HIV positive person must have an extremely healthy lifestyle with adequate access to clean water and a balanced diet rich in vitamins and protein.

- The HIV positive person must also have appropriate medical treatment for opportunist infections commonly associated with the disease such as TB, skin or chest infections etc. Prompt medical response to these infections can increase the life span of the infected person and help him/her stay healthier longer.
- Some medicines for opportunist infections are readily available and easy to use. They are often provided through home-based care, clinics or local hospitals.

Fighting the Virus

- HIV infections are commonly treated with ARVs. They are instrumental in reducing the effects of the virus and extend the lives of HIV positive people but they are do not completely cure the HIV infection.

Source: A Resource for Journalists: Soul City Institute for Health and Development Communication

Post-Exposure Prophylaxis (PEP)

This is an emergency medical response that can be used to protect individuals initiated within 2-24 hours. PEP is a combination of medication, lab tests and counseling and has to be administered in no less than 48-72 hours of possible exposure to HIV. Treatment must continue for 4 weeks.

The efficacy of PEP is probably higher if treatment is started within the first few hours of exposure and is probably progressively reduced if started earlier. After 48-72 hours, the benefits are probably minimal or non-existent and the risk of intolerance and side effects associated with AVTs will outweigh any potential benefits.

Any workplace that presents chances of occupational accidental exposure to HIV must keep a PEP starter kit. This contains:

- The medication required for the first 5 days of PEP
- A pregnancy test kit and emergency oral contraception (morning-after pill)

After 48-72 hours, the benefits are probably minimal or non-existent and the risk of intolerance and side effects associated with AVTs will outweigh any potential benefits.

- Guidelines for the attending physician and patient
- A required consent form

In some countries such as India, all Government hospitals are mandated to provide free PEP to their medical staff, in case of accidental exposure.

Source: Positive Times, IPPF, SARO; Issue 6: June 2005

II

Overview of the Current Situation

Global Statistical Summary of the AIDS Epidemic

Number of people living with HIV in 2006

Total	**39.5 million (34.1-47.1 million)**
Adults	37.2 million (32.1-44.5 million)
Women	17.7 million (15.1-20.9 million)
Children under 15 years	2.3 million (1.7-3.5 million)

People newly infected with HIV in 2006

Total	**4.3 million (3.6 -6.6 million)**
Adults	3.8 million (3.2-5.7 million)
Children under 15 years	530,000 (410 000-660 000)

AIDS Deaths in 2006

Total	**2.9 million (2.5-3.5 million)**
Adults	2.6 million (2.2-3.0 million)
Children under 15 years	380,000 (290 000-500 000)
Children under 15 years orphaned (by the death of single/both parents to AIDS)	4.5 million (2004)

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information

Source: AIDS epidemic update, 2006; UNAIDS

Adults and Children Estimated to be Living with HIV in 2006

Americas

North America	1.4 million (880 000-2.2 million)
Caribbean	250 000 (190 000-320 000)
Latin America	1.7 million (1.3-2.5 million)

Europe and Central Asia

Western and Central Europe	740 000 (580 000-970 000)
Eastern Europe and Central Asia	1.7 million (1.2-2.6 million)

Asia

East Asia	750 000 (460 000-1.2 million)
South and South East Asia	7.8 million (5.2-12.0 million)

Africa and the Middle East

North Africa and the Middle East	460 000 (270 000-760 000)
Sub-Saharan Africa	24.7 million (21.8-27.7 million)

Oceana

Oceana	81 000 (50 000-170 000)

Total **39.5 (34.1-47.1 million)**

Source: AIDS epidemic update, December 2006; UNAIDS, WHO

Estimated Number of Adults and Children Newly Infected with HIV during 2006

Americas	
North America	43 000 (34 000-65 000)
Caribbean	27 000 (20 000-41 000)
Latin America	140 000 (100 000-410 000)
Europe and Central Asia	
Western and Central Europe	22 000 (18 000-33 000)
Eastern Europe and Central Asia	270 000 (170 000-820 000)
Asia	
East Asia	100 000 (56 000-300 000)
South and South East Asia	860 000 (550 000-2.3 million)
Africa and the Middle East	
North Africa and the Middle East	68 000 (41 000-220 000)
Sub-Saharan Africa	2.8 million (2.4-3.2 million)
Oceana	
Oceana	7 100 (3400-54 000)
Total	**4.3 (3.6-6.6 million)**

Source: AIDS epidemic update, December 2006; UNAIDS, WHO

Estimated Adults and Children Deaths from AIDS during 2006

Americas	
North America	18 000 (11 000-26 000)
Caribbean	19 000 (14 000-25 000)
Latin America	65 000 (51 000-84 000)
Europe and Central Asia	
Western and Central Europe	12 000 (15 000)
Eastern Europe and Central Asia	84 000 (58 000-120 000)
Asia	
East Asia	43 000 (26 000-64 000)
South and South East Asia	520 000 (320 000-850 000)
Africa and the Middle East	
North Africa and the Middle East	36 000 (20 000-60 000)
Sub-Saharan Africa	2.1 million (1.8-2.4 million)
Oceana	
Oceana	4000 (1800-2400)
Total	**2.9 (2.5-3.5 million)**

Source: AIDS epidemic update, December 2006; UNAIDS, WHO

National Statistical Summary of the AIDS Epidemic

People infected with HIV	
Total	**85 000**
Adults	84 000 (15-49 years)
Women	14 000 (15-49 years)

HIV prevalence rate among the adult population	0.1%
Male to female ratio of HIV infected cases	7 to 1
Number of reported cases	3073 (Sep, 2005)
Number of deaths	3000

Mode of transmission as per reported cases	
Heterosexual transmission	63%
Exposure to infected blood or blood products	7%
Male to male sex	5%
Mother to child transmission	3%
Injecting drug users	1%
Unknown mode of transmission	21%

Areas	HIV Positive	AIDS Cases	Total
Federal Centres	360	38	398
Punjab	412	52	464
Sindh	561	84	645
NWFP	366	54	420
Balochistan	180	12	192
AJK	18	04	22
Total	1897	244	2141

Countrywide distribution of Reported HIV and AIDS Cases1 (as at 30 September 2003)

There is ample evidence that HIV does yield to determined and concerted interventions. But that did not take away the fact that in 2005, HIV reached its highest level. The AIDS epidemic continues to outstrip global and national efforts to contain it.

December 2005 update by UNAIDS

[1] Source : National AIDS Control Programme

The National Response to HIV and AIDS

Government
▪ National AIDS Control Program ▪ Ministry of Health ▪ Ministry of Labour and Manpower
United Nations
▪ United Nations UNAIDS ▪ United Nations Educational Scientific and Cultural Organization-UNESCO ▪ United Nations Development Program-UNDP ▪ United Nations Population Fund-UNFPA ▪ International Labour Organization-ILO ▪ United Nations High Commissioner for Refugees-UNHCR ▪ United Nations Children's Fund-UNICEF ▪ United Nations Office on Drugs and Crime-UNDOC ▪ World Food Program-WFP ▪ World Health Organization-WHO
Multilaterals
▪ World Bank
International NGOs
▪ Catholic Relief Services (CRS) ▪ Future Group ▪ International Rescue Committee (IRC) ▪ Save the Children US ▪ Save the Children UK ▪ Mercy Corps International ▪ Orphan Refugees Aid International ▪ Population Services International ▪ Interact Worldwide ▪ Voluntary Services Overseas
National NGOs
▪ UKS-A Research & Resource Publication Center On Women And Media ▪ Amal Human Development Network ▪ Society for the Protection of the Rights of the Child (SPARC) ▪ Society for the Advancement of Community, Health, Education and Training (SACHET) ▪ New Light Aids Control Programme ▪ The Pakistan National AIDS Consortium (PNAC) ▪ The AIDS Prevention Association of Pakistan (APAP)

The National AIDS Control Programme:

The Federal Committee on AIDS was established by the Ministry of Health, Government of Pakistan soon after the first case of HIV and AIDS was detected in Pakistan in 1987. Subsequently, The National AIDS Control Programme (NACP) was formed in 1988. This was housed in the Pakistan National Institute of Health. Initially this plan was for a period of three years but by 1994 NACP was strengthened and expanded through the approval of additional funds. However, NACP faced certain budgetary constraints since only 15% of the actual budgetary requirement was fulfilled and in subsequent years also the allocation of funds has not matched the requirement due to the country's economic situation. Despite these limitations, it has emerged as a leading institution in the fight against the epidemic.

NACP has played an important role in creating awareness, through a variety of activities. These include, publication of educational materials, electronic media campaigns, sensitization of health workers, conducting workshops and education meetings.

The Programme is being implemented in all four provinces, AJK, FATA and Northern Areas over the period 2003-2008 through the executing agencies NACP and its provincial partners.

Provincial Implementation Units

In 1995, NACP established Provincial Implementation Units (PIUs) in four provinces and two federally administered areas for improved coordination of its activities at the Federal and Provincial level. This has been enhanced by a network of surveillance centers throughout the country.

Enhanced Program on HIV and AIDS

Following the United Nation's General Assembly Special Session(UNGASS) on HIV AND AIDS in June 2001, the government launched the Enhanced Programme on HIV and AIDS with the support of donor agencies and the World Bank. The stated aim of the programme is to "prevent HIV from becoming established in vulnerable populations and spreading to the general adult population, while avoiding stigmatization of vulnerable populations." The Programme is being implemented in all four provinces, AJK, FATA and Northern Areas over the period 2003-2008 through the executing agencies NACP and its provincial partners.

The four components of the Programme are:

- Expansion of interventions of vulnerable populations
- Improved HIV prevention by the general public
- Prevention of transmission through blood transfusion and blood products
- Capacity building and programme management

Government Programme

The programme has a resource pool of 2.9 billion, funded by the World Bank, CIDA and DFID. The programme aims at preventing HIV&AIDS in vulnerable groups of the population and at avoiding its spread to the wider population by avoiding stigmatisation.

The Strategic Framework can be found at www.nacp.com.pk

Surveillance Centers

In 2000 there were at least 46 Surveillance Centers working throughout the country. Most of these centers are not fully operational due to shortage of diagnostic kits for HIV and other STIs. They largely work as blood screening centers for the cases that are referred to them rather than surveillance and reporting centres.

The main thrust of the AIDS Control Strategy in Pakistan is prevention. Following are its salient features:

- Enhanced resource allocation, with the Government sponsoring 80% of the total budget for AIDS control;
- Decentralization of the Programme through the formation of PIUs;
- Development of a comprehensive awareness strategy through campaigns in the electronic and print media.
- Coordination with relevant NGOs through the NGO consortia on HIV and AIDS at the provincial headquarters;
- Strengthening of surveillance system, through logistical support of free HIV antibody testing in the public sector and the establishment of a second generation surveillance system;
- Promoting safe blood transfusions since 1995 through free HIV and Hepatitis screening;
- Formulation of guidelines and protocols and human resource development for counseling, care, surveillance and blood safety by NACP
- Promotion of research through national studies and surveys and an external evaluation of the national programme for strategic guidance on policy;
- Formation of a Strategic Framework for the next five years in collaboration with UNAIDS and its cosponsors. The nine priority areas of this programme include: expanded response, vulnerable and high risk groups, youth surveillance and research, care and support, general awareness, blood and blood product safety, STIs and infection control;

NACP has played an important role in creating awareness, through a variety of activities. These include, publication of educational materials, electronic media campaigns, sensitization of health workers, conducting workshops and education meetings.

United Nations Joint Programme on HIV and AIDS

According to the "UN Implementation Support Plan on HIV and AIDS (2004):

The Joint United Nations Programme on HIV and AIDS, UNAIDS, is the main advocate for the global action on the epidemic.

The co-sponsors of the Joint United Nations Programme are, UNICEF, UNDP, UNFPA, UNESCO, WHO, World Bank, UNODC, WFP, ILO and UNHCR. Each agency may or may not have its own HIV AND AIDS programmes independent of the Joint Programme.

It leads, strengthens and supports an expanded response aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV and AIDS, and alleviating the impact of the epidemic.

How UNAIDS supports a more effective global response to AIDS:

- Leadership and advocacy for the effective action on the epidemic.
- Strategic information to guide efforts against AIDS worldwide
- Tracking, monitoring and evaluation of the epidemic and of responses to it.

The MCH Programme aims to strengthen the involvement of religious leaders, conduct a situation assessment of adolescent in 14 districts for life skills and HIV prevention, and support on World AIDS day on 1st December.

- Civil society engagement and partnership development.

UNDP

UNDP has supported the national response to HIV and AIDS financially. Also, through its own programmes on gender and poverty, it addresses the important determinants of the vulnerability towards HIV infection. At the district level, UNDP has worked towards enhancing the efforts to combat the virus by:

- promoting safer practices among commercial sex workers (CSWs)
- networking and information sharing among NGOs
- strengthening counseling centers for HIV patients and their families
- facilitating research and training of national professionals in relevant Asian countries

UNICEF

UNICEF is addressing HIV and AIDS as part of the Child Protection and Empowerment of Adolescents Programme (CPEA) and also part of the Maternal and Child Health Care Programme (MCHC), under the new 2004-2008 Country Programme. The Program activities include:

- life skills package for out-of-school youth
- advocacy for religious leaders and mass media
- assessment of existing Voluntary Counseling and Testing (VCT) centers
- collaborating with NACP on adolescents and HIV AND AIDS

The MCH Programme aims to strengthen the involvement of religious leaders, conduct a situation assessment of adolescent in 14 districts for life skills and HIV prevention, and support on World AIDS day on 1st December.

ILO

ILO's Programme creates awareness about HIV and AIDS among workers through the implementation of a preventive HIV and AIDS education Programme for Workers (including factory workers, truck drivers and migrant labour). ILO's HIV and AIDS Project for Worker's Education was completed in early 2004. At present ILO creates awareness through its ongoing programmes and training activities.

UNESCO

UNESCO has been supporting HIV and AIDS control interventions with a trickle down country-wide effect. The programme aims to promote and sensitize policy planners and curriculum developers to the need to including HIV and AIDS prevention education in the school system. Main ongoing activities are:

- Development and production of advocacy/Information Education Communication (IEC) material for policy makers on the need of integrating HIV and AIDS in to the education system.
- Publication of a guide book for teachers on adolescent education
- Seminars for policy makers, text book writers, curriculum developers and teachers

UNFPA

UNFPA is the executing agency for the 2002-2004 UNAIDS funds. A project was developed to test an HIV and AIDS service package among the female sex workers of the Hyderabad red light area. UNFPA also indirectly works on HIV prevention through its contraceptive procurement programme. In addition, UNFPA funds a regional project, the ARSH-Web,which is implemented by UNESCO Bangkok. The ARSH-Web, "Advocacy and Educational Support to Adolescent Reproductive Health (ARH)", supports regional collaboration among a network of national and international NGOs, academic and research institutions, government agencies, community-based religious and cultural groups, and individuals working to address the reproductive and sexual health needs of adolescents and young people in Asia and the Pacific region. This includes supporting the promotion, planning, implementation and follow-up of adolescent reproductive and sexual health programmes and policies, which include a significant focus on HIV&AIDS.

UNHCR

UNHCR is involved in HIV and AIDS control in all officially recognized refugee camps in Pakistan through 110 health units. HIV and AIDS prevention is integrated in to primary health care activity, and all health unit staff are trained to raise awareness among the communities of refugees. In addition all UNHCR health-implementing partners in Pakistan are involved in HIV and AIDS at all levels. The activities of each include awareness raising for health staff and community; training of health staff; treatment of STIs; and the development of IEC material.

UNDOC

UNDOC assists control interventions with a project on drugs and HIV and AIDS prevention among youth (13-19 years). Activities under the project include:

- Sensitizing policy and decision makers, UN organizations and the donor community on drug demand reduction; community centered drug abuse prevention interventions for young people
- Develop and implement eight selected target districts
- Organization of an annual national campaign to commemorate June 26th, International Day against Drug Abuse and Illicit Trafficking.
- Involvement in the "Health Guidance Services for STIs to prevent HIV and AIDS among Intravenous Drug Users and CSWs"

WHO

WHO assists HIV and AIDS control interventions in a multitude of different areas, predominantly at the policy level and in field activities. The HIV and AIDS program objectives correspond to the objectives of the NACP Enhanced Program . Activities within the specific HIV AND AIDS programme include:

- Improvement in the prevalence of safe behaviour among vulnerable populations
- Improvement in counseling and clinical management of STI/HIV cases
- Developing a surveillance system for STIs
- Human resource support (programme officers) for programme management to the Provinces

The World Bank

The World Bank has signed an agreement of a US$ 38 million credit with the government for implementation of a five year 2003-2008 enhanced HIV and AIDS control Programme . The broad activities of the program are:

- Providing vulnerable populations with services to prevent the spread of HIV
- Mass media campaign by private sector, targeted interventions for youth, police and formal sector workers, improved management of STI cases
- Prevention of transmission through blood by building capacity of blood transfusion authorities, blood screening and implementation of quality assurance systems
- Strengthen the capacity of NACP and its provincial counterparts for effective implementation of the HIV AND AIDS programme.

LNGOs Pakistan

There are many organizations working on HIV&AIDS in Pakistan and there is unfortunately no time or space to mention them all. A few examples however, follow below.

The AIDS Prevention Association of Pakistan (APAP) is working on Preventive Health, HIV&AIDS, STIs awareness, Sexuality, Reproductive health and Population Welfare (Family Planning) in the Punjab. APAP started its AIDS awareness programme on a voluntarily basis in Lahore and its suburbs. Since 1996 this NGO has been engaged in AIDS awareness activities like organizing seminars, conferences, walks and visit of rural and suburb areas of Lahore city. APAP is an Executive Member of Punjab AIDS Consortium (PAC), a platform for NGOs working on HIV & AIDS. APAP also has an affiliation with National Trust for Population Welfare (NATPOW).

The Pakistan National AIDS Consortium (PNAC) is a network of 6 provincial/regional NGO networks throughout Pakistan. PNAC was founded in 2000 and registered with the government of Pakistan in 2005. PNAC is made up of the Azad Jammu Kashmir AIDS Consortium (KAC), Balochistan AIDS Network (BAN), the Northern Areas AIDS Control Consortium (NAACC), the Northwest Frontier Province AIDS Consortium (NAC), the Punjab AIDS Consortium (PAC) and the Sindh NGO Network on HIV/AIDS (SNNHA).

Each provincial/regional network was established in order to facilitate cooperation, collaboration, and Communication between and among nongovernmental organizations in Pakistan that work to try to prevent the Spread of HIV and/or to provide care or treatment for people living with HIV/AIDS. PNAC does not currently Have members, but instead represents the provincial/regional consortia at the national level. In the near future, PNAC Will also provide support and services to provincial NGO consortia and their members.

SACHET

Established in 1999, the Society for the Advancement of Community, Health, Education and Training (SACHET) is a gender sensitive and environmental friendly welfare/development-oriented organization. SACHET seeks to provide social development, primarily in low-income localities, by investing in health, education, poverty alleviation, income generation skills, human resource and rural development. Their HIV&AIDS work includes awareness-raising, training and recently the production of resources such as videos, children's books etc.

New Light Aids Control Society (NLACS)

Pakistan's leading People Living with HIV organization, New Light's work includes addressing the lack of appropriate treatment, e.g. by lobbying pharmaceutical companies, the lack of education materials available in local languages they produced a documentary specifically for those who are illiterate and an outreach programme providing those living with HIV with anti-retroviral therapy, counseling and financial aid amongst others.

Moving Forward

It is evident that in regards to HIV and AIDS Pakistan stands at a critical juncture. Its response thus has to be immediate and effective. It must include a **multi-sectoral approach** since the epidemic has its root causes in development issues like gender inequality, poverty, illiteracy, unequal access to health facilities etc. The various programmes in line for combating HIV and AIDS must work in collaboration and formulate a combined HIV AND AIDS control and prevention strategy with continued resource mobilization and donor support.

Along with these measures, the **capacity building** of all agencies, NGOs, and the government to better plan manage and coordinate HIV and AIDS related activities and advocacy campaigns to sensitize all important stakeholders at the national, provincial and district level.

Any HIV and AIDS programme must address the needs of **vulnerable populations**. Catering to the information needs of high-risk categories and increased advocacy specifically designed for these groups. Access to reproductive health services for effective handling of STI/HIV cases and to facilitate the use of safe practices such as condoms.

The HIV and AIDS programme must also work towards mapping of HIV positive cases and lessons learnt from the field. **Best practices** in combating the epidemic in the region can serve as a basis for any policy development. This must be undertaken in addition to a monitoring mechanism to ascertain the effectiveness and outreach of current HIV and AIDS programmes at the national and provincial level.

Transfusion of **contaminated/infected blood** is an important factor in the spread of HIV and AIDS. Infection control program must be geared towards decreasing the risks associated with unsafe blood and blood products. Pre screening of blood, regulation and monitoring mechanisms for purchase and distribution of blood are essential components of any health policy. In addition to this, the provision of blood screening kits and training programmes for health practitioners on safe blood transfusion is essential.

Health practitioners must be made increasingly aware of the clinical needs and the sensitivity, care and confidentiality with an HIV and AIDS case needs to be handled. In addition to health care, community support groups must be formed for and by PLWHAs.

The development of an effective intervention programme must be geared towards creating awareness through **dissemination of accurate information** and steps to counter the misinformation and misreporting of HIV and AIDS cases, their causes and modes of transmission. A **c**omprehensive media and communication strategy to promote safe practices, address misconceptions that serve to strengthen negative and gender-insensitive stereotypes.

Though the number of reported cases of HIV and AIDS is relatively low, it is evident that they may not remain so because of under reporting and the prevalence of high risk factors. Over the passage of time, the **health care and psychological needs of People Living with HIV and AIDS (PLWHA)** is bound to increase. Health practitioners must be made increasingly aware of the clinical needs and the sensitivity, care and confidentiality with an HIV and AIDS case needs to be handled. In addition to health care, community support groups must be formed for and by PLWHAs.

HIV and AIDS Overview

AIDS has killed 25 million people globally since it was first detected. The situation is worsening in some regions notably Eastern Europe and Central Asia, where the number of people living with AIDS has increased twenty times in the last ten years. In several countries, including the two worst affected regions Sub-Saharan Africa and the Caribbean, HIV infection rates have fallen. But Sub-Saharan Africa continues to be badly affected; two-thirds of the new cases have occurred there. Among the countries responding to sustained efforts are Kenya, Zimbabwe, Brazil, Burkina Faso, Bahamas and Thailand. Even after considerable efforts, just one in ten patients in Africa and one in seven in Asia have access to required drugs. For those at risk, only one in five has access to basic prevention services.

A comprehensive media and communication strategy to promote safe practices, address misconceptions that serve to strengthen negative and gender-insensitive stereotypes.

Asia

HIV and AIDS Statistics and Features, in 2003 & 2005

2005

Adults & Children living with HIV	8.3 million [5.4-12.0 million]
Women living with HIV	2.0 million [1.3-3.0 million]
Adults & Children newly infected with HIV	1.1 million [600 000-2.5 million]
Adult Prevalence (%)	0.4 [0.3-0.6]
Adult and Child deaths due to AIDS	520 000 [330 000-780 000]

2003

Adults & Children living with HIV	7.1 million [4.6-10.4 million]
Women living with HIV	1.7 million [1.1-2.5 million]
Adults & Children newly infected with HIV	940 000 [510 000-2.1 million]
Adult Prevalence (%)	0.4 [0.3-0.5]
Adult and Child deaths due to AIDS	420 000 [270 000-620 000]

In certain regions across Asia, situation is worsening, especially in Central Asia where the people living with AIDS has increased twenty times in the last ten years. According to the AIDS Epidemic Update (December 2005), injecting drug use is the most significant mode of transmission across Asia. Even though the actual number of drug injectors may be small but their contribution to the epidemic is substantial. This is because these drug users are sexually active and engage in commercial sex. This trend is visible in Indonesia, Vietnam and parts of China. Recent studies in five Asian countries suggest that sex workers are the first sex partners for 17% to 50% of young men.

Another factor contributing to the spread of the disease is that in Asia just one in seven patients have access to the required drugs. According to UNAIDS, in Southeast Asia only 0.1% of people between the ages of 15-49 have received counseling or have been tested for HIV infection.

Country Situation Analyses

India

An estimated 5.1 million people are living with HIV and AIDS in India. . It has the world's second highest number of people living with HIV. Six states in India are already designated 'red' or high prevalence states - with an HIV prevalence of over 1% of the total population. And though the levels of prevalence appear to have stabilized in the worst affected states of Tamil Nadu, Andhra Pradesh, Karnataka and Maharashtra (Manipur and Nagaland are the other states), it is still increasing in at-risk population groups in several states. The HIV prevalence for India as a whole is about 0.92 %, a mere 0.1 % rise in prevalence means there would be an extra half million people with HIV and AIDS.

Trends

- HIV is spreading in rural areas
- HIV prevalence among female sex workers has not fallen below 52% since 2000, according to the National AIDS Control Organization (NACO).
- Lack of awareness is a prime factor in the spread of the disease. In states like Haryana, only less than half of all sex workers, (brothel or street-based,) knew that condoms prevented the spread of HIV/AIDS. Over 30% of street sex workers still do not know that condoms prevent HIV infection and many in India still decide a 'client' has AIDS or not based on his physical appearance.

The HIV prevalence for India as a whole is about 0.92 %, a mere 0.1 % rise in prevalence means there would be an extra half million people with HIV and AIDS.

- While sexual relations are the main transmission medium for most of India, in the Northeast there is an increasing overlap of sex work and injecting drug use. About 20% of the female sex workers said they injected drugs.
- Of men who had sex with men, as estimated 7% are HIV positive and more than half of them were married.
- An increasing portion of married women are infected by husbands who either recently or in the past have gone to sex workers
- Of the 600,000 people in India who need anti-retroviral drugs, only around 100,000 have access-and that too at great cost.

Best Practices

India

Community focused AIDS response can meet the needs of HIV positive women. Comprehensive home and community based care includes clinical management, nursing, counseling and social and economic support. However, the strategic focus is on community awareness and the engagement of civil society in the response towards HIV and AIDS.

- Community mobilization and engagement on treatment and facilitation of ownership and sustainability of HIV and AIDS effort;
- Reduction of gender inequalities through an integrated and holistic community based approach;
- Possible and meaningful involvement of PLWHAs;
- Focus on prevention among marginalized groups and populations;

A national association working in three Indian states supports the innovative programme of home and community based care. This is done by providing technical support to partners. The organization has a lead partner in each state and several dozen NGOs to support state-level efforts. The national groups assists these NGOs with organizational development and increased capacity in technical, programmatic and financial areas.

Home based care in turn strengthens capacity of communities and PLWHA families to provide home based care. Awareness, care, support and access to treatment are part of the continuum of home based care. As access to ARVs increases, NGO teams focus on community education and preparedness for ARVs.

PWLHAs and community members are the focus of a participatory process of project design, planning, implementation and assessment.

Information from these community assessments informs a dynamic planning cycle. The association and lead partners at the state level and community based NGOs at the local level review their strategic plans every six months. The project appraisals are conducted in partnership with all stakeholders. Economic appraisals examine efficiency and cost effectiveness. Financial appraisals adjust budgets and make cost projections. In social appraisals, community stakeholders review project design in terms the gender component, level of participation and obstacles encountered.

A national association working in three Indian states supports the innovative programme of home and community based care. This is done by providing technical support to partners. The organization has a lead partner in each state and several dozen NGOs to support state-level efforts.

Another community based intervention is a campaign called "**A Handful of Rice**". This campaign has been conducted in several Indian states and it raises awareness and helps families of PLWHAs. Women in the community put away a handful of rice each time they cook a meal. The rice is then collected and delivered to households that are unable to manage their daily food requirements due to the illness of one or more of their family members.

National Response

As in Pakistan the first ever HIV/AIDS case was reported in 1986. The country responded immediately through a collaborative effort amongst the government and civil society. The National AIDS Control Program was launched in 1987. The Program went through various evolutionary phases. In the initial phase, the focus was research with surveillance centers launched in 55 cities in three states

In the second phase the National AIDS Control Organization (NACO) was created. Although there were groundbreaking activities in this phase including awareness raising among university students, improvements in blood safety and projects focusing on CSWs, it was marked by lack of political will on the part of the states and involvement of NGOs remained limited. AIDS was seen primarily as a health issue.

a large number of women travel to work in the Middle East, for which HIV testing is mandatory, more women than men have tested positive in Sri Lanka

The third phase saw a significant shift towards decentralization with the responsibility resting on individual states. Flexible State AIDS Societies were formed, these were strengthened by the formation of technical groups called Technical Resource Groups (TRGs) each covering different thematic areas of HIV and AIDS.

Sri Lanka

Sri Lanka has a relatively small number of people living with HIV/AIDS, but high-risk behaviors that contribute to the spread of HIV are prevalent, making the country vulnerable to an increase in infections. Sri Lanka has a narrowing window of opportunity to forestall the spread of HIV among high-risk groups.

The Program went through various evolutionary phases. In the initial phase, the focus was research with surveillance centers launched in 55 cities in three states

State of the Epidemic

According to UNAIDS, Sri Lanka has a relatively small number of people living with HIV about 3,500 adults. Since 1986, only 712 cases have been officially reported, with underreporting mainly due to limited availability of counseling and testing, fear associated with seeking services and the stigma and discrimination associated with being identified as HIV positive. Of the total number of HIV cases reported from 1987 to 2000 in which the mode of transmission is known, 98 percent were sexually transmitted. Only a few cases of HIV transmission from mother to child and through blood transfusions have been reported and transmission through intravenous drug use has not yet been reported.

Because a large number of women travel to work in the Middle East, for which HIV testing is mandatory, more women than men have tested positive in Sri Lanka. The current ratio of HIV-positive men to women in Sri Lanka is reportedly 1.4 to 1, although in reality, there are probably far more men infected then women as in most early phase HIV epidemics

Amal Human Development Network; Women, Girls and HIV/AIDS "Have you heard me today"16-17
Http://www.worldbank.org/

Risk and Vulnerability

Despite an estimated low prevalence rate, there are mounting concerns because of the significant presence of risk factors and vulnerability.

- Condom Use: Although research on sexual behavior has been limited, a few studies conducted suggest low condom use among men. For example, in 1997, only 4.7 percent of men between the ages of 15 and 49 in the rural area of Matale and 9.6 percent of men in the capital of Colombo reported ever using condoms, although about two thirds of them had heard about them. Among men who stated that they have had sex with casual partners during the last year, only 26.3 percent in Matale and 44.4 percent in Colombo reported using a condom.
- Commercial Sex: It is estimated that about 30,000 women and girls and 15,000 boys work in the commercial sex industry in Sri Lanka. The risk of HIV spreading among sex workers is heightened by low condom use and high prevalence of sexually transmitted infections (STIs), which make a person more susceptible to contracting HIV. In one study, 45 percent of female sex workers had experienced multiple STIs, and 70 percent of male patients at STI clinics had reported frequenting sex workers. In addition, women and children in prostitution are considered most vulnerable to HIV infection because they often lack the ability or power to negotiate condom use with clients or to seek STI treatment. They are often "hidden," making it a challenge for HIV prevention services to reach them.
- STIs: Every year, estimates of detected STI cases in Sri Lanka vary from about 60,000 to 200,000, of which only 10 to 15 percent are reported by government clinics. STIs facilitate the spread of HIV infection and serve as indicators for low condom use and other high-risk sexual behaviors.
- High Mobility: Migration within Sri Lanka and emigration to the Middle East and neighboring countries is necessary for the economic survival of many households in both rural and urban areas. Thousands of women and men live away from their families as migrants abroad and as workers in Sri Lankan Free Trade Zones. Removal from traditional social structures, such as family and friends, has been shown to foster unsafe sexual practices, such as having multiple sexual partners and engaging in casual and commercial sex, as well as to increase vulnerability of women and girls to sexual abuse. An estimated 1.2 million Sri Lankans work in the Middle East and 79.1% of unskilled migrants are women. International female migrants account for more than 40% of reported HIV infections among females.
- IDUs: Sri Lanka has an estimated 30,000 drug users, of whom about two percent inject drugs. Although there have been no reported cases of HIV in this group thus far, its members are at high risk because of needle sharing. Drug users also often experience difficulty accessing information and services for both prevention and treatment.
- Low Levels of Awareness among Poor People: HIV/AIDS awareness and knowledge levels in underserved communities remain drastically low. Only 40 percent of women working in rural tea estates, for example, have even heard of HIV/AIDS, as compared to 90 percent of women in other rural and urban areas.

National Response

Government: In 1992, the Government of Sri Lanka initiated HIV prevention and control efforts through the National STD and AIDS Control Programme (NSACP) of the Ministry of Health under the Director General of Health Services. In addition, the National Blood Transfusion Services (NBTS) and the National Programme for Tuberculosis and Chest Diseases (NPTCCD) are strengthening their responses to reduce transmission and prevent further spread of HIV. These services are provided in collaboration with eight Provincial Directors of Health Services and the respective District staff. The NSACP in collaboration with the Provinces has made remarkable progress in institutionalizing HIV prevention activities and in providing care and treatment to people living with HIV. Some of these activities include a mass media communications strategy to improve the knowledge and awareness of HIV among the general population. In addition, Sri Lanka has a well established sero surveillance system and work is underway to establish second generation surveillance (behavioral) among vulnerable groups. The first round of the survey is expected to start by March, 2006. Furthermore, a Management Information System is being established currently linking all STI clinics in the country to the central NSACP based on a Monitoring and Evaluation Framework for HIV.

The NSACP has made significant progress in improving STI services by refurbishing STI clinics, providing equipment, and facilitating HIV

prevention work conducted through contracted NGOs and through the Government Provincial and District Health authorities to reach vulnerable groups. The NSACP has also engaged 12 line Ministries including National Institute of Education, Ministry of Labour, Foreign Employment Bureau, Vocational Training Authority, Ministry of Fisheries, National Child Protection Authority, National Youth Services Council, Army, Navy, Air Force and the Police. This work includes advocacy, improving HIV prevention awareness and knowledge of facilities available, encouraging condom use in the military and introducing VCT facilities.

In addition, the program has helped to ensure blood safety by increasing the voluntary blood donation rates towards a 100% goal and through upgrading blood banks and transfusion screening for HIV. Furthermore, the NBTS has initiated a Communication Program through mass media to increase voluntary blood donation in the country and raise the level of awareness and knowledge of HIV/AIDS among the general population.

In addition to these primary prevention efforts initiated by the NSACP through the National HIV Prevention Project, the NSACP has now established Care and Treatment resources needed to make treatment available to the HIV positive patients who need treatment. In 2004, it was estimated that 100 people needed treatment and currently 62 people are registered and receiving care and treatment through the national Programme.

Nongovernmental Organizations (NGOs): Work of both local and international NGOs in the area of HIV/AIDS prevention in Sri Lanka has been limited, unlike that of other neighboring countries, such as India, Bangladesh, and Nepal. The NGO work remains largely uncoordinated, and its programme coverage of high-risk populations is estimated to be less than 10 percent. Efforts are being undertaken to improve NGO collaboration and coordination with the government.

Key actions needed are to increase the capacities of NGOs to work with vulnerable groups and of the government to systematically contract and fund NGOs.

Issues and Challenges: Priority Areas

Stigma and discrimination abound. Reducing the stigma associated with HIV/AIDS in Sri Lanka will require greater involvement of civil society organizations, businesses, the entertainment industry, religious leaders, and the medical community. As respected opinion leaders, they can play an effective role in reducing harassment of groups promoting positive attitudes towards people with HIV/AIDS and creating an enabling environment for prevention efforts. Training police to reduce harassment of vulnerable groups and engage HIV-positive groups are central to these efforts.

The Health Ministry cannot do it alone. Scaled-up prevention efforts require a multisectoral approach, involving other ministries and departments covering finance, education, agricultural extension, transportation, the police force, and the military, as well as partnering with NGOs, the private sector, and civil society organizations, such as trade unions. These organizations and institutions are better placed to mobilize and provide services to at-risk groups. As focusing on HIV prevention is relatively new, the capacity of these institutions needs rigorous strengthening.

Shift focus from inputs to outcomes. Monitoring and evaluation, including surveillance systems, need to be improved, particularly in collecting data, using such data for policy and programme management decisions, and disseminating it. Reliable data on coverage and the impact of interventions on behavioral and biological outcomes is critical for mounting an effective nationwide response. Following WHO's guidelines to tailor surveillance activities according to the country-specific epidemic, Sri Lanka, with its low-level epidemic, is further expanding coverage of high-risk groups.

Thailand

PLWHAs face stigma and discrimination in their communities. Any HIV and AIDS programme or strategy must this into account. In Thailand, 94% of the population is Buddhist. Monks and nuns play a pivotal social and spiritual role in their communities and are thus in a position to change mindsets and stereotypical responses to HIV and AIDS. Due to the respect and outreach that these individuals have within their communities, they are in a unique position to address the socio-cultural issues associated with the disease.

In 2001, there were more than one million PLWHAs in Thailand. Therefore there was an urgent need to liaise with all important stakeholders; the government, religious organizations, civil society organizations and affected communities and develop a multi-sectoral collaborative approach towards the epidemic. While the communities have to be educated and informed through awareness raising, they must play a proactive role in devising plans and strategies and recognize that they already have all the resources within the community to deal with the disease.

Based on this premise, a programme was introduced in 1997 and has expanded to neighboring Buddhist countries. This programme trains and supports monks to expand their traditional teaching role to include HIV and AIDS prevention, care and outreach. Faith based organizations, NGOs and communities are the prospective users of this practice.

It enables the religious community to integrate HIV and AIDS in their teaching and equips them with participatory approach and life skills training for effective outreach. It is a sustainable project since its is largely funded by temple donations, private donations and by linking to funded government activities.

The purpose of the intervention was to:

- Provide Buddhist monks with an opportunity to take part in HIV and AIDS prevention and care;
- Establish a network of monks working on this issue;
- Create awareness among them and provide accurate information on prevention, care and transmission;
- Enable monks to serve as a resource center for providing materials on HIV and AIDS;
- Promote the role of monks, nuns and novices in the fight against the epidemic;

Project Implementation

- Training seminars were conducted for monks and nuns on HIV and AIDS and its socio-cultural context and life skills and participatory approach;
- Through an interactive approach, monks and nuns engaged in community development work are invited to address the seminars and PLWHAs are given a platform to communicate their needs to the monks and communities;
- Trainees return to their temples and conduct 3-5 day seminars on the same pattern for fellow monks and community leaders(village headmen, members of the village development community and local government representatives).
- These in turn form groups to draft action plans and devise strategies for managing HIV and AIDS related issues at the community level;
- Home visits are also carried out as part of this programme;
- Target groups for these seminars include youth, orphans, students and PLWHAs on prevention topics with a perspective on Buddhist values and five precepts of Buddhism;
- They promote and support community initiatives such as income generating activities, orphan care, herbal gardens and network with supporting organizations;
- The Sangha Mehta Project organizes specialized seminars on topics including child and adult counseling, facilitation skills, and media training at district, provincial and regional levels to further train the monks. It also offers technical advice on community projects set up by monks;

China

HIV and AIDS has been detected in 48% of China's counties but has been detected in all 31 provinces. The epidemic, especially in the south and west of the country, has been clustered among specific population groups; injecting drug users, sex workers, former plasma donors, and their partners.

The major trends in the spread of the virus are:

- High prevalence(especially the late 1990s) among networks of injecting drug users;
- An estimated 20% of HIV infections among commercial sex workers due to unprotected heterosexual contact;
- An overlap between injecting drug

users and commercial sex, with female sex workers not using condoms and injecting drugs through non-sterile needles;

- Most female sex workers originating from rural areas with no knowledge of HIV and AIDS;

In China, any effective national response must take into account the poor public awareness of the epidemic and the stigma and discrimination associated with PLWHAs .

In 1996, the Yunnan Red Cross and the Australian Red Cross started a ground breaking HIV and AIDS prevention Programme based on peer education. The project demonstrates and effective and sustainable approach to AIDS prevention among the youth. As of June 2001, the Youth Peer Education Project has trained 260 young project facilitators who in turn have educated over 15,000 participants, of whom over 90% have acquired a good understanding of AIDS with increased awareness of self-protection and non-discriminating attitude towards AIDS patients. These trainees in turn spread AIDS preventive information to their peers, friends and families. The Project demonstrated that youth can be an effective medium of outreach and awareness on HIV and AIDS related issues.

In China, any effective national response must take into account the poor public awareness of the epidemic and the stigma and discrimination associated with PLWHAs

Sub-Saharan Africa

HIV and AIDS Statistics and Features, in 2003 & 2005

Adults & Children living with HIV	25.8 million [23.8-28.9 million]
Women living with HIV	13.5 million [12.5-15.1 million]
Adults & Children newly infected with HIV	3.2 million [2.8-3.9 million]
Adult Prevalence (%)	7.2 [6.6-8.0]
Adult and Child deaths due to AIDS	520 000 [330 000-780 000]

2003

Adults & Children living with HIV	24.9 million [23.0-27.9 million]
Women living with HIV	13.1 million [12.1-14.6 million]
Adults & Children newly infected with HIV	3.0 [2.7-3.7 million]
Adult Prevalence (%)	7.3 [6.7-8.1million]
Adult and Child deaths due to AIDS	2.1 [1.9-2.4 million]

"Young People and Social Change in China". A survey of Risk Factors for HIV/AIDS in Yunnan Province; December 1998, Bilingual Chineese/English.

According to the AIDS epidemic update (December 2005) Sub Saharan Africa has just 10% of the world's population but is home to more than 60% of the people living with HIV worldwide. Although the statistics show an increase in the number of adults and children living with HIV from approximately 24.9 million in 2003 to approximately 25.8 million in 2005, there has been a decline in HIV prevalence in three Sub-Saharan African countries: Kenya, Uganda and Zimbabwe. In most parts of Sub-Saharan Africa, knowledge about HIV transmission remains low with women less aware than men and people in rural areas less knowledgeable than those living in urban areas.

Although Southern Africa is considered the core area in the AIDS epidemic, current trends reveal that there may be a decline. In Zimbabwe, for example, recent data reveals a decline in the HIV prevalence rate with the prevalence rate declining from 26% in 2002 to 21% in 2004 among pregnant women. This trend is also reflected in decline among the general population. This can be attributed to changes in sexual behaviour with increased use of condoms and reduction in casual sexual partners.

In South Africa, HIV prevalence in pregnant women is as high as 29.5% (2004). The significant feature of South Africa's epidemic is that the HIV prevalence rate has increased tremendously in the past decade, with it being 1% in 1990 to 25% within ten years.

In East Africa, there are indications that the epidemic can be reversed. HIV prevalence rate among pregnant women in Uganda has dropped since the 1990s. The same trend is seen in urban parts of Kenya, where infection levels are dropping significantly. In both countries, behavioural changes are the contributing factors. In other places in East Africa, and HIV prevalence has either decreased slightly or remained stable.

Best Practices

Kenya

The Empowering Africa's Young People Initiative

The Empowering Africa's Young People Initiative is a collaboration of seven organizations representing the world's largest Youth Movement. It is envisioned as a long-term effort to build-up, coordinate and expand youth programmes that combat the HIV/AIDS pandemic by drawing upon the core competencies of each organization.

For the first time in thirty years, seven global youth organizations have joined together to create the Empowering Africa's Young People Initiative an inter-generational, multi-sectoral programme that seeks to empower youth through holistic approaches to HIV/AIDS prevention, care and support. The organizations together represent more than 20 million young people in Africa, and more than 100 million young people worldwide. The network brings a great added value in the fight against HIV/AIDS.

Following are the defining characteristics of these organizations:

- They are African-led and Africa influenced with deep community ties
- Have access to young girls and women and ability to address their vulnerabilities
- Reach out to young boys and men to improve their social and interpersonal skills
- Focus on non-formal education to reach out young people who are not in school.

- Have a holistic approach, to prevention care and advocacy against stigma and discrimination

Lessons Learnt

- Youth involvement and active participation at all levels is key for the success of the partnership due to their dynamism and commitment
- The success in developing effective youth-adult partnership requires a lot in changing attitudes of both stakeholders towards each other.

The significant feature of South Africa's epidemic is that the HIV prevalence rate has increased tremendously in the past decade, with it being 1% in 1990 to 25% within ten years

Recommendation

Scale-up existing peer education and life skills programs by replicating best practices in under-served areas to under-served youth populations.

Uganda

Facilitating Country to Country Learning through Documentation by Uganda

Inter-country learning through documentation of Best practices that have worked in Uganda is a methodology that has worked to scale up HIV/AIDS national responses and reduce HIV/AIDS in nine African countries that include Ghana, Ethiopia, Nigeria, Lesotho, Swaziland, Zanzibar, Rwanda, Burundi and Tanzania.

The Support to International Partnership against AIDS in Africa (SIPAA) is a programme facilitating inter-country learning by documenting best practices and supporting their replication in other countries. Exchange visits, e-forums, meetings and workshops are facilitated by learning officers who also make follow up to ensure that what they learnt is replicated.

Lessons Learnt

- The countries involved almost have similar problems related to HIV/AIDS with Uganda and have found it easy to learn and adopt interventions from Uganda to their own situations.
- No need to re-invent the wheel, for example, Ethiopia has replicated the Uganda HIV/AIDS Partnership to its own situation.
- Resources that may have been used to research on new interventions are saved, for example, Prevention of Mother to child.
- Documentation of the learning process has resulted in learning cycle as new countries are learning from those who learnt from Uganda.

The Support to International Partnership against AIDS in Africa (SIPAA) is a programme facilitating inter-country learning by documenting best practices and supporting their replication in other countries.

- Countries can easily adopt interventions which they have seen working else where.
- Uganda has improved its interventions based on feed back.

Recommendations

- Supporting learning among countries is important for scaling up national HIV/AIDS responses.
- African countries with limited resources to carry out research can adopt interventions that have worked elsewhere to their situations.
- Follow up and supporting the learning countries is important in ensuring that the what they learnt has been used and solutions to challenges can be sought.
- Documentation of the learning process ensures continuity of the learning as more countries learn from those that have implemented.

The socio-economic factors that hinder preventions and care are poverty, illiteracy, inadequate hospital facilities and inaccessibility to ARV drugs.

Nigeria

HIV/AIDS Prevention, Care and Support Programmes (including best practices) for and by Sexual Minorities

HIV and AIDS has become a major public health concern in low-income and developing countries like Nigeria. Several factors have contributed to the rapid spread of HIV/AIDS in Nigeria. For example, in the eastern part of the country, this spread can be attributed to the economic and cultural phenomenon of sexual networking (polygamy), sexual practices of adolescents exposed to sub-cultures, genital mutilations and low condom use. The socio-economic factors that hinder preventions and care are poverty, illiteracy, inadequate hospital facilities and inaccessibility to ARV drugs.

The Hope of Life Foundation advocated for support programmes in partnership with the Nigerian state government in a workshop titled "Mode of Prevention" in June 2003.

The methods used were:

- Education programmes and advocacy sensitization of communities, churches and PLWHAs.
- Economic empowerment and skill acquisition programmes to alleviate poverty especially for women to stop prostitution.
- Care and support programmes via home-based care, hence supporting the promotion of sexual and reproductive health.
- Ensuring the proper use of condom and abstinence of sex before marriage.

The programmes addressed cultural biases with the help of PLWHA, home-based care givers and the PABA through awareness raising leading to a reduction in mortality rates.

In 2002, about 3.5 Million Nigerians were infected with HIV and AIDS of which 270,000 were the easterners. After the conducted programmes there was a rapid decrease to 120,000 HIV and AIDS carries in the East.

Several factors have contributed to the rapid spread of HIV/AIDS in Nigeria. For example, in the eastern part of the country, this spread can be attributed to the economic and cultural phenomenon of sexual networking (polygamy),sexual practices of adolescents exposed to sub-cultures, genital mutilations and low condom use.

XV International AIDS Conference; Bangkok Thailand; J.N. Batte. UNAIDS/SIPAA, Kampala, Uganda

Some Civil Society Initiatives in Pakistan

AMAL Human Development Network

AMAL's significant achievements in HIV and AIDS include the interventions for vulnerable groups who are difficult to reach and motivate for behavioral change such as commercial sex workers in the red light areas for Lahore. The efforts of AMAL in this area led to the significantly increased use of contraceptives of mainstream HIV-related concerns through provincial and district level non-governmental activities in four provinces including AJK and Northern areas. It also supports the national and provincial AIDS control programmes to establish a creative partnership and an effective monitoring mechanism for HIV/AIDS prevention programme. Furthermore, the organization is collaborating with other NGO's on the capacity-building and the dissemination of sensitive information in a socially and culturally acceptable manner.

In 2001, Uks invited Mr. Nazeer Masih, an HIV+ at a UNDP funded media mobilization workshop in Islamabad. The media did not know that he was a PLWHA.

Uks

In 2001, Uks invited Mr. Nazeer Masih, an HIV+ at a UNDP funded media mobilization workshop in Islamabad. The media did not know that he was a PLWHA. The proceedings also included debates on whether or not one could recognize a PLWHA. Most of the media personnel believed they could recognize a PLWHA as s/he *'would be sick looking with obvious marks of this virus.'* Towards the end of the workshop when Mr. Nazir was asked to disclose his HIV+ status, the reaction from other participants was one of shock and disbelief. The media professionals admitted their ignorance and realized how wrong they were. Hence their stereotypical perceptions were challenged.

when Mr. Nazir was asked to disclose his HIV+ status, the reaction from other participants was one of shock and disbelief.

In a recent attempt to create media awareness among the indigenous media in the Northern Areas, Uks went to Kohat (a city in the Northern region of Pakistan) to mobilize the local media for positive reporting on HIV and AIDS. Only a handful of journalists attended the meeting, and only one out of them could be motivated. Just 18 months later, Uks has been able to bring HIV and AIDS as a priority issue for at least some media persons in Kohat.

Recognizing that radio is an effective medium to communicate AIDS messages, and spread awareness among the general population, Uks has broadcast a series of radio programmes on HIV and AIDS on the emerging and independent FM radio

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Mainstreaming HIV Prevention into Disaster Response

Overview

The direct and indirect impact of the October 2005 Earthquake and the Asian Tsunami is staggering. According to the UN the Earthquake left 2.8 million homeless, more than 80,000 dead and an equal number injured. In the Tsunami, the estimated death is over 146 000, with over 525 000 injured, over 20 000 missing,

(SACHET) is a gender sensitive and environmental friendly welfare/development-oriented organization. SACHET seeks to provide social development, primarily in low-income localities

close to 1.6 million displaced and over 1 million estimated homeless.

This poses a serious challenge and opportunity for legislatures, planners, international agencies, policy makers, government, civil society and community developers. Although in the initial response to the disasters the priority was the provision of food, medicines, shelter and clothing, presently, relief efforts are progressing towards long-term rehabilitation of affected communities and families. At this juncture, it is extremely important to mainstream HIV and AIDS as part of this development phase.

The efforts of AMAL in this area led to the significantly increased use of contraceptives of mainstream HIV-related concerns through provincial and district level non-governmental activities in four provinces including AJK and Northern areas.

Five Principles for Mainstreaming HIV into Disaster Response

Based on current experiences aimed at mainstreaming HIV/AIDS at different levels, five simple principles have emerged that attempt to provide a comprehensive framework to analyze where and when to introduce and implement HIV/AIDS mainstreaming (UNADS GTZ 2002).

- Principle 1 underscores the importance of developing a clearly defined and focused entry point or theme for mainstreaming HIV/AIDS in order to maintain the critical focus necessary to make an impact.

- Principle 2 maintains that, at the country level, mainstreaming does not take place outside of the existing national context. Thus National Policies or Strategic Framework for HIV/AIDS should be used as the frame of reference. Mainstreaming efforts should be located within existing institutional structures.

- Principle 3 necessitates advocacy, sensitization and capacity building in order to place people in a better position to undertake mainstreaming. Mainstreaming cannot be expected to develop of its own accord.

- Principle 4 asserts the need to maintain a distinction between two domains in mainstreaming: the internal domain or workplace, where staff risks and vulnerabilities are addressed; and the external domain, where the institution undertakes HIV/AIDS interventions based on its mandate and capacities in support of local or national strategic efforts.

- Principle 5 highlights the importance of developing strategic partnerships based upon comparative advantage, cost effectiveness and collaboration.

Disaster response presents an opportunity to use the community links established through disaster relief programmes to ensure that men, women and children are aware of their rights to aid which is not conditional on accepting sexual exploitation. The long term disaster relief staff should have access to HIV and AIDS awareness, and to train them to opportunities to carry out HIV education as part of the overall disaster response.

The United Nations Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings has produced a detailed guideline for HIV/AIDS interventions in emergency settings. The purpose of this guideline is to enable governments and cooperating agencies, including UN Agencies and NGOs, to deliver the minimum required multi-sectoral response to HIV/AIDS during the early phase of any emergency situation.

These guidelines, focusing on the early phase of an emergency, should not prevent organizations from integrating such activities in their preparedness planning. As a general rule, this response should be integrated into existing plans and the use of local resources should be encouraged. A close and positive relationship with local authorities is fundamental to the success of the response and will allow for strengthening of the local capacity in the future.

Paul Harvey (2004) analyzed the relationship between livelihood and HIV/AIDS in the context of humanitarian programming. Livelihood insecurity due to disaster could increase HIV vulnerability as local social security

Networks have been severely disturbed by the disaster.

Based on Harvey's and UNADS/GTZ observations the following points in relation to humanitarian programming in the context of an HIV/AIDS epidemic should be taken into consideration:

1. Early-warning systems and assessments need to incorporate analyses of HIV and AIDS and its impact on livelihoods.
2. The emergence of new types and areas of vulnerability due to HIV and AIDS should be considered in assessment. Groups such as widows, the elderly and orphans may be particularly vulnerable, and urban areas may need to be assessed.
3. Targeting and the delivery of aid must be sensitive to the possibility of AIDS-related stigma and discrimination.
4. The HIV/AIDS epidemic reinforces the existing need for humanitarian programmes to be gender-sensitive.
5. Emergency interventions must aim to ensure that they do not increase people's susceptibility to infection with HIV/AIDS.
6. Food aid in the context of HIV/AIDS should review ration sizes and types of food and assess delivery and distribution mechanisms in light of HIV/AIDS related vulnerabilities, such as illness, reduced labour and increased caring borders.
7. Labour-intensive public works programmes should consider the needs of labour-constrained households, the elderly and the chronically ill.
8. HIV and AIDS reinforce the need for health issues to be considered as a part of any humanitarian response.
9. Support to agricultural production (including seed distribution) should recognize adaptations that people are making in response to HIV/AIDS.
10. Micro economic impact on people living with HIV in the disaster affected areas to be considered.
11. As part of the disaster challenge, all the agencies must be encouraged to explore the possibility of mainstreaming HIV prevention into their work.
12. All long term responses must explore the possibility of distribution of condoms, where appropriate, in line with the UNAIDS minimum package for HIV prevention in emergencies.
13. Mainstreaming HIV response into disaster relief starts with the concerns of the community; policy makers and institutions need to understand these issues.
14. There is an urgent need to document the evaluation and monitoring of mainstreaming work into Disaster response.
15. Disaster response must also have an enabling environment which would provide space for sharing HIV and AIDS concerns and to propose solutions.
16. HIV prevention and care needs to be integrated into the disaster needs assessment.
17. Long term Disaster response must take into account HIV prevention and care needs of the community.
18. Disaster affected national governments must ask their national HIV programs to assess the impact of the disaster on their HIV programs and to respond adequately.
19. Donor agencies and humanitarian agencies must allocate line item specific funding for integrating HIV programs into the current humanitarian responses.
20. UNAIDS along with other key stake holders may take leadership to establish a regional mechanism to monitor the progress of mainstreaming HIV into humanitarian responses and for rapid diffusion of lessons learned from each setting.

III

Gender Dimensions of HIV and AIDS

What is gender?

This term continues to be misinterpreted and misused. Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other.

Overview

World wide, the growth of HIV and AIDS infection has been a source of grave concern to international health agencies, which state that at present, almost half of the people infected with HIV are women. According to State of the World Population, 2005, young women (15-24 years) are 1.6 times as likely as young men to be HIV positive. Likewise, in many countries, the majority of new infections are occurring in women, particularly adolescents and young adults.

The factors that increase women's vulnerability to infection are numerous and cross cutting. They include; limited access to knowledge and information on sexual and reproductive health. Others are inadequate access to education and services necessary to ensure sexual and reproductive health; sexual violence; harmful traditional or customary practices - such as early and forced marriage; lack of access to legal recourse and inequality in areas such as marriage and land and property ownership and inheritance.

Developing appropriate responses to the gender issues that continue to make both women and men vulnerable to HIV is critical to all efforts to prevent HIV transmission, improve care and support, and mitigate the impacts of the HIV and AIDS pandemic.

> ***"There is something going on here and it has to do with gender. And what we think it is, is a whole series of violations of women's rights that contribute to their vulnerability to being infected with HIV and that also interfere with their access to information and treatment"***
>
> *Janet Walsh, Human Rights Watch, New York*

HIV impacting Women More

The epidemic is impacting everyone with more children being orphaned, economies being severely challenged and human resources being hugely affected. World wide women are being impacted more because:

- Social services are collapsing, with women subsidizing the public sector by providing services for the ill.
- Malnourished and anemic pregnant women are facing the risk of being transfused with unsafe blood every time they give birth
- The epidemic has confronted the extended family. Women are now bearing an even greater burden in terms of their household responsibility, as they are now not only caring for their children alone but of the orphaned children of extended families

- Female headed households are increasing. In instances where the male head of the household has died, women can face a tragic set of circumstances in terms of loss of social support from family members, ostracization from the community, and lack of legal protection to inherit land or property.

- Poverty exposes women and girls to abuse and to high risk behaviour. They become vulnerable to sexual exploitation and other forms of violence

- Women, in particular girls often lack the bargaining power to make decisions that will affect their own lives, especially in regards to sexual issues

- Poverty is not only a cause; it is also the result of HIV and AIDS. Families who have individuals living with HIV and AIDS become poor not only because their income decline, but because their health care expenses increase. Poorer families spend disproportionately more of their income on such expenses and women now head many of these households.

Did you know

A decade ago women seemed to be on the periphery of the epidemic, today they are at the epicenter

- Today 48% of the 37.2 million people living with HIV are women and this proportion is growing
- Of the 1600 new infections that occur everyday, up to 60% are now amongst women (ILO)
- Women now account for 52% of the 21 million adults who have died from the disease since the epidemic began (UNAIDS)
- Since the beginning of the epidemic, over 9 million women have died from HIV and AIDS- related illnesses
- 55% of all HIV positive adults in Sub-Saharan Africa are women. In South Africa, HIV prevalence among women 17% compared with 4.4% among men
- In one Kenyan study, over one quarter of teenage girls interviewed had sex before 15, of whom, one in 12 was already infected
- A Zambian study confirmed that less than 25% women believe that a married woman can refuse to have sex with her husband. Only 11% thought they could ask their husband to use a condom
- In Trinidad and Tobago, nearly 30% of teenage girls said they had sex with older men. As a result, HIV rates are 5 times higher in girls than in boys aged 15-19
- By the mid nineties, more than 25% of sex workers tested in India were HIV positive. By 1997, the prevalence rate had reached 71%

Women are biologically more vulnerable to becoming infected with HIV than men are. In addition to that biological vulnerability, women face a range of other challenges; discrimination, stigma, lack of access to information and education, lack of access to rights and property rights and ownership rights. All of these things combine to make women more vulnerable, particularly young women

Jennifer Kates, Head HIV Policy, Health Research Group, Kaiser Family Foundation, Washington D.C.

Women's Vulnerability

There are several characteristics that contribute towards this vulnerability:

- In many societies there is a **culture of silence** that surrounds sex that dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions.
  This makes it difficult for women to be informed about risk reduction or, even when informed makes it difficult for them to be proactive in negotiating safer sex.

- The **traditional norm of virginity** for unmarried girls that exists in many societies , paradoxically increases young women's risk of infection because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active.
  Virginity also puts young girls at the risk of rape and sexual coercion in high prevalence countries because of the erroneous belief that sex with a virgin can cleanse a man of infection and because of erotic imagery that surrounds the innocence and passivity associated with virginity. In addition, in cultures where virginity is highly valued research has shown that some young women practice alternative sexual behaviours such as anal sex, in order to preserve their virginity, although these behaviours may place them at increased risk of HIV.

- Due to the strong norms of virginity and the culture of silence that surrounds sex, **accessing treatment** services for sexually transmitted diseases can be highly stigmatizing for adolescent and adult women.

- In many cultures because motherhood, like virginity, is considered to be a **feminine ideal**, using barrier methods or non-penetrative sex as safer sex options presents a significant dilemma for women.

- Women's **economic dependency** increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favours, less likely that they will succeed in negotiating protection, and less likely that they will leave a relationship that they perceive as risky. Death or illness impacts women doubly because of their already unequal economic status with the household and in the community at large.

- Marriage may give women a false sense of security. Monogamy does not protect women from HIV infection. This is because of their lack of **rights within the marriage,** difficulties negotiating safer sex and extended absence of the husband. They are not empowered by their male sexual partners to exercise protective measures such as the use of condoms.

In Sub-Saharan Africa, the majority of newly HIV positive women are contracting the virus from their husbands within the institution of marriage. This pattern is reflected around the world. In many areas, the prevalence of the disease is declining among sex workers and increasing among married women. For instance, in a recent study, 80% of HIV infected women were monogamous. Thus promoting abstinence or faithfulness to spouses as the only ways to prevent infection will leave women without the ability to protect themselves. Improving women's status and enhancing their negotiation skills is key to any prevention strategy.

Carovano, 1992
Weiss, Whelan, and Rao Gupta 2000
Weiss, Whelan, and Rao Gupta 2000; de Bruyn et al 1995
Heise and Elias 1995; UNAIDS 1999
Heise and Elias 1995; Mane, Rao Gupta, and Weiss 1994; Weiss and Rao Gupta 1998
Amir, 2004 AIDS and Us

- The epidemic also has a disproportionate impact on women because of their socially-defined **role as care givers** which places the brunt of looking after an AIDS patient on them.

Violence against Women

Violence against women (VAW), contributes both directly and indirectly to women's vulnerability to HIV. In population based studies conducted worldwide, anywhere from 10 to over 50% women report physical assault by an intimate partner. And one-third to one-half of physically abused women also report sexual coercion.

Research has shown that physical violence, the threat of violence, and the fear of abandonment act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky.

Types of Violence

Domestic Violence

According to the UN Special Repporteur on Violence against Women (2002) fear of domestic violence inhibits women from questioning their husbands on their fidelity even though they may suspect them to be HIV positive. They may also be perceived unfaithful themselves if they try to or insist on the use of a condom during sexual intercourse. Women, who are infected, may not disclose their status for fear of violent repercussions from the male members of their family and allegations of infidelity and "dishonoring the family name". Every year around 1000 women are killed in the name of "honour" in Pakistan.

Around the world, at least one in every three women, or up to one billion women, have been beaten, coerced into sex, or otherwise abused in their lifetime. Usually the abuser is a member of her own family and someone known to her.

During conflict, women are physically and economically forced into prostitution, sometimes in order to survive.

Sexual Violence

Rape is a human rights issue and this type of physical aggression affects the emotional, physical and mental well being of the victim. Rape is associated with unwanted pregnancies, STIs and HIV AND AIDS. According to a report by World Health Organization (WHO) (1997) around the world one in five women will be a victim of rape or attempted rape in her lifetime.

Women as Violence Victims during War

The incidence of violence is intensified during periods of conflict and war. Women are increasingly used as primary targets of armed groups and rape is often used as a weapon of war thus placing them in a very high risk category. During conflict, women are physically and economically forced into prostitution, sometimes in order to survive. In Afghanistan, for example, rape including a significant occurrence of mass rape, rape of women and girls from minorities in the north, nomadic women and girls, female aid workers and their female family members, has been a common and recurrent manifestation of the current insecurity.

Positive Times; Issue 6, June 2005
Heise, Ellsberg, and Gottemoeller 1999
Mane, Rao Gupta, and Weiss 1994; Weiss and Rao Gupta 1998
E, L Heise, M Ellsberg, M Gottemoeller, 1999

"In Dafur, we have heard cases where women have gone in to report a rape and have been harassed, have been arrested for adultery. And on top of that, its even more difficult because in order to get medical treatment for a rape, a woman has to fill out a police report and the police are turning them away from the clinics. The plight of rape victims is especially dire in Dafur because roughly nine out of ten Sudanese women undergo an extreme form of female circumcision. This is particularly why it is so vital thay they receive medial care after the rape, because often they are bleeding, they are injured, and without treatment, they can get infected and die. Even if women survive the rape, they may still contract the HIV virus"

Sarah Martin, Refugees International.

Trafficking of Women and Girls

Trafficking is one of the fastest growing and increasingly profitable crimes in the world. It involves transporting or recruiting another person in order to place them in a situation of abuse and exploitation such as forced prostitution. In his address on 25 November 2003, the UN Secretary General stated that around the world 700,000 people are trafficked each year for sexual exploitation. According to UNIFEM (2002) each year 2 million girls between 5-15 are introduced into the commercial sex market.

"***Most trafficking victims believe that they will find a legitimate job in another country, but end up trapped in slave like conditions. Most of them choose to go overseas. However, they do not realize that once they arrive in the destination countries, their passports are taken away, they are forced into prostitution or all kinds of other types of work"***

Wenchi Yu Perkins, Anti-trafficking Program, Vital Voices

***Women and Girls as Victims in Natural** Disasters*

The October 8th earthquake in Pakistan had a serious impact on women and girls. With the death toll rising to 61,222 and the number of injured totaling 58,642 has significantly altered the social structure of the region. With the loss of the male head of household, women have become economically and physically vulnerable. Women's access to health services is especially limited in areas that practice Purdah such as Kohistan, Batgram and Mansehra since women are reluctant to go to areas where relief operations are underway because of the social stigma attached to being in the presence of male strangers. Similarly medical rescue teams find access to women difficult unless they are accompanied by female workers. The vulnerability of marginalized groups, women and children increases because of displacement and exposure to insecure conditions leading to possible sexual abuse and violence, hence their susceptibility to HIV and AIDS infections. This is compounded by the fact that in such situations, there is an insufficient supply of condoms and access to health care facilities.

E, L Heise, M Ellsberg, M Gottemoeller, 1999
Integrated Monitoring Matrix; 6 Feb 2006; HicPakistan.Data@un.org

At times of disaster as medical personnel perform emergency relief, they may face challenges that contribute to increased possibility to HIV and AIDS infections. Some factors include, inadequate safe blood, no facilities for blood screening or sterilization of surgical equipment and inadequate access to disposable syringes.

It is therefore imperative to mainstream HIV and AIDS prevention and care programmes in any strategy for disaster response. As humanitarian assistance moves from the emergency to the developmental phase, the affected need to have access to HIV and AIDS awareness, prevention and care.

Biological Vulnerability of Women towards HIV and AIDS

A woman is at least twice as likely to contract HIV from a male par sex partner with the virus than the other way around because of her body's structure. During sex between men and women, the woman is the receptive sex partner. Semen infected with HIV stays in the vagina for some time after sex and has more opportunity to enter the bloodstream. Data from a number of studies suggest that male to female transmission during sexual intercourse is about twice as likely to occur as female to male transmission, if no other STIs are present.

Moreover, younger women are biologically more susceptible to infection than older women before menopause. Likewise, women under the age of 20 are more vulnerable to HIV than older women as their genital tracts are more prone to infection Risk is multiplied if a woman has sores or cuts in her virginal wall, as these enable HIV to go straight into the bloodstream. These sores can be caused by cancer of the cervix or STDs such as chancroid or herpes, which frequently go unnoticed and untreated as they are often symptom less in women.

Although a woman's risk is greater, she can transmit the HIV virus to the uninfected partner through sexual intercourse through blood (including menstrual blood), vaginal secretions and cells in the vaginal and anal walls.

Men's Vulnerability

Despite being in a position of greater power and influence over women, men are also vulnerable to HIV infection. In patriarchal societies they are considered the heads of household and decision makers and any admittance of vulnerability is perceived as undermining their position of authority in the household.

UNAIDS (1999) reports that prevailing **norms of masculinity** that expect men to be more knowledgeable about sex, put men, particularly younger men at greater risk of infection because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and coerce them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood.

Notions of sexuality that emphasize sexual domination over women as a defining characteristic of masculinity contribute to the **stigmatization of men who have male sexual p**artners. The stigma and fear that results force men who have sexual intercourse with men to keep their sexual behaviour a secret and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners; female or male.

In many societies world wide it is believed that **variety in sexual pa**rtners is essential to men's nature as men and that men will seek multiple partners of sexual release- a hydraulic model of male sexuality that seriously challenges the effectiveness of prevention messages that call for fidelity in partnerships or a reduction in the number of sexual partners**.**

According to WHO (1999) men in many societies are socialized to be self-reliant, not to show their emotions, and not to seek assistance in times of need or stress this **social expectation** makes men vulnerable because it puts them at a greater risk of infection and also hinders the acknowledgment of the disease and hence its treatment. Generally speaking, the social pressure to adhere to these notions of male superiority are strongly associated with high risk behaviour patterns. A national survey of adolescent males between the ages of 15-19 in US found that young men who adhered to traditional views of masculinity were more likely to report substance use, violence, delinquency, and unsafe sexual practices**.**

Gender and the ABC Model

Women's rights activists have emphasized that the ABC model which stands for "abstaining from sexual intercourse", "being faithful" and "consistently using condoms" is not reflective of the reality on ground in regards to the gender issues related to the disease. It does not acknowledge the power imbalance between male and female and how this imbalance manifests itself in sexual relations. Marriage itself does not protect a woman from risk of infection. Married women cannot legally refuse sex with their husbands. They cannot at times question the fidelity of their partners and many are not empowered to demand the use of condoms during sexual intercourse for fear of domestic violence or other such repercussions. The promotion and protection of women's rights has to be center stage in devising any media strategy to deal with the HIV AND AIDS epidemic.

Some Experiences from the Field

A Sex Workers Experience

Well dressed and self assured, Kiran Zareen looks nothing like the stereotypical exploited sex worker. She is only 23 and was born in the red light district of Hyderabad Pakistan. She has been a sex worker since the age of 12. "I am happy but it will be difficult for me to find someone who will accept me in marriage, this is one of the disadvantages of my profession" she readily points out. She is aware of the fact that the prospect of remaining single, however dismal, is nothing compared to the enormous health risk and vulnerability to HIV she faces in her job. This has motivated her to volunteer for the Green Star Project. This is a government supported venture in Serey Ghat, the fourth largest red light district in Pakistan.

The Clinic works as a resource center that disseminates health and disease prevention messages. Kiran along with 5 more sex workers operate from here as peer outreach workers. "As a peer outreach worker, my duty is to spread knowledge about HIV and AIDS and STIs and the importance of using condoms to prevent its spread in the community. " "I teach other sex workers and also my clients". She attended the first Asia Pacific Women, Girls and HIV Best Practices Conference" held in Islamabad. Kiran was present not only to represent local sex workers but also to gain knowledge about the disease and share this with the peer outreach workers back home.

Mane, Rao Gupta, and Weiss 1994; Heise and Elias 1995
Courtenay 1998

An HIV Positive Woman Recalls her Ordeal

"My name is Shukriya Gul and I am 34 years old. In 1995, I found out that I was HIV positive. This was the time when my husband fell sick and was hospitalized. Since he was not responding to any medication, the doctors suggested some tests, without specifying the nature of these tests. At the testing center, we saw posters of HIV and AIDS and other diseases. I was ignorant about the disease at the time. When we went to collect the report, the doctors demanded that me and the children be screened before we were given the test results. Subsequently, we found out that my husband and I were HIV positive and our children were negative. I was extremely grateful to Allah that my children had tested negative. Being a mother, I was more concerned about their health than mine; only a mother can understand how I felt.

My husband passed away shortly after that. The cause of his death was made public and the newspapers reported it with his name and address. Although, their intentions may have been good, but it made my life as a widow with three children extremely difficult. Wherever I went I was singled out as an "AIDS patient". I was asked to vacate my house. In the beginning, my family and friends avoided me but as they became aware of HIV and its modes of transmission, their attitude towards me became normal.

This experience made me realize that I have to raise my voice to create awareness about the disease. Now I present myself as an example that AIDS is not only contracted through sin (sexual promiscuity).

I have been living with HIV for ten years now. During this time I have ensured that I do not transmit this disease to anyone else. I do not share injections or needles and have not indulged in any activity that can be a source of transmission."

HIV Positive Migrant

Sukhan belonged to Shikarpour district was the spouse of an overseas labourer in one of the Gulf States. The man was deported after a positive diagnosis of HIV. Insensitive to the risk that he was putting is wife in, he continued to have marital relations with her till such time that she was brought to the provincial capital for an irrelevant medical condition. Her doctor suggested that she undertake tests for HIV and was tested positive. According to the HIV and AIDS Control Program, 70% of all confirmed cases of HIV and AIDS are of deported workers from the Gulf and many infected women are spouses of these workers.
A man suffering from full-blown AIDS was responsible for passing the infection to his unsuspecting wife. He was the father of four children; the youngest two were born after the onset of the disease. This man from Baluchistan was asked by the doctor to bring his wife and children for testing. It took him two days to bring his wife and one-year-old son for tests.

The wife was screened and diagnosed as HIV positive but the child tested negative. Mr. A was deported from UAE in 1995 without being informed of the reason for his deportation. He attributed his deportation to prejudice of the Egyptian and Turkish doctors working there and was convinced that there was nothing physically wrong with him. He remained in apparent good health for a number of years after his return and learnt of his illness in 1998 when a blood test in the Overseas Employment Office, as a routine part of their employment process, confirmed his HIV positive status. Even after he learnt of the disease he continued to have sexual relations with his wife.

Recorded for AIDS-Hum Aur Aap" a radio program produced by Uks Radio Project in collaboration with AMAL Human Development Network and aired on FM channels to mark World AIDS day; 1st December

When his doctor asked him about his insensitivity to the wife's well being, he expressed no remorse over his actions, instead blamed others for his condition stating that he was not informed about the reason for deportation in UAE and did not receive any counseling at any stage of his illness.

Although the doctor at the Overseas Employment Office disclosed his HIV infected status but did not sufficiently warn him against the danger of transmitting it to his wife even though he informed him of the danger of unprotected sex. As per the advice of his doctor, he used condoms but only for a few months. His fourth child was conceived during this period. His wife has accepted her condition as will of God without blaming it on her husband.

Moving Forward: What can be Done

Any policy devised to combat the disease must be gender sensitive in order to be effective. This implies that it must recognize and cater to the specific needs of men and women. A multi-pronged approach is required. While AIDS programming must cater to gender-specific needs, it must, simultaneously work towards altering the existing status quo in gender relations.

Some measures, for example can be to integrate STDs treatment with family health services where women can take care of their reproductive health without fear of any censure or repercussions from males. Similarly, promoting the use of female condoms empowers women to exercise their reproductive choices, since they do not have influence or control over the use of condoms since they are a male controlled technology. This gender mainstreaming is effective in promoting women's access to prevention, treatment and care. Although they empower women to some extent, they are only partly addressing the balance of power in gender relations.

Further to this are strategies that aim to create more gender-equitable relationships. Some of them are listed below:

Promote Awareness about Gender Dimensions of HIV and AIDS

It is essential to address the need for gender equality and women's empowerment in order to begin to reverse the epidemic. Gender should be integrated into National AIDS policies.

Change Existing Policies and Attitudes

Policy makers, health care providers, the mass media, development assistance agencies and others concerned with stemming the pandemic must take account of gender relations and power dynamics in order to devise effective solutions. The Convention on Elimination of Discrimination against Women (CEDAW) provides an important instrument in this regard.

Focus on Strategies for Men and Boys

Promotion of condom use is critically important. However, such a campaign can only be successful if women feel empowered to say “No” and are not socially ostracized if they do so. For this, traditional gender relations need to be re-evaluated and addressed and male behaviour that strengthens and sustains this attitude needs to be checked. Early socialization among boys towards a more gender sensitive and equitable society is essential. Of course this requires the consent cooperation of men towards this change.

Dr. Abdul Majeed: Dawn: 15 August, 2001

Provide Equal Access to ARV treatments

There is a gender disparity in access to treatment and care. Men enjoy greater access compared to women. Access to medical care is as much a fundamental right to men as it is of women. As the biomedical technologies for HIV and AIDS advance, access to them must not be impeded because of gender barriers. Before the vaccines/technologies are made available, the gender-specific constraints to their use and ways to overcome them must be identified.

Ensure Economic Empowerment of Women

Women need to be economically independent in order to escape high risk situations, sustain their families and negotiate the "how" and "when" of their sexual lives. Micro credit schemes, equal access to employment and equitable remuneration for equal amount of work are some important elements.

Undertake Legal Reform

Existing legal policy needs to be reviewed and revised with a gender lens to provide sustainable changes in laws relating to marriage, inheritance and cultural practices. Ensure CEDAW recommendations related to HIV and AIDS and women's legal rights are implemented and monitored.

Women need to be economically independent in order to escape high risk situations, sustain their families and negotiate the "how" and "when" of their sexual lives.

That women are more socially, culturally, and biologically vulnerable than men is a reality that arises directly out of the nature of global inequalities between the sexes. On the one hand, millions of women do not have the power or the wherewithal to say "No!" to unwanted or unprotected sex. At the same time, women often sick themselves are continuing to care for the sick, an extension of their daily responsibilities within the home.
If we are to tame and reverse the AIDS epidemic, we need to protect women's human rights and put an end to laws that violate them.

Noeleen Heyzer, Executive Director, UNIFEM.

Media's Role to address Gender Inequalities

Since women constitute an increasing proportion of HIV carriers worldwide, the media must play its role to publicly discuss these gender disparities in order to check the ways in which this impacts the spread of HIV and AIDS. It must expose certain trends and mind sets that serve to increase the vulnerability of women and encourage the spread of the virus. Media's role in influencing and mobilizing public opinion and shaping political will cannot be understated.

The media perpetuates the culturally determined norms of behaviour thus reinforcing the damaging gender and sexual stereotypes associated with the superior status of the male. It portrays women as powerless recipients and repositories of infection.

Unfortunately, aside from a few exceptions, the public discourse on sex and sexuality is virtually non-existent in the media. This discourse must however be conducted in a culturally sensitive manner as an initial step in acknowledging our vulnerabilities as

Active and substantive involvement of the media and communication practitioners is critical, if knowledge and awareness about the gender dimensions of the epidemic are to increase.

defined by gender. An integral part of this discussion must be the acknowledgement of women's human rights as defined by international conventions. Inequality in the home, workplace and matters of reproductive rights must be discussed and women treated as equal citizens of their countries and communities.

The media must promote the argument that empowering women does not imply that men are disempowered in any manner. Economic, social and legal empowerment of women can only lead to empowering households, communities and in turn entire societies. Active and substantive involvement of the media and communication practitioners is critical, if knowledge and awareness about the gender dimensions of the epidemic are to increase.

Gender and HIV and AIDS Media Coverage in Pakistan:

According to a survey conducted by the Pakistan Reproductive Health and Family Planning in 2000-2001, 42% of all ever-married women had heard of AIDS. In rural women only 25% had heard of AIDS.

Those 42% heard about AIDS from:

- TV/Radio 37%
- Relatives/ friends/ neighbours 9%
- Husbands 7%
- Newspapers/ Posters/ Pamphlets 6%
- Medical personnel 2%

Of those who heard of AIDS:

- 77% said it was spread by sexual activity
- 60% by blood transfusion
- 55% contaminated equipment
- 40% reported it could be transferred from mother to baby
- 11-5% believed the myth that it could be transferred by using clothes/ utensils of the sick person, touching a sick person, touching a sick person or using the combined toilet.
- 2% knew a person with AIDS or who died with AIDS.
- 1% had a family friend/ close friend with AIDS or who had died of AIDS.

The media must promote the argument that empowering women does not imply that men are disempowered in any manner. Economic, social and legal empowerment of women can only lead to empowering households, communities and in turn entire societies.

The Cultural Context: HIV and AIDS as a Stigma

Introduction

Discrimination and stigmatization have fueled the epidemic from its onset and has presented major barriers to any response to it. This has been a universal phenomenon and continues to impede programmatic interventions to prevent its spread, combat its negative effect and provide support and care to the patient.

Stigmatization is both a cause and effect. The non-disclosure of the HIV positive status and the inability to access treatment and care further reinforces this cycle. Disclosure of HIV positive status is either delayed or avoided and this in turn encourages denial, leads to further infection and delays medical response. This often leads to lack of planning for children orphaned as a result of death by AIDS and women or dependants who suffer serious economic ramifications due to the death of the care giver.

Also, the sources of transmission are often "taboo" subjects and are not discussed openly in many societies. PLWHA are often seen as a "menace" rather than agents of change through which an effective response towards the epidemic can be devised.

Stigmatization associated with HIV and AIDS stems from many factors. These include:

- Lack of awareness and misconceptions regarding the transmission sources of the disease;
- Lack of access to treatment;
- Stereotypes perpetuated by the media and the society at large;
- Categorization of people who are HIV infected i.e. those belonging to already marginalized social groups such as prisoners, migrants, drug addicts, CSWs, homosexuals etc.;
- Social sensitive issues that surround the disease, death, sexuality and drug use;

The fact is that any one can infected with HIV. There are many socio-cultural repercussions that people who are infected with AIDS have to contend with. The professional and social rejection that the infected have to contend with puts the patient and his/her family into a serious personal crisis: community and family ties are often severed and this leads to deep psychological and social distress. They may often be labeled as "bad" people who deserve to be infected and thus do not receive any support or sympathy from family colleagues and even the community at large. They face ostracization at a sensitive time when they need support and care. This fear makes disclosure of HIV infection increasingly difficult for the patient and thus impedes the effective dispensation of prevention and treatment programs at every level and stage. At the prevention stage, people must be ensured confidentiality while being tested or while receiving counseling. Steps need to be taken to facilitate voluntary testing and the fear of repercussions associated with revealing HIV positive status need to be addressed. Those who test positive must receive counseling on prevention in order to stay negative.

Also, the sources of transmission are often "taboo" subjects and are not discussed openly in many societies. PLWHA are often seen as a "menace" rather than agents of change through which an effective response towards the epidemic can be devised.

Stigma and the discrimination associated with HIV and AIDS effects not only those living with the disease but also those associated with it, particularly, family and care givers. This increases the suffering of patients and those associated with them and reduces their capacity to offer support and care.

Another dimension to this problem is how as a result of this stigma, the patients own self image or self worth is affected leading to feelings of "shame". PLWHAs often suffer from denial as a safety mechanism and thus do not exercise their right to treatment, counseling, working, attending school etc. They become vulnerable to depression, self blame, worthlessness, self-imposed isolation and at times suicide. Thus they internalize the negative responses and reactions of people and this process is known as 'self' or 'internalized' stigmatization.

This leads to further discrimination of already marginalized groups and the violation of basic human rights. Examples of such stigmatization of PWLHAs abound where they suffer from denial of their right of access to health services, employment, education, and freedom of movement and confidentiality.

What is stigma?

Stigma is defined as an attitude that is extremely discrediting (and that reduces the bearer).....from a whole and usual person to a discounted and tainted one

Stigma has to be understood in the cultural context and seen as a process rather than a static concept. It is attributed to certain qualities in the individual such as skin colour, sexual inclinations etc which are perceived as "discreditable or unworthy".

It changes over the course of the epidemic

Stigma and the discrimination associated with HIV and AIDS effects not only those living with the disease but also those associated with it, particularly, family and care givers.

and over the course of the life of PLWHAs. A child orphaned as a result of AIDS would have the stigma of being an orphan, of living on the street or of not being able to go to school as an overriding concern rather than the stigma of losing his parent/s to AIDS per se.

The defining features of stigma are:

- Incomplete knowledge, fears of death and disease, sexual norms, and limited recognition of stigmatizing actions;
- Socio-economic status, age and gender that influences the experience of stigma;
- Social and physical isolation, gossip and voyeurism, and a loss of rights and access to resources;
- Internalized stigma which is important and a result of PLWHA's life experiences

Combating Stigma

- Language is a powerful tool for stigma or support. It can serve to either reinforce it or weaken its impact;
- PLWHA's and their families often devise strategies to cope with stigmatization;
- Stigma often impedes programmatic action around treatment, disclosure, prevention, care and support;
- Despite stigma, positive experiences exist which provide opportunity for hope and change

Goffman E. (1963) Stigma: notes on the management of a spoilt identity. New York: Simon and Schuster

Stigma, Inequality and the Cultural Context:

Stigma is deep rooted, operating with the values of everyday life. Although images associated with AIDS vary, they are patterned so as to ensure that AIDS related stigma plays into and reinforces social inequalities .These inequalities are rooted in gender, race, ethnicity, language and sexuality. Groups that are already marginalized and stigmatized are often more vulnerable to HIV infection. Their HIV positive status further marginalizes them and intensifies these pre-existing qualities. The pre-existing stigma is further compounded by association with a disease that has been generally perceived as belonging to marginalized groups. These groups end up dealing with this additional stigma along with the pre-existing stigma of being poor, or a homosexual or a woman etc.

On the other hand, the poor unlike the rich, they do not have access to nutritional food and health facilities for treatment and care and thus cannot delay the physical signs of an HIV positive individual

Societal response to an **HIV positive woman** may be different from an HIV-positive man. She may be further marginalized and feelings of shame and "dishonor" may be directed towards her. She may not be accepted into her community or family even if the source of infection is her spouse. Thus she may conceal her status just to avoid being labeled and isolated from traditional support networks within the family and community. Women also suffer greatly since the onus of the care of an infected family member conventionally rests with them.

Very often women may have to engage in commercial sex to meet the basic needs of their families and their HIV positive status further marginalizes them. They are thus labeled as 'immoral', 'immodest' or 'bad' and suffer from harsher consequences.

Similarly, a **poor HIV positive patient** is likely to experience more stigma compared to a rich one. The rich are able to conceal their status longer because of greater access to resources and thus opportunities for staying healthy longer. On the other hand, the poor unlike the rich, they do not have access to nutritional food and health facilities for treatment and care and thus cannot delay the physical signs of an HIV positive individual. The poor also cannot afford private care and counseling where their confidentiality can be maintained and often have to disclose their status, thus suffering from stigma early in their disease. They have to make choices in spending and may prioritize children's education over health care for themselves, especially if the HIV infected person is a woman.

Youth are generally perceived as lacking 'sexual control' and defying traditions and the norms set out by the elders. Therefore, when they are infected, the society 'blames' them because of their perceived ignorance and defiance of sexual mores, their disobedience towards parents and their desire for material acquisition which induces young women to engage in sex for material gain.

The culturally defined and reinforced **notions of sexuality** also play a role in perpetuating stigma and enhancing gender inequality. Men are often perceived as having a greater natural desire for sexual gratification. Women are perceived as passive repositories in the sexual equation with more controllable sexual urges. Thus women who get infected are often considered 'deserving' of this because of their 'improper sexual conduct'.

Laura Nyblade (2003) Disentangling HIV/AIDS and Stigma: Overview of Findings from a two-year Study in Ethiopia, Tanzania and Zambia
Parker R and Aggleton P (2003) HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. Social Science and Medicine, 57, 13-24

Additionally, ideas about masculinity and femininity have historically resulted in women being blamed for the transmission of STIs of all kinds, and have guilt imputed to them out of assumed 'promiscuity'. Similarly, the attribution of blame to homosexual and transgender people builds on long standing stigmatization related to assumptions about their lifestyles and sexual practices. Racial and ethnic stereotyping also underpins AIDS related stigma.

Discrimination and its Manifestations

What is discrimination?

When stigma is acted upon, the result is discrimination. Discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatized. Discrimination as defined by UNAIDS (2000) in the Protocol for identification of Discrimination against People Living with HIV refers to:

Any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group-in the case of HIV and AIDS, a person's confirmed or suspected HIV-positive status-irrespective of whether or not there is any justification of these measures.

In family or community settings discrimination may take the form of:

- Shunning and avoiding everyday contact;
- Verbal harassment;
- Physical violence;
- Verbal discrediting and blaming;
- Gossip;
- Denial of funeral rites

In institutional settings discrimination may take the form of;

- Reduced standard of health care, denial of access to treatment and care, HIV testing without consent, breaches of confidentiality including identifying someone as HIV-positive to relatives and outside agencies, negative attitudes and degrading practices by health care workers;
- Denial of employment based on HIV-positive status, compulsory HIV testing at the workplace, exclusion of HIV-positive people from pension schemes and medical benefits;
- Denial of entry to HIV infected children in schools, or dismissal of teachers;
- Mandatory segregation of HIV positive prisoners and their exclusion from collective activities

At the national level discrimination may take the form of:

- The compulsory screening and testing of groups of individuals;
- The prohibition of people living with HIV from certain occupations and types of employment;
- Isolation, detention and compulsory medical examination, treatment of infected persons and;
- Limitations on international travel and migration including mandatory testing for those seeking work permits and the deportation of HIV-positive foreigners;
- Omission or absence of laws, policies and procedures that offer redress and safeguard the rights of people living with HIV.

Alarming testimonies from women living with HIV illustrate the adverse impacts that discrimination and stigmatization have had on their enjoyment of the right to the highest attainable standard of health and an adequate standard of living, including adequate housing. Many report living with a constant fear of being forcibly evicted. Even wh dere inheritance and property rights are in principle protected by legislation, widows are being evicted from their homes following their husbands' death from AIDS or an HIV-related illness. Reports and testimonies also reveal that customary traditions and practices linked to women's housing and property, and to their sexual and reproductive health, may contribute to the transmission of HIV. These include "wife inheritance" and "cleansing" practices in certain communities, where unprotected sex is seen to "cleanse" the wife of the dead husband's spirits, and is viewed as a prerequisite for a wife to keep her home or stay on her land.

Special Rapporteur on adequate housing of the United Nations Commission on Human Rights, Miloon Kothari, and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, on the occasion of World AIDS Day, 1 December 2005.

Case Studies

In August 1987, the case of **Mumtaz Begum** was widely publicized in the local press. While living in Dubai, she had received blood transfusion contaminated by the HIV virus. The blood had been imported from USA. Subsequently, she was diagnosed as HIV positive during a medical check up. She was deported to Pakistan with a letter stating that she was infected. Back in her village in Pakistan, she required medical care and had to reveal her HIV positive status to the local doctor. The doctor, upon discovering from her medical record that she was HIV positive informed the police and the press. The story was widely publicized. As a consequence, the village community burnt down her house and stoned the family and her. Both the woman and her family were banished from the village, arrested by the police and incarcerated in Kot Lakhpat Jail, Lahore. Subsequently she was sent to another jail in a remote area and subjected to solitary confinement. Her food was pushed into her cell and she did not receive any medical treatment. She died within three months and there is no record of what happened to her family members.

Whenever **Mazhar Masih** receives guests in his office, he carefully scrutinizes them for prejudice and discrimination in their tone and mannerism. He has been living with the disease for 15 years and in the course of these 15 years AIDS awareness has steadily increased, but as he states " It has improved, but is still not good enough. AIDS patients are still made to feel like second class citizens." Masih had aspirations to expand his father's business, get married and have children before he discovered his HIv positive status. The disease has inspired him to become an AIDS activist. He works for an NGO that provides counseling and financial support to AIDS patients. With him sits a middle-aged man, who told his story:

"Ever since I was 10 years old, I had loved my cousin. When she married another man, I was heartbroken, but within three years she became a widow. We were told that my cousin's husband had been HIV positive and now she was infected too. Although I was aware of this I proposed to her and she accepted. It has been two years since we got married. And now both of us are living with HIV"

Masih's story in his own words:

"I dropped out of school when I was 11 and tried becoming a bicycle repair mechanic. Low earnings, long hours and the smell of cycle oil soon made him detest his line of work. A number of my friends were going to Abu Dhabi and I decided to join them. It was my good fortune that I found work as a domestic worker with a wealthy Arab family and began to send money home. I was earning much more than I could ever earn here and was thankful to Allah for the opportunity.

A couple of years later when I returned to Lahore, my mother had lined up a girl for me to marry. Within a month, I was married to a woman I hardly knew and within two months she became pregnant. I could not afford to take her to Abu Dhabi since I lived in bachelor accommodation with two other men. I made a crucial mistake, I had the money and the opportunity and began to visit brothels on weekends, where sex cost 100-150 dirham. I am pretty sure that I got infected from these women.

I learnt of my disease when I went to the Pakistani Embassy to have my passport renewed and visa extended. As per law, a medical test is obligatory for applicants. I went through it as a matter of routine only to learn that I was HIV positive. I was asked to leave Dubai. My first few months in Pakistan were very difficult as I could not come to terms with my disease and accept my fate.

As neighbors and friends found out they began to avoid me. We weren't invited to anyone's house. My children were not allowed to go to school and my wife's family refused to come over. I felt ostracized and rejected. I could not believe that my entire family was being punished for my mistakes. I was seriously contemplating suicide when I was contacted by this Christian NGO. I have been working for it ever since and hope that I can make a difference".

A four-year old **HIV-positive boy** was expelled from Sishu Niketan Primary School, in the industrial town of Namrup in eastern Assam. This was done under pressure from the parents of his school mates. The Assam Network of Positive People (ANPP) has appealed to the Assam Human Rights Commission to intervene on behalf of the boy. According to the Principal, "Some parents threatened to take their children out of class if the infected boy was allowed to stay. We were forced to dismiss him because of the pressure of other parents whose children were studying in this school." The boy's parents had tested positive five years ago but choose to keep it a secret. When the news leaked out they were ostracized by members of their community. They ran a small business and were shocked at their regular customers who refused to interact with them. After their son's dismissal from school, they have moved to Assam's main city of Guwahati where they are undergoing treatment.

"When in 1990, I was declared an HIV patient; I became a great threat to the nation and a sign of shame for the people in the society. My biggest fear was that this will separate me from my kids and family. I was restricted to my room and became alien for other people"

Nazeer Masih, the first registered AIDS patient in Pakistan

Daily Times: 13th July 2005; Ayesha Javed Akram
Daily Times: 25th February 2005; AFP

The enormous and frightening challenges that the HIV and AIDS epidemic represents can be fought by finding new and creative ways to work together as a community. If you blame yourself and take what people say; it makes you weaker. At this time your family is the most important thing that matters. If they are willing to accept you it boosts your morale. When I first broke the news to my family, they became very afraid but now they have emerged as my biggest strength. Unfortunately, doctors in our country are very ignorant about the disease. Their attitude is very humiliating.

20-year-old HIV positive patient

Prafulla Dash is waiting without any hope. For AIDS has started draining life out of his body. But more than death, it is the isolation that haunts him. He has been dumped in a hut outside his village. His wife and daughters have deserted him. He wants to live last few days of his life with his family. But his last wish may not be fulfilled. "I wish I had died immediately after AIDS was detected rather than have to undergo such disgrace, pain and trauma. This is much worse than death," he says, with tears in his eyes. Dash, 42, was born in a remote village in Kendrapara district and worked as a plumber in Kolkata till he was found carrying HIV virus last year. Soon after, he realised he was left alone on the planet. People including his family members refused to come near him for the fear of infection and social stigma. **Budhia Nayak** contacted HIV/AIDS from a sex worker in Surat, where he was working in a spinning mill. Nayak was denied medical help when he went to Berhampur medical for treatment. When the ill-treatment from his family members and exclusion from the community became unbearable, he finally committed suicide.

Nirmala Mishra, 33, of a village near Aska in Orissa's Ganjam district, was locked up in a goat-shed as soon as the news of her HIV positive status leaked to the village people. Fortunately, she was rescued by an NGO

12 year old **Sunita** is a fifth grade student in a local Government school in India. She has three siblings; the youngest is four years old. Recently, Sunita's father donated blood and was diagnosed as HIV positive. When the entire neighborhood and Sunita's school learnt of her father's HIV positive status, the school authorities decided not to allow her to attend school.

The Assam Network of Positive People (ANPP) has appealed to the Assam Human Rights Commission to intervene on behalf of the boy. According to the Principal, "Some parents threatened to take their children out of class if the infected boy was allowed to stay.

"AIDS is not a disease; it is a stigma, a mark of disgrace on my forehead which will live with me and my family till doomsday. People hate us; no one wants to interact with us. For us, life is a journey that is full of thorns and people throw stones at us."

An AIDS patient from Karachi, at the New Light AIDS Society

I am a 54 year old disabled mother to twin boys who are still in high school. I was diagnosed with HIV a year ago and have been discriminated against twice. I applied for a job, got the job and was fired because I might infect others. Then I started vomiting and bleeding from my stomach. My family doctor referred me to a gastroenterologist. My doctor scheduled an appointment and I waited a month for my exam. They called me the day before the exam to confirm, which I did. The next day I wasn't feeling well, and called to reschedule, which was fine. The woman I spoke to then insisted that I go in that day so the doctor could diagnose what was ailing me. I told her I had to travel by bus (I lost my car with my job), and that I was HIV+. She told me to hold and when she came back she said "I'm sorry but we can't help you because we don't have the equipment for people like you." God, I was crushed. There are no words to describe my feelings. I didn't know that discrimination was so rampant. I am the sole care giver of my twins and I need my health. My infectious disease doctor referred me to another specialist and I had an endoscpoy, colonoscopy, ultrasound and finally a two hour long nuclear HIDA scan. I was diagnosed with gallstones and am now on medication. The first doctor was so unethical and inhuman I would never refer anyone else to him.

Cases of ostracisation and mistreatment of AIDS patients by society at large, including the medical community and family members, are very common. It continues unabated as the number of HIV positive people continues to rise.

Men in Denial

Vie is a 27-year-old, black, living in South Africa, and is HIV positive. According to her *'this is no longer a shocking matter. It has become like getting flu, only deadlier.*' She was diagnosed in 2005, and immediately thereafter had pneumonia, and landed up in hospital and was also diagnosed with meningitis. She states, '*I never thought I'd make it. But one thing that kept me going was the thought of leaving my 10 yr old little girl behind. I just couldn't bare the thought. So I fought, and I must say, the battle is being won.'*

She started when her CD4 count was a shocking 5 and attributes her survival to God, *'this is a miracle of God, because death was knocking. I thank God for the strength that He has given me to fight my enemy. Without Him I would not have survived. A lot of people seem to underestimate the power of prayer, I say, God is the only way.*

She is still with her boyfriend but initially both dealt with accusations and counter accusations on who was the source of the infections. Although they are gradually healing together, he has continued to be an alcoholic. She sates 'In *a way he's in denial. I want to help him, but he's not opening up. He does not even want to talk about the subject. We have not seen each other since I've been sick, 3 months now, but we talk on a regular basis. We are getting closer but mostly I want to get him closer to God, because that is how I found peace within myself'.*

Anonymous

'I read your story, and believe me I can I identify with what you are going through. My boyfriend also refuses to speak of the subject. I have lost all interest in sex, and in him on an intimate level. I'm glad that we are 100's of km apart. Since I've been diagnosed I haven't seen him.

All you need to focus on now is your well-being and the well-being of your child. The men, I don't know if it happens in all other countries, in South Africa are in denial. They think they are immune to HIV. Don't worry yourself about him, don't nag him about it. He will come to you in his own time, even if he's on his death bed. The only thing you need to do is to pray for him, and pray hard. Pray to God for guidance on how to handle the situation, because I find that's the only way through this whole dilemma. I also pray to God that I at least see my child turn 21, and she is able to take care of herself. I pray so hard. .'

'My name is ***Bongi*** *from South Africa. I tested HIV positive in June 2005. I felt I had to go for the test when my husband began losing weight and looking terribly ill. I knew he would not agree to an HIV test so I decided to be brave and go first. I knew my results would probably indicate his because I only slept with him and was negative before I met and married him. He had been having a series of extramarital affairs some of which I discovered and others I only suspected. We have been together for 8 years and married for 4 years now but I can count the times when we had sex. Only when I got tested did I realize why he had 'lost' interest in sex like he would claim. I used to be sad and worried when he would not let me be intimate with him. He would even literally push me to the side and tell me he was too tired. It was worse when I conceived my baby(who is negative - thank God!). He would stay in the living room watching movies and only join me in bed in the early hours of the morning until the baby was delivered. And, come to think of it, he was angry when I told him I was pregnant. He said he did not want us to have a baby yet...(maybe he did not want baby to have HIV)*

I am extremely depressed by my husband's reaction after he heard about my status. He went for the test on the same day and also tested positive.

I am extremely depressed by my husband's reaction after he heard about my status. He went for the test on the same day and also tested positive. Luckily I took a test 2 months after we had met (8 years ago) for insurance purposes and it was negative. And, we both know that I have never slept with anybody else since then. Anyway, what hurts me more is the fact that he does not want to talk about HIV at all. He refuses to answer me when I try to ask him about his feelings. He keeps saying that he is not ready to talk yet and that's his way of ending discussion. And, he has not even apologized for putting me through this. I want to disclose my status and help other people and he does not want to. Maybe he does not want his sexual partners to realize that he has infected them as well. Or maybe he is still spreading the virus. I feel that he has not just infected me but continues to control my life. Whenever he falls sick I silently pray that he should die so that I could be able to live the life I want. I hate nursing and caring for him whenever he becomes sick. I feel that our lives would be better if he at least apologized for what he has put me through.
I pray everyday for God to give me at least 20 more years so I could see my baby grow up. But what can we say, only God knows all our destinies. And He would not take us thus far to leave us.

So, to all you HIV+ brothers and sisters just take it one day at a time and remember, everybody will die someday, no matter who they are and no matter what crimes they have committed or how innocent they were...'

Critical Elements for Interventions

- Create recognition of stigma;
- Foster in depth applied knowledge about all aspects of HIV and AIDS in an interactive setting;
- Provide safe spaces to discuss the values and beliefs that underlie the stigma;
- Find common language to talk about the stigma;
- Ensure a central role for people living with HIV and AIDS

We must recognize that stigma exists and identify the words, attitudes and actions that serve to reinforce it. Also, acknowledge that it is harmful to families and communities. A change can be brought about by changing perspectives and actions and to foster such a change, the narrowness of information available about HIV and AIDS must be tackled. Accurate information on how HIV is and or is not transmitted, the difference between HIV and AIDS, what it means to live with HIV, that opportunist infections are treatable and that PLWHA can have longevity and lead a productive life. HIV and AIDS can serve as a platform or safe environment in which difficult and taboo topics such as sex, death and inequality can be discussed. Voicing fears of premature death that may be disfiguring and shameful can help bring latent fears of stigmatization in to the open. Another important resource to tackle stigma and discrimination associated with HIV and AIDS is to involve PLWHAs since they have the life experience and knowledge on which to build stigma reduction strategies.

Case Studies of Successful Programmes

Zambia Integrated Health Progamme (ZIHP), Zambia

Approach: Mobilizing community leaders to encourage greater openness around sexuality- and HIV-related issues within communities by building on positive social norms

Background

The Zambia Integrated Health Programme (ZIHP) is a technical assistance programme running from 1999 to 2004 that was jointly designed by the Ministry of Health and USAID in the context of decentralization of the health system. Assistance to the health sector is provided at different levels and follows an integrated approach. Topics addressed include AIDS, malaria, integrated reproductive health, and child health nutrition. ZIHP has a geographical focus on 12 of 72 districts and has a nationwide focus primarily directed at (but not limited to) developing systems and mass-media interventions. A key aim has been to help that health sector test new methodologies and identify successful strategies to achieve health impact at community level, with a view to scaling these up countrywide.

The project provides technical assistance on:

- Communication and behavioural change;
- Community partnerships;
- Improved health worker performance;
- Nongovernmental organization strengthening; and
- Private sector partnerships and systems support.

Nyblade, L., (2003) Disentangling HIV/AIDS and Stigma: Overview of Findings from a two-year Study in Ethiopia, Tanzania and Zambia
UNAIDS (2005) HIV-related Stigma, Discrimination and Human Rights Violations: Case Studies of Successful Programs 42-44

Key audiences include the entire community: women, children men. Specific to AIDS, the project's aim is to increase the practice of behaviours and the utilization of services known to be effective in preventing the spread of HIV.

Actions Taken

- Community members have specific functions locally. Some community members hold power in specific matters. These individuals include chiefs, traditional healers, teachers, and heads of government departments. Communities have norms that are culturally respected and shared, and people's actions occur within cultural contexts. Those in leadership positions can play a key role in encouraging behavioral change. Based on this, important HIV-prevention strategies include promoting behavioural change through the use of community-centered and interpersonal approaches, and supporting investments in advocacy and leadership development for influential community members. So far as stigma and discrimination are concerned, two approaches, are being taken: building facilitation skills among key people to encourage more open discussion about AIDS, gender and sexuality; and supporting voluntary counseling and testing initiatives.

Traditional healers are influential people in communities and are key to reducing stigma and discrimination.

- Teachers, schools heads and officials from the district education office have been trained as advocates for the reduction of youth sexual-health-related stigma and discrimination in schools.
- Training of middle management staff in the Judiciary Department has been undertaken to influence policy and reduce stigma, discrimination and marginalization of women and young people during the interpretation of local culture and tradition in the courts
- Training of district heads of government and private sector departments in selected districts has been carried out to lead and strengthen HIV responses in the workplace. At the same time, employment-based agents have aimed to facilitate ongoing dialogue around stigmatizing practices.

Some community members hold power in specific matters. These individuals include chiefs, traditional healers, teachers, and heads of government departments.

- Community HIV educators have been trained in four districts as facilitators in this ongoing dialogue.
- Training of 21% of traditional healers in the target districts has been undertaken to increase dialogue about AIDS. Traditional healers are influential people in communities and are key to reducing stigma and discrimination.
- Support has been provided to the HIV/AIDS Prevention and Care Project in Lundazi district, which provides mobile voluntary counseling and testing services at community level. The Project runs a 'Know your status' voluntary counseling and testing campaign, and serves a population of 65000.

Reported Outcomes

The outcomes to date reflect changes in perceptions, relationships and practices within target communities, as follows.

- Six out of 11 chiefs in Lundazi district have mobilized their communities to fight HIV- and AIDS-related stigma and discrimination. This is evidenced by the fact that more than 10% of community members have tested for HIV. Coupled with this are positive changes in some of the traditional practices that make women and girls vulnerable. Practices such as widow inheritance, ritual sexual cleansing and early marriages have been discouraged through a written decree. Three of the six chiefs have taken an HIV test and a female chief has shared her results with her subjects.

- Support groups have been formed by people who have taken an HIV test. These include community leaders, senior headmen, church leaders and advisers to the chiefs. Groups comprise both HIV-positive and HIV-negative individuals. A large number of the community support groups are managed by women against the background of a male-dominated society. They organize community meetings to discuss gender-related issues. Women are challenging male dominance in sexual relations and contribute to community discussion very assertively. "When we introduced the gender tools, we did have a problem but, after discussing with the men more, we found that they started accepting what we were trying to share with them, " says a programme officer, "Now we don't have a lot of problems with men's resistance. Women now are even coming on their own to collect the condoms on behalf of their husbands. That is quite a great change."

- There has been increased demand for AIDS information and a willingness among communities to learn. Target communities are discussing gender and sexuality issues more openly and thus reducing the stigma that is associated with people's sexual behaviour. Community meetings on gender, sexuality and AIDS are challenging traditional counseling messages given about girl-children, which emphasize the rule of girls as sexual objects. Instead, traditional counselors are encouraged to give more appropriate messages on sex and sexuality.

- In one district, churches have formed a coalition to support HIV prevention, care and support activities for people living with HIV and for young people.

- Traditional healers are beginning to change their perceptions of AIDS. The perception that a person gets HIV because they act contrary to community norms is now being replaced by facts. This approach puts AIDS in a more realistic perspective and results in greater respect towards community members who are living with HIV. Some traditional healers are members of home-based-care teams and distribute condoms. During education sessions, they emphasize issues of stigma and discrimination.

- Civic leaders in one district have an active programme on sexuality and AIDS, addressing stigma and discrimination on the local community radio once a week.

- In most schools, girls who become pregnant while at school are now given the chance to take leave and then return to continue their schooling.

Soul City, South Africa

Approach: Raising awareness through the media

Background

Soul City is a nongovernmental organization, a national multi-media 'edu-tainment' project that has been running since 1992. It aims to impact positively on people's quality of life by integrating health and development issues into prime-time television and radio dramas in a mixture of South Africa Languages. Soul City has developed and aired five television series of about 13 episodes each, in which a variety of topics has been addressed, including HIV and AIDS, tobacco, TB, youth sexuality, child health and violence against women. Soul City also has a number of offshoot projects including life skills materials and a children's 'edu-tainment' TV series called *Soul Buddyz*.

All of the TV series have addressed issues relating to AIDS, including living positively, and AIDS-related stigma and discrimination. The radio series was developed largely to appeal to rural audiences and uses similar storylines and messages as the television. The storylines concerning AIDS were designed to make this an open issue, portraying it as an illness that can affect ordinary people, living ordinary lives in a typical township or rural area. One of Soul City's goals has been to address stigma and to encourage support for people living with HIV.

Actions Taken

- From the first series, broadcast in 1994, Soul City addressed topics related to AIDS. The second TV series (broadcast in 1996) dealt with living with HIV and AIDS and support groups, myths surrounding HIV transmission, the reaction of people who are uninformed to people living with HIV, dealing with being HIV-positive, and AIDS and death. The third TV series emphasized that people living with HIV have choices and can choose to live positively. It also emphasized the rights of people living with HIV. The fourth TV series of Soul City (broadcast in 1999) contained two episodes dealing with AIDS-related stigma and discrimination one on discrimination in the workplace, and one on revealing an HIV-positive status and others' reactions to it. Related themes in the fifth series (broadcast in 2000) included an episode on HIV-related death and living positively with HIV, one on the support and care of people living with HIV and community action to help in this, and another episode on prejudices about AIDS, the need for people to be informed and educated about it, and the importance of living.
- In a parallel TV series targeting children, Soul Buddyz 1 (26 half-hour episodes, broadcast in 2000), five episodes addressed people's reactions and prejudices to people living with HIV.
- A series of 15-minutes daily radio broadcasts following storylines similar to those of the TV series has been developed.
- Soul City has produced a serried of booklets, including those on AIDS in our community and Living Positively with HIV/AIDS. Youth education material aimed at the 12 to 18 age group includes Choose Life: Living with HIV and AIDS. Also available is a guide on how to design and manage an 'edu-tainment' project for social development. Soul Buddyz has materials aimed at children, containing facts about AIDS, as well as how to support people living with HIV, and with a chapter specifically on discrimination.

http://www.soulcity.org.za

Reported Outcomes:

An internal evaluation of the second series revealed that, overall, attitudes towards people living with HIV have improved as a result of exposure to Soul City, and levels of uncertainly have been dramatically reduced. This was particularly striking among the younger age groups. Soul City gave the audience knowledge about the disease, enabling them to have informed opinions.

Findings of the evaluation of the fourth series included the following:

- In terms of attitudes towards people living with HIV, the greatest quantitatively observable change was not in individuals' own attitudes, but in their perception of others' attitudes. That is, the perceived social norm regarding whether people living with HIV should be avoided and/or moved away, changed significantly towards a more tolerant position. Both Sour City TV and radio had a significant impact on the perception of this social norm, and the more exposure a person has had to Soul City, the greater the shift towards greater tolerance.
- Prominent themes emerging from the qualitative research on Soul City's impact on AIDS were: 1) accounts of personal attitudes and values shifting towards greater acceptance, inclusion, support an normalization of people living with HIV; and 2) awareness of the fact that one can live a normal, healthy life as an HIV-positive person.
- Soul City was significantly associated with people's professed willingness to perform the following acts, which could lead to safer sexual practices or greater acceptance of, and care for, people living with HIV: phone the AIDS helpline; help someone who is HIV-positive; ask partners to sue condoms: and go for an HIV test. There was, however, less apparent impact on actual reported behaviour regarding these actions.
- Soul City was significantly associated with promoting interpersonal communication about HIV and creating greater openness and willingness around talking about sensitive subjects, including youth sexuality.
- Soul City helps to create an enabling environment with respect to AIDS. In particular, there is evidence that Soul City has had a positive impact on community leadership (e.g., traditional and religious leaders, and local councilors) and service-providing institutions (e.g., health and education services, as well as the community-based organizations and nongovernmental organizations sector). Soul City is recognized as a relevant educational vehicle in terms of AIDS by these organizations and institutions, and people in these leadership roles or support positions are themselves influenced by Soul City, and actively use Soul City messages during the course of their community involvement. Thus, Soul City messages are effectively actively 'amplified' through community-based vehicles, structures, services and larger community forums.
- The Soul Buddyz evaluation found that Buiddyz reached 67% of children aged between eight and twelve. Of children who had watched the serried on TV, 77% said that they talked about the things they had seen on Soul Buddyz with other people. Of children who had TV but had not watched Soul Buddyz, 48% were willing to be friends with someone who had HIV, while 80% of those with high exposure to Soul Buddyz on TV were willing to be friends with someone living with HIV.

Thailand Business Coalition on AIDS (TBCA), Thailand

Approach: Mobilizing the private sector to implement non-discriminatory AIDS policies and promote understanding about AIDS

Background

The Thailand Business Coalition on AIDS (TBCA) is non-profit organization established in 1993 to bring together business across the country to mobilize the private sector to respond effectively to the problems posed by AIDS, and to help tackle the discrimination faced by employees living with HIV, Established with support from the Thailand Ministry of Public Health, the World Health Organization, and the business sector in Bangkok, TBCA's basic approach has been to view AIDS as a management issue that must and can be managed in order to prevent further losses of valuable resources, such as human capital and expertise.

In 1997 and 2001, TBCA carried out surveys among 404 and 125 Thai companies respectively. These revealed that discrimination was rife, with many companies randomly breaching employees' rights to confidentiality by conducting mandatory pre-employment and on-the-job HIV testing, and most failing to provide staff with an understanding of AIDS through training programmes.

Actions Taken

- TBCA is the founder of the Asian Business Coalition on AIDS (ABC on AIDS), a network of nongovernmental organizations and businesses in 11 countries in Asia that aims to increase the business response to AIDS on a regional level. Two main strategies are pursued: 1) capacity-building of business partners, such as local nongovernmental organizations and other business coalitions on AIDS; and 2) international outreach to business to implement HIV workplace programmes in Asia. ABC on AIDS coordinates the implementation of policies and intervention strategies and assists companies with information through its website www.Abconaids.org.

- The ABC on AIDS website offers many resources, including a booklet identifying strategies for a business response inside and outside the workplace; a manual giving a comprehensive overview of AIDS-related interventions in the workplace case studies of workplace programmes; a directory of AIDS organizations in the region; sample AIDS policies and guidelines for writing them; advice relating to reasonable accommodations for HIV-positive employees in order to assist them in staying in employment for as long as possible; information about testing and the importance of non-discrimination and the protection of human rights; advice about problem solving in the workplace; and an outline of training programmes designed to prevent discrimination in the workplace.

- TBCA provides business with six training curricula that aim to prevent and control HIV in the workplace. Services include: executive briefing (senior management advocacy); human resource management training; staff training on HIV prevention and working together with HIV-positive people; peer education; training of counselors; and training of trainers.

- TBCA manages several community-based programmes to assist former employees living with HIV and to provide care and counseling services to those in need. As part of this work, TBCA operates an automated telephone service (1645 AIDS Hotline).

- TBCA provides ongoing consultation services to business on policy development, legal issues, and access to care and support. TBCA has developed and disseminated a manual on AIDS in the workplace as a resource for managers.

- TBCA organizes professional attachment programmes for business and non-business representatives on HIV workplace intervention strategies and private sector advocacy.

- TBCA designs and implements HIV intervention projects that target specific industries, such as the fishing industry (its 'Seafarers Programme' is conducted in partnership with UNICEF and the Ministry of Labour) and the insurance industry. TBCA has helped to set up an accreditation scheme that provides companies that work together with American International Assurance (AIA) with a financial bonus based on the implementation of HIV-prevention-and-control activities in the workplace.

- TBCA also provides in-house employee training in the form of tailored HIV-prevention-and-education programmes. This includes training in basic counseling and other skills so that employees can continue running AIDS programmes in their workplaces.

- In the coming five years, with support from the Global Fund for AIDS, TB and Malaria, TBCA, the Ministry of Public Health, the Ministry of Labour and 34 collaborating nongovernmental organizations will work together on a project titled: 'HIV/AIDS Prevention and Management in the Workplace'.

Improving the Hospital Environmental for HIV Positive Clients in India

Approach: Improving clinical care for patients living with HIV through participatory activities with health care managers and providers

Background

Previous studies conducted in India have shown that, as elsewhere, attitudes of hospital staff towards people living with HIV are influenced by fears and misconceptions about HIV transmission, and that there is inadequate awareness and practice of procedures to ensure staff safety. The high levels of stigma and discrimination experienced by people living with HIV in care-giving contexts can be attributed not only to prejudice among health care workers, but also to a shortage in supplies and training needed for infection control. In order to address these issues, the Horizons Project and SHARAN (Society for Service to Urban Poverty) have been testing innovative approaches for creating 'patient-friendly' hospitals in collaboration with three New Delhi hospitals.

Actions Taken

- Research was first undertaken to identify the strengths and limitations of services for people living with HIV in three hospitals in New Delhi. The project team interviewed health-care workers, medical superintendents, and patients and their caregivers to explore manifestations and causes of stigma and discrimination in clinical settings, and to develop a framework and indicators for designing and evaluating the intervention. This was followed by baseline research during which the researchers observed hospital practices, documented policies and conducted a survey among doctors, nurses, ward

Mahendra V., George B. and Gilborn L. (2002)Reducing Stigma by Promoting PLHA-friendly Hospitals. XIV International AIDS Conference, Barcelona, Spain, July 2002

staff (ward boys and sweepers) and patients. In addition, focus group discussions and interviews were conducted with HIV-positive individuals and their caregivers.

Researchers found that people living with HIV and their caregivers reported receiving differential and discriminatory treatment from health-care workers. This limited their access to care and included isolation in wards, early discharge from hospital, delays in surgery, and serious breaches of confidentiality-all effectively limiting access to care. There were few links to community-based care and support services. The study team also found that, within the health-care setting, misconceptions about HIV transmission, negative and judgmental attitudes towards people living with HIV, inadequate training and supplies for infection control, and lack of institutional policies on confidentially and HIV testing all contributed to inequality in treatment.

Users of the checklist can use hospital records, survey data, observation or simply 'guesstimates' to rate their own institution.

- Based on these findings, the project team designed a tool called 'The Patient/PHLA friendly Achievement Checklist'. This helps managers to identify how well their facility reaches, serves and treats HIV-positive people, in particular institutional strengths and weaknesses, and assists them in setting goals for the improvement of services for people living with HIV.

  The checklist is designed in a simple format that can be readily adapted for each unique context. It can be used by individual managers or groups of managers and /or staff, and can be applied to large hospitals, clinics or specific departments. Users of the checklist can use hospital records, survey data, observation or simply 'guesstimates' to rate their own institution.

To develop the checklist, 'gold standards' were compiled from national and international guidelines and policies on the human rights of people living with HIV, HIV testing and counseling, infection control, and care and management of AIDS. These standards were reviewed and endorsed by the National AIDS Control Organization (NACO) and by hospitals participating in the study through a series of consultative discussions. They were then adapted into a checklist format.

Staff (ward boys and sweepers) and patients. In addition, focus group discussions and interviews were conducted with HIV-positive individuals and their caregivers.

The checklist has the following sections:

1. Access to care services.
2. Testing and counseling.
3. Confidentiality.
4. Infection control.
5. Quality of care.

Within each of these domains, there are four sub domains:

- Practice (practices and behaviours of staff);
- Training (building and maintaining the capacity of staff to practice these standards);
- Quality assurance (institutional mechanisms to monitor and ensure practice of gold standards); and
- Policy (institutional rules and regulations stipulating or enforcing the gold standards).

In each of these sub domains, there are between one and five checklist items in the form of simple 'true/false 'statements that represent gold standards.

- Using a participator process that has included discussion of the baseline data and the self-assessment tools, managers at each hospital worked with the project team to draft an action plan to improve services for people living with HIV and working conditions for staff. The checklist has enabled hospital managers to develop and set priorities for activities to address the gaps identified. Action plans vary by hospital, but include such actions as developing and posting materials with clear visual imagery on universal precautions to reach all staff, training designated health-care workers from each hospital in pre-and post-test HIV counseling, and offering staff participatory sensitization training, designed and implemented by local AIDS organizations. Hospital managers were also engaged in developing policy guidelines for AIDS are and management that were then widely disseminated to staff.

The interactive training module has been piloted to sensitize health-care workers on various issues related on AIDS.

The objectives are:

- To improve knowledge on the basics on HIV transmission and procedures for infection control in order to allay health-care workers' fears and misconceptions;
- To introduce concepts of confidentiality, patient rights, voluntary counseling and testing, and social care and support to sensitize health-care workers to the needs and rights of people living with HIV;
- To change the negative attitudes of health-care workers in order to ensure the provision of humane and equitable care and treatment and
- To test the feasibility and effectiveness of implementing an innovative participatory training module among a group of health-care workers.

Reported Outcomes

- The checklist enabled managers of health facilities to engage in participatory problem identification and recognize issues of stigma, discrimination and quality of care when, initially, they had been reluctant to acknowledge the existence of problems in these areas.
- By developing solutions through producing an action plan tailored to their particular setting, hospital are actively cooperating and appear to feel a sense of ownership of the project.
- Reported outcomes following the piloting of the interactive training module include positive changes in Attitudes and behaviours in all categories of health-care workers immediately after training.

George B., Jadhav S., Mahendra VS., Mudoi, R., Gilborn L. (2002) Implementing a Participatory and Interactive Training Module to Sensitize Health Care Workers on HIV/AIDS Issues: Experiences from India. XIV International AIDS Conference, Barcelona, Spain, July 2002

After a two-month follow-up, attitudes among doctors continued to show an improvement, whereas hose of nurses and ward staff showed a slight decline.

- Post-intervention, a follow-up survey (N=885) and checklist scores were used to measure progress towards 'patient/PLHA-friendly' hospital environments. Overall, significant improvements in health workers' knowledge, attitudes and practices were recorded. Some examples of this are described below, based on a comparison of pre and post-intervention data compiled from all three intervention hospitals.

- Knowledge about HIV transmission and prevention increased considerably, especially among ward staff. More ward staff know that HIV cannot be transmitted by sharing utensils with people living with HIV (67% at baseline versus 83% at end line), touching someone with AIDS (81% versus 96%), an sharing clothes with a person living with HIV (63% versus 86%).

- Attitudinal improvement were seen in all health care workers with respect to general perceptions of people living with HIV, as well as issues related to caring for them in clinical settings. More health workers disagreed with the statement that HIV spreads due to immoral behavior (29% versus 51%), more stated that they would be willing to share a meal with someone with AIDS (42% versus 72%), buy food from a food seller with AIDS (54% versus 84%), and move into a home next to a neighbour with AIDS (73% versus 94%). In relation to clinical care, there was an increase in the proportion of health workers who disagreed with discriminatory statements, such as "HIV-positive patients should be kept at a distance from other patients' (44% versus 57%) and 'clothes and linen of HIV positive patients should be burned or disposed' (32% versus 46%).

- Greater understanding and better practice in relation to voluntary counseling and testing procedures, infection control measures and confidentiality were observed. More doctors agreed that a patient's blood should never be tested without consent (39% versus 67%), and more sought informed consent the last time they ordered an HIV test (40% versus 59%). In addition, more doctors reported having arranged pre-test counseling for patients who had received an HIV test (31% versus 46%). There was an increase in health workers reporting glove use for at-risk procedures as well as awareness of how to access post-exposure prophylaxis. There were also significantly fewer hospital staff reporting lack of supplies for universal precautions and infection control after the intervention. Significantly fewer doctors (51% versus 29%) reported informing ward staff in the hospitals about HIV-positive patients admitted in the department, as well as fewer nurses (43% versus 28%) reporting segregation of HIV-positive patients from other patients.
- Despite the positive outcomes, there were some areas that require attention for improvement. While health workers exhibited increased respect For the importance of informed consent, they also continued to support the need for widespread testing and sharing of information about patient's HIV-status. In addition, even though there was an overall improvement in knowledge regarding HIV transmission and prevention, some misinformation persisted.

Mahendra VS., Gilborn L., Mudoi R., Jadav S., Gupta I., Bharat S., Prasad R., Upadhyay D., and Raman V. (2004) Making Hospitals more PHLA Friendly: Findings from operations research in New Delhi, India 132nd Annual Meeting of the American Public Health Association (APHA), Washington. DC. November 2004

Conclusion

Participatory methods, access to facility-specific data and the checklist served as critical tools in mobilizing hospital managers to take actions to make hospitals "Patient/PLHA-friendly'. In addition, the adoption of a collaborative approach by government, non-profit groups and researchers was effective in contributing to the reduction of stigma and discrimination in the hospitals. Furthermore, the attempt to effect change in each setting was not top-down, but involved all levels of health workers, from ward staff to hospital managers and administrators. At the same time, there is need for further research to determine whether the improvements reflect actual reductions in stigma and discrimination as perceived by people living with HIV, and whether they will be sustained over time.

HIV/AIDS Unit, lawyers' Collective, India

Background

The Lawyer's Collective is a non-profit organization based in India, which was established in 1981 to provide legal aid to marginalized groups in public interest litigation. The Collective is a public interest group of professional lawyers, law student sand other law affiliates, whose aim is to meet the unmet legal needs of society and particularly the disadvantaged sections of society through legal aid, advice and public interest litigation. The public interest work in which the collective as a whole is engaged includes legal aid, advice and public interest litigation on the issues of women's rights, rights of the homeless and housing, environmental protection and promotion, health issues including AIDS, reproductive rights, and the rights of the unorganized sector of workers, particularly contract labourers.

In response to the AIDS epidemic, the Collective established a HIV and AIDS unit in Mumbai, with financial assistance from the European Commission. This provides legal aid, advice and allied services to people living with HIV.

Actions Taken

- The HIV and AIDS Unit has initiated public interest litigation on the following public health issues: access to treatment and services; HIV testing; privacy and confidentiality; consent to testing; safe blood supplies; decriminalization of homosexuality; the protection of sec workers; discrimination in employment and services; and rights of HIV-positive women in the family and home, as well as outside these domains.

The Lawyer's Collective is a non-profit organization based in India, which was established in 1981 to provide legal aid to marginalized groups in public interest litigation.

- The Unit has raised awareness through advocacy about the legal ethical implications of the AIDS epidemic, including dialogue on law reform, training national networks of lawyers on AIDS issues, and conducting workshops on legal and ethical issues relating on AIDS for people living with HIV, the legal community, policy planners, activists, nongovernmental organizations, and other organizations working on AIDS-related concerns. The Collective has also raised public awareness about AIDS through public rallies, and mobilizes public opinion against stigma and discrimination by advocating for the rights of marginalized groups.

UNAIDS (2005) HIV-related Stigma, Discrimination and Human Rights Violations: Case Studies of Successful Programs 63-64

Reported Outcomes

- The HIV and AIDS Unit has successfully defended workers who have been discriminated against and lost their jobs on account of their HIV-positive status. One of its most significant achievements in this area has been the upholding of the 'suppression of identity' clause. This allows a person living with HIV to file his or her case under a pseudonym. This is important, as people living with HIV are often reluctant to proceed with litigation for fear that their positive status will be disclosed to the public at large, and that they will suffer discrimination. The unit has also won a case relating to breach of confidentiality in which a hospital disclosed a patient's HIV-positive status to his employer.

- The Unit has won cased in the area of human rights of marginalized groups. The Mumbai sex workers case is a notable example. Based on a newspaper report to the effect that there were many under-age girls in the sex trade in Mumbai, many of whom were HIV-positive, an order was passed by the Bombay High Court directing the police to round them up. They were detained and placed in state protective homes. A large number of those who were rounded up were not under age and were therefore held without legal authority. By an order of the court, they were all tested for HIV without consent. The Lawyers' Collective then intervened and obtained an interim order for proper medical treatment of the persons and restraint from any HIV testing. A petition filed by the collective to release the sex workers who were over 18 was, however, dismissed.

A large number of those who were rounded up were not under age and were therefore held without legal authority. By an order of the court, they were all tested for HIV without consent.

V

HIV and AIDS and the Media

Introduction

HIV and AIDS was first reported in the international media in the 1980's. Subsequently, it has not been reported only as a health issue but a broader social phenomenon underpinned by several sensitive issues including sex, culture, taboo, religion and national/global politics.

Journalists in the US for example, report great difficulty in persuading their news organizations to run HIV and AIDS stories, stating that there is already 'AIDS fatigue' in the American Media. Very often HIV and AIDS is considered 'newsworthy' only if it coincides with certain mega media events such as the World AIDS Day, Bangkok AIDS Conference (2004) or news of celebrities being affected by it (see quote below).

"I announce that my son has died of AIDS, let us give publicity to HIV/AIDS and not hide it, because the only way to make it appear like a normal illness like TB, like cancer, is always to come out and to say somebody has died because of HIV/AIDS. And people will stop regarding it as something extraordinary,"

86-year old Nelson Mandela at a news conference announcing the death of his son fromAIDS

What is significant is the decline in stories that have a "consumer education component," This is of particular concern to medical practitioners and development specialists world wide because the increase in HIV and AIDS cases over the years has not matched its coverage by the media. Media's role has been questioned in terms of their responsibility to educate and create awareness rather than only reporting the news.

Similarly, other issues such as the more recent threat of avian bird flu generates greater media attention and is considered a more urgent health issue since it threatens to emerge as a pandemic and is expected to affect many more people than HIV and AIDS has over the past few decades. This leads to a decline in public perception of the 'urgency' of the issue and its media coverage and becomes a challenge for journalists competing for limited news space.

Nonetheless, the mass media has the unique advantage to reach a complex and varied audience with uniform messages. Despite the overwhelming evidence of mass media effectiveness in raising awareness, increasing knowledge and changing attitudes and behaviour, critics say coverage of global HIV is inadequate and very often serves to fuel misconceptions, misunderstanding, ignorance, stigma and fear that surround the epidemic. Some also question the balance of topics covered in HIV news, particularly with regard to coverage of treatment versus prevention. Others say that, in fact, there have been few fundamentally new scientific developments in the HIV epidemic recently, and that for the most part, HIV is not 'news'

'I would like to ask the media: are you out to help us lead our lives normally or just get some smug satisfaction by sensationalism?'

HIV + Salim Akhtar, Coordinator of Nepal Plus, an organization working on HIV and AIDS

Nelson Mandela's announcement of his personal AIDS tragedy challenged the widespread taboo which keeps many people from openly discussing the epidemic and how it has affected them and their families. Deaths from the disease are usually attributed to a "long illness," pneumonia, or other secondary causes.

Moreover, HIV and AIDS has often been covered as a 'dramatic' or sensational event rather than a lasting issue that requires sustained attention. This is not only the fault of the media but also of AIDS advocates who often treat the pandemic as an 'emergency' rather than a health/development issue that requires a long term and systematic attention from the media.

Ultimately, coverage of HIV/AIDS by mainstream news media serves as one important gauge of how prominent the issue is on the policy and cultural agenda of the nation, and how overall attention to the epidemic has changed over time, both in terms of quantity and content.

'The levers of change are to be found in pulpits and press rooms as much as they are in health centers. Changing norms surrounding behaviour which is at the heart of HIV prevention has never been a task best left to men in white coats. We need doctors and nurses to provide treatment, but when it comes to HIV prevention more lives will be saved by journalists, teachers and politicians.'

Peter Piot, Executive Director of the Joint U.N. Programme on HIV/AIDS

In analyzing media's response to HIV and AIDS the following questions need to be addressed:

- Has the amount of coverage of the epidemic increased or decreased over time?
- How have the topics covered changed?
- How often do stories strive to educate the public about transmission, prevention, testing, and treatment?
- What is the balance of optimism versus pessimism in AIDS coverage?
- Are there important differences between print and broadcast coverage?
- Is the language used to report on cases 'derogatory' or discriminating?
- How does it impact public perception and reaction to the disease and PLWHAs?

"The media has the unparalleled ability to save millions of lives by providing them with vital life saving information on AIDS and creating a supporting environment for social change."

Peter Piot, Executive Director of the Joint U.N. Programme on HIV/AIDS

Media Utilization

There are two distinctive ways of media utilization:

- the usual media coverage of news events, regular programmes and entertainment material;
- the use of the media in the context of a planned and systematic process for the clear purpose of influencing attitudes and behaviour.

Regular Entertainment and Media Coverage

Mass media regularly cover all sorts of issues, such as health, arts, crime, sports and political events. In countries which have a "free" press, the guiding principle is more or less to sell more newspapers, reach a larger audience, or sell advertising space. The objective in other countries may be to act as government or political propaganda tools. In all cases, however, the media do not even claim to play a role in health education in their regular treatment of health-related issues.

Elkamel, Farag M. (1996) Can Mass Media Prevent AIDS: the Need for Well Planned Behaviour Change Communication Programmes; Volume 2, Issue 3, Pages 449-458

The fact that AIDS, for example, has received more "regular" media coverage in some countries than any other health issue in the history of humanity could very well be due to the fact that AIDS is a disease that involves sex and death, thus providing journalists with all the ingredients for sensationalist copy. Not only is this coverage not motivated by the desire to provide health education, but it may often be a negative force in this regard. For example, journalists often report AIDS in a manner which reflects their own prejudices. In fact, the media coverage of AIDS has been described as having been slow, erratic, distorted and bizarre. Journalists have consistently emphasized rare or bizarre ways in which HIV can spread, rather than concentrating on the common modes of transmission.

An investigation of the content of two soap operas shown in the USA throughout 1980 (All My Children and General Hospital) revealed that the most common themes presented were deceit, murder and pre- and extra-marital sex

While it may seem that news organizations are doing a public service by communicating important health information to their audiences, they do so not because of an altruistic desire to better the human condition, but to sell more newspaper space or charge higher rates for commercial time. A leader in the news media puts it even more bluntly, asserting that the media "will not and cannot serve as direct relays for campaigns to reduce smoking, to use safety belts or condoms, or to submit to frequent breast examinations". He claims that it is unrealistic to expect that the media will "systematically pass on repetitive messages from the medical community or anyone else".

Usual media programming may even run in the opposite direction. For example, it has been reported that Russian television has aired regular shows hosted by psychotherapists who claim to cure the audience's mental and physical illnesses from a distance. Millions of people watched those shows where the audience was instructed to put bottles of water in front of their television screens; the bottles were "energized" by the hosts of the show, and as a result, became a kind of "medicine". Among other examples of such media coverage were the distinctions repeatedly drawn by the media between "innocent victims" of HIV, such as children, and those "other" patients who are perceived as guilty of causing their own affliction.

Regular entertainment material also has the potential both to misinform and mislead the public. There is sufficient evidence that soap operas, music videos and movies are among the most popular television material, especially for women viewers and young adults. There is also sufficient evidence as to the impact of this entertainment material on the audience. Striking examples of the possible negative impact are the documented reports that violent fictional television stories trigger imitative deaths and near-fatal accidents With respect to AIDS, one would be concerned with how sex is presented and if safe practices are emphasized, considering that sex is a major theme in entertainment. An investigation of the content of two soap operas shown in the USA throughout 1980 (*All My Children* and *General Hospital*) revealed that the most common themes presented were deceit, murder and pre- and extra-marital sex. Even more important, there was no reference verbal, implied or physic alto pregnancy prevention or sexually-transmitted diseases, including HIV/AIDS.

This has led communication researchers and analysts to conclude that Hollywood does not yet acknowledge safe sex, as condoms are non-existent in the movies or soap operas despite all the sex. It has been argued that it would be very difficult for Hollywood to promote condoms, because Hollywood tends to cater to our fantasies and condoms, no matter how life-saving, will never figure in our fantasies. This is indeed a challenge, because it was not until Hollywood had the hero fasten his seat belt that it became more socially acceptable. Even when AIDS is a theme in television material, it is often not addressed in the most responsible way, because television is a business, and "customers" must not be offended.

All of this leads to the conclusion that unplanned, regular media and entertainment material will never, on its own, provide health education which would in any significant way influence HIV and AIDS-related behaviour. Yet media and entertainment are more like nuclear power: they are neither good nor bad in themselves; it all depends on how they are used and for what purposes.

The following section, therefore, reviews a different side of mass media and entertainment: professionally planned efforts to harness the powers of the mass media and entertainment for the well-being of audiences.

Planned Media and Entertainment Material

Communication experts and planners have realized the need for, and importance of, professional media planning. Manufacturers of commercial products, in realization of this fact, have devoted a sufficient amount of their budget to the use of communication services, marketing and advertising professionals to plan campaigns to influence the buying behaviour of potential customers. Efforts to curb the HIV and AIDS epidemic cannot rely on news media to do it on their own. Communication experts have called for the mass education of the general public, and argued that this large-scale education has the potential for not only correcting misinformation, but also for creating and maintaining a more favourable environment for AIDS prevention. In addition, it is generally accepted among communication specialists that public education can change and maintain social norms and render the new attitudes more acceptable, more openly expressed and more likely to be acted upon. It is also believed that mass media publicity about AIDS influences people to take actions they might otherwise not.

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An expert group concluded at their meeting at the World Health Organization (1993) that mass media campaigns "have promoted widespread AIDS awareness, safer sex and condom use". In fact, an analysis of 10 major social marketing programmes concludes that mass media advertising has contributed more to increased condom sales than any other factor, including price, cultural attitudes towards family planning and the level of national socioeconomic development.

Evaluation studies show that there have been positive changes in condom use following AIDS prevention campaigns in the Netherlands, Switzerland, the United Kingdom and the USA. For example, the Swiss campaign resulted in an over 50% increase in the use of condoms, with over 70% among those between 17-20 years of age. This has led to the conclusion that large-scale education appears to have the capability of increasing the social acceptance of condoms and their use among persons more at risk. Radio spots used as part of a campaign to increase condom use among Kenyan commercial sex workers have led to a significant increase in condom use. Following mass media publicity, which included specific telephone numbers, calls to AIDS hotlines in the USA almost doubled from May 1990 (16 691) to July 1991 (32 482). In Mexico City, calls increased more than ten-fold, and in Israel, attendance at a major AIDS testing site increased 431% after the first major television programme on AIDS.

Planned entertainment material has achieved impressive results as well. In the Philippines, a popular music video, intended to encourage young people to postpone sex and avoid unwanted pregnancy, resulted in enhancing young people's communication with their parents. It also motivated over 150 000 Filipino youths to call a sexual responsibility hotline, as promoted in the television video featuring musical stars, and 25% of young people sought contraception information as a result of the song. As many as 240 000 women in Turkey are estimated to have adopted modern family planning methods as a result of television dramas and humourous spots. In Mexico, which has been a pioneer in the deliberate use of soap operas for educational purposes, soap operas were the primary cause of a 63% increase in attendance at adult literacy centres in one year, and a rise of 560 000 in those adopting family planning methods. A Ugandan film, *It's not Easy*, was so effective that those who had seen it were more than twice as likely to have used condoms in the two months prior to the interview, as were those who had not seen it.

In the Philippines, a popular music video, intended to encourage young people to postpone sex and avoid unwanted pregnancy,

Does this suggest that all planned mass media and entertainment efforts succeed in achieving their objectives? Not by any means. In the United Kingdom, for example, injecting drug users, the intended target of a campaign using posters and television spots, did not even perceive that the messages were aimed at them. The slogan "zero grazing", which was used in the Ugandan campaign to mean "stay with one partner", was not even understood by the target audience, and another frequently repeated spot, using drum beats to spread a sense of fear, did not appeal to young people who interpreted the drums as an appeal for abstinence. Just as sensational news coverage can set back AIDS prevention efforts, poorly planned mass media efforts can do the same. In Nigeria, for example, frightening and confusing mass media material has resulted in negative attitudes towards people with AIDS and unfounded fears about the risk of infection. The level of fear aroused by the Australian campaign, which used death visuals, was apparently so great that those at highest risk practiced denial and did not respond.

What is needed, therefore, is not just planned campaigns, as opposed to regular media programming, but *well planned* campaigns which utilize the full potential of mass media and entertainment. The "technology" and methodology for planning and implementing such campaigns do exist. Research has established that mass media are most likely to change behaviour when the information is targeted at specific audiences, comes from a credible source, and provides a personally relevant and engaging message.

Effective use of mass media requires:

- careful planning
- audience research
- message development
- pre-testing
- dissemination strategy
- evaluation
- coordination with existing service
- linking mass media with interpersonal communication

Measures for Prevention of AIDS through the Mass Media

The potential for what the mass media can do in the prevention of AIDS is influenced by how, and how well, the media are used. For example, the media may be used to achieve one or more of the following:

- general advocacy
- endorsement of society's leaders
- community endorsement/support
- community involvement
- specific programme support
- religious leaders' participation
- general public information and education.

To be effective, the media, in particular, and communication programmes in general, have to achieve specific "hierarchical" objectives. The effectiveness and success of media interventions should be evaluated in terms of the extent to which each one of the following ten objectives or outputs has been accomplished:

- exposing audience to the message;
- attracting attention to the message;
- creating interest in and liking of the message;
- audience comprehending the message becoming aware of what the problem is;
- audience being taught those skills related to solving the problem;
- audience understanding of the message understanding why they should behave in the prescribed manner;
- yielding audience changing pre-existing unfavourable beliefs and attitudes;
- audience retaining new information;
- audience deciding to comply with the message and adopt changes;
- audience behaviour changing in accordance with message [21].

Non governmental organizations and other AIDS advocacy groups can bring pressure to bear on government officials to counteract anticipated pressures from other sources.

Finally, a legitimate question which can be raised at this point is this: if we have the methodology and the evidence, why have not all countries implemented well planned mass media and entertainment campaigns for AIDS prevention?

Obstacles and Challenges to Media and Entertainment Campaigns for AIDS Prevention

Lack of Political Commitment

Political commitment to AIDS prevention is the most important first step. Policy-makers have generally been reluctant to air prevention messages on the mass media, which constitutes a major obstacle. Carefully designed materials have not been released because of opposition from politicians, broadcasters, or other gatekeepers afraid of arousing religious or other resistance.

An evaluation of 21 public service announcements about AIDS from public health departments in Canada, Denmark, Norway, Sweden, the United Kingdom and the USA, revealed that three of the five spots considered most effective by 56 knowledgeable reviewers had been rejected for general broadcast. The announcements judged least effective, on the other hand, were broadcast much more frequently.

Communication planners and others have tried to overcome this hurdle for many years. For example, a workshop intended to increase awareness of the social and economic impact of AIDS persuaded policy-makers in Papua New Guinea to promote and support mass media AIDS educational efforts; and pre-test and impact evaluation reports, as well as audience research results showing the desire of the public to receive clear information, have persuaded policy-makers in Peru and Colombia to do the same. Non governmental organizations and other AIDS advocacy groups can bring pressure to bear on government officials to counteract anticipated pressures from other sources. The role of international health and development organizations in promoting, supporting and advocating the use of well planned mass media campaigns can also make a significant difference.

High Start-up Costs

When given the choice, many policy-makers tend to hesitate in choosing well planned media campaigns because of their initial high start-up costs, despite the fact that mass media may be the cheapest approach to use, on the basis of per capita cost. However, using mass media effectively requires more investment at the beginning than other approaches, which may discourage many countries from effective use of mass media opportunities available to them.

Even though the available data on mass media costs are less than would be desired, some good examples are already available. In Turkey, a multi-media campaign cost about US$0.04 to reach one woman of reproductive age and about US$0.67 to gain one user of a modern contraceptive method. It is also reported that in Zimbabwe, a radio soap opera for men cost about US$0.16 for each man reached and US$2.41 for each new contraceptive user. Mass media effort is therefore more cost-effective than other approaches, such as group talks or printed materials.

A meeting in WHO on effective approaches to AIDS prevention concluded that "although mass media education is often expensive, it may be cost-effective in terms of costs per person reached". It also recommended certain measures to reduce mass media costs, such as the provision of free air time on radio and television for AIDS prevention campaigns.

Lack of Sufficient Technical Expertise

An in-depth analysis of the mass communication component of medium-term plans (MTPs) of national AIDS programmes of a sample of seven countries revealed that the plans lacked definitions of appropriate "media-mix" or audience segmentation. They did not seem to be based on good knowledge of media habits and preferences of the various segments of the target audience in different regions of the countries, and among different socioeconomic groups and different age groups, as well as between males and females.

These are only a few of the basic components of a good AIDS prevention communication plan which are often neglected, despite their extreme importance. For example, the media-mix selected for a specific campaign should be closely linked to specific audience segments which may require tailored messages, such as women, unmarried youth and people who practice high-risk behaviour or are likely to be in more high-risk situations. Each one of those segments may have different preferences and media habits and thus requires a different approach. Furthermore, when the audience is segmented, it becomes possible both to involve each segment in the design of messages which are intended for it, and engage them in the pre-test of those messages in order to ensure better impact.

In addition, AIDS prevention materials have to compete with commercial advertising for air time and audience attention, which requires that AIDS messages be more professionally and creatively packaged. The high quality of the Ugandan AIDS film It's not easy has enabled this film not only to reach 90% of the Ugandan workforce, but to also reach beyond Africa to Asia, Latin America and the USA. The film is considered an unusual case of a developing country's product being used to change attitudes and behaviour in an industrialized country.

Conclusion

What emerges from the foregoing discussion is that, with respect to AIDS prevention, although there is a clear opportunity for effective mass education of the general public, unplanned media coverage and entertainment material will not be appropriate or sufficient. Well planned and professionally designed mass media and entertainment material can achieve remarkable results in raising awareness, increasing knowledge, changing attitudes and social norms and changing behaviour, including the use of condoms. Actions that can be taken to overcome the obstacles reviewed above, and to strengthen national capacities to undertake successful media campaigns, should constitute priority activities.

In particular, there are three main areas which require special and immediate attention by governments and international donor agencies:

Persuasion and Mobilization of Decision-Makers

Without their active support and involvement, the first necessary steps towards effective use of the media cannot be taken. Their support is needed in acknowledging the following:

- the importance of AIDS as a national problem;
- the commitment to using mass media for public education and persuasion;
- the importance of using the media systematically and by professional media planners and producers;
- the need to allocate resources, including the provision of free time and space.

Activities needed in this priority area may include public relations campaigns directed at these policy-makers, and utilizing different approaches such as documentaries, booklets, statistics, computer programmes, presentations and seminars.

Effective use of Available Media

Most countries have, in fact, already used mass media for some sort of AIDS communication. However, one often hears the complaint that using the media did not help. As already discussed, this may very well be due to the way mass media were used. To avoid this problem, training of national programme managers and their communications officers is vital, with the objective of helping them realize the importance of using media through professionally planned campaigns, and providing them with the basic knowledge and skills to recruit, manage and coordinate needed assistance.

Training Communicators and Journalists. They need to be instructed in the ways to present their material, first to avoid stereotyping and unintended negative effects, and second to enhance and support the main communications programme. They need to be more sensitive to certain factors such as audience segmentation, pre-testing, and evaluation of material impact.

A Journalist Speaks

Ceci Fadope, is a journalist now working in the Internews media development program that is attempting to advance the media's approach to HIV and AIDS beyond basic awareness. Outlining the issues and obstacles she has faced in implementing the organization's agenda she states:

"We are now looking at more in-depth pieces, more investigative pieces and looking at more informative pieces that are more knowledge-based. In Nigeria, where I have been working, the Ministry of Health surveys indicate that basic awareness of HIV was broad, but shallow. The general public did not have a full understanding of the virus and the means of transmission.

Catchy phrases in public service announcements weren't doing it. Billboard ads weren't quite doing it. People needed a little more in-depth information, which is what journalists bring to the table. I am encouraging journalists to spark a broader social discussion about the virus and the disease. To do that, some taboos must be broken.

We're bringing sexuality issues to the front. In countries where we work, like Nigeria, some parts (of the country) you can't use the word 'condom'. We're trying to crack open those closed areas. We have worked with about 120 Nigerian journalists since the program began in early 2003. As a result, reporting on HIV and AIDS issues has become more sophisticated, evolving from basic reporting on events, statistics and official statements to more in-depth and nuanced stories about the epidemic, its victims and its social implications.

We're now looking specifically at what are the conditions of orphans and vulnerable children; how transmission happens; what happens to the baby who has HIV through his or her mother; we're looking at how poverty intersects with HIV.

The approach is now not reporting statistics, not reporting events, but touching people, connecting people with the information that really makes a difference.

Beyond the effort to create greater depth in African journalism, the Internews "Local Voices" project also works to build

By Charlene Porter, Washington File Staff Writer

greater awareness and sensitivity to AIDS issues in the entertainment side of media, working with radio disc jockeys that often set community standards in the perception of the epidemic particularly among the young. Internews is also involving popular local musicians in performances to build greater awareness.

Internews is using music, using DJs, using the radio and using accurate balanced HIV/AIDS information to target young people in a peer education process. Besides improving the quality of information about the epidemic, the media development efforts are also working to diminish social stigma and discrimination against people living with HIV. Internews-trained journalists are doing more to give voice to people living with HIV, getting them to tell their stories, knowing that other people can learn something from what they have to share ... that is very, very empowering.

In Nepal, it is estimated that over 62,000 people have contracted HIV/AIDS although the reported number of cases stands at less than 4,000.

Some Examples from the Field

Despite these limitations, a few dedicated journalists have demonstrated personal interest and commitment while reporting on HIV and AIDS. They have taken up issues other than official statements and reported on AIDS from a social perspective.

The increasing number of PLWHAs are declaring their positive status and willing to speak to the media. Presently, reporting on HIV and AIDS has moved from quantitative to qualitative. Thousands of human interest stories, and oral testimonies (with consent) of PLWHAs would make for very powerful and effective media coverage.

An increasing numbers of journalists are also sensitized, and understand that it is a complex issue and must only be reported by those who have factual knowledge of it.

Although a large number of urban media persons have substantial knowledge of HIV and AIDS mainly through the effort of the Government, NGOs and the international development agencies, there are still a significant number of journalists in many parts of Pakistan who have either never heard of the virus, or are not interested in knowing or talking about it. The challenge, therefore is to reach out to the least aware or interested and motivate them to own the issue rather than discard it as 'someone else's' and not 'theirs'. It is this ownership that will lead to the much needed, sustained and committed advocacy expected and required of the media.

Role of Media in Nepal

In Nepal, it is estimated that over 62,000 people have contracted HIV/AIDS although the reported number of cases stands at less than 4,000. HIV/AIDS in Nepal is now concentrated in certain vulnerable groups, but it could enter into the general masses if immediate measures are not taken on time.

Ignorance

According to a study, more than fifty per cent of the PLWHAs do not know about the disease. And this widespread ignorance is one of the factors behind the multiplication of the disease. In this context, the media can educate and make people aware about the pandemic by breaking the silence about it. It can launch a crusade against the stigma, discrimination and taboos associated with HIV and AIDS. It can encourage people to Talk openly about HIV/AIDS and impel the government and non-government agencies to provide prompt service delivery to the HIV patients.

Experts are of the view that effective media coverage can humanize and localize the HIV and AIDS issue, and spur public discourse, which, in turn, will promote the government to prioritize HIV and AIDS issues into the country's social and political agenda. Media content shapes beliefs about the disease and Influences response from governments and public attitude towards the PLWHAs. It can advocate accountability and responsibility and help the people to raise their voices.

In Nepal, the media have been playing significant roles in generating awareness About the pandemic. The media have been reporting HIV cases hidden in the Remote parts of the country and exposing the poor medical services Provided by the hospitals and health centres. More importantly, they have brought to the fore the stigma and discrimination faced by the people infected with HIV at the health centers, families and society.

Despite this laudable job the Nepalese media are doing, their potential has not been fully harnessed to fight the pandemic that is ticking like a time bomb. A research jointly conducted by POLICY Project, Nepal and Sancharika Samuha says that the Nepalese media have not yet fully realized their responsibility for the prevention, care and treatment of the disease.

The study of the print media, radio, television and billboards revealed that a number of gaps exists which hinder them from effectively playing a role to spread awareness against HIV/AIDS. It states that the Nepalese print media lack depth and there is little investigative reporting on HIV/AIDS. The reporters working in the districts also lack adequate knowledge on the issue.

Likewise, they have failed to include the views of the infected and high-risk people. They are not giving space to the coverage of the issue with priority. 'While the reporters lack Sociological perspective on the issue, most of their reports fail to deal with the role of gender in the spread of the disease', it says.

Radios and television stations do not have specific policies to address the issue in their newsrooms. They heavily depend on the sponsors to air the programmes. While their reporters and programme producers lack proper knowledge on the matter, they do not pre-test their advertisements before airing.

Likewise, their programmes and advertisements suffer from inconsistencies when it comes to matters relating to HIV/AIDS. In the case of billboards, it found the PLWHAs opting to portray persons infected with HIV than actors or singers to effectively convey the message. 'Portrayal of actors and singers have sent negative messages to the rural people who believe that the person presented in the billboards have AIDS.'

It has presented an array of recommendations to the media, policy makers and the government agencies for the wider coverage of the issue in the media so that people become aware about the deadly disease. It has called for regular interaction and rapport between the media and government agencies and planners. It suggests reporters conduct in-depth, investigative and analytical reporting on the issue.

"The media should encourage their reporters for accurate, insightful and sustained coverage of the issue, and respect the rights and sensitivity of vulnerable groups," it says. It has also proposed guidelines and tools for the media for reporting HIV/AIDS.

Partnership

The research is a timely attempt to reassure the role of media to battle this scourge confronting humans. There is a need for capacity building of the media for the purpose. Only a partnership among the line agencies such as the government, NGOs, civil society and the media will ensure effective media coverage of the issue and finally mainstream it in the overall media performance.

Stories of Hope Told on Air: Women Widowed by AIDS Get Back Their Land

Case Study from Kenya

On December 1, World AIDS Day in Kenya was marked with seven radio stations telling the stories of disinherited AIDS widows who have managed to get back their deceased husbands' land. The broadcasts followed a two-day training in Nairobi for senior journalists on the issue, organized by Internews and the POLICY Project.

When **Beatrice Nyanza's** husband died from an AIDS-related disease, her brother-in-law chased her from her husband's land within a month after his death. She and her three children had to move to a mud hut. She could no longer afford to pay their school fees and could

Only a partnership among the line agencies such as the government, NGOs, civil society and the media will ensure effective media coverage of the issue and finally mainstream it in the overall media performance.

hardly feed them. One of her daughters was sexually abused and became pregnant at the age of 12.

After the story of Beatrice was played on A Stitch in Time, a one hour call-in HIV and AIDS programme on the national English service of the Kenya Broadcasting Corporation, the POLICY Project that had helped get her land back, was flooded with text messages from people condemning the practice. Speakers for the radio programme included representatives from POLICY Project and the Human Rights Commission so that they could tell listeners about their rights and how they could help them.

The speakers at the radio programme stated that widows whose husbands died of AIDS were more vulnerable to disinheritance than older widows. AIDS widows were normally young, mostly in their twenties or thirties, as AIDS kills many of their husbands in their productive years. Being young and often sick themselves, these widows were generally uninformed on their cultural rights and did not have much negotiating power.

Http://www.internews.org/news/2005/20051202_kenya.html

Beatrice Nyanza's culture did not condone the disinheritance of women, yet many become victims of this practice. The POLICY Project worked with the Council of Elders to help at least 20 women get back their land and make a living for their children. Many of these widows are still involved in negotiations.

Focus attention on topics that have been hitherto ignored in the media including policy, best practices and medical advances

Although Nyanza's culture encourages people to look after widows, but the opposite happens because people are misinformed and others abuse this fact. That is why it is so important that journalists help in giving people access to the right information.

Similarly, the Catholic station, Radio Waumini, broadcast two programmes on the issue because they recognized their responsibility to tell audiences that there is hope and that no one has the right to discriminate against people with HIV. These features were presented so that other presenters also have material on disinheritance for their programmes.

The specific objectives with regard to HIV/AIDS coverage in the media are to:

Pakistani Scenario

Until 1994 HIV and AIDS was not owned by the Government of Pakistan, it remained shrouded in silence, denial and ignorance. Gradually, the global focus and donor preferences helped HIV and AIDS surface on the national agenda and become a priority. There were campaigns on HIV and AIDS on PTV, the state-owned television channel. Though the issue did make it to the media and through them to the public, there was no clearly defined communication strategy. This ambiguity and lack of political will resulted in unique, though at times farcical, attempts to inform and educate the public on the why's and how's of HIV and AIDS. Communication was ad hoc and sporadic and this resulted in confusion and misinformation. Spots and messages were not instrumental in guiding the public towards a better understanding of the crucial three: Abstinence, Fidelity and Consistent Condom Use.

The POLICY Project worked with the Council of Elders to help at least 20 women get back their land and make a living for their children.

In 1990, Herald, a leading English language magazine in Pakistan, did a cover story on AIDS. It was one of the first detailed report on the subject to be published in the country.

In 1992 India Today, a leading political magazine in India, did a cover story on AIDS. In 1994, Herald did another story on AIDS. The *Herald* story, substantiated with statistical data, portrayed a male face painted a ghoulish blue with eyes reddened and painted a terrifying image of the disease. This instigated terror and panic among the readers. On the other hand, the *India Today* story (showing a young woman and child) gave a human face to the disease.

Although HIV and AIDS was first reported in the Pakistani media more than a decade ago, even today many campaigns remain vague, even though they are packaged differently. Misconceptions regarding the source of infection, prevention and care are still prevalent in the Pakistani media.

Although the amount of coverage is indicative of media's commitment towards the disease, the type of images and terminology used to report on the disease is of prime importance in perpetuating these misconceptions. A glaring example of the misinformation by the media is when in 1998, during a media workshop in Islamabad, a mid-career journalist stated that HIV infection could be acquired 'by holding hands and sitting under a tree.' This assumption was based on an advertisement which showed a couple holding hands and sitting under a tree with a caption that said, *'apney azdowaji taaluqat apney jewan saathi tak mehdood rakhein'* (which roughly translates as limit your marital relationships to your spouse.)

A sustained media advocacy campaign is required to address misconceptions and implement national AIDS policy.

In Pakistan, we are far from giving HIV and AIDS a human face, let alone a woman's face. HIV and AIDS is still not discussed as a social or health issue. State-owned organizations working on AIDS are satisfied with media reports that begin and end with quotes from officials. The less reported the better.

Media coverage in Pakistan gains momentum only on specific events such as World AIDS Day (December 1st) or while reporting on Conferences/Seminars on the subject. A sustained media advocacy campaign is required to address misconceptions and implement national AIDS policy.

The media must therefore:

- Rise to the challenge by promoting awareness of HIV and AIDS and educating listeners and viewers about the facts of HIV and how to stop it;
- Influence the policy makers to develop continued, compact and correct messages focusing unambiguously on modes of infection and prevention;
- Realize and recognize levels of awareness among public which may vary from ignorance to denial;
- Reach out to the most vulnerable, yet often neglected segment of our youth with information, services and life skills that may enable them to reduce their vulnerability;
- Counter the reactionary forces and extremist elements with a balanced and convincing campaign;
- Continue to organize sensitization training for the media for better understanding of the issue and positive reporting;
- Address HIV and AIDS in daily programmes for sustained impact;
- Allow candid discussion on HIV and AIDS in the media and debate issues of stigma, denial and discrimination through these discussions;
- Campaign on how to create an enabling and supportive environment;
- Refrain from the typical bureaucratic approach of holding back or clinging to information, partial dissemination or/and giving information selectively;
- Learn from successes and failures of other communities, including India, Thailand, South Africa, Uganda as well as Muslim countries like Bangladesh, Malaysia and Indonesia.

Pakistani Media and its Inhibitions

At a Radio conference in Melbourne, a researcher from a South African University presenting a paper on *Campus Radio and HIV/AIDS Awareness*, was asked by a Pakistani media professional to guide her on how to devise/design messages for HIV and AIDS without using the words 'sex, condom or sexual intercourse'? She was unable to do so despite consultations with colleagues. Although Pakistani media is inhibited in the use of these terms but they are now emerging from it. The first campaign using the word 'condom' is out in the print media. Even though of ten newspapers reviewed on December 1, 2005 (World AIDS Day), a condom-specific advertisement appeared in only one Urdu newspaper but this is at least an initial step forward towards direct and candid advocacy campaigns.

Moving Ahead

Following are suggestions for media interventions for HIV and AIDS

- Keep information updated through all sources, websites, Media Manual on HIV and AIDS, related publications etc;
- Increase coverage of HIV and AIDS in the media that is factual and unbiased;
- Improve quality of HIV and AIDS coverage by avoiding sensationalism and focusing on the issue through a development perspective;
- Sensitize media persons to HIV and AIDS issues and perspectives through workshops and seminars
- Acquaint media persons with the world of People Living with HIV and AIDS to shatter myths and misconceptions;
- Focus attention on topics that have been hitherto ignored in the media including policy, best practices and medical advances;
- Focus attention on gender and diversity/ discrimination issues;
- Focus attention on stigma, discrimination and rights;
- Introduce media participants to technical and epidemiological inputs;
- Introduce media persons to international expertise and opinion;
- Have cross-cultural learning reflected in published or broadcast content;
- Reach consensus among media personnel on a code of ethics and good media practices for reporting on HIV and AIDS cases;
- Create and foster linkages among television, radio and print media for a collective communication strategy;

Keep information updated through all sources, websites, Media Manual on HIV and AIDS, related publications etc

Media Coverage

NGOs have recognized the need for such a campaign. Organisations like PNAC are actively working with media on the HIV&AIDS issue. PNAC for example has had seminars in 2005 and 2006 with the media on 'Communicating for HIV and AIDS Prevention' (Mar 21, 2006), 'HIV&AIDS in Pakistan' (27 Dec 2005) and 'Increased Vulnerability to HIV and AIDS as an aftermath of the Earthquake' (22 Dec 2005). PNAC has also had a wealth of press releases, amongst others in Quetta News, The Nation, DAWN and the Daily Express.

Annex: Some news articles from 2007 on HIV&AIDS

DAWN

May 8, 2007 KARACHI: Law to check re-use of syringes
By Our Staff Reporter
KARACHI, May 7: Lack of awareness of HIV/Aids among the high-risk groups is making the fight against the disease difficult as they are considered to be marginalised segments of the society with limited access to information.

These views were expressed at a seminar titled 'Establishment of PLWHA—People living with HIV/Aids' — held in Lyari Town and organized by Mehran Reproductive Health Organization, an NGO which is working with people living with HIV/Aids to give them support care mechanism through its networking.

The speakers stressed the need for creating awareness of the diseases among the masses to check it effectively.

Area MPA Rafiq Engineer was chief guest on the occasion which was largely attended by the social workers of the locality.

Statistics released by the NGO show that by the end of 2006 the total number of adults living with HIV globally was 37.2 million while the number of women infected with the disease was 17.7 million and the children under 15 years were 2.3 million.

The global estimates for newly infected people with HIV by the end of 2006 was 3.8 million adults while the children under the age of 15 were 0.53 million.

The total number of deaths by Aids across the globe by the end of 2006 was 2.9 million while the reported deaths of adults were 2.6 million and the children under the age of 15 years were 38,000.

In South and South East Asia, the statistics show that the number of adult and children living with HIV/Aids was 7.8 million while the number of adults and children newly infected with HIV virus by the end of 2006 was 0.86 million while adults and children death due to AIDs by the end of 2006 was 0.59 million. In Pakistan, 3,224 HIV positive and 367 Aids cases were reported by the end of 2006 while 165 death cases were reported. Around 1,670 HIV positive cases and 108 Aids cases were reported in Sindh by the end of 2006.

The speakers also urged the NGO workers to launch advocacy campaigns in vulnerable populations. MPA Rafiq Engineer expressed his concern over the rampant re-use of syringes and promised to take the issue to the provincial assembly so that proper legislation could be initiated against the re-use of syringes.
KARACHI, Feb 26 2007: Speakers at a seminar on Monday stressed the need for collaborative efforts on a priority basis to avert any generalised spread of HIV/Aids in the country.

They suggested scaling up of interventions in high-risk population and focusing on male and female sex workers, prisoners, truckers, etc. The three main transmission routes of HIV are sexual contact, exposure to infected body fluids and tissues and infected foetus or baby during prenatal period.

The observations and expert opinions came at the seminar organised as part of the third annual international symposium by the Dow University of Health Science (DUHS).

Chief guest, retired chief justice Saiduzzaman Siddiqui, speaking on the occasion, said that extra-marital relations and homosexuality were being considered as the major source of the HIV/AIDS spread, but such a trend could be countered through the social code of life as prescribed by Islam, which condemns all such acts.

Highlighting the constitutional safeguards available to an HIV-positive/Aids patient in the country, he said that access to reasonable health service to sustain and enjoy life was a basic right of every citizen whereas the budgetary allocations for health services exposed government's apathy towards constitutional obligations. He observed that the size of the allocations for healthcare was nowhere close to the ideal "Health for all" notion.

Talking about HIV/Aids stigma, the former chief justice said that it was severer than those associated with other life-threatening conditions and extended beyond the disease itself to providers and even volunteers involved in looking after the HIV/Aids patients.

Lack of knowledge on the part of masses vis-a-vis HIV/Aids had resulted in the isolation of patients and discriminatory treatment, he noted, adding that health care workers even in highly knowledgeable societies were often labelled public health threats and lost their livelihood.

He observed that the patients' right to privacy was upheld internationally. Measures like screening of high risk groups of people for Aids virus antibodies and counseling and education of those showing test results positive might help limit the risk that could contribute to transmission of the virus.

He expressed the view that people should be tested only when the purpose of the tests, its range of reliability, and its potential for social harm was clearly explained, and with the individual's consent. However, things should be handled with care and it should also be kept in mind that any third party knowledge of results being positive might cause stigmatisation and discrimination and jeopardise important civil rights in such areas as housing, employment and access to health care, he cautioned.

Justice Zaman also highlighted the rights available to people with HIV under the American HIV Patient Bill of Rights, and said that the Bill provided a useful guideline to formulate rights of HIV/Aids patients in Pakistan.

In his key-note address, Sindh Advocate General Anwar Mansoor Alam said that the national HIV/Aids policy was almost ready for approval and could be adopted if HIV/Aids posed a real threat to the health of individuals, families and communities in

Pakistan.

He said that the presence of a number of vulnerabilities and the risky behavioural patterns suggested the need for urgent prioritised and coordinated action to avoid the emergence of the virus like an epidemic.

Poverty, gender inequalities and low level of education and literacy all contributed to HIV vulnerability in the country but other related factors that could increase vulnerability at the individual level included unemployment, social exclusion or marginalisation, physical and/or mental abuse and gender-based discrimination should also be taken into consideration, he said, adding that delayed response to these activities were placing people at risk of HIV infection as well.

He was of the view that HIV/Aids pattern emerging since after the report of first Aids case in the country in 1980, there was a dire need to put things in order so that citizens could be cautioned and protected by law, in addition to being protected by the socio-economic dependency. “With the epidemic continuing to spread at alarming rates in many parts of the world, particularly Pakistan, it is important that HIV/Aids policy explores new and creative measures for dealing with the challenges facing it,” he remarked.

Vice-chancellor of DUHS Prof Masood Hameed Khan, said that 50 to 60 per cent people were suffering from one or another illness in Pakistan, hence the health problems were on the up swing and claiming heavy toll in the health care system and causing losses in the economy of people, besides government. “Illiteracy is the root-cause of all problems, therefore, it is need of the hour to promote education and it should be given top priority by all stakeholders,” he added.

Director of the Ojha Institute of Chest Diseases Dr Ashraf Sadiq discussed HIV/Aids in relation to TB, and said spread of the former fuelled prevalence of the latter by promoting progression to active TB and increasing risk of reactivation of latent TB. In both the diseases, patient loses his immune system and becomes more vulnerable to the other diseases. He suggested that programmes for HIV/Aids and TB in Pakistan should be interlinked to combat these health problems.

Dr Sharaf Ali Shah, Project Director at the Institute of Infectious Diseases, DUHS, said that Pakistan was at present experiencing concentrated HIV spread and there was a serious threat of ‘generalised epidemic’. As such, he added, there was a need for strengthening the prevention and control programmes in the country.

Prevalence of HIV among the most at risk exceeds five per cent, while the HIV infection among the injectable drug users in Karachi had jumped from 4 per cent in January 2004 to 26 per cent in 2005. He pointed out that Sindh had reported the maximum number of HIV/Aids cases in the country, i.e. 1,212 cases out of which 1,109 were HIV-positive and 103 Aids cases.

Mehtab Akbar Rashidi, Dr Srichand Ochani, Prof M. Zaman Shaikh and Zahid Saeed Syed also spoke on the occasion.

At one scientific session of the symposium on diabetes mellitus, Prof Paul Thornally of UK expressed the view that the advanced technology and treatment methods should be applied in diabetes patients to improve their quality of life.

Prof Samad Shera and Prof M. Zaman Shaikh discussed the root-causes of diabetes in children under the age of 10 years. They stated that it was increasing due to obesity and excessive use of cold drinks, fast food and oily foods, besides lack of physical activities.

In a session on gastroenterology, Dr Altaf Anwar stressed the need for importing and employing latest instruments for diagnosis and treatment of gastrointestinal diseases so that millions of people suffering from such disorders could be provided proper treatment.
RAWALPINDI, April 17: The current drug abuse level and trends in the country have raised fears of increasing transmission of HIV/Aids, while results of an ongoing national drug-abuse assessment study will help the government to formulate a policy to tackle the menace of drug abuse, informed sources said on Tuesday.

Pakistan is facing a serious HIV/Aids epidemic driven by a combination of injecting drug use and commercial sex, when a major epidemic was detected among injecting drug users in Karachi, 26 per cent of whom were found to be HIV-positive. Results of the national drug-abuse assessment study being jointly carried out by the UN Office of Drug Control (UNODC) in collaboration with the Anti-Narcotics Force (ANF) were currently being evaluated and would be released before June this year, the sources said.

The study will help shape up a policy and determine where to allocate resources, the sources told Dawn. A Steering Committee formed under the overall scope of the Second National Drug Control Master Plan for 2007-2011, comprising ANF and UNODC was finalizing a plan, which would be submitted to the federal government for approval. The plan deals with law enforcement, drug demand reduction and HIV/Aids prevention.

Pakistan is one of the countries hardest hit by narcotics abuse in the world. According to national drug abuse surveys, the number of chronic abusers of heroin increased from about 20,000 in 1980 to more than 1.5 million in the late 1990s.

Drugs in the region are mostly ingested orally; heroin is usually smoked or the smoke is inhaled. In Pakistan, a small number of heroin injection cases have begun to emerge in the Karachi area.

This practice — previously unknown in the sub- region — has been observed in recent studies and raises concerns about the increase in risk of transmitting blood-borne diseases, such as hepatitis and HIV/Aids, through the process of needle sharing.

According to ANF, an amount of Rs1072 million has been allocated and approved for demand reduction programmes under the Drug Abuse Control Master Plan (1998-2007) keeping in view the increasing number of drug addicts and problems associated with the drug abuse.

THE NEWS

Women face greater risk of HIV-AIDS in Pakistan: Nasir
By Rasheed Khalid
Islamabad

Dr Muhammad Nasir Khan, Federal Minister for Health, has said that women in Pakistan face greater risk of HIV-AIDS infection due to biological and social circumstances.

Dr Nasir was speaking as chief guest at one-day consultative workshop on "Socio-economic and psychological factors involved in the spread of HIV-AIDS in Pakistan" organised by Department of Anthropology, Quaid-i-Azam University, at DSS Auditorium here Thursday. Dr Qasim Jan, Vice-Chancellor, QAU, was in the chair.

The minister said in addition to biological reasons, gender disparities in literacy, education, economic empowerment and control of resources also contribute to the spread of the disease in Pakistan. He said men are decision-makers in our society and women in rural areas in particular depend upon men for access to outside information.

He said 85,000 people are living with HIV in the country which is 0.1 per cent of the population. He said that many people who are not tested do not know that they had acquired the disease. He said that at the moment, more men are infected in Pakistan who are passing on the deadly virus to their sexual partners which may result in dramatic increase in the incidence of the disease in female population.

He said use of intravenous drugs is further aggravating the situation. He said 52% drug users in Karachi and 82% in Lahore use non-sterile syringes. He said a shift in drug users to urban centres made it a concentrated epidemic in cities like Karachi where prevalence rates increased over 25% in the last three years. He also referred to sex workers including men, women and eunuchs who engage in unsafe sexual activities due to their marginalisation or lack of awareness.

Dr Fillippo Osella, link coordinator, HEC-BC Joint Higher Education Programme, said 1 per cent of Indian population is suffering from HIV-AIDS while it is 0.5 per cent in case of Pakistan. He said UN disputes Indian data. He said the spread depends upon sexual practices outside the pail of morality of the people. He said globalisation, migration and Westernisation could be reasons for the increase in the incidence of the deadly disease.

He said youth in India are suffering from moral decline. Referring to sex workers, he said that more responsibility lies on the shoulders of women. Dr Aldo Landi from UNAIDS said every day we get 49 new HIV-AIDS cases and women constitute more than 50 per cent in this group. He said 50 per cent of HIV victims are not married. He said HIV spread is also linked with poverty and ignorance.

Dr Qasim Jan referring to the rise in HIV risk stressed the need for greater research and awareness. He said QAU would welcome intra-institutional projects to study the incidence and finding means to check the menace. Asma Bokhari from National Aids Control Programme, and Dr Hafeezur Rehman, chairperson, Department of Anthropology, QAU, also spoke on the occasion.

Dow conference on HIV/AIDS in Pakistan

KARACHI: Senior health care professionals met to discuss how best to shape Pakistan's response to the HIV/AIDS crisis. The seminar, held at Dow University of Health Sciences, agreed that a broad and multi-sector approach was needed to deal with the situation. Noting that the country is experiencing a concentrated epidemic, with 5 % of its high risk group infected, speakers discussed the need for widespread public education on the nature of the illness, as well as countering the conditions that allow it to spread.

Speakers at the program included the Advocate General of Sindh, Anwar Mansoor Khan, Former Chief Justice of Pakistan, Mr. Saeed uz Zaman, Prof. Masood Hameed, Vice Chancellor - DUHS, Dr. Sharaf Ali Shah, Director, Infection Control Centre - DUHS, Dr. Ashraf Sadiq, Director, Ojha Institute of Chest Diseases, Dr. Sri Chand Ochani and Mehtab Akber Rashdi.

They unanimously agreed that public education was the key to counter any further spread of the disease, and said that those suffering from HIV/AIDs should not be ostracised or discriminated against based on the stigma attached to the infection. Poverty, illiteracy, demographic vulnerabilities - with more than 60% of the population comprising young people, the low status of women, an inefficient blood transfusion system which relied largely on unscreened blood and a poor STI managements service were all identified as major challenges for the country.

According to statistics although Pakistan is registering a comparatively low prevalence of the disease amongst the general population, more and more cases of infection are being detected in the high risk social groups. “The prevalence of HIV increased from four per cent among IDUs in 2004, jumping to 26 per cent in 2006 in different parts of the country,” Dr. Sharaf Ali Shah said.

IDUs are not the only high risk group, i.e whose behaviour and practices making them more vulnerable to contracting infections. While the scenario must not be generalised as this could lead to the cornering of the concerned segments.

First association for HIV/AIDS victims in Pakistan

ISLAMABAD: Coinciding with World AIDS Day, the United Nations joint programme on HIV/AIDS (UNAIDS) has launched Pakistan's first association of people suffering from the infection.

“Only a few individual NGOs with limited capacity were providing support to people with HIV/AIDS, but there was no association of such people in Pakistan, whereas most countries in the region have already established their associations,” Fawad Haider, a UNAIDS official, was quoted as saying by IRIN.

The overall objective of the association has been described as a platform for HIV/AIDS victims to voice their concerns in the fight against the stigma of victims.

Pakistan, where the number of HIV cases continues to rise, is currently classified to be in the 'concentrated epidemic' stage, by definitions of the World Health Organisation (WHO) and UNAIDS.

According to Pakistan's National AIDS Control Programme (NACP), some 3,393 HIV/AIDS cases have been reported in the country, but according to WHO and UNAIDS, the number is as high as 85,000.

Pakistan is also considered at high risk from the spread of HIV to the general population because of an illiterate population of more than 50 million, high prevalence of sexually transmitted diseases, high number of migrant workers, high number of both male and female sex workers, limited safety in blood transfusions, increasing number of injecting drug users and a highly mobile refugee population.

In Pakistan, young people make up the major chunk of people vulnerable to HIV/AIDS.

“The newly established association would promote an improved access to treatment, especially anti retroviral therapy,” said Haider.

Pakistani health authorities have recently started providing HIV/AIDS treatment services through eight centres across the country, but the scope of coverage in the face of a concentrated HIV epidemic remains limited, according to analysts. ppi

Overall Media Coverage of AIDS Epidemic Decreasing, Shifting From Domestic to Global AIDS Issues, Study Says

March 2, 2004

Overall media coverage of the AIDS epidemic is decreasing, and the focus of such coverage has shifted from domestic to global issues, according to a study included as a supplement to the March/April issue of the *Columbia Journalism Review*. Researchers from the Kaiser Family Foundation and Princeton Survey Research Associates International conducted a comprehensive review of more than 9,000 HIV/AIDS-related news stories appearing since 1981 in four national newspapers: *New York Times*, *Wall Street Journal*, *Washington Post* and *USA Today*; in three regional papers from areas that were "particularly hard-hit" by the epidemic: *San Francisco Chronicle*, *Miami Herald* and *Los Angeles Times*; and on three network news programs: "ABC World News Tonight," "CBS Evening News" and "NBC Nightly News." Researchers also examined news stories from London's *Times* in order to compare U.S. print media to European print media, according to a Kaiser Family Foundation release.

Findings

Researchers found that total media coverage of HIV/AIDS increased from the early 1980s through the decade and peaked in 1987. Aside from minor peaks in coverage following Magic Johnson's 1991 announcement of his HIV-positive status, the introduction of highly active antiretroviral therapy in 1996 and increased attention to the global epidemic in 2001, overall coverage of HIV/AIDS has declined steadily since 1987. Although the decline in media coverage appears to mirror a drop in the number of new AIDS cases in the United States, the decline began six years before the number of new AIDS cases began to decrease. In addition, the decline in coverage continued as the total number of AIDS cases in the United States rose above 500,000, according to the release (Kaiser Family Foundation release, 3/1). Over the 22-year time period, 94% of the stories included in the review had U.S. datelines and 86% of the stories presented a U.S.-only perspective on the epidemic. However, the number of stories presenting some global aspect of the epidemic increased 118% between 1997 and 2002, and the number of articles with a domestic-only focus decreased 57% over the same time period. In addition, the study found that after 1986, media coverage of HIV/AIDS among gay men accounted for 5% or less of the overall coverage. Other specific populations disproportionately affected by the epidemic also received "relatively little" coverage, with 3% of stories focusing on U.S. minorities, 3% on teens and young adults and 2% on women, the study says. Overall, the focus of coverage has shifted away from stories about HIV transmission and social issues toward stories about government funding and philanthropic efforts, the study says.

conclusions

The overall decline in the total number of stories on HIV/AIDS and stories focusing on domestic AIDS issues could be evidence of what some have called "AIDS fatigue on the part of media organizations," the study says. However, the decline in coverage also is consistent with "the usual and customary news practice to focus on other things when an epidemic switches to a global focus," the study says. Regardless, a "more important trend" is the decline in the number of stories with a "consumer education component," the study says, adding that the trend is "particularly disturbing" in light of the fact that the number of new AIDS cases in 2002 increased for the first time since 1993.

The findings raise the question of whether media outlets covering the epidemic "have a responsibility to educate the public, as opposed to focusing only on reporting the news," the study says. Although the media's shift to a more global focus on the epidemic "is particularly important given its enormity and growing impact in many parts of the world," maintaining "some focus on the domestic epidemic while telling these and other new stories will remain a challenge for journalists competing for limited news space," the study concludes (Brodie et al., "AIDS at 21: Media Coverage of the HIV Epidemic 1981-2002," 3/1).

Commentary

This "ambitious study ... illustrates how, from the beginning, the AIDS story has been driven by a series of big, attention-grabbing events," Kai Wright, senior editor of the New York City-based news magazine *City Limits*, writes in a piece published in the March/April issue of *Columbia Journalism Review*. Although the study does not address "how much the hot story of the time colored how life with HIV was depicted," it gives a "disturbing hint" that this approach to the coverage misses the impact of the disease on minorities, Wright says, adding that although African Americans account for half of all new infections each year, they "have rarely been involved in the epidemic's high drama." The "quest for a dramatic story angle" is not only the fault of the media but also of AIDS advocates who "insist on framing [the epidemic] as an emergency rather than [as] a lasting concern" and who have sought to create a "sense of urgency ... by focusing on hyperbolic scenarios," Wright says. As a result, there is a "myopic understanding" of the AIDS epidemic and people are presented with "something that demands our attention for just a few fleeting, hysterical moments when we're actually facing a systemic, decades-long problem," Wright concludes (Wright, *Columbia Journalism Review*, March/April 2004).

Daily times

Wednesday, December 06, 2006

First association for HIV/AIDS victims in Pakistan

ISLAMABAD: Coinciding with World AIDS Day, the United Nations joint programme on HIV/AIDS (UNAIDS) has launched Pakistan's first association of people suffering from the infection.

“Only a few individual NGOs with limited capacity were providing support to people with HIV/AIDS, but there was no association of such people in Pakistan, whereas most countries in the region have already established their associations,” Fawad Haider, a UNAIDS official, was quoted as saying by IRIN.

The overall objective of the association has been described as a platform for HIV/AIDS victims to voice their concerns in the fight against the stigma of victims.

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According to Pakistan's National AIDS Control Programme (NACP), some 3,393 HIV/AIDS cases have been reported in the country, but according to WHO and UNAIDS, the number is as high as 85,000.

Pakistan is also considered at high risk from the spread of HIV to the general population because of an illiterate population of more than 50 million, high prevalence of sexually transmitted diseases, high number of migrant workers, high number of both male and female sex workers, limited safety in blood transfusions, increasing number of injecting drug users and a highly mobile refugee population.

In Pakistan, young people make up the major chunk of people vulnerable to HIV/AIDS.

“The newly established association would promote an improved access to treatment, especially anti retroviral therapy,” said Haider.

Pakistani health authorities have recently started providing HIV/AIDS treatment services through eight centres across the country, but the scope of coverage in the face of a concentrated HIV epidemic remains limited, according to analysts. ppi

Media and HIV: New report on frontline perspectives of the media

Press Release

News Media Still Struggle to Report on HIV/AIDS Accurately, Says New Report

(November 29) On the annual commemoration of World AIDS Day this Friday, December 1st, the news media around the world will focus their attention on HIV/AIDS. But lost in the annual headlines and sound bites is the fact that day-to-day coverage of HIV/AIDS worldwide leaves much to be desired in both quality and quantity, according to a report issued today

The report is issued by Internews Network's Local Voices project, in collaboration with two of the leading international networks on HIV/AIDS, the Global Network of People Living with HIV/AIDS (GNP+), and the International Council of AIDS Service Organizations (ICASO). It analyzes responses from people living with HIV and frontline AIDS care and service providers from 44 countries who were asked their views on local news coverage on HIV/AIDS

According to the report, "Twenty-five years since the first news stories on HIV surfaced, media outlets are still struggling to report news on HIV/AIDS accurately, with depth and sensitivity-especially in developing countries that are most affected by HIV."

More than 300 respondents from two online surveys, focus groups in three countries, and several interviews said that although reporting on HIV/AIDS has improved somewhat over the last five to ten years, the quality of media coverage in their countries is still mainly infrequent and inaccurate.

According to the report, "Voice and Visibility: Frontline perspectives on how the global news media reports on HIV/AIDS," one problem is that reporters and editors still tend to stigmatize HIV/AIDS and People Living with HIV/AIDS (PLHIV). A focus group respondent in Ukraine said, "Journalists often request to use HIV-positive children in films or programs and ask HIV-positive people to tell negative and terrifying stories about their lives-even if they are not true."

Josephine Kamara, a journalist and current Resident Advisor for Internews Nigeria, said, "The idea to survey PLHIV and frontline AIDS workers on how they view media coverage of their issues arose from our experience working with journalists on the ground in developing countries. In Nigeria for example, many of the journalists we train have never met someone openly living with HIV until they attend one of our HIV reporting workshops, and it is the rare journalist who has ever invited an HIV-positive person to be a lead source in a story on HIV/AIDS."

Internews Network launched its HIV/AIDS-focused Local Voices project in 2002, in Nigeria and Kenya, with support from the US Agency for International Development (USAID) and continuing support from the President's Emergency Plan for AIDS Relief (PEPFAR), to train and support local radio journalists, talk show hosts and DJs to improve their reporting and programming on issues related to HIV/ AIDS. Since then, Local Voices projects have expanded to Ethiopia, India, and Côte d'Ivoire, and with funding from the UK's Department for International Development (DFID), Internews Europe's "Turnaround Time" project focuses on improving HIV/AIDS coverage in the Mekong region.

The Global Network of People Living with HIV/AIDS (GNP+) is a global network for and by people living with HIV. GNP+ works closely with six regional networks of people living with HIV in Africa, Asia, the Caribbean, Europe, Latin America and North America. The overall aim of GNP+ (www.gnpplus.net) is to improve the quality of life of people living with HIV/AIDS

The International Council of AIDS Service Organizations (ICASO) mobilizes and supports diverse community organizations to build an effective global response to HIV and AIDS. Through its work, ICASO (www.icaso.org) seeks to build community sector capacity to directly advocate for its own needs, to mobilize and strengthen community sector partnerships and networks, and to advocate for the effective implementation of universal access to comprehensive HIV and AIDS services.

The "Voice and Visibility" report was made possible by grants from USAID and PEPFAR to Internews Network.

PAKISTAN: Silence on HIV/AIDS Kills Women, Children

Posted: 2005-12-01

By Ashfaq Yusufzai, Asia Media Forum

Fears of HIV/AIDS rattle a rural backwater on the Pakistan-Afghan border: Marikhel village.

At least two labourers died from AIDS there in the past year. Both had been deported HIV-positive from the United Arab Emirates.

"We don't know whose turn will be next because people tend to hide the disease. If people die of AIDS, his relatives don't confirm their death from the disease," said Dr Habibullah Jan, who runs an NGO and a blood bank offering free screening to people in Kurram Agency.

Since 1990, 110 HIV/AIDS cases have been reported in federally administered tribal areas (Fata) that have a population of six million in its seven tribal units over 27,224 square kilometres.

Located along the 1,600-km border with Afghanistan are the Fata areas administered by the federal government of Pakistan. Many Fata residents migrate abroad for work and send remittances back home as the areas are impoverished.

"Not many suffered from AIDS. Only deportees from foreign countries died from it. The deportees are often HIV-infected and local people are aware of it," Dr Habibullah said.

A Middle Eastern country deported a driver last year because he was tested HIV-positive in medical screening, which is mandatory for visa renewal. Workers with HIV are deported straight away without being allowed to take luggage from home, he said.

"This is an inhuman act on the part of the officials of these countries. They should inform the Pakistan government about the expulsion of HIV patients so that others can be protected from infections," said Dr Quaid Saeed, HIV/AIDS programme officer for WHO. "Lack of screening facilities at airports has intensified fears of infections among patients' wives and children," he said.

Dr Quaid suggested that patients back from UAE and other Middle Eastern countries should be examined at airports and -- if tested positive -- authorities should inform their relatives, especially their spouses.

Two patients from Fata, including a woman, tested positive for HIV at Pakistan Medical Research Centre under Khyber Medical College in Peshawar in July.

"A woman, 34, was tested HIV-positive on July 14. She came from Mohmand Agency, one of Fata's tribal units. Her husband, who had worked in Dubai for 20 years, was deported to Pakistan a year ago," a pathologist said.

The lives of the workers' wives and children are at risk because they often are not told that their loved ones have HIV.

Often too, people do not usually come for an HIV test, but doctors refer them to AIDS screening when the patients see them for other diseases, he said.

The same woman was operated on for miscarriage in hospital in Peshawar and her husband asked the doctor to carry out an HIV test on his wife, which turned out to be positive.

Such patients are harmful to other patients who are routinely operated on in the same operating theatres. Oblivious of AIDS infections, the surgeons might have used the same operating table for other patients without fumigation.

Another person, 45, who came from Khyber Agency, was tested positive at Pakistan Medical Research Centre the same day. More than a month ago, a young woman in Kurram Agency died after her husband, who worked as a porter in Dubai, died last year of AIDS. He had been expelled after an HIV test.

Doctors insist that the disease did not turn endemic. But some pathologists in the city said they recorded 20 HIV/AIDS cases in the last two years and all patients had been deported from the Middle East.

"The number of patients might be higher as people avoid blood tests for HIV in fear of social stigma. Nor do they inform their friends and relatives as it is a sex-borne disease," said Dr Muzaffar Tareen, a clinical sexologist.

Dr Tareen, who earned a degree from California in sexually transmitted infections, said the deported people are aware of the disease. But they often keep it secret, and transmit it to their unsuspecting wives and children. He said the workers living abroad -- away from their wives -- often end up in risky sexual behaviour, including commercial sex.

Unfortunately, officials said non-governmental organisations involved in building anti-AIDS awareness are not operating in the region.

Dr Iftikhar Ali, programme manager of the HIV/AIDS control programme for Fata, said the project planned a campaign to train medical staff and build awareness through community mobilisation as part of preventive measures. Doctors, women health-visitors, paramedics, health workers and dispensers trained in preventive and palliative methods in the first phase of the programme, he said.

The second phase will cover Kurram Agency, Bajaur, Miranshah and frontier regions of Peshawar and Kohat and focus on building awareness through special group sessions, workshops and gatherings for tribal elders, councillors, barbers, journalists and religious leaders, Dr Ali said. Organisers will distribute AIDS kits among hospitals and information literature as part of the programme.

The Fata health directorate laid out a plan to control the disease in collaboration with WHO, UNICEF and the federal and NWFP governments.

He said that 49 HIV cases were recorded in Kurram Agency, 27 in North Waziristan, 18 in South Waziristan, seven in Orakzai Agency, six in Khyber and three in Bajaur Agency.

Of 34 million U.S. dollars earmarked for the countrywide awareness campaign, only 70,000 dollars has been allocated to Fata.

Pakistan recorded about 2,800 HIV/AIDS cases. The figure will reach 80,000 if all the people are screened for the disease, a WHO official said. He blamed the increase in AIDS cases on the low literacy rate, poor socio-economic conditions and risky sexual behaviour among mobile populations such as truckers, barbers, quacks and Fata expatriates in common destinations for migrant work such as the Gulf states.

Dr Hussein A Gezairy, regional director for WHO's Eastern Mediterranean Region, said in a message to mark World AIDS Day: "The theme of this year's campaign is HIV/AIDS: Stand up for the challenge. It's everyone's responsibility. Through this theme, the World Health Organisation (Regional Office of the Eastern Mediterranean) is trying to motivate all members of the community to play their roles in response to HIV/AIDS."

He said that by the end of 2004, the number of people estimated to be living with HIV/AIDS in the region reached more than 715,000. The number of new infections occurring in that year was 92,000, the second highest proportional increase in the world, compared with other regions. "This situation should force us all to realise the size of the challenge and to stand together in facing it," he said. "We all need to share the responsibility."

DOUBLE DISCRIMINATION

AIDS patients suffer also from lack of treatment in hospitals, a doctor told â€˜The Dawn', an English-language newspaper in Pakistan. Most patients are denied admission to hospitals as they have no separate wards for them.

"Neither of the three teaching hospitals in the city admitted a 20-year-old woman, who contracted the disease from her husband. Her husband died of AIDS in May," a doctor said.

Five years ago, the Khyber Agency-based woman married the 30-year-old man, who worked as labourer in Saudi Arabia. "Now she and her two minor daughters are running from one place to another for treatment. She needs symptomatic treatment, which is not forthcoming," he said. Her daughters, one aged three years and the other four months, have also been diagnosed with HIV. "My mother did not approve of my marriage with a married man, but my father forced me into it," the doctor quoted the woman as telling him.

"The woman cannot afford the education and upbringing of her daughters, let alone medicines," he said. The woman said the hospital doctors refused to eve examine her.

Another doctor, who works for an NGO, said he sent two AIDS patients to hospital, but doctors and nurses did not take care of them. "Health professionals were afraid of touching the patients," he said.

Patients in need of emergency treatment are often denied treatment in hospital. "Dozens of health workers, doctors, nurses and technicians have been tested positive for hepatitis-C and are paying for their treatment themselves," a pathologist said, explaining this behaviour.

The provincial AIDS Control Programme requested hospitals in Peshawar to allocate isolated rooms for AIDS treatment three months ago, but the request went unheard, he said. Authorities closed the isolation room of a local teaching hospital for fumigation after an HIV-positive mother gave birth there.

A 17-year-old woman from Miranshah in North Waziristan Agency was brought to the labour room, but was shifted to the isolation room when it was discovered that she had AIDS, said a doctor who attended to the woman. The room where she delivered the baby was closed for fumigation afterwards, the doctor added.

According to other doctors of the hospital, the woman's relatives tried to get her admitted to other hospitals, but none of the gynaecologists agreed to treat her there. "We knew she had AIDS, but we have the means to help all sorts of patients coming here for treatment," said a gynaecologist who was part of the team that attended to the woman. This is the second time that an HIV-positive mother gave birth at a Peshawar-based hospital - a 34-year-old from Miranshah was tested HIV-positive whose husband worked in Dubai for 20 years before being deported back to Pakistan.

HOPE AGAINST HOPE

A woman who got HIV from her husband is running a public awareness campaign besides pushing for better treatment facilities.

Amina Bibi, whose husband died of AIDS last year, said she wanted to work to remove the social stigma associated with the disease. "I will contact people with HIV or AIDS to form an association and launch a joint struggle to force the government to make appropriate drugs available, at least in government hospitals," the 35-year-old woman said.

A five-year programme was launched in 2003 to check the spread of the disease through unscreened blood, commercial sex and syringe reuse. Despite its several recommendations, no province has a functional HIV/AIDS clinic. Hospitals are ill-prepared and do not have proper treatment facilities, said WHO's Dr Quaid.

Amina, who is from Kurram Agency, 270 kilometres west of Peshawar, contracted HIV from her husband who was deported from the UAE because of his HIV infection three years ago. He did not disclose it to his wife. Amina stressed the need for changing people's attitude toward HIV patients and urged the government to open treatment centres at government hospitals.

Because of the stigma attached with sexually transmitted diseases, patients avoid visiting hospitals, fearing a public disclosure, Dr Tareen said. "The situation is alarming. Drivers, sex workers, homosexuals no longer constitute a vulnerable group. We have patients who have never strayed but have been tested HIV-positive," he said.

Amina said: "It is a depressing situation. I feel it is my responsibility to lead the way or at least give hope to the people living with the disease."

Prof Fazle Raziq, a haematologist who heads the pathology section at Khyber Medical College in Peshawar, said many of those living with HIV were migrant workers back from the Middle East - some have stayed away from home for up to 20 years.
She expressed concern over the unfriendly attitude toward HIV/AIDS patients, especially women and children, who are looked down upon by their relatives.

Women who contracted the disease from their husbands and children from their fathers should be treated with love, Amina emphasised. She cited the example of relatives' hostility toward a two-year-old girl from Kurram Agency whose father had been sent back home from the UAE after he was diagnosed with AIDS three years ago.

"The women and children are not responsible for the infections. Treating them harshly makes no sense," she said.

"I was all right three years ago. My husband returned home, seriously ill, from Dubai. We took him to a doctor in the city. He had full-blown AIDS," said a woman from Khyber Agency.

Her husband died a month later and she gave birth to a girl a few months afterwards. "Now, my daughter and I are HIV-positive. Our family and neighbours have distanced themselves from us," said the 40-year-old woman, her daughter in her lap.
(END/AMF/IPSAP/AY/BB/JS/011205)

Media must rethink AIDS coverage

Edmund Settle and Bill Valentino
2005-08-24 05:49
Last weekend, CCTV's "New Investigation" aired an unprecedented programme about the relationship between HIV/AIDS and gay men in China.
While the show aimed to demonstrate that stigmatizing gay men and irresponsible sexual behaviour both increase the risk of HIV transmission in China's gay communities, it failed to place this vulnerable group in the larger context of the country's AIDS epidemic. This omission could lead the television audience to mistakenly believe gay men are responsible for spreading AIDS in China, or that homosexuality causes AIDS.
The media play a vital role in the joint response to HIV/AIDS. Objective and complete reporting is crucial for informing the general population.
According to a recent national survey, 87 per cent of Chinese consider television news programmes a reliable source of HIV/AIDS information, and up to half trust newspapers.
Undoubtedly the media could be instrumental in encouraging discussion of what remains a taboo.
China has an estimated 840,000 HIV cases, with needle sharing remaining the primary mode of transmission, accounting for 44 per cent of all infections. Sexual transmission accounts for 30 per cent of cases - of which 11.1 per cent follow unprotected gay sex, or 3 per cent of all confirmed HIV infections.
Experts warn China may have between 10 million and 15 million HIV/AIDS cases in five years.
Media organizations have a social duty to be credible, trusted sources that reflect the diverse and changing society. The media should not be proscriptive, but should help its audience form their own informed opinions.
The media play an important role in setting the public agenda. HIV/AIDS needs to hold a more predominant position on the agenda of national and local policy-makers.
Reporting on HIV/AIDS is not easy. Fear, ignorance, prejudice, denial, and cultural and political considerations all play a part in how individuals view HIV/AIDS.
Ethical dilemmas such as balancing what is in the public interest with the interests of the individual need to be resolved by journalists and the media profession as a whole.
To realize the important role the media have in combating HIV/AIDS in China, journalists need to understand the relevant medical, economic, political and international factors.
http://www.chinadaily.com.cn/english/doc/2005-08/24/content_471614.htm (1 of 2)2005-8-25 10:57:41
Media must rethink AIDS coverage
Chinese journalists are just beginning to discuss their role in China's national HIV/AIDS prevention strategy. Few concentrate on HIV/AIDS beyond December 1, the World AIDS Day, and few outlets have committed to ongoing coverage.
Ensuring interesting and ethical reporting of HIV/AIDS is no longer enough - journalists and media institutions need to think beyond individual stories and develop an overall sustained strategy for their involvement in the struggle.
The media could improve their HIV/AIDS and healthcare reporting by developing a

resource centre where journalists could access reliable and current information such as quotes, statistics and other resources required for balanced reporting.
Another important step would be to create a national platform for healthcare reporting by engaging and training media professionals to promote the development of leaders and experts dedicated to reporting on HIV/AIDS and other healthcare matters.
While it is clear China's top-level policy-makers have demonstrated a strong personal commitment to combating HIV/AIDS, the media, being strategically placed to educate, need to play a proactive and responsible role in the fight against HIV/AIDS.
China Daily 08/24/2005

Internews Network

Internews Network (www.internews.org) is an international non-profit organization that works to improve access to information for people around the world by fostering independent media and promoting open communications policies in the public interest.

Formed in 1982, Internews Network has worked in 70 countries, and currently has offices in 23 countries in Africa, Asia, Europe, the Middle East, and North America. Internews Network is a founding member of Internews International, an umbrella organization, based in Paris, made up of 12 media development NGOs.

Internews launched its HIV/AIDS-focused Local Voices project in 2002, in Nigeria and Kenya, with support from the US Agency for International Development (USAID) and continuing support from the President's Emergency Plan for AIDS Relief (PEPFAR), to train and support local radio journalists, talk show hosts and DJs to improve reporting and programming on issues related to HIV/ AIDS. Since then, Local Voices projects have expanded to Ethiopia, India, and Côte d'Ivoire, and with funding from the UK's Department for International Development (DFID), Internews Europe's "Turnaround Time" project focuses on improving HIV-focused journalism in Thailand, Cambodia, Burma, and Vietnam. Each of these country-based projects are meeting diverse needs, often expanding in scope to provide support for print journalists, television journalists, photojournalists, and media owners.

The information gathered in this survey will build Internews work with journalists, media owners, and people living with HIV/AIDS and HIV/AIDS program managers, to find new and creative ways at strengthening quality local news coverage on HIV/AIDS.

Internews' HIV/AIDS-focused programs encourage journalists to incorporate the views and voices of those personally affected by HIV/AIDS into news and feature reporting. Local Voices does not produce its own programs, but builds the capacity of local media professionals to report on the pandemic. Our work is to: Enlist the support of radio station owners and managers to expand coverage of HIV/AIDS; Train and mentor journalists, talk show hosts, and DJs to produce their own material on HIV/AIDS; Provide travel grants to allow reporters to research HIV/AIDS stories outside of capital cities; Provide small equipment grants for journalists to build their professional capacity to produce stories; Offer media resource centers on HIV/AIDS, including production studios, where trainees receive follow-up assistance with story research and production, assistance in writing accurate/quality stories, feedback on aired stories, tools to measure the impact of their reports; Train local NGOs and associations of people living with HIV/AIDS on effective media relations and communications, thus adding their voices to the public dialogue; and, Create relationships between journalists, PLHIV and local HIV/AIDS leaders.

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First and foremost, we are very grateful to the individuals who responded to our web-based surveys, and to those who agreed to participate in focus group discussions. The fact that they shared their perspectives made this possible.

This report is dedicated to the memory of Omololu Falobi, a journalist and activist from Nigeria who was a champion of the journalists' role in HIV/AIDS prevention, care and treatment.

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Photos: courtesy Internews Network. These photos represent media development projects around the world but do not all represent HIV-related projects.

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