

CHOICES

DECEMBER 2004 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE

FACING EUROPE'S HIV/AIDS EPIDEMIC: INTEGRATION WITH SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

**HIV/AIDS in the European Region:
Trends and Challenges**

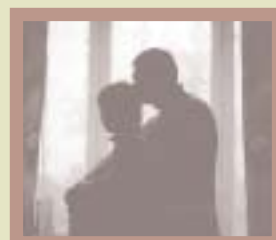
**Integrating HIV/AIDS and Sexual
and Reproductive Health and
Rights: A Happy Marriage?**

**Microbicides: Expanding
the Options in HIV and STI
Prevention**

**Involving Young People in
HIV/AIDS Prevention:
Ways that Work**

Table of Contents

Editorial: AIDS in Europe: From the Political to the Personal	3
HIV/AIDS in the European Region: Trends and Challenges	4
Waking the Giant: Making the Case for Mainstreaming	7
Integrating HIV/AIDS and Sexual and Reproductive Health and Rights: A Happy Marriage? ..	9
The EU Confronts HIV/AIDS	12
Europe's Response to the AIDS Epidemic	13
Sex Workers and the Integration of Sexual and Reproductive Health and HIV/AIDS	16
Can Safe Sex be Good Sex? Mixing Pleasure and Prevention	18
Silent Voices: HIV-Positive Women and Drug Use	20
Challenges in Bringing HIV Prevention to Bulgaria's Roma Ethnic Community	21
Microbicides – Expanding the Options in HIV and STI Prevention	23
Involving Young People in HIV/AIDS Prevention: Ways that Work	25
Hope for 'Positive' Pregnancy in Russia	27
Russian Health Providers' Perspectives on HIV/AIDS	29
AIDS NGOs in Central and Eastern Europe Face Multiple Obstacles to Fighting the Epidemic ..	31
HIV/AIDS Resources	34



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IPPF European Network

As the largest voluntary organization in the field of sexual and reproductive health and rights, the International Planned Parenthood Federation (IPPF) helps improve the lives and wellbeing of hundreds of millions of individuals around the world.

The IPPF European Network is one of IPPF's six regions. With 39 member associations in as many countries, IPPF European Network increases support for and access to sexual and reproductive health services and rights throughout Europe and Central Asia.

Mission statement

To advance the basic human right of all people to make free and informed choices in their sexual and reproductive lives; and to fight for the accessibility to high quality information, education and health services regarding sexuality and sexual identities, conception, contraception, safe abortion, sexually transmitted infection and HIV/AIDS.

Editorial



Vicky Claeys

AIDS in Europe: From the Political to the Personal

We are beginning to face AIDS as a growing threat in Europe. Russia and parts of Eastern Europe are now facing the fastest growing infection rate of HIV in the world. WHO and UNAIDS estimate that in 2003, there were as many as 1.88 million people living with HIV/AIDS in Europe. In addition, there are rising rates of STIs all over the region, which can make people more physically vulnerable to contracting HIV.

Despite these alarming statistics, AIDS is not yet felt as a real issue for many in Europe. The European Commission has started to actively acknowledge the need for all public sectors across the European Union to take a coordinated and integrated approach to address the issue of HIV/AIDS. However, to really assimilate HIV/AIDS into the general public's concern and understanding, it is also necessary to take a grass roots approach.

By demonstrating that HIV/AIDS is a sexual disease that can affect anyone and is not just something that affects marginalized populations such as injecting drug users and sex workers, HIV/AIDS can begin to rise to the forefront of people's concerns. Comprehensive sexual and reproductive health and rights (SRHR) services are essential for promoting this message. However, the question of when, where and how to integrate HIV/AIDS into SRHR programmes has been plaguing policy makers, donors and service providers for a considerable time. Answering these questions with meaningful action is long overdue.

Many organizations are now starting to lean towards a more integrated approach, and are mainstreaming HIV/AIDS into their work and policies. Mainstreaming is vital because HIV and AIDS are affecting not only individuals' lives, but entire national economies and global development as a whole. HIV and AIDS now exist side-by-side with all other aspects of societies, including poverty, gender inequality, abuse and war.

SRHR organizations (and women's organizations) have traditionally stayed away from HIV/AIDS due to the lack of capacity and resources, as well as not seeing the urgency of the epidemic. Yet given that in Europe we see a shift from HIV infection due to injecting drug use to sexual transmission, linking HIV and reproductive health services is crucial.

Sexual and reproductive health services can play a crucially important role in helping to prevent HIV transmission by providing information, education to reduce risky sexual behaviour, detecting and managing sexually transmitted infections (STIs) and promoting the correct and consistent use of condoms. Linking HIV prevention and the prevention and treatment of STIs with family planning and maternal health interventions can improve outreach, reduce stigma and save money by using existing resources and infrastructure.

Through the well-established network of sexual and reproductive health organizations and services, IPPF is a prime channel for bringing HIV/AIDS prevention, treatment and care to the people who need these services most. And for people who would face discrimination or social pressure by visiting a dedicated HIV/AIDS facility, sexual and reproductive health clinics offer a more neutral resource for testing, prevention and information about HIV/AIDS. In addition, IPPF's current campaign focuses on Mainstreaming AIDS, and to find out more visit www.ippf.org

The articles in this issue of *Choices* are a collection of different perspectives on the HIV/AIDS epidemic in the European Region. It is unfortunately impossible to cover every important subject on this issue in one magazine. However, I hope they leave you in no doubt of the magnitude of HIV/AIDS in Europe. AIDS is a sexually transmitted disease as much as it is a social disease. If the world continues to avoid this fact, and if HIV/AIDS prevention efforts continue to be removed from an SRHR context, we will make no headway in the fight to stop its growth.

Vicky Claeys
IPPF EN Regional Director



World AIDS Day celebrations
in Bosnia and Herzegovina, 2003

HIV/AIDS in the European Region:

By Martin Donoghoe, Jeffrey V. Lazarus and Srdan Matic, World Health Organization/Europe

HIV/AIDS is fast becoming a major threat to health, economic stability and human development in many parts of the European region¹. WHO and UNAIDS estimate that at the end of 2003, 1.88 million people were living with HIV/AIDS in the 52 countries of Europe – the majority of these (1.3 million) in the countries of Eastern Europe and Central Asia². This article reviews how the epidemic has spread differently in parts of Europe, and addresses the synergies between preventing and treating HIV/AIDS.

The estimated HIV prevalence in adults now exceeds 1% in three European countries: Estonia, the Russian Federation and Ukraine³. Yet, for the first time, the promise of increased access to highly active anti-retroviral therapy (HAART) for people in need allows us to develop a comprehensive public health response to the epidemic that fully integrates prevention, care and treatment. Evidence indicates that introducing treatment in affected communities can reduce fear, stigma and discrimination

that surround HIV/AIDS, increase demand for uptake of HIV testing and counselling and reinforce prevention efforts⁴. HAART also reduces the level of HIV in the body to undetectable levels in many patients⁵. While the virus is never eliminated (and no one is cured), the risk of a person on effective treatment transmitting HIV is greatly reduced. Coupled with strategies to emphasise safer approaches in behaviour towards HIV/AIDS, there will be a considerable impact on the spread of HIV infection.

1 World Bank (2003) *Averting AIDS Crises in Eastern Europe and Central Asia* Washington: World Bank

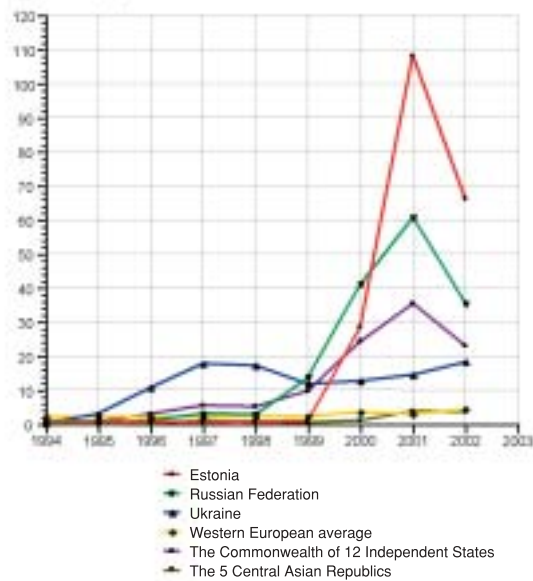
2 UNAIDS (2004) *Report on the Global AIDS Epidemic: 4th Global Report* Geneva: UNAIDS/04.16E

3 Ibid

4 Global HIV Prevention Working Group (2004) *HIV Prevention in the Era of Expanded Treatment Access* available at www.gatesfoundation.org and www.kaisernetwork.org

5 Porco TC, Martin JN, Page-Shafer KA, Cheng A, Charlebois E, Grant RM, Osmond DH (2004) Decline in HIV infectivity following the introduction of highly active antiretroviral therapy *AIDS* 18(1):81-8

New HIV infections in Europe, reported per 100 000 population



Source: WHO European Health for all database, accessed 22 October 2004

declined sharply in the mid/late-1990s and continued to fall, albeit with a noticeable levelling off after 1998. Recent increases in HIV and AIDS in some western European countries raises important concerns about the vulnerability of migrants, increased risk behaviours among homosexual and bisexual men, treatment complacency, weakening Government commitment and waning prevention efforts.

Central Europe

The overall rates of both newly diagnosed HIV infection and AIDS in Central Europe remain relatively low and unchanged in recent years. Around 21,000 HIV infections were reported in this region by the end of 2003. Three quarters of all cases are in Romania and Poland. In the same period, 12,791 cases of AIDS and 5,869 AIDS deaths were reported.¹¹ Trends of newly reported HIV cases and of AIDS deaths have stabilized over the past decade, while the numbers of reported AIDS cases have declined slowly in the last six years. High levels of risk behaviour coupled with low levels of knowledge and poorly developed prevention and treatment services in some central European countries create the conditions for potentially devastating HIV/AIDS epidemics¹².

Trends and Challenges

Western Europe

In Western Europe, after a period of relative decline and stability, following peaks in HIV incidence in 1983 (among homosexual men) and 1987/88 (among intravenous drug injectors), the rate of newly diagnosed HIV infection is once again increasing⁶. Persons infected through heterosexual contact increased markedly in 2001 and 2002, mostly due to cases diagnosed in heterosexuals originating from countries with generalised epidemics – mainly countries in sub-Saharan Africa – and where infections were probably acquired in those countries⁷. Western European countries experiencing such increases include, notably, the United Kingdom and Ireland, but also Belgium, Denmark, Germany, Sweden and Switzerland⁸. However, it is not only among heterosexuals that infections have increased. The number of cases among homosexual and bisexual men also multiplied in Western European countries from 2001 to 2002⁹. Following the introduction and widespread use of HAART in countries in this region, AIDS incidence and AIDS deaths

Eastern Europe and Central Asia

The majority of people living with HIV/AIDS in Europe are from countries in Eastern Europe and Central Asia. Here, overall rates of newly diagnosed HIV infection increased dramatically between 1995 and 2001, mainly among injection drug users (IDUs)¹³. In many Eastern European and Central Asian countries more than 80% of reported HIV cases are among IDUs. Well documented epidemics of HIV among IDUs have been reported in Belarus, Estonia, Latvia, Lithuania, Kazakhstan, Moldova, the Russian Federation and Ukraine. In some countries in Eastern Europe – notably Estonia, Latvia, the Russian Federation and Ukraine - HIV incidence rates are among the highest in the world. By December 2003, the Russian Federation reported a total of over 268,367 HIV infections¹⁴, but only about 800 AIDS cases and about 600 AIDS deaths.¹⁵ In 2002 and 2003 the number of new HIV diagnoses in Eastern Europe and Central Asia declined¹⁶, but this should not lead to complacency as

6 European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) (2004 – In Press) *HIV/AIDS Surveillance in Europe* End-year Report 2003. Saint Maurice: Institut de Veille Sanitaire. No. 70 <http://www.eurohiv.org>

7 Hamers FF and Downs AM (2004) The changing face of the HIV epidemic in western Europe: what are the implications for public health policies? *Lancet* 364:83-94

8 Ibid

9 Ibid

10 Mocroft A, Brettle R, Kirk O, et al. (2002) Changes in the cause of death among HIV positive subjects across Europe: results from the EuroSIDA study *AIDS* 16:1663-71

11 European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) (2004 – In Press) *HIV/AIDS Surveillance in Europe* End-year Report 2003. Saint Maurice: Institut de Veille Sanitaire. No. 70 <http://www.eurohiv.org>

12 Hamers FF and Downs AM (2003) HIV in Central and Eastern Europe. *Lancet* 361:1035-1046

13 Ibid

14 European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) (2004 – In Press) *HIV/AIDS Surveillance in Europe* End-year Report 2003. Saint Maurice: Institut de Veille Sanitaire. No. 70 <http://www.eurohiv.org>

Photo appears thanks to APP-XY Family Planning Association of Bosnia and Herzegovina

reported cases greatly underestimate actual cases. Eastern Europe and Central Asia have the highest incidence of tuberculosis and multi-drug resistant tuberculosis in Europe. TB/HIV co-infection is associated with a higher morbidity and mortality among people living with HIV/AIDS and increased tuberculosis transmission to the general population¹⁷.

Anti-retroviral treatment

Inequities in access to HIV/AIDS treatment and care are most evident in the inadequate provision of HAART in many European countries. It is estimated that as of mid-2004, of the 475 000 people needing HAART in Europe, only 291 000 were receiving it¹⁸. There is an urgent need to scale up access to anti-retroviral treatment (ART) especially in Eastern European countries (particularly the Russian Federation and Ukraine) where the gaps between treatment access and treatment need are immense. It is estimated that by 2010 between 580 000 and one million Europeans will need HAART¹⁹.

Prevention efforts

Two decades of experience, controlled scientific studies and descriptive case analyses have demonstrated the effectiveness of HIV prevention. HIV prevention strategies can reduce the number of new infections and be cost-effective. There is no one correct way to provide prevention services, however, countries and cities where prevention has been most successful have responded with a range of interventions (or core components²⁰), often combining components in an integrated and comprehensive strategic response.

Interventions developed for HIV prevention in infants, for example, provide a unique opportunity to link HIV prevention with care and treatment services for HIV-infected women, infants and other family members. Such interventions are an important entry point for the provision of quality care and treatment, including ART. In the current context of increased access to ART, especially in countries of Eastern Europe and Central Asia, the vast majority of HIV-infected women and their infants who are in need of ART will be identified through programmes for the prevention of mother to child transmission of HIV (PMTCT)²¹. The ultimate goal being to improve maternal and child health, prevent HIV infection in infants, and address the prevention, care and treatment needs of mothers, infants and other family members.

Challenges to halt and reverse the spread of HIV
Access to HIV/AIDS treatment offers new opportunities as well as new imperatives for strengthening prevention efforts²². In some wealthy countries with wide access to treatment, a resurgence in risky behaviour and rising rates

of some sexually transmitted infections have been seen in specific populations – for example in homosexual and bisexual men in Western Europe²³. Inaccurate and unrealistic perceptions of the benefits of treatment must not be allowed to undermine prevention efforts. Better information and counselling are needed to ensure that the beneficial preventive effect of HAART – reducing stigma and increasing demand for testing and counselling – are not lost. These messages are an integral part of any ART programme.

Another challenge ahead is to make the most of the potential synergies between prevention and treatment so that they have a naturally accelerating effect. New initiatives are required that emphasise the benefits of knowing one's HIV status, addressing stigma and discrimination and integrating specific prevention services with treatment, care and community action. This requires reaching out to vulnerable communities and ensuring that people living with HIV and their communities are meaningfully engaged in shaping and scaling up a comprehensive response to the epidemic.

Conclusion

It is important to acknowledge that HAART is not a treatment that can be successfully provided without a range of ancillary services and without adapting, where necessary, existing social and health services. To do this it may also be necessary to influence opinion leaders and change the perceptions of the community at large. To achieve good practice in this field it is essential to have reliable situation assessments, good data, pragmatic approaches to prevention, treatment and care, and the employment of multiple strategies that lead to integrated and comprehensive approaches.

There is a growing demand for the development of approaches to ensure access to prevention and treatment interventions for women from vulnerable groups such as IDUs, ethnic minorities, migrants, refugees, sex workers and trafficked women who come to antenatal care services too late to benefit from available interventions. Linkages must be established between mainstream health services, harm reduction programmes and programmes for marginalized groups. Several other impeding issues in Europe which need to be urgently addressed include: strengthening counselling and testing services for pregnant women and HIV infected women of childbearing age, capacity building and training of health care workers on PMTCT interventions, improvement of surveillance, monitoring and evaluation, and ensuring protection rights for HIV-infected women, infants and other family members.

Contact Jeffrey Lazarus [jla@euro.who.int] for more information on HIV/AIDS in the European Region.

15 EuroHIV (2003); *HIV Infection, Information Bulletin No. 25*. Ministry of Health of the Russian Federation (2003)

16 European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) (2004 – In Press) *HIV/AIDS Surveillance in Europe* End-year Report 2003. Saint Maurice: Institut de Veille Sanitaire. No. 70 <http://www.eurohiv.org>

17 Corbett EL et al. The growing burden of tuberculosis: global trends and interactions with HIV epidemic. *Archives of Internal Medicine*, 2003; 163:1009-1021

18 WHO Regional Office for Europe (2004) – unpublished data

19 Ibid

20 World Health Organization (2003) *Global Health-Sector Strategy for HIV/AIDS 2003-2007 Providing a Framework for Partnership and Action* Geneva: WHO

21 World Health Organization Regional Office for Europe (2004) *Strategic Framework for the Prevention of HIV Infection in Infants in Europe*. Copenhagen: WHO

22 Global HIV Prevention Working Group (2004) HIV Prevention in the Era of Expanded Treatment Access available at www.gatesfoundation.org and www.kaisernet.org

23 Hamers FF and Downs AM (2004) The changing face of the HIV epidemic in western Europe: what are the implications for public health policies? *Lancet* 364:83-94

“ The HIV/AIDS epidemic does not respect boundaries - and we must ensure in our response that we do not create our own artificial boundaries. ”

From A European Commission Working Paper - Coordinated and Integrated Approach to Combat HIV/AIDS within the European Union and its Neighbourhood, www.europa.eu.int/comm/health

Waking the Giant: Making the Case for Mainstreaming

Mobilizing the sexual and reproductive health community in the fight against HIV/AIDS

By Kevin Osborne, IPPF Senior Advisor for HIV/AIDS

Mainstreaming HIV/AIDS into sexual and reproductive health and rights (SRHR) services, policies and practices enables the SRHR community to improve its capacity for integrated prevention, treatment and care while mobilizing a largely untapped resource in the global fight against the disease. While increased political attention for integrating components of HIV/AIDS into SRHR work has been evident in the past year, mainstreaming represents a more effective, long-term strategy for addressing the disease. IPPF's Senior HIV/AIDS Advisor, Kevin Osborne, highlights the benefits and challenges of mainstreaming for the SRHR community.

The importance of addressing HIV/AIDS from a stronger sexual and reproductive health and rights (SRHR) perspective has gained increased global momentum and recognition over the past year. In April 2004, the UK All-Party Parliamentary Group on Population and Development and Reproductive Health held hearings into the very question of integration: its successes, failures and contextual realities. In June 2004, the *Glion Call to Action* specifically addressed the integration aspects involved in the prevention of mother-to-child transmission of HIV (PMTCT) programmes and policies. And in May, the United Nations Population Fund (UNFPA) hosted a

series of technical meetings that aimed to explore some of the broader technicalities of integration and produced a document that was presented at the International AIDS Conference in Bangkok in July.

Though the issue is being raised more and more, the questions of when, where and how to integrate HIV/AIDS into SRHR services and programmes has been plaguing programmers, policy makers, donors and service providers for years. Moreover, in the process of exploring means and methods for integration, another fact has come to light:

integration is not enough. The SRHR community, along with development, health and various other sectors, must work to *mainstream* HIV and AIDS into programmes, policies and practices. This involves the recognition of HIV/AIDS as a long-term exceptional issue that requires a sustained process-orientated response. And it means redefining not only our understanding of SRHR work but, fundamentally, *how* we work to improve SRHR in a world in which HIV/AIDS exists.

At the programme, policy and practice levels, this requires the implementation of a proactive and dynamic response that moves beyond the boundaries of simply integrating HIV/AIDS work into existing projects and practices or of adding HIV/AIDS-related projects to existing programming. By mainstreaming HIV and AIDS, the mandate and goals of SRHR organizations remain the same, but all of our work is viewed from a broader perspective that is more relevant and effective.

Determining when, where and how to mainstream HIV/AIDS is not only long overdue, but it takes us into what could be the most unexplored terrain of our international response to HIV/AIDS. For it is only with the concerted effort and co-ordinated involvement of the SRHR community that the Millennium Development Goals, the UNGASS Commitments and WHO's '3 by 5' targets can be achieved. The mainstreaming of HIV/AIDS into SRHR programmes and policies is not only a virtually untapped avenue, but it has the potential to awaken a vastly under-utilized resource.

Mainstreaming is not a simple act – it is a process that requires a change in mindset for everyone involved. The exceptionality of HIV/AIDS as a largely sexually-transmitted infection (STI) requires an exceptional response – especially from sexual and reproductive health (SRH) providers. Fortunately, mainstreaming makes both good economic and programmatic sense. This is true whether it involves utilizing voluntary counselling and testing (VCT) as a pivotal entry point for prevention and care in sexual health services; addressing integrated prevention, including the prevention needs of the HIV positive community; syndromic management of other STIs; or meeting the maternal health needs of HIV-positive women.

If mainstreaming is to be effective and long-lasting, though, it has to take place concurrently at the personal, policy and programme levels, which involves SRH providers as well as policymakers, donors and other stakeholders.

All of this we know. The challenge now is to apply this knowledge not only to what we do, but more importantly to how we do it – globally, regionally and at a national level.

Mainstreaming at the Clinic Level

All individuals involved – programme staff, service providers and clients – must feel they are contributing to the process of change. This sense of 'ownership' is a key step towards collective responsibility, as opposed to the traditional culture of separation. A commonly voiced fear is that the linking of, for example, family planning with HIV/AIDS prevention and care services (with their associated stigma) will lower the acceptance of use of modern family planning methods by conventional clients.

However, these prejudices can be overcome by training and guidance. In some places, indeed, the integration of HIV and other STI prevention elements may actually have advanced family planning objectives by lowering rates of infection. Thus, mainstreaming means investing and believing in people who are already providing sexual health services, which is cost-effective and promotes programmatic synergy. Building the AIDS competencies of SRH service providers will simultaneously begin to address in a clear and practical manner the global AIDS capacity gap.

Mainstreaming at the Policy Level

From a policy perspective, two avenues need to be more fully explored. The first relates to the broad structural national environment in which mainstreaming occurs, and the other relates directly to the policies that flow from this environment. Without a clear understanding of how the one informs and influences the other, policy reform on mainstreaming will remain haphazard at best.

In most developing countries, primary health care facilities are used mainly by women and children and integration has meant adding new activities to these existing services. For the vertical programmes that support these services, such as family planning, malaria control and HIV/AIDS prevention and treatment, integration has implied collaboration rather than merged responsibility. Moreover, difficulties with integration have in some instances been worsened by the activities of external donors. For example, some donors set up two funding streams – one for SRH and one for HIV specifically, which could impede the very process of mainstreaming HIV for SRHR organizations. At present there is no consensus about how integration or mainstreaming should be accomplished at the country level, therefore the set policy of a particular donor can sometimes result in bad practice.

Successful mainstreaming can be achieved only through political commitment to institutional collaboration. Simple expansion of vertical programmes can never be the answer. At a time when the US Administration's stance is worsening the segregation of SRH from HIV/AIDS programmes, the counter-arguments need to be heard more strongly in the policy and political community. In particular, the Global Fund to Fight AIDS, Tuberculosis and Malaria should also link SRH issues more concretely into its guidelines.

Mainstreaming is neither a panacea nor an end in itself. It is a means of enabling the SRHR community – just like any other community with a specific niche and focus – to improve its capacity to contribute to the global fight against HIV/AIDS. It is of paramount importance that HIV/AIDS is seen as primarily a sexually transmitted disease whose defeat will require the full resources and capacities of the SRH community. By working more closely with other sectors, without damaging its traditional activities, the SRH community can make a greater contribution to this global fight. And in parallel to this, the HIV/AIDS community needs to incorporate natural linkages between existing programmes and broader SRH issues. For collectively we have the opportunity to alter the course of the seemingly inevitable HIV/AIDS history. And this is a task to which we must and will rise.

Integrating HIV/AIDS and Sexual and Reproductive Health and Rights: A Happy Marriage?

By Chris Lambrechts and Dirk Pyck, Executive Directors, Sensoa, Belgium

What happens when a dedicated AIDS organization joins forces with a sexual and reproductive health organization? The Co-Directors of Sensoa – Flemish Belgium’s merged organization for sexual health and HIV – tell the story of their integration and highlight the benefits, pitfalls and opportunities of the integration process.

AIDS organizations and organizations that work for sexual and reproductive health and rights (SRHR) have sufficient interests in common to pool their resources and work with each other structurally – the differences between the two are mostly superficial. Yet it seems that the waters between the potential spouses often flow too deeply and they often collide with each other in a variety of ways.

For example, AIDS organizations are accused of being one-issue organizations and paying too little attention to the wider framework of sexual health and rights. In some cases, their activities have led to a situation where condoms are promoted for HIV prevention at the expense of efforts and funding to prevent unwanted pregnancy. This has resulted in an increase in unwanted pregnancies among young people and a subsequent increase in abortions. On the other hand, organizations involved with other aspects of sexual and reproductive health are blamed for a lack of flexibility and speed in their approach to new health problems.

What binds us together and what separates us

The promotion of SRHR and working for adequate AIDS prevention and care have much in common. To begin with, they have common factors related to risk behaviour, whereby the social context plays a decisive role. It is no accident that, from an international point of view, the groups that run the greatest risk of unwanted pregnancy or of becoming the victims of sexual violence are also those most affected by HIV and AIDS. In both cases, prevention and care consequently thrive best in an environment with the following characteristics:

- There is a social attitude that allows open discussion on the theme of sexuality.
- There is a legal framework that guarantees individual sexual and reproductive rights and that excludes discrimination on the basis of sex, gender, sexual orientation, sero-status, age, social and cultural identity, political and ideological views, philosophy of life and social environment.
- There is a guarantee of basic rights that everyone can call upon – especially socially vulnerable target groups, such as young people, women, *holebi*'s (HOMosexuals, LESbians, BIsexuals), the deprived, ethnic minorities, etc. – for client-friendly care and information, together with access to preventive methods and customized treatment.

- The provision of good sexual and relational education that gives young people basic information and social and communication skills.
- There is respect for the individuality of (sub-)target groups when any type of intervention is being developed – they are actively involved in working out plans of activities.

Yet the gulf between both sectors remains wide and there is often too little collaboration between them. The causes of this situation, which are diverse and may vary from region to region or country to country, including the following:

- The fact that provisions for sexual and reproductive health (SRH) are, as a rule, run for women and that AIDS organizations – especially in the western world – are often started by homosexual men who are not overly concerned about reproductive health gives rise to different emphases and a different corporate culture.
- Furthermore, both sectors are at different stages of organizational development. Organizations dedicated to SRH were most active in the 1970's and 80's and are now at a later stage of organizational development than the relatively more recent AIDS organizations that had to continually adapt their structure to the fast-developing AIDS situation.
- The reference framework of both sectors derives from another perspective. If the promotion of SRH is by definition a long-term strategy – and here it should be mentioned that the perspective has moved since the mid-1990's from the aspect of 'health' to that of 'rights' – then the prevention of HIV derives rather from a medically-inspired emergency model.
- Internationally, the very active participation of people with HIV in the HIV/AIDS organizations ensures that attention is concentrated on treatment (translated to developing countries as the availability of generic, affordable ARV remedies), at the cost of attention to prevention *and* basic health care. This sometimes causes a certain degree of resentment among SRH organizations, as it does among NGO's for development collaboration.
- The lack of vision by both governments and other donors – who moreover have made finances available for combating AIDS at the cost of other budgets – has increased the competition with regard to subsidies.

The Sensoa Story

At the end of 2001, the then-Flemish¹ Minister of Public Health in Belgium, Ms. Mieke Vogels, launched a public awareness campaign for young people aimed at prevention of both unwanted pregnancy and HIV/AIDS. CGSO Trefpunt (the Flemish Belgian IPPF member association) and Sensoa (a merger organization of five Flemish AIDS organizations) were both appointed to coordinate the content of the campaign. The campaign's success convinced the minister of the added value of an integrated approach to HIV/AIDS and SRH, and she also put that approach into policy. The minister allowed for the necessary financing for future planning, but imposed the condition that she would only do so if both organizations genuinely combined forces – and therefore not just on paper. *Sensoa* and CGSO *Trefpunt* were given a year to do this.

How it grew

Sensoa and CGSO Trefpunt had already started discussions about possible collaboration at the beginning of 2001. Detailed analysis of both organizations made it clear that their offerings were strongly complementary. Moreover, the AIDS groups had already pursued a path of professionalization, transforming themselves from a movement into a group of skilled organizations.

The integration had an auspicious start, but there were also major challenges to be faced. Both organizations had already gone through a thorough process of reorganization and integration. So enthusiasm for yet another integration process was not particularly great. Fear about the loss of individuality and marginalization of their own themes resulted in a 'cold feet'. Nonetheless, a number of heads of departments and directors were able to convince their respective organizations that there was more to gain than would be lost in structural collaboration. Aversions were put aside in favour of a more objective acquaintance; the exchange of information was hesitant at first, but then smoothed out. In the Flemish style – that is to say, accompanied by much coffee, chocolates and cake – increasingly clearer attempts at rapprochement were made. Two years later, on the 1st of January 2003, the new organization became a reality, and the new *Sensoa* was officially recognized by the Flemish government as a partner organization for sexual health and HIV.

An unfinished symphony

Nearly two years into the integration process, we count the following as the most important results.

1. A stronger organizational unit. The new *Sensoa* employs more than fifty people and also calls upon the services of some 150 volunteers. There is a good mix of expertise among the staff with regard to content and technical matters, and the larger scale also provides them with more possibilities for career development. The agreement with the Flemish government guarantees substantial core funding for *Sensoa* for a period of four years, making it possible to invest in specific areas of expertise, including fund-raising. The integration has afforded the AIDS organizations an opportunity to institutionalize their work

– and that of course applies equally to CGSO Trefpunt. The fear that the integrated organization would lose flexibility, become more bureaucratic and more difficult to run appeared in the end to be groundless.

2. Updating and broadening content. Both organizations contributed their respective fields of expertise. *Sensoa* had a great deal of experience with regard to social marketing and media work; CGSO Trefpunt had strong concepts for educating young people about sex and relationships, together with a clear reference framework for sexual and reproductive rights. Existing activities and services are being fertilized by new angles of approach and the broadened reference framework.

3. A bigger social basis of support and a bigger impact. The official recognition of *Sensoa* as a partner organization of the Flemish government in the field of sexual health and HIV ensures a direct impact on Flemish preventive health policy. But that impact has grown in other policy domains as well, such as the Flemish and Belgian policy on development collaboration. The merger means that, from now on, Flanders has one strong champion for the theme of sexual health and HIV. That near-monopoly position gives *Sensoa* a strong negotiating position with the private sector as well, which is showing a lot of interest in working with *Sensoa* on concrete projects. The social basis of support has also broadened because the networks of both partners can be better deployed and because public awareness of the name is continually growing.

We can definitely say that the integration has been successful, although it is far from complete. What is needed is a vision and plan of action for the long term to take care of these sticking points – and that is what we will continue to work on.

A step-by-step plan for a successful marriage

A number of factors have indisputably contributed to the success of *Sensoa*, which we will list here.

Start from common interests and equality

Make sure the marriage has a firm foundation: tax-deduction alone is a poor motivation. The marriage will only last if the partners know one another well and appreciate one another for their specific individuality and expertise. For us, a detailed SWOT analysis soon made clear the mutual interests and strong points. The process of strategic planning that followed marked out the boundaries for the coming years by defining the joint mission and strategic objectives for which the new organization would aim.

Even though *Sensoa* had twice as many staff members as CGSO Trefpunt, the starting-point was not one of a takeover. At the start of discussions, the final form of the collaboration was left open. The question of who would lead the organization was also postponed until the moment when all other sticking-points had been cleared

¹ Flanders is the Dutch-speaking part of Belgium. The activities of *Sensoa* cover the Flemish Community, including the 150,000 or so Dutch-speaking residents of the Region of Brussels.

up. Thus the initiative was prevented from perishing just because the leadership of the organization could not reach agreement on the division of mandates. The final choice of working with two directors, one from each of the merging organizations, emphasized their equality.

Involve everyone in the preparations

All members of staff were invited to examine the consequences of the merger and worked together within thematic groups, which jointly prepared part of the merger in practice. All the existing teams are composed of a mixture of staff members from both organizations. By working together on concrete projects in which they were able to achieve positive results, the staff members got to know and appreciate each other better, and resistance to the merger was reduced. That resistance was accepted as a fact, and members of staff were encouraged to express their feelings about it. In this respect, attention was paid especially to the source of the resistance. It was mainly a question of the genuine concerns of staff members who were asking for clarity. The management committed itself to establishing that clarity as soon as possible. In addition, all those involved were given feedback about the various stages in the merger.

Burn all bridges

Make sure that the partners cannot run back to their mothers whenever there is the slightest disagreement. The intention to establish the merger contractually in an accord with the government meant that there was no way back. For the management it was clear that there was no room for failure. *Bailing out was not an option.*

During the preparatory talks it became clear that, in order for the new unit to function best, the current forms of organization had to be updated. It was therefore decided to give the new organization a matrix structure. In this respect members of staff set up departments that bring people with a particular expertise together into programme teams that concentrate on target groups and result objectives. This method of working increases the focus on the final output rather than on the processes. It also made it clear that the combined organization really was a new unit.

Prepare the marriage thoroughly

Living together for a while before getting married is usually a good idea. The new structure could go through a test run while the old familiar structure continued to function in parallel. In this way, teething troubles could be smoothed away and members of staff were able to fall back on their familiar environment during the difficult initial period. During the long engagement period an extensive integration schedule was drawn up, in which staffing policy was adapted, a new strategic framework devised, publicity plans worked out, and so on.

Obtain the blessing of the government

Although the AIDS organizations (and afterwards, Sensoa and CGSO Trefpunt) had already been having discussions

about more structural collaboration with each other, things only really began to move when the Minister of Public Health gave concrete substance to her view on policy and announced that integration would be a condition for further subsidization – in that sense one might speak of an “arranged” marriage with the minister as the broker. The minister also indicated that the total budget would not be affected, so that staffing levels could remain. Nevertheless this still meant a saving for the government, in a certain sense: with the same budget and number of staff the newly-merged organization had to address more target groups and expand activities.

Is Sensoa an example for other countries?

Sensoa's positive experience in Flanders cannot automatically be transposed to other countries. Integration is ultimately the finishing point of a more structural collaboration between AIDS organizations on the one hand and SRH organizations on the other. For Sensoa, it is now clear that such collaboration is in itself very rewarding.

The active role of the Flemish Government should not be underestimated in the creation of this merger. In other countries, we are forced to the conclusion that governments often make a very strict distinction between HIV/AIDS and SRHR, and the separate budgets offer few incentives to collaboration, if any at all.

Such collaboration is also hindered because AIDS organizations and those for SRHR operate under a different reference framework. Sensoa has explicitly opted for sexual health as the coordinating framework, with HIV/AIDS, reproductive health (unwanted pregnancy, abortion, etc.) and sexual violence as the main themes. In addition, Sensoa orientates its activities towards five priority target groups: people with HIV, young people, adults, immigrants and holebi's. In our activities – given our governmental task – we focus mainly on prevention; Sensoa is also developing care-provision, but only for the target group of people with HIV.

Sensoa opts for a holistic approach in which all the themes and priority target groups are given a chance. When determining the deployment of people and resources, Sensoa is guided mainly by the extent and seriousness of the problem among the target group, and we take into account the services that other organizations in the field provide. Sensoa deliberately opts for complementary provision that can be both innovative and supportive.

In light of our experience, an either/or approach – opting for either HIV/AIDS or SRH – is counter-productive and even absurd. It undermines the complexity of the challenge and the added value that an integrated approach can offer. It boils down to finding an appropriate mix, customized to local needs and requirements. We therefore appeal to our European colleagues to make (even) more efforts to get to know and value each other. Our objectives and our target groups have much to gain.

The EU Confronts HIV/AIDS

EU is committed to work in partnership to fight HIV/AIDS in Europe and Central Asia. To draw attention to the new threat posed by the rising HIV/AIDS epidemic in the European Union and Central Asia, the Irish Presidency hosted a Ministerial Conference from 23 to 24 February 2004 on HIV/AIDS in the region. Representatives of States and Governments from Europe and Central Asia declared their commitment to fight HIV/AIDS in their region.

After an initial draft declaration was produced, IPPF EN and its Member Associations submitted comments and sought to ensure that the following points were addressed in the final Declaration.

- Although HIV/AIDS cases in Europe and Central Asia still represent a relatively small share of the total number of cases globally, the region has the highest growth rate in the world and the risks of an epidemic on a massive scale are more acute than ever.
- Sexual and reproductive health and the fight against HIV/AIDS are intimately related. The lack of knowledge on sexual and reproductive health is a key factor contributing to the spread of HIV/AIDS.
- The shift in transmission from marginalized groups to the general public progressively exposes the heterosexual population to the risk of infection.
- Stigma and discrimination against people living with HIV/AIDS causes them serious harm and poses a serious threat to the implementation of effective HIV/AIDS treatment and prevention strategies.
- There is a link between poverty and HIV/AIDS: the disease not only causes poverty but also spreads faster in situations of poverty.
- The EU and its member states should not forego the opportunity to renew and strengthen their existing commitments to the Programme of Action of the International Conference on Population and Development.
- There should be an integrated sexual and reproductive approach to HIV/AIDS prevention. Comprehensive, early and relevant sexuality education both in and outside of schools is key to the prevention of sexually transmitted infections, including HIV/AIDS.

- There is a need to make condoms both widely available and affordable and efforts need to be made to bring down barriers to their use since the condom is the only prophylactic method known to provide reliable protection against HIV/AIDS and other sexually transmitted infections.
- Strategies to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection should also involve men, encouraging them to take up a greater responsibility in protecting their own health as well as that of their partners.
- There is a need for specific programmes for marginalized groups such as drug users.

All these recommendations were addressed, in some measure, in the final Declaration.

The Dublin Declaration is an essential and valuable tool for re-focusing attention on the HIV/AIDS epidemic in Europe and Central Asia. The Declaration stresses the importance of greater coordination, cooperation and partnership to tackle the HIV/AIDS crisis. The contribution of people living with HIV/AIDS and civil society is essential.

All documents related to the EU policy on HIV/AIDS can be found on:

http://europa.eu.int/comm/health/ph_threats/com/aids/aids_en.htm

Civil society's response to the Dublin Declaration can be consulted at:

http://www.integrationprojects.org/keydocs/NGO_Perspective_on_the_Dublin_Declaration.doc

Europe's Response to the AIDS Epidemic



An Interview with Dr. Lieve Fransen,
Head of the Human and Social Development Unit
at the Directorate-General for Development
of the European Commission

By Wendy Knerr

What role has the European Union (EU) played in confronting HIV and AIDS in the world? From its Member States to the European Institutions, Europe hosts the largest number of donors to development aid in the world. This means that its policies and funding decisions have a major impact on the work being done in developing countries, including efforts to prevent HIV and provide treatment and care. Moreover, now that HIV/AIDS is increasing at rapid rates within the Europe region itself, what might the EU's role be in stemming the epidemic?

To find some answers, we spoke with Dr. Lieve Fransen, who has been involved in the fight against HIV and AIDS for more than 20 years, first as a physician and researcher in Africa, and now as Head of the Human and Social Development Unit at the Directorate-General for Development of the European Commission. As both a physician and a policymaker, Dr. Fransen plays a pivotal role in guiding EU policy on funding and support for HIV/AIDS programmes. She was the founder and Executive Director of the AIDS Task Force of the European Commission's HIV/AIDS programme for developing countries and is currently a Board Member for the Global Fund to fight AIDS, Tuberculosis and Malaria.

What do you feel have been some of the successes that the EU member states and the EU institutions have helped bring about with regard to HIV/AIDS?

Lieve Fransen: First, I'd like to mention that at the end of October we released a progress report that outline's the [European] Commission's perspective on where we have

been successful and where there are still gaps with regard to our actions on the three communicable diseases (Tuberculosis, Malaria and HIV/AIDS). So this is a good place to start in answering your question.

Overall, since 2000, the Commission and the member states together have been quite successful in giving HIV, TB and Malaria higher profiles throughout the world, as well as other related issues like sexual and reproductive health and rights and the need for choice. This has certainly been a goal of the Commission, and it has been supported by most member states.

The Commission and member states have also had collective success in increasing resources for the three communicable diseases, with the Commission alone increasing resources by four or five times what they were previously. Plus, there has been more political visibility and leadership and more internal cooperation between the different Commission departments, including trade, health, research, etc.

I think another area where we have been really successful is in developing partnerships with WHO/UNFPA, UNAIDS and with other organizations, including NGOs, for the very first time. Policy dialogue is much more open now, including NGOs, people living with HIV and AIDS, industry, and other groups. Since about the year 2000 we started holding policy & information consultations with these groups, and they have increasingly been seen as real partners. Our policy area has been at the forefront of these efforts.

There's one more area where I feel the Commission has been really successful, and this is in pushing down the price of drugs. We have been leaders in putting the drug price issue on the agenda, and since we organised a ground breaking round table in September 2000 prices of key products have gone from very high to much lower today.

What do you think are some of the areas where EU member states and the EU institutions could improve with regard to their response to the epidemic?

LF: My main concern is that we have not succeeded in accelerating sufficiently the delivery of access and resources at country level. Health and HIV and sexual and reproductive health are not really in the foreground of the Country Strategy Papers¹. Also, we have not succeeded sufficiently in developing human and institutional capacities faster in the South to confront these issues. We generally leave it to the countries, but often they do not already have the capacities in place. With regard to sexual and reproductive health and rights, we also have a human resources gap in the South and a brain drain in many countries. We need to invest more in the capabilities of people in the South so that we can keep human resources in social sectors where they are most urgently needed.

We also have not succeeded in having enough civil society voice.

For HIV, we have done better – not thanks to our own instruments, but thanks to our instruments created in the Country Coordinating Mechanisms² (CCMs) [for the Global Fund]. The CCMs are not perfect, but they always include non-state actors, including people living with HIV and AIDS, gender activists, women's groups and also businesses. This has enabled us to make a quantum leap in including the voices of civil society in policies.

The worst story is, of course, that we haven't managed to control the epidemic. And we haven't done enough to ensure that people have choices with regard to sexual and reproductive health. UNFPA's recent report³ showed that there has been progress politically on sexual and

reproductive health, but not in access. Examples are that commodities are not accessible and we have not improved maternal health. There's still a lot to be done.

What steps should the Member States and the Commission take in the coming years to make an impact on the epidemic?

LF: On the most basic level, I would like to see us do more of what we – meaning Europe – have done well already, and for us to fill in the gaps that I mentioned before.

Aside from that, one of my wishes is to make a major step forward in ensuring that we have a common strategy for dealing with the epidemic. All of the Member States and the Commission share a common vision, but we also must have a common strategy. Now, there are 26 partners – the 25 member states and the Commission – often doing virtually the same things. We all know that we need to make commodities available, improve gender equality, make life skills education more appropriate and available to young people, but if we keep working separately as we are now, we are wasting time.

Based on your experience with the epidemic in Africa, are there lessons that could apply to the epidemics in Russia, Central Asia and other former Soviet countries, where the disease is spreading?

LF: Before I worked on HIV, I worked in Africa, and HIV came as part of my work in several countries there. What I learned from this was that each country has to go through the same phases of facing the epidemic – denial, complacency, anger, urgency. These are the same things people go through in reaction to illness. Because of this reality, transferring lessons-learned from one country to another is difficult.

I can say, though, that it helps a great deal if the political leadership can get past the denial phase quickly. This is best done by having a political leader speak out and be courageous, bold and honest about the connection between HIV sex including homosexuality and drug use in some regions. It also helps if a political leader pays attention to the poorest and most vulnerable groups, which are the most vulnerable to HIV, because they are also the most powerful force in fighting HIV and we have to invite them into the dialogue.

In Europe, we have a mixed epidemic. I was involved with caring for the first people infected with HIV in Belgium at the hospital in Antwerp, and I'll always remember the odd mixture of patients I was dealing with. There were artists,

1 Country Strategy Papers, which are produced by all countries that receive funding from the EU, are used as the basis for national programmes for development in each country.

2 Country Coordinating Mechanisms (CCMs) are country-level partnerships that develop grant proposals and submit them to the Global Fund, monitor their implementation and coordinate with other donors and domestic programs.

3 UNFPA, 'The State of the World Population Report 2004'. (<http://www.unfpa.org/swp/swpmain.htm>)

ballet dancers, gay people, and then a group of Africans, mostly wealthy Africans who could afford to come to Europe for treatment.

So the epidemic in Europe is quite varied, but the reaction has been similar to other regions. For example, ten to 15 years ago, I said there was going to be a major epidemic with TB and other communicable diseases in Russia, and then six or seven years ago, I worked with the issue of HIV in prisons in Russia. Finally, after 10 years, people have woken up to these problems.

Unfortunately, some of my colleagues are saying that the epidemic in the countries neighbouring the EU – like Russia and Ukraine – is different because, until recent years, it concentrated mostly among drug users. I don't see why it's different. An epidemic of HIV clearly has a phase of introduction in a country. For example, in America, this was in the gay community but it didn't stay there. As public policy makers, we shouldn't be blind to the fact that it will enter the general population eventually and the epidemic moves in phases in each country.

No matter where or how the epidemic starts in a population, we still have to be honest about sex and protect ourselves from risk with condoms (safe sexual practices) improve gender equality and supply clean needles. The epidemic goes to the first group, then to others, then to the general population, and it's frustrating because people don't see further than what is happening now. It would be wrong only to focus on drug use because, in a few years, it will be more than just drug users' problem.

What impact do you think the meetings in Dublin could have on the epidemic globally and in Europe and Central Asia? ⁴

LF: The positive impact of the first meeting in Dublin is that Europe moved forward. We are now putting some of the conference conclusions into our policy framework for HIV/AIDS, Malaria and Tuberculosis and external action...and this includes the Cairo agenda issues. This will go to the Council of Ministers and then it becomes policy. We are now making this into concrete policy that will affect all external action outside the EU, which means all action in Ukraine, Russia, the Mediterranean, developing countries – everywhere outside of the 25 member states.

As a physician, could you comment on the efforts to integrate or mainstream sexual and reproductive health and HIV/AIDS services – pros, cons, etc.?

LF: I find mainstreaming of sexual and reproductive health and HIV a non-issue if we only approach it from our own

perspective. As a woman, I don't have an isolated problem with a disease and then a separate one with contraception. What we are trying to do is to create more choice. People need to have the right to choice, including which partner they choose to be with, how they choose to protect themselves, etc. It's all part of life. So I find it strange that people need to go to one place to get a condom, another to get their disease treated and another to have a baby. Also, I think it's been a failure of women's organizations that they haven't dealt sufficiently with this issue and haven't had an integrated approach to choice.

However, I'm not necessarily translating that people-focus into donor funding. Last year we had a single budget line for sexual and reproductive health and HIV/AIDS. I agreed we split them because I could see a movement against sexual and reproductive health and there was momentum for HIV funding. We have to be opportunistic. The Commission has seen a 150% increase in funding for HIV and only a 20% increase for SRH.

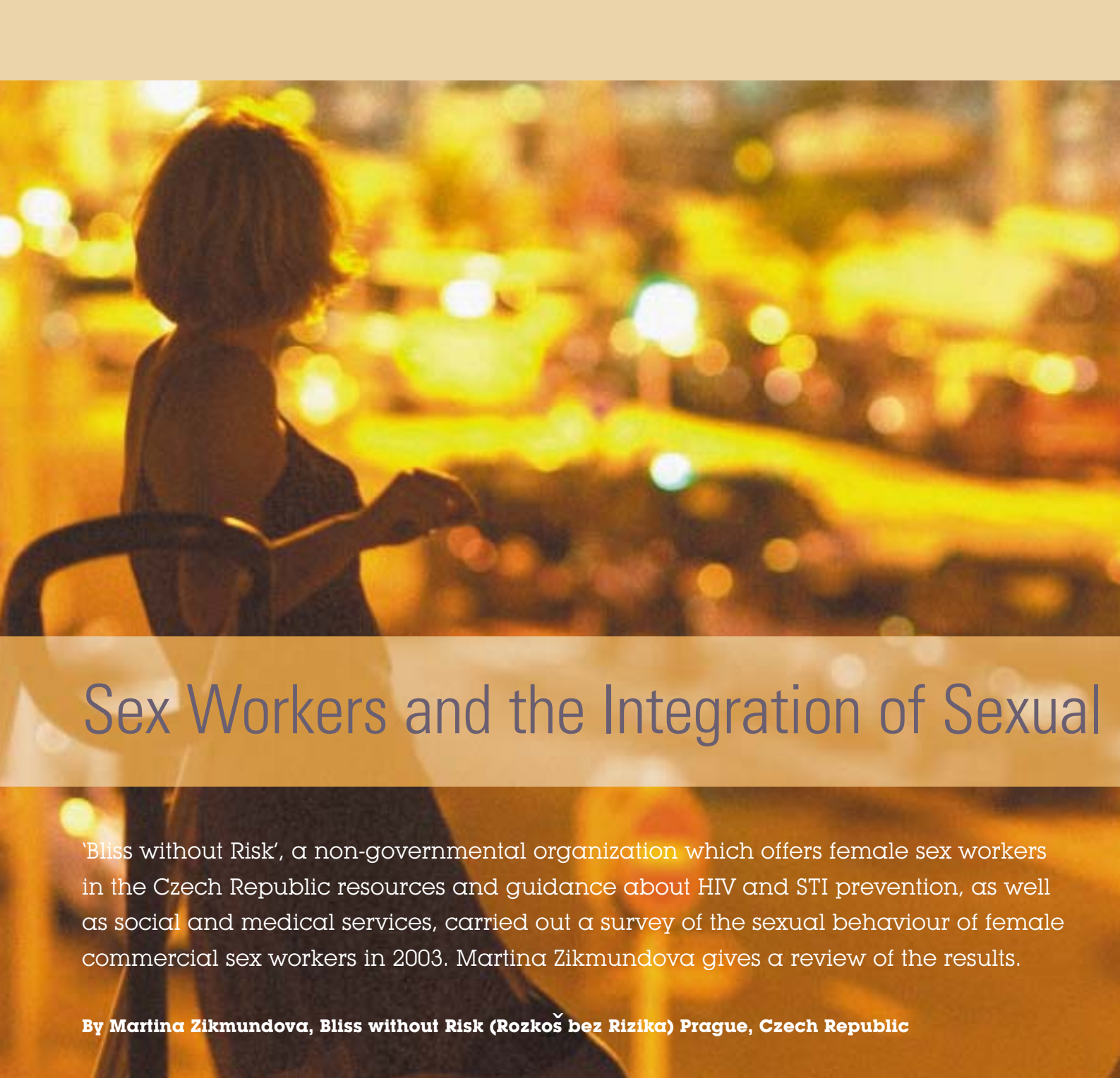
What do you see as the priority areas for research on microbicides and a vaccine, especially since the second Dublin Conference on New Technologies that took place in June?

LF: In terms of vaccines, if the vaccine protects and is safe, people in the developing and the developed worlds will be interested in it. However, I don't see a safe and available vaccine for the next ten years ... but anything can happen, anything can change.

For microbicides, my expectations are more positive for the moment. I think science has progressed enough so that we will have a microbicide that works in the next few years. We should make more investments in microbicide research and production, and we should prepare women for microbicides. We did a study with women in 11 countries that showed a lot of interest in microbicides. This tells me that the forward momentum needs to continue, especially with women's advocates. Microbicides will not work without a strong lobby from women's groups because it is not a product that stands to be highly profitable for pharmaceutical companies.

Overall, we need to demand more investment in microbicides because we need a protective measure that women can control. And, as I said before, it's women's organizations that have to take action. I come from a generation of women's groups where there was much more energy for issues affecting women. Where HIV is on the agenda, it is because of people living with HIV and gay groups. Sixty per cent of people living with HIV are women, but they are not vocal. I hope that young women will begin to speak out.

⁴ See page 12 for more information about the Dublin conferences.



Sex Workers and the Integration of Sexual

'Bliss without Risk', a non-governmental organization which offers female sex workers in the Czech Republic resources and guidance about HIV and STI prevention, as well as social and medical services, carried out a survey of the sexual behaviour of female commercial sex workers in 2003. Martina Zikmundova gives a review of the results.

By Martina Zikmundova, Bliss without Risk (Rozkoš bez Rizika) Prague, Czech Republic

Altogether, 119 female commercial sex workers (CSW) aged between 18 and 53 years were interviewed, with an average age of 26.4 years. The typical length of work in the sex business was 3.5 years, and the respondents worked in a variety of places – on the streets, in sex clubs, and in escort services. Seventy-seven were of Czech nationality, while 42 were immigrants (mostly from Slovakia or the Ukraine).

Contraceptive behaviour

According to the survey, CSW favoured the condom as their chosen method of contraception when they were working. Some 91.6% respondents said that they always used a condom during sex with their customers, compared to only 5% using this method in their private lives. Although the number who said that they always used condoms with their customers was high, it is believed that this was probably

not quite accurate, because the level of risk intercourse also revealed was still high. In their private lives, and with permanent partners, 22.7% respondents used condoms "sometimes" and 31.1% respondents never used them. More than half of those questioned (53.8%) answered positively to the question: "Do you know a female sex worker who does not always use a condom?", and 5% respondents admitted that they had probably been in the same situation themselves.

The reasons given for not using a condom were usually that they were too expensive, because customers pay more to have sex without a condom, or threaten them if they consider using one. It was also revealed that some sex workers engaged in relations with their customers (one respondent called it "love at work"), and in these instances

did not always use condoms. In fact, the majority of CSW used the withdrawal method (68.1%) in their private lives, followed by contraceptive pills (21.1%), fertility awareness (11.8%) and intrauterine device (7.5%).

Marriage, divorce and children

Almost 30% of respondents were married or had been married at least once in their lives, while 16.8% were divorced. The average age of their first marriage was 20.88. Almost 40% of those interviewed were mothers, and it was clear from the data that at least eleven were unmarried mothers. However, only approximately one half of children were still in the care of their mothers.

Bearing this in mind, a sample of respondents aged between 18 and 29 years were compared with a sample of women of equal age from a survey of the general population.

It was found that a greater number of women from the general population (32.5%) than women from the sample of CSW (14.8%) got married, but there was no difference found

Homosexual experience

Almost half (47.9%) of respondents stated that they had experience sexual contact with a woman at some point some during their life (compared to 4.4% in the whole population). Of this total number, 25.5% said that this contact was in their private life, 12.6% in their work and 10.9% in both cases. However, 65% of women who had experienced homosexual sex refused to be named "lesbian", and only four out of the 119 respondents considered themselves to be a lesbian. In total eight women, i.e. 6.7% of respondents had been involved in a long-term relation with a woman.

Conclusion

Female sex workers are potential mothers, they want to become mothers and they are an important target group for family planning. Prostitution is usually only an episode in woman's life and after this episode ends or sometimes even during this episode, the woman becomes a mother. The objective should be to minimize the health, physical and social risks that exist during the period when women are commercial sex workers, i.e. in the period of significant

and Reproductive Health and HIV/AIDS

in the incidence of divorce. It was also found that a similar number from both sample groups had children (25% of women from the general population and 28% of CSW), and that both had equally similar numbers of children.

The economical and social situation of commercial sex workers is potentially the main reasons why these women become prostitutes. This theory was confirmed when compared to the women from the general population. The fact that only one half of children were in the care of their mothers is worrying. The children are often adopted, or sent to state institutions (infant facilities, children's homes). However, in most cases, the children are raised by a relative. Almost all children of the immigrant CSW questioned were cared for by their grandparents. By working in the Czech Republic, they supported themselves, their children and also their family back at home.

Abortion

There was a big variation between the sample of sex workers and the general population concerning the question of spontaneous abortion (miscarriages) and induced abortion. It was observed that a greater number of CSW (18.8%) than women from the general population (6.7%) had experienced a spontaneous abortion. Furthermore, 25.6% CSW compared to 11.8% from the general population had had an induced abortion.

This occurrence could relate to the higher promiscuity of female sex workers and also to the fact that they often face violence in both private and working life.

vulnerability. A woman who is not criminalized, stigmatized or mentally or physically harmed can return to regular life more easily.

The only way to approach this vulnerable sector of society is through acceptance and empathy, not condemnation. Making medical care and psychological, legal and social help and support available is paramount, as is expert consultation about contraception and abortion, increasing awareness and improving the relation towards women's bodies.

Bliss without Risk was established in 1992 due to the boom of prostitution in the Czech Republic after the Velvet Revolution. It aims to fight the spread of sexually transmitted disease by providing free medical examinations and treatment, as well as psychological and social help for sex workers at a drop-in centre in Prague. Bliss without Risk has approximately 30 voluntary members, who help over 1000 sex workers. The organization has also developed a mobile ambulance which travels throughout the Czech Republic, making wide-spread testing on STD and HIV. For more information, contact: rozkos@volny.cz, zikmundova.m@seznam.cz

Sources - Literature: (1) Weiss, P., Zv__ina, J.: *Sexual Behaviour in the Czech Republic- Situation and Trends*, Portál, Prague 2001 (Weiss, P., Zv__ina, J.: *Sexuální chování v _R -*. Portál, Praha 2001.)

Photo: © Gilles Fonlupt/Corbis



Safe sex and good sex are not mutually exclusive, yet many educational materials give this impression. At best, the conventional line seems to be that safer sex is a necessary evil – protect yourself or face the consequences. Anne Philpott reports on The Pleasure Project, an initiative which promotes safer sex by focusing on the prime motivators for actually having sex: desire and pleasure.

Can Safe Sex be Good Sex? Mixing Pleasure

By Anne Philpott, The Pleasure Project

The Pleasure Project was born out of frustration. A frustration that we in the HIV prevention world do not talk about sex, desire and pleasure. A huge element of sex is missing in sexual health. I finally snapped, and decided to try and change this, when sitting in a session of an international AIDS conference, listening to a presentation and not even realizing that the presenter was talking about sexual intercourse. It could have been an airborne disease that was being discussed: the details of the sexual act described were so obscured in clinical language. Our own taboos about sexual and especially pleasure were impinging on our ability to discuss sexual realities, restricting our ability to work towards reducing HIV and other sexually transmitted disease transmission.

During this time, I was working to promote the female condom. In a wide variety of settings, women were “selling” the use of the female condom as a pleasure accessory and not a preventative measure against disease or pregnancy as a means to encourage men to use them. They would introduce the female condom in an entirely sex-positive fashion as a new sex toy or device, without mentioning disease or HIV. In Sri Lanka, women told me how they invited men to insert it to provide a ‘new thrill’ for the men. In Senegal women were promoting the female condom’s occasional noise as a turn on similar to that of the local sex “bine bine” beads. In Ghana, men were buying the female condom to masturbate with as this reminded them of the pleasurable “tickle” of their penis on the inner ring of the condom – and indeed in Zimbabwe a whole new word “ketecyenza” had entered the Shona vocabulary to describe this sensation. I felt that my traditional sexual

educational background promoting the condom as “good for you” was just not enough, not creative and indeed not as pleasure-focused as these people all over the world who were telling me these great condom marketing tips.

To add to these Feelings I attended a Sexual Liberation conference in London, for people working in the sex industry, owners of sex shops, porn and erotic film makers and people working to create sexual pleasure through their resources or selling sex. I spoke to many people there who were equally keen to include safer sex instructions with their materials or use condoms in their porn films. I also worked as a safer sex consultant for two erotic film makers, advising and informing them to include male and female condoms in their films. This worked well, the condom use was integral to the action and not simply included as a “health warning”. The pleasure industry, I found, was just as keen to learn more about safer sex as the safer sex industry was to learn more about pleasure. And so The Pleasure Project was born.

*The Pleasure Project:
Because sex education is
rarely sexy.
And erotica is rarely safe.
Putting the sexy back
into safer sex.*

The Pleasure Project was launched at this year’s International AIDS conference in Bangkok, where it received a great reception, a huge audience and lots of media coverage. For the first time, an explicit erotic film was shown at an International AIDS conference. A range of fascinating speakers from around the globe spoke of their experiences including the use of the Karma Sutra as an educational tool, the promotion of water-based sexual lubricant in Asia, pleasuring women safely through erotic literature after a positive HIV diagnosis, turning young gay men onto safer sex through erotic literatures and selling condoms through erotic imagery in India.

Many people commented that this was the first time that they had seen any sessions that actually mentioned pleasure and desire at any HIV conference – a shocking omission for a disease extensively spread through pleasurable sexual contact.

Pleasure Projects

Modern Loving – the first safer sex erotic video

Modern Loving is the first erotic instructional video for heterosexual couples that is entirely safe and features only safer sex. However, the video does not preach or promote itself as a health resource or sex educational



What is The Pleasure Project?

The Pleasure Project is an educational resource promoting safe sex to men and women.

A single belief underpins our aims: we can have safer sex if we know how to have good sex.

Our message is unique in the world of sexual education; it is positive, exciting, liberating and sexy. There's nothing revolutionary about this approach – all the evidence suggests that positive incentives are a far more effective change motivator – we're just starting from a position that is still rarely adopted in safer sex programming.

The Pleasure Project aims to build bridges between the pleasure/sex industry and the safer sex world by ensuring that erotic materials include discussions of safer sex, and that sexual health and training materials include pleasure as a key element. Many safer sex and HIV organizations avoid discussing sexual desire and enjoyment, while the pleasure industry avoids talking about safer sex, with few erotic films and resources featuring condom use and non-penetrative pleasurable sex as the norm. We want this to change. We want to provide sex education with the emphasis on 'sex', not 'education'. Sex is exciting, fun, and empowering. Our message should be too.

tool; this is a subtle element of its overall purpose – to turn its viewers on. The film is sexy and shows “real” couples having sex and is designed to be viewed to improve your sex life. The safer sex is a beautiful coincidence and a subliminal message – that safe sex is sexy. We don't talk about sexually transmitted infections or AIDS; instead we show safer sex as the norm and as a turn on. The Pleasure Project provided condom consultancy on set for the film to ensure that the sex was always safe but the film was still sexy.

Sexual Health Toolkit – in collaboration with CARE International

The Pleasure Project is currently designing a sexy sexual health toolkit in collaboration with Care International based on pilot work in Cambodia and Vietnam. This educational and training resource will enable sex educators and trainers to promote safer sex in a sex-positive way in their own settings and projects, thereby increasing safer sex and condom use through behaviour modification. This encourages people to change because they are keen to adopt behaviours, and not because they are avoiding a disease. This will be available in January 2005.

Global Pleasure Database

We are conducting interviews, a literature review and wide research to gather a global database of any work in the sexual health field that has utilised pleasure to motivate safer sex. This will take the form of listings and case studies of best practise, also available early 2005.

So far, the reception to The Pleasure Project has been almost universally welcoming. Sexual health professionals seem to realise that we need fresh approaches to tackling the ever-increasing AIDS epidemic. Motivating behaviour change towards a pleasurable experience seems

extraordinarily simple, we just don't see it in the same light when sex is involved because we have got so used to thinking of sex and disease in the same breath, and pleasure and sex as two separate entities.

For more information, contact Anne Philpott on info@the-pleasure-project.org or visit www.the-pleasure-project.org

and Prevention



Silent Voices: HIV-Positive Women and Drug Use

Drug-using women, many of whom are HIV-positive, are marginalised, stigmatised, disempowered and scapegoated by governments around the world. Well-meaning harm reduction programmes, including needle exchanges and drug treatment programmes, where they exist at all, are often geared towards men and do not meet the needs of women who could benefit from such programmes.

Statistics show that among many injecting drug user (IDU) communities, HIV prevalence is on the increase. In Eastern Europe, the numbers of HIV-infected drug users has been rising for the last five years, and in the Russian Federation, the rise of HIV prevalence is due considerably to the use of contaminated equipment when injecting drugs.

At the age of 18 I started injecting opiates. Drugs and alcohol helped me to change my reality. I drifted into theft to support my addiction. In prison I had another test. This time it was positive. After I was released, the head of police told me that if he saw me in town he would kill me. (ICW member from the Ukraine)

Although sexually active young men account for the majority of injecting drug users, women are put at risk because young sexually active drug users may not practice safe sex with their partners.

ICW is concerned that IDU's, both women and men, are discriminated against when it comes to access to care and

treatment, including anti-retrovirals (ARV). In some countries there is no provision of ARV therapy at all, whilst in others it is very limited. For instance: IDU's comprise 93% of HIV/AIDS cases in Russia but only 13% of them receive triple combination therapy. In fact, Harm Reduction Programmes in the region report that 73% of IDUS have no access to primary care from any source. There is a misconception that drug users cannot adhere to treatment, or "that they don't respect life and as such don't deserve treatment", or that they don't respond to treatment. The perception that society has regarding drug users is often internalised by drug users themselves.

ICW has collected considerable evidence to show that judgemental attitudes about who does and who does not deserve health services abound amongst health professionals and in communities. Our evidence and the evidence of other research also shows that women face considerable barriers to accessing treatment, care and support in general as well as sexual and reproductive health services in particular. Gendered barriers to services, health care and treatment are further compounded by a being an HIV-positive drug user.

The concerns raised above spurred ICW to explore the intersection between drug use, HIV/AIDS, and gender through a project called Silent Voices. The aim of Silent Voices is to research both locally and internationally and collate information on drug-related subjects such as the availability of clean syringes and relevant paraphernalia. The project also assesses ways of understanding and analysing drug use and risks, particularly as they relate to women.

Silent Voices looks at approaches and programmes which have been successful and have also included gender in their research and analysis. It aims to illustrate how different drug policies, including harm reduction, achieve different outcomes, and to assess which ones are the most successful and useful to drug users, particularly female drug users. This will form the basis of recommendations to governments and policy makers.

The International Community of Women Living with HIV/AIDS (ICW) is the only international network which strives to share with the global community the experiences, views and contributions of 19 million incredible women worldwide, who are also HIV-positive. ICW promotes and advocates for changes that improve HIV-positive women's lives.

For more information, contact Carmen Tarrades on carmen@icw.org or visit www.icw.org



Challenges in Bringing HIV Prevention to Bulgaria's Roma Ethnic Community

NGO-Government Partnerships and Roma 'Health Mediators' could be the solutions

By Dr. Dessislava Georgieva and Dr. Radosveta Stamenkova, Bulgarian Family Planning Association

As HIV prevalence rates in the Balkans increase, the Roma in Bulgaria, like many marginalized populations, face a combination of factors that put them at higher risk for the disease. This article outlines the efforts to prevent HIV/AIDS and the urgent need for an NGO-government partnership.

According to UNAIDS, Bulgaria has relatively low HIV/AIDS prevalence, but “analysis of the situation shows that there will be a rapid increase in HIV infection if no preventive measures are taken.”¹ As in the rest of the world, the marginalized and socially-excluded are statistically most vulnerable to HIV/AIDS, and in Bulgaria this includes the Roma ethnic minority.

Roma are the second largest ethnic minority in Bulgaria (after the Turkish ethnos), with a life expectancy and general health indicators that rank much lower than the national average. This is due to a variety of demographic and social factors – including lower educational level, high unemployment, high birth rate and high levels of poverty – all of which act simultaneously to create a vicious circle of de-socialization.

HIV/AIDS Prevalence in Bulgaria

Bulgaria's national programme *Prevention and Control of HIV/AIDS* reported 497 HIV-positive people (132 of whom have developed AIDS) in Bulgaria as of the 30th of September 2004. Men account for 69 per cent of cases and women 31 per cent, with sexual transmission being cited 91 per cent of the time (blood transfusion accounts for 8 per cent of cases, and mother-to-child transmission for 1 per cent).

In an effort to maintain confidentiality and eliminate stigma, Bulgarian legislation mandates that the official data-collecting mechanism on HIV/AIDS cannot register ethnicity. However, based on fieldwork research, outreach activities and in-depth interviews with Roma community leaders and volunteers, there appears to be no substantial difference in HIV rates based on ethnic origin.

Despite this apparent consistency of HIV prevalence rates among all ethnic groups, the Roma community is particularly vulnerable to HIV infection, especially those living in suburban ghettos of large cities. Overall, urban Roma communities tend to have a higher likelihood of risky sexual behaviour and drug use than their rural counterparts.

Additionally, in assessing potential vulnerability to HIV infection, it is important to consider age as a key demographic factor. Currently, the most vulnerable age group in Bulgaria is between 20 and 29 years of age, which accounts for 40 per cent of the total number of officially registered HIV positive people. The age profile of the Roma community is much younger in comparison to the national age profile. This fact, combined with a high number of school drop-outs among the Roma, a lack of access to prevention information and lack of incentive to get acquainted with the topic, the potential vulnerability of the Roma population increases further.

Unmet Needs Inspire Grassroots Action

With these factors in mind, it is clear that the Roma community deserves a special focus in HIV/AIDS prevention programmes and specifically targeted informational

¹ <http://www.unaids.org/EN/Geographical+Area/by+country/bulgaria.asp>
Photos: Ognian Kamenov/Minorities Health Problems Foundation

campaigns. To accomplish this, relevant governmental and non-governmental health prevention structures in Bulgaria and those that work to improve access to health care services for Roma must work concurrently to prevent the spread of the disease.

Bulgarian governmental initiatives on their own have not been enough. The National Convention on Equal Integration of Roma Minority in Bulgarian Society, which was adopted in 1999, defines its objectives with regard to health as follows:

“In order to achieve a satisfactory level of Roma health, it is necessary:

- to improve hygiene control of main parameters of the Roma living environment;
- to intensify health education programmes as well as to stimulate Roma participation.”

This limited response to the health needs of the Roma community, especially in the face of growing HIV/AIDS infection rates in the region, inspired two reactions by non-governmental organizations (NGOs). First, the most active NGOs working in the field began designing and implementing grass roots health prevention projects in the regions with the largest density of Roma people. Second, NGOs began to strengthen advocacy efforts in order to enlarge and deepen state programmatic documents and engagements regarding Roma health.

NGO Prevention Efforts Produce Controversial Results

In the last six to seven years, several NGOs have been actively involved in sexual and reproductive health (SRH), including HIV/AIDS prevention programmes, among Roma. ‘Initiative for Health’ Foundation administers a harm reduction and needle exchange project among Roma injecting drug users, and the ‘16 Plus’ Centre offers a day shelter for homeless young people over the age of 16, most of whom are Roma.

Since 1998, BFPA has conducted informational and service provision projects targeted at the Roma population, with special attention to those aged 12-20 years. Additionally, comprehensive SRH centres operate in two urban Roma districts (Sofia and Plovdiv) and one rural district (Dolna Mitropolya, Central North Bulgaria).

In 2002, in collaboration with the Ministry of Health and the World Health Organization (WHO), BFPA opened the first HIV/AIDS voluntary counselling and testing (VCT) centre in a Roma district (Sofia, which has 32,000 inhabitants). This is the only NGO-based VCT centre in Bulgaria; all others are in the state hygiene inspectorates in Bulgaria’s largest cities.



More than one year after the addition of this new service to the range of services offered by BFPA, the results are mixed. There have been no positive HIV tests during this period, and there has been little motivation on the part of the Roma in the area to get tested. The average number of clients who come each month for counselling is 20, and for testing it is five. Also, the ‘16 Plus’ youth centre refers its clients to BFPA for SRH services. Among ten young people who have been referred for VCT and tested (with the help of Medecins sans Frontieres (Doctors without Borders), one was found to be HIV positive. The bottom line is that the service exists, the BFPA team at the Centre attempts to create demand, but the process is slow.

Successful Prevention Requires NGO-Government Partnership

Clearly, NGO’s have an important role to play in HIV/AIDS prevention among the Roma, but the success of these projects requires a joint effort with state health authorities. A major first step toward realizing this goal was made in July 2003 in Budapest, where seven prime ministers from Central and Eastern Europe (including the Bulgarian Minister) signed a programme document entitled “The decade of the Roma inclusion”, which included health as one of its general issues. Now, this development needs to move from paper to reality, which may be difficult due to a recent development related to Bulgarian public health insurance: as of 1 October 2004, two million Bulgarian citizens were removed from the health insurance system. The majority of these people have dual citizenship and so may reside in another country, but among the 700,000 living in Bulgaria, the majority are Roma.

“Health Mediators” Could Bridge Gap between Health Workers and the Roma

Despite the challenges to improving HIV/AIDS prevention among the Roma, there is a reason for optimism. In 2004, a consortium of four Bulgarian NGOs (including BFPA), with financing from the European Union and on behalf of the Ministry of Health, conducted a comprehensive training programme that included sexually transmitted infections and HIV/AIDS as integral parts of the curriculum. Participants included 30 general practitioners, 30 nurses and 50 Roma “health mediators” from 15 Bulgarian cities. The “health mediator” is a new figure on the public health stage and could be the answer to how to motivate Roma people to care about their health and to be the bridge between health specialists and the Roma community. This would represent not only a major step toward curbing HIV infection among one of the most vulnerable populations in Bulgaria, but also proof that NGO-government partnerships for HIV prevention can have a positive impact on people’s lives.

Microbicides – Expanding the Options in HIV and STI Prevention

By **Rebekah Webb**, European Coordinator, Global Campaign for Microbicides

Microbicides are simultaneously one of the most promising areas of biomedical research into HIV and STIs and yet one of the most chronically under-funded. Thanks to growing attention at the 2004 International AIDS Conference and elsewhere, most health professionals have now heard of microbicides - sometimes known as “HIV gels”. Despite growing awareness, however, microbicides are still not well understood, both in terms of what they are and how they might be integrated into existing HIV prevention efforts. The growing media attention and scientific progress has also not changed the fact that microbicide research and development remains desperately under-resourced.

What are microbicides?

‘Microbicides’ are compounds developed to substantially reduce transmission of sexually transmitted infections (STIs), including HIV, when applied either in the vagina or rectum. A microbicide could be produced in many forms, including gels, creams, suppositories, films, lubricants, or in the form of a sponge or a vaginal ring.

How do microbicides work?

There are a number of ways in which a microbicide could work to prevent infection from bacteria and viruses:

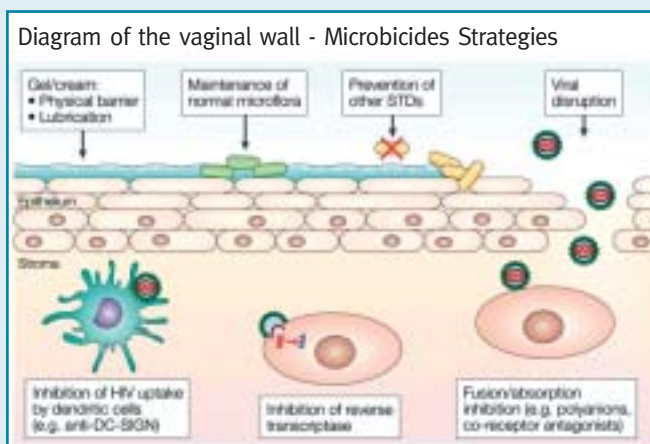
- 1) blocking infection by creating a barrier between the pathogen and the cells lining the vagina or rectum
- 2) boosting natural vaginal defences
- 3) killing or otherwise immobilizing pathogens
- 4) preventing the infection from taking hold after it has entered the body

Ideally, a microbicide would combine two or more of these mechanisms for extra effectiveness. The diagram shows the vaginal wall with HIV entering through a small opening and the range of mechanisms microbicides might use to prevent infection.

Research is already underway to develop microbicide formulations and delivery systems with characteristics that make them easy-to-use and attractive to people. For example, many of the candidates take the form of a clear odourless gel, much like a sexual lubricant, which could be

applied a few hours before sex. A second range of candidates are being investigated which could be inserted even farther in advance. Some time-released delivery systems (such as the vaginal ring) may be capable of suffusing the vagina with an effective dose of microbicide for a period of 3-4 weeks.

Some of the microbicides being developed will also be contraceptive. Many women would like to have a product that can protect them from disease and pregnancy at the same time. But scientists are also working on products that may be microbicidal without being contraceptive. Non-contraceptive microbicides are needed by women and couples who want to conceive a child while still protecting themselves from possible infection - something that is impossible with condoms. Non-contraceptive microbicides will also offer an acceptable protection alternative for women who choose not to use contraceptives for religious or cultural reasons.



Five candidate microbicides are now entering Phase III clinical trials to determine whether any of them can effectively prevent HIV and possibly other STIs. If there are no major delays, the trial results should be available in 3-4 years. If one of these leads proves successful, and if sufficient investment is available to complete the trials, **a successful microbicide could be on the market by the end of the decade.**

However, please note the ‘if’. These large trials still lack funding needed to assure their completion. To date, only a handful of European governments - Norway, the Netherlands, the UK, Ireland and Denmark - have invested in microbicides development. According to pharmaco-economic analysis, at least \$500 million (US) more is needed to ensure that the research moves efficiently toward producing at least one safe, effective microbicide. Most European Union member states have yet to commit resources to this global effort – without them a microbicide may remain a distant dream.

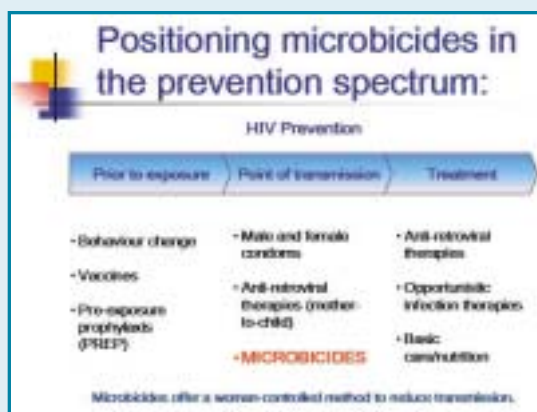
What has the EU done to date?

Over the past 2 years, the European Union has begun to actively support microbicides under its existing HIV/AIDS and research frameworks. Over the past year in particular, under the Irish and Dutch presidencies, the European Commission has given priority to highlighting the role that new prevention technologies including microbicides could play in fighting HIV in the developing world. Within the European Commission's Program for Action (PfA), which began in 2001, the Commission has increased the level of resources for microbicide research, begun to create a supportive regulatory environment for their introduction and established the Developing Countries Clinical Trial Partnership, designed to improve trial infrastructure and capacity on the ground¹. However this is just the beginning of what is needed to ensure that a microbicide becomes a reality. The contribution that microbicides could make to improving the sexual and reproductive health of Europeans has not even been raised.

What role could microbicides play in Europe?

According to the European Commission, the prevalence rate of HIV in some new member states is approaching the highest in the world, with the Baltic states particularly affected. The number of newly reported HIV infections has doubled in western Europe since 1995 and STI rates are rising alarmingly across the EU, as recently reported in the British Journal *Sexually Transmitted Infections*².

Microbicides are designed primarily to stop HIV but many candidate products appear to be “broad-spectrum” – with preventive activity against a range of ‘microbes’ including bacteria and other viruses. Each of the five lead candidates, for example, is expected to be active against either gonorrhoea, chlamydia or both. This “broad spectrum” capability may make the new microbicides particularly useful in Europe.



Lessons from family planning

In the family planning field, we observe that the rate of unintended pregnancies decreases each time a new, acceptable contraceptive option becomes available. More choices are clearly better than fewer choices when it comes to self-protection. As a user-controlled tool that does not interrupt intimacy, microbicides could offer an important new protection option for women and couples who do not or cannot use condoms. As such, they could play a significant role in

improving the reproductive and sexual health of both Europeans those in developing countries. Researchers at the London School of Hygiene and Tropical Medicine have shown that if even a small proportion of women in lower-income countries used a 60% efficacious microbicide in half the sexual encounters where condoms are not used, **2.5 million HIV infections could be averted over three years.** In Europe, microbicides could have a very similar public health impact, if not greater.

No one strategy or technology will “solve” the AIDS pandemic. A pandemic of this magnitude warrants full use of all existing prevention strategies and expansion of our prevention repertoire with new tools.

How can sexual and reproductive health clinics and service providers help?

Service providers and clinics in the European Union are uniquely positioned to raise public awareness about what microbicides are (making clear that these products are not yet available), inform policymakers of the urgent need for them and raise important scientific and ethical questions about how development these new products is proceeding. More importantly, health professionals can add their authoritative voices to the global demand for microbicides and put pressure on their national governments and the European Union to commit further resources at a time when they are critically needed.

The Global Campaign for Microbicides advocates greater investment in research and a community-based demand for new, user-controlled HIV prevention options. The Campaign has made a particular effort to engage European civil society in this effort, and active microbicides advocacy campaigns are now underway in Spain, the Netherlands, the UK, Denmark and Ireland. The Global Campaign invites anyone – individual, service provider, NGO or network – to join the Campaign and get involved. We have a bi-weekly newsletter, GC News, which you can sign up to on our website: www.global-campaign.org.

For more information on how you can join the Global Campaign for Microbicides, contact:

Rebekah Webb, European Coordinator

Global Campaign for Microbicides

Email: rwebb@global-campaign.org - Tel: +32 2507 1221

¹ Second Progress Report on the EC Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, Commission Staff Working Document, 26 November, 2004.
² K. A. Fenton, C. M. Lowndes, the ESSTI Network: Recent trends in the epidemiology of STIs in the European Union, in: *Sexually Transmitted Infections*, 2004, Vol. 80, pp 255-263.
 Vaginal wall diagram appears thanks to Dr. Robin Shattock, St. George's Hospital Medical School, UK.



Young people's involvement in HIV/AIDS prevention is a common goal among international non-governmental organizations (NGOs). Yet it still seems far easier to say than to achieve when it means the sharing of power and authority over project management and design. This article highlights two ways that organizations can make it work: involving young people throughout the project cycle and ensuring the youth-friendliness of their 'business culture'.

Involving Young People in HIV/AIDS Prevention: Ways that Work

By Lise Rosendal Østergaard, Co-ordinator, AIDSNET (The Danish NGO Network on AIDS and Development) and Jeffrey V. Lazarus, Board member, Foreningen Sex og Samfund (Danish member association of IPPF)

The impact of the HIV/AIDS pandemic on adolescents and youth is painfully known by most people involved in sexual and reproductive health and rights (SRHR) programmes. Young people are disproportionately infected and affected compared to adults. With no known cure, it is particularly painful to see a young person's entire life compromised by a preventable, fatal disease when we know that proven, evidence-based prevention efforts work. Although for the past twenty years sub-Saharan Africa has been at the epicentre of the pandemic, parts of the European region are catching up far too quickly, followed by parts of south-east Asia.

According to figures from the United Nations Joint Programme on HIV/AIDS (UNAIDS), 80 per cent of people infected in eastern Europe are under age 25, and countries such as Estonia, the Russian Federation and Ukraine are now experiencing some of the highest increases in new cases in the world. In western Europe, the availability of treatment has made HIV/AIDS endemic, yet these countries are experiencing generalized epidemics of Chlamydia among young people and syphilis among young gay men, indicating a need for improved sexual health promotion efforts.

Fortunately, young people are not only at the core of the problem but also its solution. Given that they are at a critical stage of their lives when they are still likely to change sexual practices and adopt safer behaviours, and that they often have more energy and new energy to address the problems, they need to be fully involved in order to benefit from their inputs. NGOs, with our (ideally) intimate knowledge of the target group, focused niche of interventions and flexible institutional structures, possess all the necessary ingredients to draw upon young people's resources.

That was the concern of the Danish member association of IPPF (Foreningen Sex & Samfund) when it decided to develop a catalogue of ideas for NGOs that wish to confront HIV/AIDS through greater youth involvement. The recommendations are based on inputs from a workshop, held in Copenhagen in 2001, with more than 30 young and adult activists representing NGOs and youth organizations in Armenia, Denmark, Finland, Mexico, the Netherlands, the Philippines, South Africa, Tanzania and Uganda. The workshop aimed at demonstrating some of the participatory methods through self-managed as well as facilitated group work. At the end of the workshop, a group of prominent Danish parliamentarians were invited to a session where they could pose questions to a panel of youth participants.

However, youth participation did not end there. AIDSNET, the Danish NGO Network on AIDS and Development, facilitated the finalizing of the publication, entitled 'Confronting HIV/AIDS through Youth Involvement: A Catalogue of Ideas for NGOs', and consulted the workshop participants throughout the compiling and editing process. The catalogue covers the following subjects:

- How young people perceive barriers to their involvement in HIV/AIDS prevention
- The implications of a rights-based approach to youth involvement
- Communication and sex
- School-teachers' approach to sex education
- Condom use
- Gender stereotypes
- Methods to ensure youth participation through the steps of the project cycles
- Questions to ask in a youth-sensitive process evaluation.

Photo shows a session from the 'People on the Move' project in Dushanbe, Tajikistan 2004

Communication and condoms

The workshop participants identified a number of barriers but dwelled in particular on improved communication on sexual health topics and how to achieve genuine youth participation. Many young people have experienced awkward and embarrassing communication skills with schoolteachers, health care providers and parents. As one of the Finnish NGO workshop participants noted: “talking about young people’s sexuality is very often automatically associated with experimental ‘running around’. How can we as adults understand young people’s sexuality in a broader sense that also includes feelings and love?” Many pointed to the need to upgrade the communication skills of health professionals and schoolteachers, but even more emphasized that peer educators are the most likely to establish a ‘climate of confidence’ that enables communication that resonates with the target group.

Peer education is an approach that is so widely used by NGOs today that participants from the African continent were able to share their experiences with those from eastern Europe and Asia. Danish peer educators told about their struggle with developing what they refer to as ‘an unbiased approach to condom promotion’ in classroom dialogue sessions with students. Everyone wants to promote the consistent and correct use of condoms to avoid sexually transmitted HIV transmission as a part of primary and secondary prevention. Yet, all agreed that this is not done by simply passing on health-related information about condoms. Instead, the Danish peer educator said that they try to include sexuality in their sessions on condoms in which they “...try to create a dialogue with the participants on the pros and cons of condom use. Brainstorming can be one way. Instead of having young people tell what they expect you to want to hear, you can ask them to recall or imagine some issues that are involved in condom use”. Peer educators from the Mexican Family Planning Association have gone even further by adopting an approach where they reframe prevention and “focus on prevention as a part of the eroticization of the act”.

Participation rights and responsibilities

Given that HIV/AIDS prevention is a complex public health problem that intimately involves stigma, sexuality, marginalization and gender issues, knowing the target group is vital. In this sense, participation by young people at the levels of idea development, preparation, implementation, monitoring and evaluation was perceived as a means and a goal in itself by the workshop participants.

Participation and youth involvement are key concepts for many NGOs, but to move beyond the rhetoric and achieve meaningful participation, the same organizations must be ready to look inward, assess and be willing to change their communication forms, practices and priorities. This is particularly important if an NGO decides to work with peer educators to ensure that they are partners in the project. It is a common assumption that youth organizations –

whether they are political, cultural, sport- or health-oriented – by definition are youth-inclusive. However, this is not always the case. In addition, it is often the most vocal and experienced young people who are in strategic positions and participate in important meetings. It is therefore useful to assess the level of youth participation in your own organization.

If young people are only token representatives at high-level meetings or if only certain groups of young people are involved, it might be time for an organizational check up. The ‘Ladder of Participation’ shown below provides a simple tool for NGOs that want to rank the levels of participation of young people in a given project.

The ladder of participation: a tool for assessing and promoting the participation of young people

Value	Levels of participation
8	Youth-initiated, shared decisions with programme managers
7	Youth-initiated and directed
6	Programme manager directed, shared decision with youth
5	Youth consulted and informed
4	Youth assigned but informed
3	Tokenism
2	Decoration
1	Manipulation
0	No participation
Additional questions	Who gets to participate? (Equity checks according to sex, age, social status, urban/rural setting, HIV status, education level, etc.)

Source: Rajani RR. (2001) *The Participation Rights of Adolescents: A Strategic Approach*, UNICEF Working Paper Series

“Confronting HIV/AIDS through Youth Involvement” is a helpful resource on the ways that young people can be involved in HIV/AIDS prevention projects. In addition to concrete examples of relevant activities, it offers insight into the different structural levels where young people can be involved, the timing of their interventions and a hint of the relative cost of their involvement.

The catalogue has been published with technical and financial support from AIDSNET, the Danish NGO Network on AIDS and Development. For information on how to receive a copy, please contact the Danish member association of IPPF at info@sexogsamfund.dk or telephone +45 (33) 931 010.

Although major gains have been made in Western Europe to prevent mother-to-child transmission of HIV, the possibility for a safe 'positive' pregnancy in Russia is still out of reach for many women. Staff members from AIDS Foundation East-West (AFEW) recount their success in working with the Russian government to address the need for prevention during pregnancy, but also highlight the unmet need that remains.



Hope for 'Positive' Pregnancy in Russia

By Amy Paton Walsh and Julie Dixon, AIDS Foundation East-West

Twenty-five year-old Nina, who is from the Moscow region, discovered she was HIV-positive three years ago. Soon after, she was surprised to learn that it was possible for her to get pregnant and give birth to a healthy child. Nina became pregnant almost one year later and in May 2003 gave birth to a healthy, HIV-negative girl. As Nina discovered, preventing mother-to-child transmission (known as PMTCT) is not only possible, but involves only a few simple steps.

"All you need to do is make sure you've found out everything you need to know, including whether or not your region can provide the appropriate services for a 'positive' pregnancy, and then follow the guidelines religiously," says Nina.

Simple things like choosing a caesarean section over natural delivery, receiving the right antiretroviral drugs during pregnancy, and making sure the baby is given antiretroviral drugs within three days of birth can ultimately save the child's life. It is also important to provide the baby with an alternative to breast milk so as to avoid HIV transmission during breast-feeding.

As straightforward as these steps are, though, the rate of mother-to-child transmission in the former Soviet Union is increasing rapidly. The registered number of children living with HIV/AIDS in Russia was just six in 1996¹, but as of June 2004 had risen dramatically to 9,918. Today, 19% of babies born to HIV-positive mothers in Russia have HIV. This is compared to a rate of only 2% in Western Europe, where mother-to-child-transmission Plus (MTCT-Plus) programmes – an expanded approach that also includes care for the mother after the child's birth – have been using triple-dose antiretroviral drugs since 1997.

The reason for the increased (and increasing) rates in Russia is simple: many HIV-positive women are not as fortunate as

Nina – they are unable to access the appropriate information or treatment during pregnancy and birth. Russia has been slow to adopt the World Health Organization's guidelines for PMTCT of HIV, and PMTCT is not yet a regular part of healthcare services. Currently, many women considered to be at 'high risk' – which include drug users and sex workers – do not seek prenatal care because they do not trust the medical system and fear they may be judged or even punished for their lifestyle. These same reasons also mean that they often do not have regular HIV tests, preferring to ignore the risks rather than face the potential stigma associated with AIDS. The sad fact is that their fears are often justified as the medical system discriminates against people living with HIV/AIDS and groups that are at most risk because of a lack of information. The majority of HIV-positive pregnant women in the Russian Federation find out about their HIV status only when they are about to give birth. At that stage only one option is left: a single dose of the drug Nevirapine for the mother during labour coupled with further medical treatment for the child. This can be effective in preventing transmission, but, sadly, the resources needed to do this are unavailable in many regions of the country.

Civil Society Partners with the Russian Government to Help HIV Positive Women

In an environment where civil society is still emerging, the non-governmental organization (NGO) *AIDS Foundation East-West (AFEW)* has taken major steps towards addressing the urgent needs of HIV-positive pregnant women in Russia. *AFEW* launched an ambitious PMTCT pilot programme in five regions in Russia in January 2003, which is a first-of-its-kind partnership with the government in the Russian Federation. This three-and-a-half-year programme includes elements gleaned from a previously successful project conducted by *Médecins sans Frontières* in Odessa, Ukraine.

¹ Federal AIDS Centre, Russian Federation, June 2004 report
Photo appears courtesy of AIDS Foundation East-West

The ultimate goal of the programme is to prevent HIV transmission from women living with HIV/AIDS to their (unborn) children. To accomplish this, *AFEW* has formed partnerships with key players in the national and local health infrastructures, as well as with NGOs, to establish a model programme that can later be continued by the Russian Ministry of Health. The programme received funding from the Dutch Postal Lottery, the Dutch AIDS Fund and the Dutch Ministry of Foreign Affairs.

In addition to increasing safe delivery practices for pregnant women living with HIV/AIDS and training medical staff on international standards for PMTCT in antenatal and maternity clinics, the programme also includes counselling parents-to-be about prevention at family planning clinics. Through the distribution of informational materials on HIV/AIDS-related issues, women and their partners can learn about contraception and overall sexual and reproductive health.

The programme also includes a training module for medical professionals which deals with everything from appropriate treatment of infections stemming from HIV to pre- and post-HIV test counselling. Drugs and other medical resources are also a key component of the programme, providing for proper medical intervention for both mother and child and guaranteeing the safety of health care personnel. For example, rapid tests ensure that women who have not been tested prior to or during pregnancy can have an instant diagnosis before going into labour. Healthcare workers who may be exposed to blood during the labour procedure are given drugs to reduce the chances of infection. Biseptol syrup prevents pneumonia for the newborn, and Nevirapine during labour and milk formula for the first six months of life can decrease the risk of HIV transmission to the infant to as low as 2 %.

Finally, in an attempt to strengthen support among and between women living with HIV/AIDS, peer counselling and self-help groups have been set up.

Building a support network for women living with HIV/AIDS

Nina attended her first peer counselling training with *AFEW* in October 2003, when her child was already four months old.

“This training was important for me not only because of the information I got out of it, but because it gave me the feeling of belonging to a community,” said Nina.

The training aimed to find peers who could also be counsellors, visit family planning, maternal and antenatal clinics, and reaching out to women living with HIV/AIDS.

Participants sharpened their knowledge on how pregnancy is affected by HIV, what methods are taken to prevent disease transmission to the child, and how best to carry out family planning before or after learning of a positive HIV diagnosis.

“HIV-positive women need information. Doctors can't provide you with all the information you need because they don't have time and they often talk in a medical vocabulary that you don't understand,” said Nina.

Can Services Expand as Fast as the Epidemic?

So far, *AFEW* has developed its PMTCT programme in only five of Russia's 89 regions: Kazan, Chelyabinsk, Omsk, Irkutsk and Penza. In August of this year, it began preliminary work for nine other regions of Russia where HIV is spreading at a high rate, with funding coming through the Global Fund to Fight AIDS, Tuberculosis and Malaria, to which *AFEW* applied with a consortium of NGOs. Money from the Global Fund will be used for everything from advocacy for anti-retroviral price reduction to work with street children to mass media campaigns. Importantly, it will also allow *AFEW* to expand its model of PMTCT in Russia so that is an MTCT-Plus programme, which will reach out not only to pregnant women but to their affected infants and family members. This expanded programme aims to put high-risk women in care early in their pregnancy and will provide for significantly increased drugs supplies.

On the one hand, Russia has a huge advantage in the task it faces because it is entering the fight against the HIV/AIDS epidemic at a point when triple-therapy drugs have been developed and are already in wide use globally, which means that the disease is already chronic rather than fatal.

However, if Russia does not step up to the challenge of implementing programmes such as MTCT-Plus in all of its 89 regions, it faces dire consequences. Earlier this year, the World Bank estimated that combined HIV, tuberculosis and drug-use epidemics will reduce the Russian workforce by 900,000 by the year 2005. And according to UNICEF, “Increasingly, HIV/AIDS is affecting women, with rates of heterosexual transmission and the numbers of children born to HIV-positive mothers both steadily growing. The problem of care for these children becomes more acute as their numbers increase.”² While these predictions seemed implausible to many just a few years ago, the reality is much closer than most people would like to believe. It remains to be seen if efforts to prevent the spread of HIV in the Russian Federation will keep up with the growing epidemic.

² <http://www.unicef.org/infobycountry/russia.html>

AIDS Foundation East-West (AFEW) was founded in January 2001 with support from Médecins Sans Frontières – Holland, Open Society Institute and the Dutch government to fight HIV/AIDS in Eastern Europe and Central Asia. *AFEW* works in six programme areas:

- Harm reduction trainings
- Pre- and post-HIV test counselling
- Prevention of mother-to-child-transmission of HIV
- HIV prevention and health promotion among sex workers
- Mass media campaigns on safer sex and solidarity with people living with HIV/AIDS
- HIV prevention and health promotion in prisons.

AFEW works in the Russian Federation, Ukraine, Belarus, Moldova, Kazakhstan, Uzbekistan, Tajikistan, Kyrgyzstan and Mongolia. It has more than 160 employees and offices in Moscow, Kyiv, Almaty, Dushanbe, and Tashkent.



Russian Health Providers' Perspectives on HIV/AIDS

By Neill McKee - Chief of Party, Healthy Russia and Elena Dmitrieva - Executive Director, Healthy Russia Foundation

Since 2000, Russia has become a country with one of the fastest growing rates of HIV/AIDS in the world. With the rate of infection rising dramatically among all sectors of society, the impact on the resources and expertise of the Russian medical community is great. Neill McKee and Elena Dmitrieva report on a study which examined Russian health care providers' knowledge, attitudes, and practice in respect to HIV/AIDS.

Over the past four years Russia has officially registered over 260,000 cases of HIV/AIDS, and of these cases, between 70-80% were transmitted via intra-venous drug use (IDU). However, while IDUs are currently driving the epidemic, evidence suggests that other sectors of society are increasingly affected. The rate of sexual transmission of HIV has increased five-fold in the last three years from 4% to approximately 20%. The majority of new cases are now occurring in males aged 18 to 25, but high risk groups experiencing these growing rates also include commercial sex workers (CSWs), men having sex with men (MSM), children in orphanages, people living with HIV/AIDS (PLHA), pregnant women and young people. If

preventative measures are not taken, the World Bank estimates that by 2020 there will be 5.36 million HIV cases in Russia. However, if rates continue to accelerate ever higher, the number of infected individuals could be as many as 14.53 million.

To try and combat this epidemic, a number of international projects have been set up in Russia. The United State Agency for International Development (USAID) funded "Healthy Russia" Project is being implemented by the 'Center for Communication Programs' of John Hopkins University's Bloomberg School of Public Health. It is focused on behaviour change communication

strategies, advocacy activities, social mobilization and capacity building of service providers, peer educators, facilitators and teachers. One of the formative studies undertaken for the programme was the analysis of Russian health care providers' knowledge, attitudes, and practice concerning HIV/AIDS. The research data was collected through twenty in-depth interviews with gynecologists, therapists, pediatricians and surgeons working in regular public health care services in the Central Federal and Povolzsky Federal regions of the Russian Federation. The results of this research have been used to develop different materials and training programmes for health providers to improve HIV/AIDS-related services. The summary below provides an overview of the results.

Knowledge of HIV infection

The results concluded that health care providers demonstrated a good knowledge of HIV-infection symptoms and epidemiological trends. Surgeons and gynecologists, compared to other health care professionals, were more aware of the risk of HIV-infection. They were also more careful in the application of HIV infection preventive measures on the job. Many health care professionals thought that some protective means were ineffective. For instance, many surgeons interviewed believed that rubber gloves could not fully protect them from HIV infection.

Attitudes to confidentiality

All health providers participating in the interviews supported the importance of observing confidentiality of diagnosis. They realized that disclosure of the diagnosis may result in dramatic consequences for the patient - infringement of rights and psychological trauma. They agreed that it is a patient's right to decide whether to let the family know about the disease or not. However, some also believed that the patient's family should be informed if the patient belongs to a high risk group.

The results also demonstrated that medical providers thought that it was acceptable to circulate information about HIV-positive patients within the clinic among their colleagues so that they can take precautions against infection. They did not regard discussion of HIV-positive cases with their colleagues as the disclosure of confidential information. The research revealed that those interviewed had various ways of keeping records on HIV-infected patients (in a separate room or in the registration office; in the form of a separate list or specific labeling of medical files).

Attitudes to those who are HIV-positive

It was discovered that the majority of those interviewed associated HIV-positive people with deviant groups such as drug users, homeless people, men who have sex with men, sex workers or people with erratic sexual contacts. However, many also understood that HIV infection is not necessarily determined by deviant behaviour, and those people who became HIV-positive through blood

transfusions, organ transplantations, or medical providers infected through medical manipulations were often viewed as victims of HIV-infection.

Despite the tendency to associate HIV-positive people with deviant groups, health providers believed that their attitude to HIV-positive individuals did not differ substantially from their attitudes to other patients. Many declared that they had no prejudice because their professional duty and training did not allow this. Some also said that HIV-infected patients aroused their pity, especially children who were perceived as innocent victims. Nevertheless, there was still a prevailing attitude among some that HIV-positive clients were uncooperative or incapable of adhering to treatment: e.g. they cannot follow doctors' prescriptions, or do not want to get examined. They viewed HIV-positive patients as unwilling to communicate, and that they deny their own problems in communicating with them.

Many respondents felt an inner conflict due to the fact that, on the one hand, their knowledge about HIV infection shows that their risk of infection is personally very low, but on the other hand, they still fear becoming infected. The growing probability of working with HIV-positive patients due to the current trends of the HIV/AIDS epidemic in Russia appears to be leading to greater reluctance to work with those affected.

Communication and counselling practice

Health providers reported that they usually informed clients on HIV-negative results of the test but do not provide them with further information on protecting themselves against HIV/AIDS.

They showed a general reluctance to inform patients on positive results of HIV tests since they considered this to be a "complicated" issue, possibly involving psychological trauma, which would call for special qualities and training beyond the scope of their present duties and capabilities. Most of those interviewed mentioned that in the case of HIV-positive tests, the patient would be asked to go to special HIV/AIDS centres to receive the results.

In conclusion, it is clearly evident that the Russian medical community needs greater knowledge on HIV/AIDS, education on safety precaution, and stronger in-house regulations to deal with HIV/AIDS patients. Given the lack of statutory acts in medical centres, the study identified a significant variety in health care providers' patterns in dealing with HIV patients. There is also strong evidence of violation of confidentiality by health providers.

The research has noticeably demonstrated the necessity of the further development and implementation of legislation and policy on Voluntary Counseling and Testing for HIV in Russia, both at the Federal and regional levels. This especially includes the need to provide better communication and counselling training for many levels of health care providers geared to reducing stigma of and discrimination towards HIV-positive patients.

AIDS NGOs in Central and Eastern Europe Face Multiple Obstacles to Fighting the Epidemic

An examination of community-based HIV/AIDS NGOs in Central and Eastern Europe reveals rock-solid dedication, sharp expertise and a willingness to innovate on many levels. Despite these characteristics, though, local organizations in the region face fundamental obstacles to helping prevent infection and care for those infected. The Coordinator of the pan-European coalition *The Integration Projects* details the idiosyncrasies of HIV/AIDS in the region, the challenges for local NGOs and how governments and donors must strengthen civil society in order to arrest the epidemic.

By Arnaud Wasson-Simon, Coordinator of the AIDS ACTION and INTEGRATION Projects, AIDES (France)



Needle exchange project, Romania, 2004

The Integration Projects

Formed by the French NGO AIDES, AIDSi-Tugikeskus in Estonia, ARAS in Romania, BADZ Z NAMI in Poland, along with other partners, in 2001, The Integration Projects (www.integration-projects.org) aims to support the development of local HIV/AIDS non-governmental organizations (NGOs) in Central and Eastern Europe¹.

Its mission is to ensure that each country of the enlarged European Union and the newly independent states in Eastern Europe has at least one reliable and trusted NGO offering high-quality prevention and health support to people living with HIV/AIDS and members of vulnerable communities.

In partnership with AIDS ACTION EUROPE (the pan-European NGO partnership on HIV and AIDS), EATG (the European AIDS Treatment Group), CEE-HRN (the Central and Eastern European Harm-Reduction Network) and with the financial support of the European Commission, The Integration Projects are initiating the AIDS ACTION and INTEGRATION projects. Over the next three years, the coalition will pool the best pan-European expertise it has on HIV/AIDS to strengthen the quality of prevention and support services that are provided in the ten new EU member states and the three candidate countries (Bulgaria, Romania, and Turkey).

¹ MANIF 2000 – French cohort of HIV Positive People who became contaminated through intravenous drug use: Marseille, Avignon, Nice, Ile de France - Y. OBADIA - 2002 – ANRS - www.anrs.fr
Photos courtesy of www.integration-projects.org

Eastern Europe Confronts the World's Fastest-Growing Epidemic

Since 1998, countries in Eastern Europe (including Estonia and Latvia, which joined the European Union in 2004) have been affected by what UNAIDS, in 2001 and 2002, called the fastest growing epidemic worldwide. Until now, this Eastern European epidemic has affected primarily intravenous drug users (IDUs) who share needles (90% of all cases, UNAIDS 2002). However, today, the number of infections from unprotected heterosexual intercourse is increasing (+32% between 2001 and 2002, according to EuroHIV). Until recently, there have been very few reported cases of HIV among men who have sex with men in the region, but this may be due to "the social vulnerability of homosexual and bisexual men" (EuroHIV 2003), who are reluctant to disclose their sexual orientation, even to health practitioners.

The World Bank predicts that in Russia, "without preventive policies or treatment" implemented now, HIV/AIDS will cause the GDP to decrease 4.15 percent by 2010. In the report "The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China" (released in September 2002), the US National Intelligence Council and the CIA predict that in Russia between 6% and 11% of the adult population will be living with HIV/AIDS in 2010: "in Russia, the rise in HIV/AIDS will exacerbate the population decline and severe health problems already plaguing the country, creating even greater difficulty for Russia to rebound economically".

Overall, in *Reversing the Epidemic*, released in February 2004, the UNDP assesses:

HIV/AIDS may not be poised to devastate the region entirely. But the epidemic in many countries – particularly Russia, Ukraine and Estonia – has progressed too far to be decisively defeated in the short and medium term. Latvia, Belarus and Moldova are too close to the danger zone for comfort. Like millions of its citizens, the countries of the Western CIS and the Northern Baltics – which together comprise more than half the region's population – will have to learn to live with HIV/AIDS.

Lack of access to antiretroviral treatments persists and is causing alarm among many in the region: WHO assessed in December 2003 that approximately 67,000 persons already need anti-HIV treatments in Eastern Europe – and less than 6% of them are actually receiving them. Medical practitioners in the region remain reluctant to provide treatments to drug users because they believe that drug users are not capable of complying with the strict treatment regimen that is required. By so doing, they ignore international studies that have fully demonstrated that drug users who have access to substitution treatments such as methadone or buprenorphine are, in

reality, perfectly capable of maintaining adherence to anti-HIV treatments. As a matter of fact, a French study showed that drug users taking buprenorphine had a better adherence to anti-HIV medication than even former drug users¹.

Central Europe Has Low Prevalence but Faces a Looming Threat

In Central Europe, thankfully, most countries remain far less affected by HIV than either Eastern or Western Europe. In the latest epidemiological report published by EuroHIV, the rate per million of newly diagnosed HIV infections for Central Europe in 2002 is 7.8, to be compared with 76.1 for Western Europe and 222.5 for Eastern Europe. In this region, Romania stands out with a very specific epidemic affecting perhaps up to 9,000 children contaminated through unsafe practices in the healthcare setting in the late eighties and early nineties. Today, many of them are in their teens and are likely to become sexually active yet remain poorly informed about HIV and prevention, which could contribute to the further spread of HIV in Romania (source: meetings with the NGOs Romanian Angels Appeal and ARAS, in Bucharest, January 2002).

With the striking exception of Poland, which has 4,856 reported cases of HIV among drug users, the number of drug users infected with HIV across Central Europe remains very low at between 1 and 104 cases for all 13 of the remaining countries. The explanation for these low numbers in Central Europe may well be a matter of luck: so far, the drug injecting population in most of Central Europe has simply not yet been in contact with HIV.

If some countries have acted early to prevent HIV from spreading among injecting drug users (IDUs) (notably Slovenia and the Czech Republic, which started needle exchange projects as early as 1992), there remains a very dangerous lack of commitment on this issue across the region (source: EMCDDA). In Romania for instance, ARAS (The Romanian Association against AIDS) and its partners from the Romanian Harm Reduction network advocate very strongly in favour of the urgent development of needle-exchange services for drug users.² ARAS recently interviewed 500 drug users for a study and found that more than half had shared injection equipment within the past month: clearly, unless comprehensive harm-reduction services are implemented, Romania is very likely to face a major outbreak of HIV among drug-users very soon.

Government Trust and Support Needed to Strengthen Local NGOs

The first phase of the Integration Projects from 2001 to 2004 included country missions designed to assess, from a non-governmental perspective, the situation regarding HIV/AIDS in seven EU accession countries. Quite clearly, local HIV/AIDS NGOs in Central and Eastern Europe face a range of similar

¹ Study of the health needs of drug-users in Romania, carried out by Catalina Iliuta and Emil Pislaru as part of the Integration/SAFER IDUS project with funding from EC/DG ENLARGEMENT.
² "Central Europe" and "Eastern Europe" as used in this article correspond to their use by EuroHIV for its epidemiological reports (www.eurohiv.org).

issues. For example, getting acknowledged by national authorities remains very difficult, and the very right to organize as an NGO remains quite recent in former communist countries. In many cases, governments remain suspicious of independent organizations, which can, at times, be openly critical about shortcomings in terms of HIV/AIDS prevention and support. Furthermore, many NGOs must depend upon international funds in order to be able to carry out their work: they must strike a difficult balance between the evolving priorities of international foundations and the needs of the people they serve. Most of the time, only short-term projects get funded, which obliges the members of these NGOs to spend a huge amount of time writing grant applications and reports.



The Integration Project office in Romania

Within only five years, Estonia has become the European country with the highest HIV prevalence. For the NGO AIDSi-Tugikeskus, the government holds its share of responsibility for letting this happen. In 1996, before the HIV crisis, Estonian activists warned that drug users in Estonia were sharing needles regularly – many were already contaminated with Hepatitis C. HIV, they said, could spread very rapidly. But, as Nelly Kalikova, a deputy in the Estonian Parliament, explains, “The Estonian government never considered HIV to be a priority.” Today, many new HIV services, including harm-reduction services for drug users, are being implemented thanks to a grant provided by the Global Fund to fight AIDS, Tuberculosis and Malaria. The main challenge, though, is to make sure that the Estonian government will be willing to sustain these services once the Global Fund grant expires.

Nearby Latvia is primarily affected by a similar large increase in HIV infections, which affects primarily young drug users. But, unfortunately, Latvia missed its chance to apply for funding from the Global Fund and must now rely mostly on its own resources to respond to the HIV epidemic. Ruta Kaupe, director of the DIA+LOGS NGO, deploras especially that there is barely any coordination at the national level on HIV/AIDS: local NGOs work very independently from one another, each competes with the others to secure funds, and they often end up implementing overlapping projects while most urgent needs are still not covered. The recent entry of Latvia into the European Union has in fact been detrimental to local NGOs as many international foundations have left Latvia assuming that the European Commission would prove a reliable supporter of local civil society. But so far, this has not been the case.

Fortunately, some governments have proved to be far more responsible with regard to the HIV epidemic. In the Czech

Republic, for instance, a national HIV/AIDS forum that includes NGOs, people living with HIV and governmental representatives defines priorities every year and attributes funds for both governmental campaigns and NGO services. Since 1999, the Czech AIDS Society has been running the Lighthouse in Prague, which provides a range of services for people living with HIV/AIDS, from temporary residence to psychological support. Also, the NGO Sananim has been carrying out harm-reduction services for drug users for more than ten years. Yet the governmental funds attributed to HIV/AIDS have been dangerously decreasing over the past eight years.

The NGO Roskos, which works especially with sex-workers, observes that there is an alarming problem regarding sexually transmitted infections, especially among Ukrainian sex-workers (from six cases of syphilis in 2001 to 47 in 2003). The Czech Republic should, therefore, pay close attention to the health situation of non-documented residents and should facilitate their access to essential health treatment and prevention services.

“...this is a strategic moment for the response to AIDS in Europe and Central Asia. We have the choice between two paths: the path of inaction and half-hearted measures leading to more suffering and societal losses. The other path is that of resolutely confronting the epidemic.”

Dr Peter Piot, UNAIDS Executive Director and United Nations Under Secretary-General, Dublin, February 2004

Renewed Commitment by the European Union Inspires Hope

At the Conference “Breaking the Curve: Fighting AIDS in Europe and Central Asia”, organized by the Irish presidency of the European Union in February 2004, European governments took into account the scope of the HIV catastrophe now unfolding in Eastern Europe. They pledged to “promote strong and accountable leadership at the level of our Heads of

State and Government to protect our people (...) promote human rights (...) and ensure access to education, information and services for all those in need”. One concrete outcome was the European Commission’s release of the working paper “Coordinated and integrated approach to combat HIV/AIDS within the European Union and in its neighbourhood”, in Vilnius in September 2004. This document presents key initiatives that the European Commission intends to undertake. Notably, key financial instruments of the European Union such as the Public Health Programme, the Structural Funds as well as the TACIS programmes (for the newly independent states in Eastern Europe and Central Asia) will all include HIV/AIDS as a priority. HIV/AIDS NGOs in Europe absolutely welcome this renewed commitment from our European Institutions. We hope that the European Union will prove most assertive with its Member States, the three accession countries and its “new neighbours” in Eastern Europe in encouraging forceful national responses to HIV/AIDS that include access to quality care, treatment and prevention as well as closer cooperation with local civil society. Because ultimately, national governments are responsible for protecting and promoting the health of their citizens.

IPPF's tools and guidelines on HIV/AIDS

IPPF was present at the **2004 International AIDS Conference**, 'Access for All', giving talks, holding workshops and providing publications and information about its work in HIV and AIDS. All resources provided by IPPF at this conference are available at <http://new.ippf.org/ContentController.aspx?ID=1521>

The **IPPF HIV/AIDS mainstreaming checklist and tools**



has been developed to better enable the IPPF Member Associations to mainstream HIV/AIDS into all aspects of their work at the grassroots level. Using simple tools and a checklist such as these can enhance HIV/AIDS mainstreaming efforts – ensuring that processes are systematic and practical. The toolkit is available in PDF at

<http://new.ippf.org/ContentController.aspx?ID=2622>

Integrating Voluntary Counselling and Testing: Guidelines for programme planners, managers and service providers aims to provide sexual and reproductive health programme planners, managers,

and providers with the information necessary to integrate voluntary counselling and testing (VCT) for HIV/AIDS within their services. Available in PDF at <http://content.ippf.org/output/ORG/files/2438.pdf>

HIV/AIDS: Learning from the Field

A publication containing examples of the recent work that IPPF's Member Associations have been doing to promote the prevention of sexually transmitted infections and HIV/AIDS and to respond to the extreme need for care associated with AIDS. Available at:



www.ippf.org/resource/HIV_learning_field.htm

Dreams and Desires is a collection of courageous women's voices that highlight what it means to be a sexually active HIV positive woman. The experiences and observations from these women's stories provide a basis for the design and development of appropriate, integrated sexual and reproductive health services for women living with HIV. Available in PDF at <http://content.ippf.org/output/ORG/files/5306.pdf>

European HIV/AIDS networks and organizations

To get an overview of the **HIV/AIDS organizations in different European countries**, you can search the aidsmap annual online directory of AIDS service organizations available at www.aidsmap.com/en/orgs

AIDS Action Europe: the Pan European NGO Partnership on HIV and AIDS is a new partnership between European non-governmental AIDS-related organizations which was launched at the Open Forum on AIDS Action in Europe on 22-23 March 2004. For information on AIDS Action Europe and/or how to become a member, partner or sponsor, please visit www.aidsfonds.nl/AIDSActionEurope

European Network of HIV positive people (ENP+) is the European partner organization of the Global Network of People living with HIV/AIDS (GNP+) that aims to improve

the quality of life of people living with HIV/AIDS. For more information, visit www.gnpplus.net/regions/europe

The European AIDS Treatment Group is a growing group of treatment activists from 28 European countries. Its mission is to achieve the fastest possible access to state of the art medical products and devices, and diagnostic tests that prevent or treat HIV infection or improve the quality of life for people living with HIV, or at risk of HIV infection. Find out more at: www.eatg.org

The Global Coalition on Women and AIDS is a movement which aims to raise the visibility of issues related to women, girls and AIDS and lead to concrete, measurable improvements in the lives of women and girls. Find out more at <http://womenandaids.unaids.org/>

Resources

Basic information and statistics on HIV/AIDS

All IPPF European Network Member Associations run HIV/AIDS information, education and communication (IEC) programmes. To find out about their programmes and/or to obtain **IEC material developed by MAs of the IPPF European Network**, contact them by email or consult their website at: www.ippfen.org/site.html?page=9&lang=en

AVERT, an international HIV and AIDS charity based in the UK, aims at AVERTing HIV and AIDS worldwide. It emphasises HIV/AIDS prevention, and gives support for HIV-positive people. For more information, visit www.avert.org

The Joint United Nations Programme on HIV/AIDS, **UNAIDS**, is the main advocate for global action on the epidemic. UNAIDS' **AIDS epidemic update** and **Report on the Global AIDS Epidemic** can be found on the website: www.unaids.org.

EuroHIV co-ordinates the surveillance of HIV/AIDS in the WHO European Region. Making **European HIV/AIDS**

surveillance data freely and widely available is their key purpose. HIV/AIDS Surveillance in Europe is the title of its free half-yearly report. The surveillance reports can be consulted in PDF at www.eurohiv.org

The following articles provide a summary of the main trends of the HIV/AIDS epidemic in Europe based on the latest data collected by EuroHIV:

Hamers FF, Downs AM. **The changing face of the HIV epidemic in western Europe: What are the implications for public health policies?**

http://pdf.thelancet.com/pdfdownload?uid=llan.364.9428.review_and_opinion.30152.1&x=x.pdf

Hamers FF, Downs AM. **HIV in central and eastern Europe.**

<http://image.thelancet.com/extras/02art6024web.pdf>

Non-IPPF publications

HIV/AIDS, Sexual and Reproductive Health: intimately related (*Reproductive Health Matters, Vol. 11, N° 22, November 2003*)

The aim of this issue of RHM is to raise awareness of the intersections between HIV/AIDS and sexual and reproductive health and rights and how these should be reflected in national policies and programmes.

Similar to others, yet different in many ways. HIV/AIDS prevention from a cultural diversity approach (*NIGZ, 2003*)

Compiled by a network of European experts, this book, published by the European Information Centre AIDS & Youth, offers some new perspectives on HIV/AIDS prevention and sexual health promotion with young people.

HIV/AIDS in Eastern Europe and the Commonwealth of Independent States. Reversing the epidemic: facts and policy options (*UNDP Bratislava, 2004*)

This report includes the first comprehensive survey of the HIV/AIDS epidemic in 28 countries in East and

South-Eastern Europe, the Baltic and the Commonwealth of Independent States (CIS). Available at:

<http://www.undp.sk/hiv/files/HIV%20AIDS%20intro%201.pdf>

What is it like to have HIV in Europe? (*EMHF, 2005*)

The European Men's Health Forum (EMHF) is conducting a Europe-wide HIV-related quality of life survey of both men and women. Any HIV-positive adult (over 18 years old) residing in one of the European countries can take part in this survey.

The survey is available in English, German, Spanish French and Italian and can be completed online until March 2005 at www.emhf.org/index.cfm/item_id/162

HIV, Health and your community: a guide for action (*UNAIDS, 2001*)

This practical manual is aimed at health workers, social workers, and educators confronting the epidemic in their communities. The full text of the guide can be downloaded from www.eldis.org/static/DOC12582.htm

IPPF EUROPEAN NETWORK

UK Registered Charity No: 250816

Registered in Belgium as an international NGO, No: 4008/2000

IPPF EN has consultative status with the Council of Europe and Special Consultative Status with the Economic and Social Council of the United Nations



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ALBANIA

Albanian Center for Population and Development

email: afpa@albaniaonline.net

ARMENIA

'For Family and Health' Family Planning Association of Armenia

web: www.armfha.com

email: armfha@netsys.am

AUSTRIA

Österreichische Gesellschaft für Familienplanung (ÖGF)

Ignaz Semmelweis Frauenklinik

web: www.oegf.at

email: office@oegf.at

BELGIUM

Fédération Laïque de Centres de Planning Familial (FLCPF)

web: www.planningfamilial.net

email: flcpf@planningfamilial.net

Sensoa

web: www.sensoa.be

email: info@sensoa.be

BOSNIA AND HERZEGOVINA

APP-XY - Family Planning Association of Bosnia and Herzegovina

email: bhfpa.xy@bih.net.ba

BULGARIA

Bulgarian Family Planning and Sexual Health Association (BFPA)

web: www.bfpa-bg.org

email: bfpa@online.bg

CYPRUS

Family Planning Association of Cyprus (FPAC)

email: famplan@spidernet.com.cy

CZECH REPUBLIC

Společnost pro plánování rodiny a sexuální výchovu (SPRSV)

email: planrod@centrobox.cz

DENMARK

Foreningen Sex & Samfund

Skindergade 28 1. sal

web: www.sexogsamfund.dk

email: danish-fpa@sexogsamfund.dk

ESTONIA

Eesti Pereplaneerimise Liit (EPPL)

web: www.amor.ee

email: eppl@amor.ee

FINLAND

Väestöliitto

Iso Roobertinkatu 20-22A

web: www.vaestoliitto.fi

email: central.office@vaestoliitto.fi

FRANCE

Mouvement Français pour le Planning Familial (MFPF)

web: www.planning-familial.org

email: mfpf@planning-familial.org

GEORGIA

HERA XXI (FPAGEO)

email: ntsul@caucasus.net

GERMANY

PRO FAMILIA Bundesverband

web: www.profamilia.de

email: international@profamilia.de

GREECE

Family Planning Association of Greece (FPAG)

email: HellenicFPA@hotmail.gr

HUNGARY

Magyar Család- és Nővédelmi Tudományos Társaság

Keleti Karoly u. 5)-7

web: www.szexinfo.hu/

email: arpad.meszáros@office.ksh.hu

ICELAND

Fræðslusamtök um kynlíf og barneignir (FKB)

web: www.mmedia.is/fkb

email: fkb@mmedia.is

IRELAND

Irish Family Planning Association (IFPA)

web: www.ifpa.ie

email: post@ifpa.ie

ISRAEL

Israel Family Planning Association (IFPA)

web: www.opendoor.org.il

email: ippf@post.com

ITALY

Unione Italiana dei Centri di Educazione Matrimoniale e Prematrimoniale (UICEMP)

web: www.uicemp.org

email: uicemp@tin.it

KAZAKHSTAN

Kazakhstan Association on Sexual and Reproductive Health (KMPA)

email: center.kmpa@alnet.kz

KYRGYZSTAN

Reproductive Health Alliance of Kyrgyzstan (RHAK)

email: rhak@infotel.kg

LATVIA

Latvijas Gimenes Planosanas un Seksualas Veselības Asociācija "Papardes Zieds" (LAFPSH)

web: www.papardeszieds.lv

email: lfpa@mailbox.riga.lv

LITHUANIA

Seimos Planavimo ir Seksualines Sveikatos Asociacija (FPSHA)

web: www.spa.lt

email: lithfpa@takas.lt

LUXEMBOURG

Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle (MLPFES)

email: plannlux@pt.lu

MOLDOVA

Societatea de Planificare a Familiei din Moldova

web: www.iubire.md

email: fpa@moldova.md

THE NETHERLANDS

Rutgers Nisso Groep

web: www.rutgersnissogroep.nl

email: a.dubbeldam@rng.nl

NORWAY

Norsk forening for seksualitet, samliv og reproduktiv helse (NSSR)

web: www.nsr.org

email: post@nsrr.org

POLAND

Towarzystwo Rozwoju Rodziny (TRR)

web: www.trr.org.pl

email: trr@trr.org.pl

PORTUGAL

Associação Para o Planeamento da Família (APF)

web: www.apf.pt

email: apportugal@mail.telepac.pt

ROMANIA

Societatea de Educatie Contraceptiva si Sexuala (SECS)

web: www.sexdex.ro/sd/index.jsp

email: sediu@secs.ro

RUSSIA

Russian Family Planning Association (RFPA)

web: www.family-planning.ru

email: rfpa@dol.ru

SLOVAK REPUBLIC

Slovenská spoločnosť pre plánované rodicovstvo a výchovu k rodicovstvu (SSPRVR)

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email: ssprv@nexta.sk

SPAIN

Federación de Planificación Familiar de España (FPFE)

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SWEDEN

Riksförbundet för Sexuell Upplysning (RFSU)

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SWITZERLAND

PLANes - Fondation Suisse pour la Santé Sexuelle et Reproductive

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TURKEY

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UZBEKISTAN

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