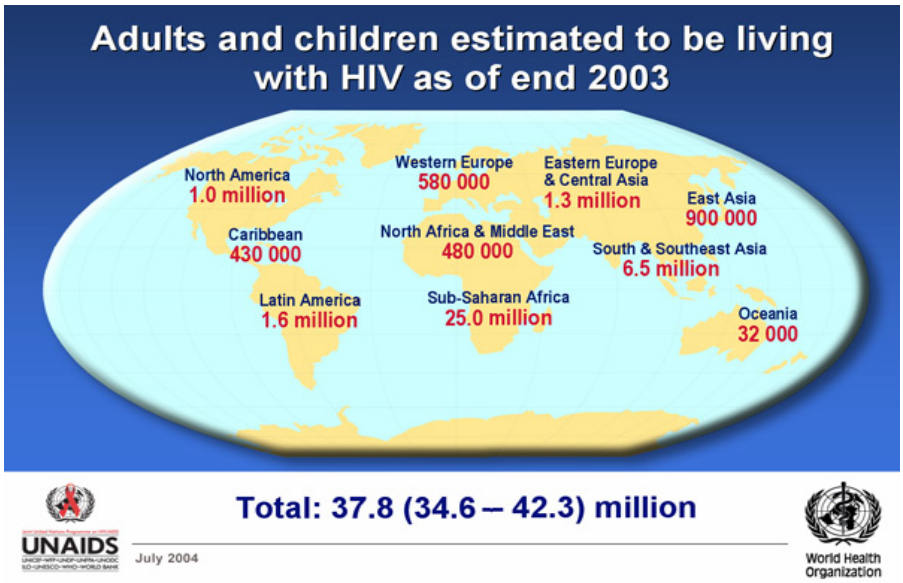
Global Health & Environment
MONITOR

Global Fight Against Aids Scores Some Wins – Faces Many Challenges

Changing the Course of the AIDS Epidemic Requires Action on All Fronts

by Peter Piot, M.D., Ph.D., Executive Director, UNAIDS, Geneva

This is a decisive moment in the global response to AIDS. Growing rates of infection and death are finally being met with the commitment to mount a truly comprehensive response. In fact, given recent statistics, AIDS is now understood as much more than a health catastrophe; it has become a long-term development crisis, and a serious security concern.



In 2003, 4.8 million people were newly infected with HIV, more than in any previous year, and nearly 3 million people died of the disease. Currently, 38 million people are living with HIV or AIDS, and infection rates are on the rise in many areas, including Eastern Europe and Asia. There is also an increasing feminization of the epidemic: Today, about half of all people infected with HIV are women, and young women in sub-Saharan Africa are 3.4 times more likely to be HIV-positive than their male counterparts.

As AIDS grows in magnitude, so does our capacity to tackle the crisis. A wealth of programs has proven effective at reducing HIV infection rates, even among the most vulnerable groups, and delivering treatments, even in the poorest settings. Substantial funding is becoming available from donor governments and multilateral organizations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank. The World Health Organization and UNAIDS have set an ambitious goal of placing 3 million people on AIDS treatment by the end of 2005.

The future course of the epidemic depends largely on how well current resources are applied. Delivery of vital AIDS services remains extremely limited. In Africa, only one pregnant woman out of 20 has access to prevention of mother-to-child transmission services, and only 3 percent of people who need antiretroviral therapy receive it. In many of the most heavily affected countries, a shortfall in trained staff seriously impedes expansion of AIDS services.

AIDS Is a Global Disease…

AIDS is truly a global disease; no region has escaped its devastation. In Asia, an estimated 1.1 million people were newly infected in 2003, and there is concern that a disastrous epidemic could unfold on the continent. Sub-Saharan Africa

remains the most seriously affected region, with 25 million people living with HIV. In Eastern Europe and Central Asia, diverse epidemics continue to spread, and 1.3 million people are now living with HIV, more than 80 percent of them under the age of 30. In Latin America, 1.6 million people have HIV, and serious, concentrated epidemics remain in several urban areas. In the Caribbean, three countries have national prevalence levels of 3 percent or greater, and approximately 430,000 people are infected. In Oceania, high sexually transmitted infection rates are raising concerns. In North Africa and the Middle East, inadequate surveillance may be failing to capture the extent of the epidemic, but it is estimated that 480,000 people are infected with HIV. In the United States and Western Europe, where most people have access to antiretroviral therapy, as many as 1.6 million people now live with HIV, and some areas have seen increased infection rates.

There's An Urgent Need to Scale Up HIV Prevention

Global AIDS treatment has emerged as a major international focus in the last few years. While the crucial effort to expand AIDS treatment access continues, we must not lose sight of the equally urgent priority of increasing delivery of HIV prevention. We know how to bring HIV infection rates down, but too often our resources and knowledge are not applied in the most effective ways.

We need to do several things. *First*, fund prevention adequately so that appropriate prevention services can reach everyone at risk. Today, fewer than one in five people who need HIV prevention programs have access to them.

Second, ensure that prevention programming is based on viable evidence and is tailored to meet the needs of those who are particularly vulnerable to infection, including youth, women, men who have sex with men, injection drug users and sex workers. Social conventions must not get in the way of saving lives. Just as we need combination therapy, we need combination HIV prevention. Prevention programs for young people should encourage abstinence and delayed onset of sexual behaviour, as well as teach the importance of condom use. Clean needles should be available to injection drug users.

Third, tackle societal factors such as stigma and unequal social and legal status, which make people particularly vulnerable. For example, traditional prevention strategies often fail to protect women and girls because these at-risk populations may not have the option to abstain from sex or to negotiate condom use. To this end, UNAIDS has launched the Global Coalition on Women and AIDS, which promotes prevention programming, legal reforms and access to schooling to help protect females from infection.

HIV prevention works. Countries such as Uganda, Thailand and Cambodia have already succeeded in significantly reducing their HIV infection rates. Thailand did this through a combination of leadership from the top, mass media campaigns, and condom promotion among sex workers and their clients.

It is estimated that global delivery of HIV prevention could avert 29 million, or more than 60 percent, of the 45 million new infections projected by 2010. Unless HIV infection rates are significantly reduced, the AIDS epidemic will continue to spin out of control, and widespread AIDS treatment will not be achievable.

Priorities for Action

Control of AIDS requires decisive action on several fronts. These include:

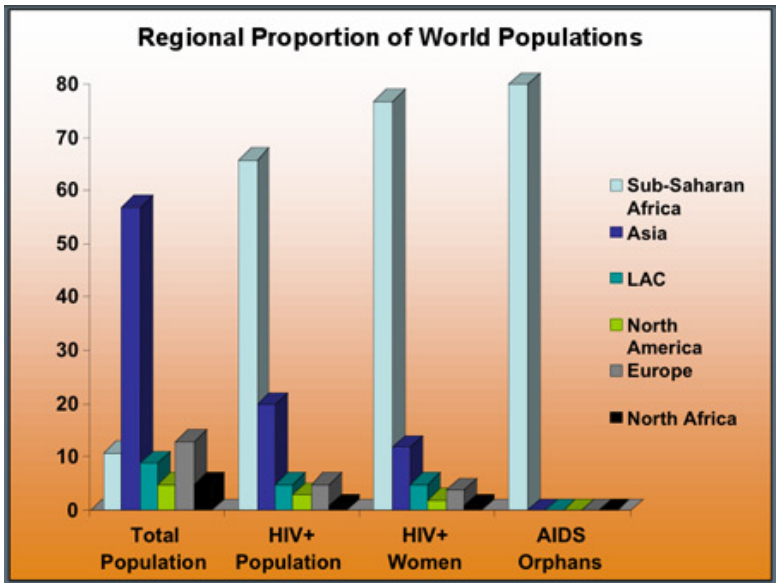
- ***Bolstering human and institutional capacity.*** Community members must be better utilized in the provision of AIDS services, and incentives are needed to keep health care expertise in heavily affected countries.
- ***Providing adequate funding for prevention and treatment.*** $12 billion will be needed in 2005 for a comprehensive response to AIDS that includes quality HIV prevention programs and expanded access to AIDS treatment. Less than half of that amount was available in 2004.
- ***Combating stigma and discrimination.*** Legal protections, education campaigns and political leadership are needed to reduce stigma against people living with HIV and AIDS, and members of particularly vulnerable groups.
- ***Addressing the needs of women and girls.*** Programs to reduce violence against women, promote legal equality, ensure universal education for girls, and increase access to HIV and reproductive health care services are essential.
- ***Promoting country ownership.*** The "Three Ones" advance coordination, harmonization of funding and country ownership of the AIDS response. These principles call for one national AIDS plan, one national AIDS authority, and one monitoring and evaluation system in each country.
- ***Accelerating research efforts.*** Improved treatments, as well as vaccines and microbicides, are imperative.
- ***Involving people living with HIV.*** Including HIV-infected individuals in programs and partnerships makes use of their expertise and helps combat stigma.

AIDS is an exceptional problem, but it is a problem with a solution. A major challenge today is to transform our knowledge and commitments into actions that can change the course of the epidemic for generations to come.

Sub-Saharan Africa: Inequality – and Effective Responses – Coexist in AIDS Epicenter

by Peter Lamptey, M.D. Dr.PH., President, and Rebecca Oser, M.PH, Associate Technical Officer, Institute for HIV/AIDS, Family Health International, Arlington, VA.

HIV/AIDS is likely to surpass the Black Plague as history's most deadly pandemic: Without drastic measures, we can expect as many as 65 million deaths from AIDS over the next 10 to 15 years.



Approximately 95 percent of new infections are currently in the world's poorest countries, but HIV/AIDS knows no boundaries, has no cultural immunity, and does not spare children, killing many and orphaning more. Recently, there have been several significant, new global political and financial commitments to expand and accelerate HIV/AIDS prevention, care and treatment. These measures provide us hope, but so much more must be done to quell the tide and impact of this devastating epidemic.

Understanding the Situation

Sub-Saharan Africa has been the hardest hit region in the world: AIDS-related illnesses kill more people there than any other single cause of death. Meanwhile, an estimated 25 million people in the region are living with the virus. In 2003, 2.9 million people worldwide died from AIDS; 2.2 million, or 76 percent, of these deaths were in sub-Saharan Africa, despite the fact that the subcontinent is home to only 10 percent of the world's population. Nearly 81 percent of the globe's 15 million AIDS-related orphans also reside in sub-Saharan Africa.

Women and adolescent girls are being infected at a particularly alarming rate. In the countries most affected by this disease, women constitute 58 percent of the HIV-positive population. They are twice as likely to be infected by a single act of unprotected sex, and girls ages 15 to 19 have rates of infection that can be 4 to 7 times higher than boys of the same age. Sexual abuse, coercion, discrimination and poverty all contribute to this inequality, as do heightened risks of stigmatization and violence for HIV-positive women.

HIV/AIDS also affects uninfected females. Women are frequently the primary care providers in a family, and many daughters and grandmothers have had to take on parenting responsibilities with very meager resources for vulnerable or orphaned children. The burden of care imposed by AIDS in a family member contributes to the further impoverishment of these women and their relatives.

Stigma and discrimination remain major obstacles in the fight against HIV/AIDS. Fear of societal disapproval restricts the freedom with which people seek information about self-protection or practice safe behaviors. Anxiety over societal ostracism also makes people resistant to voluntary HIV testing, disclosure to partners, and the use of services after diagnosis. Further, the care offered to HIV-positive people, and their perception and treatment by the community, are directly impacted by the stigma surrounding the disease.

Ensuring Program Effectiveness

In developing HIV/AIDS programs in sub-Saharan Africa, we at Family Health International (FHI) have learned that effective responses often include the following key elements:

- ***Bold, high-level political leadership and mobilization of international and local resources.*** Uganda and Botswana are excellent examples of such leadership. President Museveni of Uganda began speaking publicly about HIV/AIDS very early on. His policies of support and openness in discussing the disease helped change sexual behavior patterns in Uganda, which has aided in reducing the rate of HIV infection there significantly. In Botswana, government funding for HIV services increased, antiretroviral therapy (ART) was provided free of charge and scale-up pursued aggressively, and innovative local and international partnerships were encouraged with positive results.

- ***A comprehensive response*** consisting of: risk reduction and avoidance to prevent new HIV infections; improved access to HIV testing and counseling; prevention of mother-to-child transmission, and care for both the mother and the infant; clinical, palliative and home-based care for

the ill; and support and care for affected children. For a program to be successful, it also needs to be scaled up to reach the majority of those in need – like the national initiatives in Thailand, Cambodia, Uganda and Brazil. In Thailand, for example, the prime minister unveiled a policy in 1991 requiring all sex workers to use condoms with all of their clients. Involved were the governor, provincial chief of police and provincial health officer for each province. Outreach included providing condoms or "health vouchers" for sex workers, and public education campaigns about the need for condom use, the dangers of unprotected or casual sex, and the legal repercussions for failure to comply with the resolution. The campaign was far-reaching and thorough, and as a result, the percentage of sex workers using condoms increased, the number of men visiting sex workers decreased, and the prevalence of HIV among sex workers and young Thai males dropped impressively.

- ***Prevention programs driven by epidemiology and responsive to the needs of the population at risk.*** Market segmentation and targeting interventions and services to those most at risk and those in need have proved to be time-honored and sound public health approaches. For instance, risk avoidance messages such as abstinence are appropriate for delaying the onset of sexual debut in youth, while risk reduction strategies such as condom promotion and needle exchange are more suitable for sex workers and intravenous drug users.
- ***Involvement and ownership of HIV programming by community-based groups*** such as district-level governments, and nongovernmental and faith-based organizations. In each of FHI's four focal states in Nigeria, local and state government officials, project partners, beneficiaries and other stakeholders participated in formative assessments and meetings, and assisted in designing state-level behavior change communication strategies. Participation by these groups created a sense of control and responsibility over the programs and helped ensure that they targeted the right groups, addressed issues of local concern, and used appropriate and effective language and imagery.

Going Forward

The HIV/AIDS epidemic has surged to unfathomable proportions over the past two decades. And despite tremendous strides in public awareness, political support and, more recently, access to testing and treatment, much remains to be done.

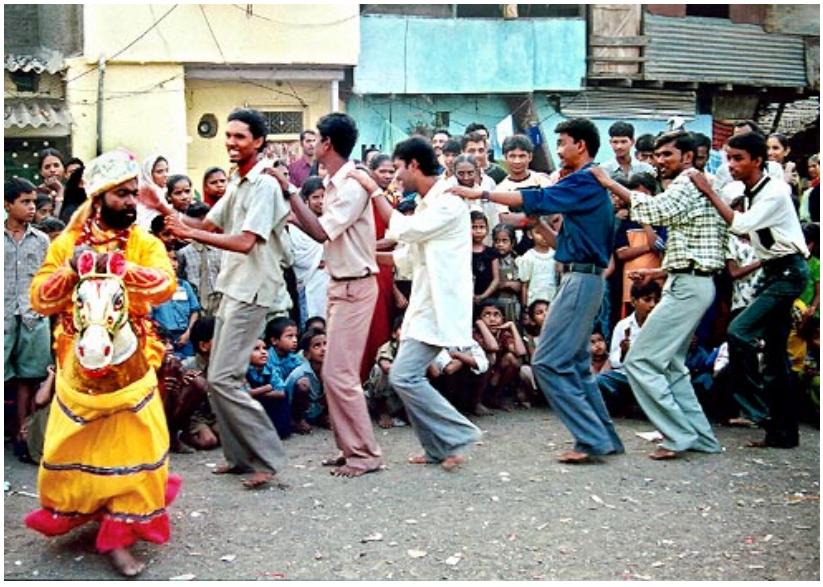
The challenges are formidable, yet we at FHI are continually impressed by the hope and faith of the people we work with, and we believe that the epidemic can be brought under control if proven interventions are implemented and sustained on a sufficiently large scale. Such an approach is the key to positive, productive impact

Insider's View

India Looks to Stop HIV Epidemic in "Early" Stages

by Ravi K. Verma, Ph.D., Program Associate, International Programs Division, Horizons Population Council, New Delhi, India

The HIV epidemic in India is growing steadily, albeit slowly and silently. More than 5 million adults are currently living with the virus, according to 2003 estimates released by the National AIDS Control Organization (NACO; http://www.nacoonline.org/facts.htm). Almost every Indian state and union territory has recorded the presence of HIV, with the heaviest impact in six "high-prevalence" states where HIV infection among pregnant women from the general population attending antenatal clinics is more than 1 percent. These states include Tamil Nadu, Andhra Pradesh and Karnataka in the south, Maharashtra in the west, and Manipur and Nagaland in the northeast.



A musical approach to HIV/AIDS education. The narrative starts: "...Kisi samay ki baat purani ek tha raja ek thi rani!" or, "Once upon a time, there was a queen, and there was a king - and so the story begins...".

Poor recording of deaths in general and HIV deaths in particular makes it very difficult to assess the mortality impact of the epidemic. According to United Nations estimates, by year-end 2003, the combined number of adult and child deaths in India due to AIDS ranged from 160,000 to 560,000. Many see the epidemic as having the potential to reverse hard-won gains in national development, particularly due to the heavy adult mortality.

At the household level, research by UNICEF and the Innocenti Research Center has revealed an adverse social and economic impact on women and children. Indian households with HIV/AIDS deaths report reduced savings, reduced expenditures on durable consumer goods, and disposal of assets in order to raise or supplement income. On the social front, many of these households experience discrimination and send their children away to distant relatives and/or withdraw them from school, adversely affecting their access to both health and education.

By all evidence, the epidemic in India is moving from high-risk behavior groups like sex-workers, truckers and intravenous drug users to low-risk behavior groups, including women and rural populations. In 2003, women accounted for 36 percent of total infections, while rural inhabitants comprised approximately 60 percent, according to estimates by NACO and the Indian Council of Medical Research. Meanwhile, youth are particularly vulnerable: Well over one-third of all the AIDS cases in India in 2002 were among individuals between the ages of 15 and 29.

Heterosexual contact remains the major route of HIV transmission in India, accounting for 86 percent of all cases; in the northeastern states, drug use through shared injections is primarily responsible for transmission. The 1990s saw more public discussion and serious research on sexuality and sexual behavior in India than ever before. Results from studies conducted in different parts of the country suggest that premarital and extramarital sex, including male-to-male sex, is not uncommon, although levels of risky non-marital sex vary widely across regions and socio-economic strata.

Continuing to fuel the epidemic are high rates of temporary labor migrations, as well as India's extensive trucking system and the high-risk sexual behaviors of its drivers. Despite serious efforts to raise awareness, risk perception in India continues to remain low among the general population, and even a significant majority of high-risk behavior groups do not see themselves at risk, according to a 2003 NACO behavioral surveillance survey. Meanwhile, stigmas, particularly in the health care arena, continue to remain a matter of serious concern, report Vaishali S. Mahendra and Laelia Gilborn in an article on hospitals that are friendly to people living with HIV/AIDS in the 2004/2 issue of *Sexual Health Exchange* (http://www.sexualhealthexchange.org/).

A focus on high-risk populations has contributed to the stigmatization and misleading messages about risk factors in India, so much so that AIDS is perceived to be the disease of "others" whose lifestyles are considered "wrong" and "immoral." While it is essential to reach out to high-risk behavior groups due to the disproportionate increases in HIV/AIDS in this population, careful community-based programs must be devised for the general population, particularly for youth, who are at an elevated risk of infection. Inequitable gender norms and practices provide the larger societal framework within which men, and particularly young men, continue to practice risky sexual behaviors, including the perpetuation of violence and coercive sex against women, according to Population Council research.

Searching for Solutions

On paper, the actions of the Indian government appear timely and well organized. In the real world, however, they sometimes seem slow, inadequate and, according to many analysts, poorly executed. Policies and programs have placed too much precedence on medical solutions, and there is a notable absence of evidence-based behavior-change prevention initiatives. Most of the preventive programs are characterized by condom distribution with safe-sex messages — and little conceptualization of factors that are responsible for the continuance of risky behavior such as sexual norms, alcohol/drugs, peer pressure and easy access to sex.

Admittedly, there is no single solution to the evolving epidemic, particularly in a country like India, which is huge, diverse and complex. However, successful national programs, including the expansion of the Voluntary Counseling and Testing services, and vaccine and "care homes" initiatives, indicate that the involvement of community-based organizations in prevention efforts and the integration of prevention with care can help to promote protective behavior and make a big difference in the quality of life of those living with the virus.

The government's intent to provide free antiretroviral drugs, including free diagnosis and treatment monitoring, to about 100,000 patients in India's six high-prevalence states in 2004 is yet another major initiative that, done right, could have profoundly positive impact. Critics of the program, however, question the capacity of the health system to deliver the drugs and monitor the patients.

It is heartening to see that, despite serious resource constraints and criticism, India is attempting to curb the HIV epidemic. Commitment at the highest level is evident, and a large army of dedicated governmental, nongovernmental and civil society members is working single-mindedly for the cause. In fact, the eradication of poliomyelitis and the push for HIV/AIDS prevention are hailed as the most highly visible public-health programs in India, according to a report on the country's response to the HIV epidemic in volume 364 of *The Lancet*. The challenge is to maximize this visibility to effectively curtail the epidemic and to improve the dignity of those who are currently living with the virus.

CECHeck-Up

"More than 20 years and 20 million deaths since the first AIDS diagnosis in 1981, almost 38 million people…are living with HIV," asserts the UNAIDS in its newly released 2004 report.

Over the past decade, we have acquired crucial knowledge about how best to prevent the spread of AIDS and improve the quality of life for people living with HIV. Yet cures remain elusive, and many challenges lie ahead. The Winter 2004 *MONITOR* addresses these issues, providing both a global and regional perspective on the situation, as it scores the wins and losses, and reveals the most promising approaches to reverse the course of this devastating epidemic.

UNAIDS chief, Dr. Peter Piot, leads off with a situational analysis of AIDS around the globe, highlighting current trends, status and impact on the development of nations. He concludes with a discussion of the global challenges to HIV/AIDS prevention and offers a list of prioritized actions to help curtail the pandemic.

Peter Lamptey of Family Health International provides a compelling analysis of the health and economic damage HIV and AIDS wreak on women and children in sub-Saharan Africa – the "epicenter" of the epidemic – pointing to successes and questioning the adequacy of current approaches to prevent and minimize disease impact.

In the *Insider's View*, Ravi Verma from the Population Council outlines the complex nature of the growing AIDS epidemic in India, pointing out that the traditional mores of Indian society must become an integral part of a comprehensive preventive strategy designed to reduce stigma and discrimination, and improve access to care and services across the country.

Using India, Russia and China as prime examples, Joan Tull of UNAIDS discusses the Global Media AIDS Initiative, which is designed to activate media organizations to disseminate information to youths in particular about how to prevent and treat HIV, and combat AIDS-related stigma and discrimination.

Russia has 800,000 HIV-infected persons and the worst prevalence rate in the Eastern European and Central Asian region; nevertheless, its countrywide tobacco addiction is giving AIDS a run for its money. *CECHE News* highlights the challenges and early successes of a CECHE-sponsored smoking-cessation program in Russia to combat this smoking scourge. This section also features a newly launched scholarship program to assist nutrition and public health scholars at Lady Irwin College in New Delhi, India.

Approaching AIDS from a policy perspective, Ambassador Randall L. Tobias reports on the U.S. Global AIDS Program, a presidential initiative that targets 15 of the world's most affected nations and aims to prevent AIDS infections as it provides anti-retroviral treatment and care for those already infected.

This issue of the MONITOR leaves no doubt that the dynamic, growing and challenging AIDS epidemic requires an all-out war to increase research funding, as well as a global political commitment to expand access to HIV treatment.

Sushma Palmer, D. Sc.,
Chairman, CECHE

Features

Media Take on Challenge of AIDS Education, Prevention

by Joan Tull, Communications Officer, UNAIDS, Geneva

It is often said that education is the only vaccine against HIV. In such a scenario, Media are best poised to inoculate.

Mindful of their pivotal role in the fight against AIDS, media outlets, whether television, radio or print, are increasingly rising to the challenge by promoting awareness of the virus, and educating listeners, viewer and readers about the facts of the epidemic and how to stop it.

According to national surveys conducted in a range of countries, the majority of individuals identify the media as their primary source of information about HIV.

In the United States, for example, 70 percent characterise the media in this way, and in India, among women who have heard about AIDS, more than three-quarters get their information from television.

The Global Media AIDS Initiative (GMAI) is a bid to harness this power. Its birth began in January 2004, when secretary-general of the United Nations, Kofi Annan, convened an historic meeting of top executives from around the globe to focus attention on media contributions to the fight against HIV. These broadcasting executives discussed a range of strategies, from making AIDS a corporate priority to ensuring that the issue is placed prominently in mainstream programming. Commitments were also made to give the epidemic significant news coverage and to dedicate airtime to public service announcements (PSAs).

GMAI is supported by the United Nations Department of Public Information, UNAIDS and the Kaiser Family Foundation. A number of activities have taken place under its auspices, including a regional media leaders meeting in Indonesia. And the creative conference mooted at the inaugural GMAI meeting took place in New York this fall, hosted by MTV Networks International, and the International Academy of Television Arts and Sciences.

An Uphill Battle

Despite the fact that AIDS has been on the radar and making news for more than 20 years, there is still an alarming lack of awareness about the disease, especially among young people. According to recent surveys from more than 40 countries, greater than half of those in the highest age risk group, ages 15 to 24, have serious misconceptions about AIDS transmission. And a 2003 survey found that 40 percent of Chinese men and women were unable to name a single way to avoid infection.

AIDS is also a very difficult subject to discuss with the requisite level of frankness and openness. An unseen virus linking sex and death, it does not necessarily lend itself to free-flowing conversation. Breaking the talking taboo on HIV will lead to expanded knowledge and awareness that will encourage behaviour change.

Denial that AIDS is a universal problem that can affect anyone at anytime is also a trend that needs to be challenged. Many people have not yet accepted that the risk of HIV/AIDS applies to them. For instance, more than nine in 10 adolescents in Haiti believe they have a tiny or non-existent chance of contracting HIV; meanwhile the nation has one of the highest prevalence rates outside sub-Saharan Africa.

Equally damaging to the effort to disseminate factual information about the epidemic is the widespread belief that HIV/AIDS is something that happens to people who are immoral and socially deviant. Or that those living with HIV deserve to be infected. A UNAIDS study in India found that more than one-third of respondents expressed this view, and a similar percentage felt that it would be better if infected people killed themselves.

There is also a need to recognise that sometimes it is necessary to challenge the extant norms and values in a given society to facilitate behaviour change. For example, the shibboleth of prevention, ABC, (where 'A' is for abstinence, 'B' is for being faithful and 'C' is for consistent condom use) is not appropriate for many women. In patriarchal societies, women rarely have the kind of control over their sexual behaviour that allows them to decide on abstinence or condom use. Often, they are faithful themselves, and become infected by husbands and partners who are not.

> "HIV/AIDS is the worst epidemic humanity has ever faced. It has spread further, faster and with more catastrophic long-term effects than any other disease.
>
> (The) media have tremendous reach and influence…We must seek to engage these powerful organizations as full partners in the fight to halt HIV/AIDS through awareness, prevention, and education."
>
> ***Kofi Annan,** United Nations Secretary-General, January 2004*

The nature of media interventions can also pose a problem. Some can do more harm than good if they, for example, rely on fear to get their message across, as many did in the early days. As a corollary to this, some campaigns today fall into the trap of stigmatising people deemed to be in high-risk groups, such as commercial sex workers, who are often portrayed as predatory vectors of the disease.

Additionally, collaborations between media, grass-roots organisations, service providers and government agencies are one of the defining characteristics of successful interventions. Yet with a number of partners come potentially competing voices, and some prevention initiatives have run aground due to disagreements between key players.

Despite myriad problems and potential pitfalls, however, media companies on every continent are opting to accept the responsibility of confronting the virus head-on.

Making Inroads in India

Some countries have a long-standing tradition of media interventions. India, for example, has historically backed a broad range of HIV/AIDS campaigns, and national public broadcaster Prasar Bharati supports the GMAI. In 1997, Bharati's All India Radio broadcast the proto-typical radio soap opera *Tinkha Tinkha Sukh (Happiness lies in Small Things*), which led to radical — if localised — social change in one particular village, Lutsaan, where the dowry system was rejected.

Currently, India's first-ever large-scale mass media campaign is underway involving a collaboration between the BBC World Service Trust, the Doordarshan television company, All India Radio and the National AIDS Control Organisation.

An Indian film crew prepares to use its media prowess to capture viewers and combat HIV/AIDS

Launched across north India in November 2002, the campaign promotes education through entertainment. Two key programme strands are the award-winning weekly reality youth show, *Haath se Haath Milaa (Let's Join Hands*), and the interactive crime series *Jasoos (Detective) Vijay*, which was voted "Best Thriller Series" at the prestigious 2003 Indian Television Awards. *Chat Chowk*, a weekly radio phone-in programme on personal health issues, has also been part of the mix, along with advertising spots. In an independent survey, 85 percent of respondents said they had learned something new from the campaign, nearly one-third said they had discussed the key messages with friends, and more than 10 percent said they had changed behaviour as a result of the intervention.

But the task is daunting in a conservative society where talking about sex is far from the norm. In fact, according to research carried out before the campaign launch, only 7 percent of those surveyed said that they had ever discussed matters of a sexual nature. Such discussions need to take place given that India is increasingly threatened by AIDS, with more than 5 million people infected, and serious epidemics brewing in many of its states and regions.

Future efforts in India include the *Heroes Project*, a three-year initiative launched in 2004 that unites the Gere Foundation India Trust with the Avahan-India AIDS Initiative (part of the Bill and Melinda Gates Foundation), the Kaiser Family Foundation and Star India to present AIDS issues via PSAs, news coverage, and TV and radio entertainment programming.

Reaching Out in Russia

The media is also motivated in Russia, which has 800,000 HIV-infected persons and the worst prevalence rate in the Eastern European and Central Asian region.

For some time, a number of Russian channels have focused on HIV via news and medical programmes, radio call-in shows and studio discussions. Noting the severity of the crisis and the pervasive lack of awareness, misconceptions, stigma and discrimination, Russia's first nationwide, multi-platform public awareness campaign was launched this fall. Under the umbrella of the Russian Media Partnership to Combat HIV/AIDS, and spearheaded by Gazprom-Media and the Transatlantic Partners Against AIDS, the initiative will deliver HIV/AIDS-related PSAs, entertainment programmes and training. Almost US$30 million have been pledged for the first year of the campaign.

Projects are also being planned across the region. A Eurasia media leaders meeting, encompassing companies from Russia, the Ukraine and Central Asian countries, took place this fall. Hosted by GMAI members Alexander Dybal (Gazprom-Media) and Viktor Pinchuk (ICTV, Ukraine), the conference invited proposals of concrete measures to educate the public about HIV.

Changing Channels in China

Authorities in China have recently acknowledged the potential for a serious HIV/AIDS epidemic in the country and have also begun to act accordingly. A new political will, evidenced by Premier Wen Jiaboa shaking hands with people living with HIV on World AIDS Day 2003, has been reinforced by a commitment to media messages and greater dissemination of information.

A still from "Ninja: The Enduring Master" PSA, courtesy of the Staying Alive Campaign, MTV China.

National broadcaster China Central Television (a GMAI member) has increased AIDS coverage in earnest and ran hundreds of news items about HIV in 2003. This is in addition to AIDS-focused TV dramas such as *If There is a Tomorrow*, broadcast in 2002, and 20 episodes of *The Red Ribbon*, shown during primetime at the end of 2003. CCTV has also partnered with MTV China to raise awareness via components that include a new PSA aired nationwide.
Other channels, such as the Hong-Kong based Phoenix TV (another GMAI participant), have also stepped up their HIV/AIDS-related news coverage, documentaries and PSA

broadcasts. In addition, Phoenix has aired a series of five one-hour features entitled *A True Report on AIDS in China* as part of *Phoenix Panorama*, one of the channel's main information programmes.

To further the situation, this spring, the Chinese government unveiled a series of binding national guidelines on AIDS publicity and education. Not only are broadcasters now required to include AIDS prevention coverage and messages, but there are also stipulations as to item frequency and position. For example, HIV/AIDS-related programmes and PSAs

should be broadcast during peak hours and not less than twice a week, with a gradual increase in frequency.

A Focus on the Future

Clearly, AIDS is on the agenda for many broadcasters around the globe. Such interest and commitment is to be commended and supported. But resting on laurels is not an option. Both countries and media companies must continue to recognise the full extent of the challenge ahead and ensure that campaigns are sustained, and replenished, over time.

The task at hand requires vision, dedication and, above all, creative programming that truly engages audiences. The media have nothing less than the power to save lives. And apparently, they remain intent on doing so.

For further information or inquiries, contact Mahesh Mahalingam at UNAIDS: maheshm@unaids.org.

CECHE News

Smoking-Cessation Program Motivates Russian Physicians to Assist Their Patients – and Themselves

The smoking prevalence in Russia is one of highest in the world: 63 percent of men and 12 percent of women in the country currently smoke, with more than 30 percent of total male deaths and 5 percent of total female deaths attributed to the habit. Even more surprising is that the smoking prevalence and corresponding death rates among Russian health professionals equal that of the general population.

All told, 40 million Russians light up, and the numbers are increasing everyday. More than half of the current smokers say they want to kick the habit. But no national anti-smoking campaigns or programs are in force, and Russia did not sign the international Framework Convention on Tobacco Control.

Health professionals may be the solution to Russia's smoking woes. Professionally respected and popularly revered, they could use such clout to change current smoking trends and spearhead a national anti-smoking movement. That is, if they weren't committed to the same smoking behaviors, misperceptions and lack of motivation as their tobacco-using patients!

A Comprehensive, Critical Program

Currently, Russian physicians are one of the main barriers to tobacco control in the country. To address, and ultimately reverse, this situation, CECHE and the Russian Cancer Research Center took on the critical task of educating, motivating and training Russian physicians to champion smoking cessation. Partnering with the Moscow Health Education Center and the Russian Public Health Association, in 2003-2004, the organizations designed and implemented a comprehensive 18-month program to expand the number of knowledgeable, skilled tobacco-

Physician training in Russia is a critical step in curbing the country's deadly tobacco addiction.

control clinicians in the country. The program includes the development, implementation and dissemination of: a cross-sectional survey of 1,000 physicians in 15 Moscow clinics; a series of 1.5-hour seminars in smoking-cessation counseling; a one-day course on tobacco-related health problems, tobacco-control measures and methods of tobacco-dependence treatment; and a science-based, practical manual for physicians.

Preliminary survey and program data revealed that, while 66 percent of male doctors, 21 percent of female doctors and 34 percent of nurses are current or former smokers, only 42 percent of smoking health professionals want to quit (as opposed to 60 to 70 percent of current smokers in the general population). Sadly, a majority of surveyed health professionals cannot name specific health hazards associated with smoking. And more disappointing, only 34 percent of

them said that they would like to participate in a workshop on tobacco and health problems, and methods of tobacco dependence treatment.
Nevertheless, resolve is strong. Prodded by clinic chiefs and official invitations from the Moscow Public Health Department, a total of 1,000 health professionals have participated in 30 educational sessions conducted in 23 outpatient clinics and 7 hospitals in and around Moscow to date. Five one-day training workshops have also taken place, involving 200 physicians in Moscow, its surrounds and Nyzney Novgorod. In addition, the physician-targeted manual, "Smoking Cessation Assistance for Your Patients" is currently being published.

Eight workshops are already on the books throughout Russia for next year. Follow-up with physicians who attended workshops is also planned to evaluate the effect of the training on participant knowledge and smoking-cessation counseling activity.

Future program elements include: free nicotine-replacement therapy (NRT) for health professionals to secure their smoke-free status and to make them more active smoking cessation counselors and NRT advocates; and a "Tobacco or Health" educational training course for post-graduate students of medical high schools.

A Step in the Right Direction

The jury is still out, but patient referrals appear to be rising. Before project initiation, health professionals directed only 1 percent of smokers to smoking-cessation clinics; today that number has climbed to 20 percent.

The ultimate goal of the project is a drop in smoking prevalence and a corresponding rise in health benefits and life span among both Russian health professionals and the general population. As Russians queue to quit, the partners plan to expand the program to other regions of the Russian Federation – and are currently in discussion to conduct workshops in Samara, Novgorod and Shatura.

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Public Health Nutrition Scholarships Unveiled in India

In the summer of 2003, graduate students at Lady Irwin College in New Delhi, India were given an opportunity to enhance their training and research. That's when CECHE partnered with the school's Food and Nutrition Department to establish a scholarship program for its master's degree and doctoral candidates.

Three public health nutrition scholarships will be awarded each year — two to master's candidates and one to a doctoral student, chosen on a merit-cum-means basis. Applications are screened by the director of Lady Irwin, the head of the Food and Nutrition Department and an instructor nominee. The school's scholarship committee then approves the final candidate list and presents the recommendations to CECHE for review.

Nidhi Goyal, Suman Anand and **Anshu Kumra** were the 2003 scholarship recipients, and the program's first awardees.

Scheduled to complete her master's degree in 2004, Ms. Goyal has developed and conducted nutrition education programs for pregnant women of mobile crèches using a variety of communication skills. She has also performed extensive fieldwork in maternal and child health, and child welfare, and has completed a six-week curriculum in medicine at the Department of Social & Preventive Medicine at S.N. Medical College, Agra.

Gender- and age-related differences in the nutritional status of affluent elderly individuals are the focus of Ms. Anand's master's dissertation. During the course of her studies, Ms. Anand completed 260 hours of fieldwork in the villages of Agra to evaluate a World Health Organization-funded Maternal Child Health and Nutrition initiative; she also worked on a project at an Anganwadi center.

Ms. Kumra completed her master's degree at Lady Irwin in 1982. Prior to returning for her Ph.D., she was a lecturer in home science at St. Bede's College, Shimla, and spent two years at the Food Craft Institute in Chandigarh in the Department of Bakery and Confectionery. Her doctoral dissertation is entitled: "Food Security in Urban Slums and the Impact of Relocation — A Comparative Study."

Established in 1932, Lady Irwin College is a pioneer institution for nutrition studies in India. Affiliated with the University of Delhi, it is recognized for imparting quality higher education to women through undergraduate, graduate and post-graduate courses in multidimensional disciplines.

America Leads New Global Attack on AIDS

by Ambassador Randall L. Tobias, U.S. Global AIDS Coordinator, Washington, D.C.

Eight thousand human lives are lost to AIDS worldwide every day. The United States is meeting this severe and urgent crisis head-on with swift action and extraordinary financial commitment. Under President George W. Bush's $15 billion Emergency Plan for AIDS Relief (www.state.gov/s/gac), the United States is currently preventing new infections, bringing lifesaving treatment to people with AIDS, and caring for those infected and affected by the disease, including orphaned and vulnerable children.

President George W. Bush and Laura Bush greet children at The AIDS Support Organization in Entebbe, Uganda, July 11, 2003.

The United States will make available a total of $2.4 billion for the fight against AIDS this year – more than the rest of the world's donor governments combined. In fact, America's financial and political will bolsters internationally coordinated efforts. The Global Fund to Fight AIDS, Tuberculosis and Malaria is a critical part of the U.S. strategy for battling HIV/AIDS, offering a vehicle for other donors to substantially increase their commitment to this fight, as the United States has done. America is asking the rest of the world to join in supporting the Global Fund, to which it is by far the largest donor nation. Since 2001, when President Bush made the founding contribution, the United States has seen the fund as both a valuable partner and an important vehicle to encourage greater investment of other donor countries, the private sector and individuals in the fight against HIV/AIDS.

With the hope of stimulating significant global investment to combat AIDS, Congress appropriated up to $547 million for the Global Fund in fiscal year 2004, provided that this sum did not exceed 33 percent of total contributions. Put another way, Congress asked only that the rest of the world's donors contribute $2 for each $1 from America. The United States will continue to work with the Global Fund to challenge the rest of the world to take action and join America in its deepened financial and political commitment to the fight against AIDS.

Prevention, Treatment and Care Demand Attention

In tandem with its support of international efforts to reduce the spread of HIV/AIDS, the President's Emergency Plan directly provides HIV/AIDS treatment, prevention and care in more than 100 nations. This includes an intense focus on 15 of the world's hardest hit countries, which are collectively burdened with half of the world's infections: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia. In each of these countries, U.S. personnel have collaborated with host governments, local community-based and faith-based organizations, international nongovernmental organizations, people living with HIV/AIDS and other stakeholders to design a Country Operational Plan that responds to the nation's particular needs. They have also worked with these nations to determine annual and five-year target numbers of persons to be reached by U.S.-funded prevention, care and treatment programs.

In addition, in these countries over the next five years, this Emergency Plan for AIDS Relief will:

- Support provision of lifesaving drug treatment to 2 million HIV-infected people
- Prevent 7 million new HIV infections
- Support care for 10 million people infected and/or affected by HIV/AIDS.

A major focus of America's commitment is keeping HIV-positive people in developing countries alive with the lifesaving drugs that are widely available in the developed world. Roughly half of the President's Emergency Plan dollars will be used to buy antiretroviral drug therapies, giving HIV-positive people in developing countries the strength to work, sustain their families and support their communities. To put this in perspective, at about the same time that the United States began to roll out its programs, the World Health

Organization estimated that some150,000 patients were then receiving antiretroviral therapy in all of sub-Saharan Africa – a fraction of the number who needed to be treated. Yet as of July 31, only a few months after U.S. Emergency Plan implementation, America had supported antiretroviral therapy for approximately 25,000 additional HIV-infected persons in nine countries, based on partial and preliminary reports. And that number continues to grow dramatically as the U.S. program rapidly expands – and as other patients receive U.S.-supported therapy through the Global Fund for AIDS, to which America is the largest donor. Some had questioned whether antiretroviral drug therapy could successfully be delivered in resource-poor settings on a large scale. Fortunately, the United States is making it clear that the answer is yes.

America's commitment to those suffering from AIDS is to provide not just any drugs, but safe and effective drugs. From the beginning, U.S. policy has been to buy safe and effective drugs at the lowest possible price regardless of who makes them or from where they come. To rapidly provide drugs with quality assurance to those in need, the Bush administration has acted to allow any producer in the world to seek accelerated review of AIDS drugs from the U.S. Department of Health and Human Services' Food and Drug Administration, which reviews drugs sold to American citizens. The President has made it clear that families in programs funded by the United States in the developing world deserve assurance that the drugs they use are safe and effective. America will not have one health standard for her own citizens and a lower standard of "good enough" for those suffering elsewhere.

Another key focus of the multifaceted U.S. approach to HIV/AIDS is preventing mother-to-child transmission of the virus. As of March 31 — in just 18 months — the United States had trained 14,700 health workers and built capacity at more than 900 different health care sites to prevent such transmission. This program also continues to grow at a rapid rate, offering services to mothers and children alike.

Investment in Infrastructure and Training is Key

America has taken on an extraordinary and extremely difficult task. And the single greatest obstacle — faced by the United States, the Global Fund and everyone else — is a desperate lack of infrastructure and health care workers in the hardest hit nations. All the AIDS drugs in the world won't do any good if they're stuck in warehouses, unable to be provided to those in need because of under-developed distribution networks or a shortage of trained personnel.

It is increasingly clear that more must be done to build up the health care capacity of the highest-risk regions. Drug therapies must reach patients who have been isolated by geography, poverty or political neglect. Treatments must be correctly administered. And patient care must be followed, prevention pursued and whole communities rebuilt on a sustainable foundation. For this reason, a substantial portion of the U.S. funds is being invested in training health care workers, and in upgrading national and local public-health infrastructure. Improving capacity is essential if these countries are to take long-term ownership of their response to HIV/AIDS, as they must.

The United States is proud to be a leader in the fight to turn the tide of this devastating epidemic.