HIV/AIDS – the pandemic continues
ENTRE NOUS is published by:
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Layout
To om bord, Aarhus. www.toombord.dk

Print
Central tryk Hobro a/s

ENTRE NOUS is funded by the United Nations Population Fund (UNFPA), New York, with the assistance of the World Health Organization Regional Office for Europe, Copenhagen, Denmark.

It is published two times a year. Present distribution figures stand at 3,000 English, 2,000 Spanish, 2,000 Portuguese, 1,000 Bulgarian, 1,000 Russian and 500 Hungarian.

ENTRE NOUS is produced in:
 Bulgarian by the Ministry of Health in Bulgaria as a part of a UNFPA-funded project;
 Hungarian by the Department of Obstetrics and Gynaecology, University Medical School of Debrecen, PO Box 37, Debrecen, Hungary;
 Portuguese by the General Directorate for Health, Alameda Afonso Henriques 45, P-1056 Lisbon, Portugal;
 Russian by the WHO Information Centre for Health for the Central Asian Republics;
 Spanish by the Instituto de la Mujer, Ministerio de Trabajo y Asuntos Sociales, Almagro 36, ES-28010 Madrid, Spain.

The Portuguese and Spanish issues are distributed directly through UNFPA representatives and WHO regional offices to Portuguese and Spanish-speaking countries in Africa and South America.

Material from ENTRE NOUS may be freely translated into any national language and reprinted in journals, magazines and newspapers or placed on the Web provided due acknowledgement is made to ENTRE NOUS, UNFPA and the WHO Regional Office for Europe.

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For information on WHO-supported activities and WHO documents, please contact the Family and Community Health Unit at the address given above.

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ISSN: 1014-8485

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In the light of recent international summits and funding decisions, *Entre Nous* is devoting an issue of the magazine to HIV/AIDS. Most health care professionals and policy-makers are well aware of the devastating situation HIV/AIDS has created globally. That is why WHO and UNFPA have programmes to combat its spread and that is why the Joint UN Programme on HIV/AIDS (UNAIDS) was created. That is also why the Barcelona conference was held this past July. Nevertheless, despite the amount of information available to us, we have yet to transform it into adequate action and commitment. The latest major initiative, the Global Fund to Fight AIDS, Tuberculosis and Malaria, is still short some eight billion US dollars.

In this issue of *Entre Nous*, we draw attention to the changing dimension of HIV/AIDS. Once considered by many a disease of gay men, heterosexual transmission, in many cases via commercial sex workers, is on the rise. In central and eastern Europe, mother-to-child transmission (MTCT) of HIV has exploded and intravenous drug users throughout the European Region account for a large percentage of people living with AIDS. In short, the disease pattern has mutated, attacking vulnerable groups who do not or cannot adequately protect themselves. Since 1998, newly reported HIV diagnoses have almost doubled in this region and according to UNAIDS, July 2002, eastern Europe is experiencing the fastest growing AIDS incidence in the history of the epidemic. Nevertheless, as Ulrich Lautkam-Josten reports in his overview of HIV/AIDS in Europe, the epidemic is still at an early stage.

There are two main fronts in the current debate on how to fight HIV/AIDS: those supporting prevention and those calling for treatment. That prevention and treatment are equally important as a means to decrease the impact of HIV/AIDS was a key message conveyed at the Barcelona meeting. Nevertheless, whereas earlier on, in the 1980s, there was very little information on HIV/AIDS, but much reporting, we now have evidence on prevention and treatment, but there are still many areas, including in Europe, where this evidence as well as skills to avoid risk factors are not adequately disseminated.

Worldwide, MTCT is the greatest source of HIV infection amongst children under 10, with over 5 million children estimated as having been infected. While the number of infants infected with HIV/AIDS in the countries of central and eastern Europe is still low, there is every reason to expect a dramatic increase in these numbers. On page 9, the prevention of mother-to-child transmission of HIV, as one of the most feasible interventions currently available to address the HIV epidemic in Europe, is discussed. The authors recommend that health workers in primary health care settings be trained to enable HIV-positive mothers to make a fully informed decision on infant feeding methods, to support them in their decisions, and to counsel mothers who are HIV-negative, or of unknown HIV status, about breastfeeding and voluntary testing. Helping an HIV negative woman to stay free from HIV infection is, however, still the most efficient way to avoid MTCT.

In addition, the earlier strategy of prioritising the provision of condoms needs to resume and be increased, such as in Kosovo, where Population Services International with help from UNFPA has been able to subsidise the cost of condoms. But such activities need to proceed cautiously, ensuring that proper structures are in place to continue the provision after assistance ends.

In her article on page 20, Frances Kissling points out that it is condoms and not ideologically driven solutions like abstinence that need to be provided. She writes that the 100 000 Catholic hospitals and 200 000 social service agencies worldwide that fall under the jurisdiction of the Vatican are forbidden from providing condoms and safer sex instruction - even to those who are not Catholic. As a result, real people continue to die of AIDS when we have a tested prevention strategy.

*Entre Nous* hopes that donors and affected governments alike will recognize the impending epidemic and increase activities in central and eastern Europe to confront it. On pages 12 and 13, a payment proposal for funding the Global Fund to Fight AIDS is presented. Is it not the responsibility of all countries to take on a greater financial burden in the fight against AIDS? Readers are encouraged to challenge governments to do more.

As we go to press, a global meeting of WHO regional advisers on sexual and reproductive health has just concluded. The advisers and a group of technical experts looked specifically at how health sector reforms have impacted on sexual and reproductive health. This subject will be the theme of the next issue of *Entre Nous* and readers should contact us with their experiences, concerns and research.
AIDS is the most devastating disease ever faced by humankind. UNAIDS estimates that by the end of 2001, close to 1.6 million people were infected with HIV/AIDS in Europe. While the number of people living with HIV or AIDS in the European Region is smaller than in some other WHO regions, eastern Europe continues to experience the fastest-growing epidemic in the world - in some of the countries in eastern Europe, the number of infected people doubles every nine to 12 months - and there is evidence of newly rising rates of HIV-infection in western Europe. The number of HIV positive persons in the region increased by more than 1300% between 1996 and 2001. This, combined with some of the highest rates worldwide of sexually transmitted infections (STIs) in a significant number of countries in eastern Europe, very high rates of injecting drug use and very significant rates of TB infection (including multi-drug-resistant TB), clearly indicates that the HIV/AIDS epidemic should be expected to grow considerably in the years to come, as well as its consequences in a variety of areas.

Despite the explosive spread, the epidemic is still at an early stage. New HIV cases are 75% in injecting drug users (IDU); 77% are men and 84% are under the age of 30. This pattern of HIV transmission and the STI epidemics occurring at the same time create the potential for massive outbreaks of sexually transmitted HIV infections in the near future, and in a few years, can lead to a large scale and generalized HIV/AIDS epidemic. Recognizing this, there is an urgent need to dramatically scale up current responses at national and international levels.

**Injecting drug use (IDU)**

The development of the HIV epidemic was slow in eastern Europe and only became evident in the late 1990s. Now HIV infection is rising faster than elsewhere in the world, mainly because of an explosive increase in injecting drug use. Since 1998, newly reported HIV diagnoses have almost doubled in this region. Injecting drug use has become widespread amongst young people, especially young men. It is estimated that 1% of the population in Russia, the Russian Federation and other countries of the newly independent states (NIS) is injecting drugs. Needle sharing is common practice among injecting drug users - and a common cause of HIV transmission.

**The magnitude of STIs in Europe**

The current high rates of STIs in eastern Europe and central Asia are both a major public health problem in their own right and a potentially important co-factor of the sexual transmission of HIV.

While in Western Europe the incidence of reported syphilis is below 2 per 100 000 and gonorrhoea is below 20 per 100 000, in eastern Europe and central Asia epidemic levels have been reached.

Although reported syphilis incidence either stabilized or declined in most countries of eastern Europe and central Asia (see figure 1 and 2), within countries the trend diverges, with increases observed in rural areas or penitentiary systems. Examples are the very high rates, up to 1400 per 100 000, reported from remote regions in the Russian Federation. Congenital syphilis continued to increase in almost all countries, indicating that more and more women are not sufficiently screened and treated for syphilis during pregnancy.

**Figures 1 and 2: Syphilis in the WHO European Region and in selected countries (A full presentation of the HIV/AIDS/STI situation is downloadable from http://cisid.who.dk/HIV-STI/)**

Changes in care seeking behaviour, service utilization, active case finding (screening and partner notification), and reporting are likely to affect the observed trends in syphilis notifications. People with an STI, including syphilis, are increasingly seeking care in the fast growing official and unofficial private sector. In particular, the population groups who are most at risk for STIs, such as young people and marginalized groups (for example the homeless, the unemployed, sex workers and street children) are unlikely to trust the government system because of its history of stigmatisation and prosecution.

Countries in the Region have started to adopt WHO recommended policies and practices on STI prevention and care, and are gradually shifting from the use of coercive and punitive approaches to the establishment of more user-friendly services. However, these changes are slow and have not been implemented on a large enough scale to result in a major reduction in syphilis or other STI transmission. There is an urgent need for further reform of the STI prevention and care system, which requires a strengthened and on-going commitment from governments and international organizations providing assistance.

> To summarize, the potential for significant sexual transmission of HIV in central and eastern Europe has three contributing factors:

1. The current epidemic of other STIs, which indicates a widespread practice of unsafe sexual behaviour, and the weakness of the health care services;
2. The widespread epidemic of injecting drug use (IDU) among young men, which is fuelled by drug trafficking through the region, mainly opium and heroin from Afghanistan, and by inappropriate public health and criminal drug policies;
3. The prevailing socio-economic factors, which lead to conditions that are well known to increase the risk for sexual HIV transmission such as poverty, sex work, migration, trafficking of women
and a lack of social cohesion. It should be noted that in central and eastern Europe, ten countries belong to the group of low-income countries (GNP per capita less than US $1,000, also referred to as "developing countries"), nine are among the low-middle income countries (GNP per capita $1,000-$3,000), and only seven countries have an annual GNP over US $3,000. Additionally, all of those countries public health and health care service delivery which are often impoverished and inefficient.

A rapidly developing epidemic
Based on recent data, Ukraine has reached the level of a generalized HIV/AIDS epidemic, meaning that the HIV prevalence is over 1% in the general population and over 5% in high-risk groups. A number of other countries are steadily progressing toward that milestone.

About 235,000 newly diagnosed HIV infections were reported from the beginning of the epidemic until the end of 2001 in eastern Europe, more than in the rest of the European region. Over two-thirds of those cases are among IDUs. The numbers of reported new HIV infections among men-having-sex-with-men (MSM) and through transfusions are relatively small and steady over the years, but the numbers of new infections through heterosexual contact, and of mother-to-child transmission (see article on page 9) are steadily rising.

It is estimated that 1% or more of the population of the newly independent states (NIS) are injecting drugs (out of a total population of about 290 million), and IDUs represent an overwhelming majority of people living with HIV/AIDS (PLWHA) in eastern Europe. Recent data show that IDUs make up anywhere between 70% and 90% of all PLWHA in Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, the Russian Federation, the Ukraine and Uzbekistan, and that significant part of IDU populations are already HIV positive (up to 19% in Armenia, 8% in Latvia, and from 20% to over 50% in cities in Belarus, the Russian Federation and the Ukraine, for example).

There are no reliable estimates of the numbers of sex workers in central and eastern Europe. For example, recent efforts by the WHO Regional Office for Europe to collect this kind of information from the Russian Federation resulted in figures ranging anywhere between 7000 and 70,000 sex workers in the Moscow region alone. However, limited studies found that 25% of commercial sex workers in Vilnius are IDUs, and 31% of those surveyed in Moscow. Sex workers, together with sex partners of IDUs, represent a significant channel of HIV transmission into the general population.

It is also characteristic for central and eastern Europe that a growing number of very young people are either IDUs or are HIV positive, or often both. Over 2% of all newly diagnosed HIV cases in NIS in the first six months of 2001 were younger than 13 years, and almost 20% were between the ages of 13 and 19. Up to over 50% of all IDUs in NIS are younger than 25.

Sex workers in the region are even younger than IDUs - some sources suggest that up to 4/5 of all sex workers are under the age of 25, and those figures are even higher among minorities, such as Roma.

The health situation in prisons in some NIS is alarmingly poor, with tuberculosis and STI and HIV/AIDS epidemics being often times worse than in the general population. Moreover, the Russian Federation has the highest number of prisoners per capita in the world, and conditions in some of its prisons are appallingly bad from the perspective of health. Studies from recent years, for example, estimated the prevalence of HIV in Ukrainian prisons at around 6%. Rates of STI are also dramatically higher in penal institutions, and injecting drug use is also a serious problem of the prison systems, even though very scant data exists.

The invisible epidemic
Eastern Europe is witnessing very high numbers and rates of newly diagnosed HIV infections, while numbers of AIDS cases are still relatively low. This makes the epidemic rather "invisible", and a timely response is needed to prepare countries in the region and their health sectors for the crisis to come. It is to be expected that numbers and rates of AIDS cases will start to grow rapidly in the near future, which will create significant pressures on national governments to respond appropriately to the growing health, economic, social and political consequences of the epidemic.

In Europe, this devastating epidemic in the making is still predominantly brewing within the so-called "vulnerable" or "marginalized" groups, such as injecting drug users and sex workers, but also prisoners, migrants and others. Without a visible impact on the general, mainstream population, effective prevention measures such as sex education, needle exchange, distribution of bleach to prisoners, methadone treatment, or the free provision of expensive antiretroviral therapy to individuals who may be perceived by many as undeserving, troublesome or even criminal remains highly controversial in many countries. However, providing appropriate services at public expense to drug addicts, alcoholics, homeless, prisoners or sex workers remains the only presently available effective investment in the health of the overall society, and the only possible tool to eventually slow down the growth of the epidemic.
THE KOSOVO AIDS COMMITTEE
by Xhevat Jakupi

In the last few years, the HIV/AIDS situation in Kosovo has been characterized by unreliable information, a lack of prevention programmes and increasing risk. Several factors contribute to the heightened level of risk: a rise in drug use, an influx of commercial sex workers from countries with high HIV-infection rates, the repatriation of thousands of Kosovans who spent years in higher-risk countries, changing social norms and poor awareness of HIV/AIDS among Kosovan youth.

To address the country's escalating risk for an AIDS epidemic, WHO and the Institute of Public Health of Kosovo (IPH) decided to develop a comprehensive action plan for HIV prevention in September 2000. Working closely with other Kosovan health institutions, the organizations established an HIV/AIDS/STI committee within IPH, and on 1 December 2000, the Kosovo AIDS Committee (KAC) was formally charged with developing a national HIV/AIDS-prevention programme.

KAC soon expanded to include representatives from UNMIK departments, UN agencies, national and international NGOs and the Kosovo Protection Corps (KPC).

After intensive consultations with all stakeholders, KAC decided in February 2001 to focus on three goals initially:

- to increase HIV/AIDS awareness among the population, particularly youth;
- to develop a reliable HIV-testing strategy with voluntary pre- and post-test counselling;
- to establish an HIV/AIDS surveillance system.

In December 2001, KAC kicked off a national awareness campaign with numerous activities. The campaign, funded mainly by the Department of Health, involves all the groups that have committee members.

Much outside expertise has been brought in by the WHO Office in Kosovo. It seconded its HIV/AIDS national professional officer to the Ministry of Health to lead KAC and the Ministry’s AIDS Office. In March 2002, it hired a CDC epidemiologist to conduct second-generation surveillance training for a selected group of Kosovan health professionals. And it followed up by hiring a consultant on HIV voluntary counselling and testing to train the same group in May.

Other help is being supplied by USAID/SC, which donated US $750 000 to PSI to provide 15 months of advanced technical support to KAC for, among other things, revising and developing its mid-term plan for HIV/AIDS. As members of the UNAIDS theme group, UNICEF and UNDP are also providing tremendous support for all KAC activities.

Despite the fact that Kosovo is still a low-prevalence area for HIV, appropriate prevention approaches, pursued with urgency, will lower rates of HIV infection. The government and UN agencies have therefore regarded HIV/AIDS as a priority in reconstructing and re-establishing government institutions. Positive developments include the HIV/AIDS Office in the Ministry of Health, a special prevention programme in the Ministry of Culture, Youth, Sports and Non-Residential Affairs, Multi-sectoral AIDS Committee, and active involvement by the Ministry of Education.

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PSI AND LOVE PLUS
Population Services International and Love Plus

PSI is a non-governmental organization that uses social marketing to address health problems in more than fifty countries. PSI programmes focus on mother and child health, spacing between births and the prevention of HIV/AIDS, malaria and other diseases. In Kosovo, PSI projects combat maternal and infant mortality, early and unwanted pregnancies, and HIV/AIDS and other sexually transmitted infections (STIs).

In order to raise awareness in Kosovo about STIs, PSI has run an extensive promotional campaign using TV, radio and the press. PSI has also educated secondary school students, teachers and members of the Kosovo Protection Corps about how these diseases are transmitted and how to protect against them.

To make such protection more widely available, PSI brought a condom called Love Plus to market in April 2001, distributing it to not only traditional venues (pharmacies), but also kiosks and supermarkets. Today, Love Plus can be purchased in numerous stores throughout the country, as well as more than 90% of all pharmacies.

Total sales from April to December 2001 were 650 000, and for the first four months of 2002, they reached 500 000. The success of Love Plus is due to a major promotional campaign—and an affordable price. PSI market research found that other condoms on the market: cost between 0.75 and 1.75. These prices are very high for Kosovo, which has faced high unemployment and other economic difficulties in the post-conflict period.

Since it is PSI’s goal to improve the sexual health of low-income people around the world, the organization enlisted the assistance of UNFPA in subsidizing Love Plus, enabling it to offer the condom for the much more affordable price of 0.50. "To make sure people don’t think that low price means low quality, PSI also makes clear that the condoms are manufactured and laboratory tested in the United States.

PSI plans to keep making Love Plus condoms available at a modest price, especially to young Kosovans. In this way, people can act responsibly and protect themselves from unwanted pregnancies, HIV/AIDS and other STIs. As the Love Plus motto says, “I do what I want, but I know what I’m doing.”
VULNERABILITY OF SEX WORKERS IN THE CIS COUNTRIES
By Irina Ermanova

Commercial sex workers, the sex industry, commercial sexual services, these are new terms which have replaced the usual term "prostitution", which "did not exist" or rather was never discussed in the USSR. Commercial sex has increased to such an extent in recent years that it is no longer possible to ignore it. For example, according to data from the mass media, in Moscow alone over 70,000 young women are involved in the sex industry. The epidemic of sexually transmitted infections (STIs) and the rapidly rising rates of HIV infection, mostly among groups at high risk of infection, make sex workers the most vulnerable group for contracting and spreading these infectious diseases. Health services and society in general therefore need to pay particular attention to this group.

What do we know about sex workers?

Generally, they are young women (70-80% of them aged between 16 and 25) and have entered the sex business for various reasons. Some of them are forced to sell sex to feed their children, some have lost their jobs and cannot find new ones, some like the work itself and some find it a way of earning good money. Most sex workers have completed secondary or higher education. Between 20% and 40% are married or have a regular sexual partner. The price of their services ranges from US$0.2 to US$150, depending on the status of the sex worker and place where she meets and serves clients. Since the sex business is not legalized in most Eastern European and Central Asian countries, there are no public brothels, and sex workers offer their services at a variety of places, starting from railway stations and streets, as well as in bars, hotels, casinos and saunas, or by telephone. The number of women employed in the sex business is not known and it is constantly changing: for example, there is seasonal sex work, when there are more sex workers in ports and spa towns in the summer, and fewer at other times of the year, or the number of sex workers varies because of police raids, which force CSWs to look for safer places and thus, often to change location.

Research into the practices of sex workers working on the streets in Odessa, Ukraine, has revealed the following information: each sex worker has 10-20 sexual contacts per week; 40% of them engage in group sex; 70% of their clients are married men. Less than half of the sex workers stated that they used condoms, for reasons, which are often more compelling than their concern for their own health. For example, they charge more for sexual services without a condom, or asking a client to use a condom is assumed to mean that the sex worker is already infected with some disease and may thus lose her client altogether. According to various researchers, between 30% and 85% of sex workers are infected with an STI as a result of high-risk sexual practices. Indeed, once a sex worker has contracted an STI, there is a high risk of its transmission to a general population. In addition, between 10% and 50% of sex workers, according to different researchers, are injecting drug users and have sex with other injecting drug users, and are thus also at a high risk of contracting HIV from a drug user in the newly independent states (NIS), the region with the highest prevalence of HIV among this group.

To a great extent, the vulnerability of sex workers is due to the unwillingness of society and the health system to address the problems encountered by this group, whose status is neither legal nor illegal. Police raids on the streets and other places where sex workers and clients negotiate their deals are a regular occurrence in the former USSR. The possibility that sex workers will be arrested for "offences against public order" or "to clean up the streets" before a public holiday or a visit from an official delegation, or simply to fulfill the police officers' required quota of arrests, drives the sex business underground. Often sex workers are forced to serve police officers free of charge. Frequent police raids disturbs the sex workers and make them move on to other areas, which makes STI and HIV prevention activities much harder, and sometimes completely impossible.

Another phenomenon affecting NIS is the residence permit (propiska).
A person's passport is stamped with his/her place of residence, which means that he/she can obtain free medical care only in that place. This considerably restricts the sex worker's access to medical care. Women employed in the sex business are forced to go to private physicians, which usually costs more than the sex worker earns. In order to pay for their care, which may cost up to US$200, many women have to serve a larger number of clients and have sex without a condom (for which they can charge more), or they may resort to self-medication. The need to change social policy and attitudes in the health system in order to reduce vulnerability and STI morbidity among sex workers is self-evident. Many non-governmental organizations are working successfully with sex workers in a range of prevention activities. Nevertheless, accessible and high quality governmental medical services for sex workers are uncommon.

The WHO Regional Office for Europe has initiated and supported a number of projects for the provision of free medical care and counselling for sex workers in order to have an impact on the STI/HIV epidemic by targeting one of the most vulnerable groups with high risk of infection. Six projects are being implemented by governmental health care services in the Russian Federation, Kyrgyzstan, Tajikistan and Georgia. These projects have demonstrated a successful collaboration between physicians and nongovernmental organizations engaged in outreach activities.

Volunteers who are former sex workers distribute prevention information developed by non-governmental organizations, condoms and information about the medical centre to which sex workers can go for consultations voluntary counselling and testing on HIV and treatment for STIs. A syndrome approach to treatment of women with STI has been successful, as treatment of a patient on the day of her first visit to the clinic, without waiting for the results of laboratory tests, has clear advantages: it reduces the time during which an infection can be passed on to a sexual partner, early treatment prevents ascending infections and there is a reduction in the need for further visits to the clinic. Effective counselling with a specialist during the sex worker's first visit enables her to make right decisions about her sexual health and the prevention of STIs. Experience at the sex workers' clinic in Bishkek (Kyrgyzstan) shows that, while 82% of sex workers attending the clinic for the first time were found to have an STI, the prevalence of STIs among those who had been to the clinic before decreased by 2-3-fold. Moreover, the sympathetic atti-
HIV infection among children is increasing worldwide. Over 90% of these HIV infections result from mother-to-child transmission (MTCT), whereby an infant acquires the infection from the mother, before or during delivery, or after delivery through breastfeeding.

Reported rates of MTCT range from 15% to over 40% in the absence of antiretroviral treatment (ART). This issue is growing in concern in the European Region. Increasing rates of HIV-infected women of childbearing age in the Region, as in high-prevalence countries such as the Russian Federation, the Ukraine and Belarus, has led to an increase in infants born HIV-positive.

Fig 1: Number of children born HIV-positive in the Russian Federation, the Ukraine and Belarus

Prevention of MTCT

Approximately one-third to one-half of overall MTCT of HIV occurs during the period of breastfeeding, therefore avoiding breastfeeding is one of the ways to reduce the risk of MTCT of HIV. There are still many questions as to the extent to which the quality of breastfeeding, whether exclusive or mixed, and the condition of the breasts, affect the risk of transmission. For example, clinical risk factors such as bleeding nipples, mastitis and breast abscesses have been associated with MTCT, as has the viral load of the breast milk. Studies even suggest that formula feeding may further exacerbate the risk of HIV-infection of infants. This is because the feeding formula may introduce foreign bacteria into the infant’s intestinal tract, which alters the function of the mucosal lining and its ability to act as a barrier against the ingested HIV viral agent. Given the controversial aspects of breastfeeding on MTCT, proper advice to mothers on these issues is crucial.

The role of health workers and policymakers

While exclusive breastfeeding for 6 months is recommended for the majority of mothers, individual HIV-positive mothers should be counselled on and assisted with their choice of replacement infant feeding where it is affordable, feasible, safe and appropriate.

The joint WHO/UNICEF/UNAIDS statement to assist policy-makers to formulate policies on HIV and infant feeding puts forth the following premises:

- All men and women, irrespective of their HIV status, have the right to determine the course of their reproductive life and health, and to have access to information and services that allow them to protect their own and their family’s health;
- High priority should be given to policies and programmes aimed at reducing women’s social and economic vulnerability to HIV infection through improving their status in society; and
- Breastfeeding significantly improves child survival and enhances quality of life of the child. In contrast, artificial feeding increases risks to child health and contributes to child mortality. Breastfeeding also contributes to maternal health in various ways including prolonging the interval between births, and helping to protect against ovarian and breast cancers.

In order to best advise mothers, particularly those who are HIV-positive, it is recommended that health workers in primary health care settings be trained to enable HIV-positive mothers to make a fully informed decision of infant feeding method; to support them in their decisions; and to counsel mothers who are HIV-negative or of unknown HIV status, about breastfeeding. The WHO/
UNAIDS/UNICEF document "HIV and infant feeding counselling: A training course" is designed to make it possible for trainers with limited experience of teaching the subject to conduct up-to-date and effective courses.

For HIV-infected women who elect to feed their infant a breast-milk substitute, it is all the more important for countries to adopt policies such as the Baby-Friendly Hospital Initiative and the International Code of Marketing of Breast-milk Substitutes to assist health workers in providing breast-milk substitutes only in such specific cases (as when a mother is HIV+) and to support breastfeeding for the general population.

For HIV-infected women who elect to breastfeed, strategies to reduce HIV MTCT must be multifactorial, including reducing the viral load of lactating women so as to minimize the excess risk of infection to breastfeeding infants. Experts from WHO, UNICEF, UNFPA, and UNAIDS concluded in October 2000 that the safety and effectiveness of antiretroviral regimens, including nevirapine, in preventing MTCT has been clearly documented and that the use of these regimens is thus warranted for preventing mother-to-child HIV transmission. The simplest regimen requires a single dose of nevirapine to the mother at delivery and a single dose to the newborn within 72 hours of birth.

### Example of effectiveness of prevention programmes

Prevention of MTCT of HIV/AIDS (PMTCT) services are available in a number of countries (e.g. the Ukraine, the Russian Federation and Belarus) and have been proven effective (Table 1) due to the ongoing joint initiative of governmental and non-governmental organizations, WHO, UNICEF and other key bodies. These services, including antiretroviral regimens such as nevirapine, should be included in the minimum standard package of care for HIV-positive women and their children.

### Useful sources of information:


### Table 1. HIV+ pregnant women receiving PMTCT services

<table>
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<td>52</td>
<td>9</td>
</tr>
<tr>
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<td>1010</td>
<td>782</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td></td>
<td>504 - AZT</td>
<td>64% - AZT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>278 - NVP</td>
<td>35% - NVP</td>
</tr>
</tbody>
</table>


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**Monthly PMTCT intelligence reports**

[www.who.int/reproductive-health/tis/MTCR/](http://www.who.int/reproductive-health/tis/MTCR/)

Monthly Intelligence Reports are compiled from a regular survey of publications related to the prevention of mother to child transmission of HIV. They also cover abstracts presented at international conferences. They include a brief summary and comments prepared by the Bordeaux Working Group.

The Intelligence Reports are commissioned by UNAIDS and WHO and are made available to policy makers, public health officials, advocates and scientists as an information service. The inclusion of material in (or exclusion from) the Intelligence Reports does not imply any endorsement or otherwise by UNAIDS or WHO and the comments are the responsibility of the Bordeaux Working Group.
In July 2001 the International Planned Parenthood Federation (IPPF) European Network (EN) started the project “Promoting Sexual and Reproductive Health Services and Human Rights for Youth and Adolescents” in the Balkan region.

This two-and-a-half-year-project was funded by the German Ministry for Economic Co-operation and Development to be implemented in four countries, namely Bosnia & Herzegovina, Croatia, the Republic of Macedonia and Yugoslavia including the UN-administered area of Kosovo. The programme focuses on HIV/AIDS prevention among adolescents and young people, but it links HIV prevention to the whole sexual and reproductive health (SRH) and rights context.

Why a project for HIV prevention in the Balkans?

Although data available on newly diagnosed HIV infections and the number of AIDS cases reported over the last years show that the situation in the Balkan region is not as dramatic as in some countries of eastern Europe or central Asia, there is reason to believe that cases are underreported, because of high risk behaviour observed in practice, such as increased early sexual intercourse in combination with low condom use, high rates of sexually transmitted infections (STIs) other than HIV and unsafe drug-injecting practices. In Croatia, where the incidence of HIV infection at the moment is still very low compared with the EU, the total number of reported HIV-positive cases has grown from 67 in 1990 to 268 in 1999, and currently some 40 new cases are registered annually.

The deterioration of the health systems and general health status of the population caused by the war is also relevant. During the war period, health services had to deal with emergency situations and the immediate basic needs of citizens, which only rarely included SRH services. The reconstruction process focused mostly on political and economic issues, relegating SRH problems quite low in the scale of government’s priorities. In Bosnia the percentage of GDP spent on health care declined from 6.5% in 1990 to 1.25% after the war. More than one third of the healthcare infrastructure was destroyed or heavily damaged and over 50% of doctors and nurses were lost because of death or migration.

The reality of SRH service provision varies from country to country with some common features. When services are in place, their quality, affordability and access are often not adequate. The main problems are the lack or poor functioning of equipment, shortages of medicines and medical supplies and the scarce knowledge of health professionals, resulting in inadequate service delivery. HIV/AIDS treatment is still hardly available or very expensive. Prevention programmes addressing high-risk groups such as drug users and sex workers are sporadic, whereas a comprehensive strategy at national level is lacking.

The IPPF EN project

The project focuses on the prevention of HIV/AIDS among youth, especially the marginalized and high-risk groups. The programme includes advocacy, information, education and communication (IEC), and capacity building of the organizations implementing the project. In order to address in a more holistic manner the sexual and reproductive health and rights of youth the activities were planned paying attention to the integration of gender issues; the importance of sexuality education; the concept of youth-friendly services, and the need to involve vulnerable and marginalized groups in such programmes. All levels of stakeholders are involved. Adolescents and young people, as primary stakeholders, are the main actors in the training component, which includes workshops, outreach work in high schools, and peer education.

Understanding of the issues that the project is promoting is pursued by stimulating a public debate about SRH and rights and HIV/AIDS at the government and community levels through seminars and debates, radio campaigns and a mass event for youth. The provision of accurate and appropriate SRH information is ensured through different means of communications such as newsletters, brochures, leaflets and a website created for the project. Advocacy work will continue throughout the whole project.

Even though the project does not include the setting up of services as part of its programme, it does aim in the long-term to improve the availability and accessibility of SRH and HIV prevention information and services. Service provision is hoped to improve through cooperation with health staff and social workers by updating their knowledge and
encouraging them to adopt a youth-friendly approach in their work.

IPPF EN policy and work in the field of SRH has always been conceived and carried out with a human rights approach based on its Charter on Sexual and Reproductive Rights, developed according to recognized international human rights laws. The NGO partners are using this Charter as a tool to advocate for SRH rights and mainstream a human rights approach throughout the issues related to HIV prevention and young people.

Partnership

Unlike many international NGOs and agencies, IPPF EN does not maintain expatriate staff in the country. Its policy is to work with autonomous local organizations, which are members of the IPPF. The organizations selected as partners for this particular project are not connected with the Federation, apart from the FPA in BiH. These organizations were selected because of their experience in working with young people and their willingness to take on sensitive and sometimes controversial issues related to HIV prevention. But not all of them have a sound expertise on HIV prevention and SRH and rights, the project started with a preparatory phase aimed at training people on HIV/AIDS issues and defining the project scenario and framework by sharing differences and similarities between countries.

For this purpose three regional workshops were organized in partnership with three experienced IPPF EN member associations, namely the Albanian, Bulgarian and Romanian FPAs. The involvement of these FPAs has stimulated East-East co-operation by providing expertise, technical assistance and the sharing of experience. This co-operation resulted in the establishment of an SRH network in the Balkan region, contributing to the overall strengthening and sustainability of the NGO sector.

For youth – with youth

Worldwide, the rates of sexually transmitted infections (STIs) including HIV/AIDS are higher amongst people aged 15-24 than any other age group. With regard to HIV more specifically, according to WHO estimates, 50% of all people infected with HIV are under 25. The context in which young people live their sexual and reproductive life has changed significantly in the Balkans, but no concrete support has accompanied such change.

As in many other parts of the world, in these countries, young people are becoming sexually active earlier and are engaging in sex with a larger number of partners. The fact that the schooling period is prolonged and that marriage is being postponed increases possibilities of risky sexual behaviour. This concerns the problem of unwanted teenage pregnancies and also of unsafe sexual practices. Information concerning such issues is generally lacking and, when provided, it does not always specifically target youth. Croatian young people complain about the lack of sexuality education taught as a subject on its own and by educators specifically trained in SRHR. Nor is sexuality education a part of the school curricula in the other project countries either. Therefore, the project has as one of its objectives raising public awareness on why and how this kind of education is necessary to improve the personal and social well-being of young people.

All six partner NGOs are volunteer-based organizations promoting youth rights and social justice. Their common feature is that they are organisations run by and for youth and that they are open to all young people regardless of their race, gender, sexual orientation, and political or religious belief. Furthermore, they already co-operate with governments and other NGOs, have a good outreach network through their branches and are rooted in their communities, which all represents important assets.

IPPF EN, in its long tradition of working with young people, believes that the most appropriate approach for carrying out a youth project is to involve young people themselves at every stage. The six partner NGOs created a core group of young volunteers who will be active in the implementation and monitoring of activities. Based on the conviction that young people know best their needs, their voice will be listened to throughout the project, which can be adapted and adjusted accordingly. In this perspective young people are being promoted from being solely the beneficiaries to being the main actors.

Young people from marginalized and vulnerable groups

In the project countries, the breakdown of the communist system and the following war have accounted for the growing seriousness of problems such as criminality, human trafficking, drug abuse and the whole question of refugees and displaced people. As a result, there is now a generation of children, adolescents and young people who are in a vulnerable situation or who belong to groups marginalized by mainstream society. These are young people living with HIV/AIDS, sex workers, intravenous drug users, displaced or refugee young people and youth from minorities, just to name a few.

The specific needs of such young people are not always acknowledged because there is a tendency among adults to look at young people as if they were a uniform group of people with the same style of life, same experiences, needs and opportunities open to them. In this sense, this project is a step in the right direction in that it puts marginalized and vulnerable youth at the heart of its activities, and pays attention to their particular needs.

A few conclusions ...

The results achieved so far are positive but we need to be vigilant about avoiding complacency and keep an objective eye on the impact of the activities. It is through the continuous critical self-assessment, even of youth involvement if need be, that we intend to keep this project flexible and active in order to promote SRH services and rights for all young people in the Balkans and maintain HIV prevention as a priority.

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No. 53 - 2002
Nearly one year ago, the majority of the world’s nations resolved at the United Nations Special Session on HIV/AIDS (UNGASS) to increase annual expenditure on the AIDS epidemic to US $7-10 billion by 2005, with much of this money to be raised and disbursed by a new global fund. When the fund was eventually set up, its mandate was extended, and it was named the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Thus far, efforts have been made to raise the money needed by the Global Fund through ad hoc voluntary donations. These efforts have failed. Governments have pledged a mere $1.8 billion. Contributions from the private sector have been even more disappointing, with not a single meaningful pledge since the Bill & Melinda Gates Foundation offered $100 million ten months ago.

It’s time for a new approach. The Global Fund needs to grow rapidly to the point where it raises US $10 billion a year. Contributions to the Global Fund should be equitably shared among the countries whose citizens live the most comfortable and unthreatened lives. This means that the wealthiest countries, such as the US, should contribute considerably more than they currently do. But it also means that contributions should come from the likes of Australia, Singapore, and the United Arab Emirates – relatively wealthy countries that have not yet contributed a penny.

Part of the problem is that to date, nobody has proposed which countries should give how much. The following table therefore offers an ‘Equitable Contributions Framework’ that can be used as a starting point for working out an appropriate contribution level for each country, and for measuring how well each country is doing against that level.

The Framework suggests that $1 billion a year should come from the private sector, as a minimum to justify the label ‘public/private partnership’ and the two seats it has out of the 18 voting seats on the Fund board. The remaining $9 billion a year should come, in proportion to Gross Domestic Product (GDP), from the 48 countries that have a ‘high’ Human Development Index, or HDI. (The UN’s HDI measures the overall quality of life based on standard of living, life expectancy, and literacy plus school-enrollment.)

The proposed contribution comes to 0.035% of GDP for each country. Not one country has yet given at this level. Assuming, in the absence of better data, that every contribution made thus far is entirely for use this year, the Netherlands (contributing at 97% of its proposed level), Sweden (73%) and Italy (57%) have done reasonably well. Seventeen countries have given between 1% and 50% of the proposed level, with Japan and the US at a very disappointing 12% and 13%, respectively. And 28 ‘high development’ countries have given nothing at all. Further details are provided at www.hdnet.org and www.aidspan.org.

It is to the credit of countries like Uganda and Nigeria that, poor as they are on a per capita basis, they have made multi-million-dollar contributions to the Fund. And it is to the shame of many of the 48 relatively wealthy countries that they have contributed little or nothing, without even stating why.

The Global Fund represents a bold new approach. The Fund’s leaders say that it will be more fast-moving, participatory, transparent and accountable than traditional channels. The Fund needs a chance to prove itself. It would be a shame if it were to fail simply because it did not receive the funding it needs to get properly established and to respond to the most urgent and obvious needs.

Note: Readers who wish to encourage contributions to the Global Fund from their own country can use the Framework to highlight their country’s appropriate contribution. Its total pledges already made, its apparent pledge for 2002, and the consequent shortfall. They can then use these figures as a basis for lobbying and other activities to increase the support for the Fund by their government and by corporations and foundations within their country.

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The principles underlying the Fund:
The Fund is a financial instrument, not an implementing entity.
The Fund will make available and leverage additional financial resources to combat HIV/AIDS, tuberculosis and malaria.
The Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes.
The Fund will seek to operate in a balanced manner in terms of different regions, diseases and interventions.

The Fund will pursue an integrated and balanced approach covering prevention, treatment, and care and support in dealing with the three diseases.
The Fund will evaluate proposals through independent review processes based on the most appropriate scientific and technical standards that take into account local realities and priorities.
The Fund will seek to establish a simplified, rapid, innovative process with effective and efficient disbursement mechanisms, minimizing transaction costs and operating in a transparent and accountable manner based on clearly defined responsibilities. The Fund should make use of existing international mechanisms and health plans.
"Equitable Contributions Framework" for the Global Fund, based on GDP (21/4-02)

<table>
<thead>
<tr>
<th>Country</th>
<th>Suggested &quot;equitable annual contribution&quot; to Global Fund ($m.)</th>
<th>Total pledge thus far to GF ($m., and as % of Col. 2)</th>
<th>Estimated portion of total pledge that applies to 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>3,479</td>
<td>450 (13%)</td>
<td>250 (7%)</td>
</tr>
<tr>
<td>Japan</td>
<td>1,649</td>
<td>200 (12%)</td>
<td>68 (4%)</td>
</tr>
<tr>
<td>Germany *</td>
<td>653</td>
<td>158 (24%)</td>
<td>35 (5%)</td>
</tr>
<tr>
<td>United Kingdom *</td>
<td>498</td>
<td>219 (44%)</td>
<td>67 (13%)</td>
</tr>
<tr>
<td>France *</td>
<td>453</td>
<td>151 (33%)</td>
<td>51 (11%)</td>
</tr>
<tr>
<td>Italy *</td>
<td>375</td>
<td>215 (57%)</td>
<td>73 (19%)</td>
</tr>
<tr>
<td>Canada</td>
<td>243</td>
<td>100 (41%)</td>
<td>38 (15%)</td>
</tr>
<tr>
<td><strong>Total for G7 countries:</strong></td>
<td><strong>7,352</strong></td>
<td><strong>1,493,580</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Non-G7 "high Human Development Index" countries:**

<table>
<thead>
<tr>
<th>Country</th>
<th>Suggested &quot;equitable annual contribution&quot; to Global Fund ($m.)</th>
<th>Total pledge thus far to GF ($m., and as % of Col. 2)</th>
<th>Estimated portion of total pledge that applies to 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spain *</td>
<td>195</td>
<td>58 (29%)</td>
<td>19 (10%)</td>
</tr>
<tr>
<td>Netherlands *</td>
<td>128</td>
<td>125 (97%)</td>
<td>42 (32%)</td>
</tr>
<tr>
<td>Switzerland</td>
<td>85</td>
<td>10 (12%)</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>Belgium *</td>
<td>81</td>
<td>19 (24%)</td>
<td>6 (8%)</td>
</tr>
<tr>
<td>Sweden *</td>
<td>80</td>
<td>58 (73%)</td>
<td>20 (25%)</td>
</tr>
<tr>
<td>Austria *</td>
<td>67</td>
<td>4 (5%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Denmark *</td>
<td>57</td>
<td>2 (4%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Finland *</td>
<td>42</td>
<td>2 (4%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Greece *</td>
<td>39</td>
<td>2 (4%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Portugal *</td>
<td>37</td>
<td>1 (4%)</td>
<td>0 (1%)</td>
</tr>
<tr>
<td>Ireland *</td>
<td>33</td>
<td>10 (31%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Kuwait</td>
<td>10</td>
<td>1 (10%)</td>
<td>0 (3%)</td>
</tr>
<tr>
<td>Luxembourg *</td>
<td>7</td>
<td>3 (41%)</td>
<td>1 (14%)</td>
</tr>
</tbody>
</table>

Argentina, Australia, Bahamas, Bahrain, Barbados, Brunei, Chile, Costa Rica, Croatia, Cyprus, Czech Republic, Estonia, Hong Kong, Hungary, Iceland, Israel, Lithuania, Malta, New Zealand, Norway, Poland, Qatar, Singapore, Slovakia, Slovenia, South Korea, United Arab Emirates, Uruguay

1 to 161 0 (0%) 0 (0%)

**Total for non-G7 "high HDI" countries:**

1,648 294 99

**Totals:**

| Total for all 48 "high HDI" countries: | 9,000 | 1,788 | 679 |
| Total for all other countries *** | 0 | 33 | 11 |
| Total for private sector (foundations and corporations) *** | 1,000 | 101 | 34 |
| **Grand total:** | **10,000** | **1,022** | **725** |

Explanatory example: The GDP in 2000 of all 48 countries totalled $25,569 billion. The GDP of the US that year was $9,882 billion, or 38.7% of the total. Thus, if the 48 countries shared equitably the donation of 19 billion annually to the Global Fund (with the remaining $1 billion coming from the private sector), the US's contribution would be the $3.479 billion that is shown in the table. Sources: Pledges: www.globalfundatm.org/files/Financial_contributions.html, www.un.org/News/ossig/ads.htm, and private sources. HDI: www.undp.org/hd2001. GDP: www.worldbank.org/data/databytopic/GDP.pdf. Pledges are as of 18/4/02.

Additional data plus future updates available at www.hdnnet.org and www.aidsen.org. The final column is based on private sources plus our own estimates, because the information is not published. We understand that total pledges are: 2002=$7,250m., 2003=$1,487m., 2004=$1,32m., 2005=$1,67m., 2006=$27m., plus $484m. for which the year(s) are not specified. We also understand that the pledges for 2002 (before adding shares of the EU pledge, when appropriate) include USA=$250m., UK=$60m., Netherlands=$40m., Canada=$37.5m., and Germany=$26.5m. For other countries and for the private sector, the 2002 portion is not known, so we have assumed it to be 33.8% of the total pledge, in order to bring the overall 2002 total to the known figure of $725. Further information received will be reflected in future versions of this table.

The European Commission has pledged $1,066.9 million to the Global Fund. In the table, this sum has been added to the direct pledges to the Global Fund of the 15 EU countries, in proportion to their respective GDPs. Denmark, Portugal, Finland and Greece have not made any direct pledges, but, like the others, have been credited here with portions of the EC pledge.

**Non "high HDI" countries that have donated are Russia ($20m.), Nigeria ($10m.), Uganda ($2m.), Zimbabwe ($1m.), Andorra ($100,000), Niger ($50,000), Liberia ($25,000), Kenya ($8,273).**

*** Of the $191.5m. pledged by the private sector as of 18 April 2002. $100 m. was from the Bill & Melinda Gates Foundation.
ARMENIA: REDUCING SEXUALLY TRANSMITTED INFECTIONS AMONG CSWS
By K.R. Babayan

The recent rise in sexually transmitted infections in the Caucasus has its roots in socio-economic upheavals, unemployment and widespread poverty. The region’s instability has led to increasing numbers of refugees, internally displaced persons (IDPs) and commercial sex workers (CSWs). The growing pool of CSWs would normally exhibit increased rates of STI infection, but in Armenia, these rates have actually fallen.

In 1995, Armenia’s Medical-Scientific Centre of Dermatology and STI (MSCD&STI) conducted the country’s first study of STI morbidity and epidemiology among CSWs. In the study’s first four years, the infection rate remained constant at about 55%. Approximately 15% of the CSWs suffered more than one kind of infection. In case of mixed infections, the patient is included in the table below as the primary registered infection, i.e., if a CSW was diagnosed as having gonorrhea, it is included in the table as it is, then also diagnosed with syphilis, the latter disease was not counted in the table. Therefore, the last row in the table refers to the infected persons, and not the infections.

were single. All of the 568 respondents reported at least one abortion. The real differences in the two survey years were behavioural. In 1996, half of the CSWs never used condoms. Their most frequently cited reasons were client refusal (42%), difficulty in suggesting use (20%) and trust in client health (12%). Condom usage rose dramatically by 2000, due to a 1999 CSW training programme. Yet the figures are somewhat misleading.

Though 87% were now reporting that they always used condoms, closer questioning revealed that most of the CSWs only encouraged safe sex with new clients and did not use condoms with known clients or cohabiting partners.

Finally, the survey showed that while most CSWs had heard about STIs and HIV/AIDS – 78% in 1996, 88% in 2000 – their knowledge of symptoms and prevention remained minimal. Nevertheless, 95% of the condom users in the later group were using them to prevent STIs, and just 5% to avoid pregnancy.

Recent Initiatives

During the 2000 survey, the MSCD&STI also took the opportunity to screen a random sample of 103 CSWs for hepatitis B. The centre conducted the test, the first such screening in Armenia, using a kit produced by Immunotest, Inc. It revealed a 31% carrier rate. Indeed, the centre has found that among CSWs, STIs are frequently latent or asymptomatic.

And beginning from year 2000, all CSW admitted at the centre are vaccinated for hepatitis B virus.

All admitted CSW are screened for HIV, using quick test kits. Positive samples undergo western blot technique. To date, only three cases have been confirmed as HIV positive ones (2 in 1998 and 1 in 2000).

In September 2000, MSCD&STI conducted several initiatives under the aegis of WHO/Europe projects targeting reproductive health issues for CSWs. Activities included information, education and counselling on sexual health and safe sex, booklet publication and distribution and condom promotion, as well as training and informational and counselling sessions. The centre also offered gynaecological and psychological consultation and began street outreach efforts. When STIs were detected, treatment and management were conducted using a syndromic approach, developed for Armenia based on recommendations from WHO/Europe.

Through these initiatives, the centre has gained better access to the closed world of CSWs, and the increased trust of the women themselves, particularly through activities that take place away from the clinic. Although such short-term projects do not guarantee long-term behavioural changes, they have generated enthusiasm for further street outreach – and a significant drop in STI cases, from 31.1% in 2000 to 24.4% in the beginning of 2001. Future priorities include maintaining the continuity of CSW contacts, encouraging routine STI check-ups and promoting new preventative measures.

From January 2002 onward, a new survey is being implemented; chlamydia screening will be performed among CSW, along with other STI screenings, including HIV. Results will be more accurate, and, surely, will be an incentive for new approaches in STI/HIV control and management.

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HIV/AIDS AND PEACE BUILDING IN THE MIDDLE EAST

By Avital Erez and Inon Schenker

Rarley can a pathogen be a factor in a peace-building process. More so, when the concrete pathogen—in our case HIV—is diversifying so many communities and groups around the world. This article tells the story of a unique case in the history of modern public health, in which a disease-causing agent was used by a local NGO to bring together medical and public health students, health professionals, professional and health educators from hostile societies in the Middle East to develop jointly strategies and frameworks to combat the spread of HIV and other sexually transmitted infections.

Since 1995, over 350 Israeli, Palestinian, Egyptian, Jordanian, Moroccan and Turkish professionals from the health and the education sectors in their respective communities have joined the Middle East Regional Network on AIDS (MENA). Initiated by the Jerusalem AIDS Project, a Jerusalem-based NGO, the network served as a forum for exchanges, networking and jointing projects of its members. This was the first time that medical and public health students from hostile communities in the Middle East region were working together towards a common goal: AIDS prevention.

An initial workshop was held in July 1995, with the participation of 62 professionals: an equal number of Israeli and Palestinian and a few Jordanian and international participants from outside of the Middle East region (Poland, Switzerland, India). In the workshops held in the following years more professionals from the Middle East joined. Experts in medicine, public health, psychology, social work and methodology reviewed the HIV epidemiology in the region, strategies for prevention and care, curriculum development and human rights. They also discussed and provided the participants with scientific and practical materials on frameworks for school education on HIV/AIDS prevention.

The workshops also included group activities in which the participants discussed and conducted exercises on approaches in educating youth about the risks of STI infections. Other subjects discussed during the workshop included religion and HIV/AIDS in the Middle East, the relationship between the increasing incidence of AIDS in the region and the peace process, techniques for teaching AIDS prevention in conservative societies, living with HIV and HIV testing.

One of the immediate results of the workshops was the joint submission of proposals for joint research and projects and for further joint workshops in the Middle East, this time to be already conducted by graduates of the Jerusalem AIDS Project workshops.

Now, however, the extreme tension between Israelis and Palestinians, and the violence that the region has been seeing since then resulted in a complete halt of all contacts between the peoples involved in this and similar projects in other fields of life. The e-mail exchanges are on a very low scale are the only thread of cooperation and exchanges that still exists between network participants. Is this a story of success or of a failure? One way of judging is by looking at the most important products of MENA, which are on-going despite the violence and conflict. These are the sustained local activities within the respective communities from where workshops’ participants come from. The steep increase in HIV/AIDS prevention activities (mostly among youth) documented in the Palestinian and Israeli communities since the initiation of this project is the most vivid proof of its sustainability and contribution to the efforts to stop the further spread of HIV/AIDS in the Middle East.

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Maternal mortality is a complex problem touching on education, the social status of women, health care and human rights. Often associated with poor economic and environmental conditions, maternal mortality is markedly higher in developing countries.

The lowest maternal mortality frequency is found in northern Europe, with rates between 0 and 11 per 100,000 live births, and the highest in some African countries, where it reaches 1000 per 100,000.

Maternal mortality (MM) in Tajikistan falls somewhere between these extremes. In 1997 it was calculated at 64.6 per 100,000 live births, and in 1998 at 99.6 per 100,000 (Tajikistan Country Population Assessment, UNFPA, 1999). Though these figures compare favourably with the average for developing countries (480 per 100,000 live births), they cannot be regarded as accurate. According to MSF data for 2000, the MM rate in Tajikistan’s Karategin district was between 120 and 170 per 100,000 live births, and in Kulob it reached 1117 per 100,000.

According to the Tenth International Classification of Diseases, a maternal death is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”

This discrepancy reflects several problems encountered in determining the republic’s MM accurately:

* MM deaths frequently remain unregistered. Until the 1990s, registering a death in Tajikistan was rewarded with money for funeral expenses. Now, however, death and birth registrations cost US $3. (approximately 10% of a monthly salary). Consequently, there is a considerable under-registration of the deaths and births connected with MM, particularly in rural districts.
* MM is often misclassified, especially due to the difficulty of accurately determining the cause of death. Sometimes, medical staff may not realize that a woman is even pregnant. At other times, a death from obstetric causes is not registered as such if the woman dies in the casualty ward rather than the maternity ward. And sometimes MM is deliberately classified as something else, for instance when due to complications from a clandestine abortion.

A significant source of maternal death in Tajikistan is weak health. A study of 162 pregnant women living in urban areas revealed that 56% had extra-genital diseases, such as pyleonephritis or endemic disorders. Almost 60% of the pregnant women in the study also suffered from gynaecological diseases. Another study of 1311 women justbefore delivery found significant malnutrition in 13%. With the malnourished group, 42% suffered from both protein deficiency and a weight deficit greater than 10 kg, while 65% had iron-deficiency anaemia (IDA).

Rural epidemiological studies in Tajikistan have shown that, among pregnant women, 17% eat meat, a key source of protein and haematinic iron, just once a week, while 13% eat no meat at all. A total of 71% of these women lacked micronutrients such as iron, iodine, folic acid and ascorbic acid.

Medical causes (1996)

A 1996 study of 67 MM cases in maternity clinics confirms this picture of poor maternal health. Forty-seven of the deceased suffered from IDA, 23 from chronic pyelonephritis and 6 from cardiac disease. In this sample, 58 of the dead women came from rural backgrounds. For 17 it was their first pregnancy, while 31 had delivered at least four times and 7 were less than 10 deliveries. More than a third of the cases came from high-risk age groups – there were 5 adolescents and 20 women over 35.

In the same study, only nine of the dead women had received prenatal care, and none of them had ever used contraceptives. (According to the Mother-Child Health Assessment (MSF-Holland, 1999), rural Tajik women know very little about contraception, and in 1996 only 2% of those living in towns used it.)

C-sections were performed in 30 of the cases, while 9 had laparotomies or hysterectomies. Uncontrolled bleeding caused death in 30 cases, and there were anaesthesia complications in 3 cases. Transfusions and full resuscitation measures were impossible due to lack of blood, blood products, antibiotics etc.

The leading medical causes of death were obstetric bleeding (22 cases), eclampsia (15), puerperal sepsis (8) and uterine rupture (8).

Although no women in this small study died from abortion complications, the relation between abortion and MM deserves closer examination. WHO statistics show that, worldwide, between 8 and 13% of MM cases typically result from such complications. Nonetheless, according to the Ministry of Health (MoH) of Tajikistan in 1998, when medical facilities conducted 16.1% of the republic’s abortions, the remaining (criminal) abortions accounted for a minimal MM of 0.1 per 100,000. In the early 1990s, MM from criminal abortion was 2 per 100,000 live births, accounting for 3.4% of overall MM (WHO, Abortion, 1994).

More recently, in 1999 the self-supporting abortion department in Dushanbe, population 600,000, performed 600 procedures, at US $3 each. Yet it is common knowledge that all maternity clinics might perform clandestine abortions, rendering official numbers low.

During the 1960s and 1970s, when maternity clinics performed all abortions legally, an official record of the procedure detailed any complications. With the flight of the European population from Tajikistan, the demand for abortions fell. The MoH tally of criminal abortions may be unrealistically low, but despite the dif-
ficulty of collecting accurate data, it still appears that abortion is used less as a form of birth control than in other newly independent states.

Non-medical factors
Several non-medical factors are also associated with MM. They include poverty, low educational levels, unavailability of transport, distance from medical care, and lack of skilled medical personnel and modern diagnostic equipment. It is well-known that women who give birth in maternity clinics have a much lower incidence of MM. In the jirgatal district, 90% of the births occur at home, often without any medical care (Mother–child health assessment, MSF–H, 1999). Nine percent of the deceased died at home or on the way to the Central District Hospital (CDH). Most of the women who did make it to the hospital arrived in critical condition, due to the great distances travelled and the difficulty in finding transport. Until 1996, only a fifth of these victims arrived by ambulance; at present, there is no sanitary transportation at all.

For many who did reach the hospital, the delay in surgical intervention proved fatal. Of those mothers who died in the CDH, 18% died within an hour of admission and 36% within the first six hours. With respect to delivery time, 7.5% of the victims died during delivery and 86% afterwards. Physicians participated in 90% of the fatal hospital deliveries, while 7.5% of all MM cases occurred at home without even a midwife present.

Recommendations
Reducing MM in Tajikistan means addressing its two primary causes: poor health in women of reproductive age, particularly from extragenital diseases such as IDA, protein deficiency and weight deficit; and non-medical factors such as the shortage of adequately trained medical personnel. The risk of MM can also be substantially reduced by initial prophylaxis — that is, by lowering pregnancy rates among the general population. Better pregnancy planning and female hygiene can achieve further reductions.

Pregnancy is not an illness. Most obstetrical complications can be accurately predicted beforehand, and most MM can be prevented. To achieve WHO’s stated aim of halving the 1990 MM rate for Tajikistan at the start of the third millennium, MoH should keep four goals in mind:

1. to educate the public on how to recognize potentially dangerous conditions during pregnancy, birth and post-partum;
2. to improve the professional skills of birth attendants;
3. to reduce the total number of pregnancies, especially high-risk and unwanted pregnancies;
4. to provide all women with high-quality care before, during and after delivery.

Safe maternity is an essential human right. It should be possible to promote maternal safety in Tajikistan through the judicious use of existing medical resources without undue economic strain. In order to bolster reproductive health, improve the accuracy of MM statistics and decrease the risk of fatal complications from pregnancy and delivery, it is strongly recommended that the Ministry of Health undertake the following measures:

- adopt WHO recommendations for the statistical reporting;
- keep accurate abortion statistics and abolish fees for registering births and deaths;
- lower the national birth rate, especially with respect to high-risk and unwanted pregnancies, by making family planning services and appropriate birth control units widely available;
- provide better access to maternity clinics with both standard and critical care units;
- optimize the management of labour and the post-partum period by making available partograph monitoring, a reliable blood supply, oxytocin and antibiotics;
- provide all pregnant women with “clean delivery” kits, such as those expectant mothers in Bangladesh receive (which cost only US $0.25 to produce);
- equip women’s dispensaries, obstetrical wards and maternity clinics with cardiographs and ultrasonic scanners;
- educate physicians and midwives in inexpensive preventive and corrective measures that minimize obstetric complications — for instance, correcting protein deficiencies, teaching patients hygiene and prescribing small doses of aspirin and calcium to women at risk for eclampsia;
- revitalize the republic’s laboratory services;
- implement a vaccination program protecting pregnant women against tetanus and the newborn against tetanus, TB, polio and hepatitis B;
- update clinical protocols to improve the prevention, diagnosis and treatment of RH disorders;
- implement on a national level women’s health programs for preventing and treating disorders such as IDA, iodine deficiency, malnutrition and STIs; and
- distribute throughout the RH sector the WHO manuals on prenatal care, delivery care, infant care and the laboratory diagnostics of STIs.

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In Serbia, reproductive health (RH) among adolescents is marked by high rates of pregnancy, abortion (50 per 1000 females under 20) and sexually transmissible infections (STIs). To lower these numbers, the Mother and Child Health Care Institute of Serbia, also known as the Republic Centre for Family Planning "Dr Vukan Cupic", or RCFP, initiated the Promotion of Adolescent Reproductive Health Project in February 1999.

Despite the highly unfavourable conditions for any health initiative then, RCFP managed to introduce a new youth-friendly approach that features counselling services for young people in a variety of community settings.

Specifically, the project aims to:
- increase adolescent knowledge of sexuality, RH and safe-sex practices;
- improve young people’s attitudes toward sexuality and RH, and their skills in dealing with related issues;
- improve detection and treatment of RH problems;
- consolidate health partnerships among different areas of society and government;
- encourage participation of local teachers, health workers and peer educators; and
- develop community awareness of adolescent needs and support for youth-friendly RH services.

The Counselling Centre for Young People, a multidisciplinary team from RCFP, now conducts two different 3-day seminars: Let’s Keep Our Health educates adolescents on RH issues, while the Counselling Service for Young People creates counselling teams of peer educators, teachers and health workers.

The Let’s Keep Our Health initiative educates adolescents about sexuality, relationships between the sexes, RH, communication skills and the prevention of STIs and unwanted pregnancies. The seminar is designed for young people from 14 to 20 and revolves around an original educational kit.

Counselling Service for Young People provides peer educators, teachers and health workers with basic counselling skills in adolescent sexuality and RH. The workshop’s primary goal is to provide participants with the knowledge and skills needed to address adolescent RH needs effectively and sensitively; a secondary goal is to improve adolescents’ access to and acceptance of health services. This seminar centres on another original educational kit, consisting of a facilitator’s guide (Let’s Keep Our Health) and a brochure (Promotion of Adolescent Reproductive Health).

Counselling Service for Young People covers current preventive and curative health measures, as well as up-to-date educational and promotional activities.

Participants learn that a good RH counselling service should include:
- adolescent health education;
- individual counselling from a psychologist, a specialist in preventive medicine, a paediatrician and a gynaecologist, and
diagnosis and treatment of RH disorders in both sexes.

This new approach has been demonstrated in two seminars. Participants in the first seminar were students, usually second- or third-year students in secondary schools. At the end of this seminar, the health and educational workers who run it help select several students to attend the Counselling Service for Young People seminar as peer educators. The health workers (a paediatrician, gynaecologist, specialist in preventive medicine and a psychologist) and teachers in the counselling seminar are nominated by their supervisors and chosen with due respect for the wishes and backgrounds of others involved.

Participants have been enthusiastic about the seminars’ content and form (creative workshops), as well as about the educational materials. Besides the guide and brochure named, a monograph (Replacement of Population and Reproductive Health Care) and a workbook help ensure that complex RH issues are addressed comprehensively and multidiscidentally.

Not only have pre- and post-seminar questionnaires shown that adolescent participants increase their RH knowledge significantly, but participating teachers and health workers have expressed interest in setting up counselling services for young people, local governmental representatives have been very positive and local media have broadly promoted the seminar and project objectives.

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The Fourteenth International AIDS Conference took place in Barcelona from 7 to 12 July 2002, bringing together over 15,000 scientists, clinical care givers, community activists, people living with and affected by HIV/AIDS, and policy experts. Through plenary sessions, panel discussions, poster sessions and satellite meetings, conference participants shared their expertise and learned from one another focusing on the conference theme, "Knowledge and Commitment for Action." This particular session of the biennial conference marked a new turn in the fight against HIV/AIDS. Since the last conference in Durban, South Africa, in 2000, the international HIV/AIDS movement has been gaining momentum, turning to greater political commitment and action, adding to the significant scientific and educational understanding gained over the past 20 years.

The statistics on HIV/AIDS are astounding, no matter how many times they are repeated. Prevalence rates in several nations in southern Africa are over 25% of the adult population, more than 13.4 million children worldwide have lost one or both parents due to the disease, and 21.8 million people have died from AIDS, according to UNAIDS. Nearly 1.5 million people are infected in industrialized nations. Thanks to great advances in and access to anti-retroviral therapies, many infected in western Europe and North America are living longer. Yet the disease continues to spread while the general population in these countries falsely believes the epidemic is in their past. Numbers continue to rise in central and eastern Europe, where the numbers of new infections in some parts of the region in 2000 alone were more than the previous years combined.

The Barcelona conference conveyed several key messages. As evidenced by the statistics of the disease, HIV/AIDS is a global emergency, leaving no country untouched. To stop further infections, immediate action is necessary to prevent growing conflicts and instability that are breeding grounds for the epidemic. In June 2001, the United Nations Special Session on HIV/AIDS (UNGASS) set out priorities and targets, including the new Global Fund for HIV/AIDS, Malaria, and Tuberculosis (read more on pages 12-13) that requires funding commitments and implementation immediately. Based on UNGASS commitments, there is new opportunity for advocacy efforts based on sound knowledge. All people working on the varied aspects of the epidemic must work together in order to achieve the enormous goals set out to end the epidemic. Furthermore, social exclusion is at the root of HIV-vulnerability and instead, dignity and respect must be extended to all people.

A key message conveyed at the Barcelona meeting is that prevention and treatment are equally important as means to decrease the impact of HIV/AIDS. At the Durban conference in 2000, a chasm widened between the two camps, some believing that the costs of treatment were too enormous and the only possible action was to increase prevention efforts. Others believed that all people with HIV have a right to treatment at no matter what the monetary cost. The Barcelona conference brought supporters of prevention and treatment together, giving equal support to both elements of the battle. Supporters of products to be used for prevention such as microbicides and vaccines presented advances in developments and acceptability of these methods. Other supporters shared significant gains in understanding about anti-retroviral treatments, and still others shared examples that treatment is possible in the poorest parts of the world.

The XV International AIDS Conference will be held in Bangkok from 11 to 16 July 2004. This will be the second time the conference will be in a country with a major HIV/AIDS epidemic and hopefully the global community will mark new achievements in the fight to end this epidemic.

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Important websites relevant to the conference and this article:

www.aids2002.com, the official site of the XIV International AIDS Conference
www.iids.se, the International AIDS Society webpage, organizers of the biennial AIDS conferences
www.unaids.org, the official site of UNAIDS
www.microbicidesnow.org, one of many sites offering explanation and links to the growing movement to develop preventive products, such as microbicides
www.iavi.org, the site for the International AIDS Vaccine Research
There is a tragic irony in the institutional Catholic church's role in the world community of health care providers. While the institutional church is a major provider of health care around the world - especially to those living in impoverished communities - its policies contribute to serious health care problems, namely the spread of HIV/AIDS and maternal mortality.

In his encyclical, Evangelium Vitae (The Gospel of Life), Pope John Paul II identifies contraception as an "evil" that contributes to a "culture of death." Hence, the institutional church's ban on condoms to prevent the spread of HIV/AIDS and unwanted pregnancy is understood by its advocates as promoting a "culture of lies," even though in one year 3 million people die from AIDS and 80 000 women die from unsafe abortion.

The institutional church's positions on modern methods of contraception are not monolithic and the views presented by institutional church representatives are subject to different interpretations. In relation to positions held by the institutional church on reproductive rights and reproductive health, it should be noted that positions of the institutional church are a minority opinion. It is in the midst of such ironies and complexities that Catholics for a Free Church launched the Condoms4Life Campaign - the first-ever global campaign to end the institutional church's ban on condoms. It invites the public to join the global campaign to end the ban at www.condoms4life.org. People who join the campaign are asked to contact local policy-makers and express their support for the availability of condoms.

For individuals who follow the Vatican's policy and Catholic health care providers who are forced to deny condoms, the bishops' ban is a disaster. Real people are dying from AIDS. Real women faced with unwanted pregnancies are risking their lives during unsafe abortions. Catholics and non-Catholics alike should no longer stand by and allow the ban to go unchallenged.

Consider that the institutional Catholic Church claims to provide treatment for 25% of those infected with HIV/AIDS - an estimated 40 million people were living with HIV/AIDS at the end of 2001. This means that approximately ten million people currently infected with HIV/AIDS are being treated by a caregiver who denies them information about and actual provision of condoms to prevent further spread of the disease. The 100 000 Catholic hospitals and 200 000 social service agencies worldwide that fall under the jurisdiction of the Vatican are forbidden from providing condoms and safer sex instruction - even to those who are not Catholic.

With AIDS devastating families on every continent and increasingly so in Europe, Catholic people know that condoms are important as much as those of other faiths or no faith do. Earlier this year, Bishop Kevin Dowling of Rustenburg, South Africa, summed up how many Catholics feel when he said, "When people for whatever reason choose not to follow the values we promote as a church - within and outside of our community - then the bottom line is the real possibility that a person could transmit a death-dealing virus to another through a sexual encounter." Bishop Dowling went on to conclude that "the use of a condom can be seen not as a means to prevent the 'transmission of life' leading to pregnancy, but rather as a means to prevent the 'transmission of death to another.'"

Over the years, bishops from France, the Netherlands, and Brazil have also publicly stated that condoms should be allowed to prevent the spread of HIV/AIDS. Yet the Vatican, rather than the Holy See - in its capacity as a Non-member State Permanent Observer at the United Nations, has used its political status at major humanitarian meetings, including the International Conference on Population and Development (1994), the Fourth World Conference on Women in Beijing (1995) and recently the Special Session on HIV/AIDS, to advance a religious view that opposes condoms and safe sex education. And in response to Bishop Dowling's statement, the Southern Africa Bishop's Conference issued a statement following their semi-annual meeting, where they considered and rejected a change in their official policy banning condoms.

From the south to the north, Condoms4Life Campaign has created a media sensation. National and international television, radio and print outlets have covered the campaign, generating a real debate about the role the Catholic church hierarchy plays in AIDS prevention and the impact of their continued lobby against condom education and provision.

Although condoms are only one aspect of a multi-pronged strategy to HIV/AIDS prevention, and condoms will not and never will be panaceas to the AIDS crisis, they are a necessary tool for many sexually active people around the world who are at risk of becoming infected with the deadly disease.

In keeping with Bishop Dowling's affirmation that condoms prevent the "transmission of death," Condoms4Life is a campaign promoting a culture of life where women and men have access to information and services to make responsible and healthy decisions about their reproductive lives. As Catholics, we take pride in the health care the institutional church provides, and we view the current bishops' ban on condoms as a blindspot that inevitably will be corrected.

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UNAIDS fact sheets. In addition to many other resources about HIV/AIDS in the European Region, including information about the Barcelona conference and the Global Fund to Fight AIDS, Tuberculosis & Malaria, the UNAIDS website has four fact sheets dealing with security, disasters, the uniformed services and peacekeeping. See www.unaids.org

AIDS and HIV Infection: Information for United Nations Employees and their Families
Of particular relevance to UN employees, this 54-page booklet provides an overview of what HIV/AIDS is, testing issues and how to stay informed. See www.unaids.org

AIDS and HIV Infection
Information for United Nations Employees and Their Families

HIV/AIDS Prevention and Care in Resource-Constrained Settings: A handbook for the design and management of programs
This 69-page comprehensive publication (2001) is divided into six sections:
1. Design and Management of HIV/AIDS Programs;
2. Reducing Risk and Vulnerability to HIV Infection;
3. Strengthening STD management and Services;
4. Reducing Risk of HIV Transmission to Infants;
5. Reducing Risk of Parenteral Transmission; and
6. Management and Support of People Infected and Affected by HIV/AIDS

Prepared by the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Established by WHO in 1977, the Programme coordinates, promotes, conducts and evaluates international research in human reproduction. This biennial report is a useful tool for policy makers and planners at national and international levels and contributes to the setting of norms, standards and guidelines – including ethical guidelines – in the field of sexual and reproductive health research.

Can be obtained from:
Marking and Dissemination
World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland
(bookorders@who.int)

Preventing HIV Infection, Promoting Reproductive Health
UNFPA Response 2002
Previously known as AIDS Update, this is the 11th annual publication to provide information about action taken by UNFPA to prevent HIV infection. Reproductive health information, services and supplies enable people to avoid HIV infection and to protect themselves, their partners and their unborn children from this deadly virus. This publication, also available online, looks at strategies for prevention, country commitments, regional responses, global action and current and future challenges.

For technical questions on HIV/AIDS, please contact:
HIV/AIDS coordinator
United Nations Population Fund (UNFPA)
220 East 42nd St.
New York NY 10017 USA
[mehat@unfpa.org]
www.unfpa.org/publications/pubmain.htm

Condom Corner
Happy birthday Entre Nous
– celebrating 20 years of existence.
INTERNET RESOURCES
Prepared by Josh Gross, Web editor

LINKS RELATED TO HIV/AIDS

Ægis (AIDS Education Global Information System)

www.aegis.com
An excellent resource with up to the minute information and articles gleaned from Fido Net®, which connects over 32,000 bulletin boards in 66 countries. Since its inception in 1990, ÆGIS has matured into a robust, fully operational service with a global network of users. The range of information available is so vast, its quality so dependable, that national and international organizations routinely log onto the system to converse or download clinical information or late-breaking news. A very user-friendly site with advanced search functions and a Windows-like user interface menu.

Terrence Higgins Trust

www.tht.org.uk
Terrence Higgins Trust (THT) is the leading HIV and AIDS charity in the UK and the largest in Europe. Established in 1982, it was the first charity to be set up in response to the HIV epidemic and has been at the forefront of the fight against HIV/AIDS ever since. Today, THT is the largest provider of direct services to the groups most affected by HIV: gay men and British Asian communities. A colourful and easily navigable site. The site makes an exemplary use of graphics and pictures. Links throughout the site are also accompanied with simple yet effective graphics. It is a pleasure to navigate.

The Internet Pathology Laboratory Textbook on AIDS Pathology

www-medlib.med.utah.edu/WebPath/TUTORIAL/AIDS/AIDS.html
The site is interesting and informative from a microbiological standpoint. The textbook includes a general discussion of the pathophysiology of HIV infection, organ system pathology of AIDS and descriptions of the opportunistic infections and neoplasms associated with AIDS, and a general discussion of issues, including safety and education, related to the AIDS epidemic. It is a second generation-style generically designed text-based site containing many images of HIV and AIDS.

HIVInSite

http://hivinsite.ucsf.edu/InSite
One of the most comprehensive and up-to-date sites on HIV/AIDS available. Produced by the University of California, San Francisco. It is a very nicely designed site with horizontal menu bars and scrolling statistical information on the index page. The site's database is enormous and current. There is also an online textbook on HIV care prevention and policy under the link Knowledge base.
The Body

www.thebody.com
The Body is a commercially sponsored site, which is nevertheless the winner of the 2000 Time Inc. Health FREDDIE Award for Best Health website and winner of the 1997 Global Information Infrastructure Award for Community. The Body’s mission is to “use the Web to lower barriers between patients and clinicians. Demystify HIV/AIDS and its treatment. Improve patients’ quality of life. Foster community through human connection.”
A superbly designed and simple to navigate site containing information on HIV/AIDS in over 550 topics.

European Project AIDS & Mobility

www.aidsmobility.org
European Project AIDS & Mobility (A&M) offers support to organizations within the European Union that provide HIV/AIDS-related services to migrant populations. This is a well-designed and easy to navigate site built up in frames. One of its noticeable features is that one can go deep into the site from the start page. There is a comprehensive menu bar including links to publications, newsletters, European seminars, research projects, exchange visits, advocacy, consultancy and advice. A&M also has an electronic newsletter called A&M Resource Scan, which provides information about existing resources on HIV prevention and care for migrants and ethnic minorities in Europe, such as:

- new literature and educational materials collected by A&M for its documentation centre
- new books and reports published by A&M and others
- interesting websites and meetings, etc.
To join the electronic newsletter, fill out the form on the website www.aidsmobility.org/frame_join.htm. You will also receive A&M News, the printed newsletter of the European Project AIDS & Mobility twice a year for free.

AIDS Foundation East-West

www.afew.org
AIDS Foundation East-West (AFEW) is an HIV/AIDS NGO working in the newly independent states of the former Soviet Union. This Dutch organization draws upon the knowledge, resources, experience, and expertise generated by the international and Russian national staff of the Moscow office of Medecins Sans Frontieres—Holland.
A thoughtfully designed and comprehensive site, but with some navigation problems. The soft colour tones seem to contrast caring. The main menu bar whose topics light up red on mouseover include Care & Support, Harm reduction and Mass media. There is also a clickable map providing information about AFEW’s projects by country.

Johns Hopkins Aids Service

www.hopkins-aids.edu
A very thorough site loaded with current information and a huge database of several thousand publications. Simple in design and surfer-friendly. The menu bar on the index page has both images and text. The secondary pages have dropdown menus for additional information in the subject area. There is also a menu located on the right side with general links such as:
Sponsors, Site map and Search engine.

The Population & Reproductive Health Portal

www.developmentgateway.org/pop
The Population & Reproductive Health Portal (POP/RIH), managed by the United Nations Population Fund (UNFPA), aims to be a community-built database of shared population information. Including data, publications, research, projects, ideas and dialogue. This site has an excellent search function to find topics by geographical location and is very comprehensive. Explore the rest of development gateway too.