

Summary of HIV/AIDS epidemiology, and useful websites / organisations to contact for countries with Champions attending the Standard Chartered India / MESA *Living with HIV* Workshop

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Compiled by Peter Labouchere, based on information from various websites including:

- UNAIDS/WHO Epidemiological Fact Sheet, 2002 Country updates
www.unaids.org
- UNAIDS Report on the global HIV/AIDS epidemic December 2002
- Centers for Disease Control & Prevention: www.cdc.gov
- www.youandaids.org, which describes itself as the “HIV/AIDS Portal for South Asia and North East Asia”
- www.utopia-asia.com/aids.htm provides country specific summaries and other regionally focussed information

28 March 2003

General information

The following is taken from: *The Business Response to HIV/AIDS: Impact and lessons learned*. UNAIDS, The Prince of Wales Business Leaders Forum and the Global Business Council on HIV and AIDS. Geneva and London 2000.) A summary of this publication is available on: <http://www.unaids.org/bestpractice/digest/files/businessresponse.html>.

There are nine key lessons learned from business experience in responding to HIV/AIDS:

1. Ensure a committed leadership (CEO, Board and management) and understanding at all levels of the workforce, particularly through demonstrating the business case for addressing HIV/AIDS.
2. Develop initiatives that match the company's core business skills and technical expertise with the needs of the target audience.
3. Engage in a multi-pronged approach to ensure real effectiveness, to go beyond the workplace and address issues within the local community.
4. Demonstrate the business costs and benefits and human resource implications of HIV/AIDS initiatives.
5. Undertake a consultative approach with all stakeholders, particularly with the involvement of people living with HIV/AIDS, to ensure that initiatives are appropriately directed and to allow for prioritisation.
6. Enter into partnerships with NGOs and governmental and intergovernmental organisations to provide the necessary expertise and knowledge of HIV/AIDS issues and to enable the scaling-up of responses.
7. Involve the use of peer educators/leaders from the target groups in the dissemination of education and prevention information.
8. Utilise low cost creative tools to ensure sustainability and replicability.
9. Undertake continual monitoring, and review the effectiveness of HIV/AIDS initiatives, with a willingness to adapt the programmes accordingly.

International Statistics

According to the [Joint United Nations Programme on HIV/AIDS](#), as of the end of 2002, the following trends of the worldwide epidemic (or pandemic) of HIV are evident:

- Today, **42 million people are estimated to be living with HIV/AIDS**. Of these, 38.6 million are adults. 19.2 million are women, and 3.2 million are children under 15.
- An **estimated 5 million people acquired the human immunodeficiency virus (HIV)** in 2002, including 2 million women and 800,000 children under 15.
- During 2002, **AIDS caused the deaths of an estimated 3.1 million people**, including 1.2 million women and 610,000 children under 15.
- Women are becoming increasingly affected by HIV. Approximately **50%, or 19.2 million**, of the 38.6 million adults living with HIV or AIDS worldwide are women.

A rise in unsafe sexual behaviour underscores the need to resist complacency and revitalise prevention programmes to access the millions of young people who reach sexual maturity each year (UNAIDS 2002)

General reference websites / contact organisations

The UNAIDS website www.unaids.org provides a broad overview of HIV / AIDS issues and their impact at global and national levels, and has an excellent searchable database of documents in English and Spanish. It includes country based Epidemiological Fact Sheets, and a 'Best Practice Digest', with publications covering a range of topics.

UNAIDS, 20, Avenue Appia, CH-1211, Geneva, 27, Switzerland Tel: 41(22) 791 3666 www.unaids.org, Email: unaids@unaids.org

The Prince of Wales Business Leaders Forum, 15-16 Cornwall Terrace, London NW1 4QP
Tel: 44(20) 7467 3600 Email: info@pwblf.org.uk

The Global Business Council on HIV & AIDS, New City Cloisters, 196 Old Street, London EC1V 9FR
Tel: 44(1225) 404 964 Email: julian.hussey@gbcaids.com

Global Business Coalition on HIV/AIDS, 1515 Broadway, 45th Floor, New York, NY 10030
Tel: 212 846 5893 www.businessfightsaids.org

The **Communication Initiative** website provides a range of reference sites, links and discussion forums for exploring, for example, behaviour change theory and its application to HIV/AIDS. www.comminit.com

The website www.HIVpositive.com also provides a lot of information and materials around issues of living with HIV and ways of supporting those who are.

International Community of Women living with HIV/AIDS, London Tel: 0207 704 0606
email: info@icw.org An international network of HIV positive women in over 100 countries
www.icw.org

International AIDS Society (IAS)

The International AIDS Society contributes to the control and management of HIV infection and AIDS through advocacy, education, facilitation of scientific networks and debate, and support for best practices in research, prevention and care.

www.ias.se

THE BODY: Information on International HIV/AIDS Service Organisations and Resources
www.thebody.com

Aids and sex education website, with sections including 'talking to children about AIDS' 'AIDS education and young people'. www.avert.org/educate.htm

Another general AIDS website with a free weekly bulletin you can subscribe to: www.aidsmap.com This UK based website provides up to date information on all treatment issues relating to HIV infection.

Asia specific regional resources / contacts / websites

www.youandaids.org describes itself as the "HIV/AIDS Portal for South Asia and North East Asia", and has a various of useful materials,

www.utopia-asia.com/aids.htm provides country specific summaries and other regionally focussed information

www.youandaids.org/New/QuietStorm.pdf provides an electronic copy of Quiet Storm, with profiles of people living with HIV from various South and North East Asian countries.

HIV/AIDS and Business in Africa and Asia: Building Sustainable Partnerships (a workshop series, contains background materials and presentations, includes the following) <http://www.ksg.harvard.edu/cbg/hiv-aids/home.htm>

- Dodson, Kate. ['Business Response to HIV/AIDS Explored in Recent Workshop.'](#) *Kennedy School of Government* 27 Feb. 2003
- de Vitton, Lawrence and Andrew Stern. ["Corporate Partnerships to Combat HIV/AIDS."](#) *The Harbus* 3 March 2003.
- Widdicombe, Elizabeth S. ["Business' Role in AIDS Epidemic Explored."](#) *Harvard Crimson* 24 Feb. 2003.

Table: HIV Prevalence and Mode of Transmission

Figures for each country derived from *UNAIDS/WHO Epidemiological Fact Sheets – 2002 Updates* and from the *Virtual AIDS office of Hong Kong*

Country	No of SCB employees in this country	Adults (15-49) HIV+ in this country (end 2001)		Female: Male ratio of HIV+ adults F : M %	Mode of Transmission (Based on cumulative reported AIDS cases) (See Notes below)					
		No.	%		Hetero	Homo/ Bi	IDU	Blood	Mother to child	Other/ Not known
India	3,544	3,800,000	0.8	39:61	No data	No data	No data	No data	No data	No data
UAE	745	No data	No data	No data	No data	No data	No data	No data	No data	No data
Bangladesh	556	13,000	<0.1	24:76	No data	No data	No data	No data	No data	No data
Sri Lanka	435	4,700	0.1	30:70	63.6	17.4	0.0	1.5	3.0	14.4
Nepal	264	56,000	0.5	25:75	No data	No data	No data	No data	No data	No data
Bahrain	157	1000	0.3	15:85	11.0	3.7	72.0	9.8	2.4	1.2
Qatar	110	500	0.1	No data	20.0	4.8	0.0	57.6	8.0	9.6
Jordan	111	<1000	<0.1	15:85	40.0	3.2	3.2	38.9	1.1	13.7
Lebanon	89	No data	No data	No data	57.7	7.3	6.8	10.9	4.5	17.3

Hetero: Heterosexual contacts

Homo / Bi: Homosexual contacts between men

IDU: Injecting drug use. This transmission category also includes cases in which other high risk behaviours were reported, in addition to injection of drugs

Blood: Blood and blood products

Mother to child: Vertical transmission during pregnancy, birth or breastfeeding.

Notes:

AIDS Case reporting provides information on transmission patterns and levels of infection approximately 5-10 years in the past, but is still useful as an indicator of how significant different modes of transmission are in particular countries. There has been an almost universal upward trend in the proportion of transmission cases resulting from heterosexual sex. Hence the figures here underestimate the percentage of current transmissions attributable to heterosexual sex, and overestimate other categories.

Early in the HIV pandemic, HIV transmission from blood transfusions was much higher, and with thorough testing, the rate of transmission through this route is now far lower than represented by the figures for Qatar and Jordan in particular.

HIV/AIDS Regional Updates: Middle East and North Africa

UNAIDS Fact Sheet for the Middle East and North Africa - 2002

From

http://www.greekorthodoxchurch.org/wfb2002/lebanon/lebanon_people.html

Despite the late arrival of HIV/AIDS in the Middle East and North Africa, the trend appears to be towards increasing HIV infection rates in several places, though they are still at very low levels in most countries. Lingering denial among both social and political leaders in some countries provides the epidemic with an ideal environment for continued growth.

Available data point to increasing HIV infection rates, with an estimated 83 000 people having acquired the virus in 2002. This brings to 550 000 the estimated number of people living with HIV/AIDS. The epidemic claimed about 37 000 lives in 2002.

Systematic surveillance, however, remains inadequate, making it very difficult to deduce accurate trends. It is possible that hidden epidemics could be spreading in this region. Better surveillance systems (such as those introduced in Iran, Jordan, Lebanon and Syria) will enable more countries to accurately track the development of the epidemic and mount effective responses.

Unless countries promptly introduce harm-reduction and other prevention services for injecting drug users, the epidemic could grow dramatically and spread into the wider population.

Other infected groups in the region include men who have sex with men, sex workers and their clients. In Morocco, the National AIDS Control Programme has noted the relatively high prevalence of other sexually transmitted infections—a sign that unsafe sex is more common than routinely assumed.

Overall, recognition of the need for more effective and far-reaching prevention efforts has grown in this region. Some countries are fashioning potentially effective responses. Examples include the mobilization of nongovernmental organizations around prevention programmes in Lebanon.

An inclination to exaggerate the protective effects of social and cultural conservatism continues to hamper an adequate response. In the absence of greater candour, political commitment and improved prevention programmes, wider HIV/AIDS spread can be anticipated.

From World Bank website:

<http://web.worldbank.org/WBSITE/EXTERNAL/>

As a result of insufficient data, HIV infection rates for the Middle East and North Africa (MENA) region are often only estimates (UNAIDS). As of the end of 2001, approximately 500,000 adults and children were estimated to be living with HIV/AIDS in the region, including an estimated 80,000 people who became infected in 2001 (UNAIDS). Compared to data from neighbouring Asia, Europe and Sub-Saharan Africa, it would seem that HIV infection rates in the region are relatively low. However low prevalence rates do not mean low risk. Many countries in the region have enough evidence of risk factors to warrant immediate investments in improved prevention programs. For instance, recent evidence suggests that the incidence of sexually transmitted infections (STIs) including HIV/AIDS is increasing, and the total number of AIDS deaths has increased almost six fold since the early 1990s.

Although the current rate of HIV infection in MENA is low compared to other regions, early intervention to curb the spread of HIV/AIDS is vital, because experience has shown that once the prevalence of the infection exceeds a certain threshold, the virus spreads very fast, sometimes increasing even tenfold in five years as has been the case in several southern African countries. The more widely HIV/AIDS spreads, the more difficult and costly prevention and treatment become. In Sub-Saharan Africa, it is estimated that a national HIV/AIDS prevention program would cost less than US\$3 per capita while prevalence remained below 5%. Once rates reach 15% however, program costs could be US\$12 per capita. The longer the introduction of programs is delayed, the greater the likelihood that the epidemic will grow exponentially. Countries therefore have two policy options: (1) delay action while HIV prevalence remains low and have far higher expenses to control it once it spreads; or (2) take comprehensive action now to prevent HIV before it becomes a menace.

Despite a lack of vaccine, behaviour change has been proven to be a highly effective means of reducing HIV transmission. Young people are especially receptive to learning safe behaviour messages and skills. Early and aggressive intervention against the epidemic has paid dividends in several places such as Uganda and Senegal in Africa, Thailand and Tamil Nadu in India. Prevention not only averts suffering and death, but also pays vast dividends in future savings to the health system and the public sector at large. Cost effective interventions such as greater use of condoms, public information programs, and treatment of sexually transmitted infections cost as little as US\$8 per infection averted, compared to the hundreds of dollars that each case of AIDS costs to treat. For many individuals and couples, finding out about their infection status could be useful. One approach is to make voluntary testing services more convenient to clients.

One major concern about HIV/AIDS in the region however, is the scant information about HIV prevalence rates and the reliability of the data. Given the global trend in the HIV/AIDS epidemic, it is necessary to establish surveillance systems to obtain up-to-date accurate data on the extent of the problem in the region, monitor trends and identify socio-economic and cultural factors which may be contributing to its spread for appropriate action. HIV/AIDS programs should be multi-sectoral, and the costs could be spread among several ministries, agencies, civil society, and private actors. All of these actions require strong political will to create an enabling environment for them to take place.

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Country Specific Information

HIV/AIDS in India

"The most serious public health challenge that the country is facing today is of HIV/AIDS that is just a decade old in the country. AIDS is a global problem - sadly with a strong Indian dimension"

Shri Atal Behari Vajpayee, Prime Minister of India.

Extracts from:

<http://www.hivanddevelopment.org/regionalupdate/india/index.asp>

HIV Situation

India's socio-economic status, traditional social ills, cultural myths on sex and sexuality and a huge population of marginalized people make it extremely vulnerable to the HIV/AIDS epidemic. In fact, the epidemic has become the most serious public health problem faced by the country since Independence.

Since the first case was reported in Chennai, the capital of the South Indian State of Tamil Nadu, HIV has spread rapidly from urban to rural areas and from high-risk groups to the general population. At the end of 2001, an estimated 3.97 million people are living with HIV/AIDS in the country.

HIV/AIDS has been reported from almost all the states and union territories of the country. Currently the infection rate is estimated to be 0.8 per cent in adult population (between 15 and 49 years of age).

The second decade of the epidemic is marked by visible heterogeneity. In fact, India's epidemic is made up of a number of epidemics and at some places, they occur within the same state.

The epidemic has become a major developmental challenge that goes beyond the realm of public health. The emerging complexity of the epidemic has made it an issue that touches all aspects of human life. And the perspectives are divers: medical, human rights, ethical, legal, religious, cultural and political. The need to prevent the epidemic and provide care and support to those infected and affected calls for an unprecedented response from all sections of society.

In the most affected state of Maharashtra, HIV has reached 60 per cent of Mumbai's sex workers, 14-16 per cent of sentinel STI clinics and over 2 per cent among women attending antenatal clinics (ANCs). The prevalence in women attending antenatal clinics, an indicator for the prevalence in general population, has reached 6.5 in Namakkal in Tamil Nadu and 5.3 per cent in Churachandpur in Manipur.

The epidemic is slowly moving beyond its initial focus among sex workers. Sub-epidemics are evolving with potentially explosive spread among groups of injecting drug users (IDUs) and among Men having Sex with Men (MSM).

The last four years have seen a broadening of the epidemic across the southern and western states of India as well as the continued concentration of HIV among IDUs in the North Eastern states. The sharp increases in Andhra Pradesh and Karnataka reveal that these two states have overtaken Tamil Nadu as states with the highest prevalence rates.

In other parts of the country, the overall levels of HIV are still low with some areas reporting no cases at all. High levels of Sexually Transmitted Infections (STIs), the presence of sexual networks and phenomena like migration and gender bias point to a significant vulnerability.

The epidemic continues to shift towards women and young people with about 25 percent of all HIV infections occurring in women. This also adds to the Mother to Child Transmission (MTCT) and paediatric HIV. Adverse gender bias adds to the biological vulnerability of women.

The burden of AIDS cases is beginning to be felt in states affected early. Mumbai in Maharashtra and Manipur in the North East have recorded 20-40 per cent bed occupancy by HIV positive persons in certain referral hospitals.

HIV in India - A fast spreading Epidemic

1986: First case of HIV detected in Chennai

1990: HIV levels among High Risk Groups like Sex workers and STI clinic attendants in Maharashtra and amongst Injecting Drug Users in Manipur reaches over 5%.

1994: HIV no longer restricted to high-risk groups in Maharashtra, but spreading into the general population. HIV also spreading to the states of Gujarat and Tamil Nadu where high risk groups have over 5% HIV prevalence

1998: Rapid HIV spread in the four large southern states, not only in highrisk groups but also in the general population where it has reached over 1%. Infection rate among antenatal women reaches 3.3 in Namakkal in Tamil Nadu and 5.3 in Churachandpur in Manipur. Among IDUs in Churachandpur it crosses 76 percent and in Mumbai, 64.4 per cent.

1999: The infection rate in antenatal women in Namakkal rises to 6.5. About 60 per cent of the sex workers in some Mumbai sites are infected. Infection rates among STI patients reaches 30 per cent in Andhra Pradesh and 14-60 per cent in Maharashtra. About 64.4 per cent IDUs at one of the sites in Mumbai and 68.4 per cent in Chruachandpur are infected.

2001: Infection crosses one per cent in six states. These states account for 75 per cent of the country's estimated HIV cases. The Prime Minister addresses the Chief Ministers of high prevalence states and urges them to intensify prevention activities.

Indicators – People living with HIV at end of 2001	Estimate
Number of HIV cases (Adults and children)	3.97 million
Number of HIV cases (Adults 15 –49)	3.80 million
Percentage of adult population living with HIV	0.8%
Number of children (under 15)	170,000

The National Response

India responded to the AIDS epidemic immediately after the first ever HIV/AIDS case was reported in the country in 1986. The country's National response encompassed the efforts of both the Government and civil society.

Recognising the seriousness of the situation, the Government constituted a high-power committee in 1986 under the Ministry of Health and Family Welfare.

Subsequently, a National AIDS Control Programme was launched in 1987. Since then, the National HIV Programme has moved through three phases.

1986-1992, Denial of the Threat of HIV: This was a period that saw the beginning of a largely research-based programme. Surveillance activities were launched in 55

cities in three states. The programme activities were left to the states without strong central guidance.

1992-97, First Acceleration of the Programme: Backed by World Bank funding and strong WHO GPA (Global Programme on AIDS) support, this phase saw the creation of the National AIDS Control Organisation (NACO). Achievements included higher levels of awareness creation, establishment of state level structures for programme implementation and improvements in blood safety. The launch of successful individual projects such as the innovative intervention in Sonagachi amongst commercial sex workers and breakthroughs in reaching out to college youth through "University Talks AIDS (UTA)" were amongst its achievements. The scope of these efforts remained however on a limited scale. Political acceptance was weak and ownership of the programme by the states proved difficult to establish. Involvement of NGOs too was difficult. While an emphasis on blood-safety and strengthening of infrastructure yielded some gains, approach remained primarily medical with HIV seen largely as a health issue.

1998-2001, Focus on Targeted Intervention: Building on the experience of the first phase, there was a twin drive to focus on coverage amongst high risk groups like sex workers, truck drivers and injecting drug users and to make the programme multisectoral. It has resulted in a strongly decentralised programme with the responsibility of implementation vested with the states. Flexible State AIDS Societies were formed with stronger mechanisms for state level programme management. An innovative approach for providing technical support to state programmes was launched by establishing a network of 12 Technical Resource Groups (TRGs), each covering different thematic areas of the epidemic. Each of them is mandated to provide technical support to states. Surveillance has been expanded and strengthened and a new national HIV policy has been submitted to the Central Government. With a new round of resources mobilised from Government of India, the IDA, major bilateral donors and the UN system, the programme is moving into an important phase of implementation.

The preparation of the new programme has given a fresh impetus to the national response. However, several challenges need to be addressed. These include building capacities to implement the strategies of prevention and building a genuinely multi-sectoral response that is sustainable. It also involves mobilizing and coordinating a considerable range of partners, including the private sector.

National Programme Manager: Mr. J.V.R.Prasada Rao, Special Secretary and Project Director, New Delhi

National AIDS Control Organisation (NACO):

In India, the National AIDS Control Organisation (NACO) carries out the country's National AIDS Programme, which includes formulation of policy and implementation of prevention and control programmes. It was established in 1993 and is now running the second phase of the National AIDS Control Project (NACP-II). The first phase (NACP-I) ended in March 1999. The duration of NACP-II is from December 1999 to March 2004.

In 1989, with the support of WHO, a medium term plan for HIV/AIDS control was developed. With a US \$10 million budget, it was implemented in five most affected states. The actual prevention activities gained momentum by 1992 and the national programme became more formalised with the establishment of NACO in 1993.

Besides NACO, the country also has a National AIDS Control Board, which is chaired

by the Union Health Secretary. The Board reviews NACO policies, expedites sanctions, approve procurement and undertake and award contracts to private agencies. The other major functions of the Board are approval of annual operational plan budget, reallocation of funds between programme components, formation of the programme managerial teams and appointment of senior programme staff.

Project Director, Mr.J.V.R.Prasada Rao, who is a Special Secretary to the Government of India, heads NACO.

Objectives:

NACO has two key objectives

- To reduce the spread of HIV infection in India and
- To strengthen India's capacity to respond to HIV/AIDS on a long-term basis.

The overall vision of NACO is

- To lead and catalyse an expanded response to the HIV/AIDS epidemic in order to contain the spread of infection.
- Reduce people's vulnerability to HIV.
- Promote community and family based care to HIV/AIDS cases within an enabling environment without any stigmatisation and discrimination and,
- To alleviate the epidemic's devastating social and economic impact

Support by Industry

Industrial federations (West Bengal Chamber of Commerce & Industry, Confederation of Indian Industry, Federation of Indian Chambers of Commerce & Industry) becoming involved in stimulating discussions on needs for industrial sectors response to HIV/AIDS. "AIDS & the Workplace" advocacy & IEC package developed by Confederation of Indian Industry (CII) with assistance from WHO/UNAIDS/USAID for promotion of industry action on HIV/AIDS prevention and workplace policies. The Trucking Corporation of India (TCI) is actively participating in a national network of NGO service providers being coordinated with support from ODA for the assurance of HIV/STI interventions for truck drivers.

Legislation and policies

- Goa Public Health Act Amendment of 1985 (Section 53.I.vii) allowed the public health authorities and police discretion to isolate people with HIV/AIDS; repealed in 1996.
- Railway Board Administrative Notification of 1989 designating HIV/AIDS as "infectious disease" which can allow denial of passage; rescinded in 1996.
- Draft legislation in 1989 Session of National Parliament, which was evaluated as extremely prejudicial to rights of PLWH/As withdrawn after intervention of WHO and national authorities.
- 1992 Administrative Notification from Minister of Health & Family Welfare (GOI) to all State Governments directing them to ensure non-discriminatory access to treatment and care for PLWH/As in all Central and State Government health care institutions.
- The Government has, by Administrative Order, required the screening for HIV of all units of blood to be used for transfusion purposes.
- May 1997 Mumbai High Court Judgement held that employers cannot base employment decisions on HIV status of employee.

Contact organisations:

UNDP Special Initiative on HIV/AIDS Regional Programme for South and North East Asia (REACH Beyond Borders)

This organisation produced and supplied the “Quiet Storm” publication and the 5 minute film: “HIV/AIDS & Stigma and Discrimination”.

Sonam Yangchen Rana

Regional Programme Coordinator

Mailing Address:

UNDP, 55-Lodi Estate, New Delhi-110003, **India**

Street Address:

13-Jor Bagh, New Delhi-110003, **India**

Tel: (91.11) 4632339; 4632602

Fax: (91.11) 4631647

email: sonam.yangchen.rana@undp.org

G Pramod Kumar

Communications & Advocacy Officer

UNDP Special Initiative on HIV/AIDS

Regional Programme for South and North East Asia

(REACH Beyond Borders)

email: pramod.kumar@undp.org

Confederation of Indian Industry (CII)

http://www.ciionline.org/sdca/2002/HIV_AIDS/

GUIDELINES FOR INDIAN INDUSTRY ON HIV / AIDS ISSUES & STRATEGIES FOR PROGRAMMES CO-ORDINATORS

a) CII has been spreading awareness on the cause of killer diseases such as HIV/AIDS, Tuberculosis, Malaria, Cancer etc., through encouraging companies to set up awareness campaigns, setting up DOT Centres for Tuberculosis, printing and issuing of one sheeters etc.

b) AIDS at the Workplace Programme

- Programme recognised nationally and internationally as one of the best workplace programmes.
- Launched in March 1996
- 1700 companies on the programme
- Launched/conducted training programme in all the regions
- AIDS awareness package sent to all members.
- Through "SWANAASH" – an AIDS awareness programme for masses on All India Radio, our efforts have reached to the remotest part of the country. What began as a purely prevention and control exercise, CII has extended its activities to Caring of HIV infected population through income generation schemes (as paper recycling etc.) recreational centres, counselling centres etc.

c) CII has brought out a HIV/AIDs Policy for Industry.

Corporate Offices

For regional offices, see: <http://www.ciionline.org/offices/offices.htm>

Mantosh Sondhi Centre

23, Institutional Area
Lodi Road, New Delhi - 110 003
Phone : 91-11-24629994-7, 24626164/24625407
Fax : 91-11-24626149/24633168
Email: ciico@ciionline.org

India Habitat Centre, Core 4A,
4th Floor, Lodi Road,
New Delhi 110 003
Phone: 91-11-24682230-35
Fax: 91-11-24682229/24682228
Email: ciico@ciionline.org

Plot No. 249 F, Sector-18
Udyog Vihar, Phase IV
Gurgaon - 122 015
Phone: 91-124-5014060-7
Fax: 91-124-5014080
Email: ciico@ciionline.org

Bangalore

N Srinivasan
Deputy Director General
Institute of Quality
Near Bharat Nagara, II Phase
Magadi Main Road, Vishwaneedam P.O.
Bangalore - 560 091
Phone: 080-3289391/3286085
Fax: 080-3289388
Email: cii-iq@ciionline.org / ciiq@bgl.vsnl.net.in

Kolkata

S Niyogi
Deputy Director General
6, Netaji Subhas Road
Kolkata - 700 001
Phone : 91-33-22207727/28/22201434/22203354
Fax : 91-33-22201721
Email : subrata.niyogi@ciionline.org

Mumbai

A C Patankar
Principal Adviser
C/o Godrej & Boyce Mfg Co Ltd
Godrej Bhawan, 5th Floor,
4-A, Home Street, Fort,
Mumbai 400 001
Phone : 91-22-2076087
Fax : 91-22-2076086/4939463
Email: arun.patankar@vsnl.net

S D Puranik

Sr Adviser
CII Naoroji Godrej Centre of Excellence
Godrej Station-side Colony
Pirojshanagar, Vikhroli (East)
Mumbai 400 079
Phone : 91-22-25745146/5148
Fax : 91-22-25743361/5946
Email: ciicoe@bol.net.in / ciicoe@vsnl.net

Samvedan Trust

Dr. Geeta Bhave,
Trustee, Samvedan Trust
Modern Pathological Laboratory
63, Dr. Ambedkar Road
Mammbai High School Building
Chinchpokali (East)
Kalachowki, Mumbai 400 033
Tel : 2372 6179

Groups for people living with HIV/AIDS in India

Infected and Affected Women Group in Churachandpur

C/O Care Agency For All (CAFA)
Laitui Medico Building
Hill Town, Churachandpur - 795128
Manipur
Phone - 03874-33211

Council of People Living with HIV/AiDS in Kerala (CPK+)

3rd Floor, Noor Mansion
St Alberts High School Lane
Cochin 68 20 35
Phone - 36 76 85
Email - cpkcpkin@yahoo.co.in

Delhi Network of Positive- people (DNP+)

c/o Sahara
E-453, Greater Kailash-1 1
New Delhi
Phone - 91 11 6216540
Email - dnppplus@yahoo.co.in

Karnataka Network of Positive People (KNP+)

11 3, 1st floor, 1 5th Cross, 8th main
Wilson Garden
Banglore- 560030
Phone - 91 80 2120409
Email - knppplus@vsnl.net

Manipur Network. of Positive People (M N P +)

Yaisul Hiruhanba Leikai
P.O. Box No. 145

Imphal 795001
Manipur
Phone - 440828/224991
Email - imp-mnpplus@sancharnet.in

Positive Women Network of India (PWN+)

No.23, Brindavan street
West Mambalam
Chennai - 690 033
Phone - 91 44 3711176
Email - poswonet@hotmail.com

Goan community for Positive People

Mount Mary Ward
Opp. Goan Maharaja Hotel
Nagoa , Saleete, Goa - 403 722
Phone - 0832 782612
Email - gcplus@redifmail.com

Tamilnadu Network of Positive People (TNP+)

Room No 41, Hayroon Mansion
No 51, Tahyar Sahib Street
Chennai-600 002
Phone - 91 44 8516482
Email - tnpplus@yahoo.com

En- Joy

49/A/1, B.P.Dey Street
Serampore, Hooghly
West Bengal-712201
Phone - 91-33-6521519
Email – en_joy59@hotmail.com

Nagaland Network of Positive (NNP+)

NMA HIV/AIDS care hospice
Kohima, Post Box-1 60
Nagaland
Phone - 0370 229195

Network of Maharashtra by People Living with HIV/AIDS (NMP+)

S. No , building B/7 Mahatma Society, Dhole Mala
Dias plot, Guttekadi, Pune - 411 037
Phone - 91 20 4266889
Email - nmplha@yahoo.com

Indian Network for People Living with HIV/AIDS (INP+)

Flat No.6/93, Kash Toweres
South West Boag road
T-Nagar, Chennai-600017
Phone - 432 9580/81
Fax - 432 9582
Email - inppplus@vsnl.com

HIV/AIDS in Bangladesh

HIV Situation

The information on HIV prevalence in Bangladesh is limited and available data suggests that the overall prevalence is low even among high-risk groups. However, several factors, mainly related to the country's poor socio-economic background, make the country vulnerable to the epidemic.

The data available is sporadic. In 1988-89, sero-surveillance was conducted among several groups of people, sex workers, STI patients, IDUs and antenatal clinic attendees, but no one was found to be positive. In a survey in Dhaka in 1996, 0.2 per cent of the sex workers were tested positive. However, there was no evidence of HIV infection among sex workers tested in 1997 and 1998. In the Central area, 0.4 per cent of the sex workers tested in 1998 were HIV positive.

There was no evidence of infection among STI patients in 1988-89. In 1996, 0.5 percent of patients tested in Chittagong were positive. In 1998, only zero to 0.3 per cent of patients tested positive. In northwest and northeast areas, the prevalence was zero in 1998

In 1998, 2.5 per cent of IDUs tested in the central area were positive. But no evidence of HIV prevalence was available among truck drivers. In one survey, 13% of sex workers reported having injected drugs and that there is widespread needle and syringe sharing. There is evidence of a high rate of syphilis (app. 60%) and other STIs among commercial female sex workers. The rate of condom use is low.

The National Response

In view of the pandemic that started in the early 80s, Government of the People's Republic of Bangladesh formed a National AIDS Committee way back in 1985 for prevention & control of HIV/ AIDS. By now it has completed a Short term Plan of Action, an interim plan of Action and many other activities related to prevention and control of HIV/AIDS. The National AIDS Committee, therefore, considered the necessity for a National policy on HIV/AIDS. The Director General of Health Services, accordingly, formed a 11-member "Task Force" with the Chairman of the Technical Committee as its convener. The Technical Committee was a body of experts supervising technical aspects of HIV/AIDS and STI prevention and control. It is the technical arm of National AIDS Committee. It also provides technical support to the Coordination Committee.

In 1996, the Government of Bangladesh endorsed the National Policy on HIV/AIDS prepared by the multidisciplinary group. In November 1997, the Government issued a Plan of Action to address HIV/AIDS within the framework of the Health and Population Sector Programme. A National Strategic Plan (1997-2002) was issued by the Bangladesh AIDS Prevention and Control Programme (BAPCP) of the Ministry of Health and Family Welfare in May 1997. The National programme has an implementation strategy and a behaviour change communication strategy. Religious leaders, students, youth leaders and community leaders have been involved in advocacy programmes.

Strategies

Prevention of sexual transmission: Sexual transmission accounts for most of the HIV infection. Prevention of sexual transmission requires education leading to changes in sexual behaviour that reduce as much as possible the rate of transmission. Educational approaches seek to reduce the number of partners and promote the use of condoms.

Prevention of blood related transmission: Transmission of HIV through blood can be reduced or prevented by universal screening of blood and encouraging voluntary blood donation, use of sterile materials for injections, prevention of IV drug use and introduction of universal precautions in the health care setting.

Prevention of perinatal transmission: Prevention of perinatal transmission can be achieved by intensive and widespread education of the population of HIV/AIDS.

Reduction of the impact of HIV on individuals, groups and societies:

Provision of appropriate counseling and care services is essential to address the psychological and other effects of HIV on both the infected persons, their relatives and the communities. Widespread education and the adoption of non-discriminatory policies are required to provide a supportive environment that will help those affected (whether infected or not) cope with the stress and burden of the situation.

In order to achieve these objectives through strategies mentioned above, the programme activities will be carried out through a '**Tripartite Coalition**' among the three main functionaries. I.e., National AIDS Committee (NAC), acting as an Advisory Body, Ministry of Health & Family Welfare (MOH&FW) as the coordinating and supreme Executive Body and, the Directorate General of Health Services (DGHS) and other ministries, directorates and agencies as the Implementing Body.

Support organisations for PLWHAs:

Ashar Alo Society

House no. 125, Road no. 3
Block A, Mirpur 12
Dhaka 1221
Bangladesh
Email - asharalo@bangla.net

HIV/AIDS in Sri Lanka

Background

Sri Lanka ranks highest of all the countries in the region in the UNDP Human Development Index. However, it faces high unemployment, leading to very high levels of migration, and remittances from migrant workers are an important aspect of the economy. There is also considerable internal migration, to the cities, and internal displacement due to the ongoing conflict in the north and east of the country. Sri Lanka has also been a target of sex tourism, though not on a wide scale.

The first incidence of AIDS was reported in a foreign visitor in 1986, and the following year the first Sri Lankan with AIDS was diagnosed.

Sri Lanka is the only Asian country where the number of female migrants far exceeds the male labour outflows. Each year approximately 160,000 people leave Sri Lanka for employment abroad, of which 70-80% are women, mostly between 18 and 40 years of age. 80% are married, and migrate to secure basic family needs or enhance family income. In their place of work, primarily in domestic work in the Middle East, they have low social status and are extremely vulnerable, experiencing many forms of exploitation, including sexual abuse. Available statistics indicate that 50% of reported HIV persons are returned housemaids from the Middle East.

Women also constitute 80% of the workers in the Free Trade Zone at Kandy. The vulnerability of these women is indicated by the high rate of unwanted pregnancies and high prevalence of sexually transmitted diseases (STIs) amongst them.

The Sri Lanka Bureau of Foreign Employment has taken important steps in instituting training programmes to protect migrant workers. In order to strengthen the capacity of these programmes to enable migrant women to protect themselves, the UNDP country office has provided support to upgrading components on personal hygiene, HIV/AIDS and sexually transmitted diseases.

The main emphasis of the National STD/AIDS Control Programme (NSACP) has been on the implementation of targeted interventions, condom promotion and availability, improvement of capacity to manage STDs, and the provision of STD/AIDS education to youth. The Centre for Women's Research, Colombo, has focussed attention on the issues relating to female migrant workers.

The UN system has provided support to NSACP in the above activities. The UNDP country office has supported numerous initiatives, including a study on the socio-economic impact of HIV/AIDS. A project has recently been approved to work with NSACP to strengthen the capacities of NGOs in implementing HIV related programmes, in particular information, education and communications (IEC) activities, and community-based initiatives. NGOs have played a very important role in HIV/AIDS prevention activities, with approximately 85 agencies involved, primarily in awareness creation for the general public and schoolchildren.

In the UNDP Project on HIV and Development in South and Southwest Asia, Sri Lanka will take the lead in initiatives aiming at the reduction of HIV incidence in migrant populations, and will participate in initiatives relating to law, ethics and human rights, and media policy and strategy.

Estimates

**Figures
Value
Year
Source**

4800
2001
UNAIDS Global HIV/AIDS Report 2002

4700
2001
UNAIDS Global HIV/AIDS Report 2002

1400
2001
UNAIDS Global HIV/AIDS Report 2002

< 100
2001
UNAIDS Global HIV/AIDS Report 2002

250
2001
UNAIDS Global HIV/AIDS Report 2002

2000
2001
UNAIDS Global HIV/AIDS Report 2002

Estimated Number of HIV cases (Adults and children)

Adults (15-49 years)

Women (15-49)

Children

Estimated number of deaths due to AIDS

Estimated Number of AIDS orphans

The National Response

The National coordinating body is the National AIDS Committee (NAC). It is a multi-sectoral body comprising different government ministries and institutions and some key NGOs. The Director General of Health Services (Ministry of Health-MOH) has recommended that the Secretary of Health should become its chairperson.

The National AIDS Control Programme (NACP), located within the MOH, functions in principle as the executive secretariat of the NAC. Overall responsibility rests with a full time programme co-ordinator.

A National AIDS Plan was endorsed by the MOH in 1994. The approach was multisectoral, with particular attention for STIs. Social sectors NGOs play an important role in the national response. Involvement of the private sector is modest.

Two research centres specialising in HIV law and Ethics for South East Asia namely CEPRA (Centre for Policy Research and Analysis) and the Human Rights Centre, are based at Colombo University.

Ministries of Education, Planning, Tourism, Labour and Youth Affairs are partners in the National Programme.

National Programme: Manager - Dr. Iyanthi Abeywickrama, Colombo

UN Offices

Ms Sarwar Sultana
Officer-in-Charge
UNDP Sri Lanka
202-204 Baudhaloka
Mawatha, Colombo 7
Sri Lanka
Mail Address: UNDP Sri Lanka
P.O.Box 1505
Colombo
Sri Lanka
Phone: 94-1-580691-7
Fax: (94-1) 581116,(94-1) 501396
E-mail: fo.lka@undp.org, registry.lk@undp.org
URL: www.undp.org/rbap

Dr. Hemamal Jayawardena
UNAIDS Focal Point
UNDP
C/o WHO
22 Baudhaloka Mawatha
PO Box 1505
Colombo 7
Phone: (94)1 50 28 42/50 28 19
Fax: (94)1 50 28 45

Mail Address:
UNICEF
P.O. Box 143
Colombo
Sri Lanka
Phone: 94- 1- 551.331, 551.332, 551.731, 551.732
Fax: 94-1- 551.333
E-mail: Colombo@unicef.org

P.O. Box 1505
Colombo 7

Dr Kan Tun
WHO Representative
No. 226, Bauddhaloka Mawatha
Colombo-7, Sri Lanka
Mail Address: P.O. 780
Colombo-7
Phone: 00-94-1-502319, 502842
Fax: 00-94-1-502845
E-mail: wr@who.lanka.net, mo@who.lanka.net

ILO Office in Colombo
202-204, Bouddhalka Mawatha,
P.O. Box 1505,
Colombo 7
Phone: (+94 1) 59 25 25
Fax: (+94 1) 50 08 65
E-Mail: colombo@ilocmb.un.lk

UN Support

CPA: Dr. Hemamal Jayawardena
Address: UNAIDS Focal Point, UNDP
C/o WHO, 22, Bauddhaloka Mawatha
P.O.Box: 1505, Colombo – 7
Tel: (94) 1 50 28 42/50 28 19
Fax: (94) 1 50 28 45
Email: hj@who.lanka.net

Theme Group on HIV/AIDS
Chair: Dr. Kan Tun, WHO representative to Sri Lanka, Colombo
Members: UNDP, UNFPA; UNICEF, WHO, WB

Sources: UN Agencies, World Bank, HIV/AIDS Surveillance Data Base (US Census Bureau), June 2000, UNAIDS Epidemiological Fact Sheet, 2000.

World Bank gives US\$12.6 million to Sri Lanka to stop spread of AIDS

<http://www.aegis.org/news/ap/2002/AP021225.html>

The World Bank will provide US\$12.6 million to Sri Lanka to fight the spread of the HIV virus and reduce the stigma attached with the disease. The island nation of 18.6 million people has a "narrow window of opportunity to prevent a nationwide AIDS epidemic," the statement said. The World Bank grant will finance a national HIV and AIDS prevention project. It will also support the island nation's efforts to reduce the risk of an emerging epidemic of tuberculosis, to which HIV infected patients are particularly susceptible, the statement said. Sri Lanka has raised its health and educational standards to levels comparable with developed countries, but the recent increase in the numbers of AIDS and tuberculosis infections was posing a new threat, it said. The World Bank commended government efforts to control the deadly disease, but said the measures were "not sufficient to prevent the further spread of HIV infection among highly vulnerable" people. The bank urged the government to conduct more awareness programs to reduce the social stigma attached to AIDS and combat discrimination against people with the disease.

Support organisation for people living with HIV/AIDS:

Lanka +
413 Havelock Road, Colombo- 6, Sri Lanka
Phone - 941 765 234

HIV/AIDS in Nepal

From: www.youandaids.org/AsiaPacific/Nepal.asp

HIV Situation

The first cases of AIDS were reported in Nepal in 1988. Surveillance data is scarce in Nepal. However, limited data indicate that HIV prevalence is currently around 0.5 percent in the general population. As of June 2002, the Ministry of Health (MoH) has reported 606 cases of AIDS and 2,392 HIV infections. Given the existing medical and public health infrastructure in Nepal and the lack of continuity in national HIV/AIDS surveillance systems, it is very likely that the actual number of cases is many times higher. UNAIDS/WHO estimate for 2002 around 60,018 people living with HIV/AIDS and 2958 AIDS related deaths in that year alone.

However, the currently low prevalence among the general population masks an increasing prevalence in several groups: CSWs in Katmandu 17.3% (SACTS/FHI, 2000), IDUs 40.4% nationwide, and 68% in the Kathmandu Valley (NCASC, 2000; FHI, 2002). It is now evident that Nepal has entered a "**concentrated epidemic**", i.e. the HIV/AIDS prevalence consistently exceeds 5% in one or more sub-groups.

The HIV situation in Nepal is characterised by the high prevalence among groups involved in high-risk behaviour. Among street sex workers in Kathmandu, it rose from about one per cent in 1992 to about 16 per cent in 1998. Among Intravenous Drug Users (IDUs), it rose from about two per cent in 1991 to 50 per cent in 1997.

The prevalence in general population in Nepal is still low, but is rising rapidly. There are indications that the transmission among housewives is increasing. Though the infection is found everywhere, it is concentrated in the capital.

Nepal's inherent socio-economic ills make the country quite vulnerable to the epidemic though reportedly the prevalence rate is still low. Commercial sex work is rampant and trafficking of women for sex work in the brothels in Indian cities is a perennial problem. Migration, increasing Injecting Drug Use and acute marginalisation of people make Nepal an easy target for HIV.

The HIV/AIDS Epidemiological Situation in Nepal

	Data Date
Reported HIV cases	2392 June 2002
Reported AIDS cases	606 June 2002
Estimated number of adults & children living with HIV/AIDS	60,018 End 2002 (WHO/UNAIDS estimates)
Estimated adult and child mortality due to HIV/AIDS	2,958 End 2002

HIV prevalence

IDUs	68 % 2002
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SWs	17.3 % 2000
STI patients	0.7-6.6 2000
Blood donors	0.28-0.48 2000
ANC	0.2 % 2000

Sources: Reported cases: MoH data; Estimates: UNAIDS/WHO working group on global HIV/AIDS and STI surveillance; Estimated HIV prevalence IDU: New Era Study 2002, MoH 1999; Estimated HIV prevalence CSW: SACTS/FHI study, 2000; STI patients: MoH/University of Heidelberg 2000; Blood donors: Red Cross Nepal; ANC: MoH/University of Heidelberg.

Epidemiological Factors

- Predominant mode of transmission is sexual contact, presumably mainly heterosexual.
- Limited information available about homosexual/bisexual transmission.
- Highest rates of HIV have been identified in injecting drug users (IDUs).
- Data indicates that risk behaviours are widespread among sex Workers (CSWs), their clients, injecting drug users, labour migrants and youth/young people.
- Current estimated HIV infection rate - 0.5 % of the adult population between the ages of 15 - 49.
- There is evidence of an explosive increase in the number of infections since 1996.
- Increasing levels of Sexually Transmitted Infections (STIs) reported.

Male/Female Ratio

- Approximately 3:1 (NCASC, 2001)

Geographic Distribution

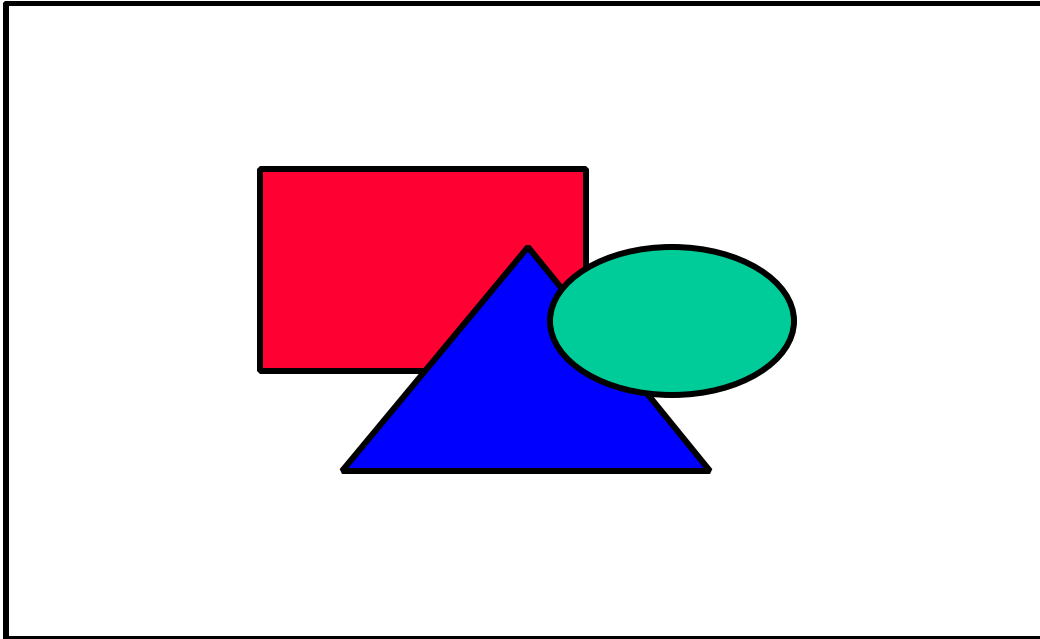
- Highest prevalence rates found in the Central Region.
- Rural / urban ratio - to be determined
- HIV infection has been noted in all regions of the country, although HIV infection appears to be concentrated in urbanized areas and districts with high labour migration

The Potential for a Rapid Increase in HIV Prevalence

Behavioural and seroprevalence data indicate the high potential for a generalized epidemic in Nepal. In the absence of effective interventions, even a "low to moderate growth scenario" would make **AIDS the leading cause of death in the 15-49 year old population over the coming years**. For Nepal this would mean that around 100,000-200,000 young adults will become infected and that overall 10,000-15,000 annual AIDS cases and deaths may be expected.

The following table shows three scenarios: a "low-stable" scenario, with the seroprevalence leveling off at 0.5% in 2005; a "low-moderate growth" estimate with a prevalence rate of 1% in three years time; and finally a "moderate growth" model, reaching 1.6% in 2005. The difference between the three scenarios is the actual gain in lives, provided that the response to the epidemic in Nepal is effective enough to impact on the development of the epidemic.

HIV Prevalence in Nepal: Historical and scenarios for its development



For Nepal, a generalized epidemic with high mortality in the productive age group would start a "vicious circle". The impact of HIV/AIDS would increase poverty and vulnerability. This increased vulnerability would lead to more HIV infections and a higher impact. Besides the negative impact on socio-economic development and the loss of productive life, the burden of disease would change dramatically over the next 10 years and would put further stress on the health sector and local communities.

Injecting Drug Users (IDUs)

Due to the limited coverage of interventions, HIV spread undetected among IDUs and a rapid assessment in 1999 showed an HIV prevalence among injecting drug users nationwide of 40% and 68% in the Kathmandu Valley (Response Analysis, 2000, FHI, 2002). Behavioural research among IDUs in Nepal clearly indicates that needle sharing, the major risk factor for HIV is common.

Although IDUs constitute the population sub-group in which HIV threatened to rise most rapidly neither governmental nor non-governmental capacity and policy were positioned to mount an effective response.

IDUs in Nepal are threatened not only by their behavioural risks but also by a societal response, which ostracizes drug use and uses a predominantly punitive model coupled with limited drug treatment facilities. HIV and STI prevention services for IDU are often of questionable quality mainly because they are not designed with the needs of the end-user in mind. These limitations signal an ominous trend of increasing HIV prevalence among this highly marginalized group.

Among all IDUs in Nepal (estimated number 30,000), approximately 40% are HIV positive, and among IDUs in Kathmandu (estimated 10,000-15,000) the rate has increased to around 70%. In addition, a survey among 300 CSWs in Kathmandu (FHI, 2000) revealed that 15 women had also injected drugs, representing 5% of the

total sample. Of these 15 women, 11 were found to be HIV positive.

Commercial Sex Workers (CSWs) and Their Clients

Due to their highly marginalized status in society, CSWs have little access to accurate information about reproductive health and STIs. Cultural, economic and social constraints limit their access to legal protection and to medical services.

A survey by Family Health International in 1999 among CSWs and truckers along the high way routes in the Terai showed that 75% of the truckers had had sex with a sex worker and that only 70% of the truckers had used a condom in the last sexual encounter. The survey showed that the STI prevalence among the truckers was 10.2% and the HIV prevalence was 1.5%. As regards CSWs, 69% of clients were truckers and 51% migrant workers. Only 40% of clients had used a condom in the last sexual encounter. Overall, HIV prevalence among CSWs was 4%. Of those CSWs who had recently worked in Mumbai (India) it was up to 50%.

A survey in Kathmandu in 2000 revealed that 17 percent of CSWs were HIV-positive - up from 2.7 percent in 1997 (USAID 2001). It is estimated that 70 percent of CSWs returning from India are HIV-positive. There are no overall national statistics for prevalence among CSWs but it is likely to be high and growing.

Most CSWs experience increased vulnerability to HIV/AIDS due to a low level of education, which restricts access to information and health care services. They have little control over the risk in sexual encounters because the client often determines whether or not to use a condom. Moreover violence against CSWs is common.

Mobile Population

"Mobility" has complex causes, ranging from economic and/or political reasons to "forced" displacement (e.g. conflict, trafficking). Each of these mobile groups and their respective families are vulnerable to HIV/AIDS/STI in different ways. Economic migration, both internal and external is not a new phenomenon in Nepal. Estimates range from 1.5 to 2 million Nepali nationals who work outside the country, 1 million are estimated to be in different parts of India alone. Although information is limited about the behaviour of labour migrants in their respective host countries, the assumption is that during their long absence from their families a considerable number of them become clients of CSWs. Recent studies among labour migrants revealed HIV sero-prevalence rates of between 2-10% for migrants returning from Mumbai/India.

Estimates of women trafficked to India range from between 150,000 - 200,000.

Conflict triggered migration from rural areas in Nepal to urban centers is not exactly known but is thought to be considerable.

Most of the 60,000 people living with HIV/AIDS (PLWHA) do not know they are infected and many of them may be engaging in unsafe sexual practices. Pervasive stigma and discrimination will prevent these people and others in the high-risk groups from practicing safe sex, undergoing testing, and if they know they are infected from seeking treatment and care.

Sexually Transmitted Infections (STIs)

STIs (often also called STDs – Sexually Transmitted Diseases) also form a significant

part of the epidemic. It is estimated that 200,000 episodes of STIs occur annually in Nepal. The STI prevalence rate in women is approximately 4.7% ranging from 2.7% - 5.4%. Access to STI services is still very poor, especially for women. In addition, the use of condoms for effective infection prevention is not yet commonly known or accepted. Condoms contributed to only 1.1% of the total contraceptive prevalence rate. At present other methods of contraception are emphasized, which leave women vulnerable to infection and force them to negotiate condom use for infection prevention.

The prevalence among STI patients has been fluctuating. In Kathmandu, it ranged from 1 per cent to five per cent in 1998. In Mahendranagar, there was a clear trend upward in 1990s. In Nepalgunj, the situation was static between 1996 and 1999. In essence, the prevalence ranged from no evidence to three per cent. Sentinel surveys in pregnant women in 1991 and 1992 in eight districts showed no evidence. (US Census Bureau, HIV/AIDS Surveillance database, June 2000).

Estimates

Figures Value Year Source

58,000
2001
UNAIDS Global HIV/AIDS Report 2002

56,000
2001
UNAIDS Global HIV/AIDS Report 2002

14,000
2001
UNAIDS Global HIV/AIDS Report 2002

1500
2001
UNAIDS Global HIV/AIDS Report 2002

2400
2001
UNAIDS Global HIV/AIDS Report 2002

13,000
2001
UNAIDS Global HIV/AIDS Report 2002

Estimated Number of HIV cases (Adults and children)

Adults (15-49 years)

Women (15-49)

Children

Estimated number of deaths due to AIDS

Estimated Number of AIDS orphans

The National Response

The National AIDS Prevention and Control Programme (NAPCP) was established in 1987. In 1995, a National policy on HIV/AIDS was drafted. It was submitted for parliamentary approval by the council of ministers. The government expressed commitment to manage HIV/AIDS and STI prevention on a priority basis with appropriate financial and human resources. It was planned to be implemented as a multisectoral programme through the Government and NGOs.

The National Strategic Plan 1997 clearly indicates Government commitment to mobilise and involve various ministries. During December 1997, the Ministry of Health, Ministry of Education and Ministry of Women and Social Welfare signed a tripartite joint statement for HIV & AIDS education for school age children, both in and out of school.

The National coordinating body for HIV/AIDS prevention and control is the National AIDS Coordination Committee (NACC), which is chaired by the Health Minister. NACC is operational from 1992. It is multisectoral and includes 40 representatives from different ministries, NGO, UN and the civil sector. The National Centre for AIDS and STI Control (NCASC), a forum to mobilize multisectoral commitment, to take major decision and to advice policy for advocacy acts as the secretariat.

Based on the National Policy, a "Strategic Plan for HIV and AIDS in Nepal", covering 1997 to 2001 was developed and adopted. It tried to operationalize the national policy and to define key activities for each policy objective. Although the strategic plan contained a number of activities aimed at prevention of a fast spread of the epidemic, only few of them were actually implemented. The strategic plan sought to broaden the response to other sectors beyond the health ministry and to integrate HIV/AIDS concerns within these sectors. Factors relating to mobility of populations, urbanization, heavy labour migration to areas where huge infrastructure programmes are being undertaken, the open border between Nepal and India and poverty have been recognized as casual factors for the spread of the infection in the country.

Recently Nepal established a "National AIDS Council" chaired by the Prime Minister. The Council with representation from government, non-governmental organisations, private sector and civil society will take the lead in policy making and will advocate for multi-sectoral participation in the fight against HIV/AIDS in Nepal.

Nepal has been a signatory to a number of international declarations - the most recent being the UNGASS Declaration on HIV/AIDS agreed to in June 2001. In addition, Nepal has been a party to other key international agreements such as the "Melbourne Manifesto" emanating from the Sixth International Congress on AIDS in Asia and the Pacific in October 2001. Further, Nepal has implicitly adopted the "Greater Involvement of People Living with AIDS Principle (GIPA)" through its

participation and approval of the UNGASS and Melbourne documents and other international agreements. Thus, at the international level, Nepal has adopted a sound fundamental set of general guidelines and principles, which should underpin the national strategy. These guidelines and principles include:

- **Multi-Sectoral Engagement:** As the epidemic is complex, affects all parts of society, involves individual, institutional and social behaviour, and far transcends the health sector, effective national responses must be multi-sectoral in spirit and structure.
- **Broad Political Commitment:** As the UNGASS Declaration states, "Leadership by governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community, and the private sector. Leadership involves personal commitment and concrete actions."
- **Civil Society Involvement:** As sub-components of a multi-sectoral approach and political commitment, the involvement of civil society is nevertheless worthy of highlighting as a central principle in the response. Without meaningful involvement of those groups representing all segments of society, the response will be inadequate. In particular, groups representing PLWHA need to be involved not only as meaningful participants in policy and program discussions, but also actively involved in the organizations and agencies that implement programs. The GIPA principle is a critical element.
- **Stigma Reduction:** The adverse impacts of stigma and discrimination are being increasingly recognized as key barriers to combating the epidemic. Commitment to reducing stigma is therefore a central guideline and principle in all-international agreements.
- **Prevention to Care Continuum:** A keystone to the international response is recognition and adoption of programmes that address the epidemic at all stages from prevention to care, support and treatment. To wit: "acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic" (UNGASS). Specifically, UNGASS emphasizes "...that care, support, and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential counseling and testing and by keeping PLWHA and vulnerable groups in close contact with health-care systems and facilitating their access to information, counseling, and preventive supplies."
- **Human Rights Based Approaches:** All international declarations reference the absolute need to take strong human rights approaches for combating the HIV/AIDS epidemic. The reasons for this are well documented and related to fundamental rights such as access to health care, information, and gender equity. In addition, human rights approaches have powerful programmatic effects as they reduce vulnerability to HIV/AIDS and also help prevent stigma and discrimination against people living with or at risk of HIV/AIDS.

UN Support

Country Programme Adviser: Mr. Michael Hahn

Address:

UNAIDS, C/o UNDP,
UN Common Building
P.O.Box: 107, Pulchowk
Lalitpur, Kathmandu
Tel: (977) 1 52 3200 Ext. 1047
Direct: (977) 1 52 8989
Fax: (977) 1 52 8989
Email: Michael.hahn@undp.org

UN Offices

(UNDP) United Nations Development Programme
UNAIDS (Joint United Nations Programme on HIV/AIDS)

Mr. Henning Karcher
UN Resident Coordinator/ UNDP Resident Representative
UNDP Nepal
United Nations Building
Pulchowk, Kathmandu,
Nepal
Mail Address: UNDP Nepal
P.O.Box 107
Kathmandu, Nepal
Phone: (977-1) 523200
Fax: (977-1) 523991, (977-1) 523986
E-mail: fo.npl@undp.org, registry.np@undp.org
URL: www.nepali.net/undp/

Michael Hahn
Country Programme Advisor
UNAIDS
C/o UNDP, UN Common Building
PO Box 107,
Pulchowk Lalitpur,
Kathmandu
Phone: (977)1 52 3200 ext 1047
Fax: (977) 1 52 8989
E-mail: <mailto:michael.hahn@undp.org>

UNICEF (United Nations Children Fund)
UNFPA (United Nations Population Fund)

Mail Address: P.O. Box 1187, Kathmandu, Nepal
Cable Address: UNICEF KATHMANDU
Telex Number: 2206 UNDP NP
Phone: 523200
Telefax No.: 977-1-527280, 535395, 523991, 523986
E-mail: unicef@unicef.org.np

P.O. Box 107
Kathmandu
E-mail: registry.unfpa@undp.org.np

UNESCO (United Nations Educational, Scientific and Cultural Organization)
WHO (World Health Organization)

Mr Yoshiaki kitamura
UNESCO Office Kathmandu
Ring Road, Bansbari
Kathmandu Nepal
Mail Address: P.O. Box 14391
Kathmandu Nepal
Phone: 977-1- 374009, 374010
Fax: 977-1- 373004

E-mail: kathmandu@unesco.org

URL: www.unesco.org.np/

Dr Klaus Wagner
WHO Representative
P.O. Box No. 108
Kathmandu, Nepal
Phone: 00-977-1-523200, 523993
Fax: 00-977-1-527756

E-mail: wr@who.org.np, wagnerk@who.org.np

ILO (International Labour Organization)
WORLD BANK

ILO Activities Office in Kathmandu
Sanepa, Ring Road,
P.O.Box 8971
Kathmandu

Phone: (+977 1) 53 17 52

Fax: (+977 1) 53 13 32

E-Mail: kathmandu@ilo.org

Mr. Rajib Upadhya
Yak and Yeti Hotel Complex
Lal Durbar, Durbar Marg
Kathmandu, Nepal
Phone: (977-1) 226792/3 Extn. 102
Fax: (977-1) 225112

E-mail: rupadhya@worldbank.org

URL : www.worldbank.org.np/

Sources: UN Agencies, World Bank, HIV/AIDS Surveillance Data Base (US Census Bureau), June 2000, AIDS Control Programme and Management in Nepal, 1995, UNAIDS Epidemiological Fact Sheet, 2000, Nepal's National HIV/AIDS Strategy, Nepal's presentation at UNGASS and Budget Speech (2000-2001) by Mr. Mahesh Acharya, Finance Minister of Nepal.

Support organisations for people living with HIV/AIDS

Makwanpur Group of Infected and Affected women

c/o RECPHEC

Bagbazar

Kathmandu, Nepal

Phone - 977 1 529503 Prerana

P.O Box:20126

Kathmandu.

Phone - 977 1 425901

Email - prerana@infociub.com.np

Nepalplus

Post Box 8801

Kathmandu, Nepal

Phone - 977 1 492904

Fax - 977 1 421070

Email - nepalplus2002@yahoo.com

HIV/AIDS in United Arab Emirates

The National Program for AIDS Control & Prevention

Available on the UAE government website:

http://www.moh.gov.ae/moh_site/Prev_med/anbk/s19.htm

AIDS Outlook in the UAE

According to World Health Organization statistics the UAE and neighboring countries have some of the lowest number of reported HIV/AIDS cases in the world (EMRO, *EMR AIDSnews*, volume 3, number 3, Sept. 1999).

Cultural, social and behavioural norms have contributed to keeping infection at these very low levels. However, another contributing factor is the AIDS Control Program, one of the first programs of its kind in the region.

National AIDS Control & Prevention Program

The National AIDS Control and Prevention Program was established in 1985 in response to the increasing awareness of policy makers of the growing health, socio-economic, and development crises of HIV/AIDS globally and regionally the of which are important for the UAE especially in view of the large communities of expatriates from endemic countries. The program is a partnership between governmental and private institutions and organizations with budget allocations from federal and local governments as well as from other sources.

The ultimate objective of the program is to prevent transmission of the disease and control its importation into the country through primary prevention, early detection and effective management. The program is implemented, coordinated and supervised by the Federal Ministry of Health in cooperation with other federal and local health authorities. These functions are conducted through central and district-level committees for national AIDS control and prevention.

The program has several components including legislation, prevention and early detection.

1. Legislation:

A number of laws and decrees have been promulgated to regulate different aspects of the program. The most important of these include:

- *Council of Ministers Order No. (10) of 1985* added HIV/AIDS to the list of notifiable diseases;
- *Ministerial Decree No. (502) of 1989* endorsed the National AIDS Control Program and mandated the screening of all blood, blood products, tissues or organs before transplantation in addition to population groups at high risk of infection. This decree also called for the formation of a Central Committee for the National AIDS Program with members from various relevant governmental and non-governmental sectors;
- *Ministerial Decree No. (506) of 1989* stipulated the formation of AIDS control committees at the district level. These committees would be responsible for the execution of all preventive measures in accordance with the National AIDS Control strategies, Plan of Action and directives issued by the Central HIV/AIDS Committee.

- Other important regulations govern the issue of confidentiality of HIV tests. For example, as results of HIV tests are highly confidential they should not be accessed except when necessary and by the relevant health authority.

2. Prevention:

Health education is the cornerstone of primary prevention of HIV/AIDS in the UAE. The Ministry of Health has published several general and risk group-specific information packets on HIV/AIDS and has organized international scientific conferences on recent advances in the prevention, diagnosis and treatment of HIV/AIDS. This is in addition to regular seminars and workshops on HIV/AIDS, its mode of transmission and risk factors as well as annual health education activities to mark the the World AIDS Day.

Furthermore, the Ministry of Health has strengthened its collaboration with the media in reaching out to the general population with health information on HIV/AIDS. It is also reinforcing its partnership with other government agencies in designing group-specific health education material. For example, the Ministries of Health and Education are working together to provide information on HIV/AIDS to students through introducing basic information on the infection and disease in school curriculums of middle and high school students. They are also developing health education programs specifically for school teachers.

3. Early Detection and Screening

Early detection and screening activities of the National AIDS Control Program include:

- Screening of blood, blood products, organs, and tissues before transfusion or transplantation;
- Screening of population groups to include:
 - blood donors;
 - hospital inpatients;
 - workers in communicable disease diagnostic laboratories;
 - workers in blood banks;
 - hospital-based health care workers;
 - attendants at antenatal care clinics;
 - attendants at STI and Skin Disease Clinics;
 - prisonors;
 - persons referred for psychiatric care as a result of drug abuse or offenses of a sexual nature;
 - active surveillance.

Initial screening takes place in 16 laboratories nationwide three of which are designated as reference laboratories.

Prospective Plans

No cases of transmission through blood or blood products provided in UAE facilities have been recorded since 1985 when the AIDS Program was first implemented. This and the very low prevalence of HIV/AIDS in the country point to the success of the National AIDS Control Program and prevalent behavioural norms in controlling the spread of infection and disease. However, and like any other program of its kind, the UAE AIDS Control Program is continuously evolving in order to meet the threat that new global patterns of infection may mean to the UAE within the context of changing social dynamics in the country.

HIV/AIDS in Bahrain

Contact organisations

Middle East & North Africa Gender Communication Network

Name: Dr. Amal Al Jowder
Email: Bahrainfp@mena-gcn.net

Bahrain Red Crescent Society

hilal@batelco.com.bh , amall234@batelco.com.bh

email:

00973-291797, 00973-279546

Fax:

00973-293171-2, 00973-279610

Tel:

▶HIV/AIDS Training Workshop in Bahrain for women

In collaboration with the Bahrain Red Crescent Society, the Office of Health Training and Programmes for fighting with HIV/AIDS (Middle East & North Africa Gender Communication Network) held a training workshop on HIV/AIDS and its discrimination. 23 participants including 10 representatives from the Islamic Association, 5 from the Women Association, 1 representative of Professional Association and 7 female specialists in health-training attended the workshop.

In this workshop, Dr. Someye Al-Joudar, Head of Programmes for Combating HIV/AIDS and Dr. Amal Al-Joudar, Head of Health Training Department facilitated the materials in area of HIV/AIDS and its discrimination for participants. The participants in this workshop were comprised of women who are members of the Non-Governmental Organisations (NGOs) as well as some specialists of health training.

The workshop aimed at promoting participants awareness, introducing the ways that this disease is spread, how the people are infected, and how to avoid infection, showing the effectiveness of health policies in increasing public awareness, developing skills as well as disseminating positive attitudes and the community support. Working groups reached consensus on 9 final recommendations as follows:

1. Issuing a compulsory law for performing HIV/AIDS test prior to marriage;
2. Setting up an Association for Combating HIV/AIDS;
3. Establishing a comprehensive centre for combating HIV/AIDS;
4. Requesting the king to support the programmes of combating HIV/AIDS;
5. Making demonstration by focusing on the disease;
6. Preparing health publications describing the disease clearly;
7. Re-establishing the National Committee for Combating HIV/AIDS by the partnership of all government and non-governmental organisations and departments;
8. Paving the way for the continued and strengthened cooperation of health training departments with the Education Ministry;
9. Holding more training workshops.

HIV/AIDS in QATAR

Statement of
The State of Qatar
Delivered by:
H.E. Dr. Hajar Ahmad Hajar Al-Binali
Minister of Public Health
at the Special Session of the
U.N. General Assembly
on HIV/AIDS
25 - 27 June, 2001
June 26, 2001 • New York

When HIV/AIDS was discovered the first time twenty years ago, no one had expected that this tiny virus would be the biggest global health threat to the entire mankind, as it disrupts the social and demographic structure and destroys economies and threatens political stability of many countries. Furthermore, the emergence of new strains of HIV, that resist the existing anti-retroviral medicines, makes it imperative that we develop a future strategy to effectively respond to these new strains of the virus whenever they are discerned.

The latest statistics indicate that the number of people living with HIV has reached 38 millions, and that 22 millions people have died since the beginning of the pandemic, most of whom were at the peak of their productive life, i.e. 15 - 49 years of age. This will definitely leave significant imbalance in the population structure of societies in many countries as well as the negative impact on human resources badly needed to move the wheels of economy. The rampant spread of this serious illness in our small planet in this short period of time requires an immediate global alertness and a sincere and firm position by all to combat this awful epidemic. And I believe that we are capable of achieving this goal since, over the past 20 years, we have accumulated great knowledge about all aspects of the disease that should enable us to stop it from spreading further. It is now time to provide the necessary political commitment to utilize and apply this knowledge.

We, in the State of Qatar, believe in the importance of cultural diversity because we trust that it enriches humans progress and development. However, when some specific risky types of behaviour in certain societies become a source of danger for the rest of the world, as they are closely linked with HIV spread, then we are required to stand up against such behaviours.

The State of Qatar is doing its best to fight this disease and to limit its spread. And since we are not isolated from the rest of the world, we have diagnosed 164 cases during the last 20 years, most of them acquired the virus from blood transfusion of imported blood before 1985. Although our numbers seem to be small, the relatively small number of the country's population, of about 600,000 people makes every newly discovered case a disaster.

The State of Qatar provides all the necessary medical services and support for people living with HIV/AIDS, including anti-retroviral therapy, psychological and social counselling for patients and their families, and ensures their enjoyment of their full civil and political rights. The State of Qatar is convinced that the best way to prevent the spread of the disease is through increasing awareness among the population. The Qatari society remains mostly religious and conservative, which helped in limiting the spread of the disease.

The lack of commitment towards the fundamental principles of good human behaviour, basic social values and religious or spiritual teachings, is the most important element in the rapid spread of this disease throughout the world. Therefore we must emphasize the importance of teaching those basic principles in our school curricula, and emphasize to our children the link between the lack of those values and the risk for many serious infectious diseases.

In addition, we need to be good examples to our youth emphasizing to them the long honored values and principles that we inherited, and discourage them from blindly following glimmering but risky types of behaviour.

This ravaging spread of HIV throughout the world requires that we stand up together and take up the responsibility as a whole, and get rid-of, the notion that this disease is someone else's responsibility. Indeed, the world has become small, and people are no longer isolated from each other, and any threat of infectious disease in any country in the world is a threat to the whole world.

Therefore, the State of Qatar supports the following steps to be taken:

First: Tackling the problem of the developing countries debts, especially the poorest countries heavily afflicted by the epidemic. Thus, there is an urgent need for providing more financial resources from developed nations in addition to the commitment of the G-7 group to write off some of the debts carried by countries afflicted with HIV/AIDS.

Second: Development and improvement of the health systems in those countries to provide proper medical care, treatment and follow up for HIV patients; permission to transfer the technologies of anti-retroviral medications and prohibits monopoly. Providing such medicines at affordable cost for low income countries, and ensuring continuity of supply of such medicines, regardless of the negative impact such policies may have on the profits of big drug companies.

Third: Exchanging expertise in the area of HIV/AIDS prevention in order to limit the spread of the virus using all necessary means and tools to achieve this, including availability of condoms and sterile syringes.

Fourth: Intensifying the efforts to support scientific research in order to hasten the fording of a definite cure for the disease, and in order to come up with an effective vaccine that can be used to eradicate the virus from the face of earth, as we did with smallpox.

Fifth: Providing prophylaxis against latent tuberculosis infection for all HIV infected individuals since TB is the main cause of death among HIV-positive people in developing countries, taking into consideration the fact that the

spread of HIV created a favourable environment for the spread of multi drug resistant TB.

Sixth : The most important action that will have an immediate positive impact is investing more money and efforts towards increasing the awareness at society level, and creating an international sense of responsibility at an individual level with more emphasis on adhering to moral values.

In conclusion, Mr. President, I extend my thanks to you, to the Secretary General, H.E. Mr. Kofi Anan, and to your assistants for your commendable efforts in organizing and sponsoring this special session of the General Assembly.

HIV/AIDS in Jordan

Jordan's Queen Noor warns against complacency in fights against HIV / AIDS

Queen Noor warned Wednesday against complacency in the fights against the spread of HIV / AIDS and urged rich countries and private businesses to assist developing nations meet the challenge of combating the virus.

“Even in regions like the Middle East, which according to available information, has not experienced the tragic numbers of infections and deaths witnessed in other parts of the world, complacency is dangerous,” Queen Noor told the closing session of the United Nations’ symposium for World Aids Day held at the UN headquarters in New York. “It is clear from the experiences of more-affected regions that if we do not act now to confront this threat more openly and honestly, and multiply our efforts to educate everyone, young and old, we may be faced with significantly wider HIV spread.”

The Middle East and North Africa have officially reported 7,400 AIDS cases and more than 29,000 HIV infections since the beginning of the epidemic until 1998. Health officials estimate that people living with HIV exceed 300,000. While Arab countries have somewhat succeeded in curtailing the first wave of the global HIV epidemic primarily caused by contaminated blood and blood products, HIV is starting to spread swiftly in some countries, according to these officials.

The Queen noted that “Lebanon has increased fourfold its reported AIDS cases in one year. Even in countries where the epidemic had appeared to be invisible, HIV outbreaks have had a considerable impact, for example among kidney dialysis patients in Egypt, hundreds of children in Libya, intervenes drug users in prisons in Iran and among STI (sexually transmitted infection) patients in Yemen.” She added that while “national AIDS programs exist in all countries, and some governments have succeeded in building effective partnerships with civil society, unfortunately, in most cases the response has not been proportionate to the magnitude of the problem. ... We are now at a crossroads and the window of opportunity for the East Mediterranean countries narrows every day.”

Queen Noor affirmed that “in our region, in particular, we have an invaluable asset in the teachings of Islam. During the Prophet Mohammed’s time, the dreaded Plague hit a town, Imuas, and people were so terrorized that they refused to call the disease by its name. The Prophet insisted to call it the ‘Imuas Plague’ to raise awareness and encouraged people to face it head on. Religious bodies in the Arab World have been very understanding and supportive in spreading the message about the disease in an effort to stem its spread.”

UN Secretary-General Kofi Annan noted that “half of those infected this year are under the age of 25 and will probably die before they reach the age of 35.” He urged the world to “fight the conspiracy of silence” and “battle the culture of shame” for “hiding AIDS behind the curtain of stigma helps to spread it.”

Over 33 million people around the world are living with HIV and AIDS, the majority in developing countries. The epidemic has been recognized as a crisis of “catastrophic” proportions in Africa, south of the Sahara. HIV / AIDS threatens not only the health and wellbeing of people living with the disease, and those close to them, but also their human rights and dignity.

“This is a problem that knows no political, economic and social boundaries; a truly global problem for a global age. But working together, we will find solutions. For the sake of our children, we must,” Queen Noor said.

National AIDS Program

The relatively low-level and stable HIV epidemic in Jordan has not aroused widespread donor action. In general, the donor community is not directly addressing at-risk populations, and HIV/AIDS prevention and care are not the primary focus of most projects.

Family Health International organized seminars and regular meetings of the National AIDS Committee to provide updates on recent advances on HIV/AIDS. In collaboration with UNAIDS, Family Health International addressed the importance of having a strategy for facing HIV/AIDS in Jordan.

Behaviour Change Communication

With USAID funds, Family Health International conducted a training workshop designed to introduce participants to the concept of behaviour change communication. Workshop participants included representatives from the Ministry of Health, the Health Education Department, various nongovernmental organizations, and representatives from the private sector and the Jordanian mass media.

Care and Support

Earlier in the year, a day clinic and a hotline were established to provide antiretrovirals and condoms, in a non-judgmental environment, to HIV-positive persons. Medical monitoring and treatment accompanied these services. During this reporting period, Family Health International, with funds from USAID, procured specialized laboratory equipment to monitor the immune functions of HIV-infected individuals.

Involving People Living with HIV/AIDS

Most people with AIDS in Jordan do not tell others of their condition, and those who do are sometimes persecuted. It will not be possible to make progress in combating the epidemic unless AIDS becomes visible, stigma is challenged, and people living with HIV are encouraged to play their part in a community-wide AIDS response. This requires resolve and courageous leadership at various levels, particularly by government and religious leaders.

Multisectoral Programs

Different sectors, such as nongovernmental organizations, private sector, government, and volunteers, are involved in all skill-building activities. USAID is providing technical assistance and training to the Jordanian Association for Family Planning. The program aims to increase efficiency in health financing and management, and provide specialized technical support. Specific activities include a program on HIV/AIDS management and impact; support for demographic and health surveys; infectious disease surveillance; efforts to introduce new family planning methods and improve the quality of services offered by public and private providers; and support for the National

Population Council and other organizations on communication strategies, policy development, and other issues.

Prevention

USAID is working with the UNAIDS initiative to assist the National AIDS Program to expand its prevention strategy for susceptible groups by increasing awareness of the risks attached to sexual activity and by teaching people how they can protect themselves against such risks. The strategy includes a situational analysis to determine awareness levels and behaviour patterns among the young population. Technical assistance is being given to the National AIDS Program to address surveillance issues; facilitate a subcommittee to oversee the study of sexually transmitted infections; and establish a strategy and policy to control the spread of such infections.

Research

Through Family Health International, USAID is working to design and implement a prevalence study of sexually transmitted infections among the general population to determine the prevalence of such infections and risky sexual behaviours related to transmission of HIV and other sexual infections. Qualitative research (focus groups) is being conducted to gain knowledge of risky sexual behaviours among youth and the results are being disseminated to National AIDS Committee members.

Youth and HIV/AIDS

Family Health International, with funds from USAID, conducted peer counselor training for more than 20 volunteers. These volunteers were composed of mainly youth from organizations such as the United Nations Children's Fund, the Red Crescent Society, the Ministry of Health, and the Family Guidance and Awareness Center. The four-day training was designed to teach the concept of peer education, provide practical skills for communicating with peers, and provide hard-to-reach groups with HIV/AIDS messages. Each trainee established targets of young people to educate, and IMPACT developed systems to monitor the numbers reached through time.

To further target youth, IMPACT produced approximately 5,000 information, education, and communication materials (notebooks and folders) to promote the HIV/AIDS Hotline and Counseling Center. These materials were distributed to students entering the University of Jordan. Currently, 1,500 youth have participated in the peer-education training.

Providing young Jordanians with the right information on prevention and promoting healthy lifestyles in a language they understand is essential for success in any AIDS response. Research has shown that regardless of the stage of the epidemic, investing in young people must always be a priority. In every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred.

Today, approximately 40 percent of Jordan's 5.2 million people are under the age of 15. The 2000 Jordan Youth Survey showed that most young Jordanians had a basic understanding of family planning and sexually transmitted infections.

According to health experts, several social factors make young people in Jordan particularly vulnerable to contracting HIV/AIDS. In a conservative culture in which open discussion of sexual behaviour is considered taboo, youth lack access to reliable information and guidance about such matters, both in and out of school. Economic hardships in Jordan have also taken their toll on youth. More and more young Jordanians are delaying their age of marriage, which leads to more sexual contacts outside of marriage. High unemployment has left young people spending their spare time in cafes and amusement centers or working as unskilled laborers, which in turn, exposes them to potential pressure for risky sexual behaviour.

Voluntary Counseling and Testing

Through Family Health International, USAID renovated and equipped a voluntary counseling and testing unit in August 2001 and provided technical assistance to the hotline and counseling center through refresher training for staff counselors and the provision of a counseling manual in Arabic. Information, education, and communication materials have been developed to raise local awareness of the Counseling Center and its services.

Contact organisation

Jordanian Association for Family Planning & Protection

Phone: 06-5161032

Address: The Jordanian Association for Family Planning and Protection
Amman –Jordan

Men in Jordan Get Involved in "Together for a Happy Family" *Royal Family, Religious Leaders Support Family Planning Campaign* (January 2003)

Getting men involved in family planning decisions can be difficult in a Muslim country like Jordan, where many people are unaware that Islam permits modern family planning methods. "Together for a Happy Family," an integrated behaviour change communication program, effectively addressed this issue by enlisting religious leaders and Jordan's royal family to help men and women increase their knowledge and change their behaviour regarding the use of modern methods.

For full report, see: <http://www.jhuccp.org/pubs/ci/14/>

To learn more about "*Together for a Happy Family*" contact:

Alfred Yassa, MD, MPH
Senior Health & Communication Advisor
Soliman Farah, MD, MPH
Jordan Resident Advisor
Johns Hopkins University
Bloomberg School of Public Health
Center for Communication Programs
111 Market Place, Suite 310
Baltimore, Maryland 21202, USA
Tel: (410) 659-6300
Fax: (410) 659-6266

HIV/AIDS in Lebanon

Contact organisations

Dr. Mostafa El Nakib
National AIDS Programme Manager
Ministry of Health
Beirut

<http://www.emro.who.int/ASD/CountryNews-SpecialProjects-LEB.htm>

Project managed through the national AIDS programme include:

PROJECT 1

Themes:

Care and access to drugs

Title:

Development of a center for medico-psycho-social care and support of people living with AIDS in Lebanon

Sites (locations) of main activities:

Beirut, and then other parts of the country.

Beneficiary groups:

People living with AIDS and their families.

Main objective:

Alleviate the impact of the epidemic on people living with AIDS.

Specific objectives:

- 1- Development of a Centre for comprehensive management of people living with AIDS
- 2- Provide appropriate medico-psych-social support to People living with AIDS.
- 3- Promote best practices.
- 4- Develop and establish the concept of partnership with non-governmental organizations.
- 5- Promote and defend rights of people living with AIDS.
- 6- Advocate for the mobilization of resources.

Strategies:

- 1- develop and institute partnership with non-governmental organizations.
- 2- reinforce the capacity of case management by reinforcing human and material capacities and resources.
- 3- promote the services provided.
- 4- develop legal support.
- 5- implicate people living with HIV/AIDS in prevention and care related to HIV.
- 6- support development of similar care centers across the country.
- 7- recuperate the costs.

PROJECT 2

Themes:

- 1- Prevention
- 2- Specific populations

Title:

HIV/AIDS prevention through outreach to vulnerable populations in Beirut, Lebanon.

Sites (locations) of main activities:

Beirut, its suburbs and the coastal areas.

Beneficiary groups:

vulnerable populations, including different categories of women involved in sex work and their male clients, men who have sex with men, street youths and illicit drug users.

Main objective:

Facilitate the adoption of HIV/AIDS risk reduction and health seeking behaviour in the context of sex work, men who have sex with men and drug use, and create a supportive environment to sustain prevention practices and norms among vulnerable populations in Beirut.

Specific objectives:

- 1- Increase awareness of HIV/AIDS risks and promote risk reduction practices among vulnerable populations.
- 2- Facilitate access to sexually transmitted diseases care and HIV counseling and testing for vulnerable populations.
- 3- Facilitate access to psychosocial support for vulnerable populations.
- 4- Propose policy measures aimed at reducing vulnerability of marginalized populations.

Key strategies:

- 1- undertake situation analysis on sex work and men who have sex with men.
- 2- develop interpersonal, group and other educational strategies for vulnerable populations.
- 3- identify and train resource persons (social workers, health educators and resource persons) in outreach.
- 4- initiate regular outreach for vulnerable population.
- 5- identify, train and support peer educators inreaching sex workers and clients.
- 6- establish drop-in services for vulnerable populations.
- 7- establish a referral network to health, counseling and social services for vulnerable populations.
- 8- initiate collaboration with different gate-keepers to facilitate reach of vulnerable populations (bar-hotel managers, police, etc.)
- 9- propose policy changes in the area of sex work.