Interventions and Program Implementation: Current Models, Realities and Some Future Needs

Track F Summary Final Report
Presented on 12 July 2002
XIV International AIDS Conference, Barcelona, Spain

Mary O'Grady, Laelia Gilborn, C.Y. Gopinath, Marta Madina, Joanne Manchester and Nkosikhulhule Nyembezi

Good morning. I am honored to be standing here this morning, and I feel the strength and enduring courage of many, many other people who are here with us: the 40 million people living with HIV in the world today. [1] Watching over us here also are the more than 20 million people who have died from AIDS over the last 21 years. [2]

As the representative of my team of Track F rapporteurs, including Laelia Gilborn of the United States, C.Y. Gopinath of Kenya (via India), Marta Madina of Spain, Joanne Manchester of Ireland and Nkosikhulhule Nyembezi of South Africa, I will highlight a number of excellent interventions being implemented in the world today providing hope—and illustrating greater knowledge and deeper commitment for effective action in 2002 and beyond on HIV and AIDS.

We all know much, much more needs to be done. We all recognize the urgency of designing and implementing a holistic, comprehensive and integrated response to the global HIV/AIDS crisis. [3] The co-chairs of this conference, Drs. Jordi Casabona and Josep Maria Gatell, provided the vision through the Barcelona framework to enable us to think more broadly about cutting through the exponential spread of this pandemic in new ways, using a new paradigm to reflect the urgency of the need as never before. [4] They deserve our thanks. And, I would like to thank all the Track F committee members, presenters and especially our track co-chairs.

It is now up to us to use what we have learned here to design new interventions, building on 21 years of scientific and programmatic knowledge, and through effective program implementation, seize the opportunity to foster greater collaboration across all sectors and among all segments of society: families, communities, municipalities, nations, faith-based groups, transnational bodies, and indeed the private sector.

An outstanding example of one initiative announced at this conference is the government of Brazil´s offer to transfer at no cost to other countries the technology needed to manufacture antiretroviral medications. [5] Brazil has served as the global model of national leadership in designing and implementing HIV treatment interventions on a national scale. [6] Now with its offer of South-South transfer of the tools and medications to extend the lives of many thousands of people living with HIV in Latin America, [7] it exemplifies the type of supranational partnership essential in our world today to extend

intervention services, whether they center on prevention, treatment or care, to all the individuals, families and communities who need them urgently, whether they know it or not. [8]

The Haiti model described yesterday, community-based STD/HIV prevention and care strategy involving directly observed therapy short-course (DOTS) for tuberculosis (TB) and highly active antiretroviral therapy (HAART) for HIV, by Dr. Paul Farmer, shows us that HIV therapy can be effectively administered in impoverished countries. It shows us how the visionary leadership of one individual, in partnership with local communities and with international support, has the ability to transform our thinking, planning paradigms and even our world.

That this multidimensional intervention was delivered amidst other concurrent health problems, extreme poverty, unemployment, and a lack of food, housing and clean water proves we have the ability to replicate this type of effort as widely as possible starting in 2002. If assuring an uninterrupted drug supply, managing scarce resources, and integrating the benefits of local traditional healers in tandem with multisectoral local and international partners could be done in Haiti, it can be done anywhere. [9]

Yesterday, a program model was presented for scaling up the response to HIV/AIDS in resource-constrained countries in Africa, based on building upon the existing health infrastructure in Zimbabwe. By taking a tool-based systems approach, necessitating leadership, guidelines, lab systems, information systems, training systems, monitoring and evaluation systems, other logistical support and substantial technical assistance and commitment, local staff were trained and the general health infrastructure was strengthened in this country, [10] currently undergoing serious economic, political and human rights challenges. This model, too, can be replicated elsewhere starting *now* in 2002.

An issue arising throughout the conference, albeit not a new one, was access. Access to condoms [11], access to medications [12], access to poverty alleviation [13], access to basic human rights [12, 13, 14], access to defending legal rights [15]. Access to the interventions that can help prevent millions of new HIV infections [16], save the lives of millions living with HIV and AIDS [17], and access by millions of children to the nurturing, supportive and life-saving environments that sound community-based interventions can create to help them learn to lead happy and productive lives. [18]

An example of a landmark legal intervention in South Africa, highlighted at this conference, involved litigation against the government by a cadre of NGOs, a university-based law clinic and local legal scholars to demand government provision of nevirapine to pregnant women to prevent mother-to-child transmission of HIV. The country´s Constitutional Court decided only last Friday that the government must implement this intervention, showing that courts also can play an important role in strengthening the response of communities, societies and nations to the HIV epidemic. [19]

Another pilot program focusing on the prevention of mother to child transmission (PMTCT) of HIV in eight countries, announced at this conference, aims to provide lifelong care and treatment to more than 10,000 women, children and their other family members. Two lessons arising from this new program include the need to design interventions based on the local conditions of *each* setting and to provide training, information and counseling to enable clients to make their own choices and act upon them. [20] According to one project presenter, "Seemingly small improvements in the efficiency of programs can translate into lives saved." [21]

Clearly, many different types of interventions can foster community support for addressing community needs. [22] Another community-based intervention in Cape Town, South Africa, involves a mentorship program for HIV-infected pregnant women. HIV-infected women in the community who have recently delivered babies return to the antenatal clinic as mentors to educate, counsel and support other HIV-infected women. In this way, these women are empowered by their peers to participate in decision-making on their mode of delivery, the use of treatment to reduce HIV transmission, and on feeding methods. [23]

Given the skyrocketing HIV infection rates in Eastern Europe over the last several years, particularly among injecting drug users (IDUs) [1], harm reduction has become an urgent prevention intervention. [24] Brazil provided a comprehensive harm reduction model at this conference, documenting a 26 percent reduction in IDU HIV incidence. [25]

Successful harm reduction projects contain the following traits: they are collaborative and comprehensive involving the community, local authorities, police, lawmakers and policy makers. They decriminalize drug use. They include safe syringe access, and in New York City, pharmacies have been enlisted to increase access, allowing up to ten syringes without a prescription in a single transaction. [26] They foster multiple aspects of harm reduction, and in Geneva, Switzerland, a safe injection room allows six users at a time the protection of a safe and secure setting. [27] An innovative NGO in Australia, partly government-funded and run by drug users for drug users, is involved in a variety of different types of interventions, including capacity building, and supported by policy advocacy on the national level. [28]

An intervention area we hope will receive greater coverage at the Bangkok AIDS conference in 2004 is behavior change interventions. [29, 30, 16] Some programs have involved young people in designing their own behavior change messages. A community program in Zimbabwe funded by a local business fostered such an excellent HIV prevention program led by young people, they found their parents respected them more because of it which, in turn, increased their self-esteem and decreased their interest in practicing high-risk behaviors. [22] Anti-AIDS clubs in Zambia have trained young people to perform home-based care. [31] And, for many years, school-based programs, such as those in Brazil currently showing 70 percent national coverage of institutions, as well as out-of-school programs for youth, have been shown to be effective. [5]

One of the most timely findings presented at this conference on a project at four sites in India showed an increased availability in HIV care leads to higher demand for both prevention and care services. Moreover, expanded care and support services on the community level results in more program implementation and utilization of prevention methods by key populations. [32]

To an increasing number of us, given the pandemic´s growth worldwide over the last several years, a paradigm shift is truly needed; not only in convincing the rich countries to spread the wealth around more to achieve greater development equity, but to help prevent further spread of HIV and to save more lives. [33, 8, 13, 17] This can be exemplified in what Mexico has done internally in partnership with civil society, NGOs, bilateral agencies, the women´s movement, working with mobile populations and other extremely vulnerable groups, addressing stigma and discrimination issues, strengthening government programs, providing home-based care, providing antiretroviral therapy since 1992, and last year successfully lobbying for a significant increase in the ART budget nationally. [34]

According to one U.S. policymaker during his recent trip to Africa, we should be taking care of "the here and now." [35] The moral imperative, increasingly being recognized, to treat all people living with HIV and AIDS who need treatment should be enough to stand on its own. However, providing treatment also offers hope and support for prevention [16]: it fosters a social norm that we care about each other, that this is not just a women´s epidemic; in short, that we can and we must take care of each other simply because we are all fellow human beings.

It is our hope that two years from now in Bangkok many more multifaceted interventions will capture the attention of conference delegates. We hope to hear more about microbicide interventions [36], male circumcision interventions [37], vaccines to prevent viral replication [38], pre- and post-exposure prophylaxis as a prevention method [16], and, effective state-of-the-art mobile populations programs [39, 40].

We hope each of you has renewed your commitment, feeling enabled, empowered, embraced and rejuvenated through the shared energies and all the activities of the past several days. We hope when we all measure Barcelona for impact, the resounding message will be, "Yes, I can; yes, you can; and, collectively, we will." Thank you.

References

1. Schwartlander B: The HIV epidemic: what is it doing? where is it going? plenary session, XIV International AIDS Conference, Barcelona, 8 July 2002.
2. UNAIDS: *Report on the global HIV/AIDS epidemic*, July 2002, p.22.
3. Orobaton N: Mitigating TB and HIV, Tuberculosis & HIV bridging session, XIV International AIDS Conference, Barcelona, 9 July 2002.
4. XIV International AIDS Conference: *XIV International AIDS Conference Final Program,* Barcelona, July 2002, p.10.

5. Teixeira PR: Program implementation and scaling up: barriers and successes, plenary session, XIV International AIDS Conference, Barcelona, 11 July 2002.
6. Santos CE, Vitoria MAA, Lima JN: Building up an AIDS care services network in Brazil, oral session, XIV International AIDS Conference, Barcelona, 11 July 2002, abstract ThOrF1514.
7. Synergy Project/USAID: Lessons learned in Latin America and the Caribbean, satellite session, XIV International AIDS Conference, Barcelona, 9 July 2002.
8. Saag M: HIV/AIDS treatment and care in the new century, plenary session, XIV International AIDS Conference, Barcelona, 10 July 2002.
9. Farmer P: Introducing ARVs in resource-poor settings: expected and unexpected challenges and consequences, plenary session, XIV International AIDS Conference, Barcelona, 11 July 2002.
10. St. Louis ME, Mugurungi O, Fussell M, Mayes R, Dhlakama D, McCray E: A programmatic model for scaling up the response to HIV/AIDS in highly affected countries in Africa, oral session, XIV International AIDS conference, 11 July 2002, abstract ThOrG1470.
11. Lopes VS and Doneda D: Coordination of health and education services in STD/AIDS prevention, oral session, XIV International AIDS Conference, 8 July 2002, abstract MoOrF1117.
12. Achmat Z: Treatment access as a human right, plenary session video, XIV International AIDS Conference, Barcelona, 10 July 2002
13. Fernandez I: The global battle cry against AIDS—health is a right not a commodity, Jonathan Mann Memorial Lecture, plenary session, XIV International AIDS Conference, Barcelona, 8 July 2002.
14. Chirila O, Petrea S, Cotoanta V and Voicu I: The opportunity of disclosure and the process of telling to HIV children and adolescents, oral session, XIV International AIDS Conference, 10 July 2002, abstract WeOrF 1326.
15. Solomon S: Empowerment of women in HIV prevention, plenary session, XIV International AIDS Conference, Barcelona, 9 July 2002.
16. Gayle H: Prevention now! A vision for the future, plenary session, XIV International AIDS Conference, Barcelona, 9 July 2002.
17. Fauci AS: Immunopathogenic mechanisms of HIV disease, plenary session, XIV International AIDS Conference, Barcelona, 10 July 2002.
18. Ponnet MGA and Ounjit N: How can you give hope to HIV-positive children in resource-poor settings? oral session, XIV International AIDS Conference, Barcelona, 10 July 2002, abstract WeOrF1329.
19. Heywood MJ: Litigating AIDS: background, strategies and outcomes of the Treatment Action Campaign's (TAC) case to prevent mother to child HIV transmission in South Africa, Toward a Political Economy of Access symposium session, XIV International AIDS Conference, Barcelona, abstract ThOrE1425.
20. El-Sadr W: Mother to child transmission, MTCT Room for Solutions bridging session, XIV International AIDS Conference, Barcelona, 10 July 2002, abstract WeOr194.
21. Stringer J: Effective strategies in resource-constrained settings, MTCT Room for Solutions bridging session, XIV International AIDS Conference, Barcelona, 10 July 2002, abstract WeOr193.

22. Serima E and Mandiki M: Going beyond the workplace: responses to HIV/AIDS by businesses – The ZAPSO experience, poster presentation, XIV International AIDS Conference, 8 July 2002, abstract MoPpF2034.
23. Besser MJ: Mothers-to-mothers-to-be: peer counseling, education and support for women in pregnancy in Cape Town, South Africa, oral session, XIV International AIDS Conference, Barcelona, 8 July 2002, abstract MoOrF1031.
24. Malinowska-Sempruch K: From concern to action: addressing HIV and drug use, plenary session, XIV International AIDS Conference, Barcelona, 9 July 2002.
25. Gandolfi D: Harm reduction policy implemented by the Brazilian AIDS Programme, Ministry of Health, oral session, XIV International AIDS Conference, Barcelona, 9 July 2002, abstract TuOrF1162.
26. Birkhead GS, Klein SJ, Candelas AR, Plavin HA and Narcisse-Pean M: New York State's expanded syringe access program (ESAP): a statewide intervention to prevent HIV/AIDS, oral session, XIV International AIDS Conference, Barcelona, 9 July 2002, abstract TuOrF1165.
27. Berthet C, Mani C and Hubner F: The first injection room in Geneva: a long marathon ending in a real partnership among different public actors, oral session, XIV International AIDS Conference, Barcelona, 9 July 2002, abstract TuOrF1167.
28. Madden A: Policy discussion around drug use, Private Lives, Public Policy symposium session, XIV International AIDS Conference, Barcelona, 10 July 2002, WeOrG218.
29. Laibuta A, Rachier C, Marum E, Gikundi E, Ouko J, Njoka G, Shitekha E and Balmer D: Youth friendly voluntary counseling and testing in Kenya, oral session, XIV International AIDS Conference, Barcelona, 8 July 2002, abstract MoOrF1118.
30. Garcia Bernal R, Negrete V, Romero A and Rosas NE: Behavioral interventions for STD/AIDS risk reduction among populations affected by armed conflict in Colombia, oral session, XIV AIDS Conference, 11 July 2002, abstract ThOrF1474.
31. Esu-Williams E, Chomba M, Chambeshi-Moyo M and Motsepe J: Involving young people in the care of PLHA: bridging the gap in community care, oral session, XIV International AIDS Conference, Barcelona, 9 July 2002, abstract TuOrF1252.
32. Castle CJ, Solomon S, Swarnalakshmi S, Thomas S, Priya S and Costello-Daly C: Strengthening HIV/AIDS care and support also improves prevention services, oral session, XIV International AIDS Conference, Barcelona, 10 July 2002, abstract WeOrF1362.
33. Cameron B: Science, implications, epidemiological modeling, Prevention and Treatment: Star-Crossed Lovers? bridging session, XIV International AIDS Conference, Barcelona, 10 July 2002, WeOr204.
34. Uribe P: Improving effectiveness of prevention, treatment and care programmes through partnerships with government organizations, Programs to Improve Prevention, Treatment and Care in Latin America and the Spanish-speaking Caribbean symposium session, XIV International AIDS Conference, Barcelona, 9 July 2002, abstract TuOrF183.

35. Blustein P: Mothers with AIDS move O'Neill to back money for treatment, *The Washington Post*, 25 May 2002.
36. Mantell JE, Myers BL and Ramjee G: Improving the assessment of microbicide acceptability, oral session, XIV International AIDS Conference, Barcelona, abstract ThOrF1463.
37. Hayes R, et al.: Conclusions and synthesis, What is the Role of STD Control in HIV Prevention? A Synthesis of Data from the Mwanza, Rakai and Masaka Intervention Trials symposium session, XIV International AIDS Conference, Barcelona, 8 July 2002.
38. Corey L: HIV prevention vaccines: science and politics, plenary session, XIV International AIDS Conference, Barcelona, 9 July 2002.
39. Green KE, Chum C, Moth SK, Suon BH and Ma SS: Home care along the Cambodian-Thai border: challenges and successes in delivering quality care to mobile people living with HIV and AIDS, oral session, XIV International AIDS Conference, Barcelona, 9 July 2002, abstract TuOrF1255.
40. Hammett TM, Des Jarlais DC, Liu W, Ngu D and Son N: A cross-border HIV prevention intervention for injection drug users (IDUs) in Ning Ming County (Guangxi Province), China, and Lang Son Province, Vietnam, oral session, XIV International AIDS Conference, Barcelona, 11 July 2002, abstract ThOrF1475.